MILLIMAN REPORT

Commercial health insurance: Detailed 2020 financial results and emerging 2021 trends

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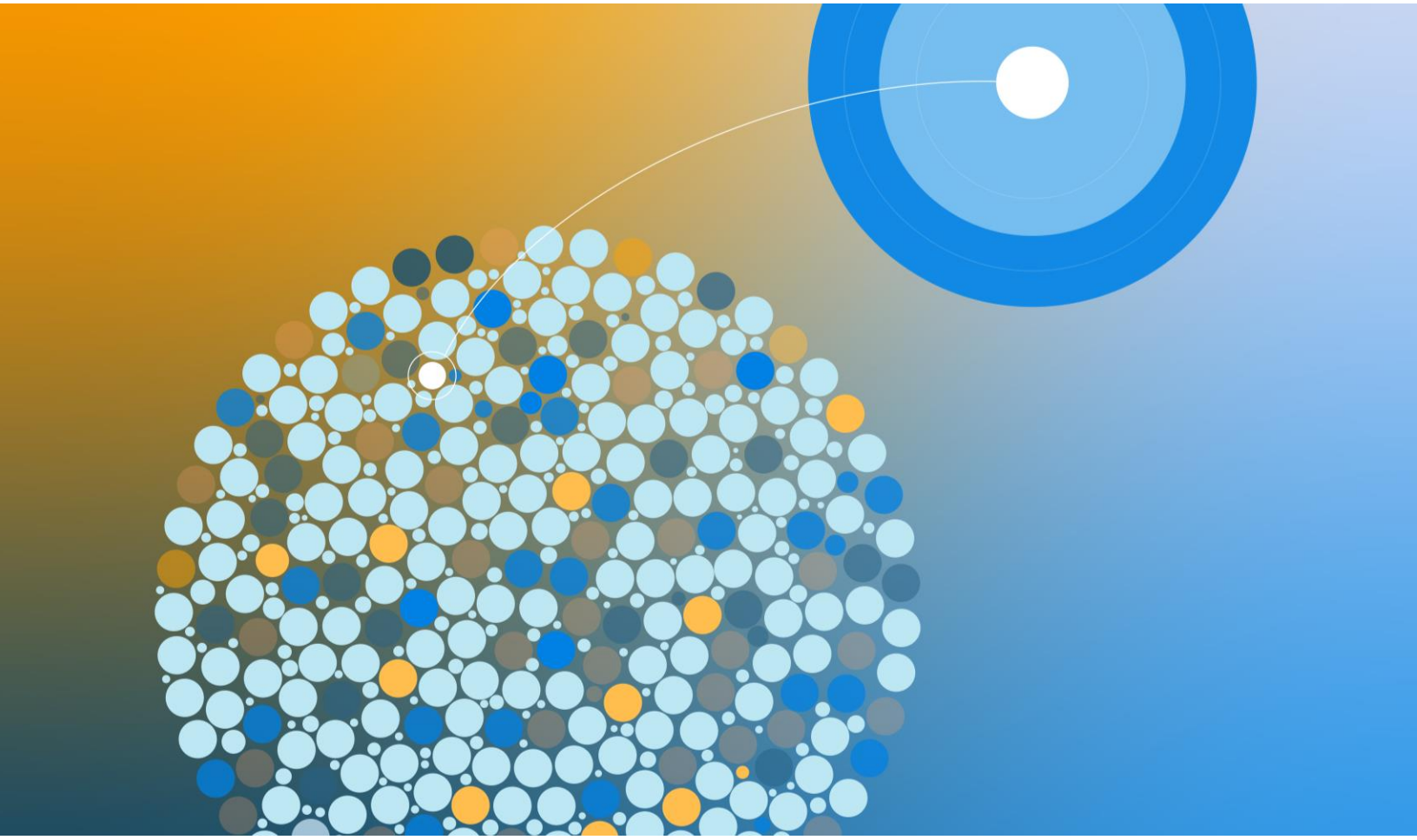

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Table of Contents

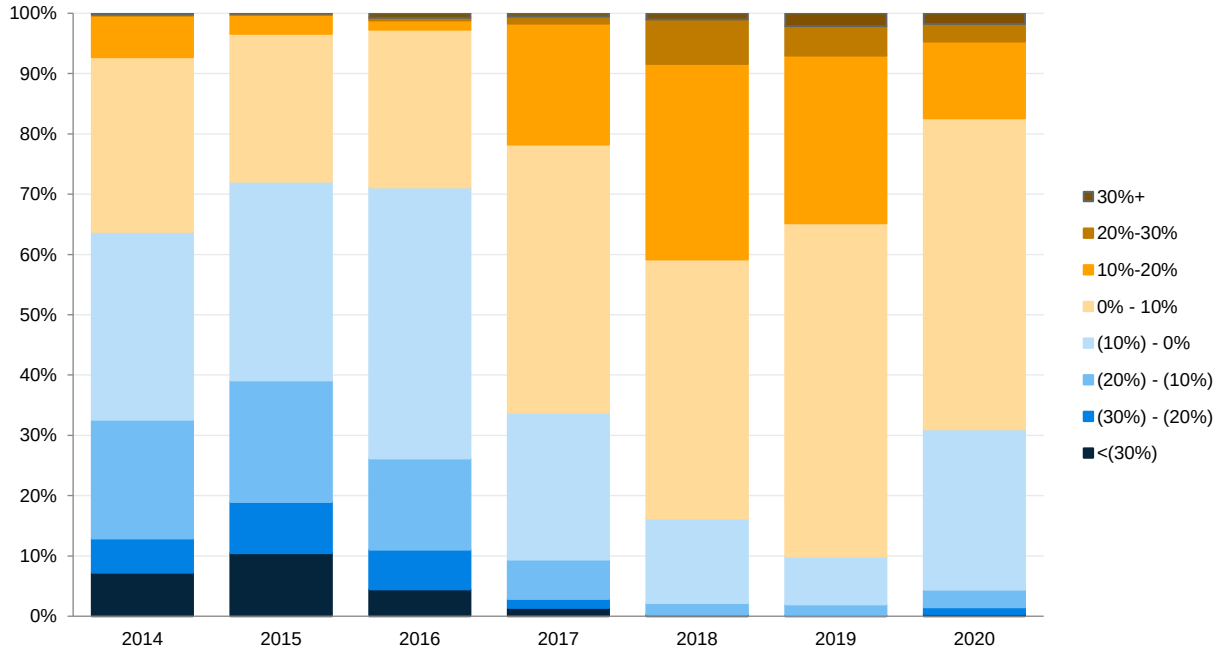
Executive Summary

Medical loss ratio (MLR) data published by the Centers for Medicare and Medicaid Services (CMS) provides a detailed picture of insurer financial results for the commercial market for the seventh full year of the Patient Protection and Affordable Care Act (ACA). MLR data, supplemented with recent 2021 and first quarter 2022 statutory data as well as insurance marketplace and risk adjustment data, enables insight into the fully insured commercial market's enrollment, insurer financial experience, and the impacts of enhanced premium subsidies made available by the American Rescue Plan Act of 2021 (ARP). The following summary includes our key observations on individual and group market financials and enrollment patterns observed in the data.

INDIVIDUAL MARKET KEY OBSERVATIONS

- Figure 1 illustrates the distribution of individual market underwriting margins (based on insured members and net of MLR rebates) from 2014 through 2020. Underwriting distributions in 2020 closely mirrored those reported in 2017, with approximately 70% of carriers operating at an underwriting gain in both years relative to approximately 85% and 90% of carriers in 2018 and 2019, respectively.

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.

- The composite underwriting gain in the individual market decreased from 8.9% to 4.4% of earned premium from 2019 to 2020.
- Individual market insurer paid claims expenses decreased by 0.1% from 2019 to 2020, primarily as a result of the COVID-19 pandemic. Under a hypothetical scenario in which normal healthcare inflation had occurred in 2020, we estimate composite individual market underwriting results would likely have been between 3% and 6% lower, for a range of (2%) to 1% for the year.

