Planning and Establishing the North Carolina Health Benefit Exchange

Webinar for TAG Meeting #3

February 13, 2012

MERCER

OLIVER WYMAN

Discussion Roadmap

- Project Goal and Webinar Objectives
- Statement of Values and Goals for TAG
- Overview of Issues for Discussion in TAG Meeting #3
- Next Steps

Discussion Roadmap

- **Project Goal and Webinar Objectives**
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Project Goal and Meeting Objectives

Project Purpose: *Develop policy options and considerations and identify areas of consensus to inform the NC DOI recommendations to the NCGA on Exchange-related market reform policies.*

(pursuant to North Carolina Session Law 2011-391)

"It is the intent of the General Assembly to establish and operate a State-based health benefits Exchange that meets the requirements of the [ACA]...The DOI and DHHS may collaborate and plan in furtherance of the requirements of the ACA...The Commissioner of Insurance may also study insurance-related provisions of the ACA and any other matters it deems necessary to successful compliance with the provisions of the ACA and related regulations. The Commissioner shall submit a report to the...General Assembly containing recommendations resulting from the study."

-- Session Law 2011-391

Goals for Today's Meeting

- Present Statement of TAG Values/Goals for Consideration
- Ensure TAG Members Have a Shared Understanding of the:
  - Policy Questions Related to Reinsurance and Risk Adjustment
  - Policy and Legal Background on Each Question (e.g., Relevant Guidance, NC Statutes, etc.)
  - Potential Market Considerations Related to Each Question
  - Options and Implications for Further Discussion at the TAG 3 Meeting

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Statement of Values to Guide TAG Deliberations

The TAG will seek to evaluate the market reform policy options under consideration by assessing the extent to which they:

- Expand coverage;
- Improve affordability of coverage;
- Provide high-value coverage options in the HBE
- Empower consumers to make informed choices;
- Ensure predictability for market stakeholders, competition among plans and long-term sustainability of the HBE;
- Support innovations in benefit design, payment, and care delivery that can control costs and improve the quality of care; and
- Facilitate improved health outcomes for North Carolinians.

TAG Input: Coverage; affordability to consumers

TAG Input: Consumer empowerment & informed choice; affordability to consumers; ease of customer engagement; accountability through transparency

TAG Input: Stability for stakeholders; improved competition; HBE sustainability

TAG Input: Innovations in payment & care delivery

TAG Input: Improved care delivery & health outcomes

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Why Risk Adjustment and Reinsurance Programs Are Needed

Adverse Selection in a Post-ACA Environment

What is Adverse Selection?

Adverse selection occurs when individuals at greater risk of high health spending are more likely to seek coverage or choose a particular coverage option than low-risk individuals. This adverse selection increases the average insured risk and results in higher premiums. The higher premiums that result from adverse selection, in turn, may lead to more low-risk individuals opting out of coverage, which would result in even higher premiums. This process is typically referred to as a premium spiral.*

Where is There Potential for Adverse Selection?

- Between plans inside and outside the Exchange
- Among plans outside the Exchange i.e. between carriers
- Among plans inside the Exchange i.e. between carriers
- Among plans of a single carrier
- Between coverage tiers – Bronze, Silver, Gold & Platinum
- Due to existence of grandfathered plans and self-insured plans outside the Exchange

* Adapted from the American Academy of Actuaries definition of adverse selection. http://www.actuary.org/pdf/Risk_Adjustment_IB_FINAL_060811.pdf

Risk Adjustment, Risk Corridor, and Reinsurance Programs Overview

Program	Reinsurance	Risk Corridors	Risk Adjustment
Description	Eases impact of high risk individuals entering Exchange market	Protects against inaccurate rate-setting; encourages exchange participation	Protects against adverse selection issues both in and out of the Exchange
Administration	State or HHS[1]	HHS	State or HHS[2]
When	2014-2016; temporary	2014-2016; temporary	2014 and subsequent years
Plans Impacted	Non-Grandfathered Individual Plans[3]	Individual & Small Group	Non-grandfathered Individual & Small Group Plans
Market Focus	In & Out of Exchange	In Exchange	In & Out of Exchange

Managing Risk Under ACA

- Protects carriers from large losses & consumers from large premium increases
- Stabilizes premiums in the Exchange and reduces uncertainty for participating carriers
- Used together to reduce risk for carriers and help mitigate effects of adverse selection
- Helps establish a level playing field inside and outside the Exchange
- Encourages carrier participation by providing financial protection
- Eases transition into an Exchange environment

(Shaded) = Out of scope for TAG discussion; no decision points required at this time

[1]Must be administered by the state if the state elects to operate a state-based exchange

[2]Can be administered by the state OR the federal government if the state elects to operate a state-based exchange

[3]Payments funded by all commercial health insurers and TPAs of self-insured plans both in and out of the exchange, including grandfathered plans

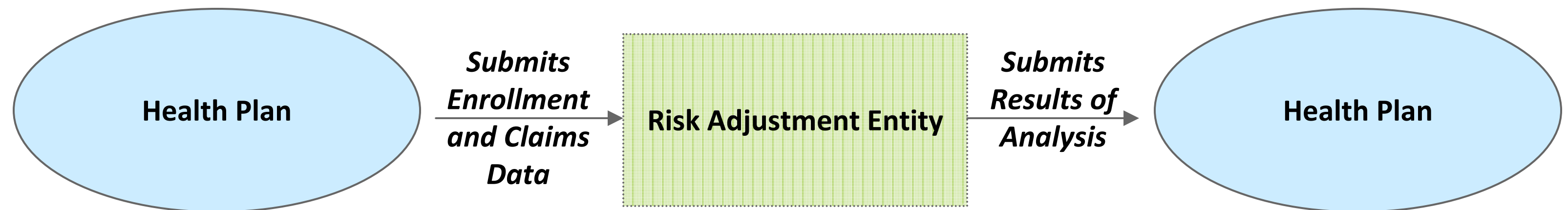
TAG Meeting #3 Issues for Discussion

Risk Adjustment and Reinsurance Market Discussion Items

- **Should NC explore development and administration of a NC-based risk adjustment model? What issues influence this decision?**
- If NC does not develop its own model, what role should NC play in administering the federal risk adjustment model at the state level? What entities are best suited to take on these administration responsibilities?
- Who should make reinsurance policy decisions in NC? What characteristics should the non-profit entity responsible for the administration of reinsurance in NC have? What, if any, existing entities could administer reinsurance in NC?

