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REALIZING HEALTH REFORM'S POTENTIAL

JULY 2016

How Has the Affordable Care Act Affected Health Insurers' Financial Performance?

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Abstract Starting in 2014, the Affordable Care Act transformed the market for individual health insurance by changing how insurance is sold and by subsidizing coverage for millions of new purchasers. Insurers, who had no previous experience under these market conditions, competed actively but faced uncertainty in how to price their products. This issue brief uses newly available data to understand how health insurers fared financially during the ACA's first year of full reforms. Overall, health insurers' financial performance began to show some strain in 2014, but the ACA's reinsurance program substantially buffered the negative effects for most insurers. Although a quarter of insurers did substantially worse than others, experience under the new market rules could improve the accuracy of pricing decisions in subsequent years.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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Commonwealth Fund pub. 1886
Vol. 18

BACKGROUND

The Affordable Care Act (ACA) created a dramatically different marketplace for individual health insurance through three key reforms: prohibiting insurers from considering subscribers' health status or risk; providing substantial subsidies for millions of people to purchase individual coverage, many for the first time in their lives; and creating an "exchange" structure that facilitates comparison shopping. In addition, the ACA limits the percentage of premiums that insurers can devote to profit and administrative expense and requires state or federal regulators to evaluate the basis for rate increases.

Until recently, reports about the financial impact of these reforms on insurers had been largely positive. Stock values increased substantially ahead of broad market indices.[1] A large number of participating insurers

July 26, 2016—This issue brief has been slightly revised to clarify that the Mercatus Center report excluded reinsurance, risk adjustment, and risk corridor payments only from its calculation of medical loss ratios but did separately discuss payments under these programs.

created strong competition, both on and off the ACA exchanges.[2] Finally, the full, unsubsidized prices in the individual insurance market have been favorable to subscribers, compared with the price of similarly comprehensive products in the group markets.[3]

Recently, however, we are hearing more troubling financial news from health insurers in the individual market.[4] Premium rates have increased more than expected.[5] Several newly established insurers that focused on the individual market have failed or are in financial distress.[6] And the nation's largest insurer, United Healthcare, announced it would be withdrawing from most of the ACA's exchange markets, based in part on its significant losses.[7]

This issue brief analyzes newly available data sources to better understand the financial performance of health insurers under the ACA during 2014, the first year of full reforms. It is important to analyze financial performance comprehensively because isolated reports can be misleading: losses from one insurer can fail to reflect better-performing insurers. In addition, adverse reports based on preliminary data can overlook the offsetting effects of reinsurance and other buffering mechanisms that the ACA included to protect insurers from excessive losses.[8]

Using rate data from the Centers for Medicare and Medicaid Services (CMS), this study compares actual to projected 2014 medical claims from ACA-compliant health plans. On average, we find that medical claims were only 2 percent higher than insurers first projected, after taking into account reinsurance payments.

We also examine CMS's medical loss ratio data, which reflects financial performance related to compliant and noncompliant plans, including payments from three risk-adjustment programs and advance cost-sharing. Using this information, we can summarize the financial performance of health insurers in the individual and group markets. Overall, within the individual market, health insurers incurred losses amounting to 4 percent of premiums while group insurers earned a profit of almost 2.5 percent.

In addition, we evaluate changes in profitability of 144 credible insurers (i.e., those with more than 1,000 members) prior to and after one year of full ACA reforms. We find that more than a third of them had either improved or remained profitable from 2013 to 2014; for the remainder, financial performance worsened.

STUDY FINDINGS

Actual vs. Projected Claims

We begin by analyzing how insurers' financial performance in the individual market compares with their original projections for 2014. Many insurers were eager to offer competitive rates in this newly subsidized market to benefit from the substantial growth in enrollment and premium revenues that was expected—and that, in fact, occurred, as further documented below. However, establishing initial rates under the newly reformed and greatly expanded individual market was particularly challenging for the first year, because insurers lacked actuarial experience under the ACA's market conditions. Therefore, actuaries had to make various assumptions based on judgment and a certain amount of guesswork.[9] In addition, after insurers filed their rates, President Obama changed the market conditions by allowing insurers to continue to offer noncompliant policies to existing policyholders rather than requiring them to switch to new ACA policies.

