MILLIMAN RESEARCH REPORT

Commercial health insurance: Overview of 2016 financial results and emerging enrollment and premium data

May 2018

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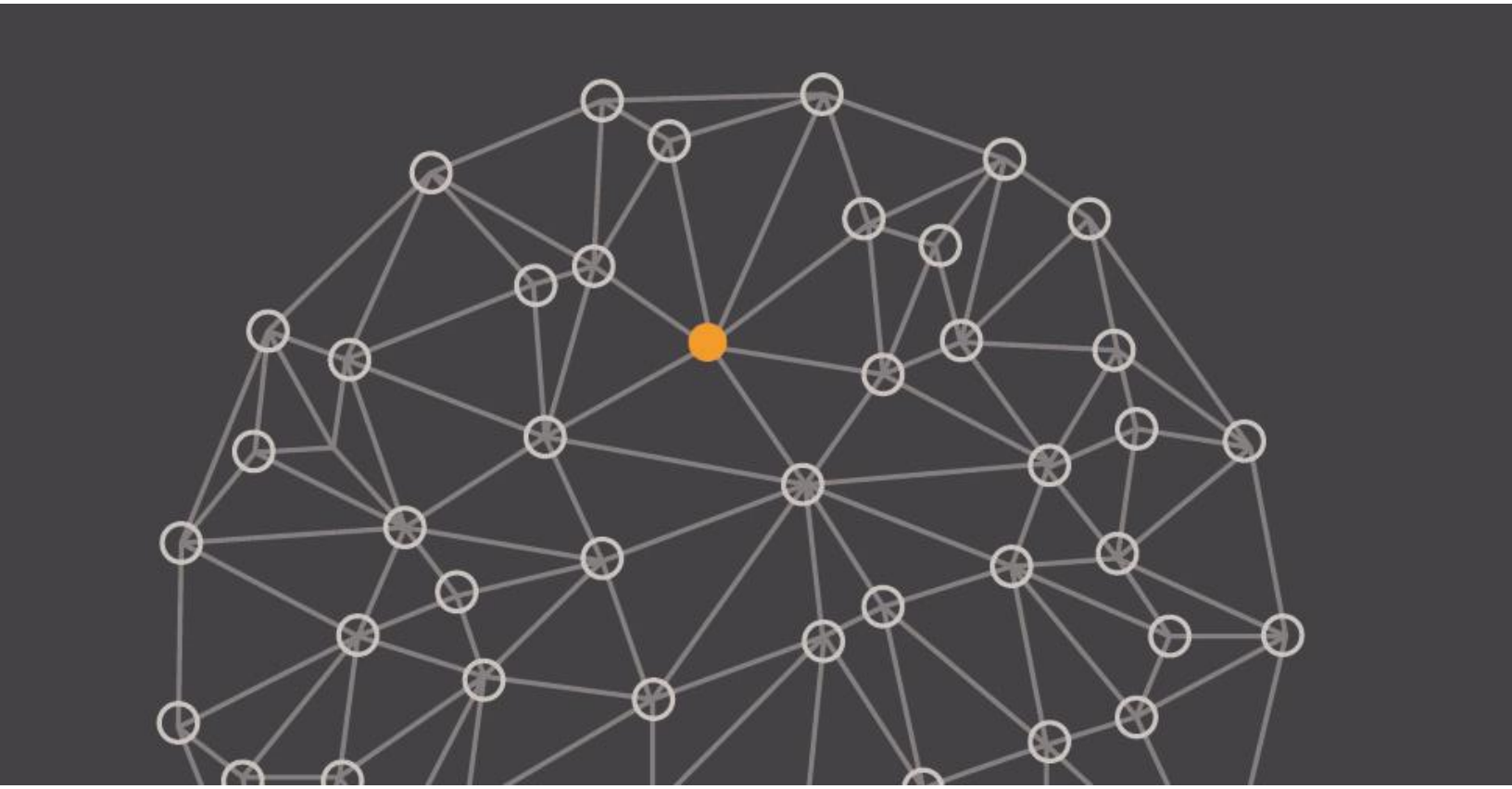

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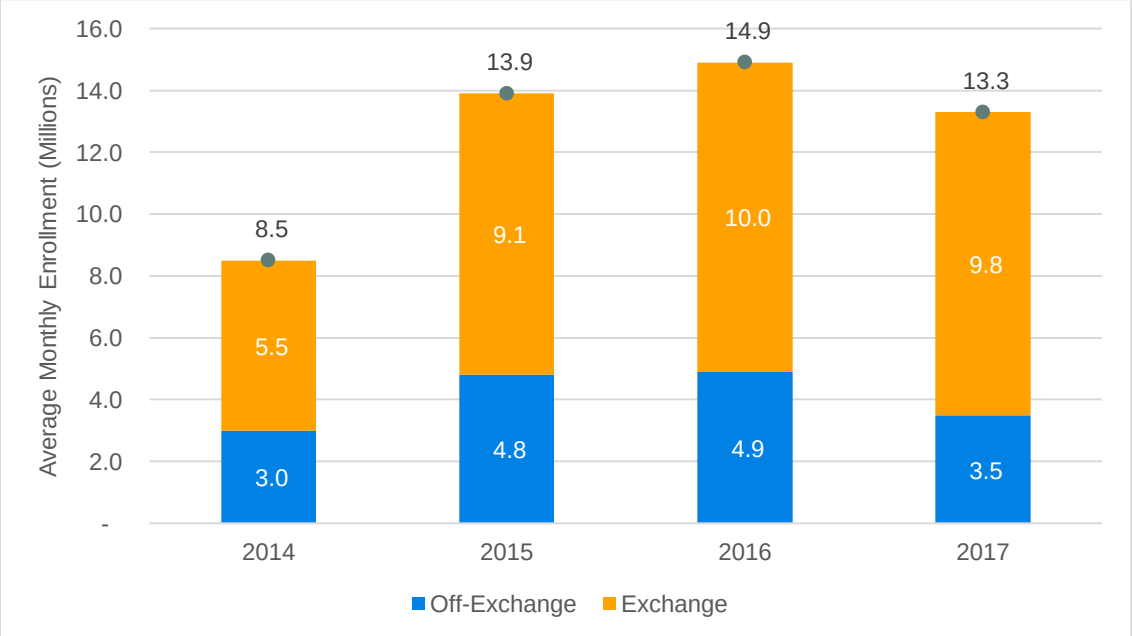
Executive Summary

Medical loss ratio (MLR) data published by the Centers for Medicare and Medicaid Services (CMS) provides a detailed picture of insurer financial results from the third full year of Patient Protection and Affordable Care Act (ACA) implementation. This data, supplemented with CMS exchange and statutory financial data through 2017, provides us insight into various components of the ACA, particularly federal premium subsidies, federal cost-sharing subsidies, and the "3R"[1] programs. The 2016 report highlights include:

Individual market enrollment declines coincide with state-based initiatives to improve affordability for nonsubsidized consumers.

