MILLIMAN REPORT

Commercial health insurance: Detailed 2019 financial results and emerging 2020 trends

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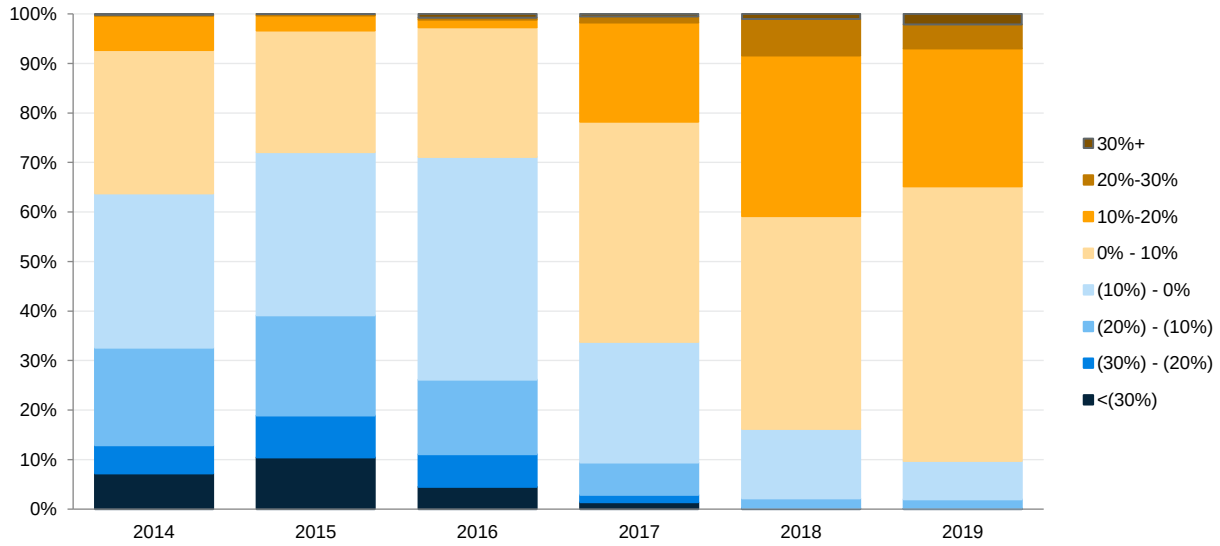
Executive Summary

Medical loss ratio (MLR) data published by the Centers for Medicare and Medicaid Services (CMS) provide a detailed picture of insurer financial results for the commercial market for the sixth full year of the Patient Protection and Affordable Care Act (ACA). Financial results from calendar year 2019 indicate continued profitability in both group and individual insurance markets, with 2019 marking the second consecutive year of composite underwriting margins approaching 10% in the individual market. As a result of the COVID-19 pandemic, 2020 insurer financial results through the end of the year suggest that the direct costs of the pandemic (treatment and testing related to COVID-19) have been more than offset by reductions in other healthcare utilization (primarily during the March through May 2020 timeframe), further increasing anticipated underwriting margins.

The composite underwriting margin in the individual market for 2019 was 8.9%, only 0.8% lower than the 9.7% margin reported for 2018, which represented the highest average margin level since ACA markets reforms first took effect in 2014. The composite underwriting margin across group insurance markets in 2019 remained steady relative to prior years, with a composite underwriting margin of 2.5% for the large group market and 4.1% for the small group market.

- Figure 1 illustrates the distribution of individual market underwriting margins (based on insured members and net of MLR rebates) from 2014 through 2019.
  - While carriers representing 60% to 70% of the individual market operated at an underwriting *loss* from 2014 through 2016, financial results for insurers indicate 84% and 90% of the individual market operated at an underwriting *gain* in 2018 and 2019, respectively.
  - Losses in excess of 10% (representing nearly 40% of the market in 2015) have largely ceased, making way for underwriting gains in excess of 10% for approximately 35% to 40% of the market in 2018 and 2019.

FIGURE 1: DISTRIBUTION OF INDIVIDUAL MARKET UNDERWRITING MARGINS



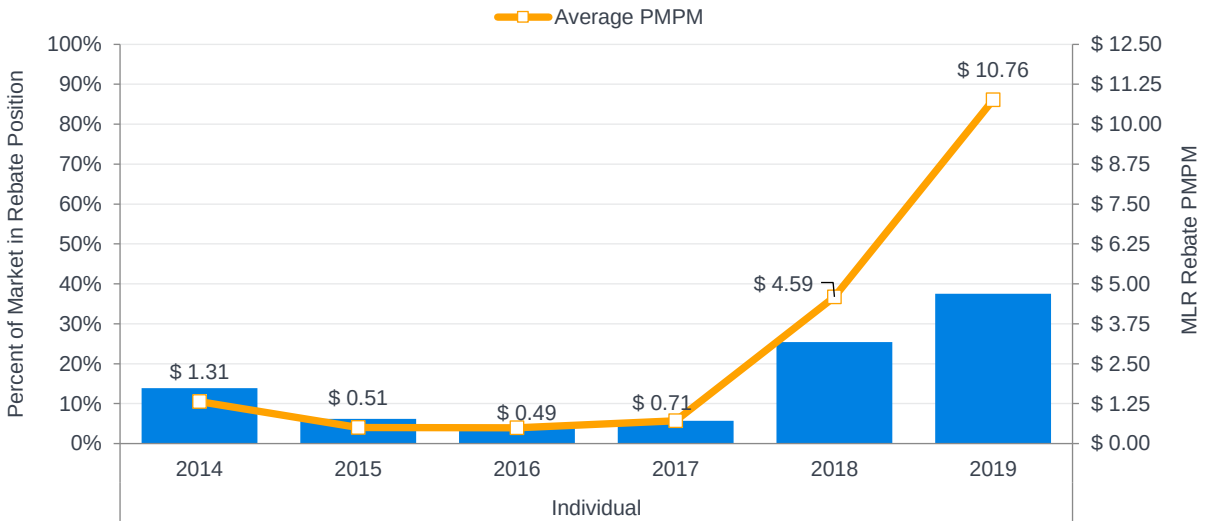
Notes:

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, 2015, and 2016 reflect 16.9%, 0.0%, and 0.0% of requested risk corridor amounts received, respectively, for the individual and small group markets. Values have not been adjusted based on the Maine Community Health Options v. United States April 2020 ruling. See https://www.scotusblog.com/case-files/cases/maine-community-health-options-v-united-states/ for more background.

Coinciding with increases in insurer margins, the proportion of the individual market in an MLR rebate position has increased from approximately 6% in 2017 to nearly 38% in 2019. Composite MLR rebates have increased from $0.71 (2017) to $10.76 (2019) on a per member per month (PMPM) basis.

- Figure 2 illustrates the proportion of the individual market (based on insured members) in an MLR rebate position (owing rebates to consumers) from 2014 through 2019.
  - The commercial MLR standard is based on financial experience over the preceding three years. For example, the 2019 result is based on 2017 to 2019 experience. As a result, excluding 2016 experience from the MLR equation and replacing it with 2019 experience resulted in the proportion of the market in a rebate position increasing from 25% to 38% and the composite market rebate PMPM more than doubling from 2018 to 2019
  - The $10.76 PMPM MLR rebate for 2019 was equivalent to 1.9% of earned premium. MLR rebates in the small group and large group markets were 0.6% and 0.1% of earned premium, respectively.

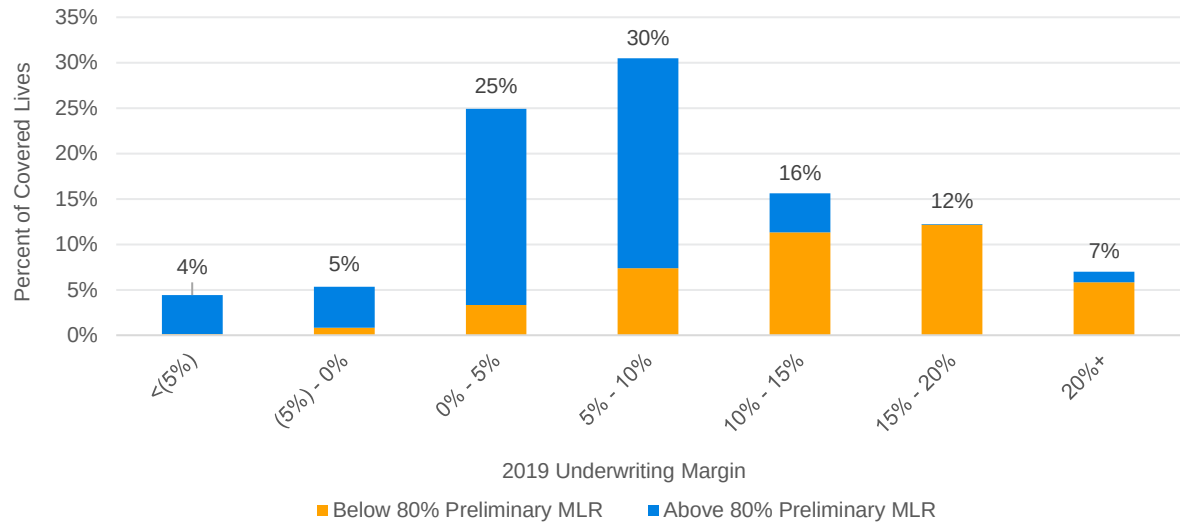
FIGURE 2: PROPORTION OF INDIVIDUAL MARKET IN A REBATE POSITION AND COMPOSITE MARKET MLR REBATE



While the commercial MLR requirements will put some downward pressure on individual market profit margins in future years, underwriting margins of 5% to 10%, in the absence of enhanced competitive forces or regulatory changes, appear to be very achievable while maintaining an MLR above the 80% minimum.

