W18 – CMS and HHS RADV Audits

Understanding and Preparing for the Marketplace Initial Validation Audit (IVA) and Medicare Advantage Risk Adjustment Data Validation (RADV) Audits

Presented by Scott Weiner

Agenda

- Who is EMSI?
- Risk Adjustment 101
- Medicare Risk Adjustment Data Validation (RADV) Audits
- Health Insurance Marketplace Initial Validation Audits (IVA)
- Understanding the Risk
- Questions
- Appendices

ABOUT EMSI

Solutions Designed to Get Results

EMSI HEALTH

Across two operating divisions, we customize and design information solutions to empower our customers to grow and improve profitability.

Healthcare Services

- **Health Plan Services**
  - Risk Adjustment Services
    - Medicare Advantage
    - Commercial
    - Managed Medicaid
  - Data Analysis and Targeting
  - Healthy House Calls®
  - Chart Retrieval
  - HCC Coding
- **Employer Services**
  - Workplace Services
  - Wellness Services
  - Clinical Services

Insurance Services

- Medical Record Retrieval
- Mobile Paramed Exams
- Electronic Application Processing / Teleinterviews
- Underwriting Services
- Inspections
- Litigation Record Retrieval

We empower Health Plans with comprehensive services for the most appropriate reimbursements, member care coordination, and to improve the lives of those they serve.

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Medical Information Solutions for:

Annual Transactions

10+ million calls handled at call centers

2.0+ million medical records retrieved

250K+ risk analytics, charts and home visits

1.5+ million in-home assessments and in-person collections

7400+ credentialed, trained providers in our networks

600K+ chart reviews

400K+ drug and alcohol screenings

75K+ claims investigations

300K+ underwriting transactions

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RISK ADJUSTMENT 101

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What is Risk Adjustment?

- A method used to adjust bidding and payment based on the health status and demographic characteristics of an enrollee
- Pay appropriate and accurate reimbursement for subpopulations with significant cost differences
- Purpose: to pay plans accurately for the risk of the beneficiaries they enroll
- Why: access, quality, protect beneficiaries, reduce adverse selection, etc.

Types of Risk Adjustment

- **Prospective/Future Prediction:**
  - Uses historical diagnoses as a measure of health status and demographic information to predict **future** expense
  - Data from 2014 used to predict expected costs in 2015
  - **Example: CMS Medicare HCC Model**
- **Concurrent (aka Retrospective):**
  - Uses historical diagnoses as a measure of health status and demographic information to predict **expected** expense for the current period done from a retrospective perspective
  - Data from 2014 used to **retroactively** predict expected costs in 2014
  - **Example – HHS-CC model for the Health Insurance Marketplace**

Why Does CMS Conduct Audits?

"*To follow by faith alone is to follow blindly*."

- Benjamin Franklin

Member Example

- 60-year-old male
- Originally disabled
- Medicaid
- Community
- HCC 17 – Diabetes w/Acute Complications
- HCC 19 – Diabetes w/o Complications
- HCC 80 – Congestive Heart Failure
- HCC 92 – Specific Heart Arrhythmias
- Interaction DM_CHF

HCC Calculation

Variable	Accurate	Missing
60-year-old male	0.411	0.411
Originally disabled	0.000	0.000
HCC 17 – Diabetes w/Acute Complications	0.339	0.000
HCC 19 – Diabetes w/o Complications	0.162	0.162
HCC 80 – Congestive Heart Failure	0.410	0.000
HCC 92 – Specific Heart Arrhythmia	0.293	0.293
Interaction for Diabetes and CHF	0.154	0.000
Total Hierarchical HCC weight	1.607	0.866
Annual payment (assumes $800/mo.)	$15,427	$8,314
Payment Difference	$7,113	
Medical expense (85% MLR)	$12,960	$12,960
Profit/Loss	$2,467	**($4,646)**

MEDICARE AND RADV

Medicare HCC Model

- Model is prospective – previous diagnosis data used to predict future member expense
- Model is hierarchical – hierarchies apply to disease categories
- Model was essentially unchanged from 2004 implementation until 2014 payment year
- Risk scores correlate directly to plan payment

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Model Comparison 2013 vs. 2016

