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Market Rules and Adverse Selection: A Background Paper

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Introduction

The Affordable Care Act (ACA) is intended to reshape and standardize the public and private health insurance markets through a series of national and state regulations and programs. A signature feature of the legislation is a system of Health Insurance Exchanges that will serve as a new entry point to the individual and small-group health insurance markets for individuals who do not otherwise have coverage. The ACA establishes national standards that constrain what insurers can do when administering health insurance offerings; for example, it prohibits medical underwriting, whereby individuals have been excluded for pre-existing conditions in the past. The ACA also provides a framework—through regulations that will be established by the Secretary of the U.S. Department of Health and Human Services (HHS)—that will shape how state Exchanges will function, including but not limited to a minimum essential benefit plan; rules that define the relationship between levels of coverage (e.g., bronze, silver, and gold) and require pricing of insurance policies within an Exchange on the basis of modified community rating; and guidelines for measures to moderate the potential adverse impact of selection effects across insurance plan options through reinsurance, risk corridors for profits and losses, and risk adjustment.

This paper provides some basic background on how the health insurance market as a whole may respond to the collection of regulatory and structural changes that are envisioned under the ACA. It focuses first on the nature of and implications for adverse selection effects—as a consequence of both health insurance carrier and individual health plan enrollee behavior—that may skew health plan enrollment, both inside an Exchange and between an Exchange and the local market outside an Exchange. The paper includes a brief description of the insurance market in Maryland to establish a sense of the scale of participation inside and outside Maryland's Exchange. This paper also introduces key components of ACA regulation that are intended to mitigate the financial risk for carriers operating within an Exchange in order to help provide a context for the collection of facets that Maryland will need to consider as its Exchange is established.

Sources of Market Distortion

Adverse selection is of particular concern in the development and administration of the Exchange system because of its potential to distort the insurance market as a whole, and to undermine the viability of Exchanges' operations in particular. It occurs whenever people make insurance purchasing decisions based on their own perceived need for health services (e.g., individuals with existing chronic conditions will tend to opt earlier for more comprehensive coverage than the young and/or healthy). Insurers use a variety of mechanisms to mitigate against adverse selection, including underwriting, pricing, and benefit design, as well as network characteristics (e.g., selective provider contracting) and administrative rules (e.g., ease or difficulty of access to providers and the claim experience for users). Insurers may also use these mechanisms to encourage the enrollment of individuals who are less likely to use covered benefits relative to the premiums for that coverage.

While general guidelines will be set nationally, states will have considerable flexibility in defining local rules that govern both how their Exchange will operate internally and the relationship between that internal operation and insurers and products that are available outside the Exchange. In the process of establishing its Exchange, for example, Maryland's Exchange Board—in concert with other policymakers such as the state Legislature and the Maryland Insurance Administration (MIA)—must identify the sources of adverse selection and consider what market rules are needed to mitigate its effects, including whether those rules should be the same inside and outside the Exchange.

Benefit Design

One of several key sources of adverse selection that should be considered in the development of an Exchange is direct competition among insurance carriers inside the Exchange. To encourage favorable selection, carriers might use riders for special services, deductibles, and other aspects of benefit design, as well as provider network design. Federal rules that establish an essential benefit package and a tiered structure within which carriers must offer coverage are intended to moderate this source of selection effects to some extent, but carriers will still have considerable flexibility to influence their own enrollment in the absence of specific state guidelines. Other federal rules require that Exchanges apply a variety of risk adjustment techniques to moderate remaining differences in financial risk associated with health service need within the tiered insurance offerings and across carriers. These rules will also serve primarily as guidelines that will require local consideration and adjustment in their application.

Market Selection Effects

Another area of concern is how benefit structure and network composition might be used by carriers to influence whether individuals select coverage inside or outside the Exchange. Carriers could, for example, try to attract individuals where that carrier might have some advantage using decisions about where to participate (e.g., Montgomery County versus the Eastern Shore), what to cover, how premiums are set, and so on. Skewed selection effects may result if particular carriers are allowed to provide competing benefit plans selectively inside and outside the Exchange. One consideration might be whether carriers that want to operate both inside and outside the Exchange should be required to offer the same plan in the same geographic area in both (Exchange and non-Exchange) markets. Further, if a carrier has such a set of plans (inside and outside the Exchange), should community rating requirements be applied using the combined covered population or can premiums for the separate plans be calculated independently? Separate premium calculations could exacerbate selection effects over time if higher-risk individuals tend to enroll inside or outside the Exchange.

Timing of Participation

One somewhat subtle area that should be considered in the process of establishing rules that constrain carrier behavior is related to the timing of a carrier's participation. As noted earlier, individuals with known health needs—and perhaps particularly those who have lower incomes and are eligible for federal subsidies—are more likely to select more coverage earlier that those with fewer needs. If these less-healthy individuals were to approach the Exchange first, it is conceivable that a carrier entering the market later than other carriers would have an advantage in the sense that earlier issuers in the Exchange enroll a less-healthy cohort of individuals. A related observation can be made regarding carriers that only operate outside the Exchange. That is, in the absence of mitigating rules, such as requirements to offer some level of coverage within the Exchange in order to operate at all in the state, a carrier could establish a high-deductible, low-premium product designed to attract relatively healthy individuals. In attracting (siphoning off) a relatively healthy mix of individuals, such a product could lead to a relatively less-healthy population being covered through the Exchange, resulting in relatively higher premiums associated with the Exchange.

Employer Behavior

Selection dynamics that are affected by employer behavior also need to be considered among the complex of new and existing factors that will shape the insurance market as Exchanges are established. Self-insured employers might alter benefits, copayments/coinsurance, premium contributions, and/or other factors in order to subtly encourage certain low-wage workers with high health-risk to select the individual market in the Exchange, thereby lowering the employer's insurance costs. Small employers may discontinue support for coverage—or in some instances forgo establishing coverage—for all employees based on the availability of the Exchange as an option.

Benefit Mandates

Aside from carrier and employer relationships, the Maryland Exchange Board, along with other stakeholders in the state, will also need to consider more specific coverage decisions. While formal guidelines for the essential benefit package have not yet been defined by HHS, each state will need to consider what, if any, additional benefits will be required of health plans that are qualified to operate within the Exchange. A report by Bunce and Wieske (2010) showed that Maryland has more than 60 separate mandates for health insurance plans—many of which may, in fact, be included in the essential benefit package that HHS defines. However, the state as a whole will need to consider whether to continue to mandate benefits that are not initially deemed essential. Federal regulations will require that the cost of any mandated benefits above those initially deemed essential be borne by the Exchange. In addition to considerations associated with the cost of those mandates, if the cost of such additional benefits are subsumed in the premium calculation used outside the Exchange, the differing treatment of those costs inside and

outside the Exchange may introduce another source of adverse selection bias as individuals with special needs associated with specific mandates consider where those needs might be met at the cheapest personal cost.

Once the market rules governing the relationship between insurance carriers and health benefit plans inside and outside the Exchange are determined, the Exchange Board will need to consider how best to coordinate the enforcement of those rules by the Exchange and the MIA. These factors also will guide the Exchange in determining purchasing strategies, such as how to offer and present qualified health plans to individuals who approach the Exchange.