- Figure 3 illustrates the distribution of the individual market (based on insured members) 2019 underwriting margins and further divides insurer experience below and above the 80% MLR standard based only on 2019 experience.
  - For insured business with an underwriting margin between 0% and 5%, approximately 87% of the cohort reported a preliminary MLR above 80% for 2019. For insured business with an underwriting margin between 5% and 10%, this percentage decreased to 76%.
  - As explored in more detail in the body of this report, while administrative costs have grown on a PMPM basis in the individual market (approximately 3% on an annualized basis since 2014), premium rate increases are responsible for driving the market's administrative expense ratio downward, from 16.0% to 9.8% over the same time period. The lower administrative expense ratio allows for insurers to maintain greater profit margins while meeting the 80% minimum MLR requirement.

FIGURE 3: PROPORTION OF INDIVIDUAL MARKET ABOVE/BELOW 80% MINIMUM MLR REQUIREMENT BASED ON 2019 PRELIMINARY MEDICAL LOSS RATIO BY 2019 UNDERWRITING MARGIN COHORT



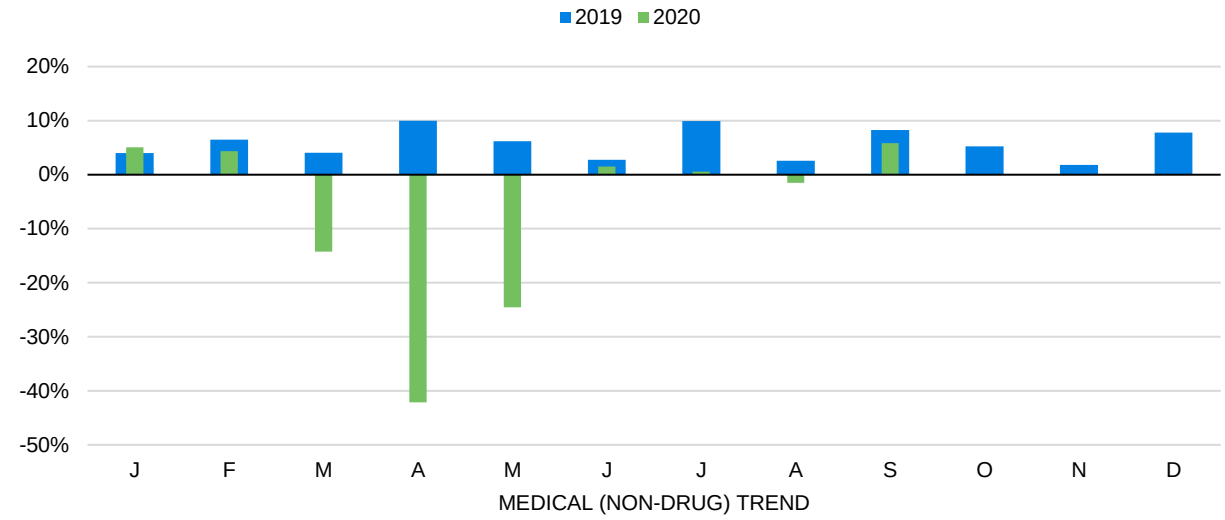
Notes:

1. Percentage labels reflect market share based on covered lives and have been rounded.
2. Insured business with underwriting margins in excess of 20% with preliminary MLR above 80% is primarily attributable to three companies that operated in states with individual market reinsurance programs. Reinsurance payments were reported outside the CMS MLR calculation and did not reduce the numerator in the MLR calculation for these companies.

Emerging insurer financial data for 2020 suggests that insurer underwriting margins were favorably impacted by the COVID-19 pandemic, particularly in the individual market. As it is hoped the pandemic comes to its conclusion in 2021, several factors are likely to contribute to market uncertainty.

- Health industry medical loss ratios for both individual and group business appear to be lower for 2020 relative to 2019.
  - Individual market financials may have been aided by an influx of new members that previously had employer-sponsored insurance. Ending several years of enrollment decline, we estimate individual market ACA-compliant enrollment increased by approximately 0.7 million average monthly lives in 2020 (12.0 to 12.7 million).
  - However, the primary factor driving favorable financial results through the third quarter is likely steep declines in healthcare utilization from March through May 2020. As shown by Figure 4, national data from the Milliman Trend Guidelines indicate utilization declines peaked in April, and then rebounded in the second and third quarters.

FIGURE 4: MILLIMAN TREND GUIDELINES, NATIONAL ONE MONTH MEDICAL TREND FOR 2019 AND 2020 (DATA AVAILABLE THROUGH SEPTEMBER 2020)



Note: Trend rates reflect year-over-year trend for a given month.

- While the COVID-19 pandemic had significant impacts on healthcare utilization and insurance market enrollment in 2020, the pandemic's effects will carry over to 2021 with additional regulatory and economic conditions to consider. A sample of these factors includes:
  - The Biden administration prescribed a special enrollment period for insurance marketplace enrollment from February 15, 2021, through May 15, 2021.
  - The American Rescue Plan Act of 2021 enhances premium subsidies for households under 400% of the federal poverty level (FPL) and also removes the 400% FPL income cap entirely.[1]
  - With the Biden administration signaling the COVID-19 public health emergency (PHE) will last through the duration of 2021, states are generally disincentivized from terminating Medicaid eligibility for beneficiaries (to the extent enhanced federal funding is desired).[2] In a normal year, insurance marketplace enrollment may occur as individuals lose Medicaid eligibility. However, this enrollment churn may be diminished in 2021 as Medicaid eligibility is maintained.

[1] Please see the Milliman article "American Rescue Plan: Impacts on private health coverage," available at https://www.milliman.com/en/insight/americas-rescue-plan-impacts-on-private-health-coverage, for more information about the health insurance provisions of the American Rescue Plan Act of 2021.

[2] Steckel, C.H., Houchens, P.R., & Wentworth, K. (November 2020). Updated Eligibility Maintenance Options for State Medicaid Programs to Qualify for 6.2% FMAP During the COVID-19 Emergency. Milliman White Paper. Retrieved April 1, 2021, from https://us.milliman.com/en/insight/updated-eligibility-maintenance-options-for-state-medicaid-programs-to-qualify.

Introduction

This report provides a detailed review of the commercial health insurance industry's financial results in 2019 and evaluates changes in the market's expense structure and enrollment relative to prior years. Additionally, based on year-end 2020 statutory financial statements, the report discusses emerging financial trends for the commercial health insurance markets. The analytics in this report were developed based on a combination of medical loss ratio (MLR) data submitted to the Centers for Medicare and Medicaid Services (CMS), insurance marketplace enrollment reports, and statutory filings. The following topics are covered in this report:

- Summary of 2019 insurer financial results based on summarized medical loss ratio data
- Commercial health insurance enrollment changes from 2014 through 2019
- Distribution of underwriting margins for the individual, small group, and large group markets
- Breakdown of individual market enrollment changes from 2014 through 2020 by key market segments
- Emerging 2020 financial results and future market outlook

While we have focused on financial results from 2014 through 2020 in the main body of the report, Appendix 1 provides a summary of composite financial results by market going back to 2010.

2019 markets and financial results overview

Figure 5 illustrates the 2019 aggregate insured lives and composite reported premium and expenses in the fully insured individual, small group, and large group commercial health insurance markets on a per member per month (PMPM) basis and as a percentage of earned premium. See Appendix 1 for further descriptions of each measure contained in Figure 5 and additional detail on insurer financial results from 2010 through 2019.

FIGURE 5: AGGREGATE REPORTED 2019 COMPREHENSIVE EXPERIENCE[1,2]

MEASURE	INDIVIDUAL[6]	SMALL GROUP	LARGE GROUP
Covered Lives[3]	13,300,000	12,500,000	41,800,000
Earned Premium PMPM	$ 562.00	$ 500.85	$ 476.02
Claims Expenses PMPM	$ 427.50	$ 404.35	$ 414.95
Fees and Taxes PMPM	$ 32.99	$ 12.88	$ 8.04
MLR Rebates PMPM	$ 10.76	$ 2.83	$ 0.63
Administrative Expenses PMPM[4]	$ 55.14	$ 60.92	$ 38.58
Underwriting Gain (Loss) PMPM	$ 50.23	$ 20.78	$ 11.85
Preliminary Medical Loss Ratio[5]	81.6%	83.5%	89.3%
MLR Rebate Expense Ratio	1.9%	0.6%	0.1%
Underwriting Margin[7]	8.9%	4.1%	2.5%
Administrative Expense Ratio	9.8%	12.2%	8.1%

Notes:

1. Values have been rounded.
2. Dollar values are illustrated on a per member per month (PMPM) basis.
3. Covered lives defined as reported member months divided by 12.
4. Administrative expenses include quality improvement, claims adjustment, and general administrative expenses.
5. Preliminary medical loss ratio is based on statutory guidelines in the Supplemental Health Care Exhibit and reflects only 2019 experience (rather than a three-year weighted average). The sum of the preliminary medical loss ratio, underwriting margin, and administrative expense ratio will not equal 100% because quality improvement expenses (included in the administrative expense ratio) are also part of the numerator in the preliminary medical loss ratio calculation. Additionally, taxes and fees are excluded from the administrative expense ratio.
6. The 2019 individual market values include Arkansas's private option Medicaid expansion population (approximately 200,000 average monthly covered individuals with paid premium in calendar year 20193).
7. Underwriting results are impacted by additional items not shown above such as reinsurance premiums and recoveries.

