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REFORM Update

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In 2014, health care reform will dramatically change the insurance market. States or the federal government will establish Health Insurance Exchanges, a new marketplace for individuals or small group health plans to purchase coverage. Small group plans could encompass less than 100 employees or less than 50 employees. Small group status will be determined by the state. Low- to moderate income people may be eligible for government subsidies to help pay for individual health coverage and possibly to help with out-of-pocket costs.

The rules for insurance carriers will change when the Exchanges launch. Insurance carriers will:

- Not be permitted to medically underwrite applicants. All eligible applicants will be offered coverage.
- Not be allowed to apply pre-existing condition limitations. Carriers will have to cover all existing medical conditions from the first day of coverage.
- Have very specific rating rules. Plans can't rate for medical conditions, health status and other factors.

This is just a brief summary of some of the changes to the health insurance market in 2014. These changes will create uncertainty as carriers attempt to develop rates for a market with new rules and a likely influx of new members.

Health care reform created three risk-spreading programs to protect against uncertainty in the new individual and small group marketplace. The programs are as follows:

- Reinsurance program
- Risk corridor program
- Risk adjustment program

The parameters of these new programs are summarized in the chart below:

Parameters	Reinsurance	Risk Corridor	Risk Adjustment
Overview	Provides funding to insurance carriers that incur high-cost claims	Limits insurance carrier losses (and gains)	Transfers funds from low-risk plans to higher-risk plans
Program responsibility	State option to operate; if not, federal government will operate	Department of Health and Human Services (DHHS)	State option to operate if state establishes an Exchange

Parameters	Reinsurance	Risk Corridor	Risk Adjustment
Who is required to participate?	**All insurance carriers and TPAs, on behalf of group health plans, contribute to the funding.** Non-grandfathered individual health plans eligible for payments.	Qualified health plans (QHPs) – plans approved to be offered in the Exchange	Non-grandfathered individual health plans
Purpose	Offset high-cost outliers for individual health insurance carriers	Protects against inaccurate rate setting	Protects against adverse selection
Applicable time frame	Three years (2014 – 2016)	Three years (2014 – 2016)	Permanent

DHHS recently released guidance on the details of these new programs.

Reinsurance Program

States are given the option to establish a reinsurance program to assist individual insurance carriers at the launch of the Exchanges. The program is temporary, slated for a three-year time period. The state can select a reinsurance entity to carry out the program requirements, and is permitted to contract with more than one reinsurance entity. Each entity will be designated to cover a specific geographical area with no overlap. DHHS will establish a reinsurance program for any state that chooses not to establish their own program. The guidance will require that each state provide oversight of the reinsurance entity to ensure compliance with all program requirements.

The reinsurance program will be funded by contributing entities, which include:

- Health insurance issuers
- Third party administrators collecting funds on behalf of self-funded group health plans

Current guidance does not provide much detail. It does indicate, however, that HIPAA-excepted benefit plans will not be subjected to the reinsurance program fees.

The program fees or contribution rates will be a per capita amount applicable to each plan member who resides in the state. A national rate will be set annually by DHHS, which will release an annual notice addressing the following information specific to the benefit year:

- The benefit and payment parameters
- The national contribution rate

- The proportional contributions that will be allocated for reinsurance payments, administrative fees and specific payments to be made to the U.S. Treasury

Each state can collect additional amounts for administrative fees or extra reinsurance payments. If a state collects an additional amount, the appropriate notice must be given, following the specific steps mandated by the guidance.

The national per capita amount has not yet been released. A proposed amount should be published in October 2012, and DHHS will allow the opportunity for public comment before finalizing the numbers in January 2013.

Reinsurance contributions will be paid on a quarterly basis. The first payments will be due by January 15, 2014.

The aggregated amount of contributions collected is set and varies each year. In 2014, $10 billion will be collected. In 2015, $6 billion will be collected, and in 2016, $4 billion will be collected.

Individual health insurance carriers that offer non-grandfathered health plans may be eligible for reinsurance benefits under this program. It will not matter if the carrier offers coverage in or outside of the Exchange. Benefits will be payable if an insured member incurs claim costs for covered benefits that exceed the attachment point, set annually by DHHS. States have the ability to increase or decrease the attachment point for carriers in their state.

The reinsurance entity will reimburse a portion of the claim cost exceeding the attachment point. Claims will be subject to the reinsurance program's coinsurance rate. For example, if the coinsurance rate is 50%, then the reinsurance entity will reimburse the insurance carrier for 50% of covered claims above the attachment factor. The reinsurance program will also include a payment cap.

DHHS will set the attachment point, coinsurance rate and payment cap annually. These parameters have not yet been released for 2014. States may also modify these parameters for their state reinsurance programs.

