BEST'S MARKET SEGMENT REPORT

March 3, 2021

Health Insurers Persevere through Pandemic as Uncertainties Remain

Health insurers navigate pandemic but large-scale pent-up demand for care and increased morbidity may present new challenges

AM Best is maintaining its Stable outlook for the US health insurance industry. Despite the pandemic, the industry reported significantly higher than expected earnings in 2020 due to delayed elective and routine care combined with the modest cost of treatment for COVID-19 (COVID) for the majority of affected individuals, most of whom isolated at home with no specific treatment. For many hospitalized individuals, the costs were manageable as the care was not as extensive and the hospital stays were shorter in duration. However, some individuals with the most severe COVID cases required lengthy hospital stays with extensive treatment, resulting in costly claims. Health insurers went into 2020 with strong risk-adjusted capitalization, which improved during the year as a result of the favorable earnings. Furthermore, health insurers have good liquidity metrics, including higher than historical levels of cash accumulation. Earnings are expected to be significantly lower in 2021, driven by a return to more normal utilization, pent-up demand from medical care not received in 2020, an anticipated increase in morbidity resulting from delays in care, and lower premium rate increases from many insurers for 2021 given the levels of profitability in 2020. AM Best believes health insurers' strengthened levels of risk-adjusted capitalization, combined with favorable liquidity, makes the industry well prepared to face challenges and uncertainties in 2021.

Health insurance companies have faced many challenges over the years, but none as unique as 2020. A virus that was first identified in late 2019 in Wuhan, the capital city of Hubei Province in China, became global and resulted in a pandemic. Health insurers started monitoring the situation early and remained vigilant. Enterprise risk management (ERM) programs quickly moved to the forefront as companies reviewed the potential risks to their organizations from escalating claims, financial market downturn, potential rising unemployment, and the need to switch the majority of their employees to a work-from-home environment, due to governmental stay- at-home-orders and to keep the virus from spreading within the workplace. The shift to the work-from-home environment led to increased cyber concerns, greater focus on maintaining service levels, and ensuring compliance with privacy laws.

The COVID pandemic created unusual predicaments: while layoffs were expected that would negatively impact the commercial group market, the enrollment declines in 2020 were less than anticipated. Conversely, Medicaid membership grew greater than expected due to legislation that prohibited states from disenrolling members during the period of the public health emergency (PHE). While additional federal funding was made available during the period of the PHE, state budgets continue to be pressured from the economic impact of COVID. Rising Medicaid enrollment could exacerbate already constrained state budgets.

Stay-at-home orders, as well as directives to postpone routine care and elective procedures, resulted in a sharp decline in claims in the second quarter of 2020. Providers found themselves without patients and experienced financial pressure. To remedy this, many providers quickly opted to see patients "virtually", resulting in a rise in telehealth visits. To assist providers, many health insurance companies provided advances and, in some cases, donated the hard-to-find personal protective equipment (PPE) to providers.

Analytical Contacts:
Bridget Maehr, Oldwick
+1 (908) 439-2200 Ext. 5321
Bridget.Maehr@ambest.com

Doniella Pliss, Oldwick
+1 (908) 439-2200 Ext. 5104
Doniella.Pliss@ambest.com

Sally Rosen, Oldwick
+1 (908) 439-2200 Ext. 5280
Sally.Rosen@ambest.com

Contributors:
Jennifer Asamoah, Oldwick
Antonietta Iachetta, Oldwick
Wayne Kaminski, Oldwick
Jeffrey Lane, Oldwick
John McGlynn, Oldwick
Brian Virostek, Oldwick
Joseph Zazzera, Oldwick

2021-024

After decades of rising health expenditures, the significant decline in claims in the second quarter was not only unforeseen but was alarming as well (**Exhibit 1**). Furthermore, even when providers were able to start seeing patients again for routine and elective care, many individuals were foregoing treatment to reduce possible exposure to the virus. Health insurers faced a multitude of concerns, including the unknown long-term health impacts for some individuals with COVID cases, whether individuals who needed medical treatment were foregoing care, how many serious conditions were not diagnosed or were exacerbated due to the delay in preventative care and testing, when would pent-up demand for medical services resume, would morbidity worsen, and when would a vaccine become available and be widely distributed. Additionally, the multiple waves of the virus are expected to continue to impact claim volumes.

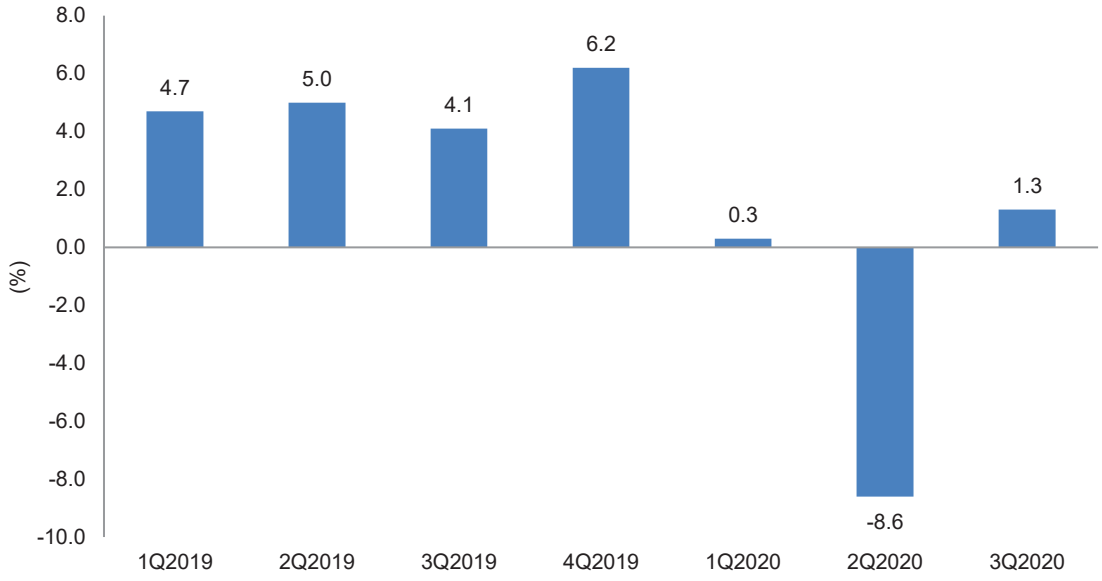
The Medicare segment continues to experience membership growth as the population ages. Similar to other lines of business, claims declined as seniors, who are considered more at risk to COVID, stayed home. Medicare Advantage (MA) writers, in addition to concerns about foregone medical care, may receive lower risk adjustment payments from the Centers for Medicare and Medicaid Services (CMS) for 2020 due to the lack of claims data, which could result in lower revenue in 2021.

The long-term care (LTC) segment remains challenged. While the effects from COVID, higher mortality, and fewer new claims have been somewhat positive for LTC writers, the impact is anticipated to be temporary. Challenges remain on the older block of business, due to inadequate assumptions. Additionally, the prolonged low interest rate environment has added to reserving issues.

The pandemic resulted in several legislative enactments that included provisions for health insurance. Cost sharing is waived for COVID testing and treatment, telehealth has been expanded under Medicare, vaccine administration is covered at no cost, and funding for Medicaid has increased.

Exhibit 1

YoY Growth in Health Services Spending



Source: Census.gov Quarterly Services Survey

The Patient Protection and Affordable Care Act (ACA) made its way before the US Supreme Court in 2020 in two cases. The risk corridors lawsuit was decided in July and granted health insurers the monies owed to them by the federal government when the amount payable was capped at 12.6% for 2014. The second case focuses on whether the repeal of the individual tax mandate invalidates the entire ACA. A decision is not expected until the spring of 2021. With a new President and administration, the probability for more changes is likely, such as enhancing provisions of the ACA to provide pandemic-related relief, as well as potentially undoing legislation enacted under the prior administration. In January 2020, President Biden signed an executive order for a special enrollment period for individuals purchasing coverage in the federal marketplace.

The impact of COVID will linger throughout 2021. The vaccine is in the process of being rolled out, but life has not returned to pre-COVID norms. There are still numerous unknowns, including the residual health impact to those individuals with cases of COVID; the effectiveness of the vaccine; when does utilization return to steady normal levels and pent-up demand occurs; and the impact on morbidity from delayed care. AM Best will continue to monitor and discuss these items with health insurance companies.

Risk Management

The pandemic has provided an opportunity for insurers to showcase their risk management capabilities. As the virus began to spread in other parts of the world, many US health insurers focused on the potential impact on operations and members As the spread of COVID accelerated, many health insurers were already meeting regularly to discuss the risks presented by the virus as well as mitigation plans.

Pandemic modeling for health insurers historically considered a large spike in claims as the number of individuals needing treatment would escalate and overwhelm the healthcare system. The occurrence of a pandemic was generally considered to be a low probability, but very high impact risk with relatively low mitigation potential. Globalization has made it more difficult to contain the virus in one region and has resulted in faster spread throughout the world. While the number of cases in the US rose quickly, models did not anticipate several factors that drove lower claims. This resulted in a divergence between actual results and stress testing model predictions. Key factors that drove the disparity were:

- Minimal treatment/claims except for those hospitalized with COVID
- Social distancing/stay-at-home orders not considered
- Shutdown of the healthcare system for routine and elective care

The unknown trajectory of the virus, including the timing of outbreaks and the availability of newer treatment and vaccines, has resulted in health insurers considering multiple scenarios and making numerous updates to financial forecasts for both 2020 and 2021. Key items that health insurers considered in both scenario planning and forecasting included:

- Potential timing for a slowdown of the virus spread and increase in utilization for more routine and elective care
- Timing for resurgence of the virus and its impact on:
  - claims (including deferral of services)
  - the economy and layoffs/late payments/terminations resulting from business shutdowns
  - economic impact from the virus negatively impacting investments
  - increased liquidity from slow premium payments and unknown market conditions, which could make short-term borrowing difficult

- Timing of availability of vaccines, and how long until a large portion of the population is vaccinated with a return to "more normal"
- Potential increase in morbidity due to deferral of care, especially post-COVID
- Increased morbidity of some individuals who had COVID

With the short-tailed nature of health insurance claims, insurance companies have increased their focus on retaining cash for liquidity due to concerns about market instability and possible cash flow disruption from a slowdown in customer payments. In the spring of 2020, there was an increased number of insurers drawing on their lines of credit, including Federal Home Loan Bank borrowings, or issuing debt to increase cash on balance sheets. Much of these borrowings were short-term and were repaid in late second or early third quarter when the markets settled down and concerns about an increase in payment delays subsided. Additionally, some insurers decided to retain cash received from maturing investments rather than to reinvest the proceeds.

Health insurers had additional factors to consider as well. The pandemic resulted in many individuals staying home and cancelling doctor appointments or tests. Health insurers added COVID symptom checkers to their websites, instructions on where to go for care, and connections to virtual providers. There have been concerns about the more vulnerable and high-risk members who may not have received necessary medical care and whose conditions may have deteriorated without appropriate treatment. Insurers have reached out to higher risk individuals to connect them with providers for care and to obtain necessary medication or treatments. Health insurers also have been cognizant of the providers who serve their members as the deferral of non-essential and elective care resulted in a significant decline in income for many providers. Several health insurers provided payment advances to providers to assist them during shutdown periods.

