



The Unpredictable Individual Health Insurance Market

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by Mark Farrah Associates

In February 2016, the Centers for Medicare & Medicaid Services (CMS) reported that 12.7 million consumers had enrolled in Marketplace plans following the open enrollment period. Subsequently in March, health insurers reported providing individual, non-group coverage for 20.2 million people. These updates indicate that 63% of individual medical members were enrolled through the Marketplace yet some carriers have announced plans to withdraw from exchanges next year. About 37% of this segment represents covered lives enrolled in off-exchange plans; currently an estimated 7.5 million. Many insurers are turning more attention to off-exchange membership, as they opt out of exchanges and focus on selling to people who do not qualify for premium subsidies.

Critics of Obamacare have recently ramped up reporting on program weaknesses and failures and several insurers have indicated their public exchange business is unsustainable. Advocates continue to defend the long term merits of the program, suggesting time and patience will pay off as inconsistencies are resolved and the enrollment base matures. The future of the Marketplace and how individual health insurance options will trend is anything but predictable. This brief provides a timely look at recent market developments with state-by-state membership comparisons and competitor insights.

Setting the Stage: Key Provisions and Outcomes

The individual health insurance market has always been somewhat volatile, posing greater risks for carriers than other segments. Before Obamacare was implemented, insurers complied with mandates, medical underwriting standards and community rating which varied state by state as insurance regulators set the requirements. One of the most controversial individual market debates prior to the enactment of the ACA (Affordable Care Act) was on the topic of pre-existing conditions. In the majority of states, regulations were such that insurers could deny people coverage based on perceived health risk and ultimate healthcare cost.

As of January 1, 2014, the ACA prohibited insurers from imposing pre-existing condition exclusions, giving health plan members access to necessary care from their first day of coverage. The ACA requires insurance companies to guarantee issue health plans to any applicant, regardless of health status, and imposes rating restrictions limiting how much insurers can vary premiums based on an individual's health status. Individual health plans, both on and off exchange, now must include the 10 essential health benefits, a package of health care services deemed to meet minimum coverage requirements.

Another ACA provision that has been met with controversy is known as the Individual Mandate. Effective since 2014, individuals are required to have health insurance or pay a penalty for noncompliance. Following an outcry of appeals that the mandate was unconstitutional, the Supreme Court upheld the law in June 2012, ruling in favor of the mandate. Those who do not comply must pay an annual fee when they file their annual tax return. The annual fee for not having insurance in 2016 is \$695 per adult and \$347.50 per child (up to \$2,085 for a family), or 2.5% of total household income above the tax return filing threshold given filing status – whichever is greater.

One more key provision of particular interest to insurers was the implementation of the 3Rs - - risk adjustment, reinsurance and risk corridors. These programs were designed to balance market uncertainty and promote healthy competition in the early years of Obamacare. Though this is a rather simplistic explanation, the idea was to offset risks as insurers grew membership and learned how to appropriately price coverage.

Fast forward to 2016, more than three years into the Marketplace, and stakeholders are withdrawing from the exchanges and litigating with the government over 3Rs payments. A recent Health Affairs Blog report provides a helpful summary of the 3Rs controversy and litigation.

Key takeaways from the Health Affairs Blog report:

- Unexpected difficulties surrounding the 3Rs have damaged the ACA-reformed insurance markets. Several insurers, including UnitedHealth and Humana, lost hundreds of millions of dollars that they expected to have repaid. Some have chosen to leave ACA markets in 2017.
- While insurers and regulators are still negotiating 2017 rates, it is most likely that rate increases will be significantly higher next year than any other year since the ACA was implemented. Meanwhile, insurers with small capital reserves—most visibly the co-ops, but others too—are going out of business.
- Some insurers that were promised relief in the event of large losses are now suing the federal government due to lack of reimbursement.
- Trouble with the 3Rs has insurers questioning the viability of the ACA-reformed markets. Based on preliminary analyses, the 2017 exchanges will have fewer options, larger premium increases, and less generous benefits than prior years since the ACA marketplaces were implemented in 2014.