- Individual market MLR rebates were $8.56 per member per month (PMPM) in 2020, a decrease from $10.76 in 2019. Individual market MLR rebates as a percentage of earned premium decreased from 1.9% in 2019 to 1.6% in 2020. MLR rebates in the individual market are higher than in the small group ($2.68 PMPM) and large group ($0.58) markets.
- While total reported individual market enrollment increased from 13.3 million to 13.7 million from 2019 to 2020, individual enrollment is projected to increase to 15.2 million in 2022, driven by enhanced insurance marketplace premium subsidies made available for 2021 and 2022 under the ARP. At the time of this report, these enhanced subsidies are scheduled to end on December 31, 2022.
- Increases in individual market enrollment are driven by non-Medicaid expansion states, which experienced a 21% increase in ACA-compliant enrollment from 2020 to 2021, while Medicaid expansion states experienced only 3% enrollment growth in the same period.
- Statutory financial data for 2021 and first quarter 2022 indicates increasing medical loss ratios for the individual market, driven by a rebound in insurer-paid claims expense after dampened healthcare utilization in 2020 associated with the onset of the COVID-19 pandemic, as well as decreases in average insurance marketplace premiums.[1]

GROUP MARKET KEY OBSERVATIONS

- In the small group and large group insurance markets, while insured paid claims were consistent between 2019 and 2020, underwriting margins in both markets decreased in 2020 relative to 2019. Small group underwriting margins decreased from 4.1% to 3.2% of earned premium, while large group underwriting margins decreased from 2.5% to 1.9%. The lack of financial windfalls for insurers in 2020 in the fully insured group markets may be attributable to premium holidays or refunds offered to employers during the coverage year.[2]
    - While the onset of the COVID-19 pandemic disrupted employment levels in the second quarter of 2020 (non-farm employment decreased by 14% from February 2020 to April 2020),[3] enrollment in fully insured group markets declined by less than 3%. In the small group market, enrollment declined from 12.5 million to 11.9 million; however, this rate of decline has been observed for the past several years. In the large group market, enrollment decreased from 41.8 million to 41.0 million from 2019 to 2020 after increasing by 0.2 million from 2018 to 2019. Although data for the self-funded employer market is not available, these data points for the fully insured markets suggest there has not been a material decline in employer-sponsored coverage during the COVID-19 pandemic.
    - Statutory health industry financial data for 2021 and first quarter 2022 indicates increasing medical loss ratios for the fully insured group markets of approximately one to two percentage points relative to 2020, driven by increasing insurer-paid claims expense.

[1] Kaiser Family Foundation (2014-2022). Marketplace Average Benchmark Premiums. Retrieved July 12, 2022, from https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[2] AHIP (August 27, 2021). Health Insurance Providers Respond to Coronavirus (COVID-19). Retrieved July 12, 2022, from https://www.ahip.org/news/articles/health-insurance-providers-respond-to-coronavirus-covid-19.

[3] FRED (July 8, 2022). All Employees, Total Nonfarm. Retrieved July 12, 2022, from https://fred.stlouisfed.org/series/PAYEMS.

Introduction

This report provides a detailed review of the commercial health insurance industry's financial results in 2020 and evaluates changes in the market's expense structure and enrollment relative to prior years. In addition, based on calendar year 2021 statutory financial statements and first quarter calendar year 2022, 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 2020 insurer financial results based on summarized MLR data
- Commercial health insurance enrollment changes from 2014 through 2021
- Distribution of underwriting margins for the individual, small group, and large group markets for each coverage year
- Breakdown of individual market enrollment changes from 2014 through 2022 by key market segments
- Emerging 2021 and first quarter 2022 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.

2020 financial results overview

Figure 2 illustrates the 2020 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 2 and additional detail on insurer financial results from 2010 through 2020.

FIGURE 2: AGGREGATE REPORTED 2020 COMPREHENSIVE EXPERIENCE[1,2]

MEASURE	INDIVIDUAL[6]	SMALL GROUP	LARGE GROUP
Covered Lives[3]	13,700,000	11,900,000	41,000,000
Earned Premium PMPM	$ 548.06	$ 513.83	$ 487.80
Claims Expenses PMPM	$ 427.03	$ 404.78	$ 416.99
Fees and Taxes PMPM	$ 39.82	$ 24.01	$ 17.54
MLR Rebates PMPM	$ 8.56	$ 2.68	$ 0.58
Administrative Expenses PMPM[4]	$ 61.48	$ 66.50	$ 40.70
Underwriting Gain (Loss) PMPM	$ 24.15	$ 16.39	$ 9.37
Preliminary Medical Loss Ratio[5]	85.0%	83.5%	89.4%
MLR Rebate Expense Ratio	1.6%	0.5%	0.1%
Underwriting Margin[7]	4.4%	3.2%	1.9%
Administrative Expense Ratio	11.2%	12.9%	8.3%

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 2020 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 2020 individual market values include Arkansas's private option Medicaid expansion population (approximately 230,000 average monthly covered individuals with paid premium in calendar year 20204).
7. Underwriting results are impacted by additional items not shown above such as reinsurance premiums and recoveries.

As shown in Figure 2, the individual market experienced the largest underwriting gain of the three markets (4.4% underwriting margin relative to 3.2% and 1.9% 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 (1.6% compared to 0.5% and 0.1% in small group and large group, respectively). The next sections of this report examine changes in the above measures from 2014 through 2020 for each market.

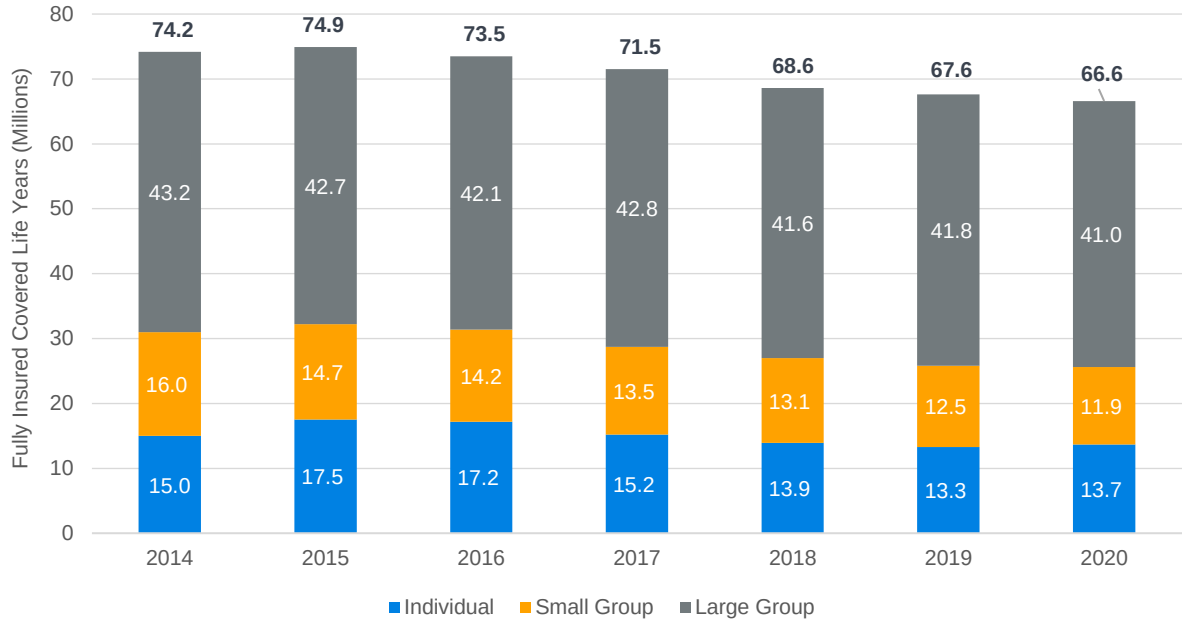
COVERED LIVES

As illustrated by Figure 3, 66.6 million individuals in 2020 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 2019. This enrollment decrease was entirely attributable to changes in the group markets, as individual market enrollment increased by 0.4 million enrollees from 2019 and 2020, likely driven by losses in

[4] Arkansas Department of Human Services. Arkansas Health and Opportunity for Me (ARHOME): A Proposed Medicaid Section 1115 Demonstration Project. Retrieved July 12, 2022, from https://humanservices.arkansas.gov/wp-content/uploads/ARHOME_Waiver_Application.pdf.

