State Health Reform Assistance Network
Charting the Road to Coverage

RESEARCH BRIEF
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Analysis of HHS Proposed Rules On Reinsurance, Risk Corridors And Risk Adjustment

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INTRODUCTION & OVERVIEW

On July 11, 2011, the U.S. Department of Health and Human Services (HHS) issued proposed rules, titled "Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment." The proposed 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 only 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 proposed rules 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with any papers produced shortly after proposed regulations are released, the comments in this paper may quickly become out-of-date as regulations are revised, clarifications are issued, and as the authors continue to discuss the issues and implications of these complex new rules.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 and issues are raised by these proposed rules, our opinion is that these rules are a large step in the right direction. 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.

For purposes of this paper, we do not refer to the rules as 'proposed' in each instance even though it is clear these are all proposed rules at this point. HHS is seeking comment and any of the rules may change based on the comments they receive. HHS has provided discussion and narrative preceding the proposed rules which we refer to as the preamble throughout this paper.

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	Yes	No	Yes	No	No	State	State or HHS[1]
Risk Corridor	Yes	Yes	No	No	No	HHS	HHS

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

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 percent of premium basis (or percent of medical costs for self-insured plans). To date, 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 proposed regulations 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 proposed regulations and accompanying narrative are addressed below (please remember—these are proposed rules, not final):

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: Under the proposed rules, each state can decide whether to do it themselves or let HHS administer the program. States can develop state-specific risk adjustment models and/or weights, but these need to be filed in advance for approval by HHS.
2. Will the federal model be a distributed model where carriers just send in results or a centralized model where carriers send in detailed encounter data and states or HHS calculates results (the distributed model seems to be favored by some insurance companies and insurance company associations)? Answer: Under the proposed rules, HHS would require a centralized model, where issuers would submit raw claims to the state or HHS acting on behalf of the state. States will not have discretion as part of the choice of the model and methodology to change this basic approach. Therefore, if states decide to develop their own model, it will be necessary to begin the planning and assessment of the program soon since as noted in the Timing of Reinsurance and Risk Adjustment section. It is recommended that these states file their model by November 2012.
3. What data will be used (likely possibilities include demographic information, medical diagnoses codes [ICD-9's], pharmacy codes [NDCs] and income level)? Answer: While not in proposed regulations, the preamble accompanying the release states that HHS intends to use demographic, medical diagnoses and pharmacy codes.
4. Will states and HHS implement auditing procedures like that in the Medicare Advantage program (called risk adjustment data validation [RADV] audits)? Answer: Yes, although the intent of the regulations is that these audits would be budget

neutral across carriers, which is not the case with RADV audits. In the ACA's risk adjustment audit program, error rates (or rates of unsubstantiated codes) will be judged relative to the rates of other carriers, not on an absolute basis.

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 proposed rules, a uniform percentage of premiums will be applied to all fully insured plans and all states (percentage of claims for self-funded employers). States have the option of increasing the assessment but may not decrease it.
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: Under the proposed rules, 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. 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 proposed rules? Answer: No—the risk corridor proposed rules are pretty straightforward and do not contain any surprises. HHS will provide pro-rata, aggregate reinsurance if health plan 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.

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). Unlike 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. Also different than reinsurance, 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
3. Is not or does not act as a health insurance issuer.

HHS will develop a federal model that states can use or HHS will use 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 proposed rules provide some minimum criteria for the model including performance similar to or better than the federal model.

If a state decides to develop its own model or adjust the federal weights, it needs to do so at least as often as the federal model is updated.

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

1. Accurately explaining cost variation;
2. Choosing risk factors that are clinically meaningful to providers;
3. Encouraging favorable behavior and discouraging unfavorable behavior;
4. Using data that is complete, high quality and available in a timely fashion;
5. Providing stable risk scores over time and across plans; and
6. Minimizing administrative burden.

HHS is requiring risk adjustment activity reports in the year after the benefit year showing average actuarial risk for each plan, the charges and payments, and likely additional information. While not stated in the proposed rules, likely information might include prevalence reports showing the drivers behind differences in the results and normalization factors. 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 include 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.

The preamble to the proposed rules identifies 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; 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.

The proposed rules assume that payments and charges will not be equal due to uncertainties in the parameters and 'standard risk'. This appears to be based on an assumption that transfers would occur according to fixed risk adjustment parameters rather than assuming the parameters themselves would be subjected to a normalization process. If the parameters themselves were subjected to this normalization process prior to payments and charges being calculated then, by definition, the results would be budget neutral.

Presumably, a state could perform this normalization before calculating payments and charges. However, if they do not and the federal approach 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 without an indication 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 has identified two possible methods 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).

