State Health Reform Assistance Network
Charting the Road to Coverage

RESEARCH BRIEF
This brief, issued April 2012, updates an earlier brief published in August 2011to reflect the final rules.

Analysis of HHS Final Rules On Reinsurance, Risk Corridors And Risk Adjustment

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INTRODUCTION & OVERVIEW

On March 16, 2012, the U.S. Department of Health and Human Services (HHS) issued final rules, titled "Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment." The rules implement standards for these programs for states and health insurance issuers ('issuers'). By compensating issuers for the risks related to the individuals they enroll, these provisions are designed to lessen the financial risk issuers and state health benefit exchanges (exchanges) will face under the Patient Protection and Affordable Care Act (ACA). This will mitigate the impact of adverse selection and encourage issuers to compete based on cost and quality, rather than attracting the healthiest, lowest-cost enrollees. Thus, these provisions are critical to the successful implementation of the ACA's coverage expansion provisions.

This paper summarizes the final rules, highlights the changes from the proposed rules of July 11, 2011, and provides our perspective on the implications. It is intended for policymakers and state officials familiar with the complexities underlying these issues. As with any papers produced shortly after regulations are released, the comments in this paper may become out-of-date as regulations are revised, clarifications are issued, and as the authors continue to discuss the issues and implications of these complex new rules. We encourage you to contact the authors directly for updates and further discussion on any of these topics. The opinions expressed in this paper are those of the authors, not of the Robert Wood Johnson Foundation or others at Wakely Consulting Group.

While a number of important details are outstanding and some critical questions still remain, our opinion is that the final rules are logical and provide a good structure for these important programs. They allow states flexibility while still providing federal support. The programs provide significant financial protections which are necessary given the market and financial uncertainties created under the ACA. A critical issue for policymakers is the aggressive timeline required for implementation of these programs; a substantial amount of analysis and interaction with key stakeholders needs to be performed in a short period of time. In addition, even with good data, states, health insurance carriers, providers and members will face uncertainty.

ABOUT THE PROGRAM
State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit *www.statenetwork.org*.

ABOUT WAKELY CONSULTING GROUP
Wakely Consulting Group is an actuarial and healthcare consulting firm specializing in government healthcare programs including state and federal reform, Medicaid and Medicare Advantage.

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CHANGES FROM PROPOSED RULES

The final rules include a long list of clarifications and changes. The most significant items addressed in the final rules are as follows:

Reinsurance

1. At a state's discretion, HHS will administer reinsurance, even if the state is operating the exchange. The proposed rules required states operating an exchange to also administer reinsurance.
2. The assessment to issuers (including Third Party Administrators [TPAs]) on behalf of group health plans) will be on a per capita basis rather than a percentage of premium as stated in the proposed rules.
3. States may not elect to collect contributions for self-insured plans and group health plans. For all states, HHS will collect reinsurance contributions from self-insured plans and TPAs on behalf of group health plans.
4. States may elect to collect reinsurance contributions from fully insured plans or choose to have HHS collect reinsurance contributions from fully insured plans.
5. All covered services will be eligible for reinsurance recoveries, not just Essential Health Benefits (EHB).

Risk Adjustment

1. HHS will use a distributed approach in states that have a federal exchange or where states opt to have HHS administer the risk adjustment program. Under a distributed approach in states where HHS administers the risk adjustment program, health plans calculate member level risk scores and submit those scores to HHS. Health plans would not submit detailed, line by line claims data to HHS. Where states elect to administer the risk adjustment program, they can choose to collect detailed data or collect individual level risk scores.
2. Even where states elect to administer risk adjustment and use a state alternative approach, they will have to use the national approach (to be determined by HHS) to applying premiums to the risk adjustment results and calculating payments and charges.
3. Risk adjustment results must be completed by June 30th in the year following the benefit year. Therefore, the federal Minimum Loss Ratio deadline will likely need to be adjusted (timing issues are acknowledged in the preamble of the final rules).

Risk Corridors

1. The target is equal to earned premium less actual administrative costs with a 20 percent limit. The preamble to the final rules indicates that guidance will be forthcoming allowing profit to be included in administrative costs (still subject to the overall 20 percent limit).
2. The risk corridor program will be applied to Qualified Health Plans (QHPs) that are offered outside of the exchange if substantially similar to a QHP offered inside the exchange.
3. Risk adjustment payments and charge, and reinsurance recoveries will be adjustments to allowable medical expenses rather than premiums as indicated in the proposed rules.
4. The final rules, especially the preamble, refer to the Minimum Loss Ratio (MLR) rules in a number of different places. Therefore, when in doubt, follow the MLR rules.

The following table shows which market segments each program affects and the administrative responsibility for each program:

Table 1
Program Applicability by Market and Administration

	Sold within Exchange		Sold Outside Exchange			Who Administers	
ACA Provision	**Individual**	**Small Group**	**Individual**	**Small Group**	**Grandfathered**	**State Run Exchange**	**Federal Run Exchange**
Risk Adjustment	Yes	Yes	Yes	Yes	No	State or HHS[1]	HHS
Reinsurance (Payments)[3]	Yes	No	Yes	No	No	State or HHS[1]	State or HHS[1]
Risk Corridor	Yes	Yes	No[2]	No[2]	No	HHS	HHS

[1]State can decide to administer or allow HHS to administer. If HHS administers, all parameters will be federal.