Model Compare	2013 (V12)	2016 (V22)
Diagnoses	2,938	3,033
Discontinued Diagnoses	129	
New Diagnoses		224
HCC	70	79
New HCC		4
Changed HCC		15
Hierarchies	17	17
Community Interactions	6	6
Institutional Interactions	5	12
Disability Interactions	5	12

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Medicare HCC Audit

- Unlike other Medicare audits, the HCC audits do not have clear guidelines
- Whether a diagnosis is acceptable is often left to plan interpretation
- This may be different than what CMS determines to be acceptable
- Every plan must determine its acceptable level of risk
- Even when CMS provides guidelines, they are not always clear

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Acceptable Provider Specialties

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CMS

2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations Participant Guide

DATA COLLECTION

TABLE 3H – ACCEPTABLE PHYSICIAN SPECIALTIES

CODE	SPECIALTY	CODE	SPECIALTY	CODE	SPECIALTY
01	General Practice	29	Pulmonary Disease	70*	Multispecialty Clinic or Group Practice
25	Physical Medicine and Rehabilitation	66	Rheumatology	97*	Physician Assistant
26	Psychiatry	67	Occupational Therapist	98	Gynecologist/Oncologist
28*	Colorectal Surgery	68	Clinical Psychologist	99	Unknown Physician Specialty

* Indicates that a number has been skipped.

Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology services (professional component only).

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Or Are They?

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Lab and Pathology Reports – Guidance

Some organizations have inquired about the use of Lab and Pathology Reports for data submission and medical record review. The following guidance must be taken into account when considering data or medical record submission from these sources.

- Official Guidelines for Coding and Reporting (Section III, B. Abnormal Findings)
- "Abnormal findings (laboratory, x-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicated their clinical significance."
- **Coders should not arbitrarily assign a final ICD-9 code based solely on an abnormal finding.**
- Written interpretation (alone) of a tissue biopsy is not equivalent to the attending/referring physician's complete clinical assessment used to assign a diagnosis.
- If submitting risk adjustment data or medical records based on pathology, note the following:
  - Outpatient pathology facilities are unacceptable risk adjustment provider sources.
  - Physician pathology (i.e., specialty code 22) is acceptable for risk adjustment. When submitting risk adjustment diagnoses for data submission or as a stand-alone medical record for RADV refer to the guidance stated in this section. AND
  - Medical records submitted as stand-alone documentation from these sources will be reviewed in accordance with the Outpatient guidelines, and will likely result in a risk adjustment discrepancy since these sources do not typically render confirmed diagnoses.

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CMS RADV Audit Process

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- Plan is notified of RADV audit
- Roughly 600 Medicare contracts and only 30 plans are selected annually
  - + Odds of being selected for a RADV Audit: ~ 5% per year
- CMS selects 201 members for audit
  - + Three strata – Low, Medium and High risk scores
- Plan required to provide support for every HCC via medical record submission to CMS

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CMS RADV Process – RAC Audits?

- The ACA required Medicare's RAC program to be expanded to Medicare Advantage and Part D plans, but that has not happened yet.
- CMS recently released a document explains how that would be done and the scope of the program.
- There is no definitive timeline for when the program would go into effect.
- Under the new Medicare Advantage auditing system, RACs would be tasked with conducting risk adjustment data validation (RADV) reviews.
- In addition to general RADV audits, RACs would conduct "condition-specific" RADV audits. Those reviews would focus on specific medical codes or health conditions, such as diabetes, that have high rates of payment errors.

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Is Your Plan at Risk for a RADV Audit?

Signs your plan may be at risk for a RADV:

- Large change in year-over-year risk scores – CMS will focus on plans with big increases in score to ensure it is correct
- Very few delete records – if you are not doing deletes, you are not reviewing your own submissions for accuracy and correcting errors
- Other corrective actions – has your plan been reviewed for something else? It may increase your likelihood of audit as CMS sees you as a risk

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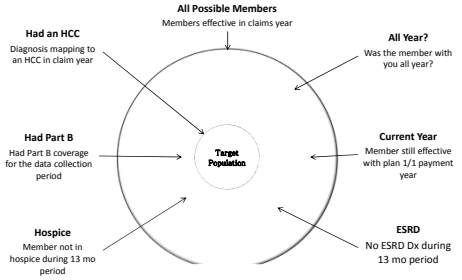
Which Members Are Included?