As was the case with most industries, health insurers quickly shifted a vast number of employees to remote work. While many health insurance companies already had a portion of their staff working remotely, they had to adapt quickly to enable the majority of their employees to work from home. This increase in remote work also increases cybersecurity risk, requiring more diligence. In addition, health insurers had to be concerned about the Health Insurance Portability and Accountability Act (HIPAA) laws and confidential claim information while ensuring quality service to their customers (members, employers, providers) within appropriate response times.

US Commercial Segment Sees Record Results

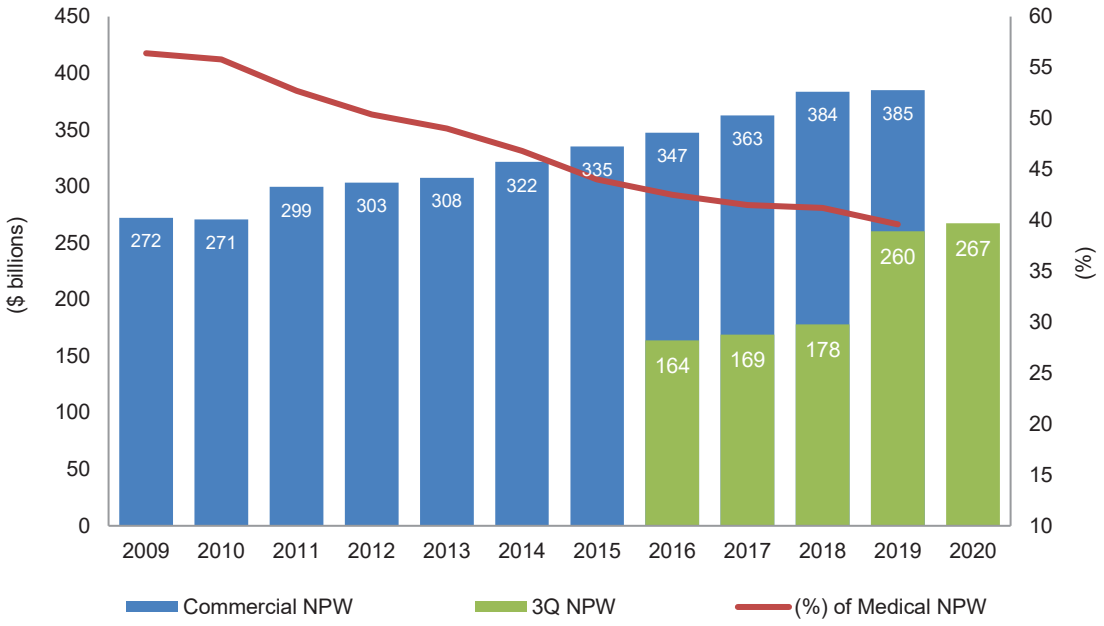
Job losses resumed in December 2020 as employment trends weakened after numerous months of positive jobs data since April. This was the first decline in payroll numbers since the mass layoffs earlier in 2020 as the pandemic took hold. The enrollment declines in the commercial health insurance segment through the third quarter was lower than expected by many insurers. We have yet to see what final year-end enrollment numbers will bring, following a rise in job losses and COVID cases during the latter part of 2020.

In the early part of 2020, many furloughed employees were given the option to keep their health insurance benefits. Furthermore, the government implemented several programs during 2020 aimed at providing financial assistance to individuals and small group employers, through vehicles such as stimulus payments, tax relief, and forgivable loans, which have somewhat helped keep workforces employed and insured during the crisis.

For commercial products overall, premiums had grown substantially over the past decade while enrollment trends have fluctuated by segment (**Exhibits 2a and 2b**). In 2020, new premium trends flattened somewhat due to COVID. However, most carriers indicated that individuals and

Exhibit 2a

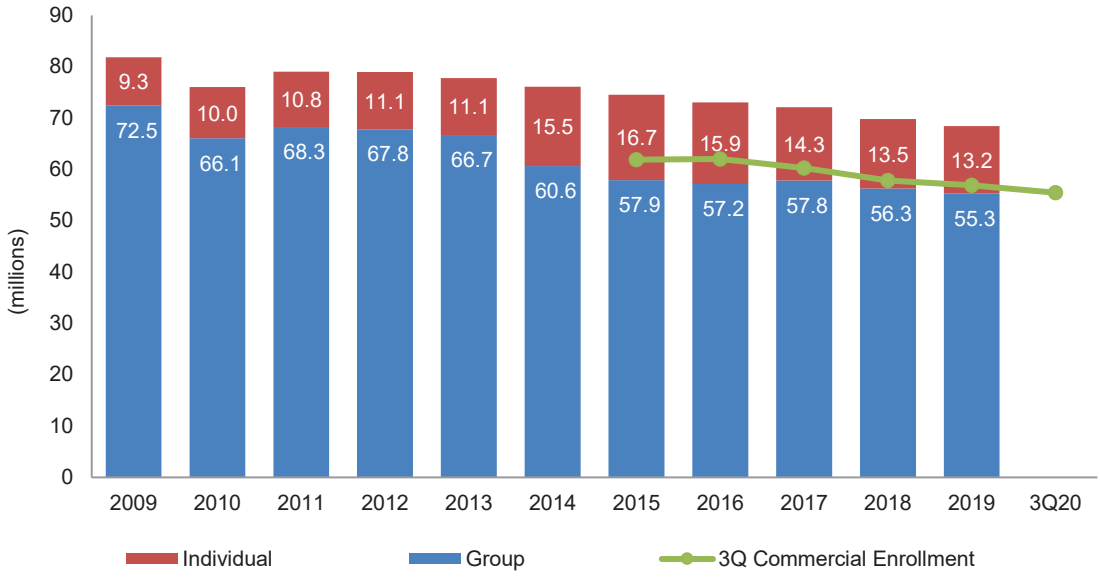
US Health – Commercial Premium, 2009-3Q20



Annual data includes Orange Book, Blue Book, and DMHC filings. Quarterly data excludes Blue Books (data unavailable).
% Medical NPW calculation includes commercial, Medicare Advantage, Managed Medicaid, and FEHBP.
Source: AM Best data and research

Exhibit 2b

US Health – Commercial Enrollment, 2009-3Q20



Annual data includes Orange Book, Blue Book, and DMHC filings. Quarterly data excludes Blue Books (data unavailable).
Quarterly enrollment displayed as a line through 3Q20 (55.5 million), down from 3Q19 (56.9 million).
Source: AM Best data and research

groups were sticking with their existing carriers during the crisis, which effectively dampened new sales while simultaneously having a positive impact on persistency, as reported consistently across health insurers. However, the commercial market share as a percentage of overall total medical premium (including Managed Medicaid, Medicare Advantage, and the Federal Employees Health Benefits Program [FEHBP]) has declined steadily, from 56% in 2009 to under 40% in 2019. The drop was not unexpected by AM Best, given the growth in government programs driven by Medicaid expansion and the growing senior population aging into Medicare, which has fueled rapid growth in both those core medical market segments.

Individual Segment

Since the rollout of the ACA, the individual commercial market has had its challenges. The segment has seen problems with website navigation, fluctuations in enrollment, and sizable financial losses for insurers. For health insurers, after several years of high double-digit rate increases, as well as successful initiatives to enroll members with chronic conditions in disease management programs to ensure that they receive the proper care, the individual line turned profitable several years ago, with record profitability in 2018. Rates filed in 2019 to be applied in 2020 also featured some of the lowest requested rate increases since inception, and some states even saw requests to cut rates. A substantially larger portion of companies reported an underwriting gain than was the case several years ago. Similar to other segments, the individual segment also experienced lower utilization due to COVID in 2020, and favorable operating performance. According to a Kaiser Family Foundation (KFF) study, the median average rate increase for 2021 ACA marketplace plans was just over 1%. Carriers have had to set rates for 2021 in the face of uncertainty about economic conditions, enrollment, vaccine effectiveness, expected morbidity trends, and utilization.

The declining trend in enrollment during the earlier years of the ACA was largely driven by the premium rate increases, the departure of many carriers from the exchanges because of the poor operating experience from this business, and the elimination of the individual mandate in 2019. However, the impact of eliminating the mandate was not as severe as many had predicted, because a large portion of individual exchange membership (nearly 87% that enrolled via healthcare.gov in 2019, according to the CMS) receives a premium subsidy. Additionally, as carriers became more adept with pricing in this new environment and the competitive market began to rationalize, some carriers have returned to the individual ACA marketplaces, with improved performance.

CMS reported in December that the Open Enrollment period for 2021 kept pace with the prior year, showing 8.2 million enrollees, despite several states having switched to state-based exchanges. This shows some stability for the segment and improvement in individual experience on the federal-based exchange website, given the recent improvements and investments in the years since it was introduced. In January 2021, President Biden signed an executive order establishing a special enrollment period on the federal marketplace from February 15 through May 15, 2021, which is expected to add to enrollment. Additionally, President Biden has proposed limiting premiums to 8.5% of income as part of his American Rescue Plan, which could result in an increase in individual enrollment in 2021.

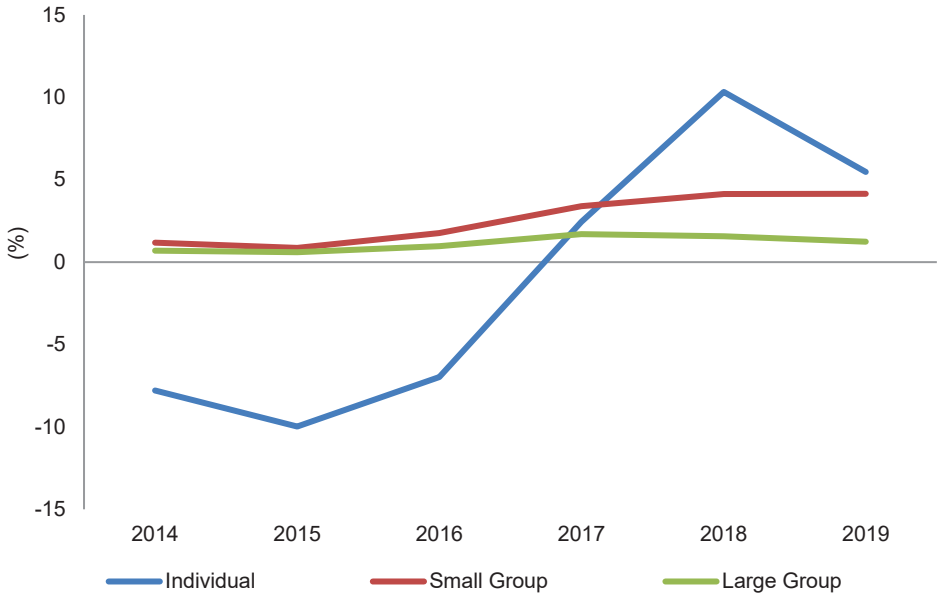
Group Segment

The fully insured employer group segment, including both large and small group markets, has been consistently profitable the last few years, with a record year in 2020 for many health insurers. AM Best expects the positive trends to continue, although margins may contract due to factors such as a return to more normalized utilization, the ongoing shift to self-insured coverage, unknowns such as the impact of the vaccine, and incremental costs related

to administering the vaccine and the rise in prescription drug prices. Margins for the fully insured group business have been tight, with large group business averaging just over 1% over the last five years, while small group business has trended up toward 4% (**Exhibit 3**).