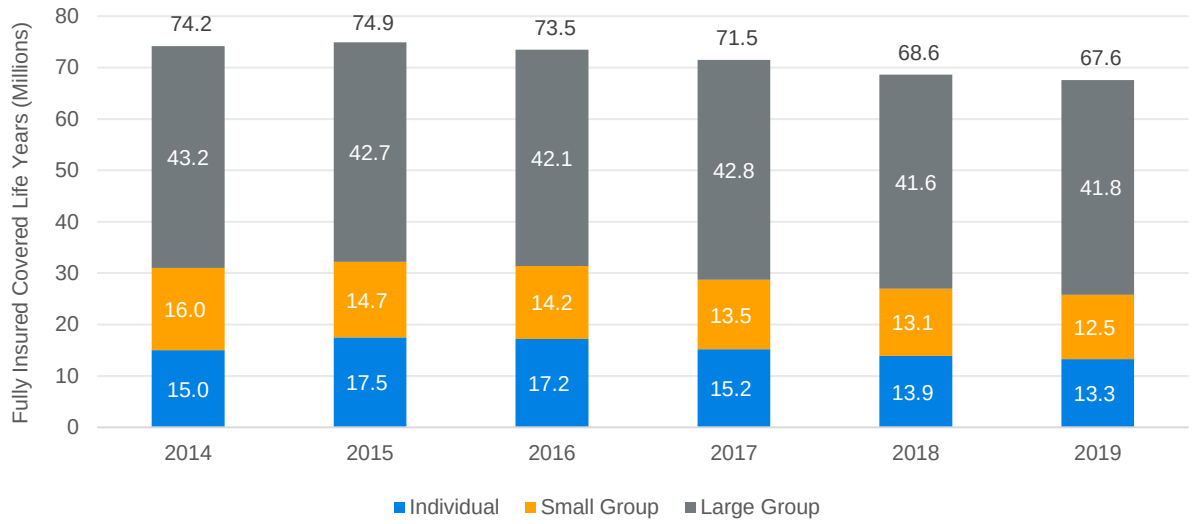
As shown in Figure 5, the individual market composite underwriting margin was significantly higher than the group markets (8.9% underwriting margin relative to 4.1% and 2.5% in the small group and large group, respectively). Insurers offering coverage in the individual market also reported a materially higher composite medical loss ratio (MLR) rebate percentage relative to the group markets (1.9% versus 0.6% small group and 0.1% large group). The next sections of this report examine changes in the above measures from 2014 through 2019 for each market.

[3] Arkansas Department of Human Services. Arkansas Private Option 1115 Demonstration Waiver: Annual Report, January 1, 2019 – December 31, 2019. Retrieved April 1, 2021, from https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-works-qtrly-rpt-oct-dec-2019.pdf. Note that prior quarterly reports were also reviewed.

COVERED LIVES

In 2019, 67.6 million individuals were insured across the three fully insured commercial health insurance markets (individual, small group, and large group), a decrease of approximately 1 million insured lives relative to 2018. This enrollment decrease was entirely attributable to changes in the individual and small group markets, as the aggregate large group market enrollment slightly increased between 2018 and 2019. The individual market enrollment decline was attributable to enrollment declines among off-marketplace ACA-compliant coverage and non-ACA coverage. Small group enrollment has continued its steady decline, which has been observed for the last decade. Data from the Medical Expenditure Panel Survey (MEPS) indicates the percentage of small employers offering health insurance has remained at approximately 30% since 2014,[4] suggesting that the decline in fully insured small group coverage is attributable to a portion of small employers transitioning from fully insured to self-funded coverage (rather than small employers no longer offering health insurance coverage).

FIGURE 6: NATIONAL COMPREHENSIVE HEALTH INSURANCE ENROLLMENT, 2014 TO 2019



Notes:

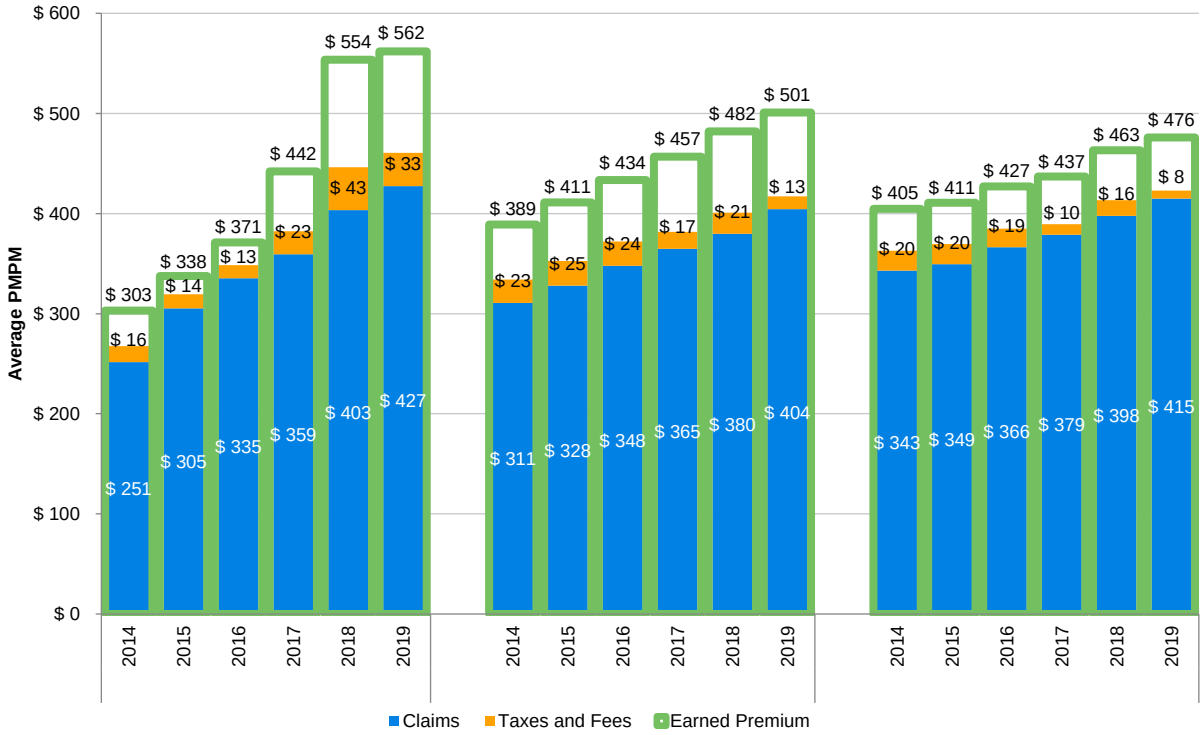
1. Covered lives defined as reported member months divided by 12.
2. Values have been rounded to the nearest 100,000.

[4] 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 2013-2019: 2013 (July 2014), 2014 (revised April 2016), 2015 (July 2016), 2016 (July 2017), 2017 (July 2018), 2018 (July 2019), 2019 (July 2020). Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC (February 15, 2021).

EARNED PREMIUM, CLAIMS EXPENSE, AND TAXES AND FEES

Figure 7 illustrates changes in earned premium, claims expenses, and taxes and fees from 2014 through 2019.

FIGURE 7: CLAIMS EXPENSE AND TAXES AND FEES VERSUS EARNED PREMIUM, 2014 TO 2019



Earned premiums and claims expenses increased in each of the three markets from 2018 to 2019, with the small group market experiencing the largest changes. Small group market premiums on a PMPM basis increased by approximately 3.9% in 2019 while PMPM claims expenses increased by 6.5%

After rising significantly in 2017 and 2018, composite individual market premiums were nearly flat from 2018 to 2019. The increase in individual market premiums observed in 2018 and 2019 relative to the 2014 through 2016 time period is attributable to a number of factors, including:

- The sunsetting of the transitional reinsurance program after 2016, which provided a directed subsidy to the ACA-compliant individual market from 2014 through 2016.[5]
- While cost-sharing reduction (CSR) payments were funded directly by the federal government from 2014 through October 2017,[6] insurers offering coverage through the insurance marketplaces made provision for CSR payments through higher premium rates in 2018 and 2019.

[5] Houchens, P.R., Clarkson, J.A., & Melek, J.P. (May 2018). Commercial Health Insurance: Overview of 2016 Financial Results and Emerging Enrollment and Premium Data, p. 16. Retrieved April 1, 2021, from https://us.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2018/commercial-health-insurance-2016-overview.ashx.

[6] CMS (March 29, 2018). Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Year 2017. Retrieved April 1, 2021, from https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-CSR-Reconciliation-Guidance-BY2017.pdf.

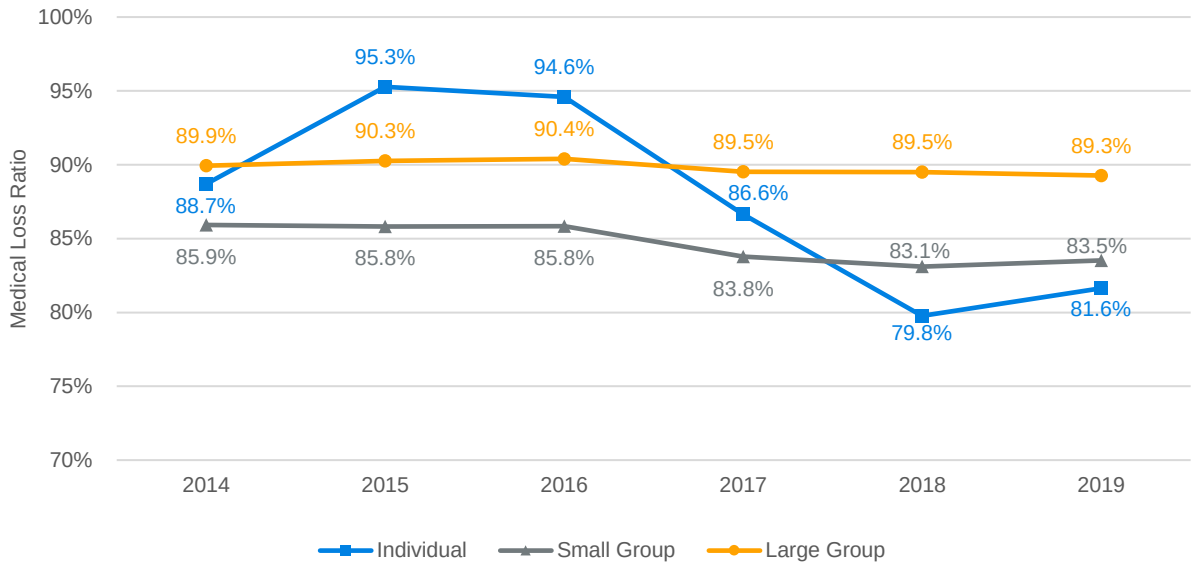
- Non-ACA-compliant coverage, which was medically underwritten in the majority of states prior to 2014 and generally offered less comprehensive covered benefits than the essential health benefits required for ACA-compliant plans, has become a smaller proportion of individual market enrollment over time (as coverage is limited to individuals purchasing a plan prior to January 2014).
- After many insurers suffered losses from 2014 through 2016 in the individual market, market participation declined materially for the 2017 and 2018 coverage years before increasing in 2019.[7] Consistent with the traditional insurance underwriting cycle,[8] reduced insurer competition was associated with profitability for the health insurance industry from 2017 through 2019. This dynamic is discussed in more detail in the following sections of this report.