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Can I Really Send in That Many Records?

- While the original RADV guidelines allowed for only the one "best medical record," the new RADV guidelines have changed
- Plans can now submit up to five medical records to support a diagnosis and HCC
- The same medical record can be used to support multiple HCC for a member as well
- But the "best medical record" may not always be the best record to submit

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How Will I Know How the Plan Did?

- CMS will issue a "Preliminary Audit Report of Findings" (AROF)
- Shows HCC-level validation and errors and eligibility for dispute
- At enrollee-level, AROF will show revised score and payment
- Information and instructions for Medical Record Dispute (MRD) will be included with report
- Plans allow to dispute findings only on certain types of RADV-related errors

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Plan Has Multiple Level of Appeals

- Plans can file initial appeal via MRD process for review by "Hearing Officer"
- The plan must:
  - File appeal within 30 days from receipt of AROF
  - Submit the "One Best Medical Record" from records submitted to IVC for this review though it does not have to be the record audited

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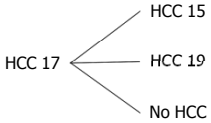
Plan Has Multiple Level of Appeals

- Plan will receive "Audit Report Post Medical Record Review," detailing results similar to AROF along with additional appeals instructions
- Only other appeal option is to CMS Administrator

CMS Identifies HCC Errors

- Charts are read 2x by the IVC Auditors
- CMS Notifies Plan of Errors



CMS Extrapolates Error

- HCC 17 drops to HCC 19 .248 - .459 = (.211)
- Multiply By Benchmark $800 * (.211) = (168.80)
- Extrapolate to Population (168.80) * 8,000 = $1,350,400
- Other HCC for same member can change
- Interactions may no longer apply

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Health Exchange RADV (HHS-RADV) aka Initial Validation Audit (IVA)

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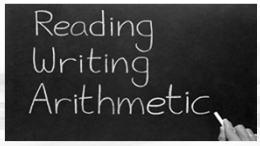
Not Your Mother's 3R's



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HHS-RADV vs. Medicare RADV

Item	Medicare RADV	HHS-RADV
Payment Years	2011 – Forward	2015 - Forward
Timeline	2-3 years after payment	Six months after year-end
Minimum Plan Size	Every Plan	Not Addressed
Number of Plans Audited	Approximately 30	**All**
Members	Stratified – 3 Strata	Stratified – 10 Strata
Diagnoses Included Thru	13 months after year-end	4 months after year-end
Medical Records	All Supporting	All Supporting
Extrapolation	Applied to Strata	Not Currently Defined
Appeal Process	Defined	Defined
FFS Offset	Included – Est. 11%	Not Applicable 2015
Clarity	Vague	Vague
First Round Audits Conducted By	CMS	Plan Contracted Vendor

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HHS-HCC Model

- More diagnoses are included and map to additional HCC because of broader disease implications for the commercial population
- What occurs in the year, affects payment for the year – retrospective or concurrent payment model
- Differences in plan type (Bronze, Silver, etc.) affect the risk score and associated payment
- Model is a zero-sum – if one plan's risk score is higher than another plan's, the lower risk score plan will have to make payments to higher risk score plan

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Zero Sum Payments

Plan	Plan A	Plan B	Plan C
Initial Revenue	$10,000,000	$10,000,000	$10,000,000
Initial Risk Score	1.15	1.07	1.23
Normalized Risk Score	1.00	0.93	1.07
Revised Revenue	$10,000,000	$9,304,347	$10,695,653
Payment Change	$0	($695,653)	$695,653

Model Population

- Because the HHS Model includes a much more varied population than the Medicare model, some additional changes were necessary
  - Age groups include infant through adults and seniors.
  - Age groups are banded smaller for children and infants

HHS-RADV Authority

- Section 1343 of the Affordable Care Act (ACA) establishes a permanent Risk Adjustment (RA) program which is intended to provide payments to health insurance issuers that attract higher-risk populations.
- The Premium Stabilization Final Rule requires states, or HHS on behalf of states, to validate a statistically valid sample of data for all issuers that submit for risk adjustment every year and provide an appeals process.
- The rule allows states, or HHS on behalf of states, to adjust average actuarial risk for each plan based on the error rate found in validation and adjust payments and charges based on the changes to average actuarial risk.

