

Bulletin on the Transitional Reinsurance Program: Proposed Payment Operations by the Department of Health and Human Services

Table of Contents

Background:	2
Purpose and Scope:	2
Section I: Identifying Claims Eligible for Reinsurance Payments	5
A. Use of a Distributed Data Approach for Reinsurance Payments	5
B. Proposed Data Collection and Payment Calculation Approach	5
C. Minimum Data Needed for Determining Reinsurance Payments	6
D. Proposed Approach for Verification of Data	7
E. Privacy and Security Standards for Data	7
F. Ongoing Coordination Efforts	7
Section II: Reinsurance Payment Timing and Processes	8
A. Overview of Payment Schedules and Processes	8
B. Quarterly Reinsurance Payments	9
C. Annual Reconciliation of Reinsurance Payments	9
Section III: HHS Operated Reinsurance Payments - Proposed Key Dates and Timeframes	10

Background:

The Affordable Care Act established a number of programs to minimize the effects of adverse selection that may occur in the initial years of operation of Affordable Insurance Exchanges (Exchanges) and during implementation of market-wide insurance reforms. These programs are a transitional reinsurance program, the subject of this bulletin, a temporary risk corridors program, and a permanent risk adjustment program. This bulletin sets forth and seeks comment on HHS's proposed approach to the implementation of the payment of reinsurance funds to issuers when the Department of Health and Human Services (HHS) is operating the reinsurance program on behalf of a State. This bulletin is not comprehensive and does not include specific reinsurance fund collection, adjustments, or calculation parameters as these details will be proposed in the draft annual HHS Notice of Benefit and Payment Parameters, which is scheduled to be published in the fall of 2012. Comments received on the contents of this bulletin will be used to inform future guidance.

Purpose and Scope:

Section 1341 of the Affordable Care Act provides that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market during the years 2014 through 2016. All health insurance issuers, and third-party administrators (TPAs) on behalf of self-insured group health plans, will submit contributions to support reinsurance payments to issuers that cover high-cost individuals in non-grandfathered individual market plans. By statute, the aggregate national contributions for reinsurance payments are \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016. The transitional reinsurance program is an important element in helping to level the playing field across the non-group health insurance market, to moderate premium changes from the implementation of insurance reforms both inside and outside of Exchanges, as well as to set the foundation for the establishment of the Exchanges.

On March 23, 2012, HHS published a final rule to implement policy parameters governing the transitional reinsurance program (see Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Final Rule (45 CFR Part 153), published at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf>). Under the rule, HHS will make payments to health insurance issuers of non-grandfathered individual market plans for the HHS-operated program in States that elect not to operate a transitional reinsurance program.

In accordance with the final rule, reinsurance payments are based on a coinsurance rate or proportion of an issuer's claims costs that are above an attachment point and below a reinsurance cap for the applicable benefit year. The attachment point is the threshold dollar amount after which the issuer is eligible for reinsurance payments, while the reinsurance cap is the dollar limit at which point an issuer is no longer eligible for reinsurance payments. The attachment point, coinsurance rate, and reinsurance cap are calculated based on an issuer's total costs for an individual enrollee in a given calendar year. These State-specific reinsurance parameters will be detailed in the annual HHS Notice of Benefit and Payment Parameters.

The Affordable Care Act directs States to establish or to enter into a contract with one or more not-for-profit reinsurance entities to carry out a transitional reinsurance program. In support of State flexibility, the final rule clarifies that States, regardless of whether they establish an Exchange, may choose to establish a transitional reinsurance program or to have HHS establish the program on their behalf. HHS will operate the reinsurance program in all non-electing States. State-operated programs may modify

the Federal reinsurance parameters; however, any modifications to the Federal reinsurance parameters must be published in the State's Notice of Benefit and Payment Parameters by March 1, 2013 for the 2014 benefit year.

While State-operated reinsurance programs can elect to have HHS collect reinsurance contributions on their behalf, any State that elects to operate a transitional reinsurance program will be responsible for all payment functions. Many States are currently in the process of deciding whether they wish to operate the transitional reinsurance program or have HHS operate the program on their behalf. Understanding how reinsurance payments will be determined and disbursed when HHS operates this program on behalf of a State is information pertinent to a State's decision as payment operations are an integral part of running this State marketplace stabilization program. This bulletin provides information regarding reinsurance payments as well as the timing of those payments for individual market issuers operating in States that choose not to operate their own transitional reinsurance program.

In keeping with our commitment to a transparent policymaking process, we are providing information on our proposed approach to payment operations when HHS operates the transitional reinsurance program on behalf of a State. We believe that consulting with various stakeholders and providing technical assistance to States, issuers, and TPAs will help ensure that the reinsurance program is efficiently, effectively, and appropriately implemented. We also recognize that ongoing consultation with these parties is critical for a smooth reinsurance program implementation.