[2]Risk Corridors will apply to QHPs offered outside of the Exchange if they are substantially similar to a QHP offered inside the Exchange.

[3]All markets contribute to reinsurance, but the payments only apply to the individual market.

Each of these programs is funded differently. Since risk adjustment is expected to be budget neutral, no funding is needed although administrative funding will be required for states that decide to administer the program. While reinsurance only benefits the individual market, the entire insurance market, including self-funded plans, contributes to the funding on a per capita basis. The CBO assumed that the risk corridor program would be budget neutral but the ultimate outcome may result in funding deficits or surpluses. There is no mention of how the risk corridor program will be funded if the amount that HHS must pay to insurers exceeds the amount HHS receives from insurers.

The final rules address a number of questions that states, health insurance carriers, providers and other stakeholders had when contemplating how to implement the ACA. The most important questions and the answers provided in the final rules and accompanying narrative are addressed below:

RISK ADJUSTMENT – KEY QUESTIONS & ANSWERS

1. Will each state have to administer their risk adjustment program or will risk adjustment be a federal program? Answer: The final rule allows States that are certified to operate an exchange the option to implement risk adjustment. If a State is not certified to operate an exchange, it may not operate a risk adjustment program and HHS will do so on its behalf. States can develop state-specific risk adjustment models and/or weights, but these need to be filed in advance for certification by HHS.
2. Will the federal data collection model be a distributed model or a centralized model where carriers send in detailed encounter data and states or HHS calculates results? Answer: HHS will employ a distributed model in states where they run the risk adjustment program and is considering various ways to execute this which could also involve HHS running software to calculate individual and plan average software. States will have discretion as part of the choice of the model and methodology to change this basic approach. Therefore, some states may collect detailed data, while others may use a distributed approach.
3. What data will be used (likely possibilities include demographic information, medical diagnoses codes [ICD-9s], pharmacy codes [NDCs] and income level)? Answer: The final rules specifically state that a number of different approaches could receive Federal certification without providing information on what data elements the federal model will use, although the final rule cites specific data collection standards around privacy and security. The preamble states that HHS is planning a number of working sessions with issuers and states in advance of the release of the federal model and parameters. Hopefully these sessions will provide further guidance on the Federal model and parameters.

4. Will states and HHS implement auditing procedures? Answer: Yes. The intent of the regulations is that these audits would be budget neutral across carriers.

REINSURANCE – KEY QUESTIONS & ANSWERS

1. Assessments of the entire insurance market will pay for the reinsurance program. How will these assessments be calculated? Exactly who will be assessed? Answer: Under the final rules, the national assessment amount will be determined on a per capita basis and will total $10 billion in 2014, and the same per capita amount will be assessed on issuers. States have the option of increasing the issuer assessment to increase the amount available for administrative expenses or to increase the reinsurance coverage, but may not decrease the assessment.
2. Will the reinsurance provision be based on specific medical conditions with a general (not member specific) reimbursement amount assigned to each condition, or will it follow typical stop loss reinsurance provisions with the reimbursement to the insurance carrier depending on actual expenditures for that specific person? Answer: The reinsurance provision will follow typical stop loss reinsurance provisions based on actual expenditures. However, unlike typical stop loss reinsurance, the attachment point will be relatively low compared to commercial reinsurance and allowable amounts will be capped at a commercial stop loss reinsurance amount (subject to available funds). Therefore, this protection will not be for the highest cost individuals, but for a disproportionate share of 'higher' cost individuals. States have the option to change the attachment point, coinsurance rate and cap amount (including eliminating the cap) compared to the federal parameters.

RISK CORRIDOR – KEY QUESTIONS & ANSWERS

Any surprises in the risk corridor rules? Answer: Not really—the risk corridor rules are pretty straightforward and do not contain any major surprises. HHS will provide pro-rata, plan specific payments or assessments if QHP results are more than 3 percent different than target. From 3 percent to 8 percent, HHS will assume 50 percent of favorable or unfavorable results and above 8 percent, HHS will assume 80 percent of favorable or unfavorable results. The target will be equal to earned premium less actual administrative expenses, with allowable administrative expenses capped at 20 percent. The preamble states that HHS intends to propose in the HHS notice of benefit and payment parameters that profit be included in allowable administrative expenses. The risk corridor program will apply to QHPs, including those offered outside the exchange if they are similar to those offered within the exchange. Finally, the risk corridor program will apply at the benefit plan level, which is the most detailed level at which the program could logically be applied.

