

June 16, 2011

# **Potential Impact of the Affordable Care Act on the Current Individual and Small Group Markets**

OLIVER WYMAN

**MERCER**

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June 16, 2011

Maryland Health Care Commission

Subject:

**Potential Impact of the Affordable Care Act on the Current Individual and Small Group Markets**

Dear Commissioners:

The Maryland Health Care Commission (MHCC) engaged Mercer and its sibling company Oliver Wyman to assess the potential impact of the Patient Protection and Affordable Care Act (PPACA) on Maryland's current individual and small group markets. This paper represents an analysis of the impact of PPACA on the existing markets, or status quo. It should be viewed as a static, baseline analysis that attempts to quantify the impact insurance reforms will have on gross premiums in the existing markets if there were no other incentives or market stabilizers/risk mitigation mechanisms integrated into PPACA. Any changes in premiums cited in this report reflect changes in "gross" premiums. By "gross" premiums, we mean the premium levels before the effect of any premium subsidies or PPACA risk mitigation mechanisms. Unless noted otherwise, we have based our analysis on publicly available information.

The impact that may occur from potential migration among the existing segments (i.e., uninsured, Medicaid, individual, small employer group, large employer group) or between fully insured and self funded benefit plans is outside the scope of this paper.

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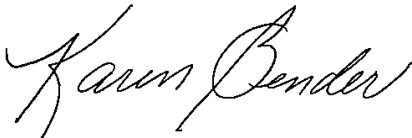
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The paper does not incorporate the following:

- Influx of newly insured members into the various markets, especially the individual market.
- Incentives such as the available premium subsidies based on income that may partially or fully neutralize increases in gross premiums resulting from insurance reforms.
- Market stabilizers such as reinsurance and risk adjusters.

This paper should be viewed as a first step in a complex process of providing basic information to policymakers and not as the final, definitive quantification of the ultimate impacts on the markets or premiums. Any estimates on premiums presented in this paper must be viewed in this context and the reader should recognize that many consumers, especially those in the individual market, will not experience the percent increase in actual net premiums because of the incentives and market stabilizer/risk mitigation mechanisms available to them.

Sincerely,

A handwritten signature in cursive script that reads "Karen Bender".

Karen Bender, FCA, ASA, MAAA

**Summary**

## **Executive Summary**

The Maryland Health Care Commission (MHCC) engaged Mercer and its sibling company Oliver Wyman to assess the potential impact of the Patient Protection and Affordable Care Act (PPACA) on Maryland’s current individual and small group markets. Unless noted otherwise, we have based our analysis on publicly available information.<sup>1</sup>

This paper represents an analysis of the impact of PPACA on the existing market, or status quo. It should be viewed as a static, baseline analysis that attempts to quantify the impact insurance reforms will have on gross premiums in the existing markets if there were no other incentives or market stabilizers/risk mitigation mechanisms integrated into PPACA. Any changes in premiums cited in this assessment reflect changes in “gross” premiums. By “gross” premiums, we mean the premium levels before the effect of any premium subsidies or PPACA risk mitigation mechanisms.

The impact that may occur from potential migration among the existing segments (i.e., uninsured, Medicaid, individual, small employer group, large employer group) or between fully insured and self funded benefit plans is outside the scope of this paper.

The assessment does not incorporate the following:

- Influx of newly insured members into the various markets, especially the individual market.
- Incentives such as the available premium subsidies based on income that may partially or fully neutralize increases in gross premiums resulting from insurance reforms.
- Market stabilizers such as reinsurance and risk adjusters.

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<sup>1</sup> Specifically, we accessed CareFirst premiums online through websites such as eHealthInsurance.com. We are relying on the accuracy of these premiums in our analysis.

This paper should be viewed as a first step in a complex process of providing basic information to policymakers and not as the final, definitive quantification of the ultimate impacts on the markets or premiums. Any estimates on premiums presented in this paper must be viewed in this context and the reader should recognize that many consumers, especially those in the individual market, will not experience the percent increase in actual net premiums because of the incentives and market stabilizer/risk mitigation mechanisms available to them.

PPACA contains three types of risk mitigation mechanisms:

- Risk corridors (first three years only)
- Risk adjusters
- Temporary individual market reinsurance (first three years only)

The goal of risk corridors is to minimize the losses, as well as the gains, for the first three years of the exchange to encourage carriers to offer insurance in the exchanges in the individual and small group markets. The purpose of risk adjusters is to remove incentives for enrolling only healthy individuals in a market where medical underwriting is prohibited and rating for risks (other than tobacco) on an individual basis is not allowed. Theoretically, the only impact on aggregate average gross premium rates pertaining to the first two types of risk mitigation would be the possibility of a slightly lower risk charge incorporated into the rates. This is because there are no new funds coming into the insurance system for the individual and small group markets from external sources. (either from the federal government or from assessments to large employers)<sup>2</sup>. Therefore, the first two types of risk mitigation involve exchanging premium dollars among the carriers in the individual and small group markets. The goal of the temporary individual market reinsurance is to at least partially mitigate some of the rate shock associated with any imbalance in the entrance of high risk pool enrollees into the individual market. Initial costs may be higher in the individual market if more high risk pool individuals enroll than individuals with average or low risks that were previously uninsured. Also, initial costs could be higher if the average claim amount per member for high risk pool enrollees is not fully offset by the average claim amount per member for the new enrollees that were previously uninsured. The source for providing this reinsurance is a \$25 billion assessment on insurers and self funded plans, with \$10 billion redistributed for 2014, \$8 billion redistributed for 2015 and \$4 billion redistributed for 2016. The details as to how carriers in the individual Exchange market will be reimbursed for high risk individuals are as yet, undefined, as is the amount available to each state.

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<sup>2</sup> PPACA does not specify a specific funding source for any short fall that may occur if the losses for health plans participating in the Exchanges are greater than the gains. General discussions seem to imply that HHS does not anticipate this situation to occur, based upon the experience of Medicare Part D, which also incorporated risk corridors. For Medicare Part D, the gains were materially greater than the losses. Since there is no specific funding source and no specific authorization to provide additional funds if necessary, we are assuming that the only sources for funding the health plans sustaining losses are from the shared gains from the health plans with positive financial results. Therefore, while there may be monies distributed among the health plans within the Exchanges, the average premium will not change.

**Potential Impact of the ACA on the Current Individual and Small Group Markets**

Section 1 discusses many of the changes that will be required in Maryland due to PPACA, and explains how these changes will affect individual and small group premium rates. These changes include minimum loss ratio requirements, minimum benefit requirements, rating restrictions, and underwriting requirements. Oliver Wyman estimates that the impact of the PPACA changes discussed in this report will cause individual premiums to increase about 35% in aggregate before application of available premium subsidies. We estimate that PPACA changes will cause small group premiums to increase in the range of 2% in aggregate, assuming the small group and individual markets are kept separate in the first year of PPACA. It is important to understand that these changes may significantly affect premiums (positively or negatively) of certain policyholders in Maryland, even though the overall, aggregate premium impact across the individual and small group markets may be lower. The tables on the following pages summarize Oliver Wyman’s estimates of the impact of these PPACA changes for Maryland’s individual and small group markets.