- A significant focus of state policy makers in the last year has been attempting to improve the affordability of individual market coverage for consumers who are not eligible for Advanced Premium Tax Credits (APTCs).
- As of April 2018, three states have received approval from CMS for a Section 1332 State Innovation Waiver for implementing a state-based reinsurance program to improve premium affordability for consumers not qualifying for APTCs, while efforts to get similar programs approved are underway in many states.[2]
- The need for these state initiatives is supported by national enrollment trends observed in Figure 1. While individual exchange enrollment is estimated to have remained relatively stable between 2016 and 2017 (decrease of approximately 2%), we estimate material enrollment declines have occurred within off-exchange coverage (decrease of nearly 30%).[3]
- It is possible that a portion of previous off-exchange enrollees began purchasing coverage through the exchanges in order to access increasingly valuable APTCs.
- An improving economy and low unemployment rates may also have contributed to enrollment declines in both the subsidized and unsubsidized segments, as more individuals gain access to employer-sponsored insurance.

FIGURE 1: INDIVIDUAL MARKET ACA-COMPLIANT AVERAGE MONTHLY ENROLLMENT



[1] Risk adjustment, risk corridors, and transitional reinsurance.

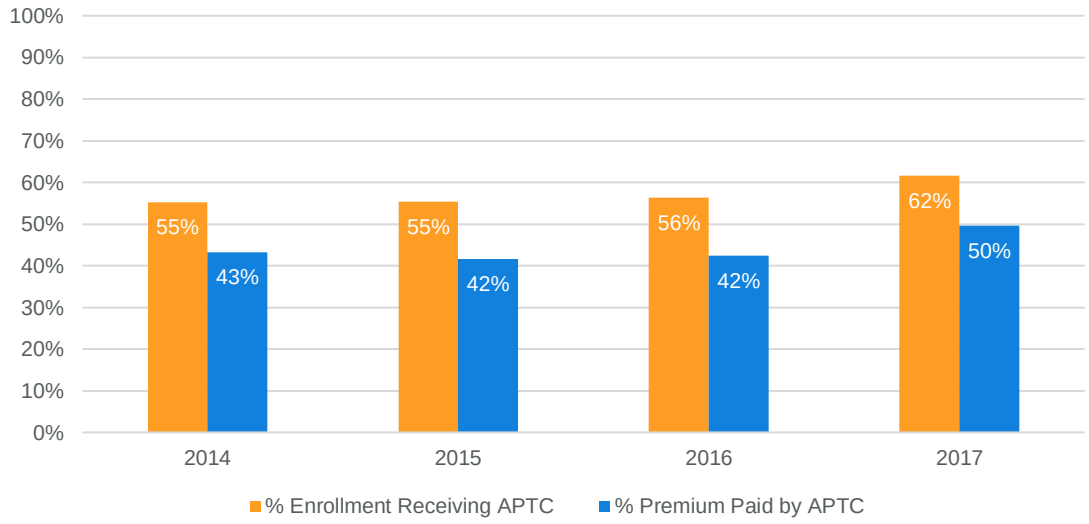
[2] See http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx for a summary of current state activity related to Section 1332 waivers.

[3] Further discussion of enrollment projection methodology is provided in the main body of the report.

Federal premium assistance, through APTCs, covered an increasing share of total ACA-compliant premium and enrollment in the individual market.

- In 2017, we estimate the share of individual market ACA-compliant premium covered by APTCs reached 50% for the first time, reflecting approximately 62% of ACA-compliant enrollment as off-exchange ACA-compliant enrollment has decreased significantly.
- As the percentage of ACA-compliant premiums covered by APTCs increases, the amount of potential pass-through funding available for a state through a state-based reinsurance program or other Section 1332 innovation waiver will also likely increase (as initiatives to reduce premium rates as part of a 1332 waiver result in federal APTC savings, which are passed on to the state).[4]
- With further reductions in off-exchange enrollment estimated for 2018, we anticipate the importance of APTCs in the individual market will continue to grow.

FIGURE 2: APTC ENROLLMENT AND EXPENDITURES AS A SHARE OF TOTAL INDIVIDUAL ACA-COMPLIANT ENROLLMENT AND PREMIUM



Cost-sharing reduction (CSR) subsidy payment termination is estimated to produce an approximate loss of $1.4 billion for insurers in 2017, or 1.9% of ACA-compliant premiums.

- CSR subsidies received increased attention in 2017 due to federal payments being terminated effective October 2017.
- CSR subsidy payments represented between 8% and 9% of ACA-compliant earned premium from 2014 through 2016.
- The impact of CSR subsidy termination will vary significantly by insurer and state due to factors such as state Medicaid expansion and insurer market share by enrollee household income levels.
- Silver exchange premiums in calendar year 2018 increased by a significant magnitude based on many insurers reflecting the loss of CSR subsidy funding across these plans only when developing premium rates.

[4] Please see http://us.milliman.com/insight/2017/Reinsurance-and-high-risk-pools-Past--present--and-future-role-in-the-individual-health-insurance-market/?lng=1048578 for more discussion around reinsurance programs.

Underwriting margins in the small and large group markets are relatively stable; however, individual market underwriting losses remain high in 2016.

- The individual market composite underwriting loss exceeded 6% in 2016, which represents an improvement from the nearly 10% loss in 2015.
- A portion of the improvement in underwriting results was the result of the release of premium deficiency reserves (PDR) by insurers. We estimate that underwriting losses in 2016 would have been approximately 1.1% higher had insurers not released PDRs recognized in prior years.
- The ACA risk corridor program's shortfall continued to have a significant impact on 2016 individual market financials, as underwriting losses would only be approximately 1.5% of earned premium had the full risk corridor amounts been received by insurers.
- The cumulative risk corridor shortfall across the individual and small group markets reached $12.3 billion in 2016.

Outlook for 2017 financials and beyond

Under the ACA, the group insurance markets have proven to be relatively stable, while the individual market has been a source of volatility in many respects (enrollment, premium rates, insurer participation, insurer financials, and regulatory changes). Individual exchange premiums increased significantly in 2017, with premium rates for subsidy benchmark plans increasing by more than 20% on average.[5] Additionally, the average number of insurers offering coverage in each state's exchange decreased from 5.8 in 2016 to 4.3 in 2017.[6] Despite material enrollment decreases outside the exchanges, emerging financial data for 2017 suggests that insurers participating in the individual market had materially improved underwriting margins relative to 2016, with industry underwriting margin improvements of more than 5% possible on an industry-wide basis. This is despite the termination of CSR subsidy payments by the federal government in October 2017.

For 2018 and beyond, insurers offering coverage in the individual market continue to face regulatory instability. However, this is not a new feature of the individual market. In particular, provisions for transitional policies and risk corridor budget neutrality introduced significant changes to market dynamics from the ACA's original framework. For the 2018 coverage year, many insurers had to adjust premium rates to reflect the termination of direct federal CSR subsidy payments, and there is still discussion at both the federal and state level as to whether these costs should be paid by the government and, barring payment, the best way for these costs to be reflected in premiums.

Legislative and regulatory changes for coverage year 2019 are also significant. Coverage year 2019 will reflect the first year without the ACA's individual mandate in place, creating additional uncertainty for insurers. Additionally, short-term limited duration insurance policies may become more prevalent to the extent their maximum duration is extended from less than three months to less than 12 months.[7] While such policy changes may only enhance the perceived affordability concerns for nonsubsidized consumers, the overall market impact may be mitigated to some degree by the ACA premium subsidy structure, which will eliminate the potential for premium rate increases for the subsidized population.[8] Finally, association health plan coverage, while focused at the individual market, may remove self-employed individuals from the ACA's single risk pool.

[5] ASPE Research Brief (October 24, 2016). Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace, Table 2. Retrieved May 10, 2018, from https://aspe.hhs.gov/system/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf.

