



# The Affordable Care Act's Risk Adjustment and Other Risk-Spreading Mechanisms: Needed Support for New Jersey's Health Insurance Exchange

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# **The Affordable Care Act's Risk Adjustment and Other Risk-Spreading Mechanisms: Needed Support for New Jersey's Health Insurance Exchange**

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## **Executive Summary**

The Affordable Care Act includes a number of provisions designed to reduce or eliminate the possibility that the health insurance exchanges the Act establishes will attract a disproportionate number of relatively sick individuals. The most notable of these checks is the individual mandate requiring that most individuals secure health insurance. Risk concentration may still occur, however, including as a result of the phenomenon known as adverse selection.

This policy brief sets forth the provisions of the Affordable Care Act that are expected to have an effect on adverse selection, as well as steps states have taken to prevent it from occurring. The brief then describes the Affordable Care Act's risk adjustment, reinsurance, and risk corridor provisions, and the corresponding provisions of the implementing regulations, all of which are designed to correct for any uneven distribution of risk across health plans that does occur, whether due to adverse selection or other causes. To the extent that these risk-distribution mechanisms function as intended, they will encourage insurers to compete on price and quality and not on the relative health of their risk pools.

New Jersey must make a number of choices with regard to the implementation of its reinsurance and risk adjustment programs; the risk corridor program will be run by the federal government. Key decisions New Jersey must make include the following: (1) whether to establish its own reinsurance program, and if so, whether to collect contributions from fully-insured plans or leave that to HHS; (2) if it chooses to establish its own reinsurance program, whether to vary certain federally-set parameters; (3) whether to establish its own risk adjustment program; (4) if it chooses to establish its own risk adjustment program, whether to use a risk adjustment methodology promulgated by HHS or to develop its own methodology for federal certification; (5) whether to coordinate risk adjustment in the individual and small group markets with risk adjustment in Medicaid managed care; and (6) what entity or entities should be responsible for the reinsurance and risk adjustment programs.

The brief concludes by noting that a planning tool New Jersey might employ to sort through its options is the creation of an expert advisory group, which could comprise exchange personnel, staff from the Departments of Human Services and Banking and Insurance,

insurance and reinsurance experts, consumers, and navigators. While HHS is responsible for implementing risk corridors, New Jersey has significant choices to make and will play a central role in the implementation of the state's reinsurance and risk adjustment programs.

# The Affordable Care Act's Risk Adjustment and Other Risk-Spreading Mechanisms: Needed Support for New Jersey's Health Insurance Exchange

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## Introduction

Two central goals of the Affordable Care Act (ACA)<sup>1</sup> are (1) providing individuals with a choice among multiple insurance plans that vary in price as a result of “plan design differences and relative medical and administrative efficiencies” rather than the relative health of their members, and (2) ensuring that private insurance markets remain fiscally sound.<sup>2</sup> To achieve these goals, the Affordable Care Act provides for the establishment of health insurance marketplaces known as exchanges through which individuals and small employers will be able to comparison shop for coverage. To ensure that the exchanges provide consumers with a meaningful choice among plans, the Affordable Care Act includes provisions designed to reduce or eliminate destabilizing over-representation of individuals at high risk for needing medical care in the exchanges or in particular plans within the exchanges.

One way that skewed risk occurs is through adverse selection, a phenomenon that has plagued prior attempts to establish entities similar to the Affordable Care Act's health insurance exchanges.<sup>3</sup> Adverse selection can arise whenever an individual is better able to predict whether an insurable event will occur than is his or her insurance company. To give a classic example, adverse selection would almost definitely arise if homeowners were permitted to wait until their homes were on fire before purchasing homeowner's insurance. In the health insurance context, an individual seeking insurance may know more about his or her personal health and, therefore, the likelihood that he or she will need health care, than the insurance company does. When those who are healthier are able to delay purchasing health insurance or

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<sup>1</sup> For ease of reference, the Patient Protection and Affordable Care Act, Pub .L. No. 111-148, 124 Stat. 119, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, is referred to in this paper as the Affordable Care Act or the ACA.

<sup>2</sup> AMERICAN ACADEMY OF ACTUARIES, RISK ASSESSMENT AND RISK ADJUSTMENT 3 (2010).

<sup>3</sup> SARAH LUECK, CENTER ON BUDGET AND POLICY PRIORITIES, STATES SHOULD STRUCTURE INSURANCE EXCHANGES TO MINIMIZE ADVERSE SELECTION 2 (2010). See also Anemona Hartocollis, *New York Offers Costly Lessons on Insurance*, N.Y. TIMES, Apr. 17, 2010, at A1 (explaining that after New York “require[d] insurers to extend individual or small group coverage to anyone with pre-existing illnesses” and “to charge the same rates for the same benefits” premiums rose, leading healthier customers to drop their coverage, leading premiums to “skyrocket[], a phenomenon known in the trade as the ‘adverse selection death spiral.’”).

decide not to purchase it all, the result can be a pool of insured individuals who are disproportionately likely to be sick. If the insurance company raises premiums as a result of the higher-than-predicted cost of care, relatively healthy individuals are likely to decline or cease to participate, leading to an even sicker insurance pool.

The ACA targets adverse selection in a number of ways, with the goal of minimizing the extent to which the relatively sick will disproportionately purchase insurance through the exchanges, and the extent to which particular health plans inside or outside of the exchanges attract a disproportionate number of sick patients.<sup>4</sup> Despite the checks that the Affordable Care Act puts in place to minimize adverse selection—the most notable of which is the individual mandate requiring that most individuals secure health insurance—adverse selection, and risk concentration, may still occur. For example, selection could occur between plans within a health insurance exchange, if those who expect to be healthy gravitate towards plans with lower actuarial value and concomitant lower cost.

This policy brief sets forth the provisions of the Affordable Care Act that are expected to have an effect on adverse selection, as well as steps states have taken to address the issue. It then reviews the Affordable Care Act's risk adjustment, reinsurance, and risk corridor provisions, and the corresponding provisions of the implementing regulations, all of which are designed to correct for uneven distribution of risk across health plans, whether due to adverse selection or other causes. To the extent that these risk-distribution mechanisms function as intended, they will encourage insurers to compete on price and quality and not on the relative health of their risk pools.<sup>5</sup> By reducing insurers' exposure to random variation in medical costs, these mechanisms will also result in more predictable insurance premiums and a more stable insurance market. Finally, the brief analyzes associated implementation issues and assesses the advantages and disadvantages of divergent risk-distribution approaches, given New Jersey's particular history.

## **The Affordable Care Act's Limits on Adverse Selection**

The Affordable Care Act seeks to encourage insurers to compete on price and quality and to discourage insurers from competing with one another to enroll the healthiest participants. In service of the latter goal, the Act eliminates insurers' ability to engage in medical underwriting, by requiring that insurance be offered on a guaranteed issue<sup>6</sup> and guaranteed renewal<sup>7</sup> basis,

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<sup>4</sup> SHARON SILOW-CARROLL, DIANA RODIN, TOM DEHNER & JAIMIE BERN, COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES: STATE ROLES IN SELECTING HEALTH PLANS AND AVOIDING ADVERSE SELECTION 4-5 (2011).

<sup>5</sup> LUECK, *supra* note 3, at 3.

<sup>6</sup> 42 U.S.C. § 300gg-1.

<sup>7</sup> 42 U.S.C. § 300gg-2.



with no limitations on coverage for pre-existing conditions,<sup>8</sup> and at a premium set without regard to an individual's health status.<sup>9</sup> While New Jersey already has guaranteed issue<sup>10</sup> and modified community rating<sup>11</sup> in its individual and small group markets, it does permit insurers to impose pre-existing condition limitation periods.<sup>12</sup>

Eliminating medical underwriting removes an important check on adverse selection, because individuals will know that if they wait until they get sick to purchase health insurance they will no longer be rejected or have to pay a high, perhaps unaffordably high, premium. The Affordable Care Act's individual mandate squarely addresses this problem. With the mandate in place, individuals will not be permitted to put off purchasing health insurance until they get sick and need health care. The mandate will help ensure that there are a sufficient number of low-risk individuals in the system to prevent a "death spiral" of escalating premiums and an increasingly high-risk, high-cost pool.

The Affordable Care Act also authorizes the Secretary of the United States Department of Health and Human Services (HHS) to provide for an initial open enrollment period and for annual open enrollment periods thereafter, to be supplemented by special enrollment periods under certain circumstances.<sup>13</sup> Limiting enrollment periods puts a brake on adverse selection because it prevents individuals from selecting the least expensive plan available to them with the intention of selecting a different plan with more generous coverage if and when they need medical care. Individuals assume the risk of getting sick and being stuck with their choice of plan until the next open enrollment period.

Other provisions of the Affordable Care Act reduce the possibility of adverse selection against the exchange by reducing the possibility that healthier individuals will gravitate towards products sold outside the exchange. The rule that individuals can only obtain government subsidies to purchase coverage if they purchase insurance through the exchange ensures that individuals with a wide variety of expected health care costs will choose to buy their health insurance through the exchange.<sup>14</sup> Massachusetts similarly required subsidized consumers to purchase through its exchange (the Massachusetts Health Connector) when it implemented its

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<sup>8</sup> 42 U.S.C. § 300gg-3.

<sup>9</sup> 42 U.S.C. § 300gg.

<sup>10</sup> N.J. STAT. ANN. §§ 17B:27A-6(a) & 19(b).

<sup>11</sup> Under New Jersey law, insurers may not vary premiums based on an insured individual's "sex, health status, occupation, geographical location or any other factor or characteristic of covered persons, other than age." N.J. STAT. ANN. §§ 17B:27A-2 & 6(a). "'Health status-related factor' means any of the following factors: health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out of acts of domestic violence; and disability." N.J. STAT. ANN. § 17B:27A-2.

<sup>12</sup> N.J. STAT. ANN. § 17B:27A-7(b).

<sup>13</sup> MARK A. HALL, THE COMMONWEALTH FUND, RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT: A GUIDE FOR FEDERAL AND STATE REGULATORS 3 (2011).

