AMERICAN ACADEMY of ACTUARIES

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Re: Potential Approaches for Identifying High-Risk Individuals and Determining Payments Under the Temporary Reinsurance Program

Dear Dr. Buntin:

On behalf of the American Academy of Actuaries'[1] Risk Sharing Work Group, I appreciate this opportunity to provide input to the Department of Health and Human Services regarding the temporary reinsurance program to be enacted as part of the Patient Protection and Affordable Care Act (PPACA). PPACA vests the American Academy of Actuaries with providing recommendations to the Secretary of Health and Human Services regarding the law's reinsurance provisions. In particular, Section 1341 vests the Academy with providing recommendations for identifying high-risk individuals and for determining reinsurance payment amounts. This letter outlines our preliminary input on potential approaches.

According to the provisions of PPACA, the temporary reinsurance program will be funded by payments from all health insurance issuers in the individual and group markets, including self-insured plans. Reinsurance payments will be made to health insurance carriers that cover high-risk individuals in the individual market (excluding grandfathered plans). Our understanding of Congressional intent with the inclusion of the reinsurance program includes: (1) protecting carriers from the potential higher costs of a newly enrolled group of individuals that may differ significantly from the population that carriers traditionally have covered, and (2) helping to keep individual market premiums affordable through subsidized reinsurance payments. Our discussion of the various potential options will include an assessment of whether and how they would meet these goals.

The Academy has a long history of providing objective technical expertise on health insurance regulatory issues, leveraging our members' professional expertise and familiarity with health insurance from a variety of perspectives. The intent of this letter, therefore, is not to advocate for a particular approach but, rather, to explore different alternatives and provide input on the advantages and disadvantages of those alternatives. The work group that developed this letter

[1] The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

includes actuaries representing a cross section of the health insurance market, including those with particular expertise with reinsurance issues. As a result, our objective in providing you these comments is to provide a balanced perspective in the hope of contributing to the development of technically sound rulemaking regarding Section 1341.

Risk-Sharing Provisions in PPACA

We recognize that reinsurance is part of a larger risk-sharing approach in PPACA that also includes risk adjustment and risk corridors. Risk adjustment will adjust carriers' premiums to reflect the relative health status risk of their enrollees. Risk corridors will mitigate large losses (and profits) through an aggregate risk-sharing mechanism. Subsidized reinsurance will provide protection against particularly high-cost individuals. The methodology adopted for each of these three risk-sharing mechanisms together will determine the success in meeting the two goals mentioned above. Since the risk adjustment and risk corridor features still are being designed, this letter focuses on reinsurance methodologies. It also provides some insights on the potential interaction of the reinsurance program with the risk adjustment and risk corridor mechanisms.

Key Evaluation Criteria

There are several key criteria that should be considered when developing the reinsurance program. The prioritization of these criteria will help determine which methods are more appropriate to meet the intended goals. These criteria are listed below and are briefly considered as each potential method is discussed later in this document:

- The inclusion of appropriate incentives to control costs;
- The appropriate alignment of payments with risk/needs;[2]
- The interaction between the various risk-sharing mechanisms;
- The interaction between the private reinsurance market and the reinsurance program, especially since this is a temporary program;
- The administrative burdens on carriers and the administering agency must be considered, especially since this is a temporary program;
- The availability of necessary data.

Outline of Discussion

The different methodologies for the reinsurance program are outlined briefly. Then we describe each of the methodologies in detail, listing the key considerations and tabulating the advantages and disadvantages per the key evaluation criteria above. These advantages and disadvantages are summarized in the Appendix to provide a quick comparison across the methodologies.

We hope that these details will help clarify which methodologies should be further considered by the Secretary.

[2] Note that it is important to match payments to risks on the carrier level, not necessarily on the individual level. Some individual risks will be under reimbursed, and others will be over reimbursed, but the goal should be to match risks in the aggregate for a given carrier.

Potential Approaches for the Reinsurance Program

We address two components of the reinsurance program. The first is the identification of the insureds who would be subject to reinsurance. The second is the determination of reinsurance payments. Listed below are potential approaches for identifying high-risk individuals and determining the reinsurance payments. Within certain boundaries, each option may be modified to achieve key outcomes in the implementation of the temporary reinsurance program.

Please note the following regarding these approaches:

- Not all identification methodologies are compatible with all payment methodologies.
- The discussion of these methods is presented on a fairly high level. Upon selection of one or two preferred methodologies, further analysis may be needed to work out the implementation details and to verify that the goals of the program are met.