Risk Adjustment Scenario

Risk adjustment is the process through which the actual health risk of the enrolled members is assessed across plans. Adjustments are made to compensate plans who have sicker than average members and to take funds away from those with healthier than average members.



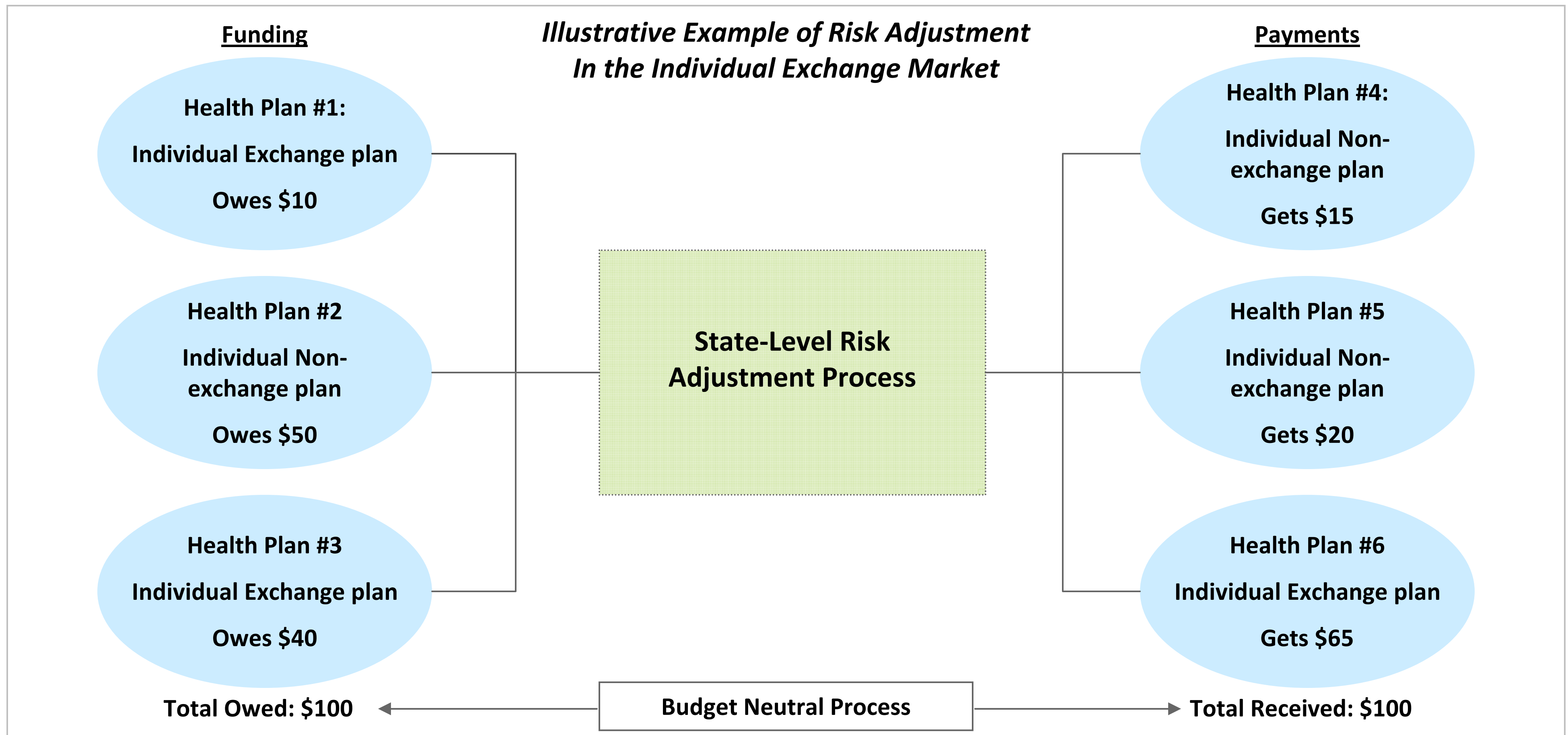
- Sells policies either inside and/or outside of the exchange
- Notices that utilization is higher than anticipated

- Accepts data from all plans
- Applies the risk-adjustment model
- Identifies risk score and corresponding payment (or amount owed)

- Risk score comes back at 1.10 (Note: Average risk of market is 1.00)
- Plan does have higher risk (i.e.- sicker members than other plans in the market)
- Plan is eligible for a payment

Risk Adjustment Across Health Plans in a Market

Risk adjustment is funded by non-grandfathered plans with a lower than average risk population in or outside of exchange in a state. Risk adjustment payments are made to non-grandfathered plans with a higher than average risk population. Risk adjustment is done separately for individual and small group (SHOP) markets, unless they are merged into a single pool.