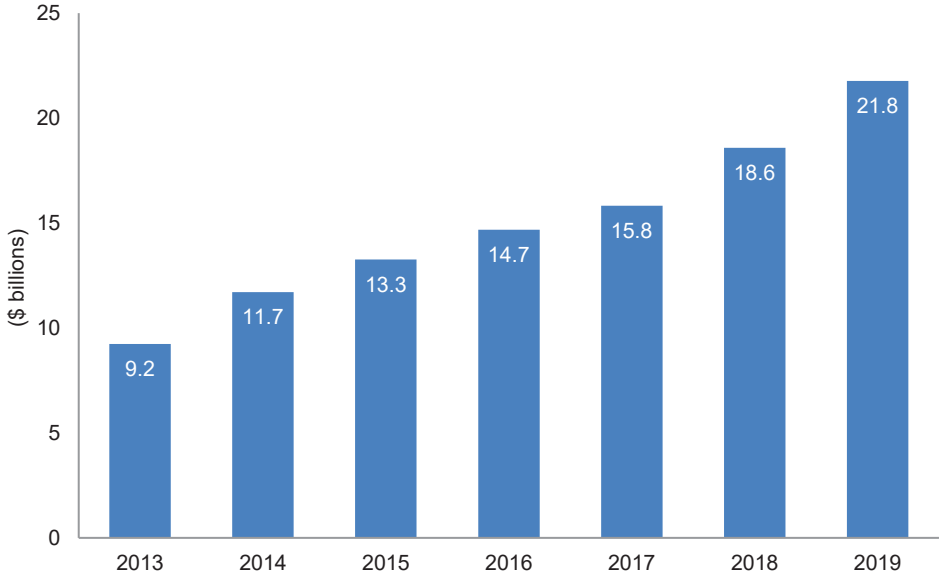
While the shift from fully-insured to self-insured commercial group has been occurring for some time now, various ACA provisions, including the minimum medical loss ratio (MLR) requirements and the health insurer fee, as well as rising medical costs, have made the employer group market more expensive. The stop-loss segment has seen premiums more than double, from $9 billion in 2013 to nearly $22 billion in 2019, in line with the market's enrollment growth (**Exhibit 4**).

Exhibit 3
US Health – Margins by Market, 2014-2019



Includes Orange Book and Blue Book filing companies.
Source: AM Best data and research

Exhibit 4
US Health – Stop Loss Net Premiums Earned, 2014-2019



Includes Orange Book and Blue Book filing companies.
Sources: CMS, AM Best data and research

Despite the transition to ASO and stop-loss, large group premium has still risen consistently the last five years, while small group premium has fluctuated. Individual saw strong growth for several years before dipping in 2019, correlating with rate increases and related enrollment declines. Overall premiums reported for the full year will be affected in 2020, as many insurers have been offering premium credits during the pandemic, and AM Best-rated companies have indicated that rate increases for individual and small groups for 2021 are likely to be

in the single digits. Additionally, the health insurance fee (HIF), which had been collected on an annual alternating cycle, has been eliminated as of 2021. As the HIF was passed on through premiums, its elimination for 2021 was reflected in premium rate increases. For more information on the commercial segment, please refer to AM Best's special report "*US Commercial Health Premium Flattens, Enrollment Continues to Slide*" dated January 5, 2021.

Medicaid

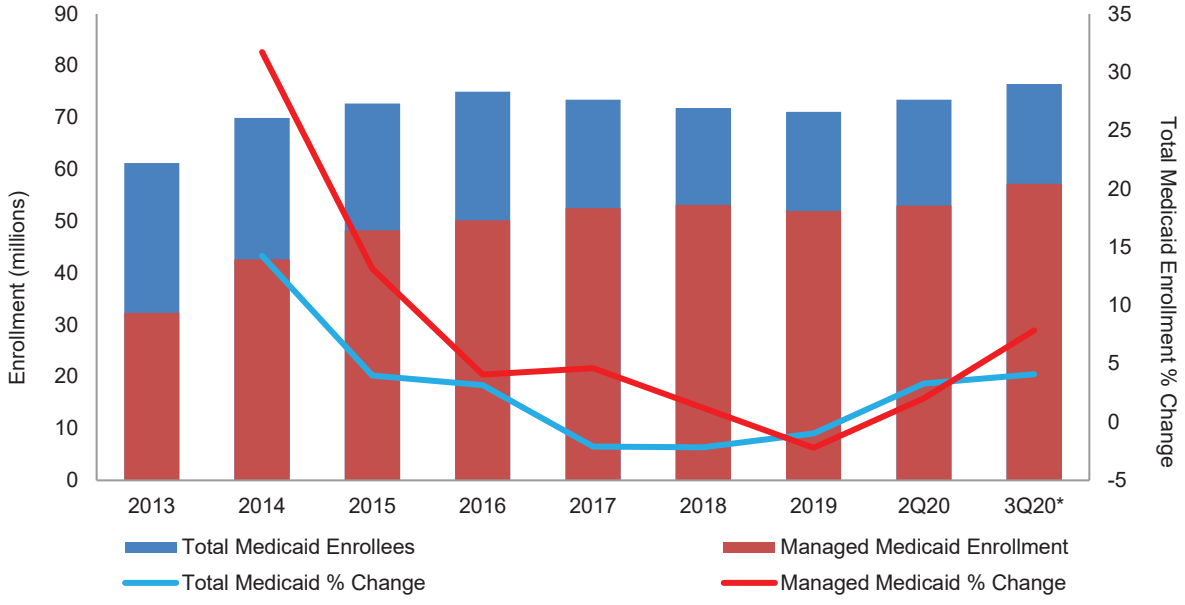
After a brief period of Medicaid membership decline through year-end 2019, the pandemic's broad effect on the US economy from business shutdowns and stay-at-home directives early on in the pandemic led to layoffs and furloughs, which had accelerated unemployment rates and started the reversal of this trend. While the unemployment rate is expected to decline to 5.5% according to the Federal Reserve's December 2020 forecast for year-end 2021, the reported rate was 6.3% in January 2021. Additionally, the Fed also estimates that four million people stopped searching for employment during the pandemic and are not included in the official unemployment rate. With Medicaid being an income-based program, many of these people may qualify for Medicaid coverage. Medicaid enrollment is counter-cyclical to the economy. Increases during periods of economic stress on the job market, such as what has been prevalent through much of 2020, is a primary driver of the surge in Medicaid enrollment.

Total enrollment in all Medicaid programs increased by 4.1% (**Exhibit 5**) as of August 2020 from year-end 2019, exceeding all the members lost in 2019. Membership grew to 76.5 million participants, compared to 71.1 million at the end of 2019. Additionally, according to CMS enrollment data through August 2020, total managed Medicaid, which is provided by health insurers, enrollment grew by 7.9% to approximately 57.2 million beneficiaries accounting for three-fourths of total Medicaid membership.

Most of the enrollment increases in Medicaid are attributed to the affected population that has either lost employer group coverage through layoffs or furloughs from the pandemic.

Exhibit 5

US Health – Total Medicaid Enrollees



* Latest available data for total Medicaid enrollees as of Aug 2020.
Sources: CMS, AM Best data and research

Additional gains have been linked to the Families First Coronavirus Response Act (FFCRA), which was enacted in March 2020. The FFCRA provided states with additional Medicaid funding during the period of the PHE. However, to receive the increased funding, states may not terminate Medicaid benefits for those who are no longer eligible during this timeframe.

State budget revenues are already being pressured by shelter-in-place orders, business closings, and increased spending for COVID testing and vaccine distribution. The increase in Medicaid membership places additional budget pressure on the states. Should Medicaid funding come under pressure due to constrained budgets, states typically reduce benefits, lower the reimbursement rates paid to providers, or decrease premiums paid to health insurers under Medicaid managed care contracts. The government spending and COVID relief bill that was enacted on December 27, 2020 provided little relief for states to address any budget shortfalls. The most recent proposal, the American Rescue Plan, President Biden's $1.9 trillion COVID bill, provides some financial relief for states. As of February 28, 2021, the bill has passed the House and is in discussion in the Senate. Additionally, any increases in utilization in 2021 from deferral of care in 2020 or from increased COVID claims could place additional pressure on health insurers. The ability of insurers to control medical costs for the Medicaid population, especially for those with chronic conditions and co-morbidities, has been based on an outreach and care engagement approach. Given the COVID impact, some of these processes might have been interrupted, making it more difficult to control the ongoing and future medical costs. Instability in state funding of Medicaid programs could cause earnings pressure for participating health plans and market exits could result if losses are incurred and unable to be remedied.

In May 2020, CMS outlined program amendments that would be considered retroactively for risk mitigation strategies in response to COVID. One such method includes a two-sided risk corridor for all medical costs. The risk corridor can be based on the Medicaid managed care plans' MLR and would limit risk for both the state and insurance company. If the MLR is above or below the target, the state and insurance company share in the savings or losses. However, this type of arrangement can limit both profits and losses for the Medicaid managed care plan. Another option put forth by CMS is a block-grant funding arrangement. With block grant funding, the state would get a fixed amount of federal funding, using a baseline period of Medicaid spending with annual inflationary adjustments. To date, only Tennessee has applied and been approved for a Section 1115 Waiver to amend its Medicaid financing in the form of a 'modified block grant' and 50% retention of any federal "savings" achieved under the block grant demonstration. The future of Medicaid waivers may be in question. In January 2021, President Biden signed an executive order asking the Secretaries of the Departments of Treasury, Labor, and Health and Human Services (HHS) to examine demonstrations and waivers that may reduce coverage under Medicaid.

The new Biden administration may come with a reinvigorated interest in expanding Medicaid in the twelve states that have not expanded their coverage under the ACA. Additionally, in 2020, the states of Missouri and Oklahoma put the expansion decision to a vote and the approved ballot measures call for their respective Medicaid programs to expand on July 1, 2021. This growth, however, comes with costs to the states, which are already seeing their budgets stretched. Federal funding was increased by 6.2% through the enactment of the FFCRA in March 2020 and remains in effect for as long as the PHE is in effect, which was recently extended to 90 days from January 21, 2021. While this extra funding has alleviated some of the state budget shortfalls, additional federal funding would most likely be needed for these states to expand.

