



Cost-sharing reduction plan payments under the ACA

Summary of health insurer cost-sharing reduction payments in CY 2014 and CY 2015

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I. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (ACA) provides a federal subsidy, known as a cost-sharing reduction (CSR), to qualifying low-income households that purchase silver-level coverage in the insurance marketplaces. Qualifying low-income households are those at 100% to 250% of the federal poverty level (FPL). Members eligible for this federal subsidy receive CSR plan variants of standard silver-level coverage, which reduce a household’s out-of-pocket healthcare cost-sharing expenditures (deductibles, copays, coinsurance, out-of-pocket maximums). Insurers do not factor a CSR plan’s reduced member cost-sharing into their premium rate development; rather, the federal government makes payments to insurers for the estimated cost of the CSR payments throughout the year, with a final reconciliation process occurring after year-end.¹ On average for the first half of 2016, the Centers for Medicare and Medicaid Services (CMS) announced, nearly 5.9 million individuals received CSR plan variants, which equals approximately 56% of average monthly marketplace enrollment during the six-month period.² Households qualifying for CSR plan variants may also be eligible to receive federal premium assistance, which reduces the out-of-pocket cost of purchasing health insurance coverage in the insurance marketplaces.

Due to pending litigation (House v. Burwell),³ the legal status of the federal government making direct payments to insurers to offset costs related to CSR plans has come into question. Milliman, Inc. (Milliman) was contracted by the Association for Community Affiliated Plans (ACAP) to analyze the potential impact to the health insurance industry and ACAP-member insurers to the extent federal CSR payments were not paid to insurers for the 2017 coverage year in the individual health insurance market.⁴ By analyzing publicly available insurer financial data from the 2014 and 2015 medical loss ratio annual reporting form (MLR data), we have summarized the actual CSR payment amounts received by insurers in each calendar year and the impact to insurers’ financial results in the individual health insurance market. While it is certain that 2017 financial results will vary from prior years, we believe our analysis of 2014 and 2015 data illustrate the potential significance of a loss of CSR payments to insurers in the current calendar year.

Total reported cost-sharing reduction payments

As illustrated in Figure 1, the health insurance industry reported \$2.83 billion and \$4.90 billion in CSR payments in 2014 and 2015, respectively. Consistent with the significant growth in the insurance marketplace between 2014 and 2015, the number of average monthly CSR recipients is estimated to have grown by approximately 64%. For the average 12-month enrollment period, the subsidy is estimated to have equated to approximately a \$901 (2014) to \$948 (2015) reduction in out-of-pocket healthcare cost-sharing expenditures⁵. For the chronically ill and individuals with significant healthcare expenditures, the value of the CSR plan may have been significantly greater than the average yearly values. Conversely, the value of the CSR would be \$0 for an individual with no healthcare expenditures during the year.

	CY2014	CY2015
CSR Payments (\$ billions)	\$ 2.83	\$ 4.91
Average Monthly CSR Recipients	3,100,000	5,200,000
CSR Payments Per Effectuated 12-Month Recipient	\$ 901	\$ 948

Notes:

1. Average monthly CSR recipients excludes Arkansas’s Medicaid private-option enrollees.
2. CSR payments reported in 2014 and 2015 MLR Annual Reporting Form data.
3. Estimated effectuated CSR plan enrollment calculated from publicly available CMS and Internal Revenue Service (IRS) data.
4. Values have been rounded.

¹ Insurers are permitted to make an induced utilization assumption for enrollees in CSR plans.

² CMS.gov (October 19, 2016). First Half of 2016 Effectuated Enrollment Snapshot. Retrieved January 27, 2017, from <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-10-19.html>.

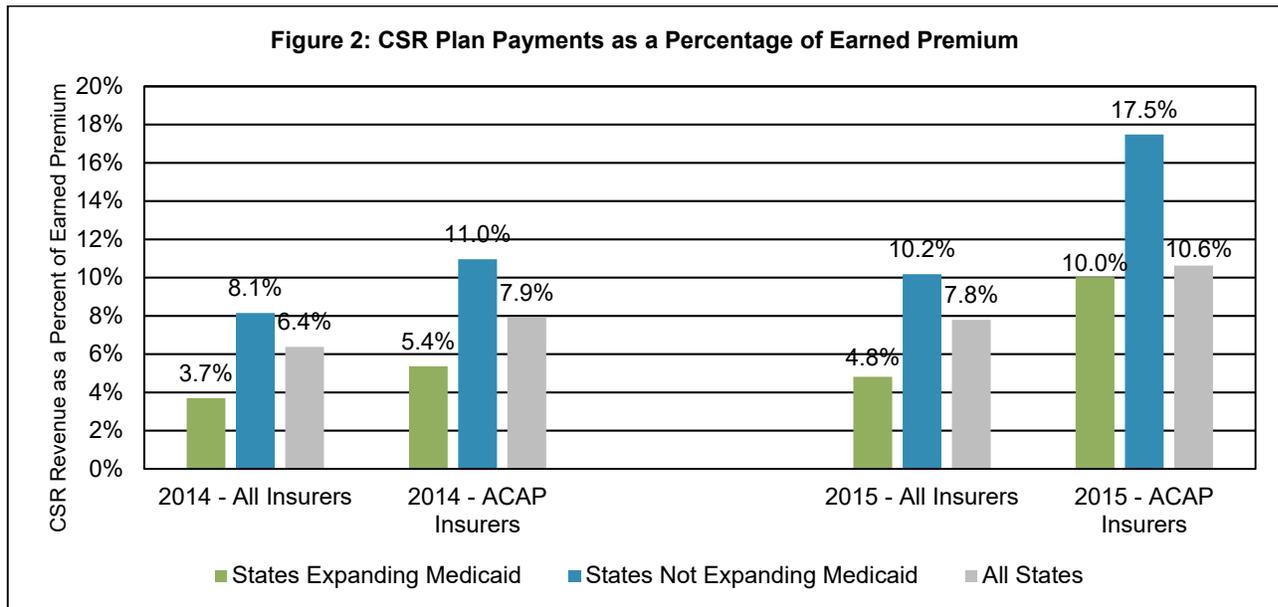
³ House v. Burwell (November 21, 2014). Retrieved January 27, 2017, from

<http://online.wsj.com/public/resources/documents/HouseACAComplaint112014.pdf>.

⁴ ACAP insurers participating in the marketplace are identified at <http://www.communityplans.net/about/our-plans/>.

Cost-sharing reduction payments as a percentage of earned premium

Figure 2 illustrates CSR payments in 2014 and 2015 as a percentage of earned premium for all insurers participating in the insurance marketplaces. Premium revenue includes off-exchange, transitional, and grandfathered coverage for illustrated insurers. We have summarized the results of our analysis between Medicaid expansion and non-expansion states based on whether the state decided to expand Medicaid on or before January 1 of that year, and additionally on a national level. We have also separately shown the health insurance industry in aggregate, as well as isolating experience from ACAP insurers.⁶ State-level data is illustrated in the appendix.



Notes:

- Values for "States Expanding Medicaid" and "States Not Expanding Medicaid" exclude states that expanded Medicaid midyear. "All States" figures include all 50 states and the District of Columbia.
- Minnesota and Arkansas have been excluded from the "States Expanding Medicaid" values because of unique state healthcare reform programs.
 - Minnesota provided Medicaid eligibility up to 205% FPL for adults and caretakers in 2014. In 2015, Minnesota implemented the Basic Health Plan option for beneficiaries with income up to 200% FPL.
 - Arkansas CSR values reflect the state's private option Medicaid expansion population.
- The data in the chart represents aggregated data by state for companies offering qualified health plan (QHP) medical coverage in the individual market, determined by the existence of risk-corridor-eligible business reported in the 2014 and 2015 MLR form data.

