

# **The Impact of the Affordable Care Act on the Financial Performance of Health Insurers**

## **Purpose of the Research**

The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and modified by the Health Care and Education Reconciliation Act of 2010 seven days later.<sup>1</sup> Collectively known as the Affordable Care Act (ACA), the two acts introduce sweeping changes to the U.S health care system. To achieve its key goals of expanding health insurance coverage and bringing down health care costs, the ACA establishes a plethora of federal regulations targeting various aspects of health insurers' operations.

For instance, health insurers are required to maintain minimum medical loss ratios (MLR) by state of 80% in the individual and small-group markets and 85% in the large group markets. Those that fail to meet the MLR minimums must pay rebates to their enrollees. The ACA also restricts insurers' ability to deny coverage to people with pre-existing conditions or charge differential prices based on enrollees' gender and health status.

While these new regulations help enhance consumer value and broaden insurance coverage, they may also have unintended consequences on health insurers as they work to be ACA compliant. UnitedHealth – the nation's largest for-profit health insurer – already warned that it may exit the health insurance exchanges after 2016, citing low enrollment and high usage cost.<sup>2</sup> By late 2015, more than half of the nonprofit health insurance co-ops have been shut down, and over a billion dollars in loans and backstop payments have been lost.<sup>3</sup> These developments in the health insurance market will surely leave many customers scrambling to find new coverage.

The purpose of this research is to examine how the above-mentioned MLR requirements and underwriting restrictions, as well as other relevant ACA provisions, affect health insurers' risk profiles and their financial performance. We hope our research will shed light on how to balance the interests of both consumers and insurers. After all, only by ensuring the financial health of carriers can we truly offer protection and value to health insurance consumers.

## **ACA Provisions that Affect Insurers' Risk Profiles**

Health insurers face many risks in its operation to offer coverage to their policyholders. According to the National Association of Insurance Commissioners, there are four major categories of risks health insurers must deal

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<sup>1</sup> <http://www.hhs.gov/healthcare/>

<sup>2</sup> <http://www.usatoday.com/story/money/2015/11/19/unitedhealth-group-earnings-downgrade-obamacare-affordable-care-act/76040322/>

<sup>3</sup> <http://www.thefiscaltimes.com/Columns/2015/11/05/Collapsing-Obamacare-Co-ops-Signal-Big-Trouble-Come>

with: 1) Asset Risk – this includes the risk of assets’ default for certain affiliated investments, and the risk of assets’ default of principal and interest or fluctuation in market value. 2) Underwriting Risk – This is the risk of underestimating liabilities from business already written or inadequately pricing business to be written in the coming year. 3) Credit Risk – This is the risk of recovering receivable amounts from creditors. 4) All other business risks.<sup>4</sup>

The ACA provisions generally do not have direct impact on asset risk, which concerns the value fluctuation of insurers’ investments in both affiliates and non-affiliates.<sup>5</sup> The other three categories of risks, however, may be affected in different ways by the following major ACA regulations.

#### Medical Loss Ratio Requirement

The ACA defines MLR differently than insurance regulators and carriers normally do. Traditionally, MLR is the incurred medical claims cost divided by earned medical premiums. The MLR under the ACA takes a different form as shown below:

ACA MLR = (direct medical claims + quality improvement expenses) / (direct premiums less federal and state taxes and licensing regulatory fees).

The ACA MLR uses direct premiums and claims without netting of reinsurance. It also makes adjustments for certain expenses, taxes and fees. Quality improvement expenses are counted as medical benefits, while federal/state taxes and regulatory fees will reduce premiums used in the MLR calculation. Traditional MLR is a measure of underwriting profitability. The lower the ratio, the better the insurer’s underwriting performance. Under the ACA, however, insurers must spend a minimum percentage of their premium dollars on medical benefits; otherwise they must pay rebates to their enrollees. Put it differently, the higher the ACA adjusted MLR, the better.

With the minimum MLR requirement, insurers face the risk of paying rebates if their claims turn out to be lower than projected, thus unable to shore up reserves in years of gains to subsidize losses in high-claim years. As the MLR requirements must be met across markets (individual/small group and large group markets) at the state level, insurers are also prohibited from subsidizing their poor performing blocks of business by other lines or blocks of business in other states.<sup>6</sup> As a result, the MLR requirement may result in increased underwriting risks.

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<sup>4</sup> Definitions of risks are directly taken from <http://www.naic.org/store/free/MDL-315.pdf>.

<sup>5</sup> To the extent that the ACA promotes mergers and acquisitions, insurers’ asset risk will be affected.

<sup>6</sup> [http://www.naic.org/documents/committees\\_e\\_capad\\_hrbc\\_newsltr\\_1408.pdf](http://www.naic.org/documents/committees_e_capad_hrbc_newsltr_1408.pdf)

Prior to the ACA, most health insurers focused on utilization review and other forms of cost control in the managed care environment. Traditionally, administrative expenses include claims adjustment expenses and non-claim expenses (such as commissions paid to agents and brokers, and quality improvement expenses). Now with the ACA, insurers may have an incentive to increase spending on quality improvement expenses but reduce cost containment expenses and other administrative expenses in their efforts to meet or exceed the minimum MLR requirement. Such reallocation of expenses may have an effect on insurers' administrative expense risk, which is part of "other business risks" faced by health insurers, and refers to fluctuation of administrative expenses relative to the premium needed to pay those expenses.

