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-P)

Regulatory Impact Analysis

Center for Consumer Information & Insurance Oversight

March, 2012

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.[1] 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.

[1] Please note the provisions of Premium Stabilization rule will be finalized separately and material below reflects the provisions of that rule, as proposed. This material will be updated when the Premium Stabilization rule is finalized.

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.[2] Third, two proposed regulations were published in the **Federal Register** on July 15, 2011 (76 FR

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

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).

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.[3]

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

[3] Congressional Budget Office, "CBO's Health Insurance Simulation Model: A Technical Description," (2007, October).

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.[4]

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 FY 2012 - 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

[4] 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.

not score the impact of risk corridors and assumed collections would equal payments to plans and would therefore be budget neutral.[5]

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 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[6]	---	---	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

[5] Please see Section V for a more thorough discussion on the potential impact of risk corridors.
[6] 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)

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 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.[7] 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 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.[8] 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

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

[8] Lee, C. et al. "The importance of examining movements within the US health care system: sequential logit modeling". *BMC Health Services Research*. 2010; 10: 269-276

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.[9] Uninsured adults are less likely than insured adults to have regular checkups, recommended health screening services and a usual source of care to help manage their diseases.[10] 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.[11] 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.[12]

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.[13]

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

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[9] Institute of Medicine. "Care within Coverage: Too Little, Too Late," Washington DC: National Academy Press, 2002

[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] 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

[12] Finkelstein, A et al. "The Oregon Health Insurance Experiment: Evidence from the First Year". *NBER Working Paper* No. 17190, (July 201)

[13] 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.

coverage.[14] 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.[15]

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 percentage of individuals reporting that they had a personal doctor.[16] 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.[17]

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.[18] 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.[19] Data from National Health and Nutrition Examination Survey (NHANES) was used in one 2005 study to estimate that

[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.
[15] 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.
[16] Kolstad, JT, Kowalski, AE. "The impact of health care reform on hospital and preventive care: evidence from Massachusetts." *NBER Working Paper* 16012 (May 2010)
[17] 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).
[18] Wilper,AP et al. "Health insurance and mortality in US adults." .*American Journal of Public Health*. 99. 2009: 1-7
[19] Doyle, JJ. " Health Insurance, treatment and outcomes: using auto accidents as health shocks." National Bureau of Economic Research. *NBER Working Paper* 11099 (February, 2005).

44,789 deaths among non-elderly adults could be attributed to lack of health coverage.[20] Lack of insurance coverage has been associated with additional mortality and lost workplace productivity.[21] An Institute of Medicine (IOM) study concluded that having insurance leads to better clinical outcomes for diabetes, cardiovascular disease, end-stage renal disease, HIV 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.[22] 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.[23] 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.[24]

Health Insurance Improves Financial Security

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[20] Wilper,AP et al. "Health insurance and mortality in US adults." .*American Journal of Public Health*. 99. 2009: 1-7

[21] 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.

[22] 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.

[23] 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.

[24] Decker,SL. 2005 " Medicare and the Health and Women with Breast Cancer." *Journal of Human Resources*. 40 (4). 2005: 948-968

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.[25] 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 with prior research showing the high level of financial insecurity associated with lack of insurance coverage.[26] 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.[27] 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.[28]

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

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[25] Finkelstein A, McKnight R. "What Did Medicare Do (And Was It Worth It)?" *Journal of Public Economics*. 92. 2008 :1644-1669

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

[27] 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.

[28] Cook K et al. "Does major illness cause financial catastrophe?" *Health Service Research*. 45 (2): 2010

was a significant reduction in the charges to the individual for services after enrollment.[29] Additionally, a recent study indicated that a 10-percentage point increase in eligibility for Medicaid coverage reduces personal bankruptcies by 8 percent.[30]

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.[31] Most of these bills are never paid, suggesting that 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.[32] 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.[33]

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

[29] Howell, E.M. Et al, Evaluation of the San Mateo County Adult Coverage and Systems redesign initiative. Washington DC: Urban Institute 2011

[30] Gross T, Notowidigdo M. "Health insurance and the consumer bankruptcy decision: Evidence from Medicaid expansions." *Journal of Public Economics*. 95 (7-8): 2011

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

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

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

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.[34] There is a reduction in premiums for a constant package of benefits according to CBO's analysis. Consequently, as the 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.[35] 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.[36]

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[34] 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).
[35] Cebul RD et al: Unhealthy insurance markets: search frictions and the cost and quality of health insurance. *American Economic Review*. 1010. 2011: 1842-1871
[36] 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

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.