Several key observations can be made from Figure 2:

- CSR payments are a significant percentage of insurer earned premium, particularly in states that have not expanded Medicaid.** In states that have not expanded Medicaid, the population between 100% and 138% FPL is eligible for insurance marketplace premium and cost-sharing assistance. This income segment represents a material portion of marketplace enrollment, resulting in CSR payments being 10.2% of earned premium for states not expanding Medicaid in 2015, relative to only 4.8% of earned premium for expansion states.
- ACAP insurers reported a greater amount of CSR payments relative to earned premium in both expansion and non-expansion states.** As ACAP insurers have traditionally served Medicaid and low-income populations, their insured members in the individual health insurance market are largely in the insurance marketplaces, rather than the off-marketplace distribution channels.
- The loss of CSR payments in 2017 would trigger significant losses for many insurers in the individual market.** With continued growth in insurance marketplace and CSR enrollment, CSR payments may be of even greater importance to insurers in 2017 relative to results shown in Figure 2 for 2014 and 2015. For some insurers, additional funding or higher future premiums may be needed to maintain risk-based capital requirements.

⁶ ACAP insurers for 2014 and 2015 are identified in the Methodology section of this report.

Note that we are providing no legal opinion on the merits or outcomes of House v. Burwell. The results contained in this report are based on actuarial modeling, and require readers to have an extensive knowledge of the ACA's premium assistance and CSR structures, as well as health insurer financial reporting. We have not been requested to estimate or model the effect of eliminating CSR payments beyond calendar year 2017. The information contained in this report has been prepared for ACAP. It is our understanding that this document may be distributed publicly. Any distribution of the information should be in its entirety.

II. BACKGROUND

Milliman has been retained by ACAP to summarize payments received by health insurers in 2014 and 2015 related to the ACA CSR payments.⁷ CSR payments represent one of two federal assistance programs implemented by the ACA that impact the individual health insurance market.

- Advanced Premium Tax Credits:** The first program, Advanced Premium Tax Credits (APTC), are payments made directly to the insurance company by the federal government on behalf of the qualifying members to make insurance more affordable for lower-income households. The amount of the premium tax credit varies for each qualifying household based on its income relative to the federal poverty level (FPL) and the price of the second-lowest-cost silver plan (commonly known as the “subsidy benchmark plan”) that the household can purchase in the insurance marketplace.
- Cost-sharing reduction subsidies:** The CSR payments require insurers participating in the individual insurance marketplace to automatically provide the following variants on the base silver, 70% actuarial value (AV), plan design to qualifying households purchasing such coverage.

Figure 3 Affordable Care Act Cost-Sharing Reduction Variants	
Actuarial Value of CSR Plan Design	Income Criteria (FPL)
94%	100% to 150% FPL
87%	150% to 200% FPL
73%	200% to 250% FPL

Note: Legal immigrants with income below 100% FPL are eligible for premium or CSR assistance.

The increase in actuarial value results in qualifying households receiving an insurance plan design with lower deductibles, out-of-pocket maximums, and other cost sharing relative to the standard 70% silver plan design. As illustrated in Figure 4, the Kaiser Family Foundation analyzed silver-level plans offered in the 2015 federally facilitated insurance marketplace and summarized the variation in cost-sharing features between the standard silver plan design and the CSR plan design variants.⁸

Figure 4 Affordable Care Act Cost-Sharing Reduction Plan Design Variants: CY 2015 Cost Sharing Provisions				
Type of Cost Sharing	Standard Silver Over 250% FPL	Variant Based on Income Level		
		73% Actuarial Value 200% - 250% FPL	87% Actuarial Value 150% - 200% FPL	94% Actuarial Value 100% to 150% FPL
Average Annual Medical and Drug Deductible for Single Coverage	\$ 2,556	\$ 2,077	\$ 737	\$ 229
Average Copayment for Primary Care Office Visit	\$ 28	\$ 23	\$ 17	\$ 14
Average Out-of-Pocket Limit for Single Coverage	\$ 5,826	\$ 4,624	\$ 1,692	\$ 881

Notes:

- Values reflect plans offered in the federally facilitated marketplace only.
- Legal immigrants with income below 100% FPL are eligible for premium or CSR assistance.

In addition to the CSR plan design requirements illustrated above, insurers are required to eliminate all cost-sharing requirements for Native Americans with household incomes under 300% FPL who are purchasing any qualified health plan

⁷ Patient Protection and Affordable Care Act, Section 1402. Retrieved January 27, 2017, from <https://www.hhs.gov/sites/default/files/ppacacon.pdf>.

⁸ Kaiser Family Foundation (February 11, 2015). New reports analyze cost sharing in 2015 ACA marketplace plans in 37 states. Newsroom. Retrieved January 27, 2017, from <http://kff.org/health-costs/press-release/new-reports-analyze-cost-sharing-in-2015-aca-marketplace-plans-in-37-states/>.

(regardless of metallic tier). Insurers are also not permitted to require cost sharing from any Native American who is receiving services from Indian Health Services or other healthcare service providers affiliated with a tribe.

Based on reported CSR amounts in the MLR form data and effectuated CSR enrollment values released by CMS for 2014 and 2015,⁹ we estimate that the average CSR-qualifying enrollee received a CSR benefit worth approximately \$901 (2014) and \$948 (2015) on a 12-month basis. Unlike the APTC, the value of the CSR plan varies based on a household's healthcare consumption during the year. To the extent that a CSR-qualifying enrollee did not incur any healthcare expenses during the year, the value of the CSR plan would be \$0. However, if the enrollee was hospitalized or incurred significant healthcare expenses during the year, the value of the CSR plan may exceed several thousand dollars.

When health insurers participating in the marketplace develop premium rates for silver-level coverage, insurers do not adjust premium amounts to reflect the additional healthcare costs paid above the base (70%¹⁰ AV) plan design.¹¹ Rather, insurers receive funding directly from the federal government for the additional costs resulting from the higher AV plan design. Other than purchasing a silver-level plan design in the marketplace, consumers qualifying for CSR plans do not have to take any additional actions to receive the enhanced plan design.

During the course of the calendar year, insurers receive an advanced prospective payment for the estimated cost of CSR plan variants provided to qualifying members. CMS has established processes to reconcile the advanced CSR payments made to insurers with actual claims experience.¹² On June 30, 2016, insurers were notified of final reconciled CSR amounts for both the calendar years 2014 and 2015 coverage years.¹³

The final reconciled CSR amounts for 2014 and 2015 are reported in the CY 2015 Medical Loss Ratio (MLR) annual reporting form that is completed by insurers offering commercial health insurance in the United States.¹⁴

The CSR reconciliation process, set forth in 45 CFR 156.430, is performed by the insurance companies and CMS. On a periodic basis, CMS will reconcile the advance CSR payments made to the qualified health plan (QHP) issuer. If, during the reconciliation process, it is determined that the advance CSR payments to the QHP issuer are too high, then the issuer must repay the difference. Conversely, if it is determined that the advance CSR payments to the QHP issuer is lower than the actual cost of the subsidy, then CMS will pay the insurer the difference. Insured members qualifying for CSR plan variants play no role in the reconciliation process.

