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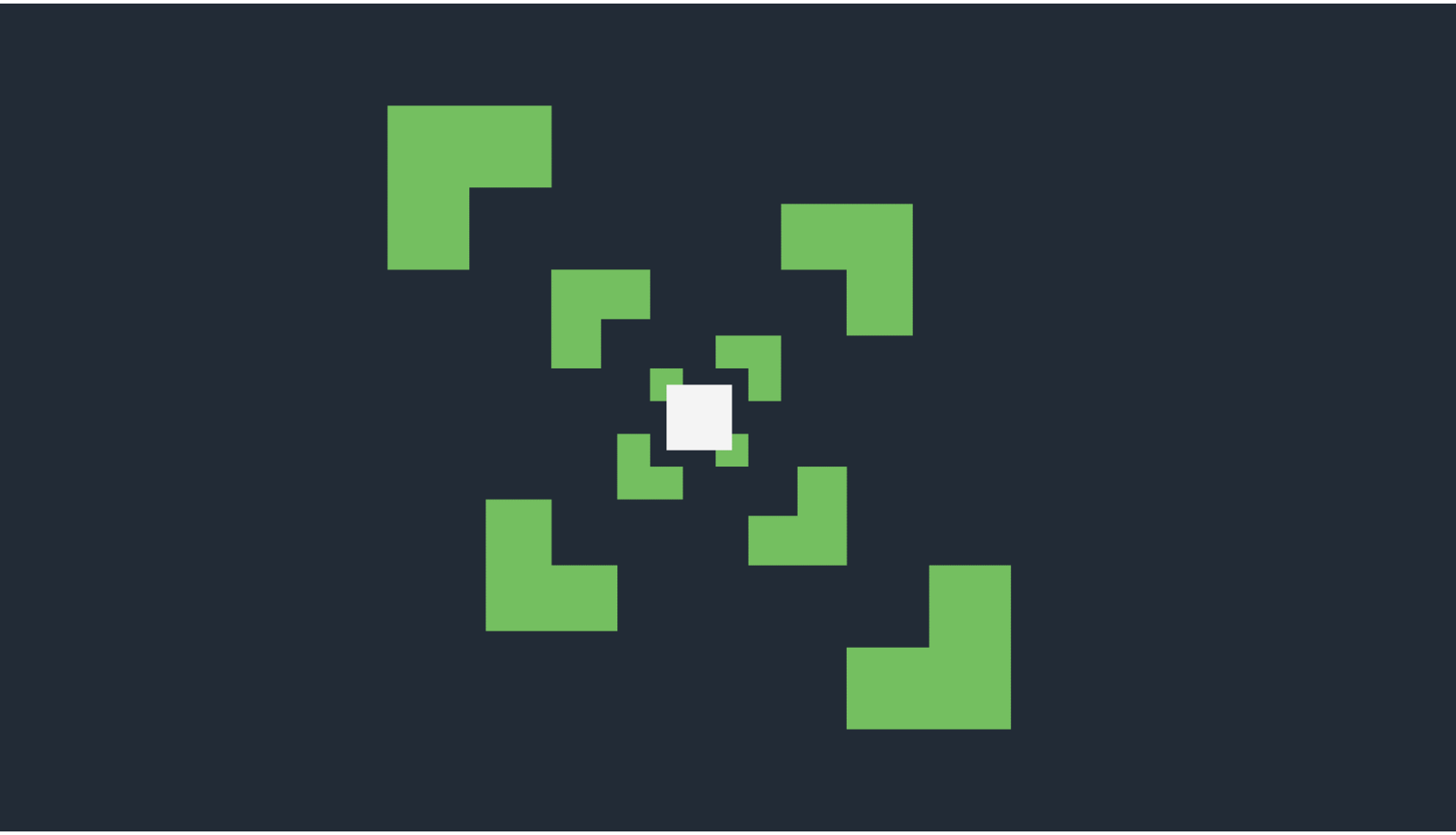
ACA market insights derived from 2024 Unified Rate Review Templates

May 2024

Matt Mraz, FSA, MAAA
Sarah Marion, ASA, MAAA



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Unified Rate Review data published by the Centers for Medicare and Medicaid Services (CMS) represents a key source of pricing transparency that can be leveraged to unravel the complexities of the Affordable Care Act (ACA) market.

This report peels back the layers of this data to address 10 specific questions regarding 2024 ACA product rate filings submitted by individual and small group market carriers in all 50 states and the District of Columbia. By delving into the rate filings for effective dates of January 1, 2024, we identify emerging trends and uncover insights that will help inform 2025 projections. While this report focuses primarily on nationwide and state-level insights, readers should be aware of the significantly more granular level of detail available within a given market (e.g., issuer-level comparisons), which can serve as a valuable resource for ACA research and strategy discussions.

Introduction

All ACA product filings require carriers to submit a Uniform Rate Review Template (URRT) as a primary component of the rate filing justification and comprehensive review process established by CMS. The URRT outlines the data and assumptions guiding rate changes for plans within the single risk pool, presenting the information in a consistent, standardized format for all carriers. Many states require additional state-specific reporting for all participating ACA market issuers, but the URRT represents a key federal standard demonstrating each carrier's adherence to the rating methodology prescribed for ACA product rate filings. Upon the conclusion of the review process across all states, CMS compiles comprehensive Public Use File (PUF) datasets, which encompass all single risk pool rate filing information submitted to all states and CMS, providing a wealth of information for further analysis. CMS released PUFs in fall 2023 detailing the URRT Worksheet 1, 2, and 3 data submitted by individual and small group carriers for plan year 2024.[1]

Consumers, issuers, and regulators alike can benefit from increased transparency and broader understanding of the implications underlying these datasets, which contain information related to the rating assumptions and underlying experience used to develop rates and justify filed rate adjustments for 2024. With issuer-level enrollment metrics included on a historical (2022), current (2023), and projected (2024) basis, the files enable aggregation of pricing assumptions to varying levels of granularity, offering useful insights at both local market and national levels. Please note that the market-wide estimates presented here, where applicable, are grounded in weighted averages, aligning with the methodology applied in the 2024 URRT released by CMS. Specifically:

- Historical costs are weighted with historical 2022 enrollment reported by carriers
- Projected trends are weighted by historical 2022 claims reported by carriers
- Market rate increase estimates are weighted by current enrollment and current premium rates reported by carriers for calendar year 2023
- Projection period factors and costs are weighted by membership projected by carriers in 2024 pricing

1 We utilize the version published by CMS on November 12, 2023 (downloaded November 21, 2023). Readers can access these files directly using this resource: https://www.cms.gov/marketplace/resources/data/rate-review-data.

This report assumes the reader is familiar with the general structure of the URRT and ACA rating practices, as well as the required data and methodology utilized in the federal template.[2] However, the insights presented are applicable to any audience with interest in commercial insurance markets. Specifically, this report seeks to answer the following questions based on data submitted by carriers for 2024 ACA rate filings:

1. On average, what rate changes were filed by individual and small group market issuers for 2024?
2. On average, what annual trend assumptions did carriers utilize to develop 2024 ACA market rates?
3. How does the distribution of essential health benefit (EHB) allowed claims by service category vary by state and market?
4. Which ACA markets have the highest or lowest issuer participation?
5. Which states have the most ACA product enrollment?
6. On average, what is the mix of ACA enrollment by metallic tier?
7. What premium loads are carriers utilizing for administrative expenses, taxes and fees, and explicit profit margin in ACA rate development?
8. How do historical risk-adjusted loss ratios vary by market and metallic tier?
9. How do allowed claim costs per member per month (PMPM) vary by market?
10. To what degree are carriers including benefits in addition to EHB adjustments on URRT Worksheet 2?

Question 1: On average, what rate changes were filed by individual and small group market issuers for 2024?

Carriers report the annual rate increase by 14-digit Health Insurance Oversight System (HIOS) ID on URRT Worksheet 2. Plan-level rate changes are weighted with total current premium by plan[3] to calculate product and issuer-level rate change estimates. This same weighting methodology can be used to estimate market-wide rate increases, as well as rate changes specific to a given metallic level.

In the individual market:

- The average 2024 gross premium rate increase was 6.0% on a nationwide basis across all metallic levels
- Average rate changes were lowest for bronze and gold plans (under 5.5%), highest for catastrophic and platinum plans (over 10%), and near the average for silver plans (6.3%)
- By state, average rate changes exceeded 10% for issuers in Alaska, Georgia, Maine, New York, Utah, and Vermont
- Rates decreased on average (rate change less than 0%) for issuers in Arizona, Idaho, Iowa, North Carolina, and Wyoming

Note that rate changes reflect measurements of gross premium in 2024 versus 2023 and do not account for premium subsidies available to the majority of marketplace enrollees. Changes in net premium can vary widely by market depending on changes in the benchmark silver premium underlying each region, in addition to the gross premium changes filed in a given market.

2 For readers seeking additional background on URRT requirements, we encourage reviewing this resource: https://www.cms.gov/cciio/resources/forms-reports-and-other-resources/downloads/urr_v5.3-instructions.pdf.

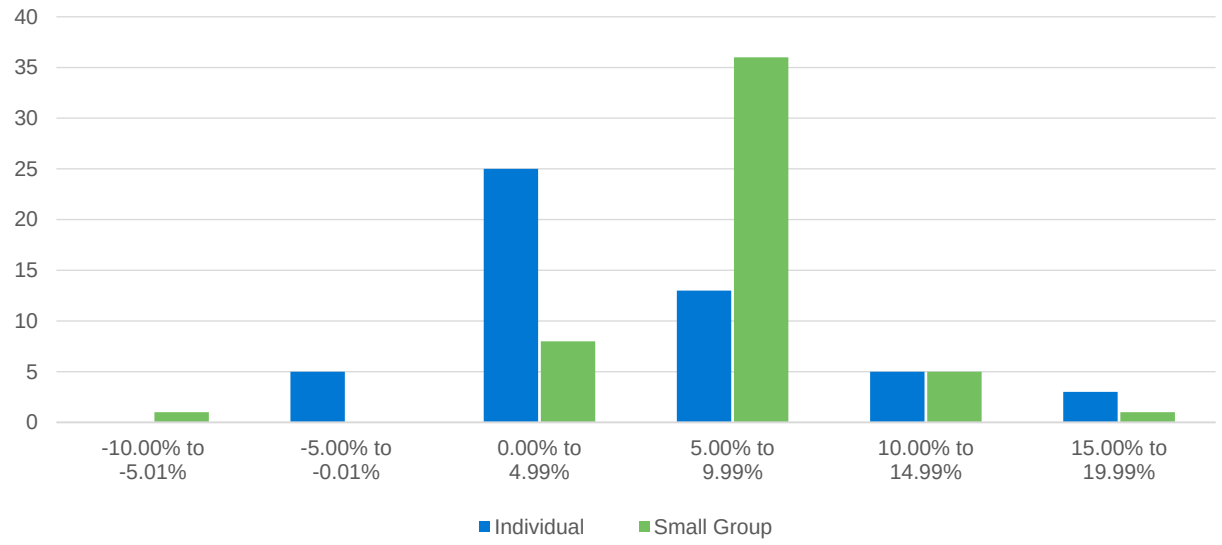
3 Total current premium by plan is calculated based on separate carrier entries on URRT Worksheet 2 that define current enrollment and current premium per member per month by plan. Note that composite rate change calculations utilize only plans marked as renewing (as opposed to new or terminated) in the scope of URRT Worksheet 2.

