Health Benefit Exchange; Reinsurance, Risk Corridors and Risk Adjustment: *Proposed* Federal Regulations

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August 22, 2011

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shaping policy for a healthier state

Agenda

- HBE Proposed Regulations
  - Overview
  - Establishment of HBE
  - Consumer Assistance, Consumer Protection, Education and Enrollment
  - Special requirements for SHOP Exchange
  - Certification requirements for HBE and QHPs
- Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

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Overview

- Proposed regulations issued: July 15, 2011
- Proposed regulations available at: http://www.healthcare.gov/center/regulations/exchanges07112011a.pdf.
- Comments due to CMS no later than September 28, 2011.

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Overview

- Proposed regulations organized into two sections:
  - Part 155: Exchange Establishment Standards and Other Related Standards under the Affordable Care Act.
  - Part 156: Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges.
- There are often parallel requirements for the HBEs and the issuers of Qualified Health Plans (QHPs).

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Agenda

- Proposed HBE Regulations
  - Overview
  - **Establishment of HBE**
    - **Governing board,**
    - **Stakeholder consultation,**
    - **Financial self-sufficiency**
    - **HBE functions**
  - Consumer Assistance, Consumer Protection, Education and Enrollment
  - Special requirements for SHOP Exchange
  - Certification requirements for HBE and QHPs
- Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

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Establishment of a State Exchange (155.105-155.106)

- States that choose to operate a HBE must have an approved plan, and demonstrate ability to execute plan through readiness assessment no later than Jan. 1, 2013.
  - Can receive conditional approval (if HBE does not meet requirements for full unconditional approval).
    - If state does not have full or conditional approval by 2013, then feds will establish and operate an HBE.
  - States can later choose to operate an HBE after 2014, but must have an approved (or conditionally approved) plan and operational readiness assessment at least 12 months in advance of effective date of coverage.
  - States can cease operation by giving notice at least 12 months in advance.

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Governing Board (155.110)

- If an independent state agency or non-profit must have a governing board.
  - Must operate under formal, publicly adopted charter or bylaws that includes ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest.
  - Must hold regular public board meetings announced in advance.
  - Must ensure overall governing board membership is not made up of a majority of voting representatives with a conflict of interest (including insurers, agents, brokers, or others licensed to sell insurance).
  - Must ensure that a majority of voting members have relevant experience in “health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.”

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Stakeholder Consultation (155.130)

- HBE must regularly consult with:
  - Educated health care consumers enrolled in Qualified Health Plans
  - Individuals/entities with experience facilitating enrollment in health coverage
  - Advocates for hard to reach populations, including individuals with mental health or substance abuse disorders
  - Small business and self-employed individuals
  - State Medicaid and CHIP agencies
  - Federally-recognized Tribes
  - Public health experts
  - Health care providers
  - Large employers
  - Health insurance issuers
  - Agents and brokers

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Financial Self-Sufficiency
(155.160, 156,50)

- State must ensure that HBE has sufficient funding to support operations after Jan. 1, 2015, by:
  - Charging assessments or user fees on participating issuers (which may include health insurance issuers, QHP issuers, multistate plans, stand-alone dental plans, or other issuers identified by the HBE), *or*
  - Otherwise generate funding for HBE operations. States may use broad-based funding (eg, general state revenues, provider taxes, or other funding that spreads costs beyond user fees on participating issuers), as long as the funding does not violate other state or federal laws.
- If the HBE charges user fees on participating issuers, it must announce the fees in advance of the plan year.

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Functions of HBE (155.200)

- HBE must:
  - Issue certificates of exemption.
  - Perform eligibility determinations.
  - Provide appeals process for eligibility determinations.
  - Perform functions for oversight and financial integrity.
  - Evaluate quality improvement strategies, and oversee implementations of enrollee satisfaction surveys, ratings of health care quality and outcomes, information disclosure and data reporting.

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Agenda

- Proposed HBE regulations
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  - Establishment of HBE
  - **Consumer Assistance, Consumer Protection, Education and Enrollment**
    - **Consumer assistance tools, Navigators, Agents and brokers**
    - **Enrollment and termination of enrollment**
    - **Payment of premiums**
    - **Notices**
    - **Privacy and security**
  - Special requirements for SHOP Exchange
  - Certification requirements for HBE and QHPs
- Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

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Consumer Assistance Tools (155.205)

- HBE must operate toll free call center.
- HBE must also maintain an Internet website that:
  - Includes standardized comparative information on QHPs, including premium and cost sharing information, summary of benefits and coverage, identification of level of plan, results of enrollee satisfaction survey, quality ratings, medical loss ratio, transparency of coverage measures, and provider directory.
  - Is accessible to people with disabilities, and must provide meaningful access to people with limited English proficiency.