Exhibit 1 compares insurers' projected per-member-per-month (pmpm) medical expenses with actual medical claims for ACA-compliant individual coverage in 2014.[10] Across the market, medical claims were 5.7 percent higher than projected ($429 vs. $406 pmpm). Some insurers did considerably worse than others. The quartile of insurers with the highest claims (75th percentile) underestimated their claims by an average of 35 percent, whereas the lowest-claim quartile projected their claims much more accurately, within 4 percent, on average, similar to the average claims underestimate of 6 percent marketwide. This indicates that serious adverse experience was concentrated among a minority of insurers. We can expect the accuracy of insurers' claims projections to improve in subsequent years, as insurers gain more actuarial experience with the new market dynamics.

Exhibit 1

Actual vs Projected Medical Claims, 2014 Individual Market

All costs are per member per month

	Percentile (N=175)	Actual	Projected	Actual minus Projected	Percent Difference
Total Medical Claims	25th (lowest claims)	$310.0	$297.0	$13.0	4.4%
	Mean	$429.0	$406.0	$23.0	5.7%
	75th (highest claims)	$718.0	$531.0	$187.0	35.2%
Reinsurance Credits	25th	$27.0	$19.0	$8.0	42.1%
	Mean	$43.0	$29.0	$14.0	48.3%
	75th	$104.0	$38.0	$66.0	173.7%
Net Medical Claims	25th	$283.0	$279.0	$4.0	1.4%
	Mean	$386.0	$377.0	$9.0	2.4%
	75th	$614.0	$493.0	$121.0	24.5%

Source: Authors' analysis of data from the Centers for Medicare and Medicaid Services, mean enrollment-weighted values within quartiles of total claims.

Reinsurance

Most of insurers' underestimated claims in 2014 were offset by $7.9 billion in reinsurance payments for high-cost patients from the federal government. The reinsurance program helps insurers transition to the new market rules, using federal funds collected through an earmarked fee on all health insurance, included self-funded plans, to pay a large portion of high-cost claims incurred in the individual market.[11]

Insurance actuaries knew the reinsurance program would cover some of their companies' claims, but they lacked precise data about how much they should expect to receive from the program. Ultimately, the reinsurance credits to insurers (net of fees that insurers paid) were almost 50 percent higher than insurers had originally estimated ($43 vs. $29 pmpm). These greater payments resulted in part because enrollees in ACA-compliant plans had more high-cost claims than first anticipated, but also because the federal government modified the reinsurance payment formula in mid-2014 to be more favorable to insurers.

Altogether, taking into account the higher reinsurance payments, insurers' net medical claims for ACA-compliant individual coverage were only 2.4 percent higher than they originally projected ($386 vs. $377 pmpm). Although gross claims were $23 greater than expected per member per month, reinsurance credits of $43—$14 higher than expected—made up over half this underestimate. This resulted in net medical claims being only $9 per member per month more than insurers originally projected for ACA-compliant coverage in the 2014 individual market. However, overall performance net of reinsurance credits remained substantially lower in the worst (75th) quartile of the market. These insurers had an average $121 per member per month in underestimated claims expenses.

In subsequent years, reinsurance payments are scheduled to decrease, because reinsurance is a transitional program designed to acclimate insurers to the new market environment. As insurers develop more relevant actuarial data on which to base rating projections, they may have less of a need to rely on reinsurance to buffer uncertain projections.

Profits and Overhead

Medical claims reveal only part of the picture of insurers' financial performance. Also relevant is how the ACA affected their administrative expenses and premiums, as well as their resulting profit margins. To show this, we include data from insurers' medical loss ratio (MLR) reports. The MLR is the percentage of premium that an insurer pays out in medical claims or devotes to quality improvement versus overhead administrative costs and profits. The ACA requires health insurers to maintain an MLR of at least 80 percent in the individual and small-group markets and of at least 85 percent in the large-group market. As part of this regulation, insurers are required to submit annual reports on their MLRs.