employer-sponsored insurance that occurred during the onset of the COVID-19 pandemic.[5] Enrollment decreases in the group markets may be partially driven by COVID-19-related job losses, though fully insured group market enrollment has also steadily declined since 2014. Data from the Medical Expenditure Panel Survey (MEPS) indicates the percentage of private sector establishments offering health insurance coverage has remained steady since 2015, suggesting that the decrease in the fully insured group enrollment may be attributable to employers shifting from fully insured to self-funded plans rather than not offering coverage.[6]

FIGURE 3: NATIONAL COMPREHENSIVE HEALTH INSURANCE ENROLLMENT, 2014 TO 2020



Notes:

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

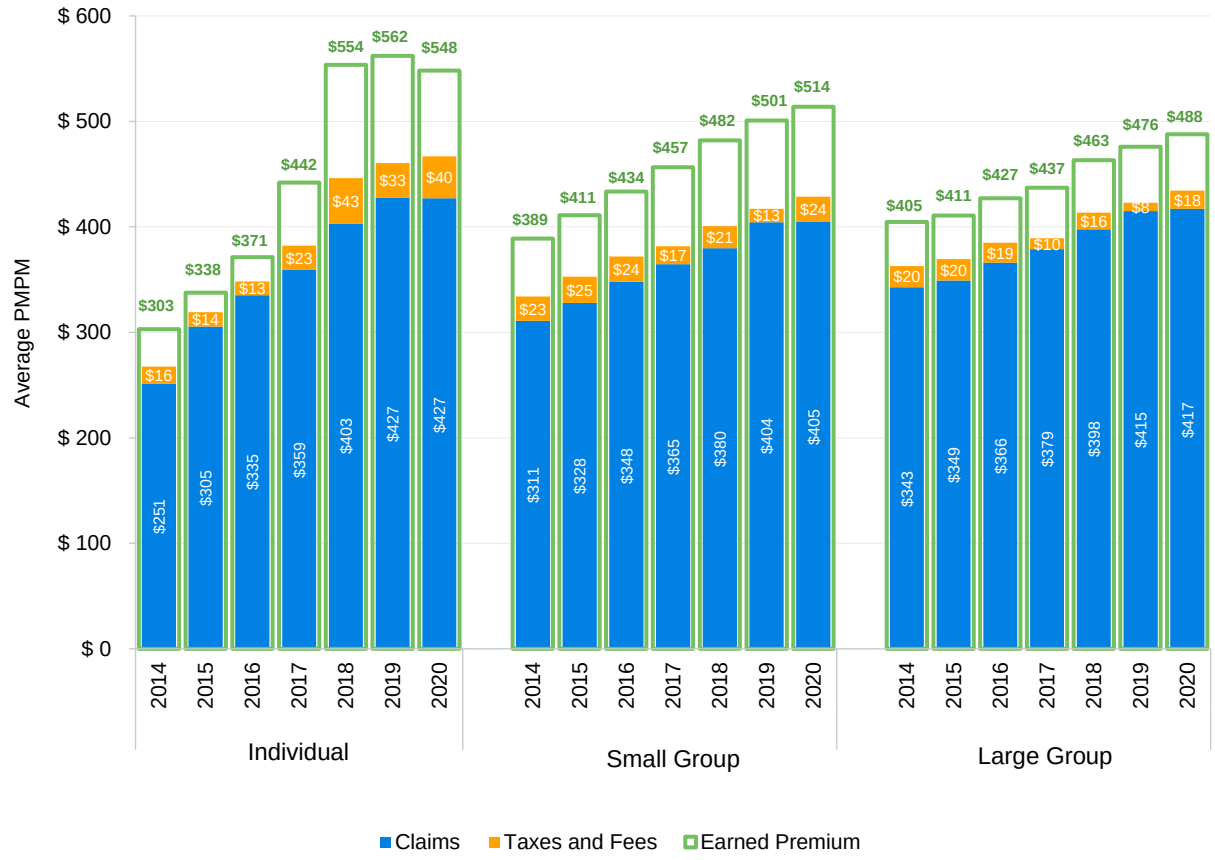
[5] The United States Census Bureau estimated the percentage of non-elderly adults with employer-sponsored insurance declined from 62.2% in early 2019 to 61.6% in early 2021. Please see https://www.census.gov/library/stories/2021/09/private-health-coverage-of-working-age-adults-drops-from-early-2019-to-early-2021.html for more information.

[6] MEPS. Medical Expenditure Panel Survey (MEPS) Insurance Component (IC). Retrieved July 12, 2022, from https://datatools.ahrq.gov/meps-ic. Percentage of private-sector establishments that offer health insurance by firm size and selected characteristics, 1996 to 2020.

EARNED PREMIUM, CLAIMS EXPENSE, AND TAXES AND FEES

Figure 4 illustrates changes in earned premium, claims expenses, and taxes and fees from 2014 through 2020.

FIGURE 4: CLAIMS EXPENSES AND TAXES AND FEES VERSUS EARNED PREMIUM, 2014 TO 2020



Earned premiums slightly decreased in the individual market from 2019 to 2020, consistent with the observed decrease in average premium subsidy benchmark premiums in the insurance marketplaces,[7] while continuing the pattern of steady increases in the group markets from 2019 to 2020. Claims expenses remained stable in each of the three markets, driven by heavily dampened healthcare utilization during the March 2020 through May 2020 time period.[8] Taxes and fees levied on insurers increased from 2019 to 2020 after decreases from 2018 to 2019 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 sunset.[10] Within the individual market, higher reported taxes and fees since 2018 were also influenced by greater federal income taxes, a result of favorable underwriting margins experienced by insurers during the time period.

[7] Kaiser Family Foundation (2014-2022). Marketplace Average Benchmark Premiums, op cit. https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[8] See https://us.milliman.com/-/media/milliman/pdfs/2021-articles/4-6-21-commercial-health-insurance.ashx, page 16, for further information.

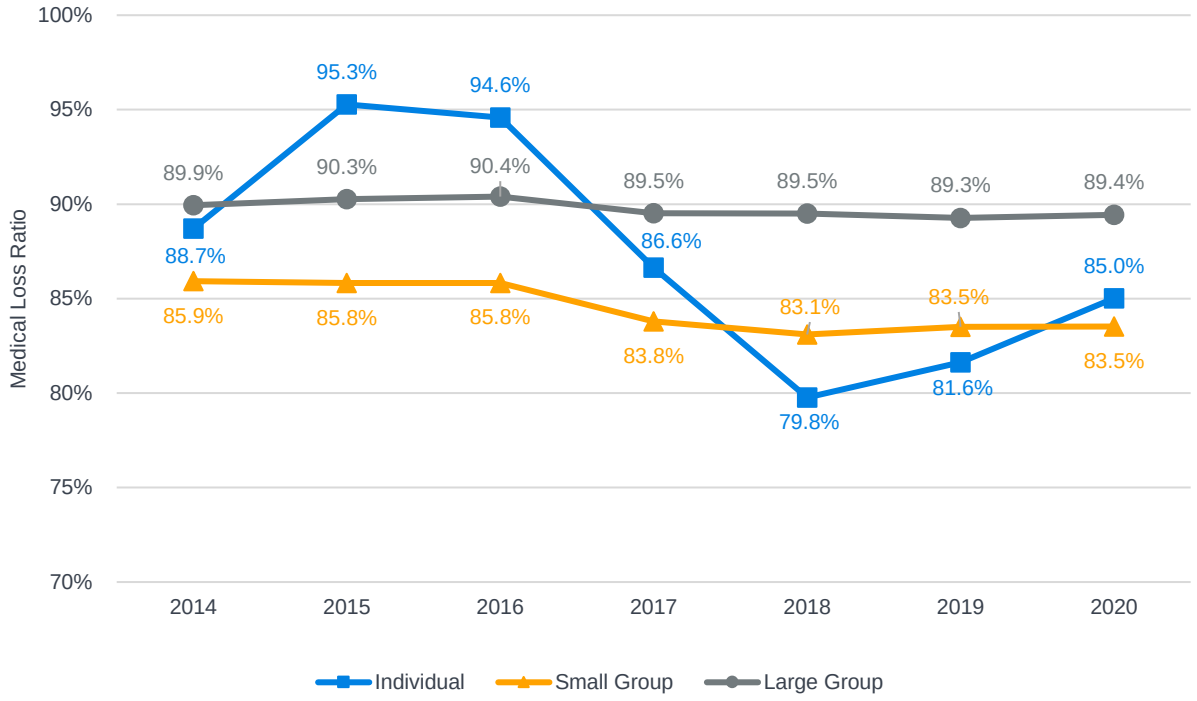
[9] IRS. Affordable Care Act Provision 9010 – Health Insurance Providers Fee. Retrieved July 12, 2022, from https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010.