RISK ADJUSTMENT DETAILS

The risk adjustment program under the ACA is a permanent program that will begin in 2014. The risk adjustment program is intended to protect health plans operating in the individual and small group markets both inside the exchange and outside of the exchange from attracting a higher than average health risk after consideration of the allowable rating variables (age limited to 3:1, family size / composition, tobacco use and geographic area). Like reinsurance, states that establish a state-based exchange do not have to administer the risk adjustment program. They can either administer the program or outsource this function to HHS. HHS will administer the risk adjustment program if the state does not establish a state-based exchange.

The state can have the risk adjustment functions performed by the exchange or another eligible entity. Per the regulations, in addition to the state Medicaid agency, an eligible entity is one that:

1. Is incorporated in at least one state;
2. Has experience in the individual and small group markets and in benefits coverage; and
3. Is not or does not act as a health insurance issuer.

HHS will develop a federal model that it will use when it is administering risk adjustment on a state's behalf. Also, states can use this model to administer the state's risk adjustment program if they choose. Alternatively, states can file their own model or use a model for which any other state has filed and received approval. The final rules require that the state provide comprehensive information on the structure, performance and suitability of the model and methodology for determining average actuarial risk.

If a state decides to develop its own model or adjust the federal weights, any recalibration of the model is subject to HHS approval and the recalibration must be performed at least as frequently as specified in the state's request for alternate methodology certification.

State models must meet criteria based on principles that guided the creation of the hierarchical condition categories (HCC) model used in Medicare Advantage risk adjustment, including:

1. Accurately explains cost variation;
2. Chooses risk factors that are clinically meaningful to providers;
3. Encourages favorable behavior and discourages unfavorable behavior;
4. Uses data that are complete, high quality and available in a timely fashion;
5. Is easy for stakeholders to understand and implement;
6. Provides stable risk scores over time and across plans; and
7. Minimizes administrative burden.

HHS is requiring risk adjustment activity reports in the year after the benefit year showing various information. Guidance will be forthcoming, but the preamble suggests that the type of information required may include average actuarial risk for each plan, the charges and payments, trends in risk scores, evidence of upcoding, and additional information. While not stated in the final rules, additional information might include prevalence reports showing the drivers behind differences in the results across issuers. We would expect HHS to develop a standardized report, allowing states the ability to include additional information. The report structure would need to be able to accommodate state-specific risk adjustment methods and models.

Applying Risk Adjustment Results

The proposed rules included a discussion of important actuarial pricing issues regarding integrating risk adjustment results with allowable rating variables under the ACA. Carrier strategies with respect to setting their rating variables (or the state requiring carriers to use standardized rating variables) make this a complex topic. Based on the proposed rules, the authors believed that states would be able to modify the methodology for taking the average actuarial risk by plan and calculating payments and charges. However, the final rules require states that file a state alternative methodology to use the national approach to calculating payments and charges. Therefore, states can only modify the model and methodology used to calculate the plan average actuarial risk. The preamble to the final rules indicates that HHS may allow states to use a modified approach for calculating payments and charges at a future date, but will not allow this in 2014. The final rules and other guidance do not indicate what the national approach will be for calculating payments and charges.

Author's Note: Because the final rules do not explicitly address possible approaches to calculating payments and charges, we have retained discussion of the approaches discussed in the preamble of the proposed rules within this paper in the following section.

The preamble to the proposed rules identified two possibilities for the calculation of premium rates to be used in the application of risk adjustment results:

1. Calculating a statewide normalized premium by taking actual premiums and adjusting them to a 100 percent actuarial value, and then applying the actuarial value of each specific plan to that statewide normalized premium (CCIIOs whitepaper on risk adjustment including several options within this first basic approach); or
2. Using actual premiums.

Approach one is intended to protect efficient health plans since it uses statewide premiums adjusted for differences in benefits only. This approach actually protects efficient health plans as compared to Approach two if they attract members with higher than average morbidity (i.e., sicker). It disadvantages them if they attract members with lower than average morbidity (i.e., healthier) since their payouts will be based on a higher average premium than their actual premium.

The discussion of these issues assumes the risk pool will be the entire state, which would prohibit states from calculating the standard risk by geographic area. This approach will cause area factors to reflect differences outside of risk, and cause a larger impact to premiums by area than would otherwise occur. For example, assume pre-ACA and risk adjustment, that premium rates in Chicago were higher than in Southern Illinois because individuals in Chicago were less healthy (and only because Chicagoans are less healthy). Under a statewide risk pool where premiums are based on the average statewide risk, ultimate risk adjusted revenue would not change but premium rates in Chicago will decrease and premium rates in Southern Illinois will increase.

Presumably, the federal approach could perform normalization calculations before calculating payments and charges. However, if it does not, then a final reconciliation would need to take place. In those instances, if payments are greater than charges, HHS has identified three possible methods in the preamble of the proposed rules without an indication in the final rules as to which approach the federal methodology would use:

1. Decrease plan payments on prorated basis to equal plan charges;
2. Increase plan charges on prorated basis to equal plan payments; or
3. Split the shortfall and prorating in both directions.

