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Health plan financial performance: 2011-2016

Chapter Three: Commercial group and individual lines of business trends

How have US health plans' commercial lines of business—group and individual—fared in the wake of health policy and market turbulence? Commercial lines of business, particularly the group segment, used to be growth and profitability engines for many health plans. However, market and policy changes have posed significant challenges and many health plans have struggled financially, particularly in the rapidly evolving commercial individual market. This paper presents five key findings from our analyses of health plans' financial performance in the commercial lines of business:

1. **The fully insured risk pools in both commercial lines of business—group and individual—deteriorated in 2014 and, to a somewhat lesser extent, in 2015.** Between 2013 and 2014, breakeven premiums per member* increased by 45 percent for the commercial individual segment and by 10 percent for the commercial group segment, likely indicating an increase in the insured population's average risk, as well as benefit design changes within these segments. By 2016, however, premium costs for both commercial risk pools increased at more moderate levels.
2. **In the fully insured commercial group segment, aggregate revenue was stable between 2011 and 2016, but profitability declined in 2014 and remained lower than pre-2014 levels in 2016.** Aggregate underwriting gains remained relatively constant between 2011 and 2013 but declined by 35 percent in 2014—from $7.8 billion in 2013 to $5.1 billion in 2014. Although underwriting gains increased somewhat in 2015 and 2016, they remained lower than their pre-2014 levels.
3. **Commercial individual business in aggregate has not been profitable since 2012, with mounting losses after 2014. Unlike other lines of business, this was true irrespective of plan size.** Between 2013 and 2014, aggregate commercial individual business underwriting losses increased by over 400 percent—from -$1 billion in 2013 to -$4.2 billion in 2014. By 2016, aggregate underwriting losses more than doubled compared to 2014 (-$10.3 billion). In contrast to our findings in other lines of business—where the largest health plans accounted for a disproportionate share of aggregate underwriting gains—the largest three plans by commercial individual revenue incurred losses. The combined underwriting losses for these plans totaled over $2 billion in both 2015 and 2016.
4. **Of the three premium stabilization programs**—reinsurance, risk adjustment, and risk corridors (also known as the 3Rs)—reinsurance was the most effective at helping contain health plan losses.** Reinsurance payouts improved aggregate underwriting margins by 12 percentage points in 2014—as the program phased out over the next two years, reinsurance payouts declined. The risk corridor program's intended protective impact was largely blunted due to lower-than-expected payouts;*** for instance, health plans received zero payouts for their 2016 claims. If health plans' risk corridor claims had been paid in full, the payouts would have improved plans' aggregate underwriting margins by four percentage points in 2016.
5. **Although the risk adjustment program was in aggregate neutral, it had large distributional consequences.** Between 2014 and 2016, the flow of aggregate payments under the risk adjustment program was generally from smaller plans with less market experience and information to larger, more experienced plans. The largest plans in the commercial individual segment, including Blue Cross Blue Shield plans, received an increasingly higher share of their premiums as risk adjustment receipts. By contrast, smaller plans and newer market entrants, including provider-sponsored plans (PSPs), paid a disproportionately larger share of risk adjustment payouts as a percentage of their premiums.

* Breakeven premiums per member refer to premium levels at which health plans are able to exactly cover their members' insured health care risk and administrative expenses. An increase in the breakeven premium per member reflects a change in the insured population's average risk and increase in health care costs due to cost trends.

** The Affordable Care Act created the reinsurance, risk adjustment, and risk corridors programs to stabilize premiums in the individual and small group health insurance markets inside and outside the health insurance exchanges.

*** The risk corridor program was net neutral in aggregate; health plans that had overpriced their products relative to their enrollee risk would pay into the common fund and these collections would help reduce the losses for the plans that had underpriced their products relative to their enrollee risk.

About this report

This report is the third and final installment in the Deloitte Center for Health Solutions series on financial performance trends in the US fully insured health plans market. We segment the fully insured market into four primary lines of business: commercial group, commercial individual, Medicare Advantage, and Medicaid managed care. The first installment in the series provided summary observations on overarching developments in the market. The second installment focused on trends in health plan government programs, specifically Medicare Advantage and Medicaid managed care. This report focuses on trends in the commercial individual and commercial group lines of business between 2011 and 2016.

As used in this series, "fully insured" refers to comprehensive medical coverage provided by state-licensed insurance companies that assume financial risk for covered health benefits in exchange for premiums paid by employers, governments, consumers, and other sponsors.

Methodology

This report presents results from our analysis of Medical Loss Ratio (MLR) forms filed by health plans between 2011-2016 with the Centers for Medicare and Medicaid Services (CMS). The analysis uses the health plans' reported data as of March 31 of the following year (e.g., for 2015, the data used is that reported by plans as of March 31, 2016). This adjustment is made to include the contribution of premium stabilization programs (reinsurance, risk adjustment, risk corridors, [the 3Rs]) to plans' revenue, as well as data on claims run-out (as claims are based on payments through March 31 of the following year plus an estimated claim liability for claims still outstanding).

The study focuses on the fully insured commercial group and commercial individual books of business of US health plans. It excludes commercial Administrative Services Only (ASO) business. The study uses financial data reported by insurers to CMS according to statutory accounting principles, rather than the generally accepted accounting principles (GAAP) reflected in public companies' financial statements.

Additionally, we use the statutory data as of March 31 of the year following the financial year, whereas GAAP information is as of December 31 of the financial year. There will, therefore, be differences in the results of this statutory data analysis compared to the financial reports of publicly traded health plans and other plans that provide public information based on GAAP.