***Individual Market: Aggregate Premium Impacts***

	<b>Average Premium Impact</b>
Minimum Loss Ratio	Not Significant
Maternity Mandate	2% – 4%
Mental Health Mandate	0%
Unisex Rating	0%
Guaranteed Issue	26%
Actuarial Value	6%
Age-Rating Restrictions	0%
Total	34% – 36%

Note, these impacts do not reflect any premium subsidies that will be available to individuals as a result of PPACA. The impact of newly insured individuals entering the market has not been taken into consideration – nor has any migration attributable to changes in dependent tier options. This table demonstrates the upward pressure on gross premiums in the current market. It does show that in order for gross premiums (i.e., premiums before premium subsidies) to remain stable, there would need to be a substantial increase in lower-cost members entering the individual pool.

*Small Group Market: Aggregate Premium Impacts*

	<b>Average Premium Impact</b>
Minimum Loss Ratio	Not Significant
Maternity Mandate	0%
Mental Health Mandate	0%
Prescription Drug Coverage	0%
Guaranteed Issue	Not Significant
Actuarial Value	2%
Age-Rating Restrictions	0%
Total	2%

Note that these impacts reflect the current market and do not reflect any premium subsidies that will be available to qualifying small groups as a result of PPACA. No estimate for any impacts resulting from finalization of the essential benefit package, which is unknown at this time, has been included.<sup>3</sup> The impact of newly insured groups entering the market is not reflected, and no attempt has been made to model small employers' decisions regarding whether to continue offering employer-sponsored insurance.

Section 2 discusses the pros and cons of merging the individual and small group markets for the purpose of complying with the PPACA minimum loss ratio and rebate requirements beginning in 2011 and as of 2014, when the exchange(s) will be effective.

Section 3 explores the possibility of erosion in Maryland's small group market caused by PPACA changes. This section discusses the use of self-insurance, associations, co-ops, and Section 125 plans (rather than traditional employer coverage) as vehicles for providing health insurance coverage to small group employees. Financial and nonfinancial impacts are considered, as well as the feasibility of using these vehicles under PPACA.

Section 4 discusses options that MHCC may want to consider to minimize the impact of anti-selection in the individual and small group markets. It will be important to minimize the extent to which individuals drop coverage when they expect they will not need it and then re-enroll when they expect to use services. In the absence of the final regulations, MHCC may want to consider the following rules that would minimize selection in the reformed markets, recognizing that ultimately some of these may not be allowable:

- Maintain equal rating inside and outside of the exchange(s).
- Maintain a single annual open enrollment period for both plans inside and outside of the exchange(s).

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<sup>3</sup> We have included adjustments for broad categories, such as maternity, mental health and prescription drugs, as reflected in the original legislation. We have based these estimates on the costs for similar benefits in the current markets. There are many other details pertaining to the scope of coverage for all the categories that are unknown at this time, including everything included in the three categories for which we have made adjustments.



## Potential Impact of the ACA on the Current Individual and Small Group Markets

- Only allow benefit changes during the annual enrollment period.
- Limit benefit coverage at initial enrollment.
- Limit the degree to which a policyholder can improve or reduce benefits within a calendar year.
- Limit benefit selection options for employees to a given level (e.g., Bronze, Silver, Gold, Platinum) selected by the employer.
- Do not allow large employers to enter the exchange.
- Actively enforce the definitions of reinsurance in the small group market until they are deemed pre-empted by ERISA.

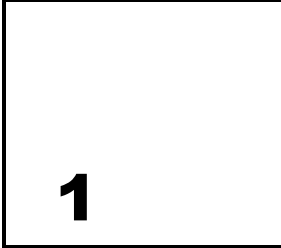
This section also discusses the lessons learned from Massachusetts health reform, which may apply to Maryland. These include the following:

- Engage stakeholders.
- Maintain strong, centralized coordination among government agencies.
- Maintain close coordination between Medicaid and the new public programs.
- Employ an intense, statewide effort to enroll currently uninsured.
- Make individuals and businesses aware of available subsidies and potential penalties.
- Understand that there will still be some uninsured and underinsured. Maintain safety-net systems.
- Collect feedback from consumers, providers, employers, and other stakeholders. Adjust policies, processes, and operations as needed.
- Advocate for health system reforms that will reduce the cost of health care while expanding coverage and care.

Many aspects of PPACA have not been finalized. Consequently, many details of the final regulation are unknown, including how the benefits will look in the essential benefit plan, which rules will ultimately govern the exchanges; how open enrollment periods will be administered; what limitations there will be on changing carriers during a 12-month period and/or purchasing richer or leaner benefits during a 12-month period, and how the area regions for the rating limitations bands can be defined.

At the time this paper is being written, several lawsuits are pending that challenge the constitutionality of the individual and employer mandates in PPACA. Therefore, this paper must be considered in this environment. Where appropriate, we have based our analysis on PPACA as currently written and/or our interpretation of PPACA.

We are not lawyers and are not qualified to render legal opinions. MHCC should seek its own legal counsel for legal interpretations. This paper is generally a qualitative analysis of PPACA's potential impact on Maryland's individual and small group markets. While we have incorporated some analytics, these metrics are based on the current markets. We have not attempted to model the impacts of migrations between markets (individual, small group, and large group) or between these markets and Medicaid. In addition, we have not modeled the number of currently uninsured that may be expected to purchase insurance in 2014.



## Individual and Small Group Premium Changes

PPACA defines a number of benefit, rating, and underwriting requirements, all of which may affect premiums in the individual and small group markets. The following tables outline these requirements (effective beginning in 2011 and later).

### Provisions Affecting Benefit Requirements

Benefit Requirements	Effective Date	Individual		Small Groups	
		Grandfathered	Non-Grandfathered	Grandfathered	Non-Grandfathered
Elimination of Annual Dollar Limits	2014		X	X	X
Essential Benefits	1/1/2014		X		X
Annual Out-of-Pocket Maximum (Limited to HDHP Levels)	1/1/2014		X		X
Deductible Limits at \$2,000/\$4,000 (Single/Family)	1/1/2014		X		X
Specific Actuarial Value Requirements <sup>4</sup>	1/1/2014		X		X
Minimum Loss Ratios <sup>5</sup>	CY 2011	X	X	X	X
Rate Review for Unreasonable Increases	2010 Plan Years	X	X	X	X <sup>6</sup>
Guarantee Issue	1/1/2014		X	Already required under HIPAA	Already required under HIPAA

<sup>4</sup> Actuarial values for Bronze, Silver, Gold, and Platinum are 60%, 70%, 80%, and 90%, respectively.

<sup>5</sup> MLRs are 80% for individual and small groups and 85% for large groups. It appears that states will be able to decide whether they want to merge the individual and small group markets to meet this requirement.

<sup>6</sup> Insurance reforms apply only to insured small group plans; they would not apply to self-funded plans.

Provisions Affecting Rates and Underwriting

Provision	Effective Date	Individual		Small Groups	
		Grandfathered	Non-Grandfathered	Grandfathered	Non-Grandfathered
Elimination of Pre-Existing Condition Periods for All	1/1/2014		X		X
No Waiting Periods > 90 Days	1/1/2014		X		X
Exchange Operational	1/1/2014		X		X
Temporary Individual Market Reinsurance <sup>7</sup>	2014 – 2016				
Modified Community Rating <sup>8</sup>	1/1/2014		X		X
Definition of Small Employer Changed	<sup>9</sup>				X
Risk Corridors <sup>10</sup>	2014 – 2016		Qualified Health Plans		Qualified Health Plans
Risk Adjustment <sup>11</sup>	1/1/2014		X		X
Interstate Sales Compacts	2016				

The proposed changes’ effects on premiums will vary between the individual and small group markets. There are some commonalities between the two.

<sup>7</sup> Requires nonprofit state-run reinsurance entities to collect payments and use amounts to make reinsurance payments to health insurers that covered high-risk individuals in the individual market. Funded by \$25 billion in assessments on all individual and group insurers as well as all third-party administrators (on behalf of self-funded plans).