The purpose of this bulletin is to provide an overview of reinsurance payment operations relevant to the HHS-operated transitional reinsurance program. In particular, this bulletin specifies the processes and timeframes HHS will employ to identify, calculate, and disburse reinsurance payments for the HHS-operated program. Additional information, such as specific reinsurance payment parameters, will be proposed in the draft annual HHS Notice of Benefit and Payment Parameters.

This bulletin contains the following sections:

- Section I: Identifying Claims Eligible for Reinsurance Payments
 - Part A: Use of a Distributed Data Approach for Reinsurance Payments
 - Part B: Proposed Data Collection and Payment Calculation Approach
 - Part C: Minimum Data Needed for Calculating Reinsurance Payments
 - Part D: Proposed Approach for Verification of Data
 - Part E: Privacy and Security Standards for Data
 - Part F: Ongoing Coordination Efforts

- Section II: Reinsurance Payment Processes
 - Part A: Overview of Schedules and Processes
 - Part B: Quarterly Reinsurance Payments
 - Part C: Annual Reconciliation of Reinsurance Payments

- Section III: HHS-Operated Reinsurance Payments - Proposed Key Dates and Timeframes

Public input is welcome on the operational procedures proposed in this bulletin. Please send comments on this bulletin to: ReinsuranceBulletin@cms.hhs.gov.

Section I: Identifying Claims Eligible for Reinsurance Payments

A. Use of a Distributed Data Approach for Reinsurance Payments

While reinsurance is typically determined based on submission of claims and benefit data for payments, we are considering calculating reinsurance payments in the HHS-operated program based on the amount an issuer paid for a claim, as derived from an extract of an issuer's claims data. We intend that this calculation will be developed using a distributed data approach, similar to what HHS intends to employ when operating risk adjustment on behalf of a State. (In a distributed data approach, the required data is collected and stored by issuers for business purposes. Data extractions for reinsurance will be performed at a predetermined time for periodic exchanges of the data.) The distributed data model will allow issuers to receive reinsurance payments using systems that they are already establishing for the risk adjustment program, rather than having to use a separate process for submitting reinsurance payments.

The following sections discuss the methods HHS is considering for determining whether an issuer is eligible for reinsurance payments under a distributed data approach for the HHS-operated program. We seek comment on the use of the distributed data approach to calculate reinsurance payments, as well as the proposed operational approach described below.

B. Proposed Data Collection and Payment Calculation Approach

As with the risk adjustment program, HHS is considering various technology options in order to implement a distributed approach in the HHS-operated reinsurance program. In particular, we are contemplating having issuers map their data into a common data format and place the data on a server that is owned by the issuer. To identify the paid claims that would be eligible for consideration under the reinsurance program, we are examining one of two options:

1. HHS will run software on the data: CMS will remotely access the claims data on the issuer's edge server at predetermined times, and will run the software. The software will calculate the total amount an issuer paid on behalf of an individual enrollee. The totals, while based on enrollee-level claims, will be aggregated at the issuer level and will not contain any personally identifiable enrollee information. The summary level data would be reported to HHS and remain on the issuer's server.
2. HHS will provide the software to the issuer: The software will calculate the amount an issuer paid for an individual enrollee and the totals, while based on enrollee-level claims, will be aggregated at the issuer level. This information will not contain any personally identifiable enrollee information. The issuer would then be responsible for reporting the results to HHS.

As reinsurance payments are based on an issuer's total cost of an enrollee's claims throughout the benefit year, subject to reinsurance parameters for the State, the results of the HHS software calculated claim totals will take into account paid claims and adjustments accrued over the course of the year. HHS will perform this analysis and make available to the issuers the total amounts eligible for reinsurance prior to payments being issued.

HHS will conduct the preliminary calculation of reinsurance payments owed to an eligible issuer. The issuer will compare the HHS calculation with its own records and attest that the proposed payment

amounts are accurate before HHS makes a reinsurance payment to the issuer. This step will provide an additional check to confirm that the proposed process has accurately determined whether an issuer is eligible for reinsurance payments and that the calculated payment amount is correct.

HHS recognizes that this proposed approach for determining reinsurance payments will require detailed instructions to issuers on technology-associated requirements, in addition to issuers procuring server capacity and installing software. However, as HHS intends to use the distributed model when operating risk adjustment in both the individual and small group market, we propose that this same approach for reinsurance is the most efficient way to run the program. Individual market issuers that are eligible for reinsurance payments will already be establishing this type of distributed data approach as part of HHS-operated risk adjustment administration.

