HEALTH REPUBLIC INSURANCE COMPANY, Plaintiff, v. UNITED STATES, Defendant.	)	Case No. 1:16-cv-00259-MMS (Judge Sweeney)

Exhibit 1

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

MODA HEALTH PLAN, INC.,	:	
	:	Judge Wheeler
Plaintiff,	:	
	:	Case No. 16-649C
v.	:	
	:	
THE UNITED STATES OF AMERICA,	:	
	:	
Defendant.	:	

THE UNITED STATES' MOTION TO DISMISS

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Pursuant to Rule 12(b)(1) of this Court's rules ("RCFC"), defendant, the United States, moves the Court to dismiss the Complaint of Moda Health Plan, Inc. ("Moda") for lack of subject matter jurisdiction. Should the Court determine that it has jurisdiction over Moda's claims, the United States moves for dismissal under Rule 12(b)(6).

INTRODUCTION

Moda brings this case seeking payments under section 1342 of the Affordable Care Act, 42 U.S.C. § 18062. Section 1342 directs the Secretary of Health and Human Services ("HHS") to establish and administer a three-year premium stabilization program known as "risk corridors" under which qualifying health plans either pay money to or receive money from HHS based on the ratio of their premiums to claims costs. Moda participated in the program in 2014 and 2015 and claims to be entitled to more than $191 million in payments for those years. Congress, however, has limited risk corridors payments to the amount of risk corridors collections, such that Moda has received only a portion of the amount alleged to be due. Moda seeks relief in this Court, but its claims fail as a matter of law.

First, Moda has no claim to "presently due" money damages, as it must to establish jurisdiction under the Tucker Act. Section 1342 does not provide a deadline by which risk corridors payments must be made, and HHS, in its role as administrator of the program, established a three-year payment framework under which it operates the program in a budget neutral manner by making payments for any particular benefit year from charges collected across all three years of the program's life span. Under this framework, HHS does not owe Moda, or any other issuer, final payment before the end of the program.

Second, Moda's claims are not ripe. Because HHS's three-year framework has not yet run its course, HHS has not determined the total amount of risk corridors payments any issuer will

receive. Upon the conclusion of the three-year program, Moda may receive the full amount of its claims. Even if it does not, it almost certainly will receive additional amounts. Because the final payment amounts are unknown and cannot be determined at this time, Moda's claims are not justiciable.

Third, Count I fails on the merits. Section 1342 does not require HHS to make risk corridors payments beyond those funded from collections. And even if that intent were unclear when the Affordable Care Act was enacted in 2010, Congress removed any ambiguity when it enacted annual appropriations laws for fiscal years 2015 and 2016 that prohibited HHS from paying risk corridors amounts from appropriated funds other than collections. Thus, Moda has, to date, received all the payments it is owed.

Finally, Moda's implied contract claims fails for the additional reason that risk corridors payments are a statutory benefit, not a contractual obligation. No contract requiring risk corridors payments could be formed as a matter of law because Congress neither established the risk corridors program as one based in contract nor conferred authority on HHS to bind the United States in contract for such payments.

STATEMENT OF THE ISSUES

1. Whether, as required by the Tucker Act, Moda has an entitlement to "presently due money damages" under a government program that does not require final payment before the end of the three-year program.

2. Whether Moda's claims for full payment are ripe for review before a final agency determination of how much will be paid.

3. Whether, on the merits, Moda can receive payments in excess of collections under section 1342 notwithstanding congressional intent that risk corridors payments be funded solely from collections over the program's three year life-span.

4. Whether the statutory and regulatory provisions establishing the risk corridors program—which were not embodied in a written contract, contain no language of contractual intent, and were never accompanied by contractual budget authority—nevertheless create a contractual right to risk corridors payments in excess of collections.

STATEMENT OF THE CASE

I. In 2010, Congress Enacted the Risk Corridors Program as Part of the Affordable Care Act

In 2010, Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010) (the "ACA"), seeking to guarantee the availability of affordable, high-quality health insurance coverage for all Americans. *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015).[1] The Act's key reforms are threefold: (1) it prohibits health insurance companies from denying coverage or setting premiums based upon health status or medical history; (2) it requires individuals to maintain health insurance coverage or make a payment to the Internal Revenue Service; and (3) it provides federal insurance subsidies in the form of premium tax credits and cost sharing reductions to make insurance more affordable to eligible consumers.

[1] HHS is responsible for overseeing implementation of major provisions of the ACA and for administering certain programs under the ACA, either directly or in conjunction with other federal agencies and/or states. *See, e.g.*, 42 U.S.C. §§ 18041(a)(1)(A), (c)(1). HHS delegates many of its responsibilities under the ACA to the Centers for Medicare & Medicaid Services ("CMS"), which created the Center for Consumer Information and Insurance Oversight ("CCIIO") to oversee implementation of the ACA. HHS, CMS, and CCIIO are referred to in this motion as "HHS."

King, 135 S. Ct. at 2486 (citing 42 U.S.C. §§ 300gg, 300gg–1(a), 18081, 18082, 18091; 26 U.S.C. §§ 5000A, & 36B); *see also* 42 U.S.C. § 18071.

A. The Health Benefit Exchanges

To implement these reforms, the Act created Health Benefit Exchanges ("Exchanges"), virtual marketplaces in each state where individuals and small groups can purchase health insurance coverage. 42 U.S.C. §§ 18031-18041. For consumers, the Exchanges provide a centralized location to shop for, select, and enroll in qualified health plans. Exchanges also are the only forum in which eligible consumers can purchase coverage with the assistance of federal subsidies. For issuers, the Exchanges provide organized, competitive marketplaces to compete for business in a centralized location, and they are the only commercial channel in which issuers can market their plans to the millions of individuals who receive federal insurance subsidies. The Exchanges also perform certain administrative functions, including eligibility verification, enrollment, and the delivery of federal insurance subsidies.

The Act contemplated that states would operate their own Exchanges ("State-Based Exchange") but provided that HHS would establish and operate Exchanges for any state that elected not to do so ("Federally-facilitated Exchange"). *See* 42 U.S.C. § 18041; 45 C.F.R. §§ 155.20, 155.105; Program Integrity; Exchange, SHOP, and Eligibility Appeals, 78 Fed. Reg. 54,070, 54,071 (Aug. 30, 2013).[2] All plans offered through an Exchange—whether State-Based or Federally-facilitated—must be "Qualified Health Plans" ("QHPs"), meaning that they provide

[2] States have three options regarding the establishment and administration of an Exchange: (1) they can elect to run their own Exchange using a state or federally-maintained information technology platform ("State-Based Exchange"); (2) they can let the federal government run their Exchange ("Federally-facilitated Exchange"); or (3) they can partner with the federal government to jointly administer their Exchange ("State Partnership Exchange"). 45 C.F.R. §§ 155.20; 155.105, 155.106, 155.200. HHS uses the term Federally-facilitated Exchanges to include State Partnership Exchanges.

"essential health benefits" and comply with other regulatory parameters such as provider network requirements, benefit design rules, and cost sharing limitations. *See* 42 U.S.C. § 18021; 45 C.F.R. parts 155 and 156.

B. The Risk Corridors Program

The ACA introduced millions of previously uninsured individuals into the insurance markets. The entry of these individuals—while creating valuable business opportunities for insurers—also created pricing uncertainties arising from the unknown health status of an expanded risk pool and the fact that insurers could no longer charge higher premiums or deny coverage based on an enrollee's health. *See* 42 U.S.C. §§ 300gg, 300gg-1; 45 C.F.R. §§ 147.104-147.110. To mitigate the pricing risk and incentives for adverse selection arising from these changes, the Act established three premium stabilization programs modeled on similar programs established under the Medicare Program. *See* Compl. ¶¶ 3, 4, 17. Informally known as the "3Rs," these programs began with the 2014 benefit year and consist of reinsurance, risk adjustment, and risk corridors. *See generally* 42 U.S.C. §§ 18061-18063.

The 3Rs program at issue in this case is the temporary risk corridors program established under section 1342 of the ACA, which seeks to reduce financial uncertainty for QHP issuers during the initial years of the Act by limiting financial losses and gains resulting from inaccurate rate-setting. Compl. ¶ 18. To do this, section 1342 requires the Secretary of HHS to "establish and administer a program of risk corridors" under which issuers offering individual and small group QHPs between 2014 and 2016 "shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." 42 U.S.C. § 18062(a). Under the "payment methodology" set forth in the ACA, if an issuer's "allowable costs" (essentially, claims costs) are less than a "target amount" (premiums minus administrative costs) by more than

three percent, the plan must pay a percentage of the difference (referred to as a "charge" or "collection") to HHS. 42 U.S.C. § 18062(b)(2). Conversely, if an issuer's allowable costs exceed the target amount by more than three percent, the issuer receives a percentage of the difference (referred to as a "payment"). 42 U.S.C. § 18062(b)(1). The payment and charge percentage is set by statute: either 50% or 80%, depending on the degree of loss or gain realized by the issuer. 42 U.S.C. § 18062(b). HHS regulations incorporate this payment methodology in substantially similar terms. *See* 45 C.F.R. § 153.510(b)-(c).

All QHP issuers are statutorily required to participate in the risk corridors program; there are no risk corridors contracts, and a QHP need not have entered any agreement with HHS to owe risk corridors charges or receive payments.[3] Instead, HHS administers the risk corridors program solely pursuant to statutory requirements, regulations, and guidance. Under the regulations, after the close of each benefit year, issuers of QHPs must compile and submit premium and cost data and other information underlying their risk corridors calculations to HHS no later than July 31 of the next calendar year. 45 C.F.R. § 153.530(d). Using these data, HHS calculates the charges and payments due to and from each issuer for the preceding benefit year. *See* 45 C.F.R. § 153.530(a)-(c); HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,473-74 (March 11, 2013). Within 30 days of HHS's announcement of final charge amounts, issuers are required to remit payment to HHS. 45 C.F.R. § 153.510(d). Neither the ACA nor the implementing regulations set a deadline by which HHS must make payments to issuers. *See generally* 42 U.S.C. § 18062; 45 C.F.R. § 153.510.

[3] With respect to the risk corridors program, QHP is defined at 45 C.F.R. §153.500 to include health plans offered outside the Exchanges that are the same plan or substantially the same as a QHP offered on the Exchanges, as defined at 45 C.F.R. §153.20.

II. In Early 2014, HHS Announced that It Would Implement the Risk Corridors Program in a Budget-Neutral Manner within a Three-Year Framework

Although Congress expressly appropriated funds in the ACA for many programs and authorized funding for others, Congress did not include in the ACA either an appropriation or an authorization of funding for risk corridors. In July 2011, HHS published a proposed rule noting that when the Congressional Budget Office ("CBO") performed a cost estimate contemporaneously with ACA's passage, it "assumed [risk corridors] collections would equal payments to plans in the aggregate." Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41,930, 41,948 (July 15, 2011). In March 2012, HHS published a regulatory impact analysis again noting that "CBO . . . assumed collections would equal payments to plans and would therefore be budget neutral." Centers for Medicare & Medicaid Services, Regulatory Impact Analysis, Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS-9989-FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-F) (Mar. 16, 2012), Appendix at A46; *see also* Centers for Medicare & Medicaid Services, Preliminary Regulatory Impact Analysis (CMS-9989-P2) (July 2011) ("CBO . . . assumed aggregate collections from some issuers would offset payments made to other issuers."), Appendix at A1.[4]

On March 11, 2014, HHS issued a final rule stating that "[w]e intend to implement th[e] [risk corridors] program in a budget neutral manner, and may make future adjustments, either upward or downward to this program . . . to the extent necessary to achieve this goal." HHS Notice of Benefit and Payment Parameters for 2015 Final Rule, 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014); *see also id.* at 13,829 ("HHS intends to implement this program in a budget neutral

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[4] A copy of this publication and other reference material not published in the Federal Register is provided in the Appendix.

manner."); Exchange and Insurance Market Standards for 2015 and Beyond Proposed Rule, 79 Fed. Reg. 15,808, 15,822 (Mar. 21, 2014) (same). On April 11, 2014, HHS released guidance explaining that in order to implement budget neutrality, it would make risk corridors payments only to the extent of collections and that any shortfall would result in a pro-rata reduction of all payments. That shortfall would then be paid from collections in the second and (if necessary) third years of the program. Under this three-year framework, final payments under the risk corridors program are not due until the end of the program. Centers for Medicare & Medicaid Services, *Risk Corridors and Budget Neutrality* (Apr. 11, 2014), Appendix at A98 ["April 11 Guidance"]. HHS reiterated and expanded upon this guidance in final rules issued in May 2014 and February 2015. *See* Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014); HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015).

HHS did note, however, that although it would strive to achieve budget neutrality consistent with the CBO's projections, it interpreted section 1342 to require full payments to issuers and that, if necessary, at the conclusion of the program, it would use sources of funding other than risk corridors collections, subject to the availability of appropriations. *See, e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In [the event that risk corridors collections are insufficient to fund payments over the three-year life of the program], HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations."); HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. at 10,779 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In the unlikely event that risk corridors

collections, including any potential carryover from the prior years, are insufficient to make risk corridors payments for the 2016 program year, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations."); HHS Notice of Benefit and Payment Parameters for 2014 Final Rule, 78 Fed. Reg. at 15,473 ("The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act."). Similarly, on September 9, 2016, HHS issued an announcement stating, "As we have said previously, in the event of a shortfall for the 2016 benefit year, HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. HHS will record risk corridors payments due as an obligation of the United States Government for which full payment is required." Centers for Medicare & Medicaid Services, Risk Corridors Payments for 2015 (Sept. 9, 2016), Appendix at A204.

III. For Fiscal Years 2015 and 2016, Congress Enacted Appropriations Riders Limiting the Total Risk Corridors Payments to the Amount of Risk Corridors Collections

Meanwhile, in February 2014, Members of Congress asked the Government Accountability Office ("GAO") for an opinion regarding the availability of appropriations to HHS to make payments to QHPs under the risk corridors program. *See* The Honorable Jeff Sessions, the Honorable Fred Upton, B-325630 (Comp. Gen.), 2014 WL 4825237, at *1 (Sept. 30, 2014) ("*GAO Op.*"). Prior to issuing its opinion, the GAO solicited the views of HHS, which identified collections from insurance issuers as the only source of funding and explained that collections could be spent pursuant to a provision of the CMS Program Management appropriation authorizing the expenditure of user fees. Letter of May 20, 2014, Appendix at A100. Shortly thereafter

Members of Congress sent a similar inquiry to HHS regarding available budget authority to make risk corridors payments, and HHS again identified collections from insurance issuers as the only source of funding for risk corridor payments. Letter of June 18, 2014, Appendix at A110.

In its opinion released on September 30, 2014, the GAO recognized that "Section 1342, by its terms, did not enact an appropriation to make the payments specified in section 1342(b)(1)," *GAO Op.*, 2014 WL 4825237, at *2. The GAO agreed with HHS that risk corridors collections could be used to make risk corridors payments under the user fee authority in CMS's Program Management appropriation. *Id.* at *4. The GAO also looked to whether any other funds were legally available to be spent on the risk corridors program and concluded that, in the annual appropriations law then in effect (the "2014 Spending Law"), a lump sum appropriation of $3.7 billion to be transferred from CMS trust funds to the CMS Program Management account for "other responsibilities of [CMS]" was sufficiently broad to cover risk corridors payments. *Id*. at *3. The opinion noted, however, that because risk corridors payments would not begin until fiscal year 2015 and "[a]ppropriations acts, by their nature, are considered nonpermanent legislation," similar appropriation language would need to be enacted for fiscal years 2015, 2016, and 2017 for the Program Management account to supply a source of funding for the program. *Id*. at *5.

On December 9, 2014—months before any payments could be made under the risk corridors program—Congress passed the Consolidated and Further Continuing Appropriations Act, 2015 ("the 2015 Spending Law") specifically addressing budget authority for the risk corridors program. Like the 2014 Spending Law, the 2015 Spending Law provided a lump sum amount for CMS's Program Management account for fiscal year 2015 to be transferred from CMS trust funds. Pub. L. No. 113-235, div. G, title II. Unlike the 2014 Spending Law, however, a rider

to the Law expressly limited the availability of Program Management funds for the risk corridors program, as follows:

> None of the funds made available by this Act from [CMS trust funds], or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services—Program Management' account, may be used for payments under section 1342(b)(1) of Public Law 111–148 (relating to risk corridors).

Id. § 227. The effect of the rider was to limit HHS's budget authority to make risk corridors payments to amounts derived from risk corridors collections. An accompanying Explanatory Statement indicated that the restriction was added "to prevent the CMS Program Management appropriation account from being used to support risk corridors payments." 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014). The Explanatory Statement observed that, "[i]n 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral," and characterized that statement by HHS as "meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect." *Id.*

On December 18, 2015, Congress enacted an identical funding limitation in the annual appropriations act for fiscal year 2016 (the "2016 Spending Law"). Pub. L. No. 114-113, div. H, title II, § 225. The Senate Committee Report to the 2016 Spending Law stated that the funding limitation "requir[es] the administration to operate the Risk Corridor program in a budget neutral manner by prohibiting any funds from the Labor-HHS-Education appropriations bill to be used as payments for the Risk Corridor program." Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2016, S. Rep. No. 114-74, at 12 (2015).

IV. In Conformity with Its Three-Year Administrative Framework and the Appropriations Riders, HHS Applied a Pro-Rata Reduction to Risk Corridors Payments in the First Payment Cycle

On July 31, 2015, issuers submitted their risk corridors data for the 2014 benefit year pursuant to the schedule established by HHS. Centers for Medicare & Medicaid Services,

Preliminary Risk Corridors Program Results (Aug. 7, 2015), Appendix at A112. On October 1, 2015, HHS announced that collections under the program for 2014 were expected to total $362 million, while payments calculated totaled $2.87 billion. Centers for Medicare & Medicaid Services, Risk Corridors Payment Proration Rate for 2014 (Oct. 1, 2015), Appendix at A113. HHS explained that, because payments exceeded collections, it could pay only 12.6% of these payments in the 2015 payment cycle. *Id.* Shortly thereafter, HHS released an individualized report of 2014 risk corridors charges and payments for each issuer. The same day, HHS released a guidance document explaining that it would make the pro-rated payments in late 2015, with "[t]he remaining 2014 risk corridors payments . . . made from 2015 risk corridors collections [in 2016], and if necessary, 2016 collections [in 2017]." Centers for Medicare & Medicaid Services, Risk Corridors Payments for the 2014 Benefit year (Nov. 19, 2015), Appendix at A114 ["November 19 Guidance"]. HHS also advised that, "[i]n the event of a shortfall for the 2016 program year, [HHS] will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments." *Id.*

In November 2015, HHS began collecting risk corridors charges for the 2014 benefit year. Centers For Medicare & Medicaid Services, Risk Corridors Payment and Charge Amounts for 2014 Benefit Year (Nov. 19, 2015), Appendix at A115. In December 2015, HHS began remitting risk corridors payments to issuers, including Moda. *Id.* HHS expects to pay additional installments of these payments in the 2016 payment cycle and the 2017 payment cycle. November 19 Guidance.

Issuers submitted their benefit year 2015 risk corridors data to HHS by August 1, 2016. *See* 45 C.F.R. § 153.530(d). HHS has not yet announced the final charge and payment amounts

due from and to issuers for benefit year 2015. HHS expects to begin making payments to issuers in December 2016. *See* Centers for Medicare & Medicaid Services, Completing the Risk Corridors Plan-Level Data Form for the 2015 Benefit Year, Health Insurance Exchange Program Training Series (June 7 & 9, 2016), at 7, ["June Webinar"] Appendix at A146.[5]

ARGUMENT

I. The Court Lacks Jurisdiction Under the Tucker Act Because Moda Has No Substantive Right to "Presently Due Money Damages"

A motion to dismiss for lack of subject matter jurisdiction is governed by RCFC 12(b)(1). When the movant challenges the jurisdictional facts alleged in the complaint, "[t]he plaintiff cannot rely solely on allegations in the complaint, but must bring forth relevant, adequate proof to establish jurisdiction." *Widtfeldt v. United States*, 122 Fed. Cl. 158, 162 (2015). The burden of proving that the court possesses subject matter jurisdiction lies at all times with the plaintiff. *Annuity Transfers, Ltd. v. United States*, 86 Fed. Cl. 173, 176-77 (2009). If the court determines that the plaintiff has not met its burden, the court "cannot proceed at all in any cause" and must dismiss the action. *Ex parte McCardle*, 74 U.S. (7 Wall.) 506, 514 (1868); RCFC 12(h)(3).

A. The Tucker Act's Waiver of Sovereign Immunity Is Limited to Monetary Claims That Are "Presently Due"

"The United States, as sovereign, is immune from suit save as it consents to be sued." *United States v. Sherwood*, 312 U.S. 584, 586 (1941). A waiver of sovereign immunity is a necessary prerequisite to the exercise of jurisdiction over the United States by any court. *See, e.g.*, *United States v. King*, 395 U.S. 1, 4 (1969). Such a waiver "must be unequivocally expressed in

[5] On September 9, 2016, HHS announced that, "based on our preliminary analysis, HHS anticipates that all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments." Appendix at A204.

the statutory text" and "strictly construed, in terms of its scope," in favor of the United States. *Lane v. Pena*, 518 U.S. 187, 192 (1996). "Absent a waiver, sovereign immunity shields the Federal Government and its agencies from suit," without regard to any perceived unfairness, inefficiency, or inequity. *Dept. of Army v. Blue Fox, Inc.*, 525 U.S. 255, 260 (1999).

The Tucker Act, under which Moda asserts jurisdiction, Compl. ¶ 10, waives sovereign immunity for certain non-tort claims against the United States founded upon the Constitution, a federal statute or regulation, or a contract. 28 U.S.C. § 1491(a)(1). The Tucker Act "does not create any substantive right enforceable against the United States for money damages." *United States v. Testan*, 424 U.S. 392, 398 (1976). "Thus, jurisdiction under the Tucker Act requires the litigant to identify a substantive right for money damages against the United States separate from the Tucker Act itself." *Todd v. United States*, 386 F.3d 1091, 1094 (Fed. Cir. 2004) (citing *Testan*, 424 U.S. at 398). In meeting this burden, it is not enough for a plaintiff to point to a law requiring the payment of money in the abstract. Instead, the law must "fairly be interpreted as mandating compensation for damages sustained as a result of *a breach of . . . duties [it] impose[s]*." *United States v. Mitchell*, 463 U.S. 206, 219 (1983) (emphasis added).

Further, the law must entitle the plaintiff to "actual, *presently due* money damages from the United States." *Todd*, 386 F.3d at 1093-94 (quoting *King*, 395 U.S. at 3) (emphasis added); *Johnson v. United States*, 105 Fed. Cl. 85, 94 (2012) ("Under the Tucker Act, the court's jurisdiction extends only to cases concerning actual, presently due money damages from the United States.") (internal quotation omitted); *see also Overall Roofing & Const. Inc. v. United States*, 929 F.2d 687, 689 (Fed. Cir. 1991) ("[T]he word 'claim' carries with it the historical limitation that it must assert a right to presently due money."), *superseded by statute on other grounds*, Pub. L. No. 102-572, Title IX, §§ 902(a), 907(b)(1), 106 Stat. 4506, 4516, 4519 (1992).

Thus, where a plaintiff has received all the money it is currently due, the Court must dismiss the complaint for lack of jurisdiction. *Annuity Transfers, Ltd.*, 86 Fed. Cl. at 179.

B. Additional Risk Corridors Payments Are Not Presently Due

With respect to risk corridors payments for benefit year 2015, issuers were not required to submit the data necessary to calculate these payments before August 1, 2016, and HHS has not announced final charge and payment amounts for 2015—much less made payments—for that benefit year. *See* June Webinar, at 7. Moda thus has no right to "actual, presently due money damages" for amounts that have not yet been announced by HHS and that, under Moda's own theory of annual payment, are not yet due.

As for payments for the 2014 benefit year, Moda's claim of Tucker Act jurisdiction rests on its mistaken assumption that the United States should have paid Moda the full benefit year 2014 risk corridors payments in 2015. *See* Compl. ¶¶ 9, 59e, 71. But neither Congress nor HHS imposed a deadline for HHS to tender full risk corridors payments to QHPs. *See* 42 U.S.C. § 18062; 45 C.F.R. § 153.510. Section 1342 requires HHS to calculate risk corridors payments and charges based on claims and other costs for a "benefit year," but it neither requires HHS to pay risk corridors on an annual basis nor sets a deadline for any such payments to be made (let alone sets a deadline that payments made in 2017 would not meet).

The very design of the risk corridors program and its inter-relationship with other 3Rs programs necessarily requires substantial flexibility in the timing of payments. For example, the ACA gives states responsibility for operating the reinsurance and risk adjustment programs unless they fail to do so, 42 U.S.C. §§ 18061(a), 18063(a), and requires that payments and charges in the federally-administered risk corridors program take into account "risk adjustment and reinsurance payments received" through these programs. 42 U.S.C. § 18062(c)(1)(B). Thus, if the statute had

set a deadline for risk corridors payments (it did not), that deadline could have come no earlier than many months after the close of a plan year, so that the federal government could wait for (what Congress contemplated to be fifty different) state-operated reinsurance and risk adjustment programs to run their course and then include "risk adjustment and reinsurance payments received" in calculating risk corridor charges and payments. *Id.* Furthermore, the ACA permits a state to "allocate[] and use[]" reinsurance collections "in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period." *Id.* § 18061(b)(4)(A). If a state were to choose to operate its own reinsurance program and exercise that option, the Secretary would not be able to definitively determine a plan's risk corridors amount for any given year until after the conclusion of the three-year reinsurance program. In light of the statutory requirement that reinsurance receivables factor into risk corridors calculations, and the ACA's express permission to allocate reinsurance collections in any of the three years of that program, the Secretary has reasonably interpreted the risk corridor provision not to require payment before the conclusion of the program, when reinsurance receivables would definitively be known. Likewise, while HHS's regulation requires issuers to pay charges within 30 days of notification by HHS, it does not establish any deadline by which HHS must make payments to issuers. *See* 45 C.F.R. § 153.510(d).

In the absence of a contrary statutory provision, "agencies, not the courts, . . . have primary responsibility for the programs that Congress has charged them to administer." *McCarthy v. Madigan*, 503 U.S. 140, 145 (1992), *superseded by statute on other grounds*, Pub. L. No. 104–134, § 803, 110 Stat. 1321 (Apr. 26, 1996). Courts must defer to an agency's interpretation of ambiguous statutory provisions, so long as that interpretation is reasonable. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984). The Federal Circuit has

stated that "the *Chevron* standard of deference applies" where, as here, "Congress either leaves a gap in the construction of the statute that the administrative agency is explicitly authorized to fill, or implicitly delegates legislative authority, as evidenced by 'the agency's generally conferred authority and other statutory circumstances.'" *Cathedral Candle Co. v. U.S. Int'l Trade Comm'n*, 400 F.3d 1352, 1361 (Fed. Cir. 2005) (quoting *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001)).

By declining to specify when payments from HHS were due and delegating to HHS the responsibility to "establish and administer" the risk corridors program, 42 U.S.C. § 18062(a), Congress conferred "broad discretion" to HHS "to tailor [the] . . . program to fit both its needs and its budget." *Contreras v. United States*, 64 Fed. Cl. 583, 599 (2005), *aff'd*, 168 F. App'x 938 (Fed. Cir. 2006). HHS exercised this discretion by establishing a three-year payment framework. Under this framework, if risk corridors claims exceed collections for a given benefit year, as they did for year 2014, payments are temporarily reduced so as not to exceed HHS's budget authority for that year. However, further payments for that benefit year are made in subsequent payment cycles (as HHS's budget authority is replenished), with final payment not due until the final payment cycle in 2017. *See* Compl. ¶ 54 (acknowledging HHS's multi-year payment cycle); *April 11 Guidance*, at 1; November 19 Guidance. Thus, HHS's three-year payment framework is well within the administrative authority delegated by Congress, and it is entitled to deference by the Court. *See, e.g.*, *W.E. Partners II, LLC v. United States*, 119 Fed. Cl. 684, 692 (2015) (deferring to agency framework for payments under statutory program because the "discretion afforded to the Treasury Department suggest Congress's intent to defer to the agency with the administration of this law"), *aff'd*, 636 Fed. Appx. 796 (Fed. Cir. 2016); *Meyers v. United States*, 96 Fed. Cl. 34, 54-55 (2010)

(deferring to agency where statute authorized it to "establish" regulatory program and did "not [expressly] proscribe" the programmatic framework established).

The 2015 and 2016 Spending Laws confirm that HHS has discretion to administer the risk-corridors program using a three-year payment framework. As noted above, the Spending Laws enacted in 2014 and 2015 preclude HHS from using appropriated funds other than risk corridors collections to make risk corridors payments during fiscal years 2015 and 2016, respectively. And Congress expressly acknowledged the three-year span of the payment framework in the Explanatory Statement to the 2015 Spending Law. 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014) (characterizing the 2014 HHS regulation as "meaning that the federal government will never pay out more than it collects from issuers *over the three year period risk corridors are in effect*.") (emphasis added). In short, Congress was fully aware of HHS's interpretation, expressly referred to it in the Explanatory Statement, and enacted the Spending Laws contemplating the same result. The three-year framework thus permits HHS to pay out the maximum amount possible on claims for each program year while also conforming to the express statutory limitation on the use of funds for risk corridors payments in fiscal years 2015 and 2016. Indeed, by implementing the risk corridors program in a budget neutral manner during the years the Spending Laws are in effect, HHS also is adhering to the restrictions in those laws, which prohibit HHS from making payments for 2014 and 2015 in amounts that exceed collections for those years. *Cf. Cobell v. Norton*, 428 F.3d 1070, 1075 (D.C. Cir. 2005) (noting that appropriations limits "unequivocally control what may be spent on [covered] activities during the period of their applicability," and concluding agency reasonably interpreted underlying 1994 statute by considering Congress's post-1994 appropriations limitations).