Relevant Laws and Regulations

ACA and Federal Guidance:

- **ACA provides for a program of risk adjustment (RA) for all non-grandfathered plans in the individual and small group markets both in and out of the exchange.** (*PPACA Section 1343)*
- **HHS, in consultation with the states, must establish criteria and methods for RA** *(PPACA Section 1343(b))*. **To fulfill this requirement, a "federally-certified risk adjustment methodology" will be developed and authorized by HHS to be used by states in determining average actuarial risk.** *(Reinsurance & Risk Adjustment NPRM §153.320)*
- **States may develop an alternate RA methodology which may become a Federally-certified RA methodology through HHS certification.** *(Reinsurance & Risk Adjustment NPRM §153.320(a)(2))*

- A state's alternate RA methodology should offer similar or better performance in that state than the Federally-certified RA methodology as determined based on specified criteria. *(Reinsurance & Risk Adjustment NPRM §153.320(a)(2))*

-After HHS approves a state alternative RA methodology, that methodology is considered a Federally-certified RA methodology. *(Reinsurance & Risk Adjustment NPRM §153.320(a)(2))*

- To assist states in assessing a potential alternate RA methodology, HHS will publish the basic standards any alternate RA methodology must meet in forthcoming guidance. *(Reinsurance & Risk Adjustment NPRM §153.320(c))*

- **States operating risk adjustment programs must use one of the Federally-certified risk adjustment methodologies that HHS will publish in future guidance which will include a full description of the risk adjustment model.** *(Reinsurance & Risk Adjustment NPRM §153.320(b))*

Pending Federal Guidance:

- Reinsurance & Risk Adjustment Final Rule currently at Office of Management & Budget (OMB) for review; expected publication in February 2012.
- HHS will release details about the federal model and an advance notice on federal parameters in mid-October 2012. States will have 30 days to submit requests to HHS for alternative risk adjustment model review and certification. In mid-January 2013, HHS will respond to state alternative models and publish the final notice.

Requirements and Functions to Develop a Risk Adjustment Model

Developing a risk adjustment model requires:

- Selection of the preferred risk adjustment model (i.e. the baseline software tool) and the technical decisions around that tool
  - Prospective vs. Concurrent/Retrospective model; Inclusion/exclusion of pharmacy categories; Data fields to be used (e.g. first five diagnosis fields versus all available); Appropriate premiums to apply risk adjustment results, etc.
- A risk adjustment methodology (rating parameters, etc.)
- Data collection and submission, model calibration, risk score calculation and reporting, charge/payment calculation and processing etc.
- Accessing, collecting, storing and analyzing large volumes of enrollment and claims data
- Establishing a data warehouse or using an All Payer Claims Database (APCD)
  - Often requires considerable time (many years) and budget.
  - NC does not have an existing APCD.

Timing is critical to the success of state alternative risk adjustment models.
If NC is leaning towards a state-based risk adjustment model, planning and data collection should begin ASAP.

Considerations

Any state operating an exchange may establish a risk adjustment program. If NC chooses to develop a risk adjustment model, it will administer all the risk adjustment functions (data collection and submission, model calibration, risk score calculation etc). Establishing a new risk adjustment model will be difficult given the tight timeline, even for states that have an existing All Payer Claims Database or existing resources and data infrastructure.

Pros of Developing and Administering a NC-based RA model	Cons of Developing and Administering a NC-based RA model
▪ Reflect NC insurance market characteristics ▪ Improved integration with other state programs such as rate review, reinsurance programs, etc.	▪ Financial burden to develop and maintain the model ▪ May cause confusion and additional costs for multi-state issuers ▪ Lack of APCD will add to the burden of developing NC-based model ▪ Additional detail forthcoming in the final regulations and in plan notice may reveal full extent of the risk adjustment responsibilities ▪ Risk adjustment tasks will be challenging in the first few years as there is no robust data set to set risk scores

Responses from Other States & Stakeholders

Other States' View Points and Approaches

- No states, thus far, have formally opted for a state-specific model. Massachusetts, Minnesota, Maryland, New York and Oregon appear to be the only candidates in a position to pursue this.
  - Massachusetts "greatly appreciate HHS's openness to allowing states that elect to operate a state-based Exchange to define their own risk adjustment model and methodology, subject to federal certification."[1]
  - Minnesota "is pleased that the proposed rule allows States with all payer claims databases the ability to propose an alternative State-based risk adjustment approach. However, we request that HHS be more specific about the validation requirements... We recommend that HHS develop a prospective risk adjustment model. We also suggest that HHS consider specific risk adjustment processes for the Native American population."[2]

[1]Massachusetts Letter to CMS, October 31, 2011; Comment Period on the Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Proposed Regulation.

[2]Minnesota Letter to CMS, October 31, 2011; Comment Period on the Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Proposed Regulation.

Options and Action Steps

Options	Action Steps
1. Defer to the Federal Risk Adjustment Model	• Wait for the federal model details that will be available October 2012 • Implement the model in NC (to be discussed next)
2. Defer to the Federal model now, but evaluate state specific model for later	• Re-evaluate decision at a later date after federal risk adjustment implementation
3. Explore development and administration of a NC-based risk adjustment model	• Start planning process for risk adjustment methodology now • Develop a broad work plan, which would include items such as: ▪ Establishing a data warehouse ▪ Selecting a vendor and develop NC-specific model ▪ Selecting an entity to administer the NC-specific risk adjustment program • Meet the federal timelines and requirements

TAG Meeting #3 Issues for Discussion

Risk Adjustment and Reinsurance Market Discussion Items

- Should NC explore development and administration of a NC-based risk adjustment model? What issues influence this decision?
- **If NC defers to the federal model, what role should NC play in administering the federal risk adjustment model at the state level? What entities are best suited to take on these administration responsibilities?**
- Who should make reinsurance policy decisions in NC? What characteristics should the non-profit entity responsible for the administration of reinsurance in NC have? What, if any, existing entities could administer reinsurance in NC?

