

Affordable Care Act Turmoil

Large Losses in the Individual Market
Portend an Uncertain Future

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June 2016

MERCATUS WORKING PAPER



3434 Washington Blvd., 4th Floor, Arlington, Virginia 22201
www.mercatus.org

Brian Blase et al. “Affordable Care Act Turmoil: Large Losses in the Individual Market Portend an Uncertain Future.” *Mercatus Working Paper*, Mercatus Center at George Mason University, Arlington, VA, June 2016.

Abstract

The Affordable Care Act (ACA) placed numerous requirements on insurance offered in both the individual and small group markets. This study presents data from the 174 insurers that offered qualified health plans (QHPs)—plans that satisfy the ACA requirements and are certified to be sold on exchanges—in both the individual and small group markets in 2014. QHPs in both markets are essentially the same and are governed by nearly identical regulations, making possible a better-controlled analysis of the performance of insurers participating in the two markets. Average medical claims for individual QHP enrollees were 24 percent higher than average medical claims for group QHP enrollees. Moreover, average medical claims for individual QHP enrollees were 93 percent higher than average medical claims for individual non-QHP enrollees. As a result, insurers made large losses on individual QHPs despite receiving premium income that was 45 percent higher for individual QHP enrollees than for individual non-QHP enrollees. These higher medical claims resulted in loss ratios for individual QHPs nearly 30 percentage points higher than loss ratios in other markets. Given that insurer performance selling individual QHPs worsened in 2015, these findings suggest that the ACA rules and regulations governing QHPs may be incompatible with a well-functioning insurance market even with subsidies to insurers and incentives for individuals to enroll in QHPs.

JEL codes: I13, I11, I18, H51

Keywords: Affordable Care Act, exchanges, qualified health plans, small group market, individual market

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The Mercatus Center gratefully acknowledges the financial support of the John Templeton Foundation for research on healthcare policy in the United States.

Affordable Care Act Turmoil:

Large Losses in the Individual Market Portend an Uncertain Future

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In the first paper in this series, we used data from the Department of Health and Human Services (HHS) to assess how insurers fared in 2014 when selling qualified health plans (QHPs) in the individual market—plans that satisfy all the Affordable Care Act (ACA) requirements and are certified to be sold on exchanges.¹ We had three key findings based on data from all 289 of those plans. First, insurers incurred substantial losses despite receiving much larger payments per enrollee through the ACA’s reinsurance program (a temporary program that reimbursed insurers for the majority of the cost of their most expensive enrollees) than they expected to receive when they set premiums. Second, in the absence of the reinsurance program, which expires after 2016, QHP premiums would have needed to be about 26 percent higher, on average, to cover insurer expenses in 2014—and higher still to account for additional selection effects that would have resulted from those higher premiums. Third, individual QHP performance varied significantly across insurers and across states, with narrow network plans appearing to fare better.

¹ Brian Blase, Doug Badger, and Edmund F. Haislmaier, “The Affordable Care Act in 2014: Significant Insurer Losses despite Substantial Subsidies” (Mercatus Working Paper, Mercatus Center at George Mason University, Arlington, VA, April 2016).

For this study, we limit our analysis to the insurers² that offered QHPs in both the individual market (individual QHPs) and the small group market (group QHPs).³ For each insurer, the QHPs were either identical or substantially the same and they were governed by nearly identical regulations in both markets. These similarities allow for a better-controlled analysis of the effects of the ACA’s regulatory changes on the individual market. We make four additional findings in this study.

First, per-enrollee premium revenue was lower (7 percent) for individual QHPs than for group QHPs, although per-enrollee premium revenue was much higher for individual QHPs (45 percent) than for individual coverage that did not qualify as a QHP (individual non-QHPs). Second, per-enrollee medical claims were noticeably higher (24 percent) for individual QHPs than for group QHPs⁴ and substantially higher (93 percent) for individual QHPs than for individual non-QHPs. Third, because of large medical claims, insurers lost considerably more money selling individual QHPs than group QHPs despite receiving larger-than-expected per-enrollee payments for their individual QHPs through the ACA’s reinsurance program. The 174 insurers netted \$5.1 billion through the reinsurance program⁵—an amount equal to more than 20

² We use a dataset compiled from insurers’ medical loss ratio (MLR) filings with the Department of Health and Human Services. Data in those filings are reported by state at the plan level and broken out by market segment (individual and small group) and by participation in the risk corridor program (explained in appendix A). Because only QHPs participate in the risk corridor program, we were able to identify the specific financial and enrollment data for those plans. We matched these data with the data released by the HHS on the premium stabilization programs. By *insurer*, we mean an issuer of a QHP. In most cases an insurer only offers one QHP per market, but in a few cases, an insurer may issue more than one QHP.

³ For the purposes of the ACA, *small group* generally refers to firms with 50 or fewer full-time equivalent workers (FTEs). The ACA (section 1304(b)) contemplated a threshold of 100 workers, giving states the option to reduce it to 50 for 2014 and 2015. Most states exercised that option in 2014. Legislation adopted in October 2015 (Pub. L. No. 114-60) reduces the threshold to 50 FTEs, effective January 1, 2016, but gives states the option to raise it to 100 FTEs.

⁴ This finding closely parallels a recent report published by the Blue Cross Blue Shield Association: “Newly Enrolled Members in the Individual Health Insurance Market after Health Care Reform: The Experience from 2014 and 2015,” March 2016.

⁵ Insurers offering individual QHPs, like most insurers in the private market, were required to pay a \$63 assessment per covered life—but, unlike other insurers, they were also eligible to receive reinsurance payments to cover a large

percent of total individual QHP premium income.⁶ Fourth, the results were generally consistent across different types of insurers although differences—particularly in claims per enrollee—were more pronounced across individual QHPs than across group QHPs.

The large medical claims and resulting losses incurred by individual QHPs—relative to individual non-QHPs, group QHPs, and group non-QHPs—demonstrate that individual QHPs did not attract a sufficiently balanced risk pool in 2014. The insurers failed to attract a balanced risk pool for these plans despite income-related subsidies available exclusively to people selecting an individual QHP through an exchange, tax penalties on many of the uninsured, and lower premiums for individual QHPs because of the reinsurance program. The Congressional Budget Office (CBO) estimated that insurers reduced individual QHP premiums by 10 percent in 2014 in expectation of reinsurance payments.⁷

Because insurers experienced even larger losses selling individual QHPs in 2015 than they did in 2014,⁸ our findings suggest that 2017 could be a challenging year for the ACA, particularly since the reinsurance program ends in 2016. Some insurers have announced plans to withdraw from individual QHP markets⁹ and many insurers are requesting substantial premium increases—increases that will make coverage look even less attractive to relatively young and

share of the claims for their most expensive enrollees. Our figures report reinsurance receipts for individual QHPs as net of their reinsurance contributions.

⁶ Premium income consists of premium payments, which include advance tax credits received, and advance CSR payments.

⁷ Congressional Budget Office, *Private Health Insurance Premiums and Federal Policy*, February 11, 2016.

⁸ A recent McKinsey&Company study of preliminary data suggests that insurers' "aggregate negative margins may have doubled" in 2015. McKinsey Center for US Health System Reform, "Exchanges Three Years In: Market Variations and Factors Affecting Performance," McKinsey&Company, May 2016. See also Deep Banerjee, Caitlin Weir, and James Sung, "The ACA Risk Corridor Will Not Stabilize the U.S. Health Insurance Marketplace in 2015," *RatingsDirect*, Standard & Poor's Financial Services, November 5, 2015, 2–3.

⁹ United Healthcare, for example, has announced that it will no longer offer exchange coverage in 2017 in most of the states in which it participated in 2016. Humana has also announced that it is withdrawing from the exchanges in Alabama and Colorado.

healthy people who do not qualify for subsidies for their coverage.¹⁰ Our findings also suggest that under the ACA the individual market, which has features that make it more prone to adverse selection than the small group market, may provide coverage that is attractive only to people earning below 200 percent of the federal poverty level¹¹ who qualify for large subsidies and to people with expensive medical conditions. If that is the case, the ACA will need to be significantly changed if policymakers intend to preserve a viable insurance market for middle-income individuals without access to employer-based coverage.