Senior Market

The increase in the senior population, as well as the popularity of managed care products, which are attractive due to low member-paid premiums and more comprehensive benefits, has driven growth in senior segment premium revenue and earnings for health insurers, a trend which is expected to continue in future years. 2019 premiums totaled $257 billion for Medicare Advantage (MA), up nearly 14% from the prior year, and account for over one quarter of all health premiums. Medicare supplement premiums were up 37% from the prior year, reaching $32.6 billion in 2019. Standalone Medicare Advantage prescription drug (Part D) accounted for an additional $16 billion in 2019; this program, however, has seen a decline in premiums as more individuals select MA products, which also provide prescription drug coverage.

Medicare Advantage

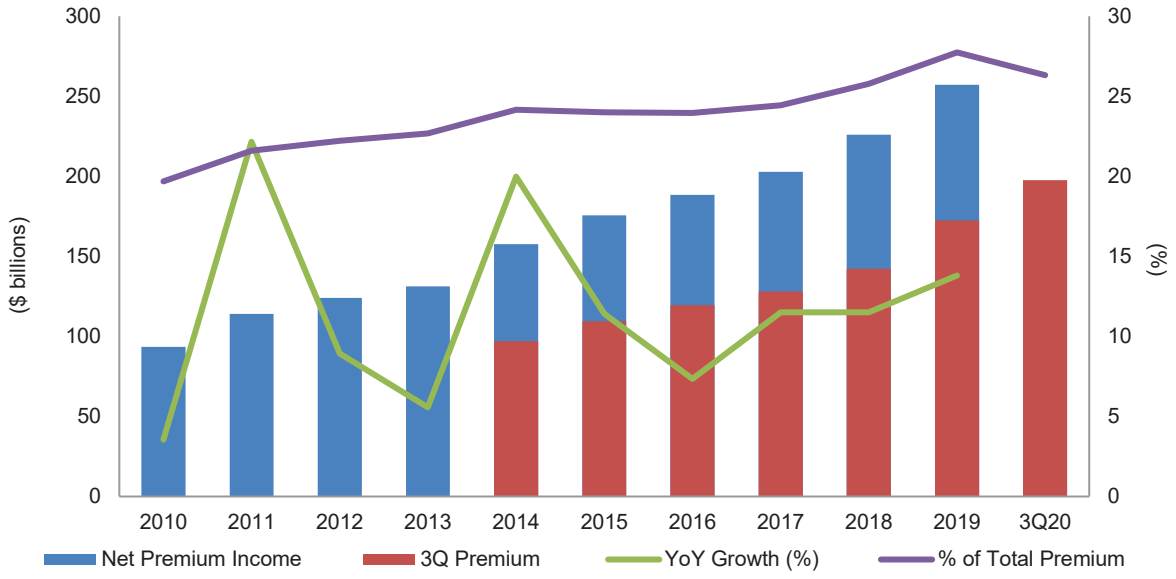
Medicare Advantage (MA) premiums grew favorably during 2019 and through the third quarter of 2020 (excluding blue book filers), with an average annual growth of 10% over the last three years (**Exhibit 6**), a trend that is most likely to continue given the aging population in the US and the increased percentage of Medicare eligible individuals enrolling in MA products versus traditional Medicare. Enrollment has more than doubled over the last ten years, from 11 million in 2010 to 24 million in 2020, showing the growth in popularity of this plan, which captures 36% of the Medicare beneficiaries (**Exhibit 7**).

MA remains a complex product for health insurers to enter into and manage given its intricacies related to the required annual bidding process, high level of compliance, adhering to the Star quality program parameters, as well as managing an older population. In addition, health insurers must run efficiently to maintain profitable product offerings, which have typically had low margins in the 1% to 3% range over the past five years.

The impact of COVID on MA premium revenue has been minimal as the majority of premiums are paid to insurers by the Federal Government. In addition, earnings have been favorably impacted by the deferral of elective procedures and non-urgent care, which resulted in a

Exhibit 6

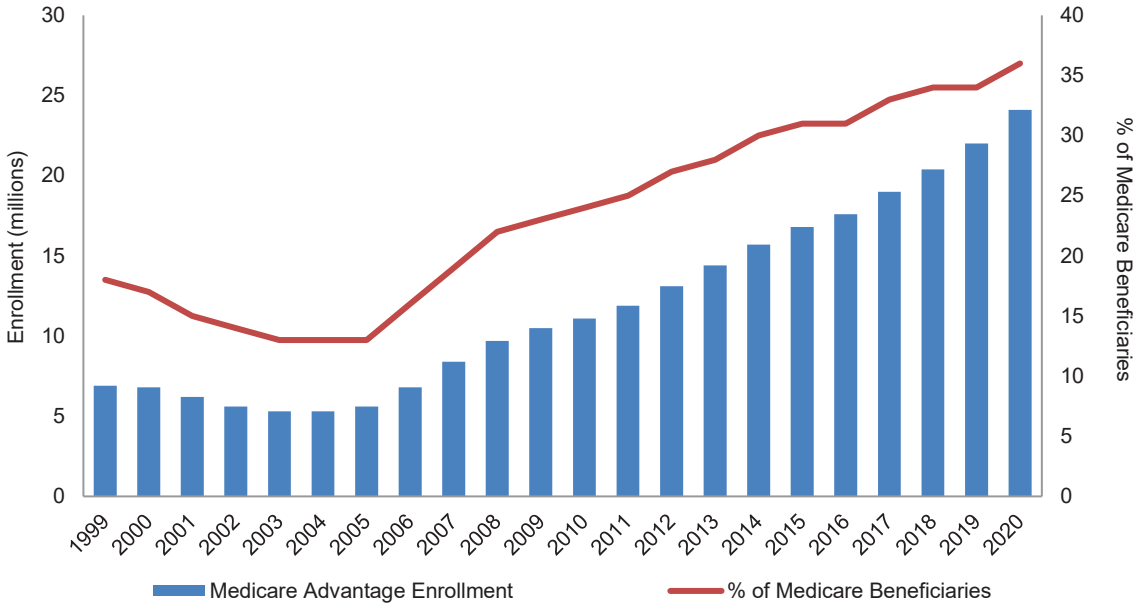
US Health – Medicare Advantage Net Premium Written



*Orange Book and DMHC filing companies only
Source: AM Best data and research

Exhibit 7

US Health – Enrollment in Medicare Advantage Plans



Source: Kaiser Family Foundation

decline in utilization that has more than offset any increase in claims from COVID testing and treatment for many carriers. However, this decline should be temporary. Insurers have actively reached out to members to facilitate the use of telehealth and to ensure the continuation of care, especially for those with chronic conditions. During the third quarter of 2020, claim volumes increased to more normal levels in parts of the country as elective and non-urgent care resumed. AM Best anticipates that premium revenue for MA will continue to grow based on increased enrollment and earnings will most likely temper in 2021 as vaccines become more readily available and utilization returns to more normal levels. Additionally, it does not appear that there will be a repeat of the mandated deferral of elective and non-essential medical care that occurred in the spring of 2020.

The potential for premium and earnings growth continues in 2021 as the newly eligible members reaching age 65 continues to rise and as a larger number of MA plans become available across the US. According to KFF, more MA plans will be available to individuals in 2021 than any other year, with nearly 80% of these plans offering prescription drug coverage. Some of the growth in the popularity of MA plans can be attributed to the ability of health carriers to market MA as a one-stop-shop product to newly eligible members turning 65 years old. The number of MA plans can vary significantly by geographies, where members in urban areas can select from twice as many MA plans as members living in rural areas. The delineation also changes across counties and states, with the highest availability of plans concentrated in Florida and California, while Alaska continues to offer none. However, the average individual will have access to 33 MA plans in 2021, compared to 28 in 2020.

Revenue streams for Medicare risk adjustments may be negatively impacted in 2021. Revenue is adjusted based on the Medicare risk scores from 2020 claims and encounter data. Due to shelter-in-place restrictions and the deferral of non-urgent care, there was a decline in utilization with seniors not being examined by their doctors. The resulting fewer encounters for the year could negatively affect risk scores. Risk adjustment payments are expected to

decline even though carriers have taken initiatives to try to ensure that seniors get appropriate care during the pandemic.

Medicare Supplement

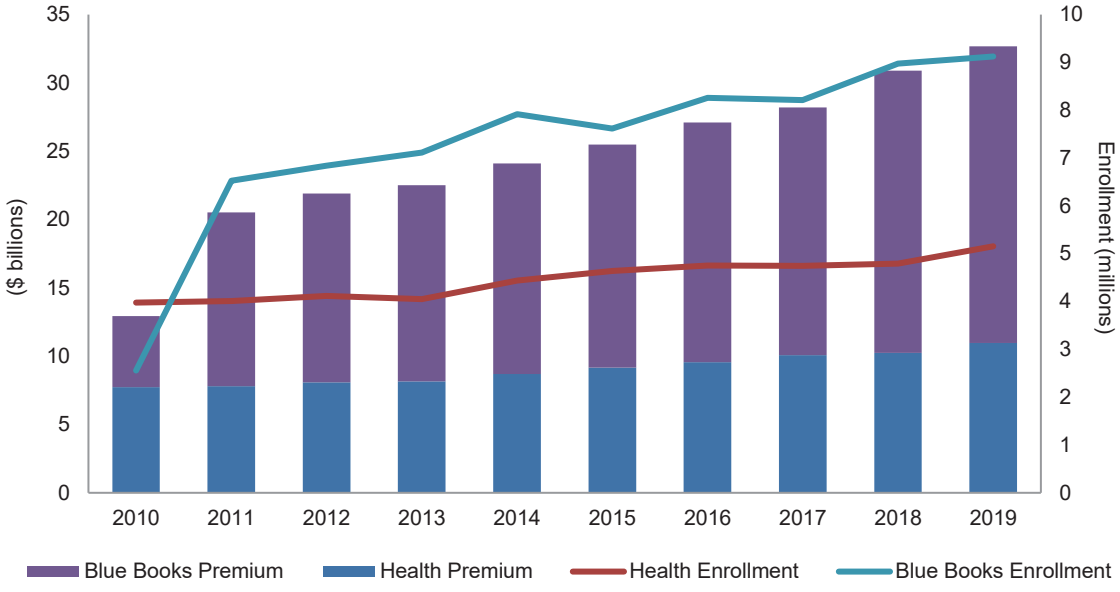
Medicare supplement premium and enrollment grew steadily from 2011 through 2019, reaching over 14 million members and $33 billion in premiums. The rate of growth has fluctuated over the years, but, on average, it has experienced single digit growth (**Exhibit 8**). Over one third of individuals in traditional Medicare have Medicare supplemental coverage. Geographically, more people in rural areas are selecting traditional Medicare with a supplemental plan due to the decreased availability of MA plans. The highest percentage of Medicare eligible individuals with a supplemental plan is in the Midwest. Medicare supplemental plans are generally preferred by retirees living in more than one location (snowbirds) who want the flexibility of coverage in multiple locations. Medicare supplement is a competitive, highly concentrated market with over a third of the market covered by one insurer. The benefits are standardized so competition is largely determined by price and brand recognition. AM Best expects that premiums and enrollment will continue to rise owing to the increased population of Medicare eligible individuals.