Relevant Laws and Regulations

ACA and Federal Guidance:

- States operating HBEs are eligible to establish risk adjustment programs; HHS will run the risk adjustment program for states that elect not to establish an exchange and/or not to administer a risk adjustment program. *(Reinsurance & Risk Adjustment NPRM §153.310)*
- State may elect to have an entity other than the exchange perform the risk adjustment functions provided that the selected entity meets the requirements for eligibility to serve as the exchange as proposed in §155.110 of Exchange Establishment NPRM. *(Reinsurance & Risk Adjustment NPRM §153.310)*

  - Eligible entities include entities incorporated under and subject to the laws of one or more states that has demonstrated experience on a state or regional basis in the individual and small group markets and in benefits coverage and is not a health insurance issuer. Eligible entities include state Medicaid agencies. The entity must also meet specified requirements related to the structure of its governing board and related governance principles. *(Exchange Establishment NPRM §155.110)*

Requirements to Perform Risk Adjustment

- Risk adjustment expertise to administer the program and ensure accuracy of calculations/federal model administration
- Ability to receive and transmit data, data validation and maintain compliance with all applicable privacy and security standards
- Coordination with reinsurance, rate review and other programs, as needed
- Ability to make claim and encounter data available to HHS
  - Provide HHS with de-identified data for recalibrating Federally certified risk adjustment models
  - Provide HHS with summarized claim costs for verifying risk corridor submissions
  - Provide reinsurance entity with summarized claim data for payment verification, and individual level data for reinsurance audit purposes
- Ability to receive and make risk adjustment payments to insurers

Characteristics of Entities Well Suited for Risk Adjustment Administration

- Incorporated under state laws, experienced with small group and individual markets and not a health insurance issuer
- A neutral risk adjustment administrator with no conflict of interests
- Has risk adjustment expertise to administer the program, or be well-positioned to hire or contract for that expertise
- Has authorization and budget to administer the risk adjustment program
- Provides operational transparency, including a hotline for issuer questions and maintenance of records for audits
- Complies with any regulatory requirements potentially subject to oversight by responsible agency

During the in-person meeting, if the TAG wants to explore administration of the federal model at the state level, the TAG will discuss in more detail the characteristics of the entity needed for administration and make suggestions on which entities are best suited to take on these responsibilities.

Considerations

If NC does not develop a NC-based risk adjustment model, it can choose to administer the risk adjustment program or defer it to HHS. If NC opts to administer the risk adjustment program they must collect the data and meet other federal requirements. The state can select qualified entities such as state exchanges, insurance departments or a new state entity.

Pros of Deferring	Cons of Deferring
▪ Allows NC to focus on other areas of health reform implementation ▪ Takes advantage of federal resources and experience in risk adjustment programs ▪ Easier compliance with federal rules	▪ Less than ideal coordination with reinsurance, rate review and other state programs ▪ NC state resources may still be needed beyond risk adjustment administration (e.g. audit data, provide a data warehouse etc.)

There may be costs associated with deferring the program to HHS. At this time, it is unclear how to weigh these costs against administration of the federal risk adjustment model at the state level.

Responses from Other States & Stakeholders

Other States' Perspectives and Approaches

To date, no states who are operating a state-based exchange have formally deferred risk adjustment to the federal government.

- States, such as Arkansas, who have elected a federal exchange will have their risk adjustment program administered by the feds.
- Massachusetts "The Health Connector strongly supports HHS's perspective that an intermediate State-level approach in which claims data is collected and aggregated at the state level is the most balanced option for states that elect to implement a state-based risk adjustment process."[1]

Excerpts of National Dialogue

- **American Academy of Actuaries:** "Because the risk-adjustment mechanism will be administered at the state level, perhaps often by the states themselves, it could be argued that the data collection decision should be left to the states. A centralized approach can be viewed as vulnerable to data privacy issues; however, the advantage of a centralized national approach is that it facilitates uniformity across states, economies of scale for the administering agency/agencies, and a lowering of administrative expenses for multi-state issuers."[2]
- **Center of Budget and Policy Priorities:** "The Secretary should establish uniform basic standards for how states shall determine the entity that will administer risk adjustment. Possibilities include state exchanges, insurance departments, a new state entity, or the federal government."[3]

[1]Massachusetts Letter to CMS, October 31, 2011; Comment Period on the Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Proposed Regulation.

[2]AAA Letter to CMS, October 28, 2011; Comment Period on the Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Proposed Regulation.

[3]CBPP Ensuring Effective Risk Adjustment: An Essential Step for the Success of the Health Insurance Exchanges and Market Reforms under the Affordable Care Act. May 18, 2011.

Options and Action Steps

Options	Action Steps
Defer the risk adjustment program administration to HHS	• Cede all administration responsibilities to the feds • Start planning coordination with HHS on any state responsibilities under this option
Administer the risk adjustment program at the state level	• Do not defer any functions to the federal government; administer entirely at the state level • Determine risk adjustment program details such as financing, governance and oversight • Select a qualified entity to perform the risk adjustment functions
Work on a hybrid approach with other states for administration	• Pursue hybrid approach with other states, via a multi-state partnership ▪ Reach out to other states to explore partnership opportunities
Work on a hybrid approach with the feds for administration	• Pursue hybrid approach with the federal government based on partnership options allowed at the federal level (Details TBD) ▪ Determine which functions are preferred to be done in NC vs. at the federal level ▪ Negotiate with CMS in terms of shared responsibility

TAG Meeting #3 Issues for Discussion

Risk Adjustment and Reinsurance Market Discussion Items

- Should NC explore development and administration of a NC-based risk adjustment model? What issues influence this decision?
- If NC does not develop its own model, what role should NC play in administering the federal risk adjustment model at the state level? What entities are best suited to take on these administration responsibilities?
- **Who should make reinsurance policy decisions in NC? What characteristics should the non-profit entity responsible for the administration of reinsurance in NC have? What, if any, existing entities could administer reinsurance in NC?**

Transitional Reinsurance Scenario

Transitional Reinsurance Program protects insurers against migration of unknown number and risk of high cost individuals inside and outside the exchange for the first three years.

