Spreading the Risk under the Patient Protection and Affordable Care Act: The Three Rs and Lessons from Another Industry's Reinsurance Mechanism

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Risk-sharing mechanisms under the Patient Protection and Affordable Care Act of 2010 ("PPACA") are intended to smooth risk across health plans and neutralize the potentially disproportionate risks and costs anticipated as a result of PPACA requirements.[1] The effectiveness of these programs depends on full and fair data reporting by participating issuers. Two of the three risk sharing mechanisms are funded by transfers from other participating plans; as a result, if one plan fails to fully and fairly report its data, its competitors may pay through higher charges or lower subsidies. The consequences for inaccurate data reporting have yet to be tested, but the Centers for Medicare & Medicare Services (CMS) already noted inconsistencies and potential errors in the data collected for the 2014 inaugural year.[2] A compelling parallel is provided by the reinsurance pooling mechanism for workers compensation insurance, where cost allocation among insurers is similarly dependent upon accurate data reporting. Within the workers compensation insurance industry, a government investigation and a whistleblower's account of fraudulent reporting led to a ten-figure regulatory settlement, industry-wide litigation and a $450 million class action settlement.[3] This article explores and describes the three risk sharing mechanisms of PPACA, the program characteristics that parallel the workers compensation reinsurance pool, and the events that transpired after a workers compensation insurer was alleged to have misreported its data to the detriment of other insurers.

The 3 Rs: Reinsurance, Risk Assessment and Risk Corridors

The three "Rs" of the PPACA – reinsurance, risk assessment and risk corridors – are programs required under the PPACA in order to avoid the negative consequences of "risk selection" and "premium spiral," promote competition on the basis of quality and value, and provide insurance market stability in the early years of the PPACA when information concerning new enrollees is limited.[4] Risk selection occurs when plans seek to attract healthier individuals while avoiding the enrollment of high-risk individuals, perhaps by offering less coverage at a lower premium, which is attractive to lower risk (*i.e.*, healthier) individuals, or a plan may offer benefits or a list of prescription drugs that are unattractive to individuals with expensive health conditions.[5] Adverse selection – otherwise known as premium spiral – is a process whereby individuals at greater risk of high health spending are more likely to seek coverage, while low risk individuals are more likely to opt out of coverage, which in turn causes higher than average insured risk, higher premiums, more opting out by healthier individuals, and a further spiral of even higher premiums.[6] Finally, the influx of previously uninsured individuals into the health insurance exchanges under the PPACA presents difficulties in pricing coverage, at least in the early years, because insurers lack detailed data and experience regarding the uninsured.[7] The three Rs are intended solutions to these issues.

The objectives of each of the three programs vary, as do the participants, the sources of funds, and the requirements for determining whether a plan receives a payment or makes a contribution, and how much. The following table summarizes pertinent aspects of each program:

	Risk Adjustment	***Reinsurance***	***Risk Corridors***
How the Program Works:	Transfers funds from plans with lower-risk enrollees to plans with higher-risk enrollees based on a per-plan average actuarial risk score, which is based on the age, sex and diagnoses for each enrollee.[8]	Provides payments to plans that enroll beneficiaries with catastrophic claims. Each insurer pays a specified amount per enrollee per benefit year. If an enrollee's costs exceed a certain threshold (called an attachment point), the plan is eligible for payment (up to a reinsurance cap).[9]	Limits losses and gains beyond an allowable range. HHS collects funds from plans with lower than expected underwriting profit margins and makes payments to plans with higher than expected profit margins. Plans with claims less than 97% of target amounts pay, and plans with claims greater than 103% of target amounts receive funds.[10]
Who Participates:	Non-grandfathered individual and small group market plans, both inside and outside of the exchanges. [11]	All health insurance issuers and self-insured plans contribute; individual market plans subject to new market rules (both inside and outside the exchange) are eligible for payment.[12]	Qualified Health Plans, which are plans qualified to be offered on a health insurance exchange.[13]
Who Foots the Bill:	Only the participating plans; the transfers net to zero within a market, within a state.[14]	Health insurance issuers and self-insured plans. When funds run out, payments stop.[15]	Qualified Health Plans and the government, since the payments do not have to net to zero.[16]
Effective Dates:	2014 onward, permanent.[17]	2014-2016, temporary.[18]	2014-2016, temporary.[19]

