

MILLIMAN RESEARCH REPORT

2015 commercial health insurance

Overview of financial results

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Executive summary

As the United States approaches a potential second round of health insurance reform, data published by the Centers for Medicare and Medicaid Services (CMS) from commercial health insurers' medical loss ratio (MLR) calculations provides a clear picture of insurers' commercial health insurance financial results for the second year of full implementation of the Patient Protection and Affordable Care Act (ACA). This data, supplemented with CMS marketplace data through 2016, provides us insight into various components of the ACA, particularly federal premium and cost-sharing subsidies and the "3R" programs. The 2015 report highlights include:

Individual health insurance market enrollment increased from 15.0 million to 17.5 million covered lives from 2014 to 2015, while small group enrollment continued its decline.

- Relative to 2013, the individual market has grown by 6.6 million enrollees, driven by federal premium assistance provided through the insurance marketplaces.
- National fully insured small group enrollment declined from 16.0 million in 2014 to 14.7 million in 2015. Since 2013, market enrollment has shrunk by 2.6 million covered lives (17.3 million to 14.7 million), a decrease of approximately 15%. Data from the Medical Expenditure Panel Survey (MEPS) suggests this 15% decline is the result of fewer small employers offering coverage.

While underwriting margins in the small and large group markets remained consistent from 2014 to 2015, individual market underwriting margins deteriorated from a 6.0% earned premium loss in 2014 to a 9.6% loss in 2015.

- The ACA risk corridor program's shortfall in funding was a significant driver of the underwriting loss. In 2015, individual market insurer risk corridor requested amounts totaled approximately \$5.3 billion. CMS announced no funding will currently be made available for requested 2015 risk corridor payments, with 2015 risk corridor payments made by insurers being applied to 2014 risk corridor requests.
- The cumulative risk corridor payment shortfall has reached \$8.3 billion, with nearly 90% of this amount owed to insurers attributable to experience in the individual market.

FIGURE 1: RISK CORRIDOR FUNDING SHORTFALL AS OF DECEMBER 2016 (\$ MILLIONS)

COVERAGE YEAR	INDIVIDUAL	SMALL GROUP	TOTAL
2014	\$2,142	\$270	\$2,412
2015	\$5,323	\$594	\$5,917
TOTAL	\$7,464	\$864	\$8,329

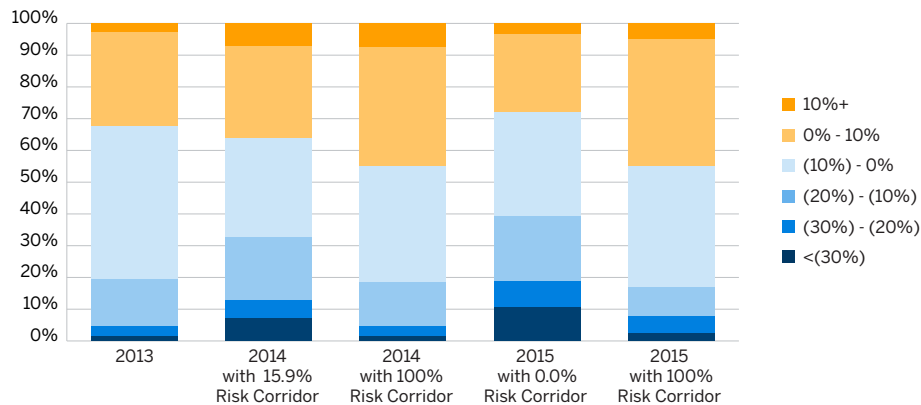
- To the extent insurers' received 100% of risk corridor receivables for both 2014 and 2015, individual market underwriting losses would be limited to approximately 2% of earned premium, equivalent to the risk corridor shortfall being approximately 4% and 7.5% of earned premium for the health insurer industry in 2014 and 2015, respectively.
- The loss resulting from the underfunding of the risk corridor program was partially offset in the individual market by lower than expected utilization of the transitional reinsurance program. In 2015, the transitional reinsurance program paid insurers approximately \$1.9 billion more than expected because reinsurance contributions exceed reinsurance payments in 2014.

1 Risk adjustment, risk corridors, and transitional reinsurance.

The proportion of individual market business experiencing severe losses in 2015 was greater than 2014. In both years, severe losses would have been significantly reduced to the extent requested risk corridor amounts were fully paid by the federal government.

- Figure 2 illustrates the distribution of individual market financial performance from 2013 to 2015. For 2014 and 2015, underwriting results are shown with actual (15.9% of requested amounts for 2014, 0% for 2015) and full risk corridor funding:

FIGURE 2: INDIVIDUAL MARKET DISTRIBUTION OF UNDERWRITING GAINS (LOSSES) AS A PERCENTAGE OF EARNED PREMIUM, 2013 TO 2015



Note: Receiving the full risk corridor receivable has the possibility of increasing an insurer's profitability into the 10%+ category because of the presence of a large premium deficiency reserve release and/or a very profitable non-QHP block of business.

Based on actual risk corridor funding, the proportion of individual market business experiencing underwriting losses of more than 30% earned premium was 7% in 2014, increasing to 10% in 2015. To the extent full risk corridor funding was provided, losses above 30% would have been reduced to 1.5% and 2.5% of national market share for 2014 and 2015, respectively.

- The proportion of the market experiencing underwriting losses of greater than 10% increased from 33% to 39% from 2014 to 2015. Losses greater than 10% would have been dampened to 18% and 17% of the national market for 2014 and 2015, respectively.
- While 2015 was the second year of the ACA's reformed individual market, insurers may have had limited experience data available on consumers purchasing coverage in the insurance marketplaces. Additionally, enrollment data from the 2014 open enrollment period may have suggested the opportunity for significant market share gains if less conservatism was used in premium rate development.
- Full risk corridor funding would have produced 2014 and 2015 underwriting distributions very similar to 2013, the last year of the pre-ACA market.

Risk adjustment transfer payments had a larger, material impact on the individual and small group markets in 2015 than in 2014.

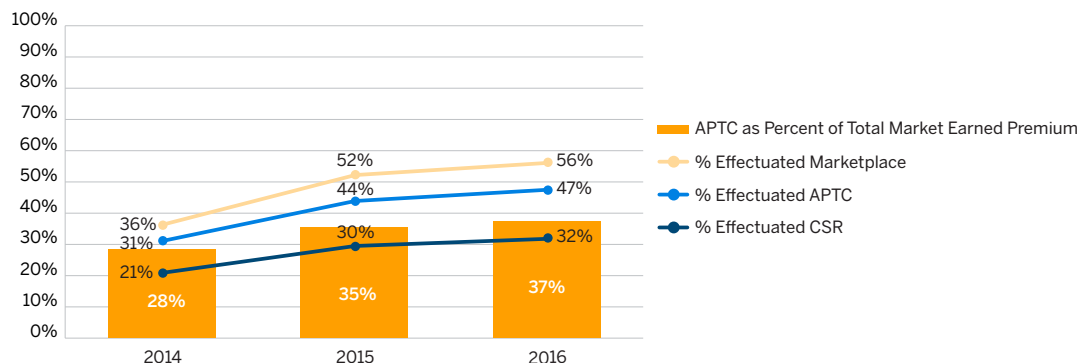
- In 2015, risk adjustment transfer payments increased to approximately 4.0% of earned premium from approximately 3.2% of earned premium in 2014 in the individual market. In the small group market, 2015 risk adjustment transfer payments increased to approximately 1.5% of earned premium from approximately 0.8% in 2014. The percentages increased in 2015 as market share of ACA-compliant membership increased.
- Insurers representing 71% and 34% of national market share in the 2015 individual and small group markets, respectively, had risk adjustment transfer payments of greater than 2% of total earned premium.

- In both the individual and small group markets, 2014 and 2015 risk adjustment transfer payments as a percentage of earned premium at the insurer level were moderately correlated. Most insurers that paid or received risk adjustment transfers in 2014 also did so in 2015.

During the first three years of operation, insurance marketplace enrollment is estimated to have increased from 36% of the total individual market in 2014 to 56% in 2016.

- Corresponding to overall insurance marketplace enrollment growth, Figure 3 illustrates the significant growth in the percentage of market enrollees receiving advanced premium tax credits (APTC) and cost-sharing reduction (CSR) subsidies from 2014 through 2016.
- In 2014, we estimate 69% of individual market member months did not receive premium assistance (off-marketplace enrollees and unsubsidized marketplace enrollees). We estimate 53% of 2016 individual market member months did not receive premium assistance.
- In the context of the significant 2017 premium rate increases observed in the insurance marketplaces in many states, APTCs will substantially mitigate the net premium increases for qualifying households. However, a substantial portion of individual market enrollees do not receive premium assistance. While these households likely have higher income on average, it is unclear how premium rate increases will impact the insurance participation rate of the unsubsidized portion of the market.

FIGURE 3: INSURANCE MARKETPLACE ENROLLMENT AND ACA SUBSIDIES ESTIMATED MARKET IMPACTS, 2014 THROUGH 2016



Notes:

1. The 2016 individual market premium data is estimated based on 3Q2016 statutory filings.
2. “% Effectuated” values represent enrollment for respective enrollees as a percentage of total individual market enrollment.

In summary, 2015 saw a continued increase in individual market enrollment; driven by growth in the individual marketplaces. With this growth come changing population characteristics and corresponding pricing challenges for insurance carriers operating in the market. These population changes, coupled with regulatory uncertainty associated with the risk corridor program, likely contributed to the underwriting losses experienced by many individual market insurers. Both the small and large group markets experienced a lower degree of market changes, corresponding to a lower degree of insurer financial performance volatility.

Based on 2017 plan selection information released by CMS, growth in the individual marketplace appears to have plateaued.² Market stabilization and additional data on marketplace enrollees have the potential to aid in improving insurer financial results, facilitated by the implementation of appropriate premium rate changes. However, the 2016 elections have renewed the potential for regulatory and legislative changes to affect the commercial health insurance markets. Insurers should be cognizant of the impact of these changes to each market’s risk pool when evaluating market opportunities and establishing premium rates.

2 Goldstein, A. (February 3, 2017). HealthCare.gov suffers first enrollment decline as GOP works to kill the ACA. Washington Post. Retrieved February 15, 2017, from https://www.washingtonpost.com/national/health-science/healthcaregov-suffers-first-enrollment-decline-ever-as-gop-works-to-kill-the-aca/2017/02/03/941e0e3a-ea2d-11e6-bf6f-301b6b443624_story.html?utm_term=.b66183146882.

Introduction

The year 2015 marked the second year of the biggest changes to the commercial insurance market under the ACA. Whereas many states permitted medical underwriting, exclusion of essential health benefits (EHBs), and no limitations on the insured member's maximum cost sharing in the pre-2014 individual and small group insurance markets, the ACA implemented essential benefit requirements and adjusted community rating, along with standardized actuarial value requirements.