<sup>8</sup> Gender is eliminated as a rating factor; the ratio of highest age factor to lowest age factor is 3:1; 50% load for tobacco use; appears to currently allow only single/family dependent tier options; area will be an allowable factor, but it appears that each state will now have the authority to establish specific rating areas and the Health and Human Services (HHS) Secretary has approval authority over the state’s recommendations; credits for wellness programs may be as high as 50%. Most notably absent from these reforms is variation attributable to morbidity.

<sup>9</sup> Definition of small employer must be self-employed up to 100 employees. However, states have the option to keep definition of small group employer at 1–50 for 2014 and 2015. Beginning in 2017, states can permit employers with more than 100 employees to join exchanges, but it appears that all insured large groups must then follow the same rating limitations as small groups (in or out of the exchange).

<sup>10</sup> Language appears to limit the risk corridors only to insuring entities’ qualified health plans (QHPs) that are participating in exchanges. The goal is to minimize the impact of selection that any particular QHP may incur as a result of participating in the exchanges. QHPs whose allowable costs are less than a targeted amount will need to return part of the premium. If a QHP shows that allowable costs are 92% to 97% of a target amount, the QHP would have to pay 50% of the excess of 97% of the target amount. If the allowable costs are less than 92% of the target amount, the QHP would pay 2.5% of the target amount and 80% of the difference between the actual amount and 92% of the target amount. If the QHP allowable costs are between 103% and 108% of a target amount, the QHP would be paid 50% of the amount in excess of 103% of the target amount. If the allowable costs exceed 108%, the QHP would be paid 2.5% of the target amount plus 80% of the excess over 108% of allowable costs. Allowable costs are defined as the total costs (other than administrative costs) of the QHP in providing covered benefits. Allowable costs are reduced by any risk adjustment and reinsurance payments received as provided in PPACA.

<sup>11</sup> Risk adjustment will apply only to non-grandfathered plans. Effective date is tied to the date the exchanges become operational, if for some reason they would not be operational by January 1, 2014.

## Minimum Loss Ratio

In order to ensure value for consumers, PPACA requires that a certain percentage of premiums be returned to consumers in the form of claims. This is often referenced as the PPACA minimum loss ratio (MLR). The PPACA MLR requirement for the individual market is 80%, meaning that for every dollar of premium at least \$0.80 must be spent by the insuring entity on claims or services that improve health care quality. The PPACA loss ratio (PLR) differs from the traditional loss ratio (TLR) often referenced in statutory statements and/or other industry reports. The TLR is generated by dividing incurred claims by earned premiums. The PLR provides for the inclusion of other services that “improve health care quality” and fraud detection<sup>12</sup> in addition to claims; premiums are reduced by taxes, licenses, and assessments. The PLR is further adjusted to reflect fluctuations attributable to smaller insurance pools and higher deductibles.

Because of these different definitions, a TLR of less than 80% may equal a PLR of 80%. The amount of difference varies by company – depending on its expenditures for services that qualify as improving health care quality; its savings from successful recoveries for fraud and abuse; its taxes, fees, and assessments; its product mix; and the size of its insurance pools.

## Essential Benefits

PPACA specifies that all health plans must cover essential benefits. Until the Department of Health and Human Services (HHS) finalizes the definitions of “essential benefits,” no one will be able to estimate with any certainty the impact of any changes in benefit levels from those prevalent in the industry today.

Recommendations for determining the “essential benefits” have been (and continue to be) provided from a variety of sources. Helen Darling, President and CEO of National Business Group on Health, discusses five key points to consider when developing the essential benefit package.<sup>13</sup>

- Medical necessity
- Efficiency and affordability of benefits
- Importance of benefit limits to reduce unnecessary care
- Recognition of the importance of consumer-directed health plans in providing affordable coverage for those who would be uninsured otherwise
- Not looking to state mandates as criteria for determining the essential benefit package

The last bullet is especially critical to a state such as Maryland, which currently requires insurers to provide many Maryland-specific state-mandated benefits. As currently

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<sup>12</sup> The amount of credit for fraud and abuse is limited to the dollar amount of direct dollars saved.

<sup>13</sup> Darling, Helen, “Recommendations on Criteria and Methods for Defining and Updating Individual Mandates and Packages – Purchaser Perspectives.” Accessed March 29, 2011. <http://www.iom.edu/~media/Files/Activity%20Files/HealthServices/EssentialHealthBenefits/2011-JAN-12/1100%202%20Darling.pdf>

written, PPACA does not allow federal premium subsidies for that portion of the premium attributable to any state-specific mandated benefits that exceed those defined in the federal essential benefit plan. Furthermore, states must make payments to individuals enrolled in a qualified health plan (QHP) or to carriers offering the QHP to "defray the cost" of the additional required benefits associated with state-specific mandated benefits that exceed those defined in the federal essential benefit plan. Furthermore, this payment is not limited to only those individuals who receive premium subsidies, but to *any* individual enrolled in a QHP in the Exchange. Quantifying that portion of the premium that reflects state-specific mandated benefits that exceed the federal essential benefit plan will be administratively challenging. Based on the considerations outlined by Ms. Darling, state-specific mandated benefits would not automatically, by definition, be part of any federal essential benefit plan. This will be addressed later in the paper.

In a presentation to the Institute of Medicine (IOM, the entity charged with initially recommending to HHS what constitutes essential benefits), Alan M. Garber expands on the concept of medical necessity and distinguishes between benefit "coverage" decisions and "medical necessity" decisions:<sup>14</sup>

- "A [benefit] coverage decision is a policy decision about categories of health interventions provided to a population as part of the statutory mandate."
- "A medical necessity decision is about the appropriateness of a specific treatment for a specific patient."
- "Not all [benefit] covered services are medically necessary; not all medically necessary treatments are covered."
- "Unless the contrary is specified, the term "medical necessity" must refer to what is medically necessary for a particular patient, and hence entails an individual assessment rather than a general determination of what works in the ordinary case."

Garber makes an important distinction: providing an essential benefit package to address the needs of covered persons may not always ensure the benefits that are medically necessary for each specific person, and in some cases may provide additional benefits that are not medically necessary for a specific person. Therefore, including medical necessity criteria in the essential benefit package may better address these targeted issues.

However, that would appear to neutralize any internal limits (such as number of visits) that may be incorporated into any essential benefit package.

Including "medical necessity" in the essential benefit plan that is interpreted as including benefits exceeding a literal interpretation of scope of the benefits listed could introduce two additional types of costs associated with providing medically necessary benefits. There are the additional direct costs of the claims that are identified as medically necessary today that would not have been paid previously due to plan limitations. In addition to these direct costs, there are also costs involved with managing a higher volume of appeals due to inclusion of medically necessary coverage. We found only one

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<sup>14</sup> Garber, Alan M., "Medical Necessity, Coverage Policy, and Evidence Based Medicine." January 13, 2011.

study that attempted to quantify the impact of inclusion of “medical necessity” that could result in expansion of coverage. The S.6 Patients’ Bill of Rights Act of 1999 was being considered and included similar language regarding medical necessity. In its summary of the S.6 Patients’ Bill of Rights Act of 1999, the Congressional Budget Office estimated that these costs contribute an additional 0.8% to the overall premiums.<sup>15</sup> In our opinion, this may understate the ultimate impact since patients may pressure physicians to designate expansions of coverage as “medically necessary.”