As used in this paper:

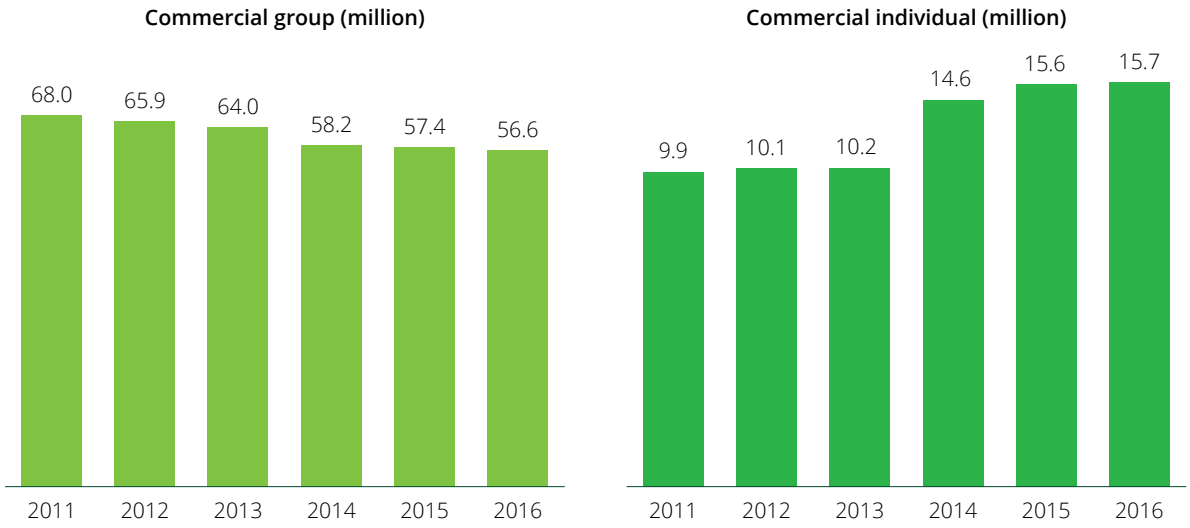
- **Revenue** refers to "total direct premium earned" fields in MLR filings. In the commercial individual segment, it includes payments for premium tax credit subsidies, reinsurance, and projected adjustments for risk adjustment payouts as of March 31 of the following year.
- **Underwriting gains** are derived by subtracting federal and state taxes and fees, claims costs, non-claim costs, and health care quality improvement expenses from the premiums in MLR filings.
- **Underwriting margins** are calculated as underwriting gains as a percentage of revenue.

Key finding 1: The fully insured risk pools in both commercial lines of business—group and individual—deteriorated in 2014 and, to a somewhat lesser extent, in 2015. By 2016, however, both commercial risk pools changed at more moderate levels.

In 2016, commercial group enrollment represented approximately 40 percent of total enrollment in the fully insured market (or 22 percent of the US population).[1] For many health plans, the commercial group line of business has been a major growth and profitability engine. However, due to rising health care costs and increased premium volatility, employers, particularly smaller establishments, are increasingly opting out of providing group coverage for their employees.[2] In addition, larger employers usually are self-insured, enlisting health plans as third-party administrators (ASO business) rather than as providers of comprehensive medical coverage (fully insured services).[3] This reduces medical expenses for employers with healthier-than-average employees,[4] increases employers' ability to tailor benefits to their employees' needs, and eases the regulatory burden since self-insured products are exempt from state insurance regulations and premium taxes.[5]

Consistent with these trends, commercial group enrollment in the fully insured market declined steadily from 2011 to 2016—from 68 million in 2011 to 56 million in 2016, a decline of 17 percent (Figure 1).

Figure 1. Aggregate enrollment in the fully insured commercial group line of business, 2011-2016



Source: Deloitte analyses based on data from health plans' MLR filings with CMS

Enrollment in the fully insured commercial individual line of business also saw significant changes during this period; however, enrollment grew rather than declined. Due to insurance coverage expansions under the Affordable Care Act (ACA),[6] commercial individual enrollment increased by 59 percent between 2011 and 2016—from 9.9 million in 2011 to 15.7 million in 2016—with a particularly sharp increase in 2014, the ACA's first expansion year. Between 2013 and 2014,[7] fully insured commercial individual enrollment increased by 43 percent, from 10.4 million to 14.6 million.

The large and rapid enrollment changes in both commercial lines of business likely contributed to risk pool deterioration in these segments. Average population risk tends to be more predictable when the pool of potential enrollees is broader and has a relatively stable composition over time.[8] By contrast, large changes in enrollment over a short period are associated with larger changes to the risk pool, typically through adverse selection effects.[9] Adverse selection can happen if lower-risk people stop buying coverage or if a disproportionately large number of higher-risk people start buying coverage.

Although information on the composition of the fully insured commercial group risk pool is not available in our data, trends in breakeven premium revenue per member per year (PMPY) indicate that costs likely have risen faster than premiums. This could result from less healthy people (or companies) being left in the risk pool as companies with healthier employees opt to self-insure or from companies with healthier employees opting out of group coverage. The premiums could also grow if employers increased the generosity of offered benefits.

By breakeven premium revenue, we refer to premium levels (including premium tax credit subsidies and premium stabilization payments) at which health plans are able to cover their members' insured health care risk and administrative expenses. As such, changes in breakeven premium revenue reflect changes in the cost to cover an insured population; this, in turn, could be driven by a change in the insured population's average risk, and changes in health care costs, including the average administrative cost of providing plan services.

Figure 2 shows trends in the breakeven premium revenue PMPY in the fully insured commercial group and commercial individual segments. Between 2011 and 2016, breakeven premium revenue PMPY in the commercial group segment grew by 23 percent, with a particularly sharp increase in 2014. Between 2013 and 2014, fully insured commercial group enrollment declined by 10 percent, and breakeven premium revenue PMPY increased by 10.2 percent—compared to an average 3.4 percent annual growth rate in the preceding two years.

In the commercial individual segment, changes in the breakeven premium revenue PMPY were even more pronounced, particularly in 2014 and 2015. Between 2013 and 2014, the breakeven premium revenue PMPY grew by 45 percent.

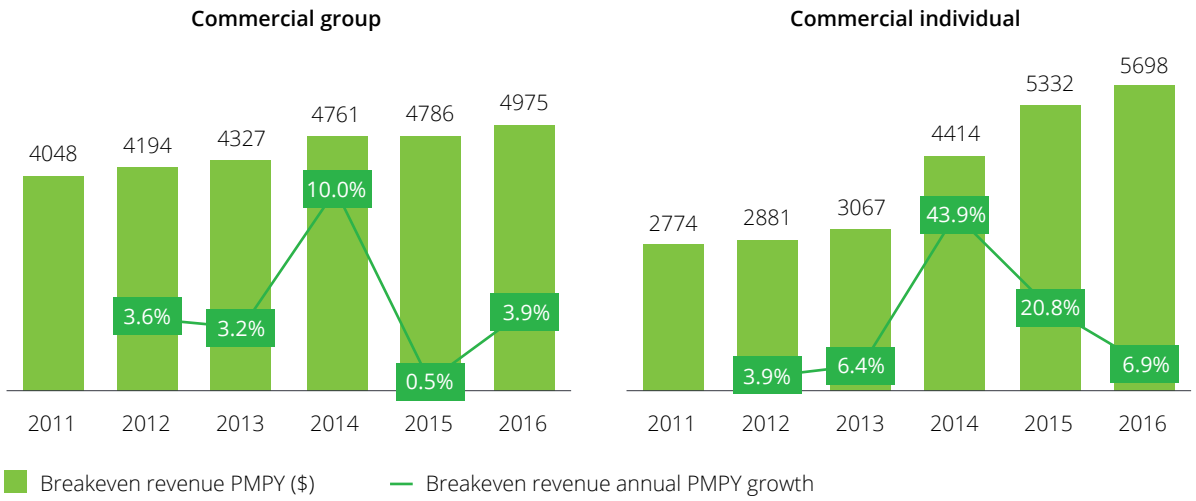
The large and rapid enrollment changes in both commercial lines of business likely contributed to risk pool deterioration in these segments.