Part I: Potential Approaches for Identifying High-Risk Individuals

We have identified four potential approaches for identifying high-risk individuals. Below is a brief description of each approach. A detailed discussion of each method's key considerations, advantages, and disadvantages is provided later in this document.

***Method 1*:** Use a pre-set list of conditions (and potentially services) based on diagnoses (and potentially procedures, their volume and/or prescription drugs). This list may differentiate between severity levels within a condition. Co-morbidities also may be considered.

***Method 2*:** Use a pre-set list of conditions (and potentially services and their volume) based on self-reported answers to questionnaires.

***Method 3*:** Use a pre-set risk score threshold from the risk-assessment model used for implementing risk adjustment.

***Method 4*:** Use a pre-set threshold of actual health care costs (i.e., attachment point) or actual health care utilization priced at a fixed-fee schedule.

Variations or combinations of the above methods are discussed later in this document.

Part II: Potential Approaches for Determining Reinsurance Payments

We have identified two approaches for determining reinsurance payments. Below is a brief description of each approach. A detailed discussion of each method's key considerations, advantages, and disadvantages is provided later in this document.

***Method A*:** Prospective payment using a fixed schedule by condition (and, potentially, services). This also may be viewed as another layer of risk adjustment that refines risk assessment at the "right-hand tail" of the cost distribution.

***Method B*:** Determine payment using a traditional individual reinsurance approach of applying an attachment point, a coinsurance percentage, and a ceiling.[3] Variations within this approach may be the use of actual costs versus the use of actual utilization priced at a fixed fee schedule.

Variations and combinations of these methods are also considered.

Detailed Discussion of Potential Approaches for Identifying High-Risk Individuals

Method 1: Claims-Based Identification per a Pre-Set List of Conditions

This approach is already specified as an option in Section 1341 (b)(2)(A)(i). It would use a specific list of medical conditions based on diagnostic (and, potentially, procedure codes) that are indicative of preexisting high-risk conditions. Individuals found to have one or more conditions on the condition list based on historical claims data would be considered high-risk and therefore eligible for payment/reimbursement.

Key Considerations

- The condition list could be limited to conditions with an average cost greater than a given attachment point, or it could include conditions with a significantly higher than average likelihood of exceeding the attachment point.
- The condition list could be limited to conditions associated with catastrophic claims costs (e.g., threshold of $250,000 or higher), or it could include conditions that are generally high-cost, but noncatastrophic (e.g., threshold of $50,000). The appropriate threshold would be dependent upon several factors, including, but not limited to:
  - Available reinsurance funds, and
  - The proportion of catastrophic claims costs targeted to remain as the carriers' responsibility.
- Condition lists that differentiate individuals by severity of condition as well as condition itself (i.e., Stage I breast cancer vs. Stage III breast cancer) would be more accurate but would add complexity.
- Conditions could be limited to preexisting conditions that might have led a carrier to reject an application prior to the implementation of guaranteed issue. Alternatively, conditions could include those diagnosed after the policy is issued as well. The prospective approach would identify the increased risks associated with guaranteed issue, but would not reflect the carrier's entire risk for the year as well as a concurrent or retrospective approach.
- The condition list could be based on diagnoses only, or it also could include high-cost procedures/services (e.g., transplants) and measures of service volume. If high-cost procedures/services are not chosen carefully, carriers could be rewarded for poor management of these services. In other words, if the reinsurance program is not designed carefully, there could be no disincentives for the overutilization of high-cost procedures that are covered by the program.

[3] The work group also discussed an aggregate reinsurance approach. We have not included that methodology in this document since it is similar to the risk-corridor approach, which is already part of PPACA's risk-sharing framework.

- The quality of claims data used to identify individuals may exhibit a lack of uniformity. These disparities may exist between individuals with and without previous health coverage. Disparities also may be a result of differing data capabilities of carriers and non-uniform data-collection processes for carriers inside and outside the exchange. This could lead to bias in the identification of high-risk individuals. A strong claims audit function would assure carriers that they and their competitors would be subject to similar data standards.
- The condition list may need to be updated over time.

