|  |  |
| --- | --- |
|  | 3407 S. Jefferson  St. Louis, MO 63118  314.556.7379  cara@moconsumers.org  moconsumers.org |

September 25, 2017

**Comments on Individual Market (On-Exchange) Rate Filings of Cigna Health and Life Company, HIOS Issuer ID #74483, Proposed Effective Date Jan. 1, 2018**

**I. Introduction**

Cigna Health and Life Insurance Company (“Cigna”) has made an application to the Missouri Department of Insurance (“the Department”) to increase its rates, on average, by 35.0% for the 2018 year. At the individual plan level, Cigna has proposed to increase rates between 17.06% and 72.51%. This change will affect approximately 83,760 people in Missouri.

We urge the Department to exercise its authority under Mo. Rev. Stat. § 376.465.10(4) and deem Cigna’s rates unreasonable absent further justification. Cigna inappropriately redacted or entirely omitted several fundamental assumptions from its filing, thus impeding the public’s ability to provide meaningful comments and the Department’s ability to critically analyze the proposed rate increases. Moreover, Cigna did not clearly explain how the assumptions it made regarding the elements of the rate filing will result in a 35.0% average increase. We are particularly concerned that Cigna’s proposed rate increases fail to account for regulatory changes set forth in the revised Market Stabilization Rule that Cigna and other issuers projected would reduce its costs in 2018.

**II. “Significant Factors” Identified by Cigna**

In Parts II and III of its rate filing—the Written Description Justifying the Rate Increase and the Actuarial Memorandum, respectively—Cigna identified four significant factors behind its proposed rate increase. Despite highlighting the importance of these factors, Cigna’s explanations of why they contribute to a 35.0% average rate increase are lacking.

1. Medical Trend

First, unlike other Missouri issuers, Cigna redacted its expected annual medical cost trend on which its calculations were based from its Actuarial Memorandum.[[1]](#footnote-1) This unnecessary redaction undermines the public’s ability to evaluate the overall rate filing. Cigna’s assumed overall trend should be unredacted to allow consumers the opportunity to better understand the reasoning behind Cigna’s proposed rate increase. Medical trend estimates such as this do not constitute trade secrets and, moreover, Cigna’s decision to redact its assumed overall trend factor from its Actuarial Memorandum is further unjustifiable given that it included unredacted “Annualized Trend Factors” (both for cost and utilization) for various benefit categories in one of its supporting documents.

Second, Cigna neither explained nor disclosed any of the underlying data or assumptions on which Cigna based its trend calculations for 2018, providing only a generalized summary of the reasoning behind these adjustments. Other aspects of Cigna’s filing lead us to be concerned that it may overestimate trend, however. For example, the Written Description implies that Cigna is a passive price-taker, forced to accept the prices providers assert without any bargaining power to drive down the cost of care. Additionally, although the public cannot see and thus cannot evaluate Cigna’s expected annual medical cost trend, the Department should consider that Milliman calculated the 2017 countrywide trend to be the 4.3%, the lowest trend has been in 16 years.[[2]](#footnote-2) This reflects a long-term decline in medical trend from more than 10% in the early 2000s to less than 5% today.[[3]](#footnote-3) To the expect Cigna’s trend estimates are higher than Milliman’s it should explain why. For example, Cigna should explain why it is assuming a trend factor of 12.5% for prescription drugs given that Milliman calculated only a prescription drug cost

increase of 8% in 2017 and prescription drug trends have been on the decline since 2015.[[4]](#footnote-4) Of course there are market-specific differences that Cigna presumably took into account, but it is not enough to merely say that; rather, Cigna’s should update its filing to elaborate on what those differences are so that a consumer and officials can better understand the company’s trend calculations (both in the aggregate and for specific benefit categories) and their impact on the overall rate increase for 2018.

