

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

Patient Protection and Affordable Care Act;
Establishment of Exchanges and Qualified Health Plans
(CMS-9989-P) and Standards Related to Reinsurance,
Risk Corridors and Risk Adjustment (CMS-9975-P)

Preliminary Regulatory Impact Analysis
(CMS-9989-P2)

Center for Consumer Information & Insurance Oversight

July 2011

SUMMARY:

This document announces the impact statement for the proposed rules entitled “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans,” and “Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment,” which are published in the **Federal Register**.

Table of Contents

I. Executive Orders 12866 and 13563	4
II. Estimates of the Impact of Exchanges	7
III. Benefits	11
IV. Costs	15
V. Impacts of the Proposed Rule on Standards Related to Reinsurance, Risk Corridors and Risk Adjustment	30
VI. Alternatives Considered	39
VII. Limitations of Analysis	42
VIII. Accounting Statement	44
IX. Citations	44

IMPACT ANALYSIS:**I. Executive Orders 12866 and 13563**

We have examined the impacts of these regulations under Executive Order 12866 on Regulatory Planning and Review (September 30, 1993) and Executive Order 13563 on Improving Regulation and Regulatory Review (February 2, 2011).

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for rules with economically significant effects (\$100 million or more in any 1 year). Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule that may:

- (1) Have an annual effect on the economy of \$100 million or more in any one year or adversely affect in a material way a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal government or communities [also referred to as “economically significant”];
- (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency;
- (3) Materially alter the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or
- (4) Raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in [Executive Order 12866].

OMB has determined that this rule is “economically significant” within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of \$100 million in any one year. Accordingly, we have prepared a Regulatory Impact Analysis that presents the costs and benefits of these proposed rulemakings.

This analysis focuses on an initial set of proposed requirements for the establishment of Affordable Insurance Exchanges (Exchanges), Qualified Health Plans (QHPs) and the Small business Health Options Program (SHOP). The notices of proposed rulemaking (NPRMs) described in this impact analysis implement provisions related to Exchanges, including reinsurance, risk adjustment and risk corridors. The NPRMs set forth proposed standards for States that seek to establish an Exchange and for health insurance issuers. Specifically, the NPRMs propose: (1) standards for States with respect to the establishment and operation of an Exchange; (2) standards for health insurance issuers with respect to participation in the Exchange, including the minimum certification requirements for qualified health plan (QHP) certification; (3) risk-spreading mechanisms for which health plan issuers both within and outside of the Exchange must meet requirements; and (4) basic requirements that employers must meet with respect to their voluntary participation in SHOP. Authority lies primarily in Title I of the Patient Protection and Affordable Care Act, sections 1301-1302, 1311, 1313, 1321, 1323, 1331-1334, 1341-1343, 1401, 1402, and 1411-1413. HHS has drafted these proposed regulations to implement Congressional mandates in the most economically efficient manner possible.

Need for Regulatory Action

A central aim of Title I of the Affordable Care Act is to expand access to health insurance coverage through the establishment of Exchanges. The number of uninsured Americans is rising

due to lack affordable insurance, barriers to insurance for people with pre-existing conditions, and high prices due to limited competition and market failures. Millions of people without health insurance use health care services for which they do not pay, shifting the uncompensated cost of their care to health care providers. Providers pass much of this cost to insurance companies, resulting in higher premiums that make insurance unaffordable to even more people. The Affordable Care Act includes a number of policies to address these problems, including the creating of Affordable Insurance Exchanges.

Starting in 2014, individuals and small businesses will be able to purchase private health insurance through State-based competitive marketplaces called Affordable Insurance Exchanges, or “Exchanges.” Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs. And Exchanges will give individuals and small businesses the same purchasing clout as big businesses. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) are working in close coordination to release guidance related to Exchanges in several phases. The first in this series was a Request for Comment relating to Exchanges, published in the Federal Register on August 3, 2010 (75 FR 45584). Second, Initial Guidance to States on Exchanges was issued on November 18, 2010. Third, a proposed rule for the application, review, and reporting process for waivers for State innovation was published in the **Federal Register** on March 14, 2011 (76 FR 13553). Fourth, two proposed regulations are being published in the **Federal Register** to implement components of the Exchange and health insurance premium stabilization policies in the Affordable Care Act.

Subjects included in the Affordable Care Act to be addressed in subsequent rulemaking include (but are not limited to): standards for individual eligibility for participation in the

Exchange, advance payments of the premium tax credit, cost-sharing reductions, and related health programs and appeals of eligibility determinations; standards with respect to ongoing Federal oversight of Exchanges and actions necessary to ensure their financial integrity; and standards for Exchanges and QHP issuers related to quality, among others.

The budget and coverage effects described in this analysis also include provisions that will be implemented by other Departments. For example, section 1401 of the Affordable Care Act contains the provision that pertains to the establishment and administration of the premium tax credits that will primarily be implemented by the Department of Treasury. The Departments of Labor and the Treasury have primary jurisdiction over employer responsibility provisions in section 1513 of the Affordable Care Act. This analysis will serve as the base for estimating the non-tax and non-Medicaid impacts of these interrelated provisions.

II. Estimates of the Impact of Exchanges

This preliminary impact analysis references the estimates of the CMS Office of the Actuary (OACT) (CMS, April 22, 2010), but primarily uses the underlying assumptions and analysis completed by the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation. Their modeling effort accounts for all of the interactions among the interlocking pieces of the Affordable Care Act including its tax policies, and estimates premium effects that are important to assessing the benefits of the NPRM. A description of CBO's methods used to estimate budget and enrollment impacts is available elsewhere.¹ The CBO estimates are not significantly different than the comparable components produced by OACT. Based on our review, we expect that the requirements in these NPRMs will not substantially alter CBO's estimates of the budget impact of Exchanges or enrollment. The proposed requirements

¹ CBO. "CBO's Health Insurance Simulation Model: A Technical Description." (2007, October).

are well within the parameters used in the modeling of the Affordable Care Act and do not diverge from assumptions embedded in the model. Our review and analysis of the proposed requirements indicate that the impacts are within the model's margin of error.

CBO estimated outlays for the Exchanges and Exchange-related requirements in two areas: reinsurance and risk adjustment programs, and estimates of State Planning and Establishment Grants for the implementation of State Exchanges. Below we display the estimates for outlays and enrollment by type of health insurance coverage over a five-year period (FY 2012 - FY 2016 for outlays and calendar year 2012-2016 for enrollment). Individuals will not begin enrollment in the Exchanges until January 1, 2014. Hence, while there are no Exchange enrollment estimates for 2012 and 2013, other provisions of the law related to the preparation for Exchange implementation, such as State grants are estimated.

Table 1 includes the CBO's estimates of outlays for reinsurance and risk adjustment, and estimates of grants from 2012 to 2016. It does not include costs related to reduced Federal revenues from refundable premium tax credits, which are administered by the Department of the Treasury subject to IRS rulemaking, the Medicaid effects, which are subject to future rulemaking, or the policies whose offsets led CBO to estimate that the Affordable Care Act would reduce the Federal budget deficit by over \$200 billion over the next 10 years. Table 2 includes the CBO's estimates of receipts for reinsurance and risk adjustment.

Table 1. Estimated Outlays for the Affordable Insurance Exchanges FY 2012 - FY2016, in billions of dollars

Year	2012	2013	2014	2015	2016
Reinsurance and Risk Adjustment Program Payments ^a	---	---	11	18	18
Grant Authority for Exchange Start up ²	0.6	0.8	0.4	0.2	0.0

^a Risk-adjustment payments lag receipts shown in Table 2 by one quarter.

Source: CBO

CBO. 2011. *Letter to Hon. John Boehner. Feb. 18, 2011* <http://www.cbo.gov/ftpdocs/120xx/doc12069/hr2.pdf>
Accessed on 7/6/11

CBO. 2011. *Letter to Hon. Nancy Pelosi. March 20, 2010.*
<http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>. Accessed on 7/1/11

Table 2. Estimated Receipts for the Affordable Insurance Exchanges FY 2012 - FY2016, in billions of dollars

Year	2012	2013	2014	2015	2016
Reinsurance and Risk Adjustment Program Receipts ^a	---	---	12	16	18

^a Risk-adjustment payments shown in Table 1 lag receipts by one quarter.