Method 1: Claims-Based Identification per a Pre-Set List of Conditions
Cost Control
• Provides incentives for cost control since identification is based on the presence of conditions, not high-cost outcomes. • Potential for perverse incentives to perform procedures that are included in the condition/procedure list.
Matching Payment to Risk
• Given an appropriate list of conditions, there is a fairly good potential to match payments to risk This method, however, still might not capture all actual spending in the tails of the distribution. • To the extent that historical claims are not available, identification of risk will be incomplete if done prospectively. • While the use of procedures and services, in addition to diagnoses for identifying high-risk individuals, would add to the method's predictive power, it still could miss some individuals who have one or more of the stated conditions. • To the extent that coding is not uniform across providers, this method's objectivity in matching payment to risk will be somewhat compromised.
Interaction with other Risk-Sharing Mechanisms
• Assuming the list of conditions is a subset of that used in the risk-adjustment model, the mechanisms can be coordinated effectively. • Interaction with risk corridors is dependent on the design of the risk corridors. It is not expected to be complex.
Interaction with Private Reinsurance
• Private reinsurance still could be purchased to cover large claims not covered by the condition list.
Administrative Burden
• Administrative burden on carriers is likely to depend heavily upon the similarity of condition lists and data requirements to those associated with the risk-adjustment model. • The administering agency will need to develop the list of conditions (and potentially measures of co-morbidities, procedures, and/or service volume) based on a large research effort.
Data Availability
• Necessary claims data may not be available, particularly in the first year of the program if prospective identification is used. This is due to the expected high number of previously uninsured individuals who will enter the individual insurance market.

Method 2: Questionnaire-Based Identification per Pre-Set List of Conditions

This is a variation on Method 1, but instead of using claims-based data to identify high-risk individuals, covered individuals would be asked to complete a questionnaire regarding health

status. Individuals found to have one or more conditions on the condition list (based on questionnaire responses) would be considered high-risk and therefore be eligible for payment/reimbursement.

Key Considerations

- The condition list could be limited to conditions with an average cost greater than a given attachment point, or it could include conditions with a significantly higher-than-average likelihood of exceeding the attachment point.
- The condition list could be limited to conditions associated with catastrophic claims costs (e.g., threshold of $250,000 or higher), or it could include conditions that are generally high-cost, but noncatastrophic (e.g., threshold of $50,000). The appropriate threshold would be dependent upon several factors, including but not limited to:
  - Available reinsurance funds, and
  - The proportion of catastrophic claims costs targeted to remain as the carrier's responsibility.
- Condition lists that differentiate individuals by severity of condition, as well as condition itself (i.e., Stage I breast cancer vs. Stage III breast cancer), would be more accurate but would add complexity.
- Conditions could be limited to preexisting conditions that might have led a carrier to reject an application prior to the implementation of guaranteed issue. As an alternative, conditions could include those diagnosed after the policy is issued, as well. The prospective approach would identify the increased risks associated with guaranteed issue, but would not reflect the carrier's entire risk for the year as well as a concurrent or retrospective approach.
- The condition list could be based on diagnoses only, or it also could include high-cost procedures/services (e.g., transplants) and measures of service volume. If high-cost procedures/services are not chosen carefully, carriers could be rewarded for poor management of these services.
- The condition list may need to be updated over time.
- The questionnaire could be administered either prior to enrollment or at some time after enrollment. The former approach would allow prospective reinsurance payments, but preexisting conditions disclosures may not always be self-reported accurately if individuals have concerns about privacy or that revealing information could result in coverage denial or higher premiums. The latter approach may elicit more truthful and complete responses since the member has already secured coverage, is using health care services, and may become more aware of the PPACA provisions.
- Self-reported data can be unreliable. Efficient processes to improve reliability, objectivity, and uniformity should be considered if this approach is implemented.

Method 2: Questionnaire-Based Identification per Pre-Set List of Conditions
Cost Control
• Provides incentives for cost control since identification is based on the presence of conditions, not high-cost outcomes. • Potential for perverse incentives to perform procedures that are included in the condition/procedure list.

Matching Payment to Risk
• Given an appropriate list of conditions, there is a fairly good potential to match payments to risk. This method, however, still might not capture all actual spending in the tails of the distribution. • The lack of objectivity may lead to inconsistent identification of risk, particularly if the condition list includes distinctions related to condition severity. • While the use of procedures and services, in addition to conditions for identifying high-risk individuals, would add to the method's predictive power, it still could miss some individuals who have one or more of the stated conditions.
Interaction with other Risk-Sharing Mechanisms
• Assuming the list of conditions is a subset of that used in the risk adjustment model, the mechanisms can be coordinated effectively. Differences in the data sources used for the two mechanisms (claims data vs. questionnaires) may pose some problems in coordinating the two mechanisms. • Interaction with risk corridors is dependent on the design of the risk corridors. It is not expected to be complex.
Interaction with Private Reinsurance
• Private reinsurance still could be purchased to cover large claims not covered by the condition list.
Administrative Burden
• The distribution and processing of questionnaires may be burdensome, particularly to smaller carriers. If one central agency distributes and processes the questionnaires, the agency will have the burden of coordinating the effort in a timely manner. • The administering agency will need to develop the list of conditions (and potentially measures of co-morbidities, procedures, and/or service volume) based on a large research effort.
Data Availability
• Data would not be immediately available, but could be gathered through the dissemination of questionnaires. • Availability would be dependent on the willingness of covered individuals to respond.

