ABSTRACT

Wakely Consulting Group assessed[1] the potential impact to Delaware's individual (i.e., non-group) and small group markets that may result from the regulatory requirements of the Patient Protection and Affordable Care Act (ACA) in 2014 and beyond. This memorandum provides an overview of the key findings from this assessment. Because the estimated impact differs so significantly across these two market segments, this overview examines each market separately.

In the individual market, major changes in the way commercial health insurance in Delaware will be structured (i.e., the benefits) and priced (i.e., the rating rules) will greatly affect some current policyholders. For consumers eligible for premium subsidies and reduced cost sharing the Exchange, the negative effects of the ACA will be entirely or largely mitigated. However, for consumers not eligible for premium subsidies – particularly younger people and people who currently opt for less comprehensive coverage – the impact may be extreme. Because the small group market is subject to different regulations and rating rules than Delaware's individual market, current policyholders in this market will be largely unaffected by the ACA's requirements.

As discussed further below, the differences between these two markets is due to their starting point and the rules that currently apply in each market. The rules that apply to the individual market – in particular the lack of guarantee issue (i.e., the ability of insurers to reject applicants) – are materially different from the requirements under the ACA. Also, the types of policies purchased by consumers in this market, compared to the policies purchased by small employers, are less comprehensive than those that will be required by the ACA in 2014 and beyond. These two factors drive the results of the analysis.

Individual Market

Premiums in the individual market, on average, are estimated to increase 32%, compared to current premiums. This estimate does not factor in the premium subsidies that will be available to individuals and families with income at or below 400% of the federal poverty level (FPL) that purchase coverage through the Exchange.

To put this percentage increase into context, the average monthly premium for single coverage in Delaware's individual market was $238 in CY 2010. An increase of 32% would add $73, bringing the

[1] "Actuarial Analysis: Impact of the Affordable Care Act (ACA) on Small Group and Non-Group Market Premiums in Delaware," Wakely Consulting, November 18, 2011.

average monthly premium to $311. By comparison, the average monthly premium for single coverage in the small group market in CY 2010 was $487. The Kaiser Family Foundation reported that the average premium in Delaware's individual market was among the lowest in the nation.[2]

The vast majority of this projected increase – 29% according to Wakely's mid-point estimate – is due to the requirement that policies be guarantee issue and that carriers no longer use medical underwriting. That is, in 2014 and beyond, insurers must accept all applicants and will be prohibited from using health status as a rating factor in setting premiums. Currently, carriers are not required to accept all applicants wishing to purchase coverage in Delaware's individual market. Wakely reports that more than one out of every four applicants (28%) is denied coverage. This figure likely understates the number of Delawareans who may wish to purchase coverage but do not bother to apply, knowing they will be denied coverage based on their or a family member's health status.

A further 8% increase in premiums is due to the requirement that certain benefits be covered (i.e., essential health benefits requirement) and minimum actuarial value standards (i.e., limits on cost sharing). Some individuals purchasing coverage today are enrolled in policies that do not cover all of the essential health benefits (e.g., prescription drugs, maternity coverage) and/or enrolled in catastrophic policies that have an actuarial value below the 60% minimum required by the ACA.

The negative effect on the existing market is modestly offset by minimum loss ratio (MLR) requirements and the transitional reinsurance programs (discussed further below). Wakely estimates that requiring carriers to meet an 80% MLR standard will reduce premiums 6%, on average, and the reinsurance program may further reduce premiums 4%.

For individuals and families that purchase coverage through the Exchange, the advance premium tax credit will, on average, completely offset the increase in premiums. Wakely estimates that the average consumer in the individual market will see a net reduction of 7% of premiums, after factoring in the availability of the advance premium tax credit. However, the impact on an individual or family will depend on their income. The premium impact ranges from an 88% decrease to a 32% increase.

Small Group Market

Premiums in the small group market are estimated to increase 3% due to the changes required under the ACA. The small group market in Delaware is already guarantee issue and there are limits on the use of health status as a rating factor. In addition, the plan designs and benefits covered in the small groups are generally richer (i.e., more comprehensive) than they are in the individual market. The combination of these largely negates the impact of the ACA requirements that adversely affect the individual market.

[2] "Mapping Premium Variation in the Individual Market," The Henry J. Kaiser Family Foundation, August 2011.

There has been concern expressed by some small employers and key stakeholders with regard to the deductible limits that will apply in the small group market in 2014 (i.e., $2,000/$4,000 limit), and the effect this may have on the market. However, based on plan design information provided by the carriers, less than 1% of the membership is in plans that are not compliant with the essential health benefits package, with the vast majority enrolled in plans that exceed the deductible limits.

Conclusions

The analysis by Wakely Consulting raises a cautionary flag on the impact of the ACA on Delaware's individual market. Because the current rules allow insurers to exclude applicants based on health status, the risk profile (i.e., average health status) of the existing individual market is favorable compared to the uninsured and compared to the small group market. Requiring guarantee issue in the individual market will allow Delawareans who are currently unable to purchase coverage to become insured. However, as noted above, some residents who are currently insured will be adversely affected.

To minimize the impact to the individual market, Delaware should explore the development of an aggressive reinsurance program that could blunt the shock to the individual market. The ACA includes a transitional reinsurance program to be funded through a nationwide assessment on all markets, including self-funded plans. The Wakely assessment estimated that reinsurance would reduce premiums by 4%. While the federal government is developing the specific parameters of the reinsurance program to be funded by the nationwide assessments, states are allowed to develop their own reinsurance program.

A reinsurance program with a low attachment point could reduce premiums by minimizing the financial exposure of insurers. For example, Healthy New York has successfully reduced premiums for individuals and small employers in New York through a reinsurance program that uses an attachment point of $5,000, with the reinsurance fund paying 90% of claims for medical costs incurred between $5,000 and $75,000. The reinsurance program for Healthy New York reduces premiums by approximately 30%.

There certainly are costs associated with an aggressive reinsurance program. However, given the relatively small size of Delaware's individual market, this may be an option worth pursuing. Modeling reinsurance programs with different attachment points and co-insurance levels should be evaluated as a way to minimize the premium increase expected in the individual market.

Actuarial Analysis: Impact of the Affordable Care Act (ACA) on Small Group and Non-Group Market Premiums in Delaware

Prepared on November 18, 2011

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1. EXECUTIVE SUMMARY

Wakely was retained by the state of Delaware through a subcontracting agreement with Public Consulting Group (PCG) to support planning activities related to the creation and operation of health benefit exchanges under the Affordable Care Act (ACA). This report presents the actuarial component of our scope of work. All results presented in this report are specific to the state of Delaware and may not apply to other states. The following components are discussed in this report:

1. Current Delaware regulations and market composition for the individual (non-group) market.
2. Analysis of the impact of the ACA reforms on the Delaware individual market, including the impact on benefit plan offerings, rating and underwriting as well as the impact due to newly insured individuals under ACA.
3. Small Group Analysis.
4. Impact of Small Group and Individual Merger.
5. Impact of Increasing Small Group to 100 Members.

For the individual and small group markets, we received data from the largest insurers in the market. The data received includes: summarized plan benefit packages, premiums, claims, underwriting, non-benefit expenses, commissions, and current members' demographic information. We supplemented this information with publicly available rate filings and survey information, data from other states, and information provided by the Delaware Department of Insurance (DOI). We reviewed this information for reasonability, but did not audit the information.

Results for each component of the analysis are included in the sections below. Please see individual sections of the report for important information regarding our methods, assumptions, data and inherent limitations with our estimates. In summary, analysis of this nature is inherently uncertain because of the large number of forces affecting the insurance market, including actions by consumers and health plans. In addition, many structural decisions regarding the exchange and the insurance market have not been decided by the state; such decisions may significantly impact premiums and product offerings.

A summary of the results and conclusions is listed below.

Individual Market Under ACA

Estimated changes to individual market premiums that may occur due to ACA regulatory reforms, as compared to the current Delaware market (as of 2010) are shown in Table 1 below. Each of the requirements outlined in Table 1 are discussed in detail throughout this report. Note that the table below represents the 2016 impact, when the ACA should be in a relatively steady state. Some of these impacts, such as reinsurance, will vary considerably by year.

The best estimate of the increase in premium is approximately 32% above what it would be without the ACA changes. This reflects the change in the premium required to cover the health risks of the expected population after the ACA changes. It can also be viewed as the expected change in the "filed" rates of an insurer.

Beginning in 2014, some lower income individuals will be eligible to receive premium tax credits and cost sharing subsidies to make health insurance affordable to lower income individuals and families. As a result of these premium tax credit subsidies, for those individuals that are currently covered in the individual market the effective premium change under the best estimate would be an average decrease of 7% after taking into account the premium tax credits for which these individuals will be eligible. This estimate is based on the second lowest silver plan's premium and assumes that only individuals over 133% of the Federal Poverty Level (FPL) will be in the exchange. The impact to any one member is greatly impacted by the income of that person. While an average decrease in premium of 7% is projected for all current members, the premium impact will range from 88% decrease to a 32% increase per person. A detailed table walking through this calculation is provided later in the body of this report.

Table 1: Changes to Individual Market Premiums under ACA (2016 compared to 2010)

Requirement Description	Low Estimate	Best Estimate	High Estimate
Essential Benefits Requirement	3%	4%	5%
Bronze Minimum Act. Value and Max out of Pocket Limit	3%	4%	5%
Minimum Loss Ratio = 80%	-8%	-6%	-2%
Demographic Factors	0%	0%	0%
Underwriting - Rate Classes Not Allowed	0%	0%	0%
Durational Factors Not Allowed	0%	0%	0%
Morbidity Changes	12%	25%	37%
Pre-Existing Conditions Not Allowed	1%	4%	7%
Provider Fee	3%	3%	3%
Reinsurance	-5%	-4%	-4%
Total	**10%**	**32%**	**58%**

As shown above, we estimate that average individual market premiums will increase significantly due to the ACA reforms and the influx of newly insured individuals. The increase in premiums is mostly driven by benefit increases, the elimination of pre-existing condition exclusions, and the morbidity (or population) changes from newly insured individuals entering the market. Some of the impacts, such as demographic factors, have no overall impacts but the impact to a particular insured can be significant. The impact of risk corridors is not included in the analysis since the methodology that will be applied is largely unknown. Additionally, the risk corridors will integrate with the minimum loss ratio requirement and given the current loss ratio assumptions, any impact would be negligible.

It is important to note that many of the changes, while they increase premiums, actually decrease out of pocket expenses for individuals. For example, while the essential benefits requirement is expected to

increase premiums by 4%, this increase will be offset by a decrease in out of pocket expenses as these additional benefits will be covered post-ACA. Excluding changes that decrease out of pocket expenses, since these have offsetting effects, results in a range of overall health cost impacts of 2% to +33%, with a best estimate of +17%. This is prior to any further relief due to premium tax credits and cost sharing subsidies.

While our primary focus is on the premium change to the currently enrolled members, it should be noted that the average premium and cost sharing subsidies vary significantly when looking at the currently enrolled and the projected ultimate enrolled. The ultimate population is expected to receive an average premium tax credit of 36%. If these individuals choose a silver level plan, and otherwise meet qualifications for cost sharing subsidies, the average cost sharing subsidies for the population is projected to be 19%. Combined using a weighted average, the premium tax credit and cost sharing subsidy could result in a 32% reduction for health care costs in the ultimate population, as shown in Table 2 below. This compares to a 23% overall cost reduction for the current population.

The estimated subsidies for the ultimate population reflect the blend of the current population and the incoming population, which are coming from the uninsured population and generally have lower incomes. Table 2 shows how the population mix by income range shifts to lower income levels for the incoming population compared to current. While the subsidies by income range are the same, the population weights by income range vary, thus making the weighted average subsidies significantly different. The current, higher income population can expect premium tax credits of 27% while the incoming, lower income population can expect an average premium tax credit of 41%. These average to a 36% premium tax credit for the ultimate combined population. Similarly, it can be seen that the cost sharing subsidies expected for the currently insured population (11%) are lower than the subsidies for the incoming population (23%).

Table 2: Total Potential Subsidies by Income Range

Income Range	Premium Tax Credit	Cost Sharing Subsidy	Total Subsidy	Current Population	Incoming Population	Ultimate Population
133-150%	83%	80%	82%	2%	15%	10%
151-200%	66%	57%	64%	11%	16%	14%
201-250%	44%	10%	35%	34%	21%	26%
251-300%	37%	0%	27%	5%	20%	14%
301-350%	13%	0%	10%	8%	10%	9%
351-399%	9%	0%	7%	6%	4%	4%
400%+	0%	0%	0%	35%	15%	22%
Total Population Projection				16,531	28,655	45,186
Total Premium Tax Credit				27%	41%	36%
Total Cost Sharing Subsidy				11%	23%	19%
Total Subsidy				23%	36%	32%

The premium tax credits displayed in Table 2 should be considered as the best estimate average subsidies to expect for an individual covering only themselves, with no covered dependents. For simplification in our projections, and due to not having enrollment figures broken out by income levels by age in the data received by the carriers, we are using CPS data to estimate the number of individuals in each age band by income level. The figures in Table 2 are calculated based on the weighted average expected premium across all ages compared to the maximum premium for the income range. For a given income level, younger people who are more likely to have lower premiums will be more likely to have a lower premium tax credit, if any. Conversely, older people having higher premiums will be more likely to have greater premium subsidies. We are reflecting only the subsidies for individuals with no dependents. The subsidies for families may be different from the values above.

Small Group Market Under ACA

Table 3 contains our estimates of the following changes to small group market premiums (on a PMPM basis) beyond current legislation in force in Delaware. The impact of the ACA requirements that have already gone into effect, such as the dependent definition expansion to age 26, are not included in the table below.

Table 3: Changes to Small Group Market Premiums under ACA

Description	Best Estimate	Range [1]		Notes
Benefit Coverage Changes	0.2%	0.2%	0.2%	
Elimination of U/W	0.0%			[2]
Tobacco Restrictions	0.0%			[2]
Age/gender Restrictions	0.0%			[2]
MLR Requirements	-2.5%	-4.0%	0.0%	
Premium Tax	3.0%			
Tax Credits for Employers	-1.0%			[3]
Morbidity Change	3.0%	0.0%	12.0%	[4]
Overall impact to small group premiums in 2014	2.7%	-3.8%	12.2%	

[1] Indicates uncertainty in the estimate
[2] Overall change to morbidity handled in Morbidity Change line
[3] Temporary credit that does not impact premiums
[4] This includes impact of new group and worker entrants to and exits from the small group market

As shown above, we estimate that small group market premiums will increase by approximately 2.7% under the base scenario, with a range shown for the most uncertain estimates and overall results. Employer behavior in light of the significant market changes that will take effect in 2014 creates the most uncertainty with respect to our estimates.

Merger of the Individual and Small Group Markets

Using the best estimate post ACA premiums, we project that small group premiums would decrease by approximately 5%, and individual premiums would increase approximately 7% if the markets were merged. These results are due to the small group market having higher projected morbidity than the projected individual market. Note that if the high estimate premiums are used for the individual market, the post ACA premiums for the two markets are similar. These estimates should be viewed as a comparison to if the markets were not merged post-ACA rather than a comparison to the current rates in the markets. Also, these results are based on enrollment projections showing the small group market only slightly larger than the individual market once the ACA is fully implemented; this is a significantly impactful assumption that should be discussed with the State.

Important Caveats

Estimates of future premiums and programs over four years into the future under a set of changes as sweeping as the ACA are inherently uncertain. The following issues were most notable in creating this uncertainty:

1. Our analysis was completed with 2010 market information. Even in the absence of ACA changes, the market will change significantly over the course of four to six years (2010 to 2014/ 2016).

2. Important decisions have yet to be made regarding the health insurance exchange (HIX), including how active of a purchaser the state will be, oversight responsibilities, adverse selection avoidance strategies, risk adjustment methods, and others. These decisions will all affect competition among carriers, carrier rate setting methods and assumptions, and member behavior.

3. Pending guidance and regulations from the federal government may affect the appropriateness of our estimates.

4. Rates, especially in 2014, depend on how health plans think costs will change under the ACA reforms and population expansions, not necessarily on how costs actually change in 2014. Results and information as presented in analyses such as this are important to communicate with the health insurance carriers. Feedback from these carriers on information they will find useful (e.g., state rules around rate review, information on the uninsured population, risk adjustment simulations, and others) will be critical to avoid irrational pricing.

5. Rate changes in the small group market and other financial incentives may drive employers to make unanticipated decisions around coverage.

6. The currently uninsured population will likely represent a significant portion of the individual insurance market in 2014. While migration assumptions were made, a more detailed "Who Goes Where" (WGW) analysis should be completed to better understand expected migration under the ACA. Shifts in enrollment may occur differently than what has been projected in the current WGW analysis if the rate changes in the small group market and other financial incentives drive some employers to drop coverage.

7. Pent up demand has been shown to significantly increase costs in the first year of enrollment for those previously uninsured. Our estimates do not reflect estimates for pent up demand since the effect is expected to be minimal after 2014.

8. Due to the limited scope of our work and timing requirements, we requested and received summary level market information from the carriers, rather than detailed data which would have allowed more validation and refined estimates. We did not audit the data supplied.

9. The behavior of individual members and employers is difficult to predict.

10. It is difficult to predict the number and impact of grandfathered plans. The more individuals and small groups that stay enrolled in grandfathered plans, the less of an impact the ACA guaranteed issue rules will have. However, the more grandfathered plans that remain, the higher the absolute level of non-grandfathered rates since grandfathered plans are assumed to have favorable risk pools. Further, the impact of merging the individual and small group market could be skewed if the proportion of enrollment in grandfathered plans is very different between individual and small group.

11. Any adjustment to costs and premiums resulting from revised contracting post ACA was not considered. Reduced contract costs might result from eliminating the level of uncompensated care for uninsured residents.