Because HHS's three-year payment framework has not yet run its course, Moda has no present right to full payment of its 2014 risk corridors receivable, let alone payment for its 2015 receivable (if any). As a result, Moda does not seek "presently due money damages" in compensation for any discernable legal violation, but instead seeks relief for which it has no substantive right: immediate payment. The Tucker Act does not confer jurisdiction under such circumstances. *See, e.g.*, *Casitas Mun. Water Dist. v. United States*, 708 F.3d 1340, 1358 (Fed. Cir. 2013) (observing that "a compensable injury [under the Tucker Act] could not have occurred because [a legal violation] has not yet occurred"); *Annuity Transfers, Ltd.*, 86 Fed. Cl. at 179 (holding that a plaintiff's mere "desire to receive a lump sum payment in lieu of" installment payments does not establish a legal violation by the United States or give rise to presently due money damages); *Wood v. United States*, 214 Ct. Cl. 744, 745 (1977) ("At best, plaintiff is claiming that he is not going to get [when the time comes] what is due him; such a claim is for future relief which we may not now entertain."); *cf. Barlow & Haun, Inc. v. United States*, 118 Fed. Cl. 597, 622 (2014) (dismissing claim where agency "had not actually failed to perform a presently due . . . obligation prior to plaintiffs filing suit"), *aff'd*, 805 F.3d 1049 (Fed. Cir. 2015). Moda's Complaint should be dismissed for lack of jurisdiction.[6]

II. Moda's Claims Are Not Ripe

Moda's claims also should be dismissed because they are not ripe. "Ripeness is a justiciability doctrine that prevents the courts, through avoidance of premature adjudication, from

[6] Count II is also dependent on an alleged right, under section 1342 or 45 C.F.R. § 153.510, to receive risk corridors payments in full annually. *See* Compl. ¶ 76 (alleging section 1342 and the implementing regulations constituted an offer to enter an implied-in-fact contract). Accordingly, in addition to the reasons set forth more fully below, because annual payments are not required, Count II fails as a matter of law and should be dismissed.

entangling themselves in abstract disagreements." *Shinnecock Indian Nation v. United States*, 782 F.3d 1345, 1348 (Fed. Cir. 2015) (citations and internal punctuation omitted); *see also Barlow & Haun, Inc.*, 118 Fed. Cl. at 614-15 ("[T]he court may find that it possesses jurisdiction over the subject matter of a claim but that the dispute is nevertheless nonjusticiable.").[7] Because "[t]he role of the federal courts is to provide redress for injuries that are 'concrete in both a qualitative and temporal sense,' . . . '[a]dherence to ripeness standards prevents courts from making determinations on the merits of a case before all the essential facts are in.'" *Shinnecock Indian Nation*, 782 F.3d at 1351-52 (quoting *Whitmore v. Arkansas*, 495 U.S. 149, 155 (1990)). "[A] claim is not ripe for adjudication if it rests upon 'contingent future events that may not occur as anticipated, or indeed may not occur at all' . . . [or] 'if further factual development is required.'" *Id.* at 1349 (quoting *Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 580-81 (1985); *Rothe Dev. Corp. v. Dep't of Def.*, 413 F.3d 1327, 1335 (Fed. Cir. 2005)).

Moda's claims are not ripe because HHS has not yet finally determined the total amount of payments that Moda (or any other issuer) will receive under the risk corridors program. HHS has not completed its data analysis for benefit year 2015, and benefit year 2016 is still underway. Whether sufficient funds will be available to make full payment of claims for any particular benefit year, and for all three years combined, is unknown. HHS may collect sufficient funds in future years to pay risk corridors claims in full. Alternatively, Congress may appropriate additional funds for the program in future years to pay all risk corridors amounts as calculated under section 1342(b). This Court does not address hypothetical situations that may be fully addressed by agency

[7] Although the constitutional basis for the justiciability doctrine derives from the "cases or controversies" requirement in Article III of the Constitution, this Court applies the doctrine on prudential grounds. *See, e.g.*, *CW Gov't Travel, Inc. v. United States*, 46 Fed. Cl. 554, 557-58 (2000) (collecting cases).

action, legislative action, or the passage of time. *See, e.g.*, *Shinnecock Indian Nation*, 782 F.3d at 1351-52 (affirming dismissal for lack of ripeness where "multiple possible . . . outcomes and factual developments could impact the Court of Federal Claims' adjudication" of plaintiff's claims). In short, it is too soon to determine whether Moda will receive less than the full amount of its risk corridors claims, much less the extent of any such underpayment. This case is not ripe and should be dismissed.

III. If the Court Reaches the Merits, Count I Should be Dismissed for Failure to State a Claim upon Which Relief Can Be Granted

For the reasons set forth above, the Complaint should be dismissed for lack of jurisdiction and lack of a justiciable claim. If, however, the Court determines that it has jurisdiction and that the claims are justiciable, Count I should be dismissed under Rule 12(b)(6). RCFC 12(b)(6) requires a court to dismiss a claim that fails to state a claim on which relief can be granted. To avoid dismissal, a plaintiff must "provide the grounds of [its] entitle[ment] to relief" in more than mere "labels and conclusions." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (citation and quotation marks omitted); *see also Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). A "formulaic recitation of the elements of a cause of action" is insufficient. *Twombly*, 550 U.S. at 555. Rather, the complaint must "plead factual allegations that support a facially 'plausible' claim to relief," *Cambridge v. United States*, 558 F.3d 1331, 1335 (Fed. Cir. 2009). The Court must dismiss a claim "when the facts asserted by the claimant do not entitle [it] to a legal remedy." *Lindsay v. United States*, 295 F.3d 1252, 1257 (Fed. Cir. 2002).

A. HHS's Pro-Rated Payments Are Rational Because the ACA Does Not Mandate Risk Corridors Payments In Excess of Amounts Collected

HHS's determination to operate the risk corridors program on a three-year, budget neutral basis, in which annual payments are limited by the amount of funds collected across all program

years, must be upheld because Congress has not mandated that HHS make risk corridor payments in excess of collections. Rather, Congress planned the program to be self-funding: insurers that have lower-than-expected costs for a given year are required to make contributions to the program, and those contributions are used to fund payments to insurers that have higher-than-expected costs. Subsection (a) of section 1342 requires HHS to establish and administer a temporary "payment adjustment system" based on the ratio of a plan's allowable costs to the plan's aggregate premiums. HHS fulfills that role by collecting charges from plans whose allowable costs are less than the threshold and distributing those funds to plans whose allowable costs exceed the threshold. But nothing in section 1342 requires HHS to make up a shortfall in collections. To the contrary, section 1342 creates a program with only "payments in" and "payments out." 42 U.S.C. § 18062(b) (capitalization altered). Insurers are assessed charges or receive payments "under the program," 42 U.S.C. § 18062(b)(1) and (2), and HHS distributes the monies accordingly. The statute contains no reference to any other source of funds.[8]

Moda relies on the language of subsection (b), which, in setting forth the "payment methodology," states that "the Secretary shall pay" amounts calculated in specified fashion. 42 U.S.C. § 18062(b)(1). But subsection (b) merely describes the "methodology" to be applied by HHS as it adjusts funds between plans "under the program"; it nowhere states that HHS or the United States must provide additional funds to insurers when the funds available "under the

[8] Responding to a request for an opinion regarding the availability of appropriations to make risk corridors payments, the GAO concluded that, as a matter of appropriations law, the CMS Program Management appropriation then in effect would have been available to make risk corridors payments and also would have appropriated risk corridors collections to HHS to make risk corridors payments had any obligation to make payments existed in that fiscal year. *See GAO Op.*, 2014 WL 4825237, at *5. HHS had identified only collections as a source of funds for payments. *Id.* The GAO did not address whether HHS was required under section 1342 to make payments in excess of collections.

program" fall short of the statutory amounts. Under Moda's interpretation, HHS would be the uncapped insurer of the insurance industry itself, under criteria—the ratio of a plan's allowable costs to its aggregate premiums—which are wholly dependent upon issuers' business judgment. Congress did not intend that result.

That Congress did not intend such a result is confirmed by the contrast between section 1342 and the preexisting risk corridors program under Medicare Part D. Although Congress specified that the ACA's temporary risk corridors program was generally based on the already-existing risk corridors program under Medicare Part D, *see* 42 U.S.C. § 18062(a), Congress omitted from the ACA the explicit statutory language that obligates the Secretary to make payments under the Medicare Part D risk corridors program in excess of amounts collected under that program. The Medicare Part D provision expressly provides: "This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section." 42 U.S.C. § 1395w-115(a)(2). By contrast, there is no such language in section 1342.

Accordingly, when the CBO performed a cost estimate contemporaneously with the Affordable Care Act's passage, it omitted the risk corridors program from its scoring. *See* Letter from Douglas Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker, House of Representatives, Tbl. 2 (Mar. 20, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/amendreconProp.pdf. The CBO's cost estimate was critical to ACA's passage, and was referenced in the text of ACA itself. *See* ACA § 1563(a), 124 Stat. 270-271; *see also* David M. Herszenhorn, *The Numbers Come Out Just Where Obama Wanted, With No Magic Involved*, N.Y. Times, Mar. 19, 2010, at A16. And that critical estimate of ACA's fiscal consequences was predicated on the understanding that the risk corridors program

would not impose liability on the government for payments in excess of amounts collected under the risk corridors program.[9]

Thus, under the ACA's text and statutory structure, insurers' entitlement to risk corridors payments extends only to the extent of amounts collected under the program. Because section 1342 does not give insurers a right to risk corridors payments from the Secretary in excess of collections, Moda's Tucker Act claims fail as a matter of law.

B. Congress's Post-ACA Enactments Confirm That Insurers Do Not Have an Entitlement to Risk Corridors Payments In Excess of Collections

The appropriations riders that Congress enacted after the ACA's passage further reinforce the conclusion that the liability of the United States is limited to amounts collected under the risk corridors program. HHS announced its three-year framework for implementing budget neutrality in final rules and guidance issued in the spring of 2014. 79 Fed. Reg. 13744, 13787 (March 11, 2014); 79 Red. Reg. 30240, 30260 (May 27, 2014); April 11 Guidance, Appendix at A98. In September 2014, the GAO released its opinion that, under the language of CMS's then-effective Program Management appropriation, monies transferred to the Program Management account from CMS trust funds would be available for risk corridors payments. *See GAO Op.*, 2014 WL 4825237, at *3. On December 9, 2014, in response to the GAO's conclusion and well before any risk corridors payments could be made, Congress passed the 2015 Spending Law with a rider prohibiting the use of appropriated funds other than collections to make risk corridors payments. The following year, Congress enacted an identical rider in the 2016 Spending Law. Pub. L. No. 114-113, div. H, title II, § 225. Congress's intent in each of the Spending Laws was clear: to

[9] HHS's various statements, described on pp. 9-10, addressed the agency's efforts to make risk corridors payments, subject to the availability of appropriations. The statements do not address the validity of claims against the United States under the Tucker Act.

ensure "that the risk corridor program will be budget neutral . . . over the three year period risk corridors are in effect," 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014), and to "requir[e] the administration to operate the Risk Corridor program in a budget neutral manner," Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2016, S. Rep. No. 114-74 at 12, (2015). The 2015 and 2016 appropriations riders thus confirm that Congress intends HHS to administer the risk corridors program as a self-funding program of redistribution among insurers.

Even if this were not the intent behind Section 1342 as originally enacted, "it is a well-established doctrine that Congress can authorize a deviation from pre-existing law by a provision in an appropriations act." *Bickford v. United States*, 228 Ct. Cl. 321, 329 (1981); *see, e.g.*, *United States v. Dickerson*, 310 U.S. 554, 555-56 (1940) (Congress can "suspend or repeal [an] authorization contained in [its own acts] . . . by an amendment to an appropriation bill, or otherwise"); *Republic Airlines, Inc. v. U.S. Dep't of Transp.*, 849 F.2d 1315, 1320 (10th Cir. 1988) ("Congress can amend substantive legislation through a provision in an appropriations act."); *Envirocare of Utah Inc. v. United States*, 44 Fed. Cl. 474, 482 (1999) (appropriations laws are "'just as effective a way to legislate as are ordinary bills relating to a particular subject'") (citation omitted); GAO, GAO–04–261SP, *Principles of Federal Appropriations Law (Vol. I)* 2-62-63 (4th ed. Mar. 10, 2016) ("Congress may enact a subsequent appropriation that makes a smaller payment than was contemplated in the permanent legislation . . . as long as the intent to reduce the amount of the payment is clear.").

A long line of Supreme Court and appellate cases have held that provisions enacted in annual appropriations laws, such as the spending limits at issue here, can substantively amend money-mandating provisions in previously enacted laws, thereby eliminating or reducing a

claimant's right to payment. In *Dickerson*, for example, the Supreme Court considered the effect of an annual appropriations law providing that "no part of any appropriation contained in this or any other Act for the fiscal year ending June 30, 1938, shall be available for the payment of [an] enlistment allowance . . . notwithstanding . . . [previously enacted legislation mandating that such allowance 'shall be paid']." *Dickerson*, 310 U.S. at 556-57. The Court held that the plaintiff was not entitled to collect such an allowance, notwithstanding the prior statute, because the statutory context and the legislative history showed that "Congress intended [the appropriations law] to suspend the enlistment allowance" for the fiscal year at issue. *Id.* at 561-62.

Similarly, in *United States v. Will*, 449 U.S. 200 (1980), the Supreme Court held that appropriations language providing that "[n]o part of the funds appropriated for the fiscal year ending September 30, 1979 . . . may be used to pay" salary increases mandated by earlier legislation "indicate[d] clearly that Congress intended to rescind these raises entirely, not simply to consign them to the fiscal limbo of an account due but not payable. The clear intent of Congress . . . *was to stop for that year the application of the . . . Act*." *Id.* at 224 (emphasis added); *see also United States v. Mitchell*, 109 U.S. 146, 148 (1883) (holding that "by the appropriation acts which cover the period for which the appellee claims compensation, congress expressed its purpose to suspend the operation of [a prior statute fixing salaries] and to reduce for that period the salaries of the appellee and other interpreters of the same class from $400 to $300 per annum"); *Matthews v. United States*, 123 U.S. 182, 186 (1887) (appropriations law capping salaries "in full compensation" for services "repealed, by necessary implication[,] . . . previous enactments" setting higher compensation).

In *Highland Falls–Fort Montgomery Cent. Sch. Dist. v. United States*, 48 F.3d 1166, 1171-72 (Fed. Cir. 1995), the Federal Circuit likewise gave effect to congressional intent in an

earmarked appropriation that limited and modified previously enacted statutory directions for the payment of money. Other circuits have reached similar conclusions. For example, in *Republic Airlines*, an annual appropriation law stated that "notwithstanding any other provision of law, none of the funds appropriated by this Act shall be expended under section 406 [of the Federal Aviation Act of 1958] for [certain] services provided after ninety-five days following the date of the enactment of this Act." 849 F.2d at 1317 (citing Pub. L. No. 97-102). The Tenth Circuit held that the appropriations restriction substantively amended the previously existing subsidy program under section 406 of the Act, thereby limiting the Civil Aeronautics Board's power to pay subsidies. *Id.* at 1319-22 (citing *Will*, 449 U.S. at 223; *American Fed'n of Gov't Employees, AFL–CIO v. Campbell*, 659 F.2d 157, 157 (D.C. Cir. 1980)). In so holding, the court rejected the airlines' argument that "Congress intended in section 406(b) to create an entitlement which was to survive appropriations actions," concluding that the "appropriations act directly addressed, and limited, the subsidy payable by the Board under section 406 and, perforce, altered any 'entitlement' to which the Airlines refer." *Id.* at 1319. *See also City of Arcata v. Slater*, 133 F.3d 926, 1997 WL 812258, at *2 (9th Cir. 1997) [unpublished table op.] (holding that the "plain language" of the appropriations law stating that "none of the funds in this Act may be obligated or expended to operate" flight service station "defunds everything that [the prior act] obligates the FAA to do. Accordingly, the FAA's obligation to implement that section has been suspended") (citing *Burtch v. United States Dep't of the Treasury*, 120 F.3d 1087, 1090 (9th Cir. 1997)); *Am. Fed'n of Gov't Emp., AFL-CIO*, 659 F.2d at 161 ("the [appropriations act] in this case contains words that by clear implication, if not express statement, modified *pro tanto* the previous substantive law. Consequently, we conclude that Congress, by express reference to the earlier statute, effectively

modified the prevailing rate statute to provide that wages for prevailing rate employees could not be increased by more than 5.5% for fiscal year 1979.").

In many of these cases, Congress prohibited payment from the appropriations act as a whole (or, in *Dickerson*, from any appropriations act for the fiscal year at issue), or Congress capped payments at a lesser amount than specified. In contrast, because the risk corridors program includes collections from issuers, Congress did not intend through the 2015 and 2016 Spending Laws to eliminate risk corridors payments under section 1342 entirely or reduce payments by a specific amount, but instead intended to limit payments to the extent of risk corridors collections. Moreover, because collections are themselves considered an appropriation as a matter of appropriations law, rather than prohibiting payments from the Spending Laws as a whole (as the riders at issue in many cases did), Congress included riders that limit risk corridors payments only from the CMS Program Management appropriation, the only source of funding the GAO had determined to be legally available for risk corridors payments. The riders thus demonstrate Congress's intent that the risk corridors program be budget neutral.

The cases discussed above demonstrate that Congress can suspend or modify the extent of the government's obligation in an appropriations statute, and that Congress can demonstrate its intent to do so through the text of the appropriations statute itself, the surrounding context in which the appropriation was made, or the statute's legislative history. Here, in enacting the 2015 and 2016 Spending Laws, Congress demonstrated its intent that the risk corridors program be budget neutral for those fiscal years. Thus, even if Congress's intent to limit the United States' liability to the extent of risk corridors collections were unclear at the time the ACA was enacted, by the time any payments could be made, Congress had "directly spoken" to the issue by restricting the

use of HHS funds to support the risk corridors program. *Highland Falls*, 48 F.3d at 1170. Issuers' remedy "must lie with Congress." *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 432 (1990).

C. Congress Could Limit the United States' Liability Through Appropriations Restrictions Because the Risk Corridors Program Does Not Impose Contractual Obligations on the United States

The Supreme Court has recognized a limitation on Congress's ability to curtail the government's contractual liability through the appropriations process. *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2189 (2012); *Cherokee Nation of Oklahoma v. Leavitt*, 543 U.S. 631, 646 (2005). The Court made clear, however, that this limitation is based on "longstanding principles of Government contracting law," *Ramah Navajo*, 132 S. Ct. at 2186, and the observation that "[a] statute that retroactively repudiates the Government's contractual obligation may violate the Constitution," *Cherokee Nation*, 543 U.S. at 646. Thus, this Court and the Court of Appeals have held that the rule of *Ramah Navajo* is confined to obligations based in contract and does not apply to other statutory programs, such as the risk corridors program at issue here. *See, e.g.*, *Prairie Cty. Mont. v. United States*, 113 Fed. Cl. 194, 200 (2013) (observing that "'there is great room in benefits programs to find the government's liability limited to the amount appropriated'") (quoting *Greenlee Cty. v. United States*, 487 F.3d 871, 879 (Fed. Cir. 2007)), *aff'd*, 782 F.3d 685, 690 (Fed. Cir. 2015) ("[T]his case does not involve the same question as that addressed by the Supreme Court in *Ramah* and *Cherokee Nation*. *Absent a contractual obligation*, the question here is whether the statute reflects congressional intent to limit the government's liability.") (emphasis added), *cert. denied*, 136 S. Ct. 319 (Oct. 13, 2015).

As set forth more fully below, the limited contract-based doctrine of *Ramah Navajo* does not apply here because section 1342 provides for the creation of a benefits program. HHS has no contractual obligation to make risk corridors payments, and in the absence of such an obligation,

Congress was free to "readjust[] rights and burdens" and even "upset[ ] otherwise settled expectations," *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 16 (1976), by limiting the "government's liability . . . to the amount appropriated," *Prairie Cty. Mont.*, 113 Fed. Cl. at 200. *See also Richardson v. Belcher*, 404 U.S. 78, 80-81 (1971) (noting "the power of Congress to make substantive changes" to benefits programs such as risk corridors); *Kizas v. Webster*, 707 F.2d 524, 539 (D.C. Cir. 1983) (government benefits "are 'limited, as a general rule, by the governmental power to remove, through prescribed procedures, the underlying source of those benefits.'") (citations omitted, emphasis removed).

Congress has done so here. Accordingly, Count I must be dismissed for failure to state a claim upon which relief may be granted.

IV. Count II Must Be Dismissed Because HHS Has No Contractual Obligation to Make Risk Corridors Payments

In Count II, Moda alleges that, by making partial rather than full risk corridors payments in the 2015 payment cycle, HHS breached an implied contract. This claim fails because it relies on the existence of an implied contract between HHS and Moda for the payment of risk corridors payments, but no such contract exists. Section 1342 establishes a statutory program, not a contractual undertaking. Insurance issuers do not "agree" with HHS to offer QHPs in exchange for a promise by HHS to make risk corridors payments. Rather, issuers of QHPs automatically are subject to the risk corridors program—along with numerous other regulatory benefits and burdens—and any amounts determined to be owed by or due to them arise wholly as a matter of statute and regulation.

In Count II, Moda alleges that it "entered into an implied-in-fact contract" with the Government under which Moda "agreed to sell and provide health care coverage . . . in exchange for timely reimbursement from the Government." Compl. ¶ 76. The elements of an implied-in-

fact contract are the same as the elements of an express contract, namely: (1) mutuality of intent; (2) an unambiguous offer and acceptance; (3) consideration; and (4) actual authority of the government's representative to bind the government in contract. *Hanlin v. United States*, 316 F.3d 1325, 1328 (Fed. Cir. 2003). Moda has not alleged and cannot allege facts plausibly establishing these requirements.

A. Nothing in Section 1342 or 45 C.F.R. § 153.510 Indicates an Intent by the Government to Enter into a Contract for Risk Corridors

First, Moda fails to offer any well-pleaded factual allegations indicating that the government intended to contract for risk corridors payments. "[A]bsent some clear indication that the legislature intends to bind itself contractually, the presumption is that a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued until the legislature shall ordain otherwise." *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465–66 (1985) (internal quotations, citations omitted). Courts must presume that a statutory enactment constitutes a statement of policy rather than a binding commitment, because "the principal function of a legislature is not to make contracts, but to make laws that establish the policy of the state . . . [which], unlike contracts, are inherently subject to revision and repeal[.]" *Id.*; *see also Baker v. United States*, 50 Fed. Cl. 483, 489 (2001) ("[T]he United States cannot be contractually bound merely by invoking the cited statute and regulation.").

Moda cannot overcome this presumption. It points to section 1342, HHS's implementing regulations and "the words and actions" of HHS officials. Compl. ¶ 78. This does not suffice. Rather, "to overcome th[e] presumption [that general laws do not create private rights in contract], plaintiffs must point to specific language in [the statute or regulation] or to conduct on the part of the government that allows a reasonable inference that the government intended to enter into a contract." *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 27 (2011).

When courts have found an intent to contract with program participants, the statutes at issue clearly expressed Congress's intent for the government to enter into contracts. *See, e.g.*, *Grav v. United States*, 14 Cl. Ct. 390, 392 (1988) (finding an implied-in-fact contract where statute provided that "Secretary shall offer to enter into a contract"), *aff'd*, 886 F.2d 1305 (Fed. Cir. 1989); *Radium Mines, Inc. v. United States*, 153 F. Supp. 403, 405 (Ct. Cl. 1957) (opining that agency regulation could give rise to implied contract where it stated that "[u]pon receipt of an offer" the agency would "forward to the person making the offer a form of contract containing applicable terms and conditions ready for his acceptance"). In contrast, neither section 1342 nor 45 C.F.R. § 153.510 contain any contract language; they simply provide for the creation of a program and a formula for determining charges and payments.

Nor do HHS's acknowledgments of its risk corridors duties, Compl. ¶ 78, evince an intent to contract; they merely recognize HHS's understanding of its existing *statutory* duties. *See, e.g.*, 79 Fed. Reg. at 30,260 ("HHS recognizes that the *Affordable Care Act* requires the Secretary to make full payments to issuers."); 80 Fed. Reg. at 10,779 (same). An agency's acknowledgment of a statutory duty is not evidence of an intent to contract. *AAA Pharmacy, Inc. v. United States*, 108 Fed. Cl. 321, 328 (2012). Thus, there is no support for Moda's contention that Congress or HHS intended the risk corridors program to operate as a contractual obligation. *Cf. Hanlin*, 316 F.3d at 1329-30 (noting that statute and regulation "set forth the [agency's] authority and obligation to act, rather than a promissory undertaking" and "[w]e discern no language in the statute or the regulation that indicates an intent to enter into a contract"); *AAA Pharmacy, Inc.*, 108 Fed. Cl. at 329 (finding no intent to contract in Medicare Act and regulations where statute "only provides for payment" and regulation "provides for a review process"); *ARRA Energy Co. I*, 97 Fed. Cl. at 28 (dismissing implied-in-fact contract claim because statute "simply provides that

the government will make an outright payment to any applicant who meets specified conditions"). Absent any intent by the United States to contract for the payment of risk corridors, Count III must be dismissed.

B. HHS Lacked Authority to Enter Contracts for Risk Corridors Payments

Regarding authority to enter an implied contract with issuers, Moda again relies on HHS's representations and assurances, Compl. ¶ 78, but Moda fails to identify the source of their purported authority. *See id.*

"A government agent possesses express actual authority to bind the government in contract only when the Constitution, a statute, or a regulation grants it to that agent in unambiguous terms." *McAfee v. United States*, 46 Fed. Cl. 428, 435 (2000). Moreover, budget authority is a prerequisite to contract formation with the United States. The Anti-deficiency Act prohibits government officials from involving the "government in a[n] . . . obligation for the payment of money before an appropriation is made unless authorized by law." 31 U.S.C. § 1341(a)(1)(B). Without such authorization (or appropriation), a valid contract for the payment of money cannot be formed. *See, e.g.*, *Cherokee Nation of Oklahoma v. Leavitt*, 543 U.S. 631, 643 (2005) (recognizing that "without . . . special authority, a[n] . . . officer cannot bind the Government in the absence of an appropriation") (citations omitted). Nothing in the ACA or HHS's regulations grants authority to HHS to enter contracts for the payment of risk corridors.

In any event, the agency assurances relied on by Moda do not advance its case. An agency simply cannot bind itself to the payment of money through its oral or written statements—absent express contracting authority bestowed by Congress. "If agents of the Executive were able, by their unauthorized . . . statements to citizens, to obligate the Treasury for the payment of funds, the

control over public funds that the [Appropriations] Clause reposes in Congress in effect could be transferred to the Executive . . . in violation of the Constitution." *Richmond*, 496 U.S. at 428.

CONCLUSION

For these reasons, Moda's Complaint should be dismissed.

Dated: September 30, 2016

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 30th day of September 2016, a copy of the foregoing, *The United States' Motion to Dismiss*, was filed electronically with the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing with be sent to all parties by operation of the Court's ECF system.

/s/ Phillip M. Seligman
PHILLIP M. SELIGMAN
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APPENDIX

Index to Appendix

[1] The document is incorrectly dated September 9, 2015.

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.**

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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

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[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

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[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.

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[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.

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[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

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[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.

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[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," (Baltimore2011).
[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 Woods 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 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

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[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 Girosi, Carter C. Price, Amado Cordova, Peter Hussey, Alice Beckman, and Elizabeth McGylnn(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.			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

Regulatory Impact Analysis

Center for Consumer Information & Insurance Oversight

March, 2012

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SUMMARY:

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

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 these rules are "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 rulemakings.

This analysis focuses on the requirements for the establishment of Affordable Insurance Exchanges (Exchanges), Qualified Health Plans (QHPs) and the Small business Health Options Program (SHOP). The final rules described in this impact analysis implement provisions related to Exchanges, including reinsurance, risk adjustment and risk corridors. The rules set forth standards for States that seek to establish an Exchange and for health insurance issuers. Specifically, the rules establish--(1) standards for 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: (4) basic requirements that employers must meet with respect to their voluntary participation in SHOP; and (5) standards for eligibility determination. Authority lies primarily in Title I of the Patient Protection and Affordable Care Act, called the Affordable Care Act, sections 1301, 1302, 1311, 1312, 1313, 1321, 1322, 1323, 1331-1334, 1341-1343, 1401, 1402, and 1411-1413. HHS has drafted these 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 of 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 who pass it along resulting in higher premiums paid by the insured, or by State and local governments. Providers pass much of this cost to insurance companies, resulting in higher premiums, making health insurance more unaffordable. The Affordable Care Act includes a number of policies to address these problems, including the creation 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 individual and small businesses the same purchasing power as big business. 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.[1] Third, two proposed regulations were published in the **Federal Register** on July 15, 2011 (76 FR 41930 and 76 FR 41866) to implement components of the Exchange and health insurance premium stabilization policies in the Affordable Care Act. Fourth, a proposed rule was published in the Federal Register on August 17, 2011 to implement components of the Exchange policies relating to eligibility determinations and Exchange standards for employers (76 FR 51202). Fifth, a final rule for the application, review, and reporting process for waivers for State innovation was published in the **Federal Register** on February 22, 2012 (76 FR 13553).

[1] http://cciio.cms.gov/resources/files/guidance_to_states_on_exchanges.html.

Subjects included in the Affordable Care Act to be addressed in subsequent rulemaking include (but are not limited to) 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 the Treasury. The Departments of Labor and the Treasury have primary jurisdiction over employer responsibility provisions in sections 1511-1514 of the Affordable Care Act. This analysis will serve as the basis for estimating the non-tax and non-Medicaid impacts of Exchange provisions.

II. Estimates of the Impact of Exchanges

This impact analysis references both estimates from the Congressional Budget Office (CBO), as well as Center for Medicare & Medicaid Services (CMS) estimates. The CBO estimate remains the most comprehensive accounting of all the interacting provisions pertaining to the Affordable Care Act, and contains cost estimates of some provisions that have not been independently estimated by CMS. Based on our review, we expect that the requirements in these final rules will not significantly alter CBO's estimates of the budget impact of Exchanges or enrollment. The requirements are well within the parameters used in the modeling of the Affordable Care Act. Our review and analysis of the requirements indicate that the impacts are within the model's margin of error.

In the RIA that accompanied the proposed rule, we displayed CBO estimates of enrollment for Exchanges, outlays and receipts for the reinsurance and risk adjustment programs,

and State Planning and Establishment Grants. The estimates in this analysis utilize those same estimates, except they reflect the FY 2013 President's Budget for State Planning and Establishment Grants. A description of CBO's methods used to estimate budget and enrollment impacts is available.[2]

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). While open enrollment through Exchanges begins on October 1, 2013, coverage will not be effective 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 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 and subject to IRS rulemaking. It does not include the Medicaid effects, or the policies whose offsets led CBO to estimate that the Affordable Care Act would reduce the Federal budget deficit by over $100 billion over the next 10 years. Table 1 also includes the estimates for outlays for grants to States for Exchange start up. Table 2 includes the CBO's estimates of receipts for reinsurance and risk adjustment.[3]

[2] Congressional Budget Office, "CBO's Health Insurance Simulation Model: A Technical Description," (2007, October).
[3] Please note that although the estimate relies on CBO analysis, the CBO did not include the reinsurance collections in their score of reinsurance, consequently the receipts in the President's Fiscal Year 2013 Budget are higher than the CBO display, though not appreciably different.

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

Year	2012	2013	2014	2015	2016	2012-2016
Reinsurance and Risk Adjustment Program Payments[a]	---	---	11	18	18	47
Grant Authority for Exchange Start up[b]	0.9	1.1	0.8	0.4	0.1	3.4

[a] Risk-adjustment payments lag receipts shown in Table 2 by one quarter.
Source: Congressional Budget Office *Letter to Hon. Nancy Pelosi*. March 20, 2010.
[b] FY 2013 President's Budget, *Analytical Perspectives*, Table 32-1

Table 2. Estimated Receipts for the Reinsurance and Risk Adjustment Program Provisions of Affordable Insurance Exchanges FY2012 - FY2016, in billions of dollars

Year	2012	2013	2014	2015	2016	2012-2016
Reinsurance and Risk Adjustment Program Receipts[a]	---	---	12	16	18	46

[a] Risk-adjustment payments shown in Table 1 lag receipts by one quarter.
Source: Congressional Budget Office *Letter to Hon. Nancy Pelosi*. March 20, 2010.