[10] Ibid.

PRELIMINARY MLR AND MLR REBATES

Figure 5 illustrates the preliminary MLR for the three commercial health insurance markets from 2014 through 2020. The preliminary MLR is based on insurer experience for a single year and does not include credibility adjustments for insurers with limited enrollment.

FIGURE 5: PRELIMINARY MEDICAL LOSS RATIO 2014 THROUGH 2020

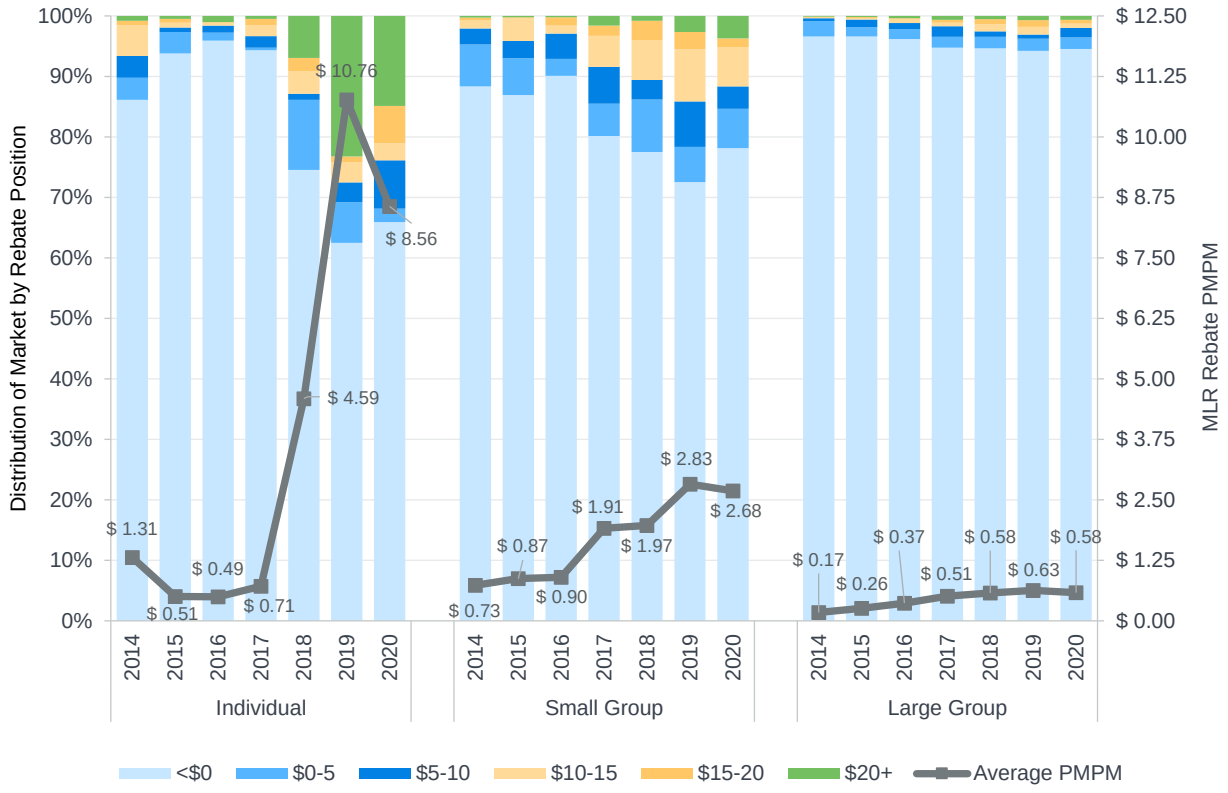


As in prior years, the preliminary MLR for the group markets has remained stable while greater fluctuations have been observed in the individual market. The individual market preliminary medical loss ratio (MLR) increased from 81.6% to 85.0% from 2019 to 2020. This increase was attributable to incurred claims decreasing by (0.1%) and quality improvement expense PMPMs increasing by 28.8%, while adjusted earned premium[11] PMPM decreased by (3.8%).

Figure 6 illustrates the distribution of MLR rebates across the three commercial insurance markets from 2014 through 2020, as well as the composite MLR rebate in each reporting year.

[11] Premium net of taxes and fees.

FIGURE 6: MEDICAL LOSS RATIO REBATE, 2014 THROUGH 2020



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.

In 2020, rebates were owed to just under 35% of individual market members based on the 2018 to 2020 MLR experience period, with 15% of the market being owed rebates in excess of $20 PMPM. The average rebate per rebatable member in 2020 was $25.12 PMPM or about $300 on an annualized basis, a decrease from $28.71 PMPM in 2019. It is likely that MLR rebates will continue to decline in the individual market in 2021 and 2022 as a result of two primary factors:

- Average marketplace benchmark premiums declined by (2.2%) and (3.1%) in 2021 and 2022, respectively.[12]
- 2021 statutory data indicates insurer-paid claims expenses increased materially from 2020 to 2021 in the individual market, rebounding from COVID-19-related suppressed utilization in 2020.

Facing potentially large MLR rebates, it is possible that some insurers have reduced premiums for 2021 and 2022 to gain enrollment market share and reduce MLR rebate liability in future years. Potential new market entrants to the insurance marketplaces should consider this pricing environment when evaluating market share and profitability projections.

[12] Kaiser Family Foundation (2014-2022). Marketplace Average Benchmark Premiums, op cit. https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

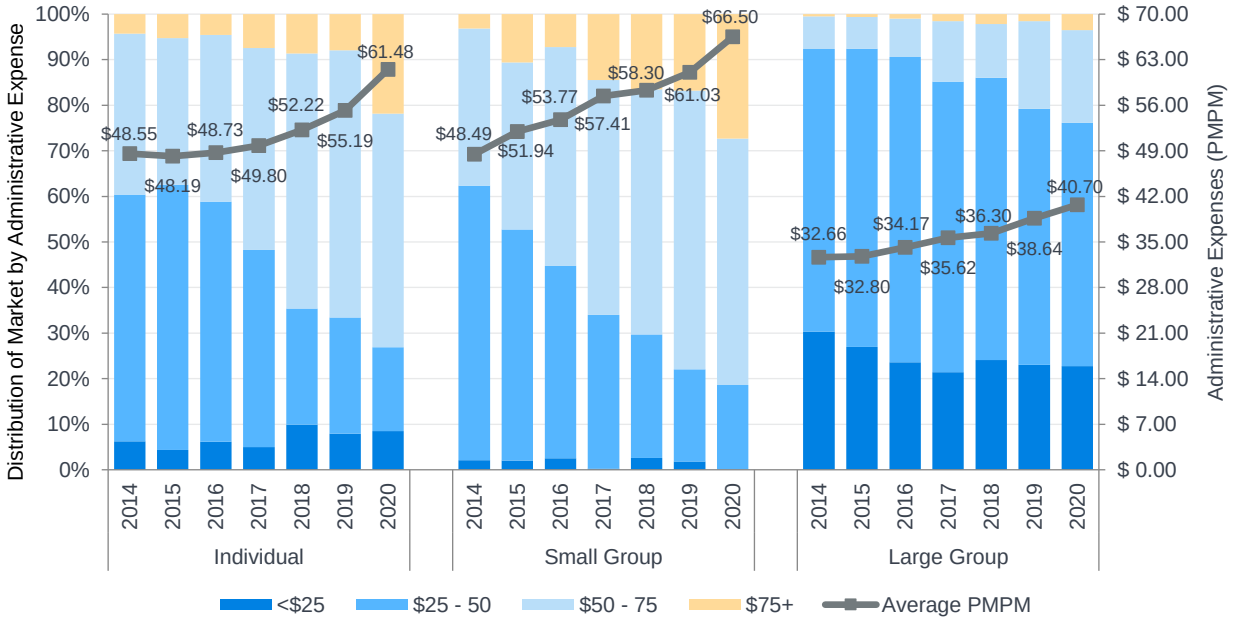
From 2019 to 2020, MLR rebates in the small group market also slightly declined, with rebates decreasing from $2.83 to $2.68 PMPM. The proportion of the small group market with rebates in excess of $20 PMPM (4%) is nominal compared to the individual market. MLR rebates in the large group market continued to be low relative to other markets, with a small decrease from $0.63 PMPM in 2019 to $0.58 PMPM in 2020.