Methodology

We identified 174 QHPs sold in both the individual and small group markets on the basis of their participation in the ACA's risk corridor program. The risk corridor program, discussed in detail in appendix A, was intended to transfer money from QHPs whose costs were lower than a threshold amount to QHPs whose costs exceeded a higher threshold.

Regulations established separate risk corridor pools for individual QHPs and group QHPs. The definition of a QHP used to determine eligibility for the risk corridor program is broader than the definition employed in regulations pertaining to the ACA's income-related subsidies.¹² The narrower definition limits QHPs to plans sold through an exchange, since individual market enrollees are only eligible for premium tax credits and cost-sharing reductions (CSRs) if they purchase coverage through an exchange and meet income and other applicable requirements.

¹⁰ We discuss the two types of exchange subsidies—premium tax credits and CSR payments—in footnote number 26.

¹¹ In 2016, 200 percent of the federal poverty level equals \$23,760 for a single person and \$48,600 for a family of four. Office of the Assistant Secretary for Planning and Evaluation, "Poverty Guidelines," US Department of Health and Human Services, January 25, 2016.

¹² 45 C.F.R. § 155.20.

The broader definition of a QHP, which is consistent with the data released by the HHS and which we use in this study, includes plans sold off the exchanges, so long as the plan is “the same” or “substantially the same” as the product sold on an exchange.¹³ A plan can meet that equivalence condition so long as any differences in benefits, premiums, cost-sharing structure, and provider networks between the products sold on and off an exchange are “tied directly and exclusively” to “federal or state requirements or prohibitions on the coverage of benefits that apply differently to plans depending on whether they are offered through or outside the exchange.”¹⁴ It is worth noting that the vast majority of group QHPs are sold off the exchanges.¹⁵

HHS regulations establishing standards for QHPs generally do not distinguish between plans sold in the individual and group markets.¹⁶ Both individual QHPs and group QHPs were required to meet the same benefit standards and designs, including the essential health benefits package, cost-sharing limits, and narrow actuarial standards (i.e., bronze, silver, gold, and platinum).¹⁷ They also had to meet regulatory standards relating to network adequacy,¹⁸ rate review,¹⁹ reporting requirements,²⁰ marketing,²¹ and accreditation.²² The large similarities between individual and group QHPs and the regulations governing each form the basis for this

¹³ *Id.* at § 153.500.

¹⁴ *Id.*

¹⁵ Few small employers obtained group coverage for their workers through the Small Business Health Options Program offered by the exchanges. According to the Centers for Medicare and Medicaid Services, only 85,000 people were enrolled in plans sold through SHOP exchanges as of May 2015. “Update on SHOP Marketplaces for Small Businesses,” *CMS Blog*, July 2, 2015.

¹⁶ 45 C.F.R. § 156, subpart C, and § 155, subpart K. The regulations do, however, apply additional standards specific to SHOP exchanges that do not apply on individual exchanges (see 45 C.F.R. § 156.285).

¹⁷ 45 C.F.R. § 156.200(b), which incorporates benefit standard requirements set forth in 45 C.F.R. § 156.20. Bronze plans have an actuarial value between 58 percent and 62 percent, silver plans have an actuarial value between 68 percent and 72 percent, gold plans have an actuarial value between 78 percent and 82 percent, and platinum plans have an actuarial value between 88 percent and 92 percent.

¹⁸ 45 C.F.R. § 156.230.

¹⁹ 45 C.F.R. § 156.210.

²⁰ 45 C.F.R. § 156.220.

²¹ 45 C.F.R. § 156.225.

²² 45 C.F.R. § 156.275.

study. We contrast how the 174 insurers fared selling QHPs in both the individual and small group markets and non-QHPs in both the individual and small group markets.

Non-QHPs include grandfathered plans, so-called “transition” or “grandmothered” plans, and ACA-compliant coverage that is not certified as a QHP (because, while the coverage is ACA-compliant, the insurer does not offer it on the exchanges, and thus does not obtain QHP certification). Grandfathered plans are health plans that were in effect when the ACA was passed on March 23, 2010, and are exempt from certain provisions of the law, such as requirements to cover preventive benefits without cost sharing, have an external appeals process, or comply with the new benefit and rating provisions in the small group market.²³ Grandmothered plans are policies purchased between the 2010 passage of the ACA and 2014 and are neither ACA-compliant nor grandfathered plans, but remain on the market in accordance with an HHS policy announced in the fall of 2013 permitting renewals of such plans.²⁴ Neither grandfathered nor grandmothered plans were eligible for payments through the risk corridor or reinsurance programs. Moreover, enrollees in these plans, as well as enrollees in QHPs purchased off the exchanges, were ineligible for the premium tax credits and CSR payments.²⁵

Despite Benefits to Individual QHPs, the ACA Caused Greater Uncertainty for Insurers about the Individual Market

Although plan design and regulatory requirements for individual QHPs and group QHPs are essentially the same, there are important differences in how the individual and group markets function. For example, the ACA contained two central provisions that benefit individual QHPs.

²³ “2015 Employer Health Benefits Survey; Section Thirteen: Grandfathered Health Plans,” Henry J. Kaiser Family Foundation, September 22, 2015.

²⁴ Louise Norris, “Like Your Grandmothered Health Plan?,” Healthinsurance.org, March 22, 2016.

²⁵ See appendix A for a description of these programs.

First, premium tax credits and cost-sharing reduction subsidies are only available for enrollees who purchase an individual QHP through an exchange.²⁶ Second, individual QHPs, from 2014 to 2016, are subsidized by payments received through the reinsurance program.

The reinsurance program provides protection to insurers by compensating them for a large share of expenses incurred by “high risk individuals.” The program is financed by fees on nearly everyone with private insurance. Prior to insurers setting their 2014 premiums, the HHS issued regulations specifying that the reinsurance program would have an attachment point of \$60,000, a reinsurance cap of \$250,000, and a coinsurance rate of 80 percent.²⁷ As an example, an insurer could expect to receive a reinsurance program payment of \$112,000 for an enrollee with \$200,000 in claims ($\$200,000 - \$60,000 = \$140,000 \times 0.8 = \$112,000$). Largely as a result of fewer individual QHP enrollees than expected and a reprioritization of funds originally intended for the US Treasury, the HHS subsequently lowered the attachment point to \$45,000 and increased the coinsurance rate to 100 percent for the 2014 plan year.²⁸ Therefore, the effect in the above example was to increase the payment received by the insurer to \$155,000 for the individual. As a result of HHS changes to the formula, the reinsurance

²⁶ Premium tax credits are available to people who are lawful residents, who purchase a policy through an exchange, and who have incomes between 100 percent of the federal poverty level or FPL (133 percent in states that have adopted the ACA’s Medicaid expansion) and 400 percent of the FPL (although generally they phase out at a much lower income level for younger, single enrollees). Credit amounts are calculated with reference to the percentage of income that people pay for their share of the premium for the second-lowest-cost silver plan. The credit can be applied to any bronze, silver, gold, or platinum plan purchased through an exchange. The ACA also authorized CSR payments to insurers to compensate them for the requirement that they lower plan deductibles and other cost-sharing amounts for enrollees with incomes below 250 percent of the FPL who purchase silver plan coverage. The CSR requirements raise the actuarial value of silver plans to 94 percent for enrollees between 100 and 150 percent of the FPL, 87 percent for enrollees between 150 and 200 percent of the FPL, and 73 percent for enrollees between 200 and 250 percent of the FPL. In May 2016, a federal district court judge “enjoin[ed] the use of unappropriated monies to fund” the CSR program, but stayed her order pending appeal. *House v. Burwell*, 130 F. Supp. 3d 53 (D.D.C. 2015).

²⁷ Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2014, Proposed Rule, 77 Fed. Reg. 236 (December 7, 2012), 73118–73218; Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2014, Final Rule, 78 Fed. Reg. 47 (March 11, 2013), 15410–15541.