House v. Burwell

On November 21, 2014, the U.S. House of Representatives filed a lawsuit against Sylvia Burwell, Secretary of the U.S. Department of Health and Human Services (HHS), and Jacob Lew, Secretary of the U.S. Department of the Treasury (House v. Burwell).¹⁵ With regards to CSR payments, the House filed a complaint alleging that the CSR monies reimbursed to issuers were not in fact appropriated by Congress.¹⁶

The U.S. District Court for the District of Columbia found that: "The Affordable Care Act unambiguously appropriates money for Section 1402 premium tax credits but not for Section 1402 reimbursements to insurers. Such an appropriation cannot be inferred."¹⁷

The Court further says that "The insurers are supposed to get their money back... Nothing in Section 1402 prescribes a "periodic and timely payment process, however. Nor does Section 1402 condition the insurers' obligations to reduce cost sharing on the receipt of offsetting payments."¹⁸

⁹ CMS.gov (July 1, 2016). Quarterly Marketplace Effectuated Enrollment Snapshots by State. Retrieved January 27, 2017, from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Effectuated_Quarterly_Snapshots.html.

¹⁰ Insurers are permitted to offer silver-level coverage with an actuarial value range of 68% to 72%.

¹¹ Insurers are permitted to modify healthcare utilization assumptions in premium rate development based on additional induced utilization from CSR enrollees.

¹² Please read the following Milliman research paper for more details concerning the reconciliation methodologies offered by CMS: <http://us.milliman.com/uploadedFiles/insight/2014/csr-subsidies.pdf>.

¹³ CMS (March 16, 2016). Manual for Reconciliation of the Cost-Sharing Component of Advance Payments for Benefit Years 2014 and 2015. Retrieved January 27, 2017, from https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS_Guidance_on_CSR_Reconciliation-for_2014_and_2015_benefit_years.pdf.

¹⁴ CMS. Filing Instructions for the 2015 MLR Reporting Year. Retrieved January 27, 2017, from <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2015-MLR-Form-Instructions-2016-05-08.pdf>.

¹⁵ House v. Burwell, *ibid.*

¹⁶ U.S. District Court, D.C. (May 12, 2016). House v. Burwell: Opinion. Retrieved February 3, 2017, from <http://www.scotusblog.com/wp-content/uploads/2016/05/HofR-challenge-to-ACA-Dct-5-12-16.pdf>.

¹⁷ U.S. District Court, D.C. *ibid.*, p. 2.

¹⁸ U.S. District Court, D.C., *ibid.*, p. 7.

The Court finds that, “Congress authorized reduced cost sharing but did not appropriate monies for it, in the FY 2014 budget or since. Congress is the only source for such an appropriation, and no public money can be spent without one.”¹⁹ However, it also acknowledges a number of unintended consequences, which are that: “Insurers cannot escape cost-sharing reductions, which are a mandatory feature of participation in the Exchanges. If the insurers are not reimbursed, they will charge higher premiums to cover their expenses,” and that “if federal spending decreased on the cost-sharing side, it would increase disproportionately on the tax-credit side. Congress would end up spending more through Section 1401 alone than it would through Sections 1401 and 1402 working together.” In addition, insurers would likely have standing to sue the federal government if they go unreimbursed.²⁰

Actuarial modeling

As a result of the lower court decision in *House v. Burwell*, ACAP requested that we model the potential financial consequences of health insurers participating in the marketplace losing funding related to CSR provided to marketplace participants during 2017. Using 2014 and 2015 MLR annual reporting form data, we have calculated the financial impact to insurers to the extent CSR funding was eliminated or reduced in these coverage years based on insurer-specific reconciled CSR data. While it is certain that the impact to the health insurance industry and individual insurers of eliminating or reducing CSR funding in 2017 would differ relative to these simulated calculations, we believe the 2014 and 2015 MLR data is the best data currently publicly available to do this analysis and that the resulting values do assist insurers, their advisors, and policy makers in understanding the potential implications of reducing or eliminating CSR funding in 2017.

¹⁹ U.S. District Court, D.C., *ibid.*, p. 13.

²⁰ U.S. District Court, D.C., *ibid.*, pp. 27-28.

III. RESULTS OF ANALYSIS

CSR annual payments and enrollees

The 2014 and 2015 CSR amounts received by health insurers from the federal government were summarized in the 2014 and 2015 MLR annual reporting form data made publicly available by CMS.

- In 2014, \$2.8 billion in CSR payments were reported, increasing to \$4.9 billion in 2015.
- On a national level, we estimate 3.1 million and 5.2 million covered life-years received CSR plan variants in 2014 and 2015, respectively.²¹
- In 2014, CSR-qualifying covered lives are estimated to have equaled 21% of all individual market insured lives (including insurers not participating in the insurance marketplace), increasing to approximately 30% in 2015.
- Relative to insurance marketplace enrollment only, CSR-qualifying covered lives represented approximately 57% of marketplace enrollment in both 2014 and 2015.
- Based on the aggregate CSR payments reported and the estimated covered life-years, the CSR plan value per covered life-year was \$901 in 2014, increasing to \$948 in 2015. Further details on the development of these estimates is provided in the Methodology section of this report.

It is imperative to understand the importance of CSR payments as it relates to insurers' total earned premium (which excludes CSR payments) in the individual market, including premium from non-CSR-eligible covered lives. Figure 5 illustrates for all insurers in the individual health insurance market, non-ACAP insurers in states where an ACAP-member plan offers coverage, and for ACAP insurers, the following CSR payments metrics: aggregate dollar, per member per month (PMPM), and as a percentage of earned premium basis. In addition, we have also illustrated the covered life-years for both calendar years. Covered life-years and earned premium in the base calculations reflect all insurers, excluding those that did not report risk-corridor-eligible lives in each calendar year. The absence of risk-corridor-eligible lives indicates the insurance entity did not participate in the insurance marketplaces and therefore would not receive any CSR payments. For insurers included in the analysis, covered life-years and earned premium includes marketplace, off-marketplace, transitional, and grandfathered coverage.²² To the extent marketplace business could be isolated by itself, CSR payments would be a higher percentage of earned premium relative to the values illustrated in Figure 5.

Figure 5 Cost-Sharing Reduction Plan Payments Under the Affordable Care Act Summary of Calendar Year 2014 and 2015 Cost-Sharing Reduction Payments						
	CY 2014			CY 2015		
	All Insurers	All Other Insurers ACAP States	ACAP Insurers	All Insurers	All Other Insurers ACAP States	ACAP Insurers
Covered Life-Years (in thousands)	11,713	5,273	134	15,294	6,635	363
Aggregate CSR Payments (in thousands)	\$ 2,833,933	\$ 935,746	\$ 45,428	\$ 4,910,048	\$ 1,428,295	\$ 150,076
PMPM CSR payments	\$ 20.16	\$ 14.79	\$ 28.23	\$ 26.75	\$ 17.94	\$ 34.41
CSR Payments as % of Earned Premium	6.4%	4.5%	7.9%	7.8%	5.2%	10.6%

Notes:

1. Covered life-years (in thousands) reflects all comprehensive individual health insurance market during the calendar year associated with insurers having risk-corridor-eligible business, including enrollment not associated with CSR-eligible plans. Covered life-years are calculated as member months divided by 12.
2. Earned premium revenue includes all comprehensive individual health insurance market coverage during each calendar year, including premium not associated with CSR-eligible plans.
3. PMPM: Per member per month.