Standalone Medicare Part D

Medicare Part D is a voluntary prescription drug benefit for people with Medicare provided through private plans and approved by the federal government. Subscribers may enroll in either a standalone drug plan in conjunction with traditional Medicare coverage or in an MA plan that includes prescription drug coverage. Standalone plans continue to be viable, but enrollment dropped over the past three years to 20.4 million members in 2019. Furthermore, Part D premiums declined 11% percent in 2019. The decrease can be attributed to the shift of Medicare-eligible individuals enrolling in MA plans that include Part D benefits, as well as an increase in enrollment in basic or lower premium plans versus enhanced benefits, and competitive pricing pressure.

Exhibit 8

US Health – Medicare Supplement Trends



Includes all companies (health, DMHC, life/health).
Source: AM Best data and research

Supplemental Health

There had been a lot of interest in the supplemental health and voluntary benefits markets as insurers looked to grow top line and diversify revenues. The market saw a number of new entrants and increased competition. Over the past year, even with the impact of COVID, there have not been any material changes in the dynamics of the market. However, insurers are looking at ways to maintain their current level of business in an economically challenged environment and to focus on possible new product lines or product development in order to meet the changing needs of the market. The downturn in the economy is pressuring the supplemental market revenue, especially in dental, vision, and voluntary benefits.

The supplemental health space has expanded in recent years, led by dental and disability insurance (DI). There also has been favorable growth across other product lines by niche carriers focused on specific supplemental health products, including limited benefit, short-term medical, critical illness, and senior-focused ancillary products. The growth in these products had been driven by a strong economy combined with the need for affordable healthcare products. Supplemental products can fill voids in coverage of major medical products, as well as provide non-ACA compliant policies to individuals who do not want the full comprehensive coverage under an ACA policy. The type of carriers offering supplemental health products ranges from large health insurers to niche writers to Medicare writers whose products focus solely on the senior market.

While competition remains a top concern in the supplemental space, the economic pressure from COVID has emerged as a prevalent concern in the market. Furthermore, given the shift in Washington with a new president and administration there are concerns that regulatory or legislative changes may disrupt certain products in the supplemental market space and affect sales, product offerings, underwriting, and, ultimately, profitability. Insurers have expanded their supplemental product portfolios and marketing efforts with a focus on the needs of the senior market. This market is less sensitive to economic pressure compared to commercial markets and the under-65 population. The focus of the products for the senior market segment is on gaps in coverage, especially those enrolled in traditional Medicare. Product offerings in this space usually include dental, vision, and hospital indemnity, but can also include short-term care, critical illness, and final expense life insurance. Dental remains a key product in this segment as over 37 million people in traditional Medicare have no dental coverage at all.

AM Best anticipates that in the near term revenues for the supplemental health market will likely be pressured and material growth is not expected until there is more stability in commercial employment. However, it is expected that the supplemental segment will continue to be profitable although margins may compress.

Disability Income

Macroeconomic factors such as unemployment rates and interest rate movement are significant influencers on the results in the disability income (DI) sector. Through year-end 2019, results for the DI writers showed consistent profitability and top-line growth. Sustained economic growth and good employment numbers through 2019 had provided relatively stable results for the DI segment despite pressure on interest rates that resulted in companies making adjustments to the discount rate. However, the COVID pandemic has driven changes in the US economy, and somewhat negatively affected morbidity. The pandemic caused a notable rise in short-term disability (STD) claims in 2020 and the surge in COVID cases in the US during the latter part of the year will likely keep the number of STD claims elevated into 2021. Furthermore, while the long-term disability (LTD) loss ratio has been on a decline for a number of years, the number of LTD claims could be impacted by both the long-term health impact of COVID and increased

morbidity for those with underlying heath conditions who have put off seeking care.

Additionally, premium revenue for this segment is likely to decline due to layoffs, furloughs, and other workforce reductions. The stable economy through 2019 contributed to better reported morbidity, lower claims incidence, and better claims recovery rates. The weakened economy is now having the opposite effect on the DI business segment, with an uptick in claims incidence and poorer claims recovery rates reported by some. Although increased morbidity has not been a significant factor to date, it has the potential to rise in the medium term. In addition, both net premiums written and number of covered lives for group LTD is now trending downward due to the higher unemployment rate and a decline in new sales. Both the STD and LTD markets are highly concentrated, with the top 10 writers in each segment accounting for about three-fourths of these markets (**Exhibit 9**). At year-end 2020, Cigna Corp., which had a top 5 position in this segment, sold its employee benefits business, including its DI business, to New York Life Insurance Company, which was not previously a leading writer in this sector. This was one of the most significant shifts in the DI segment in several years, and a notable step with another large mutual life insurer joining the top 10 with a sizable market position.

Exhibit 9

2019 Life/Health Short & Long Term Disability Market Share

($ millions)

Short Term Disability

AMB#	Company Name	Earned Premium	Market Share
069743	Unum Insurance Group	1,372	15.3
069824	Aflac U.S. Group	1,175	13.1
070351	Lincoln Financial Group	730	8.2
007285	Hartford Life and Accident Insurance Co	586	6.6
070173	Cigna Life Group	585	6.5
070192	Metropolitan Life and Affiliated Cos	495	5.5
069685	Guardian Life Group	451	5.0
070203	Mutual of Omaha Group	359	4.0
070398	Standard Insurance Group	354	4.0
020516	Principal Financial Group Inc.	265	3.0

Long Term Disability

AMB#	Company Name	Earned Premium	Market Share
069743	Unum Insurance Group	2,706	14.5
070192	Metropolitan Life and Affiliated Cos	1,851	9.9
070351	Lincoln Financial Group	1,628	8.7
070173	Cigna Life Group	1,585	8.5
007285	Hartford Life and Accident Insurance Co	1,340	7.2
069515	Northwestern Mutual Group	1,284	6.9
069685	Guardian Life Group	1,172	6.3
070398	Standard Insurance Group	1,099	5.9
070189	Prudential of America Group	796	4.3
020516	Principal Financial Group Inc.	746	4.0

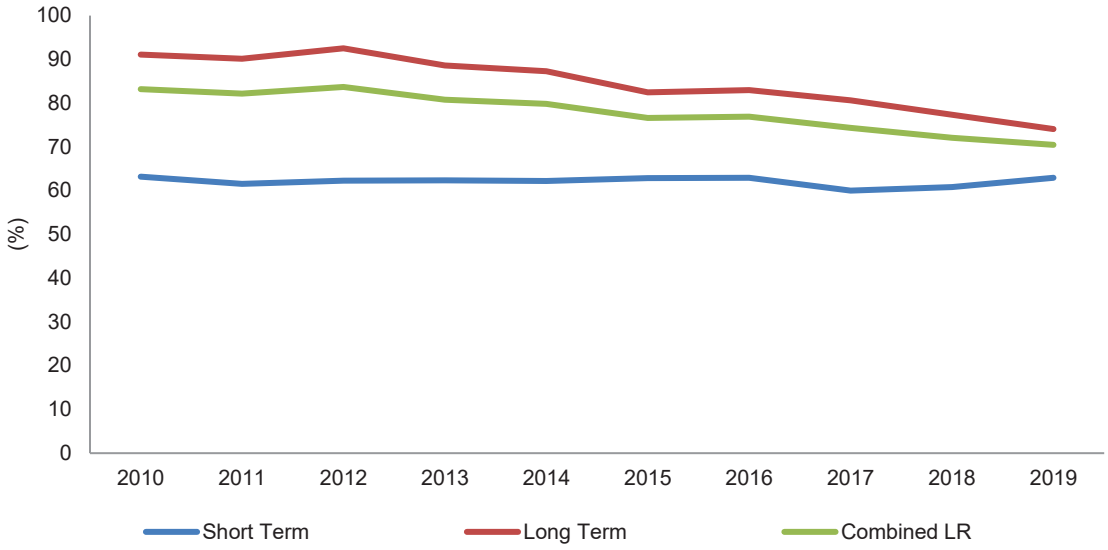
Note: In December 2020, Cigna Corp sold its employee benefits business, including disability, to New York Life Insurance Company.

Source: AM Best data and research

The DI market represents the second largest supplemental segment behind dental insurance, with many smaller players making up the remainder of the DI markets. While the market is very competitive, there has been a downward trend in the loss ratios, through 2019, demonstrating disciplined pricing of products and an increased focus on the loss ratio through new models for claim management across the industry over the last decade (**Exhibit 10**).

DI writers continue to innovate and differentiate themselves in the market. There has been increased digitalization and automation, from the sales and underwriting process to account management (including enrollment) to enhance customer service and improve retention. Additionally, DI writers continue to build up their absence/leave management capabilities for claims management, as well as for additional revenues.

Exhibit 10
US Life/Health Short & Long Term Disability Loss Ratios



Source: AM Best data and research

Long-Term Care

AM Best continues to view long-term care (LTC) insurance as a high-risk product. The numerous assumptions required to price and reserve for the product, coupled with the lengthy duration of liabilities, remain a significant risk. Common problems faced by issuers of LTC products include how many policyholders will retain their policies, claim costs of policyholders, and the length of the benefit period for these claims. The inadequate assumptions, primarily on the older blocks of business, have haunted LTC insurers for decades as they are forced to continue to seek premium rate increases. Furthermore, the prolonged low interest rate environment has added to reserving issues. Numerous insurers have been required to strengthen LTC reserve levels multiple times, negatively impacting financial results. The challenges in this segment, particularly on the legacy blocks, are expected to persist.

Traditional LTC insurance product sales continue to decline. While current LTC products have revised pricing assumptions and reduced benefits, they remain costly. Additionally, the number of writers of LTC products has dwindled to a few carriers. Inforce policies continue to receive large rate increases as carriers try to improve financial results on this line of business.

Nevertheless, the COVID pandemic has provided some relief to LTC insurers with increased mortality and fewer new claimants. The pandemic's effects have been extremely harsh on residents of long-term care facilities across the country. According to data from CMS, more than 100,000 long-term care facility residents have died as a result of COVID. These deaths account for over 20% of total US deaths of the more than 500,000 reported by the CDC. It is extremely disproportionate considering that less 1% of the US population lives in nursing homes or assisted living facilities. AM Best notes that the number of reported deaths at long-term care facilities due to COVID will depend upon the methodology used.

The larger number of COVID patients in long-term care facilities has caused a reduction in new claims and increased mortality among people who are on claim. According to the Health Actuarial Task Force at the National Association of Insurance Commissioners (NAIC), a number of carriers have noted that the pandemic has caused a temporary drop in the number of new LTC claims as a result of reluctance to admit individuals into long-term care facilities or to let paid home care workers into their homes. Many families prefer care to be provided by a family member rather than an outside home health care worker even though most long-term care policies do not pay for family members to provide care. While claims activity has decreased as a result of the pandemic, it is expected to return to more normalized levels over time depending on widespread administration of vaccines and the easing of COVID cases.

Insurers are also aware that future operating results may be impacted by morbidity deterioration resulting from delayed treatments and diagnosis during 2020. The CDC reported that in the first six months of 2020, nearly one-third of adults delayed routine care, including management of chronic conditions, routine vaccinations, or early detection of new conditions. The result of missed or severely delayed initial diagnoses could lead to overall worsening of a claimant's health as well as the potential for increased need for long-term care in the future.