Furthermore, for coverage beginning January 1, 2014, new financial assistance became available to millions of lower-income Americans who purchase coverage in the individual market via premium and cost-sharing assistance in the federal or state marketplaces. This expected influx of new enrollment into the individual market resulted in new companies offering individual products, including traditional Medicaid managed care health plans and consumer operated and oriented plans (CO-OPs). To mitigate some of the increased uncertainty arising from adjusted community rating and the new enrollment, the ACA's "3R" programs (permanent risk adjustment, transitional reinsurance, and temporary risk corridors³) were established to help mitigate risk associated with member plan selection, high-cost claims, and general pricing uncertainty.

While the 3Rs were intended to provide more stable insurer financial outcomes, they added significant uncertainty and complexity to the financial results of insurers in 2014 and 2015. Because risk adjustment and risk corridor results in the individual and small group markets are tied to the performance and reporting of other insurers within a specific market and are not calculated until well after statutory deadlines, financial results reported in year-end statutory statements were based on estimated results for these programs.

In particular, the risk corridor program has been a source of significant political and regulatory uncertainty for insurers:

- On October 1, 2015, the Center for Consumer Information and Insurance Oversight (CCIIO) announced that insurers would only receive 12.6% of risk corridor receivables for the 2014 coverage year, which was due to a lack of available funding for the program.⁴
- On November 18, 2016, CCIIO announced that risk corridor payments from 2015 would be applied to the remaining 2014 risk corridor receivables.⁵ This announcement resulted in insurers receiving a cumulative total of 15.9% of the risk corridor receivables that were due for 2014, but 0% of payment for the 2015 coverage year.

Data used in this report was provided by health insurers in their Medical Loss Ratio Reporting Forms (MLR forms) submitted to CCIIO for 2011 through 2015, along with 2010 Supplemental Health Care Exhibit (SHCE) data, to summarize financial results in the commercial health insurance markets.⁶ For 2014 and 2015, the MLR data is unique because it provides a final accounting of ACA 3R results for insurers, rather than estimated revenue or charges that were included in statutory annual statements, including the SHCE.

This report provides an overview of health insurer financial results in 2015 and evaluates changes in the health insurance industry's expense structure and enrollment relative to prior years. We explore impacts to the insurance markets from the insurance marketplaces and the ACA 3R programs. Additionally, we review marketplace enrollment and associated subsidies from 2014 through 2016 in the context of the aggregate individual health insurance market.

3 For more information on the basic structure of the risk corridor program, see Norris, D, van der Heijde, M. and Leida, H. (October 2013). Risk Corridors under the Affordable Care Act—A Bridge over Troubled Waters, but the Devil's in the Details. *Health Watch*. Retrieved March 7, 2016, from <http://us.milliman.com/uploadedFiles/insight/2013/Risk-corridors-under-the-ACA.pdf>.

4 Katterman, S. (October 5, 2015). Headwinds cause 2014 risk corridor funding shortfall. Milliman Healthcare Reform Briefing Paper. Retrieved March 7, 2016, from <http://us.milliman.com/insight/2015/Headwinds-cause-2014-risk-corridor-funding-shortfall/>.

5 CMS (November 18, 2016). Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year. Retrieved February 15, 2017, from <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf>.

6 See appendix for more information on these data sources.

2015 markets and financial results overview

Figure 4 illustrates the aggregate insured lives and composite reported premium and expenses in the individual, small group, and large group health insurance markets on a per member per month (PMPM) basis and as a percentage of premium in 2015. Figure 5 provides the same measures but reflects the changes in enrollment and financial metrics from 2014 to 2015. The appendix of this report provides additional detail on insurer financial results from 2010 through 2015.

FIGURE 4: AGGREGATE REPORTED 2015 COMPREHENSIVE EXPERIENCE

MEASURE	INDIVIDUAL	SMALL GROUP	LARGE GROUP
COVERED LIVES	17,500,000	14,700,000	42,700,000
EARNED PREMIUM PMPM	\$337.64	\$410.95	\$410.68
CLAIMS EXPENSES PMPM	\$305.43	\$327.92	\$349.30
FEES AND TAXES PMPM	\$13.86	\$24.81	\$20.35
MLR REBATES PMPM	\$0.51	\$0.87	\$0.26
TOTAL ADMINISTRATIVE EXPENSES PMPM	\$48.19	\$51.94	\$32.80
UNDERWRITING GAIN (LOSS) PMPM	(\$32.55)	\$4.64	\$6.61
PRELIMINARY MEDICAL LOSS RATIO	95.3%	85.8%	90.3%
REBATE EXPENSE RATIO	0.1%	0.2%	0.1%
UNDERWRITING MARGIN	(9.6%)	1.1%	1.6%
ADMINISTRATIVE EXPENSE RATIO	14.3%	12.6%	8.0%

FIGURE 5: AGGREGATE CHANGES 2014 TO 2015 COMPREHENSIVE EXPERIENCE

MEASURE	INDIVIDUAL	SMALL GROUP	LARGE GROUP
COVERED LIVES	2,500,000	(1,300,000)	(500,000)
EARNED PREMIUM PMPM	\$34.68	\$21.96	\$5.89
CLAIMS EXPENSES PMPM	\$53.79	\$17.02	\$6.42
FEES AND TAXES PMPM	(\$2.14)	\$1.73	\$0.25
MLR REBATES PMPM	(\$0.81)	\$0.14	\$0.08
TOTAL ADMINISTRATIVE EXPENSES PMPM	(\$0.35)	\$3.45	\$0.14
UNDERWRITING GAIN (LOSS) PMPM	(\$14.46)	(\$0.51)	(\$0.40)
PRELIMINARY MEDICAL LOSS RATIO	6.5%	(0.1%)	0.3%
REBATE EXPENSE RATIO	(0.3%)	0.0%	0.0%
UNDERWRITING MARGIN	(3.7%)	(0.2%)	(0.1%)
ADMINISTRATIVE EXPENSE RATIO	(1.8%)	0.2%	(0.1%)

Notes:

- Dollar values are illustrated on a PMPM basis.
- Covered lives equals reported member months divided by 12.
- Values have been rounded.
- Actual rebate expense ratio was 0.15% (individual), 0.21% (small group), and 0.06% (large group).
- Preliminary medical loss ratio is based on statutory guidelines. The sum of the preliminary medical loss ratio, underwriting margin, and administrative expense ratio will not equal 1.
- The 2015 financial results reflect applicable insurers receiving 0% of risk corridor receivables in the individual and small group markets, which is reflected in claims expenses. The 2014 financial results reflect applicable insurers receiving 15.9% of risk corridor receivables in the individual and small group markets.
- The 2014 and 2015 individual market values reflect Arkansas's private option Medicaid expansion population (approximately 210,000 individuals as of December 2014⁷ and 200,000 individuals in December 2015⁸).

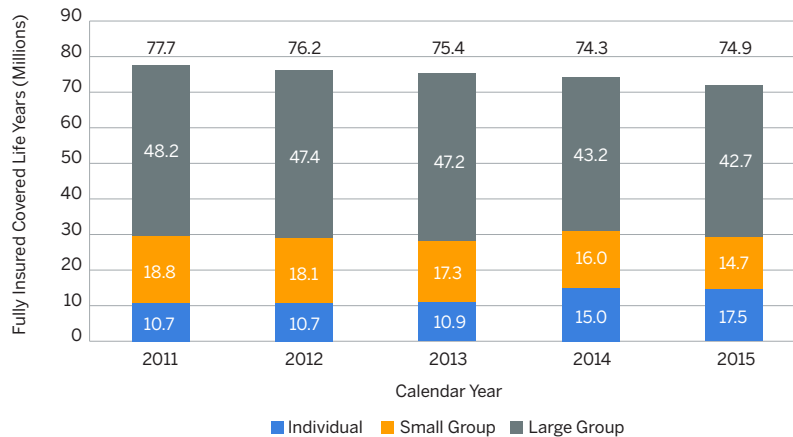
7 Arkansas Department of Human Services (October-December 2014). Arkansas Private Option 1115 Demonstration Waiver: Quarterly Report, October 1, 2014 to December 31, 2014. Retrieved March 7, 2016, from <https://www.medicaid.state.ar.us/Download/general/publicdata/POQrtlyRptOct-Dec.pdf>.

8 Arkansas Department of Human Services (October-December 2015). Arkansas Private Option 1115 Demonstration Waiver: Quarterly Report, October 1, 2015 – December 31, 2015. Retrieved February 15, 2017, from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-private-option-qtrly-rpt-oct-dec-2015.pdf>.

COVERED LIVES

In 2015, 74.9 million individuals were insured across the three insurance markets, which reflects an increase of approximately 700,000 insured lives relative to 2014. While the individual health insurance market grew by 2.5 million lives (coinciding with enrollment growth observed in the insurance marketplace), both the small group and large group fully insured markets continued a downward trend in covered lives in 2015. Enrollment in the small group market declined by more than 8% from 2014 to 2015.

FIGURE 6: NATIONAL COMPREHENSIVE HEALTH INSURANCE ENROLLMENT, 2011 TO 2015



Notes:

1. Covered lives defined as reported member months divided by 12.
2. Values have been rounded to the nearest 100,000.

The MEPS published by the Agency for Healthcare Research and Quality (AHRQ) indicated a material drop in the number of private sector establishments with fewer than 50 employees that were offering health insurance from 2013 to 2015. On a national level, the percentage decreased from 34.8% in 2013, to 32.2% in 2014, falling further to 29.4% in 2015.⁹ This percentage decline closely resembles the overall decrease in insured lives in the small group market from 2013 to 2015. While it is possible that a portion of the decline in the small group market enrollment was a result of employers moving from fully insured to self-funded coverage, MEPS data does not indicate that a significant change occurred in the rate of self-funded plans among establishments with fewer than 50 employees offering health insurance.¹⁰

Conversely, in the large group market, it is likely that the decline in insured lives is attributable to employers moving from fully insured to self-funded coverage. MEPS data indicates that the percentage of establishments with 100 to 499 employees self-funding at least one plan increased from 25.3% in 2013 to 30.1% in 2015.¹¹ Employers may have had additional incentives to self-fund their employer-sponsored insurance coverage in 2014 and 2015, as doing so could reduce expenses related to the ACA's Health Insurer Fee (HIF).

⁹ Agency for Healthcare Research and Quality. Percent of private-sector establishments that offer health insurance by firm size and selected characteristics (Table I.A.2), year 1996-2015. Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC (January 22, 2017).

¹⁰ Agency for Healthcare Research and Quality. Percent of private-sector establishments that offer health insurance that self-insure at least one plan by firm size and selected characteristics (Table I.A.2.a), year 1996-2015: Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC (January 22, 2017).