HHS-RADV Authority

- The Secretary of HHS has designated CMS to implement the HHS-RADV program in accordance with the following regulations:
- 45 CFR §153.350
- 45 CFR §153.620
- 45 CFR §153.630
- Premium Stabilization Final Rule
- 2014 Payment Notice Final Rule
- 2015 Payment Notice Final Rule

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Key Components

- CMS selects a statistically valid sample of enrollment and medical claims data submitted to the issuer's EDGE server.
- Data validation of the selected sample is conducted by an initial validation auditor (IVA Entity) selected by the issuer and approved by CMS.
- CMS selects a second validation auditor (SVA Entity) to validate a subsample of the original IVA sample.
- CMS establishes an issuer-level error rate based on data validation results.
- CMS applies the error rate to each issuer's RA covered plan average liability risk score (PLRS) to produce an error estimate.
- CMS provides an HHS-RADV appeals process for issuers.
- CMS adjusts the PLRS for issuer's risk adjustment covered plans based on errors discovered as a result of data validation.

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2015 Payment/Benefit Year Timeline

Date	Description
Fall 2015	HHS-RADV Training Begins
December 31, 2015	Payment/Benefit Year Ends
March 15, 2016	CMS sends Senior Official (SO) Designation Letter
April 25, 2016	SO Designation Letters are due back to CMS
April 30, 2016	Data Submission Deadline
May 9, 2016	Issuers must select and submit IVA Entity Attestation Letter to CMS
Late May 2016	CMS deploys HHS-RADV sampling command and Issuers execute command
Early June 2016	CMS provides IVA Entities access to audit tool
June 2016	CMS validates IVA samples
July 1, 2016	CMS releases IVA samples
July 2016 – December 2016	HHS-RADV Audits are conducted
Early December 2016	IVA Entities submit IVA results and supporting documentation
December 2016 – March 2017	Second Validation Audits (SVA) are conducted
Spring 2017	CMS releases Benefit Year 2015 pilot results, lessons learned & error rates

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Initial Validation Auditors

- Unlike Medicare Advantage, the Health Insurance Marketplace Initial Validation Auditors are contracted by the plan
  - Both Health Insurance Marketplace and "Off-Exchange Plans" are included
  - Members with and without HCC will be audited
  - All auditors must be certified by the American Association of Professional Coders (AAPC) or the American Health Information Management Association (AHIMA)
  - Senior auditors must have at least three years of experience in 2015 and five years in 2016 and beyond
  - Enrollment sources will be verified
  - Initial Validation Auditors must be free from conflicts of interest

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Conflicts of Interest

- Issuer must attest to being conflict free to the best of its knowledge
- Neither the issuer nor any member of its management team (or any member of the immediate family of such a member) may have any material financial or ownership interest in the initial validation auditor
- Owners, directors and officers of the issuer may not be owners, directors or officers of the auditor (and vice versa)
- Audit Team members may not be married to, in domestic relationship with or immediate family of owners, directors, officers or employee of the issuer
- The initial validation auditor may not have had a role in establishing any relevant internal controls of the issuer related to the risk adjustment data validation process

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Audit Strata

80 % of Members	No HCC – Demographic Only			33 % of Sample
	Adult High Risk Score	Child High Risk Score	Infant High Risk Score	67% of Sample
20% of Members	Adult Medium Risk Score	Child Medium Risk Score	Infant Medium Risk Score	
	Adult Low Risk Score	Child Low Risk Score	Infant Low Risk Score	

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CMS Example of Sample Size

Stratum	Members	IVA Sample	SVA Sample
1 – Adult Low	1,200	22	11
2 – Adult Medium	300	11	6
3 – Adult High	100	8	4
4 – Child Low	400	15	8
5 – Child Medium	100	15	8
6 – Child High	100	18	9
7 – Infant Low	200	18	9
8 – Infant Medium	100	11	6
9 – Infant High	100	15	8
10 – No HCC	10,400	67	34
Total	**13,000**	**200**	**103**

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Members with No HCC

- For enrollees without risk adjustment HCCs for whom the issuer has submitted a risk adjustment eligible claim or encounter, HHS would require the initial validation auditor to review all medical record documentation for those risk-adjustment eligible claims or encounters, as provided by the issuer, to determine if HCC diagnoses should be assigned for risk score calculation, provided that the documentation meets the requirements for the risk adjustment data validation audits.

