

STATEMENT OF

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ON

**THE AFFORDABLE CARE ACT'S PREMIUM STABILIZATION PROGRAMS:
REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT**

BEFORE THE

**U. S. HOUSE COMMITTEE ON OVERSIGHT & GOVERNMENT REFORM,
SUBCOMMITTEE ON ECONOMIC GROWTH, JOB CREATION & REGULATORY
AFFAIRS**

**U. S. House Committee on Oversight & Government Reform,
Subcommittee on Economic Growth, Job Creation & Regulatory Affairs
The Affordable Care Act's Premium Stabilization Programs: Reinsurance, Risk
Adjustment, and Risk Corridors
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Chairman Jordan, Ranking Member Cartwright, and members of the Subcommittee, thank you for the opportunity to discuss the premium stabilization programs that Congress created in the Affordable Care Act. The Centers for Medicare & Medicaid Services (CMS) is working to implement these statutory programs to help provide stability in the health insurance market as the Affordable Care Act extends new benefits to consumers.

The Affordable Care Act made many significant reforms in the individual and small group health insurance markets, including ending discrimination based on pre-existing conditions, establishing essential health benefits, and removing annual and lifetime dollar limits on these benefits. These reforms work in tandem with the medical loss ratio, also known as the 80/20 rule, and rate review, to result in significant benefits for consumers, providing many with access to high-quality, affordable health insurance.

The Affordable Care Act also included programs – reinsurance, risk adjustment, and the risk corridors program – to stabilize premiums and the health insurance market. Based on similar, successful programs in the Medicare Part D prescription drug benefit, these programs are designed to reduce uncertainty, which improves the pricing and functioning of the health insurance market. They mitigate the impact of potential adverse selection inside and outside the Marketplace, while stabilizing premiums and encouraging plan participation in the individual and small group markets, including in the Marketplace.

Thanks in part to these programs, the Affordable Care Act will continue to provide consumers with affordable coverage options next year, encouraging issuers to participate in the Marketplace and compete on price and quality. In fact, multiple insurers have expressed confidence in the pricing environment for Marketplace plans, and CMS hopes that additional issuers will seek to participate in the Marketplace in 2015, as several have already said they will.

The reinsurance, risk adjustment, and risk corridors programs help ensure that the Affordable Care Act works as intended, with insurance plans competing on the basis of quality and service and not by seeking to attract the healthiest individuals. Better competition leads to improved coverage so that consumers — whether they are healthy or sick — can pick the best plan for their needs.

Background

CMS is working to implement the premium-stabilization programs as established by the Affordable Care Act. On March 23, 2012, CMS issued the Premium Stabilization Final Rule establishing standards related to reinsurance, risk corridors, and risk adjustment.¹ This Final Rule set a regulatory framework for implementing the three premium stabilization programs and other related policies. CMS provided additional guidance on the structure and administration of the programs in the Notice of Benefit and Payment Parameters for 2014, also known as the 2014 Payment Notice.² CMS released further details on the programs in the 2015 Payment Notice.³

Transitional Reinsurance Program

Section 1341 of the Affordable Care Act directs that a transitional reinsurance program be established in each state from 2014 through 2016. The reinsurance program is designed to partially reimburse the costs of high-cost enrollees in the individual market and thereby reduce premiums for enrollees in the individual market, to ensure market stability. The transitional reinsurance program is an important element in smoothing risk across the individual health insurance market as the 2014 market reforms go into effect, and sets the foundation for the establishment of the Marketplace. In accordance with section 1341, health insurance issuers and group health plans make contributions. Reinsurance payments are made to individual market issuers that cover high-risk individuals. As established by statute, estimated aggregate contributions for benefit year 2014 will total slightly more than \$12 billion – \$10 billion to be used for reinsurance payments and \$2 billion for the U.S. Treasury. For benefit year 2015,

¹ <https://www.federalregister.gov/articles/2012/03/23/2012-6594/patient-protection-and-affordable-care-act-standards-related-to-reinsurance-risk-corridors-and-risk>

² <https://www.federalregister.gov/articles/2013/03/11/2013-04902/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2014>

³ <https://www.federalregister.gov/articles/2014/03/11/2014-05052/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2015>

estimated aggregate contributions will total a little over \$8 billion, with \$6 billion to be used for reinsurance payments and \$2 billion for the U.S. Treasury. And for benefit year 2016, the target for aggregate contributions will total a little over \$5 billion, with \$4 billion to be used for reinsurance payments, and \$1 billion for the U.S. Treasury. In all three years, a small amount of contributions will go towards reinsurance administrative expenses.

Reinsurance contributions are based on a national per capita contribution rate, which CMS announces in the annual Payment Notice. Reinsurance payments to issuers are based on a portion of costs per enrollee paid once claims costs reach a certain level (attachment point) and until a payment limit (cap) is reached.⁴ States have the option to establish a reinsurance program and collect additional reinsurance contributions, regardless of whether they establish a Marketplace. If a state elects not to establish a reinsurance program, the Department of Health & Human Services (HHS) will establish the program and will perform all the reinsurance functions for that state.⁵

Temporary Risk Corridors Program

Section 1342 of the Affordable Care Act provides for a temporary risk corridors program from 2014 through 2016. The risk corridors program applies to qualified health plans (QHPs), both on and off the Marketplace, and certain substantially similar plans in the individual and small group markets. The temporary risk corridors program protects issuers of QHPs from uncertainty in rate setting from 2014 to 2016 by sharing in gains or losses resulting from inaccurate rate setting.