<sup>14</sup> *Id.*

system of near-universal coverage.<sup>15</sup> The Congressional Budget Office (CBO) estimates that of the 20 million people it expects to be buying insurance through exchanges in 2016, 16 million will be subsidized to some extent and therefore likely to purchase through the exchange.<sup>16</sup>

The ACA's tax credits to small businesses will also only be available if the businesses provide coverage through the exchange, although these are expected to be a lesser incentive to participate.<sup>17</sup> The Congressional Budget Office (CBO) predicts that nationwide just 2.9 million employees of small businesses will be covered by insurance purchased through an exchange;<sup>18</sup> the CBO estimates that the total small group market (defined to include only insurance plans sponsored by employers with 50 or fewer employees) will encompass approximately 25 million employees inside and outside the exchange.<sup>19</sup>

The Affordable Care Act sets forth a number of ground rules that apply to individual and small group insurance products regardless of whether they are sold inside or outside an exchange. Leveling the playing field in this way reduces the chance that a price differential will arise between products sold inside the exchange and products sold outside. The universally-applicable rules include, among others:

- the requirement that all insurance plans cover the “essential health benefits package”;<sup>20</sup>
- the prohibitions on annual and lifetime limits on the dollar value of benefits;<sup>21</sup>
- the prohibition of preexisting condition exclusions or other discrimination based on health status;<sup>22</sup>
- the requirement that insurance be offered on a guaranteed issue<sup>23</sup> and guaranteed renewal<sup>24</sup> basis;
- the prohibition on health insurance policy rescissions;<sup>25</sup> and
- the requirement that insurers' medical loss ratio meet or exceed eighty percent.<sup>26</sup>

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<sup>15</sup> SILOW-CARROLL ET AL., *supra* note 4, at 6.

<sup>16</sup> *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act*, CONGRESSIONAL BUDGET OFFICE, <http://cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf> (last visited Mar. 16, 2012).

<sup>17</sup> *Id.*

<sup>18</sup> *CBO's March 2011 Baseline: Health Insurance Exchanges*, CONGRESSIONAL BUDGET OFFICE, <http://www.cbo.gov/budget/factsheets/2011b/HealthInsuranceExchanges.pdf> (last visited Mar. 16, 2012).

<sup>19</sup> Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Honorable Evan Bayh, United States Senate, Nov. 30, 2009, *available at* <http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf>.

<sup>20</sup> 42 U.S.C. §§ 300gg-6(a) & 18022. The term “essential health benefits package” is defined as a plan that (1) covers the essential health benefits prescribed by the Secretary of Health and Human Services, (2) provides one of four standardized levels of benefits which the Affordable Care Act denominates bronze, silver, gold, and platinum, and (3) limits cost-sharing in accordance with the Act.

<sup>21</sup> 42 U.S.C. § 300gg-11.

<sup>22</sup> 42 U.S.C. § 300gg-3.

<sup>23</sup> 42 U.S.C. § 300gg-1.

<sup>24</sup> 42 U.S.C. § 300gg-2.

<sup>25</sup> 42 U.S.C. § 300gg-12.

The new federal rules regarding the factors by which premiums may permissibly vary apply inside and outside the exchange as well. These rules provide that whether a plan is offered inside or outside of an exchange, its premium can only vary based on whether it covers an individual or family, geography (with the geographic regions to be specified by each state), age (and then by no more than a factor of three to one, with the rating bands to be established by the Secretary), and tobacco use (by no more than a factor of one and a half to one).<sup>27</sup>

Another Affordable Care Act provision that will reduce the chance that healthier individuals will gravitate towards products sold outside the exchange is the requirement that issuers “consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.”<sup>28</sup> The same rule applies to the small group market.<sup>29</sup> The significance of the “single risk pool” requirement is that plans that are offered inside and outside the exchange will have the same price regardless of point of access. This will help to prevent adverse selection against the exchange for all plans that are offered both inside and outside the exchange.<sup>30</sup>

Massachusetts likewise requires that insurers consider plans offered inside the Connector to be part of the same risk pool as plans offered outside.<sup>31</sup> In Utah, health insurance companies were initially free to charge different premiums depending on whether a plan was offered inside or outside that state’s exchange.<sup>32</sup> They did so, with some quoting higher prices inside the exchange and some lower.<sup>33</sup> In March 2010, Utah passed legislation that requires health insurers that sell insurance through the exchange to establish a single risk pool and charge the same premium for health insurance plans offered inside and outside of the exchange.<sup>34</sup>

## Adverse Selection in Health Insurance Markets after the Affordable Care Act

Although no one knows for sure whether or how adverse selection will occur after the implementation of the Affordable Care Act, experts have predicted that it could occur in a number of different ways. For example, adverse selection could occur

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<sup>26</sup> 42 U.S.C. § 300gg-18(b).

<sup>27</sup> 42 U.S.C. § 300gg.

<sup>28</sup> 42 U.S.C. § 18032(c)(1).

<sup>29</sup> 42 U.S.C. § 18032(c)(2).

<sup>30</sup> LUECK, *supra* note, 3 at 4.

<sup>31</sup> SILOW-CARROLL ET AL., *supra* note 4, at 11.

<sup>32</sup> *Id.* at 13.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

- between plans within a health insurance exchange,
- between the market for health insurance inside the exchange and the market outside the exchange, or
- between market segments, e.g., between employer-sponsored health insurance and individual, non-group health insurance, or between the small-group and self-insured market segments.

First, adverse selection among plans within the exchange could occur. All things being equal, individuals who anticipate having fewer medical needs are likely to choose lower actuarial value plans with less expensive premiums. Individuals who expect to be high utilizers of medical care are more likely to choose plans with more generous benefits. More surprisingly, high utilizers are also likely “to enroll in the plans with lower cost sharing, *even after the plan design differences are reflected in the premium.*”<sup>35</sup> People who have survived cancer have been shown to prefer plans which offer the best network of cancer doctors.<sup>36</sup> Those with histories of other types of medical problems are likely to behave similarly, gravitating towards plans where those problems would best be addressed, even when there is no reason to believe that the problems will reoccur.<sup>37</sup>

Second, there may be adverse selection against the health insurance exchange. People who are lower risk may congregate in plans sold outside the exchange, while people with higher risk may congregate in plans sold inside the exchange. While insurers who offer insurance inside the exchange are required to treat their enrollees inside the exchange as being in a single risk pool with their enrollees outside the exchange, the Affordable Care Act does not bar insurers from exclusively offering insurance outside the exchange.<sup>38</sup> In addition, while an insurer operating within the exchange is required to offer at least one silver plan and one gold plan, an insurer operating outside the exchange is not.<sup>39</sup>

Outside the exchange, then, an insurer could offer, for example, only a bronze plan. Bronze plans are less comprehensive and will therefore be relatively inexpensive. As a result, they are likely to attract healthier people. Because the single risk pool requirement does not apply to insurers who exclusively offer insurance outside the exchange, to the extent that they are able to attract healthier individuals to their products they will be able to price their products accordingly. This, in turn, could entice more relatively low-risk individuals to leave the exchange.

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<sup>35</sup> AMERICAN ACADEMY OF ACTUARIES, *supra* note 2, at 3 (emphasis added).

<sup>36</sup> HALL, *supra* note 13, at 3.

<sup>37</sup> David Cutler, Bryan Lincoln & Richard Zeckhauser, *Selection Stories: Understanding Movement Across Health Plans*, 29 J. OF HEALTH ECON. 821, 823 (2010).

<sup>38</sup> HALL, *supra* note 13, at 4.

<sup>39</sup> 42 U.S.C. §18021(a)(1)(C)(ii).

Exacerbating the problem is the fact that there are a number of rules, set forth in Section 1311(c) of the Affordable Care Act, that only apply to health insurance plans that are “qualified” to be sold within an exchange.<sup>40</sup> The Secretary can also add to these statutory requirements by regulation.<sup>41</sup> As Sarah Lueck of the Center for Budget and Policy Priorities explains, the additional regulatory burden associated with participating in the exchange “leaves substantial opportunity for adverse selection because insurers in these external markets will effectively be competing for enrollees against the exchange plans, but will not have to comply with standards that are as strict.”<sup>42</sup> In addition to offering both a silver and a gold level plan through the exchange, participating insurance issuers must, among other things, ensure that their network of providers is adequate and includes community providers who serve low-income, medically-underserved populations, and implement a quality improvement strategy.<sup>43</sup> Issuers operating within the exchanges are also forbidden from using marketing practices or benefit designs to discourage individuals with significant health needs from enrolling, while issuers operating outside the exchange can, to the extent compatible with state law,

- design their products with the wants and needs of the relatively healthy in mind (a phenomenon known as “risk classification by design”),<sup>44</sup>
- choose certain physicians and not others for their networks with an eye towards encouraging low-risk patients to enroll and discouraging high-risk patients from enrolling,<sup>45</sup> and
- engage in marketing efforts to the same end.<sup>46</sup>

On the other hand, the Congressional Research Service has noted that insurers may be able to lower their prices for products offered inside the exchange because the exchanges will take over some administrative functions and, thereby, reduce insurers’ overhead expenses.<sup>47</sup>

Adverse selection against the exchanges could also occur if, as Professors Amy Monahan and Daniel Schwarcz warn, employers “implement a targeted dumping strategy designed to induce low-risk employees to retain [their employer-sponsored health insurance (ESI)] but

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<sup>40</sup> 42 U.S.C. § 18031(c).

<sup>41</sup> *Id.*

<sup>42</sup> LUECK, *supra* note 3, at 5.

<sup>43</sup> 42 U.S.C. § 18031(c).

<sup>44</sup> Tom Baker, *Health Insurance, Risk, and Responsibility after the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1607-11 (2011).

<sup>45</sup> In making these choices, issuers operating outside the exchange would be constrained by New Jersey’s regulations governing network adequacy. N.J. ADMIN. CODE § 11:24-6.2.

<sup>46</sup> These marketing efforts would be governed by New Jersey’s statutory provisions governing unfair trade practices. N.J. STAT. ANN. §§ 17B:30-1 et seq.