Because the provisions do not take effect 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 did not score the impact of risk corridors and assumed collections would equal payments to plans and would therefore be budget neutral.[4]

Table 3 contains the CBO estimates of the number of people enrolled in Exchanges from 2012 through 2016. These numbers do not account for an estimated half a million individuals

[4] Please see Section V for a more thorough discussion on the potential impact of risk corridors.

who are now likely to enroll in Exchanges instead of Medicaid due to changes in eligibility criteria enacted in P.L. 112-56, the Three Percent Withholding Repeal and Job Creation Act. Participation rates among potential enrollees are expected to be lower in the first few years of Exchange availability as employers and individuals adjust to the features of the Exchanges. These estimates show that there will be over 21 million people enrolled in Exchanges by the year 2016.

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[5]	---	---	8.9	14.3	21.7

CBO, March 2011 Baseline

III. Benefits

This RIA accompanies the final 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 provisions and policies in the Affordable Care Act is to make affordable health insurance available to individuals who do not have 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 quality insurance for the average consumer by pooling risk and promoting competition. Risk adjustment, reinsurance, and risk corridors as implemented in the final rule play a critical role in ensuring the

[5] OACT estimates that total Exchange enrollment will be 16.9 million in 2014, 18.6 million in 2015, and 24.8 million in 2016 (Letter from Richard Foster. April 22, 2010. Estimated Financial Effects of the "Patient Protection and Affordable Care Act" as Amended).

success of the Exchanges. Risk corridors encourage health insurance issuers to offer QHPs through Exchanges during 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, reducing issuers' need to accumulate precautionary savings and, lowering premiums. Risk adjustment plays a similar role by reducing the advantages of the selection of healthy individuals with low risk by a plan.

There are many other provisions of the Affordable Care Act that are integral to the goal of expanding coverage, such as the availability of premium tax credits to certain individuals who do not have access to affordable insurance. Here, we do not attempt to isolate the benefits associated with each particular provision of the Affordable Care Act. Instead, we discuss the evidence on the benefits of affordable health insurance coverage,- which is the overarching objective of the Exchanges and the related provisions of the Affordable Care Act. We present quantitative evidence where it is possible and supplement with qualitative discussion.

Health Insurance Coverage Improves Access to Health Care Services Including Preventive Services

One recent evaluation of an expansion of Oregon's Medicaid program allowed researchers to isolate the effects of health coverage on health care utilization and outcomes because the people who gained access to coverage were assigned at random.[6] In 2008, Oregon conducted a lottery to expand Medicaid eligibility to uninsured adults with incomes below 100 percent of the Federal Poverty Level. Approximately 10,000 randomly selected low-income adults gained Medicaid coverage as a result. Comparing outcomes for those who received coverage through the lottery with outcomes for those who applied but did not receive coverage

[6] Finkelstein, A. et al. "The Oregon Health Insurance Experiment: Evidence from the First Year." *NBER Working Paper* No. 17190, July 2011.

yields an estimate of the benefits of having coverage. The evaluation concluded that for low-income uninsured adults, health coverage has the following benefits:

- Higher utilization of preventive care (mammograms, cholesterol monitoring, blood tests for high blood sugar related to diabetes, etc.),
- Increase in the probability of having a regular office or clinic for primary care, and
- Better self-reported health.

Because the Oregon expansion targeted a population with lower incomes than individuals who will obtain insurance through Exchanges, these results may not be completely generalizable to the likely impacts of Exchange coverage. However, these results do provide solid evidence of quantifiable benefits associated with coverage expansions for a population of non-elderly adults.

Data from the Survey on Disparities in Quality of Health Care reveal critical characteristics of health care utilization in the US.[7] The researchers used income and insurance status as proxy for "ability to pay" for and use specialty services. The study found that lack of health coverage and lack of income were the principal impediments to using specialty care, and that, regardless of race, gender, age and education, adults who were uninsured or low-income did not seek specialty care even after recognizing a need.

Several studies have also looked at the relationship between health coverage and access to basic health care and preventive health care services.[8] Uninsured adults are less likely than insured adults to have regular checkups, recommended health screening services and a usual

[7] Lee, C. et al. "The importance of examining movements within the US health care system: sequential logic modeling." *BMC Health Services Research*. 2010; 10: 269-276.
[8] Institute of Medicine. "Care within Coverage: Too Little, Too Late," Washington DC: National Academy Press, 2002.

source of care to help manage their diseases.[9] Similarly, data from 1996 Medical Expenditure Panel Survey (MEPS) found significant differences in access to preventive services between the insured full-year and the uninsured full-year. This data provides evidence that access to health care is somewhat dependent on the stability of health coverage.[10] The rates of cancer-related and cardio-vascular preventive services were significantly lower for people who were uninsured for longer than 6 months out of the year.[11]

Another study found that uninsured individuals were significantly more likely than individuals with health coverage to report that cost prevented them from seeing a physician when needed. Uninsured individuals were also more likely than similar but insured individuals to report that they did not have a routine check-up in the past two years.[12]

In 2006, Massachusetts enacted a health reform law and studies related to its implementation there provide an opportunity to assess the benefits of increasing access to health coverage.[13] In 2010, approximately 94.2 percent of non-elderly adults in Massachusetts had insurance coverage, significantly higher than the 86.6 percent who had health coverage when the law passed.[14]

Other recent studies that compare changes in outcomes in Massachusetts to changes in other States find that after reforms went into effect in Massachusetts, there was an increase in the

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[9] Bednarek, HL, Schone, BS. "Variation in preventive service use among the insured and uninsured: does length of time without coverage matter?" *Journal Health Care Poor Underserved.* 14(3). 2003:403-419.
[10] Bednarek, HL, Schone, BS. "Variation in preventive service use among the insured and uninsured: does length of time without coverage matter?" *Journal Health Care Poor Underserved.* 14(3). 2003:403-419.
[11] Finkelstein, A. et al. "The Oregon Health Insurance Experiment: Evidence from the First Year". *NBER Working Paper* No. 17190, (July 201).
[12] Ayanian JZ, Weissman JS, Schneider EC, Ginsburg JA, Zaslavsky AM: Unmet Health Needs of Uninsured Adults in the United States, *JAMA.* 28416. 2000: 2061-2069.

[13] Long, SK, Stockley K, Dahlen, H. "Massachusetts Health Reforms: Uninsurance Remains Low, Self-Reported Health Status Improves as State Prepares to Tackle Costs." *Health Affairs.* 29. 2012: 1234-1241.
[14] Long, SK, Stockley K, Dahlen, H. "Massachusetts Health Reforms: Uninsurance Remains Low, Self-Reported Health Status Improves as State Prepares to Tackle Costs." *Health Affairs.* 29. 2012: 1234-1241.

percentage of individuals reporting that they had a personal doctor.[15] Over the same period, rates of non-urgent emergency department use fell in Massachusetts hospitals, and fewer patients were admitted through the emergency departments or with conditions that could have been avoided if the patient had received appropriate primary care.[16]

Health Insurance Coverage Improves Clinical Outcomes

Research suggests that there is a strong, positive relationship between insurance coverage and clinical outcomes. Lack of insurance coverage has been associated with additional mortality and lost workplace productivity.[17] One study estimated that victims of automobile accident who do not have health coverage receive 20 percent less in hospital treatment and are 37 percent more likely to die from their injuries than victims with health coverage.[18] Data from National Health and Nutrition Examination Survey (NHANES) was used in one 2005 study to estimate that 44,789 deaths among non-elderly adults could be attributed to lack of health coverage.[19] Lack of insurance coverage has been associated with additional mortality and lost workplace productivity.[20] An Institute of Medicine (IOM) study concluded that having insurance leads to better clinical outcomes for diabetes, cardiovascular disease, end-stage renal disease, HIV

[15] Kolstad, JT, Kowalski, AE. "The impact of health care reform on hospital and preventive care: evidence from Massachusetts." *NBER Working Paper* 16012 (May 2010).
[16] Miller, S. "The effect of Insurance on emergency room visits: an analysis of the 2006 Massachusetts health reform." Unpublished manuscript, University of Illinois (November 2011).
[17] Wilper, AP et al. "Health insurance and mortality in US adults." *American Journal of Public Health*. 99. 2009: 1-7.
[18] Doyle, JJ. "Health Insurance, treatment and outcomes: using auto accidents as health shocks." National Bureau of Economic Research. *NBER Working Paper* 11099 (February, 2005).
[19] Wilper, AP et al. "Health insurance and mortality in US adults." *American Journal of Public Health*. 99. 2009: 1-7.
[20] Institute of Medicine, *Care without coverage: too little, too late* (National Academies Press, 2002). Ayanian J, et al. "Unmet Health Needs of Uninsured Adults in the United States." *JAMA*. 284(16). 2000:2061-9. 27; Roetzheim R, et al. "Effects of Health Insurance and Race on Colorectal Cancer Treatments and Outcomes." *American Journal of Public Health* 90(11). 2000: 1746-54; Wilper, et al. "Health Insurance and Mortality in US Adults." *American Journal of Public Health*. 99(12). 2009: 2289-2295; S. Dorn, "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality," Urban Institute (2008); Richard Kronick, "Health Insurance Coverage and Mortality Revisited." *Health Services Research*. 44(4). 2009: 1211-31.

infection and mental illness. The study found 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.[21] Other studies that compare changes in hospital utilization find that Medicare eligibility leads to an increase in hospital admissions for discretionary procedures, especially for groups with low rates of insurance coverage prior to Medicare eligibility.[22] Medicare eligibility also leads to increased screening for breast cancer and a decrease in the probability of late-stage diagnosis. These studies do provide evidence that having health coverage significantly affects treatment decisions and ultimately health outcomes.[23]

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. One study estimated that the advent of Medicare in the 1960s resulted in a welfare gain of $9.9 billion (2000 dollars) annually due to reduced exposure to financial risk.[24] This study also found that Medicare coverage resulted in a one-third reduction in out-of-pocket spending on physician and outpatient services.

Additionally, the Oregon study found that people who gained health coverage were less likely to have unpaid medical bills referred to a collection agency. Again, this study is consistent

[21] Institute of Medicine, Care without coverage: too little, too late (National Academies Press, 2002); see also Jack Hadley. "Insurance Coverage, Medical Care Use, and Short-term Health Changes Following an Unintentional Injury or the Onset of a Chronic Condition." *JAMA*. 297(10). 2007:1073-1084. doi: 10.1001/jama.297.10.1073.
[22] Card, D, Dobkin C, Maestas N. "The impact of nearly universal insurance coverage on health care utilization and health: Evidence from Medicare." *American Economic Review*. 98 (5). 2008: 2242-258.
[23] Decker, SL. 2005 "Medicare and the Health and Women with Breast Cancer." *Journal of Human Resources*. 40(4). 2005: 948-968.
[24] Finkelstein A, McKnight R. "What Did Medicare Do (And Was It Worth It)?" *Journal of Public Economics*. 92. 2008:1644-1669.

with prior research showing the high level of financial insecurity associated with lack of insurance coverage.[25] Furthermore, a 2011 analysis by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) found that most of the uninsured be unable to afford a single hospitalization, because 90 percent of the uninsured reported having total financial assets below $13,000.[26] Other research indicates that households with uninsured individuals who experience illness suffer an average a loss of 30 percent to 50 percent of assets relative to similar households with insured individuals.[27]

An evaluation of recent health reform initiatives in San Mateo County, CA that were designed to increase health coverage for adults without health coverage, and promote access and quality of care showed several positive outcomes for newly-insured adults. Particularly, there was a significant reduction in the charges to the individual for services after enrollment.[28] Additionally, a recent study indicated that a 10-percentage point increase in eligibility for Medicaid coverage reduces personal bankruptcies by 8 percent.[29]

Decreased Uncompensated Care

The improved financial security provided by health insurance may also have benefits for providers. The Oregon study found that coverage significantly reduces the level of unpaid medical bills sent to a collection agency.[30] Most of these bills are never paid, suggesting that

[25] Finkelstein, A. et al. "The Oregon Health Insurance Experiment: Evidence from the First Year." *NBER Working Paper* No. 17190, July 2011.
[26] Assistant Secretary for Planning and Evaluation The Value of Health Insurance: Few of the Uninsured Have Adequate Resources to Pay Potential Hospital Bills: 2011. Washington DC: US Department of Health and Human Services.
[27] Cook K et al. "Does major illness cause financial catastrophe?" *Health Service Research*. 45 (2): 2010.
[28] Howell, E.M. Et al, Evaluation of the San Mateo County Adult Coverage and Systems redesign initiative. Washington DC: Urban Institute 2011.
[29] Gross T, Notowidigdo M. "Health insurance and the consumer bankruptcy decision: Evidence from Medicaid expansions." *Journal of Public Economics*. 95 (7-8): 2011.
[30] Finkelstein, A. et al. "The Oregon Health Insurance Experiment: Evidence from the First Year". *NBER Working Paper* No. 17190, July 2011.

expanded health insurance coverage leads to 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, the State realized annual savings of about $250 million from lower payments to hospitals for uncompensated care for the uninsured and underinsured.[31] Payments and utilization of the State's dedicated fund for uncompensated care have decreased and the rate of non-urgent emergency department visits declined by 2.6 percentage points among patients with premium assistance for coverage and uninsured patients in 2008 compared to 2006.[32]

Lower Premiums

According to CBO's letter to Senator Evan Bayh from November 30, 2009, the Exchanges and their associated policies will reduce for the cost of the same benefit package compared to prior law. CBO estimated that, in 2016, people purchasing non-group coverage through the Exchanges would pay seven to ten percent less in premiums due to the healthier risk pool that results from the coverage expansion. An additional seven to ten 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.[33] There is a reduction in premiums for a constant package of benefits according to CBO's analysis. Consequently, as the

[31] Massachusetts Division of Health Care Finance and Policy, "2009 Annual Report Health Safety Net."
[32] Smulowitz, Peter B. et al., "Emergency Department Utilization After the Implementation of Massachusetts Health Reform," *Annals of Emergency Medicine* In Press, Corrected Proof.
[33] Congressional Budget Office, "Letter to the Honorable Evan Bayh: An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act " (Washington, DC 2009).

unit cost of health insurance declines, (in large part due to premium subsidies) people tend to purchase more insurance, therefore, the total spending on insurance is predicted to increase.

CBO also estimates that premiums for small businesses purchasing through the Exchanges would be up to two percent lower than they would be without the Affordable Care Act, for comparable reasons. CBO estimated that the administrative costs to health plans (discussed below) would be more than offset by savings resulting from lower overhead due to new policies such as limits on underwriting.

Finally, the Exchanges provide transparent information on plan characteristics that will help reduce the high consumer search costs that impede price competition in the health insurance market.[34] Evidence from large employers shows that employees often switch plans in response to small differences in premiums when the information is clearly presented and easy to compare.[35]

IV. Costs

This section discusses the costs of implementing these rules. This discussion is divided into two parts – costs of policies for Exchanges (45 CFR part 155 and part 157 of the Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers final rule) and costs of policies for issuers of QHPs (45 CFR part 156). This final rule places no new burdens on employers that elect to offer coverage through SHOP Exchanges, as burdens are comparable for employers offering insurance coverage outside of Exchanges. The costs and impact for the reinsurance, risk adjustment and risk corridors programs (45 CFR part 153) are addressed in part V of this RIA.

[34] Cebul RD et al: Unhealthy insurance markets: search frictions and the cost and quality of health insurance. *American Economic Review*. 1010. 2011: 1842-1871.
[35] Buchmueller T: Consumer-Oriented health care reform strategies: a review of the evidence on managed competition and consumer-directed health insurance. *The Millbank Quartely*. 87(4). 2009: 820-841.

Part 155 and Part 157: Policies for Exchanges

This section discusses the impact of part 155 and part 157 of the Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers final rule, particularly as it relates to administrative expenses and health plan certification and eligibility determination. States seeking to operate an Exchange will incur administrative expenses as a result of implementing and subsequently maintaining Exchanges in accordance with this rule. It is important to note that although States have the option to establish and operate an Exchange, there is no Federal requirement that any State establish an Exchange. A State may also elect to cease operations of its Exchange in any given year after providing HHS with 12 months' notice. State costs for 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 $3.4 billion dollars for fiscal years 2012 through 2016. After this initial phase of Exchange planning and implementation, the law requires that States ensure that their Exchanges be self-sustaining.

Therefore, ongoing maintenance of Exchanges 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. For example, the Commonwealth Connector in Massachusetts requires issuers to pay a fee that is structured as a percentage of premium revenue. The administrative costs of operating an Exchange will almost certainly vary by the number of enrollees in the Exchange, 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 final rule sets general policies related to the establishment of Exchanges prior to and after 2014, including the approval process for Exchanges, governance principles for the Exchange, and rules for regional and subsidiary Exchanges. The Exchange final rule establishes that each State choosing to establish an Exchange shall comply with the State Exchange approval requirements and process, submit an Exchange Blueprint for approval and a readiness assessment, and, if applicable, develop a plan jointly with HHS to facilitate transition from a Federally-facilitated Exchange to a State-based Exchange. The rule also establishes that States choosing to operate an Exchange through a non-profit or independent authority must establish a governance structure that adheres to certain standards, including procedures for the disclosure of financial interests by members of the Exchange board or governance structures. Furthermore, States must consult with stakeholders in the design and implementation of an Exchange.

To operate effectively, in the early phases of establishment, each Exchange will most likely hire Exchange personnel, including a chief executive officer or executive director, information technology personnel, financial management personnel, policy analysts, and other general support staff. In addition, each Exchange may invest in physical office space to house the Exchange operations. As stated previously, the Table 1 estimate of total grant outlays for States setting up an Exchange totals $3.4 billion from 2012 through 2016. Administrative costs for start-up and initial implementation of these activities are subsumed in this estimate for State Planning, IT (Information Technology) Early Innovator and Establishment Grants. Estimates of State spending for specific components of the Exchange are provided below.

Exchange Establishment

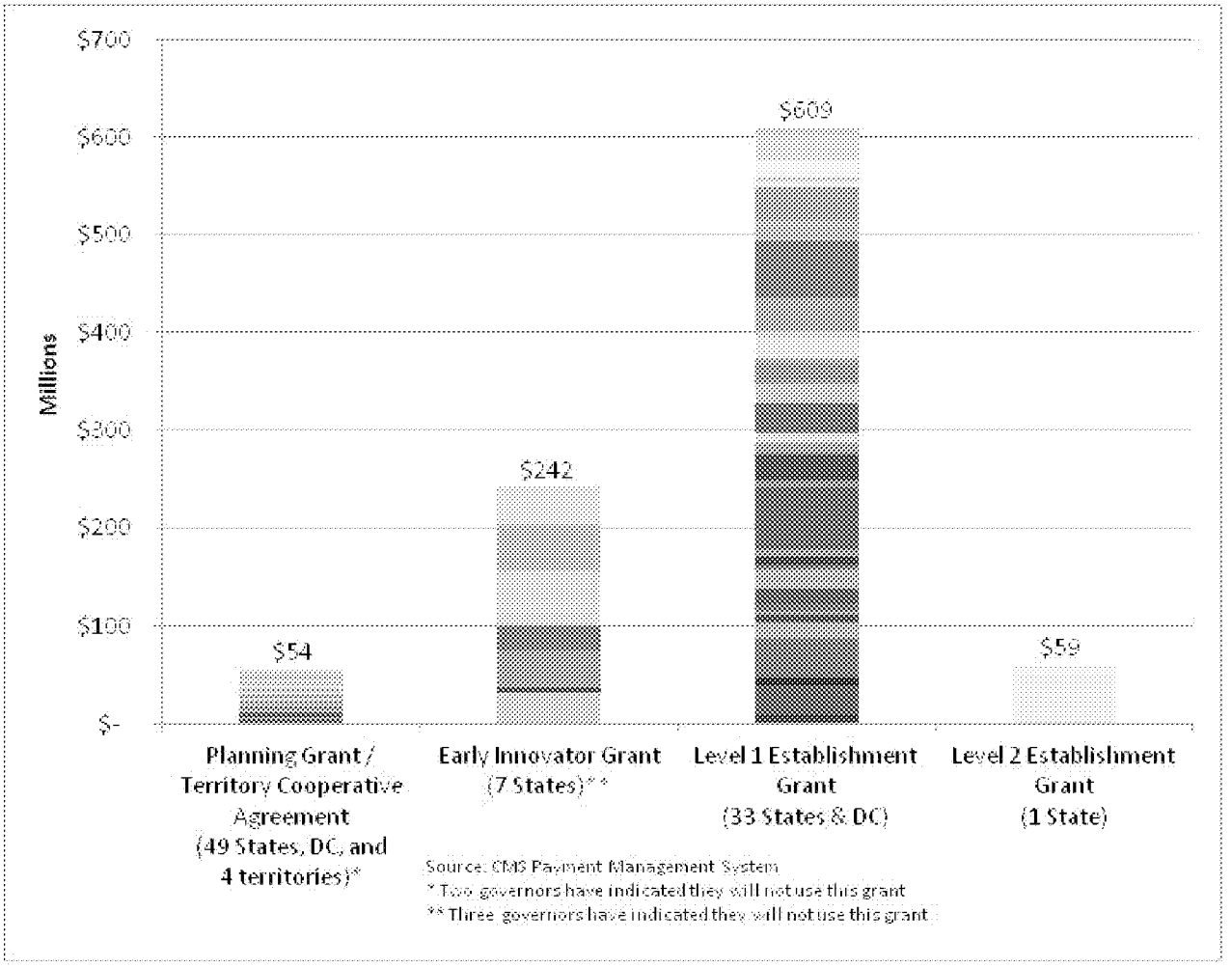
In order for an Exchange to be approved, a State will need to submit an Exchange Blueprint that provides information on how it will meet all of the standards for the approval of an Exchange. We estimate that it will take a State approximately 211 hours for the time and effort needed to develop the Blueprint and submit it to HHS (State Exchange Certification Application, 76 Fed. Reg. 70148, Nov. 10, 2011). States will already be gathering most of the information needed for the Blueprint through the Planning, IT Early Innovator, and Establishment Grants provided by HHS. State grantees report on progress in establishment of their Exchanges, which will provide a foundation from which States can develop the Exchange Blueprint. This streamlined approach will reduce the administrative burden on States related to approval of an Exchange.

HHS has made three types of grants available to enable States to establish Exchanges. HHS is no longer awarding new grants under the Planning Grant and Early IT Innovator Grant programs, but Establishment Grant funding opportunities are ongoing. Figure 1 shows the distribution of grants awarded as of publication of this final rule. Planning Grants were available for States to engage in research and planning around stakeholder involvement, program integration, resources and capabilities, governance, finance, technical infrastructure, business operations, regulatory or policy actions, and background research. Forty-eight States and the District of Columbia received Planning Grant funds and four Territories received Cooperative Agreements, totaling $54 million.[36] Early IT Innovator Grants were available for States to design and implement Exchanges' IT infrastructure in a way that is reusable and transferable to other Exchanges. Six States and one multi-State consortium received IT Early Innovator funds,

[36] The Governors of two States subsequently indicated they would not use Planning Grant funds.

totaling $242 million.[37] Establishment Grants are available at two levels; Level One grantees can address any of the eleven core areas of Exchange establishment, while Level Two grantees must address all eleven areas. Thirty-three States and the District of Columbia have received Level One grants ($609 million total), and Rhode Island is the only State to receive a Level Two grant ($59 million) thus far. Funding opportunities for Establishment Level One and Level Two grants are ongoing, and States may receive multiple grants. State Exchange establishment and HHS approval of an Exchange do not require that States receive all three types of Exchange grants.

Figure 1. State Grant Distribution ($ in millions)



[37] The Governors of three States subsequently indicated they would not use Early IT Innovator Grant funds.

State flexibility in Exchange establishment will lead to variation among States in the scope of certain activities, including in relation to the building and adaptation of IT systems relative to current systems. As an example of IT costs, IT Early Innovator Grants are listed in Table 4, below. The Early IT Innovator Grants were awarded 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. Costs vary by State based on various factors including the State's current IT systems, the system that will be implemented, and the population of the State.

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

State Grantee	Award Amount ($ millions)
Oklahoma*	55
Oregon	48
Wisconsin*	38
New England consortium representing Connecticut, Maine, Massachusetts, Rhode Island, and Vermont	36
Kansas*	32
New York	27
Maryland	6

*The Governors of these States subsequently indicated they would not use these grant funds.

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 through these initial grants. 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.

Subpart C of part 155 of the Exchange rule primarily sets forth the minimum functions that each Exchange must perform, including certifying qualified health plans, making qualified health plans available through a comparative website, performing eligibility determinations for individuals, establishing enrollment processes, and providing consumer assistance. Subpart C also establishes minimum standards for consumer assistance tools to support the Exchange, including an Exchange internet portal, 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 a 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 these 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.

The importance of developing these tools is evidenced by research by the Pew Internet and American Life Project. Of the 78 percent of US adults who use the Internet, 80 percent utilize the Internet to find health information, and 67 percent visit a local, State, or Federal government website, according to Pew research.[38] 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 receive notices and other information online 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

[38] Pew Internet & Life Project, "Trend Data," http://www.pewinternet.org/Trend-Data/Online-Activites-Total.aspx.

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. As HHS develops these capabilities, we seek to share these resources with States, in order to take advantage of available efficiencies. While HHS is providing grant funding for the implementation of Exchanges and the development of IT systems, State-based Exchanges will be responsible for the maintenance costs of their systems. In addition to the cost impact of web tools, Exchanges will incur administrative expenses to develop and operate a call center and any contracting costs associated with this function.

States may continue to apply for Establishment Grants to support IT development. Establishment Grants support States in activities to establish an Exchange, including developing IT systems. Establishment Grant Level One grantees can address any of the eleven core areas of Exchange establishment. Level Two grantees must address all eleven areas and meet other requirements, such as developing: legal authority to establish and operate an Exchange; a governance structure for the Exchange; a budget and initial plan for financial sustainability by 2015, a plan outlining steps to prevent fraud, waste, and abuse; and a consumer assistance plan, including provision of a call center.

The majority of Establishment Grant funds are allocated to the "Exchange IT systems" core area; additionally, a significant portion of grant funds are allocated to the "business operations" core area. Thirty-three States and DC have received Level One grants, and Rhode Island has received both a Level One grant and Level Two grant. States may continue to apply for Establishment Grants, as the grant cycles are ongoing.

Navigators

Subpart C of part 155 of the Exchange rule also proposes requirements for Exchanges in connection with the Navigator program. Navigators are grant-funded entities that educate the public about the availability of health coverage through the Exchange and facilitate the enrollment of individuals in qualified health plans through Exchanges. Exchanges, which must have Navigator programs, have substantial flexibility in designing these programs. By statute, Navigator programs may be funded only through Exchange operational funds, which are separate from the Exchange Planning and Establishment Grants awarded to States. The Exchange must publicly disseminate training and certain conflict of interest standards for Navigators. We expect Navigators to increase access to and enrollment in QHPs. For example, Navigators will provide a potential means of accessing 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 establishing Navigator programs in State Exchanges.

Medicare's existing State Health Insurance Assistance Program ("SHIP") offers a somewhat comparable example to the Navigator program that may be useful when estimating the cost of operating a Navigator program. SHIPs are grant-funded, State-based offices that provide education, outreach, and assistance to Medicare beneficiaries. SHIPs employ volunteers for much of the outreach and assistance they provide to consumers, while Navigators will receive grant funding directly from the Exchange. Although the population served by SHIPs is different from the population Navigators will serve, SHIPs' operating data provides a baseline for comparison. CMS estimates that SHIPs have reached 4.7 million people through outreach events

and one-on-one counseling in the 2009 grant year.[39] In the same year, SHIPs conducted 54,656 public information and outreach events.[40] Either in their existing role or as Navigators, and consistent with State requirements, we expect that agents and brokers will enroll individuals into qualified health plans through an Exchange, similar to the work currently performed in the individual and small group markets.

Notifications

The Exchange must also provide notices to qualified individuals, qualified employees, qualified employers and enrollees regarding enrollment and eligibility-related information or actions taken by the Exchange. These notices may communicate eligibility determinations, annual open enrollment periods, termination of coverage, rights to appeal other information, and Exchanges are encouraged to use electronic and streamlined notices wherever possible. Exchanges may reduce administrative costs associated with notices where these interactions can take place in electronic or automated format. The Exchange establishment final rule includes notices that Exchanges must provide to issuers, enrollees, employers and HHS. Exchanges' estimated costs related to these notification requirements will be affected by the time and effort needed to develop the notice and automate its distribution when appropriate.

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. Additionally,

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

there are some notice requirements that affect QHP issuers. For example, section 156.260(b) requires QHP issuers to provide notice of an effective date of coverage to enrollees.

Payment of Premiums

Subpart C sets minimum standards for the payment of premiums. It includes a statutory provision that allows individuals to pay premiums directly to the QHP issuer, but also allows Exchanges to establish a premium aggregation function as another option for individuals. If the Exchange chooses to take on the role of premium aggregator for the individual market, it will likely incur costs to build the payment system with the appropriate safeguards. However, very few costs will be incurred if an Exchange requires individuals to make direct payment to the QHP issuer.

Privacy and Security

Subpart C also establishes minimum standards for privacy and security of personally identifiable information that is collected, used or disclosed by an Exchange, including standards for the contractual imposition of parallel standards by the Exchange on its contractors, Navigators, and agents and brokers. Such information will be collected, used and disclosed by the Exchange for the purposes of determining eligibility for Medicaid or CHIP, facilitating enrollment in a QHP, advance payments of the premium tax credit, cost-sharing reductions, or the exemptions described in section 5000A of the Code. It also establishes a list of required critical security safeguards these privacy and security standards must include, and requires Exchanges to develop and utilize secure electronic interfaces when sharing personally identifiable information electronically. This will likely add to the cost of establishing the information technology infrastructure of the Exchange. 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.

Eligibility and Enrollment Process

The Affordable Care Act also envisions a coordinated and streamlined system for eligibility determination and enrollment into health plans. Sections 1311(d)(4)(F), 1413, and 2201 of the Affordable Care Act provide for a system whereby an individual may apply for advance payments of the premium tax credit, cost-sharing reductions, and enrollment in other insurance affordability programs through the Exchange, and receive a determination of eligibility for coverage for any such program. In subpart D of part 155, we specify standards related to verifying applicant information and determining eligibility for Exchange participation, advance payments of the premium tax credit, cost-sharing reductions, Medicaid and CHIP. Consistent with this eligibility and enrollment system, the Affordable Care Act aligns most of the rules under which individuals will be determined eligible for Medicaid and CHIP with those for advance payments of the premium tax credit and cost-sharing reductions, by generally using modified adjusted gross income (MAGI) as the basis for determining income eligibility, effective January 1, 2014. If an individual is determined to be eligible for Medicaid, and therefore ineligible for advance payments of the premium tax credit or cost-sharing reductions, the use of the MAGI data will reduce the burden associated with the Medicaid income eligibility and verification process for States and individuals.[41]

To support this new eligibility structure, States would likely build new or modify existing information technology systems. How each State constructs and assembles the components necessary to support its Exchange and Medicaid infrastructure will vary and depend on the level

[41] The use of a MAGI-based standard for Medicaid and CHIP was proposed in the Medicaid Eligibility proposed rule (76 FR 151202) and finalized in the Medicaid Eligibility final rule.

of maturity of current systems, current governance and business models, size, and the specific approaches taken regarding the integration between programs and its decision to build a new system or use existing systems. We also believe that overall administrative costs may increase in the short term as States build information technology systems; however, in the long-term, States will see savings through the use of more efficient systems. We anticipate that Medicaid agencies, CHIP agencies, and Exchanges will leverage the Federally managed data services hub for connections to SSA and DHS to support verification of citizenship and immigration status, which will streamline State verification processes and may further reduce State burden regardless of what IT infrastructure investments they choose to make.