Insurers have still been requesting premium rate increases despite the favorable impact from COVID, which is viewed as temporary. While some of the increases are due to the unknowns of the pandemic, most are a result of low interest rates limiting returns on investments and reserve strengthening, which are the result of worse than anticipated results versus initial pricing assumptions.

The LTC market is concentrated across a small number of companies. The top two, Genworth Financial Companies (25%) and John Hancock Life Insurance Group (15%), accounted for approximately 40% of the market in 2019. Both companies have maintained similar market share for a number of years. Additionally, the top ten companies accounted for nearly 80% and the top twenty account for more than 90% of the 2019 LTC market share. Premiums for LTC have remained relatively flat while new business has been on a declining trend (**Exhibit 11**).

Exhibit 11
Top LTC Writers

Name	2015 NPE ($ thousands)	2015 Market Share (%)	2019 NPE ($ thousands)	2019 Market Share (%)
Genworth Financial Companies	2,693,243	24.6	2,777,417	25.3
John Hancock Life Insurance Group	1,720,350	15.7	1,662,570	15.2
Northwestern Mutual Group	551,501	5.0	752,340	6.9
Metropolitan Life and Affiliated Cos	753,196	6.9	725,597	6.6
Unum Insurance Group	635,470	5.8	658,061	6.0
Aegon USA Group	599,762	5.5	519,529	4.7
Mutual of Omaha Group	333,300	3.0	475,980	4.3
Prudential of America Group	382,588	3.5	414,878	3.8
CNO Group	473,472	4.3	394,888	3.6
New York Life Group	259,743	2.4	301,130	2.7
Top 5	**6,402,021**	**58.5**	**6,575,985**	**59.9**
Top 10	**8,402,625**	**76.8**	**8,682,390**	**79.2**
Top 20	**10,018,884**	**91.6**	**10,211,254**	**93.1**

Source: AM Best data and research

Genworth Financial, Inc. (Genworth), the top LTC writer, has been involved in a prolonged process to be acquired by China Oceanwide Holdings Group (Oceanwide). The purchase of Genworth by Oceanwide, which was originally proposed in 2016, has experienced numerous extensions, the last of which ended December 31, 2020. The companies retain the ability to ultimately complete the transaction if Oceanwide can secure the required funding and the parties can complete the remaining steps to closing.

Another concern for LTC writers is the US Securities and Exchange Commission (SEC) officially taking an interest in the accounting for General Electric Company's LTC insurance reinsurance operations. In September 2020, the SEC sent a Wells notice to the company. General Electric is a major reinsurer of LTC business and holds reserves estimated at $15 billion, of which over one-half is assumed business from Genworth.

In early 2020, Senior Health Insurance Company of Pennsylvania (SHIP) was placed in rehabilitation by regulators in Pennsylvania due to a substantial surplus deficit. The company was formed in 2008 when the Pennsylvania Insurance Department gave Conseco Inc. permission to pass Conseco Senior Health Insurance Company, a unit with a large closed block of LTC insurance policies, to an independent trust, which became known as SHIP. The financial condition of SHIP is poor and there is the potential for SHIP to become insolvent and require guarantee fund assessments from the industry.

Earnings

Statutory underwriting and net earnings have shown steady and sizable growth over the past five years, reaching record high levels in 2019. The earnings have been supported by a lower medical cost trend, positive results in the individual market achieved through rate increases and product modifications, and profitable growth of government programs. Furthermore, for the first nine months of 2020, the consolidated operating profitability metrics have been quite favorable for health insurers despite the COVID pandemic. The industry reported record underwriting results, net income, and increased capital levels through the third quarter 2020 (**Exhibit 12**). These favorable results were driven by a substantial decline in claims from the deferral of elective procedures and routine care due to federal and state directives as well as patients reluctant to visit providers during the pandemic. The decline in utilization

Exhibit 12

US Health – Earnings

Includes Orange Book and DMHC Filers
($ thousands)

Annual	2015	2016	2017	2018	2019
Net Premium Written	732,161,688	785,903,716	829,509,062	877,097,810	927,389,587
Underwriting Gain/Loss	13,365,642	15,918,457	25,143,307	27,101,533	25,215,770
Net Investment Income	3,832,211	5,117,419	7,114,781	6,325,360	12,138,647
Pretax NOG	16,433,188	20,692,236	31,078,212	32,791,706	36,360,163
Net Income	8,953,894	12,833,035	23,301,395	28,502,681	34,196,049

Quarterly	3Q2016	3Q2017	3Q2018	3Q2019	3Q2020
Net Premium Written	578,574,692	610,561,462	648,239,975	683,325,712	742,768,369
Underwriting Gain/Loss	13,273,417	24,964,625	24,888,012	27,247,295	40,893,632
Net Investment Income	3,100,221	4,344,464	4,918,703	8,190,519	5,697,950
Pretax NOG	16,147,222	28,977,172	29,375,976	35,027,460	46,010,362
Net Income	9,344,353	21,660,436	25,724,487	32,120,856	38,914,332

Source: AM Best data and research

and reduction in cost trends have been reported across the majority of lines of business and geographic locations. In addition, for most insurers the decline in medical claims for non-COVID conditions has more than offset the impact of COVID claims as the majority of individuals diagnosed with COVID have been advised to isolate at home with little medical treatment available. The treatment for those admitted to the hospital has remained lower than what would have been modeled for a pandemic. Furthermore, the length of stay in the hospitals for COVID cases has declined gradually as more effective protocols have developed.

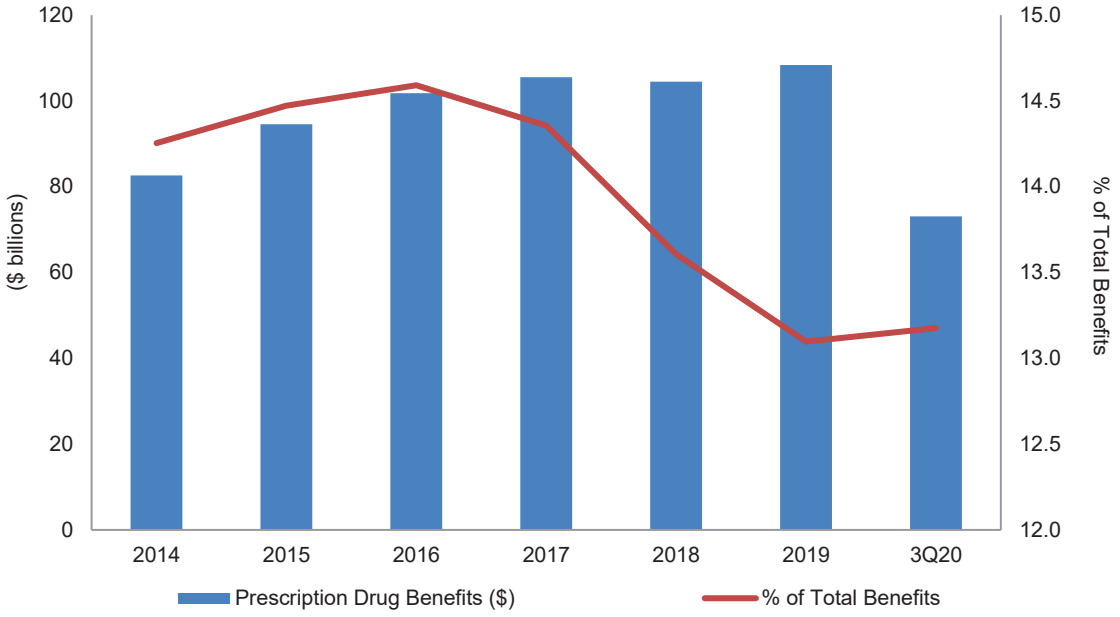
In order to partially offset historically low claims levels, many health insurers offered premium credits to both individual and group plans, provided grace periods for premium payments, waived telehealth co-pays, and eliminated cost sharing for COVID testing and treatment. Carriers also provided support and direct payments for personal protective equipment for providers.

In addition to lower utilization of medical services, claims cost in 2020 continued to be impacted by a lower trend of prescription drug benefits. While the industry has seen high pharmaceutical costs, the amount spent by health insurers on prescription drugs has declined since 2018. Health insurers saw fewer new high dollar prescription drugs over the past few years and through 2020. The percentage of prescription drugs to total benefits was 13.18% in the third quarter 2020 compare to above 14% a few years ago (**Exhibit 13)**.

The ruling by the US Supreme Court in 2020 on the risk corridors lawsuit resulted in numerous health insurance companies receiving payment from the federal government for the balance owed from 2014 and 2015. The case stemmed from HHS and CMS drastically reducing the risk corridors payment to only 12.6% of the amount owed for 2014, resulting in financial hardship for some insurance companies. Many health insurance companies received payment in 2020 for the amount owed for risk corridors, some of which were quite sizable, which contributed to favorable earnings during the year.

Exhibit 13

Prescription Drug Benefit Trends



Source: AM Best data and research

AM Best notes that medical claims utilization increased in the third quarter and early fourth quarter of 2020 as most states moved to re-open, which allowed providers to conduct routine care and elective procedures. There are notable exceptions to that trend, such as California, where strict lockdowns in major metropolitan areas continued through the later months of the year. Utilization levels for the most part returned to near normal levels through the first half of the fourth quarter, before a nationwide spike in cases around the latter part of the quarter. Additionally, many health insurers accrued for the MLR rebates in the fourth quarter of the year due to the favorable claims experience, which resulted in a lower loss ratio. Future earnings are expected to temper due to claims costs returning to more usual patterns. In addition, utilization might be pushed to a higher level, resulting from the number of delayed procedures and increased severity of certain medical conditions due to a lack of proper treatment or diagnosis during the pandemic. There is also some concern about the cost of treating individuals with severe COVID cases who have lingering health impacts.

The publicly traded companies reported strong GAAP earnings through 2020. Net premium for the publicly traded companies increased 8.2%, to $413.1 billion, through third quarter 2020 compared to $381.7 billion at the prior year's period. In addition, average total revenue has grown quarter over quarter through 2020 (**Exhibit 14**).