ADMINISTRATIVE EXPENSES

Figure 7 illustrates the distribution of reported administrative expenses from 2014 to 2020 for each market (inclusive of quality improvement, claims adjustment, and general and administrative expenses) 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 and large group market administrative costs increasing annually by approximately 2.6% from 2014 to 2019 and the small group increasing annually by approximately 3.9%. However, from 2019 to 2020, administrative costs increased by 11.4% in the individual market and 9.0% in the small group market. Administrative cost trends in the large group market were 5.3% from 2019 to 2020, relative to a 3.4% annualized trend rate from 2014 through 2019.

The increases seen in both the individual and small group markets are attributable to increases in both quality improvement expenses[13] and general and administrative expenses.[14] The observed cost increases appear across the detailed administrative expense categories rather than being confined to a single category.

FIGURE 7: TOTAL ADMINISTRATIVE EXPENSE 2014-2020



Notes:

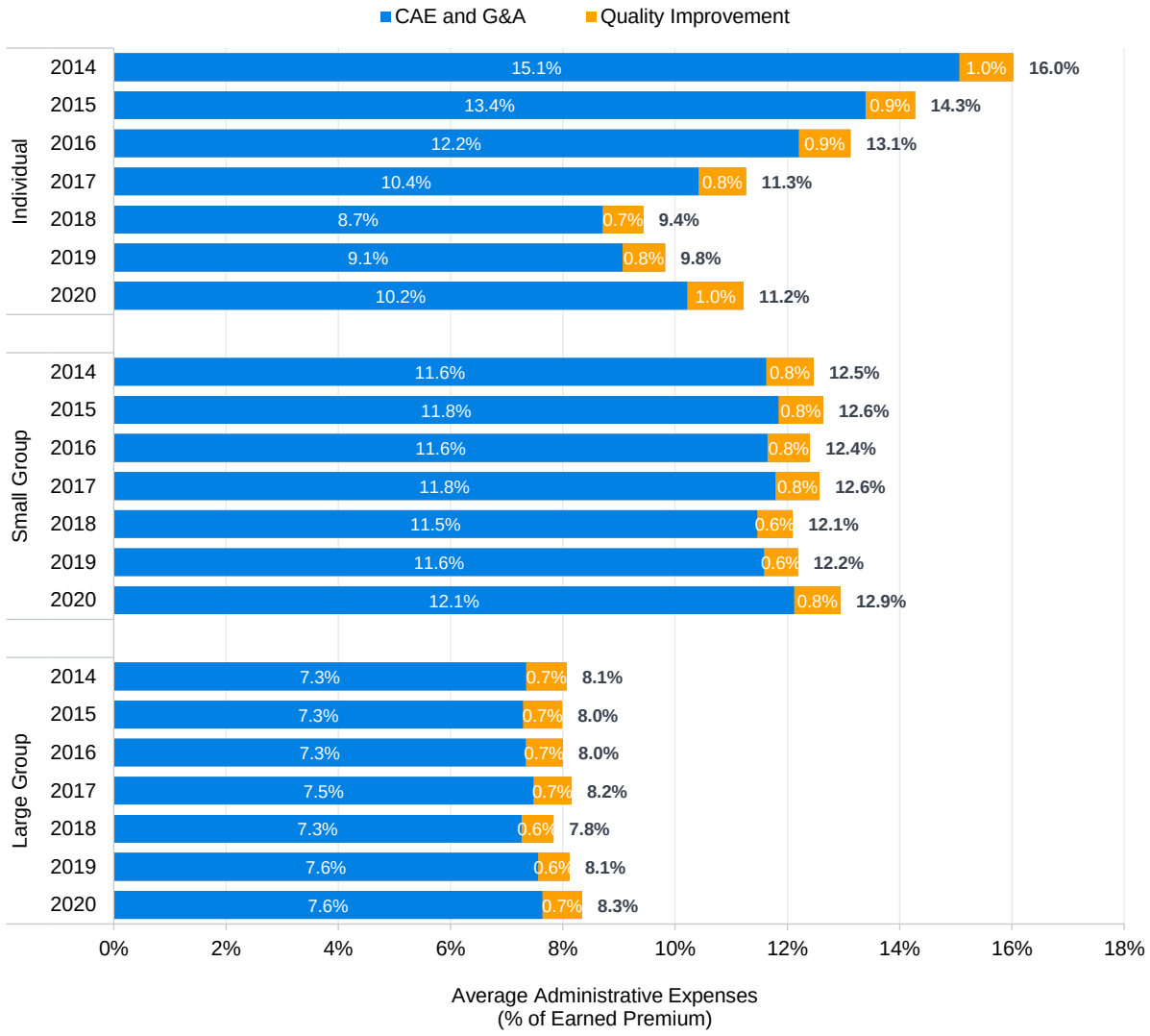
1. Distributions weighted by reported member months in each calendar year. Results reflect all insurers that reported data in the given year.

[13] For details on what expenses constitute a quality improvement expense, please see https://www.cms.gov/files/document/2021-mlr-form-instructions.pdf, Section 4.

[14] For details on what expenses are classified as "general and administrative," please see https://www.cms.gov/files/document/2021-mlr-form-instructions.pdf, Section 5.

Figure 8 illustrates administrative costs as a percentage of earned premium. For the individual market, administrative costs as a percentage of earned premiums increased for the second straight year, after several years of declines. In the group markets, 2020 marked the highest percentage of earned premiums for administrative expenses during the seven-year experience period, although the increases in the small group market were smaller than those in the individual market. Figure 8 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.

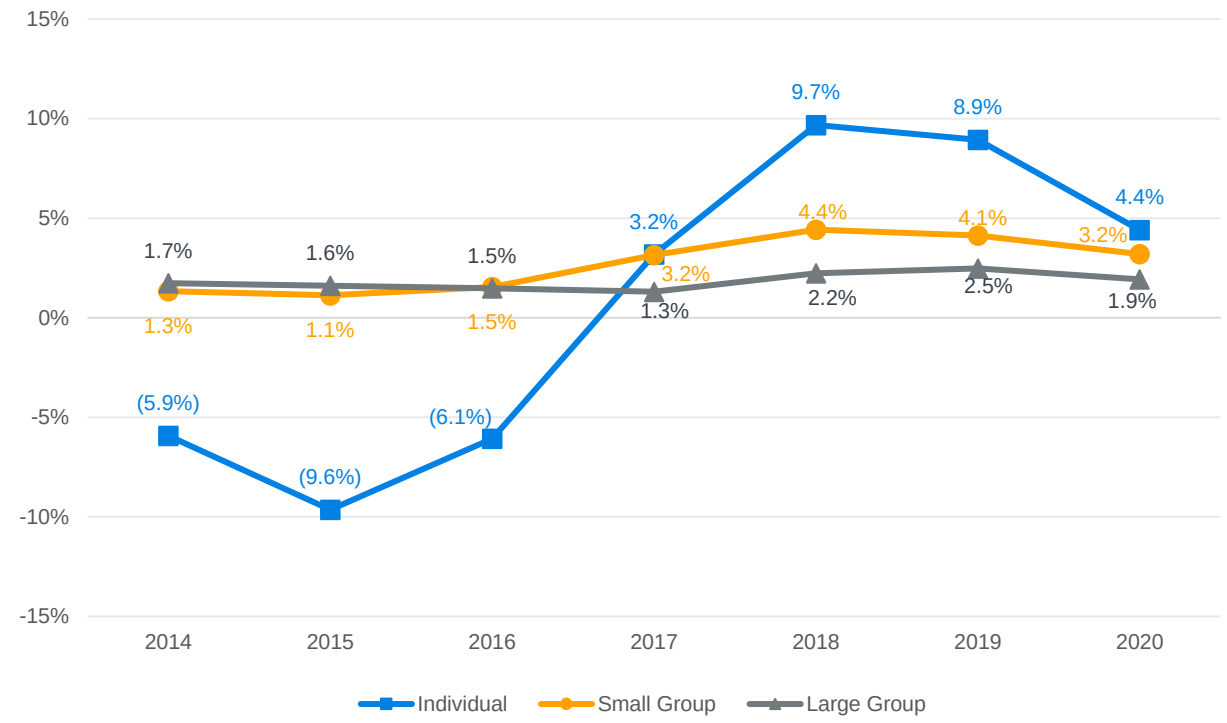
FIGURE 8: ADMINISTRATIVE EXPENSE AS A PERCENTAGE OF EARNED PREMIUM



UNDERWRITING RESULTS

Figure 9 illustrates the underwriting results from 2014 through 2020 for the three commercial insurance markets. The individual market composite underwriting gain was 4.4% in 2020, a material decrease from the past two years but still a favorable underwriting gain relative to individual market underwriting results prior to 2018 and typical financial experience in group markets. Underwriting margins in the group markets decreased in 2020 relative to 2019, despite stable insurer-paid claims experience between the two years. The decrease in underwriting margins despite dampened claims expense may be attributable to premium credits insurers provided to employer customers during 2020.[15,16]

FIGURE 9: UNDERWRITING MARGIN, 2014 THROUGH 2020



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.