Source: CBO. 2011. *Letter to Hon. Nancy Pelosi. March 20, 2010.*
<http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>

Because Exchanges do not begin operation until 2014, there are no outlays for reinsurance and risk adjustment in 2012 and 2013. CBO estimates that risk adjustment payments and collections are equal in the aggregate, but that risk adjustment payments lag revenues by one quarter. CBO

² OACT estimates that the initial start-up costs for Exchanges will be \$4.4 billion for 2011-2013 (Sisko, A.M., et al., "National Health Spending Projections: The Estimated Impact of Reform through 2019," *Health Affairs*, 29, no. 10 (2010): 1933-1941.

did not score the impact of risk corridors, but assumed collections would equal payments to plans in the aggregate.

CBO's estimate of the number of people receiving tax credits through Exchanges under the Affordable Care Act is based in part on the assumption that Exchanges would be operational by January 2014. Participation rates among potential enrollees are expected to be lower in the first few years (beginning in 2014) as employers and individuals adjust to the features of the Affordable Care Act and Exchanges become fully operational.

Table 3 contains the estimates of the number of people enrolled in Exchanges from 2012 through 2016. These estimates show that there will be nearly 22 million people enrolled in Exchanges by the year 2016, and that there will be 32 million fewer uninsured due to the combined impact of all of the provisions of the Affordable Care Act.

Table 3. Estimated Number of People Enrolled in Exchanges 2012-2016, in millions by Calendar Year

Year	2012	2013	2014	2015	2016
Total Exchange Enrollment ³	---	---	9	14	22
Exchange Enrollees Receiving Tax Credits	---	---	8	12	18
Employment-Based Coverage Purchased Through Exchanges	---	---	3	2	3
Change to Uninsured Coverage ⁴	-3	-3	-21	-26	-32

³ OACT estimates that total Exchange enrollment will be 16.9 million in 2014, 18.6 million in 2015, and 24.8 million in 2016.

⁴ OACT estimated that the number of uninsured covered will be 26.2 million in 2014, 29.5 million in 2015, and 32.1 million in 2016.

^ Figure includes total effects of Affordable Care Act on change in number of uninsured individuals. Totals may not add up due to rounding.

Source:

CBO. 2011. *CBO March 2011 Baseline: Health Insurance Exchanges.*

<http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceExchanges.pdf>. Accessed on 4/29/2011

CBO's March 2011 Baseline: Health Insurance Exchanges.

<http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceExchanges.pdf> Accessed on June 30, 2011.

CBO's March 2011 baseline: Health Insurance Exchanges. March 18, 2011.

III. Benefits

This RIA accompanies proposed rules that implement key provisions of the Affordable Care Act related to Affordable Insurance Exchanges, including risk adjustment, reinsurance, and risk corridors. It is difficult to discuss the benefits of these provisions in isolation. The overarching goal of Exchanges and related policies in the Affordable Care Act is to make affordable health insurance available to individuals without access to affordable employer-sponsored coverage. Different elements of the Affordable Care Act work together to achieve this goal. Affordable Insurance Exchanges, which create competitive marketplaces where individuals and small businesses can shop for coverage, reduce the unit price of insurance for the average consumer by pooling risk and promoting competition. Risk adjustment, reinsurance, and risk corridors as envisioned in the NPRM play a critical role in ensuring the success of the Exchanges. Risk corridors encourage health insurance issuers to offer QHPs on Exchanges in the first three years of their operation by ensuring that all issuers share the risk associated with initial uncertainty in the pricing of QHPs. Reinsurance protects health insurance issuers from the risk of high-cost individuals, enabling issuers to offer coverage at a lower premium. Risk adjustment plays an ongoing role in ensuring that Exchanges are not harmed by adverse selection.

There are of course many other provisions of the Affordable Care Act that are integral to the goal of expanding coverage, such as the premium tax credits. Here, we do not attempt to isolate the benefits associated with a particular provision of the Affordable Care Act. Instead, we will discuss the evidence on the benefits of having affordable health insurance coverage. We present quantitative evidence whenever it is available and rely on qualitative discussion when it is not.

Evidence on the Impact of Health Insurance Coverage

The best available evidence on how health insurance affects medical care utilization, health, and financial security comes from a recent evaluation of an expansion of Oregon's Medicaid program.⁵ In 2008, Oregon conducted a lottery to expanded access to uninsured adults with incomes below 100 percent of the Federal Poverty Level. Approximately 10,000 low-income adults were newly enrolled in Medicaid as a result. Comparing outcomes for those who won the lottery with outcomes for those who did not win yields an estimate of the benefits of having coverage. The evaluation concluded that for low-income uninsured adults, coverage has the following benefits:

- Significantly higher utilization of preventive care (mammograms, cholesterol monitoring, etc.),
- A significant increase in the probability of having a regular office or clinic for primary care, and
- Significantly better self-reported health.

While there are limitations on the ability to extrapolate from these results to the likely impacts of coverage expansions as a result of the Affordable Care Act – in particular, the Oregon

⁵ Amy Finkelstein, et al, "The Oregon Health Insurance Experiment: Evidence from the First Year," National Bureau of Economic Research Working Paper No. 17190, July 2011.

expansions targeted a population that is lower income, on average, than those likely to gain coverage through Exchanges – these results provide solid evidence of quantifiable health and financial benefits associated with coverage expansions for a population of non-elderly adults.

The results of the Oregon study are consistent with prior research, which has found that health insurance coverage improves health outcomes. The Institute of Medicine (2002) analyzed several population studies and found that people under the age 65 who were uninsured faced a 25 percent higher risk of mortality than those with private coverage. This pattern was found when comparing deaths of uninsured and insured patients from heart attack, cancer, traumatic injury, and HIV infection.⁶ The Institute of Medicine also concluded that insurance leads to better clinical outcomes for diabetes, cardiovascular disease, end-stage renal disease, HIV infection and mental illness if they have health insurance, and that uninsured adults were less likely to have regular checkups, recommended health screening services and a usual source of care to help manage their disease than a person with coverage.

Health Insurance Improves Financial Security

Another important benefit of health insurance is improved financial security. Comprehensive health insurance coverage provides a safety net against the potentially high cost of medical care, and the presence of health insurance can mitigate financial risk. The Oregon study found people who gained coverage were less likely to have unpaid medical bills referred to a collection agency. Again, this study is consistent with prior research showing the high level of financial insecurity associated with lack of insurance coverage. A recent analysis found that more than 30 percent of the uninsured report having zero (or negative) financial assets and uninsured families at the 90th percentile of the asset distribution report having total financial assets below

⁶ Institute of Medicine, *Care without coverage: too little, too late* (National Academies Press, 2002).

\$13,000 – an amount that can be quickly depleted with a single hospitalization.⁷ Other research indicates that uninsured individuals who experience illness suffer an average a loss of 30 percent to 50 percent of assets relative to households with insured individuals.⁸

Decreased Uncompensated Care

The improved financial security provided by health insurance also has benefits for providers, as insured patients can pay their medical bills. The Oregon study found that coverage significantly reduces the level of unpaid medical bills sent to a collection agency.⁹ Most of these bills are never paid, so this reduction in unpaid bills means that one of the important benefits of expanded health insurance coverage, such as the coverage that will be provided through the Exchanges, is a reduction in the level of uncompensated care provided.

Again, the results of the Oregon study are also consistent with other evidence. For example, subsequent to the enactment of health reform in Massachusetts in 2006,¹⁰ the Massachusetts government realized annual savings of about \$250 million from lower payments to hospitals for uncompensated care for the uninsured and underinsured.¹¹ Payments and utilization of the uncompensated care pool/health safety net trust fund have decreased and the rate of non-urgent emergency department visits declined by 2.6 percent among patients with premium assistance for coverage and uninsured patients in 2008 compared to 2006.¹²

Lower Premiums

⁷ ASPE. The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills. (2011).

⁸ Cook, K. et al., "Does major illness cause financial catastrophe?," *Health Services Research* 45, no. 2 (2010).