<sup>47</sup> CHRIS L. PETERSON & BERNADETTE FERNANDEZ, CONGRESSIONAL RESEARCH SERVICE, PPACA REQUIREMENTS FOR OFFERING HEALTH INSURANCE INSIDE VERSUS OUTSIDE AN EXCHANGE 8 (2010). *See also* LINDA J. BLUMBERG, HOW WILL PPACA IMPACT INDIVIDUAL AND SMALL GROUP PREMIUMS IN THE SHORT AND LONG TERM? 4 (2010) (“Administrative costs of insurance should be lower in the small group and non-group markets due to centralized marketing functions performed by the exchanges, reduced churning among small groups in particular, and elimination of insurance underwriting activities.”).

incentivize high-risk employees to voluntarily opt out of ESI and instead purchase insurance through the exchanges[.]”<sup>48</sup> This dynamic, they fear, “could render insurance exchanges unsustainable and thereby jeopardize health insurance reform writ large.”<sup>49</sup>

Finally, there is also the potential for adverse selection against the small-group market as a whole, as a result of small employers with relatively healthy employees choosing to retain “grandfathered” health plans or to self-insure. An employer who self-insures does not purchase a group health insurance policy. Instead, it pays for its employees’ health care directly. In New Jersey, small employers with relatively healthy employees have been encouraged by issuers of stop-loss coverage to leave the state’s Small Employer Health Benefits Program and self-insure instead.<sup>50</sup> Stop-loss policies that have relatively low attachment points and include an “advance funding” feature, meaning that they pay out as soon as an employee meets the stop-loss deductible, function very similarly to traditional health insurance and are particularly likely to be attractive to small employers. In October 2011, Thomas B. Considine, then the Commissioner of the Department of Banking and Insurance, issued a bulletin directing issuers of stop-loss coverage to stop engaging in “selective underwriting” of “groups less likely to incur claims, leaving the groups more likely to incur claims to the state’s guaranteed issue insured market.”<sup>51</sup>

Self-insuring will enable employers to avoid the ACA rules that apply to insurance carriers or insurance plans.<sup>52</sup> For example, a small employer with a relatively healthy work force might choose to self-insure to avoid the Affordable Care Act’s community rating rules, which prevent insurers from offering lower priced plans to employers with lower risk.<sup>53</sup> Employers will be more willing to take on the risk inherent with self-insuring after the Act is fully implemented because, if their claims experience is unexpectedly negative, they will be free to enter the exchange at that point. The ACA also expands the definition of “small” for purposes of the small group market to encompass all employers with 100 employees or fewer.<sup>54</sup> This, too, makes it

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<sup>48</sup> Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?* 97 VA. L. REV. 125, 128 (2011).

<sup>49</sup> *Id.* at 131-32. Professor David Hyman counters that what Monahan and Schwarcz consider a “bug” might in fact be a “feature” of health reform, particularly since for risk classification by design to “‘work,’ Monahan and Schwarcz are clear that it has to make employers and employees better off-both individually and collectively.” David A. Hyman, *PPACA in Theory and Practice: The Perils of Parallelism*, 97 VA. L. REV. 83, 101 (2011).

<sup>50</sup> Memorandum from Thomas B. Considine, Commissioner, State of New Jersey Department of Banking and Insurance, to All Authorized and Admitted Insurers Writing Stop Loss Insurance to Small Employers and All Licensed Producers 1 (Oct. 3, 2011), available at [http://www.state.nj.us/dobi/bulletins/blt11\\_20.pdf](http://www.state.nj.us/dobi/bulletins/blt11_20.pdf).

<sup>51</sup> *Id.*

<sup>52</sup> Mark A. Hall, *Regulating Stop-Loss Coverage May Be Needed to Deter Self-Insuring Small Employers from Undermining Market Reforms*, 31 HEALTH AFFS. 316, 316 (2012).

<sup>53</sup> *Id.* (noting that by self-insuring small employers could also avoid the ACA’s requirement that insurance cover “essential health benefits”).

<sup>54</sup> 42 U.S.C. § 18024(b)(3) & 18032(f)(2)(B)(i) (providing that states can choose (1) to define “small” as 50 employees or fewer prior to 2016 and (2) to allow employers with more than 100 employees to access the exchange after 2017).

more likely that employers will leave the small group market in favor of self-insuring. All else equal, self-insuring is a more realistic option the larger a “small” employer is, because larger employers are better able to absorb unpredictable expenses. These factors raise the specter of adverse selection against the small group market leading to a concentration of relatively high-risk employers in that market.

## Steps States Can Take to Prevent and Counteract Adverse Selection

The Affordable Care Act gives the states flexibility to take additional steps to prevent and counteract adverse selection. One step available to states is to extend the requirements that qualify a plan to be sold inside the exchange to plans sold outside the exchange.<sup>55</sup> This would level the playing field and reduce the possibility, discussed above, that an increased regulatory burden within the exchange would lead to higher premium prices for plans sold there. States could also require standardization of plans over and above requiring that they be qualified for sale within the exchange. Extending the restrictions that the Affordable Care Act imposes on qualified health plans to plans in the non-exchange market would, in addition to leveling the playing field, make it illegal for firms operating outside the exchange to design and market their plans with the goal of attracting relatively healthy individuals.

A second step would be to require insurers who offer a product outside the exchange to offer the same product inside the exchange, and vice versa.<sup>56</sup> Essentially, this would be an extension of the Affordable Care Act’s single risk pool requirement. In California, insurers will be, and in Massachusetts insurers already are, required to offer identical health insurance products at identical prices in the exchange as they do in the non-exchange market.<sup>57</sup> PacAdvantage, a previous attempt to establish an insurance exchange in California, failed in part because the price of insurance within the exchange exceeded its price in the non-exchange market.<sup>58</sup> In Utah, the health reform legislation passed in 2010 requires participating carriers to offer within the exchange—and charge the same price for—their four most commonly selected plans from the non-exchange market.<sup>59</sup>

Tying the market outside the exchange to the market inside could complicate a state’s efforts to establish an “active” exchange that would evaluate plans on price, quality, and other measures before choosing which to qualify for sale inside the exchange. An active exchange

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<sup>55</sup> TIMOTHY STOLTZFUS JOST, THE COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: EIGHT DIFFICULT ISSUES 11-12 (2010).

<sup>56</sup> *Id.* at 12; LUECK, *supra* note 3, at 7.

<sup>57</sup> SILOW-CARROLL ET AL., *supra* note 4, at 11 & 15.

<sup>58</sup> MICAH WEINBERG & LEIF WELLINGTON HAASE, THE COMMONWEALTH FUND, STATE-BASED COVERAGE SOLUTIONS: THE CALIFORNIA HEALTH BENEFIT EXCHANGE 6, 10 (2011).

<sup>59</sup> UTAH CODE ANN. § 31A-30-205(d) (2011).

would have as its goal using its market power to improve offerings available to participants. A rule requiring that the offerings inside be the same as those outside would mitigate against adverse selection but it would also take away an “important putative advantage [of the exchange]—lower prices.”<sup>60</sup>

There are alternatives to requiring that every plan offered outside the exchange be offered within it that would be more compatible with an active exchange. States could require insurers to offer at least one silver and one gold plan outside the exchange, as they are already required to do inside.<sup>61</sup> California has gone even further, requiring that every issuer, whether or not it participates in the exchange, offer a plan at each actuarial value.<sup>62</sup> Another option, strongly recommended by the Center for Budget and Policy Priorities, would be to bar plans from offering only bronze or only catastrophic plans in the non-exchange market.<sup>63</sup> In California, plans will not be permitted to offer catastrophic coverage and, thereby, access the young and healthy individuals to whom it appeals, unless they participate in the exchange.<sup>64</sup>

Other steps that states can take to prevent adverse selection against and within their newly-established exchanges include levying fees on all plans to sustain the exchange, not just those that participate in the exchange<sup>65</sup> and structuring broker commissions so that they do not incentivize steering healthy people out of the exchange.<sup>66</sup> States may also want to consider whether their network adequacy requirements, marketing restrictions, and other consumer protections need strengthening.<sup>67</sup> As the National Association of Insurance Commissioners has explained, older consumers with pre-existing conditions are more likely to choose a health insurance plan based on the robustness of its health care provider network than are younger, healthier consumers.<sup>68</sup> Network adequacy requirements serve as a brake on the risk concentration that could result by limiting the extent to which provider networks can vary across plans.

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<sup>60</sup> WEINBERG & WELLINGTON HAASE, *supra* note 58, at 10.

<sup>61</sup> LUECK, *supra* note 3, at 7.

<sup>62</sup> WEINBERG & WELLINGTON HAASE, *supra* note 58, at 2.

<sup>63</sup> LUECK, *supra* note 3, at 7.

<sup>64</sup> WEINBERG & WELLINGTON HAASE, *supra* note 58, at 2.

<sup>65</sup> LUECK, *supra* note 3, at 6.

<sup>66</sup> *Id.* See also JOST, *supra* note 55, at 52-53.

<sup>67</sup> Also of potential importance is ensuring that these protections are uniformly enforced inside and outside the exchange.

<sup>68</sup> HEALTH INSURANCE AND MANAGED CARE (B) COMMITTEE, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, ADVERSE SELECTION ISSUES AND HEALTH INSURANCE EXCHANGES UNDER THE AFFORDABLE CARE ACT 2 (2011).



## Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act

The potential for problematic risk distribution – whether due to random variation or to adverse selection or other market problems – persists despite the steps outlined above.<sup>69</sup> To address this, the Affordable Care Act provides for a permanent risk adjustment program<sup>70</sup> and two temporary risk-sharing programs: a state-based reinsurance program that compensates plans that cover high-risk individuals<sup>71</sup> and an HHS-run risk corridor program that limits plans' downside risk and upside profit potential.<sup>72</sup> On March 12, 2012, HHS released final regulations setting forth “Standards Related to Reinsurance, Risk Corridors and Risk Adjustment” (the “Premium Stabilization Rule”) which took effect on May 22, 2012.<sup>73</sup>

Risk adjustment rests on risk assessment. In order to adjust the payments made to an insurer to account for the relative health of its enrollees, one must be able to assess the likelihood that those enrollees will incur healthcare costs. As Joanne Fontana and Rong Yi explain, risk assessment “results are presented in the form of relative risk scores, which is a numeric representation of members’ health status relative to each other, i.e., a risk score of 2.7 times sicker than an average member of the population.”<sup>74</sup>

A widely-cited study by the Society of Actuaries compared twelve claims-based health risk-assessment tools and found that they were able to explain between 14.9 and 27.4 percent of the variation in an individual’s medical claims.<sup>75</sup> While these percentages may seem low, they add up. For groups of at least five hundred insureds, the available tools can explain in excess of ninety percent of aggregate claim variation.<sup>76</sup> Being able to assess risk and predict claims expenditures with this degree of accuracy provides the necessary foundation for risk adjustment.<sup>77</sup>

That said, in the first three years after the Affordable Care Act goes into full effect—2014-2016—risk adjustment will be hampered by a number of factors including a “lack of

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<sup>69</sup> Jonathan P. Weiner, Erin Trish, Chad Abrams & Klaus Lemke, *Adjusting for Risk Selection in State Health Insurance Exchanges Will Be Critically Important and Feasible, but Not Easy*, 31 HEALTH AFFS. 306, 309 (2012)(reporting the results of a simulation demonstrating that “large incentives for insurers to attract healthier enrollees” will persist under the Affordable Care Act’s rules).