In the 1990s there were multiple lawsuits concerning how carriers administered “medical necessity.” Carriers were accused of conspiring to improperly deny, delay, or reduce payment to physicians by engaging in allegedly improper conduct, including failing to pay for “medically necessary” services in accordance with member plan documents. Under the terms of the settlements, each company agreed to accept a definition of medical necessity. The definition is generally the same for each company, as follows:<sup>16</sup>

*“Medically Necessary” or “Medical Necessity” shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: a) in accordance with generally accepted standards of medical practice; b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and c) not primarily for the convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.”*

This definition appears to be more restrictive than the one offered by Alan Garber. Furthermore, any definition of “medical necessity” that results in expanding benefits beyond those in the insurance contract could significantly increase claims and, in turn, premiums.

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<sup>15</sup> Congressional Budget Office Cost Estimate, “S.6 Patients’ Bill of Rights Act of 1999.” June 16, 1999.

<sup>16</sup> Thomas Litigation.

## State-Mandated Benefits

PPACA requires that any ultimate essential benefit plan reflect the benefits typically provided by employers. Employers purchasing fully insured products will, by law, be required to provide all mandated benefits in a specific state. Therefore, to estimate the impact of state-mandated benefits, it is beneficial to study the benefit plans of the self-insured employers, because they are not required to provide mandated benefits prescribed in any specific state.

MHCC conducts a comprehensive review of Maryland's state-mandated benefits every four years. At the time this report is being written, the most recent review was published in January 2008. This study compares the full and marginal costs of Maryland-mandated benefits in effect in 2007 with those of surrounding states. The marginal cost equals the full cost of the services minus the value of the services that would be covered without the mandate.<sup>17</sup> To determine the services that would be covered without the mandate, MHCC conducted a survey of the types of benefits the largest carriers administer for self-funded clients. The study found that, while the full costs of Maryland-specific mandates represent about 15% of total premiums for the small group market (19% for the individual market), the marginal costs were significantly lower – only a little over 2% of total premiums. These statistics may be understated to the extent that additional mandates have been passed since December 31, 2007 that are not reflected in the previous study.

However, if the ultimate “essential benefit” package does not include the Maryland mandates in effect in 2007, the cost to the State of Maryland for these mandates would be almost \$43 million (based on 2009 premium dollars) for the individual and small group markets.<sup>18</sup> Costs for 2014 can be expected to be higher due to medical inflation between 2009 and 2014. Expanding the covered enrollment in these two markets would also increase costs to Maryland. If the ultimate essential benefit package contains fewer benefits than those represented in the MHCC study, then the cost to the state of providing the Maryland-specific mandated benefits would be higher than the marginal costs reflected in the January 2008 MHCC study.

## Costs

The comprehensiveness of the “essential benefit” package is directly related to the ultimate costs of the premiums, government subsidies, and overall level of insurance coverage. Very rich “essential benefits” will result in high premiums. Jonathan Gruber estimates that a 10% increase in costs resulting from a rich essential benefit package translates into a 14.5% increase in government subsidy costs. Consequently, the higher premium charges would enable an additional 4.5% of insureds<sup>19</sup> to drop coverage without being subject to any penalties, since the requirements regarding mandatory coverage with

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<sup>17</sup> MHCC, “Study of Mandated Health Insurance Services: A Comparative Evaluation.” January 1, 2008.

<sup>18</sup> Based on information from the Maryland Insurance Administration, earned premium for calendar year 2009 for the individual and small group comprehensive major medical markets was just under \$2 billion. The cost of the marginal benefits from the MHCC 2008 study was about 2.2% of premiums.

<sup>19</sup> Gruber, Jonathan, “Economic and Political Considerations in Setting Essential Benefits.” January 2011.

penalty apply only when premiums (as a percentage of income) are below a certain level. Therefore, it is important to note that providing coverage for additional “essential benefits” will improve the benefit plan, but will adversely affect both the level of premiums charged (i.e., drive up the costs) and the number of people covered (i.e., reduce the number of people insured as more will be exempted from any financial penalties for not carrying insurance because premiums, which are relatively higher, will be deemed unaffordable for a larger share of the population than would have been with a “leaner” set of essential benefits).

## Dependent Tier Options

As currently written, PPACA provides for only two types of dependent tiers: single and family. Most small group carriers employ either three-tier or four-tier dependent options. (Three-tier: employee only, employee plus one, and employee plus two or more dependents. Four-tier: employee only, employee and spouse, single parent, and family.) We know of some carriers that employ per-member rating to develop premiums, so that a family of five would pay more than a family of four. Most individual carriers offer four-tier dependent options. It is much more common in the industry for individual carriers to use a “per child” rate than in the small group market.

The limits on the number of tiers are further complicated by the fact that PPACA has already mandated extending dependent coverage to age 26. The combination of a two-tier dependent structure and extended coverage will encourage younger individuals to continue coverage under their parents’ plan in lieu of participating in their own employer’s plan. In a two-tier rate structure, no additional premium is charged – whether only a spouse is covered or one or more children are covered. Thus, even a married child with his or her own employment can continue to be covered under a parent’s plan for “free,” whereas he or she may be required to contribute toward his or her own employer’s insurance and/or fully fund any insurance purchased in the individual market. This could result in significantly fewer younger people in both the individual and small employer pools. This is the population that is providing the premium subsidies to the older populations, whose premiums are artificially capped due to the 3:1 age rating band. Fewer people in this young insured segment will result in higher gross premiums for everyone in the pool, all other factors being equal.<sup>20</sup>

## Market-Specific Impacts

In this section, we identify the impacts that will differ by market segment.

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<sup>20</sup> This comment is based upon the existing market. Migration modeling to estimate that potential increase in the number of insured and their relative morbidity was outside the scope of this study.



## **Individual Market**

### **Minimum Loss Ratio (MLR)**

The 2009 traditional loss ratio (TLR) for the individual market as a whole in Maryland was 83.4%.<sup>21</sup> As previously noted, a TLR ratio of 83.4% will result in a higher PPACA loss ratio (PLR) because PPACA allows for additional costs to be included in the claims component compared to the TLR and PPACA allows for premiums to be reduced for certain expenses. Higher claims and lower premiums, as allowed under PPACA, will result in the PLR being equal to or higher than its corresponding TLR.

CareFirst covered 89% of Maryland's individual market in 2009 and had a TLR of 83.8%. Since the TLR for the individual market as a whole in Maryland and for CareFirst were both above the PPACA MLR requirement of 80%, we would not expect premiums in this market to decrease materially as a result of the PPACA MLR requirement. However, even with CareFirst's majority market share, theoretically some of the smaller insurers could be required to reduce their premiums or provide rebates to meet the requirement.

We reviewed the TLRs for the non-CareFirst insurers for 2009 and found the aggregate TLRs for these companies to be 80.9% which is slightly above the PPACA MLR requirement of 80%. Within this aggregation, four of the carriers have TLRs below 80%. These carriers make up \$27 million of the total \$356 million of 2009 premium. The 2009 TLR for these carriers was 65.6%. However, PPACA allows for credibility adjustments based on the number of life years and average deductible, in addition to other adjustments previously described.

Adjusting *only for the life-year credibility*, as we do not have information regarding the average deductible for each carrier, there is only one carrier whose loss ratio is still lower than the PPACA MLR requirement of 80%<sup>22</sup>. It is very possible that the other adjustments allowed under PPACA may enable this carrier to achieve the minimum level. However, if this was not the case, this carrier had only \$9 million in earned premiums for 2009, or only 2.6% of the total individual premium in Maryland. Even if this carrier pulled out of the state entirely, this would not result in a major disruption. Nor would material premium rebates be awarded if this carrier chose to remain in the state and failed to meet the PPACA MLR requirement. If 2009 is a typical year for the Maryland individual market, we would not expect the introduction of PPACA MLR requirements to substantially affect premium levels or access to insurance products.