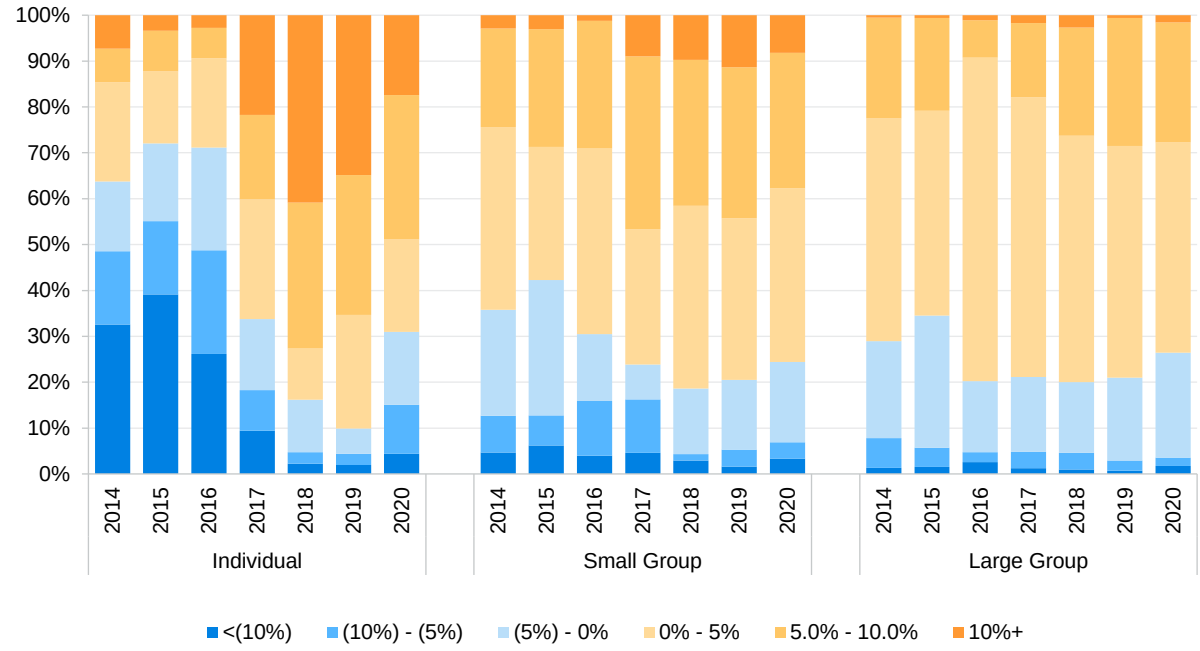
[15] AHIP, Health Insurance Providers Respond, op cit. https://www.ahip.org/news/articles/health-insurance-providers-respond-to-coronavirus-covid-19.

[16] CMS (August 4, 2020). Temporary Policy on 2020 Premium Credits Associated With the COVID-19 Public Health Emergency. Retrieved July 12, 2022, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Premium-Credit-Guidance.pdf.

DISTRIBUTION OF UNDERWRITING RESULTS 2014 THROUGH 2020

When considering aggregate market underwriting results from 2014 through 2020, 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 10 examines the distribution of underwriting results, weighted by member months, in each commercial market for the experience period.

FIGURE 10: COMMERCIAL HEALTH INSURANCE: UNDERWRITING MARGIN DISTRIBUTIONS, 2014 TO 2020



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 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), and 2020 underwriting distributions mirroring 2017.

Detailed individual market enrollment trends: 2014 through 2022

Publicly available reports released by the federal government focus largely on the individual insurance marketplace.[17] A more comprehensive look is necessary to understand the enrollment and stability of the individual market as a whole (on and off the marketplace). On-marketplace enrollment as well as the number of marketplace enrollees receiving federal health insurance subsidies should be examined in the context of the aggregate market. Federal subsidies, through advance 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 11 illustrates covered lives in the individual market from 2014 through 2022 (estimated values for 2021 and 2022), along with the following effectuated[18] 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.

FIGURE 11: INDIVIDUAL HEALTH INSURANCE MARKET ESTIMATED ENROLLMENT BY MARKET SEGMENT, 2014 TO 2022 (MILLIONS)

COVERED LIFE YEARS	2014	2015	2016	2017	2018	2019	2020	2021	2022
ACA-COMPLIANT									
MARKETPLACE	5.5	9.1	10.0	9.8	9.9	9.8	10.4	11.9	13.2
OFF-MARKETPLACE	3.1	4.8	4.9	3.6	2.7	2.2	2.4	2.1	1.9
TOTAL ACA-COMPLIANT	*8.5*	*13.9*	*14.9*	*13.4*	*12.6*	*12.0*	12.8	14.1	15.2
NON-ACA-COMPLIANT									
TOTAL NON-ACA-COMPLIANT	*6.5*	*3.6*	*2.3*	*1.8*	*1.4*	*1.3*	*0.9*	*0.4*	*0.3*
TOTAL INDIVIDUAL MARKET	**15.0**	**17.5**	**17.2**	**15.2**	**13.9**	**13.3**	**13.7**	**14.5**	**15.5**
FEDERAL SUBSIDY POPULATION									
MARKETPLACE APTC	4.7	7.7	8.4	8.2	8.6	8.5	9.0	10.3	11.8
MARKETPLACE CSR	3.1	5.2	5.6	5.6	5.2	5.0	5.2	6.0	6.4

[17] CMS. 2021 Marketplace Open Enrollment Period Public Use Files. Retrieved July 12, 2022, from https://www.cms.gov/research-statistics-data-systems/marketplace-products/2021-marketplace-open-enrollment-period-public-use-files.

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

FIGURE 11: INDIVIDUAL HEALTH INSURANCE MARKET ESTIMATED ENROLLMENT BY MARKET SEGMENT, 2014 TO 2022 (MILLIONS) (CONTINUED)

COVERED LIFE YEARS AS PERCENTAGE OF TOTAL INDIVIDUAL MARKET	2014	2015	2016	2017	2018	2019	2020	2021	2022
ACA-COMPLIANT									
MARKETPLACE	37%	52%	58%	64%	71%	74%	76%	82%	85%
OFF-MARKETPLACE	20%	27%	29%	24%	19%	16%	17%	15%	13%
TOTAL ACA-COMPLIANT	*57%*	*80%*	*87%*	*88%*	*90%*	*91%*	94%	97%	98%
NON-ACA COMPLIANT									
TOTAL NON-ACA COMPLIANT	*43%*	*20%*	*13%*	*12%*	*10%*	*9%*	*6%*	*3%*	*2%*
TOTAL INDIVIDUAL MARKET	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
FEDERAL SUBSIDY POPULATION									
MARKETPLACE APTC	31%	44%	49%	54%	61%	64%	66%	71%	76%
MARKETPLACE CSR	21%	30%	33%	37%	37%	38%	38%	41%	41%

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 2021 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 2021 and 2022 values have been estimated based on a combination of publicly available federal government data and reports, as well as 2021 and 1Q 2022 statutory data 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 11, marketplace enrollment increased notably from 2020 through 2022, driven by the COVID-19 pandemic and enhanced premium subsides provided by the American Rescue Plan Act of 2021 (ARP).[19]

While marketplace enrollment has increased the last three years, we estimate that *off-marketplace* ACA-compliant coverage has decreased by approximately 60% from its peak in 2016 (from 4.9 million to 1.9 million), largely coinciding with the material premium rate increases that occurred for the 2017 and 2018 coverage years. In addition, it is possible that the enhancement of premium subsidies for households with income up to 400% of the federal poverty level (FPL) and the extension of premium subsides to households with income above 400% FPL under the ARP shifted some off-marketplace enrollment into the marketplaces in 2021 and 2022. Note that premium and cost-sharing subsidies are only available to consumers purchasing marketplace coverage.