Citation: Mike Adelberg and Nicholas Bagley, [Struggling To Stabilize: 3Rs Litigation and The Future of the ACA Exchanges](http://healthaffairs.org/blog/2016/08/01/struggling-to-stabilize-3rs-litigation-and-the-future-of-the-aca-exchanges/), Health Affairs Blog, August 1, 2016, <http://healthaffairs.org/blog/2016/08/01/struggling-to-stabilize-3rs-litigation-and-the-future-of-the-aca-exchanges/> (<http://healthaffairs.org/blog/2016/08/01/struggling-to-stabilize-3rs-litigation-and-the-future-of-the-aca-exchanges/>), Copyright ©2016 Health Affairs by Project HOPE – The People-to-People Health Foundation, Inc.

Insurers React

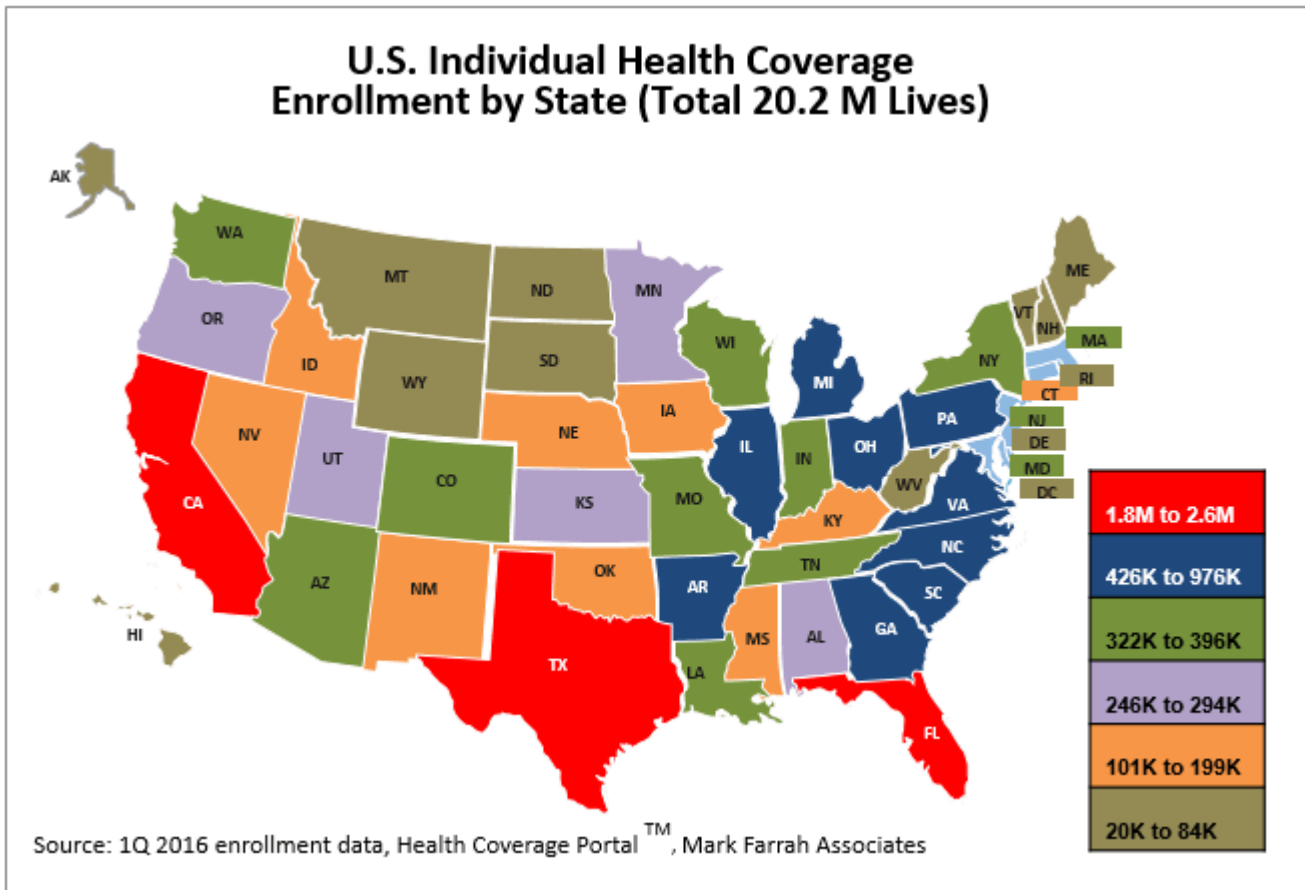
Insurers have attributed high medical claims, adverse selection, 3Rs program challenges, immature risk pools, and under-enrollment of younger, healthier individuals as factors resulting in significant losses on Marketplace business. Growing concerns about sustainability have motivated some insurers to pull out of the exchanges. UnitedHealth was one of the first to announce plans to downsize exchange participation. In April 2016, officials cited high medical costs and reported the company will operate in only a handful of exchanges in 2017. Humana followed in June 2016, indicating they too would pull out of many exchanges after a year of nearly \$1 billion in losses. Most recently, in August 2016, Aetna reported it would sharply reduce its participation in the public Marketplaces next year. Several Blue Cross Blue Shield plans and regional competitors, e.g. Scott and White Health Plan, have also announced intentions to scale back.