1. Morbidity (Risk Pool) Adjustments

In its Written Justification, Cigna acknowledged that a number of factors can impact the health of its risk pool. Nonetheless, Cigna failed to offer explanations in its Actuarial Memorandum of how it calculated its morbidity adjustments for 2018 and redacted what little data it did provide. Although the Actuarial Memorandum states that “external factors such as the strength of the individual mandate, overall awareness of Individual health insurance products, and the presence or absence of transitional policies” can affect average morbidity, it does not disclose how Cigna actually weighed these different factors nor Cigna’s reasoning behind such weights.[[5]](#footnote-5) Another particularly troubling omission is the absence of any indication of whether Cigna expects to receive a risk-adjustment payment for calendar year 2016, on which it based its projections. This is important for Cigna to clarify because a projection of receiving rather than making a risk adjustment payment would indicate that Cigna has calculated that its insureds, as a group, were less healthy than average in 2016.

Cigna also failed to address the impact of a number of recent regulatory changes, many of which were adopted for purposes of improving health and stability of the individual market risk pool at the behest of the insurance industry. We discuss these changes in further detail below. In light of their absence from Cigna’s Actuarial Memorandum, we encourage the Department to

look critically upon Cigna’s unsupported assumption that average market-wide morbidity will increase from 2017 to 2018 and to demand further explanation.

1. Changes to Federal Standard Age Curve

One of the few regulatory changes Cigna identified in its materials is the change to the federal standard age curve with respect to children, which Cigna noted “results in a one-time material increase for children under the age of 21.”[[6]](#footnote-6) We point this out because it is telling that Cigna chose to prominently identify one of the few changes from the Market Stabilization Rule that supports an increase in rates while omitting any discussion of the numerous changes that put downward pressure on rates.

1. Funding of Cost-Sharing Reduction Subsidies

Cigna stated that their assumptions are based on the belief that it will not receive cost-sharing reductions in 2018. Certainly there is lots of uncertainty in this area, but Cigna has provided no information to show how or to what extent this assumption has affected their price calculations. Moreover, even though Cigna has claimed that it assumed that no cost-sharing reduction payments will be made to issuers in 2018, it has redacted key information and adjustment factors from Section 2, under Part III of the Actuarial Memorandum. Given that Cigna itself identified the potential loss of cost-sharing reduction payments as a “Significant Factor” requiring its rate increase, the Department must demand a fuller and more transparent explanation of these changes.

**III. Market Stabilization Rule**

The U.S. Department of Health and Human Services (HHS) proposed the Market Stabilization Rule in an effort to “improve the risk pool and promote stability in the individual insurance market.[[7]](#footnote-7) The rule made changes to a number of requirements, including Guaranteed Availability of Coverage, Open Enrollment Periods, Special Enrollment Periods, Levels of Coverage, Network Adequacy, and Essential Community Providers. Cigna’s failure to address these changes casts doubt on the validity of their morbidity assumptions.

1. Guaranteed Availability of Coverage (45 C.F.R. § 147.104)

Guaranteed availability of coverage requires each health insurance issuer that offers coverage in the individual or group market in a state to accept every individual and employer that applies for coverage.[[8]](#footnote-8) Previously, HHS interpreted this requirement to prohibit issuers from applying new enrollment premiums towards past-due premiums owed from previous coverage unless an individual sought to renew prior coverage with the same issuer in the same product. It also prohibited issuers from refusing to effectuate coverage based on the enrollee’s previous history of failing to pay their coverage premiums.[[9]](#footnote-9) Issuers objected to this interpretation, however, citing unfair gaming and adverse selection by consumers. They contended that individuals were purposefully declining to make premium payments near the end of a benefit year knowing they could sign up for new coverage during the next open enrollment period.[[10]](#footnote-10) HHS directly addressed these concerns in the Market Stabilization Rule, providing a new interpretation of guaranteed availability of coverage. Under this new interpretation, before effectuating new coverage issuers are allowed to attribute premiums paid for new coverage towards past-due premiums owed to them for coverage from the prior year from the same issuer.[[11]](#footnote-11) In support of this change, HHS cited a study showing that 21% of consumers enrolled in individual market plans stopped making their premium payments in 2015; 87% of these consumers then repurchased plans in 2016, with nearly half repurchasing the same plan in which they were previously enrolled.[[12]](#footnote-12)