Figure 5 indicates that CSR payments represented a material percentage of earned premium for the health insurance industry ("all insurers") in both calendar years, with CSR payments being equivalent to 10.6% of earned premium for ACAP insurers in aggregate, compared with approximately 7.8% for all insurers in CY 2015. In states where ACAP insurers offer coverage, 2015 CSR payments are over 90% higher for ACAP insurers on a PMPM basis relative to other insurers offering

²¹ Covered life-years equal to covered member months, divided by 12.

²² The exclusion of insurers that did not report risk-corridor-eligible lives resulted in a decrease of 3.3 million and 2.2 million covered life-years from the 2014 and 2015 base data, respectively. Covered life-years is calculated as member months divided by 12.

coverage, likely attributable to the ACAP insurers' focus on low-income consumers purchasing coverage in the insurance marketplace.

Medicaid expansion vs. non-expansion states

The population with household income between 100% and 138% FPL is eligible for premium and CSR assistance in the insurance marketplaces in non-expansion states, resulting in a higher proportion of insurance marketplace enrollees qualifying for CSR assistance relative to states that have expanded Medicaid. Therefore, a reduction or elimination of CSR payments is likely to impact non-Medicaid-expansion states to a greater degree, as supported by our analysis of CSR payments for Medicaid and non-Medicaid-expansion states in 2014 and 2015:

- For states that had expanded Medicaid for the entire calendar year in 2014, CSR payments represented 3.7% of earned premium in the individual market, while CSR payments equated to 8.1% of earned premium in non-expansion states.
- For states that had expanded Medicaid for the entire calendar year in 2015, CSR payments represented 4.8% of earned premium in the individual market, while CSR payments equaled 10.2% of earned premium in non-expansion states.
- For ACAP insurers operating in states that expanded Medicaid for all of calendar year 2014, CSR payments represented 5.4% of earned premium in the individual market, while CSR payments equated to 11.0% of earned premium in non-expansion states.
- For ACAP insurers operating in states that expanded Medicaid for all of calendar year 2015, CSR payments represented 10.0% of earned premium in the individual market, while CSR payments equaled 17.5% of earned premium in non-expansion states.

Figure 6
Cost-Sharing Reduction Plan Payments Under the Affordable Care Act
State Summary of CSR Payments as Percentage of Earned Premium in Calendar Years 2014 and 2015

State or DC	Medicaid Expansion Effective Date	CSR payments as a % of Earned Premium			
		2014		2015	
		All Insurers	ACAP Insurers	All Insurers	ACAP Insurers
Alabama	No Expansion	7.5%		11.1%	
Alaska	9/1/2015	8.0%		9.1%	
Arizona	1/1/2014	5.3%	10.4%	5.0%	12.0%
Arkansas	1/1/2014	24.1%		27.7%	
California	1/1/2014	3.6%	3.5%	3.6%	5.4%
Colorado	1/1/2014	3.2%	24.7%	3.1%	29.2%
Connecticut	1/1/2014	3.0%		3.6%	
Delaware	1/1/2014	3.1%		3.1%	
District of Columbia	1/1/2014	0.1%		0.2%	
Florida	No Expansion	8.6%		10.5%	
Georgia	No Expansion	10.4%		12.2%	
Hawaii	1/1/2014	0.3%		3.6%	
Idaho	No Expansion	12.1%		12.4%	
Illinois	1/1/2014	3.2%	7.3%	4.6%	11.7%
Indiana	2/1/2015	7.0%	12.9%	8.1%	9.4%
Iowa	1/1/2014	16.5%		15.8%	
Kansas	No Expansion	5.9%		8.3%	
Kentucky	1/1/2014	3.0%		4.2%	11.1%
Louisiana	7/1/2016	5.1%		6.2%	
Maine	No Expansion	9.3%		11.5%	
Maryland	1/1/2014	3.5%		5.6%	
Massachusetts	1/1/2014	0.1%	0.2%	7.1%	12.6%
Michigan	4/1/2014	8.4%		7.8%	
Minnesota	1/1/2014	0.0%		0.1%	
Mississippi	No Expansion	13.3%		16.8%	
Missouri	No Expansion	8.2%		10.0%	
Montana	1/1/2016	8.3%		8.7%	

Figure 6 Cost-Sharing Reduction Plan Payments Under the Affordable Care Act State Summary of CSR Payments as Percentage of Earned Premium in Calendar Years 2014 and 2015					
State or DC	Medicaid Expansion Effective Date	CSR payments as a % of Earned Premium			
		2014		2015	
		All Insurers	ACAP Insurers	All Insurers	ACAP Insurers
Nebraska	No Expansion	4.8%		6.8%	
Nevada	1/1/2014	4.9%		6.5%	
New Hampshire	8/15/2014	7.5%		5.7%	
New Jersey	1/1/2014	1.9%		4.3%	
New Mexico	1/1/2014	3.4%		5.7%	
New York	1/1/2014	4.4%	7.3%	4.1%	5.6%
North Carolina	No Expansion	9.3%		10.2%	
North Dakota	1/1/2014	1.6%		3.0%	
Ohio	1/1/2014	5.4%	11.9%	5.3%	8.3%
Oklahoma	No Expansion	9.6%		13.6%	
Oregon	1/1/2014	3.5%		4.3%	
Pennsylvania	1/1/2015	7.0%	8.8%	7.2%	7.5%
Rhode Island	1/1/2014	9.2%	18.0%	9.8%	18.4%
South Carolina	No Expansion	9.0%		11.3%	
South Dakota	No Expansion	10.5%		12.1%	
Tennessee	No Expansion	10.3%		11.8%	
Texas	No Expansion	6.4%	12.4%	8.8%	17.5%
Utah	No Expansion	6.5%		10.9%	
Vermont	1/1/2014	3.6%		4.0%	
Virginia	No Expansion	10.5%		9.7%	
Washington	1/1/2014	3.8%	8.7%	4.2%	13.1%
West Virginia	1/1/2014	7.6%		8.8%	
Wisconsin	No Expansion	8.1%		9.6%	
Wyoming	No Expansion	6.2%		7.4%	
Total		6.4%	7.9%	7.8%	10.6%
States that expanded Medicaid		3.7%	3.7%	5.4%	4.8%
States that did not expand Medicaid		8.1%	8.1%	11.0%	10.2%

Notes:

- The data in the table represents aggregated data by state for companies offering QHP medical coverage in the individual market, determined by the existence of risk-corridor-eligible business reported in the 2014 and 2015 MLR form data.
- Arkansas values reflect that state's private option Medicaid expansion population.
- Massachusetts's CSR payments in 2014 were significantly lower because of its transition from the Commonwealth's existing state healthcare reform plan.
- Minnesota provided Medicaid eligibility up to 205% FPL for adults and caretakers in 2014. In 2015, Minnesota implemented the Basic Health Plan option for beneficiaries with income up to 200% FPL.
- Composite values for "States that expanded Medicaid" and "States that did not expand Medicaid" exclude Arkansas, Minnesota, and states that expanded Medicaid midyear. The "Total" percentages reflect all states.
- Medicaid expansion decisions based on information collected by the Kaiser Family Foundation.

CSR payments: Impact to insurer profitability

Figure 7 illustrates the impact to insurers' MLR and insurance operation profits (losses) to the extent CSR payments were eliminated in 2014 and 2015. Similar to Figures 5 and 6, we have excluded insurers that did not have risk-corridor-eligible business or insurance marketplace business. Values illustrated in Figure 7 assume no change in an insurer's risk corridor transfers for 2014 and 2015 as a result of the elimination of CSR payments. While insurer losses would increase for these years, the revenue shortfall in the ACA's risk corridor program²³ makes it unlikely that net risk corridor payments would change. Values reflect actual risk corridor program revenue received by insurers as of January 2017.