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<sup>21</sup> Information provided by Maryland Insurance Administration.

<sup>22</sup> To reflect the random fluctuation in claims associated with smaller insurance pools, NAIC recommended and HHS adopted credibility adjustments as part of the calculation of the PLR, as well as adjustments for pools that reflect high deductible amounts. The credibility adjustments are based upon the number of life years, which is calculated by taking the total number of member months (i.e., a single member insured for twelve months is reflected as twelve member months) and dividing by 12. The actual credibility factors can be found on Table 1, of Federal Register, Volume 75, Number 230, Wednesday, December 1, 2010, Rules and Regulations. <http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf>

## Essential Benefits

In the pre-PPACA individual market, it was not uncommon for people to minimize or eliminate certain types of benefits that they believe they did not need, or to begin self-funding totally or partially. Among these were maternity benefits, prescription drugs, preventive services, and oral and vision care for dependents.

In Maryland, carriers are only required to provide 48 hours of inpatient hospital care for maternity. Physician expenses associated with maternity and prenatal care are not mandated benefits. CareFirst, which covers the majority of the individual market, offers expanded maternity coverage including physician services as an optional benefit. With PPACA, all costs associated with maternity must be covered. CareFirst is currently charging an additional \$126 per month for the optional maternity benefit regardless of age.<sup>23</sup> This is roughly 60% to 150% of the base plan rates, depending on the plan chosen and the insured's age.

In order to estimate the overall impact of mandating maternity coverage, we have assumed that only females under age 45 in family policies will require maternity benefits. Using the age distribution and premium relativities from the HIAA survey<sup>24</sup> and assuming maternity costs are equal to the loads currently charged by CareFirst, we estimate the overall impact of including maternity coverage to be 5% to 8% of premiums. Two items were not accounted for in the development of this estimate. First, the current CareFirst maternity rates most likely include a portion for adverse selection, since maternity coverage is currently optional. This selection charge will not be necessary with PPACA, where maternity coverage will be provided for all. Second, since CareFirst currently offers maternity as an optional benefit, we anticipate that maternity benefits are currently being provided for some portion of the individual market. Therefore, we think that actual maternity costs will be lower than our 5% to 8% estimate. Selection costs alone could be worth half of the current maternity charges. Therefore, we think that actual maternity costs with PPACA will cause aggregate premiums to increase in the range of 2% to 4%.

Mental health is currently a mandated benefit in Maryland. Additionally, Maryland already mandates coverage for preventative services such as child wellness, mammograms, routine gynecological care, and prostate cancer screening. Therefore, there should not be a significant premium impact due to PPACA benefit requirements for mental health and preventative services.

## Unisex Rating

In Maryland's current individual market, premium rates may vary by gender. However, CareFirst, which covers the majority of the individual market, uses unisex rating (adding a charge for females who choose optional maternity coverage). With PPACA, premium rates may not vary by gender. Since the largest carrier already charges unisex premium

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<sup>23</sup> Based on [www.eHealthInsurance.com](http://www.eHealthInsurance.com) quotes for CareFirst plans (3/1/2011 effective date).

<sup>24</sup> Musco, Thomas D., "HIAA Survey: Individual Medical Expense Insurance Affordable, Serves Young and Old." 2002.

rates, we anticipate that the only major impact that insureds will experience under PPACA is a spreading of the maternity charge across both males and females. In other words, we think the “average” premium rate will not change significantly due to unisex rating, but the rates at various ages and genders could vary significantly.

As discussed in the prior section, the additional maternity charge is anticipated to be in the range of 2% to 4%. However, based upon publicly available CareFirst premium rates, the additional maternity charge for a young male and a young female (currently without maternity coverage) could be as high as 55% to 75%, assuming carriers allocate the equivalent female load at that age equally to both males and females. On the other hand, the oldest ages may not see any change in their premium rates due to the unisex rating requirement, depending on how carriers decide to charge for mandatory maternity coverage. Additionally, any females that currently have maternity coverage should see a premium rate reduction, as the premium rate charged for the maternity risk will be spread across both males and females.

As previously discussed, 11% of the individual market is covered by non-CareFirst plans. A brief survey of current rates for plans available on *ehealthinsurance.com* indicated that Coventry may be using a unisex rating structure in Maryland. However Aetna, Kaiser, and UnitedHealth all appear to use gender-specific rating in Maryland. Individuals on any of these plans may see a rating impact in addition to the maternity impact described above, due to PPACA’s mandatory unisex rating structure. For instance, a 29-year-old male could see an additional 15% increase attributable solely to changing from gender-specific rates to unisex. These rates could increase another 55% to 75% for young males if the maternity load is allocated equally across males and females. This is before any impact due to expansion of benefits.

### Guarantee Issue

Under PPACA, individual policies must be issued on a guaranteed basis. This is a significant change from the current individual underwriting environment, in which applicants may be denied coverage on the basis of health conditions. We can use the costs of the existing high-risk-pool insureds to estimate the impact of guaranteed issue in the individual market.

### Inclusion of High-Risk-Pool Insureds in the Individual Market Effective 2014

Currently, Maryland has two high-risk pools. The Maryland Health Insurance Plan (MHIP) was created in 2002. The MHIP rates are limited to 150% of the standard risk rate for individual insurance. An applicant may qualify for the MHIP if he or she has been a Maryland resident for at least six months and meets any of the following criteria:

- The applicant has been denied coverage by an individual insurance company.
- The applicant has health insurance, but coverage for the pre-existing condition(s) is either limited or excluded.
- The applicant has been diagnosed with a condition that is on the MHIP conditions list.

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- The amount of the applicant's current health insurance premium is higher than the MHIP premium or what a person with no pre-existing condition would pay in the individual market.

The Pre-existing Condition Insurance Plan (PCIP) is the new high-risk pool that is offered under PPACA. Applicants may qualify for the PCIP if they have been uninsured for at least six months and have a pre-existing condition or have been denied coverage or excluded coverage for the pre-existing condition by a private insurance company. The PCIP rates must be 100% of the standard risk rates. The MHIP Federal Plan has been designated as the entity that would implement the PCIP for Maryland. The MHIP Federal Plan took effect September 1, 2010.

Starting in 2014 under PPACA, all individual applicants will have to be issued coverage on a guaranteed basis. Therefore, we anticipate that in 2014 there will be an inflow of higher-cost customers to the individual market from Maryland's current high-risk pools.

Insureds in the high-risk pools have increased costs. While the premium rates for the MHIP are limited to 150% of the standard risk rate for individual insurance, the actual premium rates have varied over time as a percentage of the standard risk rate. From July 2008 to June 2009, the premiums ranged from 115% to 135% of the standard risk rate, depending on plan. The most current rates range from 112% to 134% of the standard risk rate.<sup>25</sup>

We cannot calculate the average premium rate as a percentage of the standard risk rate across all plans, as we do not have a distribution of members by plan. For the purposes of analyzing impacts, we have assumed that the average premium rate is 120% of the standard risk rate. The rates for the MHIP Federal Plan are limited to 100% of the standard risk rate. Since the MHIP Federal Plan began in late 2010, we have been unable to locate statistics on the plan's current enrollment and experience. However, if we assume that when the high-risk pools are combined with the current individual market, the 20% high-risk-pool rating load related to the MHIP will be spread among all individuals in the new market, then the resulting average load spread across all of the insureds in the new individual market would be 2% to 3%.

