The Affordable Care Act in 2014

Significant Insurer Losses despite Substantial Subsidies

Brian Blase, Doug Badger,
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April 2016

MERCATUS WORKING PAPER

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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, March 2016.

Abstract

The ACA significantly altered the rules governing the individual insurance market, and the general effect was to lower premiums for older and less healthy people and raise premiums for younger and healthier people. To induce younger and healthier people to enroll, the law contained the individual mandate and subsidies for both buyers and, for the first few years of the program, sellers of insurance in the form of premium stabilization programs. This study analyzes data from HHS from 2014, the first year of the ACA's implementation, and finds that insurers suffered significant losses despite eventually receiving much larger payments from the law's reinsurance program (one of the premium stabilization programs) than they expected when setting their 2014 premiums. Given the same population and same utilization of services from that population, insurers would have had to price average premiums more than 25 percent higher to avoid losses in the absence of the reinsurance program. While insurers' performance varied significantly across carriers and states, the large overall losses in 2014 raise questions about the long-term stability of the changes made by the ACA, particularly after 2016 when the reinsurance and risk corridor programs end and premium revenue must be sufficient to cover expenses.

JEL codes: I13, I11, I18, H51

Keywords: Affordable Care Act, exchanges, reinsurance, risk corridors, loss ratio, qualified health plans

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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.

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Introduction

The Affordable Care Act (ACA) significantly altered the regulation of health insurance in the United States, with the most sweeping changes imposed on the individual and small group markets. Plans now have to meet numerous new federal regulations, including benefit requirements, actuarial value standards, and premium restrictions.[1] These requirements made insurance more attractive to older and less healthy individuals and less attractive to younger and healthier individuals, all else being equal. Of critical importance to the ACA's success is whether younger and healthier people enroll in significant enough numbers to cross-subsidize insurers for lower than actuarially fair premiums on older and less healthy people. To induce healthy people to enroll, the ACA included the individual mandate penalty as well as subsidies for many people to reduce their out-of-pocket premiums and cost-sharing amounts.[2]

[1] The ACA required insurers to offer coverage to all applicants (guaranteed issue) during open enrollment periods, or during special enrollment periods for people with a qualifying life event, without varying premiums based on health status (ban on medical underwriting). The ACA also prohibited insurers from varying premiums by more than three to one for individuals of different age who are 21 years and older. Premiums may not vary by more than 50 percent for similar individuals who only differ in tobacco usage. The ACA also required Qualified Health Plans (QHPs) to comply with narrow actuarial value bands with a minimum actuarial value of 60 percent.

[2] The ACA authorized premium tax credits for people enrolling in an exchange plan who generally have income between 100 and 400 percent of the federal poverty level (FPL) and are not eligible for another government health care program or insurance through the workplace. The credits are structured to limit the amount of income that people pay for premiums. The law also authorized cost-sharing reduction (CSR) payments, which lower plan deductibles and other cost-sharing amounts, for people with income below 250 percent of the FPL who purchase silver plan coverage. The CSR payments raise the actuarial value of plans to 94 percent for people between 100 and 150 percent of the FPL, 87 percent for people between 150 and 200 percent of the FPL, and 73 percent for people between 200 and 250 percent of the FPL. The US House of Representatives has filed a lawsuit against the Department of Health and Human Services (HHS), claiming that the House did not appropriate money for the CSR program and that HHS is making illegal payments to insurers through the CSR program.

The fact that almost all of the changes occurred simultaneously made it difficult to predict their effects. In an attempt to mitigate the uncertainty for insurers and to support lower overall premiums between 2014 and 2016, the ACA established three premium stabilization programs: a temporary reinsurance program for the individual market, a temporary risk corridor program for Qualified Health Plans (QHPs), and a permanent risk adjustment program for both the individual and small group markets.[3]

This is the first in a series of papers[4] in which we provide the most comprehensive analysis to date of the impact of the ACA on the individual and small group insurance market in 2014. In this overview, we provide information on how insurers fared in their first year selling QHPs—plans that satisfy all of the ACA's requirements and are certified to be sold on exchanges—using a data set compiled from medical loss ratio form that insurers are required to file with the Department of Health and Human Services (HHS).[5] Data in those filings is 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. 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 this data with the data released by HHS on the premium stabilization programs.

First, we find that in the aggregate, insurers incurred substantial losses despite receiving much larger reinsurance payments per enrollee than they expected when they set their premiums

[3] The appendix provides a summary description of each of the three programs, commonly referred to as the premium stabilization programs or the 3Rs, and the order in which they operate.
[4] In the second paper, we draw conclusions from the differences in performance for insurers that offered QHPs in both the individual and small group markets. In the third paper, we assess insurer performance (profits/losses, administrative costs, claims, premiums, and 3R payments) across carriers and across states. In the fourth paper, we assess the effectiveness of the 3R programs, particularly risk adjustment.
[5] Insurers were required to file MLR forms for plan year 2014 with HHS by June 30, 2015. We accessed the data reported in those filings through a dataset compiled and formatted by Mark Farrah Associates (www.markfarrah.com), a subscription-based aggregator of health insurance regulatory filing data. The data is also available directly from HHS in a public use file at Centers for Medicare & Medicaid Services, "Medical Loss Ratio Data and Systems Resources," https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.

for the 2014 plan year. The purpose of the reinsurance program is to "help stabilize premiums for coverage" by compensating insurers for much of the claims incurred by "high risk individuals."[6] The larger than expected reinsurance payments were the result of HHS revising the payment formula twice after premiums had been set. Those revisions made the program about 40 percent more generous than the original specifications that insurers relied on when setting premiums.[7] That effectively reduced QHP losses relative to what they otherwise would have been.

Second, our findings quantify how much insurers underpriced individual market QHPs in 2014, despite receiving larger subsidies than expected through the reinsurance program. One possible explanation is that some insurers may have deliberately underpriced their coverage offerings in an attempt to gain market share, based on expectations that the reinsurance and risk corridor programs would subsidize losses if they incurred. However, the large losses by carriers in the aggregate suggest that medical claims incurred were far higher than what insurers could have expected, even with a strategy of underpricing in year one. To break even in 2014 without the reinsurance program, we estimate that premiums would have needed to be more than a quarter more expensive in the aggregate—assuming, implausibly, that no additional selection effects would have resulted from such higher premiums. Under the original reinsurance program parameters (those at the time insurers set 2014 premiums), premiums would have needed to be nearly a third higher in the aggregate, again assuming no additional selection effects.