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Consumer Assistance Tools (155.205)

- HBE must also maintain an Internet website that (cont'd):
  - Includes financial information on licensure, regulatory and other required payments to HBE, HBE administrative costs, and monies lost to waste, fraud and abuse.
  - Provides information on navigators and consumer assistance services.
  - Allows for eligibility determinations and enrollment in coverage.
  - (Note: DHHS considering requirement to allow applicants/enrollees to store and access personal account information.)
- HBE must also make available an electronic calculator (to facilitate comparison of QHPs after premium tax credits and cost sharing reductions).
- HBE must conduct outreach and education.

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Navigator Requirements (155.210)

- To be a navigator, an entity must:
  - Demonstrate an existing, or that it could readily establish relationships with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible to enroll in a QHP.
  - Meet licensure or certification or other standards.
  - Not have a conflict of interest during the term as Navigator.
    - Navigator cannot be a health insurance issuer.
    - Navigator cannot serve both as a navigator and agent/broker (with financial compensation from insurer) for plans sold inside the HBE; however, agent/broker can serve as a navigator for plans sold inside the HBE, and still receive commission to enroll employers or individuals in non-QHPs (ie, outside the HBE).

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Navigator Requirements (155.210)

- HBE must provide Navigator grants to at least two of the following category of entities:
  - Community and consumer-focused nonprofit groups
  - Trade, industry, and professional associations
  - Commercial fishing industry organizations, ranching and farming organizations
  - Chambers of commerce
  - Unions
  - Resource partners of the Small Business Administration
  - Licensed agents and brokers, and
  - Other public or private entities that meet the requirements of this section (such as Indian tribes, tribal organizations, or state and local human service agencies).

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Navigator Requirements (155.210)

- Navigators must be able to:
  - Maintain expertise in eligibility, enrollment and program specifications and conduct public education.
  - Provide information/services in fair, accurate, and impartial manner.
  - Facilitate enrollment in QHPs.
  - Provide referrals to applicable consumer assistance or ombuds program.
  - Provide information in manner that is culturally and linguistically appropriate.

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Navigator Funding (155.210)

- Funding may *not* be from federal funds received by the State to establish the HBE.
- However, if the state chooses to permit or require Navigator activities to address Medicaid/CHIP administrative functions (eg, outreach and enrollment), and such functions are performed under a contract or agreement that specifies a method for identifying costs/expenditures related to Medicaid and CHIP activities, the Medicaid/CHIP agency may claim federal funding for the share of expenditures at normal administrative match rate.

NCIOM

Agents and Brokers (155.220)

- States may choose to allow agents and brokers to:
  - Enroll qualified individuals, employers or employees into a QHP offered through the HBE.
  - Assist individuals in applying for advance payments of premium tax credit and cost sharing reductions.
- The HBE may provide information regarding licensed agents and brokers on its website.

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Enrollment Periods for Qualified Individuals (155.410-420; 156.260)

- Initial enrollment period: Oct. 1, 2013-Feb. 28, 2014.
- Annual enrollment period: Oct. 15-Dec. 7th (for Jan. effective date).
- Special enrollment period (60 days after triggering event):
  - Some of the triggering events include, but are not limited to: losing minimum essential coverage; gaining dependent (eg, through marriage, adoption, birth); newly eligible for advance payment of premium tax credit or has change in eligibility for cost sharing reductions; a permanent move.
  - Coverage usually effective first day of following month if selection before 22nd of prior month, or first day of 2nd month following selection; however, special effective dates for specific categories (eg, birth or adoption effective on first day).

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Termination of Coverage for Qualified Individuals (155.430; 156.270)

- Individuals may terminate coverage with appropriate notice.
- QHP/HBE may terminate coverage if:
  - Individual no longer eligible for coverage through the HBE.
  - Enrollee becomes covered with other minimum essential coverage.
  - Payments cease (after 3 consecutive month allowable grace period for people receiving advance payment of tax credits).
  - Coverage is rescinded.
  - QHP is terminated or decertified.
  - Enrollee changes QHP during open or special enrollment period.
- QHP must provide HBE and enrollee with a notice of termination.

NCIOM

Payments of Premiums
(155.240)

- HBE *must* allow individuals to pay premiums directly to the QHP issuer.
  - HBE *may* allow individuals to pay premiums to HBE.
- HBE *may* permit Indian tribes or tribal organizations to pay QHPs premiums on behalf of qualified individuals.
- HBE *must* accept payment of aggregate premium by a qualified employer.
- HBE *may* establish a process to facilitate collection and payment of premiums through electronic means.
- HBE *must* establish protocols to ensure integrity of financial transactions.