It is important to note that the MHIP high-risk pool is currently running at a 242.5% loss ratio.<sup>26</sup> It is reasonable to think that carriers would like a loss ratio closer to the current individual loss ratios (83.4%). If this loss ratio was targeted for this segment, and if the new individual market reflects only the membership of the combined existing individual market and the members in the high-risk pools, then the resulting average increase to the premiums of the resulting individual market would be roughly 26%. This demonstrates the critical need to enroll many new, healthy members into the individual market in order

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<sup>25</sup> Provided by Kent McKinney, Executive Director, Maryland Health Insurance Plan on March 4, 2011.

<sup>26</sup> Maryland Health Insurance Plan, "Statutory Financial Statements and Supplemental Information as of June 30, 2009 and 2008 and for the Years Then Ended."

to avoid a significant increase in premiums resulting from the merging of the high-risk pools with the existing medically underwritten individual market. PPACA has recognized the potential for this upward pressure and has included reinsurance for high-cost claimants for the first few years, risk corridors for the first few years, and risk adjusters ongoing.

### Actuarial Value

In addition to changing underwriting, the individual market will have to meet the minimum actuarial value requirements. All health plans must have an actuarial value of at least 60% for Bronze plans. A complete analysis of the impact of this particular feature of PPACA would entail obtaining information from all carriers currently participating in Maryland's individual market, which is outside the scope of this particular study. However, Oliver Wyman has estimated the impact of the actuarial value requirements nationwide.<sup>27</sup> Approximately 5.4 million people currently insured in the individual market (approximately 32% of the total individual market) have policies that do not meet the 60% threshold for the Bronze plans. These insureds would have to purchase higher-cost plans as a result of this requirement. Oliver Wyman estimates that reaching a minimum actuarial value of 60% for the Bronze plan would raise premiums in the individual market by 6% (excluding the cost of other minimum-benefit requirements).

### Modified Community Rating

Under PPACA, the premium rate for a given age cannot be more than three times the premium rate for any other age (i.e., 3:1 age band). Maryland's individual market does not currently restrict premium rates by age. The majority, or roughly 89%,<sup>28</sup> of the individual market consists of CareFirst insureds. Therefore, we have used CareFirst premium rates to determine the impact of the PPACA age-rating restrictions. It appears that CareFirst uses slightly different age-rating slopes for the HSA and Saver products; we have reviewed both. The impact of the age-rating restrictions is shown in the following table. CareFirst currently has roughly 4.5 to 1.0 rating, meaning that the premium rates for the oldest age are 4.5 times those of the youngest age. This range will need to be compressed under PPACA; either the rates for the youngest ages will need to be increased, the rates for the oldest ages will need to be decreased, or some combination of both. We have assumed that carriers will first decrease the rates for the oldest ages and then recover the shortfall in premium by increasing rates across all ages evenly.

Given the age slopes shown in the following table and the Maryland distribution of individual insureds by age,<sup>29</sup> the HSA rates for a 59-year-old and a 64-year-old will need to decrease by 13% and 31%, respectively, and the HSA rates for individuals age 19 to 54 will need to increase by 4% to offset the premium shortfall. Similarly, the Saver rates for

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<sup>27</sup> Grau, Jason, and Kurt Giesa, "Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets." December 3, 2009.

<sup>28</sup> Based on insured information provided by Maryland Insurance Administration on 3/22/2010 for 2009.

<sup>29</sup> 2008 count of insureds in the Individual Maryland market by age, provided by the Maryland Health Care Commission.

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a 59-year-old and a 64-year-old will need to decrease by 10% and 27%, respectively, and the Saver rates for individuals age 19 to 54 will need to increase by 3% to offset the premium shortfall.

We have assumed that the average impact of the age-rating restrictions will be revenue neutral in the aggregate, or 0%. Please note that these are gross rates. Some individuals will be eligible for premium subsidies, which may mitigate some of the increases attributable to the PPACA changes.

***CareFirst Rating Impact Due to Age-Rating Restrictions Only  
(Does NOT Include Adjustments for Benefits)***

***Example 1: Reduce Oldest Ages, Increase Youngest and Mid-Ages Evenly<sup>30</sup>***

Age	Premium Change Required		Current Age Slope		Revised Age Slope	
	BluePreferred HSA	BluePreferred Saver	BluePreferred HSA	BluePreferred Saver	BluePreferred HSA	BluePreferred Saver
19	4%	3%	1.00	1.00	1.00	1.00
24	4%	3%	1.06	1.08	1.06	1.08
29	4%	3%	1.15	1.20	1.15	1.20
34	4%	3%	1.32	1.30	1.32	1.30
39	4%	3%	1.49	1.43	1.49	1.43
44	4%	3%	1.84	1.76	1.84	1.76
49	4%	3%	2.30	2.19	2.30	2.19
54	4%	3%	2.87	2.73	2.87	2.73
59	-13%	-10%	3.61	3.43	3.00	3.00
64	-31%	-27%	4.50	4.27	3.00	3.00

\*Based on www.eHealth.com quotes as of 2/3/2011, with an effective date of 3/1/2011 for 21201 ZIP code.

Carriers may hesitate to adopt this particular adjustment to rates because of the expansion of coverage to dependents (even married dependents who have access to their own employer insurance, to age 26) that has already been enacted as part of PPACA. There may not be enough individuals under age 26 to be enrolled to offset the loss of premiums for the older ages. Also, no carrier will want to have “the lowest highest rate,” as that would result in a higher-than-anticipated enrollment of older individuals, whose premiums are not self-supporting.

Another pricing option would be to lower the rates of the oldest insureds, increase the rates of the youngest insureds, and make no change to the rates for insureds in the middle age bands. The rating changes under this example may look like those shown in the table below.

<sup>30</sup> Revised Age Slope factors are anchored on the age 19 factor and cannot be directly compared with the Current Age Slope factors to estimate the Premium Change Required.

*CareFirst Rating Impact Due to Age-Rating Restrictions  
Example 2: Reduce Oldest Ages, Increase Youngest Ages<sup>31</sup>*

Age	Premium Change Required		Current Age Slope		Revised Age Slope	
	BluePreferred HSA	BluePreferred Saver	BluePreferred HSA	BluePreferred Saver	BluePreferred HSA	BluePreferred Saver
19	20%	21%	1.00	1.00	1.00	1.00
24	9%	7%	1.06	1.08	0.97	0.96
29	6%	3%	1.15	1.20	1.02	1.02
34	3%	1%	1.32	1.30	1.13	1.09
39	0%	0%	1.49	1.43	1.24	1.18
44	0%	0%	1.84	1.76	1.53	1.45
49	0%	0%	2.30	2.19	1.92	1.81
54	0%	0%	2.87	2.73	2.39	2.26
59	-8%	-7%	3.61	3.43	2.77	2.64
64	-20%	-15%	4.50	4.27	3.00	3.00

\*Based on www.eHealth.com quotes as of 2/3/2011, with an effective date of 3/1/2011 for 21201 ZIP code.

This example shows substantially higher increases for the youngest ages and significant decreases for the older ages.

Both examples shown above result in the oldest rates being three times the youngest rates and an overall aggregate premium impact of 0%. However, the impact to individual policyholders can vary significantly based on the insured's age and the rate compression strategy chosen by the insurer.