Third, we find that QHP performance varied significantly across insurers and across states. In the aggregate, the health care cooperatives (co-ops) created with federal loans authorized by the ACA performed the worst, while QHPs with narrower provider networks

[6] Public Law 111-148 § 1341, codified at 42 USC § 18061.
[7] Seth Chandler, "How the Obama Administration Raided the Treasury to Pay Off Insurers," *Forbes*, January 18, 2016.

generally fared the best. QHPs issued by Blue Cross and Blue Shield (Blue) carriers, which accounted for nearly three out of five enrollees in 2014, fared slightly better than other QHPs in the aggregate but still made net risk corridor claims. Some, like Anthem and Blue Shield of California, were net payers into the risk corridor program, while other Blues plans, such as those in Texas and North Carolina, incurred very large losses and made sizeable claims against the program.

Some of the state-level variation may be explained by state decisions with respect to expanding Medicaid or permitting insurers to renew non-grandfathered non-ACA-compliant policies (transition policy). This is because insurers generally fared better with their QHPs in states that expanded Medicaid and did not adopt the transition policy. However, most of the state-level variation disappeared after controlling for California, which expanded Medicaid and did not adopt the transition policy.[8] In a subsequent paper, we will further investigate factors that might explain variations in insurer performance. We will do this using regression analysis to control for variables such as state decisions with respect to expanding Medicaid, creating their own exchange, or adopting the Obama administration's transition policy.

While detailed information on insurer performance and payments and claims through the premium stabilization programs in 2015 is not yet available, reports indicate that insurers' losses were at least as high in 2015 as in 2014.[9] The Blue Cross Blue Shield Association reports that not only did ACA enrollees use more medical services across all sites of care, but the "medical costs associated with caring for the new individual market enrollees, were, on average, 19

[8] California accounted for more than 20 percent of individual market QHP enrollment in 2014, and insurers did much better than average selling QHPs in California.
[9] Deep Bannerjee, 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.

percent higher than employer-based group members in 2014 and 22 percent higher in 2015."[10] This suggests that our findings of what happened in 2014 were likely replicated at a macro level in 2015, and those findings almost certainly have implications for future years. Overall, the large losses incurred by insurers selling QHPs raise questions about the long-term stability of the changes made by the ACA, which will face additional pressure when the reinsurance and risk corridor programs end and premium revenue must be sufficient to cover expenses.

Reinsurance Payments per Enrollee Much Higher Than Expected

The ACA's reinsurance program provides significant protection to insurers offering ACA-compliant plans in the individual market between 2014 and 2016. The program accomplishes this by compensating the insurers for a large share of expenses incurred by "high risk individuals." As a result of this program, insurers priced premiums lower than they otherwise would have. While all ACA-compliant individual market plans are eligible for reinsurance payments for their "high risk individuals,"[11] the overwhelming majority of those payments were received by QHPs.[12] In 2014, individual market QHPs received net reinsurance payments—largely a transfer from group health plans—of about $6.72 billion.[13]

Prior to insurers setting their 2014 premiums, HHS issued regulations specifying that the reinsurance program would have an attachment point of $60,000, a reinsurance cap of $250,000,

[10] 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.
[11] Pub. L. 111-148 § 1341.
[12] In 2014, insurers selling QHPs received $7.15 billion (90.8 percent) of the of $7.87 billion in total reinsurance payments.
[13] The program is largely funded by group health plans. In 2014, nonexempt plans were assessed a fee of $63 per enrollee to finance the reinsurance program. Individual market plans were also required to contribute to the program. Thus, for individual market plans, net reinsurance payments received are their gross receipts from the program minus the assessments imposed on them to fund the program.

and a coinsurance rate of 80 percent.[14] HHS's rationale was that "the parameters would not interfere with traditional commercial reinsurance, which typically has attachment points in the $250,000 range."[15] 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 x 0.8 = $112,000). The Congressional Budget Office (CBO) estimated that the reinsurance program lowered 2014 premiums by approximately 10 percent.[16]

On March 5, 2014, HHS changed the parameters of the reinsurance program, lowering the attachment point to $45,000. HHS stated that if there were still funds unexpended, it would also increase the coinsurance rate, so as to "maximize the benefits of the reinsurance program."[17] In March of 2014, Seth Chandler of the University of Houston estimated that the reinsurance parameters with the lower attachment point would have enabled insurers to set premiums for their 2014 QHPs about 11 percent lower than they otherwise would have been if those parameters were known to insurers at the time.[18] In June 2015, HHS increased the coinsurance rate to 100 percent—making the program, ex post facto, about 40 percent more generous relative to the original specifications.[19] Adjusting Chandler's estimate to reflect the final reinsurance program parameters—his original analysis was based on a $45,000 attachment point and 80 percent coinsurance rate—implies that the reinsurance program as implemented provided QHPs with compensation sufficient to cover discounting their premiums by about 13.5 percent.

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[14] "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, Proposed Rule," *Federal Register*, Vol. 77, No. 236 (December 7, 2012), 73118–732128; and "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, Final Rule," *Federal Register*, Vol. 78, No. 47 (March 11, 2013), 15410–15541.
[15] *Ibid*., "Final Rule," *Federal Register*, Vol. 78, No. 47, 15467.
[16] Congressional Budget Office, "Private Health Insurance Premiums and Federal Policy," February 2016.
[17] Centers for Medicare & Medicaid Services, "HHS 2015 Health Policy Standards Fact Sheet," March 5, 2014.
[18] Seth Chandler, "Reinsurance Reduction Will Add 7% to Gross Premiums for 2015," *ACA Death Spiral*, March 31, 2014.
[19] 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.

Table 1 shows that the reinsurance payment per individual market QHP enrollee[20] equaled $833 in 2014; the mean amount equaled $934 after weighting QHPs by medical claims.[21] Weighting by medical claims allows us to account for the variation in spending by QHP on expenses of its enrollees and place greater weight on QHPs that incurred higher medical claims. The unweighted and claims-weighted per-enrollee 2014 reinsurance payments amount to about 18.8 percent and 20.6 percent of premium income, respectively.[22]

A comparison of actual per-enrollee reinsurance payments to what insurers likely expected as estimated by CBO and Chandler, strongly suggests that insurers received substantially more in reinsurance payments per enrollee—nearly twice as much—than they anticipated when they were setting their 2014 premiums. Since insurers received substantially larger reinsurance payments than they expected when they set premiums, their large losses likely resulted from a combination of factors. These likely include aggressive pricing and less aggressive utilization management, both of which insurers were incentivized to do because of the premium stabilization programs. However, the most significant factor that explains the widespread losses is likely an overall risk pool that was older and less healthy than insurers expected.

[20] We report per-enrollee figures 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 accurately corresponds to the associated financial data (premium, claims, and government program transfers).

[21] The calculations for these two values are $\frac{\sum_{\alpha \epsilon QHP} NRI_i}{\sum_{\alpha \epsilon QHP} LY_i}$ and $\frac{\sum_{\alpha \epsilon QHP} NRI_i / LY_i x MC_i}{\sum_{\alpha \epsilon QHP} MC_i}$, respectively, where NRI are net reinsurance payments received by a QHP, LY are the life years enrolled by that QHP, and MC are total medical claims incurred by that QHP.