The sharp increases in both commercial market segments' breakeven premium revenue PMPY in 2014 and, to a lesser extent, in 2015, are consistent with a higher average insured risk for the covered pools, as well as expanded benefit design. In the commercial group segment, changes in the average risk pool likely were driven by risk pool shrinkage due to the employer trend towards self-insurance,[10] as well as several employers, especially smaller ones, dropping coverage.[11] The increase in breakeven premium PMPY in the group segment, especially in 2014, is also likely due to premium hikes in the small group business to cover essential health benefits,[12] and to many states eliminating rules to permit medically underwriting group cases.

In the commercial individual segment, changes in the average risk pool likely were driven by numerous interrelated factors, such as increased benefit coverage for the average plan product,[13] expanded insurance access for a population with significant pent-up demand for health care,[14] guaranteed issue, benefit subsidies, and "plan shopping" in which potential enrollees could price-compare exchange plans and pick the lowest-premium plan based on their health care needs.

As illustrated by the increase in breakeven premium revenue PMPY, the commercial segments' average risk and costs appear to continue to rise. However, in 2016, breakeven premium revenue PMPY growth rates appear to have returned to their pre-2014 levels, which is suggestive of less change in the risk pools in these segments compared to 2014.

Figure 2. Trends in breakeven premium revenue PMPY, 2011-2016



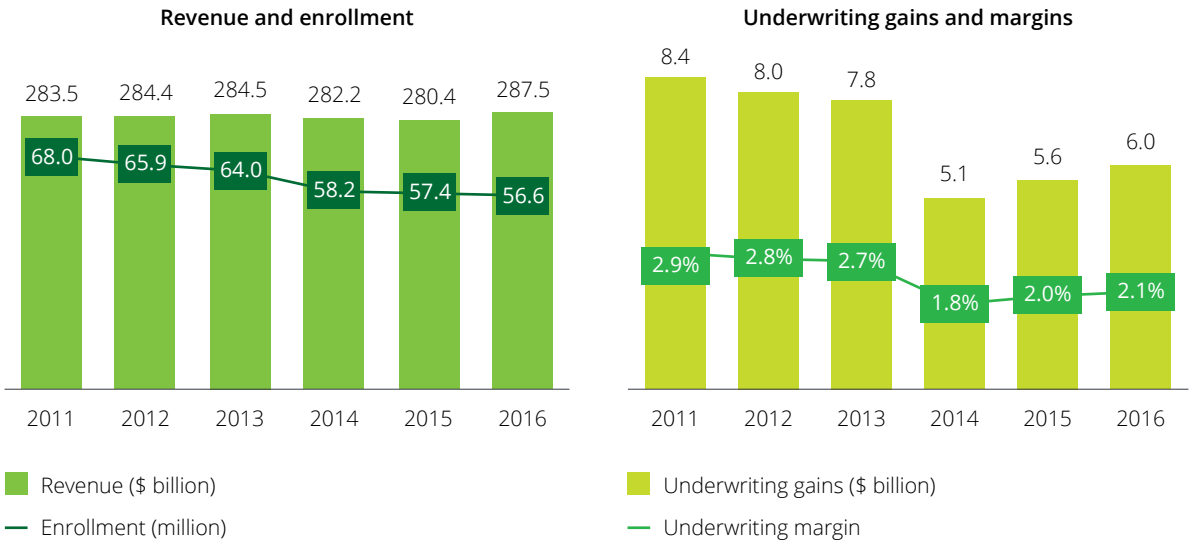
Notes: Breakeven revenue is calculated as a difference between total premium and underwriting gains.
Breakeven revenue PMPY is calculated as breakeven revenue divided by total enrollment.

Source: Deloitte analyses based on data from health plans' MLR filings with CMS

Key finding 2: Aggregate revenue in the commercial group line of business was relatively stable between 2011 and 2016. However, underwriting gains declined in 2014 and remained lower than pre-2014 levels in both 2015 and 2016.

As seen in Figure 3, industry-wide revenue from commercial group business was flat between 2011 and 2016. Aggregate underwriting gains also remained relatively constant between 2011 and 2013, but declined 35 percent from 2013 to 2014—from $7.8 billion to $5.1 billion. Although underwriting gains increased somewhat in 2015 and 2016, they remained lower than their pre-2014 levels. Margins followed a similar pattern. Although the margin stayed relatively constant between 2011 and 2013—around 2.8 percent—in 2014 the margin declined to about two percent, where it remained through 2016. The decline in profitability likely was driven, to some extent, by the deterioration of the risk pool described in the previous section. In addition, smaller groups in the commercial market were subject to ACA provisions and encountered profitability challenges similar to those in the individual market (discussed in the next section).