In the small group market:

- The average 2024 gross premium rate increase was 7.0% on a nationwide basis across all metallic levels
- Average rate changes were lowest for platinum plans (6.5%), highest for bronze plans (7.7%), and close to the average for silver and gold plans
- By state, average rate changes exceeded 10% for issuers in Georgia, Kentucky, Maine, Nebraska, Ohio, and Vermont
- Average rate increases were less than 3.5% for issuers in Iowa, Mississippi, Missouri, North Dakota, and Wyoming
- Only one state (Mississippi) experienced decreased rates on average in the small group market

Figure 1 summarizes the number of states with average 2024 ACA market rate changes (per the calculation above) falling within defined rate change thresholds.

FIGURE 1: COUNT OF STATES BY AVERAGE 2024 ACA RATE CHANGES



On average, rate changes were higher for the small group market than the individual market,[4] with material variation in the rate increase differential by state. In Alaska and Mississippi, the average rate change for the individual market was at least 10% higher than the average rate change for the small group market. A stark difference exists in Iowa, North Carolina, Ohio, and Virginia, where the average rate change for the small group market was at least 6.5% higher than the average rate change for the individual market. Interest and uptake in individual coverage health reimbursement arrangements (ICHRAs) may be higher among small groups in markets having a smaller differential between individual and small group market rates.[5] As such, monitoring changes in the average rate spread between

4 For states with merged individual and small group ACA markets (Maine, Massachusetts, and Vermont), carriers submit separate URRT files for the individual and small group cohorts of the market, reflecting the applicable details for each cohort (e.g., experience, current enrollment, HIOS IDs). As a result, CMS PUF datasets also include distinct individual and small group market URRT data even within the context of merged market states. This report uses those distinct URRT submissions (i.e., does not distinguish merged markets separately). Note that, while product portfolios and plan-level rate changes by region are consistent for both cohorts within merged markets, the potential for a given carrier to have varying distributions of enrollment by plan in the individual versus small group market cohort can result in a variable average rate change for a given carrier's individual versus small group market enrollment. In these cases, the merged market carrier's average overall rate increase in the context of URRT reporting could be calculated as an average across the individual and small group cohorts, but we do not include such aggregation in this report.

5 Business Wire (December 16, 2021). Vericred Releases Annual Map of ICHRA-friendly States. Retrieved May 15, 2024, from https://www.businesswire.com/news/home/20211216005404/en/Vericred-Releases-Annual-Map-of-ICHRA-friendly-States#:~:text=The%20number%20of%20ICHRA%2Dfriendly,Indiana%2C%20South%20Carolina%20and%20Mississippi.

individual and small group markets from one year to the next (as driven by average rate changes filed in each market) may offer early indicators for markets in which ICHRA plans may become more or less attractive. Further analysis is warranted over several years to identify markets in which cumulative individual market rate increases are materially lower than cumulative small group market rate increases (or vice versa), and the potential impact this has on churn between insurance markets.

Additional detail can be determined within each state, such as metallic level rate increases by carrier to track these patterns over time and aid in strategic and competitive decisions.

Question 2: On average, what annual trend assumptions did carriers utilize to develop 2024 ACA market rates?

URRT Worksheet 1 requires issuers to support two years of cost and utilization trend factors by major service category (Inpatient, Outpatient, Professional, Other, Capitation, and Pharmacy). Using these factors and the starting claim costs by service category provided by issuers, we can aggregate pricing trends by issuer and market level using weights reflecting total EHB claims by service category for a given issuer. We can also combine the separate Year 1 (2022 to 2023) and Year 2 (2023 to 2024) trend values included in Worksheet 1 to develop an annualized trend estimate applicable to the 2022 to 2024 time period.

Based on this methodology, we note the following for the individual market:

- Reported annualized pricing trends averaged 6.7% on a nationwide basis (4.3% cost, 2.2% utilization)
- Average annualized trends exceeded 9% for issuers in Alaska, Delaware, Utah, and West Virginia
- In contrast, average annualized trends were less than 5.5% for issuers in Illinois, New Hampshire, Wisconsin, and Wyoming
- By service category, average annualized trends are highest for Pharmacy claims (9.7%) followed by Outpatient claims (7.5%), with less than 6.0% annualized trend assumed for all other service categories

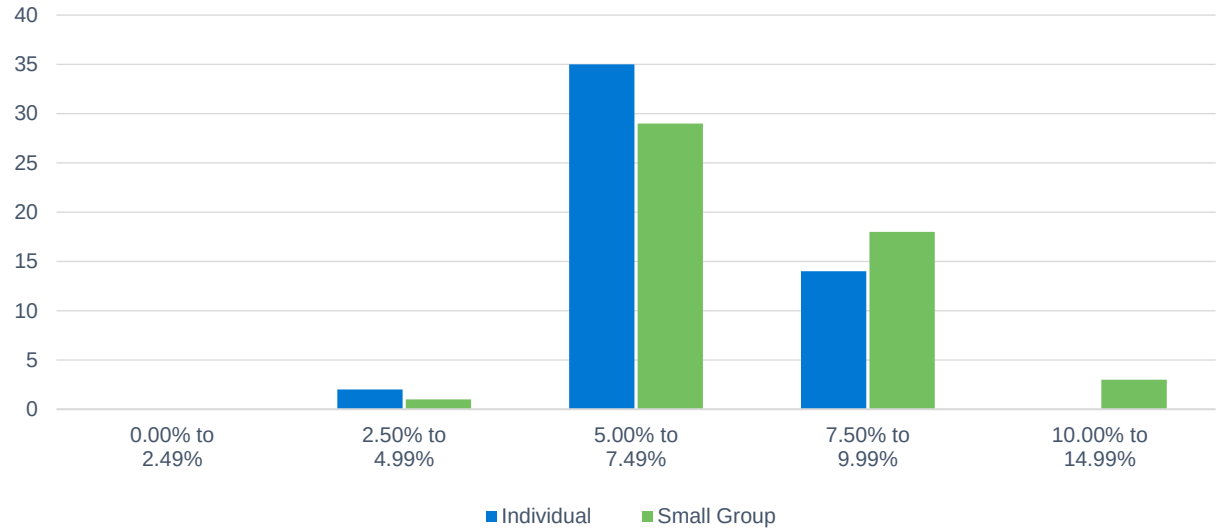
Note that reported pharmacy claims and projected trends should reflect pharmacy rebates (per rate review guidelines), though carriers can also adjust for changes in pharmacy costs via the “Other” projection adjustment factor on URRT Worksheet 1.

For the small group market:

- Reported pricing trends averaged 7.1% on a nationwide basis (4.5% cost, 2.5% utilization)
- Average annualized trend exceeded 9% for issuers in Georgia, Indiana, Kentucky, Ohio, Vermont, and West Virginia
- In contrast, average annualized trends were less than 5.5% for issuers in Hawaii, Kansas, and Mississippi (with Wyoming slightly above this threshold)
- By service category, average annualized trends are highest for Pharmacy claims (10.5%) followed by Outpatient claims (7.7%), with less than 6.0% annualized trend assumed for all other service categories

Figure 2 shows the number of states with carriers utilizing various ranges of average 2024 pricing trends.

FIGURE 2: COUNT OF STATES BY 2024 ANNUALIZED PRICING TRENDS



In both the individual and small group markets, cost and utilization components of trend suggest emerging trends are highest for the Pharmacy service category, followed by Outpatient facility. Many factors have been placing upward pressure on recent pharmacy trends, including but not limited to a rapid increase in utilization for glucagon-like peptide-1 (GLP-1) medications[6] and the impact of new high-cost prescription drugs and therapies coming to market. That said, offsetting forces, including an increased adoption rate of biosimilar products, offer potential dampening from where pharmacy trends would otherwise be projected.[7]

Additional detail can be determined within each state, where average annualized pricing trends can have significant variation among carriers and by service category.

Question 3: How does the distribution of EHB allowed claims by service category vary by state and market?

In addition to trends by service category, issuers reported EHB claims by service category per member per month (PMPM) on URRT Worksheet 1. Based on 2022 reported enrollment weights by issuer and market, we can estimate the distribution of claims by service category on a nationwide basis.

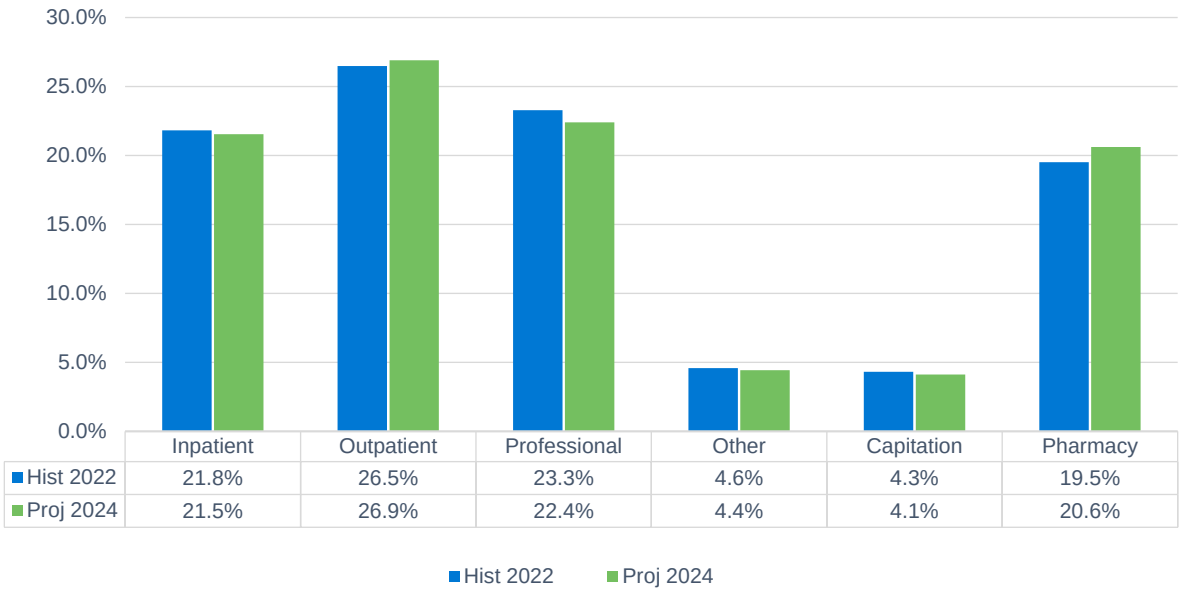
In the individual market, approximately 48% of total essential health benefit (EHB) claims are facility claims. Given higher pricing trends for pharmacy claims (noted above), pharmacy spend is projected to become a larger portion of total 2024 EHB claims relative to the historical 2022 distribution of EHB costs. By state, pharmacy spend is projected to be the largest percentage of total EHB spend in Tennessee (32.8%) and the lowest percentage of total EHB spend in Alaska (6.7%). Note that guidance dictates the pharmacy costs are to be reported net of estimated pharmacy rebates for the single risk pool experience. In practice, carriers may reflect historical or projected pharmacy rebates through various rate filing assumptions (e.g., annual pharmacy trend, "Other" adjustment factor on URRT Worksheet 1, etc.).