According to information released by the Department of Health and Human Services (HHS), total payments to plans for the reinsurance program were $7.9 billion for 2014, while payments for risk adjustment and risk corridors were $4.6 billion and $362 million, respectively.[20] For the risk adjustment program, transfers among plans are expected to represent 10 percent of the premiums received in the individual market, 21 percent of the premiums received in the catastrophic market, and six percent of the premiums received in the small-group market.[21] Although the reinsurance program received more funds than the total payments requested by plans for 2014, the $362 million in risk corridor payments are substantially less

than the $2.87 billion requested by participating plans.[22] As a result, risk corridor payments will be prorated to approximately 12.6 percent due to a 2015 appropriations bill that blocked government funding for any shortfall, although HHS will explore other sources for funding in the event of a shortfall for the 2016 program year.[23]

The 2014 Data and Oversight by CMS

CMS has already noted discrepancies in the 2014 data submitted under the programs.[24] Specifically, CMS noted inconsistencies between the premium and/or claims data that was reported by issuers under the risk corridors program and data that had previously been submitted by the same issuers under the reinsurance and risk assessment programs.[25] These discrepancies were noted to be "significant" and "material" and were identified while conducting program integrity reviews.[26] In light of the noted discrepancies, the original August 14, 2015 deadline for releasing the risk corridors data was postponed by CMS.[27] CMS required every company that submitted risk corridor data for the 2014 benefit year to complete and attest to a checklist identifying critical components of the risk corridors submission, and companies with large discrepancies in their data were required to complete a Discrepancy Worksheet in order to quantify and explain the differences.[28] The information submitted in connection with the checklist and the Discrepancy Worksheet were required to be attested to as accurate by a representative with authority to legally and financially bind the company.[29] However, where discrepancies were not attributable to particular circumstances specified in the Discrepancy Worksheet, an issuer could elect to make a voluntary resubmission of its risk corridor data without explanation.[30] CMS released the risk corridor data on October 1, 2015 following receipt

of the requested information.[31] CMS reported that over half of the participating plans resubmitted their risk corridor data filings as part of this data validation process.[32]

To the extent companies disagree about the reinsurance and risk adjustment calculations, there is an appeals process, but it is limited to alleged processing errors, allegations that HHS incorrectly applied the relevant methodology or purported mathematical errors.[33] CMS intends to implement an audit process, which would include review of claims-specific data that CMS does not otherwise receive, but according to the Government Accountability Office, the audit procedures were still in development as of April 2015.[34] For the risk adjustment program, CMS intends to audit a sub-set of claims-specific data that is first validated through an independent third party.[35] Since the audit process is expected to take over a year, adjustments to average actuarial risk will not occur until the 2016 benefit year and the first adjustments to payments (for the 2016 benefit year) will be issued in 2018.[36] Whether payers will be satisfied with the enforcement efforts of regulatory authorities is yet to be seen. Certainly the incentives for government oversight and enforcement are arguably reduced where the effects of inaccurate reporting are largely borne by the other participating payers.

The Workers Compensation Insurance Industry's Reinsurance Mechanism

Although the three Rs have only been in effect since January 1, 2014, risk sharing among competing insurance companies, and issues arising from alleged improper data reporting, is not new. Similar to the three Rs, the reinsurance pooling mechanism for workers compensation insurance allocates costs based on data reported by each participating insurer, and inaccurate reporting affects the obligations of other insurers. The sequence of events that occurred within the workers compensation insurance industry after an insurer was alleged to have inaccurately reported its data provides an interesting comparison for those impacted by the risk sharing

requirements under the PPACA and suggests the potential for an enforcement pressure potentially more onerous than regulatory action.

Every state requires employers to have workers compensation insurance, but not every employer can find an insurer willing to provide it with coverage for whatever reasons.[37] A pooling mechanism (the "Pool") was established to facilitate the proportional sharing of costs among insurers in more than 40 states by allocating to insurers responsibility for workers compensation insurance coverage for those employers who are unable to find a willing insurer.[38] This group of employers unable to find coverage in the voluntary market is known as the "residual market" for workers compensation insurance.[39] Each insurer's share of the costs associated with the residual market is directly proportional to the amount of premiums it collects within the "voluntary market," the market of employers that are able to find willing insurance companies to provide them with coverage.[40] Much like the risk sharing mechanisms of PPACA, the effectiveness of the workers compensation reinsurance Pool depends upon full and accurate reporting from each participating company, specifically, the amount of written premium from the voluntary market.