²⁸ Daniel J. Perlman, Doug Norris, and Hans K Leida, “Transitional Reinsurance at 100% Coinsurance: What It Means for 2014 and Beyond,” Milliman, June 2015.

program was made about 40 percent more generous on a per-enrollee basis than insurers expected when setting 2014 premiums.²⁹

While the income-related subsidies for coverage and the reinsurance program benefitted insurers offering individual QHPs in 2014, other ACA provisions presented greater risks for insurers participating in the individual market. The ACA fundamentally changed individual insurance market rules by requiring that insurers offer coverage to any applicant without being able to charge an actuarially appropriate premium—a premium that accurately reflects an applicant’s expected healthcare expenditures. These changes made insurance significantly more expensive for relatively young and healthy people, particularly men, and provided individuals with an incentive to delay purchasing coverage until they anticipate incurring medical expenses.³⁰

In order to deter people from waiting until they are sick to purchase coverage, and to induce young and healthy people to enroll, the ACA provided income-related subsidies for individual exchange coverage and imposed a tax penalty on people without the government-required coverage.³¹ Such subsidies were not extended to the small group market,³² although

²⁹ Seth Chandler, “How the Obama Administration Raided the Treasury to Pay Off Insurers,” *Forbes*, January 18, 2016.

³⁰ Among adults, women have higher healthcare costs than men until about age 60, after which the pattern reverses. Furthermore, even under a unisex rating restriction, the age-related variation in healthcare cost for pre-retirement adults (ages 19–64) is about 5:1, whereas the ACA permits only a 3:1 variation in insurance rates. Thus, the effect of the ACA’s sex and age rating restrictions are to significantly increase premiums for younger adults, particularly males—even before accounting for the cost of the law’s other regulations, such as new benefit requirements. See Dale H. Yamamoto, “Health Care Costs—From Birth to Death,” Society of Actuaries, Health Care Costs Institute, June 2013, <http://www.healthcostinstitute.org/SOA-1-2013>.

³¹ In 2014 the tax penalty under the mandate was relatively small: the greater of \$95 per person or one percent of household income above the tax filing threshold. The penalty increased to the greater of \$325 per person or 2 percent of household income above the tax filing threshold in 2015, and to the greater of \$695 or 2.5 percent of household income above the tax filing threshold in 2016. The penalty is capped by the average premium for a bronze policy, although few uninsured taxpayers would have hit this cap in 2014. There are numerous hardship exemptions from the individual mandate penalty. Nearly 7.5 million taxpayers paid the penalty in 2014 with an average penalty equal to about \$200.

³² A small business tax credit was available to employers with fewer than 25 full-time equivalent employees with an average annual salary of less than \$50,000. Because the credit was both a small amount and complicated to claim, very few employers claimed it. “Small Business Health Care Tax Credit and the SHOP Marketplace,” IRS, last updated January 6, 2016.

long-standing federal tax policy exempts premiums for employer-based health insurance from both income and payroll taxes.

Two other provisions of the ACA—special enrollment periods and a 90-day grace period—affect the individual exchange market, but not the group market, and they appear to have advantaged consumers over insurers. While pre-ACA law provided special enrollment periods in group plans for people who experience changes in employment or family status, the ACA gave the HHS authority to establish additional special enrollment periods for plans sold through exchanges.³³ The 90-day grace period allows subsidized enrollees to retain their plan for up to three months without paying premiums.³⁴ Many insurers have raised concerns that people are taking advantage of lax enforcement of the special enrollment period to sign up just shortly before they need to use expensive services.³⁵ The 90-day grace period provides consumers with a particularly large incentive to stop paying premiums during the last three months of the year and to only pay if they need to utilize health care services during that period. In both 2014 and 2015, there was significant attrition during the course of the year in the number of people with effectuated individual market exchange coverage.³⁶

³³ 42 U.S.C. § 18031(c)(6) and 45 C.F.R. § 155.420.

³⁴ Rachana Dixit Pradhan, “Health Policy Brief: The Ninety-Day Grace Period,” *Health Affairs*, October 16, 2014.

³⁵ The administration has acknowledged that these special enrollment periods provided an opportunity for consumers to game the system by waiting until they require medical care to sign up for coverage. It is worth noting that after numerous complaints from insurers, the administration has taken steps to limit the use of special enrollment periods. See Centers for Medicare and Medicaid Services, “Fact Sheet: Special Enrollment Confirmation Process,” February 24, 2016; Centers for Medicare and Medicaid Services, “Special Enrollment Periods for the Health Insurance Marketplace,” May 6, 2016. Relatedly, the Government Accountability Office was able to enroll 10 out of 10 fictitious applicants in exchange policies, an indication of relatively weak enrollment controls. Government Accountability Office, “Patient Protection and Affordable Care Act: Preliminary Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015,” October 23, 2015.

³⁶ Brian Blase, “Obamacare Losing Enrollees: Exchange Enrollment Drops by over 1.1 Million in Last Half of 2015,” *Forbes*, March 14, 2016.

Although some of the ACA's changes to insurance rules also affect group plans,³⁷ inherent features of the employment-based insurance system reduce the uncertainty for insurers that result from these changes. In general, risk pools for employment-based coverage are less prone to selection effects, as employment decisions by both firms and workers are typically made based on any number of factors other than a worker's health status.³⁸ Moreover, many jobs require a level of health that reduces the fraction of outlier instances of extremely high medical claims. Finally, the criteria for special enrollment in a group plan are clearer and more easily verified.

Findings

Table 1 shows aggregate values of premiums, CSR payments,³⁹ premium income (premiums plus CSR payments), medical claims, net reinsurance payments, net risk adjustment payments, net risk corridor claims, and enrollment (as measured in life years)⁴⁰ for the 174 QHPs offered in both the individual and group markets in 2014.

³⁷ For example, small group health plans are subject to the ACA's minimum actuarial value and essential health benefits requirements.

³⁸ While this is true within an employer group, the ACA prohibited insurers from varying premiums between groups. Firms whose workers are at heightened risk of job-related medical problems can no longer be charged higher premiums based on that risk.

³⁹ We treat CSR payments, which were advanced to insurers, as additional premium income because those payments are based on the expected cost to the insurer of altering its plan design in ways that shift an incremental share of total medical spending from the enrollee to the plan (by reducing enrollee out-of-pocket contributions) and induce marginally higher utilization—both of which increase a plan's claims payouts. In other words, absent the CSR program, the higher actuarial value plans selected by enrollees would have, of necessity, carried higher face premiums, and thus, the advance CSR payments functionally constituted additional, indirect premium payments. The advance CSR payments were estimates and there is a reconciliation process that will occur. Therefore, insurers may end up receiving somewhat more or less than the advanced amount at the conclusion of the reconciliation process. Only after those payments are reconciled (something that the HHS is still in the process of doing for the 2014 plan year) would it be appropriate to apply the alternative approach of instead subtracting them from the expense side of the insurer's ledger.

⁴⁰ We report enrollment using the life year convention. Life years are reported on the MLR form and are simply an annualized per-enrollee equivalent equal to the number of member months (also reported on the form) divided by 12. Thus, expressing enrollment in life years incorporates enrollment changes over time, and it accurately corresponds to the associated financial data (premium, claims, and government program transfers).

Table 1. Qualified Health Plan Aggregates, by Market Type, and as Percentage of Premium Income, 2014

	Individual market	% individual QHP premium income	Small group market	% small group QHP premium income
(1) Premiums	\$23.343 billion		\$11.761 billion	
(2) CSR payments	\$1.900 billion			
(3) Premium income (1) + (2)	\$25.243 billion		\$11.761 billion	
(4) Medical claims	\$27.778 billion	110.0%	\$9.677 billion	82.3%
(5) Net reinsurance payments ^(a)	\$5.109 billion	20.2%	-\$0.147 billion	-1.3%
(6) Net risk adjustment payments ^(b)	\$0.439 billion	1.3%	\$0.024 billion	0.1%
(7) Subtotal revenue (3) + (5) + (6)	\$30.791 billion	121.5%	\$11.638 billion	98.8%
(8) Net risk corridor claims ^(c)	\$1.807 billion	7.2%	\$0.294 billion	2.5%
(9) Fully funded risk corridor revenue (7) + (8)	\$32.599 billion	128.7%	\$11.932 billion	101.3%
Enrollees ^(d)	5,585,893		2,414,927	

(a) For their QHPs, these 174 insurers received payments of \$5.395 billion through the reinsurance program and made contributions of \$0.286 billion.

