EXPERT UPDATE

Health Reform's Premium Stabilization Programs

HENDERSON BROTHERS

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On December 7, 2012, HHS released proposed regulations for Health Reform's Premium Stabilization Programs. There are three separate programs that have been designed to work together to reduce the uncertainty of insurance risk and provide issuers with greater payment stability beginning in 2014. Following is a brief summary of the three programs based on the most recent information available. We recognize that many of our clients are very alarmed about the Temporary Transitional Reinsurance Program fee. We are also aware that there is significant concern about the possibility of additional unspecified fees.

Temporary Transitional Reinsurance Program

The Act directs that a transitional reinsurance program be established in each State to help stabilize the premiums that will be charged in the INDIVIDUAL market from 2014 to 2016. If a state decides that it will not establish a transitional reinsurance program, HHS will establish the program for the state. The temporary reinsurance program, regardless of where it is operated, is designed to alleviate the need to charge extra premium for individuals enrolling in 2014 with "unmet" medical needs.

HHS intends to collect contributions from health insurance issuers and self-insured group health plans in all states, including those states that operate their own reinsurance programs. The proposed regulations also designate HHS as the entity to

distribute reinsurance payments to the individual market plans. The goal is to have a centralized and streamlined process for the collection of the fees and distribution of the reinsurance payments.

The proposed regulations indicate that HHS will require health insurance issuers and self-insured plans to submit an annual report that includes the average number of covered lives for each benefit year. The report will be due November 15th in 2014, 2015 and 2016. Issuers and self-insured plans will have the flexibility to select from several member counting methods to calculate this fee; the same methods that are available to calculate the Patient-Centered Outcomes Research (PCOR) Trust fee. The proposed regulations do not require that issuers and self-insured plans select the same exact method they use to calculate the PCOR fee.

Within 15 days of the submission of the annual enrollment count or by December 15, whichever is later, HHS intends to notify issuers and self-insured plans of the amounts to be paid based on the annual enrollment provided. Issuers and self-insured plans will then be obligated to remit the contribution within 30 days.

HHS has estimated the fee to be $5.25 per enrollee (member) per month in benefit year 2014. This estimated fee on an annual basis will increase plan cost for employers by $63 per member and will apply to full-insured and self-insured health plans offered in both the small and large group markets.

This new reinsurance provision will not apply to products offered by an issuer for Medicare Part C or D plans and it also will not impact expatriate group policies that are not filed and approved in a State. Some expatriate plans, specifically those that are written on a form filed with and approved by a State department of insurance, will be subject to this reinsurance program contribution, just as it is subject to other Affordable Care Act regulations. Issuers and third-party administrators will not be required to remit fees for "excepted benefits", including most Flexible Spending Accounts, Health Savings Accounts, EAP plans, wellness programs and disease management programs.

States may eliminate or modify their high-risk pools to the extent necessary to carry out the transitional reinsurance program. Because State high-risk pools and the transitional reinsurance program both target high-cost enrollees, high-risk pools can operate in parallel with the reinsurance program. Ultimately, States have the ability to decide whether to maintain, phase out, or eliminate their high-risk pools.

The proposed rule estimates administrative expenses for this program to be approximately $20.3 million. **This produces an estimated per member annual**

contribution rate of $.11 for the administration of the reinsurance program. It appears that this small fee will be assessed on fully-insured and self-insured health plans in addition to the $63 annual reinsurance contribution. HHS has requested comments on the approach to calculate administrative cost for the Transitional Reinsurance Program.

Risk Adjustment Program

This provision, which is a permanent program, is intended to mitigate the impact of possible adverse selection in the INDIVIDUAL and SMALL group markets, both inside and outside the public Exchange. It is designed to transfer funds from lower risk health plans to higher risk health plans. States that operate their own Exchange are eligible to establish their own risk adjustment program and risk adjustment rate methodology, or they may opt to have HHS operate the program for them instead.

The risk adjustment methodology proposed by HHS contains five elements, and it is built on the premise that premiums should reflect the differences in benefits and plan efficiency, not on health status of the enrolled individuals. The methodology HHS intends to use takes into account a member's recorded diagnoses, demographic characteristics, and other variables to determine how costly that individual is anticipated to be. Once the risk is determined for plan participants, HHS intends to average all the individual risk scores to develop the plan average actuarial risk. A plan's average risk score and its plan–specific cost factors relative to averages within the state risk pool will determine whether the plan is assessed charges or receives payments or funds from other plans.

HHS intends to collect a "user fee" for risk adjustment programs that they operate on a State's behalf. This fee, which is expected to be a user fee based on number of covered members just like the Patient Centered Outcomes Research Trust (PCOR) fee and the temporary transitional reinsurance fees, will be collected by HHS and will apply to issuers of risk adjustment plans in States that do not operate their own program. HHS anticipates that the total cost for them to operate the program on behalf of States for 2014 would be less than $20 million, and that the per capital (per member) user fee would be no more than **$1 per member per year.**

Temporary Risk Corridors Program

This risk program permits the Federal government and Qualified Health Plans (QHPs) to share in profits or losses between insurers resulting from inaccurate rate setting from 2014 to 2016. HHS proposes that QHPs will be permitted to include profits and taxes within its risk corridors calculations consistent with the Medical Loss Ratio calculation. Because the Risk Corridors Program and the Medical Loss Ratio (MLR) Rules have similar policy goals, the intent is to align both programs when practicable. It is possible the MLR rebate calculations for 2014-2016 will need to be modified to allow for reinsurance, risk corridor payments and risk adjustment payments and credits. HHS has requested comments.

Link to the proposed rule for HHS Notice of Benefit and Payment Parameters for 2014:

http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/html/2012-29184.htm

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