Figures 3 and 4 illustrate the nationwide distribution of EHB allowed claims by service category (2022 experience and 2024 projected) for the individual and small group markets, respectively.

6 Ally, A.J., Bell, D., Craff, M. et al. (August 2023). Payer Strategies for GLP-1 Medications for Weight Loss. Milliman White Paper. Retrieved May 15, 2024, from https://www.milliman.com/en/insight/payer-strategies-glp-1-medications-weight-loss.

7 Anderson, B., Bayram, R., Dressler, A. et al. (October 2023). Commercial Drug Trends. Milliman Report. Retrieved May 15, 2024, from https://www.milliman.com/-/media/milliman/pdfs/2023-articles/10-13-23_2023-commercial-drug-trend-study.ashx.

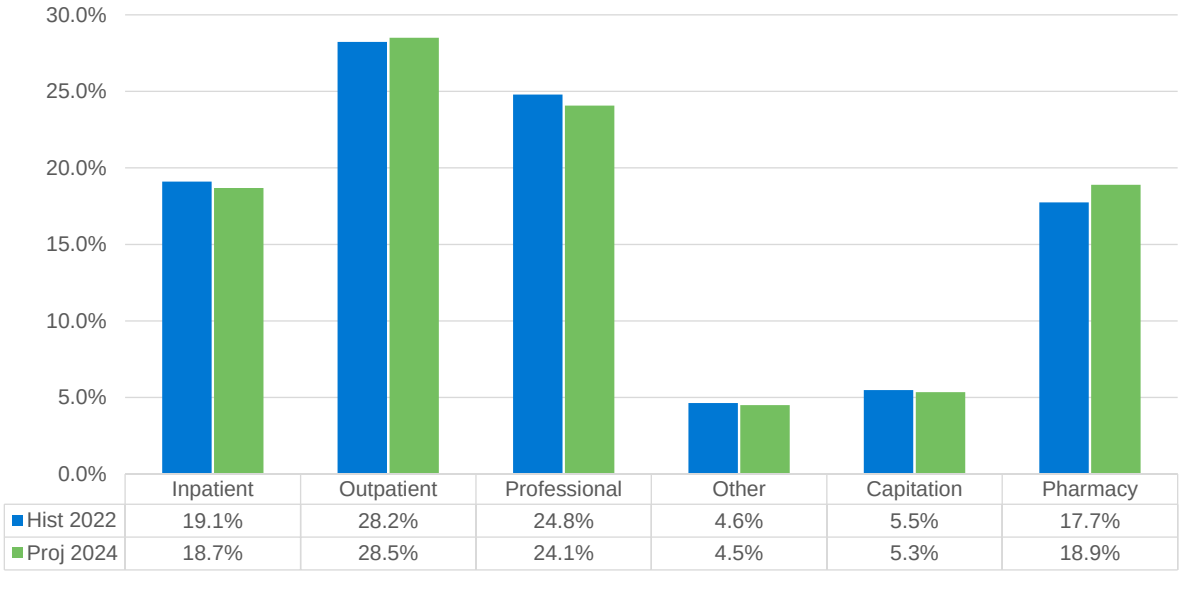
FIGURE 3: DISTRIBUTION OF EHB ALLOWED CLAIMS BY SERVICE CATEGORY (2022 AND PROJECTED 2024), INDIVIDUAL ACA



	Inpatient	Outpatient	Professional	Other	Capitation	Pharmacy
Hist 2022	21.8%	26.5%	23.3%	4.6%	4.3%	19.5%
Proj 2024	21.5%	26.9%	22.4%	4.4%	4.1%	20.6%

In the small group market, approximately 47% of total EHB claims are facility claims. Much as with the individual market, trends are highest for pharmacy claims, resulting in pharmacy spend becoming a larger portion of total projected 2024 EHB claims relative to the historical 2022 distribution of EHB costs. By state, pharmacy spend is projected to be the largest percentage of total EHB spend in Kentucky (29.9%) and the lowest percentage of total EHB spend in Alaska (10.9%).

FIGURE 4: DISTRIBUTION OF EHB ALLOWED CLAIMS BY SERVICE CATEGORY (2022 AND PROJECTED 2024), SMALL GROUP ACA



	Inpatient	Outpatient	Professional	Other	Capitation	Pharmacy
Hist 2022	19.1%	28.2%	24.8%	4.6%	5.5%	17.7%
Proj 2024	18.7%	28.5%	24.1%	4.5%	5.3%	18.9%

Note that carriers utilize varying degrees of precision and granularity when submitting trend assumptions for rate review. For example, carriers in Alaska (and some other markets) did not vary the reported cost and utilization trend factors by service category; in these cases, aggregate trends reflect the carrier's overall trend assumption. As such, projected costs by service category may not reflect true expected trends in some markets, meaning the distribution of costs by service category may also be skewed. However, many carriers appear to be reporting more granular expectations of trend by service category (with cost and utilization components differentiated). This observation suggests the distributions by service category could offer some individual and small group market benchmarks on a national level.

Question 4: Which ACA markets have the highest or lowest issuer participation?

In the individual market, there are four states (New York, Pennsylvania, Texas, and Wisconsin) in which 15 or more issuers submitted rate filings for 2024. Individual markets in all states have two or more issuers participating, though there are five individual markets (Alaska, Hawaii, Rhode Island, Vermont, and Wyoming) in which just two carriers submitted rate filings for 2024.

In the small group market, there are five states (California, New York, Pennsylvania, Virginia, and Wisconsin) in which 15 or more issuers submitted rate filings for 2024. Vermont has two small group issuers participating, Wyoming has three issuers participating, and all other small group markets have four or more issuers participating for 2024.

The majority of states have more issuers filing small group market rates than individual market rates, and the weighted average number of issuers per state (weighted on current 2023 enrollment by state) is 11 for the individual market and 12 for the small group market. A total of 12 states have more individual market carriers than small group market carriers, 13 states have the same number of individual and small group market carriers, and 26 states (including the District of Columbia) have more small group market carriers than individual market carriers.

Figures 5 and 6 summarize the number of issuers filing 2024 rates in each state for the individual and small group markets, respectively.

FIGURE 5: NUMBER OF ISSUERS SUBMITTING 2024 ACA RATE FILINGS, INDIVIDUAL

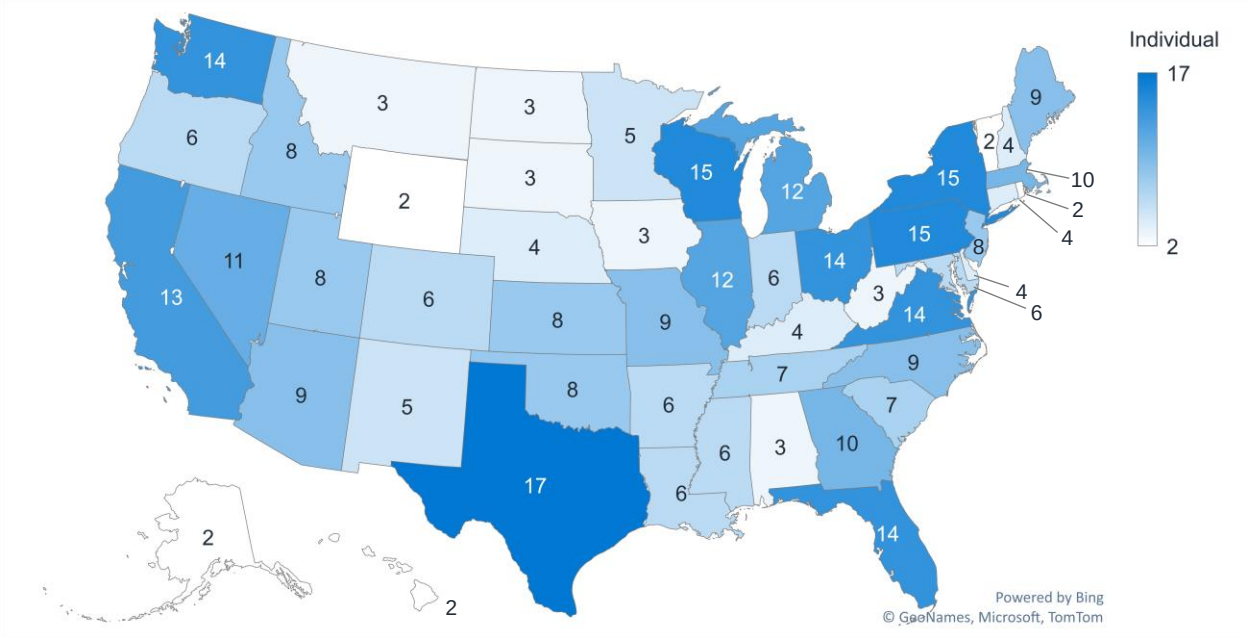
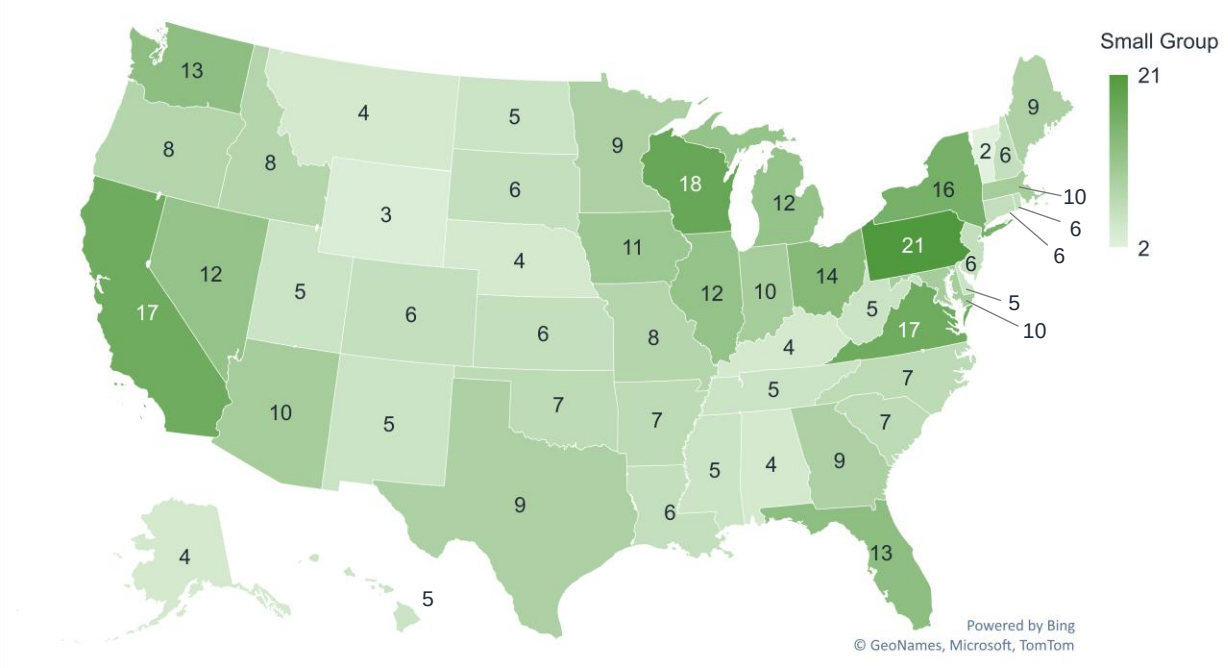