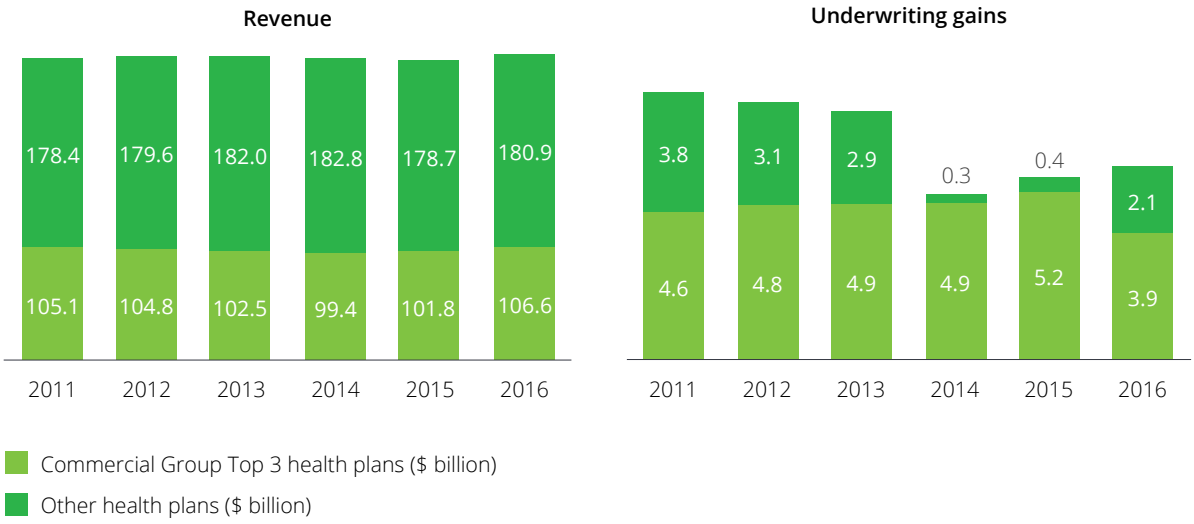
Figure 3. Revenue, enrollment, and underwriting gains and margins in the US fully insured commercial group market, 2011-2016



Source: Deloitte analyses based on data from health plans' MLR filings with CMS

In this series' previous reports, we found that, between 2011 and 2015, operating at a national scale was a significant driver of health plan profitability overall, and in the Medicaid managed care and Medicare Advantage lines of business. Underwriting gains and margins trends in the commercial group line of business provide no exceptions to this rule. The segment's three largest health plans as measured by national commercial group revenue ("Commercial Group Top 3") were Anthem, Kaiser Foundation Health Plan, and UnitedHealth. As Figure 4 illustrates, the combined revenue for the three largest plans was relatively stable between 2011 and 2016, and accounted for over a third of the industry-wide revenue in each year. Underwriting gains for Commercial Group Top 3 plans were also relatively stable, even as the profitability of all other plans decreased substantially in 2014 and 2015. Between 2013 and 2014, underwriting gains for the Commercial Group Top 3 plans remained unchanged but underwriting gains for other plans declined from $2.9 billion to $0.3 billion.

Figure 4. Revenue and underwriting gains of Commercial Group Top 3 health plans versus all other plans, 2011-2016



Note: "Commercial Group Top 3" is defined as the three largest health plans nationally by revenue in commercial group business in our data. These plans were Anthem, Kaiser Foundation Health Plan, and UnitedHealth.

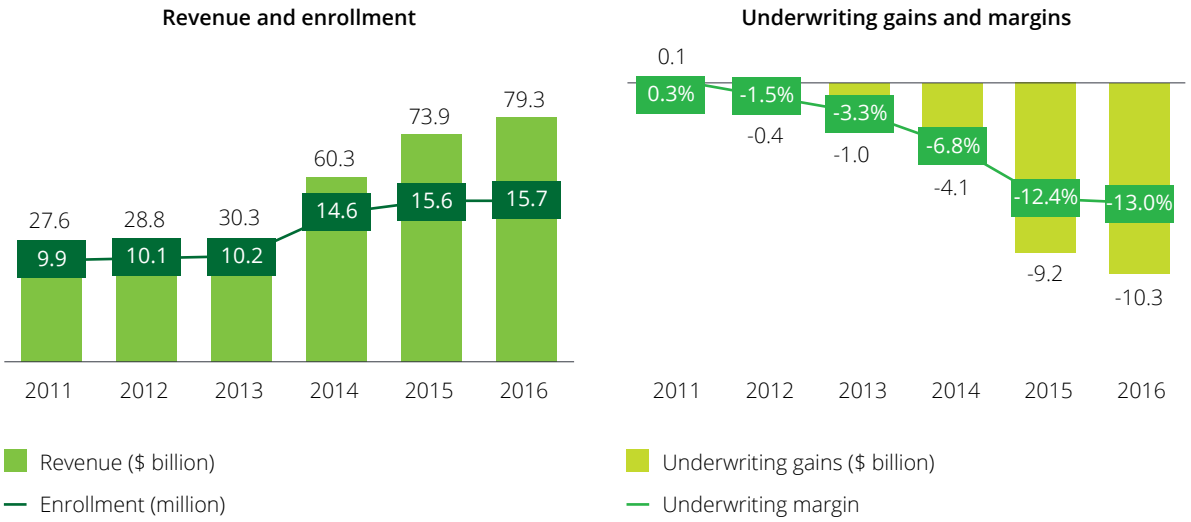
Source: Deloitte analyses based on data from health plans' MLR filings with CMS

Key finding 3: Commercial individual business in aggregate has not been profitable since 2012, with mounting losses after 2014 irrespective of plan size.

Health plans' aggregate revenue from commercial individual business—which includes payments from advanced premium tax credits, cost-sharing reduction subsidies, reinsurance, and projected risk adjustment payouts—increased threefold between 2011 and 2016; from $27.6 billion in 2011 to $79.3 billion in 2016. The large increase in revenue, particularly during 2014-2016, was largely driven by ACA-related market and policy changes and enrollment increases.[15]

In contrast, trends in underwriting gains and margins followed a markedly different pattern during this period. Aggregate underwriting gains in the fully insured commercial individual segment totaled $0.1 billion in 2011; however, health plans reported aggregate underwriting losses every year between 2012 and 2016, with mounting losses beginning in 2014 (Figure 5). Between 2013 and 2014, aggregate underwriting losses increased by over 400 percent—from -$1 billion in 2013 to -$4.2 billion in 2014. By 2016, aggregate underwriting losses totaled -$10.3 billion, more than double their 2014 levels. The increase in underwriting losses was faster than enrollment growth so, on average, underwriting losses per member grew during this period. Health plans' average underwriting losses per member totaled $98 in 2013, $282 in 2014, and $656 in 2016.