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Enrollment Validation

- The initial validation auditor would validate information by reviewing plan source enrollment documentation, such as the 834 transaction, which is the HIPAA-standard form used for plan benefit enrollment and maintenance transactions. These enrollment transactions reflect the data the issuer captured for an enrollee's age, name, sex, plan of enrollment, and enrollment periods in the plan.

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Issuer Audit Risk

- While no direct financial penalties will result from the 2015 payment year audit, the possibility of financial penalties and further audit does exist:
  - Office of the Inspector General (OIG) – as noted in the OIG Work Plan, the OIG is cracking down on over-coding of HCC.
  - False Claims Act – knowingly submitting false diagnoses
  - Whistleblowers – disgruntled employees, etc. may cry foul.

Understanding the Risks

Blind Faith

"Blind faith in your leaders or anything will get you killed."

- Bruce Springsteen, "War"

Blind Faith

"Blind faith in your providers and claim submission will get you adverse findings."

- Scott Weiner, EMSI Health

Top 10 Medicare Risk Adjustment Coding Errors

- The record does not contain a legible signature with credential.
- The electronic health record (EHR) was unauthenticated (not electronically signed).
- The highest degree of specificity was not assigned the most precise ICD-9-CM code to fully explain the narrative description of the symptom or diagnosis in the medical chart.
- A discrepancy was found between the diagnosis codes being billed versus the actual written description in the medical record. If the record indicates depression, NOS (311 Depressive disorder, not elsewhere classified), but the diagnosis code written on the encounter document is major depression (296.20 Major depressive affective disorder, single episode, unspecified), these codes do not match; they map to a different HCC category. The diagnosis code and the description should mirror each other.

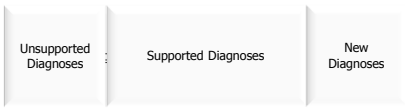
Top 10 Medicare Risk Adjustment Coding Errors

- Documentation does not indicate the diagnoses are being monitored, evaluated, assessed/addressed, or treated (MEAT).
- Status of cancer is unclear. Treatment is not documented.
- Chronic conditions, such as hepatitis or renal insufficiency, are not documented as chronic.
- Lack of specificity (e.g., an unspecified arrhythmia is coded rather than the specific type of arrhythmia).
- Chronic conditions or status codes aren't documented in the medical record at least once per year.
- A link or cause relationship is missing for a diabetic complication, or there is a failure to report a mandatory manifestation code.

http://news.aapc.com/index.php/2013/03/top-10-medicare-risk-adjustment-coding-errors/

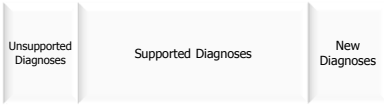
Why Do Medical Record Review?

Single Medical Record



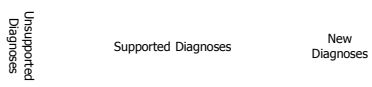
Why Do Medical Record Review?

Two to Three Medical Records



Why Do Medical Record Review?

Four or More Medical Records



Claims Data Submission

Advantages

- Chart review volume would be too great if we had to look at every record
- Can provide additional dates of services for a diagnosis beyond what is found via chart review

Disadvantages

- "75%" Accurate
- Will not stand up to a RADV Audit
- Limited to how many the provider can submit on a claim
- May not be able to tell if the service was done by an acceptable provider

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Medical Record Review

Advantages

- More accurate than claim submission only
- More complete than claim submission
- Able to identify the provider of service
- Additional diagnoses that may not have been on claim
- Fix the "30/30" issue

Disadvantages

- Time consuming
- Intrusion on the provider office
- Retrospective
- Chart coding is often open to interpretation
- Physician handwriting
- EMR issues