C. Minimum Data Needed for Determining Reinsurance Payments

Regardless of the specific mechanism for data collection, HHS plans to leverage commonly used data elements from existing claims data standards in order to minimize the burden to issuers. HHS intends to outline a minimum dataset needed to perform a reinsurance payment calculation and verify data submissions early in the process to ensure high quality data is available. HHS will define and provide business and technical information regarding each of the datasets needed and all included data elements needed from issuers in order to perform reinsurance payment calculations. Below is an example of a dataset that HHS could utilize to derive the reinsurance payment calculations.

Example: Dataset for Reinsurance Payments (Not for Final Requirement Purposes)

Data Types	Data Elements	Use of Data Types
Enrollee-level data	Enrollment effective dates	Reinsurance payments calculation
	Enrollment plan type	Verification of data
	Location (e.g. zip code, geographic rating area or both)	State parameters selection for reinsurance payments calculation
Plan-level data	Benefit year	Reinsurance payments calculation
	Individual versus small-group*	Verification of data
Medical claims data	Date of service	Reinsurance payments calculation
	Paid claim amount	Verification of data
Pharmacy claims data	Date of service	Reinsurance payments calculation
	Paid claim amount	Verification of data

*While reinsurance payments are only available to issuers in the individual market, if a common data format was used for risk adjustment and reinsurance, HHS will only look at individual market data when determining reinsurance payments.

HHS is also proposing to use a distributed data model when running risk adjustment on behalf of States. We are considering employing a common data format to administer both the reinsurance and risk adjustment programs. We seek comment on the proposed data types and elements needed for reinsurance payments, as well as the use of a common data format for the reinsurance and the risk adjustment programs.

D. Proposed Approach for Verification of Data

HHS aims to ensure the quality of the claims data used to determine reinsurance payments. Data verification will promote confidence and ensure integrity in the data used for calculating reinsurance payments. HHS seeks to promote consistency by establishing uniform verification requirements, and to protect privacy information by limiting data transfers through the process of verifying data.

To meet these objectives, HHS intends to verify all relevant reinsurance claims data on the issuer's edge server to ensure these data meet national coding standards, and only valid paid claims in the individual market are used in calculating reinsurance payments. For example, we are considering verifying specific claims elements such as Current Procedural Terminology (CPT) codes, place of service, and bill type, to ensure valid values exist. In addition, verification of data may include a review of claim dates of service and individual enrollment periods to ensure services are within the benefit year, and therefore, eligible for consideration for reinsurance payments. No individual claims level data with personally identifiable health information will be directly transmitted to HHS for the purpose of verification of data.

We will provide additional guidance on the development of the verification methodology and program audits as we address oversight and financial integrity in future rulemaking, under sub-regulatory technical guidance or other technical assistance engagement with stakeholders.

E. Privacy and Security Standards for Data

The policy objectives for the HHS-operated reinsurance distributed data approach are to ensure that issuer proprietary data remains within the issuer environment, and to minimize transfers of personal health information in order to lower privacy and security risks. As mentioned above, in a distributed approach, the data required to operate the reinsurance program is collected and stored in the issuer environment. HHS will receive summary level data by issuer; in addition, no individual claims level data with personally identifiable health information will be directly transmitted to HHS. This distributed data approach allows HHS to determine reinsurance payments in a manner that protects personal health information.

HHS will provide further direction in the form of user group calls, guidance, and technical assistance detailing specifications for encryption of data and security standards for reinsurance programs and databases. As we are intending to use a distributed data approach in the HHS-operated risk adjustment program, we anticipate that many of the specific privacy and security policies and procedures will apply to both programs. We solicit comment on specific privacy and security policies to apply.

F. Ongoing Coordination Efforts

HHS plans to consult with health insurance issuers about the use of the distributed data to calculate reinsurance payments, as we recognize that this method differs from how commercial reinsurance payments are typically determined. We also encourage stakeholders to submit comments regarding

how this proposal will interact with various delivery system models that operate in the individual market. HHS will continue to engage with issuers on the various technology platforms to implement a distributed approach. HHS also will continue to consult with States and issuers about their current data collection tools and capacity.

Section II: Reinsurance Payment Timing and Processes

A. Overview of Payment Schedules and Processes

In accordance with the final rule, reinsurance payments are based on claims incurred and paid by an issuer for an enrollee in a given calendar year. HHS intends to ensure payments do not exceed available contributions by prorating payments based on available funds. As the reinsurance program is a State-based program, this proration will be calculated at the State level, using funds collected in each State. In the event reinsurance contributions exceed payments for a particular benefit year, the remaining funds will be carried over to the following year. All payments will be made at the issuer level, based on the issuer's State of license.