(b) The risk adjustment program also applied to ACA-compliant plans that were not QHPs. The dataset we used did not distinguish ACA-compliant non-QHPs from grandfathered and grandmothered plans. We adopt the same approach as we did in our previous paper by dividing risk adjustment payments by total premium income collected for these 174 insurers instead of just premium income for the QHPs. Total premium income for the 174 insurers equaled \$35.01 billion and \$39.39 billion in the individual and small group markets, respectively. Using total premium income in the denominator, we obtain net risk adjustment payments as a percentage of premium income of 1.3% in the individual market and 0.1% in the group market. Using QHP premium income in the denominator would increase these respective percentages to 1.7% and 0.2%. The actual percentage of net risk adjustment payments as a percentage of premium income will be between these percentages and depends on the ratio of ACA-compliant, non-QHP premium income to the insurer's premium income from grandfathered and grandmothered policies.

(c) Net risk corridor claims equal the claims made by insurers (even though only 12.6 percent of them were paid) less payments made by insurers with actual costs at least 3 percent below target costs. For their individual QHPs, 108 insurers made claims on the risk corridor program totaling \$2.07 billion, 35 insurers made payments into the risk corridor program totaling \$262 million, and 31 insurers had actual costs within 3 percent of the target amount and so did not make claims or payments. For their small group QHPs, 101 insurers made claims on the risk corridor program totaling \$303 million, 39 insurers made payments into the risk corridor program totaling \$9 million, and 34 insurers had actual costs within 3 percent of the target amount and so did not make claims or payments.

(d) Enrollees are shown in life years, which are the total number of months that people were enrolled in coverage divided by 12.

Sources: These data are from insurer medical loss ratio filings with the HHS combined with HHS data on the premium stabilization programs.

The 174 insurers collected \$23.3 billion in premiums for their individual QHPs in 2014, with total premium income equal to about \$25.2 billion when the CSR payments are included. As table 1 shows, insurers collected slightly more than twice the amount of premium income for individual QHPs relative to small group QHPs, yet they paid nearly three times more in medical claims for individual QHPs than for small group QHPs.

In 2014, the 174 insurers collected about \$5.1 billion in net reinsurance payments for their individual QHPs and about \$439 million in risk adjustment payments for their QHPs and ACA-compliant non-QHPs. In addition to receiving more than \$5.5 billion in transfers through reinsurance and risk adjustment—an amount totaling 21.5 percent of premium income—these insurers also claimed \$1.8 billion (7.2 percent of premium income) in net payments from the risk corridor program.

Risk corridors are a rough proxy measurement for insurer gains or losses.⁴¹ They are computed after factoring in the effects of risk adjustment and reinsurance. Table 1 shows that, as a percentage of premium income, the net risk corridor claims for individual QHPs were nearly three times more than for group QHPs. Aggregate net reinsurance, net risk adjustment, and net risk corridor claims totaled 28.7 percent of premium for individual QHPs, compared with just 1.3 percent for group QHPs. That indicates individual premiums would have needed to be about 30 percent higher for individual QHPs to break even in the absence of these programs—excluding additional selection effects that would have resulted from the higher premiums.

⁴¹ As explained in appendix A, the risk corridor figures do not reflect the full extent of insurer gains and losses. Thus, even full payment of their risk corridor claims would have left insurers with risk corridor claims more than 3 percent short of meeting their medical and administrative losses. As explained in footnote 62 (in appendix A), the HHS also made the risk corridor formula, as well as the reinsurance formula, more generous for the 2014 plan year.

Per-Enrollee Premiums Were Lower for Individual QHPs

Table 2 shows the information contained in table 1 on a per-enrollee basis for individual QHPs and group QHPs, as well as the difference between the individual and group numbers.

Table 2. Qualified Health Plan Aggregates per Enrollee, 2014

	Individual QHPs	Small group QHPs	Difference
(1) Premium	\$4,179	\$4,870	-\$691
(2) CSR payment	\$340		\$340
(3) Premium income (1) + (2)	\$4,519	\$4,870	-\$351
(4) Medical claims	\$4,973	\$4,007	\$966
(5) Net reinsurance payment	\$915	-\$61	\$976
(6) Net risk adjustment payment	\$50	\$3	\$47
(7) Subtotal revenue (3) + (5) + (6)	\$5,484	\$4,812	\$672
(8) Net risk corridor claim	\$324	\$122	\$202
(9) Fully funded risk corridor revenue (7) + (8)	\$5,808	\$4,934	\$874

Note: The data correspond to the aggregate data in table 1 divided by enrollment. Rows (1)–(5) use QHP enrollment in the denominator. Row (6) uses total enrollment in the denominator since the risk adjustment program also applies to ACA-compliant non-QHPs. If QHP enrollment were used, the net risk adjustment amounts would total \$79 for individual QHPs and \$10 for group QHPs. Enrollees are shown in life years, which are the total number of months that people were enrolled in coverage divided by 12.

Sources: These data are from insurer medical loss ratio filings with the HHS combined with HHS data on the premium stabilization programs.

The first row in table 2 presents per-enrollee premiums collected by individual and group QHPs, before CSR payments and payments through the premium stabilization programs.⁴² The average premium was \$691 (16.6 percent) higher per enrollee for group QHPs than for individual QHPs. After accounting for CSR payments received by individual QHPs, this difference narrowed to \$351 (7.8 percent) higher for group QHP premium income relative to individual QHP premium income.

⁴² Premiums paid by policyholders include the share paid on behalf of policyholders through advanced premium tax credits. Like employer premium contributions, advanced premium tax credits simply constitute the portion of premium paid by someone other than the enrollee. Because of this, the eventual reconciliation of those tax credit payments that occurs between the policyholder and the government is irrelevant to the insurer, although the reconciliation is important for individuals enrolled in coverage. All federal and state taxes and fees that are imposed on top of premiums are excluded from the calculations.

Per-Enrollee Claims Were Much Higher for Individual QHPs

On their individual QHPs, insurers incurred medical claims averaging \$4,973 per enrollee, 24.1 percent higher than the \$4,007 per-enrollee medical claim on their group QHPs. Table 3 shows that the loss ratio—the ratio of the sum of medical claims to the sum of premiums—for group QHPs equaled 82.3 percent. This is a loss ratio well within the pre-ACA norm and far better than insurers fared with their individual QHPs, which had a 110.0 percent loss ratio.

Insurers Fared Worse in Individual Market Despite Large Reinsurance Payments

As table 2 shows, per-enrollee net risk corridor claims for individual QHPs were on average \$202 higher than claims for group QHPs (\$324 versus \$122). With full payment of risk corridor claims, insurers would have received total revenue per enrollee that was \$874 (17.7 percent) more for individual QHPs than for group QHPs. The main reason insurers collected more on their individual QHPs despite lower premiums is the reinsurance program. Insurers received an average of \$915 per enrollee for their individual QHPs in 2014. For group QHPs, reinsurance cost carriers an average of \$61 per enrollee. Despite this \$976 disparity in per-enrollee reinsurance payments, insurers incurred much larger losses, as proxied by risk corridor claims, on their individual QHPs than on their group QHPs.

Large Individual QHP Loss Ratios Mainly Resulted from Much Higher Medical Claims

Table 3 displays premium income, medical claims, loss ratios, and enrollment for individual QHPs, individual non-QHPs, small group QHPs, and small group non-QHPs. The table shows that loss ratios for individual non-QHPs, group QHPs, and group non-QHPs were between the narrow range of 80.9 percent and 82.6 percent. These loss ratios are normal for health insurers

and show that premiums were generally sufficient to cover medical and administrative costs in each of these three market segments.

Table 3. Per-Enrollee Premium Income, Medical Claims, and Loss Ratios

	Individual market		Small group market	
	QHPs	Non-QHPs	QHPs	Non-QHPs
Premium income	\$4,519	\$3,126	\$4,870	\$4,525
Medical claims	\$4,973	\$2,581	\$4,007	\$3,660
Loss ratio	1.100	0.826	0.823	0.809
Enrollees	5,585,893	3,124,308	2,414,927	6,107,275

Note: Premium income for individual QHPs includes cost-sharing reduction payments of \$349 per enrollee. The table excludes premium stabilization payments. Enrollees are shown in life years, which are the total number of months that people were enrolled in coverage divided by 12.

Sources: These data are from insurer medical loss ratio filings with the HHS combined with HHS data on the premium stabilization programs.