Fees and taxes levied on insurers decreased from 2018 to 2019 after increases from 2017 to 2018 for each of the commercial insurance markets. This pattern is driven by the moratorium on the ACA's health insurer fee (HIF), which occurred for the 2017 and 2019 fee years.[9] Note that, after the 2020 fee year, the HIF has been permanently ended.[10] Within the individual market, the higher reported taxes and fees in 2018 and 2019 were also driven by greater federal income taxes, a result of favorable underwriting margins experienced by insurers in both years.

PRELIMINARY MLR AND MLR REBATES

Figure 8 illustrates the preliminary MLR for the three commercial health insurance markets from 2014 through 2019. The preliminary MLR is based on insurer experience for a single year and does not include credibility adjustments for insurers with limited enrollment.

FIGURE 8: PRELIMINARY MEDICAL LOSS RATIO 2014 THROUGH 2019



[7] Houchens, P., Kotecki, L., & Leida, H. (March 2020). Fifty States, Fifty Stories: A Decade of Health Care Reform Under the Affordable Care Act. Figure 11. Society of Actuaries. Retrieved April 1, 2021, from https://www.soa.org/globalassets/assets/files/resources/research-report/2020/50-states-50-stories.pdf.

[8] Ibid. See Figure 9 for additional background.

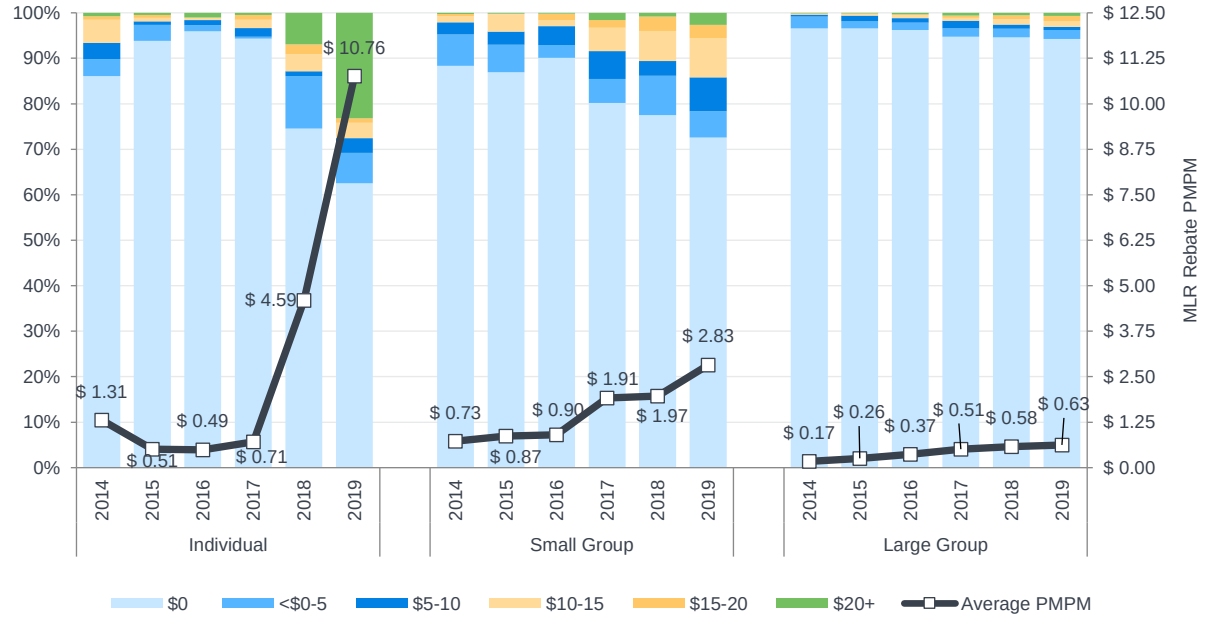
[9] IRS. Affordable Care Act Provision 9010 – Health Insurance Providers Fee. Retrieved April 1, 2021, from https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010.

[10] Ibid.

As in prior years, the preliminary MLR for the group markets has remained stable while greater fluctuations have been observed in the individual market. The individual market preliminary medical loss ratio (MLR) increased from 79.8% to 81.6% from 2018 to 2019. This increase was attributable to incurred claims and quality improvement expense PMPMs increasing by 6.0% and 6.5%, respectively, while adjusted earned premium[11] PMPM increased by only 1.5%.

Figure 9 illustrates the distribution of MLR rebates across the three commercial insurance markets from 2014 through 2019, as well as the composite MLR rebate in each reporting year.

FIGURE 9: MEDICAL LOSS RATIO REBATE, 2014 THROUGH 2019



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, 2015, and 2016 reflect 16.9%, 0.0%, and 0.0% of requested risk corridor amounts received, respectively, for the individual and small group markets. Values have not been adjusted based on the Maine Community Health Options v. United States ruling.

Because commercial medical loss ratios are calculated based on a three-year average for rebate purposes, individual market losses in 2016 are no longer reducing medical loss ratio rebates in 2019 as occurred in 2018. As forecasted by Milliman actuaries at the beginning of 2019,[12] this resulted in a second substantial increase in medical loss ratio rebates for the individual market in 2019 relative to past years, despite the increase in preliminary MLR in 2019 illustrated in Figure 8 above. The composite MLR rebate in the individual market increased from $0.71 PMPM in 2017 to $4.59 PMPM in 2018, and then more than doubled to $10.76 PMPM in 2019. In 2019, rebates were owed to nearly 40% of individual market members based on the 2017 to 2019 MLR experience period, with 23% of the market being owed rebates in excess of $20 PMPM. The average rebate per rebatable member in 2019 was $28.71 PMPM or nearly $350 on an annualized basis.

[11] Premium net of taxes and fees.

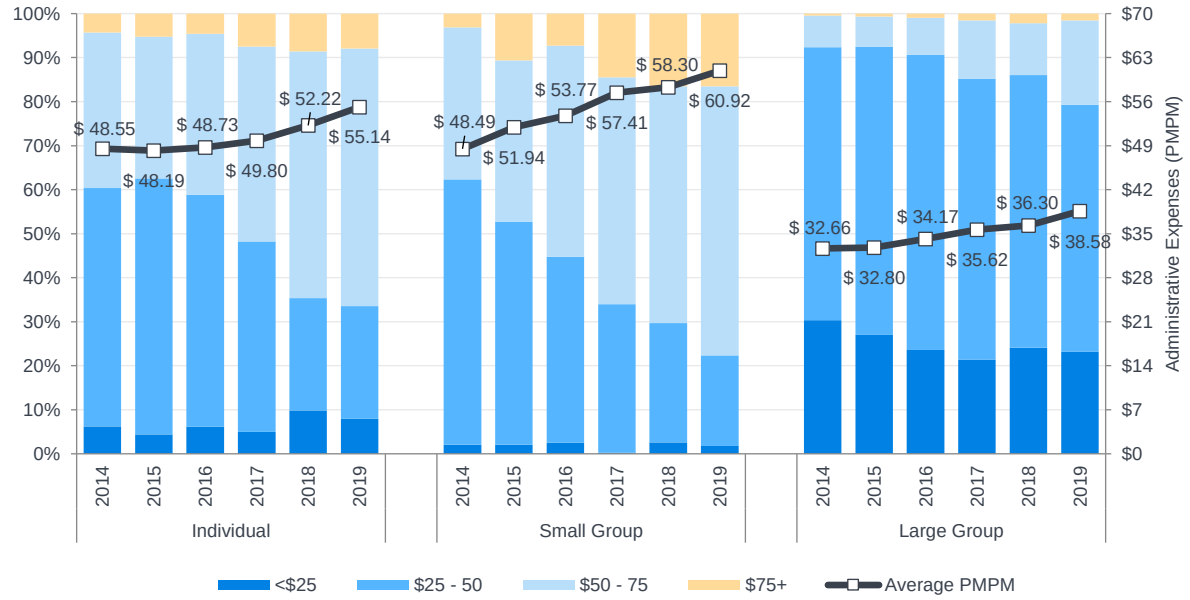
[12] Blount, E., Klein, M., & Fasching, A. (February 2019). Could 2019 Be the Year of MLR Rebates for ACA Issuers in the Individual Market. Milliman White Paper. Retrieved April 1, 2021, from https://www.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2019/2019-mlr-rebates.ashx.