**Summary**

The following table summarizes the average premium impacts of the PPACA requirements discussed above for the individual market. The largest driver of the average premium increase is the guarantee issue requirement under the current environment, followed by the actuarial value requirement of PPACA. We anticipate that the average aggregate premiums in the individual market will increase by roughly 35% for the requirements discussed above. However, depending on an insured's specific characteristics, the rate increases experienced by individual policyholders could be significantly higher (or lower) than those shown in the table on the following page. Some rating cells may see no change in their rates.

<sup>31</sup> Revised Age Slope factors are anchored on the age 19 factor and cannot be directly compared with the Current Age Slope factors to estimate the Premium Change Required.

*Individual Market Aggregate Premium Impacts*

	Average Premium Impact
Minimum Loss Ratio	Not Significant
Maternity Mandate	2% to 4%
Mental Health Mandate	0%
Unisex Rating	0%
Guarantee Issue	26%
Actuarial Value	6%
Age-Rating Restrictions	0%
Total	34% to 36%

Note, these impacts do not reflect any premium subsidies that will be available to individuals as a result of PPACA. The impact of newly insured individuals entering the market has not been taken into consideration – nor has any migration attributable to changes in dependent tier options. This table demonstrates the upward pressure on premiums in the current market. It does show that in order for gross premiums (i.e., premiums before premium subsidies) to remain stable, there would need to be a substantial increase in lower-cost members entering the individual pool.

**Small Group Market**

Minimum Loss Ratio

The PPACA MLR requirement for the small group market is 80%. The 2009 small group traditional loss ratio (TLR) in Maryland was 80.5%, based on data provided by the Maryland Insurance Association (MIA). We note that the loss ratio calculation defined by PPACA provides for a number of adjustments that are applied to the premium and claims to develop the resulting PPACA loss ratio (PLR). We have assumed that if the TLR, defined as claims divided by premium, is at least 80%, this loss ratio will definitely meet the minimums required by PPACA. CareFirst, which covered 77% of Maryland’s small group market in 2009, had a TLR of 80.6%. Since the historical small group TLRs for Maryland and CareFirst are both above the PPACA MLR requirement, we do not expect premiums to change significantly across the small group market to meet the PPACA MLR requirement.

However, some of the smaller insurers may have to reduce their premiums or provide rebates to meet the requirement. The average TLR for non-CareFirst insurers is 80.1%, which is slightly above the minimum requirement of 80%. Based on the 2009 experience, there are five carriers whose TLR does not meet the MLR requirement for the small group market. These carriers make up \$0.221 billion, or 13.8%, of the total \$1.596 billion of 2009 premium. The 2009 TLR for these carriers was 75.1%. However, PPACA allows for credibility adjustments based on the number of life years and average deductible. Adjusting for only the life-year credibility, as we do not have information regarding the average deductible for each carrier, only three carriers fail to meet the PPACA MLR requirement.



These carriers had \$0.2 billion, or 11.1%, of the total small group premium for 2009. Since these carriers make up 11.1% of the market, there may be some disruption if they pull out of the market due to the PPACA MLR requirement. However, all three of these carriers are relatively close to the requirement (credibility-adjusted loss ratios of 76.6% or higher). Therefore, with the permitted PPACA loss ratio calculation adjustments and average deductible credibility adjustment that we have not included, some of these carriers may actually have met the PPACA MLR requirement. Therefore, the degree of impact to the small group market may actually be lower than we have estimated.

### **Essential Benefits**

PPACA requires all health plans to cover essential benefits. Before PPACA, groups in the small group market sometimes chose to minimize or eliminate certain types of benefits that they deemed unnecessary, or chose to self-fund, either totally or partially. Among these are maternity benefits, prescription drugs, preventive services, and oral and vision care for dependents. This self-selection occurs less in the small group market than in the individual market because the employer choosing coverage may not be fully cognizant of all the medical conditions of his employees and their dependents. This lack of knowledge increases as the group size increases. In the individual market, the person purchasing insurance is very attuned to their medical needs and will choose, if allowed, a policy which best fit these needs and will not purchase policies that include features, such as drugs, that they think they will not use.

Currently, mental health and maternity are mandated benefits in Maryland's small group market. It also appears that coverage in Maryland is already mandated for preventative services such as child wellness, mammograms, routine gynecological care, and prostate cancer screening. Therefore, premium impact for these services should not be significant due to PPACA benefit requirements.

Prescription drug coverage is also mandatory in Maryland's Comprehensive Standard Health Benefit Plan (CSHBP). The mandatory current coverage includes generic and brand drug coverage with \$2,500 individual/\$5,000 family deductibles and 25% plan coinsurance. It is unclear at this time how prescription drug coverage will be mandated under PPACA. We note that Maryland's current mandated coverage is not a rich drug plan design but was constructed to allow plans maximum flexibility in plan design and pricing while ensuring that the Commission retained its regulatory oversight over the pharmacy benefit. However, based on data that carriers provided during audits of the small group information, less than one percent of the groups choose the basic small group health plans – meaning 99% of the groups elect richer pharmacy benefits.

### **Guarantee Issue**

Guarantee issue will have minimal impact in the small group market because the passage of HIPAA required guarantee issue in this market beginning in 1996. HIPAA did not, however, require employers to purchase insurance. So, the existing small group market

reflects guaranteed issue in a voluntary market. Maryland's small group market should not be significantly affected by PPACA's new guaranteed issue requirements.

### Actuarial Value

Historically, small groups have purchased richer benefits than those common in the individual market. Therefore, we would not expect the impact on premium due to PPACA's required benefit levels to be as great for this market as for the individual market.

All health plans must have an actuarial value of at least 60% for Bronze plans in the small group market. We cannot quantify this requirement's impact in Maryland, but we can discuss the impact on a nationwide basis. Based on Oliver Wyman analysis,<sup>32</sup> the actuarial value of products currently purchased in the small group market nationwide is estimated to be 70%, with about 9% of small groups having products with actuarial values below the Bronze plan minimum requirement of 60%. If we apply the individual impacts discussed earlier to the small group market, we estimate that the premiums in the small group market would need to increase by roughly 2% to meet the actuarial value threshold for Bronze plans. This is based on nationwide statistics. To generate Maryland-specific data, we would need to survey the carriers to determine the existing distribution of groups by actuarial value which is outside the scope of this work order.

### Modified Community Rating

Under PPACA, the premium rate for a given age cannot be more than three times the premium rate of any other age (i.e., 3:1 age band). With the exception of groups that were uninsured for the previous 12 months, Maryland law currently requires a maximum rating band of 3:1 for both age and area in the small group market. Gender is not an allowable rating factor in the small group market. It is unknown at this time how many geographic rating areas, if any, will be allowed in the exchange. PPACA does allow a 3:1 variation for age within each defined geographic area. We are assuming that Maryland will not change its laws to eliminate area as a factor from the 3:1 band. Therefore, with the exception of the very small cohort of groups eligible for a wider rating band for a limited period of time (i.e., those uninsured the previous 12 months), PPACA community rating will not affect premium rates in the small group market.

### Summary

The following table summarizes the average premium impacts of the PPACA requirements discussed above for the small group market. We do not expect significant premium increases in the small group market, as many of the PPACA requirements are already in effect in Maryland's small group market. We anticipate that the average aggregate premiums in the small group market will increase by roughly 2% for the requirements discussed above. However, depending on a group's specific characteristics

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<sup>32</sup> Grau, Jason, and Kurt Giesa, "Impact of the Patient Protection and Affordable Care Act on Costs in the Individual and Small-Employer Health Insurance Markets." December 3, 2009.

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(benefits and dependent tier structure), the rate increases experienced by employers and employees could be significantly higher (or lower) than those shown in the following table. Some rating cells may see no change in their rates.