FIGURE 6: NUMBER OF ISSUERS SUBMITTING 2024 ACA RATE FILINGS, SMALL GROUP



Carriers are not required to offer products statewide in most ACA markets, leading to many regional players with specific non-statewide service areas. Given the prevalence of regional issuers, the average number of issuers available to a given consumer is typically below the number of issuers filing rates in a specific county. In other words, the numbers of issuers shown in Figures 5 and 6 reflect carriers filing rates for 2024 in any area in each state, which does not equate to the number of issuers available to all consumers in any region of that state. Weighting issuer-level service area with county-level enrollment would produce an estimate for this metric, but such data is not available in rate review data and thus not considered within the scope of this report.

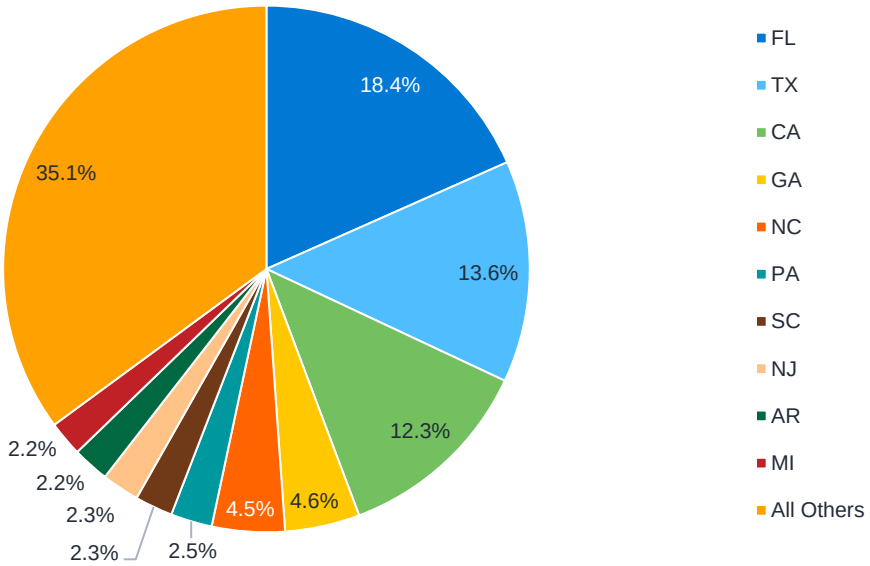
Question 5: Which states have the most ACA product enrollment?

Current 2023 enrollment is one of the plan-level reporting bases included on URRT Worksheet 2. Aggregating reported enrollment figures across all issuers in a given market provides an indication for the current ACA market size by state. Note that reported membership includes both on-exchange and off-exchange enrollment (e.g., membership is not specific to marketplace enrollment for the individual market).

In the individual market, carriers reported over 17.3 million enrollees on a 2023 enrollment basis. Florida represents nearly 18% of the total (approximately 3.2 million individuals), followed by Texas (approximately 2.4 million enrollees, or 14% of the nationwide total), and California (approximately 2.1 million enrollees, or 12% of the nationwide total). These three markets combine to represent over 44% of the nationwide individual ACA market based on current 2023 enrollment reported by 2024 issuers.

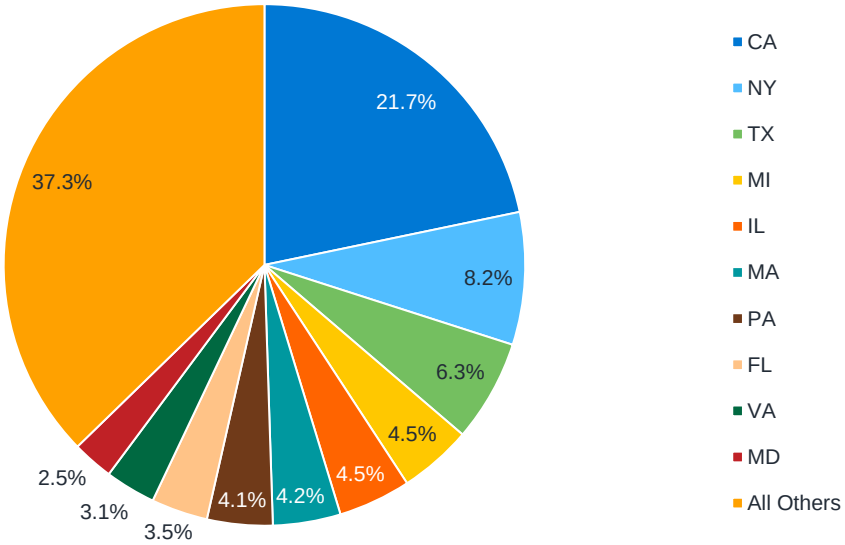
Figures 7 and 8 highlight the mix of ACA enrollment by state for the individual and small group markets, respectively.

FIGURE 7: MIX OF 2023 ENROLLMENT BY STATE, INDIVIDUAL ACA



In the small group market, carriers reported approximately 9.5 million small group ACA enrollees on a 2023 enrollment basis. Small groups in California represent 22% of that total (approximately 2.0 million enrollees), followed by New York (approximately 780,000 small group enrollees, or 8% of the nationwide total), and Texas (approximately 598,000 small group enrollees, or 6% of the nationwide total). These three markets combine to represent over 36% of the nationwide small group ACA market based on current 2023 enrollment reported by 2024 issuers.

FIGURE 8: MIX OF 2023 ENROLLMENT BY STATE, SMALL GROUP ACA



Comparison between individual and small group market enrollment for a given state yields the following additional insights:

- Twelve states have higher reported current enrollment in the small group versus individual market, and the mix of ACA enrollment by state varies widely by market, highlighting dynamics specific to each state's insurance landscape and underlying demographics
- That said, large states such as California and Texas rise to the top three in both the individual and small group markets
- New York has the second-largest small group market, but the 18th-largest individual market
  - New York operates a Basic Health Plan (BHP), which enrolls over 1 million New Yorkers,[8] greatly reducing the size of the New York individual market (compared to a scenario without the BHP)[9]
- Conversely, Florida represents over 18% of the nationwide individual market, but just 3.5% of the nationwide small group market:
  - Florida's population demographics, as well as its status as a non-Medicaid-expansion state—a very significant portion of marketplace enrollees are eligible for cost-sharing reduction (CSR) subsidies—are key drivers of its disproportionate share of the nationwide individual market

To illustrate the additional utility for the current enrollment reporting underlying the URRT, we include an Appendix to this report containing sample market share analysis (i.e., distribution of enrollment by issuer) specific to the two largest individual and small group ACA markets (Florida and Texas individual markets, California and New York small group markets).

Question 6: On average, what is the mix of ACA enrollment by metallic tier?

The 2024 URRT submitted rate filings include plan-level enrollment detail on several bases: historical member months from calendar year 2022 (for carriers with single risk pool experience), "current enrollment" at a time near the rate filing submission deadline (capturing a current membership snapshot, typically at some point in the first half of 2023), and projected member months for plan year 2024.

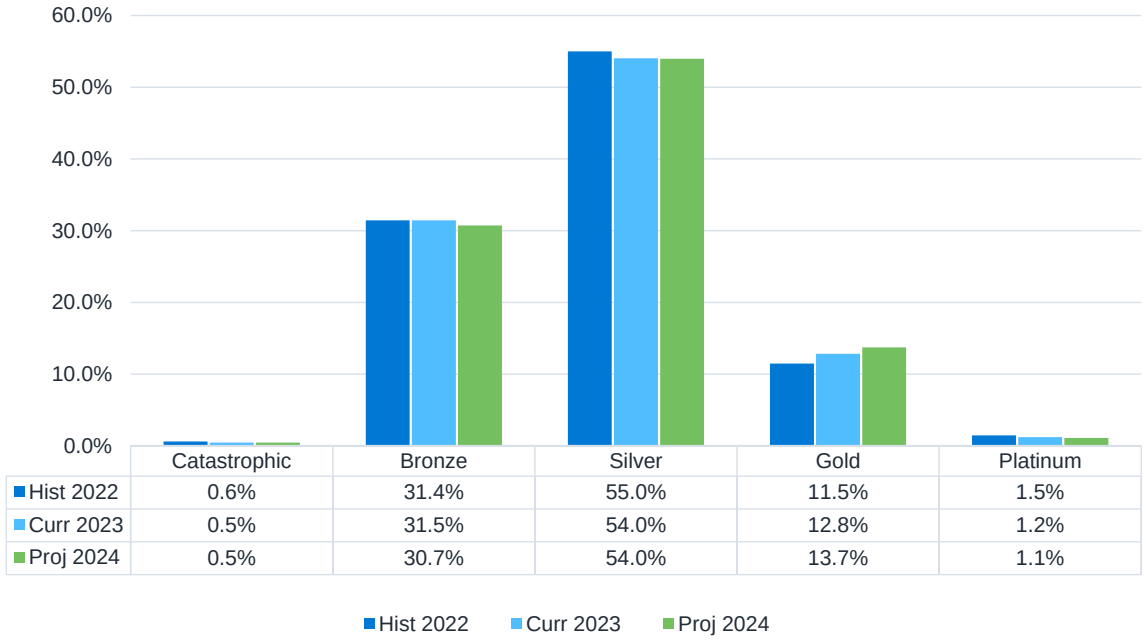
For the individual market, these three enrollment metrics yield the following insights related to metallic tier mix (further highlighted in Figure 9):

- Approximately 85% of the individual market is projected to enroll in bronze or silver plans, with less than 15% in gold and platinum plans
- The trends from 2022 to 2024 indicate a slightly higher prevalence of gold plan enrollment within the individual risk pool, but the metallic tier distribution varies widely by state in the individual market
- In five states (Delaware, Hawaii, Maryland, New Mexico, and Wyoming), over 50% of membership is projected to enroll in gold or platinum plans
- In eight states (Arizona, Florida, Indiana, Mississippi, Missouri, New Jersey, Tennessee, and Utah), over 95% of membership is projected to enroll in bronze or silver plans (including CSR variants)

8 NY State of Health (May 15, 2023). Press release: New York State Department of Health Asks Federal Government to Expand Essential Plan to Further Reduce Rate of Uninsured and Improve Health Equity. Retrieved May 15, 2024, from https://info.nystateofhealth.ny.gov/news/press-release-new-york-state-department-health-asks-federal-government-expand-essential-plan#:~:text=The%20Essential%20Plan%20currently%20covers,access%20to%20the%20Essential%20Plan.