Enrollment Standards

Subpart E of part 155 provides standards for using the single streamlined application and standards for any alternative application developed by the Exchange that incorporate both eligibility and enrollment, in order to facilitate an efficient process. In accordance with section 1311(c)(1)(F) of the Affordable Care Act, all QHP issuers must use a single, streamlined enrollment process. The Exchange must be able to accept applications from multiple channels including online, by phone, in-person, and by mail. Exchanges may experience administrative savings to the extent that they can encourage the broad use of an electronic or automated application process.

Subpart E also describes how 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 Establishment of Exchanges and Qualified Health Plans final rule defines an annual enrollment period during which individuals will make insurance selections. While we anticipate that the Exchange and QHP issuers will 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, which would have to comply with the privacy and security standards mentioned above.

SHOP

Subpart H of part 155 describes requirements related to the establishment of the SHOP, including certification standards and minimum functions. Generally, the SHOP must provide the same functionality as the rest of the Exchange, except as described below. 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.[42] Currently, 59 percent of small employers with between 1 and 199 employees offer employer-sponsored health insurance coverage.[43] The establishment of the SHOP in conjunction with tax incentives for some employers will provide new opportunities for employers to offer affordable health insurance to their employees.

The SHOP will interact with employers as well as the employees. 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 multiple 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 support both the Exchange and the SHOP. Plan

[42] U.S. Census Bureau, "Number of Firms, Number of Establishments, Employment, and Annual Payroll by Enterprise Employment Size for the United States and States, Totals: 2008," (Washington, DC 2008).
[43] Claxton, G. et al., *Employer Health Benefits, 2011 Annual Survey* (Menlo Park: Henry J. Kaiser Family Foundation, Health Research and Educational Trust, 2011).

management processes, financial management processes, and some enrollment processes may be reused for the SHOP. These returns to scale may dramatically reduce the cost of operating a SHOP when compared to free-standing operation. However, SHOP's requirement to aggregate premiums is a unique cost because the benefit of such a service will not be borne by individuals enrolling through the Exchange. With the large amount of flexibility States and Exchanges have in implementing these requirements for SHOP, the cost incurred from designing and implementing SHOP's minimum functions will vary based upon the State's vision for its SHOP. Operating both an Exchange and the SHOP under the same administrative entity may reduce total operating costs. Alternatively, States may decide that the needs of the small business community are unique and can best be served through an entirely different entity.

Certification of QHPs

Except with respect to multi-State plans and CO-OP QHPs, Subpart K of part 155 of the Exchange rule sets standards for the processes for certification, recertification, and decertification of QHPs, including stand-alone dental plans. 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. The Exchange must establish a process for the decertification of QHPs if the Exchange determines that the QHP

issuer is no longer in compliance with the general certification criteria. The Exchange must also establish a process for the appeal of a decertification of a QHP.

An Exchange has considerable flexibility in applying 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 certification or other forms of active selection, it could incur higher administrative costs. Some of these costs could be offset if the result is 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 the Exchange.

Costs of Part 156: Requirements on QHP Issuers

Part 156 of the Establishment of Exchanges and Qualified Health Plans final rule sets requirements on QHP issuers for participation in an Exchange. The cost of participating in an Exchange is an investment for QHP issuers, because substantial benefits are expected to accrue to QHP issuers due to the implementation of Exchanges. As a centralized outlet to attract and enroll consumers, the Exchanges will reduce incremental health plan sales and marketing costs as well as increase competition. These savings could be passed along to consumers in the form of reduced premiums. Estimates suggest that the market reforms of the Affordable Care Act, and administrative efficiencies from economies of scale and risk pooling will reduce insurance rates

per unit of coverage for individuals and small groups.[44] Other administrative efficiencies that could lead to lower QHP premiums inside the Exchange include: customer service functions performed by the Exchange for QHP related issues, and the premium aggregation function of SHOP.

Data Reporting

Subpart C of part 156 establishes several reporting standards for QHP issuers, including rate, benefit, enrollment and termination of coverage information, as well as the transparency in coverage information required under section 1311(e)(3) of the Affordable Care Act related to payment policies, number of denials, rating practices, and financial disclosures. The report of transparency in coverage data is a requirement on all issuers in the individual and small group markets, therefore the issuers will not incur any additional burden related to gathering and reporting this data because they are participating in an Exchange. Other reporting 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.

Accreditation

Subpart C of part 156 requires that QHP issuers must be accredited on the basis of local performance of its QHPs by an accrediting entity recognized by HHS. For health insurance issuers in States that already require accreditation as a condition of licensure, this process is a

[44] 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).

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 insurance issuers that are not already accredited, but the accreditation process will build on procedures already performed by the health insurance issuer. 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.[45] It should be noted that these are estimates. These costs will be distributed across QHPs and therefore are expected to be too small to have a discernible effect on premiums. Additionally, many States already require the accreditation of plans and many issuers are already accredited. We expect any increase in premium due to accreditation to diminish over time as the QHP issuer becomes more efficient in gaining accreditation.

Network Adequacy Standards and Essential Community Providers

The Establishment of Exchanges and Qualified Health Plans final rule permits discretion for Exchanges in setting network adequacy standards for QHP 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, provided that such requirements ensure that the QHP issuer will maintain a network that is sufficient in number and types of providers so that services will be provided without unreasonable delay. In such case, the network adequacy standard would have no impact on premiums. While it is not expected, the Exchange could set additional

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

standards in accordance with current provider market characteristics and consumer needs, which could have a minimal cost impact.

Most States' standards meet or exceed the network adequacy standards set forth in this final rule. However for any State in which the Exchange sets significantly more extensive network adequacy standards than those already enforced as a part of State licensure, QHP 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 State's more extensive network 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, while allowing QHP issuers to compete for business on the basis of provider networks, quality of coverage, and premiums. In turn, the Establishment of Exchanges and Qualified Health Plans final rule permits QHP issuers to contract with a sufficient number and geographic distribution of essential community providers to provide timely access to services for low-income and medically underserved individuals. QHP issuers are not required to contract with all essential community providers and, except for certain limited categories of providers, the issuer is not required to contract with an essential community provider if the provider does not accept the issuer's generally accepted rates for participating providers.

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, QHP issuers have fewer options of essential community providers to include in their provider networks.

Expansion of Coverage

Expansion of health insurance coverage leads to many benefits such as improved access to health care, and improved financial security for the newly insured. However, insurance coverage, which generally makes medical care more affordable, can lead to an inefficiency commonly called moral hazard. When people make economic decisions to purchase goods and services, but do not bear the full cost of these goods and services, there can be a tendency to purchase more than the efficient amount of that service. However, studies that estimated the effects of Medicare found that the cost of this inefficiency is likely more than offset by the benefit of risk reduction.[46,47]

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

The final rule entitled "Patient Protection and Affordable Care Act; Standards related to Reinsurance, Risk Corridors and Risk Adjustment" ("Premium Stabilization final rule") sets forth standards for the transitional reinsurance program and the temporary risk corridors program, as well as for the risk adjustment program that will continue beyond the first three years of Exchange operation. The purpose of these three programs is to protect issuers from the negative effects of adverse selection and to protect consumers from increases in premiums due to issuer uncertainty.

[46] Finkelstein A, McKnight R: "What Did Medicare Do (And Was It Worth It)?" Journal of Public Economics 2008, 92:1644-1669.
[47] Finkelstein, Amy, "The Aggregate Effects of Health Insurance: Evidence from the Introduction of Medicare," National Bureau of Economic Research. Working Paper No. 11619, Sept, 2005.

Issuers charge premiums based on expected costs plus a risk premium to cover unexpectedly high medical costs.[48] Payments to issuers from the reinsurance, risk adjustment, and risk corridors programs will reduce the increased risk of financial loss that health insurance issuers might otherwise expect to incur in 2014, thereby reducing the risk premium.

To mitigate the impact of risk premiums, the Affordable Care Act establishes reinsurance and risk adjustment as State-run programs guided by Federal methodologies, and establishes risk corridors as a Federally run program. The Federal cost of reinsurance and risk adjustment is estimated to be $11 billion in 2014, $18 billion in 2015 and $18 billion in 2016 (Table 1). 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)[49]. Reinsurance and risk adjustment payments were estimated to lag revenues by one quarter. The reinsurance and risk adjustment programs are each 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 effects of adverse selection.

The Premium Stabilization final rule sets forth regulations governing 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

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

[49] These estimates rely on CBO analyses. However, CBO did not account for reinsurance collections payable to the U.S. Treasury in their analysis of reinsurance receipts, consequently the receipts in the President's Fiscal Year 2013 Budget are higher than those estimated by CBO, though not appreciably different.

programs is to protect issuers from the effects of adverse selection and to protect consumers from increases in premiums due to the uncertainties that issuers face.

Reinsurance

The Affordable Care Act requires the implementation of a transitional reinsurance program for the years 2014, 2015, and 2016. Each State is eligible to establish a reinsurance program. If a State establishes a reinsurance program, the State must enter into a contract with an applicable reinsurance entity to carry out the program. If a State does not elect to establish its own reinsurance program, HHS will carry out the reinsurance program 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 for those years, respectively. These contributions are funded by health insurance issuers and third party administrators on behalf of group health plans. Section 1341(b)(3) of the Affordable Care Act directs the Secretary of HHS to establish the method for determining contribution levels for the program. HHS will establish a national per capita contribution rate designed to collect more than $12 billion in 2014 to cover the required $10 billion in reinsurance payments, the $2 billion contribution to the U.S. Treasury, and additional amounts to cover the administrative costs of the Federal and State reinsurance entities.

HHS will collect the required contributions from self-insured group health plans (or from third party administrators on their behalf). States that establish a reinsurance program have the option to either collect contributions from health insurance issuers or to have HHS collect those contributions. A State that establishes a reinsurance program may elect to collect additional contributions to provide funding for administrative expenses or reinsurance payments. Additional contributions for administrative expenses may be collected by HHS or by the State's

applicable reinsurance entity, at the State's election. All additional contributions for reinsurance payments must be collected by the State's applicable reinsurance entity.

A State bears the administrative costs of the applicable reinsurance entity that are not paid for through the reinsurance contributions, and must ensure that the reinsurance entity complies with 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 applicable reinsurance entity to carry out reinsurance in their State. Administrative costs will increase if multiple reinsurance entities are established within a State, whereas administrative efficiencies may be found if multiple States contract with one applicable reinsurance entity.

The Premium Stabilization final rule establishes that reinsurance contributions will be based on a per capita amount. The per capita approach will be less complex to administer in comparison to the percent of premium approach that HHS considered but ultimately did not decide to pursue. Further, the per capita approach will better enable HHS to maintain the goals of the reinsurance program by providing issuers with a more straightforward approach to reinsurance contributions. States would be permitted to collect additional contributions towards reinsurance payments.

Reinsurance payments will be made to issuers of individual insurance coverage for high claims costs for enrollees. HHS will propose and publish an annual payment notice that contains the values for the attachment point, reinsurance cap, and coinsurance rate. Payments will be made on a portion of claims costs for enrollees in reinsurance eligible plans incurred above an attachment point, subject to a cap. This approach, which reinsures high claims costs rather than disease status (another approach considered), may reduce incentives for health insurance issuers to control costs. 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. This approach based on claims costs is simpler to implement and more familiar to health insurance issuers, and therefore will likely result in savings in administrative costs as compared to a condition-based reinsurance approach. The program costs of reinsurance are expected to be 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 transitional reinsurance program is redistributive from the broad health insurance market to the individual market. This serves to stabilize premiums in the individual market while having a minimal impact on large group issuers and plans. Reinsurance will attenuate individual market rate increases that might otherwise occur because of the immediate enrollment of higher risk individuals, potentially including those currently in State high risk pools. In 2014, it is expected that the cost of reinsurance contributions will be passed on to enrollees through premium increases of about one percent of premiums in the total market; by contrast, it is anticipated that reinsurance payments will result in premium decreases in the individual market of between 10 and 15 percent.[50]

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. Under the program, if any enrollee incurred $30,000 in annual claims, his or her insurer was reimbursed for 90 percent of the next $70,000 in claims. Premiums for

[50] Actuarial Research Corporation, "Reinsurance attachment point estimates," (Annandale 2010).

Healthy NY were about 15 percent to 30 percent less than comparable HMO policies in the small group market.[51]

The reinsurance program permits early and prompt payment of reinsurance during the benefit year. This type of financial assistance to issuers is important to the program's ability to maintain stable premiums in the individual market since risk adjustment and risk corridors will be calculated after the benefit year. Reinsurance may offer timely financial relief to health insurance issuers that enroll the highest-cost individuals in the first year of implementation.

Risk Corridors

The risk corridors program is a temporary, three-year program that applies to QHPs. The risk corridors program creates a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers. The Affordable Care Act establishes the risk corridors program as a Federal program; consequently, HHS will operate the risk corridors program under Federal rules with no State variation. The risk corridors program will protect against inaccurate rate setting in the early years of the Exchanges by limiting the extent of issuer losses and gains.

QHP issuers must submit to HHS data on premiums earned, allowable claims and quality costs, and allowable administrative costs, reflecting data categories required under the Medical Loss Ratio Interim Final Rule, 45 CFR Part 158, Subpart A, Disclosure and Reporting. HHS will specify the due dates for data submission and the applicable standard formats in the annual Federal notice of benefit and payment parameters. In designing the program, HHS has sought to leverage existing data reporting for Medical Loss Ratio purposes as much as possible. QHP issuers also must make available to HHS any data to support auditing, and must maintain and make available to HHS upon request data and supporting information for 10 years.

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

As noted above, the risk corridors program is intended 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, issuers may not be able to predict their risk accurately, and their premiums may reflect costs that are ultimately lower or higher than predicted. To determine whether an issuer pays into, or receives payments from, the risk corridors program, HHS will compare allowable costs (essentially, claims costs) and the target amount – the difference between a plan's earned premiums and allowable administrative costs. The threshold for risk corridor payments and charges is reached when a QHP issuer's allowable costs exceed, or fall short of, the target amount by at least three percent. A QHP with allowable costs that are at least three percent less than its target amount will pay into the risk corridors program. Conversely, HHS will pay a QHP with allowable costs that exceed its target amount by at least three percent. Risk corridor payments and charges are a percentage of the difference between allowable costs and target amount and therefore are not on a "first dollar" basis.

Risk Adjustment

Risk adjustment is a permanent program administrable 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 on the State's behalf. 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 methodology. States may use this methodology or develop and propose alternate risk adjustment methodologies that meet Federal standards. Once HHS approves an alternate risk adjustment methodology, it will be considered a Federally certified model that any State may elect to use. States that elect to develop their own risk adjustment methodologies are likely to have increased administrative costs. Developing a risk adjustment methodology requires complex data analysis, including population simulation, predictive modeling, and model calibration. States that elect to use the Federally developed methodology 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 final rule requires States to collect or calculate individual risk scores at a minimum. States may vary the amount and type of data collected, provided that States meet specified data collection standards.

Administrative costs will vary across States and health insurance issuers depending on

the type of data collection approach used in the State. In States opting to operate risk adjustment using a distributed model of data collection, the costs associated with mapping and storing the required data and, in some cases, the costs associated with running the risk adjustment software will be borne by the issuer.

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 data for Medicare Advantage (MA) or Medicaid Managed Care may see minimal additional administrative burden for risk adjustment. Additionally, some States risk-adjust 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.[52] Reported annual State funding to establish an all-payer claims database system ranges from $350,000 to $2 million.[53] 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 affect administrative costs. In general, national issuers will be better prepared for the requirements of risk adjustment than small 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 methodology.

[52] Miller, Patrick B, et al. All-Payer Claims Databases. (Robert Woods Johnson Foundation. , 2010).
[53] Council, APCD, "Cost and Funding Considerations for a Statewide All-Payer Claims Database (APCD)," (2011).

The final rule requires States to audit a sample of data and ensure proper implementation of risk adjustment software by all issuers that participate in risk adjustment. 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 Advantage, where audit sample error rates will be extrapolated to contract-level payments to recoup overpayment amounts.

Risk adjustment transfers dollars from health plans with lower-risk enrollees to health plans with higher-risk enrollees. From 2014 through 2016, it is estimated that $27 billion will be transferred between issuers.[54] Risk adjustment protects against 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 non-grandfathered individual and small group plans. This mitigates the potential for excessive premium growth within the Exchange due to anticipated adverse selection.

VI. Alternatives Considered

The final rule on Establishment of Exchanges and Qualified Health plans provides States with a great deal of flexibility on the operation and enforcement of the Exchange. Exchange standards aim to: facilitate insurers competing on price and quality, minimize the total cost of establishment and maintenance of Exchange functions, and provide Exchanges with the

[54] Analysis based on CBO estimates for reinsurance and risk adjustment. Amounts for risk adjustment were calculated by subtracting reinsurance contribution amounts as specified in statute.

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 as QHPs. 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, while the Affordable Care Act requires that Exchanges must be self-sustaining, States may determine how that is achieved.

Alternative #1: Uniform Standard for Operations of Exchanges

Under this alternative, HHS would require a single standard for State operations of Exchanges. The 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 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 (for example, 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 even though research has noted that State differences will likely impact Exchange needs and functions.[55] 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.[56]

Alternative #2: Uniform Standard for Certifying Health Insurance Coverage

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

[55] Corlette, Sabrina and JoAnn Volk. 2011. Active Purchasing for Health Exchanges: An Analysis of Options: Georgetown University: Health Policy Institute.
[56] Volden, Craig. 2006. "States as Policy Laboratories: Emulating Success in the Children's Health Insurance Program" American Journal of Political Science. P. 294-312.

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,[57] 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 risk corridors 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 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.

[57] Corlette, Sabrina and JoAnn Volk. 2011. Active Purchasing for Health Exchanges: An Analysis of Options: Georgetown University: Health Policy Institute.

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. Many variables that are not measurable contribute to the decisions of these actors, including expected 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 affect individual decisions on Exchange participation.

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.[58]

[58] Eibner, Christine Federico Girosi, Carter C. Price, Amado Cordova, Peter Hussey, Alice Beckman, and Elizabeth McGylnn(2010) *Establishing State Health Insurance Exchanges.* Rand Health.

An Urban Institute study estimates that large employer coverage would increase by two percent and small and medium business coverage would be relatively unchanged.[59] A Lewin Group study estimated a net reduction in the number of people with employer sponsored coverage of 2.8 million.[60] Moreover, experience in Massachusetts showed an increase in employer-sponsored insurance following the introduction of its affordable insurance Exchange.[61] Thus, while CBO assumes a slight decrease in employer-sponsored insurance, other analyses suggest that employer-sponsored insurance could increase. Therefore, while we have used the best available estimates in this analysis, all estimates are subject to limitations.

[59] Garret, Bowens and Matthew Buettgens. 2011 "Employer Sponsored Insurance under Health Reform: Reports of Its Demise are Premature" Urban Institute.
[60] Group, The Lewin, "Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Gvoernments, Employers, Families and Providers," Staff Working Paper # 11(2010).
[61] Long, Sharon and Karen Stockley (2010) *Health Reform in Massachusetts An Update As of fall 2009*. Urban Institute.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: **April 11, 2014**

Subject: **Risk Corridors and Budget Neutrality**

Q1: In the HHS Notice of Benefit and Payment Parameters for 2015 final rule (79 FR 13744) and the Exchange and Insurance Market Standards for 2015 and Beyond NPRM (79 FR 15808), HHS indicated that it intends to implement the risk corridors program in a budget neutral manner. What risk corridors payments will HHS make if risk corridors collections for a year are insufficient to fund risk corridors payments for the year, as calculated under the risk corridors formula?

A1: We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments. If, after obligations for the previous year have been met, the total amount of collections available in the current year is insufficient to make payments in that year, the current year payments will be reduced pro rata to the extent of any shortfall. If any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year.

Example 1: For 2014, HHS collects $800 million in risk corridors charges, and QHP issuers seek $600 million risk corridors payments under the risk corridors formula. HHS would make the $600 million in risk corridors payments for 2014 and would retain the remaining $200 million for use in 2015 and potentially 2016 in case of a shortfall.

Example 2: For 2015, HHS collects $700 million in risk corridors charges, but QHP issuers seek $1 billion in risk corridors payments under the risk corridors formula. With the $200 million in excess charges collected for 2014, HHS would have a total of $900 million available to make risk corridors payments in 2015. Each QHP issuer would receive a risk corridors payment equal to 90 percent of the calculated amount of the risk corridors payment, leaving an aggregate risk corridors shortfall of $100 million for benefit year 2015. This $100 million shortfall would be paid for from risk corridors

charges collected for 2016 before any risk corridors payments are made for the 2016 benefit year.

Q2: What happens if risk corridors collections do not match risk corridors payments in the final year of risk corridors?

A2: We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments over the life of the three-year program. However, we will establish in future guidance or rulemaking how we will calculate risk corridors payments if risk corridors collections (plus any excess collections held over from previous years) do not match risk corridors payments as calculated under the risk corridors formula for the final year of the program.

Q3: If HHS reduces risk corridors payments for a particular year because risk corridors collections are insufficient to make those payments, how should an issuer's medical loss ratio (MLR) calculation account for that reduction?

A3: Under 45 CFR 153.710(g)(1)(iv), an issuer should reflect in its MLR report the risk corridors payment to be made by HHS as reflected in the notification provided under §153.510(d). Because issuers will submit their risk corridors and MLR data simultaneously, issuers will not know the extent of any reduction in risk corridors payments when submitting their MLR calculations. As detailed in 45 CFR 153.710(g)(2), that reduction should be reflected in the next following MLR report. Although it is possible that not accounting for the reduction could affect an issuer's rebate obligations, that effect will be mitigated in the initial year because the MLR ratio is calculated based on three years of data, and will be eliminated by the second year because the reduction will be reflected. We intend to provide more guidance on this reporting in the future.

Q4: In the 2015 Payment Notice, HHS stated that it might adjust risk corridors parameters up or down in order to ensure budget neutrality. Will there be further adjustments to risk corridors in addition to those indicated in this FAQ?

A4: HHS believes that the approach outlined in this FAQ is the most equitable and efficient approach to implement risk corridors in a budget neutral manner. However, we may also make adjustments to the program for benefit year 2016 as appropriate.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

The General Counsel
Washington, D.C. 20201

MAY 20 2014

Julia C. Matta
Assistant General Counsel
for Appropriations Law
U.S. Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Ms. Matta:

This is in response to your April 15, 2014 letter requesting information regarding budget authority available to operate the risk corridors program established in section 1342 of the Patient Protection and Affordable Care Act (PPACA)[1]. The responses to your questions are set forth below.

1. *Agencies may incur obligations and make expenditures only as permitted by an appropriation. U.S. Const., art. I, § 9, cl. 7; 31 U.S.C. §1341(a)(1); B-300192, Nov. 13, 2002. The making of an appropriation must be expressly stated in law. 31 U.S.C. §1301(d). A direction to an agency to pay funds without a designation of funds to be used for the payment does not make an appropriation. B-114808, Aug. 7. 1979. PPACA section 1342(b)(1) provides that, under some circumstances, HHS "shall pay" specified amounts to participating plans. Does any provision of law, be it PPACA section 1342 or another provision, currently provide HHS with an appropriation necessary to obligate and expend the payments specified in PPACA section 1342(b)(1)? Please explain.*

   Response: Section 1342 of PPACA requires the Secretary of Health and Human Services (HHS) to establish a temporary risk corridors program that provides for the sharing in gains or losses resulting from inaccurate rate setting from 2014 through 2016 between the Federal government and qualified health plans (QHPs). The risk corridors program applies only to participating plans defined to be qualified health plans (QHPs) at 45 CFR 153.500. Section 1342(b)(1) and (2) establishes the payment methodology for the payments in and the payments out, thereby establishing the formula to determine the amounts the QHPs must pay to the Secretary of HHS and the amounts the Secretary must pay to the QHPs if the risk corridors threshold is met.

   As section 1342 of PPACA requires the Secretary to establish and administer the risk corridors program and requires the Secretary to collect payments from and make payments to certain QHPs, section 1342 authorizes the collection and payment of user fees to and from

[1] Pub. L. No. 111-148, §1342, 124 Stat. 119, 211-212 (Mar.23, 2010), codified at 42 U.S.C. § 18062.

the QHPs. QHPs enjoy a special benefit resulting from the operation of the risk corridors program, in that the fees charged are ultimately utilized to balance risks among the QHPs, thus promoting stability in this sector of the market. This is consistent with OMB Circular A-25[2], which is intended to provide guidance to agencies regarding their assessment of user fees pursuant to 31 U.S.C. § 9701 and other statutes. Further, we view it as consistent with the definition of user fees as set forth in OMB's Fiscal Year 2015, *Analytical Perspectives*[3] and GAO's *Glossary of Terms Used in the Federal Budget Process*[4].

Section 1342 of PPACA requires the collection and payment of risk corridor user fees. The Centers for Medicare & Medicaid Services (CMS) Program Management (PM) appropriation for fiscal year 2014[5], which states ". . .such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until September 30, 2019: . . .", appropriates the section 1342 user fees. Together, section 1342

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[2] "General policy: A user charge, as described below, will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public. When the imposition of user charges is prohibited or restricted by existing law, agencies will review activities periodically and recommend legislative changes when appropriate. Section 7 gives guidance on drafting legislation to implement user charges.

a. Special benefits

1. Determining when special benefits exist. When a service (or privilege) provides special benefits to an identifiable recipient beyond those that accrue to the general public, a charge will be imposed (to recover the full cost to the Federal Government for providing the special benefit, or the market price). For example, a special benefit will be considered to accrue and a user charge will be imposed when a Government service:

(a) enables the beneficiary to obtain more immediate or substantial gains or values (which may or may not be measurable in monetary terms) than those that accrue to the general public (e.g., receiving a patent, insurance, or guarantee provision, or a license to carry on a specific activity or business or various kinds of public land use); or

(b) provides business stability or contributes to public confidence in the business activity of the beneficiary (e.g., insuring deposits in commercial banks); or . . ." Office of Mgmt. & Budget, Exec. Office of the President, OMB Cir. A-25, User Charges, section 6(1)(a)-(b)(2010).

[3] "In this chapter, user charges refer to fees, charges, and assessment levied on individuals or organizations directly benefiting from or subject to regulation by a Government program or activity, where the payers do not represent a broad segment of the public as those who pay taxes." Fiscal Year 2015 Analytical Perspectives, Budget of the U.S. Government, Office of Management and Budget, p. 192. Available on the Internet at *http://www.whitehouse.gov/sites/default/files/omb/budget/fy2015/assets/spec.pdf.*

[4] "A fee assessed to users for goods or services provided by the federal government. User fees generally apply to federal programs or activities that provide special benefits to identifiable recipients above and beyond what is normally available to the public. U.S. Government Accountability Office, GAO-05-734SP, *A Glossary of Terms Used in the Federal Budget Process* (2005), p. 100.

[5] Consolidated Appropriations Act, 2014, Div. H, Pub. L.113-76 (2014).

of PPACA and the CMS PM appropriation allows for the collection, retention, obligation and expenditure of the section 1342 user fees until September 30, 2019.

2. *PPACA section 1342(b)(2) provides that, under some circumstances, HHS will receive payments from participating plans. Absent specific statutory authority, agencies must deposit money for the government into the Treasury without deduction for any charge or claim, and such deposits are available for obligation and expenditure only as permitted by an appropriation. 31 U.S.C. §3302(b); B-271894, July 24, 1987; 22 Comp. Dec. 379 (1916). May HHS obligate and expend amounts that participating plans pay to HHS under PPACA section 1342(b)(2)? If so, please explain the statutory authority that permits HHS to obligate and expend these amounts and the permissible purposes of such obligations and expenditures.*

   Response: The CMS PM appropriation permits HHS to collect, retain, obligate, and expend the user fees in a manner consistent with section 1342.

3. *Has HHS made or received any payments under PPACA section 1342? If so, please explain the amount and source of any payments made or the amount and disposition of any payments received.*

   Response: To date, HHS has not made or received any payments under section 1342 of PPACA. HHS intends to begin collections and payments in fiscal year 2015 pursuant to continued CMS PM user fee authority.

Thank you for the opportunity to provide the Department's views on this matter.

Sincerely,

William B. Schultz

William B. Schultz
General Counsel

GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
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B-325630

September 30, 2014

The Honorable Jeff Sessions
Ranking Member
Committee on the Budget
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

Subject: *Department of Health and Human Services—Risk Corridors Program*

This responds to your February 7, 2014, request for our opinion regarding the availability of appropriations to make payments to qualified health plans pursuant to section 1342 of the Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, title I, subtitle D, part V, § 1342, 124 Stat. 119, 211, 212 (Mar. 23, 2010), *classified at* 42 U.S.C. § 18062. Section 1342 directs the Department of Health and Human Services (HHS) to establish a temporary risk corridors program to limit the profits and losses of qualified health plans in the individual and small group markets.[1]

In accordance with our regular practice, we contacted HHS to obtain additional factual information and its legal views on this matter. GAO, *Procedures and Practices for Legal Decisions and Opinions*, GAO-06-1064SP (Washington, D.C.: Sept. 2006), *available at* www.gao.gov/legal/lawresources/resources.html. HHS provided us with information and its legal views. Letter from General Counsel, HHS, to Assistant General Counsel for Appropriations Law, GAO (May 20, 2014) (HHS Letter).

[1] The phrase "risk corridors," as used in section 1342, is generally understood to mean a mechanism for limiting an insurer's losses or gains because costs are higher or lower than expected.

BACKGROUND

PPACA required the establishment of American Health Benefit Exchanges (Exchanges) in each state for the purchase of insurance in the individual and small group markets. Pub. L. No. 111-148, §§ 1311(b), 1321(c). Insurers that choose to participate in the Exchanges must meet certain requirements to offer qualified health plans. *See* 45 C.F.R. § 155.1000. Qualified health plans offered through the Exchanges are subject to the risk corridors program. 42 U.S.C. § 1342(a).