From 2018 to 2019, MLR rebates in the small group market also rose noticeably, with rebates increasing from $1.97 to $2.83 PMPM. The proportion of the small group market with rebates in excess of $20 PMPM (3%) is minimal compared to the individual market. MLR rebates in the large group market continued to be low, with a small increase from $0.58 PMPM in 2018 to $0.63 PMPM in 2019.

ADMINISTRATIVE EXPENSES

Figure 10 illustrates the distribution of reported administrative expenses (inclusive of quality improvement, claims adjustment, and general and administrative expenses) from 2014 to 2019 for each market, as well as the composite market average administrative expense PMPM for each year. Since 2014, the administrative expense PMPM has steadily risen in each market, with individual market administrative costs experiencing the lowest increase (approximately 2.6% annualized increase from 2014 to 2019), and with the small group and large group markets experiencing increases of approximately 4.7% and 3.4%, respectively.

FIGURE 10: TOTAL ADMINISTRATIVE EXPENSE 2014-2019



Notes:

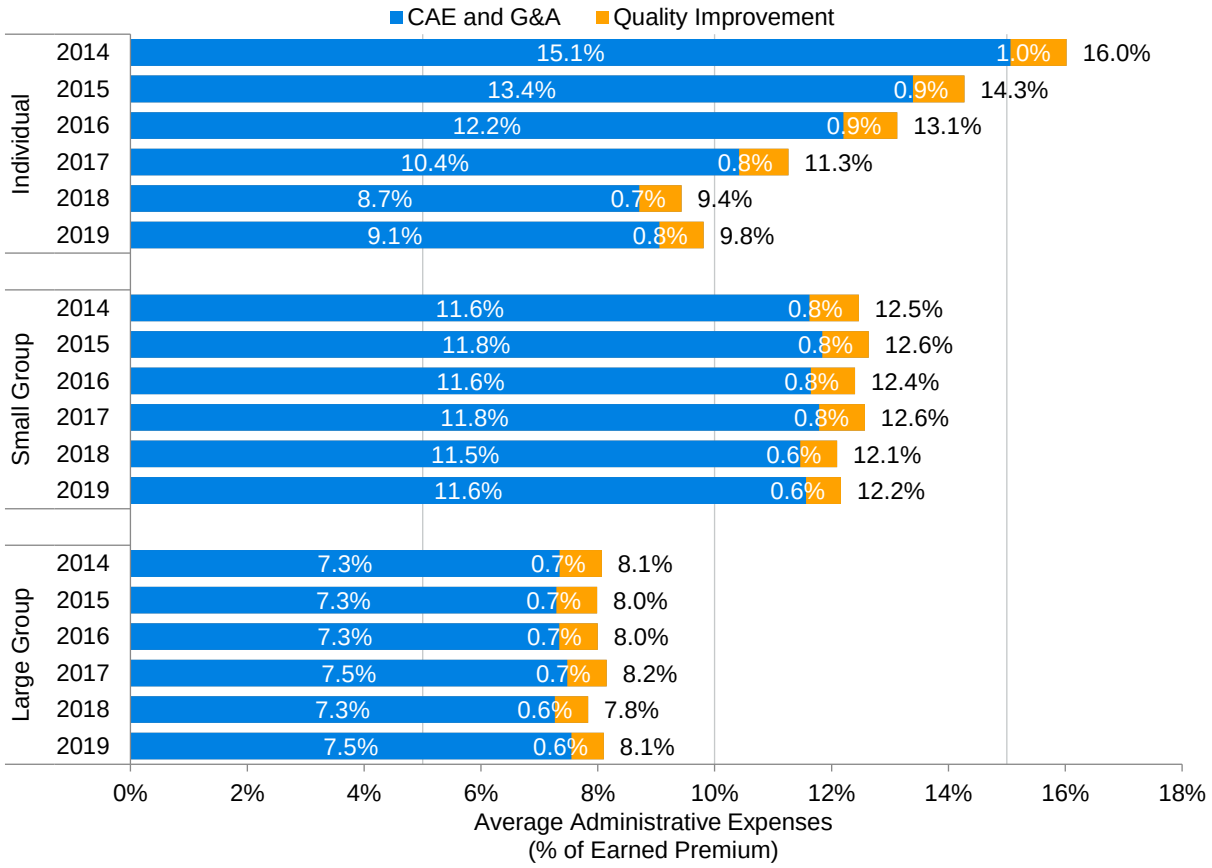
1. Distributions weighted by reported member months in each calendar year. Results reflect all insurers that reported data in the given year.

2. Results for 2014, 2015, and 2016 reflect 16.9%, 0.0%, and 0.0% of requested risk corridor amounts received, respectively, for the individual and small group markets.

While Figure 10 indicates increasing administrative costs on a PMPM basis, administrative costs have been declining as a percentage of earned premium, particularly for the individual market since 2014 (Figure 11). For the group markets, Figure 11 indicates that administrative expenses have been a consistent percentage of premium, so administrative expenses have been growing at approximately the same rate as market premiums. However, for the individual market, premium trends have far outpaced administrative expense trends, partially attributable to the phase-out of the transitional reinsurance program and CSR loading that began in 2018. Going back to the year of the ACA's passage (2010) the composite administrative expense PMPM reported by insurers was $40.86, equivalent to approximately 19% of earned premium. In 2014, the first year of the ACA's new market rules for the individual market and its marketplaces, administrative expenses were equivalent to 16% of earned premium. In 2018 and 2019, after a steep increase in the average individual marketplace premium, administrative expenses were approximately 9.5% of earned premium.

Figure 11 also splits claims adjustment expenses (CAE) and general and administrative (G&A) expenses from quality improvement expenses. In the CMS MLR formula, quality improvement expenses are included in the numerator of the MLR calculation, thus increasing a carrier's calculated MLR.

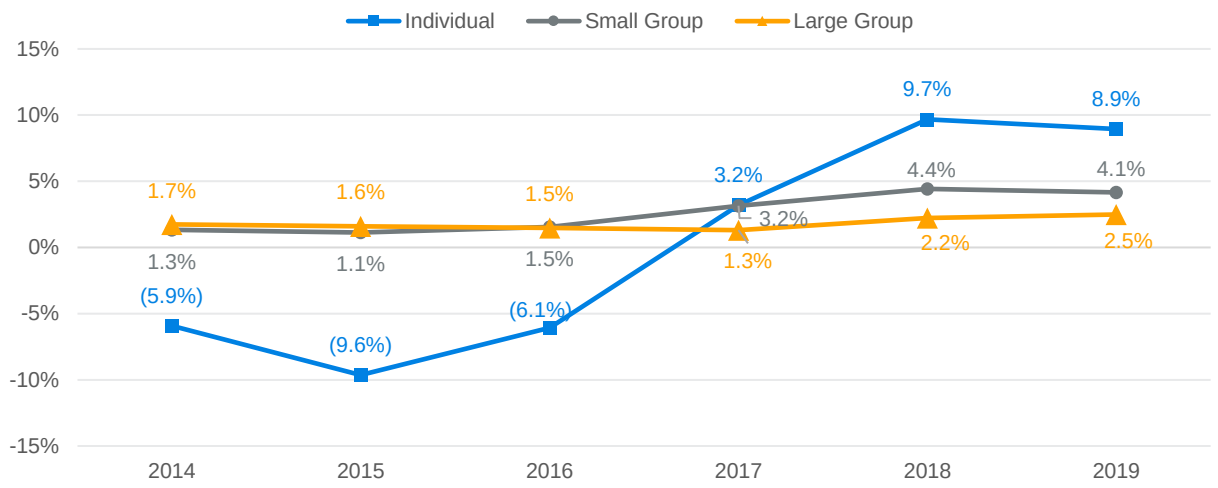
FIGURE 11: ADMINISTRATIVE EXPENSE AS A PERCENTAGE OF EARNED PREMIUM



UNDERWRITING RESULTS

Figure 12 illustrates the underwriting results from 2014 through 2019 for the three commercial insurance markets. The individual market composite underwriting gain was 8.9% in 2019, representing the second-highest composite underwriting gain for the individual market since 2014 (second only to 2018). The year 2019 also manifested the second-largest underwriting gain since 2014 for the small group market (4.1% versus 4.4% in 2018). The large group market underwriting margin of 2.5% was also the highest since 2014, 0.3 percentage points higher than the previously highest margin year of 2.2% in 2018.

FIGURE 12: UNDERWRITING MARGIN, 2014 THROUGH 2019



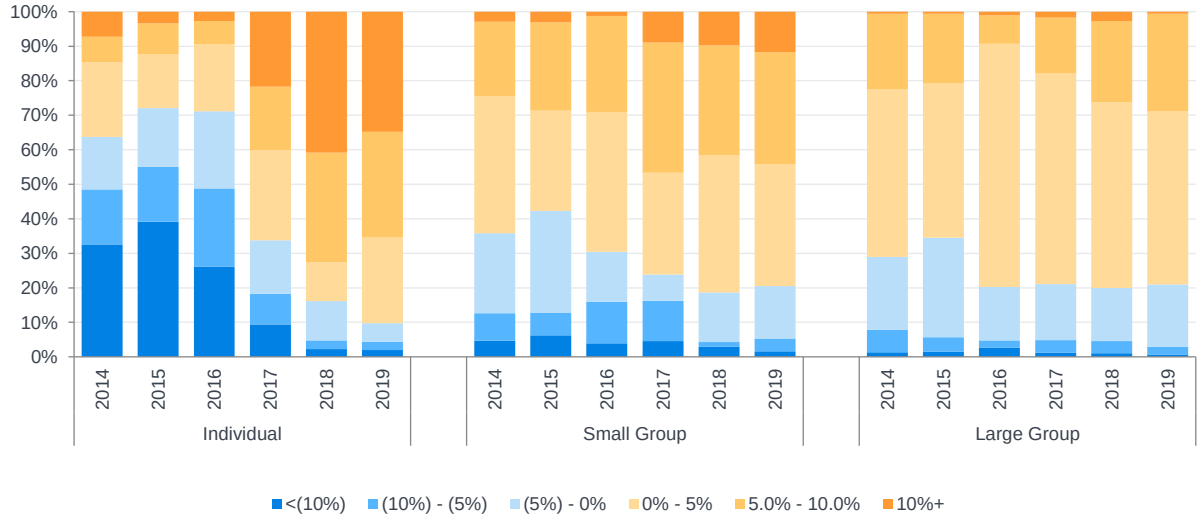
Notes:

1. Results for 2014, 2015, and 2016 reflect 16.9%, 0.0%, and 0.0% of requested risk corridor amounts received, respectively, for the individual and small group markets. Values have not been adjusted based on the Maine Community Health Options v. United States ruling.