<sup>70</sup> 42 U.S.C. § 18063.

<sup>71</sup> 42 U.S.C. § 18061.

<sup>72</sup> 42 U.S.C. § 18062.

<sup>73</sup> Patient Protection and Affordable Care Act; Standards Relating to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17220 (released March 12, 2012) (to be codified at 45 C.F.R. pt. 153) [hereinafter “Premium Stabilization Rule”].

<sup>74</sup> JOANNE FONTANA & RONG YI, MILLIMAN, RISK ADJUSTMENT: HEALTH CALCULUS FOR THE REFORM ENVIRONMENT 1 (2010).

<sup>75</sup> ROSS WINKELMAN & SYED MEHMUD, SOC. OF ACTUARIES A COMPARATIVE ANALYSIS OF CLAIMS-BASED TOOLS FOR HEALTH RISK ASSESSMENT 1 (2007).

<sup>76</sup> AMERICAN ACADEMY OF ACTUARIES, *supra* note 2, at 3.

<sup>77</sup> *Id.*

comparable data on the health status of enrollees in the myriad of plans inside and outside the exchanges.”<sup>78</sup> The reinsurance and risk corridor programs provide health insurers with increased predictability during the time of transition.

## Transitional Reinsurance for the Individual Market

The Affordable Care Act’s reinsurance program will supplement the reinsurance products that are available on the private market with the goal of “stabiliz[ing] premiums for coverage in the individual market [in the early years] when the risk of adverse selection related to new rating rules and market changes is greatest[.]”<sup>79</sup> The reinsurance program will be in place in 2014 when the Act is fully effectuated, will collect funds through 2016, and will remain active for as long as necessary to pay out the funds collected, albeit not beyond December 31, 2018.<sup>80</sup> In its Regulatory Impact Analysis, HHS’ Center for Consumer Information and Insurance Oversight writes that “[i]n 2014, it is expected that the cost of reinsurance premiums will be passed on to enrollees through premium increases of about one percent of premiums in the total market; by contrast, it is anticipated that reinsurance payments will result in premium decreases in the individual market of between 10 and 15 percent.”<sup>81</sup>

The Premium Stabilization Rule provides that each state can either establish its own reinsurance program or permit HHS to establish a reinsurance program for it.<sup>82</sup> A state that chooses to establish its own program must contract with a non-profit “applicable reinsurance

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<sup>78</sup> LUECK, *supra* note 3, at 4.

<sup>79</sup> 42 U.S.C. § 18061(c)(1)(A).

<sup>80</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,225 (discussing 45 C.F.R. § 153.210). Note that the reinsurance program applies to the entire individual market which will include plans offered inside and outside of an exchange.

<sup>81</sup> CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT, U.S. DEP’T OF HEALTH & HUMAN SERVS. PATIENT PROTECTION AND AFFORDABLE CARE ACT: ESTABLISHMENT OF EXCHANGES AND QUALIFIED HEALTH PLANS, EXCHANGE STANDARDS FOR EMPLOYERS (CMS-9989-FWP) AND STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS AND RISK ADJUSTMENT (CMS-9975-F) REGULATORY IMPACT ANALYSIS 42 (2012) (citing “Actuarial Research Corporation, ‘Reinsurance attachment point estimates,’ (Annandale 2010)”).

<sup>82</sup> 45 C.F.R. § 153.210(a) & (c). On May 31, 2012 HHS issued a bulletin that “specifies the processes and timeframes HHS will employ to identify, calculate, and disburse reinsurance payments for the HHS-oriented program.” CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT, U.S. DEP’T OF HEALTH & HUMAN SERVS., BULLETIN ON THE TRANSITIONAL REINSURANCE PROGRAM: PROPOSED PAYMENT OPERATIONS BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES 3 (2012).

entity” or entities to carry it out.<sup>83</sup> One reinsurance entity can serve several states, but if it does each state must be treated as a separate risk pool.<sup>84</sup>

All of a state’s “health insurance issuers, and third party administrators on behalf of group health plans,” will be required to contribute to the state’s reinsurance program.<sup>85</sup> HHS is responsible for “collect[ing] contributions from self-insured plans and third-party administrators on their behalf[.]”<sup>86</sup> A state that establishes its own reinsurance program can choose to collect contributions from fully-insured plans itself or have HHS handle collections from those plans as well.<sup>87</sup> The reinsurance entity will be responsible for gathering data from non-grandfathered health plans in the individual market that enroll high-cost individuals<sup>88</sup> and for calculating and making the payments to which they are entitled.<sup>89</sup> The program is designed to be revenue neutral; payments made by a reinsurance entity must not exceed contributions to it.<sup>90</sup>

The Affordable Care Act specifies that, nationwide, the reinsurance program is to be funded by contributions in the amount of \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016.<sup>91</sup> Additional funds in the amounts of \$2 billion in 2014, \$2 billion in 2015, and \$1 billion in 2016 are to be collected “for deposit into the general fund of the U.S. treasury.”<sup>92</sup> The Premium Stabilization Rule makes clear that “[a]dministrative expenses of the applicable reinsurance entity or HHS when performing reinsurance functions” must also be funded by contributions.<sup>93</sup> Notably, the Act sets a floor and not a ceiling; states can choose to collect more money to cover the reinsurance entity’s administrative expenses and to do risk spreading beyond what the amounts specified in the federal law support.<sup>94</sup>

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<sup>83</sup> 45 C.F.R. § 153.210(a). The Premium Stabilization Rule provides that “[i]f a State contracts with more than one applicable reinsurance entity, the State must: (i) Ensure that each applicable reinsurance entity operates in a distinct geographic area with no overlap of jurisdiction with any other applicable reinsurance entity; (ii) Use the same payment parameters with respect to each applicable reinsurance entity; and (iii) Notify HHS in the manner and timeframe specified by HHS of the percentage of reinsurance contributions received from HHS for the State to be allocated to each applicable reinsurance entity.” 45 C.F.R. § 153.210(a)(2).

<sup>84</sup> Patient Protection and Affordable Care Act; Standards Relating to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41930, 41,934 (proposed July 15, 2011) (to be codified at 45 C.F.R. pt. 153) [hereinafter “Proposed Premium Stabilization Rule”].

<sup>85</sup> 42 U.S.C. § 18061(b)(1)(A) & (c).

<sup>86</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,227 (discussing 45 C.F.R. § 153.220(a)(2)).

<sup>87</sup> 45 C.F.R. § 153.220(a)(1).

<sup>88</sup> 45 C.F.R. § 153.240(a).

<sup>89</sup> 42 U.S.C. § 18061(b)(1)(B).

<sup>90</sup> 45 C.F.R. § 153.240(b).

<sup>91</sup> 42 U.S.C. § 18061(b)(3)(B)(iii).

<sup>92</sup> 42 U.S.C. § 18061(b)(3)(B)(iv).

<sup>93</sup> 45 C.F.R. § 153.220(c)(3).

<sup>94</sup> 45 C.F.R. § 153.220(g). HHS will collect additional amounts for administrative expenses for a state, but collecting additional amounts for reinsurance payments is the responsibility of the state’s reinsurance entity. Premium Stabilization Rule, 77 Fed. Reg. at 17,227.

The Act charges the Secretary with setting forth “the method for determining the amount each health insurance issuer and group health plan ... is required to contribute.”<sup>95</sup> The contribution amount for each issuer should “proportionally reflect[] each issuer's fully insured commercial book of business for all major medical products and the total value of all fees charged by the issuer and the costs of coverage administered by the issuer as a third party administrator[.]”<sup>96</sup>

HHS explained in the preamble to the proposed Premium Stabilization Rule that it will ensure that the Act’s reinsurance funding targets are met by setting a national “contribution rate.”<sup>97</sup> HHS believes that a national rate will be simpler and less ambiguous than other options, which is important because of “significant uncertainty about individual market enrollment, the overall health of the enrolled population, and the cost of care for new enrollees[.]”<sup>98</sup> What each plan must contribute will be determined by multiplying the contribution rate times the number of enrollees in the plan. The Secretary initially proposed that insurers’ obligations be determined as a percent of premium (or, for self-insured plans, incurred medical costs) rather than by reference to the number of individuals enrolled, but eventually decided that while the percent of premium approach is the “fairest method[.],”<sup>99</sup> its advantages were outweighed by the administrative ease of the per capita approach.<sup>100</sup>

Turning from reinsurance contributions to reinsurance payouts, the ACA requires that the formula for determining payment amounts from the reinsurance fund result in an equitable allocation based on either (1) a payment schedule that specifies an amount to be paid for each of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions or (2) “any other comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care coordination and care management programs for high risk conditions.”<sup>101</sup> The Secretary has rejected the Act’s suggestion that a plan’s entitlement to reinsurance payments be determined based on the number of individuals with high-risk conditions it enrolls. Instead, the Secretary has determined that reinsurance-eligible individuals will be identified based on the medical

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<sup>95</sup> 42 U.S.C. § 18061(b)(3)(A).

<sup>96</sup> 42 U.S.C. § 18061(b)(3)(B)(i).

<sup>97</sup> Proposed Premium Stabilization Rule, 76 Fed. Reg. at 41,935. *See* 45 C.F.R. § 152.220(e) (providing that “HHS will set in the annual HHS notice of benefit and payment parameters for the applicable benefit year the national contribution rate and the proportion of contributions collected under the national contribution rate to be allocated to: (1) Reinsurance payments; (2) Payments to the U.S. Treasury as described in paragraph (c)(2) of this section; and (3) Administrative expenses of the applicable reinsurance entity or HHS when performing reinsurance functions under this subpart.”). *See also* 45 C.F.R. § 153.20 (defining “contribution rate” as “the per capita amount each contributing entity must pay for a reinsurance program established under this part with respect to each reinsurance contribution enrollee who resides in that State.”).

<sup>98</sup> Proposed Premium Stabilization Rule, 76 Fed. Reg. at 41,935.