If charges are greater than payments, HHS identified two possible methods in the preamble of the proposed rules without an indication as to which approach the federal methodology would use:

1. Reduce gross plan charges on a prorated basis; or
2. Put excess plan charges in a reserve account for future use (risk adjustment only presumably).

RETROSPECTIVE OR PROSPECTIVE?

Will the federal model use 2014 data to develop risk adjustment results for 2014 (typically described as a retrospective approach or model), or will data prior to 2014 be used (prospective approach or model)? This is one of the key questions and the final rules do not explicitly answer it. The comment and response section included in the preamble to the final rules states that HHS does not intend to curtail the use of a prospective risk adjustment model. This likely indicates that the federal model will be retrospective and that HHS would allow a state to use a prospective approach if the right conditions existed. A prospective approach could be developed in the few states that already have an all payer claims database (APCD), know quite a bit about their uninsured (or have a very low uninsured rate), and already mandate coverage of fairly comprehensive benefits. However, a prospective approach would require a leap of faith concerning the previously uninsured and inherently would not be able to capture potentially meaningful differences in the health status of previously uninsured across health plans. Further, a prospective approach would require the use of data prior to 2014 which would mean that health plans submitting data would need to be well aware of the payment implications of data submitted in 2012 and 2013. These hurdles are significant and we expect the federal model to be retrospective for 2014 and probably 2015. Further, we would expect states that wanted to use a prospective approach to be required to provide significant proof to HHS that such an approach accomplishes HHS' stated objectives for risk adjustment.

Data Collection

The final rules state that HHS has selected a distributed approach where HHS will be administering the risk adjustment program on behalf of a state. Under this approach, issuers will run a risk adjustment model on their detailed data and submit member level results to HHS. HHS will not collect detailed claim data from the issuers. This decision is logical given the challenges associated with collecting detailed data and the limited time available to implement the programs. Because detailed data will not be reviewed by a central authority, data issues may not be discovered if issuers, HHS, and states do not implement careful review and validation procedures. The risk adjustment software program that issuers will run should, and likely will, have a reporting component that will provide the issuer, HHS, and states with metrics on the number of diagnoses by each type of claim (e.g., inpatient, outpatient, physician), average diagnoses per claimant, proportion of covered members with a claim, and others. In addition, rather than just calculating risk scores by member, the model should report detail on the condition categories flagged for each member, like HHS currently does under the Medicare Advantage risk adjustment system (CMS Model Output Report or MOR file).

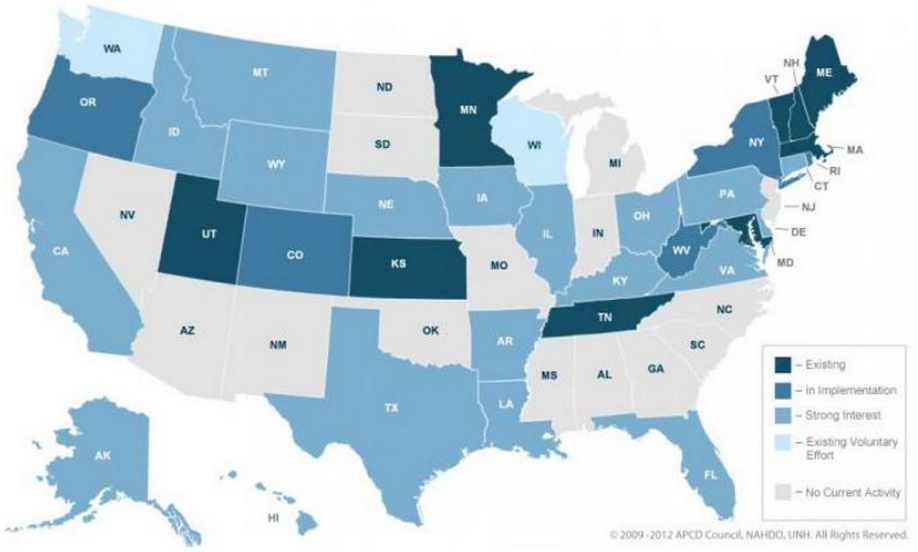
The final rules allow states the flexibility to use a distributed approach or collect detailed data where the state has elected to administer the risk adjustment program.

The preamble to the final rules discusses privacy concerns extensively because of a significant number of comments that were received by HHS in response to the proposed rules which indicated detailed claims data would be collected.

Presumably, these comments and concerns around privacy, and the limited time available to develop data collection procedures caused HHS to change direction and decide on a distributed approach. If a state collects detailed data, they may only collect enough information as is reasonably required to run the risk adjustment program. However, if a state already has an APCD and state regulations currently allow or could be modified to allow use of the APCD in risk adjustment, our understanding is that this would be acceptable.

The following chart shows the status of APCD efforts by state as of March 2012.

Chart – Status of APCD Efforts as of March 2012[1]



We have reviewed documentation or loaded actual data in states with existing APCDs and identified significant limitation with respect to using the APCDs for risk adjustment calculations. In some cases, these limitations are systemic (e.g. missing a critical field) or legislative (legislation does not allow use for risk adjustment). In most states (and maybe all states), there are limitations in data quality that are a result of the data not having been used for risk adjustment and issuers not having their financial results at risk because of data quality. In these states, like in those without an APCD, risk adjustment simulations in advance of 2014 will be critical.