The risk corridors program is part of what the Centers for Medicare and Medicaid Services (CMS) refers to as the "premium stabilization programs." CMS, *Premium Stabilization Programs*, *available at* www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html (last visited Sept. 30, 2014). The premium stabilization programs "are designed to provide consumers with affordable health insurance coverage, to reduce incentives for health insurance issuers to avoid enrolling sicker people, and to stabilize premiums in the individual and small group health insurance markets inside and outside the Marketplaces."[2] *Id.*

Generally, insurers set premiums based upon their past experience and anticipated costs related to their pool of enrollees. However, individuals seeking coverage through the Exchanges may have potential health risks that are different than those historically handled by an insurer, resulting in a health plan having higher costs than anticipated. *See* 77 Fed. Reg. 17220, 17221 (Mar. 23, 2012). Because health insurance issuers may be uncertain about the proportion of high-cost enrollees under the new Exchanges, they may include a margin in their pricing to offset the potential expenses of these enrollees, especially during the first few years of the Exchanges. *Id.* at 17221. HHS expects that this uncertainty will decrease as the issuers gain actual claims experience with this new population. *Id.* In order to minimize the possible negative effects of this uncertainty during the initial years of operation of the Exchanges, section 1342 of PPACA directs the Secretary of HHS to operate a temporary risk corridors program. Pub. L. No. 111-148, § 1342(a). This program is intended to protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains for calendar years 2014, 2015, and 2016. 77 Fed. Reg. at 17221.

Section 1342(a) provides that qualified health plans that choose to participate in the Exchanges "shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." Pub. L. No. 111-148, § 1342(a). Section 1342(b) sets forth the payment methodology. Under this system, HHS will make payments to qualified health plans experiencing losses above a set amount; conversely, plans realizing gains above a set amount will make payments to HHS. Section 1342(b)(1) provides that "the Secretary shall

[2] CMS uses the term "Marketplaces" to refer to the American Health Benefit Exchanges (Exchanges) required to be established by PPACA.

pay" to the qualified health plan a given amount to compensate for certain losses the plan incurs as a result of its allowable costs exceeding its premiums.[3] *Id.* § 1342(b)(1). Section 1342(b)(2), in contrast, provides that a qualified health plan "shall pay to the Secretary" a given amount to account for certain gains the plan recognizes because the amounts it collects in premiums exceed its allowable costs. *Id.* § 1342(b)(2).

The Secretary of HHS has delegated authority for section 1342 to the CMS Administrator.[4] 76 Fed. Reg. 53903 (Aug. 30, 2011). HHS informed us that as of May 20, 2014, it had not made or received any payments under section 1342. HHS Letter, at 3. HHS intends to begin collections and payments for this purpose in fiscal year (FY) 2015. *Id.*

DISCUSSION

At issue here is whether appropriations are available to the Secretary of HHS to make the payments specified in section 1342(b)(1). Agencies may incur obligations and make expenditures only as permitted by an appropriation. U.S. Const., art. I, § 9, cl. 7; 31 U.S.C. § 1341(a)(1); B-300192, Nov. 13, 2002, at 5. Appropriations may be provided through annual appropriations acts as well as through permanent legislation. *See, e.g.*, 63 Comp. Gen. 331 (1984). The making of an appropriation must be expressly stated in law. 31 U.S.C. § 1301(d). It is not enough for a statute to simply require an agency to make a payment. B-114808, Aug. 7, 1979. Section 1342, by its terms, did not enact an appropriation to make the payments specified in section 1342(b)(1). In such cases, we next determine whether there are other appropriations available to an agency for this purpose.

CMS Program Management Appropriation

We first examined the availability of the CMS Program Management (PM) appropriation for FY 2014, which provides:

> "For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and *other*

[3] The payments required under section 1342(b) are calculated based upon the ratio of the allowable costs of the plan to the "target amount" of the plan. This target amount "is an amount equal to the total premiums (including any premium subsidies under any governmental program) reduced by the administrative costs of the plan." Pub. L. No. 111-148, § 1342(c)(2).

[4] In the same delegation of authority, the Secretary delegated several responsibilities established by PPACA to CMS, including authorities vested in the Secretary by certain provisions of titles I, II, and X of PPACA. 76 Fed. Reg. 53903.

> *responsibilities of the Centers for Medicare and Medicaid Services*, not to exceed $3,669,744,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; *and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until September 30, 2019.*"

Pub. L. No. 113-76, div. H, title II, 128 Stat. 5, 374 (Jan. 17, 2014) (emphasis added).

When interpreting any statute, we begin by looking to the language of the statute itself. B-316533, July 31, 2008, at 5. The CMS PM appropriation is available for the expenses that CMS incurs to carry out its responsibilities. The CMS PM appropriation for FY 2014 provided funds for carrying out a list of enumerated statutes, as well as "other responsibilities of [CMS]." Pub. L. No. 113-176, 128 Stat. at 374. Under the purpose statute, 31 U.S.C. § 1301(a), appropriated funds may be used only to achieve the objects for which they were appropriated. However, we do not read the purpose statute to require that every item of expenditure be specified in an appropriations act. B-323449, Aug. 14, 2012, at 4. Further, we have long held that existing agency appropriations that generally cover the type of expenditure involved are available for expenses of new or additional duties imposed by proper legal authority. *See, e.g.*, B-290011, Mar. 25, 2002; 15 Comp. Gen. 167 (1935). Section 1342(b)(1) directs the Secretary to make payments to qualified health plans, but that section neither designates nor identifies a source of funds. The CMS PM appropriation for FY 2014 made funds available to CMS to carry out its responsibilities, which, with the enactment of section 1342, include the risk corridors program. Consequently, the CMS PM appropriation for FY 2014 would have been available for making the payments pursuant to section 1342(b)(1).

Amounts Collected Under Section 1342

In addition to the general lump sum of $3.6 billion, the CMS PM appropriation for FY 2014 provides that "such sums as may be collected from authorized user fees ... shall be credited to this account and remain available until September 30, 2019." Pub. L. No. 113-176, 128 Stat. at 374. This language includes amounts collected from qualified health plans pursuant to section 1342(b)(2).

A user fee (often referred to as a user charge) is defined as "[a] fee assessed to users for goods or services provided by the federal government."[5] GAO, *A Glossary of Terms Used in the Federal Budget Process*, GAO-05-734SP (Washington, D.C.: Sept. 2005), at 100. User fees "apply to federal programs or activities that provide special benefits to identifiable recipients above and beyond what is normally available to the public." *Glossary*, at 100. *See also Analytical Perspectives, Budget of the United States Government for Fiscal Year 2015*, ch. 13, "Offsetting Collections and Offsetting Receipts," at 192 (defining user charges as fees, charges, or assessments "levied on individuals or organizations directly benefiting from . . . a Government program or activity, where the payers do not represent a broad segment of the public").

The Supreme Court and GAO have recognized OMB Circular No. A-25[6] as guidance for agencies administering user fee programs. *See Federal Power Commission v. New England Power Co.*, 415 U.S. 345, 349–351 (1974); B-307319, Aug. 23, 2007, at 9. OMB Circular No. A-25 defines what constitutes a special benefit and provides some examples. Specifically:

> "[A] special benefit will be considered to accrue . . . when a Government service: (a) enables the beneficiary to obtain more immediate or substantial gains or values (which may or may not be measurable in monetary terms) than those that accrue to the general public (e.g., receiving a patent, insurance, or guarantee provision, or a license to carry on a specific activity or business or various kinds of public land use); or (b) *provides business stability or contributes to public confidence in the business activity of the beneficiary* (e.g., insuring deposits in commercial banks)."

OMB Cir. No. A-25, at § 6a (emphasis added).

Insurers may choose to offer plans in the Exchanges and in doing so, must offer qualified health plans as defined by 45 C.F.R. § 153.500. The risk corridors program applies only to this specific group of qualified health plans offered through the Exchanges. Accordingly, if an insurer chooses not to offer coverage through the Exchanges, then it is not subject to the risk corridors program established by

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[5] Agencies have general statutory authority to charge fees under the Independent Offices Appropriations Act of 1952, codified at 31 U.S.C. § 9701, commonly known as the User Charge Statute, to offset the government's provision of a "service or thing of value." The User Charge Statute does not authorize a federal agency to retain and obligate collected fees. B-307319, Aug. 23, 2007. However, the User Charge Statute does not supersede more specific statutes providing for the setting, collection, and/or use of user fees, such as section 1342(b)(2). 31 U.S.C. § 9701(c).

[6] OMB Circular No. A-25, *User Charges* (July 8, 1993).

section 1342. When an insurer offers qualified health plans through the Exchanges, the risk corridors program provides these plans with a special benefit—specifically, the program provides business stability by balancing risks among the qualified health plans. 77 Fed. Reg. 17220, 17221 (Mar. 23, 2012). When a qualified health plan makes a payment under section 1342(b)(2), it is paying for the certainty that any potential losses related to its participation in the Exchanges are limited to a certain amount, thus minimizing risk and maximizing business stability for the plan. Pursuant to OMB guidance, therefore, payments under the risk corridors program are properly characterized as user fees.

Section 1342(b)(2) directs the Secretary to collect certain amounts from qualified health plans. The CMS PM appropriation for FY 2014 appropriated funds including "such sums as may be collected from authorized user fees." Consequently, any amounts collected in FY 2014 pursuant to section 1342(b)(2) would have been available, along with the general CMS PM lump-sum appropriation, for making the payments pursuant to section 1342(b)(1).[7]

Appropriations acts, by their nature, are considered nonpermanent legislation. B-319414, June 9, 2010. Language appropriating funds for "other responsibilities of the Centers for Medicare and Medicaid Services" would need to be included in the CMS PM appropriation for FY 2015 in order for it to be available for payments to qualified health plans under section 1342(b)(1). Similarly, language appropriating "such sums as may be collected from authorized user fees" would need to be included in the CMS PM appropriation for FY 2015 in order for any amounts CMS collects in FY 2015 pursuant to section 1342(b)(2) to be available to CMS for making the payments pursuant to section 1342(b)(1).[8]

In accordance with our regular practice, we asked HHS for its legal views regarding the availability of appropriations to make payments to qualified health plans pursuant to section 1342(b)(1). While HHS did not identify the PM appropriation's lump sum as available, HHS asserted that section 1342 "authorizes the collection and payment of user fees to and from the [qualified health plans]" and that the CMS PM appropriation for FY 2014 would have appropriated these user fees. HHS Letter, at 1-2. HHS's description of the amounts collected as user fees is consistent with our conclusion.

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[7] HHS informed us that it intends to begin collections and payments for this purpose in FY 2015. HHS Letter, at 3.

[8] The terms and conditions of the CMS PM appropriation for FY 2014 continue during the pendency of the Continuing Appropriations Resolution, 2015. Pub. L. No. 113-76, 128 Stat. at 374, *as carried forward by* Pub. L. No. 113-164, div. A, §§ 101(a)(8), 103, __Stat. __ (Sept. 19, 2014).

CONCLUSION

Section 1342 of PPACA directs the Secretary of HHS to collect from and make payments to qualified health plans. The CMS PM appropriation for FY 2014 would have been available to CMS to make the payments specified in section 1342(b)(1). The CMS PM appropriation for FY 2014 also would have appropriated to CMS user fees collected pursuant to section 1342(b)(2) in FY 2014. HHS stated that it intends to begin collections and payments under section 1342 in FY 2015. However, as discussed above, for funds to be available for this purpose in FY 2015, the CMS PM appropriation for FY 2015 must include language similar to the language included in the CMS PM appropriation for FY 2014.

If you have any questions, please contact Edda Emmanuelli Perez, Managing Associate General Counsel, at (202) 512-2853 or Julie Matta, Assistant General Counsel, at (202) 512-4023.

Susan A. Poling
General Counsel

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

June 18, 2014

The Honorable Jeff Sessions
United States Senate
Washington, DC 20510

Dear Senator Sessions:

Thank you for your letter requesting information about the Department of Health and Human Services's (HHS) legal authority to make payments in connection with the risk corridors program. The temporary risk corridor provision in the Affordable Care Act is an important safety valve for consumers and insurers as millions of Americans transition to a new coverage in a brand new Marketplace. For consumers, the program will play an important role in mitigating premium increases in the early years as issuers gain more experience in setting their rates for this new program.

Section 1342 of the Affordable Care Act provides for a temporary risk corridors program from 2014 through 2016. The risk corridors program applies to qualified health plans (QHPs), both on and off the Marketplace, and certain substantially similar plans in the individual and small group markets. The temporary risk corridors program protects issuers of QHPs from uncertainty in rate setting from 2014 to 2016 by sharing in gains or losses resulting from inaccurate rate setting.

Modeled after a similar, permanent program established in the Medicare Modernization Act of 2003 for Medicare Part D, the temporary risk corridors program protects against uncertainty issuers face when estimating enrollment and costs resulting from the market reforms. The risk corridors program protects against uncertainty in rate-setting in the first three years of the Marketplace by creating a mechanism for sharing risk between the federal government and issuers of QHPs.

As established in statute, plans participating in the program with allowable costs that are at least three percent less than the plan's target amount will remit charges to HHS, while plans with allowable costs at least three percent higher than the plan's target amount will receive payments from HHS to offset a percentage of those losses. The risk corridors payment or charge amount will be calculated at the issuer level and then pro-rated based on the issuer's percentage of the market enrolled in QHPs, inside or outside the Marketplace, and plans that are substantially the same as a QHP.

In response to your questions regarding the legal analysis to make payments under the risk corridors program, enclosed please find HHS's response to the Government Accountability Office's request for information regarding budget authority available to operate the risk corridors program.

We appreciate your interest in this issue and do not hesitate to contact me if you have any further thoughts or concerns. We are providing the same response to Chairman Fred Upton, co-signer of your letter.

Sincerely,

Sylvia M. Burwell

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: August 7, 2015

From: Center for Consumer Information & Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS)

Subject: **Preliminary Risk Corridors Program Results**

CMS has received timely submission of the risk corridors and Medical Loss Ratio (MLR) forms from virtually all QHP issuers, which were due July 31. This is the first year of data submissions for the temporary risk corridors program. While conducting quality assurance of the risk corridors data, we have identified a significant number of discrepancies in the data, which makes it necessary to conduct additional data validation. This review includes, but is not limited to, comparing risk corridors submissions with other data available to CMS.

CMS previously indicated its intention to publish preliminary estimates of program-wide payments and charges for the risk corridors program on August 14, 2015.[1] In order to allow for a full validation of these data discrepancies, we are **postponing the publication of the preliminary risk corridors program results at this time**. We will provide further information when the risk corridors data is accurate, complete, and validated. If CMS determines that an issuer must resubmit its risk corridors data, CMS will work with the issuer to do so. CMS remains committed to the risk corridors program, and we thank issuers for their continued cooperation in implementing this program effectively.

[1] "Key Dates in 2015: QHP Certification in the Federally-Facilitated Marketplaces; Rate Review; Risk Adjustment, Reinsurance, and Risk Corridors" http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-Key-Dates-QHP-Certification-in-the-FFM-Rate-Review-and-3Rs-final.pdf

Department of Health & Human Services
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Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: October 1, 2015

Subject: Risk Corridors Payment Proration Rate for 2014

Section 1342 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (HHS) to establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Marketplace. This program, which was modeled after a similar program used in the Medicare prescription drug benefit, encourages issuers to keep their rates stable as they adjust to the new health insurance reforms in the early years of the Marketplaces.

Under the risk corridors program, the federal government shares risk with QHP issuers – collecting charges from the issuer if the issuer's QHP premiums exceed claims costs of QHP enrollees by a certain amount, and making payments to the issuer if the issuer's premiums fall short by a certain amount, subject to certain adjustments for taxes, administrative expenses, and other costs and payments. On April 11, 2014, HHS issued a bulletin titled ''Risk Corridors and Budget Neutrality," which described how we intend to administer risk corridors over the three-year life of the program. We stated that if risk corridors collections for a particular year are insufficient to make full risk corridors payments for that year, risk corridors payments for the year will be reduced pro rata to the extent of any shortfall.

Today, HHS is announcing proration results for 2014 risk corridors payments. Based on current data from QHP issuers' risk corridors submissions, issuers will pay $362 million in risk corridors charges, and have submitted for $2.87 billion in risk corridors payments for 2014. **At this time, assuming full collections of risk corridors charges, this will result in a proration rate of 12.6 percent.**

HHS will begin collection of risk corridors charges in November, 2015, and will begin remitting risk corridors payments to issuers starting December, 2015.[1]

We thank QHP issuers for their hard work and timely responses to our data validation requests. We note that all QHP issuers submitted certifications or explanations and just over 50 percent of QHP issuers resubmitted their MLR/risk corridors filings on short notice as part of this important process.

[1] We note that the risk corridor payment and charge amounts reflected in this bulletin do not reflect any payment or charge adjustments due to resubmissions after September 15, 2015, or the effect of subsequent appeals. Neither these amounts nor the proration rates reflected in this bulletin constitute specific obligations of federal funds to any particular issuer or plan.

DEPARTMENT OF HEALTH & HUMAN SERVICES
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200 Independence Avenue SW
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: November 19, 2015

From: Center for Consumer Information & Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS)

Subject: **Risk Corridors Payments for the 2014 Benefit Year**

On October 1, 2015, the Centers for Medicare & Medicaid Services (CMS) announced that for the first year of the three year risk corridors program, qualified health plan (QHP) issuers will pay charges of approximately $362 million, and QHP issuers have requested $2.87 billion of 2014 payments, based on current data for the 2014 benefit year.[1] Consistent with prior guidance, assuming full collections of risk corridors charges for the 2014 benefit year, insurers will be paid an amount that reflects a proration rate of 12.6% of their 2014 benefit year risk corridors payment requests.[2] The remaining 2014 risk corridors payments will be made from 2015 risk corridors collections, and if necessary, 2016 collections.

In the event of a shortfall for the 2016 program year, the Department of Health and Human Services (HHS) will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments.

HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers, and HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligation of the United States Government for which full payment is required.

[1] "*Risk Corridors Payment Proration Rate for 2014*." October 1, 2015. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf
[2] "*Risk Corridors and Budget Neutrality*." April 11, 2014. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf. "*Risk Corridors Payment Proration Rate*." October 1, 2015. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf

Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: November 19, 2015

Subject: Risk Corridors Payment and Charge Amounts for Benefit Year 2014

Background:

Section 1342 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (HHS) to establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Marketplace. The program, which was modeled after a similar program implemented as part of the Medicare Part D prescription drug benefit program, encourages issuers to keep their rates stable as they adjust to the new health insurance reforms in the early years of the Marketplaces.

HHS has previously stated that if risk corridors collections for a particular year are insufficient to make full risk corridors payments for that year, risk corridors payments for the year will be reduced pro rata to the extent of any shortfall.[1] On October 1, 2015, HHS announced the payment proration rate for 2014 will be approximately 12.6 percent, reflecting risk corridors charges of $362 million and payments of $2.87 billion requested by issuers.[2] This proration rate was based on the most current risk corridors data submitted by issuers and assumes full collection of charges from issuers.

Today, HHS is releasing issuer-level risk corridors payments and charges based on the most current risk corridors data submitted by issuers and assuming full collection of charges from issuers, by market and state, for the 2014 benefit year. The tables below include the risk corridors payment or charge amounts for the individual and small group markets, respectively, and the prorated risk corridors payment, if applicable. **Risk corridors charges payable to HHS are not prorated, and the full risk corridors charge amounts are noted in the chart below. Only risk corridors payment amounts are prorated.** HHS will begin collection of risk corridors charges in November 2015 and will begin remitting risk corridors payments to issuers starting in December 2015.[3]

[1] "Risk Corridors and Budget Neutrality", published April 11, 2014 and posted at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf

[2] The exact proration rate for 2014 is 12.6178665287897%.

[3] We note that the risk corridor payment and charge amounts published in this bulletin do not reflect any payment or charge adjustments due to resubmissions after September 15, 2015 or any amount held back for appeals.

Table 1 – Alabama

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
AL	44580	Humana Insurance Company	$ 947,116.86	$ -	$ 119,505.94	$ -
AL	46944	Blue Cross and Blue Shield of Alabama	$ 354,762.84	$ -	$ 44,763.50	$ -
AL	59809	UnitedHealthcare Life Insurance Company	$ -	$ (4,761.86)	$ -	$ (4,761.86)

Table 2 – Alaska

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
AK	38344	Premera Blue Cross Blue Shield of Alaska	$ 8,126,435.92	$ 122,178.45	$ 1,025,382.84	$ 15,416.31
AK	73836	Moda Health Plan, Inc.	$ 1,237,418.79	$ 448,597.16	$ 156,135.85	$ 56,603.39

Table 3 – Arizona

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
AZ	23307	Humana Health Plan, Inc.	$ 1,851,728.19	$ -	$ 233,648.59	$ -
AZ	51485	Health Net Life Insurance Company	$ 38,309,878.15	$ 6,528,368.90	$ 4,833,889.29	$ 823,740.87
AZ	53901	Blue Cross Blue Shield of Arizona, Inc.	$ 11,688,096.55	$ (216,623.22)	$ 1,474,788.42	$ (216,623.22)
AZ	60761	Meritus Health Partners	$ 3,401,552.87	$ 88,126.95	$ 429,203.41	$ 11,119.74

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
AZ	70239	Health Choice Insurance Company	$ 1,258,219.04	$ -	$ 158,760.40	$ -
AZ	84251	Aetna Life Insurance Company	$ 60,071.04	$ -	$ 7,579.68	$ -
AZ	86830	Cigna Health and Life Insurance Company	$ 173,356.66	$ -	$ 21,873.91	$ -
AZ	88925	University of Arizona Health Plans-University Healthcare, Inc.	$ 645,097.22	$ -	$ 81,397.51	$ -
AZ	91450	Health Net of Arizona, Inc.	$ 44,674,893.78	$ 1,189,199.69	$ 5,637,018.47	$ 150,051.63
AZ	92045	Meritus Mutual Health Partners	$ 1,546,274.44	$ 327,316.81	$ 195,106.85	$ 41,300.40

Table 4 – Arkansas

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
AR	62141	Celtic Insurance Company	$ (15,850,813.36)	$ -	$ (15,850,813.36)	$ -
AR	70525	QCA Health Plan, Inc.	$ 4,181,163.09	$ -	$ 527,573.58	$ -
AR	75293	USAble Mutual Insurance Company	$ -	$ -	$ -	$ -

Table 5 – California

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
CA	18126	Molina Healthcare of California	$ -	$ -	$ -	$ -
CA	27603	Blue Cross of California	$ (8,679,121.40)	$ -	$ (8,679,121.40)	$ -
CA	40513	Kaiser Foundation Health Plan, Inc.	$ (65,768,044.51)	$ 36,933,195.21	$ (65,768,044.51)	$ 4,660,181.28
CA	47579	Chinese Community Health Plan	$ -	$ 712,789.33	$ -	$ 89,938.81
CA	67138	Health Net of California, Inc.	$ -	$ -	$ -	$ -
CA	70285	CA Physician's Service dba Blue Shield of CA	$ (106,990,058.09)	$ (136,577.80)	$ (106,990,058.09)	$ (136,577.80)
CA	84014	County of Santa Clara	$ -	$ -	$ -	$ -
CA	92499	Sharp Health Plan	$ -	$ 7,775.72	$ -	$ 981.13
CA	92815	Local Initiative Health Authority for Los Angeles County	$ 13,561,651.72	$ -	$ 1,711,191.11	$ -
CA	93689	Western Health Advantage	$ (228,695.71)	$ 138.73	$ (228,695.71)	$ 17.50
CA	99110	Health Net Life Insurance Company	$ -	$ 5,058,867.84	$ -	$ 638,321.19
CA	99483	Contra Costa Health Plan	$ -	$ -	$ -	$ -

Table 6 – Colorado

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
CO	11555	New Health Ventures, Inc.	$ 106,520.81	$ -	$ 13,440.65	$ -
CO	20472	Colorado Health Insurance Cooperative, Inc.	$ 14,137,039.21	$ 163,367.72	$ 1,783,792.75	$ 20,613.52

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
CO	21032	Kaiser Foundation Health Plan of Colorado	$ 14,160,790.95	$ -	$ 1,786,789.70	$ -
CO	49375	Cigna Health and Life Insurance Company	$ (632,444.16)	$ -	$ (632,444.16)	$ -
CO	63312	Colorado Choice Health Plans	$ 5,893,514.24	$ 114,299.01	$ 743,635.76	$ 14,422.10
CO	66699	Denver Health Medical Plan, Inc.	$ 287,542.11	$ -	$ 36,281.68	$ -
CO	74320	Humana Health Plan	$ 3,183,617.97	$ -	$ 401,704.67	$ -
CO	76680	HMO Colorado, Inc., dba HMO Nevada	$ 1,479,675.14	$ (21,811.05)	$ 186,703.43	$ (21,811.05)
CO	80208	Rocky Mountain Health Care Options	$ -	$ 440,553.54	$ -	$ 55,588.46
CO	92137	All Savers Insurance Company	$ (107,467.82)	$ -	$ (107,467.82)	$ -
CO	97879	Rocky Mountain HMO	$ 1,470,136.36	$ 578,003.29	$ 185,499.84	$ 72,931.68

Table 7 – Connecticut

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
CT	49650	UnitedHealthcare Insurance Company	$ -	$ 11,299.51	$ -	$ 1,425.76
CT	76962	ConnectiCare Benefits, Inc.	$ (717,037.34)	$ -	$ (717,037.34)	$ -
CT	86545	Anthem Health Plans, Inc. (Anthem BCBS)	$ (863,733.24)	$ (26,699.38)	$ (863,733.24)	$ (26,699.38)
CT	91069	HealthyCT, Inc.	$ 1,561,247.18	$ 272,638.90	$ 196,996.09	$ 34,401.21

Table 8 - DC

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
DC	41842	UnitedHealthcare Insurance Company	$ -	$ (991,539.08)	$ -	$ (991,539.08)
DC	73987	Aetna Health, Inc. (a PA corp.)	$ -	$ (64,837.39)	$ -	$ (64,837.39)
DC	75753	Optimum Choice, Inc.	$ -	$ (254,567.86)	$ -	$ (254,567.86)
DC	77422	Aetna Life Insurance Company	$ (85,707.77)	$ (599,078.47)	$ (85,707.77)	$ (599,078.47)
DC	78079	Group Hospitalization and Medical Services, Inc.	$ -	$ -	$ -	$ -
DC	86052	CareFirst BlueChoice, Inc.	$ -	$ -	$ -	$ -
DC	94506	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$ 668,656.18	$ 592,476.32	$ 84,370.14	$ 74,757.87

Table 9 – Delaware

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
DE	13537	Coventry Health and Life	$ (98,081.56)	$ -	$ (98,081.56)	$ -
DE	76168	Highmark BCBSD, Inc.	$ 6,075,398.71	$ (90,018.42)	$ 766,585.70	$ (90,018.42)
DE	81914	Coventry Health Care of Delaware, Inc.	$ -	$ (83,436.61)	$ -	$ (83,436.61)

Table 10 – Florida

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
FL	16842	Blue Cross and Blue Shield of Florida	$ 14,407,419.27	$ 28,169.07	$ 1,817,908.93	$ 3,554.34
FL	23841	Aetna Life Insurance Company	$ -	$ -	$ -	$ -
FL	27357	Health First Health Plans, Inc.	$ -	$ 102,999.55	$ -	$ 12,996.35
FL	30252	Health Options, Inc.	$ 11,363,630.16	$ 18,103.08	$ 1,433,847.69	$ 2,284.22
FL	35783	Humana Medical Plan, Inc.	$ 41,231,083.98	$ -	$ 5,202,483.14	$ -
FL	48121	Cigna Health and Life Insurance Company	$ 4,068,246.94	$ -	$ 513,325.97	$ -
FL	51398	Preferred Medical Plan, Inc.	$ 34,777,521.17	$ -	$ 4,388,181.20	$ -
FL	54172	Molina Healthcare of Florida, Inc.	$ 39,035.74	$ -	$ 4,925.48	$ -
FL	56503	Florida Health Care Plan, Inc.	$ (1,687,550.49)	$ (123,177.85)	$ (1,687,550.49)	$ (123,177.85)
FL	57451	Coventry Health Care of Florida, Inc.	$ 30,600,508.00	$ -	$ 3,861,131.26	$ -
FL	77150	Health First Insurance, Inc.	$ 1,549,229.65	$ 303,120.12	$ 195,479.73	$ 38,247.29
FL	86382	Sunshine State Health Plan	$ (420,664.88)	$ -	$ (420,664.88)	$ -

Table 11 - Georgia

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
GA	45495	Peach State Health Plan	$ (675,263.76)	$ -	$ (675,263.76)	$ -
GA	49046	Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	$ (5,981,961.36)	$ (3,041.08)	$ (5,981,961.36)	$ (3,041.08)
GA	83761	Alliant Health Plans	$ -	$ 125.18	$ -	$ 15.80
GA	89942	Kaiser Foundation Health Plan of Georgia	$ -	$ 2,003,716.30	$ -	$ 252,826.25
GA	93332	Humana Employers Health Plan of Georgia, Inc.	$ 83,973,253.40	$ -	$ 10,595,633.03	$ -

Table 12 – Hawaii

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
HI	18350	Hawaii Medical Service Association	$ -	$ -	$ -	$ -
HI	60612	Kaiser Foundation Health Plan, Inc.	$ 12,727,673.62	$ 6,060,129.80	$ 1,605,960.87	$ 764,659.09

Table 13 - Idaho

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
ID	26002	SelectHealth	$ 24,386,583.14	$ 1,574,917.17	$ 3,077,066.51	$ 198,720.95
ID	44648	Regence Blue Shield of Idaho	$ -	$ -	$ -	$ -
ID	59765	BridgeSpan Health Company	$ 27,918.21	$ -	$ 3,522.68	$ -
ID	60597	PacificSource Health Plans	$ 2,242,712.26	$ -	$ 282,982.44	$ -
ID	61589	Blue Cross of Idaho Health Service, Inc.	$ 39,437,313.04	$ 600,529.29	$ 4,976,147.52	$ 75,773.98

Table 14 – Illinois

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
IL	20129	Health Alliance Medical Plans, Inc.	$ 2,759,245.94	$ 14,837.77	$ 348,157.97	$ 1,872.21
IL	35670	Coventry Health & Life Company	$ 338,246.81	$ -	$ 42,679.53	$ -
IL	36096	Blue Cross Blue Shield of Illinois	$ 193,846,813.95	$ 3,325,244.33	$ 24,459,332.25	$ 419,574.89
IL	58288	Humana Health Plan, Inc.	$ 800,982.85	$ -	$ 101,066.95	$ -
IL	68303	Humana Insurance Company	$ 4,801,295.28	$ -	$ 605,821.03	$ -
IL	72547	Aetna Life Insurance Company	$ 156,532.35	$ -	$ 19,751.04	$ -
IL	79763	Land of Lincoln Mutual Health Insurance Company	$ 4,165,273.75	$ 326,970.05	$ 525,568.68	$ 41,256.64
IL	96601	Coventry Health Care of Illinois, Inc.	$ 3,177,608.98	$ -	$ 400,946.46	$ -

Table 15 – Indiana

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
IN	17575	Anthem Insurance Companies, Inc. (Anthem BCBS)	$ 812,580.18	$ (319.45)	$ 102,530.28	$ (319.45)
IN	35065	Coordinated Care Corporation Indiana	$ (263,623.41)	$ -	$ (263,623.41)	$ -
IN	50816	Physicians Health Plan of Northern Indiana, Inc.	$ 2,918,313.81	$ 386,940.55	$ 368,228.94	$ 48,823.64
IN	85320	MDwise, Inc.	$ (14,303,011.22)	$ -	$ (14,303,011.22)	$ -