12. We did not attempt to model the impact of state mandatory benefits above and beyond the federal requirements of essential benefits, including how they will be reflected in the small group and individual markets after implementation of the ACA.

2. ANALYSIS OF THE DELAWARE INDIVIDUAL MARKET

2.1 Summary of Individual Analysis

In summary, we expect ACA provisions to produce the following individual market changes for 2016 (as compared to 2010):

1. Overall increase of 32% to individual premiums due to ACA, with possible outcomes ranging from 10% to 58%. The impact to each individual will vary significantly based on the benefit plan and type of rate they currently have with an insurer, and will vary as a result of premium tax credits that the individual may be eligible to receive.

2. Qualified low income individuals may also be eligible to receive cost sharing subsidies to offset out of pocket costs beyond the premium if they enroll in a silver plan through the exchange.

3. A compression of rates due to changes in the maximum age rate difference. The current market has age ratios greater than the 3:1 ratio permitted under the ACA. While this change will not have an overall impact on the total premiums, at the individual member level it will cause rates for younger members to increase and rates for older member to decrease. Furthermore, two of the three insurers still use gender specific rates so the gender-neutral ACA requirement will affect premiums for some members. While the factors vary by benefit plan and age, demographic factors for females can be as much as 44% higher than males in the 19-24 age band and males can be as much as 42% higher than females in the 60-64 age band, all else equal.

4. One insurer currently uses pre-existing condition exclusions in their underwriting; such exclusions will not be allowed under ACA.

5. The individual market will see a significant influx of new enrollees coming mostly from the current uninsured population. While the estimated impact of this change contains the most uncertainty, it drives the majority of the overall expected change in premiums.

There are three primary insurers in the Delaware individual market, with a wide variety of benefit plan options. While most actively sold plans are preferred provider organization (PPO) plans, one insurer does offer Independent Practice Association (IPA) plans, which are basically a health management organization (HMO) plan with a lower premium since the provider network includes physicians in small practices that contract with a managed care organization (MCO) to provide a more limited network with a lower reimbursement rate.

In addition, it should be noted that rating approaches for the three insurers currently analyzed vary notably across almost all rating variables. Thus, currently enrolled individuals will be impacted differently based on their insurer in addition to the variables noted above.

2.2 Current Regulations and Market Composition

Market Composition

The Delaware individual market has three primary insurers, Blue Cross Blue Shield of Delaware (BCBS DE), Golden Rule Insurance Company (Golden Rule, a UnitedHealthcare company), and Aetna, Inc. (Aetna). There are other smaller insurers in the market but our analysis focused on the three insurers with the largest market share.

Table 4: Insurers and Members in the Delaware Individual Market

Coverage by Three Largest Insurers

Insurer	2010 Average Members
Blue Cross Blue Shield of Delaware	8,849
Golden Rule	3,368
Aetna	2,350
Total	14,557

Based on information provided to the Center for Consumer Information and Insurance Oversight[3], the total 2010 individual market membership was 16,531. Thus, this analysis represents approximately 88% of the market. Note that the membership by insurer in the analysis does not completely align with the market share in the memo but is directionally correct. Note that the results of this analysis assume the remaining market and rating characteristics are similar to the insurers included in this analysis. Any variations could significantly impact the results.

According to research conducted by the Kaiser Family Foundation, in 2008-2009, approximately 4% of the Delaware population was insured through the individual market, while 12% were uninsured, 55% were covered under group coverage, and 19% were insured through public programs (Medicaid and Medicare).[4] Note that the Kaiser Family Foundation also states that the number of individuals insured through the individual market was approximately 32,800 in 2008-2009. Since this membership is almost double the 2010 membership noted in the DOI memo, the Kaiser statistic of 4% of the population in the individual market is likely over stated.

A summary of individual market benefits, commissions and loss ratios (for 2010) is provided below.

1. Benefits – An actuarial value (AV) reflects the relative richness of the benefit and is calculated by dividing the insurer's expected claims cost by the total covered amount of health care expenditures under ACA, including any essential benefits. AV values for the plans with the largest enrollment range from minimal coverage of less than 20% to as much as 89%.

[3]Memo to the Delaware Department of Insurance regarding Delaware's Request for Adjustment to Medical Loss Ratio Standard, http://cciio.cms.gov/programs/marketreforms/mlr/states/delaware/de_mlr_adj_determination_letter.pdf

[4] Delaware: Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009), http://www.statehealthfacts.org/profileind.jsp?ind=125&cat=3&rgn=9

Maternity is currently not part of the standard benefit package but is offered as a rider by all insurers. Since a maternity rider will only be purchased by individuals who expect to need maternity services, the premium amount of the rider is typically in line with the expected cost of prenatal and delivery costs spread over the expected coverage period, typically a year or two.

Mental health and substance abuse services appear to be covered similar to other benefits.

The majority of insured individuals have prescription drug coverage, although a portion of members are enrolled in catastrophic plans that do not include coverage for prescription drugs or office visits. Several plans also cover generic prescriptions only with no brand drug coverage.

2. Broker/Sales Commissions – – Overall, all of the insurers included in our review are experiencing 2010 commissions that are 9-11% of premium. Based on a current rate filings, as well as revised commission schedules, commissions are expected to decrease to around 5-7% in 2011.

3. Loss Ratios – The 2010 actual and expected loss ratios (paid claims over premium) vary significantly for the three insurers. One insurer's individual book of business has a loss ratio that is already around the ACA minimum Medical Loss Ratio (MLR) of 80%. The other two insurers are notably below with loss ratios of approximately 42% and 65%. For the insurer with the 42% loss ratio, a rate filing was submitted in 2011 that implies a higher lifetime loss ratio will be experienced but the insurer also appears to be decreasing rates in anticipation of the upcoming loss ratio requirements. Note that none of the three insurers is fully credible under the ACA rules and thus, only a portion of any calculated rebate would need to be refunded.

Regulations

Delaware currently allows significant rate variation based on health status and demographic category. In general, there are no limits on individual premium variation by age, gender, health status, family size, and other factors. The following highlights current regulations in the Delaware market.

1. Underwriting – Delaware insurers are not required to accept all applicants and medical underwriting may be used, requiring individuals to complete detailed health questionnaires. Based on completed data request questionnaires, roughly 28% of applications are currently denied. The percent of denied applications varies significantly by insurer, from 18-38%. The insurer with the lowest denial rate utilizes pre-existing condition exclusions and more frequently rates up substandard risks. Prior to August 2010, denied applicants did not have access to a high risk pool. Effective August 1, 2010, Delaware began participation in the federal pre-existing condition program. As of June 30, 2011, only 73 individuals were enrolled in this program.[5]

[5] Footnote – Enrollment in the Pre-Existing Condition Insurance Plan, as of June 30, 2011, http://www.statehealthfacts.org/comparemapreport.jsp?rep=74&cat=7

2. Mandatory Benefits – Delaware has minimal required benefits but does require the following: cancer screening for women, breast cancer screening, cervical cancer screening, reconstructive surgery after mastectomy, direct access to OB/GYNs, OB/GYNs as primary care providers, and eating disorder parity.

3. Rate Filings – Rating actions are required to be filed and approved by the state prior to implementation.

4. Rating Variables

    a. Demographic Rating – there is currently no limit on variability of rates by age or gender in Delaware. One insurer has already implemented gender neutral rating while the other two vary rates by gender. The current ratio of rates varies significantly by insurer, plan and by gender. The oldest to youngest adult insured is between 2.7:1.0 and 7.4:1.0. While the factors vary by benefit plan and age, demographic factors for females can be as much as 44% higher than males in the 19-24 age band and males can be as much as 42% higher than females in the 60-64 age band, all else equal.

    b. Pre-Existing Condition Exclusions – While pre-existing condition exclusions are allowed, only one of the three insurers utilizes these exclusions, with 20% of this insurer's issued policies receiving an exclusion.

    c. Rate Up for Substandard Health Status – Rather than deny coverage to an applicant who has a moderate health condition, some insurers will accept these applicants at a higher than standard rate. Insurers applied "rate ups" to approximately 27% of the policies issued in 2010. While the insurers' rate filings imply they can give rate increases (due to health status) of up to 200%, most of the 2010 policies received rate ups at a much lower level, with the average rate increase of approximately 42%.

    d. Smoking – One insurer also uses smoking status as a factor in setting rates. For the other insurers, tobacco use is likely included in the medical underwriting information collected by the carrier during the application process.

    e. Durational Rating – One of the three insurers varies rates based on the duration (or time from when the policy was issued to the rating period) of the insurance policy, with a cumulative rate increase for later durations as high as 30%. Based on this insurer's 2010 rate filing, it appears that this insurer will no longer apply durational rate increases effective April 2011. Any durational rate increases previously applied will remain, but no future increases will be applied.

f. Geographic Rating – Based on the rate filings, it appears that geography (or area) factors are not utilized for most insurers and plans. One insurer did utilize area factors on an older product line but the impact is not significant.

Of the primary rating variables noted above, only demographic (age only), area and benefit factors will be allowed under ACA and even these variables will have limits around the factors that may be utilized. Smoking factors, currently assumed to be implicit in the insurers' underwriting factors, will also be allowed under ACA.

2.3 Data Received

The analysis in this report is based on data provided by the insurers and the state. This information includes but is not limited to:

1. Detailed benefit plan information for plans representing at least 80% of the insurer's individual book of business. The detailed information includes:

   a. 2010 earned premiums, allowed and paid claims, and member months by benefit plan. The same data elements were also provided in aggregate for the balance of the remaining plans in the insurer's small group book of business.

   b. High level cost sharing and covered services information for each benefit plan.

2. Summary of member months, premium, claims and allowed cost experience by line of business (small group, individual, 51-100 size groups) and product type.

3. Underwriting experience for 2010 sales.

4. Member months by gender and age band.

5. Commission information including commission schedules and amount as a percent of 2010 premiums.

All information provided by the insurers was for fully insured business. Note that most data received were for plans that have been closed, likely in anticipation of significant changes due to ACA. Since closing a plan does not necessarily imply the plan will be grandfathered and assuming so would limit the data with which to analyze, for the purpose of this report we have assumed all closed plans will be impacted by the ACA. That is, it is assumed these plans will make all necessary changes to be ACA compliant, whether or not they are grandfathered. This assumption is conservative and any variance from this assumption will lessen the number of individuals who are impacted by the ACA requirements.

To the extent insurers offer and sell new plans in 2011-2013 that incorporate some or all aspects of ACA, this would also lessen the number of members impacted as well as the magnitude of the impact.

2.4 ACA Impact on Individual Market Summary

The ACA includes a provision for states to develop an exchange through which individuals can purchase health insurance. The ACA also includes significant new underwriting and rating requirements for the individual market. The purpose of this section is to analyze the estimated impact of these new requirements on current individual premiums. Since the ACA dictates that rates need to be the same for insurers who offer insurance both in and out of the exchange, the focus of the analysis is on premiums in the overall individual market, in or out of the exchange.

Overall premiums are estimated to increase by 32% due to the ACA's underwriting and rating requirements. This change is not uniform over all individuals, as some enrollees could see their premiums decrease by as much as 50% while others could see their premiums more than double before taking into consideration premium tax credits. Table 4 (below) shows the overall projected change for each of the requirements. As can be seen in the table, the most significant requirement to the Delaware individual market, as measured by overall impact to premium, is the morbidity change (driven by new entrants in the market). While changes to the demographic factors and removal of underwriting factors have no overall impact, their impact to individual enrollees may be significant. The overall premium impacts (gross of premium tax credits) by ACA requirements are shown in the following sections.

Table 5: Changes to Individual Market Premiums under ACA (2016 compared to 2010)

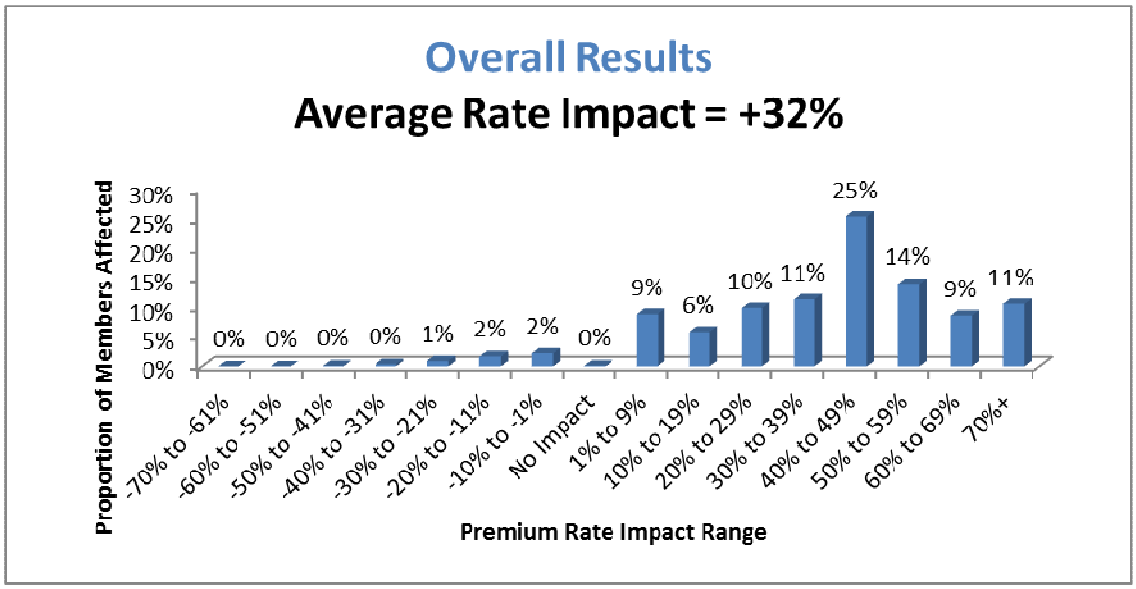
Requirement Description	Best Estimate Impact ($ PMPM)	Best Estimate Impact (%)
2010 Average Individual Monthly Premium	$238	
Essential Benefits Requirement	$9	4 %
Bronze Minimum Act. Value and Max out of Pocket	$11	4%
Minimum Loss Ratio = 80%	-$13	-6%
Demographic Factors	$0	0%
Underwriting - Rate Classes Not Allowed	$0	0%
Durational Factors Not Allowed	$0	0%
Morbidity Changes	$60	25%
Pre-Existing Conditions Not Allowed	$10	4%
Provider Fee	$7	3%
Reinsurance	-$10	-4%
Overall Impact (2010 Dollars)	$311	32%

Note that the above table does not include the impact of pent up demand or other rating requirements. See the Additional Requirements and Considerations section for information on these topics.

Figure 1 below shows the various estimated premium changes and the corresponding percent of members affected. Enrollees receiving the greatest premium increases are likely to be males, especially younger males, who are currently in catastrophic benefit plans and receive non-substandard rates. Conversely, enrollees receiving the largest premium decreases are likely older enrollees with substandard rates.

Note that the premium changes included in this section reflect the average premium change from the perspective of the insurer. They do not take into account the impact of the premium tax credits that will be available to lower income individuals. The premium tax credits would be layered on to the changes reflected in this section. We did not receive information on income ranges of individuals in each plan or pool, so we were unable to combine the impacts at this level of detail.

Figure 1: Estimated Premium Changes and Percent of Members Impacted



Premium Impact

Essential Benefits

The ACA requires that all benefit plans cover services for essential health benefits, some of which are often excluded in the current individual market. The definition of essential health benefits has not yet been defined by the Secretary of HHS, particularly with regard to minimum coverage levels, and further regulations are forthcoming. Based on the services enumerated in the ACA, the essential health benefits will include, but are not limited to, the following categories:

1. Inpatient and outpatient services.
2. Office visits.
3. Emergency services.
4. Laboratory services.
5. Rehabilitation services and devices.
6. Preventive and wellness services.
7. Maternity and newborn care.
8. Mental health and substance abuse.
9. 3-tier (generic, brand, non-formulary brand) prescription drugs.
10. Oral and vision pediatric services.

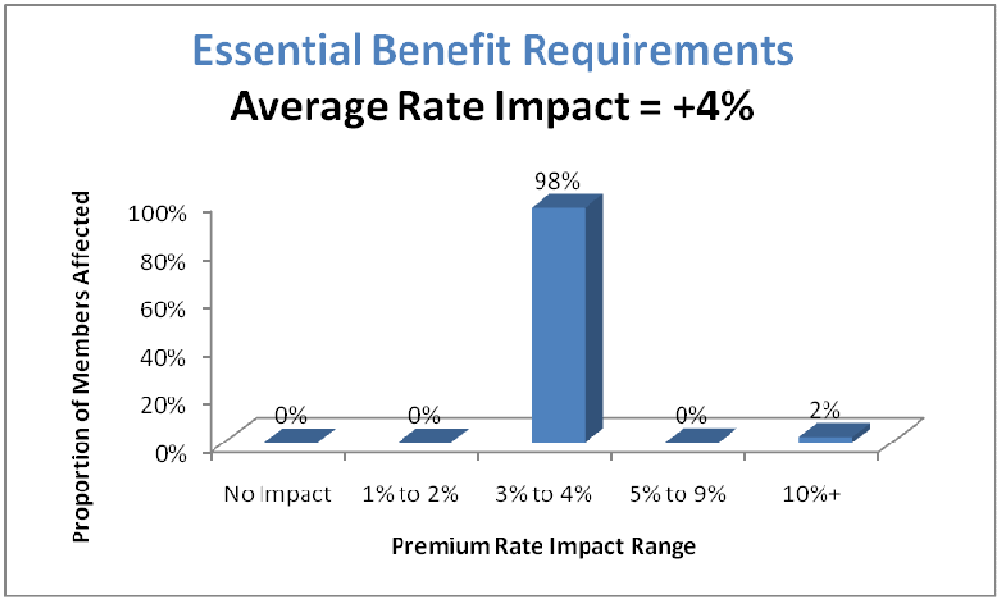
Currently, individual insurers in Delaware only offer maternity coverage as an optional rider. Mental health and substance abuse coverage is a standard benefit offered by most of the insurers. With minor exceptions most current benefit plans include prescription drug coverage. One insurer has catastrophic plans that do not cover prescription drugs or office visits. Currently 2% of members are enrolled in a

benefit plan with no or generic-only drug coverage and 4% are in plans with an AV amount less than 40%.