Issuers, including Cigna and others seeking to participate in the Missouri individual and/or small group market in 2018, supported this reinterpretation in comments to HHS.[[13]](#footnote-13) Anthem specifically observed that the stricter rules around eligibility for consumers who haven’t paid premiums “will help mitigate potential misuse and ‘gaming’ of the [system].”[[14]](#footnote-14) Cigna more broadly acknowledged that HHS’s proposed rule would “increas[e] the incentives for individuals to maintain enrollment in health coverage and decreas[e] incentives for individuals to enroll only after they require medical services.”[[15]](#footnote-15)

By the insurance industry’s own logic, HHS’s new interpretation should encourage individuals to maintain more continuous coverage and thus improve the 2018 risk pool. This, in turn, should put downward pressure on rates. Yet Cigna failed to acknowledge this development in its 2018 rate justifications. Absent further clarification from Cigna regarding if and how it took the new interpretation into account, the Department should deem Cigna’s proposed rate increases unjustified and thus unreasonable.

1. Open Enrollment Periods (45 C.F.R. § 155.410)

HHS has shortened the open enrollment period for the 2018 plan year from 90 days to 45 days, with the new open enrollment period beginning on November 1, 2017 and ending on December 15, 2017.[[16]](#footnote-16) HHS adopted this change to improve the morbidity of the risk pool, “by reducing opportunities for adverse selection by those who learn they will need medical services in late December and January[] and [by] encourag[ing] healthier individuals who might have previously enrolled in partial year coverage after December 15th to instead enroll in coverage for the full year.”[[17]](#footnote-17)

Issuers applauded this change.[[18]](#footnote-18) In its comments on the proposed rule, Cigna explained that, “[s]hortening open enrollment to end on December 15th ensures everyone’s coverage is effective the first day of the plan year which complements the underlying goal of full year continuous coverage and risk pool stability.”[[19]](#footnote-19) The BlueCross BlueShield Association likewise stated that shortening the open enrollment period was “critical” “to encourage that consumers maintain coverage for a full year.”[[20]](#footnote-20) Anthem also observed that it believed a shorter enrollment period “will improve the risk pool,”[[21]](#footnote-21) and Centene agreed that the change “will promote a stable risk pool.”[[22]](#footnote-22)

Despite this consensus view among issuers, it is not apparent that Cigna took this change into consideration in its proposed rate increase. While it may have been one of the factors Cigna relied on when formulating its Morbidity Factor, Cigna never stated as much in its Actuarial Memorandum. And because Cigna did not provide its actual morbidity calculation and instead merely provided a list of generalized factors that it relied upon when formulating its Morbidity Factor, it is impossible to ascertain whether the shortened enrollment period was considered. Absent further clarification from Cigna regarding if and how it took this change into account, the Department should deem Cigna’s proposed rate increases unjustified and thus unreasonable.

1. Special Enrollment Periods (45 C.F.R. § 155.420)

Special enrollment periods ensure that people who lose health insurance during the year—due to the non-voluntary loss of minimum essential coverage provided through an employer or other qualifying events such as marriage or birth or adoption of a child—have the opportunity to enroll in new coverage or make changes to their existing coverage.[[23]](#footnote-23) Issuers have raised concerns, however, that allowing previously uninsured individuals to enroll in coverage via a special enrollment period can increase the risk of adverse selection, negatively impact the risk pool, and contribute to market instability by leading issuers to leave the market.[[24]](#footnote-24) Issuers have also specifically criticized HHS’s decision to allow consumers to self-attest to their eligibility for most special enrollment periods, with trade groups arguing that “without verification, a significant number of people will only purchase coverage when they need it, driving up cost for everyone.”[[25]](#footnote-25)