Table 16 – Iowa

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
IA	18973	Aetna Health, Inc. (an IA corp.)	$ 2,707,707.64	$ -	$ 341,654.94	$ -
IA	27651	Gundersen Health Plan, Inc.	$ 105,688.49	$ 8,152.09	$ 13,335.63	$ 1,028.62
IA	71268	CoOportunity Health	$ 40,166,052.95	$ 15,838,758.46	$ 5,068,098.95	$ 1,998,513.40
IA	74980	Avera Health Plans, Inc.	$ 96,106.84	$ 4,805.45	$ 12,126.63	$ 606.35
IA	77638	Health Alliance Midwest, Inc.	$ -	$ -	$ -	$ -
IA	85930	Sanford Health Plan	$	$ 129,136.07	$ -	$ 16,294.22

Table 17 – Kansas

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
KS	18558	Blue Cross and Blue Shield of Kansas, Inc.	$ 13,740,981.12	$ 298,179.85	$ 1,733,818.66	$ 37,623.94
KS	61430	Coventry Health and Life	$ 22,889,994.47	$ -	$ 2,888,228.95	$ -
KS	65598	Coventry Health Care Of Kansas, Inc.	$ 9,497,537.20	$ -	$ 1,198,386.57	$ -
KS	94248	Blue Cross and Blue Shield of Kansas City	$ 1,261,531.48	$ (265,838.16)	$ 159,178.36	$ (265,838.16)

Table 18 - Kentucky

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
KY	15411	Humana Health Plan, Inc.	$ 6,029,009.18	$ -	$ 760,732.33	$ -
KY	23671	UnitedHealthcare of Kentucky, Ltd.	$ -	$ (26,994.08)	$ -	$ (26,994.08)
KY	36239	Anthem Health Plans of KY(Anthem BCBS)	$ (620,075.73)	$ (12,523.99)	$ (620,075.73)	$ (12,523.99)
KY	40586	Bluegrass Family Health, Inc.	$ -	$ 1,472,085.68	$ -	$ 185,745.81
KY	77894	Kentucky Health Cooperative	$ 77,074,941.10	$ (69,347.11)	$ 9,725,213.20	$ (69,347.11)

Table 19 - Louisiana

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
LA	19636	HMO Louisiana, Inc.	$ 2,638,100.44	$ 540,123.96	$ 332,871.99	$ 68,152.12
LA	44965	Humana Health Benefit Plan of Louisiana, Inc.	$ 414,666.60	$ -	$ 52,322.08	$ -
LA	67202	Louisiana Health Cooperative, Inc.	$ 11,945,268.95	$ 13,935.30	$ 1,507,238.09	$ 1,758.34
LA	67243	Vantage Health Plan, Inc.	$ -	$ 24,218.07	$ -	$ 3,055.80
LA	97176	Louisiana Health Service & Indemnity Company	$ 27,386,455.30	$ 7,951,249.65	$ 3,455,586.38	$ 1,003,278.07

Table 20- Maine

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
ME	33653	Maine Community Health Options	$ (2,045,819.48)	$ 241,717.00	$ (2,045,819.48)	$ 30,499.53
ME	48396	Anthem Health Plans of ME (Anthem BCBS)	$ -	$ (4,426.93)	$ -	$ (4,426.93)

Table 21 – Maryland

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MD	14468	Coventry Health Care of Delaware, Inc.	$ -	$ (3,504.62)	$ -	$ (3,504.62)
MD	23620	UnitedHealthcare Insurance Company	$ A126	$ (2,371,783.62)	$ -	$ (2,371,783.62)

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MD	28137	CareFirst BlueChoice, Inc.	$ 17,927,378.59	$ (200,100.92)	$ 2,262,052.70	$ (200,100.92)
MD	31112	UnitedHealthcare of the Mid-Atlantic, Inc.	$ -	$ (552,561.24)	$ -	$ (552,561.24)
MD	36677	All Savers Insurance Company	$ 138,564.85	$ -	$ 17,483.93	$ -
MD	45532	CareFirst of Maryland, Inc.	$ 5,442,263.96	$ (52,255.73)	$ 686,697.60	$ (52,255.73)
MD	65635	MAMSI Life and Health Insurance Company	$ -	$ (1,511,616.91)	$ -	$ (1,511,616.91)
MD	68541	Coventry Health and Life	$ -	$ (3,959.56)	$ -	$ (3,959.56)
MD	72375	Optimum Choice, Inc.	$ -	$ (1,635,883.00)	$ -	$ (1,635,883.00)
MD	72564	Evergreen Health Cooperative, Inc.	$ 902,808.54	$ 3,232,843.21	$ 113,915.18	$ 407,915.84
MD	90296	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$ 220,063.25	$ 347,036.82	$ 27,767.29	$ 43,788.64
MD	94084	Group Hospitalization and Medical Services, Inc.	$ 1,021,545.92	$ (133,466.80)	$ 128,897.30	$ (133,466.80)

Table 22 – Massachusetts

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MA	29125	Tufts Associated HMO	$ -	$ -	$ -	$ -
MA	31234	CeltiCare Health Plan of MA	$ 191,649.92	$ -	$ 24,182.13	$ -
MA	34484	Health New England, Inc.	$ -	$ -	$ -	$ -
MA	36046	Harvard Pilgrim Health Care, Inc.	$	$ -	$ -	$ -
MA	41304	Neighborhood Health Plan	$ 7,389,737.55	$ 10,543,621.21	$ 932,427.22	$ 1,330,380.05

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MA	42690	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	$ -	$ -	$ -	$ -
MA	59763	Tufts Health Public Plans Inc.	$ -	$ -	$ -	$ -
MA	73331	Minuteman Health, Inc.	$ 1,138,642.67	$ -	$ 143,672.41	$ -
MA	82569	Boston Medical Center Health Plan, Inc.	$ 1,736,581.18	$ -	$ 219,119.50	$ -
MA	88806	Fallon Community Health Plan, Inc.	$ 200,285.65	$ 435,622.91	$ 25,271.78	$ 54,966.32
MA	95878	HPHC Insurance Company, Inc.	$ 255,319.27	$ 959,303.93	$ 32,215.84	$ 121,043.69

Table 23 – Michigan

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MI	15560	Blue Cross Blue Shield of Michigan Mutual Insurance Company	$ -	$ (676,390.04)	$ -	$ (676,390.04)
MI	20393	McLaren Health Plan	$ 532,813.30	$ -	$ 67,229.67	$ -
MI	29241	Priority Health Insurance Company (PHIC)	$ 1,049,112.59	$ 50,769.62	$ 132,375.63	$ 6,406.04
MI	29698	Priority Health	$ 452,162.74	$ 12,391.43	$ 57,053.29	$ 1,563.53
MI	37651	Health Alliance Plan (HAP)	$ (617,846.91)	$ (461,796.54)	$ (617,846.91)	$ (461,796.54)
MI	40047	Molina Healthcare of Michigan, Inc.	$ (33,005.69)	$ -	$ (33,005.69)	$ -
MI	41895	Consumers Mutual	$ 198,351.54	$ 1,442,311.90	$ 25,027.71	$ 181,988.99

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
		Insurance of Michigan				
MI	45002	UnitedHealthcare Life Insurance Company	$ -	$ 32.68	$ -	$ 4.12
MI	46275	Humana Medical Plan of Michigan, Inc.	$ 8,102,093.26	$ -	$ 1,022,311.31	$ -
MI	58594	Meridian Health Plan of Michigan, Inc.	$ (11,519.73)	$ -	$ (11,519.73)	$ -
MI	67183	Total Health Care USA, Inc.	$ -	$ -	$ -	$ -
MI	67577	Alliance Health and Life Insurance Company	$ 64,626.98	$ (176,039.32)	$ 8,154.55	$ (176,039.32)
MI	98185	Blue Care Network of Michigan	$ 17,193,568.72	$ (47,526.91)	$ 2,169,461.55	$ (47,526.91)

Table 24 – Minnesota

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MN	31616	Medica Insurance Company	$ -	$ 316,966.63	$ -	$ 39,994.43
MN	34102	Group Health Plan, Inc.	$ 2,612,104.28	$ -	$ 329,591.83	$ -
MN	49316	BCBSM, Inc.	$ 6,955,635.49	$ -	$ 877,652.80	$ -
MN	65847	Medica Health Plans of Wisconsin	$ -	$ -	$ -	$ -
MN	85736	UCare Minnesota	$ -	$ -	$ -	$ -
MN	88102	PreferredOne Insurance Company	$ 53,344,373.74	$ 176,995.83	$ 6,730,921.88	$ 22,333.10

Table 25 - Mississippi

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MS	48963	Humana Insurance Company	$ (900,401.14)	$ -	$ (900,401.14)	$ -
MS	61794	UnitedHealthcare Life Insurance Company	$ -	$ (1,130.50)	$ -	$ (1,130.50)
MS	94237	Magnolia Health Plan	$ (13,190,322.25)	$ -	$ (13,190,322.25)	$ -

Table 26 - Missouri

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MO	32753	Healthy Alliance Life Company (Anthem BCBS)	$ -	$ 22,591.92	$ -	$ 2,850.62
MO	34762	Blue Cross and Blue Shield of Kansas City	$ 2,807,773.67	$ (183,601.01)	$ 354,281.13	$ (183,601.01)
MO	44240	Coventry Health and Life	$ 29,076,804.73	$ -	$ 3,668,872.41	$ -

Table 27 – Montana

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
MT	23603	PacificSource Health Plans	$ 1,938,055.47	$ -	$ 244,541.25	$ -
MT	30751	Blue Cross and Blue Shield of Montana	$ 23,457,847.95	$ 554,107.74	$ 2,959,879.94	$ 69,916.58
MT	32225	Montana Health Cooperative	$ 6,754,127.62	$ 62,383.51	$ 852,226.81	$ 7,871.47

Table 28 – Nebraska

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NE	15438	Coventry Health Care of Nebraska, Inc.	$ -	$ -	$ -	$ -
NE	29678	Blue Cross and Blue Shield of Nebraska	$ 14,143,024.12	$ (267,402.83)	$ 1,784,547.91	$ (267,402.83)
NE	43198	CoOportunity Health	$ 51,080,793.04	$ 22,870,010.14	$ 6,445,306.29	$ 2,885,707.35
NE	77931	Health Alliance Midwest, Inc.	$ (53,340.12)	$ 7,317.35	$ (53,340.12)	$ 923.29

Table 29 – Nevada

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NV	16698	Prominence HealthFirst	$ (71,742.47)	$ -	$ (71,742.47)	$ -
NV	34996	Nevada Health CO-OP	$ 10,388,059.14	$ 312,181.20	$ 1,310,751.44	$ 39,390.61
NV	60156	HMO Colorado, Inc., dba HMO Nevada	$ (53,370.48)	$ 2,715.74	$ (53,370.48)	$ 342.67
NV	95865	Health Plan of Nevada, Inc.	$ -	$ -	$ -	$ -

Table 30 – New Hampshire

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NH	96751	Matthew Thornton Health Plan (Anthem BCBS)	$ (2,966,744.60)	$ -	$ (2,966,744.60)	$ -

Table 31 – New Jersey

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NJ	10191	Freelancers CO-OP of New Jersey, Inc.	$ (2,895,760.17)	$ 150,164.60	$ (2,895,760.17)	$ 18,947.57
NJ	77606	AmeriHealth HMO, Inc.	$ 3,360,296.37	$ 138,744.96	$ 423,997.71	$ 17,506.65
NJ	91661	Horizon Healthcare Services, Inc.	$ (27,523,171.51)	$ 3,185,432.61	$ (27,523,171.51)	$ 401,933.64
NJ	91762	AmeriHealth Insurance Company of New Jersey	$ (2,318,123.55)	$ 1,157,648.85	$ (2,318,123.55)	$ 146,070.59

Table 32 – New Mexico

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NM	19722	Molina Health Care of New Mexico, Inc.	$ (628,432.85)	$ -	$ (628,432.85)	$ -
NM	52744	Presbyterian Insurance Company, Inc.	$ -	$ -	$ -	$ -
NM	57173	Presbyterian Health Plan, Inc.	$ 2,478,787.11	$ (82,897.17)	$ 312,770.05	$ (82,897.17)
NM	75605	Blue Cross Blue Shield of New Mexico	$ 6,56[illegible]3	$ 3,789.97	$ 828,124.54	$ 478.21

NM	93091	New Mexico Health Connections	$ 4,211,650.62	$ -	$ 531,420.45	$ -

Table 33 – New York

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NY	11177	MetroPlus Health Plan	$ 8,754,733.06	$ -	$ 1,104,660.53	$ -
NY	18029	Independent Health Benefits Corporation	$ (2,870,470.22)	$ (530,639.45)	$ (2,870,470.22)	$ (530,639.45)
NY	25303	New York State Catholic Health Plan, Inc.	$ (3,499,761.14)	$ -	$ (3,499,761.14)	$ -
NY	31808	American Progressive Life & Health Insurance Company of New York	$ (344,586.33)	$ -	$ (344,586.33)	$ -
NY	40064	HealthNow New York	$ (4,020,217.24)	$ (1,216,594.18)	$ (4,020,217.24)	$ (1,216,594.18)
NY	54235	UnitedHealthcare of New York, Inc.	$ (626,658.79)	$ -	$ (626,658.79)	$ -
NY	56184	MVP Health Plan, Inc.	$ (3,547,343.87)	$ 1,550,702.41	$ (3,547,343.87)	$ 195,665.56
NY	57165	Affinity Health Plan, Inc.	$ 1,179,368.76	$ -	$ 148,811.18	$ -
NY	71644	Freelancers Health Service Corporation d/b/a Health Republic Insurance of New York	$ 89,568,960.58	$ 59,765,898.72	$ 11,301,691.90	$ 7,541,181.33
NY	74289	Oscar Insurance Corporation	$ 9,342,723.93	$ -	$ 1,178,852.44	$ -
NY	78124	Excellus Health Plan, Inc.	$ (5,505,909.10)	$ 7,526,489.35	$ (5,505,909.10)	$ 949,682.38
NY	80519	Empire HealthChoice HMO, Inc.	$ A133	$ -	$ -	$ -

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NY	82483	North Shore-LIJ Insurance Company, Inc.	$ 3,109,088.97	$ 407,827.19	$ 392,300.70	$ 51,459.09
NY	85629	Oxford Health Insurance, Inc.	$ -	$ -	$ -	$ -
NY	88582	Health Insurance Plan of Greater New York	$ -	$ -	$ -	$ -
NY	91237	Healthfirst PHSP, Inc.	$ 75,523.98	$ -	$ 9,529.51	$ -
NY	92551	CDPHP Universal Benefits, Inc.	$ -	$ 14,607,068.85	$ -	$ 1,843,100.45
NY	94788	CDPHP	$ (1,382,551.74)	$ -	$ (1,382,551.74)	$ -
NY	95456	Atlantis Health Plan	$ -	$ -	$ -	$ -

Table 34 – North Carolina

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NC	11512	Blue Cross and Blue Shield of NC	$ 147,421,876.38	$ 53,091.97	$ 18,601,495.60	$ 6,699.07
NC	56346	Coventry Health Care of the Carolinas, Inc.	$ 10,188,775.76	$ -	$ 1,285,606.13	$ -

Table 35 – North Dakota

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
ND	37160	Blue Cross Blue Shield of North Dakota	$ 458,378.00	$ -	$ 57,837.52	$ -
ND	73751	Medica Health Plans	$ 135,903.29	$ 104,395.86	$ 17,148.10	$ 13,172.53
ND	89364	Sanford Health Plan	$ (36,822.51)	$ (525,477.50)	$ (36,822.51)	$ (525,477.50)

Table 36 – Ohio

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
OH	20126	HealthSpan Integrated Care	$ 11,010,446.61	$ 192,005.52	$ 1,389,283.46	$ 24,227.00
OH	28162	AultCare Insurance Company	$ (352,697.76)	$ 653,633.59	$ (352,697.76)	$ 82,474.61
OH	29276	Community Insurance Company (Anthem BCBS)	$ (1,827,325.84)	$ 16,036.90	$ (1,827,325.84)	$ 2,023.51
OH	41047	Buckeye Community Health Plan	$ (138,688.52)	$ -	$ (138,688.52)	$ -
OH	52664	Summa Insurance Company, Inc.	$ 1,029,971.11	$ 1,126,100.28	$ 129,960.38	$ 142,089.83
OH	64353	Molina Healthcare of Ohio	$ (59,275.67)	$ -	$ (59,275.67)	$ -
OH	66083	Humana Health Plan of Ohio, Inc.	$ 9,268,399.33	$ -	$ 1,169,474.26	$ -
OH	74313	Paramount Insurance Company	$ -	$ -	$ -	$ -
OH	77552	CareSource	$ (2,330,396.51)	$ -	$ (2,330,396.51)	$ -
OH	92036	HealthSpan	$ 4,984,820.40	$ 82,913.27	$ 628,977.98	$ 10,461.89
OH	98894	Coventry Health and Life	$ 572,626.39	$ -	$ 72,253.23	$ -
OH	99969	Medical Health Insuring Corporation of Ohio	$ 4,162,818.87	$ 814,705.62	$ 525,258.93	$ 102,798.47

Table 37 – Oklahoma

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
OK	53524	Coventry Health and Life	$ 160,301.63	$ -	$ 20,226.65	$ -
OK	66946	Aetna Life Insurance Company	$ 430,044.89	$ -	$ 54,262.49	$ -
OK	76668	Coventry Health Care of Kansas, Inc.	$ 1,263,023.77	$ -	$ 159,366.65	$ -
OK	85408	GlobalHealth, Inc.	$ 2,789,907.94	$ 15,603.96	$ 352,026.86	$ 1,968.89
OK	87571	Blue Cross Blue Shield of Oklahoma	$ 51,750,597.82	$ 2,141,587.80	$ 6,529,821.36	$ 270,222.69
OK	87698	CommunityCare Life & Health Insurance Company	$ -	$ 153,238.12	$ -	$ 19,335.38
OK	98905	CommunityCare HMO, Inc.	$ (89,579.39)	$ 324,873.59	$ (89,579.39)	$ 40,992.12

Table 38 – Oregon

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
OR	10091	PacificSource Health Plans	$ 3,007,808.62	$ -	$ 379,521.28	$ -
OR	10940	Health Net Health Plan of Oregon, Inc.	$ 2,355,054.51	$ -	$ 297,157.63	$ -
OR	32536	ATRIO Health Plans	$ 79,569.24	$ 38,865.04	$ 10,039.94	$ 4,903.94
OR	39424	Moda Health Plan, Inc.	$ 86,224,498.21	$ 1,515,915.79	$ 10,879,692.10	$ 191,276.23
OR	56707	Providence Health Plan	$ (884,714.62)	$ (14,562.34)	$ (884,714.62)	$ (14,562.34)
OR	63474	BridgeSpan Health Company	$ (10,125.33)	$ -	$ (10,125.33)	$ -
OR	71287	Kaiser Foundation Healthplan of the NW	$	$ (103,672.86)	$ -	$ (103,672.86)

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
OR	85804	LifeWise Health Plan of Oregon	$ 4,825,921.49	$ -	$ 608,928.33	$ -
OR	95417	Trillium Community Health Plan	$ (4,991.57)	$ -	$ (4,991.57)	$ -
OR	96383	Health Republic Insurance Company	$ 4,206,407.40	$ 3,678,478.75	$ 530,758.87	$ 464,145.54
OR	99389	Community Care of Oregon, Inc.	$ 1,528,717.06	$ (53,520.17)	$ 192,891.48	$ (53,520.17)

Table 39 – Pennsylvania

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
PA	16481	UPMC Health Network, Inc.	$ -	$ 222,263.08	$ -	$ 28,044.86
PA	22444	Geisinger Health Plan	$ 17,817,403.51	$ 5,080,960.02	$ 2,248,176.19	$ 641,108.75
PA	31609	Independence Blue Cross (QCC Ins. Co.)	$ (1,308,105.69)	$ 10,769,563.46	$ (1,308,105.69)	$ 1,358,889.14
PA	33709	Highmark, Inc.	$ 158,255,675.15	$ 1,561,432.70	$ 19,968,489.86	$ 197,019.49
PA	33871	Keystone Health Plan East, Inc.	$ 14,274,873.45	$ 14,996,681.97	$ 1,801,184.48	$ 1,892,261.31
PA	33906	Aetna Life Insurance	$ 305,303.92	$ -	$ 38,522.84	$ -

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
		Company				
PA	52899	UPMC Health Plan, Inc.	$ -	$ 13,607.91	$ -	$ 1,717.03
PA	53789	Keystone Health Plan Central	$ 116,511.72	$ (10,554.40)	$ 14,701.29	$ (10,554.40)
PA	55957	First Priority Life Insurance Company, Inc.	$ 10,933,783.20	$ -	$ 1,379,610.17	$ -
PA	64844	Aetna Health Inc. (a PA corp.)	$ (345,573.38)	$ -	$ (345,573.38)	$ -
PA	70194	Highmark Health Insurance Company	$ 31,690,007.63	$ -	$ 3,998,602.87	$ -
PA	75729	Geisinger Quality Options	$ 3,707,248.35	$ 3,991,516.95	$ 467,775.65	$ 503,644.28
PA	82795	Capital Advantage Insurance Company CAIC	$ 235,466.09	$ 54,647.55	$ 29,710.80	$ 6,895.35
PA	91303	HealthAmerica Pennsylvania, Inc.	$ 2,042,302.79	$ -	$ 257,695.04	$ -

Table 40 – Rhode Island

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
RI	15287	Blue Cross & Blue Shield of Rhode Island	$ -	$ -	$ -	$ -
RI	77514	Neighborhood Health Plan of Rhode Island	$ (211,788.19)	$ (4,014.40)	$ (211,788.19)	$ (4,014.40)
RI	79881	UnitedHealthcare of New England, Inc.	$ -	$ 762.71	$ -	$ 96.24

Table 41 – South Carolina

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
SC	26065	Blue Cross and Blue Shield of South Carolina	$ (5,288,866.75)	$ (529,578.40)	$ (5,288,866.75)	$ (529,578.40)
SC	41614	Coventry Health Care of the Carolinas, Inc.	$ 5,095,926.05	$ -	$ 642,997.15	$ -
SC	49532	BlueChoice HealthPlan of South Carolina, Inc.	$ (2,329,264.72)	$ (21,230.33)	$ (2,329,264.72)	$ (21,230.33)
SC	65122	Consumers' Choice Health Insurance Company	$ 12,425,229.72	$ (1,019.57)	$ 1,567,798.90	$ (1,019.57)

Table 42 – South Dakota

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
SD	31195	Sanford Health Plan	$ 2,970,388.46	$ 566,171.13	$ 374,799.65	$ 71,438.72
SD	60536	Avera Health Plans, Inc.	$ 7,572,477.64	$ 394,223.31	$ 955,485.12	$ 49,742.57
SD	62210	South Dakota State Medical Holding Company, Inc.	$ 66,565.39	$ 12,552.90	$ 8,399.13	$ 1,583.91

Table 43 – Tennessee

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
TN	14002	BlueCross BlueShield of Tennessee	$ 78,721,051.43	$ -	$ 9,932,917.20	$ -
TN	66842	Community Health Alliance Mutual Insurance Company	$ 212,418.39	$ 155,095.17	$ 26,802.67	$ 19,569.70
TN	82120	Humana Insurance Company	$ 7,292,392.28	$ -	$ 920,144.32	$ -
TN	99248	Cigna Health and Life Insurance Company	$ (31,703.92)	$ -	$ (31,703.92)	$ -

Table 44 – Texas

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
TX	26539	SHA, LLC DBA FirstCare Health Plans	$ 1,675,416.16	$ 359,876.56	$ 211,401.77	$ 45,408.74
TX	27248	Community Health Choice, Inc.	$ (4,628.30)	$ -	$ (4,628.30)	$ -
TX	32673	Humana Health Plan of Texas, Inc.	$ 61,229,555.45	$ -	$ 7,725,863.58	$ -
TX	33602	Blue Cross Blue Shield of Texas	$ 275,081,527.88	$ 19,226,824.55	$ 34,709,420.03	$ 2,426,015.06
TX	40788	Scott and White Health Plan	$ 770,409.24	$ -	$ 97,209.21	$ -
TX	45786	Molina Healthcare of	$ (421,460.88)	$ -	$ (421,460.88)	$ -

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
		Texas				
TX	46224	Community First Health Plans, Inc.	$ 10,771.93	$ -	$ 1,359.19	$ -
TX	55409	Cigna Health and Life Insurance Company	$ 12,881,279.86	$ -	$ 1,625,342.70	$ -
TX	63141	Humana Insurance Company	$ 5,073,997.06	$ -	$ 640,230.18	$ -
TX	71837	Sendero Health Plans, Inc.	$ -	$ -	$ -	$ -
TX	87226	Superior Health Plan	$ (141,809.67)	$ -	$ (141,809.67)	$ -
TX	91716	Aetna Life Insurance Company	$ 1,101,457.25	$ -	$ 138,980.41	$ -

Table 45 – Utah

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
UT	18167	Molina Healthcare of Utah	$ (34,983.73)	$ -	$ (34,983.73)	$ -
UT	27619	Arches Mutual Insurance Company	$ 11,541,794.74	$ 475,006.15	$ 1,456,328.26	$ 59,935.64
UT	34541	BridgeSpan Health Company	$ 2,017,051.99	$ -	$ 254,508.93	$ -
UT	38927	Aetna Health of Utah, Inc.	$ 2,007,972.57	$ -	$ 253,363.30	$ -
UT	56764	Humana Medical Plan of Utah, Inc.	$ 9,670,212.71	$ -	$ 1,220,174.53	$ -
UT	66413	UnitedHealthcare of Utah, Inc.	$ -	$ (83,844.54)	$ -	$ (83,844.54)
UT	68781	SelectHealth	$ 62,294,564.39	$ 21,242,298.51	$ 7,860,244.99	$ 2,680,324.87

Table 46 – Vermont

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
VT	13627	Blue Cross Blue Shield of Vermont	$ (30,650.56)	$ (36,128.73)	$ (30,650.56)	$ (36,128.73)
VT	77566	MVP Health Plan, Inc.	$ 918,153.01	$ 644,843.45	$ 115,851.32	$ 81,365.49

Table 47 – Virginia

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
VA	10207	CareFirst BlueChoice, Inc.	$ 730,771.62	$ -	$ 92,207.79	$ -
VA	12028	Innovation Health Insurance Company	$ 426,857.46	$ -	$ 53,860.30	$ -
VA	20507	Optima Health Plan	$ -	$ -	$ -	$ -
VA	38234	Aetna Life Insurance Company	$ (659,270.22)	$ -	$ (659,270.22)	$ -
VA	40308	Group Hospitalization and Medical Services, Inc.	$ (64,661.14)	$ (1,025,296.29)	$ (64,661.14)	$ (1,025,296.29)
VA	88380	HealthKeepers, Inc.	$ -	$ (2,548.51)	$ -	$ (2,548.51)
VA	95185	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.	$ -	$ 178,089.11	$ -	$ 22,471.05
VA	99663	Coventry Health Care of Virginia, Inc.	$ -	$ -	$ -	$ -

Table 48 – Washington

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
WA	18581	Community Health Plan of Washington	$ (753,546.87)	$ -	$ (753,546.87)	$ -
WA	23371	Kaiser Foundation Healthplan of the NW	$ (3,394,261.77)	$ (369,811.39)	$ (3,394,261.77)	$ (369,811.39)
WA	38498	LifeWise Health Plan of WA	$ (1,919,519.31)	$ -	$ (1,919,519.31)	$ -
WA	49831	Premera Blue Cross	$ (5,476,090.21)	$ -	$ (5,476,090.21)	$ -
WA	53732	BridgeSpan Health Company	$ (2,033,720.54)	$ -	$ (2,033,720.54)	$ -
WA	61836	Coordinated Care Corporation	$ -	$ -	$ -	$ -
WA	80473	Group Health Cooperative	$ (6,356,225.50)	$ -	$ (6,356,225.50)	$ -
WA	84481	Molina Healthcare of Washington, Inc.	$ (1,376,733.58)	$ -	$ (1,376,733.58)	$ -

Table 49 – West Virginia

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
WV	31274	Highmark Blue Cross Blue Shield West Virginia	$ 14,385,457.00	$ 38,227.31	$ 1,815,137.76	$ 4,823.47

Table 50 – Wisconsin

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
WI	35334	MercyCare Insurance Company	$ -	$ 355,607.79	$ -	$ 44,870.12
WI	37833	Unity Health Plans Insurance Corporation	$ -	$ -	$ -	$ -
WI	38166	Security Health Plan of Wisconsin, Inc.	$ -	$ 875,656.06	$ -	$ 110,489.11
WI	38345	Dean Health Plan	$ 15,750,038.55	$ -	$ 1,987,318.84	$ -
WI	47342	Health Tradition Health Plan	$ 297,680.24	$ 282,631.37	$ 37,560.90	$ 35,662.05
WI	52697	Molina Healthcare of Wisconsin, Inc.	$ (2,294,384.22)	$ -	$ (2,294,384.22)	$ -
WI	57637	Medica Insurance Company	$ -	$ 481,277.84	$ -	$ 60,727.00
WI	57845	Medica Health Plans of Wisconsin	$ (1,883,070.63)	$ -	$ (1,883,070.63)	$ -
WI	58326	MercyCare HMO, Inc.	$ 628,033.47	$ 555,110.94	$ 79,244.43	$ 70,043.16
WI	58564	Physicians Plus Insurance Corporation	$ (400,853.60)	$ -	$ (400,853.60)	$ -
WI	79475	Compcare Health Services Insurance Company (Anthem BCBS)	$ 4,931,489.14	$ -	$ 622,248.72	$ -
WI	84670	WPS Health Plan, Inc.	$ 6,415,135.24	$ -	$ 809,453.20	$ -
WI	87416	Common Ground Healthcare Cooperative	$ 44,457,568.86	$ 784,154.58	$ 5,609,596.70	$ 98,943.58
WI	91058	Gundersen Health Plan, Inc.	$ -	$ 2,074,673.03	$ -	$ 261,779.47
WI	94529	Group Health Cooperative-SCW	$ (214,772.33)	$ (487,586.65)	$ (214,772.33)	$ (487,586.65)

Table 51 – Wyoming

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
WY	11269	Blue Cross Blue Shield of Wyoming	$ (3,909,210.30)	$ 607,415.77	$ (3,909,210.30)	$ 76,642.91
WY	53189	WINhealth Partners	$ 4,996,309.90	$ 70,330.08	$ 630,427.71	$ 8,874.16

COMPLETING THE RISK CORRIDORS PLAN-LEVEL DATA FORM FOR THE 2015 BENEFIT YEAR

June 7, 2016 & June 9, 2016

Health Insurance Exchange Program
Training Series

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

WWW.REGTAP.INFO

Session Guidelines

- This is a 90-minute webinar session.
- For questions regarding content, submit inquiries to REGTAP at https://www.REGTAP.info/.
- For questions regarding logistics and registration, contact the Registrar at: (800) 257-9520.

Purpose

- This session will explain the steps necessary to complete and submit the Risk Corridors (RC) Plan-Level Data Form for the 2015 Benefit Year.
- Intended for issuers of major medical Qualified Health Plans (QHPs) in the **2015 Benefit Year** only.
- This content will be repeated on June 9, 2016.