- "John" has been diagnosed with leukemia and treatment involves expensive blood products and a stem-cell transplant
- In the current market, John is unable to purchase insurance with his existing condition
- In 2014, under the ACA, John will be able to purchase a policy at the uniform rate
- Some of the excess costs for John's treatment, previously avoided by carriers via underwriting process, will be funded by temporary reinsurance under ACA

Payment for Treatment

Without a reinsurance program

- Health insurers reject high-risk/high-cost applicants, or price them at their actual risk – usually leaving them without coverage

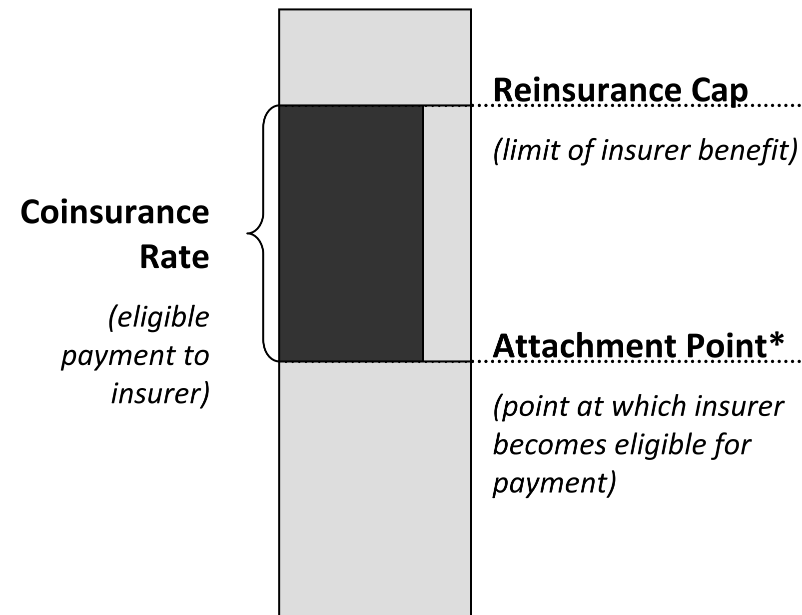
With a reinsurance program

- Health insurers forced to accept all applicants, regardless of health risk
- Reinsurance entity pays a significant portion of costs after the attachment point is met in transitional years 2014 - 2016

Reinsurance Details

The reinsurance is funded by all commercial health insurers and TPAs of self-insured plans both in and out of the exchange, including grandfathered plans. Benefits are paid to non-grandfathered individual market plans in or outside of the exchange.

Payment Model for Reinsurance



Sample Reinsurance Calculation

Reinsurance Parameters	
Attachment Point	$50,000
Coinsurance Rate	80%
Reinsurance Cap	$150,000
Insurer Liability if Total Claims Cost is $200,000	
Initial Claims Up to Attachment Point	$50,000
Claims Cost Up to Reinsurance Cap	$20,000 (20% x $100,000)
Claims in Excess of Reinsurance Cap	$50,000
Total Claims Cost Insurer	**$120,000**
Total Reinsurance Benefit	**$80,000**

*Attachment point is met when expenses for items and services within the essential health benefit package meet a certain $ amount

Source: Manatt Analysis; Wakely Consulting, *Analysis of HHS Proposed Rules on Reinsurance, Risk Corridors and Risk Adjustment*, July 2011

Relevant Laws and Regulations

ACA and Federal Guidance:

- By January 1, 2014 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. *(PPACA Section 1341)*
- States must enter into a contract with an existing "applicable reinsurance entity" or establish an applicable reinsurance entity to administer the reinsurance program. *(PPACA Section 1341(a))*
  - "Applicable reinsurance entity" means a "not-for-profit organization the purpose of which is to help stabilize premiums for coverage in the individual market in a State during the first 3 years of operation of an exchange." *(PPACA Section 1341(c))*
  - PPACA allows state flexibility in selecting an applicable reinsurance entity and proposed regulations do not provide more specific guidelines. *(Reinsurance & Risk Adjustment NPRM Preamble)*
- States may have more than one reinsurance entity. *(PPACA Section 1341(c)(2)*)
  - States that choose to have more than one reinsurance entity must publish information regarding geographic divisions between applicable entities; these divisions must be distinct and, together, cover the entire individual market in the state. *(Reinsurance & Risk Adjustment NPRM §153.210(a)(2))*
- Applicable reinsurance entities may operate reinsurance programs for more than one state, provided the entity maintains separate risk pools for each state's program. *(PPACA Section 1341(c)(2) and Reinsurance & Risk Adjustment NPRM §153.210(b))*

North Carolina Statute:

- Small Group Reinsurance Pool Statute (*NCGS 58-50-150; no longer in effect*), NC Motor Vehicle Reinsurance Facility Act (*NCGS 58-37*), Mandatory or Voluntary Risk Sharing Plans (*NCGS 58-42*), Life and Health Guaranty Association Statute (*NCGS 58-62*) are all statutes which address establishment of reinsurance programs within the state.