Group health plans, insured or self-funded, will **not** be eligible for any benefits under the reinsurance program.

Risk Corridor Program

All qualified health plans will participate in the risk corridor program, which is designed to limit insurance carriers' losses and potential gains in the short term. A qualified health plan is one that is approved to be offered in the Exchange. A qualified health plan is required to adhere to the requirements set forth by DHHS. DHHS will publish an annual notice of benefit and payment parameters affiliated with the risk corridor program. This program will apply in 2014, 2015 and 2016.

Qualified health plan insurance carriers **will receive payments** from DHHS, in relation to this program, in any of the following circumstances:

- The qualified health plan's allowable costs for any benefit year are more than 103%, but not more than 108%, of the targeted amount. DHHS will reimburse 50% of the allowable cost in excess of 103% of the targeted amount. The targeted amount will be set annually. The numbers for 2014 have not been published yet.
- The qualified health plan's allowable costs for any benefit year are more than 108% of the targeted amount. In this case, DHHS will reimburse an amount equal to the sum of 2.5% of the targeted amount, plus 80% of the allowable cost over 108% of the targeted amount.

Qualified health plan insurance carriers **will be required to remit funds** to DHHS in the following circumstances:

- The qualified health plan's allowable costs for any benefit year are less than 97%, but not less than 92%, of the targeted amount. The insurance carrier will be required to remit 50% of the difference between 97% of the targeted amount and the allowable cost.
- The qualified health plan's allowable costs for any benefit year are less than 92% of the targeted amount. The insurance carrier will be required to remit an amount equal to the sum of 2.5% of the targeted amount, plus 80% of the difference between 92% of the targeted amount and the allowable cost.

The details of this program will be published annually by DHHS. The amounts for 2014 have not yet been published. A number of requirements will apply to insurance carriers in terms of rate setting and data sharing. The goal is to limit the potential gains and losses of insurance carriers that will likely occur because of uncertainty about the experience in the new Exchange marketplace.

Risk Adjustment Program

States that establish and operate their own Health Insurance Exchanges will be eligible to operate a risk adjustment program. These states can also choose to defer administration to DHHS. A state can contract the risk adjustment activities to a separate entity that meets the standards set forth by DHHS. If the state allows the federal government to operate the Exchange, then DHHS will automatically be responsible for the risk adjustment program administration.

The goal of the risk adjustment program is to reallocate funds from low-risk plans to higher-risk plans. Insurance carriers will pay into a risk adjustment fund. The risk adjustment charges assessed against a carrier must be communicated by June 30 of the year preceding the benefit year. Thus, the risk adjustment charges for 2014 need to be communicated by June 30, 2013. This program is a permanent one, unlike the temporary reinsurance and risk corridor programs. The adjustment program will be integrated into the Exchange operations.

DHHS will develop a federally-certified risk adjustment methodology. This methodology will be published annually in the DHHS notice of benefit and payment parameters. States can use an alternate methodology, but it must be approved by DHHS.

The insurance carriers must provide risk adjustment data to the state or DHHS, depending on who is responsible for administration. The state or DHHS will use this data and the risk adjustment methodology to calculate individual risk scores for plan members.

Although few details are included in the guidance, the risk adjustment program will include these features:

- The risk adjustment program will balance payments within a state and within a market.
- DHHS will not remit payments to issuers until after receipt of the charges owed by issuers in that state. DHHS may adjust payments based on receipt of funds, in order to ensure that payments and charges remain balanced.
- The intent is that payments and charges will be calculated at the plan level, and be aggregated up to the issuer level.

Insurance carriers, DHHS and, potentially, states will work together to manage the risk adjustment program. The goal is to distribute claim costs more evenly across plans, to keep premiums stable over the long term in the Exchange.

Concluding Thoughts

All three of these programs are designed to smooth out uncertainty in the new Exchange marketplace. Carriers will be setting rates without knowing the potential demographics, claims experience or health status of their members. There is a chance for dramatic swings in rates and a health insurance carrier's sustainability.

From an employer's perspective, the reinsurance program will affect your health plan directly. Group health insurance carriers and self-funded health plans will be required to make contributions to this program. However, they will not benefit from the program. Only individual insurance carriers will be eligible for benefits under the reinsurance program.

In addition, if these programs affect insurance carriers' operating costs, that may influence groups' fully-insured rates in the future.

Many of the specific parameters for these three programs have not yet been published. Employers are particularly anxious for the details relating to contributions for the reinsurance program. Preliminary estimates are expected in October, with the actual numbers published in January 2013.

Employers must absorb this cost into their benefit plans' budgets for 2014, 2015 and 2016.