- The health insurance industry experienced significant losses from insurance operations in the individual market in both 2014 and 2015. The losses for ACAP insurers and the insurance industry as a whole are similar for both years.

²³ Please see <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf> for more information.

- Eliminating the CSR payments in both years would have had a more significant impact on ACAP insurers, as CSR payments represent a greater share of earned premium relative to the insurance industry as a whole.
- Unlike other insurers that have traditionally served the commercial market, ACAP insurers generally focus on low-income populations, including Medicaid and the insurance marketplace. Therefore, ACAP insurers are less likely to have a significant percentage of their individual market business off-exchange, which would be unaffected by the loss of CSR payments.

Figure 7 Cost-Sharing Reduction Plan Payments Under the Affordable Care Act Impact to Insurers' MLR and Insurance Profits if CSR Payments Were Eliminated in CY 2014 and 2015						
	CY 2014			CY 2015		
	All Insurers	All Other Insurers ACAP States	ACAP Insurers	All Insurers	All Other Insurers ACAP States	ACAP Insurers
Actual Reported Medical Loss Ratio	89.2%	87.4%	91.6%	95.7%	96.4%	97.1%
Medical Loss Ratio Without CSR Payments	95.9%	92.2%	99.9%	103.8%	101.8%	108.2%
Change in Insurance Profits (Losses) Resulting From CSR Payment Removal as % of Earned Premium	(6.4%)	(4.5%)	(7.9%)	(7.8%)	(5.2%)	(10.6%)

Notes:

1. Insurance operations profit (loss) is commonly referred to as "underwriting gain (loss)" in the insurance industry.
2. Insurance operations profit (loss) does not assume any modification to an insurer's enrollment, revenue, or expenses, other than the loss of CSR payments for the calendar year.
3. The information contained in Figure 5 above and part of Figure 7 has been illustrated separately for all 50 states and the District of Columbia. That information can be found in the appendix of this report.
4. The data in the table represents aggregated data by state for companies offering QHP medical coverage in the individual market, determined by the existence of risk-corridor-eligible business reported in the 2014 and 2015 MLR form data.
5. Medical loss ratio calculated based on CMS commercial health insurer guidelines.

While 2017 insurer financial experience may differ from 2014 and 2015 for several reasons, historical experience dating back to 2010 does not suggest insurers have been able to generate significant profits in the individual market.

- In the last six years (2010 through 2015), the health insurance industry has experienced losses from insurance operations in the individual market.²⁴
- During that time, when there was stability in insurance regulations through 2013, the health insurer industry operating in the individual market had the highest margins on insurance operations in 2010 and the industry, as a whole, still reported losses of 0.3% of earned premium.²⁵
- Historical financial experience suggests that a shortfall in CSR payments during 2017 (absent other revenue changes) would likely result in significant insurer losses. For ACAP insurers, data from 2015 suggests that the absence of CSR payments would have created additional losses of approximately 10.6% of earned premium.

Insurers are required to meet minimum risk-based capital (RBC) requirements. RBC requirements were developed by the National Association of Insurance Commissioners (NAIC) to ensure that insurance carriers will not become insolvent if they sustain losses. If an insurer's RBC ratio falls below a certain threshold, the insurance commissioner has the ability to—or is mandated to—assume operational control over the insurer. To avoid such a situation, an insurer may need to raise its surplus through outside investment, by generating higher profit margins in future premium rates, or by limiting future enrollment. If CSR payments are terminated and assuming insurers are not able to modify premiums, it will negatively affect insurers' financial results, producing lower RBC ratios. This may increase the potential that consumers have fewer insurance options or higher premiums in future years. Likewise, it may increase the cost of federal premium assistance for marketplace enrollees as a result of higher premium rates.

²⁴ Insurance operations' profits or losses exclude revenue related to investment income generated by insurers. This measure is commonly referred to as "underwriting margin."

²⁵ Houchens, P.R. et al. (March 2016). 2014 Commercial Health Insurance. Milliman Research Report. Retrieved January 27, 2017, from <http://us.milliman.com/uploadedFiles/insight/2016/2014-commercial-health-insurance.pdf>.

CSR payments market distribution

We also reviewed the distribution of CSR payments as a percentage of earned premium in calendar years 2014 and 2015 for all insurers and ACAP member-plans only. Figure 8 illustrates that CSR payments are greater than 10% of earned premium for nearly 50% of ACAP member-plans premium in both calendar years. In comparison, about 25% of the aggregate individual health insurance premium was associated with insurers receiving CSR payments in excess of 10% of earned premium in calendar year 2015.

Figure 8 Cost-Sharing Reduction Plan Payments Under the Affordable Care Act Distribution of CSR Payments as Percentage of Earned Premium in CY 2014 and 2015						
CSR Amount as Percentage of Earned Premium	CY 2014			CY 2015		
	All Insurers	All Other Insurers ACAP States	ACAP Insurers	All Insurers	All Other Insurers ACAP States	ACAP Insurers
<1%	4.7%	3.7%	18.1%	3.7%	3.5%	0.0%
1% to 5%	40.6%	47.8%	23.3%	34.2%	57.2%	0.0%
5% to 10%	36.1%	43.0%	6.0%	33.6%	30.4%	47.4%
10% to 15%	13.6%	5.5%	51.5%	22.2%	8.7%	40.6%
15% to 20%	2.8%	0.1%	0.9%	3.8%	0.1%	11.9%
20% to 25%	1.7%	0.0%	0.0%	1.9%	0.0%	0.0%
>=25%	0.5%	0.5%	0.1%	0.6%	0.6%	0.1%

Notes:

1. Distribution weighted by earned premium at company/state level.
2. The data in the table represents cumulative data by state for companies offering QHP medical coverage in the individual market, determined by the existence of risk-corridor-eligible business reported in the 2014 and 2015 MLR form data.

As illustrated in Figure 8, removing the CSR payments would not affect all insurers equally. As marketplace consumers have a high degree of price sensitivity, enrollment has gravitated toward the lowest-cost plans offered in the insurance marketplace.²⁶ Therefore insurers offering the most competitively priced marketplace plans will tend to attract the greatest proportion of CSR-eligible enrollees. Conversely, insurers not competitively priced in the insurance marketplace or with a stronger distribution channel outside of the marketplace may enroll relatively few CSR enrollees. As illustrated in Figure 8, many ACAP insurers had CSR payments as a percentage of earned premium in 2014 and 2015 that were significantly higher than a large portion of the health insurer industry. Approximately 53% of ACAP insurer earned premium was associated with insurers receiving CSR payments of more than 10% of earned premium in 2015.

²⁶ Houchens, P.R. & Pantely, S.E. (July 2014). The Proposed Federal Exchange Auto-Enrollment Process: Implications for Consumers and Insurers, Figure 5. Milliman Healthcare Reform Briefing Paper. Retrieved January 27, 2017, from <http://us.milliman.com/uploadedFiles/insight/2014/federal-exchange-auto-enrollment.pdf>.

