Canceled plans, part III: An extension, an expansion, and more changes to 2014 rules

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Two important pieces of federal regulatory guidance for health insurers were released on March 5, 2014. First, the government announced[1] a further extension of certain transitional health insurance policies that had been exempted from many Patient Protection and Affordable Care Act (ACA) requirements under a November 14, 2013, letter from the Centers for Medicare and Medicaid Services (CMS). Second, the final 2015 Notice of Benefit and Payment Parameters[2] was released, which includes important additional policy adjustments related to these formerly canceled plans. Some of these changes will take effect for the 2014 plan year.

The original transitional policy for canceled plans allowed certain individual and small group plans that did not comply with the ACA to be renewed for one additional year. This change, announced long after health insurers filed their premium rates for 2014, could result in a less healthy population in the ACA-compliant market, since healthier individuals may be more likely to retain their noncompliant plans. If this occurs, there is an increased risk that the filed premium rates could be inadequate to cover the higher claim costs. To mitigate this concern, the government proposed changes to certain rules for 2014—namely, the federal reinsurance program, the risk corridor program, and the medical loss ratio (MLR) requirement. The final 2015 Notice finalizes several of these changes, although key provisions may be subject to further alterations.

In prior papers (linked in the sidebar below), I explored the original transitional policy, as well as the initial proposed changes to 2014 rules related to that policy. The linked papers also provide background on the federal reinsurance and risk corridor programs. These programs are at the heart of how the administration intends to manage the impact of the transitional policy on the fledgling ACA marketplaces.

MORE THAN AN EXTENSION, AN EXPANSION

In the original announcement last fall, the government allowed the renewal of certain non-ACA-compliant individual and small group health insurance plans that were in force as of October 1, 2013. However, the exemption only allowed a single additional year of coverage in the "transitional" plan.

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1 Centers for Medicare and Medicaid Services, Center for Consumer Information and Oversight (March 5, 2014). Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1, 2016. Retrieved March 11, 2014, from http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf.

2 Department of Health and Human Services (March 11, 2014). 45 CFR Parts 144, 147, 153, et al. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule. Federal Register v.79 no. 47 (March 11, 2014). Retrieved March 11, 2014 from http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf.

The new guidance allows the transitional policies to be renewed until October 1, 2016—which means that some transitional policies could persist through September 30, 2017. As before, the new guidance leaves it up to state regulators to decide whether or not the extension of pre-ACA policies will be allowed in their jurisdictions, and issuers must provide prescribed notices to policyholders in transitional plans each year. A further extension to 2017 will be considered in the future.

The CMS letter also expands the class of policies that can be extended, addressing future potential cancelations proactively.

- In states that did not allow the original transitional plan extensions, regulators have the option to allow non-ACA compliant policies issued in 2013 that have not yet rolled over into ACA-compliant plans (including, for example, "early renewals"—policies that were renewed off of the regular schedule to delay implementing ACA requirements), to be renewed.

- In 2016, the ACA will subject groups with 51 to 100 employees to small group regulations instead of the less strict large group regulations that currently apply in all[3] states. Under the new transitional policy rules, a state can allow these groups to renew their prior plans instead. In other words, this rule could allow states to effectively delay the expansion of the small group market to 51 to 100 employee groups until 2017.

The new guidance allows quite a bit of flexibility for state regulators:

- They can choose to allow this transitional relief or not separately for each market (individuals, small groups, large groups that will become small groups, or any combination thereof).

- They can allow extensions all the way through October 2016, or limit them to a shorter time frame.

Of course, this flexibility means issuers will have to track regulators' decisions and account for their potential impacts as they develop premium rates for 2015. Those rates must generally be filed in the spring and early summer of 2014.

Starting in 2014, the ACA mandates that all individuals maintain a minimum level of coverage or pay a penalty, unless they qualify for an exemption. Under the prior guidance, members whose plans are canceled were granted a "hardship exemption" from the individual mandate. These exemptions will continue to be available for anyone whose noncompliant coverage is canceled between now and October 1, 2016.