### Underwriting Restriction

Under the ACA, health insurers must offer coverage to all comers, regardless of their gender or health status. They cannot deny coverage to people with pre-existing conditions.

Traditionally, insurers used health status to differentiate risks and charge different prices. The ACA, however, only allows the following underwriting factors: age; tobacco use; geographic location; family size, and actuarial value of the plan. Adverse selection may follow, namely, older or sicker people are more likely to purchase health insurance than younger or healthier people. If a risk pool is mainly composed of high-risk enrollees, claims cost will eventually go up, which in turn will drive up insurance premiums. In other words, the new underwriting restrictions will increase insurers' underwriting risks.

### Risk-sharing Provisions

Recognizing the aforementioned adverse selection problem and difficulty for insurers to predict claims cost, the ACA also includes three risk-sharing provisions, namely, temporary reinsurance, temporary risk corridors, and permanent risk adjustment programs (3 R's). According to the Centers for Medicare & Medicaid Services, these programs are designed to help limit the amount an insurance company can lose by participating in the health insurance exchange. Risk adjustment is used to spread risk among plans to mitigate adverse selection, reinsurance works to subsidize plans with high-risk individuals, and risk corridors protect both health plans and the federal government against uncertainty in pricing during the earlier years of the health care reform.<sup>7</sup>

While the 3 R's may reduce an insurer's underwriting risk (assuming it is due payments from the programs), they also increase the company's credit risk as the payments of receivables may be delayed or unpayable. On the

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<sup>7</sup> <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/>

other hand, insurers also need to set up reserves to account for the possibility that their claims are better than expected and they become responsible for paying into the 3 R's programs. As such, the insurer's underwriting risk will be affected. Given above, the net effect of the risk sharing programs on insurers' underwriting risks is not clear *a priori*.

### **Research Methodology: ACA and Insurer Financial Performance**

As insurers' underwriting risk, credit risk, and other business risk may be affected in various ways by the ACA regulations, we are interested in studying how their financial performance changes with the enactment of the ACA. We plan to use statutory financial statements reported to the National Association of Insurance Commissioners to conduct our research. More specifically, we will do trend analyses of the following performance metrics.

*Traditional MLR:* As indicated above, traditional MLR defined as the ratio of incurred medical claims to earned premiums is a measure of underwriting performance. Beginning in 2011, all health insurers that write direct, comprehensive major medical health business must file the Supplemental Health Care Exhibit (SHCE) and report aggregate financial data across markets, including premiums, claims and expenses information at the state level. We will calculate each insurer's traditional MLR across markets in each state, as well as at the country level.

*Administrative Expenses:* We will also use the SHCE to examine insurers' spending on administrative expenses, including claims expenses, quality improvement expenses, and other non-claim expenses. We are interested in finding out if there is any trend in terms of insurers' reallocation of spending between quality improvement and cost containment activities. We will also explore whether the administrative expenses excluding quality improvement expenses have declined in the past few years, as some insurers attempt to reduce premiums to boost their ACA-compliant MLRs.

*Business Mix:* Health insurers usually report the following lines of businesses: individual comprehensive coverage (including both hospital and medical benefits), small group comprehensive coverage, large group comprehensive coverage, Medicare Supplement, vision only plans, dental only plans, federal employees health benefit plan, Title XVIII Medicare, and Title XIX Medicaid. Under the ACA, only the first three lines are subjected to the MLR requirements, with 80% for individual and small group markets and 85% for large group markets. As such, it'd be interesting to see if insurers have changed their business mix after the ACA enactment. We will use

the SHCE to examine the premium share of each line of business and analyze any possible trends across markets, states and over time.

*Risk-based Capital:* The insurance regulators require insurers to carry a minimum amount of capital (Risk-based Capital) commensurate with their risks. If the RBC falls below a certain level, the insurer will be subjected to regulatory actions.<sup>8</sup> The ACA provisions have differing impacts on underwriting risk, credit risk, and other business risk, which are all important determinants of the RBC. As such, we will examine if insurers' RBC has strengthened or deteriorated with the ACA enactment. We will use the five-year historical data in the NAIC financial statements to examine the trend of the RBC.

*Premium Growth:* with the individual mandate and employer mandate, health insurers may experience a sharp increase in enrollments. The high premium growth is concerning if insurers do not have sufficient surplus or reserves to pay medical claims and expenses. We will explore insurers' premium growth in relation to their surplus growth and reserve growth and will try to identify carriers that may be growing faster than their capital would allow.

*Return on Equity:* we will finally bring everything together by examining insurers' return on equity, which is after-tax net income divided by surplus. This is a commonly used measure of insurers' overall financial performance. Again, we will analyze trends over time.

### **Importance of the Study**

In sum, we will examine trends in above-mentioned metrics and explore how the trends are associated with firm characteristics, such as organizational forms (stock, mutual, blue cross or blue shield, etc.), firm size, firm age, firm product diversification, and firm geographic diversification. We expect that our results will deepen our understanding of the ACA impact on health insurers and help design better policies and regulations to balance interests of both insurers and their policyholders.

While many researchers have examined enrollment and premium change after the ACA became law, there is little literature focusing on insurers' financial performance in various aspects. This study is intended to fill the gap and provide a unique perspective on the ACA impact.

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<sup>8</sup> <http://www.naic.org/store/free/MDL-312.pdf>