The loss ratios for individual QHPs, which reached 110 percent, were significantly higher and were driven by substantial medical claims. Per-enrollee premium income for individual QHPs was 45 percent higher than for individual non-QHPs (\$4,519 versus \$3,126). However, the much larger per-enrollee premium income on individual QHPs was still not enough to cover medical claims that were 93 percent higher for their individual QHPs (\$4,973 versus \$2,581) than for group QHPs.

These data suggest that insurers anticipated that the ACA’s rules, which required more extensive coverage, would also attract a more expensive set of enrollees. Insurers priced QHP premiums significantly above non-QHP premiums for individual market plans, despite the availability of reinsurance and other stabilization programs for their individual QHPs. Insurers, however, seem to have underestimated just how expensive the population enrolled in individual QHPs would be. The substantially higher average premiums were still not high enough to cover the cost of insuring enrollees overall, as too few relatively healthy people were part of the individual QHP risk pool in 2014.

In the group market, the loss ratio for QHPs and non-QHPs was similar. Although per-enrollee medical claims were 7.6 percent higher for QHPs, per-enrollee premiums were 9.5 percent higher.⁴³

Despite Some Variation, Insurers Had Consistently Higher Claims for Individual QHPs

In the first paper, we reported significant variation in how insurers fared selling individual QHPs in 2014.⁴⁴ The carrier with a sizeable market share that fared the best was Kaiser Permanente, while the healthcare cooperatives (co-ops), established with funding through the ACA, generally fared the worst. Individual QHPs affiliated with Blue Cross Blue Shield (BCBS), which accounted for about 60 percent of 2014 enrollment, generally performed slightly better than average, but there was significant variation in performance among the Blues' plans.

Table 4 displays data for plans affiliated with BCBS, Kaiser, the co-ops, and all the residual insurers for the 174 insurers that offered both individual and group QHPs. Appendix B provides additional breakouts for the three carriers with significant market share in 2014. Although there was variation across carrier groups, insurers generally collected less in premiums, paid out more in medical claims, and recorded larger losses for their individual QHPs—as proxied by net risk corridor claims—than for their group QHPs.

The Co-op Risk Adjustment Numbers Were Curious

Co-ops fared especially poorly in both the individual and group market in 2014. They had risk corridor claims of \$1,109 per enrollee (24.3 percent of premium income) for their individual

⁴³ Group QHPs made aggregate risk corridor claims of \$294 million (\$122 per enrollee), indicating that they incurred small losses in the aggregate.

⁴⁴ Blase, Badger, and Haislmaier, “Affordable Care Act in 2014.”

QHPs and \$1,306 per enrollee (29.9 percent of premium income) for their group QHPs. Those higher risk corridor claims in the group market occurred despite much lower per-enrollee medical claims—\$1,769 less—for their group QHPs than for their individual QHPs. Extremely high medical claims explains co-op losses on their individual QHPs, but not the high losses incurred on their group QHPs.

Per-enrollee medical claims for the co-op group QHPs were nearly the same as per-enrollee medical claims for Blue Cross Blue Shield group QHPs. The losses co-ops incurred on their group QHPs are, in large part, attributable to risk adjustment payments that co-ops made for their group QHPs. Co-ops incurred substantial risk adjustment assessments—\$975 per enrollee—for their group QHPs in 2014. It is difficult to understand why the co-ops were assessed such large risk adjustment amounts. These findings may support the view, expressed by some who have examined the issue, that the risk adjustment program favored larger, more established insurers at the expense of the co-ops.⁴⁵ We will examine this issue in more detail in a subsequent paper.

⁴⁵ See, for instance, David M. Liner and Jason Siegel, “ACA Risk Adjustment: Special Considerations for New Health Plans” (Milliman Healthcare Reform Briefing Paper, July 2, 2015). Appendix B reports similarly anomalous results for other insurers. The Centers for Medicare and Medicaid Services recently addressed some of these criticisms. “March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting” (white paper, Centers for Medicare and Medicaid Services, March 24, 2016). We provide additional data relevant to this issue in appendix B.

Table 4. Averages Per Enrollee for Co-op QHPs, Blue QHPs, Kaiser QHPs, and Other QHPs

	Co-ops (n=23)			Blue Cross Blue Shield (n=67)			Kaiser Permanente (n=9)			Other (n=75)		
	Individual QHPs	Small group QHPs	Difference	Individual QHPs	Small group QHPs	Difference	Individual QHPs	Small group QHPs	Difference	Individual QHPs	Small group QHPs	Difference
Premium	\$4,197	\$4,353	-\$156	\$4,212	\$4,992	-\$779	\$4,176	\$4,347	-\$171	\$4,012	\$4,660	-\$648
CSR payments	\$362		\$362	\$368		\$368	\$207		\$207	\$279		\$279
Premium income	\$4,559	\$4,353	\$206	\$4,581	\$4,992	-\$411	\$4,383	\$4,347	\$36	\$4,291	\$4,660	-\$370
Medical claims	\$5,848	\$4,064	\$1,784	\$4,982	\$4,062	\$920	\$3,887	\$3,566	\$321	\$5,269	\$3,952	\$1,317
Net reinsurance	\$1,065	-\$56	\$1,121	\$925	-\$54	\$979	\$540	-\$135	\$675	\$1,037	-\$61	\$1,098
Net risk adjustment	-\$209	-\$975	\$767	\$65	\$22	\$42	\$82	-\$19	\$101	\$13	-\$32	\$45
Net risk corridor claims	\$1,109	\$1,301	-\$192	\$263	\$40	\$223	-\$82	\$260	-\$342	\$574	\$223	\$351
Risk corridor claims as % of premium income	24.3%	29.9%	-5.6%	5.7%	0.8%	4.9%	-1.9%	6.0%	-7.9%	13.4%	4.8%	8.6%
Revenue including BRs	\$6,525	\$4,622	\$1,902	\$5,834	\$5,000	\$834	\$4,922	\$4,452	\$470	\$5,914	\$4,790	\$1,124
Enrollees	302,054	66,787		3,959,155	1,758,096		501,862	175,754		822,822	414,290	

Note: The data correspond to the per-enrollee values for each carrier group or insurer classification. Premium, CSR payments, premium income, medical claims, net reinsurance, and net risk corridor claims are the aggregates for the QHPs divided by the number of QHP enrollees in each market. The net risk adjustment values are the aggregate amounts divided by the number of enrollees in each market. Differences are the per-enrollee values for individual QHPs less the per-enrollee values for group QHPs. Enrollees are shown in life years, which are the total number of months that people were enrolled in coverage divided by 12.

Sources: These data are from insurer medical loss ratio filings with the HHS combined with the HHS data on the premium stabilization programs.

Discussion

The ACA's changes created greater uncertainty for insurers with respect to the individual market than with respect to the small group market. Because of the greater uncertainty, insurers may have been inclined to charge higher premiums for individual QHPs relative to group QHPs. On the other hand, some insurers, cognizant that people often retain coverage because of the costs involved with switching plans, may have tried to capture market share in 2014 with lower premiums.

The availability of the premium stabilization programs, particularly the reinsurance program, created additional incentives for insurers to aggressively price individual QHPs in 2014. HHS Secretary Sylvia Burwell testified at a February 2016 congressional hearing that reinsurance payments were intended to exert “downward pressure” on premiums in the individual market.⁴⁶ As discussed earlier, the Congressional Budget Office estimated that the reinsurance program reduced premiums by about 10 percent in 2014.⁴⁷ The temporary risk corridor program likely also resulted in many insurers charging lower premiums, as insurers expected the program would provide a degree of protection from underpricing coverage and incurring higher claims than anticipated.⁴⁸

While the degree to which the premium stabilization programs induced individual QHPs to set premiums lower is uncertain; most insurers selling both individual QHPs and group QHPs took in significantly less premium income per enrollee for their individual QHPs despite the

⁴⁶ Sylvia Burwell, secretary, HHS, “The Fiscal Year 2017 HHS Budget” (testimony before House Energy and Commerce Subcommittee on Health). It is also worth noting that in addition to affecting premiums, it is also possible that the reinsurance program affected the amount of medical claims incurred. Aware that the reinsurance program would relieve them of a large share of the medical claims of some of their most expensive enrollees, insurers may have been less attentive to utilization control than they might have been in the program's absence.