⁹ Finkelstein, Amy et al., "The Oregon Health Insurance Experiment: Evidence from the First Year," *National Bureau of Economic Research Working Paper Series* No. 17190(2011).

¹⁰ Chapter 58 of the Acts of 2006 of the Massachusetts General Court.

¹¹ Massachusetts Division of Health Care Finance and Policy, "2009 Annual Report Health Safety Net."

¹² Smulowitz, Peter B. et al., "Emergency Department Utilization After the Implementation of Massachusetts Health Reform," *Annals of Emergency Medicine* In Press, Corrected Proof.

The Exchanges and policies associated with them would also, according to CBO's letter to Evan Bayh from November 30, 2009, reduce premiums for the same benefits compared to prior law. It estimated that, in 2016, people purchasing non-group coverage through the Exchanges would pay 7 to 10 percent less due to the healthier risk pool that results from the coverage expansion. An additional 7 to 10 percent in savings would result from gains in economies of scale in purchasing insurance and lower administrative costs from elimination of underwriting, decreased marketing costs, and the Exchanges' simpler system for finding and enrolling individuals in health insurance plans.¹³ CBO also estimates that premiums for small businesses purchasing through the Exchanges would be up to 2 percent lower than they would be without the Affordable Care Act, for comparable reasons. CBO estimated that the administrative costs to health plans (described in greater detail below) would be more than offset by savings resulting from lower overhead due to new policies to limit benefit variation, prohibit "riders," and end underwriting. Premium savings to individuals and small businesses allow for alternative uses of income and resources, such as increasing retirement savings for families or investing in new jobs for small businesses.

IV. Costs

This section discusses the costs of implementing these proposed rules. This discussion is divided into two parts – costs of requirements on Exchanges (part 155 of the Exchange NPRM) and costs of requirements on issuers of QHPs (part 156 of the Exchange NPRM). The costs and impact for the reinsurance, risk adjustment and risk corridors programs (part 153 of the Premium Stabilization NPRM) are addressed in part V of this RIA.

Part 155: Requirements on Exchanges

¹³ Congressional Budget Office, "Letter to the Honorable Evan Bayh: An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act " (Washington2009).

This section discusses the impact of part 155 of the Exchange NPRM, particularly as it relates to administrative expenses and health plan certification. States seeking to operate an Exchange will incur administrative expenses as a result of implementing and subsequently maintaining Exchanges in accordance with the requirements in this proposed rule. It is important to note that although States have the option to establish and operate an Exchange, there is no Federal requirement that each State establish an Exchange. Any costs of the initial implementation of Exchanges will be funded through State Planning and Establishment Grants authorized under section 1311(a) of the Affordable Care Act. Table 1 shows that total grant outlays are estimated at \$2 billion dollars until grants cease at the end of calendar year 2014. After this initial phase of Exchange planning and implementation, the law requires that Exchanges be self-sustaining.

The maintenance of Exchanges beginning in 2015 requires another source of funding. Specific funding sources are left to the discretion of the Exchange and can be structured in several different ways including, but not limited to, assessments on health insurance issuers or other user fees. The Exchange may charge user fees or assessments to fund their ongoing operations and maintain broad discretion in determining how to structure these assessments or user fees, either by assessing a fee as a percentage of premiums or on a per capita basis. For example, the Commonwealth Connector in Massachusetts requires issuers to pay a fee that is structured as a percent of premium. The administrative costs of operating an Exchange will almost certainly vary by the number of enrollees in the Exchange due to economies of scale, variation in the scope of the Exchange's activities, and variation in average premium in the Exchange's service area.

Subpart B of part 155 of the Exchange proposed rule sets forth general requirements related to the establishment of Exchanges prior to and after 2014, including the approval process for Exchanges, governance principles for the Exchange, and requirements on regional and subsidiary Exchanges. The Exchange rule proposes that each State choosing to establish an Exchange shall submit an Exchange plan and a readiness assessment. The rule also proposes to that States that opt for a non-profit or independent authority Exchange establish a governance structure for it.

Subpart C of part 155 of the Exchange proposed rule primarily sets forth the minimum functions that each Exchange must perform. To operate effectively, in the early phases of establishment, each Exchange will most likely pursue one or more of these activities: hire Exchange personnel, including a chief executive officer or executive director, information technology personnel, financial management personnel, policy analysts, and other general support staff. Each Exchange may invest in physical office space to house the Exchange operations. As stated previously, the estimate in Table 1 of grant authority for States setting up an Exchange totals nearly \$2 billion from 2012-2016, and we assume that the administrative costs for start-up and initial implementation of these activities are all subsumed in this estimate for State Planning and Establishment Grants. Below, we lay out some estimates of State spending for specific components of the Exchange to provide some granularity for the type of costs involved.

Exchange Plan

In order for an Exchange to be approved, a State will need to submit an Exchange plan that provides information on how it will meet all of the requirements for the approval of an Exchange. As discussed in the Collection of Information Requirements, we estimate that it will

take a State approximately 160 hours (approximately one month) for the time and effort needed to develop the plan and submit to HHS. We estimate minimal burden requirements for developing the Exchange plan as States will be gathering most of the information needed for the plan through the planning and establishment grants provided by HHS.

States already report to HHS on the activities they are undertaking with Exchange grant funds based on eleven core areas of Exchange planning, as presented in the Department's funding opportunity announcement, including: business operations, legislation and governance, stakeholder consultation and program integration. States report on progress in establishment of their Exchanges, which will provide a foundation from which States can develop the Exchange plan. This streamlined approach will reduce the administrative burden on States related to approval of an Exchange.

Information Technology (IT) Infrastructure

We have not provided State-specific estimates related to establishment and approval of an Exchange due to the impact of State flexibility on Exchange establishment. This flexibility will lead to broad variation among States in the scope of certain activities, primarily in relation to the building and adaptation of IT systems relative to current systems, as well as any evidence from State enabling legislation on the specific role the Exchange will play, and the costs that will be associated with that role. However, as an example of IT costs, the Cooperative Agreements to Support Innovative Exchange Information Technology Systems (Early Innovator grants) are listed in Table 4, below. The Early Innovator grants were made to a handful of States to develop efficient and replicable IT systems that can provide the foundation for other States' work in this area. These amounts vary from \$6 million to \$48 million per State. We believe that the low-end cost of \$6 million for Maryland may not be representative of an average State as it is based on

the project proposal Maryland outlined in the Early Innovator application. Maryland may request additional funds from the Exchange Planning and Establishment grants and costs vary by State based on reasons including population of the State, the system that will be implemented, and the State's current IT systems.

These Early Innovator grants are the first IT grants provided to States. As more States develop IT systems to support Exchange functionality, we expect the cost of developing these systems to decline, capitalizing on the investments made by these initial grantee States. As a result, States that subsequently invest in an IT infrastructure may have lower costs.

Administrative costs for IT systems will likely vary depending on current State systems as well as the approaches Exchanges take to building and streamlining their eligibility and other systems.

Table 4. Cooperative Agreements to Support Innovative Exchange Information Technology Systems Award Amounts by Grantee (*in millions of dollars*)

Grantee	Recommended Award Amount
University of Massachusetts Medical School (New England consortium)	36
Wisconsin Department of Health Services	38
Oregon Health Authority	48
Kansas Insurance Department	32
Maryland Dept of Health and Mental Hygiene	6
New York Department of Health	27

Subpart C of Part 155 of the Exchange rule also proposes requirements for consumer assistance tools to support the Exchange, including an Exchange website, a call center, and an electronic calculator. The Affordable Care Act requires that every Exchange operate a toll-free

telephone hotline to respond to requests for assistance, maintain an Internet website through which enrollees and applicants of QHPs may obtain standardized comparative information on QHPs, establish and make available a calculator to determine the actual cost of coverage after the application of any advance payments of the premium tax credit and any cost-sharing reduction, and provide a quality rating to each QHP. As such, the Exchange will develop the above-mentioned tools and integrate them into other systems and resources provided by the Exchange to accurately convey and display information to applicants and enrollees about costs and coverage in QHPs.