[19] Please see https://www.milliman.com/en/insight/americas-rescue-plan-impacts-on-private-health-coverage for more information.

The ACA-compliant enrollment increase from 12.8 million to 14.1 million from 2020 to 2021 was largely driven by states that have not implemented the ACA's Medicaid expansion.[20] ACA-compliant enrollment trend for states that expanded Medicaid is estimated to be approximately 3%, whereas enrollment trend for non-expansion states is approximately 21%.[21] The enrollment trend difference is driven by the population with income between 100% and 138% FPL that qualifies for marketplace premium subsidies ($0 out-of-pocket premium for the second-lowest-cost silver plan under the ARP-enhanced subsidy structure) in non-expansion states but is enrolled in Medicaid in expansion states.

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.[22]

Since 2014, enrollment within the marketplace has come to represent an increasing 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 85% in 2022.
- Likewise, the percentage of the individual market covered lives receiving an APTC is estimated to have increased from 31% in 2014 to an estimated 76% in 2022.
- If the ARP subsidies end as currently scheduled on December 31, 2022, these percentages may subsequently decline.

[20] Note, state-level detail is not available for 2022 enrollment.

[21] Please see https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ for a list of states have expanded Medicaid. For the purpose of our analysis, Missouri and Oklahoma were treated as non-expansion states despite having implemented Medicaid expansion during the course of 2021. Wisconsin was treated as an expansion state because it does not have a Medicaid coverage gap.

[22] See https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Extension%20of%20Limited%20Non-enforcement%20policy%20through%20CY%202023%20and%20later%20benefit%20years%20%281%29.pdf for additional background on transitional coverage.

Insurer financial outlook for 2021 and 2022

Similar to findings from the 2022 Milliman Medical Index,[23] statutory financials for calendar year 2021 and first quarter 2022 indicate a rebound in insurer-paid claims expenses relative to 2020. Figure 12 illustrates preliminary medical loss ratios for the individual, small group, and large group markets from the National Association for Insurance Commissioners (NAIC) Supplemental Health Care Exhibit for calendar years 2018 through 2021. While the data does not encompass all insurers, particularly several California insurers, it indicates increasing medical loss ratios for all markets from 2020 to 2021. Note that differences in timing of the reported data and other factors result in the values differing from those calculated using the CMS MLR data in Figure 5 above, particularly individual market results for 2020 where we observed one major insurer reporting a spread of 25 percentage points in its preliminary medical loss ratio between the Supplemental Health Care Exhibit and MLR data.

FIGURE 12: PRELIMINARY MEDICAL LOSS RATIO 2018 THROUGH 2021 NAIC SUPPLEMENTAL HEALTH CARE EXHIBIT

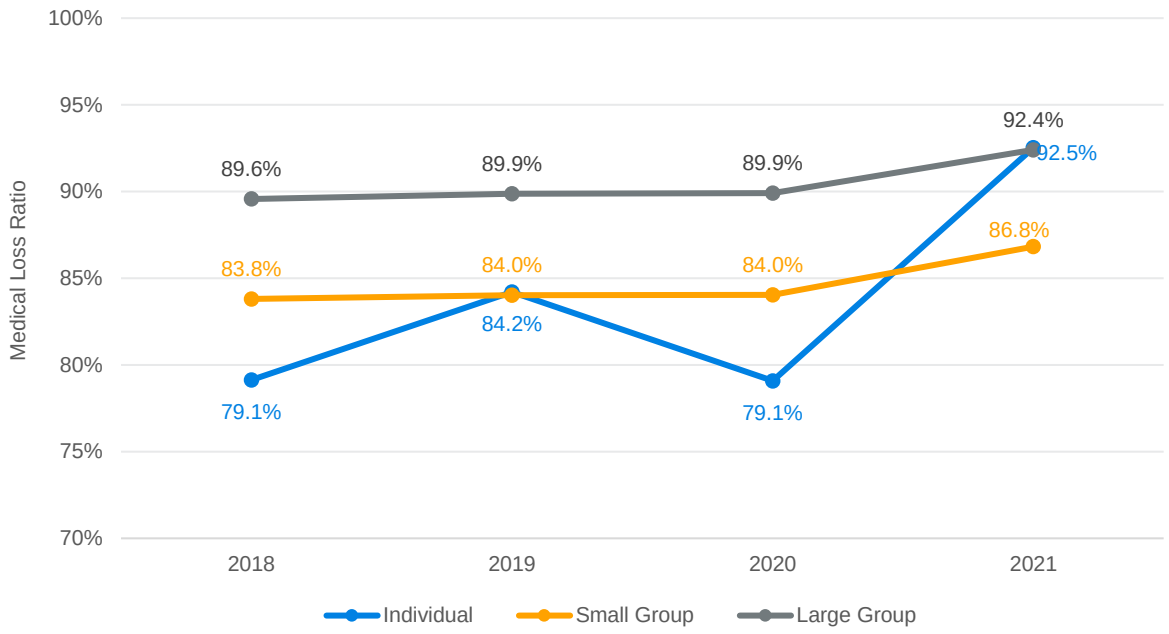


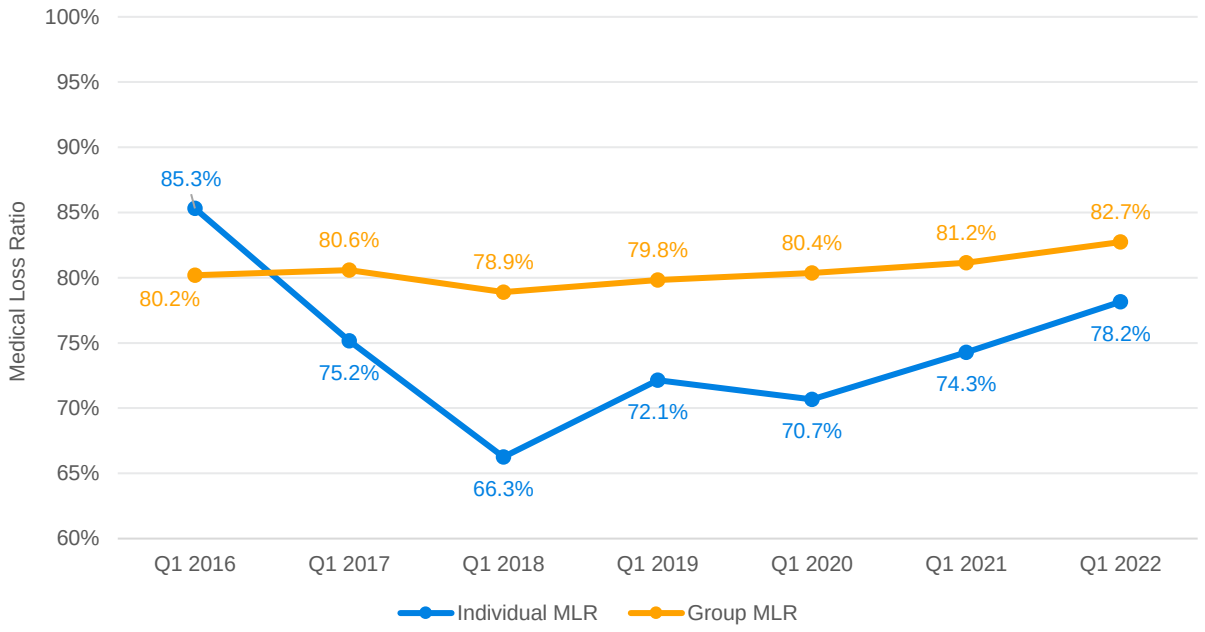
Figure 13 summarizes first quarter statutory statement health industry (orange blank companies[24]) medical loss ratio data for the last five calendar years, including recently reported experience for first quarter 2022 from the Exhibit of Premiums, Enrollment, and Utilization. The medical loss ratio shown in Figure 13 is not adjusted for fees and taxes or quality improvement expenses, making it not directly comparable to medical loss ratio values shown elsewhere in this report. Additionally, first quarter medical loss ratios are generally lower than calendar year medical loss ratios for the commercial markets as member cost sharing covers a larger percentage of total allowed claims expense than at the end of the calendar year. Note that some individuals or groups may have coverage years that do not operate on a calendar year basis where this cost-sharing pattern may differ.