Figure 5. Total revenue, enrollment, and underwriting gains and margins in the US fully insured commercial individual market, 2011-2016



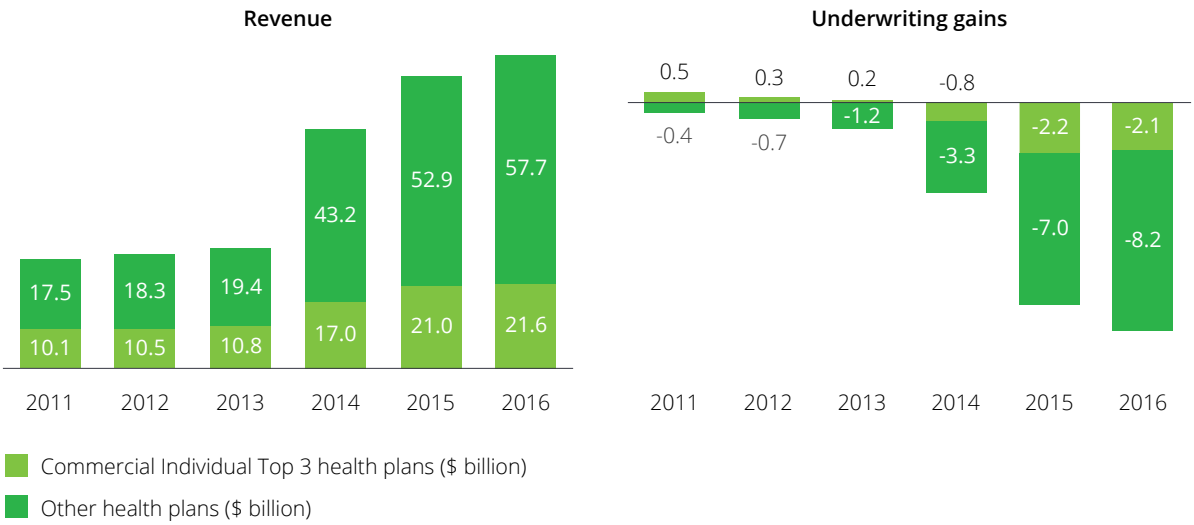
Source: Deloitte analyses based on data from health plans' MLR filings with CMS

Underwriting losses in the fully insured commercial individual market were pervasive: About 80 percent of the health plans we studied reported underwriting losses in this segment in 2014; by 2016, that figure increased to 95 percent. In contrast to our findings in the other lines of business we studied in this series—Medicaid managed care, Medicare Advantage, and commercial group—even the largest plans incurred underwriting losses in the commercial individual line of business.

The three largest health plans as measured by national commercial individual revenue ("Commercial Individual Top 3") were Anthem, Health Care Service Corporation, and UnitedHealth. As Figure 6 illustrates, the Commercial Individual Top 3 plans reported underwriting gains between 2011 and 2013, even as their peers reported aggregate underwriting losses. However, between 2014 and 2016, these three largest plans reported significant aggregate losses. In both 2015 and 2016, underwriting losses for the top three largest plans amounted to about -$2 billion per year.

There are numerous reasons for the commercial individual market's pervasive decline in profitability during this period, including: the complexity of setting premiums for a relatively new market with minimal available actuarial data;[16] a deteriorating risk pool relative to projections due to mandates often not being enforced; health plans pricing products based on overestimated initial enrollment projections;[17] uncertainty and low risk corridor payouts;[18] underestimating pent-up demand for the new enrollees;[19, 20] state transitional policies allowing people with certain individual or small group insurance policies purchased prior to the ACA to maintain the same insurance in 2014;[21] and "plan shopping," in which potential enrollees were able to price-compare exchange plans and pick the lowest-premium plan based on their health care needs.

Figure 6. Revenue and underwriting gains of Commercial Individual Top 3 health plans versus all other plans, 2011-2016



Source: Deloitte analyses based on data from health plans' MLR filings with CMS

Key finding 4: Of the three main premium stabilization programs—reinsurance, risk adjustment, and risk corridors—reinsurance was the most effective at helping contain health plan losses. By contrast, the risk corridor program's potential protective impact was largely blunted by low payouts.

As discussed earlier, the complexity and uncertainty of setting premiums for a relatively new market (with minimal available actuarial data) increased under the ACA.[22] Three programs collectively referred to as the 3Rs—reinsurance, risk adjustment, and risk corridors—were designed to provide a stabilizing effect on premiums and support the transition to a competitive and stable insurance market (see sidebar) by protecting plans against the negative effects of adverse selection and risk selection, and to help steady premiums, particularly during ACA implementation's initial years.

ACA premium stabilization programs[23, 24]

The Affordable Care Act created the risk adjustment, reinsurance, and risk corridors programs to stabilize individual and small group health insurance premiums inside and outside the health insurance exchanges.

- **The reinsurance program** transfers funds to individual market health plans with higher-cost enrollees. The program helps in ensuring that health plans do not charge higher premiums due to ACA reforms such as guaranteed issue.
- **The risk adjustment program** transfers funds from health plans with lower-risk enrollees to plans with higher-risk enrollees, adjusted for market characteristics, in the same state market. The program helps in ensuring that health plans compete based on the product value rather than by attracting healthier members.
- **The risk corridors program** transfers funds from health plans that overpriced their products to health plans that underpriced their products. The program protects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between HHS and qualified health plans to help ensure stable health insurance premiums.

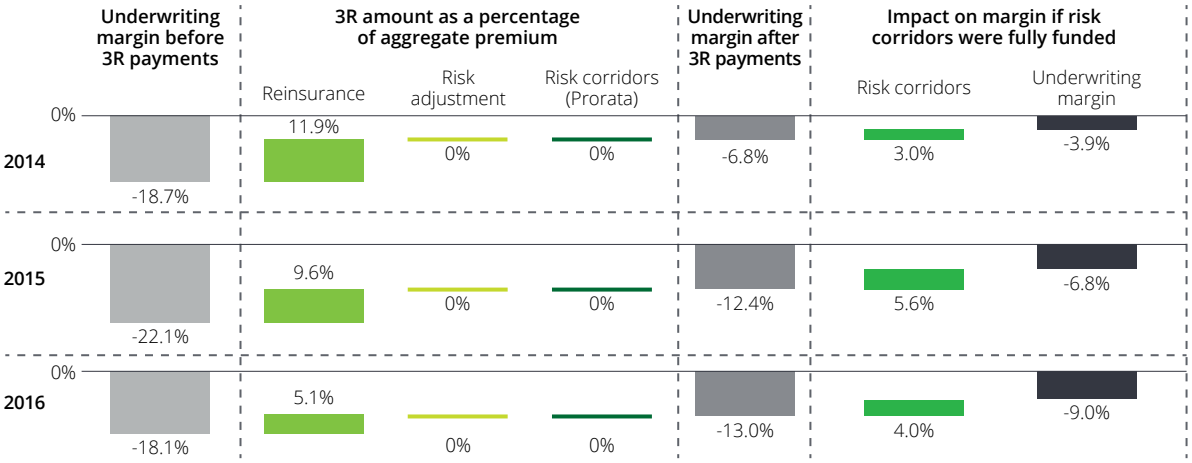
Table 1 summarizes the key provisions of the programs.