[6] Kaiser Family Foundation (November 10, 2017). Insurer Participation on ACA Marketplaces, 2014-2018. Retrieved May 10, 2018, from https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-Marketplaces/.

[7] Karcher, J. & Ortner, N. (April 10, 2018). The Terms, They May Be A-Changin': A Primer on Proposed Changes to Short-Term Medical Plans. Milliman White Paper. Retrieved May 10, 2018, from http://us.milliman.com/insight/2018/The-terms--they-may-be-a-changin-A-primer-on-proposed-changes-to-short-term-medical-plans/.

[8] Please read http://www.milliman.com/insight/2018/The-individual-mandate-repeal-Will-it-matter/ for further discussion.

Introduction

This report provides a detailed review of the commercial health insurance industry's financial results in 2016 and evaluates changes in the market's expense structure and enrollment relative to prior years. We have also provided enrollment and APTC estimates for 2017. The analytics in this report were developed based on a combination of medical loss ratio data submitted to CMS, insurance exchange enrollment reports, and emerging statutory financial information. The following topics are discussed in this report:

- Summary of 2016 insurer financial results based on summarized medical loss ratio data
- Commercial health insurance enrollment changes from 2011 through 2016
- Distribution of underwriting margins for the individual, small group, and large group markets
- Breakdown of individual market enrollment changes from 2014 through 2017 by key market segments
- Estimated federal premium and cost-sharing assistance expenditures from 2014 through 2017
- High-level impacts from the ACA's risk corridor and transitional reinsurance programs
- Emerging 2017 financial results and future market outlook

2016 markets and financial results overview

Figure 3 illustrates the aggregate insured lives and composite reported premium and expenses in the individual, small group, and large group health insurance markets on a per member per month (PMPM) basis and as a percentage of premium in 2016. Figure 4 provides the same measures but reflects the changes in enrollment and financial metrics from 2015 to 2016. The appendix of this report provides additional detail on insurer financial results from 2010 through 2016. Please see Appendix 1 for further description of each measure.

FIGURE 3: AGGREGATE REPORTED 2016 COMPREHENSIVE EXPERIENCE

MEASURE	INDIVIDUAL	SMALL GROUP	LARGE GROUP
COVERED LIVES	17,200,000	14,200,000	42,100,000
EARNED PREMIUM PMPM	$371.20	$433.52	$427.14
CLAIMS EXPENSES PMPM	$335.29	$347.95	$366.24
FEES AND TAXES PMPM	$13.01	$24.09	$18.76
MLR REBATES PMPM	$0.49	$0.90	$0.37
TOTAL ADMINISTRATIVE EXPENSES PMPM	$48.73	$53.77	$34.17
UNDERWRITING GAIN (LOSS) PMPM	($22.53)	$6.67	$6.34
PRELIMINARY MEDICAL LOSS RATIO[4]	94.6%	85.8%	90.4%
REBATE EXPENSE RATIO	0.1%	0.2%	0.1%
UNDERWRITING MARGIN	(6.1%)	1.5%	1.5%
ADMINISTRATIVE EXPENSE RATIO	13.1%	12.4%	8.0%

Notes:

1. Values have been rounded.
2. Dollar values are illustrated on a PMPM basis.
3. Covered lives equals reported member months divided by 12.
4. Preliminary medical loss ratio is based on statutory guidelines in the Supplemental Health Care Exhibit. The sum of the preliminary medical loss ratio, underwriting margin, and administrative expense ratio will not equal 1.
5. The 2015 and 2016 financial results reflect applicable insurers receiving 0% of risk corridor receivables in the individual and small group markets, which is reflected in claims expenses.
6. The 2015 and 2016 individual market values reflect Arkansas's private option Medicaid expansion population (approximately 200,000 individuals as of December 2015[9] and 250,000 individuals in calendar year 2016[10]), as well as New Hampshire's private option Medicaid expansion population for calendar year 2016 (50,000).[11]
7. As discussed in this report, a portion of the improvement in the individual market underwriting results was the result of the release of premium deficiency reserves by insurers.

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

[10] Arkansas Department of Human Services (October-December 2016). Arkansas Private Option 1115 Demonstration Waiver: Quarterly Report, October 1, 2016 – December 31, 2016. Retrieved March 28, 2018, from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/Health-Care-Independence-Program-Private-Option/ar-works-qtrly-rpt-oct-dec-2016.pdf. Note, prior quarterly reports also reviewed.

[11] New Hampshire Department of Health and Human Services (August 2, 2016). NH Health Protection Program Demographic Profile. Retrieved May 10, 2018, from https://www.dhhs.nh.gov/ombp/pap/documents/nhhpp-enroll-demo-080116.pdf.

FIGURE 4: AGGREGATE CHANGES 2015 TO 2016 COMPREHENSIVE EXPERIENCE

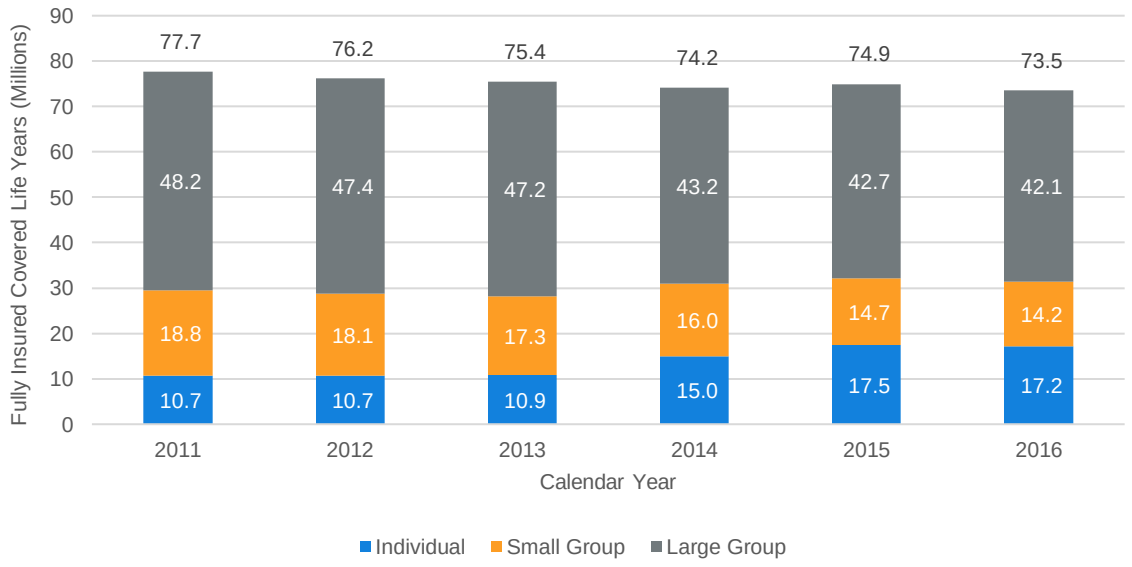
MEASURE	INDIVIDUAL	SMALL GROUP	LARGE GROUP
COVERED LIVES	(300,000)	(500,000)	(600,000)
EARNED PREMIUM PMPM	$33.56	$22.57	$16.47
CLAIMS EXPENSES PMPM	$29.87	$20.04	$16.94
FEES AND TAXES PMPM	($0.85)	($0.71)	($1.60)
MLR REBATES PMPM	($0.01)	$0.03	$0.11
TOTAL ADMINISTRATIVE EXPENSES PMPM	$0.54	$1.83	$1.37
UNDERWRITING GAIN (LOSS) PMPM	$10.01	$2.03	($0.27)
PRELIMINARY MEDICAL LOSS RATIO[4]	(0.7%)	0.0%	0.1%
REBATE EXPENSE RATIO	(0.0%)	(0.0%)	0.0%
UNDERWRITING MARGIN	3.6%	0.4%	(0.1%)
ADMINISTRATIVE EXPENSE RATIO	(1.1%)	(0.2%)	0.0%