⁴⁷ Congressional Budget Office, “Private Health Insurance Premiums and Federal Policy,” CBO, February 11, 2016.

⁴⁸ Colloquy between Representative Mark Meadows and University of Houston Law Professor Seth J. Chandler, YouTube video of hearing of the House Oversight and Government Reform Committee, June 18, 2014, <https://www.youtube.com/watch?v=WcmabR99tuw> (time 1:1:10–1:1:14).

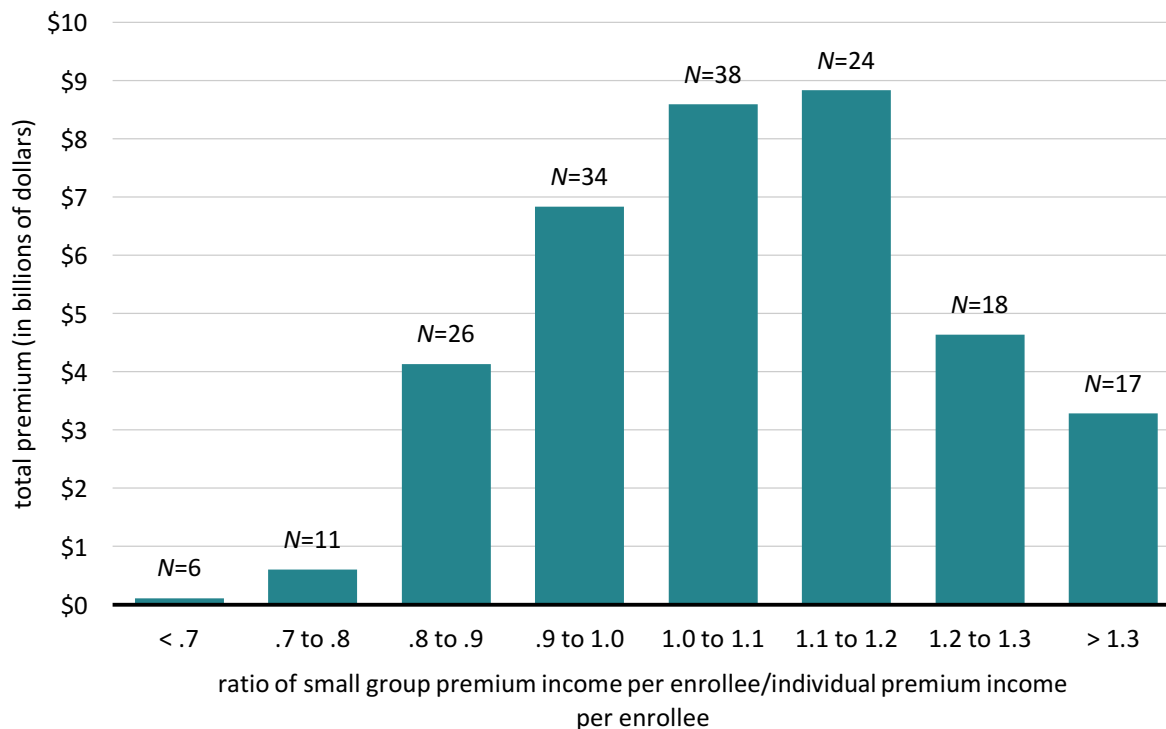
extra risk. In retrospect, the extra risk is evident since per-enrollee medical claims for individual QHPs exceeded those for group QHP enrollees by \$965.

Figure 1 illustrates the distribution of QHP premium income received by insurers for their individual and group QHPs by the ratio of group QHP premium income per enrollee to individual QHP income per enrollee. About 56 percent of insurers—97 out of the 174—received more in premium income per enrollee for their group QHP than for their individual QHP. These 97 insurers collected 68.5 percent of total QHP premium income in 2014.

Higher per-enrollee premium income for group QHPs, on average, was not likely a result of more comprehensive coverage since the average actuarial value of individual QHPs was relatively high. The HHS reported that 57.6 percent of people enrolled in an exchange plan as of December 2014 received CSR payments, which effectively raise the actuarial value of plans. We estimate that the average actuarial value of individual QHP exchange plans in 2014—using the actuarial values assigned to plans by the HHS—equaled 80 percent.⁴⁹

⁴⁹ Based on enrollment data produced by the HHS (May 2015, <https://www.cms.gov/newsroom/mediarelease/database/fact-sheets/2015-fact-sheets-items/Table-6-widget.html>), we estimate that the share of exchange enrollees in bronze plans, silver plans, gold plans, platinum plans, and catastrophic plans during 2014 equaled 18.6 percent, 66.5 percent, 8.8 percent, 5.0 percent, and 1.2 percent, respectively. Adhering to section 1302(d) of the ACA, we assigned a 60 percent actuarial value to bronze plans, 80 percent actuarial value to gold plans, 90 percent actuarial value to platinum plans, and a 50 percent actuarial value to catastrophic plans. Silver plan enrollees, who do not receive a CSR payment, have coverage with a 70 percent actuarial value. Based on 2014 enrollment data, we estimate that about 15.2 percent of silver plan enrollees did not receive a CSR payment in 2014; about 43.9 percent of silver plan enrollees made less than 150 percent of the FPL and received a CSR payment that raised the actuarial value of their plan to 94 percent; about 25.5 percent of silver plan enrollees made between 150 and 200 percent of the FPL and received a CSR payment that raised the actuarial value of their plan to 87 percent; and about 15.3 percent of silver plan enrollees received a CSR payment that raised the actuarial value of their plan to 73 percent. Therefore, the average silver plan actuarial value increased to 85.3 percent when accounting for the CSR payments. The average actuarial value we computed for exchange plans equaled 80 percent. Assuming the average actuarial value of off-exchange plans equaled roughly 70 percent and there was roughly one off-exchange QHP enrollee for every three on-exchange QHP enrollees means the overall actuarial value for individual QHPs equaled about 77.5 percent in 2014. The actual average actuarial value for individual QHPs is likely higher than this figure, however, since “actuarial value” was computed by the Centers for Medicare and Medicaid Services, based not on actual claims experience but on projected claims experience embedded in the Actuarial Value Calculator. See Department of Health and Human Services, “Patient Protection and Affordable Care Act; Actuarial Value Calculator Methodology,” accessed June 14, 2016. Actual claims expenses under the ACA were higher than projected and,

Figure 1. Distribution of QHP Premium by Market Pricing Difference



Note: *N* represents the number of insurers within that ratio.

Although per-enrollee premium income was higher for group QHPs than for individual QHPs, per-enrollee individual QHP premium income was 45 percent higher than per-enrollee individual non-QHP income. Some of this difference undoubtedly results from individual QHPs having a significantly larger actuarial value than individual non-QHPs, but an older and less healthy risk pool is also a likely factor.

since insurers pay a higher percentage of larger claims, the true actuarial value of the policies measured in a more conventional retrospective fashion, was higher than the prospective estimate.

Based on 2014 data released by the HHS, we estimate that the actuarial value for individual QHPs was similar to the actuarial value for group QHPs. The weighted national average actuarial value for group QHPs equaled 77.2 percent. We did not use the HHS report to estimate the actuarial value of individual QHPs since the report did not account for the cost-sharing subsidy reductions. HHS, “Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year,” September 17, 2015.

As a result of the ACA's changes, however, higher per-enrollee premium income is not necessarily a desirable result for individual QHPs. The ACA restricted premium variation based on age so that insurers collected a third as much premium, on a per-enrollee basis, from the youngest adult enrollees relative to the oldest enrollees.⁵⁰ Therefore, per-enrollee premium income increases as the insurer risk pool skews older. Since people near retirement spend about five times more on health care, on average, than young adults, a higher percentage of older people in the risk pool would have the effect of increasing per-enrollee claims by more than the accompanying increase in per-enrollee premiums.

Based on data released from the House Oversight Committee in July 2014, the share of insurers' 2014 individual QHP risk pools skewed older than expected. In fact, the risk pool contained about 50 percent more people over the age of 55 than insurers had expected as a share of the risk pool.⁵¹ Since the proportion of relatively old enrollees in individual QHPs was larger than expected, both per-enrollee premium income and per-enrollee medical claims were greater than likely expected.