Based on MLR data, Exhibit 2 shows health insurers' 2014 financial performance overall and also by individual versus group markets, compared with the two previous years prior to full ACA market reforms.[12] These data include all regulated health insurance, both ACA-compliant and "grandfathered" noncompliant coverage. There are several noteworthy points.

First, the ACA almost doubled insurers' premium revenue in the individual market, which increased by 97 percent, reflecting the considerable increase in enrollment brought about by the law's subsidies and market reforms. Overall, health insurers' premium revenues increased 6.2 percent, including group enrollment. This indicates that employer sponsorship of health insurance did not drop substantially in 2014.[13]

Second, medical claims increased somewhat more than premiums, reflected in the unadjusted MLR increase of 1.1 percent overall. Administrative costs (including broker commissions) rose only slightly (0.6%) as a percentage of total premiums overall. In the individual market, administrative expense decreased as a percentage of premiums because the modest increase in administrative costs was offset by a more substantial increase in premiums. This indicates that insurers were able to expand coverage efficiently in 2014.

Because both medical claims and administrative expenses increased more than premiums in 2014, health insurers' overall operating profits (known as underwriting gain) diminished noticeably from previous years. This was especially pronounced in the individual market, where the 4.2 percent underwriting loss was three points greater than the underwriting loss two years earlier. Insurers overall showed a small profit margin in 2014 of 1 percent, aided by offsetting gains in the group market, but this was well less than half of the profit margin in prior years. This does not include any additional, nonoperating profits that insurers earned from investments, which are not reported in this brief.

Exhibit 2

Health Insurers' Financial Performance by Market Segment, 2012–2014

ALL MARKETS	2012	2013	2014	Change from 2012 to 2014
N=	3514	3393	3147	
Premium ($ in Billions)	$310.5	$310.7	$329.7	6.2%
				Percentage-point change from 2012 to 2014
Net Medical Claims	$270.8	$270.9	$291.1	
% of premium	87.2%	87.2%	88.3%	1.1
Quality Improvement	$2.5	$2.5	$2.6	
% of premium	0.8%	0.8%	0.8%	0
Administrative Costs:	$28.6	$29.5	$32.2	
% of premium	9.2%	9.5%	9.8%	0.6
Broker Expense	$8.4	$8.3	$8.9	
% of premium	2.7%	2.7%	2.7%	0
Other Admin. Cost	$20.2	$21.3	$23.3	
% of premium	6.5%	6.9%	7.1%	0.6
Underwriting Gain (Loss)	$8.8	$7.8	$3.7	
% of premium	2.8%	2.5%	1.1%	–1.7

INDIVIDUAL	2012	2013	2014	Change from 2012 to 2014
N=	1669	1591	1412	
Premium ($ in Billions)	$30.3	$31.9	$59.7	97%
				Percentage-point change from 2012 to 2014
Net Medical Claims	$25.8	$27.3	$53.4	
% of premium	85.1%	85.6%	89.4%	4.3
Quality Improvement	$0.3	$0.3	$0.5	
% of premium	1.0%	0.9%	0.8%	–0.2
Administrative Costs:	$4.7	$5.3	$8.2	
% of premium	15.5%	16.6%	13.7%	–1.8
Broker Expense	$1.3	$1.3	$1.8	
% of premium	4.3%	4.1%	3.0%	–1.3
Other Admin. Cost	$3.4	$4.0	$6.4	
% of premium	11.2%	12.5%	10.7%	–0.5
Underwriting Gain (Loss)	($0.4)	($1.0)	($2.5)	
% of premium	–1.3%	–3.1%	–4.2%	–2.9