A new analysis from Avalere suggests that one-third of the United States will have only one insurer to choose for Marketplace coverage in 2017 - - [Experts Predict Sharp Decline in Competition across the ACA Exchanges](http://avalere.com/expertise/life-sciences/insights/experts-predict-sharp-decline-in-competition-across-the-aca-exchanges/) (<http://avalere.com/expertise/life-sciences/insights/experts-predict-sharp-decline-in-competition-across-the-aca-exchanges/>).

Still, Marketplace advocates maintain that the ACA is in its formative years and new companies will enter markets as others exit. Supporting analysts have expressed that the market will stabilize as insurers have access to better data to set more accurate prices.

Individual Market Covered Lives

Though it's hard to say what the future holds for the ACA, the following review of recent performance metrics may help shed some light on the volatile individual health insurance market. Enrollment in individual, non-group medical plans totaled 20.2 million as of March 2016, according to financial statements filed by insurers. No surprise, the largest membership generally resides in the largest states demographically. It is interesting to note, although Marketplace reports indicate 4.9 million new members enrolled in 2016, year-over-year total individual market enrollment actually declined slightly by about 1%. Total individual market enrollment, based on carrier reports, had been 20.4 million a year ago in March 2015.



It is important to note that Mark Farrah Associates (MFA) applied year-end 2015 enrollment figures for select carriers not required to report health enrollment on a quarterly basis and made other adjustments based on market analysis. Furthermore, individual enrollment may include Medicaid programs, such as CHIP, as some states include subsidized lines in the individual segment. These factors may have resulted in moderate understatement or overstatement of enrollment.

Competitor breakdowns of Marketplace enrollment are not readily available however the following table presents state by state breakdowns of the total individual market, separating on-exchange and off-exchange membership. For this assessment, MFA applied the assumption that the difference between total individual enrollment reported by carrier and on-exchange, Marketplace enrollment reported in ASPE (Office of The Assistant Secretary, Health and Human Services) is reasonably representative of off-exchange membership. This analysis did not include state by state research to provide local market insights about exchange positioning nor did the analysts investigate off-exchange plan options. Nonetheless, the state breakdowns provide an interesting framework for understanding the greater market opportunity.

Individual Health Enrollment On and Off Exchange			
State	March 2016 Total Individual Enrolled	February 2016 On-Exchange Enrolled	Estimated Off-Exchange Enrolled
AK	20,686	23,029	N/A
AL	246,287	195,055	51,232
AR	591,467	73,648	517,819
AZ	325,507	203,066	122,441
CA	2,632,316	1,575,340	1,056,976
CO	353,000	150,769	202,231

In terms of competition, Anthem, UnitedHealth, Aetna, Health Care Service Corporation (HCSC), Humana and Kaiser lead the industry in this segment, each reporting more than a million individual medical covered lives as of 1st quarter 2016.

