Impact of Merging the Small Group and Individual Markets in Delaware

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The State of Delaware

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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 evaluate actuarial considerations in merging the individual and small group markets under the Affordable Care Act (ACA). One of the most important factors to consider is the impact to the individual and small group premiums under a merged market. This report presents the premium impact to each market under various merger scenarios. The report also includes additional factors to consider in deciding whether to merge the two markets. All results presented in this report are specific to the state of Delaware and may not apply to other states. Actual results will vary from our estimates for a number of reasons. The ACA includes many significant changes which are difficult to quantify. Estimating premium rate changes between now and 2014 would be very difficult even in the absence of these transformative market changes. Please see Section 5 – Important Caveats, for a more detailed discussion of the limitations of our modeling and estimates, and important disclosures regarding the data we relied upon.

Individual premiums (before reduction for premium tax credits/subsidies) in most states are expected to increase under the ACA provisions, primarily due to the removal of underwriting. However, premium subsidies may significantly decrease premiums for low income individuals. For many states, post-ACA individual premiums are also expected to be higher than comparable small group premiums. For these states merging the small group and individual markets is considered a way to mitigate the high increases in individual rates. In Delaware the individual rates under the ACA provisions are expected to be significantly lower than small group rates (even more so in 2014 and 2015 due to the benefits of reinsurance on the individual market). Thus, merging the markets would increase the individual rates further. Small group rates, which are not expected to increase significantly under the ACA provisions, would experience an overall rate decrease if the markets are merged.

Before the impact of premium tax credits (and assuming business groups with one employee remain in small group), we estimate that individual market premiums will increase on average by 16% in 2014, 27% in 2015, 32% in 2016, and 37% in 2017 as compared to premium rates without the ACA reforms. Premium tax credits lessen the impact such that the average member is expected to experience a rate decrease of 35% in 2014, 32% in 2015, 30% in 2016, and 29% in 2017. Note that these rate changes are averages and individual rate changes may vary significantly from the average.

Before the impact of employer premium tax credits, we estimate that small group market premiums will increase on average by 4% to 5% from 2014 through 2017.

Using our best estimate post-ACA premiums and assuming the premiums for small group and individual policies are allowed to vary for reinsurance and administrative costs within a merged market, our analysis shows that merging the individual and small group markets would further increase premium rates for current individual enrollees by approximately 8% compared to if the markets were not merged. Small Group premiums would be 6% lower.

Table 1 summarizes the premium impact under various scenarios, by year, for the average enrollee in the individual market. Table 1a summarizes the estimated premium impacts for the individual market considering the premium tax credits. Table 2 summarizes the average premium impact for small group. All tables assume that business groups with one employee (BG1s) will remain in small group.

Table 1: Premium Impact for the Average Individual Enrollee
Assumes BG1s Remain in Small Group
Excludes Premium Tax Credits

Scenario	2014	2015	2016	2017
Individual (no merge)	16%	27%	32%	37%
Merged, vary by reins and admin	23%	37%	42%	48%
Merged, vary by admin	38%	44%	46%	48%
Merged, vary by reinsurance	21%	35%	40%	46%
Merged, no rate variation	36%	41%	43%	46%

Table 1a: Premium Impact for the Average Individual Enrollee
Assumes BG1s Remain in Small Group
Includes Premium Tax Credits

Scenario	2014	2015	2016	2017
Individual (no merge)	-35%	-32%	-30%	-29%
Merged, vary by reins and admin	-33%	-29%	-28%	-26%
Merged, vary by admin	-29%	-27%	-27%	-26%
Merged, vary by reinsurance	-33%	-30%	-28%	-27%
Merged, no rate variation	-29%	-28%	-27%	-27%

Table 2: Premium Impact for the Average Small Group
Assumes BG1s Remain in Small Group

Scenario	2014	2015	2016	2017
Small Group (no merge)	5%	5%	4%	4%
Merged, vary by reins and admin	-1%	-2%	-3%	-3%
Merged, vary by admin	-10%	-6%	-5%	-3%
Merged, vary by reinsurance	0%	-1%	-1%	-1%
Merged, no rate variation	-8%	-4%	-3%	-1%

As shown above, the individual market is expected to experience large premium increases under the ACA provisions, regardless of the scenario. The benefits of the reinsurance program are the reason there are lower individual premium impacts in 2014 compared to 2017. The benefits of the reinsurance program decrease over the years, with the program ending in 2016.