The Existing Health Insurance Market in Maryland

Those who obtain health insurance coverage in Maryland do so through one of five products/sources: (1) employer/group insurance products, (2) individual insurance products, (3) Medicaid/Children's Health Insurance Program (CHIP), (4) Medicare, and (5) other public insurance programs. As shown in Table 1, the majority of the state is covered through employer/group insurance products (3,369,800 individuals, or 60 percent). More than half of that majority is covered under self-insured health plans which, as noted below in discussing the large-group market below, are not subject to state insurance laws or MIA oversight. Thirteen percent of Marylanders (730,700 individuals) are uninsured.

Table 1. Health Insurance Coverage of the Maryland Population, by Type (2008-2009)

Coverage Type	Number of Individuals	% of Total Population
Employer/Group	**3,352,080**	**60%**
▪ Self-Insured Group	1,990,880	36%
▪ Insured Group	1,360,000	24%
Individual	**212,000**	**4%**
▪ Non-Association Plan	160,000	3%
▪ Association Plan	34,000	<1%
▪ MHIP	18,000	<1%
Medicaid	**571,100**	**10%**
Medicare	**611,700**	**11%**
Other Public	**59,500**	**1%**
Uninsured	**730,700**	**13%**
Maryland Total	**5,586,800**	**99%***

* Percentages do not sum to 100% due to rounding effects.

Sources: Kaiser Family Foundation, 2009; Milligan, 2010.

The Small Group Market

The small group market includes groups ranging from 2 to 50 employees. Small group products are subject to Maryland insurance laws and MIA oversight. Policy forms and rates are subject to prior approval, and rates may not be inadequate, excessive, or unfairly discriminatory. In addition, the carrier must have a minimum 75 percent medical loss ratio. Although small group products are generally guaranteed issue in Maryland and must be offered using modified community rating based on average age and geography, since 2009, carriers have been permitted to exclude coverage of pre-existing conditions for new individuals who purchase a small group product. Also, since July 2010, carriers may adjust premiums based on health status for new groups entering the small group market. To promote affordability, small group products, which are based on the Comprehensive Standard Health Benefit Plan (CSHBP), are exempt from state-mandated benefits. Under the CSHBP, all insurance carriers must offer the same products to all small employers. The Maryland Health Care Commission (MHCC) is permitted to update and modify the CSHBP on an annual basis to ensure that the premium does not exceed 10 percent of the average wage in Maryland. Carriers are permitted to sell riders to add benefits or to reduce employee cost sharing. Approximately 410,000 individuals are covered through small group products (Milligan, 2010).

In 2007, Maryland created the Health Insurance Partnership. Under the Partnership, a small business that has 2 to 9 full-time employees, has not offered health insurance to its employees during the previous 12 months, and meets wage and salary requirements established by the MHCC, is eligible to receive a subsidy of up to 50% of the premium. The subsidy goes to both the employer and the employee. The federal tax credit for small employers, based on average wages, has a similar goal (Health Insurance Partnership, 2011). Currently, approximately 250 employers and 1,200 employees are participating in the Partnership (Maryland Health Insurance Plan [MHIP], 2010). Enrollment is capped to stay within the Partnership's approved annual budget.

The Large Group Market

Carrier-insured large group products—those serving 51 or more individuals—are subject to Maryland insurance laws and MIA oversight. Policy forms and rates are subject to prior approval; all state-mandated benefits must be provided; and rates may not be inadequate, excessive, or unfairly discriminatory. The large group market has no minimum loss ratio. As Milligan (2010) reported, approximately 950,000 individuals are covered through large group products. Although large-group coverage is not included during the initial few years of Exchange operations, groups that cover between 51 and 100 employees are slated to be included after 2016 in Maryland under federal rules that allow states to expand group eligibility once an Exchange is established.

Large employers and other qualified large groups may self-insure, meaning that the large group

itself bears the risk if claims exceed premiums collected. Self-insured large groups are not subject to state insurance laws or MIA oversight. Approximately twice as many people are covered by self-insured large groups as insured large groups (see Table 1).

The Individual Market

The individual market has three components:

1. **Association Plans.** An individual, as a member of an insured association, may obtain coverage through a plan offered by the association. Association plans are subject to the insurance laws and oversight of the issuing state, not Maryland. Association plans are medically underwritten and are often high-deductible products. Approximately 34,000 individuals are covered by an association membership plan (Milligan, 2010).
2. **Non-Association Plans.** Non-association plans are subject to state insurance laws and oversight by the MIA. Policy forms and rates are subject to prior approval, and the benefit package must include all state-mandated benefits. Rates may not be inadequate, excessive, or unfairly discriminatory, and the carrier must have a minimum 60 percent loss ratio. Non-association products are medically underwritten, and individuals purchase coverage directly from a carrier. Approximately 160,000 individuals are covered by non-association plans (Milligan, 2010).
3. **Maryland Health Insurance Plan.** MHIP is a state-managed health insurance program for Maryland residents who have been unable to obtain individual coverage from other sources due to pre-existing health conditions. These plans operate as an independent unit of the MIA and are administered by CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. MHIP offers its participants access to both CareFirst BlueChoice HMOs (health maintenance organizations) and CareFirst BluePreferred PPOs (preferred provider organizations), and MHIP premiums are slightly higher than the average individual premium in the non-association individual market described above (MHIP, n.d.b). The stricter the underwriting standards in other sectors of the individual market, the more individuals will turn to MHIP on the basis of being "uninsurable." MHIP is partly subsidized by a 1 percent assessment on hospital revenue totaling over $100 million annually. Over 18,000 individuals are enrolled in MHIP. The MHIP+ plan subsidizes premiums for individuals below 300 percent of the federal poverty level. The new federal high-risk pool was incorporated into MHIP on September 1, 2010, and the temporary MHIP Federal Plan is intended to serve as a bridge until comprehensive health care reforms take effect in 2014. The MHIP Federal Plan will remain in effect through the end of 2013, when it will be replaced by the exchange (MHIP, n.d.a).

A Preliminary Study

As part of the Maryland Health Benefit Exchange Act of 2011 that established Maryland's Exchange as a public corporation, the Exchange Board is required to study and make recommendations on several key issues, including the rules under which health benefit plans should be offered inside and outside the Exchange. As part of that charge, the Operating Model and Insurance Rules Advisory Committee established to support the Board is currently sponsoring a study of market rules and adverse selection to be conducted by an independent contractor on the Board's behalf. Specific rules that the Maryland Health Benefit Exchange Act requires the Exchange Board to study and make recommendations on include:

1. Whether any benefits should be required of qualified health plans beyond those mandated by the ACA and the Health Care and Education Reconciliation Act of 2010, and whether any such additional benefits should be required of health benefit plans offered outside the Exchange
2. Whether carriers offering health benefit plans outside the Exchange should be required to offer either all the same health benefit plans inside the Exchange or, alternatively, at least one health benefit plan inside the Exchange
3. Which provisions applicable to qualified health plans should be applicable to qualified dental plans

The type of factors that the study is likely to address in more detail—and specific to Maryland's insurance market—include but are not limited to:

- The sources for adverse selection for individuals, small groups, carriers, employers, health benefits plans, and limited dental benefits
- The impact of future federal guidance regarding the essential benefit package on adverse selection and enrollment, including existing benefits now mandated for coverage in the state
- Potential rate changes in the individual and small group markets, potential strategies that may result in attractive premiums for those separate markets for the first year of Exchange operation, and ways to sustain this over time
- Potential risk adjustment strategies; the need for modeling potential risk selection issues; the impact of reinsurance, risk corridors, and other risk adjustment methods; and current risk adjustment methodologies in use nationally and in Maryland
- How best to coordinate the MIA's role as regulator and the Exchange's role in selection and oversight of qualified health plans, as well as the options available for defining those roles to maximize coordination

This study is due to the Operating Model and Insurance Rules Advisory Committee in November. The Exchange Board will report to the Maryland Generally Assembly on these and related issues by December 23, 2011.

