Risk Corridors Episode IV: No New Hope

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On Tuesday, President Obama signed the Consolidated and Further Continuing Appropriations Act to fund most of the federal government through the remainder of fiscal year 2015. This legislation is long, but one brief paragraph has major implications for health insurers offering individual and small group qualified health plan (QHP) coverage compliant with the Patient Protection and Affordable Care Act (ACA). The relevant portion (section 227) states:

> *None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services–Program Management" account, may be used for payments under section 1342(b)(1) of Public Law 111–148 (relating to risk corridors).*

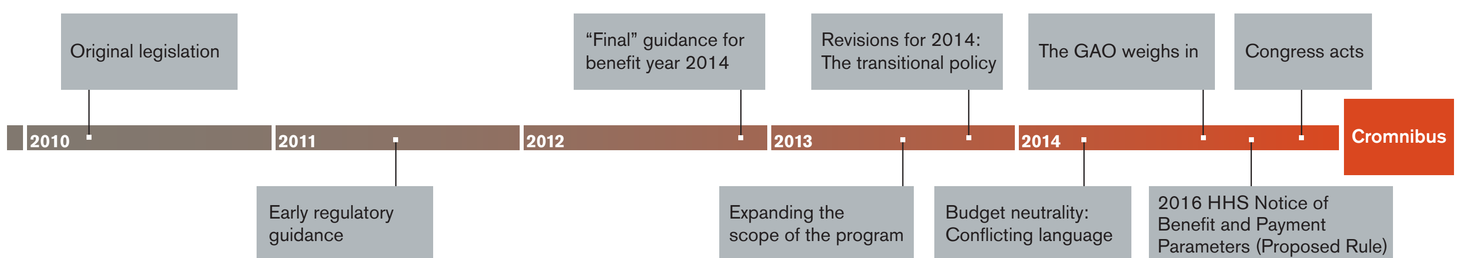
In this article we will unpack this technical language and explore the implications for health insurers. While we are at it, we will also examine other changes to risk corridors recently proposed in regulation.

These changes are only the latest twists in a long line of changes to the risk corridors under the ACA. Figure 1 gives a timeline of these changes (more details are in the appendix).

The thorny issue for the risk corridor program has long been budget neutrality–or rather, the potential lack thereof. The two cousins of the risk corridors, risk adjustment and transitional reinsurance, are either budget-neutral (risk adjustment) or come with a source of revenue (reinsurance). For both of these programs, the funding is provided totally by health plans; there is no funding obligation on the part of the government. However, in the original statute, there was no budget neutrality requirement for risk corridors, and any excess amounts that are due to health plans appeared to be a payment obligation of the government. The newly enacted law changes that (at least for fiscal year 2015).

In late September, a Government Accountability Office (GAO) letter to Congress[1] clarified that, although the ACA requires the U.S. Department of Health and Human Services (HHS) to make risk corridor payments (irrespective of whether risk corridor payments received from issuers were enough to cover those obligations), Section 1342 of the ACA did not constitute an appropriation. An appropriation authorizing HHS to spend money on risk corridors would be needed, although the GAO indicated that, based on fiscal year (FY) 2014 appropriations language, risk corridor funds received by HHS would be available to make payments. The FY 2014 appropriation language also could have allowed HHS to use funds from other sources to make risk corridor payments. There was just one problem: no risk corridor payments were actually slated to be made in FY 2014; in fact, the payments for insurer's gains or losses

FIGURE 1: HISTORY OF RISK CORRIDORS



1 Poling, S.A. (September 30, 2014). Department of Health and Human Services–Risk Corridors Program: Letter to Sen. Jeff Sessions and Rep. Fred Upton. GAO. Retrieved December 17, 2014, from http://www.gao.gov/assets/670/666299.pdf.

in calendar-year 2014 will happen during FY 2015. Accordingly, plans were waiting to see whether the appropriations language for FY 2015 would still allow HHS the latitude it had in the prior year. As it turns out, it does not.

Before the new law, the most recent guidance related to risk corridors was in a proposed rule, the Notice of Benefit and Payment Parameters for the 2016 plan year, released on November 26 by HHS. This rule included additional language regarding the budget neutrality of the risk corridor program. We have explored this feature in past articles; although the risk corridor formula appears symmetric, there are many forces that could swing the aggregate net payments in one direction or the other.