9 The New York small group market is also impacted by level-funded product regulations, which require more than 100 lives in the employer group to qualify. This rule likely drives a larger prevalence of small employer groups into the New York small group ACA market (whereas small groups with up to 50 lives in many other states are not restricted from enrolling in level-funded products).

FIGURE 9: METALLIC TIER MIX (2022, 2023, AND PROJECTED 2024), INDIVIDUAL ACA

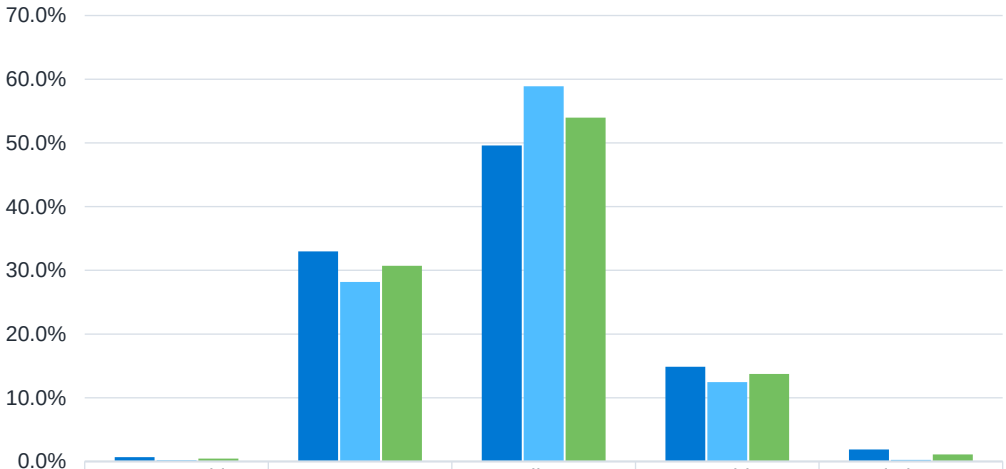


	Catastrophic	Bronze	Silver	Gold	Platinum
Hist 2022	0.6%	31.4%	55.0%	11.5%	1.5%
Curr 2023	0.5%	31.5%	54.0%	12.8%	1.2%
Proj 2024	0.5%	30.7%	54.0%	13.7%	1.1%

Plan availability and premium sloping by metallic tier can be important drivers of consumer plan selections within a given market. A state's Medicaid expansion status, whether additional state-based premium subsidies are available, and if a Basic Health Plan or public option is available to low-income consumers are factors that can alter the individual market metallic tier mix because the composition of the remaining marketplace enrollees can be highly dependent on these variables. Individual consumer preference and the income characteristics of the underlying population are additional key variables impacting metallic tier mix in the marketplace; individual markets with a higher prevalence of low-income consumers, particularly with large populations eligible for CSR subsidies (e.g., non-Medicaid-expansion states), will typically see a higher prevalence of enrollment in silver plans. This is driven by incentives to access CSR-level benefits for individuals with incomes up to 250% of the federal poverty level (FPL). However, subsidized consumers may also have access to many $0 net premium bronze plans, as well as $0 net premium gold plans in certain markets. The availability of such plans can greatly alter the plan selections of the consumers in the market, generating "buy-down effects" specific to each market and leading to highly variable distributions of enrollment by metallic tier across states.

Figure 10 highlights the variation in metallic tier mix on a projected 2024 enrollment basis for individual markets in states with Medicaid expansion versus individual markets in states without Medicaid expansion. This illustrates the significantly higher uptake in silver plans for non-Medicaid-expansion states, which reflects the higher prevalence of CSR-eligible enrollees in the marketplaces of these states. Specifically, there are significantly more members with incomes between 100% and 138% of FPL enrolling in the marketplace in non-Medicaid-expansion states, leading to a higher prevalence of silver CSR-eligible members (particularly in the 94% CSR cohort). While there are only 11 non-expansion states remaining as of this writing, individual market enrollment in these states represents over 47% of the nationwide individual market.

FIGURE 10: METALLIC TIER MIX BY STATE MEDICAID EXPANSION STATUS (PROJECTED 2024), INDIVIDUAL ACA

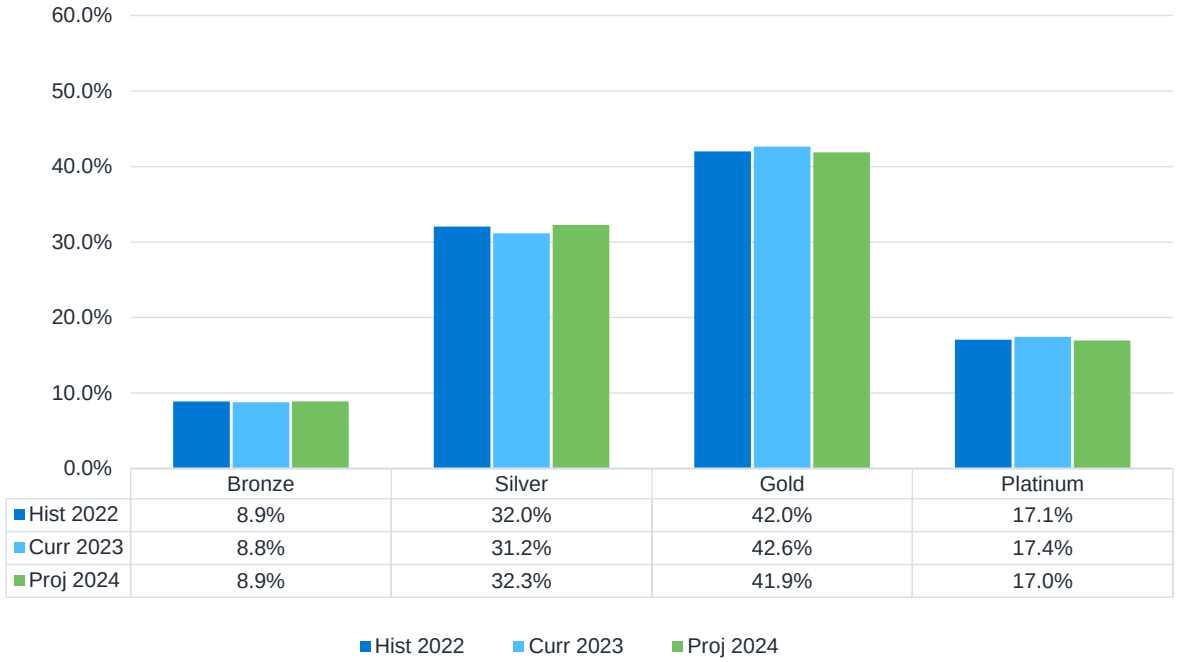


	Catastrophic	Bronze	Silver	Gold	Platinum
Expansion (40 states)	0.7%	33.0%	49.6%	14.9%	1.9%
Non-Expansion (11 states)	0.2%	28.2%	58.9%	12.5%	0.2%
All States	0.5%	30.7%	54.0%	13.7%	1.1%

In the small group market, the URRT enrollment metrics generate the following metallic tier mix insights (further highlighted in Figure 11):

- Historical 2022 member months, current 2023 enrollment, and projected 2024 member months imply a much higher prevalence of enrollment in the gold and platinum metallic tiers compared to the individual market.
- There is more consistency (less volatility) when comparing the metallic tier mix across states for the small group market, though variation still exists. For instance, over 40% of small group membership is projected to enroll in platinum plans in North Dakota (with less than 3% projected to enroll in bronze plans); in its border state to the south (South Dakota), less than 1% of small group membership is projected to enroll in platinum plans with over 33% of the market projected to enroll in bronze plans.
  - Plan availability is a key consideration here, with all five small group issuers offering platinum plans in North Dakota and only two out of six small group issuers offering platinum plans in South Dakota.
  - Premium sloping also comes into play, with bronze plans being priced lower on a relative basis in South Dakota compared to North Dakota, potentially drawing a higher prevalence of groups to these lower-premium options in South Dakota.

FIGURE 11: METALLIC TIER MIX (2022, 2023, AND PROJECTED 2024), SMALL GROUP ACA



	Bronze	Silver	Gold	Platinum
Hist 2022	8.9%	32.0%	42.0%	17.1%
Curr 2023	8.8%	31.2%	42.6%	17.4%
Proj 2024	8.9%	32.3%	41.9%	17.0%

Comparisons between the individual and small group market enrollment distributions yield the following insights:

- Close to 60% of enrollment is projected to be in gold and platinum plans in the small group market, compared to under 15% in the individual market.
- With small employers typically contributing a material portion of premium for small group market enrollees, this may lead to a preference for richer insurance coverage in the small group market compared to the individual market. However, federal premium subsidies in the individual market also increase purchasing power for most individual market enrollees, producing a subsidy dynamic similar to what is observed in the employer market, ultimately incentivizing enrollment in richer plans.10
- While the metallic tier distribution of enrollment may suggest the average small group market enrollee prefers richer plan benefits than the average individual market enrollee, it is worth noting that close to 55% of the individual market is projected to enroll in silver plans, with a significant portion of those enrollees being eligible for CSR plans offering actuarial values (AVs) of 73%, 87%, or 94% on average.
- Based on carrier reporting, 2022 individual market silver plans (including CSR variants) generated a paid-to-allowed ratio over 86% (indicating smaller member payment) compared to the standard 70% actuarial value for non-CSR silver plans, and a 78% average AV for silver plans in the small group market.
  - As such, the average silver enrollee in the individual market is enrolled in much richer coverage than the average silver enrollee in the small group market (due to average CSR benefits for the average silver individual market enrollee).

Note that paid claims in the context of the URRT reporting are net of any state reinsurance programs (i.e., the numerator in the paid-to-allowed ratio is offset for any applicable state reinsurance recoveries).

10 For example, Texas's implementation of mandated CSR loading resulted in a higher uptake in gold plan enrollment (due to increases to premium subsidies) compared to uptake prior to the mandated CSR loading. The individual market is also showing a trend toward gold plans, as shown in the charts.

Question 7: What premium loads are carriers utilizing for administrative expenses, taxes and fees, and explicit profit margin in ACA rate development?