According to December 2010 research by the Pew Internet and American Life Project, 83 percent of adult internet users utilize the Internet to find health information and 66 percent buy products online.¹⁴ Additionally, 67 percent of adult internet users in the US visit a local, state, or federal government website.¹⁵ There is the potential for great variability across Exchanges in the opportunity to create robust web resources, which may replace more labor-intensive administrative processes. For example, Exchanges may elect to create functionality for individuals to manage a personalized account, receive notices and other information online, or provide the opportunity for web chats that may reduce the need for paper and in-person resources. The initial start-up costs for creating state-of-the-art web resources to educate individuals by allowing them to compare plan options and calculate their costs online may be significant. Ultimately, however, such costs could result in lower ongoing costs of the Exchange and lower distribution costs of health insurance in general. While HHS is providing grant funding for the implementation of Exchanges and the development of IT systems, States will be responsible for the maintenance costs. In addition to the cost impact of web tools, the Exchange

¹⁴ Pew Internet & Life Project, "Trend Data," <http://www.pewinternet.org/Trend-Data/Online-Activities-Daily.aspx>.

¹⁵ Ibid.

will incur additional administrative expenses to develop and operate a call center and any contracting costs associated with this function.

Navigators

Subpart C of part 155 of the Exchange rule also proposes requirements on the Navigator program. Exchanges are required to have Navigator programs, and are given substantial flexibility in designing these programs. Funding for Navigators is provided by grants from Exchange funds separate from the Exchange Planning and Establishment Grants. We expect Navigators to increase access to and enrollment in QHPs. For instance, Navigators will provide an access point to the Exchange for individuals who lack easy access to technology, such as computers and telephones.

Estimating the impact of Navigator programs on enrollment is difficult due to the level of flexibility States have when creating the programs. Medicare's existing State Health Insurance Assistance Program ("SHIP") offers a comparable example to the Navigator program. SHIPs are grant-funded, State-based offices that provide education, outreach, and assistance to Medicare beneficiaries. Although the population served by SHIPs is different from the population Navigators will serve, SHIP operating data provides a baseline comparison throughout this section of analysis. CMS estimates that SHIPs have reached 4.7 million people through outreach events and one-on-one counseling in the 2009 grant year.¹⁶ In the same year, SHIPs conducted 54,656 public information and outreach events.¹⁷

Notifications

¹⁶ Office of External Affairs and Beneficiary Services, Unpublished, "FY 2010 SHIP Basic Grant Funding," (Center for Medicare & Medicaid Services, 2009).

¹⁷ Ibid.

The Exchange must also provide notifications to applicants, enrollees, and employers regarding enrollment and eligibility-related information or actions taken by the Exchange. These notices may communicate eligibility determinations, annual open enrollment periods, rights to appeal or other information. The Exchange must develop procedures to support these required notifications and their accompanying processes. Exchanges may reduce administrative costs associated with notices where these interactions can take place in electronic or automated format. As discussed in the Collection of Information Requirements, estimates related to notices throughout the proposed rule for Exchanges take into account the time and effort needed to develop the notice and make it an automated process to be sent out when appropriate. As such, we estimate that it will take approximately 16 hours annually for the time and effort to develop and submit a notice when appropriate. This estimate is slightly higher than the 8 hours estimated for notices discussed in the Medicare Part D rule and reflects the additional functions of the Exchange program. Cost estimates for approximately 13 notices from the Exchange are approximately \$11,000 for each Exchange.

Finally, notices, applications and forms must be written in plain language and provided in a manner that provides meaningful access to limited English proficient individuals and ensures effective communication for people with disabilities. Exchanges may face administrative costs when developing their notices, applications and forms to meet this requirement.

Enrollment Standards

In subpart E, we propose the Exchange must transmit information to the issuer of the QHP selected by an applicant to enable the issuer of the QHP to enroll the applicant. The Exchange NPRM lays out an annual enrollment period during which individuals will make insurance selections. While we anticipate that the Exchange and QHP issuers will need to allow

for a high capacity of systems use during the initial and annual open enrollment periods, these systems will also need to be available throughout the year to accommodate special enrollment periods.

Exchange enrollment systems will need to support enrollment and termination of coverage functions including data transfer functions. In turn, this function must be in alignment with industry privacy and security standards, including HIPAA. We anticipate that many private and State data systems currently comply with industry privacy standards, and therefore, it will not be an extensive burden to comply with this standard.

Initial start up and coordination of processes including data sharing may require significant resources initially as the Exchange initiates outreach, education, and engagement strategies. In addition, to facilitate seamless transitions for enrollees, the Exchange will need to coordinate with Pre-Existing Condition Insurance Plan (PCIP) to support the transition of PCIP enrollees into the Exchange, ensuring no lapses in coverage.

Application Process

Subpart E of part 155 addresses the application process. The Affordable Care Act requires the Exchange to collect specific types of information to determine eligibility. In accordance with the Affordable Care Act, all QHP issuers must use a uniform enrollment form. Further, it specifies that HHS must create a form that may be used to apply for applicable State insurance affordability programs. HHS plans to propose a single, streamlined eligibility application that applicants must complete to have their eligibility determined for enrollment in a QHP. Exchanges may either adopt the model application or develop their own application with HHS approval. The Exchange must make the application accessible to applicants and enrollees

both electronically and in paper form. Exchanges may experience administrative savings to the extent that they can encourage the broad use of an electronic or automated application process.

SHOP

Subpart H of part 155 describes general requirements related to the establishment of the SHOP, including certification standards and a set of minimum functions. Generally, SHOP has the same functionality as the rest of the Exchange, except as described below. Therefore, we estimate the additional administrative cost of building and operating a SHOP to be greatly reduced in comparison to building and operating an Exchange. As shown in Table 3, SHOP is projected to enroll nearly three million employees by 2016. According to the U.S. Census Bureau, in 2008 there were 42.1 million employees employed by employers with fewer than 100 employees in the United States.¹⁸ Currently, 67.4 percent of small employers with between 3 and 100 employees offer employer-sponsored health insurance coverage.¹⁹ The establishment of SHOP in conjunction with tax incentives for some employers will provide new opportunities for employers to offer affordable health insurance to their employees.

Enrollment in the small group market will be sensitive to premiums. Unlike for individuals who receive advance payments of the premium tax credit, the employer or employee will pay the marginal cost of coverage in the small group market. The Exchange NPRM proposes additional flexibility to each Exchange regarding the design of the SHOP. Exchanges may choose to merge the individual and small group markets. Based on the relative size and risk of the two markets, this decision may significantly impact the price of coverage.

¹⁸ Bureau, U.S. Census, "Number of Firms, Number of Establishments, Employment, and Annual Payroll by Enterprise Employment Size for the United States and States, Totals: 2008," (Washington2008).

¹⁹ Claxton, G. et al., *Employer Health Benefits, 2010 Annual Survey* (Menlo Park: Henry J. Kaiser Family Foundation, Health Research and Educational Trust, 2010).

The SHOP will interact with employers as well as the employees who will be enrolling in coverage in a QHP. This dual role requires a website, application, and support suited to the needs of employers as well as employees, and billing administration functions appropriate for the needs of small employers offering many health plans. All of these requirements could be built as extensions of the Exchange, or as entirely separate systems.

Given that SHOP functionality is so similar to the functionality of the rest of the Exchange, including enrollment of qualified employees and certification of QHPs, much of the IT and enrollment infrastructure can be reused. While the criteria for certifying a QHP for the SHOP may be slightly different, the certification process is identical. Therefore, plan management processes can be reused for the SHOP. With the large amount of flexibility Exchanges have in implementing these requirements for SHOP, the cost incurred from designing and implementing these SHOP functions varies based upon the State's vision for building its SHOP. Operating both an Exchange and the SHOP under the same administrative entity would reduce the cost of running the Exchange. Alternatively, Exchanges may decide that the needs of the small business community are unique and can best be served best through a governance structure that is entirely different.

Certification of QHPs

Subpart K of part 155 of the Exchange rule proposes standards for the processes for certification, recertification, and decertification of QHPs. To perform these processes, Exchanges will undertake various administrative functions. The Exchange will collect data and information from health insurance issuers to facilitate the evaluation of plan benefit packages, rates, networks and quality information. The Exchange may apply additional criteria and may negotiate with issuers before certifying QHPs. On an ongoing basis, Exchanges will collect

benefit, rate, network information, and other data from QHP issuers to facilitate the use of consumer tools such as the calculator and the plan comparison tool. This information will support QHP compliance as well as support the recertification of QHPs.