In response to these concerns, HHS amended the regulations governing special enrollment periods in the Market Stabilization Rule.[[26]](#footnote-26) Effective June 2017, any individual attempting to enroll using a special enrollment period must undergo pre-enrollment verification of their eligibility.[[27]](#footnote-27) In addition, HHS limited the extent to which individuals can obtain more comprehensive coverage during a special enrollment period[[28]](#footnote-28) and allowed insurers to reject applicants who lost minimum essential coverage because they failed to make premium payments unless the applicants also pay the past-due premiums.[[29]](#footnote-29) HHS also adopted a number of other new restrictions.[[30]](#footnote-30) HHS’s Office of the Actuary estimated that these changes would reduce premiums by 1.5%.[[31]](#footnote-31)

Unsurprisingly, issuers strongly supported the new restrictions on special enrollment periods.[[32]](#footnote-32) Cigna specifically noted that the changes “will aid in improving the risk pool and market stability and encourage continuous coverage.”[[33]](#footnote-33) It later reiterated that “[t]he goal of verifying the eligibility for a special enrollment period is based on preventing adverse selection.”[[34]](#footnote-34) Similarly, in encouraging HHS to adopt these changes, Anthem expressed its concern “that the ability to utilize SEPs inappropriately [] is driving up premiums and placing the market on an unsustainable path.”[[35]](#footnote-35) The BlueCross BlueShield Association likewise pointed to the higher claims costs of consumers who rely on special enrollment periods in voicing support for the changes.[[36]](#footnote-36)

Despite the insurance industry’s enthusiasm for these changes, Cigna did not specify anywhere in its filing whether it considered these changes in calculating its rates for 2018. The restriction on special enrollment periods will make it far more difficult for individuals to game the system by waiting until they get sick to purchase coverage, rather than during open enrollment, and accordingly should be reflected in Cigna’s 2018 rate justifications. Absent further clarification from Cigna regarding if and how it took these changes into account, the Department should deem Cigna’s proposed rate increases unjustified and thus unreasonable.

1. Levels of Coverage (Actuarial Value) (45 C.F.R. § 156.140(c))

Under the Affordable Care Act, issuers of non-grandfathered individual and small group health insurance plans must ensure that the plans adhere to certain levels of coverage, defined by the plan’s actuarial value.[[37]](#footnote-37) A bronze plan is required to have an actuarial value of 60%, a silver plan is to have an actuarial value of 70%, a gold plan is to have an actuarial value of 80%, and a platinum plan is to have an actuarial value of 90%.[[38]](#footnote-38) To ensure that issuers meet these benchmarks, HHS created an actuarial value calculator that estimates a plan’s average spending by a wide range of consumers in a standard population.[[39]](#footnote-39) Because the calculator’s results are necessarily approximations, HHS has allowed *de minimis* variation of +/ – 2 percentage points in the actuarial valuations used to determine a plan’s level of coverage.[[40]](#footnote-40) Under the Market Stabilization Rule, HHS adopted a new *de minimis* range of – 4/+2 for the 2018 plan year.[[41]](#footnote-41) Thus, for example, a silver plan could have an actuarial value anywhere between 66 and 72%. According to HHS, this expanded *de minimis* range will allow flexibility for issuers that will improve the health and competitiveness of the market.[[42]](#footnote-42)

Not unexpectedly, issuers supported the expanded *de minimis* range.[[43]](#footnote-43) According to Anthem, “the ability to offer a range of [plan] designs that appeal to consumers with different demographic profiles and health care needs is particularly important in the individual market,” and the “additional allowed [actuarial value] variation could protect or increase enrollment by making certain attractive plan designs more accessible to consumers.”[[44]](#footnote-44) Centene added that “[t]he flexibility allowed by creating greater variance within a metal tier will help issuers maintain their current plans year over year, while minimizing disruption by avoiding discontinuance notifications.”[[45]](#footnote-45)

In light of the issuers’ arguments that greater flexibility in plan designs fosters continuous coverage, this change should help improve the risk pool and drive down the overall cost of care. As such, it should be reflected in Cigna’s 2018 rate justifications. Absent further clarification from Cigna regarding if and how it took this change into account, the Department should deem Cigna’s proposed rate increases unjustified and thus unreasonable.