DISTRIBUTION OF UNDERWRITING RESULTS 2014 THROUGH 2019

When considering aggregate market underwriting results from 2014 through 2019, it is important to understand the degree to which underwriting results vary among insurers within a market. This variation provides insight into whether underwriting gains/(losses) are driven by a small portion of market share with highly favorable/(unfavorable) experience, or if the financial results are more evenly distributed across insurers. Figure 13 examines the distribution of underwriting results, weighted by member months, in these markets separately for each calendar year.

FIGURE 13: COMMERCIAL HEALTH INSURANCE: UNDERWRITING MARGIN DISTRIBUTIONS, 2014 TO 2019



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, 2015, and 2016 reflect 16.9%, 0.0%, and 0.0% of requested risk corridor amounts received, respectively, for the individual and small group markets.

While the distribution of underwriting margins has remained remarkably stable in the group insurance markets, the individual market has shown greater volatility, with financial results from 2014 to 2016 (large losses, minimal gains) being transposed for 2018 and 2019 (large gains, minimal losses). Insurers with underwriting losses of greater than 10% of earned premium represented more than 25% of the market from 2014 through 2016, yet less than 3% of market share in 2018 and 2019. Among individual market enrollment in 2019, almost 35% of market share was covered by insurers realizing an underwriting gain in excess of 10% (for comparison, this value was approximately 3% in 2015 and 2016).

A NOTE ON MAINE COMMUNITY HEALTH OPTIONS V. UNITED STATES AND RELATED LITIGATION

In the first three years of the ACA-compliant individual and small group markets, collections from the temporary risk corridors program were insufficient to pay amounts owed under the program.[13] Multiple issuers sued the government for amounts due, and in April 2020 the U.S. Supreme Court ruled in Maine Community Health Options v. United States that the federal government owed issuers these amounts.[14] CMS provided further guidance that issuers that receive payments as a result of litigation would be required to restate MLR reports from 2015 through 2018 to reflect full payment of risk corridor amounts for 2014 through 2016.[15] As a full list of issuers receiving payments from the federal government is not currently available, these adjustments are not reflected in the values discussed in this report, but would be primarily confined to the individual market. Preliminary MLRs in 2014 to 2016 would decrease, underwriting margins for 2014 to 2016 would increase, and MLR rebates paid in 2015 to 2018 would also increase.

Detailed individual market enrollment trends: 2014 through 2020

Publicly available reports released by the federal government focus largely on the individual insurance marketplace.[16] To understand the overall enrollment and stability of the individual market as a whole (on and off the marketplace), insurance marketplace enrollment as well as the number of individuals receiving federal health insurance subsidies must be understood in the context of the aggregate market. Federal subsidies, through advanced premium tax credits (APTCs) and cost-sharing reduction (CSR) plans, have made health insurance premiums and cost sharing more affordable for millions of Americans. Figure 14 illustrates covered lives in the individual market from 2014 through 2020 (estimated values for 2020), along with the following effectuated[17] enrollment statistics:

- Marketplace all enrollees: Estimated yearly total of effectuated marketplace member months, divided by 12.
- Marketplace APTC: Estimated yearly number of effectuated marketplace member months receiving an APTC, divided by 12.
- Marketplace CSR: Estimated yearly number of effectuated marketplace member months receiving a CSR subsidy, divided by 12.

[13] Houchens, P.R., Clarkson, J.A., & Melek, J.P. (May 2018), op cit., p. 17.

[14] Maine Community Health Options v. United States, 140 S. Ct. 1308, 206 L. Ed. 2d 764 (2020).

[15] CMS (December 30, 2020). Treatment of Risk Corridors Recovery Payments in the Medical Loss Ratio and Rebate Calculations. Retrieved April 1, 2021, from https://www.cms.gov/files/document/mlr-guidance-rc-recoveries-and-mlr-final.pdf.

[16] CMS. 2020 Marketplace Open Enrollment Period Public Use Files. Retrieved April 1, 2021, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2020-Marketplace-Open-Enrollment-Period-Public-Use-Files.

[17] Insurance policies that have been activated by the payment of premium.

FIGURE 14: INDIVIDUAL HEALTH INSURANCE MARKET ESTIMATED ENROLLMENT BY MARKET SEGMENT, 2014 TO 2020 (MILLIONS)

COVERED LIFE YEARS	2014	2015	2016	2017	2018	2019	2020
ACA-COMPLIANT							
MARKETPLACE	5.5	9.1	10.0	9.8	9.9	9.8	10.7
OFF-MARKETPLACE	3.1	4.8	4.9	3.6	2.7	2.2	2.0
TOTAL ACA-COMPLIANT	*8.5*	*13.9*	*14.9*	*13.4*	*12.6*	*12.0*	*12.7*
NON-ACA-COMPLIANT							
TOTAL NON-ACA-COMPLIANT	*6.5*	*3.6*	*2.3*	*1.8*	*1.4*	*1.3*	*1.1*
TOTAL INDIVIDUAL MARKET	**15.0**	**17.5**	**17.2**	**15.2**	**13.9**	**13.3**	**13.8**
FEDERAL SUBSIDY POPULATION							
MARKETPLACE APTC	4.7	7.7	8.4	8.2	8.6	8.5	9.2
MARKETPLACE CSR	3.1	5.2	5.6	5.6	5.2	5.0	5.4

COVERED LIFE YEARS AS PERCENTAGE OF TOTAL INDIVIDUAL MARKET	2014	2015	2016	2017	2018	2019	2020
ACA-COMPLIANT							
MARKETPLACE	37%	52%	58%	64%	71%	74%	78%
OFF-MARKETPLACE	20%	27%	29%	24%	19%	16%	14%
TOTAL ACA-COMPLIANT	*57%*	*80%*	*87%*	*88%*	*90%*	*91%*	*92%*
NON-ACA COMPLIANT							
TOTAL NON-ACA COMPLIANT	*43%*	*20%*	*13%*	*12%*	*10%*	*9%*	*8%*
TOTAL INDIVIDUAL MARKET	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
FEDERAL SUBSIDY POPULATION							
MARKETPLACE APTC	31%	44%	49%	54%	61%	64%	67%
MARKETPLACE CSR	21%	30%	33%	37%	37%	38%	39%

Notes:

1. Values have been rounded so as to sum to 100% for each calendar year.
2. Covered life years reflect average monthly enrollment.
3. Marketplace enrollment reflects effectuated member months, defined as policies that have been activated by the payment of premium, divided by 12.
4. Total ACA-compliant enrollment from 2014 through 2019 estimated based on risk adjustment transfer reports. A 1% adjustment has been applied to billable member months to reflect households with more than three children.
5. Marketplace-effectuated enrollment estimated from U.S. Department of Health and Human Services (HHS) enrollment reports. Please see the Methodology section of this paper for more information.
6. The 2020 values have been estimated based on a combination of publicly available federal government data and reports, as well as 2020 health industry quarterly financials accessed through S&P Global Market Intelligence.
7. Actual average monthly enrollment values are certain to vary from the estimates provided in the above figure.
8. ACA-compliant enrollment includes private Medicaid expansion enrollees in Arkansas and New Hampshire (ended December 2018). Effectuated APTC and CSR enrollment estimates exclude private Medicaid expansion enrollees.

As illustrated in Figure 14, while marketplace enrollment is estimated to have remained relatively stable between 2016 and 2019 and to have experienced an uptick in 2020 resulting from the economic impacts of COVID-19, we estimate that *off-marketplace* ACA-compliant coverage has decreased by nearly 60% from its peak (from 4.9 million to 2.0 million), coinciding with the large premium rates increases that occurred for the 2017 and 2018 coverage years. Note that premium and cost-sharing subsidies are only available to consumers purchasing marketplace coverage.

The enrollment declines in the non-ACA-compliant market are attributable to enrollment churn and state policies related to the continuation of transitional coverage. Members new to the individual market cannot purchase a transitional or grandfathered insurance plan, so as existing members in these plans become eligible for other health insurance coverage (e.g., Medicare, Medicaid, or employer-based coverage), there is a natural attrition of market enrollment.[18]

Since 2014, enrollment within the marketplace has taken on a significantly larger proportion of individual market enrollment as non-ACA-compliant and off-marketplace coverage has declined.

- The estimated percentage of individual market covered lives in the insurance marketplace has increased from 37% in 2014 to 78% in 2020.
- Likewise, the percentage of the individual market covered lives receiving an APTC is estimated to have increased from 31% in 2014 to an estimated 67% in 2020.

Insurer financial impacts from the COVID-19 pandemic

Nationally, the Kaiser Family Foundation reported that average marketplace premium rates decreased across metallic tiers by approximately 3% from 2019 to 2020.[19] Therefore, in the absence of the COVID-19 pandemic, these premium rate changes suggest that insurers' underwriting margins in the individual market would moderate for 2020, as a result of premium revenue decreases and the claims expense trend from healthcare inflation. For the group insurance markets, stable underwriting margins would be predicted based on the historical financial stability of the markets. However, the COVID-19 pandemic has had significant and varying impacts on healthcare utilization across insurance markets and will greatly influence underwriting margins for 2020.