In 2005, regulatory authorities conducted an investigation of American International Group Inc. and its affiliates and subsidiaries ("AIG"), one of the largest providers of workers compensation insurance in the United States.[41] The investigation revealed that AIG had, over several decades, engaged in false premium reporting practices to evade residual market obligations, as well as state insurance taxes, by generally reporting workers compensation insurance premium as general liability or reinsurance assumed premium.[42] The 2005 investigation also disclosed that the reporting practices had been the subject of a 1991-1992 internal investigation led by an AIG senior legal officer.[43] An internal written report surfaced,

which acknowledged that the conduct exposed AIG to civil liability and indicated, "[p]otential plaintiffs who could take advantage of this and other causes of action are the other insurance companies who have to pick up AIG's share of residual market assessment and other assessments . . . ."[44]

The 2005 investigation led to a $1.6 billion settlement with New York and federal authorities, including a payment of at least $301 million to victims of AIG's false workers compensation premium reporting through a fully funded settlement fund.[45] However, the participating companies of the Pool believed total damages exceeded $1 billion.[46] On May 24, 2007 the Pool, through the National Council on Compensation Insurance, Inc. (NCCI), its attorney-in-fact for the participating companies of the Pool, sued AIG in Illinois federal court alleging damages arising from AIG's alleged underreporting of voluntary market premium, including violations of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. § 1962(c) and (d) ("RICO"), fraud, accounting and claims for equitable relief.[47]

AIG took an offensive strategy in response to the NCCI, filing a third party complaint against twenty-four named participants in the Pool as well as unnamed companies, alleging widespread underreporting of workers compensation premiums by the participating companies.[48] In ruling on a motion to dismiss by the third-party defendants, the District Court held that AIG's claims against the other participating companies were properly pled under Federal Rule of Civil Procedure (Rule) 14(a) as third-party claims because of the interrelatedness of the participating companies' obligations to the Pool.[49] The Court reasoned that it was necessary to consider the impact of any other alleged underreporting by other participating companies since underreporting by one company affects the obligations of every other Pool participant.[50]

Some of the third-party defendants filed counterclaims against AIG, and claims by or against AIG concerning the alleged underreporting of workers compensation premium, including equitable claims and claims for racketeering, fraud and punitive damages, survived after multiple rounds of motions to dismiss.[51] Interestingly, however, the claims by the original plaintiff, the NCCI, were eventually dismissed for lack of subject matter jurisdiction.[52] The Court noted that although there was no dispute that the other companies participating in the Pool had standing to bring claims separately against AIG, neither the Pool nor the NCCI possessed such standing since they did not suffer a direct injury as a result of AIG's underreporting.[53]

While the motion to dismiss the NCCI's claims was pending, two participating companies filed a putative class action complaint against AIG on behalf of the other members of the Pool, and the class action was formally related to the original lawsuit.[54] On February 28, 2012, nearly seven years after the initial investigation by the New York authorities, the Court approved (1) a $450 million class settlement, pursuant to which AIG also paid an award reimbursing the class plaintiffs and certain participating companies for nearly $17 million in attorneys' fees, (2) a regulatory settlement agreement with the states for another $100 million in penalties and $46,507,385 in back taxes and assessments, and (3) agreement by AIG to reform its workers compensation data reporting practices.[55]

Conclusion

The events that transpired in the workers compensation insurance industry are worthy of attention by healthcare payers because they began with a risk sharing system not unlike the risk adjustment or reinsurance policies of PPACA where the obligations of each participating company is directly impacted by the accuracy of its competitors' data reporting. Ultimately, private, industry-wide litigation was the means to resolve alleged inequities created by inaccurate

data reporting among participating workers compensation insurers. To the extent that the risk-sharing mechanisms in the healthcare industry continue to parallel those for the residual market for workers compensation insurance, the healthcare industry may experience a similar atmosphere of scrutiny as payers are incentivized to find means to hold each other accountable for accurate data reporting.

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[1] 42 U.S.C. §§ 18061-63 (2010).

[2] Allison Bell, *CMS Sees Possible Insurer PPACA Data Integrity Problems*, LifeHealthPro (Aug. 27, 2015), http://www.lifehealthpro.com/2015/08/27/cms-sees-possible-insurer-ppaca-data-integrity-pro; Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget at 5, Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2, 5-6 (Aug. 31, 2015), https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-21476.pdf; The Three Rs: An Overview, Centers for Medicare and Medicaid Services (Oct. 1, 2015), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html.

[3] *See infra*, notes 37-55.