The 2024 URRT submitted rate filings include plan-level expense loads for administrative expenses, taxes and fees, and profit and risk on Worksheet 2. These values are reported on a percentage of premium basis[11] by plan design on Worksheet 2, but they can be aggregated to the issuer and market level. The URRT also includes an Exchange User Fee entry on Worksheet 1; this value is entered on a projected allowed basis, but it can be converted to a paid basis and ultimately compared to projected plan-adjusted index rates by carrier to determine the applicable percentage of premium load associated with the Exchange User Fee. In cases where the Exchange User Fee is nonzero on Worksheet 1, it is assumed that the taxes and fees percentages entered on Worksheet 2 do not include marketplace user fees. In the context of this report, we consider total retention to represent the sum of the implied percentage of premium exchange fee from Worksheet 1 and the three administrative cost components entered on Worksheet 2.

In the individual market:

- Average total retention on a nationwide basis is 17.5% of premium (10.6% admin, 3.9% taxes and fees including any applicable Exchange User Fee estimate on Worksheet 1, and 3.0% profit), but varies from 7.5% of premium in the District of Columbia[12] to 24.4% of premium in New Mexico
- Profit and risk loads exceeded 5% on average for issuers in Florida and Kentucky, and were negative on average for issuers in California, the District of Columbia, and New York
  - In California, one of the 13 carriers priced with -9.6% composite profit (all 12 other carriers pricing with positive profit), but this carrier enrolled over one-third of the entire individual market, driving the composite profit margin to be negative for California in aggregate
  - In the District of Columbia, two of the three carriers in the market priced with negative profit margin, with the third carrier pricing with 0% profit margin
  - In New York, three of the 15 carriers priced with negative profit margin

Note that carriers can elect to utilize negative profit margin to reflect strategy or other business decisions, but treatment and required support for such rating assumptions vary by state.

In the small group market:

- Average total retention on a nationwide basis is 14.9% of premium (11.2% admin, 1.8% taxes and fees including any applicable Exchange User Fee estimate on Worksheet 1, and 1.8% profit), but varies from 8.4% of premium in Hawaii[13] to 23.3% of premium in New Mexico
- Profit and risk loads exceeded 5% on average for issuers in Arizona, Florida, Indiana, Kentucky, Missouri, and Ohio, and were negative on average for issuers in California, Hawaii, Mississippi, New York, and Rhode Island
  - For the states with negative average margin, similar dynamics exist in the small group market as noted above for the individual market, with pricing assumptions for select issuers in a given market (as opposed to all issuers in the market) driving the averages below zero

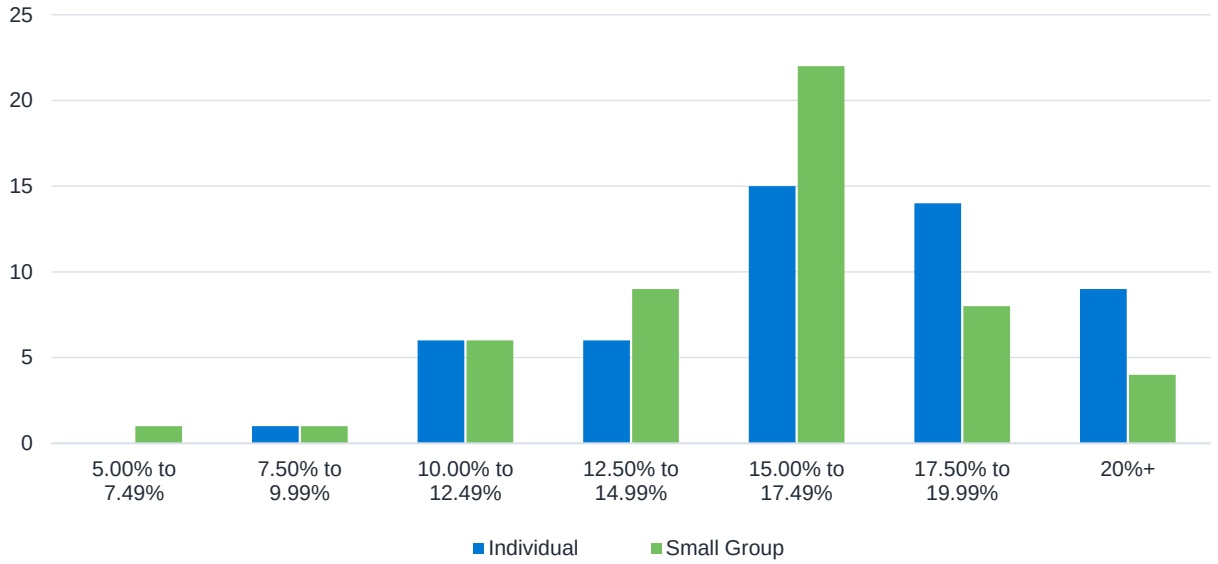
11 Carriers often price with a combination of fixed and variable expense items. All fixed and variable expense items by plan design are converted to a percentage of premium basis for URRT reporting.

12 The average retention load for carriers in the District of Columbia is a low outlier, and closer examination at the issuer level reveals variations from -0.4% to 10.4% of premium (all of which are lower than statewide average individual market retention loads across all other states); note that the issuer with a -0.4% total retention load enrolled approximately 21% of the market on a 2023 reported enrollment basis and filed with negative profit and risk of 12.3% of premium, which more than offset the sum of its assumed administrative expenses plus taxes and fees (11.9% of premium).

13 Similar to the District of Columbia in the individual market, the average retention load for small group carriers in Hawaii is a low outlier, and closer review at the issuer level reveals larger variations by issuer ranging from 3.0% to 22.3% of premium (with several carriers' average retention loads being in line with nationwide small group market averages); however, two issuers with combined 75% market share on a 2023 reported enrollment basis price with an average retention load of 6.0% of premium, which includes negative 2.4% average profit and risk (including one carrier pricing with -5.9% profit and the other pricing with 0.5% profit).

Figure 12 summarizes the count of states with average pricing retention loads within defined ranges, highlighting the wide variation in retention loads as a percentage of premium across states.

FIGURE 12: COUNT OF STATES BY 2024 TOTAL RETENTION LOAD, INCLUDING ADMIN, TAXES AND FEES, AND PROFIT (% OF PREMIUM)



Note that New Mexico is an outlier compared to other states (for both individual and small group), primarily driven by a required taxes and fees load exceeding 8% of premium, on average. This is higher than the taxes and fees load in all other states and materially higher than nationwide averages (3.9% of premium for individual, 1.8% of premium for small group).

Question 8: How do historical 2022 risk-adjusted loss ratios vary by market and metallic level?

The URRT includes a loss ratio calculation representing paid and incurred claims (net of state-specific reinsurance recoveries) divided by premium (net of risk adjustment), based on the carrier's plan-level experience reported on Worksheet 2. Based on this reporting and 2022 enrollment weights by plan and issuer, we can estimate loss ratios in total and by metallic tier on a nationwide basis for the individual and small group markets. Note that CMS published final 2022 risk adjustment transfer results in June 2023, but these results were unknown at the time of the rate filing deadlines for most carriers. As such, risk adjustment transfers reported in the 2024 URRT often do not align with the final (known) risk adjustment transfer results published by CMS. However, some carriers or states have access to reliable estimates of risk adjustment transfers by plan through statewide simulation studies (in which case risk transfers in the URRT do align closely with actual risk transfer results by plan or issuer).

Reporting accuracy of risk transfer results varies significantly by market and may have further limitations when viewed at the plan level. For example, some carriers choose to report risk adjustment transfers consistently across all plans (on a PMPM or percentage of premium basis), while others report actual or estimated risk transfers based on more granular plan-level modeling. In addition, risk-adjusted loss ratios on leaner plans may not be an indicator of true profitability, depending on operating margin for these plans. Given these limitations, loss ratio reporting at the plan level should be used with caution when correlating with profitability.

In the individual market:

- Carriers reported an average nationwide historical 2022 risk-adjusted loss ratio of 84.0%
- Carriers in Alaska, the District of Columbia, New York, and Vermont reported average loss ratios exceeding 95%, while carriers in Iowa, Louisiana, New Hampshire, and New Mexico reported average loss ratios below 73%
- By metallic tier, reported loss ratios were below 86% for catastrophic, bronze, and silver plans (including CSR variants) and above 93% for gold and platinum plans
- Platinum plans are reported to generate loss ratios of nearly 110%, which may highlight adverse selection in markets where such plans still exist (note that platinum represents less than 2% of the nationwide individual market and 0% in many states)
- Loss ratio relationships by metallic tier vary significantly by state, with gold having materially lower loss ratios than bronze and silver in some markets (e.g., Nevada)

In the small group market:

- Carriers reported an average historical nationwide 2022 risk-adjusted loss ratio of 84.7%
- Carriers in Kansas, Utah, and Vermont reported average loss ratios exceeding 93%, while carriers in Arizona, Delaware, and Missouri reported average loss ratios below 78%
- In contrast to the individual market, loss ratios were less variable by metallic tier, ranging from 78% for bronze plans to 91% for platinum plans on a nationwide basis
- Similar to the individual market, loss ratio relationships by metallic tier vary significantly by state, and platinum plans in the small group market generally appear less subject to adverse selection, given that loss ratios are more favorable than other metallic tiers in some markets (e.g., Iowa)

Figure 13 indicates the number of states with reported 2022 loss ratios falling within defined thresholds based on averages across all experience reported in 2024 rate filings.