The reason that merging the markets increases rates for the individual market is that even under guarantee issue, the morbidity of the individual market is expected to be lower than the small group market. If the high estimate of post-ACA premiums is used for the individual market, 2016 premiums for the two markets are similar.

While merging the markets is expected to result in increased rates for the individual market, premium tax credits will alleviate a portion of the premium increases for much of the post reform individual market. Almost all individuals who are in households below 300% of the federal poverty level (FPL) will experience a rate decrease after premium tax credits are taken into account. Roughly 70% of the individuals in households between 300% and 400% FPL will also receive a tax credit resulting in a rate decrease after subsidies. The remaining individuals between 300% and 400% FPL as well as those above 400%, who are not eligible for tax credits, will feel the full premium impact of the ACA requirements. In total, assuming the individual and small group markets are not merged, approximately 62% of the currently insured and 79% of the currently uninsured are expected to receive a tax credit. The higher proportion of uninsured with tax credits is due to the incomes of the uninsured tending to be less than the incomes of those currently with insurance.

Note that the impact of the tax credits relies heavily on self-reported information through the Current Population Survey (CPS). Variations in the CPS data (as compared to actuals) could affect the results, perhaps even materially.

Since regulations related to the ACA rating requirements are not issued and initial guidance is not detailed, modeling was completed to assess the rating impact to the individual and small group markets under the different scenarios. It is unclear if federal regulations will allow individual and small group premiums to vary in a merged market for administrative loads and for reinsurance offsets. If regulations do not allow the rates to vary for reinsurance, the benefits of the transitional reinsurance program would be spread between both the individual and small group markets and thus further the increase to individual premiums. If regulations do not allow the rates to vary for different administrative expenses, individual premiums would decrease slightly (compared to merged market premiums with varying administrative loads). This decrease is attributable to lower expected administrative expenses in the small group market, as compared to the individual market.

Another outstanding question is if Delaware has the authority to continue allowing BG1s to remain in small group in a non-merged market. There are varying interpretations of the ACA's definition of "employer," and it is unclear whether CMS intends for sole proprietors to be treated as individuals and, as a result, not be considered part of the small group market. If BG1s moved to the individual market, Wakely estimates that the 2017 individual market premiums would increase by 2%, BG1s would

experience a 9% decrease in their premiums, and premiums for the remaining small groups would decrease by 1%. For 2014, the impacts are greater due to the individual rates being lower due to reinsurance. The premium impacts in 2014 if the BG1s moved to the individual market are an increase of 4% for the individual market, a 24% decrease for the BG1s and a 1% decrease for the other small groups. Given the significant premium difference if BG1s move to the individual market, sole proprietors may voluntarily migrate to the individual market in a non-merged market.

While the rate impact may be the largest factor in deciding whether to merge the individual and small group markets, there are additional factors to be considered, such as the stability of the rating pools and plan standardization. If Delaware decides not to merge the markets, the state can still create regulations that would require similar requirements for the separate pools. For example, the state could mandate that all Qualified Health Plans (QHPs) participate in both markets. Plan standardization could also be mandated in the separate markets. Having similar requirements in the separate pools could make any migration between the markets easier for members and also make comparisons of the two markets more straightforward in the future.

2. BACKGROUND INFORMATION

Wakely previously produced a report[1] that outlined the estimated premium impact of the various ACA provisions on the individual and small group markets. Based on this report, the individual market is expected to see 2016 rate increases due to ACA provisions of 10% to 58% with a best estimate of 32%. The following table shows the factors impacting the premiums. It is recommended that the reader review this report to understand the expected ACA premium impacts and assumptions used.

[1] DE report - Actuarial Analysis of ACA on Insurance Mkt

Table 3: Changes to Individual Market Premiums under ACA
Excludes Premium Tax Credits

(2016 post ACA compared to 2010 pre ACA)

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, the largest expected impact to premium rates is driven by morbidity changes. There is also the most uncertainty associated with this component of the overall change.