[22] For premium income value used in the denominator of these calculations, see table 1.

Insurers Incurred Large Losses Selling QHPs

Table 1 summarizes the 2014 data for the 289 individual market QHPs, on both an aggregate and a per-enrollee/life year basis (see footnote 20). QHPs received premium payments, cost sharing reduction (CSR) payments made by HHS to insurers to reduce plan deductibles and other cost-sharing amounts for certain low-income enrollees, and reinsurance payments. Medical claims represent enrollee healthcare bills paid by the QHP. Risk adjustment can be a net receipt or payment for the QHP. Although risk adjustment payments are determined by a complicated formula, the program is intended to make payments to QHPs that enroll a less-healthy-than-average population and collect payments from QHPs that enroll a healthier-than-average population. We discuss the risk corridor program in more detail below, and in appendix A we provide a summary of all three premium stabilization programs (reinsurance program, risk corridor program, and risk adjustment program).

In aggregate, the 289 individual market QHPs collected $33.00 billion in premiums and $2.75 billion in CSR payments, for a total of about $35.76 billion in premium income.[23] The total claims incurred by these QHPs amounted to nearly $37.30 billion in 2014. As previously noted, individual market QHPs had net reinsurance receipts of $6.72 billion and a net risk adjustment outflow of approximately $340 million. Since the risk adjustment program is a budget-neutral program for non-grandfathered individual market plans, the aggregate risk adjustment outflow

[23] The data on premium payments includes all advanced premium tax credits paid by the Department of the Treasury to insurers on behalf of enrollees, as the source of funds has no effect on insurer premium revenues. We treated 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.

from individual market QHPs indicates that QHPs enrolled a healthier population than non-QHP individual market plans.

Table 1. Individual Market QHPs Totals and Mean Amounts

Variable	Total	Mean per Enrollee	Weighted Mean per Enrollee
Premium (n=289)	$33,001,369,264	$4,092	$4,182
CSR Payment (n=277)	$2,754,033,974	$345	$362
Premium Income (n=289)	$35,755,403,128	$4,433	$4,540
Medical Claims (n=289)	$37,297,039,459	$4,624	$5,000
Net Risk Corridor Claims (n=289)^	$2,202,369,764	$273	$321
Net Reinsurance Receipts (n=289)	$6,720,860,397	$833	$934
Net Risk Adjustment Payments* (n=277)	−$339,604,367	-$29	$14
Number of Life Years	8,065,799		

Note: Table 1 shows per-enrollee figures on both an unweighted basis and a claims-weighted basis. We weighted the data by claims to account for the differences across plans in expenditures so that QHPs with higher expenditures receive greater weight in calculating the means. CSR payments were not reported for 12 QHPs; these 12 QHPs totaled 74,109 life years. Since CSR payments were not reported for 12 QHPs, premium income adds up to slightly less than the sum of premiums and CSR payments in the two columns showing means. Risk adjustment information was not reported for the QHPs operating in Massachusetts, the only state that elected to operate the risk adjustment program itself, and for which data is not publicly available. Since the CSR payments are only made to insurers for individuals who select silver plans and have income within the prescribed limits for program eligibility, these amounts do not represent the mean CSR payment received per enrollee who qualifies for this type of subsidy. Rather, the mean CSR payment per enrollee represents the total CSR payments divided by QHP enrollees, reported with and without weighting the QHPs by claims. In appendix B, we show the averages per enrollee weighted by life year.

^ Net risk corridor claims is the difference between all claims made by insurers with costs exceeding target costs (even though not enough funding was available to pay insurers for their total claims) and the payments made by insurers with costs below target costs.

* The total risk adjustment figures include QHP and non-QHP enrollees. The denominator for the risk adjustment mean per enrollee, therefore, is 11,602,102 life years.

Insurers' risk corridor payments or claims, which are a function of the relationship between their allowable costs (total costs less administrative costs) and a target amount (total premiums including premium subsidies less administrative costs), provide a proxy for how their QHP line of business fared in 2014. Insurers whose target amount exceeded 3 percent of allowable costs were required to make payments to the risk corridor program. Insurers whose

allowable costs exceeded the target amount by more than 3 percent were eligible to claim reimbursements from the program.

Despite projections by the Obama administration that risk corridor receipts would likely cover risk corridor claims,[24] the program ran a deficit of nearly $2.5 billion in 2014, as shortfalls (claims of about $2.9 billion) exceeded gains (receipts of $362 million). The risk corridor program applies for both individual QHPs and small group QHPs, and the net program deficit for individual QHPs equaled $2.2 billion in 2014. Congress subsequently included provisions in appropriations legislation for fiscal years 2015 and 2016 that expressly prohibited HHS from making risk corridor payments to insurers in excess of program receipts.[25] However, even if all risk corridor claims were covered, the program would still have, by design, reimbursed insurers for only a portion of those losses. Consequently, insurers' aggregate losses were substantially greater than the $2.2 billion risk corridor deficit.

Figure 1 shows the distribution of QHPs by risk corridor claims per enrollee. Positive values correspond to risk corridor claims of insurers with allowable costs at least 3 percent greater than the target amount. Negative values correspond to the payments made by insurers with allowable costs at least 3 percent lower than the target amount. Zero corresponds to insurers with allowable costs within 3 percent of the target amount. Nearly 57 percent of enrollees were enrolled in a QHP that expected to contribute or receive less than $250 per enrollee in the risk corridor program. Of the remaining enrollees, the vast majority were enrolled in QHPs that claimed more than $250 per enrollee through risk corridors. Roughly 2.1 million QHP enrollees,

[24] Mandy Cohen, MD, 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."
[25] Consolidated and Further Continuing Appropriations Act, 2015 (Pub. L. 113-235), and Consolidated Appropriations Act, 2016 (Pub. L. 114-113).

which is about 26 percent of all enrollees, were enrolled in QHPs that claimed between $250 and $750 per enrollee. Moreover, nearly 1.2 million QHP enrollees—about 15 percent of all enrollees—were enrolled in QHPs that claimed more than $750 per enrollee.

Figure 2 shows the distribution of the 289 QHPs by their loss ratios. The loss ratio equals medical claims paid divided by the sum of premiums and advance CSR payments received, so does not adjust for payments from the three premium stabilization programs. Seventy QHPs with about 2.16 million enrollees had loss ratios below 0.875, 117 QHPs with about 3.75 million enrollees had loss ratios between 0.875 and 1.25, and 102 QHPs with about 2.16 million enrollees had loss ratios in excess of 1.25. A loss ratio in excess of 1.25 represents extremely poor performance and indicates that premiums would have needed to be significantly higher to cover expenses for the population that enrolled.