Data Collection

It is somewhat unclear if states that establish a health insurance exchange must collect detailed claims encounter data, or if states can elect to have HHS collect the data. The proposed rules seem to indicate that states can have HHS collect data, but only if HHS provides all of the other risk adjustment functions. In other words, HHS will either perform all of the functions including data collection or none of the functions.

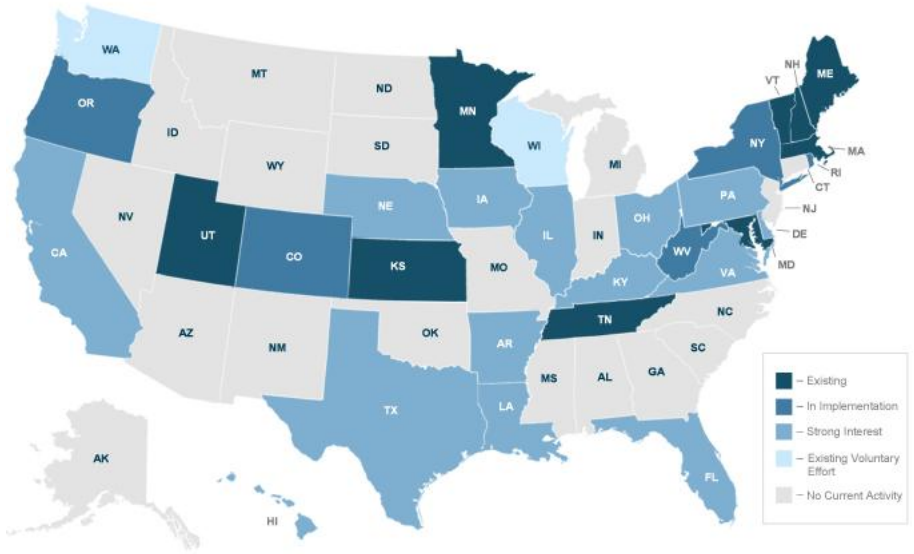
There are minimum standards governing collection of data. These include a standardized format for electronic transmission of all health care claims including enrollment and benefit information. Additionally, the state must ensure privacy of information by utilizing administrative, physical, and technical safeguards against unintended disclosure or use of individually identifiable information. Addressing these requirements will require significant resources.

States that have APCDs that are operational on or before January 1, 2013 are exempted from the minimum data collection standards described above. Eleven states have an APCD currently (two being voluntary systems not run by the state), with up to five states in the process of implementing one. The advantage of developing an APCD includes relatively lower administrative overhead as the state would not have to collect and conform to standards such as the National Council for Prescription Drug Programs (NCPDP) claim transaction or the HIPAA ASC X12N 837. These standards were developed for use within the context of an electronic data interchange (EDI) environment, and not all elements required by the standards are necessary for purposes of risk adjustment, reinsurance and risk corridor calculations.

RETROSPECTIVE OR PROSPECTIVE?

Will the federal model use 2014 data to develop risk adjustment results for 2014, or will data prior to 2014 be used? This is one of the key questions and the proposed rules do not explicitly answer it. The rules point strongly to a retrospective model with the example listed regarding claims run-out in the preamble ("For example, HHS may require that states complete risk adjustment activities by June 30 of the year following the benefit year"). However, this timing could also work under a prospective approach. 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.

Chart – Status of APCD Efforts as of July 11, 2011[1]



Risk Adjustment Auditing

The proposed rules require that the state or HHS on behalf of the state 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) extrapolate the results of the audit on a statistically valid sample to all risk adjustment covered plans offered by that issuer. An appeals process must be provided.

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 proposed rules indicate that the standard risk in the state would be adjusted for the results of the 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.

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 operate from 2014 through 2016. The reinsurance program is intended to protect health plans operating in the individual market from specific high-cost individuals. Unlike risk adjustment, states that establish a state-based exchange must administer the reinsurance program. They cannot outsource this

[1] Source: www.apcdcouncil.org/

function to HHS. States that do not operate an exchange may still operate the reinsurance program or allow HHS to operate the program.

States can contract with or establish a reinsurance administrator subject to certain standards. The proposed 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 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.

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 amounts listed are national estimates, are inherently uncertain[3], and may vary significantly by state based on the market composition.

Table 3
Reinsurance and Premium Impact Estimates (National)

Description	2014	2015	2016
Net Assessment (Reinsurance Only—Not Treasury Contribution)	1.2%	0.6%	0.4%
Net Impact to Individual Market Costs	-5.6%	-3.4%	-2.3%

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 for operation of the reinsurance entity. It is important to note that states may not use the federal assessment rate and then allocate some of those collections to administrative expenses. If the state wants to fund reinsurance administrative expenses, they must increase the assessment.