	Risk adjustment	Risk corridors	Reinsurance
Operated by	States which established marketplaces; federally facilitated marketplace	Federal government	States or federal government
Administered by	States which established marketplaces, otherwise federal government (all methods approved by HHS)	Secretary of HHS	Third-party, non-profit entity
Time span	2014 and beyond	2014-2016	2014-2016
Costs involved	Plan transfer net to zero within a market and state	TBD	2014: $12 billion 2015: $8 billion 2016: $5 billion
Plans participating	QHPs in the individual and small-group markets	QHPs in the individual and small-group markets	All major medical issuers contribute; ACA-compliant plans in the individual market (inside and outside of marketplace) receive benefits
Protect against	Adverse selection among QHPs	Uncertainty in rate setting and costs associated with pricing for a new risk pool	Individuals with high medical claims costs

Source: Deloitte analysis of the HHS Notice of Benefit and Payment Parameters for 2014 final rule

Figure 7 shows that, in the absence of 3R program payouts, health plans' underwriting margins would have dropped below -18 percent each year between 2014 and 2016.

Figure 7. Contribution of premium stabilization programs (3Rs) to aggregate commercial individual underwriting margins, 2014-2016



Note: The 3R aggregate amounts are expressed as a percentage of aggregate premium. Positive percentages indicate receipts to health plans; negative percentages indicate payouts by the respective health plans.

Source: Deloitte analyses based on data from health plans' MLR filings with CMS

Reinsurance. Reinsurance was a temporary program designed to protect plans from sustaining excessive losses from high-cost enrollees. As illustrated in Figure 7, reinsurance payouts helped contain plan losses in the individual market. In 2014, reinsurance payouts improved aggregate underwriting margin by almost 12 percentage points. However, because the program was gradually phased out between 2014 and 2016, reinsurance payouts were less effective in reducing aggregate losses in subsequent years. In 2016, for instance, they improved the aggregate margin by five percentage points.

Risk corridors. Under the risk corridors program, health plans that had overpriced their products would pay into the common fund and these collections would help reduce the losses for plans that had underpriced their products.**** However, as Figure 7 shows, the contribution of the risk corridors program to aggregate underwriting margins was essentially zero during this time period.

Between 2014 and 2016 most health plans set their premiums too low. As a result, claims under the risk corridors program totaled $11.3 billion ($2.5 billion in 2014, $5.3 billion in 2015, and $3.5 billion in 2016) while collections amounted to just $0.5 billion. Given a neutrality provision, the collections were distributed pro-rata for the 2014 claims under the program. As of 2018, health plans that underpriced their products have received approximately 16 percent of their 2014 risk corridor claims.[25] Plans that underpriced their products in 2015 and 2016 have not yet received any payouts.

If plans had received full payouts against their risk corridor claims in every year from 2014 to 2016, aggregate margins would have been higher than actual margins by three percentage points in 2014, six percentage points in 2015, and four percentage points in 2016.

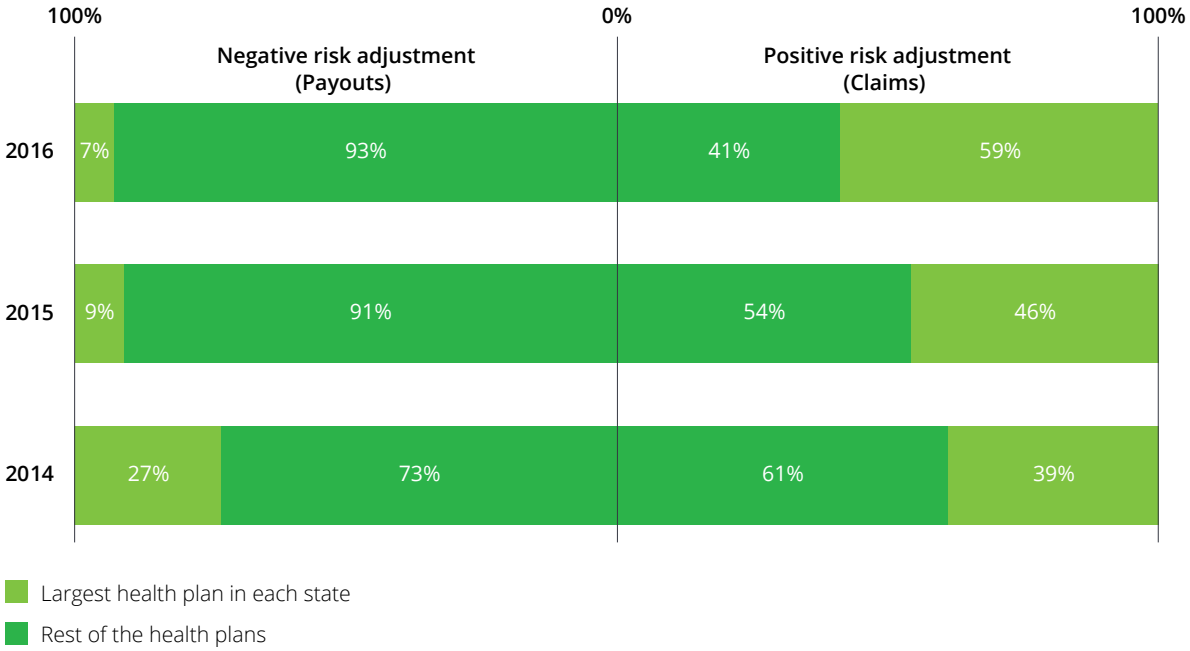
**** Under the program, a health plan calculates, a "target amount" of medical expenditures it expects for its covered risk pool, equivalent to total premiums collected minus an allowed amount for administrative costs and profits. If a plan's "allowable costs"—the actual expenditures for medical care for its enrollees—exceed the target by at least three percent, the plan will receive a payment from the risk corridors program. If the plan's allowable costs are lower than the target by three percent or greater, the plan must make a payment to the risk corridors program.

Key finding 5: Although the risk adjustment program was, in aggregate, net neutral, it had large distributional consequences.