Figure 1. Distribution of 2014 QHP Risk Corridor Claims per Enrollee

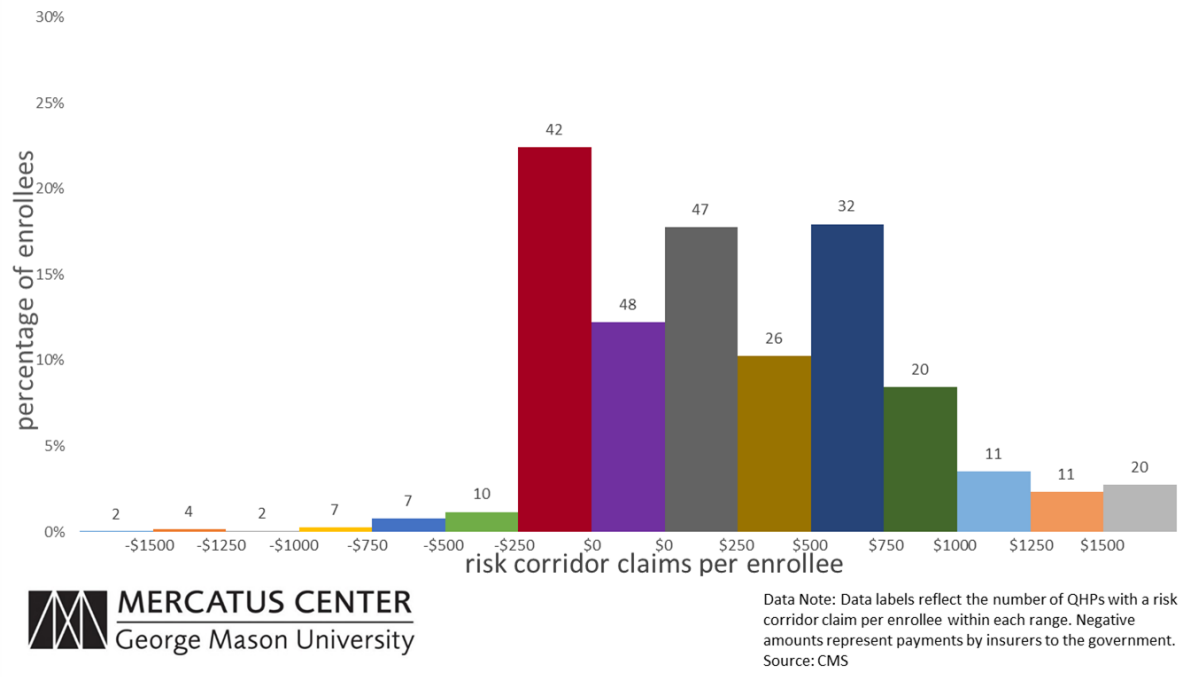
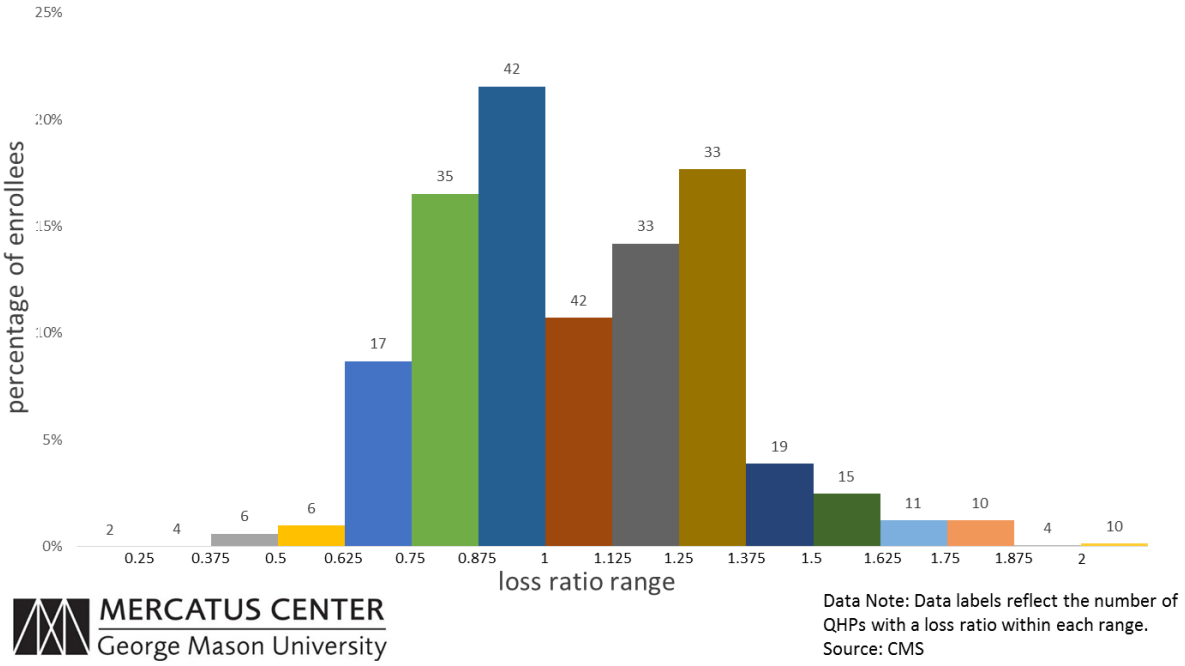


Figure 2. Distribution of 2014 QHP Enrollment by Loss Ratio



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Data Note: Data labels reflect the number of QHPs with a loss ratio within each range.
Source: CMS

Table 2 groups the 289 QHPs according to their loss ratios and presents the per-enrollee data for the QHPs in each loss ratio category. The results show that the loss ratio differences were mostly driven by large differences in average medical claims. Across the eight groupings, the coefficient of variation (a statistical measure of the data points around the mean) for medical claims is more than three times the coefficient of variation for premiums. Looking at the extremes, the difference in weighted average premiums between insurers with loss ratios less than 0.80 and more than 1.40 was only $126, but the difference in their medical claims was $3,765. As expected, insurers with larger average loss ratios had both larger reinsurance payments and risk corridor claims per enrollee. Although the pattern is not quite as clear, net risk adjustment payments were positively correlated with loss ratios—an indication that plans with less healthy enrollees at the beginning spent more on medical claims.