We recognize that some issuers may experience high costs for their enrollees initially, while other issuers may incur such high costs closer to the end of the benefit year. It is HHS's goal to ensure that the reinsurance program provides some level of protection to issuers during the course of the entire benefit year, as new enrollees with unknown health status or expected costs enter the marketplace starting January 1, 2014. At the same time, we aim to ensure that issuers that are eligible for reinsurance payments later in the benefit year have equal access to the financial protection provided by this program. To this end, we are proposing a payment process in the HHS-operated program that withholds portions of payments and makes partial interim payments throughout the benefit year in order to ensure funds are available throughout the year. Any remaining funds due to an issuer will be paid at the end of the benefit year, subject to availability of funds, during an annual reconciliation.

To provide protection for issuers that incur high claims costs for an enrollee throughout the benefit year, HHS proposes to determine on a quarterly basis issuers' claims costs that may be eligible for reinsurance payments.¹ If an issuer is determined to have claims costs that are eligible for a reinsurance payment, the HHS-operated program will make payments based upon a fixed percentage of the issuer's calculated payments at the close of the quarter, prorating that fixed percentage based upon available funds. The HHS-operated program will pay the remaining portion of reinsurance payment via the annual payment reconciliation at the close of the benefit year, subject to fund availability. By withholding a portion of an issuer's calculated reinsurance payment in a given quarter until the end of the benefit year, HHS aims to ensure more equitable access to reinsurance payments for each issuer in a given benefit year regardless of when an enrollee's claims qualify for reinsurance payments.

The following sections provide a general description of the proposed quarterly payments and annual payment reconciliation. We seek comment on these processes and intend to discuss them with issuers, States, and relevant stakeholders in the upcoming months. State-operated reinsurance programs may elect, but are not required, to adopt similar processes for calculating and distributing reinsurance

¹The claims costs eligible for reinsurance payments are the proportion of an issuer's paid claims costs based on a coinsurance rate that are above an attachment point and below a reinsurance cap for the applicable benefit year.

payments. HHS will also provide technical assistance regarding payment process to State-operated programs as requested by the State.

B. Quarterly Reinsurance Payments

As mentioned above, HHS proposes to determine on a quarterly basis whether an issuer's claims costs have met the attachment point and are eligible for reinsurance payments. This will provide funding to compensate for individuals with high claims costs throughout the year.

An issuer's payment for a given quarter will be based on the calculated reinsurance payment for the quarter minus the amount withheld for an annual reconciliation. These amounts will be prorated based on the amount of funds available in each State's individual reinsurance fund. If an issuer's calculated reinsurance payments for that quarter cannot be paid in full due to fund availability, HHS is considering including the unpaid amount either at the close of the following quarter or at the end of the benefit year as part of the annual payment reconciliation. We seek comments regarding the quarterly reinsurance payments process.

C. Annual Reconciliation of Reinsurance Payments

Following the end of the applicable benefit year, HHS will calculate an issuer's final payment. This includes any quarterly reinsurance payment percentages withheld over the course of the benefit year, as well as any quarterly payments that were not paid in full as a result of fund availability; these amounts will be aggregated by issuer and State. To ensure payments do not exceed available contributions, this calculated payment will then be prorated against the available reinsurance funds for each State. Any reinsurance eligible claims not paid in full as part of the annual payment reconciliation will not be applied to future benefit years.

Section III: HHS Operated Reinsurance Payments - Proposed Key Dates and Timeframes

The chart below details key dates related to reinsurance payments when HHS is operating the reinsurance program on behalf of a State. As noted above, a more specific schedule of HHS's collection of contributions and disbursement of payments will be published in the annual HHS Notice of Benefit and Payment Parameters.

HHS issues Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Final Rule (45 CFR Part 153).	March 23, 2012
HHS conducts user group calls conducted with stakeholders	Summer 2012
Proposed date for HHS to engage volunteer issuers to beta - test data processing concept.	Fall 2012
HHS publishes the draft annual HHS Notice of Benefit and Payment Parameters, which includes Federal reinsurance parameters.	Fall 2012
Deadline for States to submit Exchange Declaration Letter for States that intend to administer their own reinsurance program.	At least 30 business days prior to January 1, 2013 (November 16, 2012)
HHS publishes the final annual HHS Notice of Benefit and Payment Parameters.	January 2013
HHS releases requirements for data processing and storage to issuers and begins to work with ALL issuers to train, test and implement data processing for the HHS-operated program.	Early 2013
States establishing a transitional reinsurance program issue State Notice of Benefit and Payment Parameters, which includes any State modifications to the Federal reinsurance parameters.	No later than March 1, 2013
HHS makes first reinsurance payments to issuers in States where HHS is operating the reinsurance program.	May 2014