IV. METHODOLOGY

MLR data

The CSR data summaries provided in this report and appendices were sourced from the 2014 and 2015 medical loss ratio (MLR) annual reporting form data for calendar years 2014 and 2015. MLR data was sourced from the public use files made available by CMS.²⁷ Our analysis was limited to insurers offering comprehensive health insurance coverage in the individual market in 2014 and 2015 with risk-corridor-eligible business within a state. For example, we excluded insurers providing limited benefit products such as behavioral health or vision coverage that reported MLR data, as well as insurers only providing non-qualified health plan coverage in the individual market. The exclusion of insurers without risk corridor business in a state resulted in the removal of approximately 3.3 million and 2.2 million covered life-years from our analysis in 2014 and 2015, respectively. The data included in our analysis reflects 290 and 352 insurer/state combinations for 2014 and 2015, respectively.

For the ACA “3R” provisions (transitional reinsurance, risk adjustment, and risk corridors), we compared the reported amount with the actual amounts reported by the CMS.²⁸ To the extent the reported amount varied from amounts published by CMS for these programs, we replaced insurer-reported values with information made publicly available by CMS. Values contained in this report reflect risk corridor shortfalls for 2014 and 2015.²⁹ Additional adjustments were made to the data for observed reporting issues or data variances relative to statutory financial statements. The following details the specific section of the MLR reporting template for each data source in our report and appendices, as well as additional data field definitions:

- **Member months:** The total number of lives, including dependents, insured on a prespecified day of each month of the reporting period.
- **Covered life-years:** Member months divided by 12.
- **CSR payments:** The total reconciled cost-sharing reductions payments.
 - A few insurers reported a negative CSR amount in their MLR reporting forms for the 2014 and/or 2015 calendar years. For these companies, we replaced reported CSR amounts with data from their 2017 Unified Rate Review Template (URRT) submissions or the 2014 MLR reporting form for 2015 and 2014, respectively. If an insurer reported a negative CSR in both data sources for a calendar year, then we set the CSR amount to zero for that year. For a small number of insurers, we have replaced reported CSR values contained in the MLR data with information provided directly to ACAP.
- **PMPM CSR payments:** CSR payments divided by member months.
- **Earned premium (total direct premium earned):** Represents the total premium earned in the year.
- **CSR payments as % of earned premium:** CSR payments divided by earned premium.
- **MLR incurred claims:** Total incurred claims + fraud and abuse detection/recovery expenses + healthcare quality expenses.
- **MLR earned premiums:** Premiums earned including state and federal high risk programs - federal taxes and assessments - state taxes and assessments - regulatory authority licenses and fees.
- **MLR:** MLR claims divided by MLR premiums.
- **MLR w/o CSR:** (MLR claims + CSR payments) / MLR premiums.
- **Actual reported insurance profits (losses):** Premiums - incurred claims - healthcare quality expenses - total claims adjustment expenses - administrative expenses (note that this term is commonly referred to as "underwriting margin" in the insurance industry, and that profits [losses] exclude investment income).
- **Insurance profits w/o CSR payments:** Actual reported insurance profits (losses) - CSR payments.
- **Change in insurance profits w/o CSR:** Actual reported insurance profits (losses) - insurance profits (losses) w/o CSR payments.

²⁷ CMS (June 3, 2016). MLR Data Extract Table Details. Retrieved January 27, 2017, from https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/MLR_DataFilesPUF_20161019.zip (download).

²⁸ CMS (June 30, 2016). Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year. Retrieved January 27, 2017, from <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf>.

CMS (November 18, 2016). Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year. Retrieved January 27, 2017, from <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf>.

²⁹ Small, L. (November 23, 2016). More bad news for insurers in latest risk corridor data. FierceHealthcare. Retrieved February 3, 2017, from <http://www.fiercehealthcare.com/payer/more-bad-news-for-insurers-latest-risk-corridor-data>.

Marketplace effectuated enrollment data

CMS has released quarterly effectuated enrollment snapshots for the insurance marketplace on a national and state level for December 2014 through March 2016.³⁰ Effectuated marketplace enrollment at the end of each quarter is provided separately for total marketplace enrollment, CSR enrollment, and APTC enrollment. The effectuated marketplace enrollment also includes the average APTC on a national and state level for each quarter.

For 2014, the Internal Revenue Service (IRS) announced \$15.5 billion in APTC for insurance marketplace coverage.³¹ By dividing the \$15.5 billion amount by the December 2014 national average APTC (\$276), estimated monthly APTC effectuated enrollment for 2014 was calculated at 4.7 million.

For 2015, the IRS announced \$25 billion in APTC for insurance marketplace coverage.³² By dividing the \$25 billion amount by the average quarterly national APTC (\$271), estimated monthly APTC effectuated enrollment for 2015 was calculated at 7.7 million. Note that quarterly national APTC amounts varied from \$270 to \$272.

Based on the ratios between APTC and CSR effectuated quarterly enrollment snapshots from CMS, we estimated the average monthly effectuated enrollment for CSR enrollees in 2014 (3.1 million) and 2015 (5.2 million). For December 2014, CMS announced 3.7 million effectuated CSR enrollees. However, as the open enrollment period for 2014 coverage extended through April 2014 (including special enrollment period activity through April 19),³³ we estimate effectuated enrollment was significantly less in the first three months of the calendar year. For 2015, the average CSR effectuated enrollment for the four quarterly snapshot periods (March 31, June 30, September 30, and December 31) was 5.4 million. While we believe our methodology for estimating average monthly effectuated enrollment is sound, actual values are certain to vary from our estimates to an unknown degree.

ACAP insurers

ACAP insurers are included in our analysis to the extent a plan participated in the insurance marketplaces in either 2014 or 2015. 2014 and 2015 values reflect twenty and twenty-two separate ACAP insurer legal entities, respectively. ACAP insurers currently participating in the insurance marketplaces are listed at <http://www.communityplans.net/about/our-plans/>.

³⁰ CMS.gov (July 1, 2016), Quarterly Marketplace Effectuated Enrollment Snapshots by State, *ibid*.

³¹ IRS Commissioner John Koskinen (July 17, 2016). Letter to Congress updating preliminary results from the 2015 filing season related to Affordable Care Act provisions. Retrieved January 27, 2017, from <https://www.irs.gov/pub/irs-utl/CommissionerLetterwithcharts.pdf>.

³² IRS Commissioner John Koskinen (January 9, 2017). Letter to Congress updating 2016 tax filings related to Affordable Care Act provisions. Retrieved January 27, 2017, from <https://www.irs.gov/pub/newsroom/commissionerletteracafileingseason.pdf>.

³³ ASPE (May 1, 2014). Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period. Retrieved January 27, 2017, from <https://aspe.hhs.gov/pdf-report/health-insurance-marketplace-summary-enrollment-report-initial-annual-open-enrollment-period>.

V. LIMITATIONS AND DATA RELIANCE

The information contained in this report has been prepared for the Association for Community Affiliated Plans (ACAP) to understand the portion of insurer revenue in the individual market attributable to the ACA's cost-sharing reduction subsidies. The data and information presented may not be appropriate for any other purpose. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented in this report. Readers of this report should have an extensive knowledge of the ACA's premium and cost-sharing reduction subsidy structure, as well as product and premium rate development for coverage offered through the insurance marketplace.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for ACAP by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about insurer CSR payments discussed herein.

Milliman is not restricted or prevented from independently pursuing any opportunities similar or identical to the issues raised in Milliman's work under this engagement, either internally or through representation of clients or other third parties.