1. Network Adequacy (45 C.F.R. § 156.230)

Issuers of qualified health plans (QHPs) are required to maintain a network that is sufficient in number and types of providers, including specialists to assure that all services will be accessible without unreasonable delay.[[46]](#footnote-46) For the 2018 plan year, HHS will defer to the states to review these networks to the extent the states have the necessary authority and infrastructure already in place. In states without such authority and means, HHS will rely on an issuer’s accreditation from an HHS-recognized accrediting authority. Issuers that are unaccredited will be required to submit access plans to HHS as part of their QHP applications. [[47]](#footnote-47)

The insurance industry supported this approach, and generally encouraged HHS to defer to states as much as possible in this regard.[[48]](#footnote-48) The National Association of Insurance Commissioners also expressed its support for the revisions to the network adequacy standards, arguing that “State regulators have expressed for many years their opposition to unnecessary federal interference in network adequacy review. This interference has proven costly to carriers without increasing protections for consumers.”[[49]](#footnote-49)

In its Actuarial Memorandum, Cigna referred to taking into account “the level of enforcement” in calculating changes to morbidity.[[50]](#footnote-50) Yet Cigna then redacted what little data it provided and otherwise failed to explain in what ways and to what extent it took enforcement into account in its calculations. The Department should insist that Cigna clarify how its expectations around enforcement, including any effects from the HHS’s decision to defer to state review of networks, were reflected in its rate filing. Absent further elaboration on this matter, the Department should deem Cigna’s proposed rate increases unjustified and thus unreasonable.

1. Essential Community Providers (45 C.F.R. § 156.235)

In evaluating whether a QHP has a sufficient number and geographic distribution of essential community providers, the network in question must include a minimum percentage of participating practitioners.[[51]](#footnote-51) For the 2014 plan year, HHS set the minimum percentage of participating practitioners at 20% but in subsequent years it increased this threshold to 30%.[[52]](#footnote-52) For the 2018 plan year, HHS has gone back to a 20% threshold, explaining that “less expansive requirements for network size will lead to both costs and cost savings.”[[53]](#footnote-53) The cost savings would most likely result from reductions in administrative costs associated with being in compliance with QHP requirements. HHS also expects cost savings to arise from issuers focusing their networks on low-cost providers.[[54]](#footnote-54)

Issuers supported this decrease in the percentage of ECPs required in QHPs, acknowledging that this change will reduce their administrative burden.[[55]](#footnote-55) Similarly, the National Association of Insurance Commissioners voiced their support for reducing the Essential Community Provider threshold to 20% because it will, “[A]llow more insurers to cover rural and underserved areas…mak[ing] it easier for carriers to enter into contracts and provide coverage in rural and underserved areas.”[[56]](#footnote-56)

Given the anticipated reduction in administrative costs on issuers, this change should be reflected in issuers’ 2018 rate justifications. However, even though Cigna was included amongst those companies who supported this shift, it failed to account for this change anywhere in its rate filing. The Department should insist that Cigna clarify whether this change was reflected in its calculations and, if not, to update its rate filing accordingly. Absent further elaboration on this matter, the Department should deem Cigna’s proposed rate increases unjustified and thus unreasonable.

**IV. Conclusion**

Cigna has not adequately explained in its Actuarial Memorandum why a 35.0% increase is justified. The Department should insist that Cigna elaborate on the assumptions it made, without unnecessary redactions, and account for the impact of the various changes in the Market Stabilization Rule that should put a downward pressure on rates. If Cigna is unable to adequately respond to these concerns, the Department should deem Cigna’s proposed rate increase unreasonable.

