

Proposed Rules Related to Reinsurance, Risk Corridors, and Risk Adjustment
Released July 15, 2011

This document provides a summary of the Department of Health and Human Services (HHS) proposed rule (CMS-9975-P) to implement standards for reinsurance, risk corridors, and risk adjustment. Sections directly related to managed care pharmacy are highlighted in yellow. The proposed rule is available at: <http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/html/2011-17609.htm>

Comments on the proposed rule are due September 28, 2011.

This proposed rule would implement standards for states related to reinsurance and risk adjustment, and for health insurance issuers related to reinsurance, risk corridors, and risk adjustment. These programs are designed to mitigate the impact of potential adverse selection and to stabilize premiums in the individual and small group markets as insurance reforms and the exchanges are implemented, starting in 2014. The transitional state-based reinsurance program would make payments for high-cost cases in the individual market thereby reducing the uncertainty of insurance risk. The temporary Federally-administered risk corridor program serves to protect against the uncertainty in the exchange by limiting the extent of issuer losses (and gains). The state-based risk adjustment program is intended to provide adequate payments to health insurance issuers that attract high-risk populations. (page 41930)

Subpart B – State Notice of Insurance Benefits and Payment Parameters

A state operating an exchange, as well as a state establishing a reinsurance program, must issue an annual notice to describe the specific parameters that the state will employ if that state intends to use any reinsurance or risk adjustment parameters different from those specified the forthcoming annual Federal notice of benefit and payment parameters. (41932)

All health insurance issuers and third-party administrators, on behalf of self-insured plans, must make contributions to a not-for-profit reinsurance entity to support reinsurance payments to individual market issuers that cover high-cost individuals in grandfathered individual market health plans. (41933)

States operating an exchange must establish a reinsurance entity (or entities) or contract with an existing applicable reinsurance entity. States not operating their own exchange may operate their own reinsurance program. If a state does not operate their own exchange and does not determine to operate its own reinsurance program, HHS will establish the reinsurance program to perform all of the reinsurance functions for that state. This would include the collection of all contributions, including funds required to operate and administer the applicable exchange functions. (41934)

Transitional reinsurance program goals (41933):

- To offer protection to health insurance issuers against high-cost enrollees in the individual market, especially newly insured or those with previously excluded conditions, thereby allowing issuers to set lower premiums.
- To permit early and prompt payment of reinsurance funds during the benefit year to help offset the potential high costs of health insurance issuers early in the benefit year.

- Should require minimal administrative burden since it is a temporary program.

Two approaches were considered for the collection of reinsurance contribution funds: use of a national uniform contribution rate or use of a state-level allocation. The national approach is deemed a more simple approach and less ambiguous. Comments requested on state preference, the preferred method for calculating health insurance issuer contribution funds using a national rate, and regarding the most appropriate method and frequency to collect reinsurance contribution funds. (41935)

Comments requested regarding if reinsurance payments should only be for essential health benefits or to also include more generous coverage. (41935)

HHS proposes that identification of reinsurance-eligible individuals would be based on medical cost to the health insurance issuer for covered benefits. (41936)

HHS proposes that payments for costs incurred above the attachment point be employed. (41936)

Comments requested regarding most appropriate timeframe that an applicable reinsurance entity should make payments for reinsurance claims submitted. A standard deadline would allow for efficiency in payment processes, specifically the risk corridors program and the medical loss ratio reporting to support rebate calculations. (41937)

Comments requested regarding whether a high risk pool that continues operation after January 1, 2014 should be considered an individual market plan eligible for reinsurance under this provision. (41937)

Subpart D – State Standards Related to the Risk Adjustment Program

A program of risk adjustment for all non-grandfathered plans in the individual and small group market both inside and outside the exchange.

Criteria and methods to be established for states to determine actuarial risk. States operating an exchange, or HHS on behalf of states not operating an exchange, will assess charges to plans that experience lower than average actuarial risk and use them to make payments to plans that have higher than average actuarial risk.(41937)

States must assess risk adjustment charges and provide risk adjustment payments based on plan actuarial risk based on a state average. States establishing an exchange are eligible to establish a risk adjustment program. States should provide HHS with a summary report of risk adjustment activities for each benefit year in the year following the calendar year covered by the report. (41938)

HHS is to establish criteria and methods for risk adjustment in coordination with the states. HHS is to leverage existing processes of Medicare Part C and D, while recognizing there are differences in market demographics, in determining the methodologies. HHS requesting comment on proposed methodologies and to determine if there are alternative methods that may be considered. In addition, HHS will allow for states to employ alternate risk adjustment methodologies. (41938-9)

States are required to collect the data used in risk adjustment models. HIPAA transaction standards would apply. HHS also allows for the use of NCPDP claims transaction standard for prescription drug, claims and encounter data. HHS is requesting comments on whether HIPAA and NCPDP standards are enough or whether they should engage stakeholders to develop a new set of national standards for use in risk adjustment. HHS proposing that states with existing all payer claims databases may request an exception from the minimum standards for data collection.(41940-1)

States are required to have a reliable data validation process. (41941)

Subpart E – Health Insurance Issuer Standards Related to the Transitional Reinsurance Program

The elements of the program that relate specifically to the requirements for health insurance issuers and third party administrators on behalf of self-insured group health plans. (41942)

All contributing entities are to make contributions, in a frequency and manner to be determined by the state or HHS, to the applicable reinsurance entity in the state. Comments requested regarding data submission collections from contributing entities and on whether there are existing sources of this data that can be used. (41942)

The reinsurance-eligible plan issuers must submit a request for reinsurance payment to the applicable reinsurance entity. (41942)

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

The risk corridor program limits adverse selection and stabilizes markets as changes are implemented starting in 2014. Risk corridors create a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers. (41942)

HHS proposes to establish risk corridors by specifying risk percentages above and below the target amount. Risk corridors will apply to all QHPs offered in the exchange. The risk corridor thresholds are applied when a QHP's allowable costs reach plus or minus three percent of the target amount. HHS believes that prompt payment will be expected by QHP issuers that are owed these amounts and that payment deadlines should be the same for HHS and QHP issuers. (41943)

QHP issuers will be required to submit data needed to determine actual performance relative to their target amounts. HHS requests comments on the treatment of reinsurance and risk adjustment as after-the-fact adjustments to premium for purposes of determining risk corridor amounts.

Subpart G – Health Insurance Issuer Standards Related to the Risk Adjustment Program

Provision provides for a program of risk adjustment for all non-grandfathered plans in the individual and small group market both inside and outside of the exchange. The risk adjustment program employs a model to determine comparative actuarial risk of plans within a state. (41944)

The credibility of risk adjustment is important to making health insurance premiums in exchanges stable. A validation program is necessary. Risk adjusted plans issuers must provide the required validation documentation to HHS or the state to substantiate the risk adjustment data that they have submitted. (41944)