Modeled after a similar, permanent program established in the Medicare Modernization Act of 2003 for Medicare Part D, the temporary risk corridors program protects against uncertainty issuers face when estimating enrollment and costs resulting from the market reforms. The risk corridors program protects against uncertainty in rate-setting in the first three years of the Marketplace by creating a mechanism for sharing risk between the Federal government and issuers of QHPs. As established in statute, plans participating in the program with allowable costs that are at least three percent less than the plan's target amount will remit charges to HHS,

⁴ For 2014, the attachment point is \$45,000 and the cap is \$250,000.

⁵ Connecticut is the only state to establish its own reinsurance program, and is operating the program for 2014-2016.

while plans with allowable costs at least three percent higher than the plan's target amount will receive payments from HHS to offset a percentage of those losses. The risk corridors payment or charge amount will be calculated at the issuer level and then pro-rated based on the issuer's percentage of the market enrolled in QHPs, inside or outside the Marketplace, and plans that are substantially the same as a QHP.

We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, in the unlikely event of a shortfall for the 2015 program year, we recognize that the Affordable Care Act requires us to make full payments to issuers. In that event, we will use other sources of funding for the risk corridors payments, subject to the availability of appropriations (79 Fed. Reg. 30240; May 27, 2014).

Risk Adjustment Program

Section 1343 of the Affordable Care Act provides for a permanent risk adjustment program that applies to non-grandfathered individual and small group plans inside and outside the Marketplace. Risk-adjustment funds are transferred from plans with lower actuarial risk enrollees to plans with higher actuarial risk enrollees (such as individuals with chronic conditions) to protect against the potential effects of adverse selection. This is budget neutral within a market, within a state, meaning this program transfers funds between issuers. The risk adjustment program is designed to reduce the incentive for issuers to avoid the sick and market to only the healthy. Thus, the risk adjustment program is intended to create an environment in which premiums reflect differences in benefits and plan efficiency, not health status of the enrolled population.

States certified to operate their own Marketplace have the option to establish a risk adjustment program. If a state elects not to establish a risk adjustment program, HHS will establish the program and will perform all the risk adjustment functions for that state.

Operationalizing the Premium Stabilization Programs

The 2014 Payment Notice⁶ gave further guidance to issuers on how the premium stabilization programs would be implemented and administered in the 2014 plan year, the first year of Marketplace operations.

As a part of this Payment Notice, CMS finalized the reinsurance payment formula and methodology for calculating reinsurance contributions, and set requirements for the submission of reinsurance and risk adjustment data. It established uniform payment parameters for the 2014 benefit year to support fair and equitable access to the reinsurance funds. This approach allocates reinsurance contributions where they are most needed, to reimburse issuers with enrollees with high claims cost in the individual market in 2014, 2015, and 2016. This policy is consistent with the goal of the transitional reinsurance program – to stabilize premiums in the individual market in the initial years of market reform and Marketplace implementation. While each state was given the opportunity to establish and operate its own transitional reinsurance program, as of January 31, 2014, Connecticut is the only state operating a transitional reinsurance program.

In addition, CMS provided further specificity in the 2014 Payment Notice on the treatment of profits and taxes in the calculation of risk corridors, and aligned the calculation of risk corridors data with the applicable single risk pools.

2015 Payment Notice

Earlier this year, the Department issued the 2015 Payment Notice⁷ establishing the 2015 reinsurance payment parameters and contribution rate, and additional provisions related to implementing the premium stabilization programs, including certain oversight provisions for these programs.

While the Department has largely finalized the regulatory framework of these programs, we continue to work with all stakeholders to operationalize these programs. It is important to note that the premium stabilization programs work together with other market reforms, such as the

⁶ <https://www.federalregister.gov/articles/2013/03/11/2013-04902/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2014>

⁷ <http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf>

80/20 rule, to save consumers money on their premiums. We anticipate that the first payments from these programs will occur in the summer of 2015 for the 2014 benefit year. Those payments are timed to align with the data collection and payment calendar for the 80/20 rule for the 2014 benefit year.

The 2015 Payment Notice expands on the provisions of the Premium Stabilization Rule,⁸ the 2014 Payment Notice,⁹ and the first and second final Program Integrity Rules,^{10,11} by establishing HHS's authority to audit state-operated reinsurance programs, contributing entities, and issuers of risk adjustment covered plans and reinsurance eligible plans. It also finalized participation standards for the risk corridors program, and outlined a process for validating risk corridors data submissions and enforcing compliance with the provisions of the risk corridors program.

Conclusion

The Affordable Care Act created the reinsurance, risk corridors, and risk adjustment programs to stabilize premiums and the insurance market in the first years of the new Marketplace. The programs reduce uncertainty for issuers so the market can function more smoothly, encouraging issuers to participate in the Marketplace and offer high-quality, affordable plans, and stabilizing premiums for consumers. CMS believes that these programs are an important part of our efforts to mitigate adverse selection and limit the consequences of uncertainty that could prevent Americans from accessing health insurance. The first payments and transfers from these programs will not likely begin until the summer of 2015. I appreciate the opportunity to discuss the regulatory framework outlined by CMS. I look forward to answering your questions.

⁸ <https://www.federalregister.gov/articles/2012/03/23/2012-6594/patient-protection-and-affordable-care-act-standards-related-to-reinsurance-risk-corridors-and-risk>

⁹ <https://www.federalregister.gov/articles/2013/03/11/2013-04902/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2014>

¹⁰ <http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21338.pdf>

¹¹ <http://www.gpo.gov/fdsys/pkg/FR-2013-10-30/pdf/2013-25326.pdf>