The Status of Related Federal Regulation

While federal regulations regarding some key issues (such as the essential benefit package) remain to be finalized, recent guidance does outline a basic framework to mitigate whatever residual adverse selection effects will remain once basic operating rules are established (HHS, 2011). That framework includes a combination of short-term measures that apply during the initial transition to Exchange operations in order to limit and share overall financial risk among carriers operating within the Exchange, as well as requirements for on-going risk adjustment of health program payments more broadly.

Reinsurance

Reinsurance is a mechanism that insurers often use to limit their own risk in some way. An insurer can reinsure selected incidences of risk (e.g., high insurance claim costs for individual cases) or a book of business (e.g., total claim costs for an insurance product), and associated costs above a defined threshold dollar amount may or may not be shared between the insurer and the reinsurer.

The reinsurance program established under the ACA will address individual high-cost cases in order to provide insurers with greater payment stability during the first three years of Exchange operations (2014-2016). It is intended to address the uncertainty of financial risk associated with not knowing the precise characteristics of the initial population that will obtain coverage through the Exchange. With this uncertainty comes special concern for the potential effects of assimilating the existing high-risk pool population, as well as the number of currently uninsured cases with high unmet needs that will be included in initial Exchange enrollment. That uncertainty is expected to abate as carriers learn more about, and can more accurately predict, their actual risk.

The reinsurance program will be operated by each state with an Exchange. All health insurance issuers and third-party administrators on behalf of self-insured group health plans will make contributions to a nonprofit entity designated by the state to support reinsurance payments to individual market issuers that cover high-cost enrollee claims. States are afforded considerable flexibility in determining the details of the program beyond that basic structure.

Risk Corridors

The risk corridor program is also conceived as a temporary way to share overall financial risk within the changing insurance market. However, in this case, the risk is defined relative to allowable costs at the health plan level, and that risk is shared between the federal government

and qualified health plans. Between 2014 and 2016, HHS will administer the program whereby qualified health plans with costs that are at least 3 percent less than their projected allowable costs will remit charges to HHS for a percentage of those savings; qualified health plans with costs greater than 3 percent of their projected allowable costs will receive payments from HHS to offset a percentage of those losses. This program is intended as a third-level mechanism once reinsurance and other local risk adjustment efforts have been made during the first years of the Exchange market. The states are not directly involved in the administration of this aspect of market reform, although both reinsurance and locally administered risk adjustment will affect the program indirectly as prior measures to affect adverse selection.

Risk Adjustment

Risk adjustment, as it is defined in the context of the ACA (and insurance applications more generally), is a process through which health plan payments are adjusted for the actuarial risk of providing services. These adjustments may be made prospectively, as they are under Medicaid in Maryland, where risk factors are assessed prior to a given payment period and payments are made based on expected costs. They may also be made retrospectively, where risk factor are identified during a given payment period and adjustment is made after that period based on actual service use. Health plan payments for non-grandfathered plans in the individual and small group markets within a given state—both inside and outside the Exchange—will be adjusted on a budget-neutral basis to account for actuarial risk differences. In other words, enrollment in covered plans will be treated as one statewide risk pool.

HHS is charged, in consultation with the states, to establish criteria and methods for states to determine the actuarial risk of their plans. HHS will define a baseline methodology that is analogous to the methods used under Medicare Advantage and Part D, whereby clinical information, such as diagnoses in combination with other socio-demographic factors, establishes the relative financial risk of individuals, even though states will be allowed to implement alternative methodologies that are certified by HHS. The federal risk adjustment methodology has not yet been formally defined. However, guidance governing what will be required of states that expect to propose a local alternative indicate that any method will include but not be limited to demographic factors, diagnostic factors, and utilization factors, if any. This suggests that all covered health plans will be required to report detailed data sufficient to implement this risk adjustment under any federally certified risk adjustment methodology. Although the ACA leaves open the question of whether risk assessment should be implemented at the federal, state, or even (self-reported) health plan level, the current guidance suggests that states should administer the application of risk adjustment because of their role in collecting and distributing the payments that will be required across plans.

An Appendix to this paper provides a more detailed description of the most recent proposed rules that address reinsurance, risk corridors, and risk adjustment. Areas for which HHS is still seeking comment are highlighted.

Summary

The charge and challenge for Maryland's Exchange Board will be to integrate competing local and federal interests and requirements to establish an Exchange that can support and sustain itself financially, including administrative procedures (e.g., reinsurance and risk adjustment) that moderate the risk of operating inside and outside the Exchange. That includes ensuring the availability of an insurance provider network that sufficiently meets the public and private health needs in the state, and doing so within a uniquely Maryland context.

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Appendix. HHS Proposed Rules on Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

The Departments of Health and Human Services (HHS), Labor, and the Treasury are working in close coordination to release guidelines related to Affordable Insurance Exchanges ("Exchanges") in several phases. Key elements of a basic framework to address adverse selection associated with the introduction Exchanges were published recently (45 CFR part 153, file code CMS-9975-P, Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Federal Register, Vol. 76, No. 136, July 15, 2011. The public comment period on these proposed rules ends on Wednesday, September 28, 2011 at 5pm EST.

Statutory Authority for Standards Proposed in 45 CFR part 153

The general statutory authority for standards proposed in 45 CFR part 153 are based on sections 1321, 1341, 1342, and 1343 of title I of the ACA. Each section is described below.

- ***Section 1321(a).*** This section provides broad authority for the HHS Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, reinsurance, risk adjustment, and other components of title I of the ACA.
- ***Section 1321(a)(2).*** This section requires, in issuing such regulations, the HHS Secretary to engage in stakeholder consultation in a way that ensures balanced representation among interested parties.
- ***Section 1321(c)(1).*** This section authorizes the HHS Secretary to establish Exchanges and implement reinsurance, risk adjustment and other components of title I of the ACA in states that have not done so.
- ***Section 1341.*** This section provides that each state must establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation (2014–2016). The reinsurance program will reduce the uncertainty of insurance risk in the individual market by making payments for high-cost cases. This program will attenuate individual market rate increases that might otherwise occur because of the immediate enrollment of individuals with unknown health status, potentially including, at the state's discretion, those currently in state high risk pools.
- ***Section 1342.*** This section provides that the HHS Secretary must establish a temporary risk corridor program that will apply to the qualified health plans (QHPs) in the individual and small group markets for the first three years of Exchange operation (2014–2016). The risk corridor program, which is a federally administered program, will protect against uncertainty in setting rates in the Exchange by limiting the extent of issuer losses (and gains). Under the risk corridor program, an issuer of a QHP whose gains are greater than 3 percent of the issuer's projections must remit charges to HHS, while HHS must

make payments to an issuer of a QHP that experiences losses greater than 3 percent of the issuer's projections. On an ongoing basis, the risk adjustment program is intended to provide adequate payments to health insurance issuers that attract high-risk populations. Under this program, generally, funds are transferred from issuers with lower risk enrollees to issuers with higher risk enrollees.