Risk Adjustment Auditing

The final rules require that the state or HHS on behalf of the state (if HHS is operating risk adjustment) must audit data used in the risk adjustment process. The state or HHS on behalf of the state may (but appears are not required to) adjust plan average actuarial risk based on these audits. An appeals process must be provided. All plans must be audited, regardless of their size. The data validation procedures must be published in the state notice of benefit and payment parameters.

[1] Source: http://apcdcouncil.org/state/map

A similar program in Medicare Advantage has created considerable controversy because the error rates are used on an absolute basis, rather than being compared to the error rate in the fee for service Medicare program on which the risk adjustment model is calibrated. Unlike in the Medicare Advantage program, the rules indicate that the standard risk in the state would be adjusted for the results of the Risk Adjustment Data Validation (RADV) audits. Therefore, if each and every plan in the state had a two percent error rate, the standard risk in the state would be adjusted downward by two percent and risk adjustment results across plans would not change because the error rates were uniform.

This approach appears fair, but creates some logistical issues. All plans would need to be audited over the same time period for this process to result in an equitable adjustment. State resources to perform these audits will therefore be strained. The language used in the final rules indicates some potential flexibility regarding adjustments to revenue that will be made based on data validation audits.

Related to auditing, the proposed rules allow health plans to contract with providers to ensure that necessary risk adjustment data are received. This allowance is important since it permits health plans and providers to work together, and have formal financial arrangements to ensure all relevant data are being submitted.

REINSURANCE DETAILS

The reinsurance program under the ACA is a temporary program that will primarily operate from 2014 through 2016. However, HHS allows for possibility that all funds may not be used by the end of 2016, and requires all assessments collected from 2014 through 2016 to be used by the end of 2018. The reinsurance program is intended to protect issuers operating in the individual market from specific high-cost individuals. States can either run the reinsurance program or have HHS administer the program on their behalf. Unlike risk adjustment, states that do not operate an exchange may still elect to operate the reinsurance program or elect to have HHS operate the program.

States can contract with or establish a non-profit reinsurance administrator. The final rules include guidance that allows states to establish contracts with multiple reinsurance administrators, but requires their geographic coverage areas to be distinct and, in aggregate, cover the entire individual market. Subcontracting some administrative functions by the reinsurance entity is allowed, subject to review by the state (not HHS) to ensure the contracts are appropriate.

Table 2 below shows the nationwide contribution requirements published in the law. These amounts represent minimum funding for the reinsurance program and general U.S. Treasury funding. States may individually choose to increase the reinsurance funding for their state.

Table 2
Nationwide Contribution Requirements (in billions)

Program	2014	2015	2016
Reinsurance	$10	$6	$4
U.S. Treasury	$2	$2	$1

We have developed preliminary estimates of the assessment for reinsurance and the net impact to individual market premiums in Table 3 below. We have assumed 8.5 percent annual trend from 2014 to 2016.[2] The range of amounts listed are national estimates, are inherently uncertain[3], and may vary significantly by state based on the market composition.

[2] This is important since premiums will likely increase between 2014 and 2016, which decreases the calculated contribution rate.

[3] Issues including the size of the individual and group markets, premium trend, enrollment, and other issues make the estimate of the reinsurance assessment and effect on individual premiums uncertain.

Table 3
Reinsurance and Premium Impact Estimates
Higher and Lower Estimate Scenarios of Individual Market Enrollment (National)

Description	Higher Estimate of Individual Market Enrollment			Lower Estimate of Individual Market Enrollment		
	2014	2015	2016	2014	2015	2016
Net Assessment (Reinsurance Only—Not Treasury Contribution)	1.2%	0.6%	0.4%	1.2%	0.7%	0.4%
Net Impact to Individual Market Premiums (US)	-7.4%	-3.5%	-2.0%	-11.4%	-5.2%	-2.7%

HHS will publish the actual minimum contribution rate in the advance notice in October 2012 (see Table 4 for complete schedule). States can increase this rate depending on a number of factors:

1. In that state, the size of the individual market (including previously uninsured joining the market) relative to the entire market will drive the level of coverage afforded by the national minimum assessment rate. The larger the individual market as a proportion of the total market, the lower the assessments available for reinsurance as compared to potential coverage.
2. The relative health of enrollees in the individual market post reform may suggest that some states with a relatively sick population will increase the HHS rate to provide the same level of coverage all else being equal.
3. Finally, states may increase assessments to cover administrative costs not already allowed by the assessment for operation of the reinsurance entity or to increase the coverage.