Unexpectedly large medical claims per enrollee—nearly double for individual QHPs relative to individual non-QHPs—significantly outpaced the unexpectedly large premium income per enrollee. Because of the availability of lower premiums for grandfathered or grandmothered plans for relatively young and healthy people, they were more likely to maintain their coverage than relatively older and less healthy people.⁵² This phenomena likely explains

⁵⁰ See footnote 30.

⁵¹ House Committee on Oversight and Government Reform, *ObamaCare's Taxpayer Bailout of Health Insurers and the White House's Involvement to Increase Bailout Size*, July 28, 2014.

⁵² As discussed above, most states permitted insurers to renew grandmothered coverage. In all states, individuals could renew grandfathered coverage. These non-QHP policies in many cases offered less generous coverage than QHPs, something that would have reduced their attractiveness to people who expected to incur significant medical claims.

some of the large variation between per-enrollee premium income in the individual market between QHPs and non-QHPs.

As a result of an adverse risk pool, insurers experienced very high loss ratios on their individual QHPs in 2014. Despite receiving a subsidy for these plans equal to 20 percent of premium income through the ACA's reinsurance program, insurers still incurred large losses. Since insurers did reasonably well selling group QHPs without the benefit of the income-related subsidies for enrollees or the reinsurance program, the features of the employer-based insurance system that limit both adverse selection and gaming by consumers may be prerequisites for the ACA's insurance market changes to function without undo disruption.⁵³ This also suggests that the ACA rules and regulations governing QHPs may be incompatible with a well-functioning insurance market even with the reinsurance payments to QHP issuers and incentives for individuals to enroll in QHPs, whether positive, as with subsidies, or negative, as with tax penalties.

Conclusion

The reinsurance program held premiums for individual QHPs lower than they otherwise would have been, but the lower premiums, in conjunction with the income-related subsidies and the tax penalty for remaining uninsured, did not attract younger and healthier consumers in sufficient numbers to create a balanced risk pool in 2014. Individuals earning above 200 percent of the federal poverty level, who face premiums payments (that rise with income) as well as generally

⁵³ In 2013 and 2014, the Obama administration implemented the ACA in such a manner that it likely increased adverse selection among individual QHPs. Examples include the transition policy that allowed states to provide insurers with the option of renewing non-ACA-compliant plans as well as the large number of special enrollment periods created by the HHS for people to enroll for coverage outside of open enrollment.

high deductibles because of the structure of the ACA's tax credits and CSR payments, failed to purchase individual QHPs to the degree that many insurers and policy analysts expected.⁵⁴

Given that insurers' losses in selling individual QHPs significantly worsened in 2015 and given the scheduled expiration of the reinsurance and risk corridor programs, premiums will likely rise significantly above current levels in 2017.⁵⁵ These premium increases will further reduce the attractiveness of individual QHPs to younger and healthier enrollees, particularly individuals who do not qualify for large tax credits and CSR payments.

Enrollees eligible to claim these subsidies will largely be shielded from the effects of premium increases and will likely remain enrolled. Large premium increases are also unlikely to deter enrollment by people who expect to incur large medical claims, even if they don't receive subsidies. However, a risk pool consisting largely of low-income people and those who expect to file big medical claims is not conducive to a well-functioning insurance market. Such a scenario might prompt policymakers to reexamine their assumptions about how individual insurance markets work and whether the rules the ACA imposes on individual QHPs should be revised or reversed.⁵⁶

⁵⁴ Brian Blase, "Downgrading the Affordable Care Act: Unattractive Health Insurance and Lower Enrollment" (Mercatus Research, Mercatus Center at George Mason University, Arlington, VA, November 2015).

⁵⁵ Louise Radnofsky, "Insurers Seek Big Premium Boosts" *Wall Street Journal*, May 25, 2016.

⁵⁶ Presidential candidates in both parties have called for major revisions to the program. Former Secretary of State Hillary Clinton has called for more generous premium subsidies for those who enroll in individual QHPs, along with new tax credits for out-of-pocket expenditures. Donald Trump advocates repealing the ACA, although his replacement plan is not yet very detailed.

Appendix A. ACA Premium Stabilization Programs

The ACA established three so-called premium stabilization programs that were intended to mitigate the additional risks to insurers that were created by other provisions of the law. The three programs are reinsurance, risk adjustment, and risk corridors.

Reinsurance

The reinsurance program was established by section 1341 of the ACA to compensate insurers for large claims incurred by “high risk individuals in the individual market (excluding grandfathered health plans).”⁵⁷ The program lasts three years, from 2014 through 2016, and is funded from fees imposed on fully insured and self-insured group and individual major medical coverage. QHPs, which are certified to be sold on exchanges, and ACA-compliant plans not offered on the exchanges both qualify for payments from this program. Although the statute calls on the states to implement transitional reinsurance through assessments and payments, the federal government has essentially taken over implementation of the program.

The ACA set the amounts to be collected and distributed through the program at \$12 billion in 2014, \$8 billion in 2015, and \$5 billion in 2016. Of these amounts, the HHS was to deposit \$2 billion in 2014, \$2 billion in 2015, and \$1 billion in 2016 into the General Fund of the US Treasury. Payments into the reinsurance program have come in below expectations, totaling less than \$10 billion for the 2014 plan year and projected at only \$6.5 billion for the 2015 plan year. The HHS distributed \$7.9 billion to eligible insurers through the program for the 2014 plan year, rolling over \$1.7 billion for 2015. For the 2015 plan year, the HHS

⁵⁷ 42 U.S.C. § 18061.

estimates that it will pay \$7.7 billion to insurers, remitting just \$500 million to the US Treasury.⁵⁸

In 2014, after several iterations that made the program more generous to participating insurers, the program paid 100 percent of the cost of per-enrollee claims between \$45,000 and \$250,000.⁵⁹ The reinsurance formula for the 2015 plan year will be announced on June 30, 2016.⁶⁰

Risk Corridors

The risk corridor program was established by section 1342 of the ACA, and it applies to QHPs (and substantially similar plans) sold in the individual and small group markets both on and off the exchanges.⁶¹ This program also lasts three years, from 2014 through 2016, and was intended to transfer money from insurers making gains to insurers incurring losses. Under the program, insurers' allowable costs (total costs less administrative costs) and a target amount (total premiums including premium subsidies less administrative costs) are calculated for each QHP.⁶² Insurers whose target amount exceeds 3 percent of allowable costs were required to make payments to the risk corridor program. Insurers whose allowable costs

⁵⁸ Department of Health and Human Services, "The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year," February 12, 2016.

⁵⁹ Department of Health and Human Services, "Transitional Reinsurance Program: Pro Rata Adjustment to the National Coinsurance Rate for the 2014 Benefit Year," June 17, 2015.

⁶⁰ HHS, "The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year."

⁶¹ 42 U.S.C. § 18062.

⁶² For the 2014 plan year, the Centers for Medicare and Medicaid Services increased the ceiling on allowable administrative costs (previously set at 20 percent, plus the adjustment percentage, of after-tax premiums) by 2 percentage points. The agency also increased the profit margin floor in the risk corridors formula (previously set at 3 percent, plus the adjustment percentage, of after-tax premiums) by 2 percentage points. Although the adjustments were made to compensate for costs to insurers resulting from the decisions of some states to allow the renewal of non-ACA-compliant, nongrandfathered individual and group plans, these changes to the risk corridor calculation were made for all states. In its preamble to the rule making these changes, the agency wrote, "These increases to the profit floor and administrative cost ceiling in the risk corridors formula would increase a QHP issuer's risk corridors ratio if claims costs are unexpectedly high, thereby increasing risk corridors payments or decreasing risk corridors charges." 79 F.R. § 30259-60.

exceed the target amount by more than 3 percent were eligible to claim reimbursements from the program.⁶³

For the 2014 plan year, aggregate risk corridor receipts from insurers with costs below their target amount were \$362 million, while aggregate claims from insurers with costs above their targets were \$2.87 billion, a difference of \$2.5 billion. Throughout 2014, HHS officials expressed belief that receipts would cover claims and that the program would be implemented in a budget-neutral manner.⁶⁴ When it became clear that the program would run a deficit, HHS officials indicated that they would work with Congress to secure the funds to pay insurers, declaring the deficit to be “an obligation of the U.S. government for which full payment is required.”⁶⁵ The preference of Congress, however, was for the risk corridor program to operate in a budget-neutral manner, and Congress included a budget-neutrality requirement in the government funding bills for both fiscal years 2015 and 2016. Consequently, for the 2014 plan year, although the HHS collected full payment from insurers with claims less than 97 percent of their target amounts, for insurers with claims above 103 percent of their target amounts the HHS was forced to limit risk corridor payments to 12.6 percent of the full amounts claimed by those insurers. Some insurers have filed suit to recover full risk corridor collections they believe they are owed.⁶⁶

⁶³ The statute specifies that plans be reimbursed 50 percent of allowable costs between 103 and 108 percent of the target amount, and 80 percent of allowable costs above 108 percent of the target amount. Conversely, plans with allowable costs between 97 and 92 percent of the target amount are assessed 50 percent of the difference, and allowable costs below 92 percent of the target amount are assessed 80 percent of the difference between allowable costs and 92 percent of the target amount.