Exhibit 14
US Health – 9-Month GAAP Analysis

	Through September 2020					
	Total Revenue ($ Millions)	Premium Revenue ($ Millions)	Operating Income ($ Millions)	Net Income ($ Millions)	Operating Margin (%)	Profit Margin (%)
Anthem, Inc.	90,043	77,001	5,755	4,021	6.4	4.5
Centene Corp.	82,827	74,496	3,067	1,820	3.7	2.2
Cigna Corp.	118,689	38,352	6,808	4,323	5.7	3.6
Humana Inc.	58,093	55,822	5,332	3,641	9.2	6.3
Molina Healthcare Inc.	14,188	13,921	987	639	7.0	4.5
Triple-S Management Corp.	2,715	2,657	86	41	3.2	1.5
UnitedHealth Group Inc.	191,674	150,897	18,880	13,191	9.9	6.9
Aggregated Total	**558,229**	**413,146**	**40,915**	**27,676**	**7.3**	**5.0**
Average	**79,747**	**59,021**	**5,845**	**3,954**	**6.4**	**4.2**

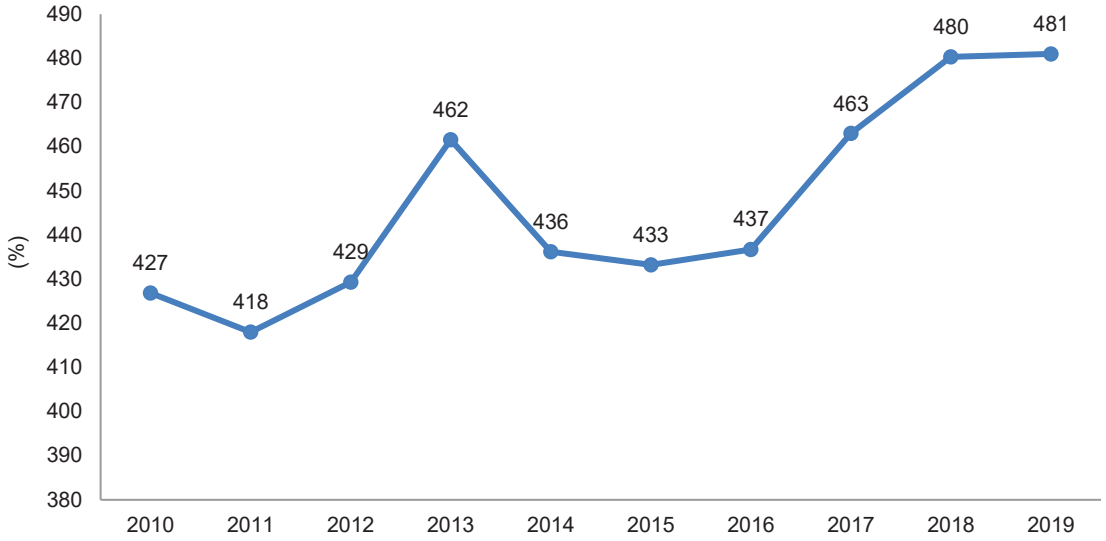
	Through September 2019					
	Total Revenue ($ Millions)	Premium Revenue ($ Millions)	Operating Income ($ Millions)	Net Income ($ Millions)	Pretax Margin (%)	Profit Margin (%)
Anthem, Inc.	76,806	70,137	5,442	3,873	7.1	5.0
Centene Corp.	55,776	50,229	1,504	1,112	2.7	2.0
Cigna Corp.	115,321	36,832	6,516	4,127	5.7	3.6
Humana Inc.	48,593	47,139	2,830	2,195	5.8	4.5
Molina Healthcare Inc.	12,555	12,452	802	569	6.4	4.5
Triple-S Management Corp.	2,502	2,443	90	14	3.6	0.6
UnitedHealth Group Inc.	181,254	142,074	14,590	10,298	8.0	5.7
WellCare Health Plans, Inc.*	20,913	20,417	809	575	3.9	2.7
Aggregated Total	**513,720**	**381,723**	**32,583**	**22,763**	**6.3**	**4.4**
Average	**64,215**	**47,715**	**4,073**	**2,845**	**5.4**	**3.6**

* WellCare Health Plans, Inc. was acquired by Centene Corp. in 2020.
Source: Bloomberg

Exhibit 15

US Health – Average Risk-Based Capital (% over CAL)

Includes Orange Book Filers Only



Source: AM Best data and research

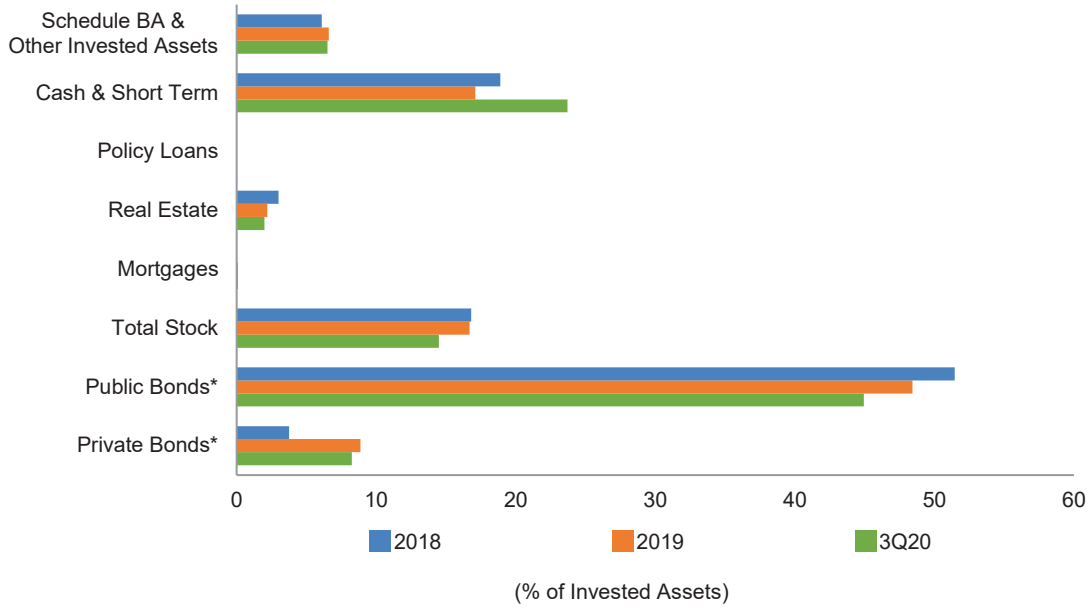
The increased underwriting earnings combined with investment income have been accretive to capital and surplus. The industry's capital and surplus increased over 9% at year-end 2019 and over 12% through third-quarter of 2020. AM Best notes that the favorable earnings trend over the past years have resulted in the continued improvement in the level of risk-adjusted capitalization (**Exhibit 15**). Further, underwriting leverage ratios and risk-adjusted capitalization have benefited from the solid growth in capital in recent years outpacing the growth in net premiums written. Despite the challenging COVID environment and the expectation that earnings will temper in 2021, AM Best expects most health insurers would maintain more than adequate risk-adjusted capitalization to withstand potential volatility in the marketplace.

Investments

In the years prior to the marketplace disruption caused by the COVID pandemic, health carriers were tilting investment allocations toward higher-risk investments in a search for yield. The goal was to generate sufficient investment income despite a historically low interest rate environment. 2019 was a continuation of this trend. Invested assets of orange book filers increased 8.0%, to $324.0 billion, and net invested income improved by 91.5%, to $12.2 billion, versus the prior year. A significant portion of the increase in net investment income in 2019 was driven by Kaiser Foundation Health Plan, which reported more than $4 billion for the year compared to under $1 billion in 2018, of which $2.5 billion was recognized gains and $1.2 billion was comprised of interest, dividends, and other income.

Portfolio tilts toward higher-risk fixed income assets and BA assets continued in 2019. Private placements (including rule 144a securities) increased to 8.9% of invested assets versus 3.8% in 2015, and BA assets increased to 6.6% of invested assets from 6.1% in 2015 (**Exhibit 16**). Financing the increased portfolio weight of these higher-risk assets were the public bond and cash & equivalent allocations. The increase in private placement and BA assets was not industry-wide, but concentrated at the largest Blue plans and publicly traded stock companies, which typically use these assets as technology accelerators for innovation or as a vehicle

Exhibit 16
US Health – Invested Assets



*3Q20 is an estimate.
Source: AM Best data and research

to share technology platforms with other carriers (typically, other Blue Cross Blue Shield plans). Interestingly, the value of joint venture investments fell in 2019, and the joint venture proportion of total BA investments fell 13.1% to 81.6%. It is not clear if this is just volatility or the emergence of a new trend away from joint ventures within the BA portfolio. Stock allocations in 2019 were roughly flat at 16.7%, versus 16.8% in 2015.

In 2020, these trends either stalled or reversed slightly as health carriers rebalanced their portfolios away from risk assets into cash, and raised capital or retained additional earnings to support liquidity. Through third quarter 2020, cash increased to 23.7% of all investment holdings from just 17.1% at year-end 2019. The increased cash holdings, however, were not driven by asset sales, as all asset classes except equities increased in nominal value through the first nine months of 2020. The increased cash was from new money, which would have been invested, or raised externally, either from lines of credit or from investors or accumulated retained earnings. Given the large decline in valuations across the asset spectrum early in 2020 and anecdotal evidence from rated entities, it is likely that early in the pandemic (March through June) the source of cash was external credit lines, Federal Home Loan Bank (FHLB) drawings, and, in some cases, capital contributions. As the year progressed and asset valuations recovered, premium collections held steady, and underwriting income proved to be favorable, carriers reduced short-term debt balances or used available cash to promote strategic or competitive objectives such as premium holidays, provider assistance, and community initiatives. Stock allocations fell to 14.5% from 16.7% at year-end and was the one asset class to decline in nominal value through nine months of 2020. It is likely that this represented some selling by carriers as US large cap stocks and the MSCI world index had fully recovered by that point.

AM Best expects trends observed in 2019 to reemerge in 2021. Private placement will likely continue to increase both in nominal value and as a proportion of investment holdings. Cash balances are likely to remain elevated in early 2021, but decline over the course of the year as carriers repay credit lines, redeploy it into other asset classes, or erode cash buffers for

operational or strategic needs such as additional support to policyholders or providers, or premium rebates that may have been accrued in 2020. In addition, carriers are likely to use some of the accumulated cash to invest in further expansion of service and technological capabilities. Investment returns are likely to remain depressed in 2021 as interest rates remain well below 2019 levels, lowering the expected return on new investments and limiting the potential capital appreciation in the fixed income portfolio. However, if the new administration is successful in implementing its policy goals of large-scale government spending, inflation expectations may drive bond yields higher, which will enhance net investment performance on new investments. These expectations have driven a limited Treasury sell-off in early 2021, pushing the yield on the 10-year Treasury above 1.0%, though Treasury yields remain very low by historical standards.

Regulatory

During 2020, regulatory developments were dominated by COVID-related measures. Numerous new rules for health insurance carriers were introduced as part of the public health emergency through executive orders, and later through new legislation – the FFCRA and the CARES Act.

Greater Regulation/Legislation from COVID-19

With the pandemic escalating in March 2020, the Trump administration implemented several measures to improve access to care and to ensure that individuals would not have concerns about the financial cost of testing and treatment for COVID. These actions included temporarily expanding Medicare telehealth services to limit the vulnerable senior population's exposure to the virus, waiving the out-of-pocket costs of COVID testing and treatment for seniors covered under Medicare Advantage plans, and FFCRA and the CARES Act expanding the waiver of out-of-pocket costs for COVID testing to all individuals covered by private plans. Previously, there was no federal requirement to waive cost sharing for COVID treatment for the non-senior population. CMS in November 2020 issued a resource toolkit for insurers regarding coverage for the vaccine, which was updated in January 2021, reaffirming that the vaccine will be available at no cost to individuals.