Given the current absence of maternity coverage from the base benefit plans, all benefit plans will be impacted by this requirement. The impact of adding mandatory maternity coverage as part of the essential benefits is estimated to be 3%. This is significantly less than the cost of the current optional rider since the cost of maternity coverage will be spread over all individuals, not just the individuals who expect to need maternity services.

The figure below shows the range of impact by members for all essential benefits. The overall impact of adding these essential benefits to the current benefit plans is approximately 4%. Plans that currently do not have prescription drug coverage are usually lean plans and the combined impact of adding all essential benefits increases these plans' premiums by as much as 25%.

Figure 2: Impact of Essential Benefits Requirement



Maximum Out of Pocket Limits

Starting in 2014, the maximum out-of-pocket (MOOP) amount cannot be greater than the HSA limit (currently $5,950 for individual policies and $11,900 for family policies, indexed annually). The percent of members in current plans that will be affected by this requirement is roughly 21%. The impact of this change has not been explicitly determined but is included in the Bronze Requirement impact (discussed below).

Bronze Requirement

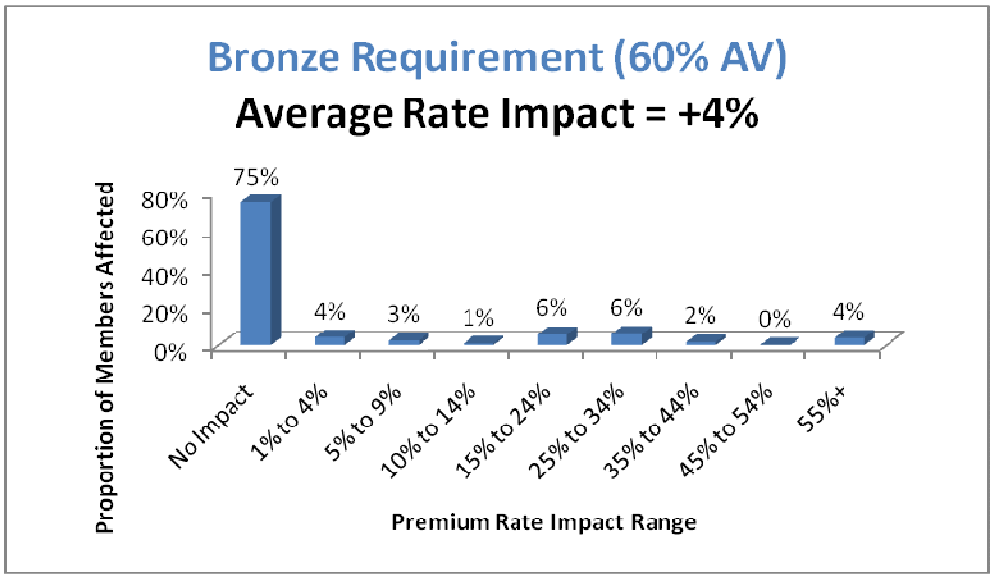
Beginning in 2014 there will be four primary levels of plan designs that may be offered, varying by their actuarial value. The four plans are: Bronze at 60% actuarial value (AV), Silver at 70%, Gold at 80% and Platinum at 90%. While not all of the specifics of this requirement have been finalized, all insurers participating in both the individual market and the exchange will be required to offer one plan at the Silver level and one at the Gold level. In addition, most states will mirror these requirements in the market outside of the exchange (assuming such a market is allowed by the state). Table 5 below shows the current distribution of plans and members by various AV levels. These AVs have been adjusted to include any essential benefits that may not currently be covered.

Table 6: Current Distribution of Benefit Levels

Current AV, Essential Benefit Adjusted	Member Distribution
AV < 0.40	4%
0.40 <= AV < 0.50	9%
0.50 <= AV < 0.60	12%
0.60 <= AV < 0.70	25%
0.70 <= AV < 0.80	25%
0.80 <= AV < 0.90	24%
AV >= 0.90	0%

Given that the individual market tends to offer leaner benefit plans than the group market, it is likely that most insurers will also offer the leanest benefit plan allowable, or the Bronze level, in addition to the required Silver and Gold plans. Because the actuarial value of a HDHP will likely be close to the Bronze AV level, we have assumed this is the minimum benefit plan members could purchase through the exchange. For our analysis it is assumed all benefit plans would at a minimum need to meet the 60% Bronze AV level. Figure 3 below shows the various impacts for members enrolled in plans that currently do not meet the Bronze requirement.

Figure 3: Impact of Bronze and MOOP Requirement



Medical Loss Ratio (MLR) Requirements

Effective January 1, 2011 insurers are required to maintain a minimum loss ratio of 80% (for the individual market) or the insurer must pay rebates back to the enrollees. While interim final regulations on the MLR requirements have been released, not all of the details for this requirement have been finalized and it is still unknown how health plans will ultimately categorize some of the traditional administrative expenses. It is expected that loss ratios under the ACA will be higher than traditional MLR calculations (incurred claims divided by earned premiums) given the allowable adjustments under the ACA.

The calculated MLR will also be subject to credibility adjustments. Credibility adjustments will be made to account for random statistical fluctuations that are inherent when an insurer has a smaller member base. Statistical fluctuations are also possible when an insurer has higher deductible plans since more of the insurers liability resides with catastrophic claims.

By 2014, for MLRs in plan years 2011 to 2013, the number of members in the calculation will be the sum of the average members in each of the previous three years. Credibility adjustments will apply to insurers that have over 1,000 but less than 75,000 members. If an insurer has less than 1,000 average members, the insurer is essentially exempt from any rebate payments. If the insurer has 75,000 or more average members, their experience is deemed to be fully credible and thus the calculated MLR will determine what, if any, rebate must be paid to their members. For plans that are partially credible (members over 1,000 but less than 75,000), an additive adjustment to their calculated MLR will be made based on the number of members. An additional adjustment may be made if the average deductible in

their block of business is $2500 or greater. These adjustments will increase their calculate loss ratio, lessening the likelihood that they will owe a rebate or if they do, decreasing the amount of rebate owed.

To assess the impact of the MLR requirement, loss ratios for the current book of business were reviewed. The incurred claims we received were not reported using the NAIC guidance for reporting medical costs in 2011. As a result, we expect that the loss ratios will increase for the disease management, quality and fraud and abuse expenses that will be allowed as medical costs. As a check of reasonability, the loss ratios provided were compared to the non-claim expense loads documented in the rate filings, if available.

2010 loss ratios were calculated by insurer, adjusting for estimated taxes. The change in premium was then calculated to determine what decrease in administrative expenses, if any, was needed to comply with the minimum 80% loss ratio. Since specific regulations are still pending and other factors may be allowed for additional non-claim expenses to be considered claim expenses, it is assumed that only half of the impact will be realized. For example, if an insurer has a current loss ratio of 72%, the insurer would need to decrease rates 10% (72% / 80% - 1) to achieve an 80% loss ratio, all else equal. However, we have assumed that other factors or changes in the loss ratio calculation will limit the amount of rate decrease an insurer needs to implement. Thus, we have assumed half of this impact, or a 5% premium decrease in this example, would be implemented by the insurer. Based on the data of the three insurers, the overall average impact is expected to be a 6% decrease in premiums. Note that while one insurer currently meets the requirement, the other two have 2010 loss ratios well below the requirement. Thus, there will be no impact for one insurer. Premiums for the other two insurers are estimated to decrease by approximately 8% and 22%. For the insurer with the lowest loss ratio, significant premium decreases appear to already be planned for the coming year.

Demographic Factors

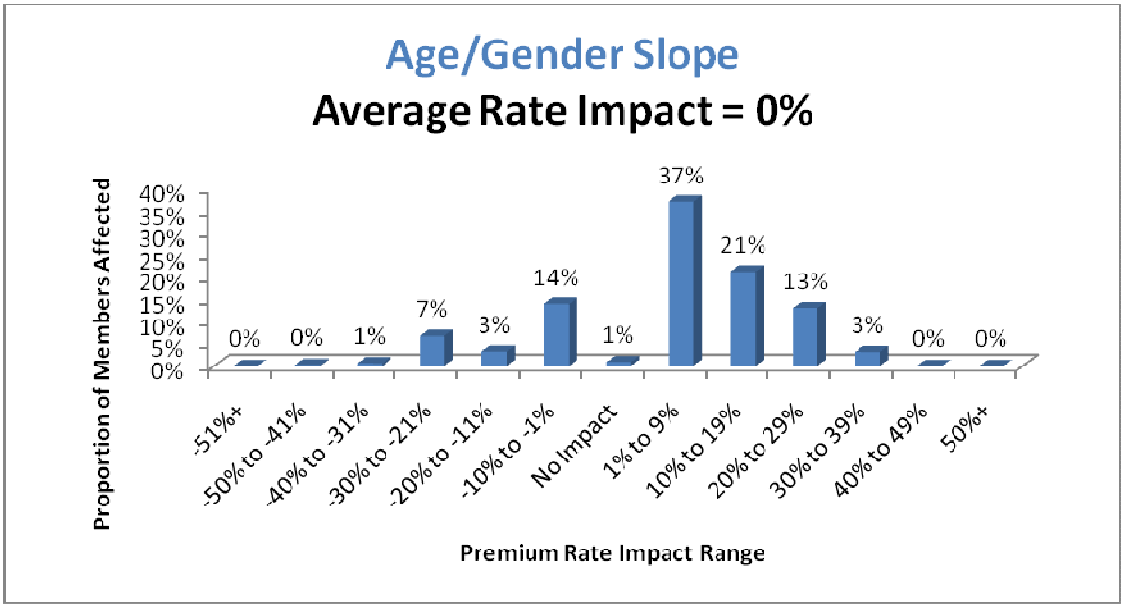
Two significant changes will be required in 2014 for any demographic adjustments to rates. Currently in Delaware, there is no limit to how much an insurer can charge an enrollee based on their age or gender. Under the ACA, rates can not differ based on gender and the maximum ratio of the highest to lowest adult rate is 3 to 1. While it is unknown what age factors the insurers will implement in 2014, and each insurer will likely develop their own factors that meet the requirement[6], an assumption was made for this analysis after reviewing current demographic factors and incorporating the new requirements.

Currently, individual insurers have adult rate ratios that vary from 2.7:1.0 and 7.4:1.0 (depending on insurer and gender). One insurer already has gender neutral rates (same for male and female) while the other two have rates that vary by male and female. The overall impact of the demographic changes is expected to be premium neutral; however, the member impact is significant. The largest premium increase due to demographic factor changes is a 35% increase while the largest decrease is 42%. The

[6] We expect that final regulations will allow states to prescribe specific factors, although doing so may limit innovation and discourage health plans from participating.

younger male enrollees will see large premium increases and the older male enrollees will see premium decreases. Furthermore, while strong variations exist by age, overall females should experience approximately a 1% decrease in premiums and males should experience approximately a 1% increase in premiums. The proportion of members impacted and the corresponding impact of the age/gender changes are in Figure 4 below.

Figure 4: Impact of Gender and Age Ratio Changes

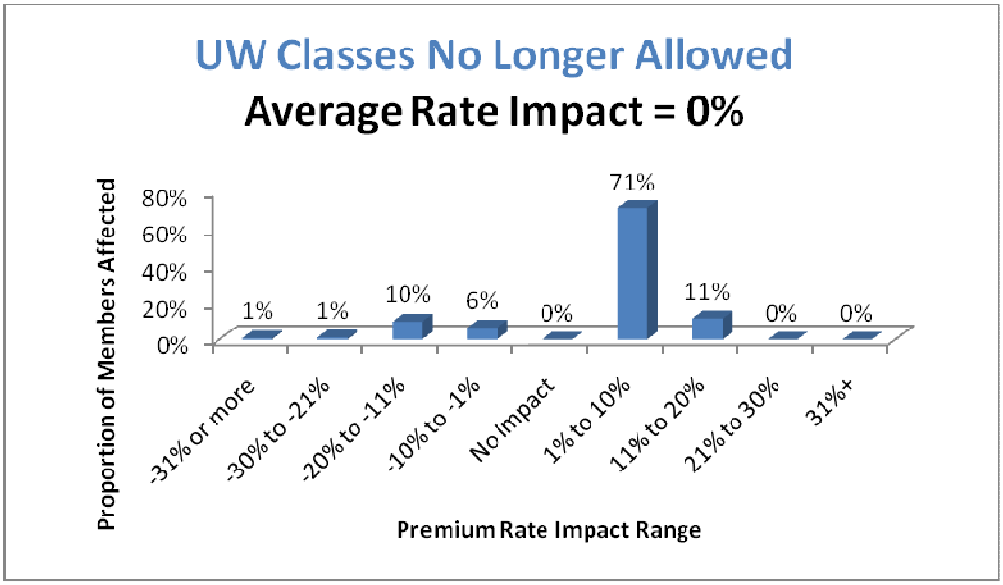


Underwriting Factors

Underwriting factors are designed to allow insurers to vary premiums such that they would be more in line with an individual's expected costs. This enables insurers to accept more applicants by accepting higher risk individuals at a higher premium level. Under ACA, underwriting factors or classes will no longer be allowed. This does not have an overall impact on rates since, similar to the demographic factors, it is a shifting of premiums between individuals. Under ACA, individuals currently enrolled with a substandard rate will experience a premium decrease, all else being equal, while individuals currently enrolled under a preferred or standard rate will experience a premium increase, all else being equal.

Current underwriting factors significantly impact the premiums offered to less healthy enrollees, as compared to the premiums for a similar enrollee with a better than average health risk. The underwriting factors applied to substandard policies (i.e., policies issued to members that likely have greater health care needs) issued in 2010 average around 42% above the standard rate. As stated, most enrollees currently receiving a substandard rate will see a significant premium decrease, while those with standard rates will see a premium increase. The premium impacts due to the removal of these underwriting factors are shown in Figure 5 below.

Figure 5: Rate Classes No Longer Allowed



Under the ACA, tobacco factors will be allowed with a maximum premium ratio of 1.5 to 1.0 (i.e., health insurers may charge tobacco users as much as 50% more than non-tobacco users for a given health plan). For this report, it is assumed that smokers are all currently receiving substandard rates and that Delaware will allow for tobacco rating in the future. Based on Medical Expenditure Panel Survey (MEPS) data, as well as other publicly available surveys on tobacco use prevalence, we assume the percent of adult tobacco users in the current individual market is around 5.5%. Given the percent of enrollees receiving a substandard rate is 27% of total individual members, this equates to 20% of the adult substandard rating pool (and 15% of the entire substandard rating pool) being tobacco users. Note that the tobacco rate for uninsured adults is estimated at approximately 29%.

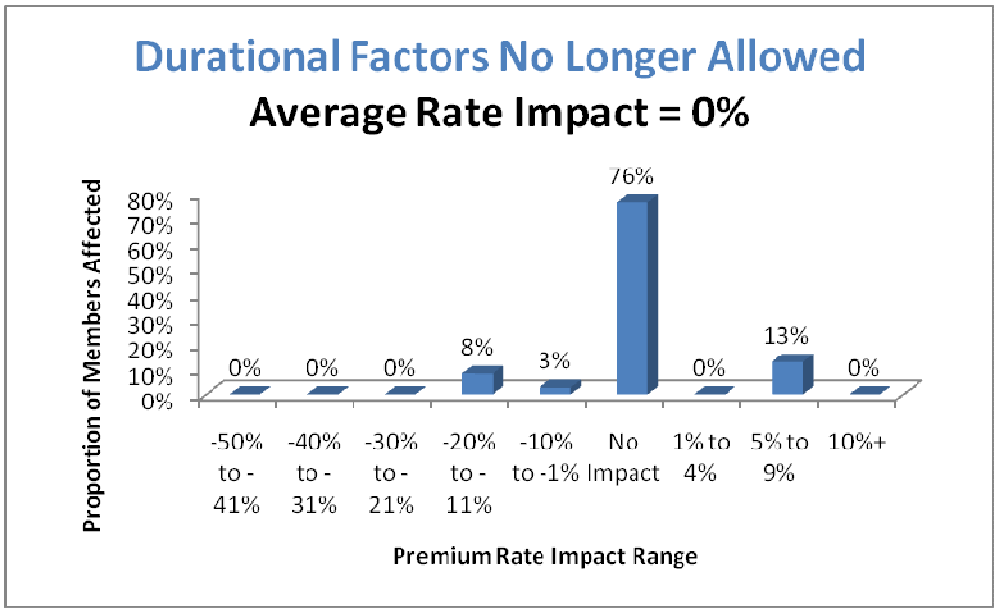
Since we do not know which members are tobacco users, we have not included the impact of the smoking factor in Figure 5 above. However, note that for the substandard members who are tobacco users, if the health plan applies the full 50% load under the ACA, these members could see premium increases of up to 22% instead of the decreases discussed above.

Durational Factors

Use of durational factors in the Delaware individual market varies by insurer. Durational factors capture the impact of underwriting decreasing or "wearing off" as an individual's enrollment span continues. The duration for the individual market is typically much lower than for people covered under group policies as people tend to drop coverage in the individual market due to cost or because they acquire group coverage through an employer.