The changes are not uniform across all individuals, as some enrollees could see their premiums decrease by as much as 50% while others could see their premiums more than double. These rate changes are before taking into consideration premium tax credits. Premium tax credits will subsidize a portion of the individual premium for enrollees under 400% of the federal poverty level (FPL). The premium tax credits will cover up to 95% of the silver level premium, depending on the income of the individual/family.

Unless discussed otherwise below, the market merger analysis presented in this report is developed based on the best-estimate assumptions shown in Table 3.

- Morbidity impact is an input that, unless otherwise stated, is assumed to be 25%.
- Reinsurance and provider fees vary by year. Reinsurance also varies based on the individual enrollment assumption, which varies based on which market the BG1s are in. In an unmerged market, with BG1 remaining in small group, the 2016 estimates for reinsurance and provider fees are similar to those shown in Table 3.
- The estimated impact of pent-up demand is included. Pent-up demand estimates vary from 2.6% in 2014 to 0.0% in 2017.
- Premium subsidies are dependent on the second lowest Silver plan. Thus, the subsidies are dependent on the final individual rating impact for the scenario in question. For example, the

premium subsidies vary by year based on the impact of reinsurance, BG1 market, provider fee and pent-up demand.

- The impact of premium subsidies was refined to incorporate household size. For the purposes of this analysis Wakely assumed the following four-tier structure: subscriber only, subscriber plus spouse, subscriber and child(ren) and family. This is a necessary refinement as a family is more likely to receive a premium tax credit than an individual, all else equal. The result of this refinement is an increase in the number of individuals receiving a tax credit as well as an increase in the average premium tax credit amount.

Small group premium rates are estimated to change by -4% to 12% due to ACA provisions, with a best estimate of 3%. Table 4 below shows the factors impacting small group premiums.

Table 4: Changes to Small Group Market Premiums under ACA

Description	Best Estimate	Range [1]		Notes
Benefit Coverage Changes	0%			
Elimination of U/W	0%			[2]
Tobacco Restrictions	0%			[2]
Age/gender Restrictions	0%			[2]
MLR Requirements	-3%	-4%	0%	
Premium Tax	3%			
Tax Credits for Employers	-1%			[3]
Morbidity Change	3%	0%	12%	[4]
Overall impact to small group premiums in 2014	3%	-4%	12%	

[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

The following adjustments were made to small group results:

- Reinsurance assessments and premium taxes vary by year. Note that reinsurance assessments are not included in the above table.
- Tax credits for employers are excluded from this analysis as they are a temporary adjustment that does not impact the premiums charged by the health insurer.
- The impact of pent-up demand is assumed to be 0.0% for small group.

The 2010 small group market premiums were approximately 47% higher than the individual market premiums, normalized for such factors as demographics and benefit design. Without additional information as to what might be driving these premium differences, it is assumed that the primary driver is the morbidity differences in the two markets. The morbidity difference is due to the individual market being medically underwritten while small group already mandates guarantee issue.

In our projected post-ACA premiums, estimates were made for the number of uninsured that would enroll in the individual market as well as the morbidity of these new enrollees. The best estimate assumption is that these new entrants would increase the individual premiums by approximately 25%. This was estimated by assuming that two-thirds of the post-ACA market would be previously uninsured individuals and that these individuals would on average have 40% higher costs than the current medically underwritten enrollees. Lower uninsured migration is assumed in the earlier years, but the first enrollees are also likely to have the highest morbidity so the overall morbidity impact may not vary significantly by year. That said, the health status of the uninsured and which of the uninsured will enroll is difficult, at best, to predict. Using an overall morbidity increase of 37%, which is at the high-end of our range, would bring the individual and small group premiums in line.

3. PREMIUM IMPACT OF MERGED MARKETS

One of the options available to states under the Affordable Care Act is to combine the small group and individual risk pools. Several states have already merged the small group and individual markets. 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 (and vice versa). The amount of the change in each market depends on the relative size of the markets prior to the merger.

Complicating this analysis is the fact that the merger decision needs to be made after implementation of the ACA changes. The ACA 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 have a significant impact on the merger decision.

Before analyzing the impact of merging the individual and small group risk pools it is important to clearly define the merger. While a combined risk pool is clearly required for the newly merged market, it is not clear from the 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 individual/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, and administrative functions, 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.