Notes: See Figure 3

COVERED LIVES

In 2016, 73.5 million individuals were insured across the three insurance markets, which reflects a decrease of approximately 1.4 million insured lives relative to 2015. While the small group and large group fully insured markets continue a downward trend in covered lives in 2016, the individual health insurance market covered lives declined for the first time since 2012 by approximately 300,000 (coinciding with enrollment decline observed in the insurance exchanges). The decrease was influenced by New York's decision to implement the Basic Health Plan (BHP) option in 2016, which resulted in individual market enrollment in the state decreasing by approximately 150,000. This decrease was partially offset by New Hampshire's decision to implement a private option Medicaid expansion, which contributed to individual market enrollment increasing within the state by 40,000 from 2015 to 2016.

FIGURE 5: NATIONAL COMPREHENSIVE HEALTH INSURANCE ENROLLMENT, 2011 TO 2016



Notes:

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

As discussed in last year's report, the Medical Expenditure Panel Survey (MEPS) published by the Agency for Healthcare Research and Quality (AHRQ) indicated a material drop in the number of private sector establishments with fewer than 50 employees that were offering health insurance from 2013 to 2016. On a national level, the percentage decreased from 34.8% in 2013 to 28.6% in 2016.[12] This percentage decline closely resembles the overall decrease in insured lives in the small group market from 2013 to 2016. It is possible that a portion of the decline in the small group market enrollment during this time period was a result of employers moving from fully insured to self-funded coverage. The MEPS data indicates an increase in the rate of self-funded plans among establishments with fewer than 50 employees offering health insurance from 14.0% in 2015 to 17.4% in 2016.[13] Fully insured groups of all sizes may have had additional incentives to self-fund their employer-sponsored insurance coverage in 2014 through 2016, as doing so could reduce expenses related to the ACA's Health Insurer Fee (HIF). Note that separate legislation has applied a moratorium to the HIF for the 2017 and 2019 fee years.[14]

EARNED PREMIUM, CLAIMS EXPENSE, FEES, AND TAXES

Earned premiums and claims expenses increased in each of the three markets from 2015 to 2016, with the individual market experiencing the largest changes. Individual market premiums on a PMPM basis increased by almost 10% in 2016, which marks the first year where actual ACA-compliant experience data could be used to determine premium rates.[15] A portion of this premium increase is attributable to market enrollment continuing to shift further to ACA-compliant coverage (versus coverage written under pre-ACA underwriting rules, such as grandfathered or transitional coverage) that had additional benefits and a higher actuarial value relative to prior coverage. As discussed later in this report, we estimate non-ACA-compliant coverage only represents 13% of non-group enrollment in 2016, relative to 21% in 2015.

Claims expenses in the individual market also increased by almost 10% from 2015 to 2016 on a PMPM basis. Consistent with the increase in earned premium, a material portion of the growth in claims expenses may be a result of insured members shifting to ACA-compliant coverage. As discussed later in this report, both premiums and insurer paid claims expenses were leveraged by the reduction in the transitional reinsurance program's claims reimbursement from $7.9 billion in 2015 to $4.0 billion in 2016.

Fees and taxes levied on insurers decreased from 2015 to 2016 across each of the three markets. This is partially attributable to the reduction in the transitional reinsurance fee from $44 to $27 per covered life.

PRELIMINARY MLR AND MLR REBATES

Within the individual market from 2015 to 2016, the preliminary medical loss ratio (MLR) decreased slightly from 95.3% to 94.6%. This slight decrease was attributable to claims expense growth being slightly less than the growth in earned premiums, as well as the reduction in taxes and fees. This composite MLR is approximately 14 percentage points higher than the composite individual market MLR in 2010. From 2010 to 2016, the average national premium increased from $214 to $371 and administrative expenses increased from approximately $41 to $49, while claims cost increased from $166 to $335 on a PMPM basis. To the extent the insurance industry operated on a breakeven basis in 2016, we estimate the market composite medical loss ratio for the individual market would be approximately 89%.

Within the small group and large group markets, small increases occurred in the preliminary MLR from 2014 to 2016. Between 2010 and 2016, the large group market has seen its composite preliminary MLR increase from 89.3% to 90.4%, while the small group market composite preliminary MLR has increased from 83.7% to 85.8%. Consistent with 2014 and 2015, 2016 MLR rebates remained below 0.5% of earned premium in each of the three markets. The large group market experienced the largest change in MLR rebates on a PMPM basis, with the composite market rebate amount increasing from $0.26 to $0.37 PMPM from 2015 to 2016.

[12] Agency for Healthcare Research and Quality. Percent of private-sector establishments that offer health insurance by firm size and selected characteristics (Table I.A.2), year 1996-2016. Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. (March 22, 2018).

[13] Agency for Healthcare Research and Quality. Percent of private-sector establishments that offer health insurance that self-insure at least one plan by firm size and selected characteristics (Table I.A.2.a), year 1996-2016: Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. (March 22, 2018).

[14] IRS. Affordable Care Act Provision 9010 - Health Insurance Providers Fee. Retrieved May 10, 2018, from https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010.

[15] However, final 2014 risk adjustment results were not available at the time of filing deadlines.

ADMINISTRATIVE EXPENSES

On a PMPM basis, administrative expenses in the individual market increased slightly from 2015 to 2016. However, 2016 administrative expenses represent a decrease of approximately 1.1% as a percentage of premium (13.1% in 2016 relative to 14.3% in 2015). The small group market reported a 3.5% increase in administrative expenses on a PMPM basis relative to 2015, whereas the large group market reported a 4.2% PMPM increase relative to 2015. In both the small and large group markets, administrative expenses as a percentage of premium have been stable for several years. This indicates that administrative expenses have been growing at the same rate as market premiums.

UNDERWRITING RESULTS

The individual market composite underwriting loss was approximately 6% in 2016, an improvement from the nearly 10% loss in 2015. A portion of the improvement in underwriting results was the result of the release of PDRs by insurers. Note that PDR amounts are excluded from the preliminary MLR calculation; the PDR release is a separate underwriting improvement not included in line items illustrated in Figure 4 above. Insurers are instructed by the National Association of Insurance Commissioners (NAIC) to establish a PDR "when future premiums and current reserves are not enough to cover future claim payments and expenses for the remainder of a contract period."[16] In other words, if an insurer believes an established premium rate is not sufficient to cover future expenses, the financial loss should be recognized in its current financial reporting. Reporting for 2016 indicates insurers released PDR amounts previously established, which improved aggregate underwriting results by slightly more than 1%. Figure 6 summarizes the reported PDR amounts for individual market insurers from 2014 through 2016. After adjusting for the PDR amounts reported in 2015 and 2016, the incremental underwriting improvement from 2015 to 2016 was less than 2%

FIGURE 6: INDIVIDUAL MARKET PREMIUM DEFICIENCY RESERVE ADJUSTMENTS: 2014 THROUGH 2016

YEAR	2014	2015	2016
EARNED PREMIUM ($ MILLIONS)	$54,695.2	$70,901.1	$76,631.0
PDR ADJUSTMENT ($ MILLIONS)	$309.7	$368.5	($837.8)
% OF EARNED PREMIUM	0.6%	0.5%	-1.1%
UNADJUSTED UNDERWRITING MARGIN	-5.9%	-9.6%	-6.1%
UNDERWRITING MARGIN WITHOUT PDR	-5.4%	-9.1%	-7.2%

Notes:

1. Values have been rounded.
2. For this analysis, we are considering all amounts reported in "Part 1, Line 2.6 of the MLR form, Other adjustments due to MLR calculations – claims incurred" as PDR amounts. Insurers are instructed by CMS to report PDR amounts in this line item.[17] To an unknown degree, expenses other than those related to PDR amounts may be reported by insurers in this line item.