1. Healthy Alliance Life Insurance Company, for example, provided their assumed trend of 13.3% to the public. Healthy Alliance, also provided its projected medical loss ratio (“MLR”) calculation, which Cigna redacted. [↑](#footnote-ref-1)
2. Chris Girod et al., *2017 Milliman Medical Index*, Milliman Research Report 3 (May 2017), http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2017-milliman-medical-index.pdf. [↑](#footnote-ref-2)
3. *Id*. at 4. [↑](#footnote-ref-3)
4. *Id*. at 3. [↑](#footnote-ref-4)
5. Cigna, Actuarial Mem. 4 (2017). [↑](#footnote-ref-5)
6. Cigna, Written Description 1 (2017). [↑](#footnote-ref-6)
7. Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 10,980, 10,981 (proposed Feb. 17, 2017) (hereinafter “Market Stabilization Proposed Rule”). [↑](#footnote-ref-7)
8. 42 U.S.C. § 300gg-1(a). [↑](#footnote-ref-8)
9. Market Stabilization Proposed Rule, 82 Fed. Reg. at 10,983. [↑](#footnote-ref-9)
10. *Id*. (citing Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 Fed. Reg. 13,406, 13,416 (Feb. 27, 2013)). [↑](#footnote-ref-10)
11. Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 18,346 18,377 (April 18, 2017) (hereinafter “Market Stabilization Final Rule”). [↑](#footnote-ref-11)
12. *Id.* (citing 2016 OEP; Reflection on enrollment, Center for U.S. Health System Reform, McKinsey & Company, May 2016, available at *http://healthcare.mckinsey.com/2016-oep-consumer-survey-findings*). [↑](#footnote-ref-12)
13. *See, e.g.*, Aetna, Comment Letter on Market Stabilization Proposed Rule 2, 7 (March 6, 2017), https://www.regulations.gov/document?D=CMS-2017-0021-1143; Anthem, Comment Letter on Market Stabilization Proposed Rule 9 (March 7, 2017), https://www.regulations.gov/document?D=CMS-2017-0021-3083; BlueCross Blue Shield Ass’n, Comment Letter on Market Stabilization Proposed Rule 1, 3 (March 7, 2017), https://www.regulations.gov/document?D=CMS-2017-0021-3144; Centene, Comment Letter on Market Stabilization Proposed Rule 1 (March 7, 2017), https://www.regulations.gov/document?D=CMS-2017-0021-1716; Cigna, Comment Letter on Market Stabilization Proposed Rule 3 (March 7, 2017), https://www.regulations.gov/document?D=CMS-2017-0021-3237. [↑](#footnote-ref-13)
14. Anthem, *supra* note 13 at 9. [↑](#footnote-ref-14)
15. Cigna, *supra* note 13 at 1. [↑](#footnote-ref-15)
16. Market Stabilization Final Rule, 82 Fed. Reg. at 18,354. [↑](#footnote-ref-16)
17. *Id*. at 18,346. [↑](#footnote-ref-17)
18. *See* Aetna, *supra* note 13 at 1; Anthem, *supra* note 13 at 3; Blue Cross Blue Shield Ass’n, *supra* note 13 at 5; Centene, *supra* note 13 at 2; Cigna, *supra* note 13 at 2. [↑](#footnote-ref-18)
19. Cigna, *supra* note 13 at 2. [↑](#footnote-ref-19)
20. BlueCross BlueShield, *supra* note 13 at 5. [↑](#footnote-ref-20)
21. Anthem, *supra* note 13 at 3. [↑](#footnote-ref-21)
22. Centene, *supra* note 13 at 2. [↑](#footnote-ref-22)
23. *See* 45 C.F.R. § 155.420 (2017); Market Stabilization Final Rule, 82 Fed. Reg. at 18,355. [↑](#footnote-ref-23)