Table 2. Summary Per-Enrollee Data Based on Loss Ratio Groupings

Loss Ratio	Premiums	CSR	Medical Claims	Reinsur-ance	Risk Adjustment	Risk Corridors	% of Enrollees	# of QHPs
< 0.80	$4,184	$273	$3,248	$518	−$509	−$13	18.9%	45
0.80–0.90	$4,364	$309	$4,031	$660	$20	−$84	21.0%	39
0.90–1.00	$4,348	$629	$4,623	$713	−$111	$91	8.5%	28
1.00–1.10	$4,241	$349	$4,852	$820	$107	$118	9.3%	35
1.10–1.20	$4,588	$454	$5,827	$1,078	$118	$363	12.9%	31
1.20–1.30	$4,003	$425	$5,620	$1,191	$125	$533	10.6%	28
1.30–1.40	$3,503	$264	$5,073	$950	−$74	$799	10.9%	18
> 1.40	$4,058	$281	$7,013	$1,599	$434	$888	8.0%	**65**
Coefficient of Variation*	0.073	0.314	0.214	0.344	18.275	1.031		

Note: Figures are averages across QHPs within each loss ratio category, weighted by claims.
* The coefficient of variation is the quotient of the standard deviation and the mean for each variable.

Table 3 shows the same data as table 2 but collapsed into two groups—QHPs with income that exceeded medical claims and QHPs with medical claims that exceeded income—as well as the magnitude of the difference. Note that roughly the same number of enrollees were in QHPs with a loss ratio below 1.0 as were enrolled in QHPs with a loss ratio exceeding 1.0.

Table 3. Summary Per-Enrollee Data Based on Loss Ratio Groupings

Loss Ratio	Premiums	CSR	Medical Claims	Reinsur-ance	Risk Adjustment	Risk Corridors	% of Enrollees	# of QHPs
< 1.00	$4,302	$363	$3,899	$625	−$182	−$24	48.4%	112
> 1.00	$4,104	$362	$5,712	$1,135	$140	$544	51.6%	177
Difference	−$198	−$1	$1,813	$510	$322	$568		

Note: Figures are averages across QHPs within each loss ratio category, weighted by claims. “Difference” represents the row containing loss ratios below 1.00 subtracted from the row containing loss ratios above 1.00.

The data in table 3 reinforce the conclusion that the differences in insurer performance in 2014 were more a function of differences in claims costs than in premium income. There are at least two plausible explanations for this result. The first is that people with more expensive conditions were more attracted to plans that ended up losing money. The risk adjustment data suggest this is likely part of the explanation as plans, on average, with lower loss ratios paid into

the program while those with higher loss ratios received money from the program. A second plausible explanation is that plans with lower loss ratios more aggressively managed utilization, perhaps because they were more likely to be health maintenance organizations (HMOs). Kaiser and carriers whose core business is Medicaid managed care performed relatively well in 2014. Moreover, it has been reported that Blue Shield of California and Anthem, both of which performed relatively well selling QHPs in 2014, employed very narrow networks. It seems plausible, therefore, that QHPs with narrower provider networks were more successful in 2014 than QHPs with broader networks and less aggressive utilization control.

Table 3 also shows that reinsurance and risk adjustment overall worked to narrow the differences in loss ratios. QHPs with ratios in excess of 1.0 were net receivers from the risk adjustment program, and they received about 80 percent more in net reinsurance payments than QHPs with loss ratios below 1.0. Including reinsurance and risk adjustment as payments to insurers narrows the average loss ratio differential between the two groupings from a 0.836 to 1.279 differential to a 0.763 to 0.995 differential.[26] If the risk corridor program were fully funded, risk corridors would have further narrowed that differential to 0.767 to 0.909. However, it is worth noting that even with a fully funded risk corridor program, most QHPs with loss ratios above 1.0 as shown in table 3 would have still incurred losses overall because administrative costs are excluded from these calculations.

[26] The first set of ratios contains medical claims divided by the sum of premiums and CSR payments for each of the two loss ratio groupings. The second set of ratios includes reinsurance and risk adjustment payments in the denominator.

Projecting Premiums without Reinsurance or Risk Corridor Programs

Insurers incurred large losses in 2014 despite receiving $6.72 billion in net reinsurance payments for their individual market QHPs. The average unweighted loss ratio for the 289 QHPs equaled 1.154.[27] The average loss ratio equaled 1.110 when weighting QHPs by claims and 1.052 when weighting QHPs by enrollment.

These loss ratios suggest that premiums for individual market QHPs will have to rise significantly when the reinsurance program ends. Assuming that insurers need an average of 15 percent of premiums to cover administrative expenses—an estimate that is likely on the low side of administrative expenses for insurers in the individual market—premiums in 2014 were roughly 26 percent too low to cover insurers' full costs of offering individual market QHPs.[28]

This is illustrated by the experience of the Blue carriers. Their average per-enrollee premium income (including CSR payments) when weighting the QHPs by medical claims, was $4,609, yet their average per-enrollee medical claims were $5,027. Adding a 15 percent administrative load to the premium income yields an average per-enrollee cost of $5,781. Thus, assuming medical costs stayed the same, the Blues plans would, on average, have needed 25 percent higher premiums for their individual QHP business to have been profitable[29]

However, if premiums had been 26 percent higher, on average, enrollment would have been lower and adverse selection would have increased. Relatively healthy people and higher income enrollees, who qualify for smaller subsidies if they qualify for any subsidies, would have been deterred to a greater degree than people who expected to use more health care services.

[27] This is the unweighted average of the loss ratios across the 289 QHPs.
[28] This calculation adds an estimated 15 percent administrative costs to the claims-weighted loss ratio.
[29] In these calculations, we assume that carriers enrolled a population of average risk and as a result are not net payers or receivers through risk adjustment.

As a result of this dynamic effect, the premium increase would likely have needed to be substantially greater than 26 percent for insurers to break even on their QHPs in 2014.

Insurer Performance Varied Significantly, but Co-ops Performed the Worst

Table 4 shows the per-enrollee means for different types of carriers, with the values in each grouping weighted by medical claims paid by the QHP. The table also breaks out the figures for each carrier that had at least 3 percent of national individual QHP enrollment.

Nearly 60 percent of the 8 million QHP enrollees in 2014 were in a Blue plan. As table 4 shows, Blue QHPs made risk corridor claims of $264 per enrollee despite receiving $955 in net reinsurance payments per enrollee. However, the performance of Blue carriers varied widely. QHPs offered by Blue Shield of California and Anthem, which owns Blue plans in 14 states (including California), incurred unexpectedly low costs. Plans offered by these carriers were reported to have very narrow networks in 2014, which may have contributed to their relatively strong performance in 2014.[30] Costs incurred by other Blue carriers, particularly the five plans that comprise Health Care Service Corporation (HCSC) and Blue Cross Blue Shield of North Carolina, substantially exceeded their estimates.

Table 4 shows that Kaiser was the insurer with a sizeable market share that performed the best in 2014. Kaiser ended up contributing $95 per enrollee to the risk corridor program. Kaiser's net reinsurance payments totaled $544 per enrollee—an amount more than 40 percent below the average. Table 4 also shows that QHPs offered by carriers whose principal pre-ACA business in the state was Medicaid managed care—such as Centene and Molina (each in nine states) and a

[30] Chad Terhune, "Anthem Blue Cross Sued Again over Narrow-Network Health Plans," *Los Angeles Times*, August 19, 2014.

number of local (mainly provider-sponsored) HMOs—also performed relatively well in 2014.[31] Like Kaiser, Medicaid managed care insurers also received relatively low reinsurance payments.