The preamble to the proposed rule affirms that HHS still expects to receive more money than will be paid out over the life of the program. If that should happen, HHS intends to alter the risk corridor formula to pay these excess funds to QHP issuers (specifically, two parameters of the program, the profit floor and the administrative expense cap, will be increased until all excess funds are used up). Whether the program will indeed result in a net gain for HHS is in question, although one way that HHS could influence the aggregate receipts would be to adjust the transitional reinsurance parameters in the individual market. If these parameters were more generous to issuers than what was expected during pricing, it would tend to decrease the risk corridors' ratios for these carriers. HHS has already made such adjustments for the 2014 plan year.

On the other hand, if the risk corridor program results in a net payment from HHS to insurers, HHS affirmed in the proposed rule that it would pay QHP issuers the monies required by the ACA using other funding sources (subject to the availability of funds). In the Health Watch article "Risk Corridors Under the Affordable Care Act"[2] (October 2013), we first discussed the potential for this situation, and it remains a very real possibility today, which is due to the continued pricing uncertainty of the markets, intense market competition in many localities, and regulatory changes made after premium rates had already been set.

This week's legislation casts significant doubt on the promise made by HHS in the proposed rule, although the administration may be able to find alternative avenues in the event that payments to QHP issuers exceed receipts.

The Consolidated and Further Continuing Appropriations Act is likely not the final word, however, because it raises a number of questions that are not well addressed by current regulations and guidance. Here, we focus on the most salient items still left to be answered, although other details are also outstanding.

WILL IT MATTER?

The law does not prohibit using collections to fund payments. Therefore, this week's act only comes into play if risk corridor payments by issuers are inadequate to cover amounts owed to

What are risk corridors?

Risk corridors are one of three premium stabilization programs under the ACA. Together with risk adjustment and federal transitional reinsurance, they make up the "3Rs" intended to mitigate risks to insurers during the transition to new health insurance rules in the individual and small employer markets.

Risk corridors share some health insurance risk between insurers and the federal government, at least for certain qualified health plans. In simple terms, insurers that make high profits would pay into the program, while those that lose money would receive a payment for part of the losses. The reality is more complex, however. For more details, see the following papers:

- Doug Norris, Mary van der Heijde, & Hans K. Leida: "Risk Corridors Under the Affordable Care Act–A Bridge Over Troubled Waters, but the Devil's in the Details." Available at **http://us.milliman.com/uploadedFiles/insight/2013/Risk-corridors-under-the-ACA.pdf**.
- Hans K. Leida: "President Obama's Transitional Policy for Canceled Plans." Available at **http://us.milliman.com/insight/2013/President-Obamas-transitional-policy-for-canceled-plans/**.
- Hans K. Leida & Doug Norris: "Update on Canceled Plans: Will Changes to 2014 Reinsurance and Risk Corridor Programs Provide Financial Relief?" Available at **http://us.milliman.com/uploadedFiles/insight/2014/update-canceled-plans.pdf**.
- Hans K. Leida: "Canceled Plans, Part III: An Extension, an Expansion, and More Changes to 2014 Rules." Available at **http://us.milliman.com/uploadedFiles/insight/2014/canceled-plans-part-III.pdf**.

2 Norris, van der Heijde, & Leida (October 2013). Risk Corridors Under the Affordable Care Act–A Bridge Over Troubled Waters but the Devil's in the Details. SOA Health Watch, p. 1, 5-10.

other issuers. HHS has stated several times that it expects to collect enough from issuers to meet all obligations. This week's act places a great deal more importance on that expectation. Will issuers whose pricing was high enough to produce the gains needed to trigger making a risk corridor payment attract enough enrollment (and generate enough gains) to compensate issuers who had premiums that were low enough to trigger being entitled to receive a risk corridor payment?

IS THIS THE FINAL WORD?

The appropriation in question is for fiscal year 2015 (ending September 30, 2015), which is when risk corridor payments for program year 2014 will be made. Nothing has been appropriated for fiscal year 2016 or later, nor has there yet been any prohibition on making payments from future appropriations that have not yet been enacted. In other words, Section 1342 of the ACA has not been repealed, and nothing has changed regarding HHS's obligations to make those payments. It remains conceivable that an appropriations act for a future fiscal year could authorize the making of risk corridor payments (including possibly for prior-year obligations that have gone unpaid).

ARE THERE OTHER FUNDING AVENUES FOR HHS?

