

# Reinsurance, Risk Corridors, and Risk Adjustment Final Rule

Center for Consumer Information and Insurance Oversight  
Centers for Medicare & Medicaid Services  
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# Background

- The Affordable Care Act establishes State-based reinsurance and risk adjustment programs, and a Federal risk corridors program.
- The overall goal of these programs is to provide certainty and protect against adverse selection in the market while stabilizing premiums in the individual and small group markets as market reforms and Exchange begin in 2014.
- This final rule establishes standards to ensure effective program implementation while providing significant State flexibility and imposing minimal burden on States and issuers.

# Overview

<b>Program:</b>	<b>Reinsurance</b>	<b>Risk Corridors</b>	<b>Risk Adjustment</b>
What:	Provides funding to issuers that incur high claims costs for enrollees	Limits issuer losses (and gains)	Transfers funds from lower risk plans to higher risk plans
Who Participates:	All issuers and third party administrators on behalf of group health plans contribute funding; non-grandfathered individual market plans (inside and outside the Exchange) are eligible for payments	Qualified health plans	Non-grandfathered individual and small group market plans, inside and outside the Exchange
When:	Throughout the year	After reinsurance and risk adjustment	Before June 30 of the calendar year following the benefit year
Time Frame:	3 years (2014-2016)	3 years (2014-2016)	Permanent

# Overview of Transitional Reinsurance Program

- Section 1341 of the Affordable Care Act provides that:
  - A transitional reinsurance program must be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016
  - All health insurance issuers and third party administrators on behalf of self-insured group health plans, must make contributions to support reinsurance payments that cover high-cost individuals in non-grandfathered plans in the individual market
- Reinsurance is a critical element in helping to ensure a stabilized individual market in the first years of Exchange operation.

# Overview of Transitional Reinsurance Program (cont.)

- States have the option to establish a reinsurance program, regardless of whether they establish an Exchange. If State elects not to establish a reinsurance program, HHS will establish program and will perform all reinsurance functions for that State.
- HHS will collect reinsurance contributions from self-insured plans, even if a State runs its own reinsurance program.
- States that establish a reinsurance program have the option to collect contributions from issuers in fully insured market or have **HHS** collect contributions from the fully insured market on behalf of the State.
- States operating their own reinsurance program must contract with a not-for-profit reinsurance entity to run its program



# Overview of Transitional Reinsurance Program: Contributions

- Contributions will be collected from all issuers and third party administrators on behalf of group health plans using a national per-capita rate announced in an annual **HHS** notice of benefit and payment parameters
- Reinsurance contributions will be allocated as defined under statute:
  - Reinsurance payments
    - \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016
  - U.S. Treasury
    - \$2 billion in years 2014 and 2015, and \$1 billion in 2016
  - Administrative expenses

# Overview of Transitional Reinsurance Program: Additional Contributions

- States may collect additional contributions for:
  - Reinsurance payments
    - These additional contributions must be collected by the State reinsurance entity
  - Administrative expenses
    - States may elect to have HHS collect these contributions or may have the State reinsurance entity collect them



# Overview of Reinsurance Program: Payments

- Reinsurance Payments:
  - Eligibility is based on total annual medical costs for covered benefits of an enrollee in an individual market plan
  - Payments will compensate a portion of those costs (coinsurance rate) incurred above an attachment point, subject to a cap announced in an annual **HHS** notice of benefit and payment parameters
    - States establishing a reinsurance program may modify the reinsurance rate, the attachment point, or the reinsurance cap

# Summary of Reinsurance Program

Reinsurance Activity	State Reinsurance Program	HHS (on behalf of State)
Collections		
Fully Insured	State or HHS	HHS
Self-Insured	HHS	HHS
Additional Administrative Fees	State or HHS	N/A
Additional Reinsurance Funds	State	N/A
Payments	State Pays Out All Funds	HHS Pays Out All Funds

# Overview of Temporary Risk Corridors Program

- Section 1342 of the Affordable Care Act directs HHS to establish a temporary risk corridors program during the years 2014 through 2016.
  - Applies to qualified health plans in the individual and small group markets
- Protects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between HHS and qualified health plans to help ensure stable health insurance premiums.
- Federal program under the statute

# Overview of Temporary Risk Corridors Program: The Methodology

- Relationship between plans' allowable costs (essentially, claims and quality improvement activities) and target amount (premiums earned less allowable administrative costs) determines risk corridors charges and payments
- Charges and payments are on percentage basis, not first dollar basis. If issuer's allowable costs are less than 97 percent of its target amount, it pays HHS a percentage of the difference
- If issuer's allowable costs are more than 103 percent of its target amount, HHS pays it a percentage of the difference
- Final rule aimed for consistency between MLR rule's rebate and risk corridors calculations.

# Overview of Risk Adjustment Program

- Section 1343 of the Affordable Care Act provides for a permanent risk adjustment program
  - Applies to non-grandfathered individual and small group plans inside and outside Exchanges
- Provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions)
- Transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection

# Overview of Risk Adjustment Program (cont.)

- States that operate a State-based Exchange are eligible to establish a risk adjustment program:
  - States operating a risk adjustment program may have an entity other than the Exchange perform this function
  - HHS will operate a risk adjustment program for each State that does not operate risk adjustment



# Overview of Risk Adjustment Program (cont.)

- HHS will develop, publish, take comment, and finalize a risk adjustment methodology for use when operating risk adjustment on behalf of a State
- A State operating risk adjustment may use the Federal methodology or propose alternate risk adjustment methodologies for certification by HHS
  - Any federally certified risk adjustment methodology can be used by a State operating risk adjustment

# Overview of Risk Adjustment Program: The Methodology

- The final rule defines a risk adjustment methodology as:
  - Risk Adjustment Model
  - Calculation of Plan Average Actuarial Risk
    - Includes removing rating variation for age, geography, smoking and family status
  - Calculation of Payments and Charges
  - Data collection approach
  - Schedule for implementation

# Overview of Risk Adjustment Program: Data Collection Approach

- States may adopt data collection approach that best suits their program's needs provided that they collect only information that is reasonably necessary for their risk adjustment methodology
- States must develop privacy and security standards, and must ensure annual validation of risk adjustment data
- HHS will use a distributed approach when operating risk adjustment on behalf of a State – data needed to operate risk adjustment will reside with the issuer

# Notices of Benefit and Payment Parameters

- HHS will publish a draft **HHS** notice of benefit and payment parameters in the Fall of 2012 for the benefit year 2014. There will be a 30 day comment period, and a final notice will be published in January 2013.
- State notices of benefit and payment parameters must be published by March 1, 2013:
  - State must publish a notice if it establishes a reinsurance program and plans to modify the Federal parameters, or if it plans to operate a risk adjustment program.
  - The notice must include: reinsurance program parameters, a description of the risk adjustment methodology (if different from the methodology used by HHS when operating risk adjustment on behalf of a State) and the risk adjustment data validation standards

# Next Steps

- Risk Adjustment Spring meeting
  - Technical Policy and Operational Issues
- Ongoing HHS Technical Support for States and Issuers
- Draft **HHS** payment notice in Fall 2012
- Final **HHS** payment notice in January 2013