Agenda

- Risk Corridors (RC) Program Overview
- Medical Loss Ratio (MLR) Reporting in HIOS
- Reporting RC Plan-Level Data
  - Downloading & populating RC templates
  - Uploading RC templates
  - Data Validation & Attestation
- Questions
- Additional Resources

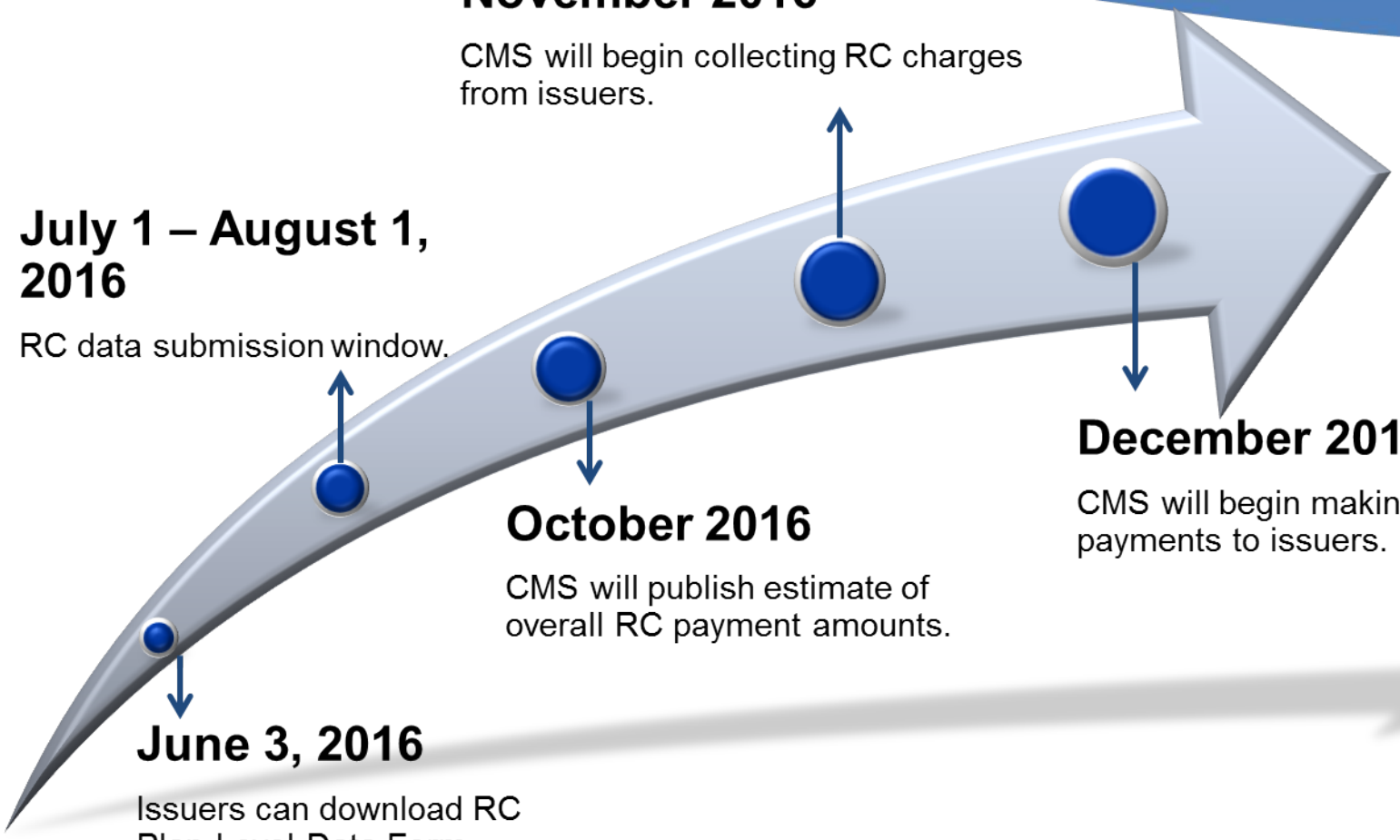
RC Overview

- The Affordable Care Act (ACA) establishes a temporary RC program that is designed to protect individual and small group market QHPs from uncertainty in rate setting during the first three (3) years of Marketplace operation.
- The implementing regulations for the RC program are codified at 45 CFR Part 153.
  - Additional information on the RC program requirements can be found at: http://www.cms.gov/cciio/Resources/Regulations-and-Guidance/index.html#Premium Stabilization Programs.

RC Overview (continued)

- RC data will be collected in two (2) ways:
  - Parts 1-3 of the MLR Form
  - Risk Corridors Plan-Level Data Form
- This includes data on premium earned, profit, allowable costs, taxes, and allowable administrative costs.
- Data is used to calculate the RC payment or charge amount, which is incorporated into the calculation of the issuer's MLR.

RC Timeline – Save the Dates



MLR Reporting in Health Information Oversight System (HIOS)

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The MLR Reporting Process

1. Register for the HIOS MLR Module.
2. Confirm company-issuer associations.
3. Download MLR-A templates.
4. Download RC Plan-Level Data templates.
5. Populate MLR-A templates.
6. Populate RC Plan-Level Data templates.
7. Upload completed MLR-A templates.
8. Upload completed RC Plan-Level Data templates.
9. Attest to accuracy of uploaded MLR data, RC Plan-Level data and supplemental materials.

HIOS Registration

- Filing MLR and RC data requires a one-time registration by the issuer through the secured CMS Enterprise Portal for the HIOS.
  - If an issuer registered for a previous MLR reporting year, the issuer is not required to re-register, but is required to confirm or update issuer associations.
  - Information on HIOS registration is available at: https://www.cms.gov/CCIIO/Resources/Training-Resources/index.html#Medical Loss Ratio.
  - The CMS Enterprise Portal can be accessed at: https://portal.cms.gov/wps/portal/unauthportal/home/.

Overview of MLR Reporting

- The ACA requires health insurance issuers to report premium revenues spent on clinical services to enrollees and all other non-claims costs.
- Collection of MLR and RC data will be conducted through the HIOS Medical Loss Ratio Reporting System (MLR Module).
- **The submission window runs from July 1 – August 1, 2016.**

Risk Corridors Data in MLR Form

Risk Corridors Payment or Charge Calculation
1 - Total percentage of market premium in QHPs For Ind (Tab 1, Column F + Column J + Column N), or For SmGrp (Tab 2, Column F + Column J + Column N)
2 - Risk corridors allowable costs (MLR Reporting Form, Part 3, Line 3.1)
3 - Risk corridors adjusted target amount (MLR Reporting Form, Part 3, Line 3.5)
4 - Adjusted risk corridors ratio (Line 2 / Line 3)
5 - Risk corridors aggregate payment or charge calculation by market
6 - Risk corridors payment expected from HHS or charge payable to HHS (Line 1 x Line 5)
7 - [FOR MLR] Risk corridors unadjusted target amount (MLR Reporting Form, Part 3, Line 3.7)
8 - [FOR MLR] Unadjusted risk corridors ratio (Line 2/ Line 7)
9 - [FOR MLR] Risk corridors aggregate payment or charge calculation by market without adjustment
10 - [FOR MLR] Risk corridors payment or charge amount used for MLR calculation (Line 1 x Line 9)

MLR 2015 Calculator and Form Tool

- The MLR 2015 Annual Reporting Form does not automatically perform the MLR and rebate calculations. When a completed form is submitted, HIOS will alert companies if submitted values do not match HIOS calculated values.
- Companies can do the MLR and rebate calculations themselves following the MLR 2015 Annual Reporting Form Filing Instructions.
  - For the user's convenience, all MLR and rebate formulas are summarized on the Formula Reference tab of this file.
- Companies can also use this MLR 2015 Calculator Tool to perform and/or verify their MLR and rebate calculations for the MLR 2015 Reporting Year.
  - The MLR 2015 Calculator and Form Tool is available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2015-MLR-Reporting-Form-2016-05-10.xlsx.

Reporting RC Plan-Level Data

RC Plan-Level Data Form

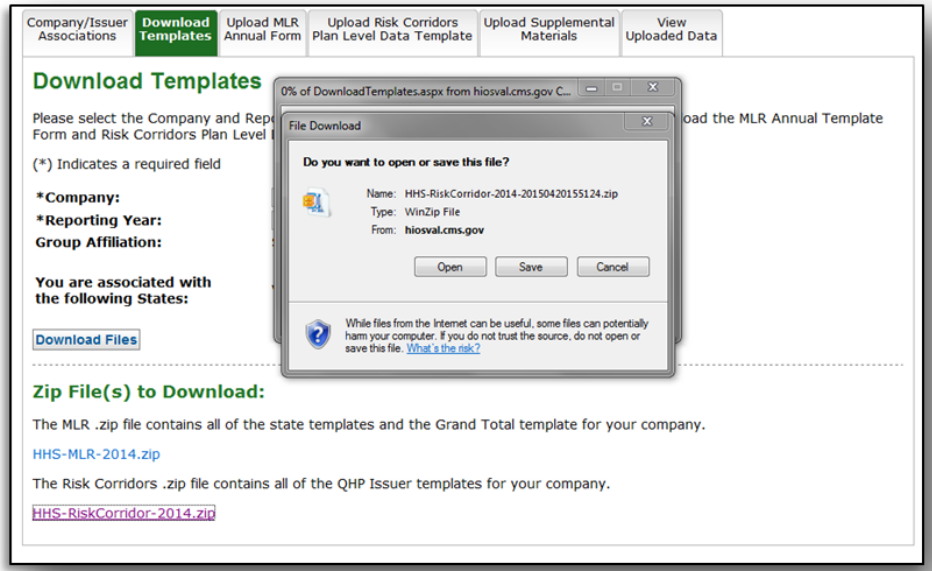
- Each company with at least one (1) health insurance issuer that offered a certified QHP through a Federal-facilitated Marketplace (FFM) or State-based Marketplace (SBM) during the 2015 Benefit Year must submit the RC Plan-Level Data Form with plan-specific premium data for each of its QHP issuers in the individual or small group markets.
- The data included in the RC Plan-Level Data Form will be used to calculate RC payments and charges as defined in 45 CFR §153.500.
- Companies that are required to submit the RC Plan-Level Data Form for the 2015 Benefit Year must also submit the MLR 2015 Annual Reporting Form for the MLR 2015 Reporting Year.

Downloading RC Plan-Level Data Templates

- The Download Templates page provides Company Uploader users with the ability to download a zip file containing RC Plan-Level Data templates for every Company that offered a QHP in 2015.
  - Only Company Uploader users have access to this page.
  - Only Companies that offered QHPs download and complete RC Plan-Level Data templates.

Downloading the RC Plan-Level Data Templates

1. Select the "Download Templates" tab from the MLR System homepage
2. Select the "Company"
3. Select the "Reporting Year"
4. Select "Download Files"
5. Extract the contents of the zip file into a folder on your computer



- The MLR Module will generate a zip file containing pre-populated RC Plan-Level Data templates (named "HHS-RiskCorridor-2015.zip").

Downloading RC Plan-Level Data Templates (continued)

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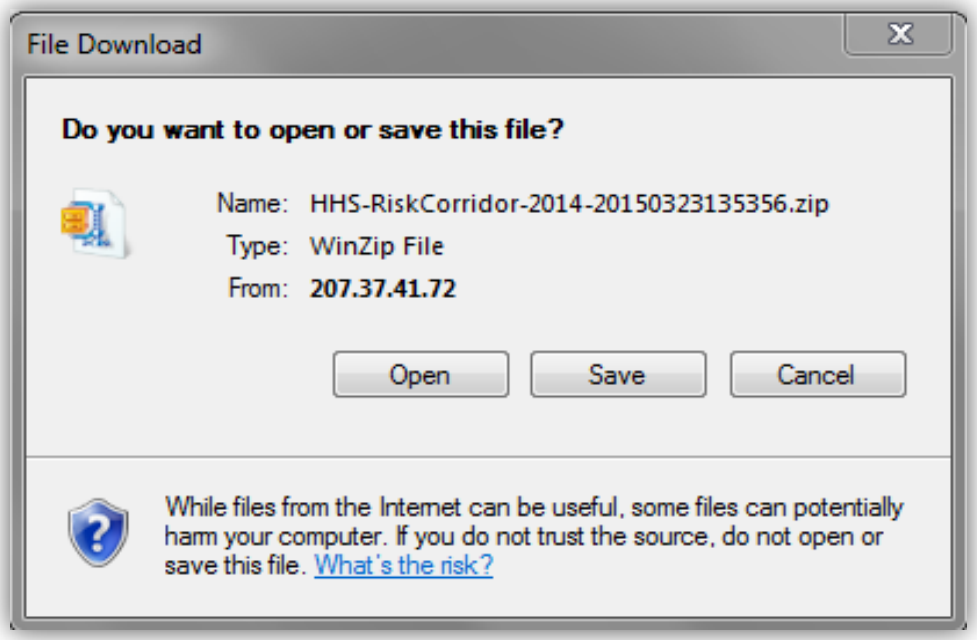
- Two (2) zip file download links will be displayed below the 'Download Files' button.
- The second zip file has the following text above it: "The Risk Corridors.zip file contains all of the QHP issuer templates for your company."
- The name of the first zip file will have the following format: "HHS-RiskCorridors-2015.zip".
- When a user clicks on the link, a dialog box will pop up allowing a user to either open the file or save the file to the user's local drive.
  - Opening or saving the zip file displays all files contained in the zip file.

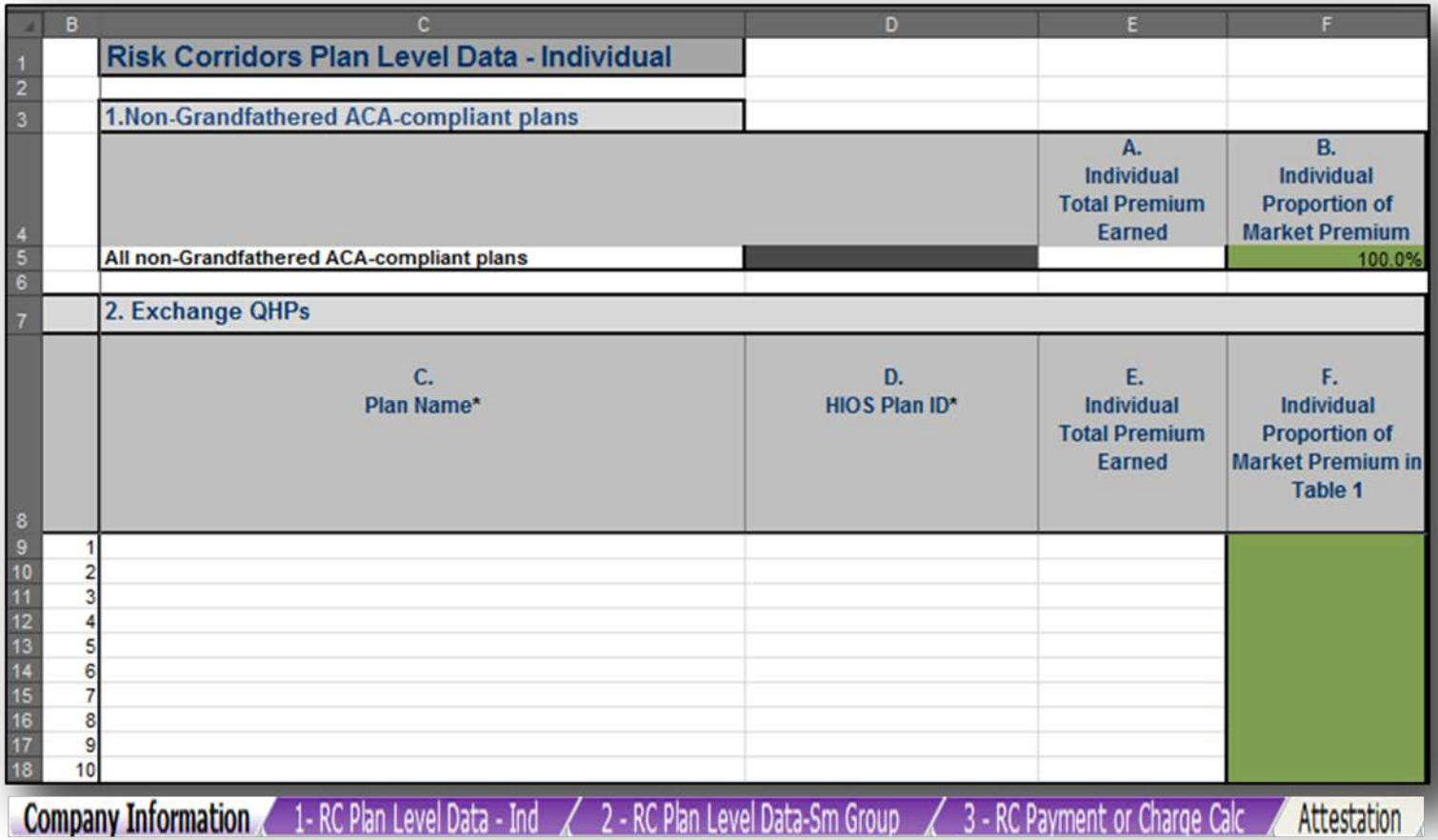


RC Plan-Level Data Form Tabs

- Company Information
- 1 – RC Plan-Level Data – Individual Market
- 2 – RC Plan-Level Data – Small Group Market
- 3 – RC Payment or Charge Calculation
- Attestation

Tabs labeled 1- and 2- RC Plan-Level Data collect the same information. One (1) is for Individual Market and one (1) is for Small Group Market.

Overview of the RC Plan-Level Data Template

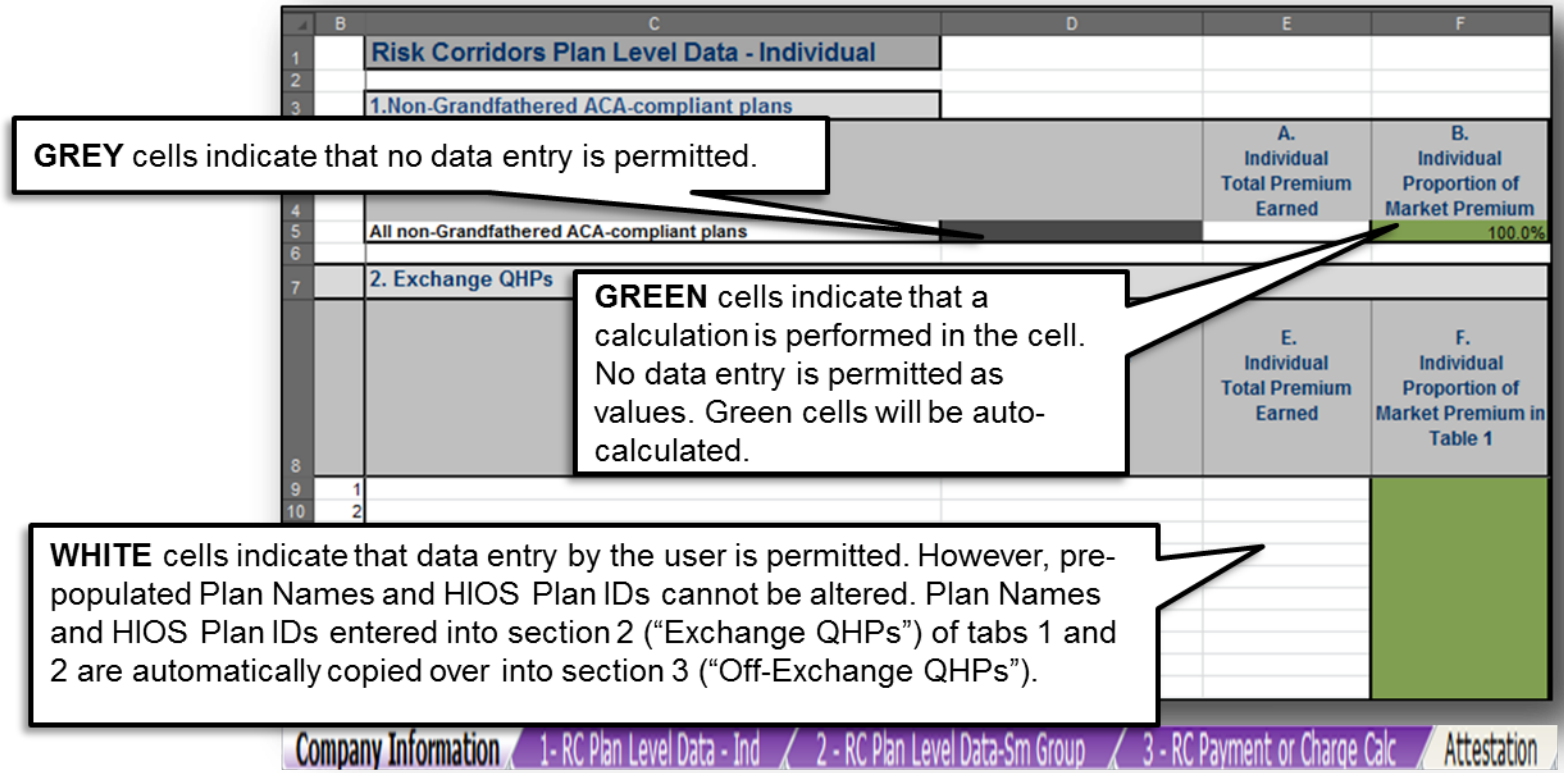


	B	C	D	E	F
1		Risk Corridors Plan Level Data - Individual			
2					
3		1.Non-Grandfathered ACA-compliant plans			
4				A. Individual Total Premium Earned	B. Individual Proportion of Market Premium
5		All non-Grandfathered ACA-compliant plans			100.0%
6					
7		2. Exchange QHPs			
8		C. Plan Name*	D. HIOS Plan ID*	E. Individual Total Premium Earned	F. Individual Proportion of Market Premium in Table 1
9	1				
10	2				
11	3				
12	4				
13	5				
14	6				
15	7				
16	8				
17	9				
18	10				

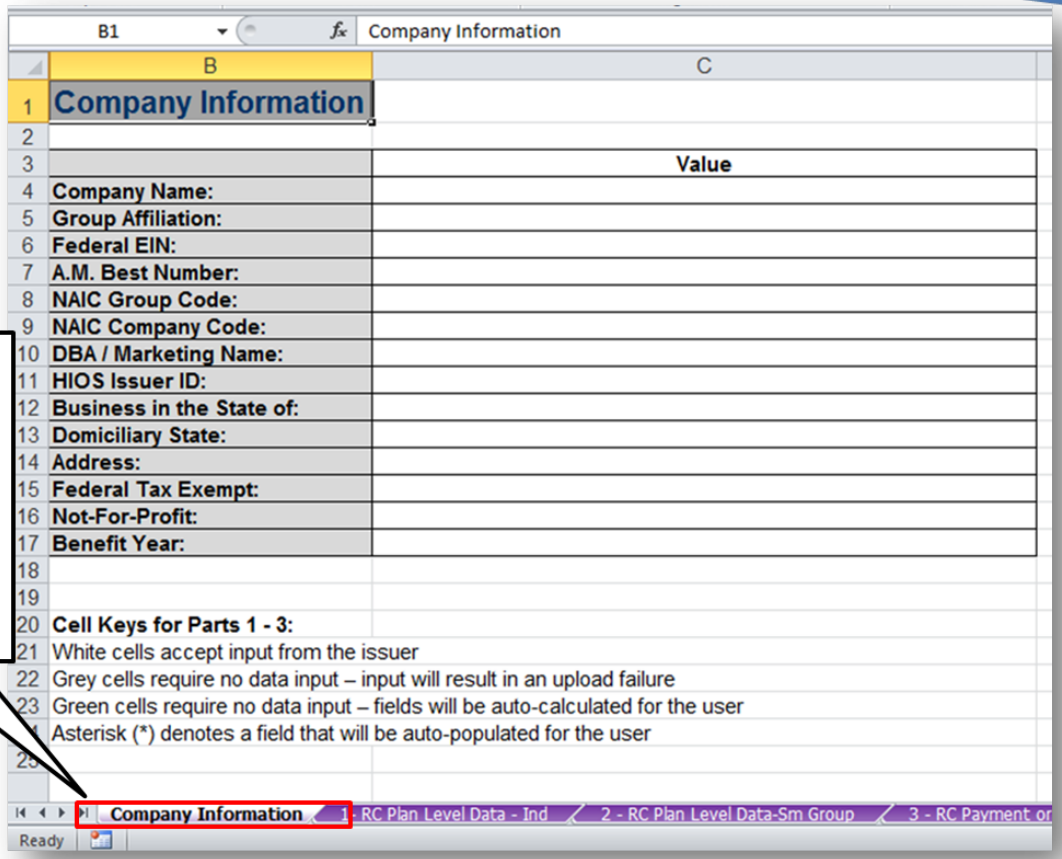
Company Information | 1- RC Plan Level Data - Ind | 2 - RC Plan Level Data-Sm Group | 3 - RC Payment or Charge Calc | Attestation

Overview of the RC Plan-Level Data Template (continued)

- Populate all cells applicable to your block of business. There are general instructions to note on populating the cells based on the color of the cells.



Company Information

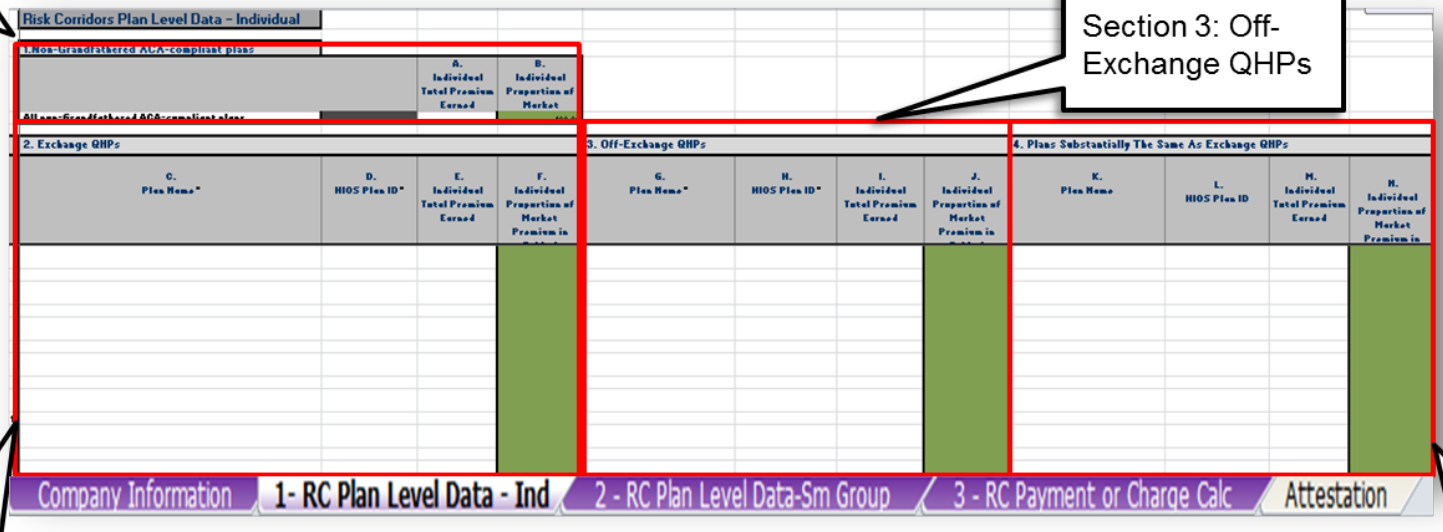


Tab 1 contains Company Information and instructions for Parts 1–3

Company Information is all auto-populated

1-RC Plan Level Data Individual Market

Section 1: Non-Grandfathered ACA-compliant plans



Section 3: Off-Exchange QHPs

Section 2: Exchange QHPs

Section 4: Plans substantially the same as Exchange QHPs

Section 1: Non-Grandfathered ACA-Compliant Plans

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Risk Corridors Plan Level Data - Individual			
1.Non-Grandfathered ACA-compliant plans			
		A. Individual Total Premium Earned	B. Individual Proportion of Market Premium
All non-Grandfathered ACA-compliant plans		$ 8,525,000	100.0%

- ACA-compliant plans are plans that were compliant with ACA market rules, single risk pool, and premium rating rules in 2015.

- Column A requires input from user.
- Column A is the issuer's total earned member premium for the individual market.

- Column B is auto-populated with 100%.

Section 2: Exchange QHPs

- This column is auto-populated for the issuer and will be the same marketing name and Plan ID that is provided in HIOS.
- This column **cannot** be blank if data is entered in Column E for the same row.

- The 14-digit HIOS standard component ID for each plan that the issuer offers through the Exchange.

2. Exchange QHPs

C. Plan Name*	D. HIOS Plan ID*	E. Individual Total Premium Earned	F. Individual Proportion of Market Premium in Table 1
ABC Gold-500	67890UT1234567	$ 500,000	5.9%
ABC Gold-1000	67890UT1234568	-	0.0%
ABC Gold-1500	67890UT1234569	1,000,000	11.7%
ABC Silver-2500	67890UT1234570	1,600,000	18.8%
ABC Silver-3000	67890UT1234571	$ 1,000,000	11.7%
ABC Silver-3500	67890UT123	$ 500,0	
ABC Catastrophic-5000	67890U	$ 1,000,0	

- Enter “0” where the issuer does not have relevant information related to premium earned because there is no plan operating under the HIOS Plan ID; or auto-populated HIOS IDs in Column D are no longer certified, have no enrollment, issuer has consolidated with another plan, or the issuer is not actively marketing.
- If plan names and HIOS Plan IDs are manually added in columns C and D, the issuer should enter a value other than “0” or blank in this column.

- This column is the proportion of individual market total premium earned attributable to the HIOS Plan ID in column D.
- Column F equals Column E divided by Column A, and will be auto-populated.

Section 3: Off-Exchange QHPs

- This column is auto-populated for the issuer and will be the same marketing name and Plan ID that is provided for the Plan ID in HIOS.
- The HIOS Plan ID in Column H is auto-populated based on the Exchange QHP Plan ID in Column D.

- This column is the proportion of individual market total premium earned attributable to the HIOS Plan ID in column H.
- This column equals Column I divided by Column A for individual plans and will be auto-populated.

3. Off-Exchange QHPs

G. Plan Name*	H. HIOS Plan ID*	I. Individual Total Premium Earned	J. Individual Proportion of Market Premium in Table 1
ABC Gold-500	67890UT1234567	$ 25,000	0.3%
ABC Gold-1000	67890UT1234568		
ABC Gold-1500	67890UT1234569		
ABC Silver-2500	67890UT1234570		
ABC Silver-3000	67890UT1234571		
ABC Silver-3500	67890UT12345[illegible]		
ABC Catastrophic-5000	67890UT12[illegible]	$ 100,000	1.2%

- This column will be auto-populated for the issuer and will include the Plan IDs of all plans offered off the Exchange that are identical to Exchange plans registered in HIOS.

- This column is the total premium earned for the HIOS Plan ID in Column H.
- In some cases, HIOS plan IDs auto-populated in Column H may correspond to an Exchange HIOS Plan ID in Column D that is no longer in use (see Section 2).
- If "0" or blank entered in Column E (Section 2), enter "0" or blank in Column I.
- If the off-Exchange HIOS plan ID is not in use, enter "0" or "blank" in Column I.