NCIOM

Notices (155.230, 156.250)

- Any notice the HBE sends to applicants, qualified individuals, qualified employers or employees, or enrollees must include:
  - Contact information for customer services.
  - Information on appeal rights, if applicable.
- Notices must be written in plain language and provide meaningful access to people with limited English proficiency or disabilities.

NCIOM

Privacy and Security of Information (155.260-270)

- HBE must ensure privacy and security of personally identifiable information.
  - Any person who willfully uses or discloses information is subject to a civil penalty of up to $25,000 per person or entity.
- HBE must also use applicable HIPAA or HIT standards and protocols.

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Small Business Health Options Program (SHOP) (155.440)

- SHOP must perform all the same functions as HBE. In addition:
  - SHOP *must* allow qualified employer to select a level of coverage (so that all the QHPS within that level of coverage are available to qualified employees).
    - Alternatively, SHOP *may* allow qualified employer to make one or more QHPs available to qualified employees.
  - SHOP *must* offer premium aggregation (eg, collect from the employer the total amount due and make payments to the QHP issuers in the SHOP for all qualified employees).

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Qualified Small Business
(155.710; 156.285)

- Qualified small employer must:
  - Meet size requirements (ie, have at least one but not more than 50 (or 100) employees).
  - Offer coverage, at a minimum, to all full-time employees.
  - Have principal business address in SHOP service area or offer coverage through the SHOP serving that employee's primary worksite.
- SHOP must verify employer and employee eligibility
  - Can verify through attestation, or through other verification methods.
  - If questions raised, must provide employer/employee 30 days to present documentary information to verify application.
  - Must provide appeal rights if denied coverage.

NCIOM

Enrollment of Qualified Employees in SHOP(155.720-730)

- SHOP must establish uniform enrollment timeline for eligibility determinations (for employers and employees), plan selection and enrollment.
  - Must reconcile enrollment information and employer participation in QHPs at least monthly.
- Rolling enrollment: Qualified employers can purchase coverage for its small group at any point during the year.
  - SHOP must establish annual open enrollment period prior to new coverage year.
  - New employees can enroll effective first day of employment.
- SHOP must use single application for employer and employee.

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Special Rules for QHPs in SHOP(156.285)

- QHP must meet corresponding requirements, including:
  - Accepting payment from SHOP on behalf of employers.
  - Adhere to SHOP timeline for rate setting, and charge the same rate for a plan year.
  - Provide for annual and special enrollment periods.
  - Provide enrollees with applicable materials (eg, enrollment information, summary of benefits).
  - Reconcile enrollment information at least monthly.
  - Follow applicable termination rules and send appropriate notices.
    - If employer terminates coverage in QHP, must send notices to all covered employees.

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    - **Accreditation**
    - **Rate and benefit Information, Transparency in coverage**
    - **Network adequacy, Essential community providers**
    - **Direct primary care medical homes, Stand-alone dental plans, Abortion services**
    - **Prescription drug and cost reporting**
- Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment

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Certification Process for QHPs (155.1010, 1075, 1080; 156.290)

- HBEs must establish QHP certification standards.
  - Multi-state plans are exempt from the certification processes.
- HBE must establish recertification process that must be completed on or before Sept. 15 of applicable year.
- HBE must establish process to decertify QHPs:
  - Appeal rights for any plan that is decertified.
  - Enrollees have special enrollment period to switch plans.
- QHPs can also choose not to renew:
  - Must notify HBE prior to beginning of recertification process, and send note to enrollees.

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Minimum Certification Requirements (156.200, 225)

- To participate in HBE, QHP must:
  - Be certified by the HBE.
  - Comply with all HBE federal and state requirements, be licensed in each state in which the issuer offers insurance, comply with benefit design, implement and report on quality improvement strategies and health care quality, pay applicable user fees, and comply with risk adjustment program.
  - Offer at least one QHP in silver and gold coverage levels, and child only plans at same coverage levels.
  - May not discriminate on basis of race, color, disability, age, sex, health history, etc.

NCIOM

Accreditation (155.1045-1050, 156.275)

- QHPs must be accredited by agency recognized by US DHHS.
  - QHPs must be accredited on performance in: clinical quality measures, patient experience, consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information.
- HBE must establish uniform standards for health plans to obtain accreditation, if not already accredited.