According to rate filings received for Delaware carriers as well as data received directly by the carriers, Wakely has determined that individual market premiums are advantaged when reinsurance is allowed to vary within a merged market environment, and small group rates are disadvantaged. The converse is true for allowing rates to vary by administrative expenses. The magnitude of the impact due to these concepts varies by year due to the annual change in reinsurance.

Appendix A provides the estimated premium impact by FPL, age band, and pool. The individual market is separated into two pools. Pool 1 represents current enrollees who receive the best or "preferred" rate offered by the health insurer. Pool 2 represents current enrollees who are given a rate higher than the "preferred" rate due to their health status. Small group is also divided into two pools, BG1s and other small groups. The premium impacts also vary by year. All figures in Appendix A represent the premium impact before any premium subsidies. Appendix B is simply Appendix A after premium subsidies. Both appendices summarize years 2014 and 2017, representing when reinsurance has its largest impact and when reinsurance no longer is incorporated (respectively). The scenarios contain permutations of the following concepts:

- If BG1s are included as small groups or individuals. This variable is only applicable in a non-merged market.
- If the small group and individual markets are merged.
- If the markets are merged, then rates for small group and individuals.
    - Are the same.
    - Vary by reinsurance and/or administrative costs. These two rating variables are only applicable in a merged market.
- If premium tax credits/subsidies are included.
- A morbidity impact assumption for the current individual market.

In all scenarios displayed, pent-up demand for the incoming, previously uninsured population has been included.

The final scenario in each of Appendix A and B (A-9 and B-9) shows a scenario where the individual and small group premiums are virtually the same under a non-merged environment in 2017. The key assumptions for this scenario are the individual morbidity assumption (37%, which is the high estimate) and merger inputs (assumes rates will not vary for administrative expenses).

The scenarios in Appendix A show the premium impacts prior to the premium tax credits/subsidies, while Appendix B incorporates the subsidies. It is important to understand the impact of these subsidies. Table 5 below shows the comparison of the premium impacts with and without the premium subsidies incorporated. Also included is the number of individuals who will receive a premium tax credit based on the non-merged scenario. If individual premiums increase under a merged scenario, more individuals are likely to get a tax credit.

Table 5: Comparison of 2016 Premium Impacts with and without Subsidies
BG1s in Small Group, Merged Rates Vary for Reinsurance and Administrative Costs

Pool and FPL Level		Not Merged		Merged		# of Members		% Eligible for Subsidy	
Current Pool	FPL	No Subsidy	Subsidy	No Subsidy	Subsidy	Currently Insured	Currently Uninsured	Currently Insured	Currently Uninsured
1 (Preferred)	133-150%	39%	-81%	50%	-81%	1,033	2,345	100%	100%
	151-200%	40%	-65%	51%	-65%	1,472	3,342	100%	100%
	201-250%	37%	-51%	48%	-50%	2,634	5,980	100%	100%
	251-300%	25%	-40%	35%	-40%	1,495	3,394	96%	94%
	301-350%	38%	-13%	49%	-12%	948	2,153	81%	74%
	351-399%	44%	1%	55%	3%	451	1,023	69%	53%
	400%+	37%	37%	47%	47%	4,368	3,093	0%	0%
	Subtotal	35%	-29%	46%	-26%	12,401	21,330	62%	80%
2 (Non-Preferred)	133-150%	24%	-83%	34%	-83%	344	805	100%	100%
	151-200%	26%	-68%	36%	-68%	490	1,148	100%	100%
	201-250%	23%	-54%	32%	-54%	877	2,054	100%	100%
	251-300%	13%	-45%	21%	-44%	498	1,166	94%	92%
	301-350%	25%	-20%	35%	-18%	316	739	79%	72%
	351-399%	28%	-8%	38%	-7%	150	351	66%	50%
	400%+	22%	22%	32%	32%	1,455	1,062	0%	0%
	Subtotal	22%	-35%	31%	-33%	4,130	7,325	61%	79%
All Individual	All	32%	-30%	42%	-28%	16,531	28,655	62%	79%
*Membership reflects a non-merged market.					Total Members Eligible for Subsidy			10,181	22,766
					Total Members Not Eligible for Subsidy			6,350	5,889