Subpart K of part 155 also proposes Exchange standards related to offering the QHPs. These standards have the potential to affect the administrative costs of some issuers. Some QHP issuers will be more prepared than others and will incur fewer costs. For example, if data reporting functions required for certification already exist within the QHP issuer, there would be no additional cost to building this functionality.

An Exchange has considerable flexibility in determining the certification standards it will use to determine whether health plans should be certified as QHPs. The administrative costs for this function will vary based on the operating model selected. For example, if an Exchange chooses to accept any qualified plan in the QHP certification process, it may require fewer administrative resources because the Exchange will not be performing competitive evaluations of plans. Alternatively, if an Exchange chooses to engage in selective contracting or other forms of active selection, it could incur higher administrative costs. Some of these costs could be offset if the Exchange contracts with a small number of QHPs, which would reduce the resources that an Exchange would devote to managing and communicating with QHPs. While start-up administrative costs for this process are included in the total estimated amount for the Exchange Planning and Establishment Grants, ongoing costs, including recertification and other ongoing operating costs, will be funded by revenue generated by the Exchange.

Costs of Part 156: Requirements on QHP Issuers

Part 156 of the Exchange NPRM proposes requirements on QHP issuers for participation in an Exchange. The cost of participating in an Exchange is an investment for QHP issuers, with

substantial benefits expected to accrue to QHP issuers. The Exchange will function as an important distribution channel for QHPs. QHP issuers currently fund their own sales and marketing efforts. As a centralized outlet to attract and enroll consumers, the Exchanges will supplement and reduce incremental health plan sales and marketing costs. These savings could be passed along to consumers in the form of reduced premiums. We estimate market reforms of the Affordable Care Act as well as administrative efficiencies from economies of scale and risk pooling will reduce insurance rates per unit of coverage for individuals and small groups.²⁰ Other administrative efficiencies that could lead to lower QHP premiums inside the Exchange include: streamlining of the eligibility process for the advance payments of the premium tax credit, customer service functions performed by the Exchange for QHP related issues, and the premium aggregation function of SHOP.

Accreditation

Subpart C of part 156 proposes that QHP issuers must be accredited on the basis of local performance of its QHPs by an accrediting entity recognized by HHS. For health plan issuers in States that already require accreditation, this process is a standard procedure and will add minimal administrative cost. Depending on a State's requirements, accreditation may be less common among issuers in the commercial market and Medicaid managed care organizations. The accreditation requirement may have some cost to health plan issuers that are not already accredited, but the accreditation process will build on procedures already performed by the health plan issuer. Health plan issuers without systems and processes set up to deal with accreditation will face a greater burden.

²⁰ Congressional Budget Office, "Letter to the Honorable Evan Bayh: An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act ".
Gabel, J. et al., "Generosity and adjusted premiums in job-based insurance: Hawaii is up, Wyoming is down," *Health Affairs* 25, no. 3 (2006).

Depending on the size of the health plan issuer and the accrediting body, the cost of accreditation may vary: with the National Committee for Quality Assurance (NCQA), the cost may range from \$40,000 to \$100,000 per issuer for a three year accreditation; with URAC, the cost is \$27,000 for a two-year accreditation.²¹ It should be noted that these are estimates, as accreditation costs for QHP issuers may differ from current pricing by accrediting bodies to date. These costs will be distributed across QHPs and should not have a significant effect on premiums. We expect the increase will diminish over time as the QHP issuer becomes more efficient in gaining accreditation. Annual accreditation requirements will be more costly than requiring accreditation less frequently.

Network Adequacy Standards

The Exchange NPRM proposes wide discretion for Exchanges in setting network adequacy standards for participating health insurance issuers. An Exchange may determine that compliance with relevant State law and licensure requirements is sufficient for a QHP issuer to participate in the Exchange. In such case, the network adequacy standard would have no impact on premiums. Since the Exchange will be able to set additional standards in accordance with current provider market characteristics and consumer needs, there could be a minimal impact on premiums.

In any State in which the Exchange sets significantly more extensive network adequacy standards than those already enforced as a part of State licensure, participating health insurance issuers may need to seek additional provider contracts in order to develop their provider networks in accordance with these standards. In some markets, issuers may need to contract with additional providers at higher reimbursement rates to meet the more extensive network

²¹ Mays, Glen. "Can Accreditation Work in Public Health? Lessons from Other Service Industries" 2005.

adequacy requirements. This may result in higher rates than would have otherwise resulted under less extensive network adequacy requirements.

In general, the network adequacy standards are aimed at maintaining a basic level of consumer protection, but allow for participating health insurance issuers to compete on these factors, with the goal of promoting higher quality of care and lower premiums. In turn, the Exchange NPRM proposes that QHP issuers contract with a sufficient number of essential community providers to provide timely access to services for low-income and medically underserved individuals. The proposed definition of essential community providers includes a broad range of providers to meet the needs of the low-income and medically underserved individuals. It is anticipated that this requirement will not add significant cost to QHP premiums, since it is not required that all of the providers be given a contract.

As with all types of providers, essential community providers may be less numerous in certain areas, particularly rural areas. In urban and suburban settings in particular, we anticipate that the broad range of essential community providers will enable a QHP issuer to integrate a sufficient number in its provider network. In rural areas, participating health insurance issuers have fewer options of essential community providers to include in their provider networks, and they may need to offer higher rates in order to attract those providers.

Premium Rating Rules

Affordable Care Act requirements help stabilize the relative risk of each market. By requiring parity in pricing, issuers cannot create price incentives for healthy individuals to prefer one market to another, a behavior that could be destabilizing. We expect this requirement to significantly improve the comparative health of the Exchange's risk pool, and prevent adverse selection that has plagued some small health insurance markets and health insurance purchasing

cooperatives. In addition, QHP issuers must pool risk for their plans both inside and outside of the Exchange.

V. Impacts of the Proposed Rule on Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

The Reinsurance, Risk Corridors and Risk Adjustment (“Premium Stabilization”) NPRM proposes rules and guidelines for the two transitional risk-sharing programs, reinsurance and risk corridors, as well as for the risk adjustment program that will continue beyond the first three years of Exchange operation. The purpose of these programs is to protect issuers, particularly QHP issuers, from the negative effects of adverse selection and to protect consumers from increases in premiums due to uncertainty for issuers.

In theory, insurers charge premiums for expected costs plus a risk premium, in order to build up reserve funds in case medical costs are higher than expected.²² Payments through reinsurance, risk adjustment, and risk corridors reduce the increased risk of financial loss that health insurance issuers might otherwise expect to incur in 2014 due to market reforms such as guaranteed issue and the elimination of medical underwriting. These payments reduce the risk to the issuer and the issuer can pass on a reduced risk premium to enrollees.

The Affordable Care Act structures reinsurance and risk adjustment as State-run programs with Federal guidelines on methodology, while it establishes risk corridors as a Federally-run program. Table 1 shows the estimated Federal cost of reinsurance and risk adjustment will be \$11 billion in 2014, \$18 billion in 2015 and \$18 billion in 2016. These outlays are offset by reinsurance and risk adjustment program receipts of \$12 billion in 2014, \$16 billion in 2015 and \$18 billion in 2016 (Table 2). Reinsurance and risk adjustment

²² Swartz, K. and Fund, C., *Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers* (Commonwealth Fund, 2005).

payments lag revenues by one quarter. In the aggregate, reinsurance and risk adjustment are budget neutral, meaning that contributions from some issuers fund disbursements to other issuers. CBO did not separately estimate the program costs of risk corridors, but assumed aggregate collections from some issuers would offset payments made to other issuers.

This section analyzes the administrative costs and premium impacts of these three programs to mitigate the negative effects of adverse selection.