Sample Reinsurance Calculation

Reinsurance Parameters	State or Federal Reinsurance	Traditional Reinsurance
Attachment Point (paid claims threshold where reinsurance begins)	$50,000	$200,000
Coinsurance Rate (percent between attachment point and cap for which reinsurer is liable)	80%	85%
Reinsurance Cap (claims in excess of the cap are not eligible for reinsurance)	$150,000	$2,000,000

Example

Insurer Initial Paid Claim Amount = $500,000

Net Insurer Liability* = $50,000 + 20% x (150,000 - 50,000) + (200,000 - 150,000) + 15% x (500,000 - 200,000) = $165,000
State or Federal Reinsurance Payment* = 80% x (150,000 - 50,000) = $80,000
Traditional Reinsurance Payment = 85% x (500,000 - 200,000) = $255,000

* Note that the State/Federal Payments may be prorated down for all insurers if the total payments exceed the available funds

HHS will publish the attachment point, coinsurance rate and reinsurance cap each year. All covered services will be eligible for reinsurance recoveries, not just Essential Health Benefits (EHB). States may modify these values[4], but must publish the modifications in a state notice by March 1 in the year before the effective date as outlined in the Timing of Reinsurance and Risk Adjustment section below.

[4] States cannot modify the structure of the reinsurance formula: For example, to re-adjudicate claims at a percentage of Medicare prior to applying the formula, or to make fixed payments for certain medical conditions.

States or HHS on behalf of the state are responsible for collecting data to administer the program and for making sure that payments do not exceed contributions.[5] Payments may be reduced on a pro-rata basis if, in the absence of such reduction, payments would exceed contributions.

States may coordinate the state high risk pool with the reinsurance program as long as it conforms to the other provisions of the proposed rules.

In the preamble, additional points are made:

1. If contributions exceed payments, states may retain those funds as surplus/stabilization funds or pay out the amounts on pro-rata basis (effectively increasing the coinsurance rate). However, the excess must be used for the reinsurance program.
2. States can adjust the attachment point, coinsurance rate and reinsurance cap to manage the amount of payments from year-to-year (e.g., if collections in one year exceed payments, the state can increase coverage offered through the pool to increase payments in the next year).
3. States can alter reinsurance parameters to adjust the way payments are distributed across the three year period (e.g., to more heavily weight payments in the first year relative to the federal payment schedule).

TIMING OF REINSURANCE AND RISK ADJUSTMENT

The rules discuss the timing of the process for releasing benefit and payment parameters and for states to file proposed changes to those parameters. The following table shows the timing of the notice for 2014 through 2016. Future years will follow this pattern.

Table 4
Annual HHS Notice of Benefit and Payment Parameters (2014 through 2016)

Annual HHS Notice	2014	2015	2016
HHS Publishes Draft Advance Notice	Mid Oct 2012	Mid Oct 2013	Mid Oct 2014
Comment Period Ends	Mid Nov 2012	Mid Nov 2013	Mid Nov 2014
HHS Publishes Final Notice	Mid Jan 2013	Mid Jan 2014	Mid Jan 2015

If states plan to modify federal parameters, they would need to issue a notice no later than March 1 in the year before the effective date (e.g., March 1, 2013 for 2014). If the state does not issue a notice by the deadline, then the federal parameters would automatically go into effect.

If states plan to file an alternate risk adjustment model, the rules require that they do so within 30 days of HHS' draft annual notice (e.g., November 2012 for 2014). HHS would commit to reviewing and notifying states within 60 days, at the time of publication of the Final Notice (see Table 4 above), whether such model was approved. After approval, any state could use the model. Updates to models would follow the same process and timing.

The state and federal notices will include a full description of the risk adjustment model, including demographic factors, diagnostic factors, utilization factors (if any), the mapping logic to the risk group (i.e., which ICD-9 codes map to which condition categories), the weights for each category, required data, and timelines for data submission and factor determination.

[5] Final rules do not state that reinsurance contributions cannot exceed payments.

Risk adjustment calculations would need to be completed by June 30 in the year following the benefit year (e.g., June 30, 2015 for 2014). Reinsurance calculations and transfers would occur throughout the benefit year and the timing can presumably be state specific, but is required to be published in the state notice of benefit and payment parameters.

The risk adjustment program will affect premium rates, potentially significantly for any given issuer. Because of the relative nature of risk adjustment, issuers cannot analyze only their own data to estimate the impact of risk adjustment. Risk adjustment simulations in 2012 and early 2013 and/or access to supplemental market-wide datasets will be critical to inform health plan pricing. Because simulations will need to take place prior to 2014, states and health plan associations will need to drive any simulations even in states where HHS will be administering the risk adjustment program in 2014 and beyond. HHS may be able to assist in the organization and distribution of supplemental datasets on the currently uninsured population, standard insured population, and provide other relevant data to simulations. Many states do not have an existing or a soon to be available APCD and therefore cannot leverage those data in running simulations. In states without an existing APCD, a simulation using a distributed model may be the only feasible approach. And while a distributed model presents significant concerns when actual funds are affected starting in 2014, it is a reasonable alternative and may be the only possibility for simulation purposes in many states. A distributed model approach will require cooperation by health insurance issuers, which would seem prudent given the stakes.