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

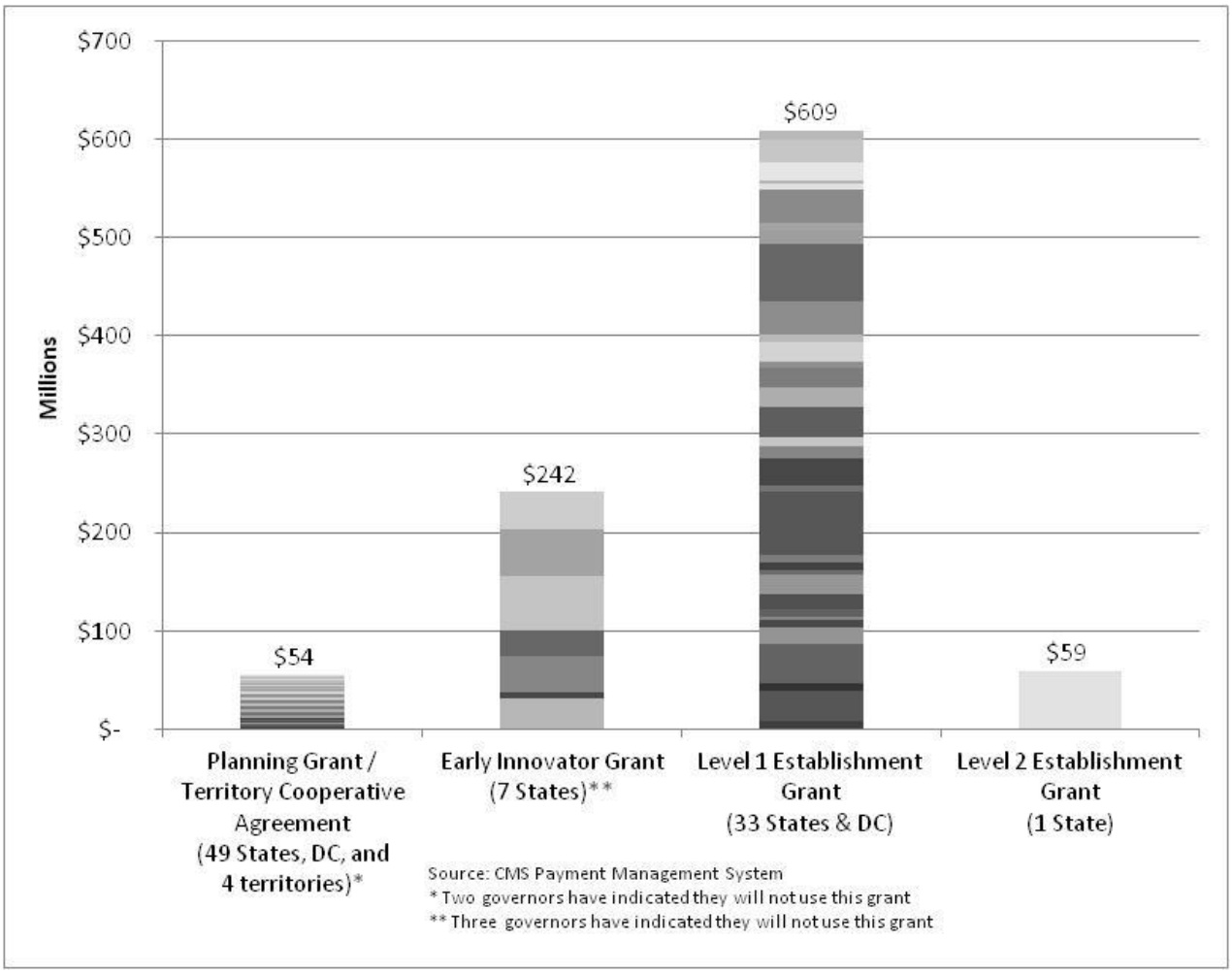
In order for an Exchange to be approved, a State will need to submit an Exchange Blueprint that provides information on how it will meet all of the standards for the approval of an Exchange. We estimate that it will take a State approximately 211 hours for the time and effort needed to develop the Blueprint 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.[37] 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, totaling $242 million.[38] 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.

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

Figure 1. State Grant Distribution ($ in millions)



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.[39] 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 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

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

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.[40] In the same year, SHIPs conducted 54,656 public information and outreach events.[41] 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

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

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, 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.[42]

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 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

[42] 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.

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.[43] Currently, 59 percent of small employers with between 1 and 199 employees offer employer-sponsored health insurance coverage.[44] 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 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

[43] 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).
[44] Claxton, G. et al., *Employer Health Benefits, 2011 Annual Survey* (Menlo Park: Henry J. Kaiser Family Foundation, Health Research and Educational Trust, 2011).

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.[45] 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

[45] 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).

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 market, 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 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.[46] 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 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

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

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.[47,48]

[47] Finkelstein A, McKnight R: "What Did Medicare Do (And Was It Worth It)?" Journal of Public Economics 2008, 92 :1644-1669.

[48] 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.

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.[49] 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 payments lag revenues by one quarter. In the aggregate, reinsurance and risk adjustment are

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

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.[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. 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.[51] This

[50]Actuarial Research Corporation, "Reinsurance attachment point estimates," (Annandale2010).
[51] 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.[52]

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

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

standard formats specified by HHS and HHS will seek to leverage existing data reporting as 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.[53] All 40 States with capitated Medicaid Managed Care Organizations collect encounter data from managed care organizations.[54] 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.[55] Reported annual State funding to establish an all-payer claims database system ranges from $350,000 to $2 million.[56] 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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[53] 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).
[54] Office of the Inspector General. Medicaid Managed Care Encounter Data: Collection and Use. (2009).
[55] Miller, Patrick B, et al. All-Payer Claims Databases. (Robert Woods Johnson Foundation. , 2010).
[56] 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.[57] 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

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

[57] 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.

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, 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.[58] 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.[59]

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 would either meet those standards and thereby be certified or would fail to meet those standards

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

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,[60] 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.

[60] 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.[61] An Urban Institute study estimates that large employer coverage would increase by two percent and small and medium business coverage would be relatively unchanged.[62] A Lewin Group study estimated a net reduction in the number of people with employer sponsored coverage of 2.8 million.[63] Moreover, experience in Massachusetts showed an increase in employer-sponsored insurance following the introduction of its affordable insurance Exchange.[64] 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.

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

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

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

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