¹¹ Ibid.

EARNED PREMIUM, CLAIMS EXPENSE, AND FEES AND TAXES

Earned premiums and claims expenses increased in each of the three markets from 2014 to 2015, with the individual market experiencing the largest changes. While individual market premiums on a PMPM basis increased by over 11%, a significant portion of this increase may be attributable to market enrollment shifting further to ACA-compliant coverage (versus coverage written under pre-ACA underwriting rules, such as grandfathered or transitional coverage) that had additional benefits and a higher actuarial value relative to prior coverage. Claims expenses in the individual market increased by over 21% from 2014 to 2015 on a PMPM basis. Consistent with the increase in earned premium, a material portion of this increase may be a result of insured members shifting to ACA-compliant coverage. Fees and taxes levied on insurers decreased from 2014 to 2015 in the individual market, while increasing marginally in the group markets.

PRELIMINARY MEDICAL LOSS RATIO AND MLR REBATES

Within the individual market from 2014 to 2015, the preliminary MLR increased from 88.8% to 95.3%. This increase was attributable to claims expense growth significantly outpacing growth in earned premiums, which contributed to an over 9% underwriting loss in 2015. Since 2010, the individual market has experienced an increase in its composite MLR of more than 14 percentage points. From 2010 to 2015, the average national premium increased from \$214 to \$338 and administrative expenses increased from approximately \$41 to \$48, while claims cost increased from \$166 to \$305 on a PMPM basis. To the extent the insurance industry operated on a breakeven basis in 2015, we estimate the market composite medical loss ratio would be approximately 86%.

Within the small group and large group markets, small increases occurred in the preliminary MLR from 2014 to 2015. Between 2010 and 2015, the large group market has seen its composite preliminary MLR increase from 89.3% to 90.3%, while the small group market composite preliminary MLR has increased from 83.7% to 85.8%.

Consistent with 2013 and 2014, 2015 MLR rebates remained below 0.5% of earned premium in each of the three markets. The individual market experienced the largest change in MLR rebates on a PMPM basis, with the composite market rebate amount decreasing from \$1.31 to \$0.51 PMPM from 2014 to 2015.

ADMINISTRATIVE EXPENSES

Administrative expenses in the individual market declined slightly from 2014 to 2015, remaining nearly \$5 PMPM higher than 2013 and \$10 PMPM higher than 2012. While 2015 represented the second year of the insurance marketplace and ACA rating rules, it is possible that a portion of the administrative cost increases are attributable to implementation costs associated with insurers offering coverage in new states or counties for the first time in 2015.¹²

The small group market reported a 7.1% increase in administrative expenses on a PMPM basis relative to 2014. Large group administrative costs were only 0.4% higher relative to 2014. On an annualized basis since 2010, administrative costs have increased 2.9% and 0.7% for the small group and large group markets, respectively.

¹² For more information on insurer participation in the insurance marketplaces, please see <http://kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace/?currentTimeframe=0>.

UNDERWRITING RESULTS

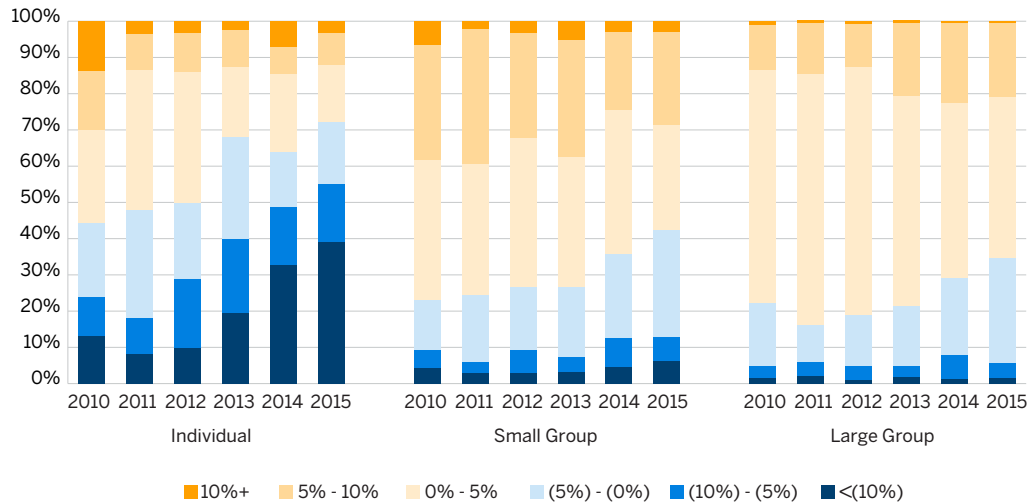
The individual market composite underwriting loss approached 10% in 2015. A significant portion of this loss was due to the risk corridor shortfall, as underwriting losses would be approximately 2% of earned premium had the full risk corridor amounts been received by insurers. Pricing for ACA-compliant coverage in 2015 was based on very limited experience from the first few months of 2014 enrollment; however, market share from the 2014 open enrollment period was known. In some states, this may have created an environment where insurers with noncompetitive insurance marketplace premiums developed less conservative premium rates for 2015, especially as the underfunding of risk corridors had not been fully established at the time these rates were developed.

Consistent with 2014, individual market underwriting results varied widely by state in 2015. Additionally, many states experienced significant changes in underwriting results from 2014 to 2015, with 17 states experiencing absolute changes in underwriting results of more than 10 percentage points relative to 2014. With insurers entering the individual market in many geographic areas, as well as some insurers exiting, underwriting margins continued to be extremely volatile from 2014 to 2015. In contrast to the individual market, 2015 underwriting results in the small group and large group markets were consistent with 2014, with both markets experiencing a small decrease in margins relative to the prior year.

Distribution of underwriting results 2010 through 2015

As we evaluate aggregate market underwriting results from 2010 through 2015, it is important to understand the degree to which underwriting results vary between insurers within a market. Figure 7 examines the distribution of underwriting results in these markets separately for each calendar year.

FIGURE 7: COMMERCIAL HEALTH INSURANCE: UNDERWRITING MARGIN DISTRIBUTIONS, 2010 TO 2015



Notes:

1. Distributions weighted by reported member months in each calendar year. Results reflect all insurers that reported data in the given year.
2. Results for 2014 and 2015 reflect 15.9% and 0.0% of requested risk corridor amounts received, respectively.

While the underwriting distribution has remained remarkably stable in the group insurance markets, the individual market has shown significantly greater volatility, particularly beginning in 2013. Underwriting losses of more than 10% of earned premium represented 33% of the individual market in 2014, increasing to 39% in 2015.

Future underwriting results

As discussed below in the Risk Corridors section of this paper, the risk corridor shortfall resulted in significantly greater underwriting losses than would have occurred had the risk corridor program been fully funded. We would anticipate a lower degree of severe losses being reported in 2016 by insurers for several reasons:

- Premium rates were developed based on actual experience from the ACA-reformed individual market.
- Insurers understood the risk corridors program may not be implemented as originally understood.
- Several insurers with significant losses in the insurance marketplaces in 2014 and 2015 elected to exit the market.¹³

The U.S. Department of Health and Human Services (HHS) has reported the average percentage increase from 2016 to 2017 for the silver subsidy benchmark premium (second-lowest-cost silver plan) is 22%.¹⁴ The APTC will insulate qualifying households from these premium increases, and in theory, would provide households additional financial incentive to purchase coverage through the marketplaces (rather than the outside market). Additionally, younger adults, who may not have qualified for premium assistance in past years when premium rates were lower and the cost of the subsidy benchmark plan did not exceed the maximum allowable cost, may have qualified for premium assistance for the first time in 2017.¹⁵ While at face value it may not seem troubling that national marketplace selections only slightly declined during the 2017 open enrollment period,¹⁶ this result is contrary to the theoretical shift from off-marketplace to marketplace coverage that should have driven additional 2017 marketplace enrollment in a stable individual market risk pool.

Additionally, households not qualifying for premium assistance may be faced with significant out-of-pocket premium increases in 2017. As many of these households may qualify for individual mandate affordability exemptions,¹⁷ enrollment levels outside of the insurance marketplace are less certain and should be monitored by insurers and policymakers during 2017.

For the above reasons, insurance industry financial results in the individual market may face uncertain outcomes during the course of 2017. While insurers will benefit from premium rate increases and in some cases less competition, the amount of regulatory and political uncertainty in the current calendar year is significantly greater than when premium rates were developed in the spring of 2016. When developing premium rates for 2018, insurers should evaluate how political and regulatory changes may impact their individual market blocks of business, and closely monitor effectuated enrollment patterns during the first quarter of 2017 to gain insights into risk pool changes relative to prior years.

13 Cox, C. et al. (November 3, 2015). Analysis of Insurer Participation in 2016 Marketplaces. Kaiser Family Foundation. Retrieved February 15, 2017, from <http://kff.org/health-reform/issue-brief/analysis-of-insurer-participation-in-2016-marketplaces/>.

14 HHS (October 24, 2016). Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace, Table 2. ASPE Research Brief. Retrieved February 15, 2017, from <https://aspe.hhs.gov/sites/default/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf>.

15 Please see http://www.milliman.com/uploadedFiles/insight/2016/2216HDP_20160427.pdf for more discussion on this topic.

16 AP (February 9, 2017). More than 12 million got Obamacare, survey shows. NBC News. Retrieved February 15, 2017, from <http://www.nbcnews.com/health/health-care/more-12-million-got-obamacare-survey-shows-n719071>.

17 For example, see Figure 10 on page 16 of this report: <http://www.milliman.com/uploadedFiles/insight/health-published/measuring-strength-individual-mandate.pdf>.

Individual market enrollment changes and federal subsidies

Publicly available reports released by the federal government, as well as media coverage of the individual health insurance markets, focus largely on the insurance marketplace. It is important to understand how insurance marketplace enrollment, as well as the number of individuals receiving federal health insurance subsidies, compares relative to aggregate market enrollment. Figure 8 illustrates covered lives in the individual market in 2014, 2015, and 2016 (estimated values for 2016), along with the following effectuated¹⁸ enrollment statistics:

- Effectuated Marketplace All Enrollees: Estimated total number of effectuated marketplace member months, divided by 12.
- Effectuated Marketplace APTC: Estimated number of effectuated marketplace member months receiving an APTC, divided by 12.
- Effectuated Marketplace CSR: Estimated number of effectuated marketplace member months receiving a CSR subsidy, divided by 12.