RISK CORRIDOR DETAILS

A federally-administered risk corridor program will limit the gains and losses of a Qualified Health Plan (QHP) operating in the exchange as well as any plans substantially similar to an exchange QHP that are also offered outside of the exchange. This program will be in place for three years (2014-2016) and is intended to stabilize the market by sharing risk at a time when implementation of reform will make accurate rate setting challenging.

The risk corridor mechanism compares the total allowable medical costs for each QHP (excluding non-medical or administrative costs) to those projected or targeted by the QHP. If the actual allowable costs are less than 97 percent of the QHP's target amount, a percentage of these savings will be remitted to HHS (limiting gain). Similarly if the actual allowable cost is more than 103 percent of the QHP's target amount, a percentage of the difference will be paid back to the QHP (limiting loss). The QHP's target amount is defined as the plan's total premiums incurred less allowable administrative costs. Allowable costs are defined as the QHP's actual total paid medical costs, excluding allowable administrative costs, in providing the QHP's covered benefits.

The following table shows the percentages that are applied based on the comparison of a QHP's target amount and allowable costs.

Table 5
Risk Corridor Parameters

Allowable/Target	Action	Amount Paid
Greater than 108%	HHS pays QHP	2.5% of Target + 80% of amount in excess of 108%
103% to 108%	HHS pays QHP	50% of amount in excess of 103%
97% to 103%	No action	No payment transfer
92% to 97%	QHP pays HHS	50% of difference between 97% of target and allowable cost
Less than 92%	QHP pays HHS	2.5% of Target + 80% of difference between 92% of target and allowable cost

The allowable costs are based on incurred claims adjusted for direct or indirect remuneration (i.e., drug rebates), quality improvement (QI), health information technology (HIT), risk adjustment, reinsurance, and cost sharing reductions received from HHS. The target amount is based on earned premiums, including any premiums received on behalf of covered members such as premium tax credits, less allowable administrative costs. Allowable administrative costs include actual costs plus any profit, capped at 20 percent. Federal and state taxes, as well as licensing and regulatory fees, can also be included in administrative expenses but are not part of the 20 percent cap.

The following table shows an example of a risk corridor payment calculation.

Table 6
Risk Corridor Example

Example: Allowable / Target less than 92%	
QHP Target	$10 million
QHP Allowable Cost	$8.8 million
Allowable/Target	88%
92% of Target	92% x $10m = $9.2 million
92% of Target - Allowable Cost	$9.2m - $8.8m = $400,000
QHP pays 2.5% of Target	2.5% x $10m = $250k
+ QHP pays 80% of difference	80% x $400k = $320k
QHP total payment to HHS	$570k
Revised Allowable / Target	($8.80m + $0.57m) / $10m = 93.7%

While HHS has not set forth any deadlines at this time, timeframes being considered include making payments within 30 days of receiving a notice from HHS (and HHS would make payments in a similar timeframe after HHS determines that a payment is owed to the QHP). The risk corridor calculations will be performed after risk adjustment and reinsurance adjustments are determined.

WHAT DO STATES NEED TO DO?

1. For both risk adjustment and reinsurance, develop a plan for which agency or organization will administer necessary functions.
2. Reinsurance—Model the funds available under various assessment rates and attachment point, coinsurance and cap options given those various assessment rates. States do not want to be in a position where funds from the assessments are insufficient to cover the stated coverage levels. The previously uninsured population and uncertainties surrounding this population will create significant uncertainty with these estimates.
3. Risk Adjustment—Key issues that states need to decide upon include:
    a. Use the federal model or file a state model?
    b. If the federal model is used, should the state or HHS administer it?
    c. How should the risk adjustment audit process function, including who will perform the audits and what the schedule and level of adjustments for payment transfers should be?
4. All Programs—States should create a stakeholder workgroup. The work plan should identify necessary steps, stakeholder feedback checkpoints and timelines. States should first meet internally to structure the stakeholder workgroup role and decide which decisions should be retained by the state versus delegated to the workgroup for recommendations. Potential workgroup members include individuals from the state exchange, department of insurance, health plans and providers.

WHAT DO HEALTH PLANS NEED TO DO?

1. Discuss forming a workgroup in your state to identify the best approach for risk adjustment and reinsurance methods and processes, including simulations in advance of 2014. Timing will be critical and risk adjustment simulations will need to be run well in advance of the summer of 2013, when premium rates will need to be developed and filed.
2. Review coding practices and provider agreements to make sure you will not be disadvantaged when risk adjustment is implemented.
3. Work with valuation actuaries and financial reporting teams to identify issues and timing with respect to reinsurance, risk adjustment and risk corridors.
4. Work with the department of insurance to ensure compliance.