[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.

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. Only costs related to essential benefits are eligible to be reimbursed (detailed definitions are pending on what constitutes essential benefits). States may modify these values, but must publish the modifications in a state notice by early March in the year before the effective date as outlined in the Timing of Reinsurance and Risk Adjustment section. It appears that the proposed rules would not allow states to modify the structure of the formula.[4]

States 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).
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).

[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.

[5] Proposed rules do not say that reinsurance contributions cannot exceed payments.

TIMING OF REINSURANCE AND RISK ADJUSTMENT

The proposed 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 Federal Notice of Benefit and Payment Parameters (2014 through 2016)

Annual Federal Notice	2014	2015	2016
HHS Publishes 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, HHS proposes that they would need to issue a notice no later than early March in the year before the effective date (for example, in early March 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 propose that they do so by November two years prior to the benefit year (i.e., 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 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's map to which condition categories), the weights for each category, required data, and timelines for data submission and factor determination.

Timing for risk adjustment transfers is not included in the proposed rules (when plans that owe to the pool would pay, and when plans that are owed from the pool would receive payment).

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. 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 at best.

The risk corridor mechanism compares the total allowable medical costs for a 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

The allowable costs are reduced for any direct or indirect remuneration (e.g., drug price concessions, discounts, grants) or cost sharing reductions received from HHS. For the target amount, QHP issuers would be required to submit *adjusted* premium data to HHS. Reported premiums are adjusted for any risk adjustment or reinsurance payments including user fees paid.

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%

On the question of timing, 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). Since the timing of the program adjustments may run concurrently, QHPs may need to estimate the reinsurance they expect to receive when reporting risk corridor premium information.

If HHS sets the allowable target equal to the minimum loss ratio as may be reasonably expected, the risk corridor program essentially prevents health plans from excess losses (50percent or 80 percent protection depending on level of losses) while the minimum loss ratio program protects against excess profits (100 percent protection). This approach creates potentially unintended consequences, especially for health plans that have administrative loads below that required under the minimum loss ratio.

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. Develop an APCD in advance of federal requirements or wait for federal 'push'?
    d. 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 develop an APCD, and to identify the best approach for risk adjustment and reinsurance methods and processes. Timing will be critical and risk adjustment results 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. Work with the department of insurance to ensure compliance.

FINANCIAL STATEMENT ISSUES FOR HEALTH PLANS

Valuation actuaries will be necessary and important in addressing ACA implications. 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.

OUTSTANDING ISSUES

1. The proposed rules seem to indicate that the same federal assessment percentage, attachment point, coinsurance amount and cap amount will apply to all federally run exchanges (across states). Because each state will have a different proportion of business in their individual market and a different risk profile of members in the individual market, it seems necessary to have state-specific parameters that would be developed by HHS. As part of the federal notice, will HHS publish state-specific parameters?
2. Will the federal risk adjustment model be retrospective, prospective or will it offer both options?
3. Can states have HHS collect data while otherwise administering the risk adjustment function?
4. When will HHS require states to start collecting and testing data or, in states that elect to outsource the risk adjustment function, when will HHS start collecting and testing data?

5. Does HHS intend for risk adjustment calculations to be statewide, thereby adjusting current geographic differences in premium? Is there state flexibility in performing risk adjustment calculations by area?
6. Will HHS run simulated risk adjustment results in states where they are administering the risk adjustment program? If so, when will this work begin and when will it be completed?
7. Will HHS meet with carriers in states where they are administering the risk adjustment system? How will carrier questions be answered?
8. 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.
9. 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.
10. The target amount definition in the proposed rules indicates the 'target amount' is equal to premiums less allowable administrative expenses. Allowable administrative expenses would seem to be defined by health plans. Health plans will likely try to maximize these administrative expenses, subject to the Minimum Loss Ratio requirement. This would appear incentivize health plans to file premium rates using a target loss ratio equal to the minimum. Is HHS considering requirements that would prevent this approach or will the states need to address this issue?

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 from 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; claim 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 large volumes of 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 data 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.

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 and administrative methodology, rely on the federal methodology but reweight based on a state-specific population, or rely on the federal model and only implement a state-specific payment adjustment methodology.
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.

Funding for this program is not contemplated in the proposed regulations, and states have options with respect to a source of funding. One approach 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 cost, 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.

CONCLUSION

The proposed rules thoughtfully address many of the key issues associated with the risk adjustment, reinsurance and risk corridor programs although important details and decisions are still pending. 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 two years. Careful planning, in-depth analysis and clear communication are critical to the success of these programs and the new health insurance marketplace.

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.

ABOUT WAKELY CONSULTING GROUP
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