The risk corridor shortfall continued to have a significant impact on 2016 individual market financials, as underwriting losses would only be approximately 1.5% of earned premium had the full risk corridor amounts been received by insurers. The risk corridor shortfall is discussed in more detail later in this report.

In the group markets, relative stability continued in 2016. Industry-wide underwriting results did not vary significantly from financial results reported in 2014 and 2015, with both markets experiencing small underwriting gains.

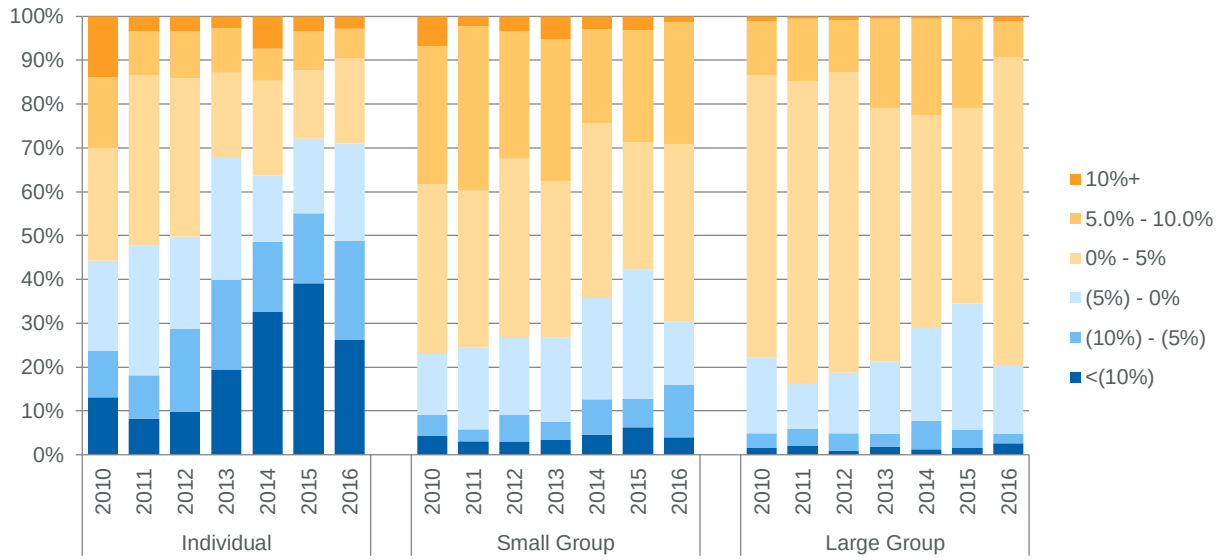
[16] Weilant, M.E. (December 2012). Premium Deficiency Reserve Requirements for Accident and Health Insurance. Milliman Research Report. Retrieved May 10, 2018, from http://www.milliman.com/uploadedFiles/insight/Research/health-rr/pdfs/premium-deficiency-reserve-requirements.pdf.

[17] CMS. MLR Annual Reporting Form: Filing Instructions for the 2016 MLR Reporting Year. Retrieved May 10, 2018, from https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2016-MLR-Form-Instructions.pdf.

DISTRIBUTION OF UNDERWRITING RESULTS 2010 THROUGH 2016

As we evaluate aggregate market underwriting results from 2010 through 2016, it is important to understand the degree to which underwriting results vary between insurers within a market. Figure 7 examines the distribution of underwriting results in these markets separately for each calendar year.

FIGURE 7: COMMERCIAL HEALTH INSURANCE: UNDERWRITING MARGIN DISTRIBUTIONS, 2010 TO 2016



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.

While the underwriting distribution has remained remarkably stable in the group insurance markets, the individual market has shown significantly greater volatility, particularly beginning in 2013. Underwriting losses of more than 10% of earned premium have been significant since 2014 (although even prior to 2014 severe underwriting losses were more prevalent in the individual market relative to the group markets), with 2016 experience indicating improvement relative to 2014 and 2015, yet still higher than pre-2014 market share.

Individual market enrollment changes and federal subsidies

Publicly available reports released by the federal government focus largely on the insurance exchange. It is important to understand how insurance exchange enrollment, as well as the number of individuals receiving federal health insurance subsidies, compares relative to aggregate market enrollment. Federal subsidies, through APTCs and CSRs, have made health insurance premiums and cost sharing more affordable for millions of Americans. Figure 8 illustrates covered lives in the individual market from 2014 through 2017 (estimated values for 2017), along with the following effectuated[18] enrollment statistics:

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

FIGURE 8: INDIVIDUAL HEALTH INSURANCE MARKET ESTIMATED ENROLLMENT CHANGES BY MARKET SEGMENT, 2014 TO 2017 (MILLIONS)

COVERED LIFE YEARS	2014	2015	2016	2017
TOTAL INDIVIDUAL MARKET	15.0	17.5	17.2	15.0
TOTAL NON-ACA-COMPLIANT	6.5	3.6	2.3	1.7
TOTAL ACA-COMPLIANT	8.5	13.9	14.9	13.3
ACA-COMPLIANT OFF-EXCHANGE	3.0	4.8	4.9	3.5
EFFECTUATED EXCHANGE (ALL ENROLLEES)	5.5	9.1	10.0	9.8
EFFECTUATED EXCHANGE APTC	4.7	7.7	8.4	8.2
EFFECTUATED EXCHANGE CSR	3.1	5.2	5.6	5.5

COVERED LIFE YEARS AS PERCENTAGE OF TOTAL INDIVIDUAL MARKET	2014	2015	2016	2017
% NON-ACA-COMPLIANT	43%	21%	13%	11%
% ACA-COMPLIANT	57%	79%	87%	89%
% ACA-COMPLIANT OFF-EXCHANGE	20%	27%	28%	23%
% EFFECTUATED EXCHANGE	36%	52%	58%	66%
% EFFECTUATED APTC	31%	44%	49%	55%
% EFFECTUATED CSR	21%	30%	33%	37%

Notes:
1. Values have been rounded.
2. Covered life years reflect average monthly enrollment.
3. Total ACA-compliant enrollment from 2014 through 2017 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.
4. Exchange-effectuated enrollment estimated from HHS enrollment reports. Please see the Methodology section of this paper for more information.
5. The 2017 values have been estimated based on a combination of publicly available federal government data and reports, as well as 2017 health industry financials accessed through SNL Financial.
6. Actual average monthly enrollment values are certain to vary from the estimates provided in the above figure.
7. Premium amounts and ACA-compliant enrollment includes private Medicaid expansion enrollees in Arkansas and New Hampshire. Effectuated APTC and CSR enrollment estimates exclude private Medicaid expansion enrollees.