Figure 15, which is based on the Milliman Health Trend Guidelines (Trend Guidelines), illustrates national one-month trends by type of service for medical costs (non-pharmacy).[20] The Trend Guidelines reflect approximately 60 million commercial insured individuals (including self-insured business) in the United States. At the time of this report, data for 2020 is available through September 2020. As shown in Figure 15, medical costs had significant declines during the March through May time period when many elective medical procedures were suspended across the country. April 2020 costs across all service categories were approximately 40% below April 2019 levels. Inpatient services had the steepest decline in the March through May 2020 time period and continued to have negative monthly trend rates until September 2020.

Utilization rebounded in the summer months but has remained below 2019 levels. Further uncertainty is created by the "fall wave," where national COVID-19 cases increased from approximately 50,000 daily cases in the third quarter to over 200,000 by December 2020.[21]

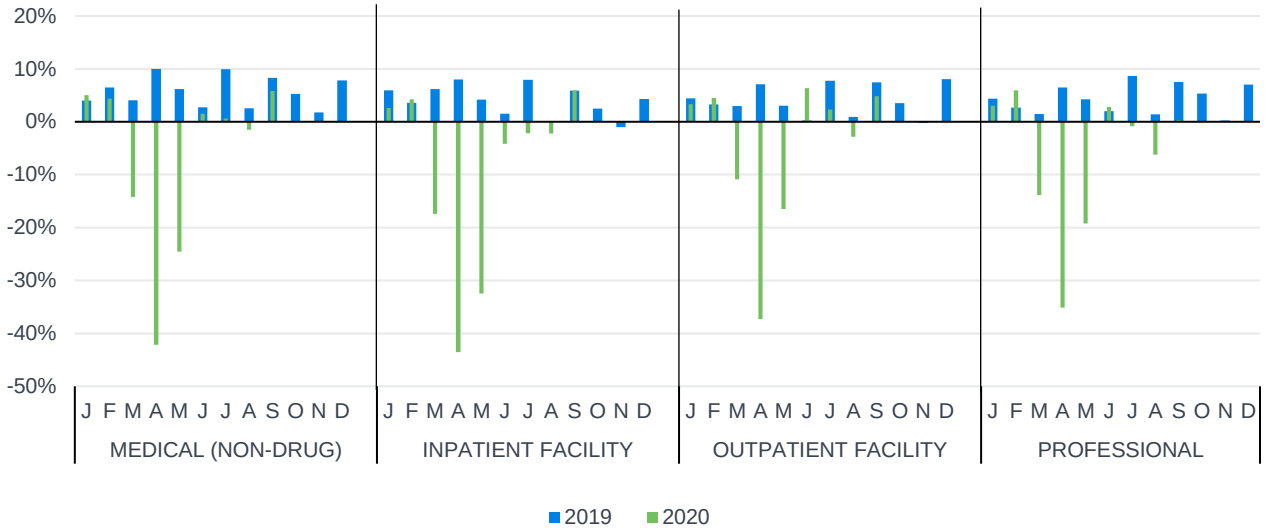
[18] See https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Limited-Non-Enforcement-Policy-Extension-Through-CY2020.pdf for additional background on transitional coverage.

[19] Fehr, R., Kamal, R., & Cox, C. (November 7, 2019). How ACA Marketplace Premiums Are Changing by County in 2020. Kaiser Family Foundation. Retrieved April 1, 2021, from https://www.kff.org/private-insurance/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2020/.

[20] Mulhern, D. (November 16, 2020). Impact of COVID-19 on commercial health trends through May 2020. Milliman Insight. Retrieved April 1, 2021, from https://us.milliman.com/en/insight/impact-of-covid19-on-commercial-health-trends-through-may-2020. Note that the chart contained in this article contains trend data through September, but follows the same methodology as outlined in the cited report.

[21] COVID Tracking Project. U.S. Daily Cases. Retrieved April 1, 2021, from https://covidtracking.com/data/charts/us-daily-positive.

FIGURE 15: MILLIMAN HEALTH TREND GUIDELINES, NATIONAL COMMERCIAL HEALTH INSURANCE ONE-MONTH TRENDS BY TYPE OF SERVICE (DATA THROUGH SEPTEMBER 2020)



Note: Trend rates reflect year-over-year trend for a given month. For example, the trend rate for March 2020 reflects the percentage change in cost from March 2019 to March 2020.

Year-end insurer financial results for 2020 are consistent with the trend patterns identified in Figure 15. Based on composite year-end statutory financials for health industry insurers,[22] statutory MLRs have decreased several percentage points in 2020 relative to 2019, particularly in the individual market. The relatively small decrease in statutory MLR in the group market may be attributable to health insurers offering premium discounts during 2020 as a result of the pandemic.[23] Note that statutory MLR values in Figure 16 are not directly comparable to the preliminary MLR values illustrated elsewhere in the report, as the year-end statutory MLR figures are simply incurred claims divided by earned premiums, excluding adjustments for quality improvement expenses and fees and taxes that are part of the CMS MLR calculation.

FIGURE 16: 2018 THROUGH 2020 STATUTORY LOSS RATIO BY MARKET SEGMENT (HEALTH INDUSTRY COMPOSITE)

MARKET	2018	2019	2020
Individual	73.4%	79.6%	74.9%
Group	83.4%	85.4%	83.9%

Notes:

1. Values are limited to insurers representing “Health Industry”—insurers completing an orange blank National Association of Insurance Commissioners (NAIC) year-end statutory statement. No orange blank insurers have been excluded from the summary statistics.
2. Medical loss ratio calculated as incurred claims divided by earned premiums from the Exhibit of Premiums, Enrollment, and Utilization.
3. Medical loss ratio values do not follow the CMS formula and should not be directly compared to other values contained in this report.
4. Statutory statement data downloaded via S&P Global Market Intelligence on March 30, 2021.

[22] Insurers filing an orange blank financial statement with the NAIC. At the end of 2020, approximately 10.6 million and 26.8 million covered lives are reflected in the health industry data for the individual and group markets, respectively. Data excludes many California insurers, insurers reporting on the blue blank financial statement ("Life Industry"), and other insurers that do not file an NAIC financial statement.

[23] Mathews, A.W. (June 4, 2020). Health insurers offer premium discounts. Wall Street Journal. Retrieved April 1, 2021, from https://www.wsj.com/articles/health-insurers-offer-premium-discounts-11591263002.

The Biden administration has taken several actions that may further influence the 2021 claims costs and enrollment across insurance markets. The administration has suggested that the public health emergency (PHE), first established in 2020 in response to the pandemic, will be extended through calendar year 2021.[24] The PHE suspends reevaluation of Medicaid eligibility for those already enrolled as a condition of receiving enhanced Medicaid funding under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. This means that those who may normally have migrated from a Medicaid plan to a commercial plan could stay in the Medicaid plan through the duration of 2021.

The Biden administration has also created an additional special enrollment period for the insurance marketplaces from February 15, 2021, through May 15, 2021.[25] Congress additionally passed the American Rescue Plan Act of 2021 (ARP), which made three changes that may affect market enrollment in 2021 and 2022.[26]

In order to understand the interconnected nature of economic changes and health insurance status, and to project impacts to U.S. health insurance markets, Milliman built a power tool we refer to as the COVID-19 Advanced Population Shift (CAPS) model. This model combines detailed information on the economic status, health insurance coverage, and health status of each state's population prior to the COVID-19 pandemic with emerging economic data. It allows us to forecast the resulting shifts in enrollment and population morbidity across healthcare markets, while providing insights into the key factors driving change. For further information, please see the Milliman report "The COVID-19 Recession and Healthcare Coverage in the U.S.," available at https://us.milliman.com/en/insight/the-covid19-recession-and-healthcare-coverage-in-the-us.

- The ARP enhanced ACA subsidies for 2021 and 2022, reducing the maximum required contribution for silver plan premiums from 9.83% to 8.5% of household income and extending subsidies to households with income above 400% FPL.
- The ARP extended eligibility in 2021 to those who receive unemployment in 2021 for the most generous level of premium and cost-sharing subsidies available.
- Lastly, the ARP provides 100% subsidies for COBRA coverage for April 2021 through September 2021.

Insurers should consider performing sensitivity testing to understand how policy decisions made by Congress and the Biden administration, as well as ongoing economic fluctuations, may influence enrollment and claims expenses across health insurance markets in 2021.

Limitations

The analyses presented in this research paper have relied on data and other information from the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE) and quarterly statutory filings, as well commercial MLR form submissions. MLR form data was obtained from the CMS Center for Consumer Information and Insurance Oversight[27] in November 2020. The 2010 SHCE data and quarterly statutory data was obtained from S&P Global Market Intelligence. 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 CMS MLR report values subsequent to December 1, 2020, are not included in this report. Statutory MLR values reflect reported data as of March 30, 2021.

[24] Secretary of HHS. Letter to Governors. Retrieved April 1, 2021, from https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf.

[25] CMS (February 12, 2021). 2021 Special enrollment period for marketplace coverage starts on HealthCare.gov Monday, February 15. Press release. Retrieved April 1, 2021, from https://www.cms.gov/newsroom/press-releases/2021-special-enrollment-period-marketplace-coverage-starts-healthcaregov-monday-february-15#:~:text=Today%2C%20in%20accordance%20with%20the,the%20HealthCare.gov%20platform%20on.

[26] Karcher, J., Norris, D., & Benz, K. (March 15, 2021). American Rescue Plan: Impacts on private health coverage. Milliman Insight. Retrieved April 1, 2021, from https://www.milliman.com/en/insight/americas-rescue-plan-impacts-on-private-health-coverage.

[27] CMS. Medical Loss Ratio Data and System Resources. Retrieved April 1, 2021, from http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.