<sup>99</sup> *Id.*

<sup>100</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,227-28.

<sup>101</sup> 42 U.S.C. § 18061(b)(2)(B)(ii).

costs they actually incur, regardless of diagnosis.<sup>102</sup> The Secretary points to two central advantages of such an approach. First, insurers are familiar with it and second, it is relatively easy to administer.<sup>103</sup> In addition, the necessary data will be available immediately (as soon as an insurer files proof of payment of a claim) and time is of the essence due to the temporary nature of the reinsurance program.<sup>104</sup>

HHS will announce a reinsurance payment formula and values for the attachment point, reinsurance cap, and coinsurance rate in the agency's annual notice of benefit and payment parameters.<sup>105</sup> The attachment point is the amount that an insurer must incur in claims costs for a single individual before the insurer would become eligible for reinsurance payments; the coinsurance rate is the percentage of the costs incurred in excess of the attachment point that the reinsurance entity will pay; and the reinsurance cap is the amount paid out above which the reinsurance entity will no longer pay a share of the costs incurred.<sup>106</sup> Because the ACA "does not suggest that the three-year reinsurance program should replace commercial reinsurance or internal risk mitigation strategies," HHS proposes setting the cap for the government program at "a level approximately equal to the attachment point for traditional commercial reinsurance."<sup>107</sup> The government reinsurance program would begin making payments before a typical commercial reinsurance policy and the government program would stop making payments at the point where a commercial policy would start paying out. If a state establishes its own reinsurance program, it will have the authority to increase or decrease the attachment point and coinsurance rate and increase, decrease, or eliminate the reinsurance cap set by HHS, as long as the modifications are "reasonably calculated to ensure that reinsurance contributions ... are sufficient to cover payments[.]"<sup>108</sup>

States will be required to issue an annual notice of benefit and payment parameters "by March 1 of the calendar year prior to the benefit year for which the notice applies[.]" if they

- establish their own programs,
- choose to use more than one reinsurance entity,
- collect contributions from fully-insured plans rather than rely on HHS to do it,
- modify the requirements for or frequency of gathering data on high-cost enrollees,
- collect additional reinsurance contributions, above those specified by HHS, or

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<sup>102</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,228 (discussing 45 C.F.R. § 153.220).

<sup>103</sup> Proposed Premium Stabilization Rule, 76 Fed. Reg. at 41,936.

<sup>104</sup> *Id.*

<sup>105</sup> 45 C.F.R. § 153.230(b).

<sup>106</sup> 45 C.F.R. § 153.20.

<sup>107</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,228.

<sup>108</sup> Proposed Premium Stabilization Rule, 76 Fed. Reg. at 41,936.

- make any of the modifications to the reinsurance payment parameters discussed above.<sup>109</sup>

States can also use the annual notice to set forth their own timeframe for making reinsurance payments.<sup>110</sup> In the preamble to the proposed Premium Stabilization Rule, the Secretary noted that states may wish to “vary the annual amounts without varying the total across all three years” or to make payments “either earlier or later in the medical cost experience” than set forth in the federal government’s timeline of claim submission and reimbursement.<sup>111</sup> The Secretary suggested that a standard deadline for submission of reinsurance claims of 6 months after the end of the coverage year “would allow for an orderly completion of the payment processes that depend upon reinsurance, specifically the risk corridors program and the medical loss ratio (MLR) reporting” that allows rebates to be calculated.<sup>112</sup>

States are required to “eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program[.]”<sup>113</sup> A state may coordinate its high-risk pool with the reinsurance program as long as the statute and regulations governing the reinsurance program can still be followed.<sup>114</sup>

## Transitional Risk Corridors for Plans in Individual and Small Group Markets

In addition to the transitional reinsurance program, the Affordable Care Act provides for transitional aggregate risk-sharing mechanisms, termed “risk corridors,” that will redistribute funds from qualified health plans<sup>115</sup> with large profits to those with large losses during calendar years 2014, 2015, and 2016.<sup>116</sup> The risk corridors will be administered by HHS, not the states,

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<sup>109</sup> 45 C.F.R. § 153.100(a).

<sup>110</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,229.

<sup>111</sup> Proposed Premium Stabilization Rule, 76 Fed. Reg. at 41,936-37.

<sup>112</sup> *Id.* at 41,937.

<sup>113</sup> 42 U.S.C. § 18061(d).

<sup>114</sup> *Id.*

<sup>115</sup> In the preamble to the Premium Stabilization Rule, the Secretary makes clear that qualified health plans are subject to the risk corridors program whether they are offered inside or outside of an exchange. Premium Stabilization Rule, 77 Fed. Reg. at 17,237.

<sup>116</sup> 42 U.S.C. § 18062. The Affordable Care Act’s risk corridor program is based on one in use for prescription plans under Medicare Part D. In that program, though, the “collections” and “payments” take the form of adjustments to the premiums paid out by the federal government. In estimating the costs and benefits of the Affordable Care Act’s program, the Congressional Budget Office assumed that collections would equal payments and that the risk corridor program would therefore be budget neutral. Proposed Premium Stabilization Rule, 76 Fed. Reg. at 41,948. Numerous commentators have questioned this assumption. Mark Hall writes that “mathematically [it] is not at all likely to be the case” that collections will equal payments; Timothy Jost notes that there are many unanswered questions about the risk corridor program including “where the funds will come from (or go) if collections do not equal payments.” Mark A. Hall, *The Three Types of Reinsurance Created by Federal Health Reform*, 29 HEALTH AFFS.

with the goal of protecting insurers from errors in premium-setting arising from a lack of data in the early years.<sup>117</sup> As the American Academy of Actuaries explains, during those years more data will become available on the “health spending patterns of the newly insured,” which will increase insurers’ “ability to set premiums accurately ... thereby reducing the need for risk corridors.”<sup>118</sup>

The risk corridors program will work as follows. Using data submitted by every issuer of a qualified health plan, HHS will calculate a “target amount” for each plan, equal to the total premiums that plan earned that year (including the Affordable Care Act’s premium tax credits) minus the plan’s “allowable administrative costs.”<sup>119</sup> The Premium Stabilization Rule limits “allowable administrative costs” to 20 percent of premiums earned.<sup>120</sup>

HHS will also determine what each plan’s “allowable costs” were. Allowable costs are defined as the plan’s incurred claims, plus spending on activities that improve health care quality and spending related to health information technology and the meaningful use requirements.<sup>121</sup> Allowable costs are to be adjusted to account for prescription drug rebates and for reinsurance or risk adjustment payments made or received.<sup>122</sup>

If a plan’s allowable costs are within three percent of its target amount, the risk corridors program is not triggered and the plan bears the additional loss or keeps the additional profit. If, however, a plan’s allowable costs for any plan year exceed 103 percent of the target, but are not more than 108 percent of the target, the Secretary will pay the plan an amount equal to 50 percent of the allowable costs incurred in excess of 103 percent of the target.<sup>123</sup> If a plan’s allowable costs rise above 108 percent of the target amount, the Secretary will pay the plan an amount equal to the sum of 2.5 percent of the target amount (i.e. 50 percent of the amount between 103 percent and 108 percent) plus 80 percent of the allowable costs incurred in excess of 108 percent of the target.<sup>124</sup>

If, on the other hand, a plan has an unexpectedly good year in terms of realized risk, it must pay the Secretary. If a plan’s allowable costs fall between 97 percent and 92 percent of the target, the plan must pay the Secretary 50 percent of its excess profits.<sup>125</sup> If a plan’s allowable costs are less than 92 percent of the target, the plan must pay the Secretary 2.5

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1168, 1171 (2010); Timothy Jost, *Implementing Health Reform: Health Insurance Exchanges (Part 3)*, HEALTH AFFS. BLOG (July 13, 2011, 10:03 AM), <http://healthaffairs.org/blog/2011/07/13/implementing-health-reform-health-insurance-exchanges-part-3/>.

<sup>117</sup> AMERICAN ACADEMY OF ACTUARIES, RISK ADJUSTMENT AND OTHER RISK-SHARING PROVISIONS IN THE AFFORDABLE CARE ACT 4 (2011).

<sup>118</sup> *Id.*

<sup>119</sup> 42 U.S.C. § 18062(c)(2); 45 C.F.R. § 153.500.

<sup>120</sup> 45 C.F.R. § 153.500.

<sup>121</sup> *Id.*

<sup>122</sup> 45 C.F.R. §§ 153.500 & 153.530 (b).

<sup>123</sup> 42 U.S.C. § 18062(b)(1)(A).

<sup>124</sup> 42 U.S.C. § 18062(b)(1)(B).

<sup>125</sup> 42 U.S.C. § 18062(b)(2)(A).

percent of the target amount (i.e. 50 percent of the amount between 97 and 92 percent) plus 80 percent of the amount by which the plan's allowable costs incurred fell below 92 percent of the target amount of premiums earned.<sup>126</sup>

In the preamble to the Premium Stabilization Rule, HHS explains that it chose to limit administrative costs for purposes of the risk corridor to twenty percent of premiums earned to conform to the medical loss ratio (MLR) rule's limits.<sup>127</sup> This will prevent "issuers with high administrative costs from receiving risk corridor payments and then using those payments to pay the required MLR rebates."<sup>128</sup> With the goal of "consistency ... when practicable[,]” the Secretary also chose to conform a number of definitions used in the risk corridors program to the definitions used in the MLR rule, including defining allowable costs to include expenditures to improve health care quality or adopt electronic medical records.<sup>129</sup> One way in which the risk corridors and MLR calculations remain inconsistent is that, as prescribed by the Act, the risk corridors calculation occurs at the plan level, while the MLR rules apply at the issuer level.<sup>130</sup>

With regard to timing, the Secretary has not yet proposed deadlines, but HHS has considered requiring issuers that owe money to remit payment within thirty days of receiving notice from the agency.<sup>131</sup> HHS in turn, could be required to pay those issuers that are owed money within thirty days of the agency's determination that payment should be made.<sup>132</sup>

## Permanent Risk Adjustment Program for Individual and Small Group Plans

In addition to the temporary reinsurance and risk corridor programs, the Affordable Care Act provides for a permanent risk adjustment program.<sup>133</sup> Under this program, all non-grandfathered "health plans and health insurance issuers (with respect to health insurance coverage)" with below average actuarial risk in a given state will be assessed a charge.<sup>134</sup> Concomitantly, a payment will be made to those plans and issuers with above average actuarial risk.<sup>135</sup> Whether a plan is low or high actuarial risk will be determined with reference to the

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<sup>126</sup> 42 U.S.C. § 18062(b)(2)(B).