Brief Insights about Financial Performance

As insurers report losing big money in the individual market, underwriting gain/loss figures from 2015 statutory financial statements confirm these accounts are valid. Insurers collectively lost almost \$6 billion in the segment last year. On an aggregate basis,

CT	178,825	116,019	62,806
DC	33,207	22,693	10,514
DE	43,305	28,256	15,049
FL	2,223,260	1,742,819	480,441
GA	976,384	587,845	388,539
HI	46,694	14,564	32,130
IA	171,904	55,089	116,815
ID	138,843	101,073	37,770
IL	609,056	388,179	220,877
IN	327,417	196,242	131,175
KS	259,456	101,555	157,901
KY	199,590	93,666	105,924
LA	322,298	214,148	108,150
MA	344,064	213,883	130,181
MD	396,479	162,177	234,302
ME	84,570	84,059	511
MI	532,581	345,813	186,768
MN	266,911	83,507	183,404
MO	373,436	290,201	83,235
MS	190,159	108,672	81,487
MT	67,418	58,114	9,304
NC	740,801	613,487	127,314
ND	61,176	21,604	39,572
NE	162,551	87,835	74,716
NH	84,369	55,183	29,186
NJ	327,133	288,573	38,560
NM	101,166	54,865	46,301
NV	182,982	88,145	94,837
NY	357,497	271,964	85,533
OH	426,221	243,715	182,506
OK	163,478	145,329	18,149
OR	253,017	147,109	105,908
PA	957,659	439,238	518,421
RI	47,004	34,670	12,334
SC	435,193	231,849	203,344
SD	73,803	25,999	47,804
TN	344,763	268,867	75,896
TX	1,801,126	1,306,208	494,918
UT	294,392	175,637	118,755
VA	609,335	421,897	187,438
VT	32,237	29,440	2,797
WA	369,067	200,691	168,376
WI	335,671	239,034	96,637
WV	48,220	37,284	10,936

individual business summed to a net loss in 41 states plus the District of Columbia. The state of Texas generated the largest total deficit, with plans reporting a combined net loss of \$717 million. Combined business in nine less populous states was favorable, driven by net gains reported by local market leaders. Bear in mind, these performance indicators include business generated both on and off exchange.

Out of 194 companies that filed the 2015 Supplemental Health Care Exhibit (SHCE), sixty-nine percent or 133 reported aggregate net losses in the individual, non-group segment. UnitedHealth, HCSC, Humana, Highmark and Assurant reported the largest aggregate losses last year. A total of 61 companies reported modest aggregate gains in the segment. Guidewell, the parent company of Blue Cross Blue Shield affiliates operating in Florida was most profitable, reporting an aggregate net gain of \$149 million for 2015.

It is important to keep in mind the underwriting gain/loss figures reported in the SHCE are preliminary and reported prior to HHS assessment of the 3Rs and ACA adjustments.

Looking Forward

The Marketplace shakeout will continue as companies both withdraw and enter new exchange markets. Meanwhile, insurers are working to firm up rates for 2017 individual plans and gear up for open enrollment beginning November 1, 2016. As for the future of Obamacare, it seems this is a wait and see proposition. Some say the program is unsustainable and will collapse. Others believe the program can learn from its mistakes and secure a solid footing in time. Without a doubt, outcomes from the upcoming presidential and congressional elections will strongly influence Obamacare's future. Analysts at Mark Farrah Associates will continue to monitor the unpredictable individual health insurance market. Stay tuned.

About Mark Farrah Associates (MFA)

Mark Farrah Associates (MFA) is a leading provider of health plan market data and analysis tools for the healthcare industry. If your company relies on accurate assessments of health plan market share and financial performance to support business planning, we encourage you to [contact us \(/Contact-Us.aspx\)](#) to learn more about our products. Our portfolio includes the Health Coverage Portal™, County Health Coverage™, Health Insurer Insights™, Medicare

WY	38,832	23,770	15,062
	20,202,813	12,681,874	7,520,939

Source: Health Coverage Portal™, Mark Farrah Associates,
presenting data from NAIC, CA DMHC, and HHS-ASPE

Business Online™, Medicare Benefits Analyzer™,
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