Insurers also were impacted by various actions that relaxed the rules around medical services delivered through telehealth. The list of telehealth services allowed by Medicare was expanded significantly as was the requirement for Medicare Advantage plans to cover telehealth on par with office visits.

In January 2021, the public health emergency was renewed for 90 days from January 21, 2021. As part of the FFCRA and CARES Act, health insurers are required to continue waiving co-pays and cost sharing for COVID during the period of the PHE.

Other Non-COVID Related Regulatory and Legislative Actions

The Trump administration's 2019 rule requiring hospitals to disclose their full costs for tests and procedures became effective January 1, 2021 after an unsuccessful challenge by hospitals. The Trump administration issued the final rule in late October 2020 for health insurers to disclose pricing and out-of-pocket costs for common tests and procedures. The transparency rule is being phased in over several years to insurers beginning in January 2022.

The Competitive Health Insurance Reform Act of 2020 was signed by the president in early January, repealing the anti-trust exemption of the McCarran-Ferguson Act, which shielded health insurers from federal competition laws. Health insurers and the NAIC opposed the bill, asserting that it would greatly increase administrative costs and hinder the regulation of insurers, and that state antitrust laws provide adequate protection to consumers. While

the impact to health insurers is not expected to be significant, it could lead to greater federal regulatory oversight.

ACA and the Supreme Court

In December, the Supreme Court stated it would consider the Trump administration's request to reinstate work rules requiring some Medicaid-enrollees to work, volunteer, or attend school as a condition of receiving coverage. However, the Biden administration is currently reviewing the work requirements for Medicaid and may opt to withdraw prior approvals, which would disallow work requirements. The justices will hear appeals of lower court rulings that overturned the Trump administration's approval of programs in Arkansas and New Hampshire but the actions of the Biden administration may render this unnecessary.

The Supreme Court, in early November, for the third time heard oral arguments in a case focused on the ACA, brought by Republican state officials and supported by the Trump administration. The justices reviewed a federal appeals court decision that the repeal of the individual tax mandate invalidated the entire law. A lower court previously ruled in favor of the Republicans, agreeing that Congress' removal of the uninsured tax penalty invalidated the entire law. While a ruling is not expected until the spring, two of the court's conservative justices indicated that they would not strike down the landmark legislation, but instead suggested that the court may discard the individual mandate but retain the rest of the law. AM Best notes that in February 2021, the Department of Justice informed the Supreme Court that the new administration was reversing the Department's view of the ACA and requesting the Supreme Court to uphold the law.

A New President

AM Best expects future enhancements to and expansion of the ACA, given the support of the new Biden administration, a Democratic House of Representatives, and a split Senate, with Vice President Kamala Harris providing a tie-breaking vote, if necessary. A Gallup poll in early December 2020 showed that 55% of Americans approved of the ACA, with 57% of independent voters approving. AM Best also believes that a number of actions under the Trump administration may be reversed under President Biden and will likely be reviewed as part of an executive order signed by President Biden in January 2021. The order directs the secretaries of Treasury, Labor, and HHS to revisit policies that impact people with pre-existing conditions or undermine the health insurance marketplace, and to review demonstrations and waivers under both the ACA and Medicaid. AM Best continues to monitor the duration of short-term medical plans, which was extended from 90 days under the Trump administration; and work requirements for Medicaid and association health plans, both of which were added under the prior administration.

What is next for the industry?

After the initial uncertainty, including the possibility of a worst-case scenario as a global pandemic was taking hold in the beginning of 2020, the health insurance industry, to its own surprise, ended up having a year of record earnings, membership growth, strengthened public image, enhanced innovation activities, and a relatively favorable regulatory environment.

Despite having a good year in 2020, health insurers have faced a challenge of planning for and now navigating 2021. The uncertainty of 2021 has been centered around three major issues – the trajectory and impacts of COVID, the speed and effectiveness of vaccination, and the impact of all the delayed care on morbidity and claims costs. The extension of the PHE in January 2021 means that rules imposed for waiving cost-sharing for COVID testing and treatment remain in effect. The number of daily positive COVID diagnoses (as tracked by the

CDC) continued to climb through the fourth quarter of 2020 and into January 2021, somewhat fueled by the holiday season and much-enhanced testing capacity. However, the share of cases requiring hospitalization has been declining. With the exception of several states, hospitals around the country have been able to return gradually to more normalized care delivery for non-COVID cases. As such, in the fourth quarter of 2020, the utilization increased, albeit lower compared to prior years. Health insurers viewed the increased claim cost favorably, as the previously depressed level of utilization was pushing many carriers into rebate territory. It is still too early to tell if the longer-term health impacts (both physical and mental) of COVID are becoming a factor in overall costs. There is some evidence of long-term lingering health issues, but its scope has not yet been determined. Another unknown is how much the delayed care of 2020 will impact the health status and future cost of care for the insured population. It can be especially impactful for people with chronic conditions who missed routine appointments, and for those who may have a severe diagnosis delayed as a result of deferred testing. The industry is watching closely and should the cost of care show significant upticks, it is likely to be incorporated into future rate increases.

The vaccine rollout has been somewhat slower than anticipated, despite hundreds of millions of doses of the vaccine having already been purchased by the Government. Health insurers will be covering the cost of vaccine administration. For Medicare Advantage members, the cost of the vaccine administration will be covered by Medicare. In addition, federal and state governments are covering vaccine administration costs for certain population groups. The volume of cost incurred by health insurers for vaccine administration will depend on vaccine availability and the willingness of the under-65 population to get the vaccine.

The effectiveness of the vaccine will be the main determinant for the return to normalcy. At the same time, the health insurance industry remains somewhat protected from the prolonged economic downturn. The Biden administration recently proposed additional stimulus measures, including various subsidies for helping individuals to keep their health insurance. If these proposals become law, health insurers will be insulated, at least for some period, from membership and premium declines if the economic recovery lags expectations. Furthermore, Medicaid and Medicare Advantage membership is projected to grow.

Health insurers entered 2021 with significant financial strength. Record earnings coupled with mostly conservative investment strategies resulted in strong capitalization and good liquidity. Furthermore, health insurers continue to innovate on both the analytical and operational sides leading to better ability to control and reduce the cost of care. The industry is more than ready to face lower earnings as utilization returns to more normal levels in 2021. Even if the consumption of medical services in 2021 increases substantially and exceeds historical levels, health insurers have strengthened their capital positions and should be able to withstand any near-term pressure that may occur.

Published by AM Best

BEST'S MARKET SEGMENT REPORT

A.M. Best Company, Inc.
Oldwick, NJ
CHAIRMAN, PRESIDENT & CEO **Arthur Snyder III**
SENIOR VICE PRESIDENTS **Alessandra L. Czarnecki, Thomas J. Plummer**
GROUP VICE PRESIDENT **Lee McDonald**

A.M. Best Rating Services, Inc.
Oldwick, NJ
PRESIDENT & CEO **Matthew C. Mosher**
EXECUTIVE VICE PRESIDENT & COO **James Gillard**
EXECUTIVE VICE PRESIDENT & CSO **Andrea Keenan**
SENIOR MANAGING DIRECTORS **Edward H. Easop, Stefan W. Holzberger**
SENIOR VICE PRESIDENT **James F. Snee**

AMERICAS

WORLD HEADQUARTERS
A.M. Best Company, Inc.
A.M. Best Rating Services, Inc.
1 Ambest Road, Oldwick, NJ 08858
Phone: +1 908 439 2200

MEXICO CITY
A.M. Best América Latina, S.A. de C.V.
Paseo de la Reforma 412, Piso 23, Mexico City, Mexico
Phone: +52 55 1102 2720

EUROPE, MIDDLE EAST & AFRICA (EMEA)

LONDON
A.M. Best Europe - Information Services Ltd.
A.M. Best Europe - Rating Services Ltd.
12 Arthur Street, 6th Floor, London, UK EC4R 9AB
Phone: +44 20 7626 6264

AMSTERDAM
A.M. Best (EU) Rating Services B.V.
NoMA House, Gustav Mahlerlaan 1212, 1081 LA Amsterdam, Netherlands
Phone: +31 20 308 5420

DUBAI*
A.M. Best - MENA, South & Central Asia*
Office 102, Tower 2, Currency House, DIFC
P.O. Box 506617, Dubai, UAE
Phone: +971 4375 2780
*Regulated by the DFSA as a Representative Office

ASIA-PACIFIC

HONG KONG
A.M. Best Asia-Pacific Ltd
Unit 4004 Central Plaza, 18 Harbour Road, Wanchai, Hong Kong
Phone: +852 2827 3400

SINGAPORE
A.M. Best Asia-Pacific (Singapore) Pte. Ltd
6 Battery Road, #39-04, Singapore
Phone: +65 6303 5000

Best's Financial Strength Rating (FSR): an independent opinion of an insurer's financial strength and ability to meet its ongoing insurance policy and contract obligations. An FSR is not assigned to specific insurance policies or contracts.

Best's Issuer Credit Rating (ICR): an independent opinion of an entity's ability to meet its ongoing financial obligations and can be issued on either a long- or short-term basis.

Best's Issue Credit Rating (IR): an independent opinion of credit quality assigned to issues that gauges the ability to meet the terms of the obligation and can be issued on a long- or short-term basis (obligations with original maturities generally less than one year).

Rating Disclosure: Use and Limitations
A Best's Credit Rating (BCR) is a forward-looking independent and objective opinion regarding an insurer's, issuer's or financial obligation's relative creditworthiness. The opinion represents a comprehensive analysis consisting of a quantitative and qualitative evaluation of balance sheet strength, operating performance, business profile, and enterprise risk management or, where appropriate, the specific nature and details of a security. Because a BCR is a forward-looking opinion as of the date it is released, it cannot be considered as a fact or guarantee of future credit quality and therefore cannot be described as accurate or inaccurate. A BCR is a relative measure of risk that implies credit quality and is assigned using a scale with a defined population of categories and notches. Entities or obligations assigned the same BCR symbol developed using the same scale, should not be viewed as completely identical in terms of credit quality. Alternatively, they are alike in category (or notches within a category), but given there is a prescribed progression of categories (and notches) used in assigning the ratings of a much larger population of entities or obligations, the categories (notches) cannot mirror the precise subtleties of risk that are inherent within similarly rated entities or obligations. While a BCR reflects the opinion of A.M. Best Rating Services, Inc. (AM Best) of relative creditworthiness, it is not an indicator or predictor of defined impairment or default probability with respect to any specific insurer, issuer or financial obligation. A BCR is not investment advice, nor should it be construed as a consulting or advisory service, as such; it is not intended to be utilized as a recommendation to purchase, hold or terminate any insurance policy, contract, security or any other financial obligation, nor does it address the suitability of any particular policy or contract for a specific purpose or purchaser. Users of a BCR should not rely on it in making any investment decision; however, if used, the BCR must be considered as only one factor. Users must make their own evaluation of each investment decision. A BCR opinion is provided on an "as is" basis without any expressed or implied warranty. In addition, a BCR may be changed, suspended or withdrawn at any time for any reason at the sole discretion of AM Best.

Version 010320