Key Functions of the Reinsurance Entity

- Receiving and transmitting data, data validation and protecting the confidentiality of data
- Conducting financial transactions, such as funds collection, management and disbursement
  - Reconciliation of data and financial transactions, such as contribution and payments
- Adjusting payments upon request to address shortfalls and excess contributions
- Analyzing and reporting, such as providing reports and data to the DOI, issuers, CMS
- Completing detailed financial analyses and projections on current and expected future federal contributions, attachment point, coinsurance rate and reinsurance cap
- Issuing annual notification on state parameters if different from federal parameters
- Providing a hotline for issuer questions, maintenance of records for 10 years
- Meeting transparency standards, such as disclosing any conflict of interest and being subject to financial audit
- Mitigating conflict of interest with any subcontractors

Reinsurance Entity Characteristics in Current NC Law

- North Carolina has established reinsurance entities through statute in the past.*
- Statutes generally establish basic parameters for the organizational and governance structure of the entity and set forth its functions and duties, while providing flexibility to the entity to establish specific operational processes.
- Statutes generally specify:
  - Organizational form (i.e., non-profit)
  - Basis for participation, including whether participation is mandatory and whether exemptions exist
  - Form of governing board (e.g., number of members, board representation, appointment process, length of terms, etc.)
  - Requirement that bylaws be established
  - Requirement that "Plan of Operations" be created, with high-level operational processes that must be addressed in plan, subject to Commissioner approval
  - Participation requirements (e.g., submission of data to entity)
  - Funding mechanisms/fee assessment amounts
  - Requirements for financial audits

* Relevant Statutes include: Small Group Reinsurance Pool Statute (*NCGS 58-50-150*), NC Motor Vehicle Reinsurance Facility Act (*NCGS 58-37*), Mandatory or Voluntary Risk Sharing Plans (*NCGS 58-42*), Life and Health Guaranty Association Statute (*NCGS 58-62*).

Reinsurance Policy Decisions

- Setting state-specific reinsurance payment parameters such as attachment point, coinsurance and reinsurance cap amounts
- Dealing with shortfalls and excess reinsurance contributions
- Increasing the carrier assessment above what is federally required or leaving the assessment “as is”
- Establishing a roadmap for transition of high risk pools into the individual exchange
- Sorting through the complexities associated with specific requirements (such as data submission standards for claims and enrollment for each benefit year and setting up a schedule for submission of data and payments to issuers/US Treasury)
- Establishing compliance monitoring tools, mechanisms and processes and reporting results

During the in-person meeting, the TAG will discuss in more detail who should have the authority to make reinsurance policy decisions. Examples for consideration include a state entity (such as the DOI), the legislature, and/or the reinsurance entity.

Technical or Operational Capacity

- Ability to collect contributions, process claims and make payments promptly
- Familiarity with reinsurance programs
- Capacity to house significant amounts of data for a long period of time to comply with federal auditing standards
- Sufficient longevity to pay reinsurance claims after 2016
- Use of HIPAA transaction standards for data collection
- Low administrative costs
- Authority to collect contributions

During the in-person meeting, the TAG will discuss in more detail what technical or operational capabilities the non-profit entity who will have responsibility for the administration of reinsurance must possess.

Governance and Organizational Characteristics

- Non-profit entity versus a non-profit subsidiary of a for-profit entity
- Existing entity versus new entity
- Single state entity versus multi-state entity (for administration only)
- Governing board composition and representation
- The role of the state in governance, oversight and/or policy-making
- Audit requirements
- Establishment of by laws or operational plans

During the in-person meeting, the TAG will discuss what governance and organizational characteristics are important to have in the non-profit entity who will have responsibility for the administration of reinsurance as well as which entities meet these characteristics.

Discussion Roadmap

- Project Goal and Webinar Objectives
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- **Next Steps**

Next Steps and Questions

- **Consider Information Provided for Discussion**
  - At next In-Person TAG Meeting, we will briefly review each area and quickly move into a discussion of each topic.
  - Email comments or thoughts on additional considerations or options to agarcimonde@manatt.com.
- **Review TAG #2 Kick Off Meeting Notes**
  - Notes will be approved at February 16th In-Person TAG meeting.
  - Notes will be used to draft briefs to the NC DOI for review.
- **Attend meeting on Thursday, February 16th from 9:00AM to 12:00PM at the NCIOM**

Any Questions?

- National Dialogue on TAG #3 Issues

National Dialogue on TAG #3 Issues

American Academy of Actuaries
Comments on Risk Adjustment Administration
"Because the risk-adjustment mechanism will be administered at the state level, perhaps often by the states themselves, it could be argued that the data collection decision should be left to the states. A centralized approach can be viewed as vulnerable to data privacy issues; however, the advantage of a centralized national approach is that it facilitates uniformity across states, economies of scale for the administering agency/agencies, and a lowering of administrative expenses for multi-state issuers. Similar considerations exist for choosing between an intermediate state-level approach and a distributed approach—balancing efficiency, transparency, maintaining confidentiality of personal health data, and ensuring the ability to audit the system." "In regard to data collection under risk adjustment, decision points include whether it should be a centralized, intermediate, or distributed approach." http://www.actuary.org/pdf/health/RSWG_comment_letter_on_3R_proposed_rule_111028.pdf
Comments on Risk Adjustment
"In regard to risk-adjustment methodology, decision points include the extent of state flexibility that should be allowed in adoption an approach to determine average actuarial risk and criteria for federal certification of state alternate methodologies." http://www.actuary.org/pdf/health/RSWG_comment_letter_on_3R_proposed_rule_111028.pdf
Comments on Reinsurance Administration
"State establishment of a reinsurance program will requires a decision point on unexpended reinsurance funds. The collection of reinsurance contribution funds will also require decision points such as a national contribution rate or state-level allocation and additional reinsurance contributions collected by states." http://www.actuary.org/pdf/health/RSWG_comment_letter_on_3R_proposed_rule_111028.pdf