Since durational factors will no longer be allowed, the more recent enrollees in the individual market will see their premiums increase slightly while those who have had policies for a longer period, and thus are also likely to have a higher health risk, will see premium decreases, often significantly. These premium impacts can be seen in Figure 6 below.

Figure 6: Impact from Durational Factors No Longer Allowed



These impacts are based on 2010 enrollees by duration. Only one insurer applied durational rate increases and this insurer ceased using this factor in April 2011. It appears any durational increases applied prior to this date will remain in effect. Thus, the number of members impacted by this change and the magnitude of the change will decrease over time.

Morbidity Changes

Insurers, under the current market rules, manage the risk that they carry by underwriting applicants. This allows an insurer to determine if they will accept the applicant and if so, what rate to charge. Insurers can also apply preexisting condition exclusions to potential enrollees; this option enables individuals to obtain health insurance with the exception of claims related to a declared pre-existing condition.

The ACA underwriting requirements are phasing in at two separate times. As of September 23, 2010, insurers may not impose preexisting condition exclusions nor deny coverage to individuals under age 19. On January 1, 2014, insurers will be required to accept every individual applying for coverage, and will not be allowed to vary premiums based on the applicant's health status.

In order to determine the impact of the incoming population that was previously uninsured, we analyzed a base set of data from Current Population Survey (CPS) for a benchmark state in the northeast and corresponding risk adjustment factors for a similar population. The CPS information provides

insight into self-reported health status. It was seen that the uninsured tend to categorize themselves as being in worse health than the population already in the individual market. The benchmark state data was used to quantify differences in health status.

Due to more limited rating restrictions and coverage of previously uninsured high risk individuals, it is expected that the overall premiums will need to be increased in order to cover the higher risk. To offset the increased costs of the higher risk individuals, each individual will be required to obtain minimum essential coverage or face a tax penalty.[7] This individual mandate to maintain health coverage will help mitigate increases to the overall risk level of the individual market (assuming the penalties are sufficient to influence individuals' behavior). For individuals below 400% of the Federal Poverty Level (FPL), subsidies will be available to cover a portion of the premium if premiums under the second lowest silver plan for that individual are greater than a particular threshold set as a function of income.

While a detailed migration analysis is needed to understand the anticipated movement of the entire insurance market, some high level assumptions were made to provide a general understanding of the potential impact of member migration into the individual market. Our high level assumptions include the following:

1. Migration will only come from those individuals who are uninsured, and there is no migration from the small or large group market.

2. The existing members in the individual and group markets will remain in their respective markets (that is, no migration from group to individual and no one will leave the individual market). Note that if there is migration from the current group market, these members are likely to be less healthy than those in the current individual market but healthier than the uninsured. Thus, migration from the group enrollment should dampen the impact of the increased costs associated with uninsured migration.

3. Nationally, subsidy eligible individuals, who constitute the majority of the uninsured, tend to have a higher risk profile than non-subsidy-eligible individuals. As a result, the more subsidy eligible individuals that migrate to the individual market, the more likely premiums will increase. For Delaware, these individuals actually reported differently from the national average. The Delaware subsidy-eligible individuals consistently reported a similar or more favorable health status than their non-subsidy eligible counterparts, regardless of insured status. See Table 7 for a comparison of self-reported health status for Delaware and nationally by income level. Note also that across all income levels and insured status, Delaware self-reports notably healthier status than the national average. Since the Delaware data varied notably from the national data, a blend of national and Delaware

[7] People may apply for an exemption from the individual mandate based on lack of affordable health insurance (i.e., premiums are more than 8.0% of a person's modified adjusted gross income), religious beliefs, or personal hardship.

data were used to develop morbidity factors for subsidy and non-subsidy eligible individuals in both the insured and uninsured markets.

Table 7: Self-Reported Health Status Comparison

Insured Status	Self-Reported Health Status	National		Delaware	
		Subsidy Eligible (FPL < 400%)	Non-Subsidy Eligible (FPL > 400%)	Subsidy Eligible (FPL < 400%)	Non-Subsidy Eligible (FPL > 400%)
Insured-Individual	Good, Very Good or Excellent	94%	96%	98%	95%
Insured-Individual	Fair or Poor	6%	4%	2%	5%
Uninsured	Good, Very Good or Excellent	88%	91%	95%	95%
Uninsured	Fair or Poor	12%	9%	5%	5%
Combined	Good, Very Good or Excellent	89%	93%	96%	95%
Combined	Fair or Poor	11%	7%	4%	5%

Ultimately, an aggregate 25% increase in rates is expected due to the influx of new individuals. However, this impact varies by year and based on the migration and morbidity assumptions used. The overall impact is expected to be 12% to 37% for all years, with the best estimate around 25% in 2016.

In 2014, migration to the individual market is expected to be less than the ultimate migration due to smaller penalties and the newness of the reform. In 2014, we expect that 10-25% of currently uninsured residents will enroll in the individual market. In 2016, this increases to an expected 20-35% of the currently uninsured. While fewer uninsured members are expected to migrate in 2014, those uninsured that do migrate are likely to be less healthy and have a higher morbidity than those who choose not to enroll. Thus, lower migration numbers are offset by higher morbidity factors. As a result, the overall morbidity impact, taking into account the number and health status of the new enrollees, is similar for all three years.

Tables 8 and 9 below show the expected impact of morbidity changes due to the new entrants into the individual market. Table 8 shows two scenarios assuming a lower migration assumption of 15%, which is more likely in the first year or two. The two scenarios use different morbidity factor assumptions since the actual health status of the new enrollees is essentially unknown. Table 9 also provides two different morbidity factor scenarios but assumes a higher uninsured migration of 35%, which is more likely in 2016. Note that the morbidity factors for the uninsured are lower in the high migration table. This is due to the assumption that the less healthy are more likely to enroll in the individual market in the initial years compared to their healthier counterparts who may be willing to pay the penalty rather than the cost of insurance.

Table 8: Morbidity Changes with Low Migration Assumption (15%)

			Low Morbidity Assumptions			High Morbidity Assumptions		
Current status	Subsidy-eligible	Estimated 2010 Average Members	Future Enroll Ind Market	Future Members	Morbidity Factor	Future Enroll Ind Market	Future Members	Morbidity Factor
Uninsured	Subsidy-eligible	89,091	15%	13,364	1.41	15%	13,364	1.75
Uninsured	Not subsidy-eligible	15,109	15%	2,266	1.43	15%	2,266	1.81
Individual	Subsidy-eligible	10,708	100%	10,708	0.99	100%	10,708	0.99
Individual	Not subsidy-eligible	5,823	100%	5,823	1.01	100%	5,823	1.01
Morbidity compared to current insured individual market					20%			37%

Table 9: Morbidity Changes with High Migration Assumption (35%)

			Low Morbidity Assumptions			High Morbidity Assumptions		
Current status	Subsidy-eligible	Estimated 2010 Average Members	Future Enroll Ind Market	Future Members	Morbidity Factor	Future Enroll Ind Market	Future Members	Morbidity Factor
Uninsured	Subsidy-eligible	89,091	35%	31,182	1.22	35%	31,182	1.51
Uninsured	Not subsidy-eligible	15,109	35%	5,288	1.23	35%	5,288	1.57
Individual	Subsidy-eligible	10,708	100%	10,708	0.99	100%	10,708	0.99
Individual	Not subsidy-eligible	5,823	100%	5,823	1.01	100%	5,823	1.01
Morbidity compared to current insured individual market					15%			36%

Pre-existing Condition Limitations

As noted above, Delaware underwriting rules allow carriers to exclude coverage for certain conditions that are pre-existing at the time a person applies for insurance (called pre-existing condition limitations). Delaware currently allows carriers to utilize lifetime exclusions for pre-existing conditions, but the ACA prohibits pre-existing condition limitations. Therefore, premiums for currently insured individuals will increase since costs for conditions subject to exclusion are not reflected in current individual premium rates.

Only one of the three insurers currently utilizes pre-existing condition exclusions. We estimate that in 2010 approximately 7% of Delaware individual applications were accepted subject to pre-existing condition limitations; while approximately 28% were denied coverage. Note that we separately estimated the impact to average morbidity of the ACA prohibition for denying coverage. Thus, estimates in this section only consider premium impacts with regard to pre-existing conditions. We reviewed continuance tables which show the distribution of costs by individual to estimate the impact to average costs of excluding pre-existing condition coverage. Costs for individuals in the 65th to 72nd percentile are more than twice those of individuals below the 65th percentile. Therefore, costs would increase by approximately 9% if the current risk pool only included those up to the 65th percentile, and individuals in the 65th to 72nd percentile were added to the risk pool. However, underwriting is an imperfect tool for many reasons, including the fact that individuals are not always truthful on applications, and because conditions are not always known when the application is submitted. Because of the removal of pre-existing condition limitations we estimate that premiums will increase by 1-7%

with a best estimate of 4%. This is half of the amount estimated if underwriting fully predicted cost distributions. Our estimate of the impact due to pre-existing condition limitations contains significant uncertainty, more than most other components in our overall estimate.

The Health Insurance Provider Fee

Beginning in 2014, health insurers will be required to pay annual fees. Total fees will be $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion 2017, and $14.3 billion in 2018, increasing annually thereafter by a premium growth rate. The fees will be allocated among insurers using a formula based on net premiums. According to Holtz-Eakin, the health insurance provider fee will result in an average increase to premiums of approximately 3%.[8] This estimate does not include any fee(s) that may be assessed by the exchange.

Reinsurance

The reinsurance program under the ACA is a temporary program that will operate from 2014 through 2016. The reinsurance program is intended to protect health plans operating in the individual market from specific high cost individuals. Unlike risk adjustment, states that establish a state based exchange must administer the reinsurance program. They cannot outsource this function to HHS. States that do not operate an exchange may still operate the reinsurance program or allow HHS to operate the program.

States can contract with or establish a reinsurance administrator subject to certain standards. The proposed rules include guidance that allows states to establish contracts with multiple reinsurance administrators, but requires their geographic coverage areas to be distinct. Subcontracting of some administrative functions by the reinsurance entity is allowed, subject to review to ensure the contracts are appropriate.

The ACA includes the following nationwide requirements for reinsurance contributions:

2014 = $10 billion

2015 = $6 billion

2016 = $4 billion

In addition, required national contributions to the U.S. Treasury to provide health reform funding are as follows:

2014 = $2 billion

2015 = $2 billion

2016 = $1 billion

[8] http://americanactionforum.org/sites/default/files/Case%20of%20the%20Premium%20Tax.pdf

Preliminary modeling suggests that the assessment on issuers will be approximately 1% of 2014 premium (or medical cost for self-insured) for the reinsurance-only portion of this assessment. This assumes that the assessment will be set based on a national calculation, which would increase by 20% in 2014 if the Treasury contribution is included.

The 2014 reinsurance assessment should decrease individual market premium rates in Delaware by approximately 14% to 21%, decreasing to a decrease of 4% to 5% by 2016. These ranges of estimates depend on a number of factors, including: strategic decisions the state makes in establishing its reinsurance program, the size of the individual market, and actual morbidity level in the individual market.

The following table shows preliminary impact estimates of the reinsurance assessment on individual market premiums in Delaware and the US. Relative to the national figures, Delaware's reinsurance proceeds would be greater due to a smaller proportion of individual business and lower uninsured rate, as compared to national averages.

Table 10: Estimates of Impact of Reinsurance to Premiums

Description	Higher Estimate of Individual Market			Lower Estimate of Individual Market		
	2014	2015	2016	2014	2015	2016
Net Assessment (Reinsurance Only - Not Treasury Contribution)	1.2%	0.6%	0.4%	1.2%	0.7%	0.4%
Net Impact to Individual Market Premiums (US)	-7.4%	-3.5%	-2.0%	-11.4%	-5.2%	-2.7%
Net Impact to Individual Market Premiums (Delaware)	-13.8%	-6.4%	-3.6%	-20.9%	-9.0%	-4.5%

2.5 Premium Credits and Cost Sharing Subsidies

The ACA provides for premium and cost-sharing subsidies for eligible individuals in the exchange who have incomes less than 400% FPL. For these individuals, premiums are limited to a sliding scale of 2% to 9.5% of the individual's income. Cost-sharing subsidies limit the members' cost-sharing and in effect increases the AV of the selected benefit plan without increasing the premium amount. These subsidies for low income individuals can be significant. This section describes the expected impact to both the premium and cost sharing from the individual's perspective. The analysis considers only individuals

earning above 133% FPL,[9] since individuals below this level will be eligible for Medicaid and will therefore not be eligible to receive premium or cost-sharing subsidies within the exchange.

Furthermore, if a State chooses to establish a Basic Health Plan (BHP), those with incomes under 200% FPL will be required to enroll in the BHP for their subsidies instead of accessing them through the exchange. Also, if the State chooses to implement a BHP, the relative risk and size of the BHP eligible population should be studied relative to the other individual consumers. To the extent that the BHP eligible population is healthier or less healthy than the other consumers in the individual market, there will be an adverse or positive selection on the individual exchange.

Premium Tax Credits

Premium tax credits will be available on a sliding scale based on the income level of the individual. Qualifying individuals at 133% of FPL will receive credits so that their premium costs are not above 3% of their income. Credits will reduce as income levels increase to the point that individuals at 400% of FPL are not paying more than 9.5% of their income for health insurance premiums. There are no premium tax credits available above 400% FPL. The following table show the limits outlined in the ACA.

Table 11: Premium Tax Credit Levels by Income Level

Income Level (% of FPL)	Max amt of income for premiums	Max Monthly Premium Contribution*	Max Annual Premium Contribution*
133%	3.0%	$ 41	$ 487
150%	4.0%	$ 54	$ 650
200%	6.3%	$ 114	$ 1,365
250%	8.1%	$ 182	$ 2,180
300%	9.5%	$ 257	$ 3,087
350%	9.5%	$ 300	$ 3,601
400%	9.5%	$ 343	$ 4,115
400%+	N/A	$ -	$ -

*as of Apr 2010 for 1 person

The premium tax credit amount will be based on the second lowest cost silver plan available to the individual in an exchange; although the individual is able to enroll in other than silver level plans and still receive the tax credit. Individuals enrolling in more expensive plans than the second lowest silver plan will have to pay additional premium amounts out of pocket.

[9] Legal residents who have not resided legally in the United States for five years will continue to be ineligible for Medicaid/CHIP, but may be eligible for subsidized coverage through the Exchange. As a result, those legal residents with income below 138% will also be eligible for coverage through the Exchange.

The expected impact of the premium tax credits, if all individuals enroll in silver plans, is expected to be an effective subsidy of 36% for premiums for the projected population to be enrolled in 2016. We modeled low and high scenarios, shifting the incoming uninsured as a percent of the total population enrolled. In the base scenario, we estimate that the incoming previously uninsured individuals will make up 63% of the total enrolled population. If this drops to 39% or increases to 69%, the effective subsidies still come in within 3% of the best estimate. We have not tested sensitivity to shifts in the mix of age or family/individual or income level beyond this. Should the actual population enrolling be significantly different than what was modeled, the impact may be significantly impacted. The following table shows the expected premium tax credits by income range. For each income range, we utilized CPS data to determine the current population mix by age. This was then used to determine the average premium tax credit for each age. The credit shown in the table is the average for the population in that income range. The credits assume that the individuals enroll in silver level plans. If they enroll in more expensive plans, the tax credit as a percent of premium will be reduced from what is shown here.

We also separate the population into those that are currently insured and those that are expected to become newly enrolled. There are more individuals in the higher income ranges in the current population, so their premium tax credit is expected to be lower than that of the incoming population as can be seen in the bottom row of Table 12.

The premium tax credits displayed in Table 12 should be considered as the best estimate average subsidies for an individual covering only themselves, with no covered dependents. For simplification in our projections, and due to not having enrollment figures broken out by income levels by age in the data received by the carriers, we are using CPS data to estimate the number of individuals in each age band by income level. The figures in Table 12 are calculated based on the weighted average expected premium across all ages compared to the maximum premium for the income range. For a given income level, younger people who are more likely to have lower premiums will be more likely to have a lower premium tax credit, if any. Conversely, older people having higher premiums will be more likely to have greater premium subsidies. We are reflecting only the subsidies for individuals with no dependents. The subsidies for families may be different from the values above.

Table 12: Effective Premium Tax Credit by Income Level

Income Range	Premium Subsidy	Current Population Distribution	Incoming Population Distribution	Ultimate Population Distribution
133-150%	83%	2%	15%	10%
151-200%	66%	11%	16%	14%
201-250%	44%	34%	21%	26%
251-300%	37%	5%	20%	14%
301-350%	13%	8%	10%	9%
351-399%	9%	6%	4%	4%
400%+	0%	35%	15%	22%
Total Population		16,531	28,655	45,186
Premium Subsidy – Weighted Average		27%	41%	36%

Cost Sharing Subsidies

Individuals who qualify for premium credits and are enrolled in a silver plan in the exchange will also be eligible for assistance in paying their cost sharing. Any plan in the exchange will already have a limit on the MOOP such that it cannot exceed the high deductible health plan limit ($5,950 in 2010). The cost sharing subsidies will further reduce these MOOP limits by two-thirds for individuals up to 200% of FPL, by one-half for individuals between 200% and 300% of FPL, and by one-third for individuals between 300% and 400% of FPL. Other cost sharing such as deductibles, coinsurance, and copays will be further subsidized, if necessary, to ensure that the health plan and subsidies cover the percentages of allowed health care expenses as shown in the following table. The individuals would be responsible for the remaining amount of allowed expenses reflected in the final column of the table below.