FIGURE 13: COUNT OF STATES BY 2022 REPORTED LOSS RATIO

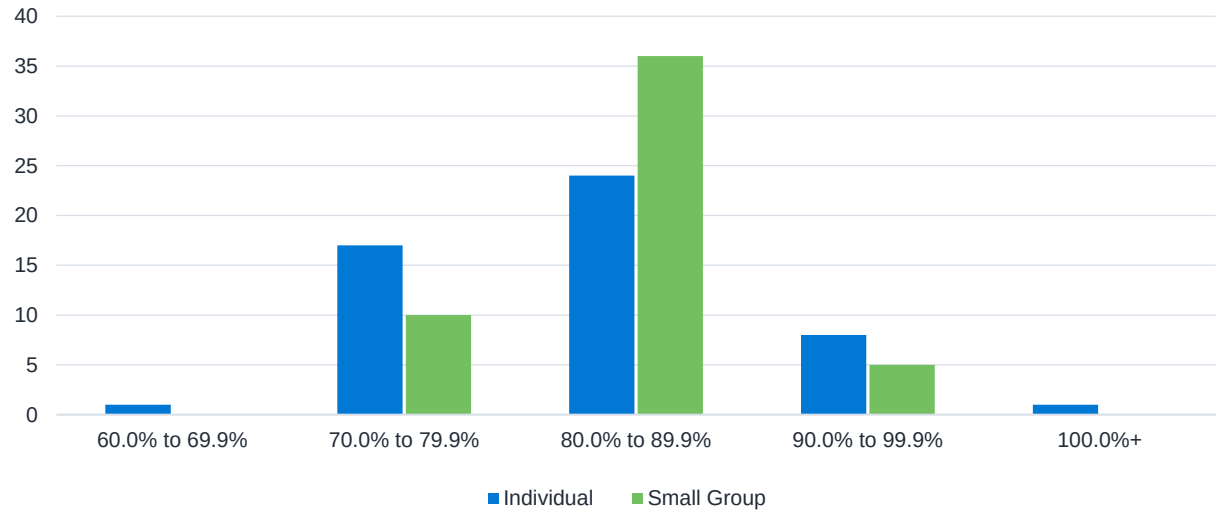
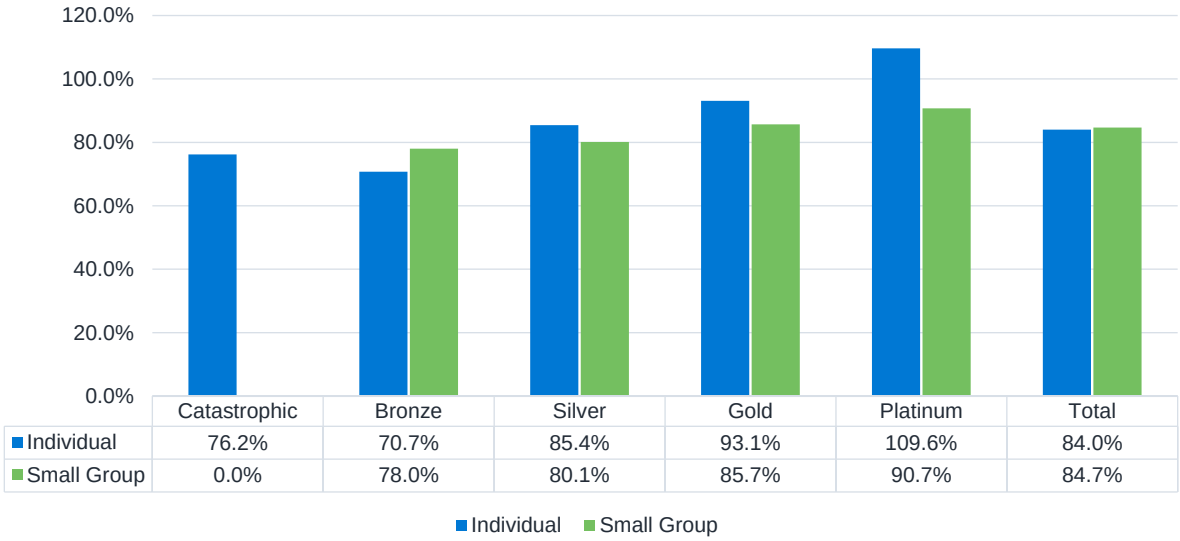


Figure 14 shows the metallic-level loss ratio results underlying the nationwide 2022 loss ratio estimates across all states and carriers.

FIGURE 14: 2022 LOSS RATIO BY METALLIC LEVEL



	Catastrophic	Bronze	Silver	Gold	Platinum	Total
Individual	76.2%	70.7%	85.4%	93.1%	109.6%	84.0%
Small Group	0.0%	78.0%	80.1%	85.7%	90.7%	84.7%

Further analysis is warranted to fully understand underlying drivers of plan performance by metallic tier, and whether insights are influenced by reporting bias or indicative of actual carrier experience. Future longitudinal studies examining multiple years of rate filing data will also offer insights into whether relationships by market and metallic tier have evolved over time.

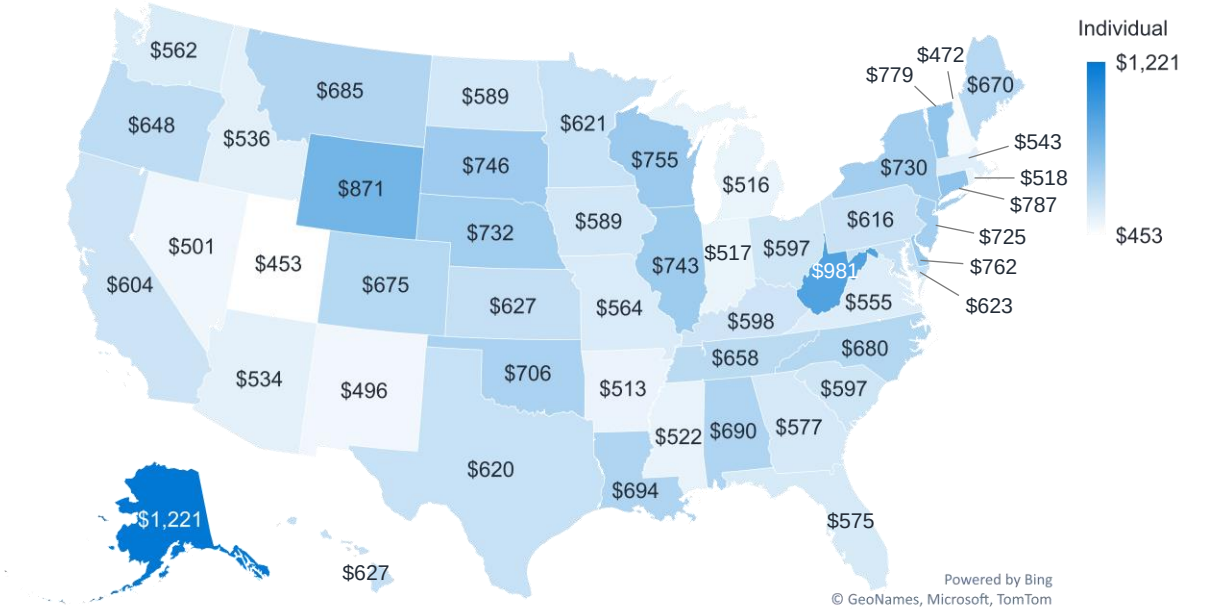
Question 9: How do allowed claim costs PMPM vary by market?

Carriers reported historical allowed claim costs per member per month (PMPM) by plan design on URRT Worksheet 2. Similar to other metrics, this reporting can be aggregated to the market and a nationwide basis to facilitate comparisons.

Reviewing historical allowed claims PMPM by market offers insights into the relative cost of coverage for consumers in a given market. Note that allowed claim differences capture the variation in provider reimbursement by region (prior to member cost sharing or state reinsurance programs) but will also reflect underlying differences in demographics and health status by state (among other factors). Adjusting the reported allowed claims by state to normalize for demographic and health status differences is outside the scope of this report, but the raw reporting can offer insights into overall differences in cost of coverage for ACA market consumers.

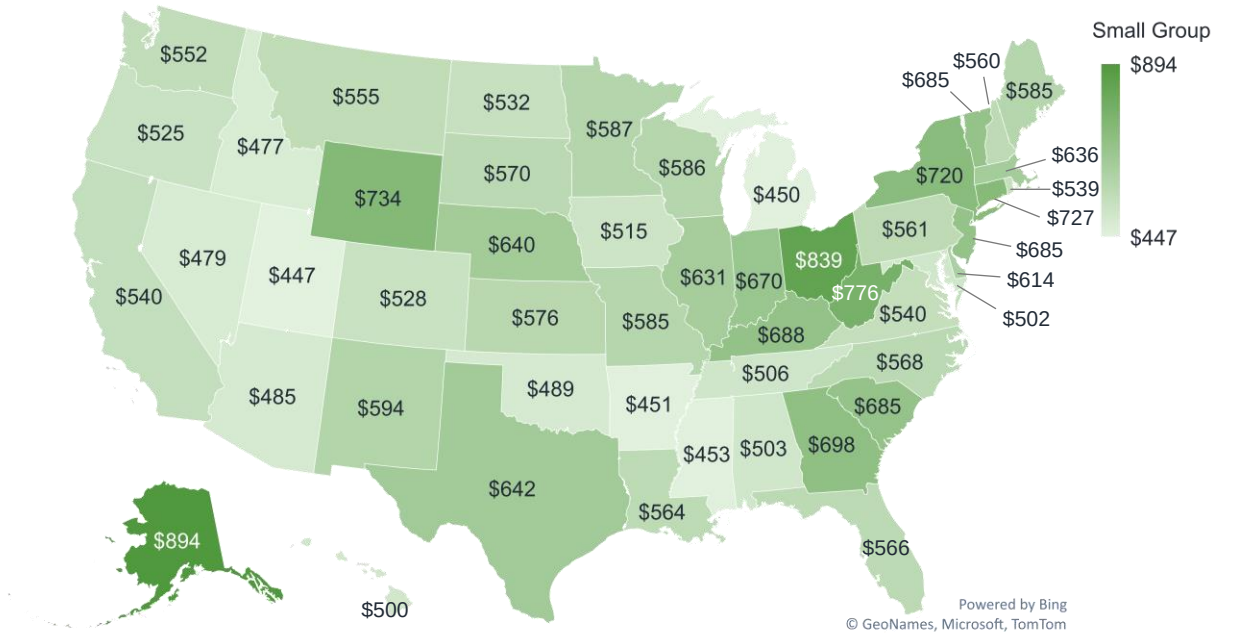
In the individual market, carriers in Alaska reported 2022 allowed claims PMPM that were more than twice the national average. Carriers in six additional states reported 2022 allowed claims PMPM that were more than 25% higher than the national average—West Virginia (61% higher), Wyoming (43% higher), Connecticut (29% higher), the District of Columbia (29% higher), Vermont (28% higher), and Delaware (25% higher). Conversely, carriers in four states reported 2022 allowed claims PMPM that were at least 17.5% below the national average—Utah (25.7% lower), New Hampshire (22.5% lower), New Mexico (18.6% lower), and Nevada (17.8% lower). These observations are illustrated in Figure 15.

FIGURE 15: HISTORICAL 2022 INDIVIDUAL ALLOWED CLAIMS PMPM REPORTED IN 2024 ACA RATE FILINGS



In the small group market, carriers in Alaska reported 2022 allowed claims PMPM that were more than 55% above the national average. Carriers in five additional states reported 2022 allowed claims PMPM that were more than 25% higher than the national average—Ohio (46% higher), West Virginia (35% higher), Wyoming (28% higher), Connecticut (27% higher), and New York (25% higher). Conversely, carriers in four states reported 2022 allowed claims PMPM that were at least 17.5% below the national average—Utah (22.2% lower), Michigan (21.7% lower), Arizona (21.5% lower), and Mississippi (21.2% lower). These observations are illustrated in Figure 16.

FIGURE 16: HISTORICAL 2022 SMALL GROUP ALLOWED CLAIMS PMPM REPORTED IN 2024 ACA RATE FILINGS



Several markets represent high-cost areas for both the individual and small group markets. For example, both individual and small group carriers in Alaska, Connecticut, West Virginia, and Wyoming reported claim costs exceeding 125% of the national average in each market. Conversely, both individual and small group carriers in Utah reported allowed claim costs at least 22% below the national average in each market.