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

As illustrated in Figure 8, while exchange enrollment is estimated to have remained relatively stable between 2016 and 2017, we estimate material enrollment declines have occurred within off-exchange coverage and non-ACA-compliant coverage. Market premium rates increased by approximately 20% on a national basis from 2016 to 2017.[19] For non-APTC-eligible consumers, the premium rate increases may have resulted in available coverage being viewed as unaffordable. Additionally, low unemployment (with corresponding greater access to employer-sponsored insurance) may have resulted in fewer consumers needing to purchase health insurance coverage in the individual market. The non-ACA-compliant enrollment declines are attributable to enrollment churn and state policies related to the continuation of transitional coverage.

Since 2014, enrollment within the exchange has taken on a significantly larger proportion of individual market enrollment.

- The estimated percentage of individual market covered lives in the insurance exchange has increased from 36% in 2014 to 65% in 2017.
- Likewise, the percentage of the individual market covered lives receiving an APTC in 2017 is estimated to have increased from 31% in 2014 to 54% in 2017.
- In 2017, approximately two-thirds of APTC enrollees are estimated to be enrolled in a CSR plan.

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

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

	CY2014	CY2015	CY2016	CY2017
TOTAL MARKET EARNED PREMIUM	$54.7	$70.9	$76.6	$80.1
TOTAL ACA-COMPLIANT EARNED PREMIUM	$35.8	$60.1	$69.0	$73.9
ADVANCED PREMIUM TAX CREDIT SUBSIDY	$15.5	$25.0	$29.2	$36.7
COST-SHARING REDUCTION SUBSIDY	$2.8	$4.9	$5.9	$5.0
APTC / EARNED PREMIUM	28%	35%	38%	46%
APTC / ACA-COMPLIANT EARNED PREMIUM	43%	42%	42%	50%
CSR SUBSIDY / TOTAL EARNED PREMIUM	5%	7%	8%	6%
CSR SUBSIDY / ACA-COMPLIANT EARNED PREMIUM	8%	8%	9%	7%
APTC PER EFFECTUATED 12-MONTH ENROLLMENT PERIOD	$3,312	$3,255	$3,481	$4,466
CSR SUBSIDY PER EFFECTUATED 12-MONTH ENROLLMENT PERIOD	$901	$948	$1,042	$899

Notes:

1. Values have been rounded.
2. APTC and CSR subsidy values based on CMS and Internal Revenue Service (IRS) data and publicly available reports. Please see the Methodology section for a full discussion of our data sources.
3. The 2017 CSR subsidy assumes a similar growth in subsidy per effectuated 12-month recipient between 2016 and 2017 as observed from 2015 to 2016, adjusted for the termination of direct CSR subsidy payments effective October 2017.
4. The 2017 aggregate market premium is estimated based on calendar year (CY) 2017 statutory filings and prior year MLR data and statutory filings.
5. The final 2017 values are certain to vary from the estimates provided in the above figure.
6. Premium amounts and CSR subsidy amounts include private Medicaid expansion enrollees in Arkansas and New Hampshire. APTC expenditures exclude private Medicaid expansion enrollees.

[19] As observed in the Kaiser Premium Subsidy Calculator and statutory financial statement data.

APTCs, which directly reduce the out-of-pocket premium for qualifying households, represented 28% of total earned premium in the individual market (43% of ACA-compliant earned premium) in 2014. In 2017, we estimate that this percentage has increased to 46% (50% of ACA-compliant earned premium), as nonsubsidized non-group market enrollment has declined and significant growth in per capita APTC has occurred. This statistic is an important benchmark for states considering a reinsurance or other initiative under a Section 1332 waiver.

CSR subsidies, which received significant attention in 2017 because of the termination of federal payments effective October 2017, due to an "invalid appropriation,"[20] represented between 8% and 9% of ACA-compliant earned premium from 2014 through 2016. The reduction in CSR subsidies from 2016 to 2017 is driven by the removal of government funding for CSR subsidies announced October 12, 2017. For the purposes of estimating CSR subsidy payments for 2017, we assumed the per capita CSR subsidy amount from 2016 would be 10% higher, yet reduced CSR subsidy payments by 23.5% to account for the October 2017 payment termination.[21] Note that we have not assumed any reduction in CSR subsidy payments for Medicaid enrollees receiving exchange coverage in Arkansas and New Hampshire, which are estimated to be in excess of $500 million in 2017 on a combined basis.

CSR subsidy payment termination is estimated to produce an approximately $1.4 billion loss for insurers in 2017, or 1.9% of ACA-compliant premium (CSR subsidy payments for 2017 are estimated to be $6.3 billion if paid in full). The CSR subsidy shortfall impact will differ greatly by insurer. For example, an insurer with members that are predominately in the exchange and enrolling in CSR plan designs will have a much greater impact than an insurer with a large proportion of higher-income and non-CSR enrollees.

[20] CMS (March 29, 2018). Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Year 2017, p. 6. Retrieved May 11, 2018, from https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Final-CSR-Reconciliation-Guidance-BY2017.pdf.

[21] The 23.5% assumption was developed based on an estimate of average member months during the fourth quarter of 2017 relative to calendar year 2017.

Transitional Reinsurance Program

The ACA transitional reinsurance program was a temporary program (calendar years 2014 through 2016) intended to stabilize the effect of high-risk members entering the individual market at the onset of the ACA. The program established a fee and payment parameters for each year of the program. The fee was $5.25 PMPM in 2014, $3.67 PMPM in 2015, and $2.25 PMPM in 2016. These fees were assessed on insured member months in individual and group markets, and were inclusive of both fully insured and self-funded employer-sponsored insurance plans.[22] While the fee was assessed on all commercially insured markets, only the ACA-compliant individual market was eligible to receive transitional reinsurance payments.

The reinsurance payment parameters are defined in the annual U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters; however, flexibility is permitted to modify the parameters if the total fees collected exceed the estimated payments. Figure 10 illustrates original and final transitional reinsurance parameters and payments. As states and federal policymakers consider state-based reinsurance programs under Section 1332 waivers and national funding for such programs, the above statistics are useful in considering the potential premium rate impact of introducing programs that are similar in scope to the transitional reinsurance program.