Reinsurance

The Affordable Care Act requires the implementation of a three-year temporary reinsurance program for the years 2014, 2015 and 2016. Each State that operates an Exchange must establish or enter into a contract with an applicable not-for-profit reinsurance entity to carry out this program. A State that does not operate an Exchange may elect to establish a reinsurance program under the Affordable Care Act. If a State does not operate an Exchange and does not elect to operate its own reinsurance program, HHS will establish the reinsurance program to perform all the reinsurance functions for that State.

The Affordable Care Act authorizes an annual reinsurance pool of \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016. It also requires annual contributions to the U.S. Treasury of \$2 billion, \$2 billion, and \$1 billion, respectively. These program costs are funded by contributions from issuers, including TPAs for self-insured plans. Section 1341(b)(3) of the Affordable Care Act sets contribution levels for the program on a national basis. HHS proposes to establish a national contribution rate that totals \$12 billion in 2014. Reinsurance entities may elect to collect additional contributions if the State decides the amount collected according to the contribution rate is not sufficient to fund required reinsurance payments (§153.220(b)(3)) or to fund the administrative requirements of the reinsurance entity. Alternatively, reinsurance entities

can decrease payments if they did not collect enough funds in contributions to make payments for reinsurance claims submitted (§153.240(b)(2)).

Reinsurance entities bear the majority of administrative costs for reinsurance, although the State must ensure that the reinsurance entity is compliant with the program requirements. A State may have more than one reinsurance entity, and two or more States may jointly enter into an agreement with the same reinsurance entity to carry out reinsurance in all States.

Administrative costs will increase if multiple reinsurance entities are established within a State, whereas administrative efficiencies can be found if multiple States contract with one reinsurance entity.

The Premium Stabilization NPRM proposes a percent of premium method by which to collect reinsurance contributions, although a per capita approach was also considered. The percent of premium method allows States with higher premium costs to collect more money towards reinsurance. A flat, per capita amount would have a slightly adverse impact on the low-price catastrophic and child-only plans that will be a form of coverage in 2014.

Reinsurance payments will be made to issuers of individual insurance coverage on the basis of their high-cost enrollees, excluding grandfathered health plans. HHS will propose and publish an annual payment notice that contains the formula for calculating payments. Payments will be based on a portion of costs incurred above an attachment point, subject to a cap. The proposal to reinsure high costs rather than disease status may reduce insurer incentive to control costs because the insurer will face only the partial cost of high cost individuals instead of receiving a payment based on medical condition regardless of claims cost. However, use of a reinsurance cap, as well as the requirement for health insurance issuer cost-sharing above the attachment point and below the cap, may incentivize health insurance issuers to control costs.

Additionally, the approach based on cost is simpler to implement and more familiar to health insurance issuers, and thus will likely result in savings in administrative costs as compared to condition-based reinsurance. The program costs of reinsurance are reflected in changes to health insurance premiums. All health insurance issuers contribute to the reinsurance pool, while only health insurance issuers with plans in the individual market are eligible to receive payments. Thus, the temporary reinsurance program is redistributive from the non-individual market to the individual market. This serves to stabilize premiums in the individual market while having a minimal impact on large group issuers. Reinsurance will attenuate individual market rate increases that might otherwise occur because of the immediate enrollment of high risk individuals, potentially including, at the State's discretion, those currently in State high risk pools. In 2014, the cost of contributions to the reinsurance pool will be passed on to enrollees through premium increases of about one percent of premiums in the total market; the benefits of reinsurance will result in premium decreases in the individual market expected to be between 10 and 15 percent.²³

Evidence from the Healthy New York ("Healthy NY") program supports the magnitude of these estimates. In 2001, the State of New York began operating Healthy NY and required all HMOs in the State to offer policies for which small businesses and low-income individuals would be eligible. The program contained a "stop-loss" reinsurance provision designed to lower premiums for enrollees. The State would pay the insurer 90 percent of annual medical claims for enrollees that were between \$30,000 and \$100,000. Premiums for Healthy NY were about 15 percent to 30 percent less than comparable HMO policies in the small group market.²⁴ This

²³ Actuarial Research Corporation, "Reinsurance attachment point estimates," (Annandale2010).

²⁴ Swartz, K. and Keenan, P.S., *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (The Commonwealth Fund., 2001).

trend has continued. In 2009, the unadjusted medical loss ratio (MLR) in Healthy NY across participating plans was 120 percent in 2009. After reinsurance payments were made, the adjusted MLR dropped to 84 percent.²⁵

The reinsurance program permits early and prompt payment of reinsurance during the benefit year. This is important to the program's ability to maintain stable premiums in the individual market since risk adjustment and risk corridors are likely to be calculated after the benefit year. Reinsurance may offer timely financial relief to health insurers that experience the most adverse selection in the first year of implementation. As the reinsurance contributions required under law decrease in 2015 and 2016, their impact on premiums should decline, tracking with the decreased uncertainty in the market. The individual market will become more stable as health plans learn their expected risk under new insurance rules and become better able to price to their expected risk.

Risk Corridors

The risk corridor program is a temporary, three-year program that applies to QHPs offered in the Exchange or purchased from an issuer or broker. The Affordable Care Act establishes risk corridors as a Federal program; consequently, the Premium Stabilization NPRM proposes to operate risk corridors under Federal rules with no State variation. The risk corridor program will protect against rate setting uncertainty in the Exchange by limiting the extent of issuer losses (and gains).

QHP issuers must annually submit to HHS data on premiums collected and allowable costs, and make available to HHS any data to support auditing. This data will be collected in standard formats specified by HHS and HHS will seek to leverage existing data reporting as

²⁵ Burns & Associates, Inc. Independent Report on the Healthy NY Program for Calendar Year 2010. (Phoenix, 2010).

much as possible. Risk corridors act as an after-the-fact adjustment to premiums based on the health insurance issuer's experience. They are designed to protect QHP issuers in the individual and small group market against inaccurate rate setting. Due to uncertainty about the population during the first years of Exchange operation, plans may not be able to predict accurately their risk, and their premiums may reflect costs that are ultimately much lower or much higher than predicted, as reflected in overall profitability. For these plans, risk corridors are designed to shift cost from plans that overestimate their risk to plans that underestimate their risk. The threshold for risk corridor payments and charges is reached when a QHP issuer's allowable costs reach plus or minus three percent of the target amount. An issuer of a QHP plan whose gains are greater than three percent of the issuer's projections must remit charges to HHS, while HHS must make payments to an issuer of a QHP plan that experiences losses greater than three percent of the issuer's projections.

Risk Adjustment

Risk adjustment is a permanent program, administered by States that operate a HHS-approved Exchange, with risk adjustment criteria and methods established by HHS, with States having the option of proposing alternative methodologies. Risk adjustment is applied to health plans offered in the individual and small group markets, both inside and outside of the Exchange, except for grandfathered plans. A State that does not operate an Exchange cannot operate risk adjustment, although a State operating an Exchange can elect not to run risk adjustment. For States that do not operate an Exchange, or do not elect to operate risk adjustment, HHS will administer the risk adjustment functions. The Exchange may operate risk adjustment, although a State may also elect to have an entity other than the Exchange perform the risk adjustment functions, provided that the selected entity meets the requirements to operate risk adjustment.

Similar to the approach for reinsurance, multiple States may contract with a single entity to administer risk adjustment, provided that risk is pooled at the State level. Having a single entity administer risk adjustment in multiple States may provide administrative efficiencies.

HHS will specify a Federally-certified risk adjustment model. States may use this model or develop and propose alternate risk adjustment models that meet Federal standards. Once HHS approves an alternate risk adjustment model, it will be considered a Federally-certified model that any State may elect to use. States that elect to develop their own risk adjustment methods will have increased administrative costs. Developing a risk adjustment model requires complex data analysis, including population simulation, predictive modeling, and model calibration. States that elect to use Federal methods would likely reduce administrative costs.

States have the flexibility to merge the individual and small group markets into one risk pool or keep them separate for the purposes of risk adjustment. Risk adjustment must be conducted separately in unmerged markets. Developing the technology infrastructure required for data submission will likely require an administrative investment. The risk adjustment process will require significant amounts of demographic and diagnostic data to run through a risk assessment model in order to determine individual risk scores that form the basis for plan and State averages. The Premium Stabilization NPRM proposes that data to run risk adjustment be collected at the State level. States may vary the amount and type of data collected, provided that States meet specified data collection standards. Any State with an all-payer claims database may request an exception from the data collection minimum standards.