SMALL- AND LARGE-GROUP MARKETS	2012	2013	2014	Change from 2012 to 2014
N=	1845	1802	1735	
Premium ($ in Billions)	$280.2	$278.8	$270.0	–3.6%
				Percentage-point change from 2012 to 2014
Net Medical Claims	$245.0	$243.6	$237.7	
% of premium	87.4%	87.4%	88.0%	0.6
Quality Improvement	$2.2	$2.2	$2.1	
% of premium	0.8%	0.8%	0.8%	0
Administrative Costs:	$23.9	$24.2	$24.0	
% of premium	8.5%	8.7%	8.9%	0.4
Broker Expense	$7.1	$7.0	$7.1	
% of premium	2.5%	2.5%	2.6%	0.1
Other Admin. Cost	$16.8	$17.3	$16.9	
% of premium	6%	6.2%	6.3%	0.3
Underwriting Gain (Loss)	$9.2	$8.8	$6.2	
% of premium	3.3%	3.2%	2.3%	–1.0

Source: Authors' analysis of data from the Centers for Medicare and Medicaid Services. Because of rounding, the underwriting gain/loss does not always exactly equal premiums minus costs.

Variability in Financial Performance

Some insurers fared much better than others in the individual market. Exhibit 3 divides credible insurers (i.e., those with more than 1,000 members) into three groups, based on quartiles of underwriting gains or losses.[14] For each group (top quartile, bottom quartile, and median), Exhibit 3 shows the mean financial performance per member per month, weighted by enrollment.

Exhibit 3

Individual Market Financial Performance, by Quartiles of Gain/Loss Per Member Per Month, 2014

All costs are per member per month

	n=	126	252	127	
PMPM*		**Bottom quartile**	**Median**	**Top quartile**	**Percentage-point change from top to bottom**
Premium		$346.7	$300.9	$381.9	
Net Medical Claims		$364.0	$268.1	$304.7	
% of premium		105.0%	89.1%	79.8%	-25.2
Quality Improvement		$3.2	$2.6	$3.1	
% of premium		0.9%	0.9%	0.8%	-0.1
Administrative Costs:		$55.1	$43.4	$41.7	
% of premium		15.9%	14.4%	10.9%	-5.0
Broker Expense		$9.2	$10.3	$10.1	
% of premium		2.7%	3.4%	2.6%	-0.1
Other Admin. Cost		$45.9	$33.1	$31.6	
% of premium		13.2%	11.0%	8.3%	-5.0
Underwriting Gain (Loss)		($75.6)	($13.2)	$32.4	
% of premium		-21.8%	-4.4%	8.5%	30.3

* Weighted mean values by enrollment within quartiles of gain/loss.
Source: Authors' analysis of data from the Centers for Medicare and Medicaid Services.

The best-performing quartile of insurers in the individual market had an 8.5 percent profit margin overall in 2014, compared with a 21.8 percent loss by the worst-performing quartile. Net medical claims exceeded premiums by 5 percent for insurers in the bottom quartile, whereas in the top quartile, medical claims averaged 20 percent less than premiums. Clearly, one insurer's experience does not reflect the others, or the industry, as a whole.

To further understand how the ACA affected insurers in its first full year, we grouped insurers according to whether their profit margins in the individual market increased or decreased from 2013 to 2014. Restricting the sample to credible insurers with primarily ACA-compliant membership resulted in a sample of 144 insurers across different states. Exhibit 4 indicates how many of these made profits both years, suffered losses both years, or switched between profit and loss.