Table 13: Cost Sharing Subsidy by Income Level

Income Level (% of FPL)	% of Allowed Expenses Covered by Plan and Subsidy	% of Allowed Expenses Covered by Individual
133-150%	94%	6%
151-200%	87%	13%
201-250%	73%	27%
251-300%	70%	30%
301-350%	70%	30%
351-399%	70%	30%
400%+	70%	30%

The silver plan level contemplates an actuarial value of 70%, consistent with the covered expenses for 251% FPL and above. While many aspects of how the cost-sharing subsidies will be operationalized and how exactly members with incomes of 251-399% of FPL will be impacted are yet to be resolved by HHS, our assumption is that only individuals with incomes of 250% of FPL or less will receive the cost sharing subsidy[10]. The following table shows the subsidy as a percent of expected cost sharing for each income level. Given the expected population mix, the overall impact is expected to be a 19% reduction in the cost sharing burden on individuals. The currently insured population, due to a higher average income level, is expected to have a lower subsidy than the incoming population.

Table 14: Effective Cost Sharing Subsidy by Income Range

Income Range	Cost Sharing Subsidy	Current Population Distribution	Incoming Population Distribution	Ultimate Population Distribution
133-150%	80%	2%	15%	10%
151-200%	57%	11%	16%	14%
201-250%	10%	34%	21%	26%
251-300%	0%	5%	20%	14%
301-350%	0%	8%	10%	9%
351-399%	0%	6%	4%	4%
400%+	0%	35%	15%	22%
Total		16,531	28,655	45,186
Cost Sharing Subsidy		11%	23%	19%

Total Impact

When considering the money that an individual has to pay for health care, it can be divided into two key components. First is the premium that is paid monthly for the insurance policy. Second is the cost sharing (deductibles, coinsurance, copays) that is paid when and if services are received. The premium tax credit and cost sharing subsidies reduce both components. The following table demonstrates the overall subsidy expected when considering the combined impact of the premium tax credits and cost sharing subsidies. For the expected mix of individuals by income range, the total costs for health care would be reduced by 32% due to these subsidies. As seen in the separate components, the subsidy for the current population is expected to be lower than the subsidies for the incoming population due to the difference in income.

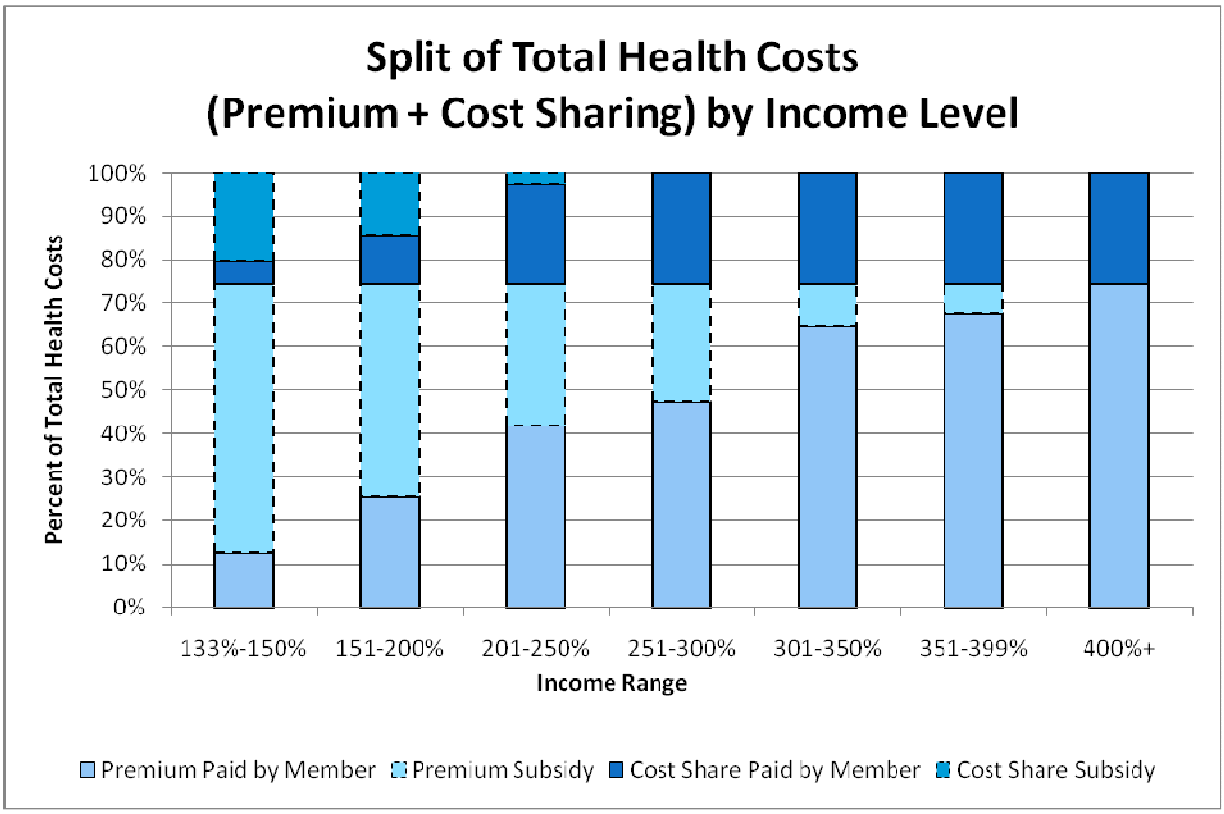
[10] Private Health Insurance Provisions in PPACA (P.L. 111-148), Congressional Research Service Report for Congress, Premium Credits and Cost-Sharing Subsidies section

Table 15: Total Subsidies Expected by Income Range

Income Range	Total Subsidy	Current Population Distribution	Incoming Population Distribution	Ultimate Population Distribution
133-150%	82%	2%	15%	10%
151-200%	64%	11%	16%	14%
201-250%	35%	34%	21%	26%
251-300%	27%	5%	20%	14%
301-350%	10%	8%	10%	9%
351-399%	7%	6%	4%	4%
400%+	0%	35%	15%	22%
Total		16,531	28,655	45,186
Total Subsidy		23%	36%	32%

The impact of the subsidies by income range can perhaps be seen most clearly in the following graph. It is expected that the premium will account for about 74% of the total health costs of a silver plan in the exchange, and cost sharing will account for the remaining 26%. The bottom two sections of each bar in the graph below represent the premium requirement while the top two sections of each bar represent the cost sharing expectation. The portion of each that is expected to be paid by the individual is the darker blue portion, outlined in a solid line. The subsidized portion is in lighter blue and is outlined in a dashed line. It can be seen that as the income range increases, the proportion of both premium and cost sharing that is subsidized decreases rapidly.

Figure 7: Split of Total Health Costs



To understand the potential overall change for individuals covered today, we developed an example considering only individuals currently covered in a comparable silver plan (i.e. with a 70% AV). When considering the change in premium, it only makes sense to look at the currently insured population in order to avoid introducing hypothetical current premiums for people not covered today. If the currently covered individuals are covered by a silver level plan that meets all post-ACA requirements, we would expect changes on the premium and cost sharing sides. As outlined in the previous section, the overall change in premiums is expected to be 32% from the perspective of the insurance company. This includes 4% increase due to changing the AV to meet the bronze level of 60%. For plans that have a current AV at a silver plan level, the total increase is then expected to be only 28%. This is also the increase that an individual today would expect to see if they were not eligible for any premium tax credits (see the results for the "400%+" row in the table below).

Due to the subsidies described above, there is a very different result by income range when looking at how the premium or cost sharing is expected to change from the current environment to the post-ACA environment. The lowest income individuals expected to be in the exchange (with income level of 133%-150% of FPL), if they were insured today and paying the average premium and cost sharing for a plan with a 70% AV, would actually expect to see a 79% decrease in premium after premium tax credits, and would pay about 82% less in cost sharing due to the cost sharing subsidies and the shift of costs for essential benefits and pre-existing conditions to the premium side. This equates to an overall decrease

of 80% in the total health care cost outlay for the individual. At the other extreme, individuals with incomes over 400% would not qualify for any subsidies and would see the full 28% increase in premium (on average). They would see a decrease of 12% in their cost sharing as claims they were paying out of pocket for essential benefits and pre-existing conditions are now covered in the premium. This would equate to about a 16% overall increase in total health care cost expenditures (premium plus member cost-sharing).

The underlying premium would be increasing by 28% on average, and be offset at lower income levels by the premium tax credit. Total change in premium paid by a member is expected to be a 7% decrease on average. Cost sharing would be decreasing due to the shift of essential benefits and pre-existing condition costs as well as the subsidy available to lower income individuals. The average change for the current population is a decrease of 22%. Together, these weigh to an 11% decrease in health care costs (premium plus cost sharing) for the individuals currently covered today. The following table shows the change to each component by income range.

Table 16: Change in Premium and Cost Sharing by Income Level (Population Currently Enrolled in a Silver Level Plan)

Income Range	Premium Change	Cost Sharing Change	Total Outlay Change
133-150%	-79%	-82%	-80%
151-200%	-56%	-62%	-58%
201-250%	-28%	-21%	-26%
251-300%	-19%	-12%	-17%
301-350%	11%	-12%	4%
351-399%	16%	-12%	8%
400%+	28%	-12%	16%
Wtd Total (Current)	-7%	-22%	-11%

When we are considering the cost sharing paid by individuals today, we also include the cost of the non-covered essential benefits and pre-existing conditions as those costs are fully borne by the individuals today.

It is important to note that the subsidy impacts described in this section are also average changes. As described in the prior section, there are also changes dependent on other underwriting factors today. It was beyond the scope of this project to develop the cost impacts at that level of detail and beyond what was possible based on the data that was provided.

2.6 Additional Requirements and Considerations

The previous sections (2.4 and 2.5) outlined our analyses with respect to requirements that had a quantifiable and significant impact on individual premiums. There are additional requirements and considerations that have already been implemented or may impact premiums and rating practices going forward and are worth noting.

SEPTEMBER 23, 2010 REQUIREMENTS

A few regulations that impacted premiums took effect September 23, 2010 (i.e., six months after enactment of the ACA). Identifying the impact of these requirements is not part of our analysis as the focus was on the impact of implementing all of the ACA requirements yet to be incorporated. We did, however, consider that the impact of these items may already be reflected in the data and filings received. The following September 2010 regulations likely had some marginal impact on premiums:

1. Preexisting condition exclusions for children under age 19 is no longer allowed.
2. 100% coverage for specified preventive benefits.
3. Lifetime benefit limits for essential health benefits is no longer allowed.
4. Annual limits on essential health benefits are restricted.

ADDITIONAL RATING RESTRICTIONS FOR THE INDIVIDUAL MARKET

Rating area – ACA requires that area rating will be determined by each state, contingent on review and approval by the Secretary of HHS. Since it appears that area factors are not currently utilized and since the state is small in size, this is not expected to affect current rating practices.

Family structure – The current proposed rules recommend a four tier rating structure. Since this will be consistent across the market, this is not expected to have a premium impact.

Grandfathered plans – These plans are exempt from many of the ACA requirements and thus will dilute the impact of the ACA requirements on the individual market. However, it is unknown how many plans will become grandfathered and how many enrollees will remain in grandfathered plans. Thus, the impact of these plans is difficult to project and was not considered in this analysis.

PENT UP DEMAND

There will be new enrollees in the individual market that were previously uninsured. Prior to enrolling in coverage, these people would have been paying out of pocket for any medical costs, and it can be assumed that they did not treat minor health problems and did not receive preventive care due to cost. Once they are covered in the Exchange, there may be an increase in utilization for this population as they will be more likely to afford to have minor issues treated or utilize preventive care visits.

Based on analysis of programs serving a similar population, it appears that the claims are higher in the first six to 12 months that an individual is newly insured. After this initial period, the claims experience

tends to revert to the average level for the market. Within the first year, claims for those newly insured may be 3-4% higher than average.

We have not factored in any increase in the premium to account for pent up demand. In the current block, insurers already are reflecting the impact of pent up demand to a degree as they already cover individuals that may be previously uninsured. The population of individuals that will be covered by the exchange is expected to consist of people coming from an insured environment (either through individual or group insurance), individuals from the high risk pool, and individuals that are currently uninsured.

3. ANALYSIS OF THE DELAWARE SMALL GROUP MARKET

3.1 Summary of Small Group Analysis

In summary, we expect the following changes in the small group market in 2014 as compared to 2010 as a result of ACA provisions:

- Compression of rates caused by the rating restrictions due the elimination of the underwriting factor.
- Overall increase of 2.7% to small group premiums due to ACA with a range of possible outcomes ranging from -3.8% to +12.2%. This range does not include the impact of the ACA requirements that have already gone into effect. The CBO estimates that the overall effect of the law on premiums for companies with fewer than 50 workers would range from an increase of 1% to a decrease of 2% in 2016, relative to current law. This is without the effects of the small business tax credit, which the CBO estimates would further reduce premiums by 8% to 11% for eligible firms.
- Insignificant impacts to the small group market size and product mix.

We have not included a full analysis of the impact of expanded self-insurance options on the small group market post ACA. Anecdotal information suggests that the number of small employers that are switching from fully insured to self-insured is increasing, and reinsurers are targeting this market for further expansion. This could, if left unchecked, destabilize a state's fully insured market.

3.2 Current Rating and Underwriting Rules in Delaware

The current rating and underwriting rules provide an important context for analyzing the premium impacts and selection issues under the ACA since underwriting and rating practices are at least partially designed to mitigate adverse selection. Current regulations in these areas are intended to provide particular consumer protections while allowing for health insurers to protect themselves against adverse selection. Regulations vary considerably by state. Delaware is generally more permissive than other states in terms of the practices they allow small group insurers to employ to mitigate adverse selection.

Delaware currently defines small employer groups as those with 50 or fewer employees for rating and risk pooling purposes. This definition includes one person groups, but the State allows higher underwriting factors for these groups. The State requires the guarantee issue of insurance to small employers, meaning that small employers cannot be turned down or cancelled because of the health conditions of their employees. However, insurers can require small employers to meet participation and contribution requirements. This means that insurers may require that a certain percentage of the employers within the group take coverage. They may also require that the employer pay a certain portion of the premium. If they do not, the small group coverage can be denied or terminated.

Insurers are required to set premiums based on adjusted community rating, and can vary premiums based on age, industry, geographic area, family composition, unhealthy lifestyle choices and group size. Specific rules regarding the adjusted community rating include:

- The index rate for any class of business shall not exceed the index rate for similar coverage for any other class of business by more than 20%.
- The premium rates for similar health benefit plans within a class of business shall not vary from the index rate by more than 35%.
- An additional variation of no more than 10% may be applied for gender and geography.
- Industry rate variations may not exceed 15%.
- The ratio of premium rate variation between high and low risk groups of 2 to 50 employees may not exceed a 5:1 ratio. A ratio of 6:1 is allowed for single employee groups. These ratios are currently set to decrease by 0.5 each year starting July 2012 until the respective ratios are 3:1 and 4:1.
- Group size variations may not exceed 20%.

3.3 Current Coverage and Costs in the Delaware Small Group Market

Data Received

The analysis was based on data provided by the insurers and the State. This information includes but is not limited to:

- Detailed benefit plan information for plans representing at least 70% of the insurer's small group book of business. The detailed information includes:
    - 2010 earned premiums, allowed and paid claims, and member months by benefit plan. The same data elements were also provided in aggregate for the balance of the remaining plans in the insurer's small group book of business.
    - High level cost sharing and covered services information for each benefit plan
- Detailed experience by group size for plans representing at least 50% of the insurer's small group book of business. The detailed information includes:
    - Underwriting experience, including group months, member months, employee months, earned premium and incurred claims by group size.

- Detailed experience for 51 – 100 size groups representing at least 25% of the group size 51 – 100 book of business. Detailed information includes:
    - Summary of member months, premium, claims and allowed cost experience by line of business (small group versus 51-100 size groups)

The following four insurers provided information for the analysis:

- Aetna Life Insurance Company
- Blue Cross Blue Shield of Delaware
- Coventry Health Care of Delaware
- United Healthcare

All information provided by the carriers was for fully insured business.

Overview of Current Small Group Market

The small group market is dominated by the Blue Cross Blue Shield of Delaware (BCBSDE). BCBSDE has approximately 2.5 times the membership of the next largest small group insurer.

The next two largest insurers are Coventry and Aetna.

Table 17: Carriers in the Delaware Small Group Market

Carrier	2010 MM	Approximate Members
Blue Cross Blue Shield Delaware	368,838	30,700
Coventry Healthcare of Delaware	146,709	12,200
Aetna Health Inc	40,985	3,400
United Healthcare	16,857	1,400

As compared to national statistics, the Delaware small group market has higher average premiums; and Delaware small employers are as likely to offer ESI. The higher premiums may be a result of any number of differences between the national market and the Delaware market, including richer benefits, higher provider reimbursement rates, an older and/or sicker workforce, or higher administrative costs.

Table 18: Delaware Small Group Market Compared to US

Description	United States	Delaware
Average Monthly Premium – 2010 [1]		
Single Coverage	$426	$487
Family Coverage	$1,117	$1,278
Percent of Private Sector Establishments that offer Health Insurance to Employees – 2010 [2]		
Firms with Fewer than 50 Employees	39.2%	41.0%
Firms with 50 Employees or More	96.4%	94.2%

[1] Source: AHIP Center for Policy and Research. Small Group Health Insurance in 2010: A Comprehensive Survey of Premiums, Product Choices, and Benefits, and statehealthfacts.org

[2] Source: Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2010 Medical Expenditure Panel Survey - Insurance Component. Table II.A.2.

When assessing the impact of ACA on the small group market, it is important to look at how the new law impacts various group sizes. Smaller group sizes behave more like individuals in that they have a wider variation of premiums, larger fluctuation of claims, and selection is a bigger factor. Larger group sizes, mainly because of the law of large numbers, tend to revert to the average of the market, with average age/gender factors and claims costs and therefore have less variation in costs. This variation in premium can be seen in the table below. The smaller group sizes have a wider variation in premium than the larger group sizes.