- ***Section 1343.*** This section provides that each state may establish a program of risk adjustment for all non-grandfathered plans in the individual and small group market both inside and outside of the Exchange. These risk-spreading mechanisms, which will be implemented by the HHS Secretary and the states, are designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets. The HHS Secretary may utilize criteria and methods similar to the criteria and methods utilized under Part C (Medicare+Choice Program) or D (Voluntary Prescription Drug Benefit Program) of title XVIII (Health Insurance for the Aged and Disabled) of the Social Security Act.

Table 1 below summarizes the proposed standards for the reinsurance, risk corridors, and risk adjustment programs.

Table 1. Proposed Standards for Reinsurance, Risk Corridors, and Risk Adjustment Programs

Program	Reinsurance	Risk Corridors	Risk Adjustment
What	Provides funding to plans that enroll highest cost individuals	Limit issuer loss (and gains)	Transfers funds from lowest risk plans to highest risk plans
Program Oversight	State or State Option if no State-Run Exchange	HHS	State Option in a State-Run Exchange.
Who Participates	All issuers and third-party administrators (TPAs) contribute funding; non-grandfathered individual market plans (inside and outside the Exchange) are eligible for payments.	Qualified Health Plans (QHPs)	Non-grandfathered individual and small group market plans, inside and outside the Exchange.
When	Throughout the year 2014–2016	After reinsurance and risk adjustment 2014–2016	After end of benefit year 2014 and subsequent years
Why	Offsets high cost outliers	Protect against inaccurate rate setting	Protects against adverse selection
Time Frame	3 years (2014–2016)	3 years (2014–2016)	Permanent

Provisions of the Proposed Regulation in 45 CFR part 153

Subpart A – Subpart A specifies what is described above, i.e., that the general statutory authority for the standards proposed in part 153 are based on sections 1321 and 1341-1342 of title I of the ACA. This subpart also specifies that part 153 establishes standards for the operation of a transitional reinsurance program, temporary risk corridors, and a permanent risk adjustment program.

Subpart B – State and Notice of Insurance Benefits and Payment Parameters. In subpart B, HHS proposes a process by which the states that are operating an Exchange or establishing a reinsurance program issue an annual notice to disseminate information to issuers and other stakeholders about specific requirements to support payment-related functions. This notice may also be a mechanism to address updates to other Exchange-related provisions proposed elsewhere that impact payment and benefit design. This provides a practical way to update certain payment and benefit factors that may change annually, such as reinsurance contribution rates that are based on annually changing thresholds.

Subpart C – State Standards for the Transitional Reinsurance Program for the Individual Market. In subpart C, HHS codifies section 1341 of the ACA as it relates to establishing a reinsurance program. Related standards on health insurance issuers with respect to reinsurance are proposed in subpart E. HHS identifies three critical policy goals of the transitional reinsurance program. First, the transitional reinsurance program should offer protection to health insurance issuers against medical cost overruns for high-cost enrollees in the individual market, particularly those that are newly insured or those with previously excluded conditions, thereby allowing issuers to set lower premiums. Second, a transitional reinsurance program should 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. This objective is particularly important since the two other risk sharing protections against adverse selection—risk adjustment and risk corridors—are likely to be calculated after the end of the benefit year. Third, the transitional reinsurance program should require minimal administrative burden since it is a temporary program. Given the short-term nature of the program, the costs of setting up and administering this program must be commensurate with its benefits over the three-year window. HHS believes that states should have discretion to make a number of decisions within the proposed standards, including the appropriateness of any specific entity as an administrator of the reinsurance program.

Subpart D – State Standards Related to the Risk Adjustment Program. In subpart D, HHS proposes standards for states with respect to the risk adjustment program required under section 1343 of the ACA. Parallel provisions on health plans are proposed in subpart G. Section 1343 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. Under this provision, the HHS Secretary, in consultation with the states, must establish criteria and methods to be used by states in determining the actuarial risk of plans within a state. States electing to operate an Exchange,

or HHS on behalf of states not electing to operate 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. Thus, the risk adjustment program is intended to reduce or eliminate premium differences between plans based solely on expectations of favorable or unfavorable risk selection or choices by higher risk enrollees in the individual and small group market. The risk adjustment program also serves to level the playing field inside and outside of the Exchange, reducing the potential for excessive premium growth or instability within the Exchange. Overall, HHS believes that states have discretion to make a number of decisions within the proposed standards.

Subpart E – Health Insurance Issuer Standards Related to the Transitional Reinsurance Program. In subpart E, HHS proposes requirements for health insurance issuers that complement the requirements for the transitional reinsurance program fully subpart C. Since the reinsurance program is operated at the state level, many elements related to the purpose, methods, and operation of this program will vary across states. In this subpart, HHS discusses the elements of the program that relate specifically to the requirements for health insurance issuers and third-party administrators (TPAs) on behalf of self-insured group health plans.

Subpart F – Health Insurance Issuer Standards Related to the Temporary Risk Corridors Program. In subpart F, HHS proposes requirements on health insurance issuers related to the temporary risk corridor program. Section 1342 of the ACA establishes a program of risk corridors for the first three years of Exchange operation. In addition to risk adjustment and reinsurance, 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.

Subpart G – Health Insurance Issuer Standards Related to the Risk Adjustment Program. Section 1343 of the ACA 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 described in section 1343 employs a model to determine comparative actuarial risk of plans within a state. This subpart proposes the health issuer standards that are necessary to carry out risk adjustment as described in subpart D.

Summary of HHS' Solicitations for Public Comment on the Proposed Regulation in 45 CFR part 153

Table 2. Subpart B – State and Notice of Insurance Benefits and Payment Parameters

Proposed Rule	Comment Solicitation
Establishment of state insurance benefits and payment parameters (§ 153.100). In § 153.100, HHS proposes that a state operating an Exchange, as well as a state establishing a reinsurance program, issue an annual notice to describe the specific parameters that the state will employ if that state intends to utilize any reinsurance or risk adjustment parameters that differ from those specified in the forthcoming annual Federal notice of benefit and payment parameters. **HHS believes the information contained in the state notice should be provided one year in advance of the benefit year so that issuers may account for any updates in their design and review of plan benefits and in establishing and reviewing rates.** HHS proposes that states that plan to modify Federal parameters issue their notice by early March in the calendar year before the effective date. HHS also proposes that if a state operating an Exchange or establishing a reinsurance program does not provide public notice of its intent to have state-specific parameters for any provision within the period specified, the parameters set forth in the forthcoming annual Federal notice of benefits and payment parameters will serve as the state parameters.	HHS is seeking comment on whether the **proposed timing allows issuers sufficient time to reflect these** **State requirements in setting rates**. In particular, HHS is seeking comment as to whether the schedule should be adjusted in the initial year to provide issuers additional time for setting rates for 2014.