Section 4: Plans Substantially the Same as Exchange QHPs

- The 14-digit HIOS standard component ID for each off-Exchange plan that the issuer offers that is substantially the same as the Exchange plan.
- Input the HIOS plan ID for the substantially similar plan in Column L in the same row as the corresponding Exchange HIOS plan ID that is represented and auto-populated in Column D.
- A HIOS Plan ID **cannot** be offered in both the individual and small group markets.

- This column is the total premium earned for the HIOS Plan ID in Column L.

4. Plans Substantially The Same As Exchange QHPs

K. Plan Name	L. HIOS Plan ID	M. Individual Total Premium Earned	N. Individual Proportion of Market Premium in Table 1
ABC Healthfirst	67890UT3456789	$ 800,000	

- The marketing name associated with the plan that is identified by its HIOS plan ID in Column L.
- This column requires manual input from issuer.
- This column cannot be blank if data is entered in Column M for the same row.

- This column is the proportion individual market total premium earned attributable to the HIOS Plan ID in Column L.
- This column equals Column M divided by Column A for individual market plans and will be auto-populated.

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3 – RC Payment or Charge Calculation

- The QHP issuer ignores either Column A or Column B if it does not participate in that market.

Risk Corridors Payment or Charge Calculation

	A. Individual	B. Small Group
1 - Total percentage of market premium in QHPs For Ind (Tab 1, Column F + Column J + Column N), or For SmGrp (Tab 2, Column F + Column J + Column N)	76.5%	100.0%
2 - Risk corridors allowable costs (MLR Reporting Form, Part 3, Line 3.1)	$7,380,000	$325,000
3 - Risk corridors adjusted target amount (MLR Reporting Form, Part 3, Line 3.7)	$7,525,000	$340,000
4 - Adjusted risk corridors ratio (Line 2 / Line 3)	98.1%	95.6%
5 - Risk corridors aggregate payment or charge calculation by market	$0	($2,400)

1 - This total is auto-calculated for the issuer and is calculated separately for individual and small group markets.
2 - Represents the numerator of the risk corridors ratio (equal to claims costs adjusted for quality expenses, net premium stabilization payments, and CSR payments).
3 - Represents the denominator of the risk corridors ratio (equal to premiums adjusted for taxes, admin costs, and profit). Includes transitional adjustment.
4 - Value is auto-calculated for issuer. This equals Line 2 divided by Line 3.
5 - Value is auto-calculated for issuer.

3 – RC Payment or Charge Calculation (continued)

Risk Corridors Payment or Charge Calculation	A. Individual	B. Small Group
6 - Risk corridors payment expected from HHS or charge payable to HHS (Line 1 x Line 5)	$0	($2,400)
7 - [FOR MLR] Risk corridors unadjusted target amount (MLR Reporting Form, Part 3, Line 3.7)	$7,800,000	$332,000
8 - [FOR MLR] Unadjusted risk corridors ratio (Line 2/ Line 7)	94.6%	97.9%
9 - [FOR MLR] Risk corridors aggregate payment or charge calculation by market without adjustment	($93,000)	$0
10 - [FOR MLR] Risk corridors payment or charge amount used for MLR calculation (Line 1 x Line 9)	($71,182)	$0

6 – Represents the RC payment an issuer expects to receive from HHS or is required to pay to HHS. This equals Line 1 x Line 5.
7 – Value is auto-calculated for issuer.
8 – Value is auto-calculated for issuer and equals Line 2 divided by Line 7.
9 – Value is auto-calculated for issuer. The user will input this amount in Part 3 of the MLR Reporting Form, line 3.11.
10 – Represents the RC amount the user will report in its MLR calculation. Value is auto-calculated for issuer and equals Line 1 x Line 9. The user will input this amount in Part 3 of the MLR Reporting Form, line 3.12.

Attestation Tab

The Attestation tab can be completed by typing the Chief Executive Officer (CEO)/President and Chief Financial Officer (CFO) names in the lines below the statement.

A
Attestation Statement
The party submitting this form attests as follows: (1) he or she is a duly authorized officer of the reporting issuer, and (2) this Risk Corridors Plan-level Data form, the Company/Issuer Associations, and any supplemental submission or related filings for the Risk Corridors benefit year are true, complete, and accurate statements, to the best of his or her knowledge, information and belief, of all the elements therein.
_____
Chief Executive Officer/President
_____
Chief Financial Officer

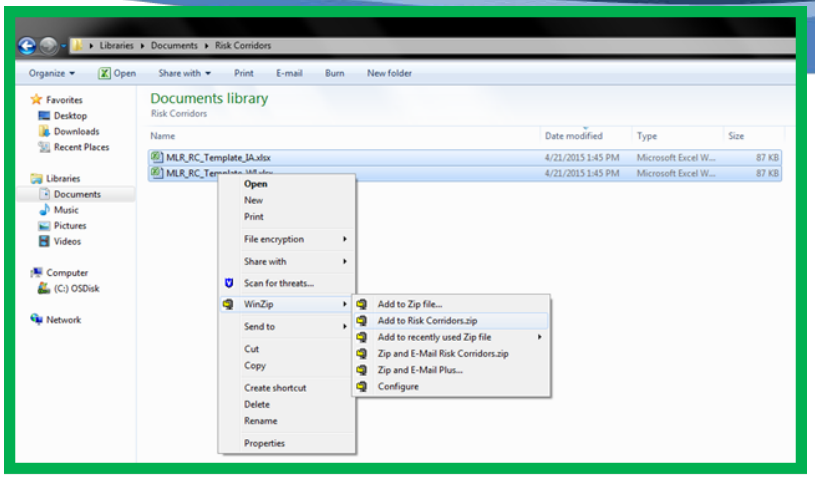
RC Plan-Level Data Form Instructions

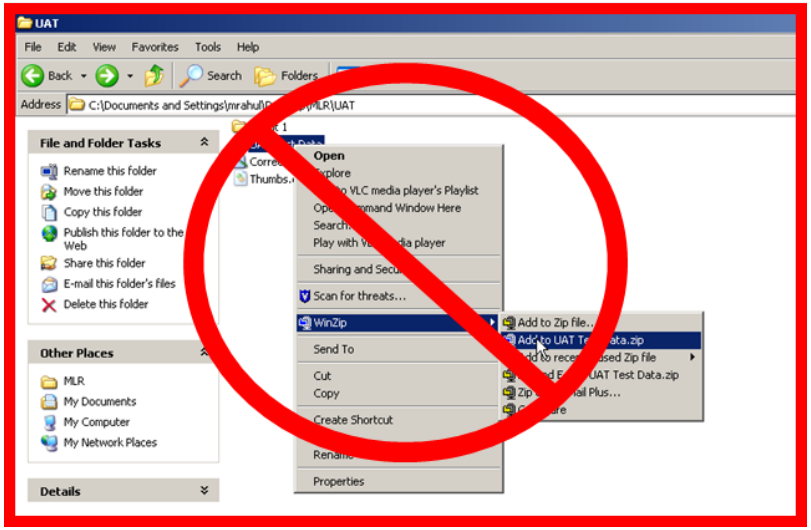
- Submitters **MUST** upload the MLR 2015 Annual Reporting Form for **before** uploading the RC Plan-Level Data Form.
  - RC zip file uploads will be allowed after the full MLR attestation has been completed.
  - Failure to take this step will result in a submission error and the RC Plan-Level Data Form will not be uploaded or processed.

Combining Completed Risk Corridors Templates into Zip File

Issuers must combine all completed Risk Corridors Plan-Level Data templates into a single zip file:

- **CORRECT:** Open the folder. Select all Excel files. Right-click on the selected files, choose “WinZip” and “Add to Zip file…” option, and type a file name at the end of the directory.
  - **Note:** No spaces are allowed in the zip file name.
- **INCORRECT:** Do **NOT** zip the files at the folder level. Files will fail to upload.

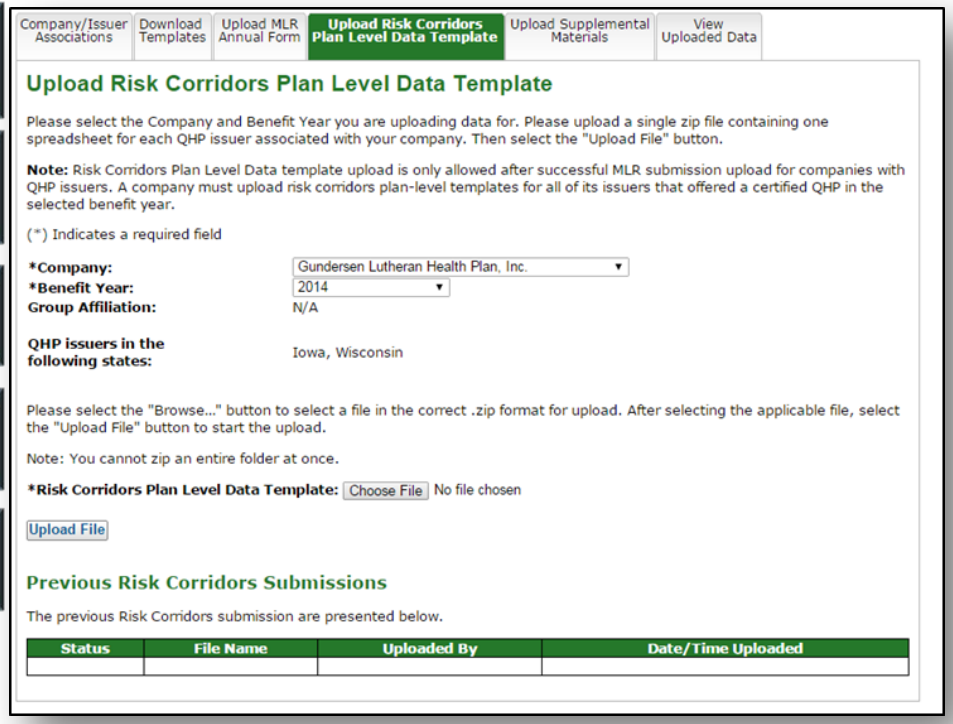




Uploading the RC Template Zip File

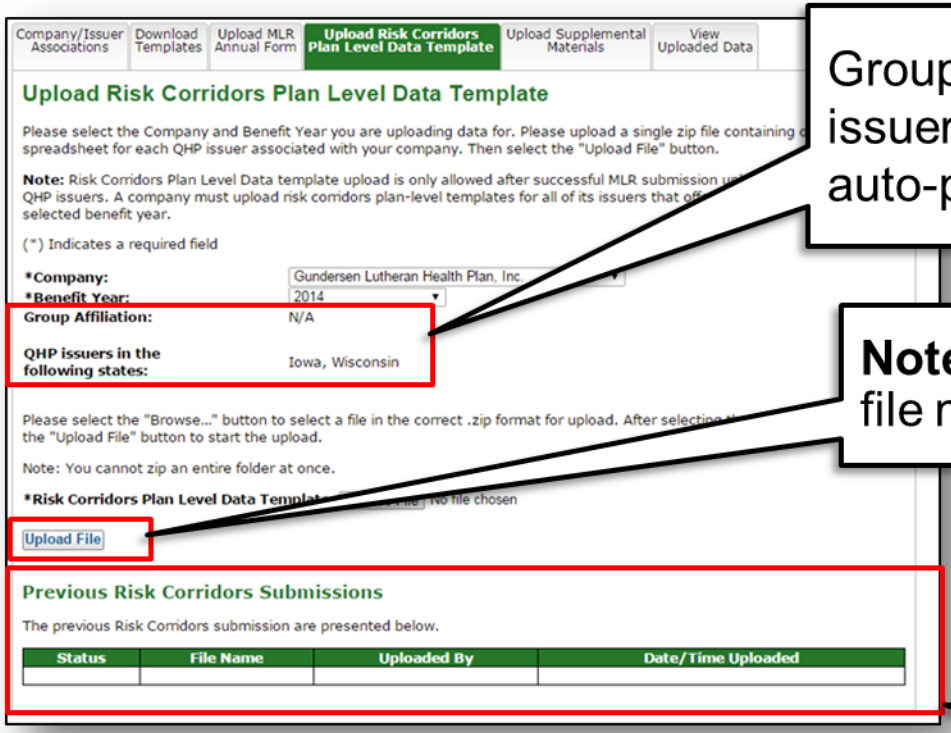
- RC Plan-Level Data template upload is only allowed after successful MLR submission upload for companies with QHP issuers.

1. Select the "Upload Risk Corridors Plan-Level Data template" tab
2. Select the "Company"
3. Select the "Benefit Year"
4. Click "Choose File" and select the zip file you created
5. Click "Upload File"



The system will indicate that the RC Plan-Level data has been uploaded, pending validation checks.

Uploading the RC Template Zip File



Group Affiliate and QHP issuers section will be auto-populated.

Note: No spaces are allowed in the zip file name.

A table is shown at the bottom of the page, displaying all previously uploaded RC submissions.

Processing Uploaded RC Templates

- Once Upload File button has been clicked, a confirmation message displays on the Upload RC Plan-Level Data Template tab indicating that the file uploaded.
- Each zip file goes through system validations when processing.
- Once a file completes system validation, which checks for errors and warnings within the zip file, users receive an email notification alerting them to whether the file successfully submitted or submitted with warning(s) validation.
- If the upload fails, the identified Uploaders will receive an email indicating the reasons why the upload has failed.
- Once successfully uploaded, the RC Plan-Level data will be ready for attestation.

Data Submission Errors and Warnings

- There are a number of errors that may be displayed immediately on the Upload RC Plan-Level Data Template tab in the user interface.

  Example: The user attempted to upload a file with an extension other than '.zip', such as a Word or Excel document, and then selects the '**Upload File'** button.

- Each zip file uploaded is validated within HIOS, to determine if there are any validation errors. Errors prevent successful upload. Users will receive an email from HIOS with a list of errors if their submission has failed processing.

  Example: The user reported individual QHP premiums that add up to more than the user-reported amount for total Affordable Care Act-compliant market premium.

Data Submission Errors and Warnings (continued)

- The HIOS validation process may identify warnings in an upload that the user should examine. Users will receive an email with all warnings and errors that apply to an upload.
- Unlike error messages, warning messages do not prevent uploads from being successfully processed.

  Example: The user may have uploaded a zip file that did not include templates for all QHP issuers that are registered for the company in HIOS for 2015.

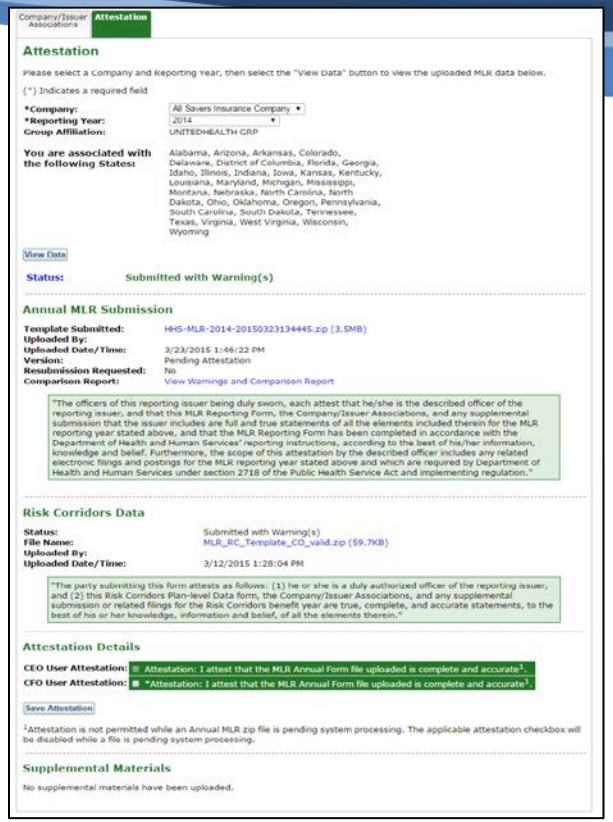
** This is not a comprehensive list of data submission errors and warnings. Instead, it is intended to provide illustrative examples. CMS encourages issuers to view the HIOS MLR Company User Manual for further guidance.*

Final Attestation Process

- If the company has QHP issuers, the RC Plan-Level Data Form and the MLR Reporting Form must be uploaded successfully before Attestation can occur.
- If the upload(s) generated validation warnings, the Attesters and Uploaders will need to determine if the data submitted is valid. If so, the Attesters should proceed with the attestation process.
- The CEO Attester and CFO Attester must both attest to accuracy of the uploaded MLR data, Risk Corridors Plan-Level data, and supplemental materials in order for the filing to be complete.

Attest to Accuracy of Uploaded MLR Data, RC Plan-Level Data

1. Select the "Attestation" tab from the MLR System homepage
2. Select the "Company"
3. Select the "Reporting Year"
4. Click "View Data"
5. Select the checkbox that indicates that you attest to the accuracy of the MLR data.
6. Select the "Save Attestation" Button



There will be one (1) checkbox for the CFO and one (1) for the CEO. Both must complete the process in order for the status to change to Attested.

Post-Submission Data Validation

- Due to data quality issues identified in 2014 benefit year data risk corridors submissions, CMS conducted extensive risk corridors data validation in the late summer/fall of 2015.
- Based on our results from data validation for the 2014 benefit year, **we do not anticipate as extensive a data validation process, and do not anticipate requiring most issuers to submit additional information to HHS for the 2015 benefit year.**
- CMS will analyze 2015 benefit year submissions for outliers in which claims and/or premium differences between EDGE and risk corridors submissions are greater than expected.

Post-Submission Data Validation (continued)

- The following elements were compared between issuers' 2014 MLR/risk corridors and EDGE server data submissions:
  - Percent difference between risk corridor and EDGE server premium.
  - Percent difference between risk corridor and EDGE server claims (individual market only).
  - Claims incurred but not reported (IBNR) as a percent of total claims.

Post-Submission Data Validation (continued)

- CMS understood that premium and claims amounts reported for risk corridors would not exactly match the EDGE server submission, but had identified greater than expected differences that indicated that issuers needed to scrutinize their submissions.
- CMS required certain issuers that had significant discrepancies between EDGE and risk corridors data submissions to quantify the amount of the discrepancy and submit written information or financial information, if necessary, stating to CMS to explain these differences.

Post-Submission Data Validation (continued)

2014 Claims Discrepancy Categories

- Capitation – Internal Pricing Methodology and Amount Attributable
- Orphan, Rejected and Claims not loaded to the EDGE server
- Paid Claims for Hospital Stays That Crossed Benefit Years (not already included in IBNR)

2014 Premium Discrepancy Categories

- Difference between Premium Billed and Earned in 2014
- Premium Not Collected for QHP Enrollees during the Grace Period
- Premium Impact Resulting from Retroactive Enrollment Changes after the EDGE server submission Deadline
- Partial Month Proration Differences

Post-Submission Data Validation (continued)

- Our experience from the data validation process revealed that there was some misunderstanding of certain critical data submission instructions.
- CMS requested issuers to correct and resubmit their data if—
  - The issuer identified errors or unexplainable anomalies in its data submission and could not explain the discrepancies between their data submissions; or
  - The issuer failed to comply with critical RC and MLR data submission instructions.

Post-Submission Data Validation—Observations from 2014

- A high percentage of claims differences between EDGE server and risk corridors submissions could be explained through the categories identified above.
- Premium differences were often not accounted for fully through the identified categories.
- A number of issuers did not follow the guidance and instructions that CMS provided for reporting RC premiums.

Post-Submission Data Validation—Observations from 2014 (continued)

Common premium reporting mistakes:

- Not reporting RC premium for ACA-compliant business only.
- Not reporting total ACA-compliant premium on the risk corridors plan level data form that matches the premium amount reported in the risk corridors columns (4A and 7A), Part 3, Line 2.1 of the MLR reporting form.
- Excluding APTC amounts from premium reported for RC.

Post-Submission Data Validation—Changes Implemented for 2015

- Issuers will receive a validation error through HIOS that will prevent upload of risk corridors data if:
  - Allowable costs on the risk corridors plan-level data form that does not match MLR reporting form (Part 3, Line 3.1).
  - Adjusted target amount on the risk corridors plan-level data form that does not match MLR reporting form (Part 3, Line 3.5).
  - Unadjusted target amount on the risk corridors plan-level data form does not match the MLR reporting form (Part 3, Line 3.7).

Post-Submission Data Validation—Next Steps

- Issuers with data inconsistencies in the 2015 reporting cycle that have not corrected or sufficiently explained these inconsistencies will be targeted for audit.
- Similar to the 2014 benefit year reporting cycle, all issuers will be required to confirm that their 2015 submissions conform to a “checklist” of critical reporting requirements.
- CMS will compare 2015 risk corridors claims and premiums to 2015 EDGE server claims and premiums to identify outliers.
  - The outlier threshold will be higher for claims than for premiums.

Post-Submission Data Validation—Next Steps (continued)

- Issuers that are identified as outliers will be notified and asked to examine their submissions, make corrections, and resubmit as necessary.
- If errors or significant inconsistencies remain, CMS may target the issuer for audit.

Questions?

To submit questions by phone:

- *Dial '*#' (star-pound) on your phone's keypad to enter the phone queue*
- *Dial '*#' (star-pound) on your phone's keypad to exit the phone queue*

Resources

Resources

Forms and Instructions	Resource Link
Risk Corridors 2015 Plan-Level Data Form	https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2015-Risk-Corridors-Plan-Level-Form-2016-03-23.xlsx
Risk Corridors 2015 Plan-Level Data Form Instructions	https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2015-Risk-Corridor-Plan-Level-Instructions-2016-05-09.pdf
MLR 2015 Annual Reporting Form	https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2015-MLR-Reporting-Form-2016-05-10.xlsx
MLR 2015 Annual Reporting Form Instructions	https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2015-MLR-Form-Instructions-2016-05-08.pdf
MLR 2015 Calculator and Formula Tool	https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2015-MLR-Calculator-20160512-FINAL.XLSM

Resources (continued)

Regulations and Guidance	Resource Link
Risk Corridors Program Regulations and Guidance	http://www.cms.gov/cciio/Resources/Regulations-and-Guidance/index.html#Premium_Stabilization_Programs
MLR Program Regulations and Guidance	http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html#MedicalLossRatio
HHS Notice of Benefit and Payment Parameters for 2017 (81 FR 12204)	https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf

Resources (continued)

Other Resources	Resource Link
The Center for Consumer Information & Insurance Oversight (CCIIO) web page	http://www.cms.gov/cciio
Registration for Technical Assistance Portal (REGTAP) - presentations, FAQs	https://www.REGTAP.info
Patient Protection and Affordable Care Act (ACA)	http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html

Locating Documents in REGTAP

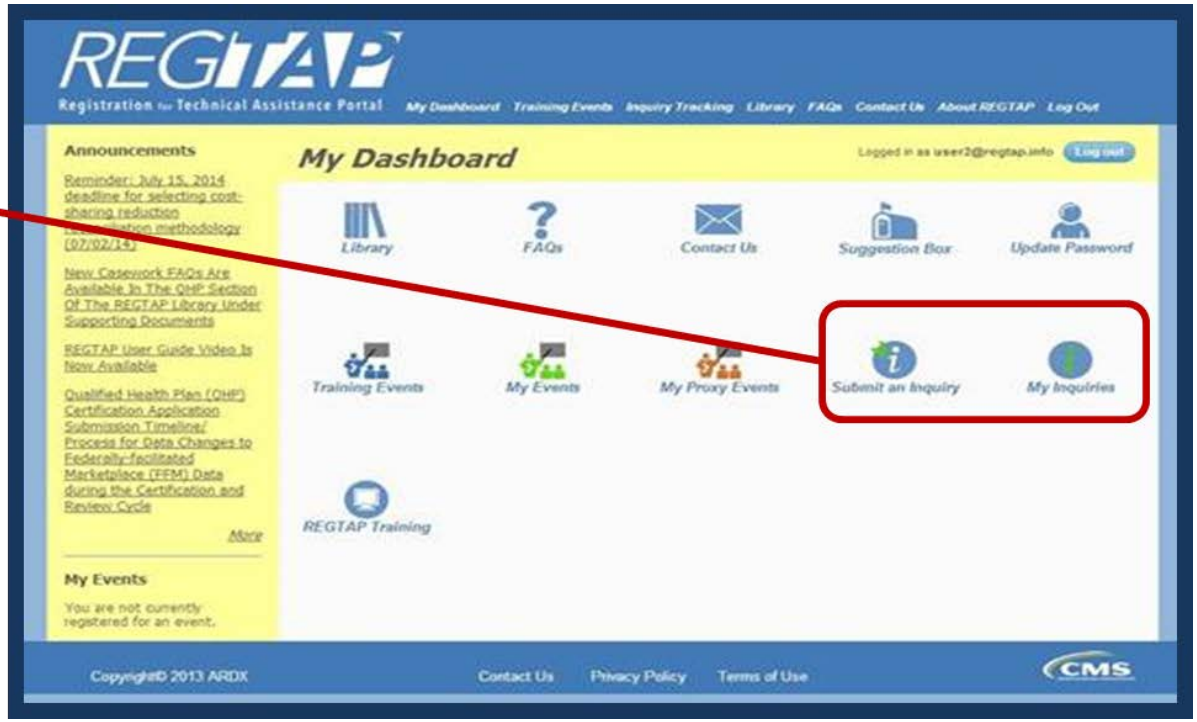
Stakeholders can access additional documents at https://www.REGTAP.info in the REGTAP Library.

Under Program Area, select 'Risk Corridors'

Inquiry Tracking and Management System (ITMS)

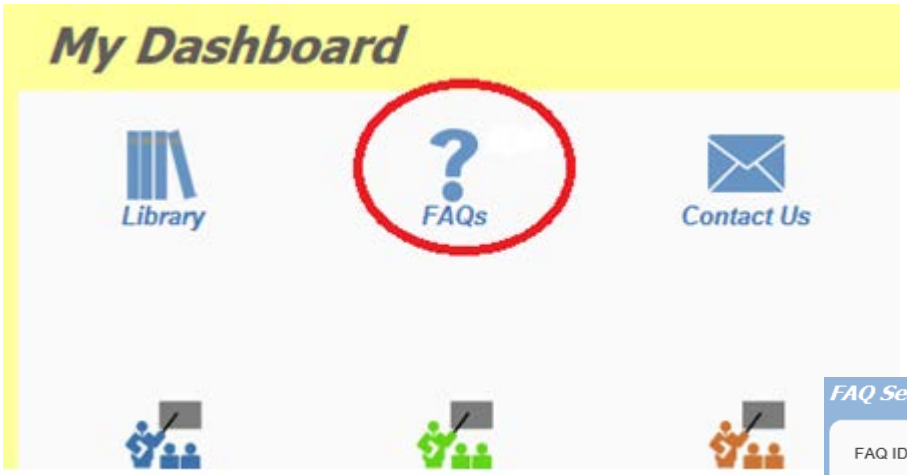
Stakeholders can submit inquiries to https://www.REGTAP.info through ITMS.

Select 'Submit an Inquiry' from My Dashboard.

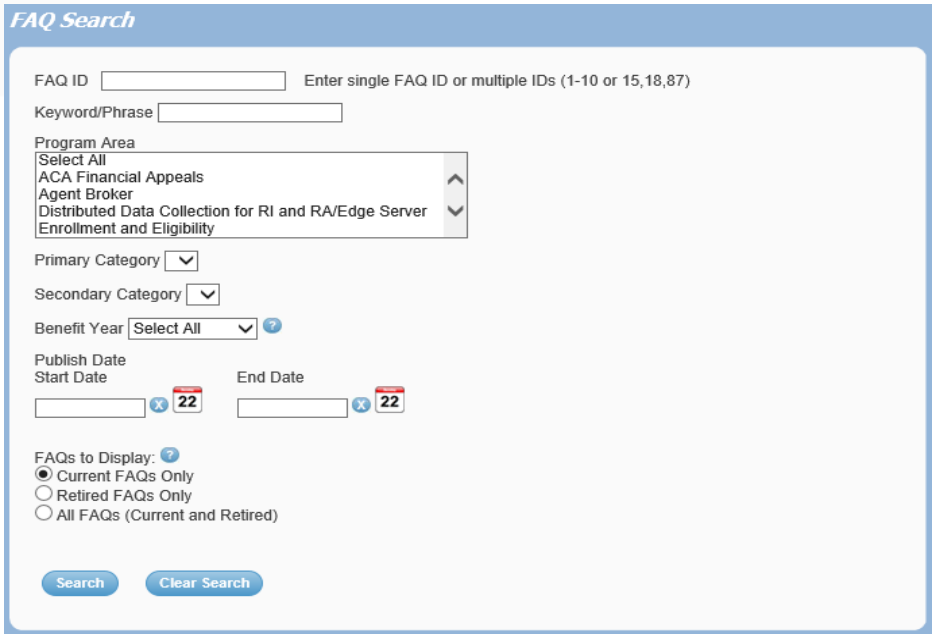


Note: Enter only one (1) question per submission.

FAQ Database on REGTAP



The FAQ Database allows users to search FAQs by FAQ ID, Keyword/Phrase, Program Area, Primary and Secondary Categories, Benefit Year, Retired and Current FAQs and Publish Date.



FAQ Database is available at https://www.regtap.info/

Closing Remarks

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: September 9, 2015

Subject: Risk Corridors Payments for 2015

Section 1342 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (HHS) to establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Marketplace. This program, which was modeled after a similar program used in the Medicare prescription drug benefit, encouraged issuers to keep their rates stable as they adjusted to the new health insurance reforms in the early years of the Marketplaces.

Under the risk corridors program, the federal government shares risk with QHP issuers – collecting charges from the issuer if the issuer's QHP premiums exceed claims costs of QHP enrollees by a certain amount, and making payments to the issuer if the issuer's premiums fall short by a certain amount, subject to certain adjustments for taxes, administrative expenses, and other costs and payments. On April 11, 2014, HHS issued a bulletin titled "Risk Corridors and Budget Neutrality," which described how we intend to administer risk corridors over the three-year life of the program. We stated that if risk corridors collections for a particular year are insufficient to make full risk corridors payments for that year, risk corridors payments for the year will be reduced pro rata to the extent of any shortfall.

Today, HHS is announcing preliminary information about risk corridors for the 2015 benefit year. Risk corridors submissions are still undergoing review and complete information on payments and charges for the 2015 benefit year is not available at this time. However, based on our preliminary analysis, HHS anticipates that all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments. HHS expects to begin collection of risk corridors charges and remittance of risk corridors payments on the same schedule as last year. Collections from the 2016 benefit year will be used first for remaining 2014 benefit year risk corridors payments, then for 2015 benefit year risk corridors payments, then for 2016 benefit year risk corridors payments.

As we have said previously, in the event of a shortfall for the 2016 benefit year, HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. HHS will record risk corridors payments due as an obligation of the United States Government for which full payment is required.

We know that a number of issuers have sued in federal court seeking to obtain the risk corridors amounts that have not been paid to date. As in any lawsuit, the Department of Justice is vigorously defending those claims on behalf of the United States. However, as in all cases where there is litigation risk, we are open to discussing resolution of those claims. We are willing to begin such discussions at any time.