Note that if the identification for all enrollees needs to be done on a prospective basis, a combination of Methods 1 and 2 is a possibility—but it would make the process quite complicated. Enrollees with claims-experience data would be identified as high-risk based on their claims data, while those without historical experience would be identified based on their questionnaire responses. Due to the differing data sources, carriers with significant ongoing enrollment (and therefore using historical claims data) may hold a meaningful advantage (or be at a meaningful disadvantage) compared to carriers with a large percentage of previously uninsured individuals (using questionnaires). As a result, this approach may not be feasible. Nevertheless, if the Secretary would like to pursue this further, we will follow up with additional details.

Method 3: Risk-Score Threshold Based Identification of High-Risk Individuals

This approach employs a threshold generated from the risk-assessment model used to risk-adjust carriers' premium revenue. Individuals who meet or exceed the threshold would be classified as high-risk and therefore would be eligible for reimbursement.

Key Considerations

- The threshold could be based on an individual's risk score (i.e., the individual's relative expected costs), the variability around the predicted risk score (i.e., the individual's risk or uncertainty), or a combination of the two (i.e., the likelihood of excessive claims costs).
- The appropriate threshold would be dependent on several factors, including, but not limited to available reinsurance funds.
- The combination of a binary selection (high-risk or not high-risk) with a continuous measurement (risk score) may make the selection of a risk-score threshold appear somewhat arbitrary. In other words, those individuals who "just miss" the cutoff may not be particularly different from individuals who "just make it."
- The quality of claims data used to identify individuals may exhibit a lack of uniformity. These disparities may exist between individuals with and without previous health coverage. In addition, disparities may result from differing data capabilities of carriers and from non-uniform processes of data collection from carriers inside and outside the exchange.

Method 3: Risk-Score Threshold Based Identification of High-Risk Individuals
Cost Control
• Provides incentives for cost control since identification is based on the presence of diseases, not high-cost outcomes.
Matching Payment to Risk
• Assuming the risk-adjustment mechanism is appropriate, those individuals identified as high risk should represent those with the highest expected cost. This method, however, still might not capture all actual spending in the tails of the distribution. • To the extent that historical claims are not available, the risk score from the risk-adjustment mechanism may not be an appropriate measure of risk, particularly if a prospective approach is used. • To the extent that coding is not uniform across providers, this method's objectivity in matching payment to risk will be somewhat compromised.
Interaction with other Risk-Sharing Mechanisms
• This method has the potential to coordinate extremely well with a risk-adjustment mechanism, since it would be based on that model. • Interaction with risk corridors is dependent on the design of the risk corridors. It is not expected to be complex.
Interaction with Private Reinsurance
• Private reinsurance still could be purchased to cover large claims not covered by the risk-score criteria.
Administrative Burden
• Unlikely to add significant administrative burdens not already being added by the risk-adjustment mechanism.
Data Availability
• Under prospective risk adjustment, data would not be available for many individuals, especially in the first year. This is due to the expected high number of previously uninsured individuals who will enter the individual insurance market.

Note that if the identification for all enrollees needs to be done on a prospective basis, a combination of Methods 2 and 3 is a possibility—but it would make the process quite complicated. Enrollees with claims-experience data would be identified as high risk based on risk scoring of their claims data, while those without historical experience would be identified based on their questionnaire responses. Due to the different data sources, carriers with significant ongoing enrollment (and therefore using historical claims data) may hold a meaningful advantage (or be at a meaningful disadvantage) compared to carriers with a large percentage of previously uninsured individuals (using questionnaires). As a result, this approach may not be feasible. Nevertheless, if the Secretary would like to pursue this further, we will follow up with additional details.

An alternative to administering questionnaires to the enrollees without claims-experience data would be to extrapolate their risk profile from the enrollees who do have claims experience data. The end result for the carrier would be to have its reinsurance payments prorated up by the proportion of enrollees without claims-experience data. While this is used frequently in risk adjustment when populations are considered relatively stationary, it would not be appropriate in this context, given that insured populations are likely to be less stationary during the years of the reinsurance program.