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Prospective Assessments

Advantages

- Provides real-time picture of the patient
- Provides a method to address care for home-bound or facility-bound patients
- Provides a look into the member's living conditions
- More complete than the typical physician's office health exam
- Not just about risk adjustment
- Provides complete and accurate documentation for RADV support depending on quality of data capture

Disadvantages

- More costly than office visit
  - + Office visit - $45-205 in Dallas
  - + Prospective Assessment ($300+)
- Physicians often see it as competition to their services
- Breaks the PCP/member relationship if not done correctly.
- Changes to CMS guidelines

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PAPER VS. EMR Record

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Paper

- Often not much more than a "super bill"
- Poor handwriting leads to misinterpretations
- Need legible signature and credentials on each page
- Need date on each page
- Need member name on each page

Electronic Record

- Usually cleaner than paper
- Menial tasks that must be done on a paper claim are done automatically.
- Several issues do exist with EMR records
  - + Cloning
  - + Drug lists not updated
  - + Meaningful use

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Reducing the Risk

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What Can BE DONE TODAY?

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- Assess organizational readiness
- Assess data quality
- Validate existing charts
- Acquire and abstract charts where gaps exist

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Assess The Organization

- What does your Revenue Improvement Program look like?
- RADV Response Team includes:
  - Business Sponsor (Senior Executive)
  - Medical Directors to call doctors
  - Executives to call office managers
  - Project Manager(s)
  - Review/Audit staff
  - Other Team Members
- Meet internally to develop strategy for RADV and determine need for assistance from vendor
  - Are policies and procedures up-to-date?

Assess Data

- Assess and clean up data
  - Have "Deletes" been processed for bad data?
  - Code Sets
    - Specialty codes (recently released)
    - CPT codes – may be acceptable provider, but not face-to-face visit
    - Are all RAPS (EDPS) resubmitted?
    - Are specialty codes updated?
    - Are CPT/Dx codes reviewed?
  - Update policies and procedures

Charting the Course

- Which HCC do medical charts substantiate?
- Are the diagnoses from acceptable providers?
- Are "Rule-out" diagnoses used?
- What is the frequency of the diagnoses?
- If using a vendor, have all charts been reviewed?

Top 10 Compliance Issues

#3 Electronic Medical Records

Some early adopters of Electronic Medical Records (EMR) software are now having to respond to ***"cloning" and/or "carry over"*** *concerns raised by ZPICs and Program Safe Guard Contractors (PSCs).*

"These audits appear to be the result (at least in part) of inadequately designed software programs which generate progress notes and other types of medical records that do not adequately require the provider to document individualized observations. Instead, the information gathered is often sparse and similar for each of the patients treated."

http://www.zpicaudit.com/2011/01/top-ten-health-care-compliance-risks-for-2011/ (emphasis added)

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Questions?

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Ask Us How We Can Help

Scott Weiner

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Phone: (757) 716-7061
Cell: (757) 553-8985
http://www.emsinet.com

RADV Extrapolation

THE IMPACT

Calculation	Sample	Strata 1 - Hi	Strata 2 - Mid	Strata 3 - Low
Modeled Payment	$1,679,213	$1,164,902	$364,531	$149,779
Modeled Errors	$218,256	$150,125	$43,392	$24,739
Extrapolated Payment	$204,061,950	$141,561,722	$44,298,702	$18,201,526
Extrapolated Errors	$26,522,990	$18,243,524	$5,273,099	$3,006,367
Standard Deviation	$238,449	$333,095	$138,927	$107,118
Variance Estimates	$17,223,049,893,090	$110,952,392,725	$19,300,754,327	$11,474,234,776
Standard Error	$4,150,066			
Lower Bound	$22,372,924			
FFS Adjuster (5%)	$10,203,097			
Final Amount Due	**$12,169,827**	**6%**		

The total HCC-related payment made by CMS to the plan

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The net effect of payment errors on the model assuming ~17% error rate.