Exhibit 4

Changes in Profit and Loss in Individual Market, 2013–2014

	PMPM-weighted mean 2013	PMPM-weighted mean 2014	Percentage-point change from 2013 to 2014
GROUP ONE: 28 insurers (20%) changed from a loss in 2013 to profit in 2014			
Total Members	965,127	2,471,478	1,506,351
Medical Loss Ratio	92.8%	81.0%	–11.8
Administrative Cost Ratio	12.8%	11.4%	–1.4
Profit Margin	–5.6%	7.6%	13.2
GROUP TWO: 25 insurers (17%) generated profits in both 2013 and 2014			
Total Members	563,536	701,420	137,884
Medical Loss Ratio	80%	82.0%	2.0
Administrative Cost Ratio	15.2%	13.6%	–1.6
Profit Margin	4.7%	4.4%	–0.3
GROUP THREE: 68 insurers (47%) incurred losses in both 2013 and 2014			
Total Members	2,173,857	3,958,517	1,784,660
Medical Loss Ratio	89.9%	96.4%	6.5
Administrative Cost Ratio	18.9%	14.4%	–4.5
Profit Margin	–8.8%	–10.8%	–2.0
GROUP FOUR: 23 insurers (16%) changed from profit in 2013 to loss in 2014			
Total Members	403,572	683,959	280,387
Medical Loss Ratio	80.8%	100.5%	19.7
Administrative Cost Ratio	15.9%	12.8%	–3.1
Profit Margin	3.3%	–13.3%	–16.6

Source: Authors' analysis of data from the Centers for Medicare and Medicaid Services.

Over a third of the total sample (53 insurers, groups 1 and 2) were profitable in 2014; these insurers accounted for 41 percent of the total members in this sample (data not shown). The remainder were either unprofitable both years or moved from profit to loss. Medical claims, rather than administrative costs, were the main driver of the negative financial experiences.

Insurers that turned profitable in 2014 (group 1) saw their medical costs decrease by almost 12 percentage points as a percentage of premium—that is, their MLR decreased. Coupled with a 1.4 point decline in the mean administrative cost ratio, these changes resulted in a substantial (13.2-point) rise in their overall profit margin to 7.6 percent, from a loss of 5.6 percent. In contrast, insurers that reported losses (groups 3 and 4) had substantially higher mean MLRs. Although they managed to reduce their administrative costs significantly, their MLR increased even more, producing a mean loss greater than 10 percent.

CONCLUSION

By subsidizing coverage, establishing insurance exchanges, and making insurance available to people with preexisting conditions, the ACA's reforms changed market conditions in ways that insurers had difficulty predicting, at least initially. In 2014, the ACA's reinsurance program offset much of insurers' underestimated medical claims in the individual market. Also, despite overall losses in the individual market, the insurance industry as a whole earned modest operating profits (in addition to profits from investments).

Only some insurers fared especially poorly. One-quarter of insurers underestimated medical claims in the individual market to a much greater extent than the rest. A fifth of insurers in the individual market substantially improved their financial performance between 2013 and 2014.

All well-functioning markets have winners and losers, so it should be no surprise that some health insurers failed to succeed in the ACA's reformed market, especially during the first year. As insurers gain greater experience with these new conditions, it can be expected that their actuarial precision will improve and that large differences in financial performance will diminish. Moreover, additional market stabilization can be expected as more previously insured people move out of grandfathered and transitional plans and into ACA-compliant coverage.

However, improved financial performance will require increased premiums, especially as the ACA's reinsurance component phases out, starting in 2017. This reinsurance has played a crucial role in helping insurers transition. Because this has taken longer than initially expected, policymakers should consider extending the ACA's reinsurance program until the reformed market has matured.

About This Study

Data were collected from two datasets maintained by the Centers for Medicare and Medicaid Services (CMS): the unified rate review template (URRT) and medical loss ratio (MLR) data.

The URRT includes two sections: a market experience section that develops planned rates from the insurers' own prior experience or from industry averages, and the product/plan section, which reports projected changes in premiums, expenses, and enrollment for the coming year. In 2016, we identified 543 insurers that did not have deactivated submissions. Insurers' 2014 rate filing provided projected information for 2014 and their 2016 filing provided actual information for 2014. We excluded health insurer plans with submission status that was "deactivated" or "terminated."