Method 4: Selection Based on Actual Claims Costs/Utilization of Services

This approach would be most similar to "traditional" reinsurance, with high-risk identification based not on the presence of a given condition, but on actual claims costs (or utilization priced at a fixed-fee schedule) exceeding an attachment point.

Key Consideration

- The attachment point could be based on actual costs or actual utilization priced at a fixed-fee schedule (e.g., a fixed percentage of the Medicare fee schedule). The former would best match payments to carrier costs. The latter would retain some incentives for cost containment by encouraging competitive provider contracting.
- The appropriate attachment point would be dependent on several factors, including but not limited to:
  - Available reinsurance funds, and
  - The level at which claims costs/utilization are believed to be largely independent of a carrier's ability to affect outcomes.
- Use of a single attachment point may result in a subsidy being provided to high-cost areas. This may be viewed positively or negatively, depending on a carrier's ability to adjust rates for geographic cost-level variations.
- Claims could be included on a paid or incurred basis, and could be aggregated on a policy-year or calendar-year basis.
- This methodology would be the most familiar to carriers.

Method 4: Selection Based on Actual Claims Costs/Utilization of Services
Cost Control
• By defining high risk as individuals who have experienced a high-cost outcome, incentives to control costs may be reduced. • Even if incentives (or lack of incentives) don't affect behavior, this method is still likely

to reward those carriers with ineffective medical management—with little or no reward for those with effective medical management.
Matching Payment to Risk
• Identifies the risk of generating a high-cost outcome most effectively. • Identification by actual utilization can account for risk characteristics that are otherwise difficult to measure, such as disease severity.
Interaction with other Risk-Sharing Mechanisms
• This approach would need to be carefully coordinated with the risk-adjustment mechanism. • Independence from the risk-adjustment mechanism may be viewed positively. • Interaction with risk corridors is dependent on the design of the risk corridors. It is not expected to be complex.
Interaction with Private Reinsurance
• The degree of disruption in the private reinsurance market for individual products would depend on the attachment point and the coinsurance percentage. As a result, it may or may not create a void that would not be filled immediately when the temporary program concludes.
Administrative Burden
• If the attachment point is based on actual medical costs, the method is not likely to add significant administrative burdens to currently reinsured carriers, given that it is likely to replace current reinsurance arrangements. Carriers that currently do not use reinsurance, however, will incur effort. • If the attachment point is determined by using a fixed-fee schedule to price actual utilization, the burden of the pricing (whether done by a central agency or by the carriers) would be significant. • Fixed-fee pricing is more familiar to HMOs than to traditional insurance carriers.
Data Availability
• The data would be immediately available, dependent only on carriers filing proof of costs/utilization.

Note that combination methodologies can be formed using approaches based on conditions (Methods 1 or 2) and approaches based on thresholds (Methods 3 and 4). If an individual has a condition on the pre-set list and crosses the threshold, he or she could be identified as high risk. Conversely, if an individual crosses the pre-set threshold, he or she could be identified as high risk if he or she has a condition on the pre-set list. These approaches are complex, not feasible, and not prevalent currently. Nevertheless, if the Secretary wishes to pursue these further, we will follow up with additional details.

Some considerations that are common to all four methodologies discussed above are as follows:

- Selection of the list of conditions, the risk-score threshold, or the attachment point would require detailed modeling to ensure that expected payouts are roughly equivalent to available funds. As a safety provision, a retrospective reconciliation process (described in the reinsurance payment methodologies below) would be needed. Retrospective reconciliation may be administratively cumbersome, however, and could create uncertainties for carriers if they have to return some of the reinsurance funds received during the course of the year.

- The claims data collection and analysis or questionnaire administration may be performed at the national level or at the state level. The former approach would ensure uniformity across all states, while the latter approach would distribute the effort across the states.

Potential Approaches for Determining Reinsurance Payments

Method A: Fixed Payment Schedule for each Condition in the Pre-Set List

This approach is already specified as an option in Section 1341 (b)(2)(B)(i). It would determine reinsurance payments according to a fixed schedule for each of the medical conditions to be identified using Methods 1 or 2.