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

	2014		2015		2016	
	ORIGINAL	FINAL	ORIGINAL	FINAL	ORIGINAL	FINAL
Attachment Point	$ 60,000	$ 45,000	$ 70,000	$ 45,000	$ 90,000	$ 45,000
Reinsurance Cap	$ 250,000	$ 250,000	$ 250,000	$ 250,000	$ 250,000	$ 250,000
Coinsurance	80.0%	100.0%	50.0%	55.2%	50.0%	52.9%
Total Reinsurance Contributions (including prior year carryover)	$ 10.0 BILLION	$ 9.7 BILLION	$ 6.0 BILLION	$ 7.9 BILLION	$ 4.0 BILLION	$ 4.0 BILLION
Reinsurance Payments		$ 7.9 BILLION		$ 7.9 BILLION		$ 4.0 BILLION
Final Payments as Percentage of ACA-Compliant Premiums		22%		13%		6%

Notes:

1. Values have been rounded.
2. The 2014 total reinsurance contributions of $9.7 billion are based on the CMS notification of April 12, 2015, titled "The Transitional Reinsurance Program's Contribution Collections for the 2014 Benefit Year."
3. The 2014 reinsurance payments equal the sum of the payments insurers received based on the CMS notification of June 30, 2015, titled "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year."
4. The 2015 total reinsurance contributions of $7.8 billion are based on the CMS notification of June 30, 2016, titled "Summary Report on Transitional Reinsurance Payment and Permanent Risk Adjustment Transfers for the 2015 Benefit Year." We believe the difference relative to the $7.9 billion in reinsurance payments is attributable to rounding and have elected to illustrate the contributions as $7.9 billion in this figure.
5. The 2015 reinsurance payments of $7.9 billion equal the sum of the payment insurers received based on the CMS notification of June 30, 2016, titled "Summary Report on Transitional Reinsurance Payment and Permanent Risk Adjustment Transfers for the 2015 Benefit Year."
6. The 2016 reinsurance payments of $4.0 billion are based on the CMS June 30, 2017, report titled, "Summary Report on Transitional Reinsurance Payment and Permanent Risk Adjustment Transfers for the 2016 Benefit Year."

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

ACA risk corridor program

The ACA risk corridor program was designed to provide insurers financial protection against unfavorable results (as well as limit potential upside gain) during the first three years of the ACA (2014 through 2016). This program was only available for qualified health plans (QHPs) offered in the insurance exchanges (plans sold outside the exchange that are nearly identical to an insurer's QHP sold in the exchange are also eligible).[23]

Insurers requested risk corridor (RC) payments of $2.9 billion, $5.9 billion, and $4.0 billion in 2014, 2015, and 2016, respectively, for a total of $12.8 billion. Because of limited funding, insurers have only received $484 million dollars, which has been applied to 2014 requested amounts. As a result, insurers have received $12.3 billion less than they would have if risk corridors would have been paid in full.[24] Figures 11 and 12 summarize statistics related to the risk corridor program for the individual and small group markets, respectively.

FIGURE 11: INDIVIDUAL MARKET: SUMMARY OF 2014 THROUGH 2016 RISK CORRIDOR ELIGIBLE ENROLLMENT AND SHORTFALL AMOUNTS

INDIVIDUAL MARKET	2014	2015	2016
RC ELIGIBLE ENROLLMENT (MILLIONS)	8.1	13.2	14.2
TOTAL ENROLLMENT (MILLIONS)	15.0	17.5	17.2
RC ENROLLMENT MARKET SHARE	53.6%	75.7%	82.4%
PREMIUM SUBJECT TO RC ($ MILLIONS)	$33,034.2	$55,817.1	$64,501.1
RISK CORRIDOR $ SHORTFALL (MILLIONS)	$2,118.5	$5,322.8	$3,504.7
RISK CORRIDOR $ SHORTFALL (% OF PREMIUM)	6.4%	9.5%	5.4%

Notes:
1. Values have been rounded.
2. Enrollment reflects total member months divided by 12.

FIGURE 12: SMALL GROUP MARKET: SUMMARY OF 2014 THROUGH 2016 RISK CORRIDOR ELIGIBLE ENROLLMENT AND SHORTFALL AMOUNTS

SMALL GROUP MARKET	2014	2015	2016
RC ELIGIBLE ENROLLMENT (MILLIONS)	2.7	5.0	6.3
TOTAL ENROLLMENT (MILLIONS)	16.0	14.7	14.2
RC ENROLLMENT MARKET SHARE	17.1%	34.2%	44.5%
PREMIUM SUBJECT TO RC ($ MILLIONS)	$13,790.6	$26,282.8	$33,860.1
RISK CORRIDOR $ SHORTFALL (MILLIONS)	$266.5	$594.0	$473.6
RISK CORRIDOR $ SHORTFALL (% OF PREMIUM)	1.9%	2.3%	1.4%

Notes:
1. Values have been rounded.
2. Enrollment reflects total member months divided by 12.

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

[24] Livingston, S. (December 5, 2016). The state of the ACA's risk corridors. Modern Healthcare. Retrieved May 11, 2018, from http://www.modernhealthcare.com/article/20161205/NEWS/161129937.

While the risk corridor program is available to insurers in both the individual and small group markets, an examination of Figures 11 and 12 indicate the risk corridor funding shortfall has been significantly more impactful to the individual market, both in terms of aggregate risk corridor funding shortfall and impact to underwriting margins. On a cumulative basis from 2014 to 2016, individual market business accounts for $10.9 billion of the $12.3 billion risk corridor funding shortfall. Additionally, the risk corridor funding shortfall represents approximately 5% to 10% of premium subject to the risk corridor in the individual market, relative to only 1% to 2% of small group risk corridor premium. These results are driven by two primary factors:

- First, the risk corridor eligible enrollment in the individual market is a much greater proportion of total market enrollment. In 2016, approximately 82% of individual market lives were subject to the risk corridor program, relative to only 45% in the small group market. Only QHP enrollment is eligible for the risk corridor program. In the individual market, insurers must offer QHPs in the exchange. As observed in previous sections of this report, individual exchange enrollment represents a significant portion of overall individual market enrollment (58% in 2016). In the small group market, the Small Business Health Options Program (SHOP) has taken on a very limited role, with only 230,000 covered lives as of January 2017.[25] Additionally, the transition from non-ACA-compliant to ACA-compliant coverage has been slower in the small group market. In 2016, we estimate approximately 65% of small group coverage was ACA-compliant on a national basis, relative to 87% in the individual market.
- Second, the individual exchange population (enrollment and health status), as well as the exchange being a new distribution channel in itself, created significant uncertainty for insurers. While the rating rules for small group coverage were altered significantly in many states, the groups purchasing coverage likely did not change dramatically. In the individual market, the availability of premium assistance in the exchange created an influx of low-income consumers who may have perceived coverage as unaffordable previously. Additionally, the ACA's guaranteed issue and modified community rating requirements and prohibition on preexisting conditions exclusions presented a more significant alteration to practices in the individual market than in the small group market. The modification to rating practices also facilitated new entrants into the individual market.

[25] CMS (May 15, 2017). SHOP Marketplace Enrollment as of January 2017. Retrieved May 11, 2018, from https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/SHOP-Marketplace-Enrollment-Data.pdf.

Limitations

The analyses presented in this research paper have relied on data and other information from the NAIC MLR forms and Supplemental Health Care Exhibit (SHCE) submitted by health insurers. MLR form data was obtained from CMS's Center for Consumer Information and Insurance Oversight[26] in December 2017. The 2010 SHCE data was obtained using S&P Global Market Intelligence. Data related to insurance exchange effectuated enrollment, and subsidies data was obtained from publicly available federal government data. The data and other information have not been audited or verified, but a limited review was performed for reasonableness and consistency. If the underlying data or information is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete. Published values subsequent to December 1, 2017, are not included in this report.

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

Acknowledgment

The authors would like to thank Colin Gray, FSA, MAAA, James Liu, ASA, MAAA, and John Paczolt for their assistance in collecting and reviewing the data contained in this report. Fritz Busch, FSA, MAAA, Erik Huth, FSA, MAAA, and Jason Karcher, 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.