<sup>127</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,237.

<sup>128</sup> *Id.*

<sup>129</sup> *Id.*

<sup>130</sup> *Id.* at 17,238.

<sup>131</sup> *Id.*

<sup>132</sup> *Id.* at 17,238-39.

<sup>133</sup> 42 U.S.C. § 18063.

<sup>134</sup> 42 U.S.C. § 18063(a)(1).

<sup>135</sup> 42 U.S.C. § 18063(a)(2).



“average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans[.]”<sup>136</sup>

As the Secretary explains in the preamble to the proposed Premium Stabilization Rule, the risk adjustment program is “intended to reduce or eliminate premium differences between plans based solely on expectations of favorable or unfavorable risk selection or choices by higher risk enrollees in the individual and small group market.”<sup>137</sup> In a simulation of an Affordable Care Act health insurance exchange performed by Jonathan Weiner and colleagues, risk adjustment “decreased the under- and overpayments to plans more than sixfold—reducing the underpayment for [plans with a relatively high proportion of sick enrollees] from 9.2 percent to 1.4 percent and the overpayment for [plans with a relatively high proportion of healthy enrollees] from 13.5 percent to 1.8 percent.”<sup>138</sup> Because it applies to plans sold inside and outside a state’s health insurance exchange, the risk adjustment program “also serves to level the playing field inside and outside of the Exchange, reducing the potential for excessive premium growth or instability within the Exchange.”<sup>139</sup>

Any state that elects to establish its own exchange may also elect to operate its own risk adjustment program.<sup>140</sup> Alternatively, the federal government will operate a state’s risk adjustment program for the state. Because it is funded by transfer payments among insurers, the risk adjustment program is expected to be budget neutral, albeit with start-up costs and ongoing administrative costs. In the preamble to the premium stabilization rule, the Secretary notes that, because “[d]eveloping a risk adjustment program is methodologically and operationally complex[.]” states may wish to focus their resources on developing the exchanges, at least initially.<sup>141</sup>

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<sup>136</sup> *Id.* In the preamble to the proposed Premium Stabilization Rule, the Secretary notes that in determining actuarial risk, a risk adjustment program will need to account for variations based on age, family size, geography, and tobacco use, “so that risk adjustment does not adjust for the actuarial risk that issuers have been allowed to incorporate into their premium rates.” Proposed Premium Stabilization Rule, 76 Fed. Reg. at 41,939. The preamble also sets forth in some detail two alternate methods “to determine the precise value of payments and charges ... multiplying plan average actuarial risk by the State average normalized premiums and multiplying plan average actuarial risk by the specific premiums collected for each plan.” *Id.*

<sup>137</sup> Proposed Premium Stabilization Rule, 76 Fed. Reg. at 41,937. To this end, HHS’ Center for Consumer Information and Insurance Oversight has explained that HHS and those states that choose to establish their own risk adjustment programs will need to decide whether to account for the fact “that the relationship between diagnoses and expenditures will vary by metal level.” CENTER FOR CONSUMER INFORMATION AND OVERSIGHT, U.S. DEP’T OF HEALTH & HUMAN SERVS., RISK ADJUSTMENT IMPLEMENTATION ISSUES 10 (2011). Mark Hall has recommended that risk adjustment be applied “to each benefit package within an insurer’s overall block of business, before summing up to the entity level. That way, insurers, state regulators, and exchanges will know the relative risk profiles of bronze versus silver subscribers, for instance, and so can determine what adjustments in premium rates might be appropriate to keep premiums in proportion to relative actuarial value of benefits.” HALL, *supra* note 13, at 5.

<sup>138</sup> Weiner et al., *supra* note 69, at 309.

<sup>139</sup> Proposed Premium Stabilization Rule, 76 Fed. Reg. at 41,937.

<sup>140</sup> 45 C.F.R. § 153.310(a)(1).

<sup>141</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,230.

Every risk adjustment program must employ a federally certified “risk adjustment methodology”, defined to include

- the risk adjustment model the program uses to predict an enrollee’s relative risk of incurring health care costs,
- the calculation the program uses to determine each covered plan’s average actuarial risk across all of its enrollees,
- the calculation the program uses to determine the payments owed by and due to each covered plan,
- the program’s approach to collecting the necessary data, and
- the program’s schedule.<sup>142</sup>

In a bulletin on the risk adjustment program released on May 1, 2012, HHS explained that the methodology must control for “[p]lan level differences in factors such as metal level or actuarial value, permissible rating variation, and induced demand” to ensure that payment transfers function as intended and compensate plans solely for differences in health care costs due to differences in health status.<sup>143</sup>

HHS will develop and promulgate one or more federally certified risk adjustment methodologies. While states may not vary the method of calculating payments owed by and due to plans, they can propose alternatives to the HHS methodology or methodologies that vary in other ways.<sup>144</sup> Once approved by HHS, these state-proposed alternatives will be considered federally certified for purposes of the Premium Stabilization Rule and any state that wishes to will be able to adopt them for use.<sup>145</sup> Per the Rule, a state which chooses to develop an alternative methodology will be required to provide HHS with information including, among other things, the following:

- a complete description of the risk adjustment model, including factors the state will employ (e.g. demographic factors, diagnostic factors, and utilization factors) to predict health plan costs;
- the weights the state will assign to each factor;
- “[t]he calibration methodology and frequency of calibration[;]” and
- “[t]he statistical performance metrics specified by HHS.”<sup>146</sup>

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<sup>142</sup> 45 C.F.R. § 153.20.

<sup>143</sup> CENTER FOR CONSUMER INFORMATION AND OVERSIGHT, U.S. DEP’T OF HEALTH & HUMAN SERVS., BULLETIN ON THE RISK ADJUSTMENT PROGRAM: PROPOSED OPERATIONS BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES 4-5 (2012) [hereinafter “MAY 2012 BULLETIN”].

<sup>144</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,232.

<sup>145</sup> *Id.*

<sup>146</sup> 45 C.F.R. § 153.330 (a)(1) (referencing 45 C.F.R. § 153.320(b)).

The Secretary expects a state's proposed methodology to "offer similar or better performance" than those that are developed and promulgated by HHS.<sup>147</sup> A state must also provide HHS with information on "the extent to which [its] methodology: (i) [a]ccurately explains the variation in health care costs of a given population; (ii) [l]inks risk factors to daily clinical practice and is clinically meaningful to providers; (iii) [e]ncourages favorable behavior among providers and plans and discourages unfavorable behavior; (iv) [u]ses data that is complete, high in quality, and available in a timely fashion; (v) [i]s easy for stakeholders to understand and implement; (vi) [p]rovides stable risk scores over time and across plans; and (vii) [m]inimizes administrative costs."<sup>148</sup> States might also consider an additional factor cited by the American Academy of Actuaries: how difficult is it to "game" the data on which the methodology rests by, for example, engaging in upcoding.<sup>149</sup>

A state that chooses to operate its own risk adjustment program will need to collect the necessary data.<sup>150</sup> The State Health Reform Assistance Network (SHRAN), a Robert Wood Johnson Foundation Program Office which provides states with technical assistance on ACA implementation, released a policy brief authored by Ross Winkelman and colleagues emphasizing that it will require significant resources to collect, store, validate, and analyze the necessary data and to comply with the requirements for keeping it private and secure.<sup>151</sup> This may be of particular concern to a state like New Jersey that does not yet have an all-payer claims database. Edwin Park of the Center for Budget and Policy Priorities suggests that states could incorporate the risk adjustment program's operating costs into the payments owed by insurers with below-average risk but Ross Winkelman and his SHRAN colleagues write that whether "states will be allowed to assess carriers to pay for the risk adjustment code audits and, more broadly, for the risk adjustment approach" is an open question.<sup>152</sup>

States could conserve resources by adopting a "distributed approach" to data collection, as HHS plans to do on behalf of those states that choose not to establish their own risk adjustment programs.<sup>153</sup> Under a distributed approach, issuers are responsible for formatting

<sup>147</sup> Proposed Premium Stabilization Rule, at 41,938.

<sup>148</sup> 45 C.F.R. § 153.330 (2). In the proposed Premium Stabilization Rule, the Secretary explained that these requirements are derived from "principles that guided the creation of the hierarchical condition categories (HCC) model used in Medicare's risk adjustment program, as well as criteria described by Academy Health in its 2004 risk assessment paper (see <http://hcfo.org/pdf/riskadjustment.pdf>) and criteria described by the American Academy of Actuaries in its 2010 risk adjustment paper (see [http://www.actuary.org/pdf/health/Risk\\_Adjustment\\_Issue\\_Brief\\_Final\\_5-26-10.pdf](http://www.actuary.org/pdf/health/Risk_Adjustment_Issue_Brief_Final_5-26-10.pdf))."

Proposed Premium Stabilization Rule, 76 Fed. Reg. at 41,940.

<sup>149</sup> AMERICAN ACADEMY OF ACTUARIES, *supra* note 2, at 5.

<sup>150</sup> 45 C.F.R. § 153.340(a).

<sup>151</sup> ROSS WINKELMAN, JULIE PEPPER, PATRICK HOLLAND, SYED MEHMUD & JAMES WOOLMAN, WAKELY CONSULTING GROUP, ANALYSIS OF HHS PROPOSED RULES ON REINSURANCE, RISK CORRIDORS AND RISK ADJUSTMENT 5 (2011).

<sup>152</sup> EDWIN PARK, CENTER ON BUDGET AND POLICY PRIORITIES, ENSURING EFFECTIVE RISK ADJUSTMENT: AN ESSENTIAL STEP FOR THE SUCCESS OF THE HEALTH INSURANCE EXCHANGES AND MARKET REFORMS UNDER THE AFFORDABLE CARE ACT 25 (2011); WINKELMAN ET AL., *supra* note 151, at 12.