FIGURE 8: INDIVIDUAL HEALTH INSURANCE MARKET ESTIMATED ENROLLMENT CHANGES BY MARKET SEGMENT, 2014 TO 2016

COVERED LIFE YEARS	2014	2015	2016
TOTAL INDIVIDUAL MARKET	15,000,000	17,500,000	18,000,000
EFFECTUATED MARKETPLACE (ALL ENROLLEES)	5,500,000	9,100,000	10,100,000
EFFECTUATED MARKETPLACE APTC	4,700,000	7,700,000	8,500,000
EFFECTUATED MARKETPLACE CSR	3,100,000	5,200,000	5,700,000
COVERED LIFE YEARS AS PERCENTAGE OF TOTAL INDIVIDUAL MARKET	2014	2015	2016
% EFFECTUATED MARKETPLACE	36%	52%	56%
% EFFECTUATED APTC	31%	44%	47%
% EFFECTUATED CSR	21%	30%	32%

Notes:

1. Covered life years reflect average monthly enrollment.
2. Marketplace effectuated enrollment estimated from HHS enrollment reports. Please see the Methodology section of this paper for more information.
3. The 2016 values have been estimated based on a combination of publicly available federal government data and reports, as well as third quarter 2016 health industry financials accessed through SNL Financial.
4. The 2016 total individual market enrollment values may be found at <https://aspe.hhs.gov/sites/default/files/pdf/211056/EnrollmentProjections.pdf>, Appendix 1.
5. Actual average monthly enrollment values are certain to vary from the estimates provided in the above figure.
6. Values have been rounded.

As illustrated in Figure 8, we estimate that the percentage of individual market covered lives in the insurance marketplace has increased from 36% in 2014 to 56% in 2016. The percentage of the individual market receiving an APTC in 2016 is estimated to approach 50%, with over 30% of the market estimated to receive CSR subsidies.

The APTC and CSR subsidies represent two permanent federal subsidies introduced by the ACA beginning in 2014. Figure 9 summarizes the aggregate estimated expenditures for these subsidies in relation to total aggregate individual market premium, as well as illustrating the APTC and CSR subsidy amounts per effectuated 12-month period.

¹⁸ Insurance policies that have been activated by the payment of premium.

FIGURE 9: INDIVIDUAL HEALTH INSURANCE MARKET FEDERAL SUBSIDIES AGGREGATE PREMIUM AND SUBSIDY AMOUNTS (\$ BILLIONS)

	CY2014	CY2015	CY2016
AGGREGATE MARKET EARNED PREMIUM	\$54.7	\$70.9	\$80.1
ADVANCED PREMIUM TAX CREDIT SUBSIDY	\$15.5	\$25.0	\$29.8
COST-SHARING REDUCTION SUBSIDY	\$2.8	\$4.9	\$5.7
APTC / EARNED PREMIUM	28%	35%	37%
CSR SUBSIDY / TOTAL EARNED PREMIUM	5%	7%	7%
APTC PER EFFECTUATED 12-MONTH ENROLLMENT PERIOD	\$3,312	\$3,255	\$3,492
CSR SUBSIDY PER EFFECTUATED 12-MONTH ENROLLMENT PERIOD	\$901	\$948	\$995

Notes:

1. APTC and CSR values based on CMS and Internal Revenue Service (IRS) data and publicly available reports. Please see the Methodology section for a full discussion of our data sources.
2. The 2016 CSR Subsidy assumes a similar growth in subsidy per effectuated 12-month recipient between 2015 and 2016 as observed from 2014 to 2015.
3. The 2016 aggregate market earned premium estimated is based on 3Q2016 statutory filings and prior year MLR data and statutory filings.
4. Values have been rounded.
5. The final 2016 values are certain to vary from the estimates provided in the above figure.

APTCs, which directly reduce the out-of-pocket premium for qualifying households, represented 28% of total earned premium in the individual market in 2014. In 2016, we estimate that this percentage has increased to 37%, as additional enrollment has shifted into the insurance marketplace. CSR subsidies represented 5% of total market earned premium in 2014, and they are estimated to grow to 7% of earned premium in 2016. For some insurers with a concentration of marketplace enrollment, CSR payments, as a percentage of earned premium, in 2014 and 2015 were much greater than the values illustrated in Figure 9.¹⁹

¹⁹ Please see <https://www.healthcarenh.com/?p=8437#sthash.8P9xK6OU.dpbs> for more information.

Transitional reinsurance program

The ACA transitional reinsurance program was a temporary program (calendar years 2014 through 2016) intended to stabilize the effect of high-risk members entering the individual market at the onset of the ACA. The program established a fee and payment parameters for each year of the program. The fee was \$5.25 PMPM in 2014, \$3.67 PMPM in 2015, and \$2.25 PMPM in 2016. These fees were assessed on insured member months in individual and group markets, and were inclusive of both fully insured and self-funded employer-sponsored insurance plans.²⁰ While the fee was assessed on all commercially insured markets, only the ACA-compliant individual market was eligible to receive transitional reinsurance payments.

The reinsurance payment parameters are defined in the annual HHS Notice of Benefit and Payment Parameters; however, flexibility is permitted to modify the parameters if the total fees collected exceed the estimated payments. Figure 10 illustrates original and final transitional reinsurance parameters and payments.

FIGURE 10: ACA TRANSITIONAL REINSURANCE PROGRAM PARAMETERS AND PAYMENTS, 2014 TO 2016

COVERED LIFE YEARS	2014		2015		2016
	ORIGINAL	FINAL	ORIGINAL	FINAL	ORIGINAL
ATTACHMENT POINT	\$60,000	\$45,000	\$70,000	\$45,000	\$90,000
REINSURANCE CAP	\$250,000	\$250,000	\$250,000	\$250,000	\$250,000
COINSURANCE	80.0%	100.0%	50.0%	55.2%	50.0%
TOTAL REINSURANCE CONTRIBUTIONS (INCLUDING PRIOR YEAR CARRYOVER)	\$10.0 BILLION	\$9.7 BILLION	\$6.0 BILLION	\$7.9 BILLION	\$4.0 BILLION
REINSURANCE PAYMENTS		\$7.9 BILLION		\$7.9 BILLION	

Notes:

1. Values have been rounded.
2. The 2014 total reinsurance contributions of \$9.7 billion are based on the CMS notification of April 12, 2015, titled "The Transitional Reinsurance Program's Contribution Collections for the 2014 Benefit Year."
3. The 2014 reinsurance payments equal the sum of the payments insurers received based on the CMS notification of June 30, 2015, titled "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year."
4. The 2015 total reinsurance contributions of \$7.8 billion are based on the CMS notification of June 30, 2016, titled "Summary Report on Transitional Reinsurance Payment and Permanent Risk Adjustment Transfers for the 2015 Benefit Year." We believe the difference relative to the \$7.9 billion in reinsurance payments is attributable to rounding and have elected to illustrate the contributions as \$7.9 billion in this figure.
5. The 2015 reinsurance payments of \$7.9 billion equal the sum of the payment insurers received based on the CMS notification of June 30, 2016, titled "Summary Report on Transitional Reinsurance Payment and Permanent Risk Adjustment Transfers for the 2015 Benefit Year."

The transitional reinsurance program pays a percentage (coinsurance) of the member claims between the attachment point and the reinsurance cap. As illustrated in Figure 10, the final transitional reinsurance parameters were favorable to the original amounts in both 2014 and 2015. The favorable transitional reinsurance parameters resulted in insurers operating in the individual market receiving higher payments than originally anticipated. As discussed previously, these additional payments were generated from fees collected from all commercially insured markets.

In 2014, the original parameters included an attachment point of \$60,000, coinsurance rate of 80%, and a reinsurance cap of \$250,000. Under the ACA, 2014 collections were expected to be \$12.02 billion, of which the first \$10 billion in contributions are allocated to reinsurance payments. The actual total contributions generated from the \$5.25 PMPM fee for 2014 equaled approximately \$9.7 billion. Because 2014 collections fell short of the estimated \$10 billion, CMS elected to use 100% of the funds received to make reinsurance payments to insurers.²¹

20 In 2015 and 2016, self-insured, self-administered group health plans that do not use a third-party administrator in connection with claims processing, claims adjudication, and plan enrollment were not considered a contributing entity and therefore are not required to make contributions. See <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Downloads/4-RIC-InfoGuide-5CR-093016.pdf>, Section 4.1 for more information.

21 CMS (April 14, 2015). The Transitional Reinsurance Program's Contribution Collections for the 2014 Benefit Year. Retrieved February 15, 2017, from <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Reinsurance->

On June 17, 2015, HHS announced that sufficient funds were available to increase the 2014 coinsurance rate from 80% to 100%,²² while lowering the attachment point from \$60,000 to \$45,000. Based on the final parameters established, insurers requested total reinsurance payments of \$7.9 billion for calendar year 2014 business.²³ As a result, this enabled HHS to carry over the remaining portion of the calendar year 2014 transitional reinsurance contributions for use in 2015.

In 2015, HHS estimated it would collect \$6.5 billion in reinsurance contributions, with \$6.0 billion being utilized for reinsurance payment and any excess allocated to the U.S. Treasury and administrative expenses. In aggregate, calendar year 2015 reinsurance payments to insurers were approximately \$7.9 billion.²⁴ The combination of unutilized funds from 2014 and lower than expected payments, based on the original parameters, enabled HHS to increase the 2015 coinsurance percentage to 55.2% and reduce the attachment point to \$45,000.

For 2014 and 2015, the enhanced transitional reinsurance parameters resulted in material improvements in individual market underwriting margins. Insurers paid \$7.9 billion and \$14.3 billion for the portion of claims that fell between \$45,000 and \$250,000 in 2014 and 2015, respectively.

- In 2014, the initial coinsurance percentage was 80% and there was enough funding to increase the coinsurance to 100%. This resulted in the health insurer industry receiving an additional \$1.6 billion or 2.9% of earned premium in 2014.
- For 2015, available funding increased the coinsurance percentage from 50% to 55.2%. As a result, the health insurer industry received an additional \$742 million or 1.0% of earned premium in 2015.

The 2016 Notice of Benefit and Payment Parameters indicates that the 2016 attachment point will be raised to \$90,000, and the reinsurance cap and coinsurance rate will be \$250,000 and 50%, respectively.²⁵ The 2016 parameters, as in prior years, can become more generous if the funding is available to do so. However, HHS did not modify the 2016 parameters in the 2017 Notice of Benefit and Payment Parameters, as was done in previous years. For 2017 individual market premium rate development, the termination of the transitional reinsurance program likely contributed to a portion of the observed national premium rate increases.

[Contributions-Total-Amount-Collected-final-.pdf](#)

- 22 CMS (June 17, 2015). Transitional Reinsurance Program: Pro Rata Adjustment to the National Coinsurance Rate for the 2014 Benefit Year. Retrieved February 15, 2017, from <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Downloads/RI-Payments-National-Proration-Memo-With-Numbers-6-17-15.pdf>.
- 23 CMS (June 30, 2015). Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year. Retrieved February 15, 2017, from <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-Draft-6-30-15.pdf>.
- 24 The sum of 2015 payments to insurers may be found here: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf>.
- 25 Federal Register (February 27, 2015). HHS Notice of Benefit and Payment Parameters for 2016; Final Rule, p. 10752. Retrieved February 15, 2017, from <https://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>.

