The Three R's
Reinsurance, Risk Adjustment, Risk Corridors

New Mexico Health Insurance Exchange
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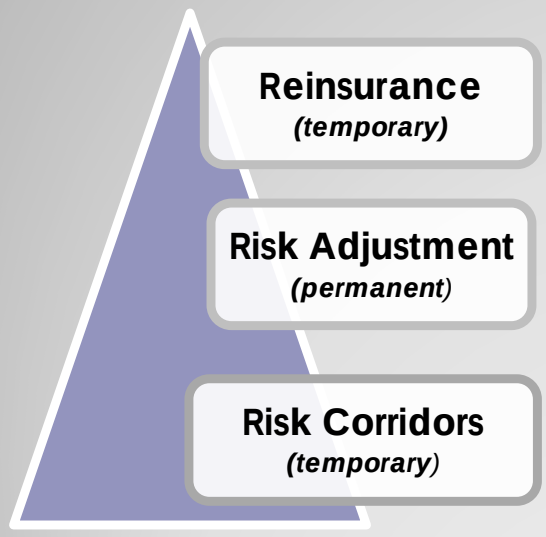
The Three R's

"Risk leveling" programs required by the Affordable Care Act (ACA) to help protect insurers in the individual and small group markets against risk selection and market uncertainty, and ensure Exchange and market viability.



Protects insurers offering individual coverage from the risk of high cost claims and allows for lower premium levels.

For individual and small group insurers, assesses charges to insurers with enrollment of less-than-average risk and "transfers" those dollars to insurers with enrollment of higher-than-average risk.

Limits the extent of issuer gains or losses inside the Exchange. Insurers with costs less than projected remit a percentage of savings to HHS; insurers with costs more than projected receive a payment from HHS.

Why The 3R's Matter

- Risk-leveling programs are critical to a viable health benefit market in 2014 and after
- Adverse selection must be minimized to ensure adequate choice and affordability
  - Adverse selection occurs when individuals at greater risk of high health spending are more likely to purchase coverage than low-risk individuals
  - Higher premiums result which lead to more low-risk individuals opting out of coverage which lead to even higher premiums
- Insurers will not be able to price Exchange products accurately if the 3 R's are not clearly understood, modeled, and communicated

Increased Insurer Risk Under ACA

- Guaranteed issue means insurers must accept all applicants regardless of health status
- Individual mandate does not have adequate penalties to ensure that healthy individuals will comply
- Insurers are prohibited from excluding pre-existing conditions or varying premiums based on health status
- Substantial influx of previously uninsured individuals makes it difficult to price plans accurately
- High risk individuals will add cost to the market that were previously managed separately

Reinsurance

- What market segment does it apply to?
  - Individual market both in and out of the Exchange
- Is it permanent or temporary?
  - Temporary for 2014, 2015, and 2016
- How does it work?
  - Reimburses individual market issuers for claims of a certain size

Year	Payment Formula	Total Payout
2014	80% of claims between $45,000 and $250,000	$10 Billion
2015	50% of claims between $75,000 and $250,000	$6 Billion
2016	Not yet announced	$4 Billion

Reinsurance

- Who pays for it?
  - All health insurance issuers and self-funded group plans (if using a TPA) through a per capita assessment

Year	Annual Per Capita Assessment
2014	$63
2015	$44
2016	Not yet announced

  - Amounts above include contributions to the US Treasury and to cover the cost of administering the program

Reinsurance

- What is the timing?

Date	Contributions	Payments
11/15/14	Issuers submit enrollment count to HHS	
12/15/14	HHS sends invoice to issuer	
1/15/15	Issuers remit $52.50 per capita to HHS	
4/30/15		Reinsurance-eligible plans submit claim data
6/30/15		HHS remits claim payments
12/15/15	Issuers remit $10.50 per capita to HHS for US Treasury and admin	

Risk Adjustment

- What market segment does it apply to?
  - Individual and small group markets both in and out of the Exchange
- Is it permanent or temporary?
  - Permanent
- How does it work?
  - A risk score is assigned to each enrollee based on parameters of age, gender, and diagnoses
  - An average risk score is calculated for each issuer licensed in a state, for each market and geographic area
  - A payment transfer formula will be used to transfer payments between issuers within the state

Risk Adjustment

- Who pays for it?
  - Issuers in the individual and small group markets both in and out of the Exchange transfer funds to each other with a revenue-neutral result
  - Issuers of risk adjustment covered plans pay a per capita fee of $1.00 per year
- What is the timing?

Date	
March 2015	Issuer data ready for 2014 risk adjustment
June 2015	Issuers pay per capita fee
June 2015	Payments and charges determined for calendar year 2014
July 2015	Payments due (or received)

Risk Corridors

- What market segment does it apply to?
  - Qualified Health Plans (QHPs) in or out of the Exchange
- Is it permanent or temporary?
  - Temporary for 2014, 2015, 2016
- How does it work?
  - HHS sets a target amount of expenditures on medical care for each QHP based on 78% of premium
  - Plan takes full risk for actual claims falling within 3% of the target
  - Plans with claims less than 97% of target pay a portion of the difference to HHS
  - Plans with claims greater than 103% of target receive a portion of the difference from HHS

Risk Corridors

- Who pays for it?
  - Risk corridor payments are not required to net to zero
  - Federal government could experience an increase in revenue or costs under the program if receipts and payments do not balance
- What is the timing?
  - After reinsurance and risk adjustment payments have been made