This week's legislation restricts HHS from appropriating funds from the Medicare trust funds and other accounts financed by this week's bill to cover any risk corridor shortfall, but are there other methods by which any shortfalls could be covered? This is likely to be a complex legal question. One potential source of funds might be the user fee that the Centers for Medicare and Medicaid Services (CMS) collects directly to cover the cost of the federally facilitated exchanges, but it is far from clear whether this would be feasible as a practical matter. One obvious problem with using exchange fees as a funding source is that doing so would potentially use funds collected from insurers in federally facilitated exchange states to benefit insurers in all states nationally.

IN THE EVENT OF A SHORTFALL, HOW WILL HHS PRIORITIZE PAYMENTS FOR ANY RISK CORRIDOR CONTRIBUTIONS IT RECEIVES?

The frequently asked questions (FAQ) published in April 2014 may be the best indication of HHS's current thinking on the matter, and in that guidance HHS stated its intent to prioritize paying off any shortfalls from prior years in each subsequent year. On the other hand, depending on how one counts, there have been at least five versions of the regulations codifying the ACA's risk corridor provisions (some being minor revisions, with others being more substantial). The passage of this legislation could result in further guidance or rule-making activity to clarify or revise exactly how any payments will be prioritized.

Risk corridor ratios are calculated separately for each carrier's individual and small group blocks of business in each state, but it is not yet known whether HHS intends to keep these funding pools separate or combine them. So far, HHS has made no mention of maintaining budget neutrality separately for different market segments. The individual and small group markets in each state have unique characteristics, and each state and market has different participating carriers.

HOW WILL MLR REPORTING AND REBATES BE AFFECTED?

The ACA's medical loss ratio (MLR) calculations are applied after application of the transitional reinsurance, risk adjustment, and risk corridor transfers. For example, receiving a risk corridor transfer will decrease an issuer's MLR, which could result in paying rebates (or increasing rebates already owed). Will issuers still be required to report receivables in the MLR calculation that may not, in fact, be received? The most recent guidance on the subject (the FAQ of April 11, 2014) suggests that insurers will not be able to make any adjustments to the risk corridor amount for MLR purposes even in the event that there is a shortfall. However, there will be an adjustment in the following year's MLR reporting to account for any reduction in the prior year's risk corridor payments. Many issuers may not be significantly impacted because the MLR calculation uses three years of experience. However, new entrants in the market, such as Consumer Operated and Oriented Plan (CO-OP) programs, may be more significantly affected.

HOW WILL STATUTORY FINANCIAL FILINGS BE AFFECTED?

The National Association of Insurance Commissioners (NAIC) has issued guidance on the financial statement treatment of the ACA's premium stabilization programs (including risk corridors). The most recent guidance, codified in the draft Statement of Statutory Accounting Principles (SSAP) No. 107,[3] includes language that requires issuers to evaluate the collectability of risk corridor receivables during each reporting period. These amounts are required to be written off if it is deemed probable that they are uncollectable. It remains to be seen how issuers and auditors will apply the "probable" standard in light of the issues described above.

WILL SEQUESTRATION IMPACT THE RISK CORRIDORS?

In March, HHS released a proposed rule, Exchange and Insurance Market Standards for 2015 and Beyond,[4] which discussed the potential for fiscal year 2015 sequestration. Here, HHS noted that the ACA's risk adjustment and transitional reinsurance programs would be subject to sequestration at a rate of 7.3% in fiscal year 2015, but in the same breath announced that sequestered funds would be paid at the beginning of the following fiscal year. The reason for this treatment was that the collections under these programs could be treated as a "revolving fund." In the event that the government decides that the new budget neutrality requirement makes risk corridors a revolving fund as well, risk corridor payment may also be subject to such sequestration.

3 NAIC (November 16, 2014). Statement of Statutory Accounting Principles No. 107: Accounting for the Risk-Sharing Provisions of the Affordable Care Act. Exposure Draft. Retrieved December 17, 2014, from http://www.naic.org/documents/committees_e_app_sapwg_exposure_14-12_ssap_107.docx.

4 *Federal Register* (March 21, 2014). Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Proposed Rule. Retrieved December 17, 2014, from http://www.gpo.gov/fdsys/pkg/FR-2014-03-21/pdf/2014-06134.pdf.

HOW WILL THE HEALTH INSURANCE MARKET REACT?

Because risk corridor protection is (essentially) afforded only to QHPs, and because QHP certification is typically done by exchanges, the risk corridor program provides a significant incentive for insurers to participate in these key marketplaces. If insurers have doubt that this protection will persist, will some carriers reduce their 2016 exchange presence accordingly?