The table highlights that while the individual market will experience large rate increases, a large portion of these increases will be absorbed by the premium tax credits. Enrollees who are not eligible for premium tax credits will bear the full impact of the ACA provisions. This is roughly 38% of the currently insured market and 21% of the currently uninsured market. The percent of enrollees estimated to be eligible for a premium tax credit does not change by more than a few percentage points based on the various scenarios presented in this report. For example, under a merged market the expected average rate increase is 42% (compared to 32% under a non-merged market). Under a merged environment, the average premium subsidy increases significantly (approximately 4%) but the number of members eligible for a premium subsidy changes by less than 1% or less than 400 members.

As stated, these impacts are the average impact for all members. For example, the average premium change after subsidies is -30%, but it is still possible for a healthy, higher income, younger male to receive over a 50% rate increase due to the impact of ACA requirements. Tax credits are less likely at

the lower ages since the premiums are lower. The exception is for the 0-18 age group where most of these individuals are dependents and thus on a higher-premium family or subscriber with child(ren) policy. Given the data limitations it is not possible to link every individual's rating impact with their expected subsidy amount. Thus, the above estimates should be viewed as averages, recognizing that variations by individual will occur.

Conclusions

Consideration of the detailed impacts by age and income level, as shown in Appendices A and B, varies widely and is therefore critical to understand prior to making merger decisions. The following is a summary of key conclusions from the Wakely scenario testing.

- If the premiums of small group and individual policies were allowed to vary for reinsurance and administrative costs within a merged market then merging the individual and small group markets would further increase the individual premiums by 7% to 8% (varies by year).
- In isolation, the impact of allowing administrative expenses as a rating variable within a merged market environment results in a 2% differential, lowering individual premiums and raising small group premiums.
- Allowing reinsurance as a rating variable within a merged market environment significantly reduces individual premiums in 2014, which would assist in transitioning individuals/families not eligible for premium subsidies. Reinsurance as a rating variable reduces individual premiums 11% in 2014, 5% in 2015, and 2% in 2016. This concept of course has the opposite directional impact on small groups but to a lesser magnitude; for example, they would experience a 9% increase in rates in 2014 due to reinsurance being an allowed rating variable.
- The premium tax credits/subsidies notably decrease the premium impact to the individual market. While more than 60% of the currently insured will actually get a rate decrease after subsidies, almost 40% of the currently insured will receive the full premium impact of the ACA requirements. An individual is less likely to receive a tax credit if they are an individual contract (compared to a subscriber plus child(ren) or family contract), have a higher household income, or are younger. Note that for a given FPL, a younger individual is likely to receive a higher than average rate increase under ACA but is less likely to receive a premium tax subsidy (or will receive less of a subsidy) than an older individual.
- Currently, BG1s have multiple options as consumers in Delaware. Because Delaware allows BG1s in the small group market, they can obtain individual or group coverage. Looking forward, one consideration is if Delaware has the authority under the ACA to continue allowing BG1s to remain in the small group market. There are varying interpretations of the ACA's definition of "employer," and it is unclear whether CMS intends for sole proprietors to be treated as individuals and not be considered as part of the small group market.

  Based on the data provided by small group carriers in Delaware, BG1s are estimated to be 14% less healthy than the average small group and account for about 6% of all small group

membership (as measured by lives covered). BG1s in Delaware have approximately 37% higher morbidity than the anticipated individual market. If BG1s moved into the individual market, they would make up approximately 6% of the anticipated individual market. Wakely estimates that the 2017 individual market premiums would increase by about 2%, BG1s would experience a 9% decrease in premiums, and premiums for the remaining small groups would be expected to decrease by about 2%. In 2014 these impacts are a 4% increase for the individual market, a 24% rate decrease for BG1s and a 1% decrease for other small groups. Given the large BG1 rate decrease, it is likely these sole proprietors will voluntarily migrate to the individual market in a non-merged environment. This voluntary migration would add to the already relatively high individual rate increases.

The estimates noted above should be viewed as a comparison to non-merged post-ACA premiums, rather than a comparison to the current rates in the markets. These estimates are after the inclusion of other ACA reforms (guarantee issue, essential benefit 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 there is a market outside the exchange.