Table 4. Individual Market QHPs Weighted Means, by Insurer Grouping

	Premium	CSR	Medical Claims	Reinsur-ance	Risk Adjustment	Risk Corridors	Enrollees	Share of National Enrollment
Overall (n=289)	$4,182	$362	$5,000	$934	$14	$321	8,065,799	100%
Blues (n=75)	$4,251	$358	$5,027	$955	$55	$264	4,629,823	57.4%
Anthem (n=14)	*$4,371*	*$258*	*$3,873*	*$766*	*−$187*	*-$12*	*962,103*	*11.9%*
HCSC (n=5)	*$3,723*	*$380*	*$5,320*	*$1,147*	*−$22*	*$697*	*788,982*	*9.8%*
BS of CA (n=1)	*$4,316*	*$237*	*$3,993*	*$730*	*$282*	*-$231*	*462,388*	*5.7%*
BCBS of NC (n=1)	*$4,658*	*$584*	*$5,912*	*$963*	*$42*	*$574*	*256,934*	*3.2%*
Other Blues (n=54)	*$4,347*	*$371*	*$5,351*	*$981*	*$129*	*$230*	*2,159,416*	*26.8%*
Aetna (n=28)	$3,320	$310	$3,431	$474	−$295	$207	572,990	7.1%
Humana (n=16)	$3,792	$500	$4,836	$899	−$220	$458	547,185	6.8%
Kaiser (n=9)	$4,203	$211	$3,919	$544	$96	−$95	501,862	6.2%
Med MC* (n=49)	$4,367	$450	$4,204	$523	−$149	$43	342,919	4.3%
Co-op (n=23)	$4,251	$372	$6,120	$1,133	−$174	$1,191	302,054	3.7%
Other (n=91)	$4,298	$367	$5,641	$1,167	$123	$440	1,172,901	14.5%

Figures are averages across QHPs, weighted by claims. The insurers in italics are all subsets of the Blues and thus are included in the Blues row as well. Coventry Health Care of Nebraska Inc., which had 3,333 enrollees, and Coventry Health and Life of Delaware, which had 602 enrollees, were classified as a Medicaid managed care plan and an Aetna plan.

* A QHP is categorized as a Medicaid managed care plan if more than half of the sponsoring carrier's pre-ACA enrollment in the applicable state consisted of Medicaid managed care enrollees.

[31] In 2014, there were 49 QHPs offered by carriers whose principal business (defined as half or more of the carrier's total enrollment) in the applicable state prior to the ACA consisted of Medicaid managed care. See discussion and appendix table of exchange participating carriers in, Edmund F. Haislmaier, "Health Insurers' Decisions on Exchange Participation: Obamacare's Leading Indicators" (Backgrounder No. 2852, Heritage Foundation, Washington, DC, November 12, 2013).

Carriers that principally focus on offering Medicaid managed care tend to have fewer providers in their networks and thus are functionally closer to Kaiser. The relative success of Kaiser, Blue Shield of California, Anthem, and insurers with a history of offering Medicaid managed care plans suggests that QHPs with narrow networks were more successful in controlling medical utilization of exchange enrollees, about two-thirds of whom have income between 100 percent and 200 percent of the federal poverty level (just above Medicaid eligibility thresholds).[32]

While table 4 shows that several insurers, such as HCSC and Humana, significantly underestimated their costs, the worst performing group of insurers was the co-ops. The co-ops' average per-enrollee medical claims equaled $6,120—more than 22 percent above the average for all insurers. The co-ops received net reinsurance payments per enrollee of $1,133—21 percent above the average amount; they made risk corridor claims per enrollee of $1,191 more than four times the average risk corridor claim per enrollee when the co-ops are excluded.[33]

Table 5 shows the correlation coefficients between loss ratios, average net reinsurance payments per enrollee, average risk adjustment payments per enrollee, and average risk corridor claims per enrollee for the four carrier groups and seven specific insurers reported in table 4, after weighting the groupings by enrollment.[34] Unsurprisingly, loss ratios, net reinsurance payments, and risk corridor claims are strongly positively correlated. Per enrollee, QHPs with higher loss ratios received significantly higher net reinsurance payments—an indication of a

[32] Sixty-eight percent of people who signed up for an exchange plan during the 2015 open enrollment period reported income between 100 and 200 percent of the federal poverty level. Dep't of Health & Human Services, "Health Insurance Marketplaces 2015 Open Enrollment Period: March Enrollment Report," March 10, 2015. Enrollment data for 2014 was not disaggregated by income level.
[33] The average risk corridor amount claimed by the 264 QHPs that were not co-ops equaled $287 per enrollee.
[34] These correlations exclude Overall and Blues categories since they are summations of other groupings.

greater number of enrollees with medical claims of at least $45,000—and made significantly higher risk corridor claims.

Table 5. Correlations, Weighting by Insurers' Number of Enrollees

	Loss Ratio	Risk Corridors	Reinsurance
Risk Corridors	0.868		
Reinsurance	0.873	0.690	
Risk Adjustment	0.252	−0.175	0.402

Note: The correlations between four variables (loss ratios, risk corridor claims per enrollee, reinsurance payments per enrollee, and risk adjustment payments per enrollee) are displayed in this table. The empty boxes are not filled to prevent duplication. Avoiding duplication is also the reason that a loss ratio category is not displayed in the last row.

QHP Performance Varied Significantly Across States

Although insurers made substantial losses selling QHPs in 2014 overall, the performance of insurers varied widely across the country. Per enrollee, table 6 shows premiums, medical claims, CSR payments, risk corridor claims, net reinsurance payments, and the number of enrollees (life years) for the 50 states and the District of Columbia. The median state with respect to insurer performance, as proxied by risk corridor claims, was Georgia (claim of $308 per enrollee).

In 16 states, the participating insurers had aggregate risk corridor claims per enrollee that were more than twice the median. In Iowa, Utah, Nebraska, and Kentucky—all states with co-ops that are now out of business—the participating insurers had aggregate risk corridor claims in excess of $1,000 per enrollee. However, in ten states, including California, participating insurers incurred lower than expected costs on their QHPs in 2014, with insurers in those states paying into the risk corridor program in the aggregate.[35]

[35] In the aggregate, insurers in nine states paid in to the risk corridor program, and Connecticut insurers' risk corridor payments summed to zero.