Insurers may also need to price QHPs more conservatively in 2016 now that risk corridors have become even more uncertain. Originally, risk corridors were designed to protect insurers until they needed to set premium rates in 2016 for coverage effective in 2017. The idea was that insurers should start having useful data from 2014 and 2015 experience by then. Unfortunately, the decision to allow transitional policies in many states has added to the unknowns for insurers trying to set rates for 2016 and 2017 (in particular, it is hard to estimate exactly when transitional members will move to ACA-compliant products, how many of them there are, and what their health statuses are relative those already in ACA-compliant plans).

LOOKING AHEAD

HHS will have an opportunity to address these (and other) concerns in the final 2016 Notice of Benefit and Payment Parameters, expected to arrive in early 2015. Although the current outlook is not bright for issuers with 2014 losses that would have otherwise been made partially whole by risk corridors, there are many ways that this could conclude. If HHS collects enough money over the three-year life of the program, then the program will be fully funded, and it becomes a payment timing issue for carriers (rather than a funding issue). Even a timing issue could create major challenges for smaller insurers and new entrants to the market, because they may not have the surplus capital necessary to weather such a delay.

Of course, if overall funds are inadequate, the consequences could be more significant for all carriers, but particularly for those smaller issuers (and carriers where ACA business is a significant portion of their overall business) described above. The HHS FAQ published in April suggests that 2014 policies would be first in line for any available payments, but carriers have been counting on this additional protection since 2014 pricing began back in early 2013 (and even earlier than that).

With 2016 plan pricing already under way, how will carriers react to the new information available? Some insurers have already assumed that risk corridors would not be fully funded when setting rates last spring, which could serve to increase 2015 premiums and dampen any 2016 impact to some degree. To the extent that the current uncertainties are not resolved early in 2015, it may be too late for insurers to change course in time for 2016 pricing.

At this point, the language behind (and the funding of) the risk corridor program is shrouded in politics and controversy. Will the next installment give underpriced carriers new hope?

OTHER CONSIDERATIONS

As described throughout this report, the rules surrounding risk corridors are continually evolving and uncertain. This report reflects our best understanding of the rules to date. To the extent that these rules change further in the future, the conclusions in this report may no longer hold.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet its qualification standards to perform the analysis and render the actuarial opinion contained herein. The authors of this report are not lawyers, and nothing in this report should be construed as legal advice.

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APPENDIX: HISTORY OF RISK CORRIDORS

1. Original legislation

The risk corridor program was initially established in Section 1342 of the ACA (enacted in March 2010).[5] It was conceived as a transitional program for the individual and small group markets, effective for plan years 2014 through 2016 only.

The legislative language is approximately one page in length. It defines a plan's "target amount" as the difference between total premiums and administrative costs. It requires plans to pay HHS if actual "allowable costs" (defined as cost of benefits, net of transitional reinsurance and risk adjustment) are less than the target. Issuers pay nothing on the first 3%, then they pay 50% of the next 5%, and then they pay 80% of any excess thereafter. (All percentages are of the target amount.) If allowable costs exceed the target amount, HHS is required to pay issuers according to the same formula.

Although the payment and receipt formulas are symmetrical, the text of the law does not explicitly cap total payouts or total receipts.

2. Early regulatory guidance

The initial proposed rule governing risk corridors was published in the Federal Register on July 15, 2011.[6] The corresponding final rule was published March 23, 2012.[7] These rules provided definitions of terms and clarified certain operational details for the risk corridor program.

3. "Final" guidance for benefit year 2014

The Notice of Benefit and Payment Parameters for 2014[8] provided regulatory guidance for implementing the risk corridor provision of the ACA. This rule adopted portions of (and made changes to) the proposed rule that was published on December 7, 2012.[9] These rules established the timing of data submission and aligned this timeline with the MLR reporting schedule. There were also changes to the definition of "allowable cost" and "taxes" and a change in how transitional reinsurance contributions were accounted for in the formula. This rule allowed issuers to include a minimum profit margin in the calculation when determining the target amount. Both the proposed and final rules included an example illustrating how the calculation was intended to work.

On the same day the rule was finalized, an interim final rule was published making modifications to the risk corridor provisions for 2014.[10] These changes, which were finalized on October 30, 2013,[11] made the calculation more in line with the ACA's "single risk pool" requirement. Allowable costs for each plan under this change were determined as a pro rata share of the pooled claim cost amount; effectively, this makes the risk corridor calculation an issuer-level calculation within each market rather than a plan-level calculation.