MLR data were collected from health insurers in 50 states and the District of Columbia, but not from the territories. Data for 2014 included claims "run-out" paid through March 2015, as well as payments for ACA cost-sharing reduction plans. These MLR data captured the effects of "the 3 Rs" (reinsurance, risk adjustment, and rate corridor payments), which we further adjusted for prorated reductions in actual rate corridor payments. The key financial accounts were remapped and recalculated by following the NAIC Supplemental Health Care Exhibit definition for net premiums, net incurred claims after reinsurance, and underwriting gain and losses. In addition, MLR data provided transitional reinsurance payments made to state insurers in 2014.

In assessing the impact of expanded and mandated coverage of the individual commercial market in 2014, we computed financial ratios (medical loss, administrative cost, and profit margin ratios) on 144 credible health insurers (i.e., those with more than 1,000 members) that reported financial data from the individual market between 2013 and 2014 and reported 2014 experience in their URRT 2016 rate filings from plans where at least 50 percent of the membership were in ACA-compliant coverage.

From the 2014 MLR data, we identified 15.1 million nongroup members from 1,412 insurers across the states, before any data adjustments for non-ACA-compliant plans. From 2016 URRT data, we identified 622 insurers, which we merged with the 2014 MLR data. We then eliminated deactivated/terminated plans and any plans where more than 50 percent of the membership were in non-ACA-compliant products. This resulted in 286 insurers, covering 8.1 members that had ACA-compliant plans in both 2014 and 2016. We further reduced the sample to 144 insurers, totaling 7.8 million members, by excluding those that did not report 2013 data and that had fewer than 1,000 members. Marketwide and quartile means are weighted by each plan's membership.

In calculating financial measures, we included insurers with any size enrollment and premiums to capture the experience of insurers that were less active and possibly exiting these markets. For financial measures, we had the following study sample:

- Individual market = 1,669 in 2012, 1,591 in 2013, and 1,412 in 2014
- Small-group market = 968 in 2012, 928 in 2013, and 879 in 2014
- Large-group market = 877 in 2012, 874 in 2013, and 856 in 2014.

Glossary

Premium: Net adjusted premium earned, including payments for risk adjustment and rate corridor payments.

Net medical claims: Incurred medical expenses net of reinsurance claims, adjusted for advance cost-sharing payment.

Medical loss ratio: Net medical claims plus total quality improvement costs, divided by premiums.

Quality improvement expenses: Activities in the following categories: improving health outcomes, preventing hospital readmissions, improving patient safety and reducing medical errors, increasing wellness and promotion, and implementing health information technology. Quality improvement expenses are included along with medical expenses in the numerator of the medical loss ratio for purposes of calculating rebates owed under the ACA.

Agent and broker expenses: Usually reported as part of administrative expenses. (In this brief we separate out this element.)

Other administrative costs: All administrative expenses other than agent and broker fees. Included are internal sales expenses, claims adjustment costs, and salary and benefit expenses, as well as all other general corporate overhead costs.

Administrative cost ratio: Other administrative costs plus agent and broker expenses, divided by premiums.

Underwriting gain or loss: Calculated by subtracting all medical, quality improvement, and administrative costs from net premium earned. As such, it does not include profit or loss from investments or taxes on investments.

Profit margin: Underwriting gain divided by premiums. A negative profit margin indicates that medical and administrative costs exceeded premiums.

Notes

1 "American Health Insurers: Fit as Fiddles," *Economist,* Dec. 5, 2015; P. R. La Monica, "Thanks, Obamacare! Health Insurer Stocks Soar," *CNN Money*, Jan. 21, 2015.

2 S. Sheingold, N. Nguyen, and A. Chappel, Competition and Choice in the Health Insurance Marketplaces, 2014–2015 (Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, July 2015); J. R. Gabel, H. Whitmore, M. Green et al., "In Second Year of Marketplaces, New Entrants, ACA 'Co-Ops,' and Medicaid Plans Restrain Average Premium Growth Rates," *Health Affairs*, Dec. 2015 34(12):2020–26.