Table 3. Subpart C – State Standards for the Transitional Reinsurance Program for the Individual Market

Proposed Rule	Comment Solicitation
***Definitions (§ 153.200)*.** In § 153.200, HHS proposes several definitions that are critical to the establishment of a properly functioning transitional reinsurance program. HHS defines an ''attachment point'' as the threshold dollar amount of costs incurred by a health insurance issuer for payment of essential health benefits provided for an enrolled individual, after which threshold, the costs for covered essential health benefits are eligible for reinsurance payments. The definition of ''essential health benefits'' will be proposed in future rulemaking. HHS defines ''coinsurance rate'' as the rate at which the applicable reinsurance entity will reimburse the health insurance issuer for costs incurred to cover essential health benefits after the attachment point and before the reinsurance cap. HHS defines the ''reinsurance cap'' as the threshold dollar amount for costs incurred by a health insurance issuer for payment of essential health benefits provided for an enrolled individual, after which threshold, the costs for covered essential health benefits are no longer eligible for reinsurance payments. **In order to ensure reinsurance payments are made on a comparable set of benefits, HHS proposes that payments be calculated for costs to cover the essential health benefits package**. HHS defines ''contribution rate'' as the rate, based on a percent of premium, used to determine the dollar amounts each health insurance issuer and third-party administrator, on behalf of a self-insured group health plan, must contribute to a state reinsurance program. HHS defines the ''percent of premium'' as the percent of total revenue, based on earned premiums in all fully-insured markets (inside and outside of the Exchange) or the percent of total medical expenses in a self-insured market. Finally, HHS defines ''third-party administrator'' as the claims processing entity for a self-insured group health plan. As such, if a self-insured group health plan processes its own claims, the self-insured plan will be considered a third-party administrator for the purpose of the reinsurance program.	HHS is soliciting comments on alternatives to the use of the **essential health benefits package**.
***Collection of Reinsurance Contribution Funds (§ 153.220)*.** In § 153.220, HHS describes standards for how states must ensure that the reinsurance entity collects reinsurance contribution funds. Section 1341 provides for the	

collection of contribution funds to cover all reinsurance payments and also permits the collection of funds to cover administrative costs incurred by the applicable reinsurance entity. These contribution funds must be collected by the reinsurance entity from all health insurance issuers and TPAs on behalf of self-insured plans. The aggregate contribution funds for purposes of making reinsurance payments are specified as $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. None of these funds can be used for any purpose other than paying reinsurance or administering the reinsurance programs. The aggregate contribution funds would be returned to those issuers that qualify for the transitional reinsurance program. Although the transitional reinsurance program is state-based, section 1341(b)(3) sets contribution levels for the program on a national basis. **HHS considered two approaches by which to collect contribution funds: (1) Use of a national uniform contribution rate, and (2) use of a state-level allocation, both set by HHS to ensure that the sum of all contribution funds equals the national amounts set forth in statute.** Use of a national contribution rate is a simpler approach. Further, since there is significant uncertainty about Exchange enrollment, the overall health of the enrolled population, and the cost of care for new enrollees, **HHS believes that a national contribution rate would be the less ambiguous approach of the two**. All contribution funds collected by a state establishing a reinsurance program, using the national contribution rate, will stay in that state and be used to make reinsurance payments on valid claims submitted by reinsurance-eligible plans in that state. A state-level allocation would be more complex to administer. There are two methods HHS considered for determining contributions using a national rate: (1) A percent of premium amount applied to all contributing entities, and (2) a flat per capita amount applied to all covered enrollees of contributing entities. HHS proposes the percent of premium method as the fairest method by which to collect these contributions, as it allows states that tend to have higher premium and health care costs, and thus reinsurance claims, to collect additional funds towards reinsurance. A flat, per capita amount could represent an excessively high percent of premium for	HHS is soliciting comments regarding whether to use a **state-level allocation or a national rate**. HHS invites comments regarding the preferred method for **calculating health insurance issuer contribution funds using a national rate**.

products that are designed and intended to have low premiums targeted toward a population such as young adults and children. HHS will establish the percentage through a forthcoming annual Federal notice of benefit and payment parameters, based on its estimate of total premiums in the fully insured market and medical expenses in the self-insured market. In paragraph (b)(2), **HHS also proposes that all contribution funds collected for reinsurance payments must be used for reinsurance, and all contribution funds collected for the U.S. Treasury must be paid to the U.S. Treasury**. In paragraph (b)(3)(i), HHS proposes that a state may collect more than its amount collected in the national rate, if the state believes that these amounts are not sufficient to cover the payments it will make under the payment formula. Nothing in the ACA precludes a state from supplementing this program. In paragraph (b)(3)(ii), HHS also proposes that a state may collect more than its amount collected at the national rate to cover the administrative costs of the applicable reinsurance entity. HHS has also considered the frequency by which applicable reinsurance entities should collect contribution funds from contributing entities. For example, applicable reinsurance entities could collect contribution funds intended for reinsurance payments and payments to the U.S. Treasury on a monthly basis beginning in January 2014 so that reinsurance payments could begin in February 2014.	 HHS invites comments on the most appropriate method and frequency to **collect reinsurance contribution funds**.
Calculation of Reinsurance Payments (§ 153.230). As required, in § 153.230 HHS set the payment policy for the reinsurance program based upon consultation with the American Academy of Actuaries. The reinsurance payment policy addresses two basic issues: (1) How to determine the individuals who are covered by reinsurance, and (2) how to determine appropriate payment amounts. Given the short-term nature of the program, our primary objective is to select an implementation approach that is administratively and operationally simple, but satisfies the goals of the program. Therefore, HHS would use reliable and readily accessible data sources that would allow health insurance issuers to receive prompt payment. **HHS proposes in paragraph (a) of this section that coverage be based on items and services within the essential health benefits for an individual enrollee that exceeds an attachment point.**	HHS invites comments regarding if it should allow reinsurance payment for more generous coverage beyond that provided by **essential health benefits**.

In paragraph (b), HHS proposes to announce the **reinsurance payment formula and state-specific values for the attachment point, reinsurance cap, and coinsurance** rate in the forthcoming annual Federal notice of benefits and payment parameters. HHS believe that publishing this information in a Federal notice is the best approach for announcing the **attachment point and reinsurance cap** as these values may change in years 2015 and 2016. The ACA does not suggest that the three-year reinsurance program should replace commercial reinsurance or internal risk mitigation strategies. There will be a continued need for ongoing commercial reinsurance.	HHS is seeking comment on its proposal to establish a **reinsurance cap set at the attachment point** of traditional reinsurance. HHS is soliciting comments for a suitable method for ensuring that issuer costs are appropriate and accurate. HHS invites comments as to the most appropriate frequency and method for applicable reinsurance entities to remit payment to the U.S. Treasury.
Disbursement of Reinsurance Payments (§ 153.240). In § 153.240, HHS proposes **parameters for the timing of reinsurance payments**. In paragraph (a) of this section, HHS proposes that states must ensure that the applicable reinsurance entity collects from health insurance issuers of reinsurance-eligible plans data required to calculate payments described in § 153.230, according to the data requirements and data collection frequency specified by the state in the notice described in § 153.110 or in the forthcoming annual Federal notice of benefit and payment parameters. Since HHS is proposing that reinsurance eligibility and payments be based on the health insurance issuer medical costs, HHS believes that a standard method of collecting the required information should be a reasonable goal and easily achievable. Further, a standard method will enable multi-state health insurance issuers to submit data promptly without causing disruption for any single-state health insurance issuer. In paragraph (b), HHS proposes that the state must ensure that each applicable reinsurance entity makes payments that do not exceed contributions and makes payments to health insurance issuers of reinsurance-eligible plans according to § 153.230. HHS also proposes in paragraph (b)(2) to allow states to reduce payments on a pro rata basis to match the amount of contributions received by the state in a given	HHS invites comments as to the **most appropriate timeframe that an applicable reinsurance entity should make payments for reinsurance claims submitted**, particularly, since reinsurance claims may exceed contributions for a given month, but not total projected contributions for the entire year.