4. Expanding the scope of the program

As stated in the ACA, risk corridors are applicable to qualified health plans (QHPs) in the individual and small group markets. A QHP gets its status as a QHP by being certified by an exchange, and as a result, plans offered only outside of the exchanges are generally not QHPs.

In a rule finalized August 30, 2013,[12] HHS allowed off-exchange plans that are "substantially the same" as a QHP to be included in the risk corridor program.

5. Revisions for 2014: The transitional policy

In the fall of 2013, a new federal policy was announced whereby policies that did not comply with the ACA (and that were in force prior to 2014) could be renewed without complying with various protections in the ACA. This policy was announced well after issuers had finalized 2014 premiums for ACA-compliant products. A consequence of this late change was that issuers would likely be enrolling a less healthy risk pool than originally expected, because many policies that were anticipated to enroll into the ACA-compliant risk pool had been previously medically underwritten and now would be able to retain their current non-ACA plans for at least another year.

In its proposed Notice of Benefit and Payment Parameters for 2015[13] (published December 2, 2013), HHS indicated that it was considering making changes to the risk corridor formula (to be effective for the 2014 plan year) to help offset the unexpected changes brought on by the transitional policy. While several options were raised in the rule commentary, no specific change was included in the proposed rule text. The final Notice of Benefit and Payment Parameters for 2015 (published March 11, 2014),[14] did include some concrete adjustments. For the 2014 benefit year, there would be an increase in the maximum allowable administrative costs and the minimum profit threshold, both of which will tend to decrease an issuer's target amount and increase its risk corridor receipt (or lower its payment).[15] The exact amount of the increase was not specified for 2014 because, although HHS described the calculation in detail, the dollars involved vary by state and rely upon information that is currently unavailable (the proportion of the market enrolled in transitional policies). A specific adjustment was announced for 2015 in a regulation issued later that same month.[16]

6. Budget neutrality: Conflicting language

The final Notice of Benefit and Payment Parameters for 2015 (from March 11, 2014) included, for the first time, language in the rule commentary about budget neutrality. The rule stated:

> *We intend to implement this program in a budget-neutral manner, and may make future adjustments, either upward or downward to this program (for example, as discussed below, we may modify the ceiling on allowable administrative costs) to the extent necessary to achieve this goal.*

Similar budget-neutrality language was found throughout the rule on Exchange and Insurance Market Standards for 2015, published March 21, 2014.[17]

Further details were included in an FAQ document published by HHS on April 11, 2014.[18] In this document, HHS clarified that if risk corridor collections for the 2014 plan year were inadequate for all payments owed, it would make a pro rata reduction in all payments to make the program budget-neutral. Collections from the 2015 plan year would first be used to cover the 2014 shortfall before being applied to 2015 payments, with a similar process for 2016. The document stated that future guidance would explain what would happen if there was still a shortfall after 2016.

HHS received comments expressing concern about the budget neutrality guidance. In the final Exchange and Insurance Market Standards for 2015 (published May 27, 2014), HHS stated:

> *In the unlikely event of a shortfall for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In that event, HHS will use other sources of funding for the risk corridor payments, subject to the availability of appropriations.*

This language could be interpreted to mean that, while HHS intends the program to be budget-neutral, it acknowledged that the statute requires HHS to make full payment, and that other sources of funding would need to be used for that purpose if collections were insufficient.

7. The GAO weighs in

In a letter dated September 30, 2014,[19] the Government Accountability Office (GAO) addressed congressional questions regarding whether risk corridor payments could be made based on laws enacted to date.

While the ACA *obligates* HHS to make payments under the program, this obligation does not actually *enable* HHS to make the payments without an appropriation. The GAO states in its letter, "Appropriations may be provided through annual appropriations acts as well as through permanent legislation…The making of an appropriation must be expressly stated in law…It is not enough for a statute to simply require an agency to make a payment."

The GAO opinion states that CMS's appropriation for fiscal year 2014 would have allowed monies received by HHS from issuers paying into the risk corridor program during that fiscal year to be used to pay HHS's obligations under the risk corridor program (including payments made in future years, until 2019). It also would have allowed funds from the general CMS program management appropriation to be used to pay for risk corridor obligations during the 2014 fiscal year. However, because CMS will not actually begin making risk corridor payments until fiscal year 2015, any future appropriations legislation would need to contain similar language to authorize any payments to be made for risk corridor obligations. As we have seen, the appropriations legislation for fiscal year 2015 strictly restricts the monies available to make risk corridor payments.