<sup>153</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,233.

and maintaining risk adjustment data and, in some cases, for using risk adjustment software to calculate individual risk scores.<sup>154</sup> While this approach would relieve the state of the obligation to collect claims data, it would necessitate a more involved data validation and audit process.<sup>155</sup>

In the preamble to the Premium Stabilization Rule, the Secretary announced that HHS' proposed risk adjustment methodology or methodologies will be included in the advance annual federal notice of benefits and payment parameters which will be issued in mid-October two calendar years before the benefit year.<sup>156</sup> States that wish to submit alternative methodologies must do so within 30 days of the issuance of the advance notice.<sup>157</sup> The Secretary believes that "any advantage in allowing States additional time would be offset by a lesser ability to leverage State alternative models and inadequate time for issuers to reflect methodology decisions in setting rates."<sup>158</sup> HHS will "notify States within 60 days, at the time of the publication of the forthcoming annual Federal notice of benefits and payment parameters whether [their proposed] methodologies have been certified."<sup>159</sup> A state choosing to employ a certified alternative methodology must then publish its own annual notice of benefits and payment parameters "by March 1 of the calendar year prior to the benefit year for which the notice applies."<sup>160</sup>

The Premium Stabilization Rule requires that states that choose to establish their own risk adjustment programs "implement risk adjustment for the 2014 benefit year and every year thereafter."<sup>161</sup> The Rule provides that the risk adjustment entity must complete its work and "notify issuers of risk adjustment payments due or charges owed annually by June 30 of the year following the benefit year[,]" that is, by June 30, 2015 for the 2014 benefit year.<sup>162</sup> This

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<sup>154</sup> *Id.* In its May 2012 bulletin, HHS explained that it is considering "two potential distributed data approaches ... 1. HHS runs software: HHS would run risk adjustment software on enrollee data that reside on an issuer's server, calculate enrollee-level risk scores and plan average risk, and provide enrollee-level risk scores back to the issuer. 2. Issuer runs software provided by HHS: Issuer would run HHS risk adjustment software using enrollee data on the issuer's own server and report back enrollee risk scores to HHS in order to calculate plan average risk scores." MAY 2012 BULLETIN, *supra* note 143, at 6. HHS went on to explain that "[i]n weighing operational considerations for either option, the policy objective would be to standardize software processes, timing, and rules to apply risk adjustment uniformly across issuers and finally, to ensure an audit sample is controlled and maintained." *Id.*

<sup>155</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,233. *See also* MAY 2012 BULLETIN, *supra* note 143, at 8-10 (discussing HHS' proposed data validation approach).

<sup>156</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,223.

<sup>157</sup> MAY 2012 BULLETIN, *supra* note 143, at 11.

<sup>158</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,223.

<sup>159</sup> *Id.*

<sup>160</sup> 45 C.F.R. § 153.100(c).

<sup>161</sup> 45 C.F.R. § 153.310(c).

<sup>162</sup> *Id.* The Premium Stabilization Rule does not prescribe a schedule for collecting charges owed or making payments due. States "have the flexibility to set a payment schedule that best suits their program administration." Premium Stabilization Rule, 77 Fed. Reg. at 17,231. For those states for which HHS is operating the risk adjustment function, issuers will be required to "remit net charges payable to HHS on behalf of the State, within 30 days of notification." MAY 2012 BULLETIN, *supra* note 143, at 5. HHS has explained that "[b]ecause the risk adjustment program will need to balance payments within a State and within a market, HHS will not remit payments to issuers until after receipt of charges owed by issuers in a given State." *Id.*

deadline is an attempt to balance, on the one hand, the need to ensure that risk adjustment is in place in the key early years of the transition to the exchange and the ACA's new insurance market rules, and, on the other, the need for data of a sufficient amount and quality to support accurate risk assessment.<sup>163</sup> As the Secretary notes, one issue with the June 30<sup>th</sup> deadline is that the deadline for submitting MLR reports is June 1<sup>st</sup>, and the MLR calculations take account of risk adjustment charges owed and payments due.<sup>164</sup> The Secretary has promised to "work to resolve this issue prior to 2014."<sup>165</sup>

The State of New Jersey has experience administering risk adjustment programs upon which it can build in designing and implementing the risk adjustment program prescribed by the Affordable Care Act. First, between 1992, when the state's health reform legislation was passed,<sup>166</sup> and 2008,<sup>167</sup> a loss assessment and reimbursement program compensated carriers who participated in New Jersey's individual health insurance market for losses they sustained. The program was funded via an assessment on all carriers who sold health insurance in New Jersey; carriers could and did seek exemptions from the assessment requirement.<sup>168</sup>

Originally, the loss assessment and reimbursement mechanism was implemented on a one-year cycle, with carriers entitled to reimbursement on a "first dollar" basis when their expenses, including non-medical expenses, exceeded 75% of the premiums earned.<sup>169</sup> This approach created a number of undesirable incentives, including an incentive for plans to set their premiums artificially low, which in turn led them to experience financial difficulties which the loss assessment and reimbursement program did not fully ameliorate.<sup>170</sup> Beginning in 1997, a two-year cycle was adopted and carriers were not entitled to reimbursement until the claims they paid out exceeded 115% of the premiums earned.<sup>171</sup> As a result of these changes, a substantial number of carriers, especially smaller carriers who were not able to absorb the larger unreimbursed losses, exited the individual market.<sup>172</sup> Many experts consider the loss

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<sup>163</sup> Premium Stabilization Rule, 77 Fed. Reg. at 17,231.

<sup>164</sup> *Id.*

<sup>165</sup> *Id.*

<sup>166</sup> MARGARET M. KOLLER & AMY M. TIEDEMANN, RUTGERS CENTER FOR STATE HEALTH POLICY, A DECADE AFTER REGULATORY REFORM: A CASE STUDY OF NEW JERSEY'S INDIVIDUAL HEALTH COVERAGE PROGRAM 1 (2004).

<sup>167</sup> N.J. STAT. ANN. § 17B:27A-12(f) ("The loss assessment for the 2007-2008 two-year calculation period shall be the last loss assessment authorized under this section, and no further loss assessments shall be calculated or collected[.]").

<sup>168</sup> KOLLER & TIEDEMANN, *supra* note 166, at 2.

<sup>169</sup> *Id.*; Alan C. Monheit, Joel C. Cantor, Margaret Koller & Kimberley S. Fox, *Community Rating and Sustainable Individual Health Insurance Markets in New Jersey*, 23 HEALTH AFFS. 167, 170 (2004).

<sup>170</sup> Monheit et al., *supra* note 169, at 170-71.

<sup>171</sup> Memorandum from New Jersey Individual Health Coverage Program Board to Fire and Casualty, and Life and Health Insurance Carriers, Notice on Changes to IHC Loss Assessment Mechanism and Changes to Filing Requirements (Feb. 24, 1998), *available at* [http://www.state.nj.us/dobi/division\\_insurance/ihcseh/bulletins/98ihcx.pdf](http://www.state.nj.us/dobi/division_insurance/ihcseh/bulletins/98ihcx.pdf).

<sup>172</sup> KOLLER & TIEDEMANN, *supra* note 166, at 2.

assessment and reimbursement mechanism a failed policy experiment and the legislature plainly agreed since it chose to phase it out in 2008.

Second, outside the commercial insurance context, there is a risk adjustment program which is still ongoing in New Jersey. Since 1999, the state has adjusted the capitation payments that it makes to Medicaid managed care plans to address “risk factors associated with certain enrollee populations.”<sup>173</sup> To determine whether and how much to adjust the payments, New Jersey uses the Chronic Illness and Disability Payment System (CDPS)/Rx risk assessment tool.<sup>174</sup> CDPS/Rx calculates a risk score for each individual enrollee using his or her demographic characteristics (i.e., age, gender, and geographic area), diagnoses, and drug utilization.<sup>175</sup> The tool is “calibrated from State-specific Medicaid and FamilyCare encounter data” and also takes into account an individual’s Medicaid eligibility category.<sup>176</sup>

New Jersey’s Medicaid managed care risk adjustment program has two key features. First, it is “prospective.”<sup>177</sup> It uses data collected in a year-long “experience period”—either April 1 to March 31 or October 1 to September 30—to estimate morbidity during the “rating period,” i.e. a period following the experience period, during which the risk-adjusted capitation payment will be made.<sup>178</sup> The state calculates a risk adjustment score for each member who has been covered by Medicaid for at least six months and for all newborns, thus assuring “a reasonable opportunity for persons with disease conditions to have a professional or facility visit in which a diagnosis is recorded.”<sup>179</sup> Other states have opted for concurrent or retrospective risk adjustment. That is, they use data gathered during the experience period to estimate morbidity during the experience period.<sup>180</sup> Simply stated, the risk adjustment payment under a prospective model is based on an assessment of member risk during a prior period, while the payment in a concurrent model is based on an assessment of member risk during the current period.

The Center for Consumer Information and Oversight explains that “[p]rospective weights place greater emphasis on ongoing chronic conditions that persist from the prior year

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<sup>173</sup> N.J. ADMIN. CODE § 10:74-12.2(b).

<sup>174</sup> DEPARTMENT OF HUMAN SERVICES & DEPARTMENT OF HEALTH AND SENIOR SERVICES & DEPARTMENT OF CHILDREN AND FAMILIES, STATE OF NEW JERSEY, SECTION 1115 DEMONSTRATION COMPREHENSIVE WAIVER 30-31 (2011), *available at* [http://www.state.nj.us/humanservices/dmahs/home/NJ\\_1115\\_Demonstration\\_Comprehensive\\_Waiver\\_9-9-11.pdf](http://www.state.nj.us/humanservices/dmahs/home/NJ_1115_Demonstration_Comprehensive_Waiver_9-9-11.pdf) [hereinafter “COMPREHENSIVE WAIVER”].

<sup>175</sup> *Id.* at 30. *See also Chronic Illness and Disability Payment System*, UNIVERSITY OF CALIFORNIA, SAN DIEGO, <http://cdps.ucsd.edu/> (last visited Sept. 21, 2011); *Focus on Risk Adjustment: The State of New Jersey Bases Medicaid Payment on Risk Adjustment for Chronic Disease*, HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, <http://horizonnjhealth.com/for-providers/focus-risk-adjustment> (last visited Mar. 17, 2012).

<sup>176</sup> COMPREHENSIVE WAIVER, *supra* note 174, at 31.

<sup>177</sup> Ross Winkelman & Rob Damler, *Risk Adjustment in State Medicaid Programs*, HEALTH WATCH, Jan. 2008, at 14.