NCIOM

QHP Rate and Benefit Information (156.210, 156.255)

- QHP issuer must set rates for an entire benefit year, or for SHOP, an entire plan year.
- QHP may vary premiums by geographic rating areas established by the state; but must charge the same premium rate whether the plan is offered through the HBE, directly from the issuer, or through an agent.
- QHPs must cover all the following groups, using some combination of: 1) Individuals, 2) two-adult families, 3) one-adult family with a child or children; and 4) all other families.
- DHHS will issue other rating rules in separate regulation.

NCIOM

QHP Rate and Benefit Information (156.210, 155.1020)

- HBEs must receive information, at least annually from the QHP, including rates, covered benefits and cost-sharing requirements.
  - HBE must consider rate increases, including the justification for the rate increase prior to implementation of the increase, recommendations from the state Dept. of Insurance, and any excess of rate growth outside the HBE as compared to the rate increase inside the HBE.
- QHP/HBE must make information on enrollee cost sharing for participating provider to enrollee in timely manner.

NCIOM

Transparency in Coverage (156.220, 155.1040)

- QHP issuer must set rates for an entire benefit (or for SHOP, plan) year.
- Must provide information to the HBE, including:
  - Claims payment policies and practices; periodic financial disclosures; data on enrollment, disenrollment, and number of claims that are denied; data on rating practices, information on cost-sharing and payments for out-of-network coverage, and information on enrollee rights.
  - Information must be provided in “plain language.”

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Service Area and Network Adequacy (155.1055, 156.230, 155.1050)

- HBE must have a process to establish or evaluate QHP service areas.
  - QHPs must cover entire counties, and cannot include racial, ethnic, language, or health status factors that exclude high cost or medically underserved populations.
- HBE must establish network adequacy standards.
  - HHS did not set uniform national standard because network adequacy standards should be appropriate to state's geography, demographics, local patterns of care and market conditions.
  - Note: HHS seeking additional comments on network adequacy
  - QHP must meet network adequacy standards.

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Essential Community Providers (156.235)

- QHP must include in the provider network *a sufficient number* of essential community providers that serve predominantly low-income, medically underserved individuals.
  - Essential community providers include 340B eligible health care providers, and other similar organizations (eg, FQHCs, public or nonprofit hospitals).
  - QHP not required to contract with all essential community providers.
- QHP must make its provider directory available to the HBE for online publication, and must identify providers who are not accepting new patients.

NCIOM

Essential Community Providers (156.235)

- HHS notes conflicting statutory provisions, and are seeking comments to address the conflicting provisions. (1302(g), 1311(c)(2) of the ACA:
  - QHP is *not* required to contract with essential community provider if the provider refuses to accept generally applicable payment rates (1311(c)(2) of the ACA); however, another section of the ACA requires QHPs to pay FQHCs no less than Medicaid prospective payment (1302(g) of the ACA).
  - Indian Health Providers have the right to recover from third party payers, including insurance companies, up to the reasonable charges billed for providing health services, or if higher, the highest amount the insurer would pay to other providers—regardless of whether or not there is a contract between the insurance company and Indian health provider. (Sec. 206 of the Indian Health Care Improvement Act)

NCIOM

Primary Care Medical Homes
(156.245)

- QHP may provide coverage through direct primary care medical home, as long as other requirements met.
  - Direct primary care medical home is an arrangement where a fee is paid by or on behalf of an individual directly to a medical home for primary care services.

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Stand-Alone Dental Plans
(155.1065)

- HBE must allow stand-alone dental plans as long as the plan covers at least pediatric dental essential benefit plan.
  - Can be offered alone or in conjunction with QHP.

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Segregation of Funds for Abortion Services (156.280)

- QHPs must comply with state laws, if state prohibits abortion coverage in QHP
  - Nothing in the ACA requires a QHP issuer to provide abortion coverage as part of its essential health benefits.
- If state allows, and QHP provides abortion coverage, the QHP may not use any of the premium tax credit or cost sharing reduction towards the cost of abortion coverage
  - Must collect payment from enrollees for the actuarial value of the abortion coverage separately from other payments and keep it in a separate allocation account.
  - In determining actuarial amount, must take into account additional costs, but may not take into account cost reductions.
  - QHP may not discriminate against providers who refuse to provide or refer for abortion services.

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Prescription Drug Reporting (156.295)

- QHPs must provide information to HHS on:
  - Percentage of all prescriptions provided under contract through retail pharmacies vs. mail order, and percentage of prescriptions for which generic drug was available and dispensed compared to all drugs dispensed by pharmacy type.
  - Aggregate amount of drugs, type of rebates (or other price concessions) that are passed through to the plan sponsor.
  - Aggregate amount of the difference between the amount the QHP issuer pays the pharmacy benefit manager and the amount the PBM pays retail pharmacies, mail order pharmacies, and total number of prescriptions dispensed.
  - Confidentiality protections for the use of the information.
  - Penalties for failing to provide required information.

