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Remain, refile, or remove?

The new 3 Rs: Considerations for 2018 commercial contingency planning

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Health plans are gearing up for product and premium development for the 2018 benefit year. The uncertainty surrounding the future of the Patient Protection and Affordable Care Act (ACA) has complicated the strategic decision-making process for 2018. Answers to questions such as "What happens if the individual mandate goes away?" and "Will cost-sharing reduction (CSR) funding continue?" could significantly affect premiums. A number of legislative and regulatory proposals designed to modify the ACA are emerging, making it unclear which changes will occur and even less clear when health plans will be required to react. Issuers need to be ready and actively prepare to respond quickly to the evolving marketplace.

Issuers should develop contingency plans to evaluate the possible changes in the marketplace and identify the circumstances under which action is necessary. In our discussions with issuers thus far, much of the contingency planning comes down to a new "3 Rs" to mitigate risk in the current environment:

- **Remain** in the market
- **Refile** in the summer if changes occur after products are initially filed
- **Remove** products from the market

In this paper, we use the framework of these new 3 Rs—remain, refile, or remove—in order to lay the groundwork for successful 2018 contingency planning.

Recent proposals may affect premium rates

Some of the changes that health plans should prepare for include, but are not limited to:

- Transitional plans continuing past December 31, 2017
- Individual mandate exemptions potentially increasing
- Risk adjustment program changes as described in the 2018 Benefit and Payment Parameters
- A new Actuarial Value Calculator and associated benefit parameters to meet its requirements from the Centers for Medicare and Medicaid Services (CMS)
- Revised age curve, including new categories under age 21 and potential widening of the 3:1 limit
- Expanded de minimis actuarial value (AV) range (per the proposed Market Stabilization Rule)

These changes, whether finalized or proposed, introduce a number of potential impacts to be considered by issuers in 2018 product development and pricing. Some could affect the range of compliant plan designs that can be offered, and others may have an impact on consumer behavior and/or the resulting morbidity in the ACA marketplace in 2018. All of these items have the potential to create additional uncertainty and require time to understand and address. Issuers have three fundamental strategies at their disposal as they develop products and premium rates for 2018.

Remain

It is plausible, even with the variety of regulatory proposals being discussed, that *the ACA could remain structurally unchanged for the 2018 plan year.* As long as changes made do not affect the fundamental design of the ACA and are made sufficiently in advance of initial filing, health plans should anticipate the rate development and submission process to resemble that of recent years. Under this status quo scenario, health plans will need to produce the standard filing forms, EDGE server submissions, and other items to ensure compliance. The proposed Market Stabilization Rule was followed two days later by a revised calendar with additional time for premium development and qualified health plan (QHP) certification, so the new administration is aware of issuers' concerns about timing.

On February 23, 2017, CMS released guidance confirming the extension of transitional plans through calendar year 2018, which will likely delay the introduction of these healthier members to the single risk pool while reducing the uncertainty surrounding marketplace morbidity for 2018 pricing.

In light of the January 20 executive order, one key consideration is the potential for the administration to make hardship exemptions easier to obtain, which would loosen the individual

mandate.[1] As a result of the executive order, the Internal Revenue Service (IRS) delayed implementation of a check that would have more strictly enforced the individual mandate than in previous filing years.[2] If the individual mandate were removed or relaxed, then health plans would most likely assume that healthier individuals will leave the market and increase 2018 premiums accordingly.

Risk adjustment will continue to be a critical feature of the ACA. The biggest change here is the new prescription drug condition categories that will be added to the calculation in 2018. Health plans must continue diligently capturing appropriate codes to achieve their full risk score potential and consider the impact the drug data will have on their risk scores. It is possible the inclusion of prescription drug data will mitigate differences between issuers in coding intensity.

Health plans will need to continue checking actuarial value compliance using the 2018 CMS Actuarial Value Calculator and change plan designs as needed. Based on limited testing thus far, we are finding many 2017 plans will require changes to maintain compliance. The proposed Market Stabilization Rule introduces the potential for a modified AV de minimis range of +2%/-4%, allowing for leaner plan designs at each metallic tier level than in previous years, but maintaining the upper bound on benefit richness in each tier. Issuers should proactively evaluate whether they would modify plan designs under this scenario and be prepared for the impact of such modifications if the rule is finalized.

There are seven new age bands under age 21 being implemented for 2018. It will be important for issuers to consider how this affects both new business rates and renewal rate increases for members under age 21. Legislation has been proposed to expand the age curve from the current 3:1 slope, which could affect rating for 2018.