[23] Gaal, M., Houchens, P.R., Liner, D.M. et al. (May 2022). 2022 Milliman Medical Index. Milliman Research Report. Retrieved July 12, 2022, from https://www.milliman.com/en/insight/2022-Milliman-Medical-Index.

[24] For more details on NAIC industry classifications, please see https://content.naic.org/cipr-topics/insurance-industry-snapshots-and-analysis-reports.

Figure 13 illustrates increasing medical loss ratios from 2020 to 2022 for both the individual and group markets, with the individual market medical loss ratio increasing by nearly eight percentage points from 2020 to 2022. Medical loss ratio increases from first quarter 2021 to first quarter 2022 are driven by increases in insurer-paid claims expense. First quarter individual market claims expense PMPM increased by 16.4% from 2021 to 2022, while group paid claims expense PMPM increased by 8.4%.

FIGURE 13: EXHIBIT OF PREMIUMS, ENROLLMENT, AND UTILIZATION, FIRST QUARTER HEALTH INDUSTRY TRADITIONAL MEDICAL LOSS RATIO



Notes:

1. The medical loss ratio shown in Figure 13 is not adjusted for fees and taxes or quality improvement expenses, making it not directly comparable to medical loss ratio values shown elsewhere in this report.
2. First quarter medical loss ratios are generally lower than calendar year medical loss ratios for the commercial markets as member cost sharing covers a larger percentage of total allowed claims expense than at the end of the calendar year.
3. Some individuals or groups may have coverage years that do not operate on a calendar year basis where this cost-sharing pattern may differ.
4. The statutory statement page used for this calculation does not split the group market between small group and large group.

Figures 12 and 13 suggest a tightening of underwriting margins in both the individual and group markets for 2021 and 2022, with more dramatic changes occurring in the individual market, driven by two primary factors:

- As illustrated in Figure 6 above, the MLR rebate payments made by insurers in the individual market ($8.56 PMPM in 2020) are much greater on a PMPM basis relative to the group markets ($2.68 and $0.58 PMPM for the small group and large group in 2020, respectively). Insurers may be managing future MLR rebate liability through less conservatism in premium rate development.
- Insurance marketplace competition in 2022 has rebounded materially from low points in 2018. In 2018, 51% of counties had only one insurer offering coverage,[25] relative to only 5% of counties in 2022.[26] With the overall enrollment growth in the individual market, premium rates may have been developed more aggressively to maintain market competitiveness or establish market share for new entrants.

[25] CMS. County by County Analysis of Plan Year 2018 Insurer Participation in Health Insurance Exchanges. Retrieved July 12, 2022, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2017-10-20-Issuer-County-Map.pdf.

[26] CMS. County by County Plan Year 2022 Insurer Participation in Health Insurance Exchanges. Retrieved July 12, 2022, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/10-16-2020-County-Coverage-Map.pdf.

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, and from commercial MLR form submissions. MLR form data was obtained from the CMS Center for Consumer Information and Insurance Oversight[27] in January 2022. 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 January 4, 2022, are not included in this report. Statutory MLR values reflect reported data as of June 3, 2022.

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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Jason Clarkson, FSA, MAAA and Jeff Milton-Hall FSA, MAAA provided peer review and editorial support for this report. The authors appreciate their assistance.

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.

[27] CMS. Medical Loss Ratio Data and System Resources. Retrieved January 4, 2022, from http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.

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Appendix 1: Aggregate health insurer financial results, 2010-2020

SUMMARY OF COMMERCIAL HEALTH INSURER FINANCIAL RESULTS

CALENDAR YEARS 2010-2020: 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
2020	13,700,000	$548.06	$39.82	$427.03	$8.56	$61.48	$24.15	85.0%	1.6%	4.4%	11.2%
2019	13,300,000	$562.00	$32.99	$427.50	$10.76	$55.19	$50.18	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
2020	11,900,000	$513.83	$24.01	$404.78	$2.68	$66.50	$16.39	83.5%	0.5%	3.2%	12.9%
2019	12,500,000	$500.85	$12.88	$404.35	$2.83	$61.03	$20.66	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
2020	41,000,000	$487.80	$17.54	$416.99	$0.58	$40.70	$9.37	89.4%	0.1%	1.9%	8.3%
2019	41,800,000	$476.02	$8.04	$414.95	$0.63	$38.64	$11.79	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 2020 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 2012-2020 MLR Rebates as % of Earned Premium equal reported rebates on Part 4, Line 5.4 (Total Column) of 2012-2020 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 January 4, 2022.

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 SHCE and 2011 through 2020 MLR Data, we evaluated health insurance industry trends over the 11-year period. A limitation of our 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 2020 MLR data sets. We summarized 2010 SHCE data, along with 2021 and first quarter 2022 statutory statement data, using S&P Global Market Intelligence.

With the exception of the 2021 and first quarter 2022 financial results, our analyses presented in this report were based upon values from the 2011 through 2020 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 our review of the reported values. For example, companies providing solely behavioral health services were flagged as non-comprehensive (offering a limited scope of insured benefits) as well as companies with per member per month premium rates below $100.

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

The 2021 and first quarter 2022 financial results we illustrated in this report are based on companies filing the orange blank NAIC statutory statement. We have not made any adjustments to the reported 2021 or first quarter 2022 statutory statement values.

Figure 14 provides a summary of the number of companies, covered lives, and aggregate premium amounts reported for calendar year 2020 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. In addition, the percentage of total premium we identified as non-comprehensive is illustrated (based on reported experience in the 50 states and Washington, D.C.) . 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.

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

FIGURE 14: 2020 COMPREHENSIVE HEALTH INSURANCE VALUES REPORTED IN MLR FORM

Market	Groups (parent companies)	Companies	Lives[1]	Premium ($ millions)	% Non-Comprehensive
Individual	129	284	13,700,000	$ 89,880	0.13%
Small Group	127	297	11,900,000	$ 73,524	0.03%
Large Group	139	338	41,000,000	$ 240,248	0.02%
Total Comprehensive	164	429	66,600,000	$ 403,652	0.04%

Notes:

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

While we reassigned the majority of the fields in the MLR data to the appropriate SHCE report line item, we did make material 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 and the following years. Adjustments related to the reporting of transitional reinsurance recoveries were based on our review of insurers' 2014, 2015, and 2016 annual statement filings, as well as our 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 we have not adjusted 2014 through 2016 data 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. To obtain further information on data and analytics that can be produced from the Medical Loss Ratio Reporting Form data, please contact us at paul.houchens@milliman.com or zach.hunt@milliman.com.

MARKETPLACE EFFECTUATED ENROLLMENT DATA

CMS has released state-level data on effectuated enrollment (including APTC and CSR enrollment), which serve as the basis for our historical values through 2020 and our 2021 estimated values.[31] We estimated enrollment outside of the marketplace based on available statutory data and CMS risk adjustment transfer reports, netting out reported effectuated marketplace enrollment. We estimated 2022 marketplace enrollment based on the CMS marketplace open enrollment report.[32]

[29] Center for Consumer Information and Insurance Oversight (November 19, 2015). Risk Corridors Payment and Charge Amounts for Benefit Year 2014. Retrieved July 12, 2022, 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 July 12, 2022, 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.

[31] CMS (June 5, 2021). Effectuated Enrollment: Early 2021 Snapshot and Full Year 2020 Average. Retrieved July 12, 2022, from https://www.cms.gov/document/Early-2021-2020-Effectuated-Enrollment-Report.pdf.

[32] CMS. 2022 Marketplace Open Enrollment Period Public Use Files. Retrieved July 12, 2022, from https://www.cms.gov/research-statistics-data-systems/marketplace-products/2022-marketplace-open-enrollment-period-public-use-files.