On a 2022 reporting basis, allowed claims PMPM is 6.1% higher in the individual market compared to the small group, with the relationship varying significantly by state:

- For example, in the District of Columbia and Oklahoma, reported allowed claims PMPM for the individual market are more than 40% higher than allowed claims PMPM for the small group market
- In Indiana and Ohio, reported allowed claims PMPM for the individual market are more than 20% lower than allowed claims PMPM for the small group market
- In total, 40 states (including the District of Columbia) indicate higher allowed claims PMPM in the individual market compared to the small group, with 11 states reporting lower allowed claims PMPM for the individual market compared to the small group market

In addition to benefit differences, individual versus small group allowed charges are influenced significantly by underlying differences in population size, average health status, demographic mix, plan mix, geographic mix, provider contracting differences, and other factors.

Question 10: To what degree are carriers including benefits in addition to EHB adjustments on URRT Worksheet 2?

On URRT Worksheet 2, carriers can adjust the market-adjusted index rate (which reflects allowed EHB claims only) for non-EHB benefits and services covered in their products (i.e., benefits in addition to EHB). This factor represents an increase to EHB claims and may be derived and applied at the plan level. Consistent with the metrics previously discussed, adjustments for benefits in addition to EHB can be aggregated to the state and nationwide levels to facilitate comparisons.

Reviewing the variation in adjustments for benefits in addition to EHB offers insights into the impact of additional coverage carriers offer (on average) beyond EHB requirements. Certain benefits, including routine non-pediatric dental services, routine non-pediatric eye exam services, and non-medically necessary orthodontia should not be considered EHB, even if the state EHB benchmark plan covers such benefits. Given that EHB benchmark plans can vary by state,[14] we observe variability in the adjustment factors by state for benefits in addition to EHB. Adjustments for non-EHBs can also vary greatly by issuer within a given state and by plan in a given carrier's portfolio. For instance, some carriers offer products covering EHBs only, as well as those with benefits in addition to EHB (at varying levels).

In the individual market, carriers in Hawaii reported the highest adjustment for benefits in addition to EHB (1.3% average increase to average EHB allowed claims, i.e., impact of non-EHBs):

- Carriers in five additional states reported adjustments for benefits in addition to EHB of between 1.006 and 1.009—Delaware (0.9% impact of non-EHBs), Maryland (0.8% impact), Mississippi (0.7% impact), Alaska (0.6% impact), and West Virginia (0.6% impact)
- Conversely, carriers in six states reported no adjustments (i.e., 1.000 factors) for benefits in addition to EHB coverage based on 2024 rate filings—this includes carriers in Colorado, Iowa, Montana, North Dakota, South Dakota, and Wyoming

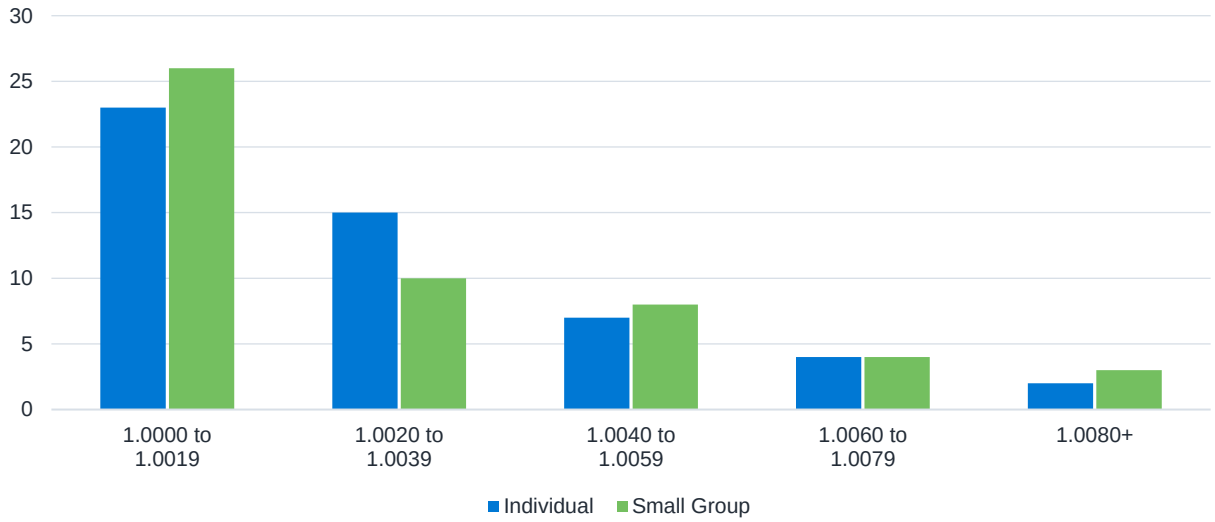
14 CMS. Information on Essential Health Benefits (EHB) Benchmark Plans. Retrieved May 15, 2024, from https://www.cms.gov/marketplace/resources/data/essential-health-benefits.

In the small group market, carriers in Hawaii reported the highest adjustment for benefits in addition to EHB (1.8% average impact of non-EHBs):

- Carriers in six additional states reported adjustments for benefits in addition to EHB of between 1.006 and 1.011—Maine (1.1% impact), New Hampshire (1.0% impact), Colorado (0.8% impact), Kansas (0.8% impact), Utah (0.7% impact), and Kentucky (0.7% impact)
- Conversely, carriers in four states reported very minimal adjustment (less than 0.01% impact) for benefits in addition to EHB—this includes carriers in Louisiana, South Dakota, Vermont, and West Virginia

Figure 17 indicates the number of states with average adjustments for benefits in addition to EHB factors falling within defined thresholds based on averages across all 2024 issuers in a given state.

FIGURE 17: COUNT OF STATES BY AVERAGE ADJUSTMENT FOR BENEFITS IN ADDITION TO EHB



Further analysis is warranted to understand differences in EHB benchmark plans, which can contribute to observed differences by state (in addition to carrier-level pricing assumptions within a given state).

Conclusion

As ACA markets have matured, each state has evolved and been shaped by state-specific laws and regulations (to varying degrees). Prior to comparing ACA carrier data across states, it is important to consider the context of each market and key items that can drastically alter a state's individual and small group ACA markets, including:

- The presence of a Section 1332 Waiver
- The presence of a Basic Health Plan, public option, or similar program
- The state's Medicaid expansion status
- Whether the individual ACA and small group ACA markets are merged
- Laws and regulations pertaining to grandfathered and transitional products, level-funded products, association health plans, and short-term medical plans

These policies can have a profound impact on the market size, market composition, and average health status underlying the ACA market, and are thus important variables to consider when comparing between states.

As highlighted, Unified Rate Review data released by CMS represents a significant resource for ACA market insights. From market-wide rate increases to metallic tier mix to retention loads used in rate development, insights are both widespread and accessible at varying levels of granularity (e.g., national vs. state vs. issuer). While there are opportunities for additional transparency, the existing framework offers a wealth of information and promotes transparency and competition in ACA product pricing.

Milliman offers robust tools and solutions to assist carriers in leveraging the latest ACA competitive intelligence and fully integrating these insights into pricing and product strategies. Experienced ACA carriers and new market entrants alike are increasingly leveraging these resources to inform strategy and enhance decision-making frameworks. To learn more about these tools, please contact your Milliman consultant.

Appendix: How is ACA enrollment divided by carrier within a given sample of ACA markets?

Given the unique attributes of each state's individual and small group insurance markets, as well as varying levels of issuer participation, competition among issuers and the resulting market share dynamics vary widely by state. The enrollment reporting on URRT Worksheet 2 facilitates market share analysis on the basis of historical enrollment (2022), current enrollment (2023), and projected enrollment (2024). A closer examination of enrollment by issuer within the two largest individual and small group markets yields the following insights:

- In the Florida individual market, 14 carriers filed rates for 2024:
  - There are four carriers with at least 10% market share on a 2023 current enrollment reporting basis—"HealhOptions, Inc." (28.2%), "Oscar Insurance Company of Florida" (18.1%), "Blue Cross Blue Shield of Florida" (BCBS, 14.3%), and "Celtic Insurance Company" (11.7%).
  - Aetna has 9.1% market share on a 2023 enrollment basis in Florida, but projections in pricing imply 11.2% market share on a 2024 basis. The remaining individual market enrollment in Florda (less than 20% of the total market) is split across the other nine carriers participating in the market for 2024.
  - Further examination by metallic tier reveals variation in market share by metallic tier among issuers. For example, "Health Options, Inc." enrolls over 35% of the market's current enrollment on bronze plans (compared to 28% across all metallic levels), while "Oscar Insurance Company of Florida" enrolls nearly 22% of the market's enrollment on silver plans (compared to 18% across all metallic levels). "Blue Cross Blue Shield of Florida" enrolls less than 15% of the market across all metallic levels, but nearly 25% of the state's membership on gold plans and 85% of the state's membership on platinum plans (note that BCBS is one of four carriers in Florida offering platinum plans).
- In the Texas individual market, 17 carriers filed rates for 2024:
  - There are four carriers with at least 10% market share on a 2023 current enrollment reporting basis—"Blue Cross and Blue Shield of Texas" (27.2%), "Celtic Insurance Company" (13.3%), "Superior Health Plan" (12.2%), and "Aetna Health, Inc." (a Texas corporation, 11.7%).
  - The remaining individual market enrollment in Texas (approximately 36% of the total market) is split across the other 13 carriers participating in the market for 2024.

- In the California small group market, 17 carriers filed rates for 2024:
  - "Kaiser Foundation Health Plan, Inc." enrolls approximately one-third of the total market based on 2023 current enrollment reporting, with "Anthem Blue Cross" and "Blue Shield of California" each enrolling an additional quarter of the market.
  - The remaining small group enrollment in California (less than 20% of the total market) is split across the other 14 carriers participating in the market for 2024.
- In the New York small group market, 16 carriers filed rates for 2024:
  - "Oxford Health Insurance, Inc." enrolls close to half of the total market based on 2023 current enrollment reporting.
  - "Excellus Health Plan, Inc." enrolls just under 20% of the New York small group market, with four additional carriers enrolling at least 4% of the total market—"Independent Health Benefits Corporation" (6.0%), "Highmark BlueCross BlueShield of Western New York" (4.7%), "Empire HealthChoice Assurance, Inc." (4.3%), and "MVP Health Services Corp" (4.2%).
  - The remaining small group enrollment in New York (less than 14% of the total market) is split across the other 10 carriers participating in the market for 2024.

Note that many carriers choose to offer plans to select regions or counties in a given ACA market. Carriers can vary rates by region based on prescribed ACA rating areas. In most states, each issuer can have varying service areas and varying premium rate relationships by rating area (with distinct provider networks). As a result, market share dynamics can and do vary greatly by region within a given state. For individual markets utilizing Healthcare.gov (32 states in total for 2024), additional PUF datasets released by CMS can be leveraged to understand the regional distribution of marketplace enrollment (overall for the state and by issuer).[15]

15 CMS. Issuer-Level Enrollment Data. Retrieved May 15, 2024, from https://www.cms.gov/marketplace/resources/data/issuer-level-enrollment-data.

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CONTACT

Matt Mraz
matt.mraz@milliman.com

Sarah Marion
sarah.marion@milliman.com