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- **Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment**

NCIOM

Proposed Standards: Reinsurance, Risk Corridors, Risk Adjustment

- DHHS also issued proposed rules on reinsurance, risk corridors, and risk adjustment
  - Released July 15, 2011, 76 Fed. Register 41930 http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17609.pdf
  - Comments due no later than September 28, 2011

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Program	Reinsurance	Risk Corridors	Risk Adjustment
What	Provides funding to plans that enroll highest cost individuals	Limit issuer loss and gains	Transfers funds from lowest risk plans to highest risk plans
Program Oversight	State or state option if no state run HBE	US DHHS	State option in a state-run HBE
Who Participates	All issuers and TPAs contribute funding; non-grandfathered individual market plans (inside and outside HBE) are eligible for payments	Qualified health plans	Non-grandfathered individual and small group market plans, inside and outside HBE
When	Throughout the year 2014-2016	After reinsurance and risk adjustment 2014-2016	After end of benefit year 2014 and subsequent years
Why	Offset high cost outliers	Protect against inaccurate rate setting	Protects against adverse selection
Time Frame	3 years (2014-2016)	3 years (2014-2016)	Permanent

76 Fed. Reg. 41932

Other Relevant Proposed Regulations

- The federal government released other proposed regulations on August 17th that are relevant to the operations of an Health Benefit Exchange. These will be discussed at a later meeting:
  - Health insurance premium tax credit. (IRS)
  - Exchange Functions in the Individual Market, Eligibility Determinations, Exchange Standards for Employers. (HHS)
  - Medicaid Program Eligibility Changes under the Affordable Care Act. (HHS)
- Copies of the proposed regulations can be obtained by searching on the federal register main page: http://www.gpoaccess.gov/fr/

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Questions

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Transitional Reinsurance Program (153.210-240)

- States that operate a state based HBE must establish a reinsurance program through a contract with one or more nonprofit reinsurance entities
  - States that do not create HBEs may still operate a reinsurance program if it chooses.
- States must collect contributions from health insurance issuers, third party administrators, and self-insured group health plans
  - Federal government will set a contribution rate based on a percentage of premiums (in fully insured market) or percent of total medical expenses (in self-funded market)

NCIOM

Transitional Reinsurance Program (153.210-240; 153.400-410)

- Non-grandfathered health plans eligible for reinsurance payment when expenses for essential health benefits of an individual enrollee exceeds an “attachment point”.
  - Reinsurer pays a portion of losses past the attachment point (“coinsurance rate”) but is less than a “reinsurance cap.”
  - Payments may be reduced, on a pro rata basis, to match the amount of contributions the state receives.

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Risk Adjustment (153.300-153.350)

- A state that elects to operate the HBE is eligible to establish a risk adjustment program, but is not required to do so.
  - HBE or other eligible entity may perform risk adjustment functions.
- States must use a federally certified risk adjustment methodology.
  - The federal government will specify the risk adjustment methodology to use in states that are not eligible or choose not to establish a risk adjustment mechanism.
  - States can choose to use an alternative methodology if approved by the federal government.

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Risk Adjustment (153.300-153.350; 153.610-620)

- State, or HHS on behalf of the state, will collect:
  - Claims and encounter data for items and services rendered; enrollment and demographic information, prescription drug utilization data.
- Data must be validated to determine accuracy of the data.
  - Claims and encounter data will be used to support other activities, such as verifying risk corridor submissions, verifying and auditing reinsurance claims.
  - Data may also be used to support other HBE activities such as cost-sharing requirements and quality reporting.

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Risk Corridors (153.500-153.520)

- US DHHS will share risk and losses with QHPs.
  - HHS sharing of losses:
    - When QHPs allowable costs are between 103%-108% of the target amount, HHS will pay the QHP 50% of the target amount in excess of 103%.
    - When QHP's allowable costs are more than 108%, HHS will pay the QHP an amount equal to the sum of 2.5 percent of the target amount, plus 80% of the allowable costs in excess of 108 percent of the target amount.

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Risk Corridors (153.500-153.520)

- HHS capturing profits:
  - If QHP's allowable costs for the benefit year are between 92-97% of the target amount, the QHP must remit an amount equal to 50% of the difference b/t 97 percent of the target amount and the allowable cost.
  - When the QHP's allowable costs are less than 92 percent of the target amount, the QHP must remit an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the allowable costs.
- QHPs must submit premium data to HHS adjusted for funds received or paid for risk adjustment, reinsurance, or other fees.

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