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Modeled payment for 201 enrollees in the sample and expand to my entire population of ~24,000

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Calculation	Sample	Strata 1 - Hi	Strata 2 - Mid	Strata 3 - Low
Modeled Payment	$1,679,213	$1,164,902	$364,531	$149,779
Modeled Errors	$218,256	$150,125	$43,392	$24,739
Extrapolated Payment	$204,061,950	$141,561,722	$44,298,702	$18,201,526
Extrapolated Errors	$26,522,990	$18,243,524	$5,273,099	$3,006,367
Standard Deviation	$238,449	$333,095	$138,927	$107,118
Variance Estimates	$17,223,049,893,090	$110,952,392,725	$19,300,754,327	$11,474,234,776
Standard Error	$4,150,066			
Lower Bound	$22,372,924			
FFS Adjuster (5%)	$10,203,097			
Final Amount Due	**$12,169,827**	**6%**		

Modeled payment errors for 201 enrollees in the sample and expanded to my entire population of ~24,000

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THE IMPACT

Calculation	Sample	Strata 1 - Hi	Strata 2 - Mid	Strata 3 - Low
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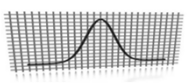

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THE IMPACT

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(~121*110,952,392,725)+…

$$V_{\bar{Y}} = \sum_{h=1}^{3} \frac{N_h^2}{67} v_h$$

The standard error is $SE_{\bar{Y}} = \sqrt{V_{\bar{Y}}}$

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THE IMPACT

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The maximum pay back to CMS for overpayments = Extrapolated Errors – Standard Error

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THE IMPACT

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Lower Bound	$22,372,924			
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For illustrative purposes only based on 5% of Extrapolated HCC Payments

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The Three "R's" of HHS Risk

MARKETPLACE 3 "Rs"

Where Sold	Sold within Exchange		Sold Outside Exchange			Who Administers	
ACA Provision	Individual	Small Group	Individual	Small Group	Grandfathered	State Run Exchange	Federally Facilitated Exchange
Risk Adjustment	Yes	Yes	Yes	Yes	No	State or HHS	HHS
Reinsurance	Yes	No	Yes	No	No	State or HHS	State or HHS
Risk Corridor	Yes	Yes	No	No	No	HHS	HHS

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Risk Corridors

Government Pays - 80%	Plan Pays - 20%	Over 10% Loss
Government Pays - 50%	Plan Pays - 50%	Over 5% Loss
Plan Pays - 100%		Break Even
Plan Keeps - 100%		
Government Keeps - 50%	Plan Keeps - 50%	Over 5% Gain
Government Keeps - 80%	Plan Keeps - 20%	Over 10% Gain

- Similar to Part D plans at start-up; the federal government will apply risk corridors to profit and loss of individual health plans in and out of the Marketplace

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Risk Corridor – Loss

- Plan has $125M revenue
- Plan expense ratio 15%
- Actual plan medical spend - $120M

Total Plan Revenue	$	125,000,000	
Plan Admin	$	18,750,000	15%
Total Medical Fund	$	106,250,000	
Medical Spend	$	120,000,000	113%
Lower Loss Limit	$	109,437,500	
Upper Loss Limit	$	114,750,000	
Above Lower Limit	$	(5,312,500)	Yes
HHS Share	$	(2,656,250)	
Plan Share	$	(2,656,250)	
Above Upper Limit	$	(5,250,000)	Yes
HHS Share	$	(4,200,000)	
Plan Share	$	(1,050,000)	
Total	$	(10,562,500)	Yes
HHS Share	$	(6,856,250)	
Plan Share	$	(3,706,250)	

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Risk Corridor – Gain

- Plan has $125M revenue
- Plan expense ratio 15%
- Actual plan medical spend - $100M

Total Plan Revenue	$	125,000,000	
Plan Admin	$	18,750,000	15%
Total Medical Fund	$	106,250,000	
Medical Spend	$	100,000,000	94%
Lower Loss Limit	$	103,062,500	
Upper Loss Limit	$	97,750,000	
Above Lower Limit	$	3,062,500	Yes
HHS Share	$	1,531,250	
Plan Share	$	1,531,250	

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Reinsurance

- Reinsurance designed to protect plans from impact of a few high risk member/catastrophic claims
  - For 2014, members with total claims in excess of $45,000 (attachment point) will be covered at 80% to a $250,000 maximum per member/claim
  - For 2015, the attachment point is $70,000
- Payments are funded from payment - all plans pay whether they are in the exchange or not.
  - 2014 - $63 per member payment
  - 2015 - $44 per member
- Plans will typically carry traditional reinsurance above the $250,000 threshold.

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