While a significant amount of scenario-testing was performed in order to develop these conclusions, the following step-by-step process outlines the underpinnings of the merger analysis. This process 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 administration 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. Please reference Appendix C for more information regarding the steps taken to calculate the premium impact of merging markets.

4. ADDITIONAL CONSIDERATIONS

Aside from cost, there are other issues to consider and address before deciding whether to merge the individual and small group markets. A summary of these issues is provided below.

Sustainability/Stability: A common argument for merging the two markets, particularly in a smaller state like Delaware, is to increase the sustainability and stability of the exchange. Vermont, another relatively small state, currently has proposed regulations that would merge the two markets. Vermont has noted stability as a driving factor in the decision to try and merge the markets.

Our previous analysis estimated an approximately tripling of the individual market post-ACA. Merging the individual and small group markets is expected to roughly double the combined market size compared to each market alone. This total pool of members could be distributed between three to four health insurers, each developing premium rates based on their pool's experience. Under a non-merged exchange, each individual and small group pool would be rated separately, with some insurers having potentially volatile experience due to lower membership levels. Under a merged exchange, the two

pools would be combined producing larger risk pools for all health insurers. This would likely result in less year-to-year rate variations.

Member Migration: If the premium changes because of the ACA are consistent with our estimates, individual premiums will remain lower than small group premiums, all else being equal. This may encourage small group employers, particularly BG1s, to leave the small group market and enter the individual market. The impact to the markets would depend on the morbidity of the migrating members, but it is likely that it would bring the individual and small group premiums closer together.

Administrative Efficiencies: Economies of scale in management and administration could be gained under one exchange, from both the carriers' and regulators' perspective. Based on our research, some believe that while combining oversight can lead to modest savings, insurers and brokers have long asserted that small groups differ from individual purchasers of health insurance in many ways, and the administration needs of individuals will differ from those of small groups regardless of a merger. In particular, the enrollment process, premium collection and plan payment operations will need to vary between the two markets even if risk pools were merged. Thus, administrative efficiencies from combining the risk pools may be small.

Plan Standardization: If the individual and small group markets were merged under one exchange, both markets may be subject to the same standardized plan offerings. Depending on the current market options, either one or both markets may face different benefit options than they did pre-ACA. In addition, the State may not want the same level of standardization within these two groups. A higher level of standardization is typically advocated in individual markets to help individual consumers make benefit decisions. More benefit options can also create risk selection, particularly in the individual market. However, standardization is less attractive to small group employers, who prefer more choices.

Some states are opting to keep the markets separate, at least temporarily, but are mandating standardization between the markets. California, for example, has mandated that the same Qualified Health Plans (QHPs) be offered in both exchanges. Some small group employers will weigh the cost of providing coverage for their employees versus sending them to the Individual exchange. Under this scenario, employees can keep their same plans and providers, even if they switch between exchanges. Similar plan designs could also benefit lower income workers who tend to have higher turn-over, and small group employees when the two year limit on the tax credit expires (and more small group employers drop coverage). Mandating the same QHPs between the two exchanges also makes market comparison and future merger analyses more predictable. As discussed above, standardizing plans across both markets also has drawbacks.

Employee Choice option: The State may also choose to promote an employee-choice model within the exchange. Under an employee-choice model, employers make defined contributions towards their employees' premiums, and the employee selects a benefit plan under pre-defined constraints. For example, states may allow employee choice only after the employer has chosen a plan tier or health insurer. Under this model, the small group members behave more like individuals. Risk selection may become more of an issue for the small group members, brokers may have a more limited role in the

small group market, and the issue of differing plan standardization needs discussed above may be somewhat mitigated.

5. 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 issues driving this uncertainty cannot be stressed enough. Specifically:

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. The impact of premium tax subsidies relies heavily on self-reported income and family size information. This information, combined with rate filings, publicly available information and actuarial judgment was used to develop the estimated premium tax subsidies. To the extent that any relied upon information is incorrect or changes substantially, such as due to an economic upturn, the results of the analysis will also change.

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

7. 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 scenarios if the rate changes in the small group market and other financial incentives drive some employers to drop coverage. If a migration analysis is conducted, the scenarios presented in this report can be easily updated with any revised enrollment assumptions.

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.