Table 19: National Premium Variation by Group Size – Small Group Market, 2010

	10th Percentile	Mean	90th Percentile	Ratio of 90th Percentile to 10th Percentile
10 or Fewer Employees	$184	$446	$803	4.4:1
11 - 25 employees	$185	$419	$721	3.9:1
26 - 50 employees	$188	$406	$676	3.6:1
All Small Groups	$181	$426	$720	4.2:1

Source: AHIP Center for Policy and Research. Small Group Health Insurance in 2010: A Comprehensive Survey of Premiums, Product Choices, and Benefits

http://www.ahipresearch.org/pdfs/SmallGroupReport2011.pdf

Along with this idea of keeping track of impacts by group size, it is also important to understand the difference between the distribution of group counts versus the distribution of members by group size.

Generally, the distribution of groups is not the same as the distribution of membership. Delaware is not an exception in this regard. The table below shows a national distribution of groups and members as well as the Delaware distribution of groups and members.

Table 20: 2010 Distribution of Groups and Distribution of Members

	National		Delaware	
	Distribution of Groups	Distribution of Members	Distribution of Groups	Distribution of Members
10 or Fewer Employees	73%	37%	82%	42%
11 - 25 Employees	19%	34%	13%	33%
26 - 50 Employees	8%	28%	5%	25%

The majority (82%) of the small groups have ten or fewer employees. However, these groups comprise only 42% of the small group market's membership. The average employer in the Delaware small group market covers 5.9 employees and has 11.2 members.

The percent of employers offering coverage also varies by group size. In general, the smaller the group size, the less likely employers are to offer coverage. The table below shows the percent of employers offering coverage by group size for both Delaware and the nation in total. The percent of Delaware employers offering coverage is higher than national levels for employer groups between 10 and 50 employees.

Table 21: Percent of Employers Offering Coverage, By Group Size

	National	Delaware
Less than 10 Employees	31.8%	30.5%
10 - 24 employees	60.9%	72.6%
25 - 99 employees	80.6%	89.0%
Less than 50 employees	39.2%	41.0%
50 or more employees	96.4%	94.2%

Of the employers that offer coverage, a smaller percentage of small employer groups chose to self-insure. The table below shows the percent of covered enrollees that are enrolled in self-insured plans. The percent of small group enrollees covered by self-insured plans in Delaware is consistent with the national level.

Table 22: Percent of Covered Enrollees in Self-Funded Plans

	National	Delaware
Less than 50 employees	12.5%	12.5%
50 or more employees	67.5%	74.6%

Loss Ratios and Actuarial Values of Benefit Plans in the Small Group Market

The loss ratios of three of the four small group insurers are consistent and range between 75% and 79%. One insurer has a loss ratio of 94%. The overall average loss ratio across all four insurers is 78%.

The actuarial value (AV) reflects the relative richness of the benefit and is calculated by dividing the claims cost by the allowed amounts under the benefit plan. An AV of 100% means the benefit plan provides 100% coverage with no cost sharing. The average AVs by carrier in Delaware are surprisingly varied, with one carrier having an average AV of 68% and another carrier having an average AV of 87%. Different AV levels can indicate differences between the carriers in the risk of the underlying populations. This difference in AVs by carrier is closely correlated with the average premium by carrier, as would be expected. The relationship for Carrier 2 in the table below is an exception. It has a lower AV but the highest revenue PMPM of all the carriers. This Carrier's 2010 membership would not be considered fully credible, which may explain the inconsistency in their AV versus revenue relationship.

Table 23: 2010 Distribution of Groups and Distribution of Members

Carrier	Average Actuarial Value	Average PMPM Revenue
1	68%	$339
2	70%	$426
3	80%	$385
4	87%	$388

Current Rating Practices

Per statute, carriers may vary rates by age, industry, geographic area, family composition, unhealthy lifestyle choices, health status and group size. We were able to review filings from three of the four carriers included in the analysis. All three appear to utilize age, family composition, health status and group size in the development of rates.

- **Geography**. Geography is an allowed case characteristic, but does not appear to be used in the rate filings we have reviewed.

- **Age/gender**. Age is an allowed case characteristic. Two of the filings have age ratios around 6:1 and the third filing has age ratios around 3:1. Gender is an allowed case characteristic, but the combined variation for gender and geography can be no more than 10%. The three filings that we reviewed did not vary rates by gender.

- **Group size.** Group size is an allowed case characteristic. The variation of group size rating is required to be no greater than 20%. Two of the filings have group size ranges of 20% and the third filing has a group size range of 15%. The experience shows that, in general, premiums decrease as group size increases. Note that the higher premium for smaller groups is consistent with national experience data, according to the previously mentioned AHIP study.

Table 24: 2010 Premiums by Group Size - Based on Data Provided by Carriers

Group Size	Earned Premium	Relativity to Average	Average # of Members/ Employee
1 Employee	$ 416	1.14	2.33
2 to 5 Employees	$ 428	1.17	1.83
6 to 10 Employees	$ 368	1.00	1.84
11 to 20 Employees	$ 363	0.99	1.82
21 to 30 Employees	$ 325	0.89	1.87
31 to 40 Employees	$ 318	0.87	1.88
41 to 50 Employees	$ 331	0.91	2.04
Total	$ 366	1.00	1.88

- **Industry**. Industry is an allowed risk factor but does not appear to be consistently used based on the three rate filings reviewed.

- **Smoking.** Delaware allows insurers to rate based on "unhealthy lifestyle choices." It is not specifically clear if tobacco use is among these characteristics. We assume that tobacco use falls under this category.

- **Underwriting factors.** Health status is an allowed case characteristic. The variation of health status rating is currently required to be no greater than 5:1 for group sizes of 2 to 50 employees and 6:1 for single employee groups, but must decrease by a factor of 0.50 annually starting July 1, 2012 until the ultimate ratios are 3:1 and 4:1, respectively. The health status factor ranges in the three filings we reviewed are between 1.3:1 and 2.3:1.

- **Benefit plan.** Various plan designs are currently available in the market. Table 8 below shows the distribution of small group membership by deductible and in-network plan coinsurance.

Table 25: Percent of Membership Enrolled in Plans

In-network Deductible	In-network Plan Coinsurance	% of Membership
$ 1,200	100%	37.7%
$ 0	100%	25.6%
$ 1,000	100%	8.2%
$ 500	100%	6.0%
$ 250	100%	5.2%
$ 1,500	100%	3.6%
$ 250	80%	2.7%
$ 0	90%	2.6%
$ 2,000	100%	1.7%
$ 2,000	80%	1.7%
$ 1,000	80%	1.1%
$ 500	80%	1.1%
$ 1,500	80%	0.8%
$ 750	80%	0.6%
Other	Other	1.5%

3.4 ACA Impact on Small Group Market Summary

In studying the impact that the ACA will have on the small group market, there are many factors to consider. In this section, we review provisions of the ACA both inside and outside the Small Business Options Program (SHOP) exchange and their impact on:

- Premium rates
- Product offering
- Market size

The small group market post ACA has many segments: the groups accessing insurance coverage through the SHOP exchange, those fully insured outside of the exchange and grandfathered, those fully insured outside of the exchange and not grandfathered, and those that choose to self-insure. The ACA impacts all fully insured non-grandfathered plans, has limited impact to grandfathered plans, but has little to no impact to the self-insured market.

Premium Impact

This section addresses the impact that the ACA will have on fully insured non-grandfathered plans.

Underwriting rules

The general guarantee issue requirements in the ACA (for children in 2010 and for all ages in 2014) are not expected to have significant effect on the small group market rates given the current guarantee issue requirements in Delaware's small employer insurance market.

The expansion of coverage to dependents to age 26 (implemented in the fall of 2010) was expected to have an overall increase to small group employer rates due to the additional members covered, but an overall decrease to the PMPM rates (as the average risk of the additional members is less than the small group market as a whole). The reviewed rate filings do not explicitly indicate the rate change due to the dependent age expansion, nor does the experience we received include the data necessary to evaluate the impact of this change. We expect the average PMPM premiums to have decreased between 0.5% and 1%.

New Plan Design Restrictions

Starting in 2010, the ACA incorporated the following benefit design restrictions:

1. Removal of lifetime limits and restricted annual maximums
2. 100% coverage of preventive care services
3. Coverage of emergency services
4. Choice of provider

Again, the rate filings and data do not explicitly indicate the rate change due to these changes. We expect the average PMPM premiums to have increased by 1-2% as a result of these changes.

Starting in 2014, the ACA has the following main provisions regarding plan design:

1. Prohibition on annual limits;
2. Essential health benefits requirements;
3. Minimum actuarial value requirements; and
4. Limits on member cost-sharing, including maximum annual deductibles of $2,000 (individual) and $4,000 (family).

Starting in 2014, all health plans sold through the exchange and in the individual and small group markets will be required to cover the essential health benefits. The ACA defines essential health benefits to "include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive

and wellness services and chronic disease management; and pediatric services, including oral and vision care."[11] .

In addition, health plans are required to offer coverage in one of four levels (platinum, gold, silver and bronze), based on the relative actuarial value (AV), which is a ratio of the expected paid amount to the expected allowed amount of costs in a plan. An AV of 100% would provide full coverage with no cost-sharing.

Table 26: Actuarial Value by ACA Plan Level

Plan Design Names	Actuarial Value
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

Regulations clarifying how these minimum values will be set by plan level have not yet been released. However, how or if these benefits are mandated outside of the exchange is not yet clear. The ACA requires that each health insurer *…that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package.* The scope of this requirement continues to be debated, and may imply that all fully insured non-grandfathered health plans both inside and outside of SHOP all need to comply with the benefit minimums as well as be equivalent to one of four specific plans as defined by the actuarial value. The Congressional Research Service has indicated that both the essential health benefits and standardized benefit packages will be required both inside and outside the exchange. [12]

The ACA limits cost-sharing in health plans by setting maximum deductibles and maximum out of pocket amounts. Deductibles for group coverage can be no more than $2,000 for a single policy or $4,000 for a family policy; and total out-of-pocket are limited to the amounts set each year by the Internal Revenue Service for high deductible health plans, which in CY 2011 are $5,950 for individual coverage and $11,900 for a family policy. The deductible limits do not apply to coverage purchased in the individual market.

Our analysis of the current small group plan designs offered in Delaware indicates:

- A majority of the small group membership is covered by plan designs that are likely to be compliant with the plan design requirements of the ACA.
- Approximately 2% of the membership is in plans that will require an increase in coverage of approximately 11% due to having benefit plans with actuarial values that are less than the

[11] Public Laws 111-148 & 111-152.
[12] "PPACA Requirements for Offering Health Insurance Inside Versus Outside an Exchange," Congressional Research Service, June 1, 2010.

minimum 60% required for the bronze plan. This will result in an overall 0.2% increase in the average premiums for the small group market.

- Less than 1% of the current membership is in benefit plans that are not compliant with the essential health benefits package. The vast majority of these non-compliant benefit plans have deductibles that exceed the $2,000/$4,000 limits. In addition, approximately 70% of the plans that are not compliant also have an actuarial value below 60% (addressed above) and will have to increase coverage anyway to meet the minimum threshold.
- Because the actuarial values for most plans are well above the 60% minimum, small employer insurers will likely transition employer groups that are not compliant with ACA benefit requirements to new plans that meet the benefit requirements but have similar costs, keeping rates similar to current rates. Therefore, we project no rate impact for groups that have plan designs that currently have AVs above the Bronze level, even if some of the benefits underlying these designs are not compliant.

New Rating Rules

Starting in 2014, the ACA introduces many new rating restrictions for non-grandfathered, fully insured health plans. The main rating rules to discuss include:

- Adjusted Community Rating
- Age and gender rating restrictions
- Elimination of underwriting factors
- Family composition requirements
- Rating area- state determined, reviewed and approved by the secretary
- Tobacco use (1.5:1)

These rating rules also apply to groups outside the exchange.

Overall, it is not expected that any one of these rating rules will have a significant impact on the average small group premiums as long as the same pool of groups remain in the small group market. However, depending on the characteristics of the group, some employers will see premium increases and some will see premium decreases.

The adjusted community rating rule requires that issuers must consider all enrollees of their small group plans part of a single risk pool, including enrollees in small group plans both inside and outside the exchange. The premiums for each group in the pool will be based on the average experience of the entire pool, adjusted for only the rating variation factors that the ACA permits.

The age and gender rating restrictions introduced by the ACA require that the highest adult rate be no more than three times the cost of the lowest adult rate and that gender cannot be used as a rating factor. Similar to the individual market analysis, groups with the youngest employees will see a rate increase and groups with the oldest employees will see rate decreases. However, the small group market rates will behave somewhat differently than the individual market in that group rates generally reflect the average rate of all employees. Therefore in order for an average group rate to change, the

majority of the employees of the group would have to be at either the very youngest or the very oldest ages. Due to the law of large numbers, the smallest groups would have the highest likelihood of being affected by a change in average premium due to a change in the age gender slope of the rates.

One of the major concerning impacts of the ACA for small groups is the elimination of underwriting factors. Currently, Delaware requires the variation of underwriting factors to be no greater than 5:1 for group sizes of 2 to 50 employees and 6:1 for single employee groups. This variation is currently set to drop to 3:1 and 4:1, over the next few years, but will be preempted by the ACA in 2014. Underwriting factors allow insurers to vary premiums consistently with the expected costs of the groups. All groups with underwriting factors different from the average will be required to be adjusted back to the average premium rate. Based on information provided by carriers in the Delaware small group market, the major carriers all have average underwriting factors by carrier of less than 1.0, with the average underwriting factor ranging from 0.79 to 0.94. The table below shows the impact of eliminating the underwriting factors. For example, 21.6% of the groups will receive a 30% to 40% increase in rates.

Table 27: Rate Change Distribution Due to Removal of Underwriting Factors

Rate Change	Groups	Members
-40% to -30%	0.3%	0.1%
-30% to -20%	27.4%	15.5%
-20% to -10%	7.1%	9.2%
-10% to 0%	5.9%	6.1%
0% to 10%	12.7%	16.7%
10% to 20%	18.6%	31.4%
20% to 30%	6.4%	3.7%
30% to 40%	21.6%	17.4%

The above distribution is further split into group size in the table below.

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Table 28: Rate Change by Group Size due to Elimination of Underwriting Factor

	Percentages Based on Group Counts								
	-40% to -30%	-30% to -20%	-20% to -10%	-10% to 0%	0% to 10%	10% to 20%	20% to 30%	30% to 40%	Total
1 employee	0.2%	10.1%	0.9%	1.2%	2.0%	3.5%	0.6%	9.8%	28.2%
2 to 5 employees	0.2%	13.5%	2.6%	2.5%	4.5%	5.1%	3.2%	6.9%	38.4%
6 to 10 employees	0.0%	2.9%	1.0%	1.3%	2.7%	3.3%	2.0%	2.2%	15.3%
11 to 20 employees	0.0%	0.8%	0.9%	0.7%	2.1%	4.2%	0.5%	1.8%	10.9%
21 to 30 employees	0.0%	0.1%	1.0%	0.2%	0.9%	1.3%	0.1%	0.7%	4.3%
31 to 40 employees	0.0%	0.0%	0.7%	0.1%	0.4%	0.9%	0.0%	0.1%	2.2%
41 to 50 employees	0.0%	0.0%	0.1%	0.0%	0.2%	0.3%	0.0%	0.1%	0.7%
Total	0.3%	27.4%	7.1%	5.9%	12.7%	18.6%	6.4%	21.6%	100.0%

As discussed above, Table 29 also shows that 21.6% of the groups will receive a 30% to 40% increase in rates, and almost half of these groups – or 9.8% out of 21.6% - are one employee life groups. In general, the smaller group sizes will see greater changes in premium (both up and down) due to the elimination of underwriting factors.

Rating by family composition (employee only, employee plus spouse, employee plus children, employee plus family) under the ACA appears to be consistent with current rating practices. However, the proposed rules are requesting comment as to what restrictions should be established around the tier structuring. Based on the guidance to date, we do not believe that the tier structuring rules will impact rates.

The ACA allows for rating by geography, as do state regulations. Based on the filings reviewed it does not appear to be used by Delaware insurers when setting rates. This rating restriction will have no impact on small group premiums.

Another rating factor that the ACA allows is tobacco use. Rates for consumers can be increased up to 50% if the consumer uses tobacco. Currently, Delaware allows insurers to rate based on "unhealthy lifestyle choices." It is not clear if tobacco use is among these characteristics, but it's not unreasonable to assume that tobacco use would fall under this category. Assuming tobacco use is currently allowed under Delaware regulations and is being utilized by issuers, this rating restriction will have no impact on

the small group premiums. However, if issuers begin to use a tobacco rating factor in a manner different that their current rating process, it could affect small group premiums.

The ACA no longer allows rating by class, industry factor, or other factors such as the number of selected health plans by group. Based on the filings we reviewed, we do not believe that these rating factors are in wide-spread use in Delaware, and therefore believe the elimination of these rating factors will have minimal impact on the small group rates.

New MLR requirements

The new medical loss ratio requirement, effective in 2011, requires that small group carriers maintain a loss ratio of at least 80%. Any carrier with loss ratios below 80% are required to rebate the difference in premiums back to the members.

As part of this analysis, we were provided incurred claims and earned premiums for 2010 small group lines of business for 2010. Only one of the four carriers currently has small group loss ratios above the 80% minimum requirement. However, the incurred claims we received were not reported using the NAIC guidance for reporting medical costs in 2011, so we do expect that the loss ratios will increase for the disease management, quality and fraud and abuse expenses that will be allowed to be included with the medical costs. Similar to the individual market analysis, we are expecting approximately half of the shortfall in loss ratios will be attained through changes in how costs are reported, and the remaining amount will be attained by lowering premiums. We expect that the minimum loss ratio to decrease premiums by approximately 2.5%. This estimate in Delaware is consistent with the national CBO estimates that indicated reduction in administrative costs would reduce premiums between 1% and 4%.