National Dialogue on TAG #3 Issues

American Medical Association
Comments on Risk Adjustment
"HHS proposes to allow states flexibility with their risk adjustment models. Such flexibility may be helpful to states as they seek to tailor methodologies that meet their individual state needs. However, this could lead to great inconsistency across state lines and could lead to problems in trying to implement the program. HHS should consider creating options from which states can choose. This could lead to greater consistency and lessen the administrative burden on health insurance issuers and the physicians who provide care as part of their networks."   http://www.ama-assn.org/resources/doc/washington/aca-risk-adjustment-comment-letter-31oct2011.pdf

National Dialogue on TAG #3 Issues

Center on Budget and Policy Priorities

Comments on Risk Adjustment Administration

"The Secretary should establish uniform basic standards for how states shall determine the entity that will administer risk adjustment. Possibilities include state exchanges, insurance departments, a new state entity, or the federal government.

- Federal administration of risk adjustment across the states would provide uniformity in the application of the standard risk adjustment system. But because of concern about whether a federal entity will be familiar with a state's specific market conditions, this option may not be feasible in all states. It also may not make sense mechanically, since the ACA does not place the federal government in the position of collecting plan premiums. Instead, insurers will generally collect premiums directly from their customers, whether individuals or small employers. But in cases where the federal government has to step in and operate an exchange directly because the state has opted not to operate its own exchange, there is a compelling case for the federal government to directly carry out risk adjustment, given its importance to the viability of the federally operated exchange.
- State-based exchanges could administer the risk adjustment system. Exchanges would then have to be authorized by their state to collect the requisite data from the insurers and to administer the other aspects of the risk adjustment system, including collecting assessments and making distributions to the insurers. Giving this responsibility to the exchange makes the most sense if the exchange is also given the responsibility of collecting premiums from individuals and small businesses on behalf of insurers (which is an option for states), because the exchange will then be in a position to adjust premiums to account for plans' risk scores. However, while the ACA does not prohibit exchanges from becoming a "premium aggregator" (and such a role would lower transaction costs for individuals and small employers and thus make the exchanges more attractive), risk adjustment funds would need to be collected from and distributed to insurers selling outside the exchange as well as among plans inside the exchanges. Concerns may therefore arise as to whether the exchange can be expected to be a neutral risk adjustment administrator, especially in any states where exchanges are also given the authority to selectively contract for qualified health plans offered in the exchange.
- Another option would be to give the role of administration of risk adjustment to the state's insurance commissioner or insurance department. This would avoid the need to create a new, separate agency and would place the risk adjustment process in the hands of a staff that may already have the technical knowledge to fulfill the major functions needed to collect data from insurers, analyze and update the risk adjustment models, and so on. But the risk adjustment function, which is basically one of collecting funds and distributing them, may not mesh well with traditional regulatory functions, may engender conflict-of interest charges from insurers, and could drain scarce resources from staffs that will already have increased responsibilities under the ACA to implement the various insurance market reforms, many of which will take effect at the same time in 2014. (With the exception of a very few state insurance departments, such as New York's, risk adjustment is not part of their current responsibilities.)
- A fourth option would be to vest the risk adjustment responsibilities in a newly created independent state entity whose sole function would be to administer risk adjustment for the individual and small-group markets. Giving this agency independence from the exchange and state insurance department could give it the necessary neutrality expected from stakeholders. Importantly, however, this new agency would also need the ongoing authority and budget necessary to fulfill its responsibilities. Such an entity could be governed by a board comprised of stakeholder representatives including consumers, with equal say in the determination of policies related to agency operations (as some state exchange boards may be structured). It is important to avoid conflicts of interest that could interfere with effective risk adjustment; for example, insurers should be prohibited from such a governing board. Whether appointments to the board are made by the governor alone or in combination with the state legislature would also have to be determined, as would the terms of the appointment. Public transparency of the risk adjustment authority's decision-making process should also be required by the federal government, with an opportunity for public hearings and comment."

http://www.cbpp.org/files/5-18-11health.pdf

National Dialogue on TAG #3 Issues

Center on Budget and Policy Priorities (cont'd)
Comments on Risk Adjustment
"The Secretary should establish a standard risk adjustment methodology to be used by all states... States would be permitted to tailor this standard risk adjustment system to their specific market conditions, subject to federal approval. To help states implement risk adjustment and make any state-specific modifications to the standard risk adjustment system, the Secretary should make available technical assistance and all needed funds through federal grants to the states for setting up the health insurance exchanges." "States should be required to establish an all-claims database (meeting federal and state patient privacy protection standards) to provide information for risk adjustment and other purposes, such as initiatives to improve patient safety and the quality of privately insured health care." "Both HHS and the states should conduct audits of insurer data for compliance purposes and enforce related federal and state risk adjustment regulations. States should be encouraged to pass legislation requiring insurers participating in the exchange or otherwise licensed in the outside markets to comply and provide the necessary data for risk adjustment." http://www.cbpp.org/files/5-18-11health.pdf
Comments on Risk Adjustment Administration
"The designated entity administering risk adjustment will need to perform a number of duties, as specified by the Secretary. Such duties include: making any appropriate modifications to the federal risk adjustment methodology, collecting the required data from insurers, receiving contributions from insurers and making distributions to insurers as appropriate, determining risk scores, ensuring that plans adjust their medical loss ratios to take into account risk adjustment, financing the operational costs of the risk adjustment system, and supporting federal efforts to improve the risk adjustment system and ensure insurer compliance. The entity will also need to address a number of start-up issues, such as determining the amount of money they need to collect from insurers in the first couple of years to redistribute to plans with above-average risk scores." http://www.cbpp.org/files/5-18-11health.pdf