OUTSTANDING ISSUES

1. Will the federal risk adjustment model be retrospective, prospective or will it offer both options? Initial indications are retrospective, but significant uncertainty exists.
2. Does HHS intend for risk adjustment calculations to be statewide, thereby adjusting current geographic differences in premium?
3. Will HHS meet with issuers in states where they are administering the risk adjustment system? How will issuer questions be answered and will any information be provided to assist them in developing premium rates?
4. Is income being considered as part of the federal risk adjustment model? Including it as an optional variable as part of the core federal model, with state- specific calibration, would offer states flexibility to address a particular concern with adverse selection in the exchange. The actuarial profession is working to provide HHS with available studies on this issue.
5. Will states be allowed to assess carriers to pay for the risk adjustment code audits and, more broadly, for the risk adjustment approach? This would align incentives for efficiencies since the risk adjustment program transfers funds across health insurance companies.

FINANCIAL STATEMENT ISSUES FOR HEALTH PLANS

Valuation actuaries are also going to be affected by the ACA. The reinsurance, risk adjustment and risk corridor programs will create new actuarial assets and liabilities for health plans. These amounts may not be known until well after the year ends. The reinsurance and risk adjustment program results will depend not only on the health plan results, about which each health plan will know something, but also on the results for other health plans in the market. Since risk corridor results will depend on reinsurance and risk adjustment results, they will also be uncertain. Health plans, states (exchanges), departments of insurance and HHS will need to work closely together to develop appropriate timelines, methods, standards and flexibility in dealing with these important issues. Current Medicare Advantage Part D reinsurance and risk corridor financial statement rules will provide a useful frame of reference. For these programs, developing interim reporting will be critical in informing year end estimates. The actuarial profession is considering forming a workgroup with the accounting profession to stay in front of these important issues.

OPERATIONAL IMPACT ON STATES

The regulations contemplate a significant role for states in the administration of both the reinsurance and risk adjustment programs. These functions can be run by the exchange or by another entity within the state. While funding for the reinsurance program can be included in the assessment from carriers, meaning no additional state or federal funding will be required to manage the program, the risk adjustment program, similar to other ACA responsibilities such as granting exemptions to the individual responsibility requirement, will create a state expenditure requiring a funding source. Some of the operational and cost considerations of this program are outlined below.

Of the two programs, the reinsurance program is less operationally complex. The role of the state in administering the pool will primarily be a fiduciary one of funds collection, management and disbursement, which will require an initial and ongoing emphasis on the development of policies and processes to ensure sound financial stewardship. Critical functions to manage this program include the establishment and periodic modification of reinsurance parameters; assessment collections and cash management; claims intake (summary level) and payment; analysis and reporting; and claims audit. These functions can be performed by the state or by an entity or entities contracted by the state, and can also be subcontracted. Funding for the administration of the reinsurance program can be included in the assessment on carriers, so no additional state or federal funding is required for the operation of the reinsurance pool.

Risk adjustment represents a more comprehensive commitment from the state. States choosing to develop and administer this program will need to develop the data collection and storage capabilities required to intake, securely store and analyze carrier claims and enrollment data, including the acquisition of data warehousing hardware and software, along with a dedicated staff to manage, analyze and report on this information. Other key cost components will be software licensing fees for the risk adjustment tool selected by the state and developing the IT infrastructure and connectivity required to interface with carriers for the acquisition of risk adjustment output as well as product rating and premium information. The calculation process itself will require the development of normalized risk scores at the individual product and carrier level, and then translating these scores into payment and recoupment amounts. A portion of these activities (namely, the acquisition and analysis of carrier claims data and software licensing) will need to be performed prior to the state's decision regarding whether or not to rely on the federal model or to self-administer the risk adjustment program.

The total cost of managing this program will vary considerably depending on several factors:

1. Existing resources the state can rely upon, such as an existing APCD. The ability to leverage an existing data infrastructure will significantly reduce the cost to the state, although a distributed approach to data collection eliminates the need to handle detailed data.
2. Existing familiarity with risk adjustment models in other state programs such as Medicaid Managed Care.
3. The level of state-specificity that states choose to pursue, including whether they wish to develop both their own model or rely on the federal model as is or with minor changes (i.e., recalibration).
4. The size of the insurance market and the number and variety of carriers and products sold in the state. Risk adjustment will be far more complex and time-consuming for states with more than 10 licensed carriers than for states with fewer carriers.

One approach to funding is to place the administration of the risk and reinsurance programs in the state exchange, and use establishment grant funding to design, develop and build the required infrastructure. Ongoing costs, which should be modest relative to the start-up of the program, can be included in the exchange assessment. For states that use risk adjustment in their Medicaid Managed Care program, further efficiencies and cost offsets can be achieved by leveraging the newly developed exchange function to calculate and administer the Medicaid Managed Care risk program (or vice versa).

CONCLUSION

The final rules thoughtfully address many of the key issues associated with the risk adjustment, reinsurance and risk corridor programs. Important details will not be released until the HHS Advance Notice of Benefit and Payment Parameters is released in October 2012. As discussed in this paper, these programs will have a significant impact on premiums and the health insurance marketplace. HHS, states, and health plans have a lot of work to do over the next several years. Careful planning, in-depth analysis, and clear communication will be critical to the success of these programs and the new health insurance marketplace.