The analyses presented in this report have relied on data and other information from the MLR annual reporting form and effectuated marketplace enrollment data for calendar years 2014 and 2015, obtained from the Center for Consumer Information and Insurance Oversight of the Centers for Medicare and Medicaid Services in December 2015 (CY 2014 values) and November 2016 (CY 2015 values). The data and other information have not been audited or verified, but a limited review was performed for reasonableness and consistency. If the underlying data or information is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete. MLR data values published subsequent to December 1, 2016, are not included in this report.

The views expressed in this report are made by the authors of this report and do not represent the collective opinions of Milliman. Other Milliman consultants may hold different views and reach different conclusions.

The services provided by Milliman to ACAP were performed under the signed consulting services agreement between Milliman and ACAP dated January 5, 2017.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

APPENDIX

Appendix - 2015							
Cost-Sharing Reduction Plan Payments under the Affordable Care Act							
State Summary of Cost-Sharing Reduction Payments and Insurance Profits as Reported in Annual Medical Loss Ratio Reporting Form Data							
State	2015						
	Covered Life Years (In Thousands)	Aggregate CSR Payments (In Thousands)	PMPM CSR Payments	CSR Payments as % of Earned Premium	Actual Reported Insurance Profits (Losses) as % of Earned Premium	Insurance Profits (Losses) without CSR Payments as % of Earned Premium	Change in Insurer Profits (Losses) Resulting from CSR Removal as % of Earned Premium
Alabama	237	\$ 100,953	\$ 35.44	11.1%	(16.8%)	(27.9%)	(11.1%)
Alaska	25	\$ 15,682	\$51.76	9.1%	(16.8%)	(25.9%)	(9.1%)
Arizona	315	\$ 51,837	\$13.69	5.0%	(37.0%)	(42.0%)	(5.0%)
Arkansas	339	\$ 358,852	\$88.08	27.7%	(3.1%)	(30.8%)	(27.7%)
California	2,163	\$ 346,615	\$13.36	3.6%	(0.6%)	(4.2%)	(3.6%)
Colorado	211	\$ 24,158	\$9.55	3.1%	(27.6%)	(30.7%)	(3.1%)
Connecticut	110	\$ 21,226	\$16.02	3.6%	1.3%	(2.3%)	(3.6%)
Delaware	35	\$ 4,970	\$11.94	3.1%	(23.2%)	(26.3%)	(3.1%)
District of Columbia	19	\$ 177	\$0.79	0.2%	(17.7%)	(18.0%)	(0.2%)
Florida	1,635	\$ 746,365	\$38.05	10.5%	(3.8%)	(14.3%)	(10.5%)
Georgia	558	\$ 261,207	\$38.99	12.2%	(22.0%)	(34.2%)	(12.2%)
Hawaii	45	\$ 5,469	\$10.21	3.6%	(24.4%)	(27.9%)	(3.6%)
Idaho	130	\$ 54,254	\$34.78	12.4%	(38.9%)	(51.3%)	(12.4%)
Illinois	639	\$ 112,482	\$14.68	4.6%	(11.6%)	(16.2%)	(4.6%)
Indiana	209	\$ 83,380	\$33.23	8.1%	(1.8%)	(10.0%)	(8.1%)
Iowa	52	\$ 32,589	\$51.81	15.8%	(4.9%)	(20.7%)	(15.8%)
Kansas	168	\$ 47,385	\$23.44	8.3%	(16.3%)	(24.6%)	(8.3%)
Kentucky	158	\$ 24,621	\$13.03	4.2%	(18.7%)	(22.9%)	(4.2%)
Louisiana	253	\$ 67,760	\$22.29	6.2%	(13.8%)	(20.0%)	(6.2%)
Maine	80	\$ 44,812	\$46.69	11.5%	(6.0%)	(17.5%)	(11.5%)
Maryland	279	\$ 53,757	\$16.07	5.6%	(9.5%)	(15.1%)	(5.6%)
Massachusetts	229	\$ 74,963	\$27.22	7.1%	(2.8%)	(9.9%)	(7.1%)
Michigan	394	\$ 127,372	\$26.95	7.8%	(11.1%)	(18.9%)	(7.8%)
Minnesota	241	\$ 669	\$0.23	0.1%	(31.8%)	(31.9%)	(0.1%)
Mississippi	68	\$ 56,430	\$68.66	16.8%	1.5%	(15.3%)	(16.8%)
Missouri	325	\$ 123,170	\$31.60	10.0%	(1.8%)	(11.8%)	(10.0%)
Montana	81	\$ 27,075	\$27.94	8.7%	(20.3%)	(29.1%)	(8.7%)
Nebraska	127	\$ 34,757	\$22.73	6.8%	(16.8%)	(23.6%)	(6.8%)
Nevada	75	\$ 20,030	\$22.28	6.5%	(25.0%)	(31.5%)	(6.5%)
New Hampshire	52	\$ 12,796	\$20.51	5.7%	(9.3%)	(15.0%)	(5.7%)
New Jersey	296	\$ 68,898	\$19.37	4.3%	5.2%	0.9%	(4.3%)
New Mexico	76	\$ 15,896	\$17.36	5.7%	(6.0%)	(11.7%)	(5.7%)
New York	483	\$ 90,822	\$15.68	4.1%	(13.5%)	(17.6%)	(4.1%)
North Carolina	707	\$ 313,310	\$36.95	10.2%	(3.4%)	(13.6%)	(10.2%)
North Dakota	50	\$ 6,616	\$11.07	3.0%	4.3%	1.3%	(3.0%)
Ohio	262	\$ 59,322	\$18.84	5.3%	(7.2%)	(12.6%)	(5.3%)
Oklahoma	177	\$ 80,758	\$37.98	13.6%	(8.9%)	(22.5%)	(13.6%)
Oregon	207	\$ 31,638	\$12.74	4.3%	(24.8%)	(29.0%)	(4.3%)
Pennsylvania	621	\$ 179,824	\$24.12	7.2%	(15.5%)	(22.7%)	(7.2%)
Rhode Island	42	\$ 17,731	\$35.42	9.8%	5.4%	(4.5%)	(9.8%)
South Carolina	234	\$ 107,461	\$38.33	11.3%	(12.4%)	(23.7%)	(11.3%)
South Dakota	29	\$ 12,622	\$36.29	12.1%	(50.2%)	(62.2%)	(12.1%)
Tennessee	305	\$ 124,930	\$34.16	11.8%	(16.1%)	(27.9%)	(11.8%)
Texas	1,407	\$ 466,005	\$27.60	8.8%	(16.0%)	(24.8%)	(8.8%)
Utah	189	\$ 56,524	\$24.97	10.9%	(54.3%)	(65.2%)	(10.9%)
Vermont	31	\$ 6,417	\$17.17	4.0%	(3.7%)	(7.7%)	(4.0%)
Virginia	412	\$ 156,736	\$31.67	9.7%	(1.9%)	(11.6%)	(9.7%)
Washington	260	\$ 46,611	\$14.96	4.2%	(3.8%)	(8.0%)	(4.2%)
West Virginia	43	\$ 18,710	\$36.56	8.8%	(14.7%)	(23.5%)	(8.8%)
Wisconsin	185	\$ 101,667	\$45.91	9.6%	(17.5%)	(27.0%)	(9.6%)
Wyoming	26	\$ 11,739	\$38.12	7.4%	(10.6%)	(18.0%)	(7.4%)
Total	15,294	\$ 4,910,048	\$26.75	7.8%	(9.9%)	(17.6%)	(7.8%)
ACAP Member States	6,998	\$ 1,578,371	\$18.79	5.4%	(9.5%)	(14.9%)	(5.4%)
Non ACAP Member States	8,295	\$ 3,331,677	\$33.47	9.8%	(10.2%)	(20.0%)	(9.8%)

The data in the chart represents cumulative data by state for companies offering qualified health plan (QHP) medical coverage in the Individual market, determined by the existence of risk-corridor-eligible business reported in the 2014 and 2015 MLR form data.