Table 6. Individual Market QHP Means per Enrollee, by State

State	Premium	CSR	Medical Claims	Net Reinsurance	Net Risk Corridor	Enrollees	% of Total Enrollees
Alaska	$6,028	$690	$9,762	$2,777	$803	11,657	0.14%
Alabama	$3,657	$307	$4,101	$585	$8	156,459	1.94%
Arkansas	$4,251	$1,271	$4,791	$382	−$68	171,625	2.13%
Arizona	$3,285	$324	$5,090	$999	$845	120,822	1.50%
California	$4,157	$204	$3,701	$661	−$103	1,631,747	20.23%
Colorado	$4,211	$150	$4,838	$1,033	$310	128,809	1.60%
Connecticut	$5,585	$308	$5,273	$1,007	$0	73,044	0.91%
District of Columbia	$3,716	$10	$3,775	$489	$74	7,864	0.10%
Delaware	$4,326	$244	$5,378	$1,122	$373	16,018	0.20%
Florida	$4,323	$437	$4,734	$807	$181	749,172	9.29%
Georgia	$4,044	$497	$4,906	$929	$308	250,672	3.11%
Hawaii	$3,251	$20	$4,248	$824	$636	20,003	0.25%
Iowa	$3,608	$471	$5,733	$838	$1,001	43,047	0.53%
Idaho	$3,308	$303	$4,933	$930	$871	75,850	0.94%
Illinois	$3,748	$224	$5,290	$1,087	$783	268,350	3.33%
Indiana	$5,069	$513	$4,728	$839	−$107	101,731	1.26%
Kansas	$2,962	$250	$4,503	$885	$714	66,337	0.82%
Kentucky	$3,691	$208	$5,554	$1,026	$1,159	71,187	0.88%
Louisiana	$4,680	$401	$5,740	$1,034	$496	85,527	1.06%
Massachusetts	$5,369	$8	$5,469	$997	$156	69,899	0.87%
Maryland	$3,340	$187	$3,857	$588	$245	104,527	1.30%
Maine	$5,210	$638	$5,361	$1,032	−$54	37,751	0.47%
Michigan	$4,228	$455	$4,518	$744	$117	229,538	2.85%
Minnesota	$2,970	$2	$4,191	$783	$314	200,068	2.48%
Mississippi	$5,405	$869	$4,533	$671	−$375	37,542	0.47%
Missouri	$3,668	$349	$4,289	$612	$226	141,099	1.75%
Montana	$3,865	$271	$5,027	$1,017	$607	52,999	0.66%
North Carolina	$4,423	$543	$5,462	$877	$513	307,360	3.81%
North Dakota	$4,035	$155	$4,291	$706	$29	19,498	0.24%
Nebraska	$3,706	$304	$6,404	$1,451	$1,121	58,155	0.72%
New Hampshire	$4,539	$344	$3,405	$426	−$91	32,431	0.40%
New Jersey	$5,313	$150	$4,188	$840	−$173	169,357	2.10%
New Mexico	$3,744	$213	$4,194	$703	$363	34,807	0.43%
Nevada	$4,171	$223	$4,214	$604	$291	35,234	0.44%
New York	$4,478	$252	$4,449	$657	$273	330,374	4.10%
Ohio	$4,428	$342	$4,611	$867	$224	117,670	1.46%
Oklahoma	$3,300	$409	$5,136	$913	$854	65,898	0.82%

Oregon	$3,517	$148	$5,086	$1,106	$761	133,166	1.65%
Pennsylvania	$3,844	$367	$5,134	$930	$685	347,113	4.30%
Rhode Island	$4,306	$373	$4,146	$627	−$6	33,980	0.42%
South Carolina	$4,312	$559	$4,782	$840	$111	88,825	1.10%
South Dakota	$4,489	$727	$6,725	$1,278	$998	10,634	0.13%
Tennessee	$3,434	$423	$5,232	$897	$657	131,126	1.63%
Texas	$3,708	$444	$5,364	$1,185	$606	589,314	7.31%
Utah	$2,913	$250	$4,644	$806	$1,067	81,990	1.02%
Virginia	$3,931	$421	$4,076	$613	$2	179,862	2.23%
Vermont	$4,896	$206	$5,328	$1,015	$33	26,795	0.33%
Washington	$4,185	$187	$3,449	$635	−$105	203,063	2.52%
Wisconsin	$5,139	$578	$6,638	$1,409	$613	113,487	1.41%
West Virginia	$4,369	$306	$6,031	$1,156	$648	22,191	0.28%
Wyoming	$6,597	$657	$8,021	$2,047	$107	10,125	0.13%

Note: These values are the totals of each variable for all QHPs in the state divided by the number of enrollees in a state. This table does not weight first the QHPs by claims.

In a subsequent paper, we will provide a more in-depth analysis of several factors that might explain state-level differences in insurer performance. Our preliminary analysis finds that net risk corridor claims per enrollee were substantially less in states that did not have a co-op, in states that expanded Medicaid, and in states that did not adopt the administration's transition policy. That policy, announced in the fall of 2013, allowed renewals of non-grandfathered non-ACA-compliant plans. However, more than half the differences for each of those three factors were attributable to California. The California insurers with the greatest QHP market share in 2014 were large net payers into the risk corridor program, and California did not have a co-op, expanded Medicaid, and did not adopt the transition policy.

Conclusion

The ACA significantly altered the rules governing the individual insurance market by restricting the type of coverage that could be offered and regulating how insurers could price that coverage. These provisions generally made insurance a better deal for older and less healthy people and a

worse deal for younger and healthier people. To induce younger and healthier people to enroll, the ACA contained the individual mandate and subsidies to make the coverage more attractive. The ACA also provided insurers with additional protection in the first three years the program was in operation, largely through the reinsurance program.

While this study was limited to 2014, as the deadline for carriers to file 2015 plan year data is June 30, 2016, the findings are important because recent reports of insurer experience in 2015 seem comparable to the data on their 2014 performance. Once the 2015 data is available and analyzed, we are likely to be left with a similar conclusion—QHPs have not yet attracted a broad enough risk pool for the individual market to stabilize despite the premium stabilization programs enabling carriers to set premiums significantly lower than they would otherwise need to absent those programs.

Crucially, insurers experienced large average losses per enrollee on QHPs in 2014 despite significantly larger than expected reinsurance payments per enrollee. This indicates that insurers significantly underpriced premiums for the population that enrolled. Insurers also may not have managed utilization as effectively as they might have in the absence of reinsurance payments. Given the same population and with the same service utilization, insurers would have had to price average premiums more than 25 percent higher in 2014 order to avoid losses. However, much higher premiums in 2014 would have diminished enrollment, particularly of younger and healthier enrollees who bring down average per-enrollee claims. Given this dynamic, it may not have been possible for insurers to avoid losses in 2014 even with higher premiums since significantly higher premiums would likely have further reduced enrollment by individuals in relatively good health.