Key Considerations

- Assigning an appropriate payment, particularly for rare conditions or conditions highly differentiated by severity, may be difficult due to the limited sample size that would be available in any study or analysis.
- The payment schedule by condition might need to be reduced from 2014 to 2016 to match the reduction in total contributions by year. As an alternative, the voluntary additional amounts mentioned at the end of Section 1341 (b)(3) or the interyear usage of contributions as mentioned in Section 1341 (b)(4)(A) could be used to create a uniform payment schedule in each of the three years.
  - The former approach can be viewed as slowly phasing out reliance on the temporary reinsurance program, similar to increasing coinsurance or an attachment point in "traditional" reinsurance.
  - The latter approach would allow carriers the opportunity to gather and assess their experience and financial outcomes prior to losing the reinsurance protection. This is true particularly for smaller carriers, which may need more than one year of experience for assessment.
- One of the following approaches could be used if the goal is for total payouts not to exceed the budgeted amounts:
  - A year-end reconciliation, including potential recoveries from carriers,
  - A first-come-first-serve approach that would not provide any additional payments once that year's funds are depleted, or
  - Setting payment amounts at levels low enough virtually to guarantee that payments will not exceed budgeted amounts.
- The payment schedule used to reimburse carriers could be based either on an expected cost or on a "best-practices" cost that represents an ideal claim-cost management target. The latter approach, while ideal, would require a significant effort to develop since this approach currently is not prevalent in the reinsurance industry.
- Payment amounts would depend on the identification method. Payments could be based on the overall average costs for individuals with a particular condition less a threshold amount. As an alternative, payments could be based on the costs exceeding the attachment point, averaged only over those individuals whose costs actually exceed the attachment point. The former method would provide lower payments to a larger set of individuals. The latter would provide higher payments, but to a smaller set of individuals.

- The payments could be adjusted for local cost levels to recognize geographic cost variations. The basis for the adjustment could be the geographic- wage index, cost of living index, or a health cost index. Using a health cost index would perpetuate health cost differences across geographic areas more so than the other methods. Another option would be to recognize geographic variations in "best practices" patterns or require that care management and care coordination be equally effective in all areas.
- The payment schedule could be adjusted across the three years to recognize inflation and treatment innovations.
- Payments could be adjusted to reflect mid-year enrollment and mid-year disenrollment. The mid-year disenrollment adjustment could recognize all causes (including death). Adjustments to incorporate enrollment periods that are shorter than a year would better match payment to risk.
- In addition to reflecting conditions based on diagnoses, payments could reflect severity adjustments based on procedures, volume, and service mix.
- The payment amounts would need to be coordinated with the risk-adjustment mechanism to ensure that carriers aren't paid twice for the same condition. Since risk adjustment will apply to small group markets too, care should be taken to ensure that the calibration for complementing the reinsurance program is performed only for the individual market risk-adjustment tool.
- Fixed-payment schedules could lead to concerns from a subset of carriers once they compare their actual costs to payment schedules. Discrepancies may be a result of poor management, random variability, or inadequate payments.

Method A: Fixed Payment Schedule for each Condition in the Pre-Set List
Cost Control
• Incentives for cost control should be strong given that carriers' gain or loss on high-risk individuals would be correlated exactly to costs.
Matching Payment to Risk
• There is a fairly good potential to match payments to risk. The overall accuracy of the match will depend on the level of detail incorporated in the payment determination (e.g., inclusion/exclusion of severity adjustments).
Interaction with other Risk-Sharing Mechanisms
• Assuming the conditions used are a subset of those found in the risk-adjustment model, this mechanism can be coordinated effectively. • If the development of the risk-adjustment mechanism and the high-risk payment amounts are not coordinated in some way, there is a risk of double payment for high-risk individuals. • Interaction with risk corridors is dependent on the design of the risk corridors. It is not expected to be complex.
Interaction with Private Reinsurance
• Would not disrupt the private reinsurance market to a large extent. • May lead to new reinsurance products provided by or in conjunction with disease management companies that carve-out certain diseases.
Administrative Burden
• A fixed payment method likely would not add significant administrative burdens not

already created by the high-risk identification mechanism. • Any reconciliation process required due to advance payments would add some administrative burden.
Data Availability
• All required data would be available through the identification mechanism.

Method B: Traditional Reinsurance Approach

This method would use a traditional reinsurance approach in which the funds pay a fixed coinsurance percentage of the costs incurred above an attachment point or deductible. There may or may not be a maximum payout amount for each individual.

Key Considerations

- To match the reduction in total contributions from 2014 to 2016, the attachment point could be raised, the coinsurance percentage raised, and/or the maximum payout lowered over time. As an alternative, the voluntary additional amounts allowed for in Section 1341 (b)(3) or the interyear usage of contributions as allowed for in Section 1341 (b)(4)(A) could be used to achieve uniform reinsurance parameters in each of the three years.
  - The former approach can be viewed as slowly phasing out reliance on the temporary reinsurance program.
  - The latter approach would allow carriers the opportunity to gather and assess their experience and financial outcomes prior to losing the reinsurance protection. This is true particularly for smaller carriers that may need more than one year of experience for assessment.