<sup>178</sup> *Focus on Risk Adjustment: The State of New Jersey Bases Medicaid Payment on Risk Adjustment for Chronic Disease*, HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY, [http://www.horizonnjhealth.com/physicians/Risk\\_Adjustment.html](http://www.horizonnjhealth.com/physicians/Risk_Adjustment.html) (last visited Sept. 21, 2011).

<sup>179</sup> COMPREHENSIVE WAIVER, *supra* note 174, at 30.

<sup>180</sup> Winkelman & Damler, *supra* note 177, at 17.

into the current year, since those types of conditions are more predictive of costs in the following year than more acute conditions.”<sup>181</sup> Under the concurrent approach, on the other hand, greater weight is placed on acute conditions. Concurrent risk adjustment is more accurate (because, for example, it is able to account for one-time costs such as those due to an injury) but it also requires retroactive adjustment of payments which causes increased uncertainty for insurers.<sup>182</sup>

Second, New Jersey’s risk adjustment program is “individual” as opposed to “aggregate.”<sup>183</sup> Under the individual approach, a risk score is calculated for each individual during the experience period. When an individual moves from one plan to another during the rating period, his or her risk score moves too. The capitation rates paid to health plans “vary based on the actual risk factors of the members enrolled on a periodic (usually monthly) basis.”<sup>184</sup> Under the aggregate approach, by contrast, the capitation rates paid to health plans are based on a composite risk score that is calculated during the experience period and that does not vary during the rating period.<sup>185</sup>

A disadvantage of the individual approach is that new enrollees who were not previously enrolled in a Medicaid managed care plan are typically assigned a risk score based on demographic factors alone.<sup>186</sup> Under an aggregate approach, by contrast, new enrollees would be assigned the same average risk score as existing enrollees.<sup>187</sup> With the influx of new enrollees expected when the Affordable Care Act’s individual mandate takes effect, a pure individual system could be problematic. Modified individual systems which better estimate new enrollees’ risk do exist and could be considered.<sup>188</sup> In its request for a comprehensive Section 1115 waiver, New Jersey proposed that, when determining cost-effectiveness for purposes of the Payment of Premium and Premium Support programs, if an individual lacks a risk adjustment score “an assumed risk score would be developed from information on the health status questionnaire that applicants will be required to complete.”<sup>189</sup>

If New Jersey decides to develop and seek federal certification of its own risk adjustment methodology, as the Premium Stabilization Rule allows, it may consider drawing on

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<sup>181</sup> CENTER FOR CONSUMER INFORMATION AND OVERSIGHT, *supra* note 136, at 6.

<sup>182</sup> Winkelman & Damler, *supra* note 177, at 17.

<sup>183</sup> *Id.* at 17, 32.

<sup>184</sup> *Id.* at 17.

<sup>185</sup> *Id.* at 17, 32.

<sup>186</sup> *Id.* at 14 (explaining that methods based on demographic factors “generally have much lower predictive power than methods based on diagnoses and historic healthcare utilization data, especially for the more chronically ill Medicaid disabled populations.”).

<sup>187</sup> *Id.* at 32.

<sup>188</sup> *Id.*

<sup>189</sup> COMPREHENSIVE WAIVER, *supra* note 174, at 31.

its Medicaid managed care experience.<sup>190</sup> New Jersey could seek federal permission to use CDPS/Rx to support risk adjustment in the individual and small group markets. Because CDPS/Rx incorporates demographic, diagnosis, and prescription drug utilization data, it allows for more accurate risk assessment than tools that do not account for all three data sources. Changes may be needed to reflect differences in utilization between individuals receiving Medicaid and those covered by commercial insurance. For a commercial population, the CDPS/Rx developers suggest using the weights developed for individuals on Medicaid who receive Temporary Assistance for Needy Families (TANF) benefits and not the weights developed for those who qualify for Medicaid based on a disability, but the weights could also be customized to best reflect the risk profile of the commercial population at issue.<sup>191</sup>

Along with her colleagues, Deborah Bachrach, the former director of Medicaid for the State of New York, recommends that states “consider the potential value of a single, standard risk adjustment program across all coverage options.”<sup>192</sup> Among the possible advantages they cite are the following:

- consumers’ risk scores could follow them from plan to plan, allowing insurers “to appropriately target resources and services to their members and better manage overall health costs and clinical outcomes[;]”
- states would benefit from “greater, population-based predictability of health costs—supporting a more refined approach to rate setting in the Medicaid/CHIP programs, and evaluation of premium rates in the private market[;]” and
- states could realize administrative costs savings by eliminating the need for re-scoring as consumers move from plan to plan.<sup>193</sup>

It is important that the risk adjustment program be transparent and predictable, so that insurers can account for risk payments when they determine what premiums to charge.<sup>194</sup> To this end, New Jersey policymakers will need to decide what entity will make risk adjustment decisions using what process. The Premium Stabilization Rule provides that risk adjustment can

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<sup>190</sup> See Proposed Premium Stabilization Rule, 76 Fed. Reg. at 41,938 (explaining that one of the reasons HHS chose not to “require[] that all States utilize a Federally-certified risk adjustment methodology” was that “some States have already implemented risk adjustment models for programs such as Medicaid.”).

<sup>191</sup> *Chronic Illness and Disability Payment System FAQs*, UNIVERSITY OF CALIFORNIA, SAN DIEGO, <http://cdps.ucsd.edu/faqs.html> (last visited Mar. 21, 2012).

<sup>192</sup> DEBORAH BACHRACH, PATRICIA BOOZANG & MELINDA DUTTON, *MEDICAID’S ROLE IN THE HEALTH BENEFITS EXCHANGE: A ROAD MAP FOR STATES* 19 (2011).

<sup>193</sup> *Id.*

<sup>194</sup> HALL, *supra* note 13, at 5. See also ROSS WINKELMAN, MARY HEGEMANN, SYED MEHMUD, TOM LEONARD, JAMES WOOLMAN, JULIE PEPPER & PATRICK HOLLAND, WAKELY CONSULTING GROUP, *RISK ADJUSTMENT AND REINSURANCE: A WORK PLAN FOR STATE OFFICIALS* 7 (2011) (“Because the risk adjustment and reinsurance programs are intended, in part, to manage premium costs by allowing issuers to be less conservative when pricing their products, ensuring that stakeholders fully understand and are reasonably comfortable with the methodology adopted by states will be an important element of program success.”).



be performed by the exchange or by an entity that “meets the standards promulgated by HHS to be an entity eligible to carry out Exchange functions.”<sup>195</sup> HHS has specified that to be “eligible to carry out Exchange functions” an entity must (1) be a state agency or other entity that has “demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage” but is not a health insurance issuer or (2) be the state’s Medicaid agency.<sup>196</sup>

New Jersey, then, has a number of options, including:

- ceding responsibility for risk adjustment to the federal government,
- assigning responsibility to the exchange,
- assigning responsibility to the Department of Banking and Insurance,
- assigning responsibility to the Department of Human Services, or
- assigning responsibility to an independent entity.

Edwin Park suggests that it may not make sense for the exchange to undertake risk adjustment, given that funds must be collected from and redistributed to plans outside the exchange.<sup>197</sup> Likewise, Park suggests that risk adjustment may not “mesh well” with a state insurance department’s current “regulatory functions, may engender conflict of interest charges from insurers, and could drain scarce resources from staffs that will already have increased responsibilities.”<sup>198</sup> With a few exceptions, including New York, risk adjustment is not currently the responsibility of state insurance departments.<sup>199</sup>

Ross Winkelman and his colleagues note that if the reinsurance and risk adjustment programs are placed in the exchange, grant funding could be available “to design, develop and build the required infrastructure” and the exchange assessment could support ongoing costs.<sup>200</sup> There may also be “efficiencies and cost offsets [that] can be achieved by leveraging the newly developed exchange function to calculate and administer the Medicaid Managed Care risk program.”<sup>201</sup> To the extent that elements of the risk adjustment program benefit Medicaid, costs can be allocated between the programs, with those allocated to Medicaid eligible for federal matching funds.<sup>202</sup>

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<sup>195</sup> 45 C.F.R. § 153.310(b).

<sup>196</sup> 45 C.F.R. § 155.110(a).

<sup>197</sup> PARK, *supra* note 151, at 23.

<sup>198</sup> *Id.*

<sup>199</sup> *Id.*

<sup>200</sup> WINKELMAN ET AL., *supra* note 151, at 13.

<sup>201</sup> *Id.*

<sup>202</sup> WINKELMAN ET AL., *supra* note 194, at 18.

## Conclusion

New Jersey must make a number of choices with regard to the implementation of its reinsurance and risk adjustment programs. These include the following:

- Whether to establish its own reinsurance program, and if so, whether to collect contributions from fully-insured plans or leave that to HHS;
- If it chooses to establish its own reinsurance program, whether to vary the federal attachment point, coinsurance rate, and reinsurance cap;
- Whether to establish its own risk adjustment program;
- If it chooses to establish its own risk adjustment program, whether to use a risk adjustment methodology promulgated by HHS or to develop its own methodology for federal certification;
- Whether to coordinate risk adjustment in the individual and small group markets with risk adjustment in Medicaid managed care; and
- What entity or entities should be responsible for the reinsurance and risk adjustment programs.

A planning tool New Jersey might employ to sort through its options is the creation of an expert advisory group.<sup>203</sup> An advisory group comprising exchange personnel, staff from the Departments of Human Services and Banking and Insurance, insurance and reinsurance experts, consumers, and navigators could come together to share their perspectives on these issues.<sup>204</sup> Members of the advisory group would bring to the table a variety of positive and negative experiences with risk adjustment methods, and could help the state avoid missteps. The group would have expertise on risk-spreading from a variety of public and private perspectives; it could identify issues and recommend implementation strategies for the state's consideration.

The Affordable Care Act's interlocking risk-spreading provisions are designed to ease insurers' transition to the Act's health insurance market reforms, smooth the establishment of the exchanges, and combat adverse selection and other market failures that have plagued prior reform efforts. While HHS is responsible for implementing risk corridors, New Jersey has significant choices to make and will play a central role in the implementation of the state's reinsurance and risk adjustment programs.

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<sup>203</sup> WINKELMAN ET AL., *supra* note 151, at 11. *See also* WINKELMAN ET AL., *supra* note 194, at 8 (setting forth a "Spectrum of Stakeholder Involvement" and noting that some states may wish to establish a stakeholder workgroup "to help structure input and feedback into the development of the risk mitigation programs").

<sup>204</sup> *Id.* at 11.



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