ACA risk corridor program

The ACA risk corridor program was designed to provide insurers financial protection against unfavorable results during the first three years of the ACA (2014 through 2016). This program was only available for qualified health plans (QHPs) offered in the insurance marketplaces (plans sold outside the marketplace that are nearly identical to an insurer's QHP sold in the marketplace are also eligible).²⁶ While the risk corridor program is available to insurers in both the individual and small group markets, the uncertainty associated with the marketplace population and health status resulted in the relative importance of the program being much greater in the individual market.

- Insurers reported that 76% of national individual market membership was impacted by the risk corridor program in 2015. This figure is a 22% increase from the reported 54% of 2014 national individual market membership. Marketplace enrollment was estimated to represent 52% of enrollment in the individual market in 2015, implying that nearly 32% of the enrollment impacted by the risk corridor program was in QHPs outside the marketplace.
- In the small group market, risk-corridor-eligible membership doubled from a reported 17% in 2014 to 34% in 2015. The significantly lower percentage of business impacted by the risk corridor program is primarily attributable to the Small Business Health Options Program (SHOP) exchanges having minimal enrollment;²⁷ however, this data suggests that 2015 saw an increase in the purchase of QHPs sold outside of the SHOP exchanges.

RISK CORRIDOR SHORTFALL

FIGURE 11: RISK CORRIDOR AMOUNTS REQUESTED COMPARED WITH RECEIVED

	INDIVIDUAL		SMALL GROUP		TOTAL	
	REQUESTED	RECEIVED	REQUESTED	RECEIVED	REQUESTED	RECEIVED
2014	\$2,548	\$406	\$322	\$51	\$2,870	\$457
2015	\$5,323	\$0	\$594	\$0	\$5,917	\$0
TOTAL	\$7,871	\$406	\$916	\$51	\$8,786	\$457

Note: Dollar amounts have been rounded and are in millions.

Insurers have requested risk corridor payments of \$2.9 billion and \$5.9 billion in 2014 and 2015, respectively, for a total of \$8.8 billion. Because of limited funding, insurers have only received \$457 million. As a result, insurers have received \$8.3 billion less than they would have if risk corridors had been paid out in full.²⁸

The year 2016 was the last year of the ACA risk corridor program. As of the writing of this report, it is uncertain whether insurers will receive risk corridor receivables for calendar year 2015 or calendar year 2016. In its memo of September 9, 2016, CMS stated:²⁹

Collections from the 2016 benefit year will be used first for remaining 2014 benefit year risk corridors payments, then for 2015 benefit year risk corridors payments, then for 2016 benefit year risk corridors payments. As we have said previously, in the event of a shortfall for the 2016 benefit year, HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. HHS will record risk corridors payments due as an obligation of the United States Government for which full payment is required.

26 Leida, H. (November 19, 2013). President Obama's transitional policy for canceled plans. Milliman.com. Retrieved March 7, 2016, from <http://us.milliman.com/insight/2013/President-Obamas-transitional-policy-for-canceled-plans/>.

27 Based on federal data released in May 2015, only 85,000 individuals are insured through the SHOP exchanges nationally. See <http://www.usatoday.com/story/news/2015/10/31/kaiser-small-businesses-snub-obamacares-shop-exchange/74759360/>.

28 Livingston, S. (December 5, 2016). The state of the ACA's risk corridors. Modern Healthcare. Retrieved March 7, 2017, from <http://www.modernhealthcare.com/article/20161205/NEWS/161129937>.

29 CMS (September 9, 2016). Risk Corridors Payments for 2015. Retrieved March 7, 2017, from <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF>.

On February 9, 2017, the U.S. Court of Federal Claims ruled on a lawsuit filed by Moda Health Plan, Inc. (Moda) against the federal government, requesting \$214 million in payments for risk corridor funding shortfalls in 2014 and 2015, stating in its conclusion:³⁰

There is no genuine dispute that the Government is liable to Moda. Whether under statute or contract, the Court finds that the Government made a promise in the risk corridors program that it has yet to fulfill. Today, the Court directs the Government to fulfill that promise.

At the time of the release of this report, it is unclear whether Moda or other insurers will receive outstanding risk corridor amounts. A similar lawsuit filed by Land of Lincoln Mutual Insurance Company was dismissed by the Court of Federal Claims in November 2016.³¹ The values presented in this section and throughout the report, unless otherwise stated, reflect insurer financial results based on risk corridor payments made through December 2016. To the extent additional funding is provided to insurers, financial results will need to be restated.

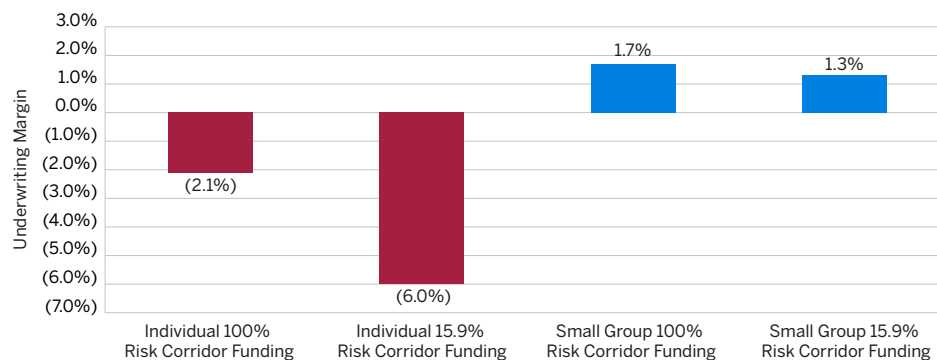
RISK CORRIDOR FUNDING: 2014 COVERAGE YEAR

On October 1, 2015, CCIIO announced that insurers would receive only 12.6% of risk corridor receivables for individual and small group market business in 2014.³² On November 18, 2016, CCIIO announced that all risk corridor collections for 2015, approximately \$95 million, would be utilized to fund a portion of the calendar year 2014 shortfall in the individual and small group markets.³³ This additional funding resulted in insurers receiving a cumulative total of approximately 15.9% of risk corridor receivables for individual and small group market business in calendar year 2014, an increase of 3.3% from the original amount paid in 2014. No funding was made available for calendar year 2015 risk corridor payments, effectively resulting in insurers receiving 0.0% of risk corridor receivables to date. CCIIO has announced that risk corridor collections for 2016 will be first applied to the remaining 2014 shortfall.³⁴

Figure 12 illustrates the 2014 individual market underwriting margin under three risk corridor (RC) payout scenarios:

- Before the risk corridor shortfall (RC at 100%)
- After the risk corridor shortfall, based on November 18, 2016, risk corridor amounts (RC at 15.9%)
 - This value was developed assuming carriers receive 15.9% of risk corridor receivables

FIGURE 12: 2014 UNDERWRITING MARGIN UNDER RISK CORRIDOR PAYOUTS SCENARIOS



30 U.S. Court of Federal Claims (February 9, 2017). *Moda Health Plan, Inc. v. United States*. Retrieved February 16, 2017, from https://ecf.cofc.uscourts.gov/cgi-bin/show_public_doc?2016cv0649-23-0.

31 U.S. Court of Federal Claims (September 23, 2016). *Land of Lincoln Mutual Health Insurance Company v. United States: The United States' Motion to Dismiss and Motion for Judgment on the Administrative Record on Count I*. Retrieved February 16, 2017, from <http://www.healthlawnext.com/wp-content/uploads/sites/89/2016/10/Land-of-Lincoln-DOJ-Motion-to-Dismiss.pdf>.

32 Katterman, S. Headwinds cause 2014 risk corridor funding shortfall.

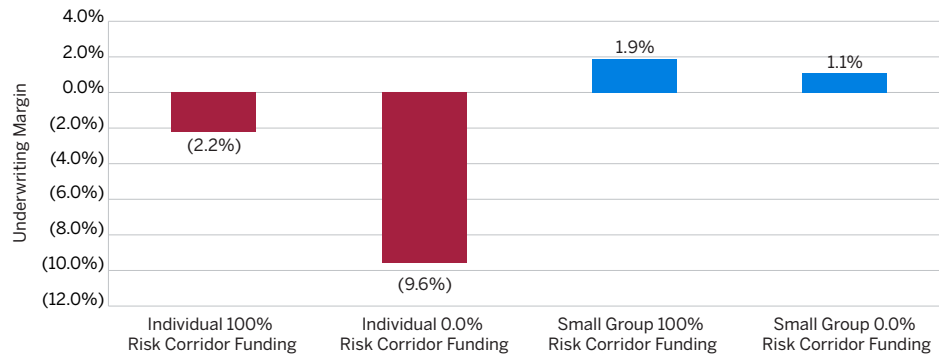
33 CMS (November 18, 2016), *ibid*.

34 CMS (September 9, 2016), *ibid*.

As illustrated in Figure 12, the risk corridor shortfall resulted in underwriting losses in the individual market being approximately three times what would have been achieved if the risk corridor program had been fully funded. The small group market as a whole had a positive underwriting margin in 2014, as the risk corridor shortfall had a minimal impact on margins, which was due to the smaller amount of business impacted by the risk corridor program.

RISK CORRIDOR FUNDING: 2015 COVERAGE YEAR

FIGURE 13: 2015 UNDERWRITING MARGIN UNDER RISK CORRIDOR PAYOUTS SCENARIOS



In 2015, requested insurer risk corridor amounts totaled approximately \$5.3 billion in the individual market and \$600 million in the small group market. To the extent the risk corridors were fully funded in 2015, insurers would have had an underwriting loss of approximately 2% or about \$1.5 billion in the individual market. The lack of funding resulted in individual market underwriting losses increasing to almost 10% of earned premium, or \$6.8 billion, nearly a fivefold increase. As in 2014, the small group market experienced a much less significant impact, with underwriting margins reduced by only 0.8% as a result of funding shortfall.