24. *See, e.g.*, Julie Appleby, *UnitedHealth Warns of Marketplace Exit*, Kaiser Health News (Nov. 20, 2015), <http://khn.org/news/unitedhealth-warns-of-marketplace-exit-start-of-a-trend-or-push-for-white-houseaction/>; Phil Galewitz, *UnitedHealthcare to Exit All but “Handful” of Obamacare Markets in 2017*, Kaiser Health News, April 19, 2016, http://khn.org/news/unitedhealthcare-to-exit-all-but-handful-of-obamacare-marketsin-2017/. [↑](#footnote-ref-24)
25. Matthew Eyles & Justine Handelman, *Appropriate Use of Special Enrollment Periods Is Key to Exchange Stability, Affordability for Consumers: Misused Special Enrollment Periods Impact All Consumers through Higher Cost* (February, 2016), https://www.ahip.org/wp-content/uploads/2016/03/AHIP-BCBSA-SEP-Analysis-Feb16.pdf. [↑](#footnote-ref-25)
26. Market Stabilization Final Rule, 82 Fed. Reg. at 18,346, 18,355-56. [↑](#footnote-ref-26)
27. *Id*. at 18,358. [↑](#footnote-ref-27)
28. *Id*. at 18,358-59. [↑](#footnote-ref-28)
29. *Id*. at 18,362-63. [↑](#footnote-ref-29)
30. *Id*. at 18,358-65. [↑](#footnote-ref-30)
31. *Id.* at 18,378. [↑](#footnote-ref-31)
32. Aetna, *supra* note 13 at 1, 5; Anthem, *supra* note 13 at 2, 4; BlueCross Blue Shield, *supra* note 13 at 1-3; Centene, *supra* note 13 at 3; Cigna, *supra* note 13 at 2-3. [↑](#footnote-ref-32)
33. *Id.* at 2. [↑](#footnote-ref-33)
34. *Id.* at 3. [↑](#footnote-ref-34)
35. Anthem, *supra* note 13 at 2 [↑](#footnote-ref-35)
36. BlueCross Blue Shield, *supra* note 13 at 1-3. [↑](#footnote-ref-36)
37. 42 U.S.C. § 18022(d). [↑](#footnote-ref-37)
38. *Id.* [↑](#footnote-ref-38)
39. Market Stabilization Proposed Rule, 82 Fed. Reg. at 10,989. [↑](#footnote-ref-39)
40. *Id.* [↑](#footnote-ref-40)
41. Market Stabilization Final Rule, 82 Fed. Reg. at 18,369-71; 45 C.F.R. § 156.140(c). [↑](#footnote-ref-41)
42. Market Stabilization Final Rule, 82 Fed. Reg. at 18,369. [↑](#footnote-ref-42)
43. Aetna, *supra* note 13 at 1, 6; Anthem, *supra* note 13 at 10, 4; BlueCross Blue Shield, *supra* note 13 at 3; Centene, *supra* note 13 at 3-4; Cigna, *supra* note 13 at 3. [↑](#footnote-ref-43)
44. Anthem, *supra* note 13 at 11. [↑](#footnote-ref-44)
45. Centene, *supra* note 13 at 3. [↑](#footnote-ref-45)
46. 45 C.F.R. § 156.230 (2017). [↑](#footnote-ref-46)
47. Market Stabilization Rule, 82 Fed. Reg. at 18,372. [↑](#footnote-ref-47)
48. Aetna, *supra* note 13 at 2; Anthem, *supra* note 13 at 11-12; BlueCross Blue Shield, *supra* note 13 at 4; Centene, *supra* note 13 at 4; Cigna, *supra* note 13 at 4. [↑](#footnote-ref-48)
49. Nat’l Ass’n of Ins. Comm’rs, Comment on the Market Stabilization Proposed Rule 2 (March 7, 2017), https://www.regulations.gov/document?D=CMS-2017-0021-3109. [↑](#footnote-ref-49)
50. Cigna, Actuarial Mem. 3 (2017). [↑](#footnote-ref-50)
51. 45 C.F.R. § 156.235 (2017). [↑](#footnote-ref-51)
52. Market Stabilization Final Rule, 82 Fed. Reg. at 18,373. [↑](#footnote-ref-52)
53. *Id.* at 18,737-74. [↑](#footnote-ref-53)
54. *Id.* at 18,379. [↑](#footnote-ref-54)
55. Aetna, *supra* note 13 at 2; Anthem, *supra* note 13 at 12-13; BlueCross Blue Shield, *supra* note 13 at 4; Cigna, *supra* note 13 at 4. [↑](#footnote-ref-55)
56. Nat’l Ass’n of Ins. Comm’rs, *supra* note 49 at 2. [↑](#footnote-ref-56)