While co-ops, which received reinsurance payments equal to more than one-quarter of premium income, incurred the most significant losses in 2014, more established insurers also incurred steep losses. It appears that QHPs with narrow provider networks performed better than QHPs with broader networks in 2014. That may suggest that healthier people disproportionately gravitated to such plans, although our data do not address that issue directly. It may also be the result of more aggressive utilization management by insurers with more restrictive networks. In both 2015 and 2016, insurers narrowed QHP networks, often by replacing their offerings of preferred provider organization (PPO) plans with HMO plans.[36] As the end of the reinsurance and risk corridor programs approaches, and insurers face the reality that premiums for the first time must cover expenses, the key question is whether insurers that continue offering QHPs can reverse their losses through some combination of higher premiums and plan redesign or whether the ACA's provisions are unsustainable and need to change.

[36] Robert Woods Johnson Foundation, "Burnt Offerings? PPOs DECLINE in Marketplace Plans," November 3, 2015,

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 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)."[37] 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, 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. HHS distributed $7.9 billion to eligible insurers through the program for the 2014 plan year,

[37] 42 U.S.C. § 18061.

rolling over $1.7 billion for 2015. For the 2015 plan year, HHS estimates it will pay $7.7 billion to insurers, remitting just $500 million to the US Treasury.[38]

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.[39] The reinsurance formula for the 2015 plan year will be announced on June 30, 2016.[40]

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.[41] The 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' compare allowable costs—total costs less administrative costs—and a target amount—total premiums including premium subsidies less administrative costs—are calculated for each QHP. Insurers whose target amount exceeds 3 percent of allowable costs were required to make payments to the risk corridor program. Insurers whose allowable costs exceed the target amount by more than 3 percent were eligible to claim reimbursements from the program.[42]

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[38] Dept. of Health & Human Services, "The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year," February 12, 2016.
[39] Dept. of Health & Human Services, "Transitional Reinsurance Program: Pro Rata Adjustment to the National Coinsurance Rate for the 2014 Benefit Year," June 17, 2015.
[40] Dept. of Health & Human Services, "The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year," February 12, 2016.
[41] 42 U.S.C. § 18062.
[42] 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 for allowable costs below 92 percent of the target amount, 80 percent of the difference between allowable costs and 92 percent of the target amount.

For the 2014 plan year, aggregate risk corridor receipts from insurers with costs below their targets amounted 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 the belief that receipts would cover claims and that the program would be implemented in a budget-neutral manner.[43] 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."[44] 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.[45] Consequently, for the 2014 plan year, although 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 HHS was forced to limit risk corridor payments to 12.6 percent of the full amounts claimed by those insurers.

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 were the budget-neutrality requirement not enforced, and we also display the actual payments for insurers with lower claims than expected.

[43] Mandy Cohen, MD, 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."
[44] Dept. of Health & Human Services, "Risk Corridors Payments for the 2014 Benefit Year," November 19, 2015.
[45] 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).

Risk Adjustment

The risk adjustment program was established by section 1343 of the ACA, and it applies to all non-grandfathered individual and small group plans.[46] 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 plan selection decisions by consumers. 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 prospectively 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. Unlike the reinsurance program, there is no outside funding for the risk adjustment program, as it operates on a budget-neutral basis within each market (individual or small group) 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, HHS determines whether an issuer 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.

[46] 42 U.S.C. § 18063.

Appendix B

The tables below weight QHPs by life years/enrollees instead of by claims.

Table 2a: Summary Data Based on Loss Ratio Groupings

Loss Ratio	Premiums	CSR	Medical Claims	Reinsur-ance	Risk Adjustment	Risk Corridors	% of Enrollees	# of QHPs
< 0.80	$4,103	$265	$3,149	$490	−$554	$9	18.9%	45
0.80–0.90	$4,318	$300	$3,985	$648	$5	−$73	21.0%	39
0.90–1.00	$4,250	$611	$4,518	$696	−$133	$104	8.5%	28
1.00–1.10	$4,048	$329	$4,615	$750	$62	$139	9.3%	35
1.10–1.20	$4,465	$446	$5,676	$1,043	$92	$387	12.9%	31
1.20–1.30	$3,869	$415	$5,429	$1,138	$75	$563	10.6%	28
1.30–1.40	$3,474	$257	$5,028	$944	−$80	$790	10.9%	18
> 1.40	$3,888	$258	$6,598	$1,480	$358	$871	8.0%	65
Coefficient of Variation	0.072	0.323	0.204	0.332	11.119	0.968		

Figures are averages across QHPs, weighting QHPs by life years.

Table 3a: Summary Data Based on Loss Ratio Groupings

Loss Ratio	Premiums	CSR	Medical Claims	Reins-urance	Risk Adjustment	Risk Corridors	% of Enrollees	# of QHPs
< 1.00	$4,222	$340	$3,752	$595	−$238	−$10	48.4%	112
> 1.00	$3,969	$349	$5,441	$1,056	$88	$538	51.6%	177
Difference	-$253	$9	$1,689	$461	$326	$548		

Note: Aggregate of data presented in table 2a.

Table 4a: Individual Market QHPs Weighted Means, by Insurer Grouping

	Premium	CSR	Medical Claims	Reinsur-ance	Risk Adjustment	Risk Corridors	Enrollees	Share of National Enrollment
Overall (n=289)	$4,092	$345	$4,624	$833	−$69	$273	8,065,799	
Blues (n=75)	$4,191	$339	$4,748	$892	$5	$224	4,629,823	57.4%
Anthem (n=14)	*$4,306*	*$243*	*$3,761*	*$749*	*−$209*	*−$14*	*962,103*	*11.9%*
HCSC (n=5)	*$3,723*	*$378*	*$5,317*	*$1,145*	*−$22*	*$698*	*788,982*	*9.8%*
BS of CA (n=1)	*$4,316*	*$237*	*$3,993*	*$730*	*$282*	*−$231*	*462,388*	*5.7%*
BCBS of NC (n=1)	*$4,658*	*$584*	*$5,912*	*$963*	*$42*	*$574*	*256,934*	*3.2%*
Other Blues (n=54)	*$4,228*	*$361*	*$5,002*	*$888*	*$48*	*$212*	*2,159,416*	*26.8%*
Aetna (n=28)	$3,284	$305	$3,312	$447	−$361	$211	572,990	7.1%
Humana (n=16)	$3,740	$506	$4,590	$834	−$277	$444	547,185	6.8%
Kaiser (n=9)	$4,176	$207	$3,887	$540	$80	−$82	501,862	6.2%
Med MC (n=49)	$4,176	$391	$3,435	$346	−$599	$97	341,849	4.2%
Co-op (n=23)	$4,197	$378	$5,848	$1,065	−$209	$1,109	302,054	3.7%
Other (n=91)	$4,166	$346	$5,137	$999	−$2	$405	1,173,369	14.5%

Note: Figures are averages across QHPs groupings, weighting QHPs by life years.