8. 2016 HHS Notice of Benefit and Payment Parameters (Proposed Rule)

On November 26, 2014, HHS published the proposed rule related to the Notice of Benefit and Payment Parameters for the 2016 plan year.[20] The primary intent of the Notice each year is to set ACA parameters that change annually, but HHS has used it to promulgate a variety of other new and revised ACA-related regulations. These draft regulations will not be finalized until early 2015, although historically, items in the proposed rule stand a good chance of becoming final.

In the preamble to this proposed rule, HHS reiterated that it expects the risk corridor program to receive more money than will be paid out over the life of the three-year program. In this case, HHS would alter the formula's profit floor and administrative cost ceiling parameters to pay these excess funds to QHP issuers.

On the other hand, if the program results in a net payment from HHS to issuers, HHS affirmed that it would pay QHP issuers the monies required by the ACA using other funding sources, subject to the availability of an appropriation to release those funds.

9. Congress acts

The Consolidated and Further Continuing Appropriations Act[21] explicitly prohibits HHS from using any assets transferred into the CMS program management fund to make risk corridor payments. This legislation appears to codify the budget neutrality requirement that HHS itself described in the regulations published in March 2014 and in the April 2014 FAQ discussed earlier.

The language does not appear to prohibit HHS from using other potential sources of risk corridor funding not transferred into the program management account, such as user fees. In the September 30 letter, the GAO opined that risk corridor collections may be characterized as user fees, and also that the 2014 appropriation language allowed such user fees to be used for risk corridor payments. The fiscal year 2015 appropriation appears to continue to allow the use of user fees, including risk corridor collections, to make risk corridor payments.[22]

5 U.S. Congress (March 23, 2010). Patient Protection and Affordable Care Act. Retrieved December 17, 2014, from http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

6 *Federal Register* (July 15, 2011). Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Proposed Rule. Retrieved December 17, 2014, from http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17609.pdf.

7 *Federal Register* (March 23, 2012). Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Final Rule. Retrieved December 17, 2014, from http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf.

8 *Federal Register* (March 11, 2013). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rules; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program; Proposed Rule. Retrieved December 17, 2014, from http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf.

9 *Federal Register* (December 7, 2012). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014; Proposed Rule. Retrieved December 17, 2014, from http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf.

10 *Federal Register (March 11, 2013).* Patient Protection and Affordable Care Act; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014. Retrieved December 17, 2014, from http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04904.pdf.

11 *Federal Register* (October 30, 2013). Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rule. Retrieved December 17, 2014, from http://www.gpo.gov/fdsys/pkg/FR-2013-10-30/pdf/2013-25326.pdf.

12 *Federal Register* (August 30, 2013). Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final Rule. Retrieved December 17, 2014, from http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21338.pdf.

13 *Federal Register* (December 2, 2013). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Proposed Rule. Retrieved December 17, 2014, from http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28610.pdf.

14 *Federal Register* (March 11, 2014). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule. Retrieved December 17, 2014, from http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf.

15 Leida, H.K. & Norris, D. (January 2014). Update on Canceled Plans: Will Changes to 2014 Reinsurance and Risk Corridor Programs Provide Financial Relief. Milliman Healthcare Reform Briefing Paper. Retrieved December 17, 2014, from http://www.milliman.com/uploadedfiles/insight/2014/update-canceled-plans.pdf.

16 *Federal Register* (March 21, 2014), Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Proposed Rule. Retrieved December 17, 2014, from http://www.gpo.gov/fdsys/pkg/FR-2014-03-21/pdf/2014-06134.pdf.

17 *Ibid.*

18 HHS (April 11, 2014). Risk Corridors and Budget Neutrality. Retrieved December 17, 2014, from https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.

19 Poling, S.A., *op.cit.*

20 *Federal Register* (November 26, 2014). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Proposed Rule. Retrieved December 17, 2014, from http://www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27858.pdf.

21 U.S. Congress (December 16, 2014). Consolidated and Further Continuing Appropriations Act, 2015. Retrieved December 17, 2014, from https://www.congress.gov/113/bills/hr83/BILLS-113hr83enr.pdf.

22 *Ibid.*