[4] 78 Fed. Reg. 15410, 15411-13 (Mar. 11, 2013); HENRY J. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE AND RISK CORRIDORS (Jan. 22, 2014), at http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.

[5] 42 U.S.C. § 18001 *et seq.* (2010); 78 Fed. Reg. 15410, 15411-13 (Mar. 11, 2013); HENRY J. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE AND RISK CORRIDORS *supra* note 4.

[6] HENRY J. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE AND RISK CORRIDORS *supra* note 4; Cori E. Uccello, *Risk Adjustment and Other Risk-Sharing Provisions in the Affordable Care Act*, American Academy of Actuaries Issue Brief, 1-2 (2011), https://www.actuary.org/files/Risk_Adjustment_IB_FINAL_060811.pdf.

[7] HENRY J. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE AND RISK CORRIDORS *supra* note 4; Cori E. Uccello, *supra* note 6, at 2. The state-based American Health Benefit Exchanges and the Small Business Health Options Program Exchanges, collectively, the "exchanges," are set up by either the individual states or the Department of Health and Human Services pursuant to PPACA requirements, 42 U.S.C. Section 18041 (2010), in order to provide a forum for insurance companies to offer insurance coverage to individuals and small businesses through qualified health plans. HENRY J. KAISER FAMILY FOUNDATION, SUMMARY OF THE AFFORDABLE CARE ACT, 1, 4 (Apr. 23, 2013), http://files.kff.org/attachment/fact-sheet-summary-of-the-affordable-care-act.

[8] 42 U.S.C. Section 1343(a); HENRY J. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE AND RISK CORRIDORS, *supra* note 4. Although states utilizing the federally-run exchange must use the federal risk adjustment model and pay an associated fee, states that operate their own exchange have the option to establish their own state-run risk adjustment program (with approval from HHS) or allow the federal government to run the program. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE AND RISK CORRIDORS *supra*. In 2014 all but one state (Massachusetts) used the federally run program. John Kautter, Gregory C. Pope and Patricia Keenan, *Affordable Care Act Risk Adjustment: Overview, Context and Challenges*, 4 MEDICARE & MEDICAID RESEARCH REVIEW E2 (Centers for Medicare & Medicaid Services 2014), https://www.rti.org/files/Affordable_Care_Act_Risk_Adjustment.pdf.

[9] 42 U.S.C. 1341(a)-(b); HENRY J. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE, AND RISK CORRIDORS, *supra* note 4; Allison Bell, *Feds: We'll Send Some PPACA Lifeboat Money in December*, LifeHealthPro (June 19, 2015), http://www.lifehealthpro.com/2015/06/19/feds-well-send-some-ppaca-lifeboat-money-in-decemb.

[10] 42 U.S.C. 1342(a)-(b); HENRY J. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE, AND RISK CORRIDORS, *supra* note 4; Allison Bell, *Feds: We'll Send Some PPACA Lifeboat Money in December*, *supra* note 9. The "target amount" for each plan is the total premiums (including premium subsidies) less administrative costs. *See* Uccello, *supra* note 6, at 4. The target amount is then compared to the plan's "allowable costs," which are expenditures on medical care for enrollees plus costs for quality improvement activities. HENRY J. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE, AND RISK CORRIDORS, *supra* note 4. If a plan's actual allowable costs (net of risk adjustment and reinsurance payments) come within ± three percent of the target amount, the plan bears its loss or keeps its gains, but if the actual costs fall outside of the three percent corridor, the government shares in the gains or losses with the plan. Uccello, *supra* note 6, at 4. The government bears 50 percent of the spending between ± 3 percent and 8 percent of the target and 80 percent of the spending beyond ± 8 percent of the target. *Id.*; 42 U.S.C. 1342(b).

[11] HENRY J. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE, AND RISK CORRIDORS, *supra* note 4. A non-grandfathered plan is a plan that was in existence at the time the PPACA was enacted in March 2010. *Id.* at n. 1. These plans were "grandfathered" under the law and are subject to fewer requirements, but they lose their grandfathered status if they make significant changes, *i.e.*, significant increases to cost sharing or the imposition of new annual benefit limits. *Id.*

[12] *Id.*

[13] *Id*.

[14] David Blumenthal M.D., *The Three R's of Health Insurance*, THE COMMONWEALTH FUND (March 5, 2014), http://www.commonwealthfund.org/publications/blog/2014/mar/the-three-rs-of-health-insurance; Kautter *supra* note 8 at E5.