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.

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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.

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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Appendix 1: Aggregate health insurer financial results, 2010-2019

SUMMARY OF COMMERCIAL HEALTH INSURER FINANCIAL RESULTS

CALENDAR YEARS 2010-2019: PER MEMBER PER MONTH PREMIUM AND EXPENSES

Individual Market - All Reported Companies

Year	Covered Lives	Earned Premium	Fees & Taxes	Claims Expenses	MLR Rebates	Total Admin Expenses	Underwriting Gain (Loss)	Preliminary Medical Loss Ratio	MLR Rebates as % of Earned Premium	Underwriting Margin	Admin Expense Ratio
2019	13,300,000	$562.00	$32.99	$427.50	$10.76	$55.14	$50.23	81.6%	1.9%	8.9%	9.8%
2018	13,900,000	$553.62	$42.89	$403.30	$4.59	$52.22	$53.59	79.8%	0.8%	9.7%	9.4%
2017	15,200,000	$442.06	$22.89	$359.34	$0.71	$49.80	$14.07	86.6%	0.2%	3.2%	11.3%
2016	17,200,000	$371.20	$13.01	$335.29	$0.49	$48.73	($22.53)	94.6%	0.1%	(6.1%)	13.1%
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	$251.50	$1.31	$48.55	($17.94)	88.7%	0.4%	(5.9%)	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 & Taxes	Claims Expenses	MLR Rebates	Total Admin Expenses	Underwriting Gain (Loss)	Preliminary Medical Loss Ratio	MLR Rebates as % of Earned Premium	Underwriting Margin	Admin Expense Ratio
2019	12,500,000	$500.85	$12.88	$404.35	$2.83	$60.92	$20.78	83.5%	0.6%	4.1%	12.2%
2018	13,100,000	$481.97	$21.11	$379.79	$1.97	$58.30	$21.32	83.1%	0.4%	4.4%	12.1%
2017	13,500,000	$456.67	$16.96	$364.66	$1.91	$57.41	$14.40	83.8%	0.4%	3.2%	12.6%
2016	14,200,000	$433.52	$24.09	$347.95	$0.90	$53.77	$6.67	85.8%	0.2%	1.5%	12.4%
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	$310.88	$0.73	$48.49	$5.16	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 & Taxes	Claims Expenses	MLR Rebates	Total Admin Expenses	Underwriting Gain (Loss)	Preliminary Medical Loss Ratio	MLR Rebates as % of Earned Premium	Underwriting Margin	Admin Expense Ratio
2019	41,800,000	$476.02	$8.04	$414.95	$0.63	$38.58	$11.85	89.3%	0.1%	2.5%	8.1%
2018	41,600,000	$463.23	$15.85	$397.64	$0.58	$36.30	$10.33	89.5%	0.1%	2.2%	7.8%
2017	42,800,000	$437.03	$10.41	$378.87	$0.51	$35.62	$5.72	89.5%	0.1%	1.3%	8.2%
2016	42,100,000	$427.14	$18.76	$366.24	$0.37	$34.17	$6.34	90.4%	0.1%	1.5%	8.0%
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:

1. Values have been rounded.
2. Covered Lives equals reported member months divided by 12.
3. The 2011 through 2019 reported premium and expenses are based on MLR form reported values as of March 31 of the following year.
4. MLR form reported values have been transposed into the same format as the NAIC SHCE form.
5. Earned Premium equals Part 1, Line 1.1 of the SHCE.†
6. Fees & Taxes equals Part 1, Line 1.5, 1.6, and 1.7 of the SHCE.
7. Claims Expenses equals Part 1, Line 5.0 of the SHCE.†
8. Total Admin Expenses equals the sum of Part 1, Lines 6.6, 8.3, and 10.5 of the SHCE.
9. Underwriting Gain (Loss) equals Part 1, Line 11 of the SHCE.
10. Preliminary Medical Loss Ratio equals sum of Part 1, Line 4 + Line 5.0 + Line 6.6 ÷ Line 1.8 of the SHCE.
11. The 2012-2019 MLR Rebates as % of Earned Premium equal reported rebates on Part 4, Line 5.4 (Total Column) of 2012-2017 MLR form ÷ Earned Premium.
12. The 2011 MLR Rebates as % of Earned Premium equal reported rebates on Part 5, Line 5.4 (Total Column) of 2011 MLR form ÷ Earned Premium.
13. Underwriting Margin equals Underwriting Gain (Loss) ÷ Earned Premium.
14. Admin Expense Ratio equals Total Admin Expenses ÷ Earned Premium.

† 2014, 2015, and 2016 values were adjusted by the impact of transitional reinsurance, risk adjustment, and risk corridors, the so-called 3Rs.

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 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 website[28] as of October 1, 2020.

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. For the purpose of this report, we only analyzed comprehensive business.

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 through 2019 MLR Data, we evaluated health insurance industry trends over the 10-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 SHCE form. However, these companies are required to report data for the medical loss ratio calculation and that data is contained in the 2011 through 2019 MLR data sets. The 2010 SHCE data, along with 2020 statutory statement data, was summarized using S&P Global Market Intelligence.

With the exception of the 2020 financial results, our analyses presented in this report were based upon values from the 2011 through 2019 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 noncomprehensive (offering a limited scope of insured benefits) as well as companies with per member per month premium rates below $100.

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

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

The 2020 financial results illustrated in this report are based on companies filing the orange blank NAIC statutory statement. We have not made any adjustments to the reported 2020 statutory statement values.

FIGURE 17: 2019 COMPREHENSIVE HEALTH INSURANCE VALUES REPORTED IN MLR FORM

Market	Groups (parent companies)	Companies	Lives[1]	Premium ($ millions)	% NonComprehensive
Individual	131	299	13,300,000	$ 89,561	0.04%
Small Group	128	307	12,500,000	$ 74,998	0.01%
Large Group	141	342	41,800,000	$ 238,632	0.02%
Total Comprehensive	166	423	67,600,000	$ 403,191	0.02%

Notes:

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

Figure 17 provides a summary of the number of companies, covered lives, and aggregate premium amounts reported for calendar year 2019 on a national basis (50 U.S. states and the District of Columbia) 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 noncomprehensive is illustrated. We reviewed data for reasonableness and consistency. However, we did not audit individual company results. 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.

While we simply reassigned the majority of the fields in the MLR data to the appropriate SHCE report line item, we did make significant adjustments to the earned premiums and incurred claims fields to appropriately account for the impact of transitional reinsurance, risk adjustment, and risk corridors (the 3Rs) in applicable markets during 2014, 2015, and 2016 and for risk adjustment in 2017, 2018, and 2019. In particular, adjustments related to the reporting of transitional reinsurance recoveries were based on a review of insurers' 2014, 2015, and 2016 annual statement filings, as well as actuarial judgment. Because risk corridor amounts reported in the MLR Data are based on a calculation that is different from amounts paid to issuers by CCIIO, we replaced all MLR Data risk corridor values with those published by CCIIO.[29] We replaced reported risk adjustment transfers in the MLR Data with actual amounts for each insurer published by CCIIO, with the exception of business in Massachusetts and Vermont (both of these states have merged individual and small group markets). Note that 2014 through 2016 data has not been adjusted for any potential risk corridor payments that may be received by insurers based on the Maine Community Health Options v. United States Supreme Court ruling.[30]

We made other adjustments to the data for observed reporting anomalies and inconsistencies with the NAIC Supplemental Health Care Exhibit, including adjustments for reinsurance transfers for a single company that resulted in large underwriting losses. 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.

[29] Center for Consumer Information and Insurance Oversight (November 19, 2015). Risk Corridors Payment and Charge Amounts for Benefit Year 2014. Retrieved April 1, 2021, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf.

[30] Keith, K. (April 28, 2020). Supreme Court rules that insurers are entitled to risk corridors payments: What the court said and what happens next. Health Affairs blog. Retrieved April 1, 2021, from https://www.healthaffairs.org/do/10.1377/hblog20200427.34146/full/#:~:text=On%20April%2027%2C%202020%2C%20the,United%20States.&text=The%20Court%20ruled%20that%20the,absence%20of%20explicit%20appropriations%20language.

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 June 2020.[31] 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.[32] By dividing the $15.5 billion amount by the December 2014 national average APTC ($276), we estimated monthly APTC effectuated enrollment for 2014 at 4.7 million. For 2015, the IRS announced $25 billion in APTC for insurance marketplace coverage.[33] By dividing the $25 billion amount by the average quarterly national APTC ($271), we estimated monthly APTC effectuated enrollment for 2015 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. 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. For calendar years 2016 through 2019 and the first half of calendar year 2020, CMS has released state-level data on effectuated enrollment (including APTC and CSR enrollment), which serve as the basis for our 2016 through 2020 estimated values.[34] We estimated enrollment outside of the marketplace based on available statutory data and CMS risk adjustment transfer reports, netting out reported effectuated marketplace enrollment.

[31] CMS. Effectuated Enrollment for the First Half of 2020. Retrieved April 1, 2021, from https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Effectuated-Enrollment-First-Half-2020.pdf.

[32] IRS (July 17, 2016). IRS Commissioner John Koskinen Letter to Congress. Retrieved April 1, 2021, from https://www.irs.gov/pub/irs-utl/CommissionerLetterIwithcharts.pdf.

[33] IRS (January 9, 2017). IRS Commissioner John Koskinen Letter to Congress. Retrieved April 1, 2021, from https://www.irs.gov/pub/newsroom/commissionerletteracafilingseason.pdf.

[34] CMS (November 28, 2018). Effectuated Enrollment for the First Half of 2018. Fact Sheet. Retrieved April 1, 2021, from https://www.cms.gov/newsroom/fact-sheets/effectuated-enrollment-first-half-2018.