Appendix - 2014							
Cost-Sharing Reduction Plan Payments under the Affordable Care Act							
State Summary of Cost-Sharing Reduction Payments and Insurance Profits as Reported in Annual Medical Loss Ratio Reporting Form Data							
State	2014						
	Covered Life Years (In Thousands)	Aggregate CSR Payments (In Thousands)	PMPM CSR Payments	CSR Payments as % of Earned Premium	Actual Reported Insurance Profits (Losses) as % of Earned Premium	Insurance Profits (Losses) without CSR Payments as % of Earned Premium	Change in Insurer Profits (Losses) Resulting from CSR Removal as % of Earned Premium
Alabama	188	\$ 48,535	\$ 21.46	7.5%	(3.1%)	(10.6%)	(7.5%)
Alaska	19	\$ 8,072	\$35.83	8.0%	(11.0%)	(19.0%)	(8.0%)
Arizona	236	\$ 38,924	\$13.74	5.3%	(18.9%)	(24.2%)	(5.3%)
Arkansas	256	\$ 219,455	\$71.32	24.1%	3.1%	(21.0%)	(24.1%)
California	1,825	\$ 289,002	\$13.20	3.6%	6.4%	2.8%	(3.6%)
Colorado	148	\$ 19,269	\$10.87	3.2%	(10.4%)	(13.6%)	(3.2%)
Connecticut	86	\$ 13,670	\$13.21	3.0%	5.3%	2.3%	(3.0%)
Delaware	24	\$ 3,206	\$11.33	3.1%	(8.1%)	(11.2%)	(3.1%)
District of Columbia	18	\$ 95	\$0.44	0.1%	(21.1%)	(21.3%)	(0.1%)
Florida	1,073	\$ 363,943	\$28.26	8.6%	(1.6%)	(10.3%)	(8.6%)
Georgia	364	\$ 130,964	\$29.96	10.4%	(8.9%)	(19.3%)	(10.4%)
Hawaii	33	\$ 285	\$0.72	0.3%	(12.1%)	(12.3%)	(0.3%)
Idaho	112	\$ 40,155	\$29.85	12.1%	(20.2%)	(32.4%)	(12.1%)
Illinois	532	\$ 60,590	\$9.49	3.2%	(27.5%)	(30.7%)	(3.2%)
Indiana	173	\$ 53,462	\$25.78	7.0%	5.2%	(1.8%)	(7.0%)
Iowa	47	\$ 27,822	\$49.10	16.5%	(30.6%)	(47.2%)	(16.5%)
Kansas	143	\$ 25,918	\$15.14	5.9%	(12.4%)	(18.3%)	(5.9%)
Kentucky	159	\$ 15,628	\$8.20	3.0%	(19.6%)	(22.6%)	(3.0%)
Louisiana	199	\$ 38,793	\$16.24	5.1%	(5.5%)	(10.6%)	(5.1%)
Maine	50	\$ 22,689	\$37.97	9.3%	1.4%	(7.9%)	(9.3%)
Maryland	193	\$ 21,128	\$9.11	3.5%	(2.2%)	(5.7%)	(3.5%)
Massachusetts	91	\$ 360	\$0.33	0.1%	(0.9%)	(1.0%)	(0.1%)
Michigan	351	\$ 102,662	\$24.37	8.4%	(8.4%)	(16.8%)	(8.4%)
Minnesota	233	\$ 323	\$0.12	0.0%	(22.6%)	(22.6%)	(0.0%)
Mississippi	43	\$ 28,904	\$56.01	13.3%	5.3%	(8.0%)	(13.3%)
Missouri	260	\$ 70,357	\$22.55	8.2%	(6.1%)	(14.3%)	(8.2%)
Montana	55	\$ 16,808	\$25.52	8.3%	(32.8%)	(41.1%)	(8.3%)
Nebraska	113	\$ 18,089	\$13.31	4.8%	(27.6%)	(32.3%)	(4.8%)
Nevada	38	\$ 7,734	\$16.81	4.9%	(14.9%)	(19.8%)	(4.9%)
New Hampshire	32	\$ 11,021	\$28.32	7.5%	5.2%	(2.3%)	(7.5%)
New Jersey	234	\$ 22,193	\$7.89	1.9%	1.8%	(0.1%)	(1.9%)
New Mexico	67	\$ 7,871	\$9.80	3.4%	(17.9%)	(21.4%)	(3.4%)
New York	335	\$ 67,176	\$16.71	4.4%	(10.3%)	(14.7%)	(4.4%)
North Carolina	584	\$ 205,486	\$29.34	9.3%	(5.2%)	(14.5%)	(9.3%)
North Dakota	43	\$ 2,776	\$5.34	1.6%	0.8%	(0.8%)	(1.6%)
Ohio	200	\$ 41,792	\$17.37	5.4%	0.3%	(5.1%)	(5.4%)
Oklahoma	140	\$ 39,505	\$23.58	9.6%	(35.7%)	(45.3%)	(9.6%)
Oregon	162	\$ 21,082	\$10.84	3.5%	(17.8%)	(21.3%)	(3.5%)
Pennsylvania	539	\$ 133,930	\$20.71	7.0%	(18.0%)	(25.1%)	(7.0%)
Rhode Island	35	\$ 13,874	\$32.64	9.2%	9.0%	(0.2%)	(9.2%)
South Carolina	155	\$ 53,566	\$28.71	9.0%	(6.5%)	(15.5%)	(9.0%)
South Dakota	19	\$ 7,761	\$33.99	10.5%	(6.2%)	(16.7%)	(10.5%)
Tennessee	235	\$ 73,048	\$25.86	10.3%	(15.5%)	(25.8%)	(10.3%)
Texas	1,070	\$ 226,817	\$17.67	6.4%	(16.9%)	(23.3%)	(6.4%)
Utah	132	\$ 22,340	\$14.09	6.5%	(34.3%)	(40.8%)	(6.5%)
Vermont	29	\$ 5,198	\$14.70	3.6%	2.5%	(1.1%)	(3.6%)
Virginia	206	\$ 83,113	\$33.57	10.5%	2.8%	(7.6%)	(10.5%)
Washington	223	\$ 35,978	\$13.47	3.8%	7.9%	4.1%	(3.8%)
West Virginia	31	\$ 10,378	\$27.68	7.6%	(9.0%)	(16.6%)	(7.6%)
Wisconsin	158	\$ 56,010	\$29.53	8.1%	(9.9%)	(18.0%)	(8.1%)
Wyoming	18	\$ 6,177	\$28.89	6.2%	(4.9%)	(11.1%)	(6.2%)
Total	11,713	\$ 2,833,933	\$20.16	6.4%	(6.6%)	(12.9%)	(6.4%)
ACAP Member States	5,407	\$ 981,174	\$15.12	4.6%	(5.6%)	(10.2%)	(4.6%)
Non ACAP Member States	6,306	\$ 1,852,758	\$24.48	8.0%	(7.5%)	(15.5%)	(8.0%)

The data in the chart represents cumulative data by state for companies offering qualified health plan (QHP) medical coverage in the Individual market, determined by the existence of risk-corridor-eligible business reported in the 2014 and 2015 MLR form data.