reinsurance year. Any pro rata reductions made by the state must be made in a fair and equitable manner for all health insurance issuers in the individual market. In paragraph (b)(3), HHS proposes that the state must ensure that an applicable reinsurance entity makes payments as specified in § 153.410(b) to the issuer of a reinsurance-eligible plan after receiving a valid claim for payment. HHS has also considered **deadlines by which a health insurance issuer could submit a claim for a given reinsurance benefit year**. In paragraph (c), HHS proposes that for each benefit year, the **state maintains all records related to the reinsurance program for 10 years**, consistent with requirements for record retention under the False Claims Act.	HHS is seeking comment as to whether the **deadline for health insurance issuers for submitting reinsurance claims** should be the same or different. HHS invites comment on the **use of a standard deadline** and the most appropriate deadline considering the interaction of the reinsurance program with risk corridor and the Medical Loss Ratio (MLR) process. HHS is soliciting comments on the **10-year record retention requirement** for reinsurance programs.
Coordination With High-Risk Pools (§ 153.250). In § 153.250, HHS codifies the requirement under section 1341(d) of the ACA that states shall eliminate or modify **high risk pools** to the extent necessary to carry out the reinsurance program. As stated in the introduction to this subpart, the reinsurance program required under the ACA is designed to help mitigate adverse selection risks in the first three years of Exchange operation. In paragraph (a), HHS codifies the above-referenced section. In paragraph (b), HHS propose to allow a state that continues its high risk pool to coordinate its high risk pool with its reinsurance program to the extent it conforms to the provisions of this subpart.	HHS is seeking comment 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.

Table 4. Subpart D – State Standards Related to the Risk Adjustment Program

Proposed Rule	Comment Solicitation
Risk Adjustment Administration (§ 153.310). Section 1343(a) of the ACA establishes that **states must assess risk adjustment charges and provide risk adjustment payments based on plan actuarial risk as compared to a state average**. HHS interprets this provision to mean that risk pools must be aggregated at the state level, even if a state decides to utilize regional Exchanges. Furthermore, section 1343(c) indicates that risk adjustment applies to individual and small group market health insurance issuers of non-grandfathered plans within a state, both inside and outside of the Exchange. Accordingly, similar to our approach in reinsurance, if multiple states contract with a single entity to administer risk adjustment, risk may not be combined across state lines, but must be pooled at the individual state-level. In this section HHS specifies that any state electing to establish an Exchange is eligible to establish a risk adjustment program. Pursuant to section 1321(a)(1)(D) of the ACA, HHS proposes that for states that do not operate an Exchange, HHS will establish a risk adjustment program. HHS also clarifies that HHS will administer all of the risk adjustment functions for any state that elects to establish an Exchange but does not elect to administer risk adjustment. HHS clarifies that the state may elect to have an entity other than the Exchange perform the risk adjustment functions of this subpart provided that the selected entity meets the requirements for eligibility to serve as the Exchange proposed in the notice of proposed rulemaking entitled, ''Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans.''	
HHS **proposes timeframes for completion of the risk adjustment process**. HHS proposes that all payment calculations must commence with the 2014 benefit year. The ACA does not explicitly set forth a timeframe by which risk adjustment programs must start. However, HHS believe risk adjustment must be coordinated with reinsurance and risk corridors to help stabilize the individual and small group markets and ensure the viability of the Exchanges, which begin in 2014. Timely completion of the risk adjustment process is important because risk adjustments affect	HHS is seeking comment on the appropriate **deadline by which risk adjustment must be completed**. For example, HHS may require that states complete risk adjustment activities by June 30 of the year following the benefit year. This timing assumes at least a three-month lag from items and services furnished in a benefit year and the end of the data

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calculations of both risk corridors and the rebates specified under section 2718 of the Public Health Service Act. By law, HHS will be performing the risk corridors calculations for all QHPs in all states. To ensure the each state's risk adjustment program is functioning properly, HHS believe that states should provide HHS with a summary report of risk adjustment activities for each benefit year in the year following the calendar year covered in the report. Since risk adjustment is designed as a budget neutral activity, states would likely need to receive remittances from issuers of low actuarial risk plans before making payments to issuers of high actuarial risk plans. The **summary report should include the average actuarial risk score for each plan, corresponding charges or payments, and any additional information HHS deems necessary to support risk adjustment methodology determinations**.	collection period. This approach is similar to the Medicare Advantage (Part C) risk adjustment data submission, in which the annual deadline for risk adjustment data submission is 2-months after the end of the 12-month benefit period, but may, at CMS's discretion, include a 6-month lag time. HHS is seeking comment on an **appropriate timeframe for state commencement of payments**. HHS is seeking comment on the **requirements for such reports**, including data elements and timing.
Federally Certified Risk Adjustment Methodology (§ 153.320). Section 1343(b) of the ACA requires HHS to establish criteria and methods for risk adjustment in coordination with the states. HHS interprets this provision to mean that HHS will establish a baseline methodology to be used by a state, or HHS on behalf of the state, in determining average actuarial risk. HHS proposes of this section that a state that is operating a risk adjustment program must use one of the Federally certified risk adjustment methodologies that HHS will publish in a forthcoming annual Federal notice of benefit and payment parameters or that has been published by the state in that **state's annual notice**. These notices will include a full description of the risk adjustment model, including but not limited to: demographic factors, diagnostic factors, and utilization factors if any; the qualifying criteria for establishing that an individual is eligible for a specific factor; the weights assigned to each factor; the data required to support the model; and information regarding the deadlines for data submission and the schedule for risk adjustment factor determination. HHS proposes that HHS will specify in a forthcoming annual Federal notice of **benefit and payment parameters the federally certified risk adjustment methodology** that will apply when the Federal government operates the risk adjustment program in states that do not elect to operate an	HHS is seeking comment on **other information that should be included in states' annual notices** of their risk adjustment model. HHS invites comments on the implications of approaches for market efficiency, potential incentives created in how issuers set rates, and how approaches address allowed rating variation for age, family size, and tobacco use. HHS requests comments on other approaches to determining average actuarial risk and whether links exist between potential actuarial risk methodology and potential payments and charges methodology HHS is also requesting comments on the extent of state flexibility that should be allowed in adopting an approach to determine average actuarial risk. HHS is requesting comment on any intentional and unintentional consequences from the use of payments and charges methodology or