The goal of the risk adjustment program was to protect against adverse selection and risk selection by spreading risk across the market. The risk adjustment program is net neutral within state markets; collections from plans with healthier-than-average members are distributed to plans with higher-risk enrollees after adjusting each plan's population for certain market characteristics. As a result of this neutrality provision, in aggregate, the contribution of the risk adjustment program to improving plans' margin—like that of the risk corridors program—was essentially zero during this time period.

Unlike the risk corridor program, the risk adjustment program had significant distributional consequences. The flow of aggregate payments under the risk adjustment program was generally from smaller plans, with less market experience and information, to larger, more experienced plans. We studied risk adjustment distribution patterns between the largest health plan in each state by enrollment as a cohort, and the rest of the health plans. As shown in Figure 8, the largest plans received 39 percent of total risk adjustment claims in 2014, increasing to 59 percent in 2016. By contrast, the largest plans contributed 27 percent of total risk adjustment payouts in 2014, declining to just seven percent in 2016. Risk adjustment receipts for the largest plans in each state increased aggregate underwriting margin for these plans by 0.4 percentage points in 2014, two percentage points in 2015, and 4.2 percentage points in 2016—relative to the levels that would have prevailed absent the program.[26]

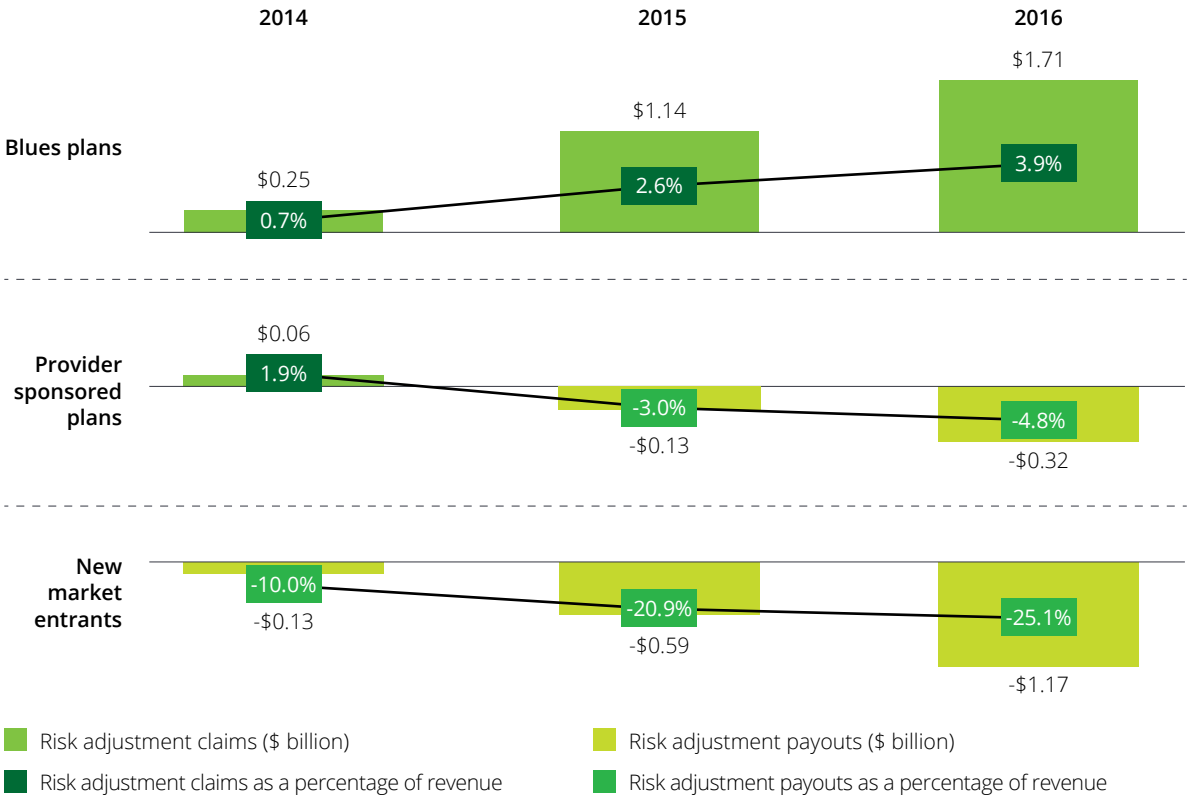
Figure 8. Distribution of risk adjustment payments: Largest health plan in each state versus rest of the plans



Source: Deloitte analyses based on data from health plans' MLR filings with CMS

Blue Cross Blue Shield ("Blues") plans, which typically have greater state-level scale than their peers as well as more experience in the individual market, captured a large share of risk adjustment payouts during this period. For example, Blues plans' risk adjustment claims of $1.9 billion in 2016 were 60 percent of the program's total claims. Risk adjustment payments as a percent of Blues' revenue increased from one percent in 2014 to four percent in 2016 (Figure 9). Blues with substantial state enrollment share such as Anthem, Blue Cross and Blue Shield of Florida, and Blue Shield of California, each received over $100 million in risk adjustment claims in 2016.[27]

Figure 9. Risk adjustment amount as a percentage of revenue, by plan type



Source: Deloitte analyses based on data from health plans' MLR filings with CMS

New market entrants—health plans that entered the individual market nationally between 2014 and 2016—had sizeable risk adjustment payouts as a percentage of their premiums (Figure 9). These plans paid $1 billion or 25 percent of their revenue as risk adjustment payouts in 2016. Provider-sponsored plans (PSPs), many of which entered the individual market in 2014 and 2015, had substantial negative adjustments to their margins under the risk adjustment program. In 2016, PSPs (excluding Kaiser Foundation Health Plan) paid five percent or $0.3 billion of their aggregate revenue as risk adjustment payouts.

Risk selection likely played a role in determining the flow of risk adjustment payments during this period. Larger, more established plans, such as the Blues plans, likely attracted higher-risk enrollees due to their market reputation.[28] In addition, newer market entrants likely kept their premiums low to attract new members; as a result, they might have attracted a disproportionately higher share of healthier enrollees.[29]

In addition to selection risk, factors such as deeper market knowledge, greater access to data, and better processing and coding capabilities likely played a role in the flow of risk adjustment payouts to the larger, more experienced plans. These plans typically had deeper (historical) market experience and better processing systems to accurately capture and load their members' diagnosis codes and, thus, more accurate risk scores.