[15] David Blumenthal, *supra* note 14.

[16] *Id.*; HENRY J. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE, AND RISK CORRIDORS, *supra* note 4; Angela Boothe and Brittany LaCouture, *The Affordable Care Act's Risk Spreading Mechanisms: A Primer on Reinsurance, Risk Corridors, and Risk Adjustment* (American Action Forum Jan. 9. 2015), http://americanactionforum.org/research/the-acas-risk-spreading-mechanisms-a-primer-on-reinsurance-risk-corridors-a.

[17] HENRY J. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE, AND RISK CORRIDORS, *supra* note 4.

[18] *Id.*

[19] *Id.*

[20] The Three Rs: An Overview, Centers for Medicare and Medicaid Services (Oct. 1, 2015), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html.

[21] Summary Report on Transmittal Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year at 5, Department of Health and Human Services, Centers for Medicare and Medicare Services (June 30, 2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-Draft-6-30-15.pdf; Allison Bell, *Feds Post PPACA Lifeboat Program Numbers*, LifeHealthPro (June 30, 2015), http://www.lifehealthpro.com/2015/06/30/feds-post-ppaca-lifeboat-program-numbers.

[22] Allison Bell, *Feds Post PPACA Lifeboat Program Numbers*, *supra* note 21; Summary Report on Transmittal Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year, *supra* note 21, at 3; The Three Rs: An Overview, *supra* note 20.

[23] The Three Rs: An Overview, *supra* note 20; Ronald E. Bachman, *Insurers Affected by 2015 Budget Change to Risk Corridors*, The Institute for Healthcare Consumerism, http://www.theihcc.com/en/communities/policy_legislation/insurers-affected-by-2015-budget-change-to-risk-co_i5gwghz1.html. The Consolidated and Further Continuing Appropriations Act of 2015 includes an amendment that forecloses HHS from using its regular operating funds to make risk corridor payments by blocking its ability to transfer money from trust funds. H.R. 83, Consolidated and Further Continuing Appropriations Act, 2015, Div. G, tit. II, § 227, at 892, http://www.gpo.gov/fdsys/pkg/CPRT-113HPRT91668/pdf/CPRT-113HPRT91668.pdf.

[24] Allison Bell, *CMS Sees Possible Insurer PPACA Data Integrity Problems*, *supra* note 2; Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget, *supra* note 2, at 5.

[25] Allison Bell, *CMS Sees Possible Insurer PPACA Data Integrity Problems*, *supra* note 2.

[26] *Id.*; The Three Rs: An Overview, *supra* note 20.

[27] Allison Bell, *Feds: We'll Send Some PPACA Lifeboat Money in December*, *supra* note 9; Bob Herman, *CMS Delays Insurance Payout Data From ACA's Risk Corridors*, Modern Healthcare (August 10, 2015), http://www.modernhealthcare.com/article/20150810/NEWS/150819994; Key Dates in 2015: QHP Certification in the Federally-Facilitated Marketplaces; Rate Review; Risk Adjustment, Reinsurance, and Risk Corridors at 2, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-Key-Dates-QHP-Certification-in-the-FFM-Rate-Review-and-3Rs-final.pdf.

[28] Allison Bell, *CMS Sees Possible Insurer PPACA Data Integrity Problems*, *supra* note 2; Allison Bell, *PPACA Risk Programs: Will Those Kidneys Work?* LifeHealthPro (Sept. 11, 2015), http://www.lifehealthpro.com/2015/09/11/ppaca-risk-programs-will-those-kidneys-work; Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget, *supra* note 2, at 5-6; Instructions for 2014 Risk Corridors Discrepancy Worksheet, Centers for Medicare & Medicaid Services, at 3, 6, 30 (2014), https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2014-Risk-Corridors-Validation-Instructions.pdf.

[29] Instructions for 2014 Risk Corridors Discrepancy Worksheet, Centers for Medicare & Medicaid Services, *supra* note 28, at 30.

[30] *Id.* at 15, 25.

[31] Risk Corridors Payment Proration Rate for 2014, Department of Health & Human Services, Centers for Medicare & Medicare Services (Oct. 1, 2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.

[32] *Id.*; The Three Rs: An Overview, *supra* note 20.

[33] 79 FR 13841 (Mar. 11, 2014), as amended at 80 Fed. Reg. 10876 (Feb. 27, 2015); Allison Bell, *Feds Post PPACA Lifeboat Program Numbers*, *supra* note 21.