Exchange, or that elect to operate an Exchange but not a risk adjustment program. To assist states in assessing a potential alternate risk adjustment methodology, HHS will publish the basic standards any alternate risk adjustment methodology must meet in the forthcoming annual Federal notice of benefit and payment parameters that contains the details of one or more federally certified risk adjustment methodologies. These standards will likely include the minimum number or types of factors that must be included and the statistical metrics the models will be expected to achieve. The statute is not specific with respect to the method by which states are expected to determine the precise value of payments and charges.	plan-specific premiums methodologies. In addition, HHS is requesting comment on whether there are **alternative methodologies** that might be used, including their strengths, limitations, intentional or unintentional consequences and any links that exist between the payments and charges methodology and the actuarial risk methodology.
State Alternate Risk Adjustment Methodologies (§ 153.330). To ensure the stability and predictability of payments, HHS contemplated proposing that **requests must be submitted to HHS no later than early November in the calendar year two years before the effective date**. HHS recognizes that health insurance issuers must have detailed information about risk adjustment prior to setting rates for any benefit year because the risk adjustment methodology will affect both the total value of premiums received after accounting for payments and charges, as well as health plan administrative costs. Therefore, under this scenario, HHS would evaluate the proposed alternate risk adjustment methodologies submitted within the required timeframes and notify states within 60 days, at the time of the publication of the forthcoming annual Federal notice of benefits and payment parameters whether such methodologies have been certified. In this scenario, if HHS approves an alternate risk adjustment methodology, such a methodology would be considered a federally certified risk adjustment methodology and could be implemented in the state that proposed the methodology as well as any other state that elects to implement an Exchange. HHS recognizes that this proposed timeframe requires states to submit requests for alternate methodology certification only 30 days after the advance annual Federal notice of benefit and payment parameters and prior to publication of the final annual Federal notice of benefit and payment parameters. However, HHS believes any advantage in allowing states additional time would be offset by a lesser ability to leverage state alternative models and inadequate	HHS is seeking comments regarding the **proposed timeline and potential alternatives for states to request submissions** for alternate risk adjustment methodology.

time for issuers to reflect methodology decisions in setting rates.	
Data Collection Under Risk Adjustment (§ 153.340). A robust risk adjustment process requires data to support the determination of an individual's risk score and the corresponding plan and state averages. HHS proposes that a state, or HHS on behalf of the state, is responsible for collecting the data for use in determining individual risk scores. HHS considered three **approaches for data collection**: (1) A centralized approach in which issuers submit raw claims data sets to HHS; (2) **an intermediate state-level approach** in which issuers submit raw claims data sets to the state government, or the entity responsible for administering the risk adjustment process at the state level; and (3) a distributed approach in which each issuer must reformat its own data to map correctly to the risk assessment database and then pass on self-determined individual risk scores and plan averages to the entity responsible for assessing risk adjustment charges and payments. A robust risk adjustment process requires data to support the determination of an individual's risk score and the corresponding plan and state averages. Although the transaction standards promulgated under the HIPAA administrative simplification provisions do not specifically apply to data collections under section 1343 of the ACA, HHS proposes to require states to utilize two specific **HIPAA transaction standards for risk adjustment data** collection: the ASC X12N 837 Health Care Claim transaction standard for any claims-related data including encounters; and the ASC X12N 834 Enrollment and Maintenance transaction standard for any enrollment or demographic data. HHS proposes that states with existing all payer claims databases may request an exception from the minimum standards for data collection. **HHS is contemplating syncing the timing of the request submission with requirements for alternate risk adjustment models**. Similarly, HHS is contemplating that HHS will notify states as to exception status concurrently with the publication of the forthcoming annual Federal notice of benefit and payment parameters. HHS proposes that requests for exception from minimum	HHS seeks comment on use of this data for auditing purposes. HHS believes the proposed **intermediate approach** would result in the most complete, actuarially sound risk adjustment methodology and provides support for other functions that also require encounter level data, while maintaining state flexibility. HHS recognizes this approach may raise concerns related to consumer privacy and standard submission formats. Accordingly, HHS proposes national standards to address each of these issues. HHS seeks comment on the proposed approach, as well as comments on the **potential advantages and disadvantages of the alternative approaches**. HHS is solicit comment on whether HHS should rely on the **existing HIPAA and NCPDP standards** or engage stakeholders to develop a new set of national standards for use in risk adjustment, for example, leveraging the claims standards developed with stakeholder input by the Agency for Healthcare Research and Quality. HHS is soliciting comments on whether submission of issuers' rate setting rules should be required. HHS seeks comment on these contemplated **timelines**.

data collection standards must include technical specifications, as well as proposed modifications to support risk adjustment and other claims-related activities. Seeking data submission efficiencies HHS proposes that the state must make certain **claims and encounter data collected under risk adjustment** available to support other activities including: recalibrating federally certified risk adjustment models; verifying of risk corridor submissions; and verifying and auditing reinsurance claims. HHS also anticipate encounter and claims data collected for risk adjustment may be required to support other Exchange-related functions such as cost-sharing requirements and quality reporting.	 HHS is soliciting comment on these **alternative uses of risk adjustment data**.
Risk Adjustment Data Validation Standards (§ 153.350). HHS proposed that states have a reliable data validation process, which is essential to the establishment of a credible risk adjustment program. The credibility of risk adjustment is important to establishing the issuer confidence required for risk adjustment to have a positive impact on premium reduction. HHS proposes that states, and HHS, when HHS performs the risk adjustment function on behalf of states, will perform some form of validation regarding the data submitted. HHS also believes that issuers will want such data validations to be performed since the effect of risk adjustment will be a transfer of premiums between issuers. One of the critical aspects of risk adjustment under the ACA is that it represents a relative actuarial risk calculation. Therefore, for any data validation to have the capacity to extrapolate to adjust specific charges and payments, the validation must cover a sufficient number of plans to allow an equitable adjustment to all health plan risk adjustment factors. HHS proposes that the state, or HHS on behalf of the state**, validate a statistically valid sample of all issuers that submit data for risk adjustment every year**. HHS also proposes an appropriate use of the information derived from the data validation. For a validation to work under this form of risk adjustment, states must be able to adjust the average actuarial risk of each plan to account for the inaccuracies noted during the data validation process. As such, HHS proposes that the state, or HHS on behalf of the state, may adjust the average actuarial risk for each plan based on the	HHS is seeking comment on **appropriate timeframes for completion of the data validation process**. For example, HHS may propose a three-year deadline for completing data validation, so as to ensure some finality in the risk adjustment process. HHS is soliciting comments on this **data validation provision** and any

error rate found in the validation. HHS further proposes that the state, or HHS on behalf of the state, adjust payments and charges based on the changes to average actuarial risk. HHS proposes that states, or HHS on behalf of the state, must provide an appeals process for issuers. HHS believes that there may be alternative methods that allow sufficient coverage to estimate the validation impact on all plans.	alternatives that may be able to satisfy the need to provide assurance that the charges and payments truly represent relative plan risk.