3 J. R. Gabel, H. Whitmore, A. Call et al., "Modest Changes in 2016 Health Insurance Marketplace Premiums and Insurer Participation," *To the Point*, Jan. 28, 2016.; J. R. Gabel, H. Whitmore, S. Stromberg et al., "Analysis Finds No Nationwide Increase in Health Insurance Marketplace Premiums," *To the Point*, Dec. 22, 2014.

4 Blue Cross Blue Shield Association, *Newly Enrolled Members in the Individual Health Insurance Market After Health Care Reform: The Experience from 2014 and 2015* (Blue Cross Blue Shield Association, 2016).

5 C. Cox, G. Claxton, L. Levitt et al., *Analysis of 2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces* (Kaiser Family Foundation, June 15, 2016).

6 S. Corlette, S. Miskell, J. Lerche et al., *Why Are Many CO-OPs Failing? How New Nonprofit Health Plans Have Responded to Market Competition* (The Commonwealth Fund, Dec. 2015).

7 J. Holahan, L. J. Blumberg, and E. Wengle, *What Does the Failure of Some Co-ops and the Possible Pullout of United Healthcare Mean for the Affordable Care Act?* (Urban Institute, Jan. 2016). Among the reasons for United Healthcare's failure to thrive in the exchange market are that it waited until the second year to enter most markets and it usually was not among the lowest-priced plans.

8 Further demonstrating this point, see P. R. Houchens, J. A. Clarkson, J. S. Herbold et al., *2014 Commercial Health Insurance: Overview of Financial Results* (Milliman, March 2016); McKinsey Center for U.S. Health System Reform, *Exchanges Three Years In: Market Variations and Factors Affecting Performance, 2016* (McKinsey & Co., May 2016). For an example of analysis that fails to take full account of the ACA's risk protection mechanisms in medical loss ratios, see B. Blase, D. Badger, E. F. Haislmaier et al., *Affordable Care Act Turmoil: Large Losses in the Individual Market Portend an Uncertain Future* (Mercatus Center, June 2016). Although they report offsetting payments from reinsurance, risk adjustment, and risk corridors, they calculate medical loss ratios prior to adjusting for these payments.

9 J. Lerche and K. Ehresmann, *Considerations for 2016 Health Insurance Rate Development, Rate Filing, and Rate Review* (Wakely Consulting Group, March 2015).

10 Per-member-per-month values are weighted by enrollment within each quartile, for top and bottom quartiles, and across the entire sample for the overall mean.

11 Reinsurance claim thresholds and payment percentages are subject to change, but in 2014 the program paid 100 percent of all claims between $45,000 and $250,000 per patient.

[12] For similar comparisons using somewhat different analyses, see P. R. Houchens, J. A. Clarkson, J. S. Herbold et al., *2014 Commercial Health Insurance: Overview of Financial Results* (Milliman, March 2016); and McKinsey Center for U.S. Health System Reform, *Exchanges Three Years In: Market Variations and Factors Affecting Performance, 2016* (McKinsey & Co., May 2016). In contrast, B. Blase, D. Badger, E. F. Haislmaier et al., *Affordable Care Act Turmoil: Large Losses in the Individual Market Portend an Uncertain Future* (Mercatus Center, June 2016) shows much worse financial performance, but their analysis differs by separating products sold through exchanges from the rest of the individual market, and by calculating medical loss ratios prior to taking into account payments from the ACA's three risk-mitigation programs (reinsurance, risk adjustment, and risk corridors).

[13] R. Galvin, "How Employers Are Responding to the ACA," *New England Journal of Medicine*, Feb. 18, 2016 374(7):604–6.

[14] The top quartile includes all insurers with per-member-per-month gain at or above $13.93, while the bottom quartile includes insurers with a loss equal to or greater than $37.72. The middle (median) group is all other insurers. Within each group, mean values are weighted by enrollment.

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Acknowledgments

We are grateful to Julie Andrews with Wakely Consulting Group, who provided very helpful actuarial advice, and Jennifer Pallazzolo, doctoral student at Virginia Commonwealth University, for her programming work.

Editorial support was provided by Deborah Lorber.

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