There are many factors that contributed to the requested risk corridor shortfall having a greater impact on insurer margins in the individual market in 2015, including the following:

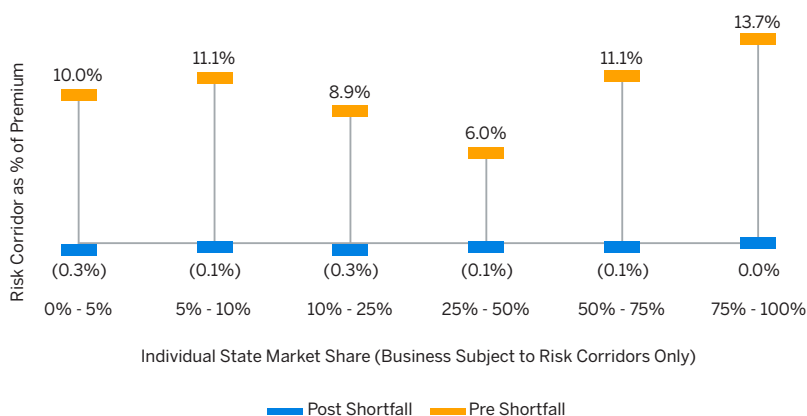
- The portion of the individual market impacted by the risk corridor program increased by approximately 5.1 million covered lives, from 8.1 million to 13.2 million in 2015. As a larger portion of the individual market is impacted by the risk corridor program, the shortfall affects insurer financial results to a greater degree.
- A total of 15.9% of 2014 risk corridor receivables were provided for calendar year 2014, compared with no risk corridor receivables currently being provided for calendar year 2015.
- Carriers had minimal 2014 emerging experience at the time carriers were required to submit 2015 individual market premiums, which was due to timing and technical issues associated with 2014 open enrollment, so 2015 premium rates could not be informed by experience incorporating the major ACA market reforms.

- The risk corridor shortfall for 2014 was announced after carriers were required to submit 2015 individual market premiums. Insurers are incentivized to maintain or even reduce premiums for the purpose of maintaining or gaining market share. While this is true in all insurance markets, it is an even greater emphasis in the individual market, which is due to the price sensitivity of enrollees, especially when combined with the mechanics of APTC calculations. In many regions, the premiums for the lowest-cost plans offered on the individual marketplace decreased between calendar years 2014 and 2015.³⁵ Without information about the degree of risk corridor shortfall, insurers may have relied on protection from the risk corridor program when evaluating the risk associated with insufficient premiums.

MARKET VARIATION

Figure 14 illustrates 2015 risk corridor receivables as a percentage of earned premium for business eligible for the ACA risk corridor program. For the purpose of this figure, issuers are segmented based on their state market shares of membership that is impacted by the ACA risk corridors in the individual market. This figure illustrates net risk corridor receivables both before and after reflecting the risk corridor shortfall.

FIGURE 14: 2015 INDIVIDUAL MARKET NET RISK CORRIDOR RECEIVABLE AS A PERCENTAGE OF EARNED PREMIUM BY INSURER MARKET SHARE IMPACTED BY THE RISK CORRIDORS



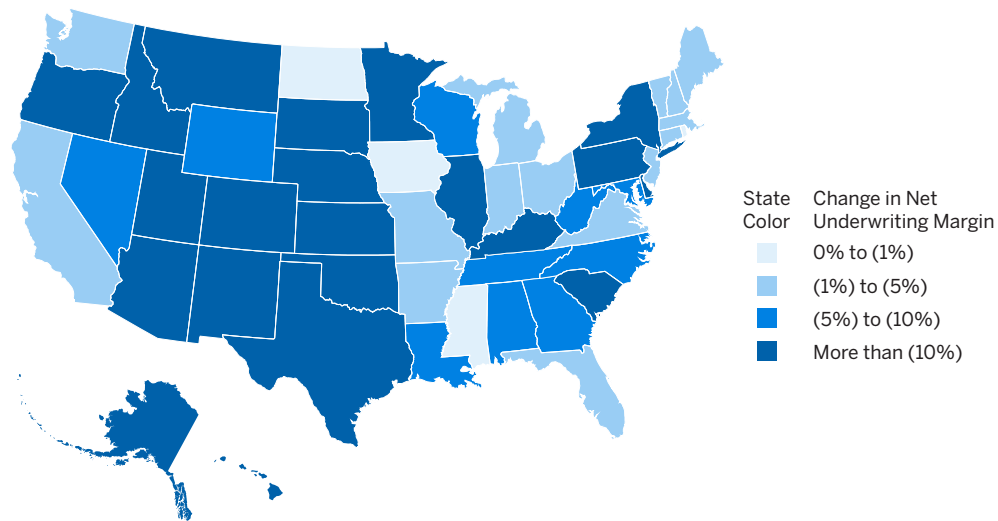
As Figure 14 demonstrates, insurers with a market share of over 50% were impacted by the risk corridor shortfall to a greater degree than insurers with market shares of 10% to 50% of the state. This is likely influenced by the price sensitivity of individual market enrollees electing to enroll in plans that were the lowest-cost offered in the market within a metallic tier.³⁶ Insurers with low market share (under 10%) were also highly affected by the risk corridor shortfall, which could partially be attributable to pricing uncertainty with low enrollment.

35 Avery, K., Gardner, M., Gee, E., Marchetti-Bowick, E., McDowell, A., and Sen A. (October 30, 2015). Health plan choice and premiums in the 2016 health insurance marketplace. Page 20, Table 7. ASPE research brief. Retrieved March 7, 2016, from <https://aspe.hhs.gov/sites/default/files/pdf/135461/2016%20Marketplace%20Premium%20Landscape%20Issue%20Brief%2010-30-15%20FINAL.pdf>.

36 Burke, A. et al. (June 18, 2014). Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014, Table 4. HHS ASPE Research Brief. Retrieved February 16, 2017, from <https://aspe.hhs.gov/sites/default/files/pdf/76896/2014MktPlacePremBrf.pdf>.

The impact of the risk corridor funding shortfall varied significantly by state. Figure 15 illustrates the change in net underwriting margin by state in 2015 that is due to carriers not receiving risk corridor payments.

FIGURE 15: 2015 INDIVIDUAL MARKET CHANGE IN NET UNDERWRITING MARGIN THAT IS DUE TO RISK CORRIDOR SHORTFALL BY STATE



As illustrated in Figure 15, the insurer financial impact associated with the risk corridor shortfall varied greatly by state, influenced by both the percentage of individual market business impacted by the risk corridor program and the financial performance of insurers under the program. In 21 states, net underwriting margin decreased by over 10%, which was due to the risk corridor shortfall, with six of these states experiencing net underwriting margin decreases of over 20%. In contrast, four states (Iowa, Mississippi, North Dakota, and Rhode Island) experienced net underwriting margin changes of less than 1%, which was due to the risk corridor shortfall in 2015.

ACA risk adjustment program

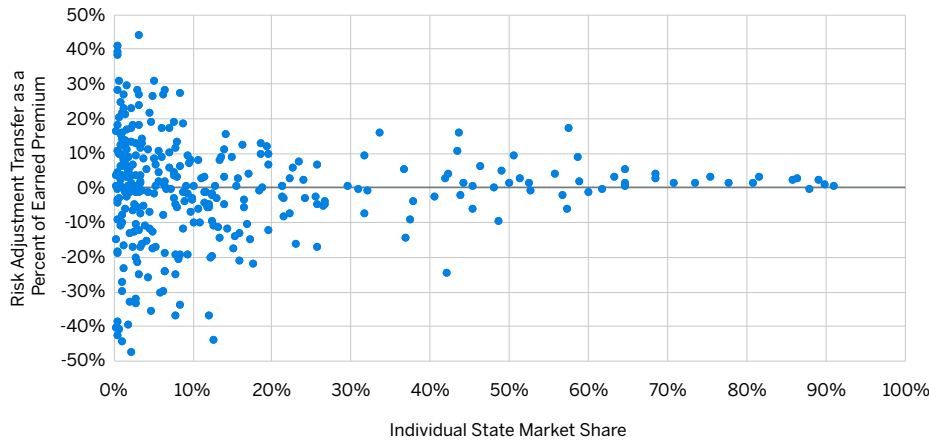
The ACA risk adjustment program, the permanent component of the 3R programs, is intended to normalize for differences in member health risk among insurers. Risk adjustment transfers within the individual and small group markets in each state³⁷ net to zero, meaning that the payments by insurers with lower-than-average-risk members are equal to the receipts by insurers with higher-than-average-risk members.

For 2015, risk adjustment transfers totaled nearly \$2.8 billion across the individual market and \$1.1 billion across the small group market. These transfers represent approximately 4.2% and 1.6% of earned premium for insurers impacted by risk adjustment for the individual and small group markets, respectively. These percentages increased from approximately 3.6% for the individual market and 0.9% for the small group market in 2014, as market share of ACA-compliant membership increased.

Although the risk adjustment transfers net to zero at the market level, the impact varies by insurer and can materially affect insurer financial results. Insurers with larger market share are less impacted by risk adjustment transfers because the risks of their memberships will naturally be closer to the market average risk. Conversely, insurers with smaller market share can be more affected by risk adjustment transfers. Figures 16 and 17 illustrate this for the individual and small group markets, respectively.

Figures 16 and 17 also illustrate that there are wider variations in risk adjustment transfers in the individual market than in the small group market. In the 2015 individual market, risk adjustment transfers of greater than 2% of total earned premium were incurred for 71% of national market share. While in the 2015 small group market, only 34% of national market share experienced risk adjustment transfers greater than 2% of total earned premium.

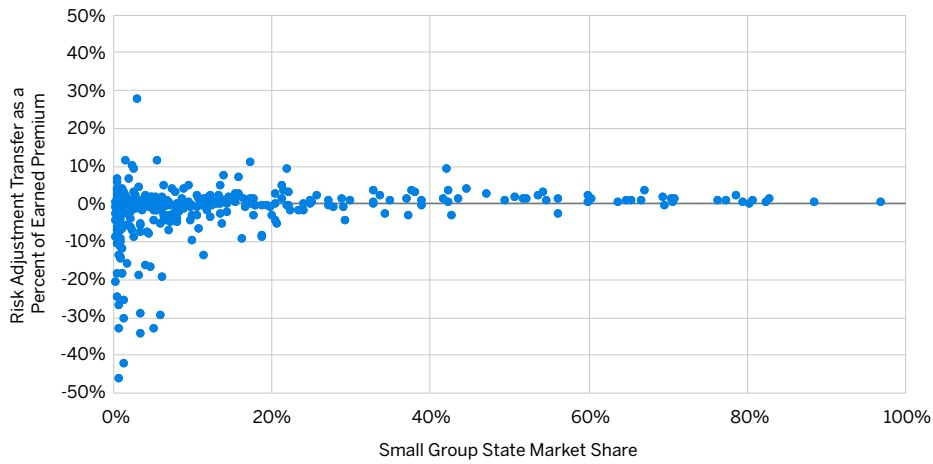
FIGURE 16: 2015 INDIVIDUAL MARKET RISK ADJUSTMENT TRANSFERS AS A PERCENTAGE OF EARNED PREMIUM BY INSURER STATE MARKET SHARE



Note: Insurers included in Figure 16 have been limited to those with at least 0.5% state market share and risk adjustment transfers as a percentage of earned premium of +/-50%.

³⁷ Massachusetts and Vermont have a combined individual and small group risk pool, so risk adjustment transfers in Massachusetts and Vermont net to zero across the individual and small group markets combined.