Table 5. Subpart E – Health Insurance Issuer Standards Related to the Transitional Reinsurance Program

Proposed Rule	Comment Solicitation
Reinsurance Contribution Funds (§ 153.400). HHS codifies section 1341 of the ACA, which requires that the reinsurance program be funded by contribution funds from contributing entities. HHS proposes that all **contributing entities make contributions, in a frequency and manner to be determined by the state or HHS**, to the applicable reinsurance entity in the state. For example, contributing entities may be required to submit contributions on a monthly or quarterly basis starting in January 2014. HHS proposes that if any state establishes multiple applicable reinsurance entities, the contributing entities must contribute an appropriate payment to each applicable reinsurance entity according to the formula established by the state. HHS proposes that **contributing entities will be required to provide the data** necessary for the applicable reinsurance entity to calculate the amounts due from each contributing entity. The type of data required will depend on the contributing entity. For contributing entities in the individual and fully insured market, HHS proposes that data on enrollment and premiums be required. For contributing entities in the self-insured market, data on covered lives and total medical expenses would be required. This data, for example, could be collected on a monthly or quarterly basis beginning January 2014.	HHS invites comments on the appropriate frequency and manner in which payments should be made by **contributing entities**. HHS invites comments on the appropriate timing to collect **data submissions from contributing entities**. HHS also seeks comment on whether there are existing sources of this data that can be drawn upon.
Requests for Reinsurance Payment (§ 153.410). The reinsurance program as proposed in subpart C will make **payments to reinsurance-eligible plan issuers**. HHS proposes that reinsurance-eligible plan issuers must submit a request for reinsurance payment to the applicable reinsurance entity. HHS proposes that this request is made according to the method that will be specified in the forthcoming annual Federal notice of benefit and payment parameters.	HHS invites comments regarding **methods for requesting payments**, and the frequency and deadline for such requests. HHS also invites comments on how to manage late claims from reinsurance eligible plan issuers.

Table 6. Subpart F – Health Insurance Issuer Standards Related to the Temporary Risk Corridors Program

Proposed Rule	Comment Solicitation
Definitions (§ 153.500). In § 153.500, HHS proposes a number of definitions for the purpose of administering risk corridors. First, HHS defines ''allowable costs'' as an amount equal to the total medical costs, which includes clinical costs, excluding allowable administrative costs, paid by the QHP issuer in providing benefits covered by the QHP. HHS defines ''**allowable administrative costs**'' as total non-medical costs including costs for the administration and operation of the health insurance issuer.	HHS invites comment on whether HHS should consider costs for activities that improve health care quality for **allowable costs** to be consistent with the MLR policy in the ACA. HHS also invites comment on whether HHS should limit **administrative costs** to 20 percent consistent with MLR. If the allowable administrative costs differ from calculations for the MLR rebate, issuers may be incentivized to use risk corridors payments to pay for their MLR rebates.
Risk Corridor Establishment and Payment Methodology (§ 153.510). The risk corridor provision in 1342 of the ACA directs HHS to establish and administer a program of risk corridors. HHS proposes to establish risk corridors by specifying risk percentages above and below the target amount. HHS proposes to require a QHP issuer to adhere to the requirements set by HHS for the establishment and administration of a risk corridor program for calendar years 2014 through 2016. HHS will issue guidance in the forthcoming annual Federal notice of benefits and payment parameters for QHPs regarding reporting and the administration of payments and charges similar to part 158. Risk corridors guidance will be plan specific and not issuer specific as indicated in part 158. HHS interprets the risk corridor provision to apply to all QHPs offered in the Exchange. While HHS is not proposing deadlines at this time, HHS has considered **timeframes for QHP issuers to remit charges to HHS**. For example, a QHP issuer required to make a risk corridor payment may be required to remit charges within 30 days of receiving owed risk corridor amounts from HHS within a 30-day period after HHS determines that a payment should be made to the QHP issuer. HHS believes that QHP issuers who are owed these amounts will want prompt payment, and also believe that the payment deadlines should be the same for HHS and QHP issuers.	HHS invites comments as to the appropriate **frequency QHP issuers should remit charges** to HHS.

HHS proposes that the reported premium amounts must be increased by the amounts paid to the QHP issuer for risk adjustment and reinsurance. Similarly, HHS proposes that the reported premium amounts be reduced for any risk adjustment charges the QHP issuer pays on behalf of the plan, reinsurance contributions that the QHP issuer makes on behalf of the plan, and Exchange user fees that the QHP issuer pays on behalf of the plan.	HHS is seeking comment on the treatment of reinsurance and risk adjustment as after-the-fact adjustments to premium for purposes of determining risk corridor amounts. HHS invites comments on how the risk corridor calculations would interact with the MLR process. HHS invites comment on an appropriate deadline for QHP issuers to complete submission of all risk corridor data especially since this would interact with the MLR process. HHS also invites comment as to how HHS could determine allowable costs for QHP issuers in calculating risk corridors, if a QHP issuer fails to comply with reporting provisions.

Table 7. Subpart G – Health Insurance Issuer Standards Related to the Risk Adjustment Program

Proposed Rule	Comment Solicitation
Risk Adjustment Issuer Requirements (§ 153.610). HHS proposes that all issuers of risk adjustment covered plans submit risk adjustment data according to the timetable and format prescribed by the state, or HHS on behalf of the state. Since there will be some variety in approaches to risk adjustment, both cross states as well as over time, HHS expects that these data will include demographic data; encounter data for items and services provided in conjunction with a risk adjustment covered plan; and prescription drug utilization data.	HHS seeks comment on whether other categories of data such as methods for setting rates should be required in support of risk adjustment.
HHS considered proposing the following timelines for risk adjustment data submission: claims and encounter data must be submitted every 30 days and no later than the end of 180 days following the date of service; enrollment and demographic information must be submitted by the end of the month following enrollment; issuer rate-setting rules must be submitted by the end of the month in which they become effective; prescription drug utilization data must be submitted every 30 days, and no later than the end of 90 days following date of service. HHS recognizes that these timeframes may limit the ability of states to collect a full calendar year of data on risk adjustment. However, given the traditional lag of claims submissions, HHS did not think a shortened timeframe was feasible. Additionally, monthly data submission would address anticipated issuer difficulty in transmitting large volumes of data at the end of the data collection period.	HHS is soliciting comments on **these and alternative data submission timeframes**.
HHS discusses the calculation of payments and charges extensively describing the methods by which HHS proposes states could perform that function. After the state, or HHS on behalf of the state, has calculated all payments and charges for all risk adjustment covered plans, the state, or HHS on behalf of the state, will determine a net value of payments and charges for each risk adjustment covered plan issuer. HHS proposes that risk adjustment covered plan issuers who owe a net balance of risk adjustment charges will be assessed those net charges upon completion of the risk adjustment process. HHS interprets the ACA to mean that the payment of	HHS is soliciting comment on this and alternative **timelines**. Since risk adjustment pools individual and small group market risk on a state level, payments and charges will be netted out at the state level, and issuers in multiple states must settle with each state individually.

charges is mandatory for issuers who have a net charges payable balance based on the difference between the charges calculated for their low actuarial risk plans and the payments calculated for their high actuarial risk plans. Additionally, HHS considered proposing that issuers be given a 30 day timeframe in which to pay all these net charges to the state that assessed those charges, or to HHS on behalf of the state.	

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