- Costs incurred could be defined as actual payments or could be calculated by pricing the actual utilization of services with a fixed-fee payment schedule (such as a fixed percentage of the Medicare fee schedule) that may or may not vary by geography or yearly trend.
  - Using actual costs would best match carrier risk.
  - Using costs based on a fixed-fee schedule would encourage competitive provider contracting.
  - The fixed-fee approach is uncommon in traditional private reinsurance among insurance carriers, but is more commonly found in reinsurance arrangements purchased by health maintenance organizations (HMOs).
- One of the following approaches could be used if the goal is for total payouts not to exceed the budgeted amounts:
  - A year-end reconciliation, including potential recoveries from carriers,
  - A first-come-first-serve approach that would not provide any additional payments once that year's funds are depleted, or
  - Setting the reinsurance parameters at stringent enough levels virtually to guarantee that payments would not exceed budgeted amounts.
- The reinsurance parameters would need to be coordinated with the risk-adjustment mechanism to ensure that carriers aren't paid twice for the same condition. Since risk adjustment will apply to small group markets, too, care should be taken that the calibration for complementing the reinsurance program is performed only for the individual market risk-adjustment tool.

- Claims could be included on a paid or incurred basis, and could be aggregated on a policy-year or calendar-year basis.
- This method is familiar to carriers and almost certain to generate fewer carrier concerns about inequity.
- Unlike Method A, this approach could be matched with any of the risk-selection methods.
- Given the limited cost-containment incentives, the Secretary may wish to set cost-management requirements (similar to those found in the early retiree reinsurance program) for carriers to participate.
- By necessity, actual payments would be retrospective. There may be a need to provide estimated prefunding amounts (similar to CMS' Part D reinsurance subsidy) to avoid cash-flow problems that may result from an influx of high-risk individuals. This may be particularly valuable to small carriers.

Method B: Traditional Reinsurance Approach
Cost Control
• Reimbursing based on actual costs may create disincentives to control costs. • These disincentives could be reduced (but not eliminated) by requiring carriers to remain responsible for a percentage of catastrophic claims (coinsurance) or using the fixed-fee schedule approach.
Matching Payment to Risk
• Compensates for the risk of generating a high-cost outcome most effectively. • Reimbursement based on actual costs can account for risk characteristics that are otherwise difficult to measure, such as disease severity.
Interaction with other Risk-Sharing Mechanisms
• Completely different framework than risk adjustment. • Must coordinate with the risk-adjustment mechanism via separate offsets to avoid double payments. • Independence from the risk-adjustment mechanism may be viewed positively. • Interaction with risk corridors is dependent on the design of the risk corridors. It is not expected to be complex.
Interaction with Private Reinsurance
• The extent of disruption in the private reinsurance market would be large if Method 4 for identifying high-risk individuals is combined with this Method B for making reinsurance payments.
Administrative Burden
• Not likely to add significant administrative burdens for currently reinsured carriers, since it is similar to current reinsurance arrangements. It would, however, add burdens to the carriers that are currently forgoing private reinsurance coverage. • Application of a fixed-fee schedule would add some level of administrative burden on the program administrator relative to reimbursement based on actual costs. • Any reconciliation process required due to advance payments would add some administrative burden.
Data Availability
• Data would be immediately available, dependent only on carriers filing proof of costs/utilization.

Summary Comments

In this letter, the American Academy of Actuaries' Risk Sharing Work Group has provided a general outline of potential reinsurance methodologies. We put forward four potential approaches for identifying high-risk individuals and two potential approaches for determining reinsurance payments. Rather than providing a single recommended approach, we evaluate the different potential approaches based on various criteria. These criteria include whether the approach includes incentives to control costs, whether the reinsurance payments are appropriately matched to the risk carriers are bearing, the impact on the current private reinsurance market, and data availability and administrative burdens.

We recognize that the reinsurance program is one element of a broader risk-sharing strategy that includes risk adjustment and risk corridors. Because the details on these other risk-sharing mechanisms have yet to be finalized, we have focused our discussion on reinsurance approaches. We have provided comments, however, on the potential interaction between various reinsurance approaches with risk adjustment and risk corridors, where appropriate.

We hope that this discussion helps clarify which methodologies should be considered further by the Secretary. We look forward to providing you with more input as the process of implementing the reinsurance program moves forward. If you have any immediate questions regarding this letter, please contact Heather Jerbi, the Academy's senior federal health policy analyst, at jerbi@actuary.org or 202.223.8196.