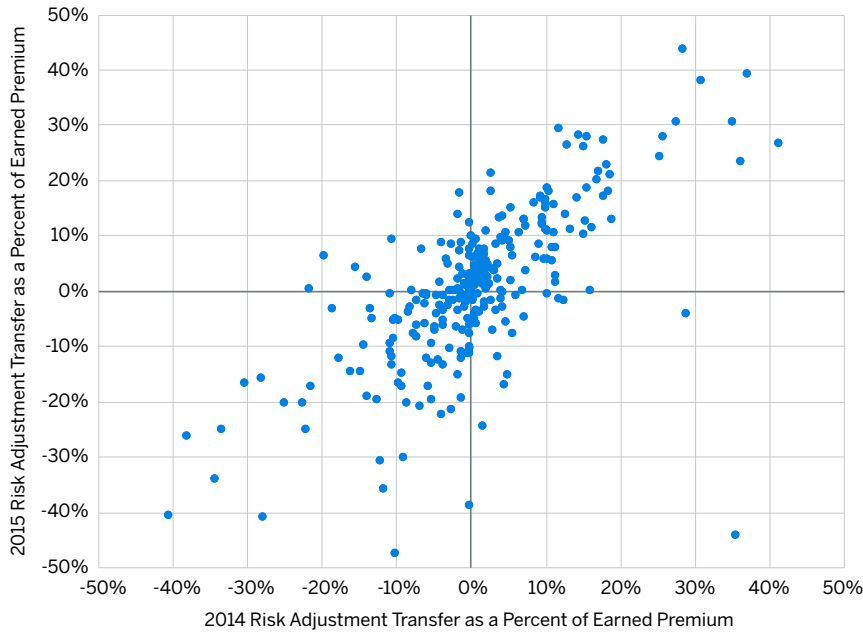
FIGURE 17: 2015 SMALL GROUP MARKET RISK ADJUSTMENT TRANSFERS AS A PERCENTAGE OF EARNED PREMIUM BY INSURER STATE MARKET SHARE



Note: Insurers included in Figure 17 have been limited to those with at least 0.5% state market share and risk adjustment transfers as a percentage of earned premium of +/-50%.

Insurers with smaller market share in the individual market may have been surprised by the amount of their 2015 risk adjustment transfers when results were announced by CMS on June 30, 2016, if they had assumed that their 2015 transfers would be about the same as their 2014 transfers. As shown in Figure 18, 2015 risk adjustment transfers as a percentage of earned premium were only moderately correlated with 2014 values in the individual market ($R^2 = 25\%$). However, the large number of observations in the lower left quadrant of Figure 18 indicate that most insurers paying out risk adjustment transfers in 2014 also did so in 2015. The large number of observations in the upper-right quadrant of Figure 18 indicates that most insurers receiving risk adjustment transfers in 2014 also did so in 2015.

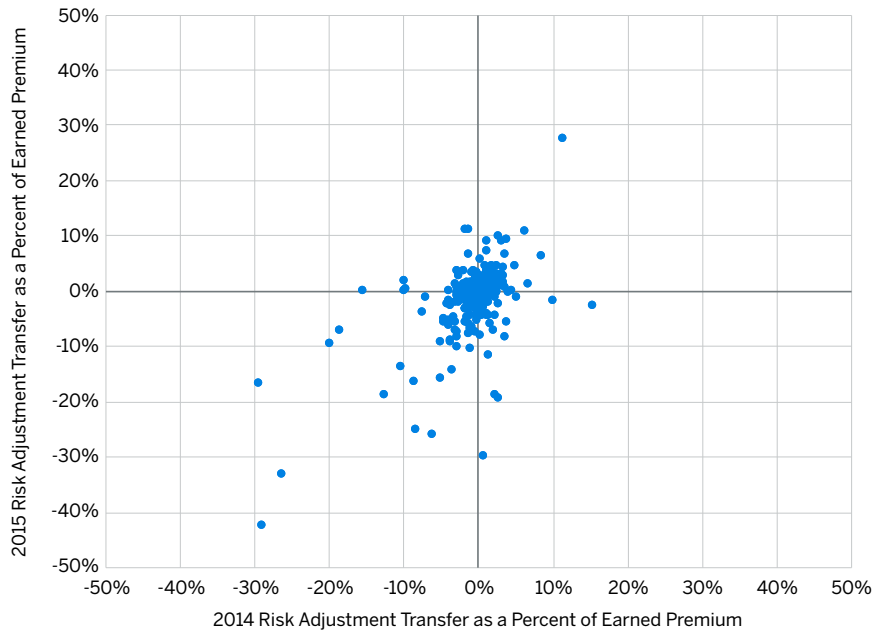
FIGURE 18: INDIVIDUAL MARKET RISK ADJUSTMENT TRANSFERS AS A PERCENTAGE OF EARNED PREMIUM BY INSURER STATE MARKET SHARE, 2015 VS. 2014



Note: Insurers included in Figure 18 have been limited to those with at least 0.5% state market share and risk adjustment transfers as a percentage of earned premium of +/-50% in both 2014 and 2015.

Figure 19 compares 2014 and 2015 risk adjustment transfers as a percentage of earned premium in the small group market. In comparison with the individual market illustrated in Figure 18, we once again note that the small group market has less variation in risk adjustment transfers than the individual market. Similar to the individual market, 2015 risk adjustment transfers as a percentage of earned premium were moderately correlated with 2014 values in the small group market ($R^2 = 28\%$) and most insurers that paid or received risk adjustment transfers in 2014 also did the same in 2015.

FIGURE 19: SMALL GROUP MARKET RISK ADJUSTMENT TRANSFERS AS A PERCENTAGE OF EARNED PREMIUM BY INSURER STATE MARKET SHARE, 2015 VS. 2014



Note: Insurers included in Figure 19 have been limited to those with at least 0.5% state market share and risk adjustment transfers as a percentage of earned premium of +/-50% in both 2014 and 2015.

Risk adjustment transfers materially impact the financial results of most insurers in the ACA individual and small group markets and are critical to the long-term viability of these markets. With two years of actual results, insurers are now able to better estimate risk adjustment transfers to report on their annual statements and reflect in premium rates. However, there will continue to be uncertainty. When developing estimates for risk adjustment transfers, insurers need to consider the risk scores of their members, changes in market average premiums, and any updates to the risk adjustment calculation. While there will always be some uncertainty about risk adjustment transfers, we believe that if there are no major legislative changes impacting these markets, the amount of uncertainty will continue to decrease in the next few years as the markets mature and only routine updates are needed to the ACA risk adjustment program. However, to the extent material changes are made to the individual and small group insurance markets, insurers may be faced with new challenges in estimating risk adjustment transfers.

Conclusion

Insurer financial experience from the MLR forms provides a transparent view into the U.S. health insurance market. For 2014 and 2015, the data provides a unique picture of the insurance markets' financial results, based on final accountings of the ACA's 3R programs. Since 2013, the individual market has undergone significant change in terms of enrollment, premium revenue, and claims expense, as well as overall market volatility relative to the group insurance markets. With the United States potentially undertaking another round of health insurance reform in the near future, insurers and policymakers should study the enrollment and financial results that have occurred under the ACA to better understand how insurance markets may react to future regulatory and legislative changes.

Limitations

The analyses presented in this research paper have relied on data and other information from the MLR forms and Supplemental Health Care Exhibits of health insurers. MLR form data was obtained from the Center for Consumer Information and Insurance Oversight of the Centers for Medicare and Medicaid Services³⁸ in December 2016. The 2010 Supplemental Health Care Exhibit data was obtained using SNL Financial. Data related to insurance marketplace effectuated enrollment, and subsidies data was obtained from publicly available federal government data. The data and other information have not been audited or verified, but a limited review was performed for reasonableness and consistency. If the underlying data or information is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete. Published values subsequent to December 1, 2016, are not included in this report.

The views expressed in this report are made by the authors of this report and do not represent the collective opinions of Milliman. Other Milliman consultants may hold different views and reach different conclusions.

Acknowledgement

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Qualifications

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

38 Centers for Medicare and Medicaid Services. Medical Loss Ratio Data and System Resources. Retrieved March 7, 2016, from <http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

Appendix 1

Aggregate health insurer financial results 2010 - 2015

**SUMMARY OF COMMERCIAL HEALTH INSURER FINANCIAL RESULTS - CALENDAR YEARS 2010 - 2015
PER MEMBER PER MONTH PREMIUM AND EXPENSES**

INDIVIDUAL MARKET - ALL REPORTED COMPANIES

YEAR	COVERED LIVES	EARNED PREMIUM	FEES AND TAXES	CLAIM EXPENSES	MLR REBATES	TOTAL ADMIN EXPENSES	UNDERWRITING GAIN/(LOSS)	PRELIMINARY MEDICAL LOSS RATIO	MLR REBATES AS % OF EARNED PREMIUM	UNDERWRITING MARGIN	ADMIN EXPENSE RATIO
2015	17,500,000	\$337.64	\$13.86	\$305.43	\$0.51	\$48.19	(\$32.55)	95.3%	0.1%	(9.6%)	14.3%
2014	15,000,000	\$302.96	\$15.99	\$251.64	\$1.31	\$48.55	(\$18.08)	88.8%	0.4%	(6.0%)	16.0%
2013	10,900,000	\$247.41	\$2.55	\$209.62	\$0.96	\$43.09	(\$9.68)	86.7%	0.4%	(3.9%)	17.4%
2012	10,700,000	\$240.10	\$5.01	\$199.47	\$1.54	\$38.30	(\$4.78)	86.0%	0.6%	(2.0%)	16.0%
2011	10,700,000	\$234.17	\$5.80	\$188.47	\$3.06	\$38.47	(\$2.55)	83.5%	1.3%	(1.1%)	16.4%
2010	10,100,000	\$214.11	\$6.24	\$166.14	\$0.26	\$40.86	(\$0.67)	80.8%	0.1%	(0.3%)	19.1%

SMALL GROUP MARKET - ALL REPORTED COMPANIES

YEAR	COVERED LIVES	EARNED PREMIUM	FEES AND TAXES	CLAIM EXPENSES	MLR REBATES	TOTAL ADMIN EXPENSES	UNDERWRITING GAIN/(LOSS)	PRELIMINARY MEDICAL LOSS RATIO	MLR REBATES AS % OF EARNED PREMIUM	UNDERWRITING MARGIN	ADMIN EXPENSE RATIO
2015	14,700,000	\$410.95	\$24.81	\$327.92	\$0.87	\$51.94	\$4.64	85.8%	0.2%	1.1%	12.6%
2014	16,000,000	\$388.99	\$23.07	\$310.90	\$0.73	\$48.49	\$5.15	85.9%	0.2%	1.3%	12.5%
2013	17,300,000	\$376.19	\$12.99	\$303.16	\$0.57	\$46.37	\$10.68	84.5%	0.2%	2.8%	12.3%
2012	18,100,000	\$361.59	\$12.23	\$291.54	\$0.93	\$44.38	\$9.81	84.5%	0.3%	2.7%	12.3%
2011	18,800,000	\$352.88	\$13.41	\$280.86	\$1.28	\$45.68	\$10.54	83.7%	0.4%	3.0%	12.9%
2010	17,600,000	\$343.26	\$11.84	\$274.66	\$0.07	\$45.05	\$10.93	83.7%	0.0%	3.2%	13.1%