The Health Insurance Provider Fee

Beginning in 2014, health insurers will be required to pay annual fees. Total fees will be $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion 2017, and $14.3 billion in 2018, increasing annually thereafter by a premium growth rate. The fees will be allocated among insurers using a formula based on net premiums. According to Holtz-Eakin, the health insurance provider fee will result in an average increase to premiums of approximately 3%.[13] This estimate does not include any fee(s) that may be assessed by the SHOP exchange.

Tax Credits

From 2010 through 2013, until the SHOP exchanges are set up, businesses with 10 or fewer full-time-equivalent employees earning less than $25,000 a year on average will be eligible for a tax credit of 35% of health insurance costs. (Companies with between 11 and 25 workers and an average wage of up to $50,000 are eligible for partial credits.)

[13] http://americanactionforum.org/sites/default/files/Case%20of%20the%20Premium%20Tax.pdf

The tax credit will remain in place, increasing to 50% of costs, for the first two years a company buys insurance through its state's SHOP. The Congressional Budget Office predicts that the tax credit will affect about 12% of individuals covered via the small-group insurance market, lowering their cost of insurance by between 8% and 11%. We anticipate tax credits will offset approximately 1% of the total premium paid by small group employers. It's important to note, however, that small employers can only claim the credit for 2010 through 2013 and for two additional years beginning in 2014, which limits the long term effect of the employer tax credit[14]

Other Items Impacting the Overall Morbidity of the Risk Pool

While the specific rating provisions described above will have varying impacts to existing groups based on the demographic characteristics and existing benefit coverage of each group, considerable thought and time needs to be spent on understanding the entrants and exits of various employer groups to the market.

According to 2010 Medical Expenditure Panel Survey (MEPS) data, approximately 40% of Delaware small employers offered employer-sponsored insurance (ESI). Of those employees that are offered ESI by small employers, only 57% enroll in coverage.[15] Key questions remain around whether small employers will be more or less likely to purchase insurance in 2014, whether employees will be more or less likely to sign up for coverage, and the relative health risk of the currently uninsured consumers relative to the existing small group market.

One of the main exchange issues states are wrestling with is the mitigation of selection inside the fully insured pool and how to structure the SHOP exchange so that it does not get adversely selected against and attracts a broad cross-section of healthy and sick individuals. CCIIO, in their guidance to states on exchanges, state "Successful Exchanges will avoid adverse selection by ensuring that those who buy through the Exchange are a broad mix of the healthy and the less healthy. The tax credits, which can only be accessed through the Exchanges, and insurance reforms required by the Affordable Care Act will reduce the potential for adverse selection against the Exchange, but will not eliminate it. States have flexibility to provide consistent regulation inside and outside the Exchange, and to take additional action to prevent adverse selection under section 1311(e)(1)(B). The federal government will work with States to maximize State flexibility in this area." [16]

Adverse selection in the context of the exchanges generally refers to individuals' propensity, acting as direct purchasers, to make decisions that benefit themselves, to the detriment of the insurance market in general or to a specific insurance issuer. Adverse selection occurs when healthy people decide not to purchase insurance, or purchase the minimum coverage necessary or when sick individuals only purchase insurance when they know they will need it, or when sick individuals purchase policies that cover the maximum amount of their expected costs. Carriers can influence the selection process by

[14] http://www.irs.gov/newsroom/article/0,,id=245334,00.html
[15] http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2010/tiia2.pdf
[16] http://www.hhs.gov/ociio/regulations/guidance_to_states_on_exchanges.html

offering only certain products or marketing to a select group of individuals. These actions can quickly multiply when they are happening simultaneously, creating a marketplace with escalating costs and decreasing participation. Avoiding and mitigating adverse selection is essential to the success of the exchange and the broader small group market, in order to keep coverage affordable for consumers, particularly those without access to subsidies.

While the various ACA provisions protect the exchange, QHPs and issuers against adverse selection, there are a few provisions that increase the potential for adverse selection in the small group market.

- No health status based rating or underwriting allowed.
- Age rating allowed at a ratio of three to one and gender rating is not allowed.
- Availability of plans outside the exchange, through grandfathered plans, self-insured options and potentially other innovations of the market

On the other side of the selection issue, certain ACA and state provisions could attract a cross-section of risks into the small group market.

- Single small group risk pool
- Individual mandate
- Penalties for employer groups

Some provisions of the ACA are unclear regarding whether they mitigate or create adverse selection issues.

- Employer tax credits.
- Subsidies for individuals.
- Risk adjustment.

Each of these provisions is examined further in the following sections.

Health Status and Age Rating

Underwriting and unlimited age gender rating (items 1 and 2) in the current market both allow insurance issuers to closely match the premiums of the health plans to the expected medical costs. When these provisions are removed, the youngest and healthiest employer groups will receive increased premiums for the same benefits, while the oldest and sickest employer groups will receive decreased premiums for the same benefits. This creates incentive for the young and healthy groups to find other sources of insurance or drop coverage altogether if premiums become cost-prohibitive. Table 29 below illustrates three scenarios of how the removal of the lowest risk score groups will increase the overall rates of the small group pool.

Table 29: Scenarios on Removal of Lowest Risk Score Groups

			Scenario 1 - 1/2 of healthiest members leave			Scenario 2 - All healthiest members leave			Scenario 3 – Worst Case		
Rate Change	Percent of Members	Average Under-writing Factor	Membership Leaving Market	Remaining Distribution	Average Under-writing Factor	Membership Leaving Market	Remaining Distribution	Average Under-writing Factor	Membership Leaving Market	Remaining Distribution	Average Under-writing Factor
-40% to -30%	0%	1.62	0%	0%	1.62	0%	0%	1.62	0%	0%	1.62
-30% to -20%	15%	1.39	0%	17%	1.39	0%	20%	1.39	0%	28%	1.39
-20% to -10%	9%	1.21	0%	10%	1.21	0%	12%	1.21	0%	17%	1.21
-10 to 0%	6%	1.09	0%	7%	1.09	0%	8%	1.09	0%	11%	1.09
0% to 10%	17%	0.99	0%	19%	0.99	0%	21%	0.99	-8%	15%	0.99
10% to 20%	31%	0.88	0%	35%	0.88	0%	40%	0.88	-16%	29%	0.88
20% to 30%	4%	0.85	-2%	2%	0.85	-4%	0%	0.85	-4%	0%	0.85
30% to 40%	17%	0.77	-9%	10%	0.77	-17%	0%	0.77	-17%	0%	0.77
	100%	1.00		100%	1.03		100%	1.06		100%	1.12
Increase in overall morbidity					3%			6%			12%

The scenarios are as follows:

- Scenario 1: Half of the groups who would see a 20% to 40% increase due to the removal of the underwriting factor would leave the market. All other groups stay.
- Scenario 2: All of the groups who get a 20% to 40% increase due to the removal of the underwriting factor leave the market. All other groups stay.
- Scenario 3: All groups who get a 20% to 40% increase due to the removal of the underwriting factor leave the market and half of the groups getting a 0% to 20% increase leave the market. All other groups stay.

The range of these scenarios is a 3% to 12% increase in the average premium of the small group market due to morbidity.

Our research of states that have moved to adjusted or modified community rating (where they have eliminated the flexibility of an underwriting factor) shows mixed results. An AHIP study of small group rates across multiple states shows that states that do not allow rates to vary by health status generally have higher average rates. [17] However, detailed studies on the state experience in Pennsylvania, Connecticut, and New York indicate that groups have not significantly selected out of the market due to

[17] http://www.ahipresearch.org/pdfs/smallgroupsurvey.pdf

the removal of the underwriting factor from the allowed rating methodologies.[18] A similar study in Colorado indicates that the removal of the underwriting factor resulted in less availability of carriers in the market, and decline in small employer coverage, but not spiraling increases in the rates.[19]

Estimating the impact of healthy small groups leaving the small group risk pool requires understanding where the groups would go for alternate coverage and potentially better rates. Options include staying in a grandfathered plan, entering the self-insured market, moving all the workers to the individual market by simply removing coverage, or potentially other non-regulated fully insured options like associations or Professional Employer Organizations (PEOs).

Availability of Plans Inside and Outside the Exchange

Health Plans outside the exchange may be grandfathered meaning that they are allowed to remain in place as long as they meet requirements for maintaining their pre-reform benefit levels, copays, contribution levels, and covered services. In addition, in order to maintain grandfathered status, employer groups must stay with the same plan design they were enrolled in as of March 23, 2010. Grandfathered plans are not subject to many ACA rules such as adjusted community rating, essential benefits and age gender restrictions. Grandfathered plans will not be available within the exchange, and may drive a different balance of risk between the population covered inside and outside the small group pool. The ACA does not require that grandfathered plans be included in the same pool as non-grandfathered fully insured plans sold in the small group market. The Blue Cross Blue Shield Association released projections that the majority of small employer group plans (size 3-99) will lose their grandfathered status by 2013[20]; however, we do not have any specific Delaware information on this statistic.

Self-funding options are attractive to healthy groups, but have generally not been accessed by the small group market historically. Only approximately 12.5% of employees in Delaware small groups with 50 or fewer employees are covered by a self-funded plan versus 74.6% above that level. [21] The self-insurance market in the small group space will grow as self-insured plans become available, but we do not expect the additional take-up rate to be significant for groups under 50 employees in Delaware.

Promoting Cross Section of Risks

The provisions below encourage a cross-section of risks in the small group market.

- Single small group risk pool
- Individual mandate
- Penalties for employer groups

[18] http://www.jstor.org/stable/3083333

[19] http://www.dora.state.co.us/insurance/rtfo/2011/rtfoSmallGroupMarket2010Report050211.pdf

[20] http://www.bcbsm.com/healthreform/reform-alerts/ra_06_15_2010.shtml

[21] http://www.meps.ahrq.gov/mepsweb

Although grandfathering and self-funding options will prevent some of the healthier groups from joining the small group risk pool, the ACA requires that all fully insured small group business sold either inside and outside of the exchange be included in the same risk pool and also the same risk adjustment calculation which will keep both rates inside and outside the SHOP on an even par. . Furthermore, any QHP that is offered in the exchange must agree to charge the same premium outside the exchange.[22] However, the ACA does not prevent carriers from offering plans only outside the SHOP.

The individual mandate and employer group penalties encourage groups with healthier employees to obtain small employer insurance. The participation of healthier employees in the market will help offset the increase in premiums, and will encourage participation by other healthy groups, preventing the situation where only groups with high cost members are purchasing insurance in the small group market and drive up costs. We note that the penalties for employer groups do not apply to employees with under 50 employees, and so will only impact the small group market once the small group definition is changed to include groups with up to 100 employees.

The estimated amounts of increased membership in the small group market resulting from these provisions vary. See the Market Size Impact section which shows the estimates of newly offered ESI.

Individual Premium Subsidies and Tax Credits of Offering ESI Coverage

The ACA provides for premium subsidies for lower income individuals, which subsidize the cost of health coverage. As the subsidies are only available within the individual exchange and not through employer sponsored insurance, there is a consistent expectation across the research that the ESI market will lose the lower income workers (and their families) to the individual exchange.[23] It is less clear, however, whether these workers are higher or lower risk than the average ESI enrollment. To the extent that those needing subsidies are also higher than average risk, individual exchange adverse selection may occur and the ESI market will benefit. Because the low income individuals are generally younger, we believe it is more likely that those leaving the ESI market will actually be better than the average risk, leaving worse risk members in the small group ESI market. A research paper for Maine quantified the impact of the removal of the workers eligible for subsidies would increase the premiums in the small group ESI market by 6% to 7%.[24] Whether this will be the case in Delaware is not yet clear and warrants follow-up analysis.

[22] Footnote: www.ahcahp.org/LinkClick.aspx?fileticket=Ow82Z107-Ns%3D... PPACA Requirements for Offering Health Insurance Inside Versus Outside an Exchange, Congressional Research Service

[23] Avalere: The Affordable Care Act's Impact on Employer Sponsored Insurance: A Look at the Microsimulation Models and Other Analyses

[24] http://www.maine.gov/pfr/insurance/reports/pdf/Impact_ACA.pdf

Tax advantages of offering coverage, penalties for employers with over 50 employees, the individual mandate, and removal of employer contribution requirements will mitigate the impact of the low income members leaving the ESI market and may encourage some employers who previously did not offer insurance to start offering ESI. Rand, through their micro simulation models, projects that the ACA will result in increased employer offer rates from

- 57% under the status quo to 80% for firms with 50 or fewer workers
- 90% to 98% for firms with 51-100 workers
- 93% to 98% for firms with more than 100 workers.

Already some insurers are seeing increased small employer enrollments, potentially due to the available tax subsidies.[25] This doesn't necessarily indicate that all employers in this group who were previously not providing coverage who join the small group market will be a good cross-section of risk, but from a small group perspective, increased numbers of employers joining the small group market likely increases the cross-section of risk in the pool.

Risk Adjustment

The risk adjustment mechanism is intended to help mitigate adverse selection by encouraging issuers to:

1. set premium rates based on average morbidity of the pool
2. offer benefit plans that attract higher risk, such as higher AV plans or more expanded networks

Based on the risk adjustment mechanism, revenue for a carrier will either be reduced or supplemented based on whether the risk for a carrier is lower or higher than average. The risk adjustment mechanism may help mitigate adverse selection by encouraging carriers to offer higher benefit plans or more expanded networks, as additional revenue can be expected from the risk adjustment mechanism if higher than average risk membership enrolls. The additional revenues should curb the typical carrier's incentives to cherry pick the healthiest of employer groups when using adjusted community rating. However, many questions still remain regarding risk adjustment and until clarifying regulations are announced, the carrier response is difficult to predict.

Product Offering Impact

The main ACA provisions affecting the products offered, including the services and the cost-sharing provisions are:

1. Essential Health Benefits
2. Required Actuarial Values

[25] http://www.kff.org/insurance/090210nr.cfm

In addition to covering the essential benefits, cost-sharing must be limited or conversely a minimum level of coverage must be provided on the essential benefits. This level of coverage is defined by the four levels of actuarial values and has various restrictions on out-of-pocket spending and deductibles.

As insurers seek to differentiate themselves in the newly reformed market, one potential result is a change to the mix of PPO, HMO/POS, HSA/HDHP or indemnity offerings. In New York, when the small group rating moved to community rating, one of the changes in the market was that more HMO/POS products emerged.[26]

An almost certain outcome of the ACA is that the small group market will result in greater homogeneity of the products offered from an AV standpoint.

Market Size Impact

Although our analysis does not contain an econometric model, we wanted to add a few comments regarding market size. In response to various ACA provisions and rating changes, insurers will make decisions to stay or leave the small group market. Generally, we do not see an exit of any major insurers from the market, and have some reason to believe that there may be some new entrants into the Delaware market. The following provisions of the ACA and the forthcoming regulations will impact how the market evolves.

1. Regional plans and regional definitions. It is not yet clear if QHPs will be able to operate in only specific regions (defined as a limited area within a state). However, we do not expect the regional definitions or restrictions to have any significant impact on the Delaware market given the small geographical size.
2. Rules in exchange /outside of exchange. Depending on how Delaware restricts benefit plans and rating outside of the exchange, whether small group and individual is pooled, and how soon groups up to size 100 are included in the exchange, some carriers might opt to only offer small group products outside of the exchange.
3. New types of health plans. With the possible introduction of co-ops, multi-state plans and health choice compacts, some opportunity exists for new insurers to enter the Delaware market.
4. Tax credit. The tax credit may cause small group employers to begin offering employer sponsored coverage, which has the potential to increase the overall size of the small group ESI market.

Avalere has done a comparison of various micro-simulation models that project impacts on the employer sponsored market. Below is a table showing their summary.

[26] http://www.jstor.org/stable/3083333

Table 1: Estimated Shifts in ESI

	CBO	Lewin Group	Urban Institute	RAND
Change in ESI	**-3 million**	**-3 million**	**-.5 million**	**+13.6 million**[29]
Newly Offer ESI	**6 – 7 million** Drivers - Increased demand from individual mandate	**14.4 million** Drivers: - Avoid penalty - Lower premiums because of elimination of health status rating or new small employer credit	Drivers: - Increased participation due to individual mandate - Premiums decline for small firms (<100) - Offer rates increase most for small firms; smallest firms (<10) have biggest increase in offer rates because of premium tax credit and savings available through small business exchanges	Drivers: - Increased demand from individual mandate and lower cost options through exchanges for small businesses - ESI offer rates increase for small firms (<50) The majority of this increase is driven by firms with ten or fewer employees
Drop ESI	**-8 to -9 million** Drivers - Lower-wage workers and small businesses may drop coverage due to subsidies	**- 17 million** Drivers: - Employers will drop coverage primarily if many employees are subsidy or Medicaid eligible - 8.6 M receive subsidy - 3.7 M enroll in Medicaid - 3.9 million move to individual exchange w/o subsidy - 1.0 million will go uninsured		Drivers: - 13% of firms drop ESI because employees are eligible for Medicaid and subsidized coverage in the individual exchanges. - 93 percent of firms that drop coverage have <10 workers; less than 3 percent of people are affected - Increased offerings among small businesses

Source: Avalere: The Affordable Care Act's Impact on Employer Sponsored Insurance: A Look at the Micro simulation Models and Other Analyses

While these models are not specific to the small group market, we believe there are some take-aways that are consistent across the models and applicable to the small group market:

1. The employer sponsored market will stay relatively stable, and
2. The main loss of coverage from employer groups are where the workers are eligible for the subsidies in the exchange and the employer does not offer affordable coverage.