Administrative costs will vary across States and health insurance issuers depending on the sophistication of technical infrastructure and prior experience with data collection and risk adjustment. States and issuers that already have systems in place for data collection and

reporting will have reduced administrative costs. For example, issuers that already report encounter data for Medicare Advantage (MA) or Medicaid Managed Care may see minimal additional administrative burden for risk adjustment. MA organizations will be required to submit encounter data beginning in 2012.²⁶ All 40 States with capitated Medicaid Managed Care Organizations collect encounter data from managed care organizations.²⁷ Some States risk-adjust in their Medicaid Managed Care programs. Also, States that have all-payer claims databases have existing infrastructure to support risk adjustment. As of 2010, 13 States had operational all-payer claims databases.²⁸ Reported annual State funding to establish an all-payer claims database system ranges from \$350,000 to \$2 million.²⁹ States with all-payer or multi-payer claims databases may need to modify their systems to meet the requirements of risk adjustment, however, these modification costs will be less than establishment costs. States and issuers that do not have existing technical capabilities will have larger administrative costs related to developing necessary infrastructure.

Issuer characteristics, such as size and payment methodology, will also impact administrative costs. In general, national issuers will be better prepared for the requirements of risk adjustment than local issuers. Additionally, administrative costs may be greater for issuers where providers are paid by capitation and where they do not receive claims or encounter data as they will have to modify their systems to account for the information required for risk adjustment.

²⁶ Center for Medicare & Medicaid Services, "Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter," (Baltimore 2011).

²⁷ Office of the Inspector General. Medicaid Managed Care Encounter Data: Collection and Use. (2009).

²⁸ Miller, Patrick B, et al. All-Payer Claims Databases. (Robert Wood Johnson Foundation. , 2010).

²⁹ Council, APCD, "Cost and Funding Considerations for a Statewide All-Payer Claims Database (APCD). ," (2011).

We propose that States audit a sample of data from all issuers that submit data for risk adjustment each year. We further propose that States may extrapolate results from the sample to adjust the average actuarial risk for the plan. This approach is consistent with the approach now used in Medicare.

Risk adjustment transfers dollars from health plans with the lowest risk to health plans with the highest risk. From 2014 through 2016, it is estimated that \$22 billion will be transferred between issuers.³⁰ Risk adjustment protects against overall adverse selection by allowing insurers to set premiums according to the average actuarial risk in the individual and small group market without respect to the type of risk selection the insurer would otherwise expect to experience with a specific product offering in the market. This should lower the risk premium and allow issuers to price their products conservatively, closer to the average actuarial risk in the market. In addition, it mitigates the incentive for health plans to avoid unhealthy members.

The risk adjustment program also serves to level the playing field inside and outside of the Exchange as payments and charges are applied to all individual and small group plans. This mitigates the potential for excessive premium growth within the Exchange due to anticipated adverse selection.

VI. Alternatives Considered

As section 1321 of the Affordable Care Act describes, States have a great deal of flexibility on the operation and enforcement of the Exchange. Exchange standards aim to: promote a level playing field that promotes insurers competing on price and quality, ensure the maximum number of eligible people enroll in the Exchange, minimize the number of ineligible individuals who are able to enroll, minimize the total cost of establishing Exchange functions,

³⁰ Analysis based on CBO estimates for reinsurance and risk adjustment and the reinsurance contributions specified in section 1341(b)(3) of the Affordable Care Act.

and provide Exchanges with the flexibility to cater to the specific needs of their populations.

Achieving all of these objectives requires fundamental tradeoffs. Below is a description of key areas of State flexibility, alternatives considered, and the effect these decisions have on the Federal budget.

Areas of State Flexibility for the Operation of Exchange

States have a number of options on how to operate their Exchanges. For instance, States have flexibility in how they structure the governance of an Exchange. If a State operates its own Exchange, the Exchange can be established as a government agency or a not-for-profit entity per section 1311(d) (1) of the Affordable Care Act. If the Exchange is formed as a government entity, States have the option of establishing it as part of an existing agency (such as, the Department of Insurance or Medicaid Agency) or creating a new, standalone entity.

A State also has flexibility in determining how many Exchanges will cover the State's service area. The State can join with other States to form a regional Exchange or operate a number of smaller, geographically distinct subsidiary Exchanges. In addition to geographical choices, the State has to decide whether to create a separate governance structure for SHOP. The Exchange also has choices in determining how much education, marketing, and outreach to provide. Additionally, States have flexibility on certain other areas within Federal benchmarks. For example, the Exchange has latitude in the number, type, and standardization of plans it certifies and accepts into the Exchange. States also have flexibility in determining network adequacy standards and in the establishment of risk adjustment models and data collection for the risk adjustment and reinsurance programs.

Finally, the Affordable Care Act requires that Exchanges must be self-sustaining by 2015, but grants States freedom in how that is achieved. Some examples of funding strategies

for Exchanges include: assessments on insurers; direct charges of individuals and employers; or through a State's general fund.

Alternative #1: Uniform Standard for Operations of Exchanges

Under this alternative, HHS would require a single standard for State operations of Exchanges. The proposed regulation offers States the choice of whether to establish an Exchange, how to structure governance of the Exchange, whether to join with other States to form a regional Exchange, and how much education and outreach to engage in, among other factors. This alternative model would restrict State flexibility to some extent, requiring a more uniform standard that States must enact in order to achieve certification. This model could reduce Federal oversight costs as there would be less variation to monitor across Exchanges. Second, it is possible that a uniform model is more cost-efficient or more effective at providing coverage than other models States may design. However, in order for this model to be more effective, the uniform standard would need to be effective regardless of individual State differences (e.g., market structure, local business needs, demographic differences, etc.). Additionally, it assumes that State policy experimentation would not lead to the discovery of more effective policies. However, research has noted that State differences will likely impact Exchange needs and functions.³¹ Furthermore, there is substantial literature that notes that certain State Exchange policies will be emulated in other States if they are successful; therefore, policies that promote State innovation can be highly effective.³²

Alternative #2: Uniform Standard for Certifying Health Insurance Coverage

³¹ Corlette, Sabina and JoAnn Volk. 2011 . Active Purchasing for Health Exchanges: An Analysis of Options: Georgetown University: Health Policy Institute.

³² Volden, Craig. 2006. "States as Policy Laboratories: Emulating Success in the Children's Health Insurance Program" American Journal of Political Science. P. 294-312.

Under this alternative, there would be a single uniform standard for certifying QHPs. QHPs would need to meet a single standard in terms of benefit packages, network adequacy, premiums, etc. HHS would set these standards in advance of the certification process and QHPs would either meet those standards and thereby be certified or would fail to meet those standards and therefore would not be available to enrollees. This approach might provide cost savings in terms of administrative burden on Exchanges as there would be no need (or ability) to negotiate with potential QHPs. This approach could be problematic, however, as uniform national standards might not match local needs. Exchanges might be more effective if they have the opportunity to recruit additional plans if there is a concentrated market,³³ or to set higher standards in markets where competition is already intense. Secondly, this approach could reduce Exchanges' and QHP issuers' ability to innovate. For example, new approaches such as tiered networks might appeal to some Exchanges that wish to experiment with health care quality improvement and delivery system reform. Given the advantages a State flexibility approach provides, we selected it over Alternatives #1 and #2.

Effects of State Flexibility on the Federal Budget

The Federal budget should be affected in multiple ways by the flexibility States are afforded in the operation of Exchanges. Estimates in this analysis predict costs arising from cost-sharing reductions, and outlays for risk adjustment and reinsurance programs and grants for Exchanges; tax credits and Medicaid costs are separately calculated, as are the offsets that resulted in CBO projecting that the Affordable Care Act would reduce the Federal budget deficit. State flexibility in the design and implementation of Exchanges, however, could affect both total enrollment as well as the administrative and health plan costs as described in those sections. For

³³ Corlette, Sabina and JoAnn Volk. 2011. Active Purchasing for Health Exchanges: An Analysis of Options: Georgetown University: Health Policy Institute.

example, selective contracting with only some health plans could bring down all premiums in the Exchange through competition, resulting in lower total advanced premium tax credits.