LARGE GROUP MARKET - ALL REPORTED COMPANIES

YEAR	COVERED LIVES	EARNED PREMIUM	FEES AND TAXES	CLAIM EXPENSES	MLR REBATES	TOTAL ADMIN EXPENSES	UNDERWRITING GAIN/(LOSS)	PRELIMINARY MEDICAL LOSS RATIO	MLR REBATES AS % OF EARNED PREMIUM	UNDERWRITING MARGIN	ADMIN EXPENSE RATIO
2015	42,700,000	\$410.68	\$20.35	\$349.30	\$0.26	\$32.80	\$6.61	90.3%	0.1%	1.6%	8.0%
2014	43,200,000	\$404.79	\$20.10	\$342.88	\$0.17	\$32.66	\$7.01	89.9%	0.0%	1.7%	8.1%
2013	47,200,000	\$368.68	\$8.59	\$320.40	\$0.14	\$29.90	\$7.36	89.9%	0.0%	2.0%	8.1%
2012	47,400,000	\$367.11	\$8.36	\$319.45	\$0.19	\$29.04	\$7.91	90.0%	0.1%	2.2%	7.9%
2011	48,200,000	\$359.20	\$9.49	\$310.49	\$0.66	\$28.98	\$8.27	89.6%	0.2%	2.3%	8.1%
2010	39,200,000	\$339.47	\$7.70	\$293.55	\$0.00	\$31.64	\$5.74	89.3%	0.0%	1.7%	9.3%

Notes:

- Covered Lives equals reported member months divided by 12.
- The 2011 through 2015 reported premium and expenses are based on MLR form reported values as of March 31 of the following year.
- MLR form reported values transposed into the same format as the NAIC Supplemental Health Care Exhibit form.
- Earned Premium equals Part 1, Line 1.1 of the Supplemental Health Care Exhibit.†
- Fees & Taxes equals Part 1, Line 1.5, 1.6, and 1.7 of the Supplemental Health Care Exhibit.
- Claims Expenses equals Part 1, Line 5.0 of the Supplemental Health Care Exhibit.†
- Total Admin Expenses equals the sum of Part 1, Lines 6.6, 8.3, and 10.5 of the Supplemental Health Care Exhibit.
- Underwriting Gain (Loss) equals Part 1, Line 11 of the Supplemental Health Care Exhibit.
- Preliminary Medical Loss Ratio equals the sum of Part 1, Line 4 + Line 5.0 + Line 6.6 ÷ Line 1.8 of the Supplemental Health Care Exhibit.
- The 2012/13/14/15 MLR Rebates as a % of Earned Premium equal reported rebates on Part 4, Line 5.4 (Total Column) of 2012/13/14/15 MLR form ÷ Earned Premium.
- The 2011 MLR Rebates as a % of Earned Premium equal reported rebates on Part 5, Line 5.4 (Total Column) of 2011 MLR form ÷ Earned Premium.
- Underwriting Margin equals Underwriting Gain (Loss) ÷ Earned Premium.
- Admin Expense Ratio equals Total Admin Expenses ÷ Earned Premium.

† 2014 and 2015 values were adjusted by impact of 3R's.

Appendix 2

Methodology

MEDICAL LOSS RATIO DATA OVERVIEW

Section 2718 of the ACA instituted minimum medical loss ratio requirements for health insurers in the individual, small group, and large group markets. The Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare and Medicaid Services (CMS) has publicly released the annual Medical Loss Ratio Reporting Data (MLR Data) that was used to fulfill and measure the minimum medical loss ratio requirements under the ACA. We have summarized and analyzed the MLR Data made available through CCIIO's website³⁹ as of December 1, 2016.

The MLR Data contains experience reported by health insurance issuers at the state and market level. Business under the medical loss ratio requirements is split between comprehensive (annual limit greater than \$250,000), "mini-med" (annual limit at or less than \$250,000), and expatriate. Data for comprehensive and mini-med business is split separately between the individual, small group, and large group markets. Individual market values exclude limited benefit plans, dread-disease policies, accident-only coverage, and other policies that are not considered comprehensive health insurance. The small group and large group categories exclude self-funded employers, many of which purchase stop-loss insurance. Business written through an association is included in the MLR Data based on the insured entity's individual, small group, or large group status. Additionally, for 2013 through 2015, student health insurance was separately reported. For the purpose of this report, only comprehensive business has been analyzed.

The information contained in the MLR data tracks closely with the Supplemental Health Care Exhibit (SHCE) form that is submitted with the insurer's year-end annual statement. The SHCE, developed by the National Association of Insurance Commissioners (NAIC), was first required in 2010. By comparing the 2010 Exhibit and 2011-2015 MLR Data, health insurance industry trends can be evaluated over the six-year period. A limitation in these comparisons is that several California-based health insurers file with the state's Department of Managed Care, rather than the NAIC, and therefore do not complete the Exhibit form. However, these companies are required to report data for the medical loss ratio calculation and are contained in the 2011 through 2015 MLR data sets. The 2010 SHCE data was summarized using SNL Financial.

The analyses presented in this report were based upon values from the 2011 through 2015 MLR Data and the 2010 SHCE data meeting the following criteria:

- Health insurance coverage lines of business.
- Business in the 50 states and the District of Columbia.
- Identified as comprehensive health insurance coverage based upon a review of the reported values by the authors of this report. For example, companies providing solely behavioral health services were flagged as non-comprehensive.

Values for certain affiliate companies were combined for analyses presented in this report in a way to avoid double-counting of enrollment values.

39 The Center for Consumer Information and Insurance Oversight website is found at <http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

Figure 20 provides a summary of the number of companies, covered lives, and aggregate premium amounts reported for calendar year 2015 on a national basis (50 U.S. states and Washington, D.C.) for the comprehensive health insurance business under the ACA's medical loss ratio requirements that is included in this report. Additionally, the percentage of total premium (based on reported experience in the 50 states and Washington, D.C.) identified as non-comprehensive is illustrated. Data was reviewed for reasonableness and consistency. However, individual company results have not been audited. To the extent that individual company data was not correctly reported, the values presented in this report will not be representative of actual financial results.

FIGURE 20: 2015 COMPREHENSIVE HEALTH INSURANCE REPORTED IN MLR FORM

MARKET	GROUPS (PARENT COMPANIES)	COMPANIES	LIVES ¹	PREMIUM (\$MILLION)	% NON- COMPREHENSIVE
INDIVIDUAL	184	406	17,500,000	\$70,901	0.04%
SMALL GROUP	175	364	14,700,000	\$72,611	0.01%
LARGE GROUP	177	382	42,700,000	\$210,662	0.06%
TOTAL COMPREHENSIVE	218	484	74,900,000	\$354,174	0.05%

Notes:

1. Lives represent reported member months divided by 12.
2. Certain values have been rounded.

While a majority of the fields in the MLR Data were simply reassigned to the appropriate SHCE report line item, significant adjustments were made to the earned premiums and incurred claims fields to appropriately account for the impact of the 3Rs in applicable markets during 2014 and 2015. In particular, adjustments related to the reporting of transitional reinsurance recoveries were based on a review of insurers' 2014 and 2015 annual statement filings, as well as actuarial judgment. Because risk corridor amounts reported in the MLR Data are based on a different calculation from amounts paid to issuers by CCIIO, we replaced all MLR Data risk corridor values with those published by CCIIO.⁴⁰ Other adjustments were made to the data for observed reporting anomalies.

If you would like further information on data and analytics that can be produced from the Medical Loss Ratio Reporting Form data, please contact the authors of this report.

MARKETPLACE EFFECTUATED ENROLLMENT DATA

CMS has released quarterly effectuated enrollment snapshots for the insurance marketplace on a national and state level for December 2014 through March 2016.⁴¹ Effectuated marketplace enrollment at the end of each quarter is provided separately for total marketplace enrollment, CSR enrollment, and APTC enrollment. The effectuated marketplace enrollment also includes the average APTC on a national and state level for each quarter.

For 2014, the Internal Revenue Service (IRS) announced \$15.5 billion in APTC for insurance marketplace coverage.⁴² By dividing the \$15.5 billion amount by the December 2014 national average APTC (\$276), estimated monthly APTC effectuated enrollment for 2014 was calculated at 4.7 million.

40 Center for Consumer Information and Insurance Oversight (November 19, 2015). Risk Corridors Payment and Charge Amounts for Benefit Year 2014. Retrieved March 7, 2016, from <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf>.

41 CMS.gov (July 1, 2016). Quarterly Marketplace Effectuated Enrollment Snapshots by State. Retrieved February 16, 2017, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Effectuated_Quarterly_Snapshots.html.

42 IRS (July 17, 2016). IRS Commissioner John Koskinen Letter to Congress. Retrieved February 16, 2017, from <https://www.irs.gov/pub/irs-utl/CommissionerLetterwithcharts.pdf>.

For 2015, the IRS announced \$25 billion in APTC for insurance marketplace coverage.⁴³ By dividing the \$25 billion amount by the average quarterly national APTC (\$271), estimated monthly APTC effectuated enrollment for 2015 was calculated at 7.7 million. Note that quarterly national APTC amounts varied from \$270 to \$272.

Based on the ratios between APTC, CSR, and total marketplace effectuated quarterly enrollment snapshots from CMS, we estimated the average monthly effectuated enrollment for CSR and total marketplace enrollees in 2014 and 2015. The 2016 average monthly effectuated values for total marketplace, APTC, and CSR are based on the ratio between the March 2015 and March 2016 marketplace snapshot enrollment reports, multiplied by the estimated average monthly 2015 enrollment for each respective measure. For the first half of 2016, CMS indicated an average of 10.4 million consumers had effectuated marketplace coverage, with 8.8 million receiving APTC and nearly 5.9 million receiving CSR subsidies.⁴⁴ While we believe our methodology for estimating average monthly effectuated enrollment is sound, actual values are certain to vary from our estimates to an unknown degree.

43 IRS (January 9, 2017). IRS Commissioner John Koskinen Letter to Congress. Retrieved February 16, 2017, from <https://www.irs.gov/pub/newsroom/commissionerletteracafilingseason.pdf>.

44 CMS.gov (October 19, 2016). First Half of 2016 Effectuated Enrollment Snapshot. Retrieved February 16, 2017, from <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html>.



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