Refile

Health issuers that file 2018 products should also plan for potential refiling of 2018 premiums as some features of the ACA could be changed after initial submission. Because each state has unique rate filing deadlines, the timing of revision notifications is important. Significant price-bearing changes made after filing could require updating premiums. Timelines related to the proposed Market Stabilization Rule appear to indicate we will know more in April, though this does not eliminate future uncertainties, and in some cases could still be too late to react appropriately for initial filing submissions. While current political discussions appear focused on a longer-term transition, there is still the possibility of full repeal of the entire ACA for plan year 2018, which would require health issuers to completely reset and refile premiums if they choose to stay in the new market.[3]

When anticipating changes communicated after premiums are submitted, health plans should outline a process to identify the circumstances under which premium modifications will be necessary. Health plans should proactively discuss with state insurance departments whether refiling will be allowed under these circumstances. In some instances, state insurance departments have also allowed for the submission of multiple sets of rates, contingent on the outcome of a potentially significant change in the market.[4] Issuers should consider the estimated impact that potential changes would have on premiums when developing their strategies. Ultimately, health plans that want to stay in the market in 2018 need to develop and file premiums according to the existing ACA structure and deadlines, while equipping themselves with a contingency plan that allows for swift premium revisions if warranted by legislative or regulatory changes.

Remove

If regulatory changes destabilize the market in such a way that continuing to offer ACA products becomes too much of a risk, issuers may consider removing their products from the market.

This approach may be necessary if significant legislative or regulatory changes occur after initial filing submissions. If health plans are not allowed to refile premiums for price-sensitive ACA revisions, they face the risk of being underpriced. Issuers may then consider removing their products from the exchange market, if applicable, or removing products from the entire market.

A full repeal of the ACA at some point in the future without clear direction for a replacement plan may also warrant removal from the market. If a full repeal of the ACA occurs effective beginning 2018, issuers may lack time for adequate pricing.

Under either of these scenarios, health plans should proactively assess their risk tolerances so they are prepared to take action. Health plans should proceed with caution when deciding to remove themselves from a market and understand the potential

1 Milliman (January 26, 2017). Milliman identifies six questions arising from the Trump/ACA executive order. Press release. Retrieved February 28, 2017, from **http://us.milliman.com/WorkArea/DownloadAsset.aspx?id=83928&LangType=1048594** (PDF download).

2 The IRS originally planned to implement a system that would reject 2016 tax returns that do not include confirmation of taxpayer compliance with the individual mandate. However, the IRS recently backtracked on this plan, indicating returns that are silent on the mandate will still be accepted as they were in 2014 and 2015. For more information, see **http://www.sfchronicle.com/business/networth/article/Quiet-IRS-change-could-undermine-Obamacare-10932798.php** or **https://www.irs.gov/affordable-care-act/individuals-and-families/individual-shared-responsibility-provision**.

3 Bradner, E. (February 6, 2017). Trump: Health care replacement could take until 2018. CNN. Retrieved February 28, 2017, from **http://www.cnn.com/2017/02/05/politics/trump-health-care-tax-cuts/**.

4 There is some precedent for this. The 2016 rate filings in the individual market faced uncertainty over the availability of premium tax credits in states using the federal exchange, and many issuers filed dual sets of premium rates addressing scenarios with and without premium tax credits.

legal consequences. Under existing regulations, exiting a market requires notifying enrollees 180 days prior to the end of coverage and comes with a ban on reentry for five years, so health plans should discuss with state insurance departments the required timing and ramifications of such a decision.

Keep in mind that issuers choosing to file 2018 exchange products can wait until September 15, 2017, in deciding whether to remove some of their products from a given state's market or to pull out of the exchange entirely. This allows issuers to evaluate legislative changes for much of 2017 before making final decisions regarding their 2018 market strategies. Issuers who pull out of the exchange would still be required to make products available under guaranteed issue regulations, but would not be required to market these products. If the market is particularly uncertain, this may be a method for issuers to limit exposure while avoiding the penalties associated with full withdrawal from the market.

What should health plans do next?

Though major changes may not take effect in time to impact the 2018 benefit year, health plans should be attentive to legislative and regulatory discussions and potential actions. A critical component of proactive contingency planning is not only deciding what action to take, but also when to take it. Health plans need to decide whether continuing to offer ACA products is in their best interests in light of the substance and effective date of proposed reforms.

Issuers should be aware of applicable 2018 deadlines for the states in which they are filing, especially as these timelines can evolve. As these deadlines approach, issuers choosing to remain will have to begin the pricing process assuming the status quo of the ACA market. Delaying the pricing process until more is known can avoid significant unnecessary work, but may also create tight timelines under which to finalize and submit premiums. Health plans should be prepared to refile premiums if significant changes are made to the ACA after a rate filing has been submitted. Exiting the exchange or the market entirely can have significant immediate effects as well as longer-term consequences and may introduce additional costs if an issuer chooses to reenter the market in the future.

During this time of uncertainty, health plans should consider the staff and budget needed for each of the new 3 Rs: remain, refile, and remove, keeping long-term strategic goals and risk tolerance in mind. While the direction of the market is uncertain now, health plans can proactively evaluate the risks and rewards of various contingency plans in order to act swiftly and confidently when the new market landscape becomes clear in the future.

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