Forthcoming Regulations

We are hopeful that many items that impact small group in the statute will become clearer with forthcoming regulations. Of particular interest are:

- Requirements of actuarial value determinations and de minimus rules
- Essential health benefits determinations.
- Geographic rating requirements.

- How consumer choice in an employer sponsored coverage decision in the exchange will be allowed or restricted.

Expanding Small Group Definition of 50 to 100

Effective for all plan years starting January 1, 2016 or after, the ACA requires the small group definition to be inclusive of all groups with up to 100 employees. However it allows the restriction of the small group definition to 50 employees for all plan years starting prior to that date. Note that this means that during 2016, there will be some groups of size 51-100 employees that will be considered large group and some that will be considered small group, determined by the starting date of their plan year. Starting in 2017, all groups up to size 100 will be considered small group.

The majority of the documentation published to date regarding this decision recommends that States continue to restrict the definition to 50 lives until statutorily required. The rationale for this is risk mitigation. Businesses with 51 to 100 workers are more likely to have alternative coverage arrangements marketed to them, including "self-insured" plan arrangements including some sort of stop-loss reinsurance. Allowing businesses with 51-100 employees into the small group market immediately could raise premiums because of adverse selection. Businesses with healthy workforces would choose to self-insure, while businesses with less healthy workforces would choose to take advantage of the non-health-rated coverage available through the small group market.

In addition to the adverse selection concern outlined above, some of the other considerations that will impact this decision include:

- All employer groups with more than 50 employees will face a penalty if they do not offer group insurance starting in 2014.
- The loss ratios, benefit designs, and administrative charges of the large group market compared to the small group market.
- Relative size of the 51-100 market compared to the current small group market.

All groups with more than 50 employees will have a financial incentive to offer coverage starting in 2014. This may cause employers that currently do not offer coverage to do so. Given that they will be just entering the insurance market, we believe such employer groups will be less sophisticated purchasers unlikely to enter into a self-insured or alternative arrangement and likely to enter the fully insured market. This fresh pool of members could be healthier than the average mix of membership for the small group market.

Generally, the loss ratios for the large group market are greater, causing lower premiums for larger groups compared to the small group market. This difference in administrative cost must be considered when combining the markets.

Lastly, the relative size of the 51-100 group market to the small group market is surprisingly small. Without econometric models, it is difficult to tell, but our best information based on combining state information about group sizes from the HRET KFF study as well as other data indicate that the 51-100

group market is likely only between 25% and 50% of the existing small group market. At most, the groups of size 51-100 will comprise only one-third of the small group market, and therefore would have somewhat limited impact to the overall small group risk pool

Similar to the analysis done in merging the small group and individual markets, we have examined potential outcomes of expanding the small group market to 100 employees. Only some of the carriers provided data for the group market between 51 and 100 lives. Where large group data was not available, we assumed that the 51 to 100 group market behaves similarly to the general large group market data that we did have. ***Note that we did not receive data from all plans so this analysis could vary significantly if all data was available.***

Based on the analysis described below, the average risk of the small group market would not be significantly affected by the addition of the group sizes 51-100. Based on the analysis, over 75% of the 51-100 employee size firms would need to leave to self-insured funding sources before the SHOP would begin to be adversely affected.

Step 1 – Establish the overall morbidity of the 51-100 population relative to the under 50 population. Although this intuitively seems likely that the morbidity would be similar, our analysis indicates the morbidity to be very different between the markets. We suspect our lack of data credibility is driving this result.

Table 30: Result of Expanding Small Group Definition

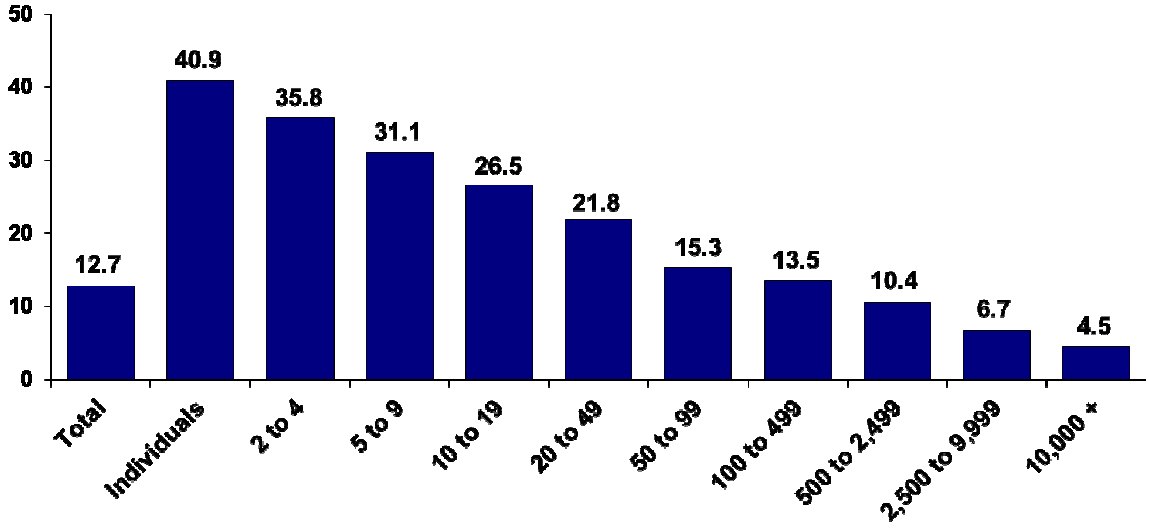
Step	Description	Groups size 51-100	SG with <50 Ees
A	2010 Premium PMPM - adjusted	$333	$381
B	Morbidity Change (guarantee issue)	1.00	1.00
C	Admin & Profit	15%	20%
D	Average Actuarial Value	89%	81%
E = A*B*(1-C)/D	2010 Allowable Claims PMPM	$318	$376
F	Ave Age/Gender	1.00	1.00
G = E/F	Normalized claim cost	$318	$376
	Morbidity difference		1.18

Step 2 – Compare the average premiums for the markets based on average administrative cost differences.

Table 31: Premium Difference, Expanding Small Group Definition

Step	Description	Groups size 51-100	SG with <50 Ees
A	Normalized claim cost	$318	$376
B	Admin cost	*$56*	*$94*
C = A + B	Premium	$374	$470
	Premium Difference		1.26

Based on a study by The Lewin Group, administrative costs vary significantly based on the size of the group. The figure below indicates the results of this study. Group size is listed along the horizontal axis and administrative cost, as a percent of premium, is listed along the vertical axis. For administrative cost differences, we assumed that the 51-100 group market would have 5% less administrative fees (as a percent of premium).



Source: The Lewin Group, Commonwealth Fund Commission on a High Performance Health System

If we stop here, it would indicate that the addition of the 51-100 life groups to the market would actually reduce the premiums in the small group market. However, it is the potential shifting of the healthiest groups to self-funded options that remains a concern. This item is addressed in Step 3.

Step 3 – Adjust the risk level of the 51-100 life groups by removing the healthiest groups

Our approach to examine this is similar to reviewing the resulting risk of small groups leaving the small group market. We make two assumptions:

1. The assumed cost ratio of the highest cost groups to the lowest cost groups in this range is 1.8:1, which is a compression of rate range by approximately a factor of 0.75 relative to the small group market, and

2. The majority of the groups are at the low end of the range (similar to small groups).

Based on these assumptions, approximately 75% of the groups (the healthiest groups) in the 51-100 market would need to leave to the self-insured market before the increase of morbidity in the 51-100 employee groups would reach 24%.

Table 32: Increase in Morbidity

Percent of Members	Underwriting Factor of Small Group 2-50	Assumed Underwriting Factor of 51-100 groups [1]	Membership Leaving to Self-Insured Market	Remaining Distribution	Average Underwriting Factor
0%	1.62	1.47	0%	0%	1.47
15%	1.39	1.30	0%	62%	1.30
9%	1.21	1.16	0%	37%	1.16
6%	1.09	1.07	-6%	0%	1.07
17%	0.99	0.99	-17%	0%	0.99
31%	0.88	0.91	-31%	0%	0.91
4%	0.85	0.89	-4%	0%	0.89
17%	0.77	0.83	-17%	0%	0.83
100%	1.00	1.00		100%	1.24
Increase in Morbidity					24%

[1] Multiplied by a compression factor of .75.

The increased morbidity with 76% of the market leaving would cause the overall premium levels in the pool to close to break-even, given the economics of the lower administrative costs in the higher group sizes. If fewer than 76% of the groups size 51 – 100 leave, the morbidity of the small group market would be improved (healthier). Based on the data provided, we believe that combining the group size 51 – 100 in with the under 50 pool could lower the small group premiums. Again, we cannot overemphasize our concerns of lack of credible data for this section of the analysis given that all carriers did not submit appropriate data.

4. INDIVIDUAL AND SMALL GROUP MERGER

One of the options available to states under the ACA is to combine the small group and individual (non-group) risk pools. While Massachusetts is the only state to fully merge the risk pools of these two markets, several states have seriously considered some merging of the risk pools prior to the ACA laws allowing them to do so. The driving force originally behind merging the markets was a desire to protect and lower costs for individual policyholders who may have less negotiating power and sophistication. From a very simple perspective, merging the markets will equalize premiums. Therefore, if premiums are lower in the small group market prior to the merger, then small group premiums will increase and

individual premiums will decrease (or vice versa). The amount of the change in each market depends on the relative size of the markets prior to the merger. If the total market is dominated by small group, the change to individual premiums can be substantial.

Complicating this analysis is the fact that the decision states need to make is after implementation of all of the ACA changes. These regulatory changes affect the two markets differently. In addition, the shifts in the market due to provisions such as the individual mandate, premium and cost sharing subsidies, and others will likely be substantial.

In order to analyze the impact of merging the individual and small group risk pools, what that means first needs to be defined. While premiums for a merged market must clearly be based on the average risk if people in both markets were combined into one pool, it is not clear from the ACA law or proposed rules if rates have to be identical in the two markets for the same product offered by the same health insurance issuer to the same person / family. Specific outstanding questions include:

1. Can rates vary due to differences in administrative expenses between the two markets? The costs of administering health insurance clearly vary between the two markets for reasons such as commissions, administrative functions like enrollment and outreach, among others.

2. Can / should rates vary due to the presence of reinsurance in the individual market? Reinsurance effectively transfers funds from the fully insured and self-insured employer markets to the individual market.

For purposes of our analysis, we have assumed that the risk pools need to be identical, but that rates do not need to be identical between the two markets and can vary for the reasons noted above.

Using the best estimate post ACA premiums, we estimate that small group premiums would decrease by approximately 5%, and individual premiums would increase approximately 7% if the markets were merged. These estimates should be viewed as a comparison to if the markets were not merged post-ACA rather than a comparison to the current rates in the markets. These impacts are based on our best estimate post ACA premiums and will vary based on the actual ultimate post ACA premiums for each market. There are many variables that will influence the ultimate premiums but we do not believe it is likely that under the probable scenarios, small group premiums would increase significantly as a result of an individual and small group merger in Delaware.

These estimates are after projections for the impact of other ACA reforms (no underwriting, essential health benefits requirements, etc.) have been accounted for. Since premium rates inside and outside the exchange need to be the same, after accounting for allowable rating characteristics, our results do not depend on the size of the health insurance exchange or whether or not there is a market outside the exchange. Other considerations in deciding whether to merge the markets include the size and stability of the market over time, disruption to policyholders and health plans, continuity of coverage, and others.

This finding was based on the following development, which generally starts with baseline 2010 premiums for each market, adjusts each for ACA requirements, and normalizes each for differences in characteristics such as age, benefit design, and administrative costs in order to determine the differences in underlying morbidity for each of the projected markets. Then using the projected membership for each market, the rate impact is derived. Specifically, the following steps were taken:

Step 1: Baseline Adjusted. The 2010 average premiums, adjusted for ACA requirements were approximately $400 PMPM for small group and $330 PMPM for individual. These figures include assumptions regarding morbidity changes in the markets.

Step 2: Administrative Costs. Remove the respective percentage of administrative costs, profit, and taxes from the small group and individual market adjusted premium figures. After accounting for projected changes in administrative costs and profit due to the ACA loss ratio requirements, we estimate that the individual market will have administrative costs and profits that are approximately 5.7% higher than the small group market.

Step 3: Benefit design levels. In order to obtain a claim cost PMPM figure, we divided the results of the first two steps by the respective average actuarial values for all plans. Small group plans in 2010 were about 9% richer than individual plans, after adjustments for Bronze requirements were taken into account.

Step 4: Age differences. To account for differences in case mix, we normalized for the average age factors in the small group and individual markets. Case mix turned out to be extremely similar for the two markets and therefore was an extremely minor adjustment.

Step 5: Calculate the morbidity relationship between the two markets based on steps 1-4. The small group market is expected to have approximately 20% higher morbidity (normalized for case mix) than the projected individual market. This is after consideration of the increase in morbidity expected for the individual market due to the influx of previously uninsured people. In other words, even though the individual market is expected to experience a significant increase in morbidity under the ACA, we expect it to still have much lower morbidity than the small group market.

Step 6: Projected membership mix. Under the ACA, we have assumed that the small group market (50,000 lives) will have slightly more enrollment than the individual market (45,000 lives). This assumed about a 173% increase in the individual market mostly due to an influx of currently uninsured. An exodus of about 11% of the current small group market was also assumed. This is a significantly impactful assumption that should be further evaluated.

Step 7: Calculate results. The results indicate that if markets were merged, small group rates would decrease by approximately 5%, and individual rates would increase by approximately 7%. **Note that if the high estimate premiums are used for the individual market, the post ACA premiums for the individual and small group markets would be similar. This would result in an insignificant impact to premiums if the markets were merged.**

5. FUTURE ANALYSES

This analysis provides a solid foundation for the state of Delaware to begin making important decisions regarding the individual market and the Exchange. However, there are additional analyses we suggest be performed in order to enhance the analysis to-date and to provide insight into items outside of our initial scope of work.

The following is a list of recommended follow-up analyses:

Issuer pricing

1. A more detailed data call to update information (2011- post state regulation changes), and measure interaction impacts and further explore issues uncovered with the summary level data call.
2. More detailed review of current denial and pre-existing condition underwriting decisions.
3. More detailed analysis of the high risk pool costs and enrollment.

Morbidity and Population Assumptions

1. Analysis of the uninsured, with a focus on their expected morbidity levels.
2. More detailed analysis of the reinsurance provisions of the ACA.

Risk Adjustment, Reinsurance and Risk Corridors

While the items in this section relate to planning rather than analysis, these planning activities will be critical as they will help carriers make rational pricing decisions.

1. Workplan for the development of an all payers' claim database (APCD), which will be critical for carrier pricing.
2. Possible methodologies/processes for risk adjustment, consistent with recently released proposed rules from HHS.
3. Preliminary risk adjustment and reinsurance results to carriers in order to begin planning for development of premium rates in 2014 and subsequent years.
4. Development of state specific reinsurance parameters including assessment level, attachment point, coinsurance amount and coverage cap.

6. IMPORTANT CAVEATS

As noted in the Executive Summary, estimates of future premiums and programs over four years into the future under a set of changes as sweeping as the ACA are inherently uncertain. The issues driving this uncertainty cannot be stressed enough and thus are repeated below:

1. Our analysis was completed with 2010 market information. Even in the absence of ACA changes, the market will change significantly over the course of four to six years (2010 to 2014/ 2016).

2. Important decisions have yet to be made regarding the health insurance exchange (HIX), including how active of a purchaser the state will be, oversight responsibilities, adverse selection avoidance strategies, risk adjustment methods, and others. These decisions will all affect competition among carriers, carrier rate setting methods and assumptions, and member behavior.

3. Pending guidance and regulations from the federal government may affect the appropriateness of our estimates.

4. Rates, especially in 2014, depend on how health plans think costs will change under the ACA reforms and population expansions, not necessarily on how costs actually change in 2014. Results and information as presented in analyses such as this are important to communicate with the health insurance carriers. Feedback from these carriers on information they will find useful (e.g., state rules around rate review, information on the uninsured population, risk adjustment simulations, and others) will be critical to avoid irrational pricing.

5. Rate changes in the small group market and other financial incentives may drive employers to make unanticipated decisions around coverage.

6. The currently uninsured population will likely represent a significant portion of the individual insurance market in 2014. While migration assumptions were made, a more detailed "Who Goes Where" (WGW) analysis should be completed to better understand expected migration under the ACA. Shifts in enrollment may occur differently than what has been projected in the current WGW analysis if the rate changes in the small group market and other financial incentives drive some employers to drop coverage.

7. Pent up demand has been shown to significantly increase costs in the first year of enrollment for those previously uninsured. Our estimates do not reflect estimates for pent up demand since the effect is expected to be minimal after 2014.

8. Due to the limited scope of our work and timing requirements, we requested and received summary level market information from the carriers, rather than detailed data which would have allowed more validation and refined estimates. We did not audit the data supplied.

9. The behavior of individual members and employers is difficult to predict.

10. It is difficult to predict the number and impact of grandfathered plans. The more individuals and small groups that stay enrolled in grandfathered plans, the less of an impact the ACA guaranteed issue rules will have. However, the more grandfathered plans that remain, the higher the absolute level of non-grandfathered rates since grandfathered plans are assumed to have favorable risk pools. Further, the impact of merging the individual and small group market could be skewed if the proportion of enrollment in grandfathered plans is very different between individual and small group.

11. Any adjustment to costs and premiums resulting from revised contracting post ACA was not considered. Reduced contract costs might result from eliminating the level of uncompensated care for uninsured residents.

12. We did not attempt to model the impact of state mandatory benefits above and beyond the federal requirements of essential benefits, including how they will be reflected in the small group and individual markets after implementation of the ACA.