By contrast, some newer health plans' relative inexperience in enabling health care providers to capture diagnosis codes resulted in claims processing delays and, sometimes, incorrect risk scores. Also, smaller health plans and newer market entrants typically had less claims data for their enrollees, which sometimes made their populations appear lower-risk than if adequate longitudinal claims data had been available.[30]

Partly to address some plans' concerns about the role of non-risk selection factors in the distribution of risk adjustment payouts, the CMS changed the risk-adjustment formula for 2017, including accounting for people who enroll for only a portion of the year because of major life changes. In 2018, the formula will factor in prescription drug data among the costs of covering enrollees.[31, 32]

New market entrants—health plans that entered the individual market nationally between 2014 and 2016—had sizeable risk adjustment payouts as a percentage of their premiums.

Perspectives

Policy as a driver: The results of our analysis underscore the importance of policy and its appropriate implementation as drivers of health plans' performance in the commercial segments of the fully insured market. These segments—the individual market, in particular—were significantly changed by the ACA. In addition, some policy changes were not implemented as originally intended, including partial or no stabilizing market mechanisms and regulations, which likely resulted in unintended consequences for health plans. Many of this paper's findings can be categorized as pre- and post-2014 results, which reflect the direct and indirect impacts of policy changes and uncertainty on health plans' commercial business.

Improving population health is important: Improving the risk pool is important to the commercial fully insured market's future viability and stability. In addition to trying to contain the short-term effects of risk and adverse selection, health plans should focus on wellness and population health initiatives, working closely with providers to better manage health conditions and improve their members' health. One way to achieve this is by investing in customer engagement technologies: As a part of Deloitte 2016 survey of health care consumers, the health exchange respondents' insights reveal that new plan enrollees have greater technology demands.[34] Investing in care management technologies and provider-engagement capabilities also could enable plans to better address members' health and health-related social needs.

Capabilities matter: Health plans of all sizes should continuously re-evaluate their position and capabilities in a changing market. High market exit rates and member turnover can lead to instability in health plans' risk profiles, making accurate pricing and predictability challenging. Price setting in an unstable market requires sophisticated premium rate-setting capabilities, including predictive data analytics, and increased flexibility to rapidly respond to health care expense increases in specific areas. In addition, the distributional impacts under the risk adjustment program in the commercial individual market illustrate the importance of accurate data collection, processing, and coding capabilities for diagnosis information capture so that health plans are paid fairly for the risk they carry.

Health plans of all sizes should continuously re-evaluate their position and capabilities in a changing market.

Appendix

Data and methodology

For this study, we used Medical Loss Ratio (MLR) forms filed by health plans between 2011-2016 with the Centers for Medicare and Medicaid Services (CMS), and 2014-2016 risk corridor claims and payouts announced by the Center for Consumer Information and Insurance Oversight (CCIIO).

Commercial individual segment

For our analysis of the commercial individual segment, we used health plans' data in their reported state of business as of March 31 of the following year (e.g., for 2015, we used the data reported by plans as of March 31, 2016). For the national-level analysis, we consolidated health plans' business from all the states.

The key performance metrics we analyzed are:

- **Revenue:** Defined as "Total direct premium earned" fields in MLR filings (the "Health insurance INDIVIDUAL Total as of 3/31" column in the "Part 1. Summary of Data" table of the MLR filing). It includes payments for premium tax credit subsidies, reinsurance, and projected adjustments for risk adjustment payouts as of 3/31 of the following year. Since the final risk corridor amount announced by CCIIO was often different from that reported by health plans in their MLR filings, we replaced the amount in the MLR filings with the amount published by CCIIO.
- **Underwriting gains:** Calculated by subtracting the various line items under federal and state taxes and fees, claims costs, non-claim costs, and health care quality improvement expenses from the premiums in MLR filings.
- **Underwriting margins:** Calculated as underwriting gains as a percentage of revenue.
- **Enrollment:** Defined as "Number of covered lives" field in MLR filings.
- **Member months:** Defined as "Member months" field in MLR filings.

Commercial group segment

For our analysis of the commercial group segment, we used health plans' reported data from their states of business as of March 31 of the following year (e.g., for 2015, we used the data reported by plans as of March 31, 2016). For the national-level analysis, we consolidated health plans' business from all the states.

The key performance metrics analyzed in the study are –

- **Revenue:** Defined as "Total direct premium earned" fields in MLR filings (from the "Health insurance SMALL GROUP Total as of 3/31" and the "Health insurance LARGE GROUP Total as of 3/31" columns in the "Part 1. Summary of Data" table of the MLR filing columns.) In the commercial small group segment, it includes payments for premium tax credit subsidies and projected adjustments for risk adjustment payouts as of 3/31 of the following year. Since the final risk corridor amount announced by CCIIO was different from health plans' reported amounts in their MLR filings, we replaced the amount in the MLR filings with the amount published by CCIIO.
- **Underwriting gains:** Calculated by subtracting the various line items under federal and state taxes and fees, claims costs, non-claim costs, and health care quality improvement expenses from the premiums in MLR filings.
- **Underwriting margins:** Calculated as underwriting gains as a percentage of revenue.
- **Enrollment:** Defined as "Number of covered lives" field in MLR filings.
- **Member months:** Defined as "Member months" field in MLR filings.

Our analysis for both commercial individual and commercial group segments includes health plans with a business focus on comprehensive medical coverage provided by state-licensed health insurance companies. We excluded health plans with a focus on non-health (such as life, P&C insurance) or ancillary health (dental, vision, etc.) services. To minimize the influence of outliers we also excluded health insurance Consumer Oriented and Operated Plans (COOPs) since majority of these COOPs have shut their operations. Additionally, for each segment—commercial individual and commercial group—we excluded health plans that had fewer than 1,000 members in a particular state. These exclusions may result in our aggregate numbers being different from other published government and private studies on these segments.

Endnotes

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Authors

James Whisler
Principal
Health actuarial practice leader
Deloitte Consulting LLP
jwhisler@deloitte.com

Andrew Davis
Senior Manager
Deloitte Consulting LLP
andavis@deloitte.com

Andreea Balan-Cohen
Senior Manager
Deloitte Center for Health Solutions
Deloitte Services LP
abalancohen@deloitte.com

Maulesh Shukla
Assistant Manager
Deloitte Center for Health Solutions
Deloitte Services LP
mshukla@deloitte.com

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Sarah Thomas
Managing Director
Deloitte Center for Health Solutions
Deloitte Services LP
sarthomas@deloitte.com

Email: healthsolutions@deloitte.com
Web: www.deloitte.com/centerforhealthsolutions

To download a copy of this report, please visit www.deloitte.com/us/commercial-health-plan-financial-trends

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