[34] UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE, PATIENT PROTECTION AND AFFORDABLE CARE ACT, DESPITE SOME DELAYS, CMS HAS MADE PROGRESS IMPLEMENTING PROGRAMS TO LIMIT HEALTH INSURER RISK, REPORT TO CONGRESSIONAL REQUESTERS, at 28, 30 (April 2015), http://www.gao.gov/assets/670/669942.pdf.

[35] 77 Fed. Reg. 73118 (December 7, 2012); 78 Fed. Reg. 72322 (December 2, 2013); UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE, *supra* note 34, at 29.

[36] KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: RISK ADJUSTMENT, REINSURANCE, AND RISK CORRIDORS, *supra* note 4.

[37] *See Nat'l Council on Comp. Ins., Inc. v. Am. Int'l Grp., Inc.*, No. 07 C 2898, 2007 U.S. Dist. LEXIS 59707, at *3-4 (N.D. Ill. Aug. 6, 2007). For details and information sources regarding state workers compensation insurance requirements, see Advanced Insurance Management LLC, Insurance Regulation by State, http://www.cutcomp.com/depts.htm.

[38] *Nat'l Council on Comp. Ins., Inc.* (Aug. 6, 2007) *supra* note 37, at *4-5. States that do not participate in the Pool, a/k/a the National Workers Compensation Reinsurance Pool or the National Workers Compensation Reinsurance Association, operate their own reinsurance pooling mechanism. *See* State by state list of residual market administrators and reinsurance mechanisms, *https://www.ncci.com/nccimain/ResidualMarkets/AdministratorsAssignedCarriers/Pages/admin_table.aspx.*

[39] *Nat'l Council on Comp. Ins., Inc.* (Aug. 6. 2007), *supra* note 37, at *4.

[40] *Id*.

[41] *Id.* at *6-7; *Nat'l Council on Comp. Ins., Inc. v. Am. Int'l Grp., Inc.*, No. 07 C 2898, 2009 U.S. Dist. LEXIS 14524, at *12 (N.D. Ill. Feb. 23, 2009). *See also* AIG Workers' Compensation Overview, http://www.aig.com/Workers-Compensation_3171_417731.html.

[42] *Nat'l Council on Comp. Ins., Inc.* (Aug. 6, 2007), *supra* note 37, at *5.

[43] *Id*.

[44] *Id.* at *6.

[45] *Id.* Under the agreement that was reached, the funds were to be released in three stages: (1) before September 1, 2007, a participating state could recover by tendering a release to defendant AIG for any claims by the state's residual market pool relating to AIG's underreporting; (2) between September 2, 2007 and October 31, 2009, defendant could use the funds to settle directly with affected parties; and (3) after November 1, 2009 remaining funds would be distributed on a pro rata basis to participating states. *Id.* at *6-7. No funds were intended to revert back to AIG. *Id.* at *7.

[46] *Id.*

[47] *Id.* at *2-3, *6-7. The NCCI is an independent not-for-profit corporation created by the insurance industry to gather data, analyze industry trends and prepare insurance rate and loss cost recommendations, in addition to serving as the administrator for many state residual markets. *See* https://www.ncci.com/NCCIMain/AboutNCCI/Pages/default.aspx.

[48] *Nat'l Council on Comp. Ins., Inc.* (Feb. 23, 2009), *supra* note 41, at *7-8, *15.

[49] *Id.* at *39-41.

[50] *Id.* at *40-41.

[51] *Id.* at *57-58, *61-62; *Am. Int'l Grp. Inc. v. ACE INA Holdings, Inc.*, 722 F. Supp. 2d 948, 955, 963-66, 967-968, 970-71 (N.D. Ill 2010).

[52] *Nat'l Council on Comp. Ins., Inc. v. Am. Int'l Grp., Inc.*, No. 07 C 2898, 2009 U.S. Dist. LEXIS 73871, at *9 (N.D. Ill. Aug. 20, 2009).

[53] *Id.* at *18-19, *25-26.

[54] *Id.* at *29-30; *Nat'l Council on Comp. Ins., Inc.* (Feb. 23, 2009), *supra* note 35, at *62*; ACE INA Holdings, Inc.*, 722 F. Supp. 2d at 955-56.

[55] *Am. Int'l Grp. v. ACE INA Holdings, Inc.*, No. 07 CV 2898, No. 09 C 2026, 2012 U.S. Dist. LEXIS 25265, at *12-13, *69-70 (N.D. Ill. Feb. 28, 2012).