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

Appendix 1: Aggregate health insurer financial results, 2010-2016

SUMMARY OF COMMERCIAL HEALTH INSURER FINANCIAL RESULTS

Calendar Years 2010-2016 - 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
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
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
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. Covered Lives equals reported member months divided by 12.
2. The 2011 through 2016 reported premium and expenses are based on MLR form reported values as of March 31 of the following year.
3. MLR form reported values have been transposed into the same format as the NAIC SHCE form.
4. Earned Premium equals Part 1, Line 1.1 of the SHCE.†
5. Fees & Taxes equals Part 1, Line 1.5, 1.6, and 1.7 of the SHCE.
6. Claims Expenses equals Part 1, Line 5.0 of the SHCE.†
7. Total Admin Expenses equals the sum of Part 1, Lines 6.6, 8.3, and 10.5 of the SHCE.
8. Underwriting Gain (Loss) equals Part 1, Line 11 of the SHCE.
9. Preliminary Medical Loss Ratio equals sum of Part 1, Line 4 + Line 5.0 + Line 6.6 ÷ Line 1.8 of the SHCE.
10. The 2012-2016 MLR Rebates as % of Earned Premium equal reported rebates on Part 4, Line 5.4 (Total Column) of 2012-2016 MLR form ÷ Earned Premium.
11. 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.
12. Underwriting Margin equals Underwriting Gain (Loss) ÷ Earned Premium.
13. Admin Expense Ratio equals Total Admin Expenses ÷ Earned Premium.

† 2014, 2015, and 2016 values were adjusted by impact of 3R's.

Appendix 2: Methodology

MEDICAL LOSS RATIO DATA OVERVIEW

Section 2718 of the ACA instituted minimum medical loss ratio requirements for health insurers in the individual, small group, and large group markets. The Center for Consumer Information and Insurance Oversight (CCIIO) within 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[27] as of December 1, 2017. For 2014 through 2016 the MLR Data is unique because it provides a final accounting of ACA 3R results for insurers, rather than estimated revenue or charges that were included in statutory annual statements, including the SHCE.

The MLR Data contains experience reported by health insurance issuers at the state and market level. Business under the medical loss ratio requirements is split between comprehensive (annual limit greater than $250,000), "mini-med" (annual limit at or less than $250,000), and expatriate. Data for comprehensive and mini-med business is split separately between the individual, small group, and large group markets. Individual market values exclude limited benefit plans, dread-disease policies, accident-only coverage, and other policies that are not considered comprehensive health insurance. The small group and large group categories exclude self-funded employers, many of which purchase stop-loss insurance. Business written through an association is included in the MLR Data based on the insured entity's individual, small group, or large group status. Additionally, for 2013 through 2016, student health insurance was separately reported. For the purpose of this report, only comprehensive business has been analyzed.

The information contained in the MLR Data tracks closely with the SHCE form that is submitted with the insurer's year-end annual statement. The SHCE, developed by the National Association of Insurance Commissioners (NAIC), was first required in 2010. By comparing the 2010 Exhibit and 2011 through 2016 MLR Data, health insurance industry trends can be evaluated over the seven-year period. A limitation in these comparisons is that several California-based health insurers file with the state's Department of Managed Care, rather than the NAIC, and therefore do not complete the Exhibit form. However, these companies are required to report data for the medical loss ratio calculation and that data is contained in the 2011 through 2016 MLR data sets. The 2010 SHCE data was summarized using SNL Financial.

The analyses presented in this report were based upon values from the 2011 through 2016 MLR Data and the 2010 SHCE data meeting the following criteria:

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

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

FIGURE 13: 2016 COMPREHENSIVE HEALTH INSURANCE REPORTED IN MLR FORM

MARKET	GROUPS (PARENT COMPANIES)	COMPANIES	LIVES[1]	PREMIUM ($ MILLIONS)	% NON-COMPREHENSIVE
INDIVIDUAL	164	380	17,200,000	$76,631	0.16%
SMALL GROUP	154	340	14,200,000	$73,900	0.01%
LARGE GROUP	165	372	42,100,000	$215,990	0.05%
TOTAL COMPREHENSIVE	202	476	73,500,000	$366,521	0.06%

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

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

Figure 13 provides a summary of the number of companies, covered lives, and aggregate premium amounts reported for calendar year 2016 on a national basis (50 U.S. states and Washington, D.C.) for the comprehensive health insurance business under the ACA's medical loss ratio requirements that is included in this report. Additionally, the percentage of total premium (based on reported experience in the 50 states and Washington, D.C.) identified as non-comprehensive is illustrated. Data was reviewed for reasonableness and consistency. However, individual company results have not been audited. To the extent that individual company data was not correctly reported, the values presented in this report will not be representative of actual financial results.

While a majority of the fields in the MLR Data were simply reassigned to the appropriate SHCE report line item, significant adjustments were made to the earned premiums and incurred claims fields to appropriately account for the impact of the 3Rs in applicable markets during 2014, 2015, and 2016. In particular, adjustments related to the reporting of transitional reinsurance recoveries were based on a review of insurers' 2014, 2015, and 2016 annual statement filings, as well as actuarial judgment. Because risk corridor amounts reported in the MLR Data are based on a calculation that is different from amounts paid to issuers by CCIIO, we replaced all MLR Data risk corridor values with those published by CCIIO.[28] Reported risk adjustment transfers in the MLR Data were also replaced by actual amounts for each insurer published by CCIIO. Other adjustments were made to the data for observed reporting anomalies.

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

EXCHANGE EFFECTUATED ENROLLMENT DATA

CMS has released quarterly effectuated enrollment snapshots for the insurance exchange on a national and state level for December 2014 through March 2016.[29] Effectuated exchange enrollment at the end of each quarter is provided separately for total exchange enrollment, CSR enrollment, and APTC enrollment. The effectuated exchange enrollment also includes the average APTC on a national and state level for each quarter.

For 2014, the Internal Revenue Service (IRS) announced $15.5 billion in APTC for insurance exchange coverage.[30] By dividing the $15.5 billion amount by the December 2014 national average APTC ($276), estimated monthly APTC effectuated enrollment for 2014 was calculated at 4.7 million.

For 2015, the IRS announced $25 billion in APTC for insurance exchange coverage.[31] By dividing the $25 billion amount by the average quarterly national APTC ($271), estimated monthly APTC effectuated enrollment for 2015 was calculated at 7.7 million. Note that quarterly national APTC amounts varied from $270 to $272.

Based on the ratios between APTC, CSR, and total exchange effectuated quarterly enrollment snapshots from CMS, we estimated the average monthly effectuated enrollment for CSR and total exchange enrollees in 2014 and 2015. While we believe our methodology for estimating average monthly effectuated enrollment is sound, actual values are certain to vary from our estimates to an unknown degree.

For calendar year 2016 and the first half of calendar year 2017, CMS has released state-level data on effectuated enrollment (including APTC and CSR enrollment) and APTC per capita values, which serve as the basis for 2016 and 2017 estimated values.[32] Enrollment estimates outside of the exchange are estimated based on available statutory data.

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

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

[30] IRS (July 17, 2016). IRS Commissioner John Koskinen Letter to Congress. Retrieved February 16, 2017, from https://www.irs.gov/pub/irs-utl/CommissionerLetterIwithcharts.pdf.

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

[32] CMS.gov (December 13, 2017). First Half of 2017 Average Effectuated Enrollment Report. Retrieved May 11, 2018, from https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-12-13-2.html.

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