National Dialogue on TAG #3 Issues

National Association of Health Underwriters
Comments on Risk Adjustment
“NAHU strongly recommends that a state elect to develop its own risk-adjustment system... NAHU believes for the 35 states that have existing high-risk health insurance pools, those pools could easily be converted for the purpose of risk-adjustment administration at little to no cost to the state.” http://www.nahu.org/legislative/connector/Exchange%20Recommendations.pdf

National Dialogue on TAG #3 Issues

National Association of Insurance Commissioners
Comments on Reinsurance
"The NAIC supports the use of a national contribution rate for the reinsurance program. State-specific contribution rates will require all health insurance issuers, including administrators of self-insured plans to allocate the assessment base (premiums or enrollment, for example). This is not something that needs to be done on an issuer-by-issuer basis. Making and verifying the calculation at a state level for each issuer would be expensive to both the issuers and the states and likely would not guarantee either its accuracy or fairness. By using total premium, premium equivalents, or enrollment statistics, the total contribution, which is fixed in the law, can be allocated to issuers. Similarly, the total contribution can be allocated to states based on state-level premium, premium equivalent, or enrollment statistics that would be reported on a consistent basis state-by-state and sum to the national total. Then, each issuer would be directed to pay a calculated share to each state in which it does business. The efficiency and equity of this is to remove the concern that the amount paid by issuer A to state N is absolutely accurate. As long as issuer A believes that the total amount paid nationally is a fair and accurate share of its business, it does not really care if the amount it pays to N is too high or too low based upon differing views of how premium or enrollment should be allocated by state. Also, as long as state N feels that the amount it receives is a fair and accurate share of the nationwide total assessment, it should similarly not be concerned with the amounts it is getting from each carrier. Furthermore, under this system there is no reason why an affiliated group of carriers cannot bundle all payments due to a state, including those attributable to all of the self-funded plans it administers, and make a single payment." http://www.naic.org/documents/index_health_reform_111005_naic_letter_centers_medicare_medicaid_services.pdf

National Dialogue on TAG #3 Issues

State Health Reform Assistance Network
Comments on Reinsurance Administration
"The oversight and administration of the reinsurance pool will require two types of functions. First, a policy-setting function related to setting parameters, issuing regulations, monitoring compliance, and reporting results to the market. Secondly, an administrative function focused on funds collection, management, and disbursement, as well as the development of policies and processes to ensure sound financial stewardship. Critical functions to manage this program include the establishment and periodic modification of reinsurance parameters; assessment collections and cash management; claim intake (summary level) and payment; analysis and reporting; and claims auditing. Some of the key specific functions include the following: Specify source data for premiums (fully insured) and claims (self-funded) to which the national "contribution rate" will be applied; Define mechanism for issuers and TPAs to submit these contributions to the state; Establish process and methodology to audit premiums and claims on which the contributions were assessed, particularly with TPAs submitting as a percent of "total medical expenses;" Collect contributions; Define data required for submission of claims for reimbursement based on HHS guidelines, for non-grandfathered plans only; Remit the Treasury Department's portion of the reinsurance contributions back to the federal government; Complete detailed financial analyses and projections on the current and expected future federal contributions, attachment point, coinsurance rate, and reinsurance cap; Communicate methodology via a "state notice." The regulations require the establishment of a reinsurance entity, or the designation of an existing, non-profit reinsurance entity to carry out the provisions in the law. While the regulations suggest delegating this task to an independent non-profit entity, the regulations leave room for the possibility that this function can be overseen and managed by a state agency... Some states will elect to administer the reinsurance pool utilizing existing internal staff resources, but most will probably elect the use of a third party administrator to run the operations of the pool. The state will therefore need to provide for the time required to issue an RFP and establish the operational interfaces needed to get the TPA integrated and up and running when making plans to establish the program." http://www.rwjf.org/files/research/73728.wakely.reinsurance.12.12.11.pdf

National Dialogue on TAG #3 Issues

State Health Reform Assistance Network
Comments on Risk Adjustment
"States need to start analyzing alternative models early in 2012 if they are at all considering an alternative model... In addition to the choice of the risk adjustment model (i.e. the software tool), if a state decides to pursue an alternative risk adjustment program, there are other key technical decisions which will need to be made including the following: a) Prospective vs. Concurrent/Retrospective model b) Include pharmacy categories or not c) Data fields to be used (e.g. first five diagnosis fields versus all available) d) Appropriate premiums to apply risk adjustment results e) Rating variables and rating variable integration f) Area calculations and adjustments g) Scoring for members with insufficient experience" http://www.rwjf.org/files/research/73728.wakely.reinsurance.12.12.11.pdf
Comments on Risk Adjustment
"Risk adjustment will require the state to access, store, and analyze large volumes of enrollment and claims data. Because risk adjustment will impact the entire individual and small group health insurance markets, collecting these data will be a substantial task for any state. States choosing to develop and administer this program will need to develop the capability to intake, cleanse, standardize, securely store, and analyze large volumes of issuer claims and enrollment data. Key elements of this activity will include the acquisition of data warehousing hardware and software, with a dedicated staff to support the management, analysis, and reporting of this information, as well as the inevitable back-and-forth with issuers to ensure data accuracy and integrity. Other key requirements will include software licensing, maintenance, and updates, as well as developing the IT infrastructure and connectivity required to interface with issuers not only for the acquisition of claims and enrollment data, but also for information related to product rating and premium amounts." http://www.rwjf.org/files/research/73728.wakely.reinsurance.12.12.11.pdf