Sincerely,

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Appendix Table 1: Potential Methodologies for Identifying High-Risk Individuals				
Evaluation Criterion	**Method 1 (Claims-based Conditions)**	**Method 2 (Questionnaire-based Conditions)**	**Method 3 (Risk-Score Threshold)**	**Method 4 (Traditional Reinsurance Attachment Point)**
Cost Control	• Provides incentives since based on conditions • Potential for perverse incentives if procedures included in conditions list	• Provides incentives since based on conditions • Potential for perverse incentives if procedures included in conditions list	• Provides incentives for cost control	• Provides relatively fewer incentives for cost control, unless fixed-fee approach used • May reward ineffective medical management
Match Payment to Risk	• Difficult to match risk for high-cost outcomes • Incomplete for members without historical claims • If procedural history used, may increase predictive power but still miss individuals with conditions • Some subjectivity if provider coding not uniform	• Difficult to match risk for high-cost outcomes • If procedural history used, may increase predictive power but still miss individuals with conditions • Subjectivity in responses	• Difficult to match risk for high-cost outcomes • Incomplete for members without historical claims • Some subjectivity if provider coding not uniform	• Matches risk for high-cost outcomes • Picks up risk driven by factors that are difficult to measure
Interaction with other Risk-Sharing Mechanisms	• Fits relatively well with risk adjustment • Interaction with risk corridors dependent on their design	• Fits relatively well with risk adjustment, except for reliance on different data sources • Interaction with risk corridors dependent on their design	• Fits well with risk adjustment • Interaction with risk corridors dependent on their design	• Needs careful coordination with risk adjustment to ensure no double payment • Independence from risk adjustment may be viewed positively • Interaction with risk corridors dependent on their design
Interaction with Private Reinsurance	• Still purchased to cover high-cost outcomes	• Still purchased to cover high-cost outcomes	• Still purchased to cover high-cost outcomes	• Degree of temporary disruption would depend on the reinsurance program design
Administrative Burden	• For carriers, burden will depend on similarity of conditions to those under risk-adjustment model • Administrator will need to develop the list of conditions (and, potentially, procedures)	• Carriers or administrator must administer and coordinate questionnaires in a timely manner • Administrator will need to develop the list of conditions (and, potentially, procedures)	• Not much incremental over risk-adjustment efforts	• If based on actual costs, incremental effort only for carriers currently without reinsurance coverage • If based on fixed-fee pricing, incremental effort for agency or carriers • HMOs more familiar with fixed-fee pricing approach
Data Availability	• Will be a problem for previously uninsured, especially in the first year under prospective identification approach	• Timeliness would depend on the administering of the questionnaires • Dependent on willingness of individuals to respond	• Will be a problem for previously uninsured, especially in the first year under prospective identification approach	• Dependent on carriers filing proof of costs (or utilization)

Appendix Table 2: Potential Methodologies for Determining Reinsurance Payments		
Evaluation Criterion	**Method A (Fixed Schedule by Condition)**	**Method B (Traditional Reinsurance with Attachment Point and Percentage Coinsurance)**
Cost Control	• Provides incentives for cost control	• Incentive not as strong since higher payment for incurring higher costs • Higher coinsurance rates (or fixed-fee payment approach) would increase the cost control incentive but may compromise the matching of payment to risk
Match Payment to Risk	• Fairly well, but depends on recognition of severity	• Matches payments to high-cost outcomes • Picks up risk driven by factors that are difficult to measure
Interaction with other Risk-Sharing Mechanisms	• Fits relatively well with risk adjustment • Must coordinate with risk-adjustment methodology to avoid double payment • Interaction with risk corridors dependent on their design	• Framework differs from risk-adjustment philosophy • Must coordinate with risk-adjustment methodology via separate offsets to avoid double payment • Independence from risk adjustment may be viewed positively • Interaction with risk corridors dependent on their design
Interaction with Private Reinsurance	• May still be purchased to cover high-cost outcomes • May lead to new private products	• Private reinsurance temporarily disrupted if combined with Method 4
Administrative Burden	• Low • Additional effort if retrospective reconciliation to available funds	• Low for currently reinsured carriers due to familiarity, moderate-to-high for carriers not currently reinsured • Administrator or carrier will incur effort if fixed-fee payment approached is used • Additional effort if retrospective reconciliation to available funds
Data Availability	• Nothing incremental over identification efforts	• Dependent on carrier filing cost (or utilization) data