⁶⁴ Mandy Cohen, Centers for Medicare and Medicaid Services, testimony before the House Committee on Oversight and Government Reform, June 18, 2014. According to Dr. Cohen’s testimony, “We anticipate that risk corridor collections will be sufficient to pay for all risk corridor payments.”

⁶⁵ Department of Health and Human Services, “Risk Corridors Payments for the 2014 Benefit Year,” November 19, 2015.

⁶⁶ On February 24, 2016, Health Republic of Oregon filed a complaint in federal court on behalf of itself and all insurers that participated in the risk corridor program. The suit seeks to recover \$5 billion in risk corridor payments for the 2014 and 2015 benefit years from the federal government. *Health Republic Ins. Co. v. United States*, Fed. Cl. No. 16-259 (2016).

The HHS published final expected and prorated risk corridor payments for the 2014 plan year in November 2015. In this paper, we use “risk corridor claim” to indicate the amount insurers would receive if the budget-neutrality requirement were not enforced, and we also display the actual payments for insurers with lower claims than expected.

Risk Adjustment

The risk adjustment program was established by section 1343 of the ACA, and it applies to all nongrandfathered individual and small group plans.⁶⁷ Regulations issued by the HHS preclude grandfathered plans from participating in risk adjustment, which means QHPs and ACA-compliant non-QHPs are the only plans that participate in the risk adjustment program.⁶⁸ Of the three premium stabilization programs, it is the lone permanent program. Risk adjustment is intended to compensate for differences among competing insurers in their aggregate risk pools that might result from consumer decisions regarding plan selections. It compensates by transferring premium revenues from plans whose enrollees represent a lower actuarial risk overall to plans whose enrollees represent a higher actuarial risk overall. Risk is measured concurrently based on demographic factors relating to the pool of enrollees in an insurer’s plans and relating to their medical conditions; actual expenses of the individuals in the pool are not used.⁶⁹ Unlike the reinsurance program and unlike Medicare risk adjustment programs, there is no outside funding for the risk adjustment program. It operates on a budget-neutral basis within

⁶⁷ 42 U.S.C. § 18063.

⁶⁸ “Because under the transitional policy, the Federal government will not consider certain health insurance coverage in the individual or small group market renewed after January 1, 2014, under certain conditions, to be out of compliance with specified 2014 market rules, and requested that States adopt a similar non-enforcement policy, transitional plans are able to set premiums and provide coverage as if they were not subject to market reform rules. For this reason, transitional plans are not subject to risk adjustment payments and charges under our methodology at this time.” 79 Fed. Reg. 13753.

⁶⁹ This is a correction to our earlier paper, where we stated that risk is measured prospectively instead of concurrently.

both the individual and small group markets and within each state. Unlike the risk corridor program, the risk adjustment program does not result in any fund transfers, either between markets or states.

Order of Operations

The payments and calculations associated with the three programs are applied sequentially. First, the HHS determines whether an insurer must make payments to, or is eligible to receive payments from, the risk adjustment program. Next, for the 2014 plan year, insurers are compensated for the full cost of claims between \$45,000 and \$250,000 through the reinsurance program. Finally, risk corridor payments are calculated after first accounting for receipts and payments under the risk adjustment and reinsurance programs.

Appendix B

The data for the four specific carriers shown in table A are a continuation of table 4. The data displayed in the table are generally consistent with the patterns discussed in the paper. In each case, the carrier had higher premium revenues for its group QHPs than for its individual QHPs.

Table 4a provides further evidence that the risk adjustment program may not have functioned as intended. Health Care Service Corporation (HCSC), for example, incurred per-enrollee medical claims for its individual QHP of \$5,317 or nearly 130 percent of premium income; it also collected an average of \$1,145 or 28 percent of premium income in net reinsurance subsidies. Both of these are indications of an unusually unhealthy risk pool. HCSC was, however, a net payer into the risk adjustment program (\$19 per enrollee), which would suggest that its enrollees were healthier, on average, than those enrolled in other plans.

Blue Shield of California, by contrast, received large risk adjustment payments for both its individual and group QHPs—\$282 per enrollee for its individual policies and \$103 per enrollee for its group plans—indicators of enrollment that presented a much higher than average actuarial risk. Blue Shield of California’s medical claims per enrollee were, however, relatively low (representing 88 percent of premium income for its individual QHP and 74 percent of premium income for its group QHP). In this case, we see the reverse of the anomaly observed with co-ops and HCSC: an insurer whose risk adjustment payments reflect the assessment that its enrollees are in relatively poor health, but medical claims indicating that they consumed a relatively small amount of medical goods and services.⁷⁰

The experiences of Blue Shield of California, HCSC, and the co-ops, raise questions about whether the risk adjustment program accurately distinguishes between what the statute

⁷⁰ Blue Shield presents another premium stabilization anomaly: It made risk corridor payments averaging \$231 per enrollee, essentially canceling out its risk adjustment receipts of \$282 per enrollee.

terms “low actuarial risk plans” and “high actuarial risk plans.”⁷¹ We will look more closely at the risk adjustment program in a subsequent paper.

⁷¹ 42 U.S.C. § 18063.

Table A. Averages per Enrollee for Co-ops and Other Insurers

	Health Care Service Corporation (n=5)			Anthem Blue Cross Blue Shield			Blue Shield of California		
	Individual QHPs	Small group QHPs	Difference	Individual QHPs	Small group QHPs	Difference	Individual QHPs	Small group QHPs	Difference
Premium	\$3,723	\$4,993	-\$1,271	\$4,666	\$5,595	-\$929	\$4,316	\$5,258	-\$942
CSR payments	\$378		\$378	\$375		\$375	\$237		\$237
Premium income	\$4,101	\$4,993	-\$892	\$5,040	\$5,595	-\$554	\$4,553	\$5,258	-\$705
Medical claims	\$5,317	\$4,529	\$788	\$4,363	\$4,114	\$248	\$3,993	\$3,867	\$126
Net reinsurance	\$1,145	-\$51	\$1,196	\$820	-\$44	\$864	\$730	-\$50	\$780
Net risk adjustment	-\$19	\$22	-\$40	-\$58	\$19	-\$77	\$282	\$103	\$179
Net risk corridor claims	\$698	\$87	\$611	-\$28	\$0	-\$28	-\$231	-\$2	-\$229
Risk corridor claims as % of premium income	17.0%	1.7%	15.3%	-0.6%	0.0%	-0.5%	-5.1%	-0.0%	-5.0%
Revenue including 3Rs	\$5,925	\$5,051	\$875	\$5,774	\$5,570	\$205	\$5,334	\$5,309	\$25
Enrollees	788,982	290,721		360,666	114,514		462,388	70,059	

Note: The data correspond to the per-enrollee values for each carrier group or insurer classification. Premium, CSR payments, premium income, medical claims, net reinsurance, and net risk corridor claims are the aggregates for the QHPs divided by the number of QHP enrollees in each market. The net risk adjustment values are the aggregate amounts divided by the number of enrollees in each market. Differences are the per-enrollee values for individual QHPs less the per-enrollee values for group QHPs. Enrollees are shown in life years, which are the total number of months that people were enrolled in coverage divided by 12. Sources: These data are from insurer medical loss ratio filings with the HHS combined with HHS data on the premium stabilization programs.