VII. Limitations of Analysis

The previous analyses apply a qualitative analysis to the results of CBO's microsimulation model of the Affordable Care Act. Although we believe these estimates are both fair and realistic, they are based on a predictive economic model and are therefore subject to fundamental uncertainty. Ultimately, the Affordable Care Act requires the creation of Exchanges, which are State markets for the purchase of health insurance in the individual and small group market through which enrollees may be eligible for a new tax credit program that will increase insurance coverage. With limited previous data and experiences, there is greater uncertainty in estimating the impacts of implementing the Affordable Care Act and the Exchanges than in estimating implications of modifying a previously existing program.

Every predictive model has some level of uncertainty. Economic models are particularly subject to uncertainty because they rely on the inherently unpredictable behavior of economic actors, individuals deciding what they want to buy. Many variables that are not measurable contribute to these decisions, including future income, changes in health risk, cultural norms, etc. Changes in economic conditions (including the distribution of income) or productivity would affect the estimates of any predictions on the effects of the Affordable Care Act. For example, external changes to the economy could affect income that, in turn, could affect the estimated number of individuals who are eligible for cost-sharing reductions in the Exchanges. Additionally, future health care cost trends could differ from projections, which could, in turn, affect individual decisions on what to buy.

Beyond changes in economic conditions, there are other sources of uncertainty. One limitation of the current analysis is uncertainty about how the Affordable Care Act will affect employer-sponsored insurance. A RAND micro-simulation estimated that the number of firms offering employer sponsored insurance would increase from 3.5 million to 4.8 million in 2016.³⁴ An Urban Institute study estimates that large employer coverage would increase by 2 percent and small and medium business coverage would be relatively unchanged.³⁵ A Lewin Group study estimated a net reduction in the number of people with employer sponsored coverage of 2.8 million.³⁶ Moreover, experience in Massachusetts showed an increase in employer-sponsored insurance following the introduction of its affordable insurance Exchange.³⁷ Thus, while CBO assumes a slight decrease in employer-sponsored insurance, other analyses suggest that employer-sponsored insurance could increase.

VIII. Accounting Statement

Category	Primary Estimate	Year Dollar	Unit Discount Rate	Period Covered
Benefits				
Annualized Monetized (\$millions/year)	Not estimated	2011	7%	2012-2016
	Not estimated	2011	3%	2012-2016
Qualitative	The Exchanges, combined with other actions being taken to implement the Affordable Care Act, will improve access to health insurance, with numerous positive effects, including earlier treatment and improved morbidity, fewer bankruptcies and decreased use of uncompensated care. The Exchange will also serve as a distribution channel for insurance reducing administrative costs as a part of premiums and providing comparable information on health plans to allow for a more efficient shopping experience.			
Costs				
Annualized	424	2011	7%	2012-2016

³⁴ Eibner, Christine Federico Giroi, Carter C. Price, Amado Cordova, Peter Hussey, Alice Beckman, and Elizabeth McGlynn(2010) *Establishing State Health Insurance Exchanges*. Rand Health

³⁵ Garret, Bowens and Matthew Buettgens. 2011 "Employer Sponsored Insurance under Health Reform: Reports of Its Demise are Premature" Urban Institute

³⁶ Group, The Lewin, "Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Gvoernments, Employers, Families and Providers," Staff Working Paper # 11(2010).

³⁷ Long, Sharon and Karen Stockley (2010) *Health Reform in Massachusetts An Update As of fall 2009*. Urban Institute

Monetized (\$millions/year)	410	2011	3%	2012-2016
Qualitative	These costs include grant outlays to States to establish Exchanges.			
Transfers				
Federal Annualized Monetized (\$millions/year)	9925	2011	7%	2012-2016
	9633	2011	3%	2012-2016
Qualitative	Risk Adjustment transfers funds among individual and small group market health plan issuers. Reinsurance collects funds from all issuers and distributes it to individual market issuers.			

IX. Citations

- Actuarial Research Corporation. "Reinsurance attachment point estimates." Annandale, 2010.
- ASPE. *The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills.* (2011).
- Bureau, U.S. Census. "Number of Firms, Number of Establishments, Employment, and Annual Payroll by Enterprise Employment Size for the United States and States, Totals: 2008." Washington, 2008.
- Burns & Associates, Inc. *Independent Report on the Healthy NY Program for Calendar Year 2010.* (Phoenix, 2010).
- Center for Medicare & Medicaid Services. "Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter." Baltimore, 2011.
- Claxton, G., B. DiJulio, B. Finder, J. Lundy, M. McHugh, A. Osei-Anto, H. Whitmore, J. Pickreign, and J. Gabel. *Employer Health Benefits, 2010 Annual Survey.* Menlo Park: Henry J. Kaiser Family Foundation, Health Research and Educational Trust, 2010.
- Congressional Budget Office. "Letter to the Honorable Evan Bayh: An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act ". Washington, 2009.
- Cook, K., D. Dranove, and A. Sfekas. "Does major illness cause financial catastrophe?" *Health Services Research* 45, no. 2 (2010): 418-36.
- Council, APCD. "Cost and Funding Considerations for a Statewide All-Payer Claims Database (APCD). ." (2011).
- Finkelstein, Amy, Sarah Taubman, Bill Wright, Mira Bernstein, Jonathan Gruber, Joseph P. Newhouse, Heidi Allen, Katherine Baicker, and The Oregon Health Study Group. "The Oregon Health Insurance Experiment: Evidence from the First Year." *National Bureau of Economic Research Working Paper Series* No. 17190 (2011).
- Gabel, J., R. McDevitt, L. Gandolfo, J. Pickreign, S. Hawkins, and C. Fahlman. "Generosity and adjusted premiums in job-based insurance: Hawaii is up, Wyoming is down." *Health Affairs* 25, no. 3 (2006): 832.
- Group, The Lewin. "Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Gvoernments, Employers, Families and Providers." Staff Working Paper # 11 (2010).

- Haider, A.H., D.C. Chang, D.T. Efron, E.R. Haut, M. Crandall, and E.E. Cornwell III. "Race and insurance status as risk factors for trauma mortality." *Archives of Surgery* 143, no. 10 (2008): 945.
- Institute of Medicine. *Care without coverage: too little, too late*: National Academies Press, 2002.
- Levy, H., and D. Meltzer. "The impact of health insurance on health." *Annu. Rev. Public Health* 29 (2008): 399-409.
- Massachusetts Division of Health Care Finance and Policy. "2009 Annual Report Health Safety Net." Boston, 2009.
- Miller, Patrick B, et al. All-Payer Claims Databases. (Robert Woods Johnson Foundation. , 2010).
- Office of External Affairs and Beneficiary Services, Unpublished. "FY 2010 SHIP Basic Grant Funding." Center for Medicare & Medicaid Services, 2009.
- Office of the Inspector General. Medicaid Managed Care Encounter Data: Collection and Use. (2009).
- Pew Internet & Life Project. "Trend Data." <http://www.pewinternet.org/Trend-Data/Online-Activities-Daily.aspx>.
- Smulowitz, Peter B., Robert Lipton, J. Frank Wharam, Leon Adelman, Scott G. Weiner, Laura Burke, Christopher W. Baugh, Jeremiah D. Schuur, Shan W. Liu, Meghan E. McGrath, Bella Liu, Assaad Sayeh, Mary C. Burke, J. Hector Pope, and Bruce E. Landon. "Emergency Department Utilization After the Implementation of Massachusetts Health Reform." *Annals of Emergency Medicine* In Press, Corrected Proof.
- Swartz, K., and C. Fund. *Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers*: Commonwealth Fund, 2005.
- Swartz, K., and P.S. Keenan. *Healthy New York: Making Insurance More Affordable for Low-Income Workers*: The Commonwealth Fund., 2001.
- Weissman, J.S., and J.A. Bigby. "Massachusetts Health Care Reform—Near-Universal Coverage at What Cost?" *New England Journal of Medicine* 361, no. 21 (2009): 2012-15.