ANSWERS TO MORE QUESTIONS

Some of the questions I raised regarding transitional policies and their interaction with other ACA provisions in my earlier papers have been answered:

- The new CMS letter and the final 2015 Notice clarify that transitional policies are not part of the "single risk pool" under the ACA. This means that they can be rated separately from other non-grandfathered policies. If rate increases for these policies exceed the threshold requiring federal review (generally 10%), issuers must use the procedure in place for such reviews prior to April 1, 2013.

- The 2015 Notice also explicitly directs[4] plans not to include transitional policy experience with their other non-grandfathered plan experience for risk corridor reporting. That means that transitional policy experience will not be blended with the rest of the non-grandfathered pool experience when determining risk corridor settlements. Therefore, we now know that—other than paying reinsurance contributions—transitional policies will not participate in any of the three R's (risk corridors, reinsurance, and risk adjustment).

REINSURANCE

The changes to the 2014 federal reinsurance program parameters that were proposed in the draft 2015 Notice were largely implemented in the final version. In particular, the attachment point will be lowered from $60,000 to $45,000 for 2014, and if there are excess funds left in a given year, the coinsurance rate will be increased to try to use them up. However, in the final rule, the U.S. Department of Health and Human Services (HHS) indicates that it does not intend to increase the coinsurance above 100% (in other words, it will not pay out more than the total claim amount between the attachment point and the cap). Any remaining funds after the coinsurance is raised to 100% will be carried forward to the next year.

3 According to Kaiser State Health Facts, as of 2013, states define small groups are to include employers with two to 50 employees, with some variation on whether sole proprietorships are treated as small groups or not. See http://kff.org/other/state-indicator/small-group-guaranteed-issue, accessed March 11, 2014.

4 Department of Health and Human Services. Op. cit. p. 13786.

RISK CORRIDORS AND MEDICAL LOSS RATIOS

In the final rule, HHS decided to implement the state-specific adjustments outlined in the proposed rule. For states in which regulators permit transitional policies for 2014 (transitional states), HHS will develop an "adjustment percentage" based on a model plan, as described in my prior paper.[5] This adjustment percentage will then be added to both the profit floor of 3% and the administrative cost cap of 20% for qualified health plans (QHPs) with allowable costs exceeding 80% of after-tax premiums.

The application of the adjustment percentage will increase overall risk corridor settlements in transitional states relative to what they would have been without the adjustment percentage. However, the adjustment percentage will be set to zero when calculating medical loss ratios to avoid generating additional rebates to policyholders.

HHS says seven times in the final rule that it intends for the risk corridor program to be "budget neutral." While the adjustment for transitional plans will increase risk corridor payments to issuers (or decrease receipts from issuers), HHS points out that the changes in the 2014 reinsurance program will have the opposite effect. That is, the reinsurance changes tend to reduce risk corridor payments to issuers (and increase receipts from issuers). This is because reinsurance payments are included in the risk corridor calculation (they reduce the costs that are compared to the target amount to determine the risk corridor ratio).

HHS also points out (as I did in a prior paper) that the risk corridor protection only applies to QHPs, not to an issuer's entire book of non-grandfathered business. This tends to reduce the impact of the adjustment for transitional plans in the risk corridor calculation relative to the reinsurance changes, because the reinsurance changes apply to all non-grandfathered, non-transitional plans.

HHS believes that the changes to reinsurance will win in this tug-of-war, so that the risk corridor program will be budget neutral. If this does not prove to be the case, HHS "may make future adjustments, either upward or downward to this program…to the extent necessary to achieve this goal."[6]

A NEW PROPOSED RULE

As this article was going to press, HHS released another proposed rule (**http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9949-P. pdf**) for comment. Among many other changes, several further modifications of the reinsurance, risk corridor, and MLR programs were proposed:

- HHS states that "[b]oth the reinsurance and risk adjustment programs are subject to the fiscal year 2015 sequestration. The risk adjustment and reinsurance programs will be sequestered at a rate of 7.3 percent in fiscal year 2015." However, the rule goes on to say that "funds that are sequestered in fiscal year 2015 from the reinsurance and risk adjustment programs will become available for payment to issuers in fiscal year 2016 without further Congressional action." It is not yet clear how this will be accomplished operationally.
- HHS intends to allocate reinsurance contributions first to the reinsurance pool and administrative costs, and only then to the U.S. Treasury. In other words, if less money is collected than intended, the U.S. Treasury will be the first to absorb the shortfall, not insurers. Prior rules had allocated the shortfall on a pro rata basis between the Treasury and insurers. This is a significant change, since under the proposed rule a shortfall of up to $2 billion out of the $12.02 billion total collection for 2014 could occur before the amount allocated to pay reinsurance-eligible claims would be reduced.
- For 2015, HHS proposes to raise the administrative cost ceiling and the profit floor in the risk corridor formula by two percentage points (to 22% and 5% of after-tax premiums, respectively). Unlike the state-specific adjustment percentage for 2014, this adjustment percentage would apply to all QHPs in all states. However, the MLR formula would not take into account the 2% adjustment percentage (in other words, the additional risk corridor relief cannot trigger MLR rebates). HHS also states again that it intends to make additional changes as needed in order to operate the program in a budget-neutral fashion (although it says it only four times in this rule).
- Several changes were proposed for the MLR program, including an extension of the time that issuers can include ICD-10 conversion expenses in the MLR numerator, technical changes for states that merge the small group and individual markets, and adjustments to increase the MLR numerator slightly in 2014 for issuers that offered transitional plans or offered QHPs through the exchanges.

5 Norris, D. and Leida, K. (January 27, 2014). Update on canceled plans: Will changes to 2014 reinsurance and risk corridor programs provide financial relief? Milliman.com. Available at: http://us.milliman.com/insight/2014/Update-on-canceled-plans-Will-changes-to-2014-reinsurance-and-risk-corridor-programs-provide-financial-relief/.

6 Department of Health and Human Services. Op. cit. p. 13787.

LOOKING AHEAD

It is hard to say how many transitional polices will remain in 2016, when the current extension expires. The individual market has historically experienced high member turnover relative to other markets, since many people used individual market coverage as a bridge between other types of coverage. Furthermore, members in transitional policies may find they are eligible for subsidies in the exchanges, or may develop health conditions that cause them to select a new plan with lower cost sharing. On the other hand, healthy individuals may want to keep a transitional plan as long as possible, which may result in a significant number of persisting policies.

Astute readers may observe that, with the addition of the budget neutrality constraint, the risk corridor program is starting to look more and more like the risk adjustment program. There are some key differences, however:

- It appears that risk corridors' budget neutrality has the potential to move money across states and markets, while risk adjustment is neutral within each state and market.
- Risk corridors are limited to QHPs, while risk adjustment applies to all non-grandfathered, non-transitional policies.
- Risk corridors take into account the impact of federal reinsurance recoveries and risk adjustment transfers, while risk adjustment does not take reinsurance into account.
- Risk corridor settlements are tied directly to an issuer's costs and revenue, whereas risk adjustment is based on a statistical model of an issuer's risk profile and a statewide average premium.

The last two bullets have subtle implications. The changes to the reinsurance parameters have the effect of injecting additional money into the individual market. Unlike risk adjustment, risk corridors can then try to move some of that money to issuers adversely impacted by the transitional policy. Risk adjustment cannot do this as directly, since it does not directly depend on an issuer's actual financial results.

The transitional policy is causing insurance issuers particular anxiety for 2014 because the regulatory change came after premium rates had been set for the ACA-compliant markets on and off the exchanges. This new guidance at least gives issuers a chance to build estimates of the transitional plan impact into rates for 2015 and 2016. However, it is now up to each state and issuer again to decide whether to allow the extensions—and expansions—or not. Even if states act quickly to publish their decisions, issuers will find it difficult to predict the number of people who will remain in transitional policies in 2015 and 2016, as well as their health status.

The one certainty at this point is that further changes are likely. In the final 2015 Notice, HHS listed many topics about which it anticipates further rulemaking. That list includes potential further changes to risk corridors (the change considered would make the parameters yet more generous). It remains to be seen whether the additional guidance will come before or after rates are set for 2015.

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