### *Small Group Market Aggregate Premium Impacts*

	<b>Average Premium Impact</b>
Minimum Loss Ratio	Not Significant
Maternity Mandate	0%
Mental Health Mandate	0%
Prescription Drug Coverage	0%
Guarantee Issue	Not Significant
Actuarial Value	2%
Age-Rating Restrictions	0%
Total	2%

Note that these impacts reflect the current market and do not reflect any premium subsidies that will be available to qualifying small groups as a result of PPACA. No estimate for any impact resulting from finalization of the essential benefit package, which is unknown at this time, has been included. The impact of newly insured groups entering the market is not reflected, and no attempt has been made to model small employers' decisions regarding whether to continue offering employer-sponsored insurance.

## Associations

We are including a brief discussion of associations since Maryland does not have regulatory oversight authority for associations that are sited outside of Maryland, even though they sell their products to Maryland residents. It appears that the associations marketed in Maryland are comprised of individuals as opposed to small employers, although there are associations in other states that include small employers, as well.

Statistics from the Maryland Insurance Administration (MIA) show there were nineteen out of state association plans consisting of about 34,000 insureds and about \$54 million in earned premium in 2010.<sup>33</sup> Two associations, one insured by Golden Rule (the largest) and the other by Time Insurance, reflect 84% of the total association earned premiums in the state. Their combined traditional loss ratio (TLR) was 43%, significantly lower than the loss ratios observed for the individual business overseen by the Maryland Insurance Administration.

MIA has indicated that the largest association, Golden Rule, has wider rating bands and does not include coverage for maternity or mental health. We are assuming that rates

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<sup>33</sup> The Maryland Insurance Administration provided these caveats to the association statistics: "This information is un-audited, self reported information from each of the carriers. Note that we do not have jurisdiction over policies and certificates issued through an out of state trust. There may be other out of state trusts that are covering Maryland residents that we may not be aware of."

vary by gender as well. Both of these companies have reputations for being very effective medical underwriters. The upward pressure on rates that we described in the section pertaining to individual coverage will be greater for members of these two plans because of the loss of this effective medical underwriting and the expansion of benefits that will be required as part of the essential benefit plan. At least partially offsetting those upward increases will be a reduction in premiums to satisfy the MLR requirements. However, it is important to note that the timing for when these two offsetting effects occur is different.

Based upon the information we have, it would appear that both of these carriers will need to lower rates by almost 50% to meet the 80% MLR requirements if this is their only business at the company level in Maryland. However, it is unclear at this time where members of associations will be counted---in the state that the association policy is issued or in the state the members reside.<sup>34</sup>

The low loss ratios for these two companies are “puzzling” in that the average premium per member per year for these two plans is about \$1,700, which is less than the \$2,300 premium per member reflected by MIA’s statistics for the individual market for 2009, one year earlier. It is very possible that the benefits represent a significant portion of the differences. The PLR provides for adjustments to the actual incurred loss ratio to reflect claim fluctuations associated with high average deductibles but these adjustments will not negate the need for rebates if 2011 experience is similar.

As indicated, there will be material increases to premium resulting from the elimination of medical underwriting, expansion of benefits and minimum actuarial values. There will be downward pressure on rates *beginning in 2011* for the implementation of the MLR requirements for these association plans.<sup>35</sup> Without additional information, we are unable to quantify the aggregate, net impacts that these opposite forces will have. But if the premium rates are lowered in 2011-2013 because of MLR requirements that will mean they will already be at a lower level when the impacts of the insurance reforms (other than MLR requirements) and essential benefits take effect in 2014. An example may be easiest to illustrate this. Let’s say the current rates are \$100. Because of MLR requirements, this rate is lowered to say \$60 in 2011, 2012 or 2013. The elimination of underwriting, gender rating, increase in benefits, etc. will take effect in 2014. Let’s say insurers think the additional cost of these requirements is similar to our estimate, or 35% of premiums. [This increase could be greater for association plans relative to Maryland individual plans if the association benefit plans are less rich than those of individual policies currently overseen by MIA; it appears that association plans do not have to

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<sup>34</sup> If MLRs for associations are calculated based upon the state where the association policy is issued, the loss ratio for Maryland residents is irrelevant. The MLR will be based upon the aggregate experience in all the states for which that particular association has members.

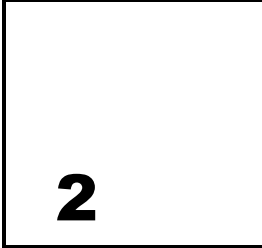
<sup>35</sup> This is true only if associations will be required to calculate MLRs based upon the state of membership versus the state of issue. If associations are allowed to calculate MLRs based upon the state of issue, then we do not know if premium reductions would be necessary because we do not know the aggregate MLR for these associations as a whole.

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include Maryland mandated benefits.] The resulting 2014 rate would be about \$81. ( $\$60 \times 1.35 = \$81$ ). While this is less than their current premium of \$100, it is still 35% greater than what they are going to pay in 2013. So the annual increase that consumers may see in 2014, may still be significant.<sup>36</sup>

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<sup>36</sup> As previously disclosed, all of these calculations use gross rates and do not consider the impacts of premium subsidies or the various risk mitigation mechanisms in PPACA.



## **Impact of Merging the Individual and Small Group Markets**

### Merging Individual and Small Group Markets

States will be required to make a decision sometime in 2011 about whether to merge the individual and small group markets. PPACA requires a MLR of 80% for the individual and small group markets. PPACA has allowed states to choose whether to merge these two markets for the purpose of complying with the MLR rebates or to have the MLR rebates calculated separately for each market.

States will also need to make a decision whether or not to have separate exchanges for the individual and small group markets, which will begin in 2014. Some of the decisions regarding the design of the exchanges will affect the advantages/disadvantages of combining these markets.

### Summary of Policy Issues Affecting the Individual and Small Group Markets (In order of timing of decisions)

#### **Should the individual and small group markets be merged for the purpose of complying with the MLR and rebate requirements effective 2011?**

##### Pros of Keeping Them Separate

- The individual and small group markets are very different in today's environment. The underwriting rules differ, the rating rules differ, the risks differ, and the carriers differ in each space. These differences need to be thoroughly evaluated before making a decision to combine such dissimilar markets solely to comply with the MLR requirements.
- The MLR requirements have the potential to cause much more disruption in the individual market since existing Maryland rules provide for a minimum *lifetime* loss ratio of 60% in the individual market and an annual loss ratio of 75% in the small group

market. A lifetime loss ratio requires an entirely different approach to rate development than an annual loss ratio. The lifetime loss ratio allows for lower annual loss ratios during the early years of the policies and higher loss ratios during the latter years. The annual loss ratio requirement provides for a level loss ratio all years. If a company has similar individual and small group blocks of relatively early duration policies both priced to the same lifetime (individual) or annual (small group) loss ratio, the individual business may have a significantly lower loss ratio at this time than the small group business.

- The small group market (about 410,000 members) has almost three times the number of members as the individual market ( about 150,000 members) and over four times as much premium. Because of this, the results of the small group market will drive the results of any individual/small group combined market for purposes of determining rebates. Given the historical difference in loss ratio requirements and rating approaches (i.e., lifetime loss ratio versus annual loss ratio rating approaches), it would be more likely that a company would not be required to provide rebates in a combined market than if the two markets remained separate.
- The rules for distributing rebates are different for the individual market and the small group market. In the individual market the rebates must be distributed to the individuals, but in the small group market the rebates must be distributed to the employer, including verbiage that the employer needs to share this with employees, if the employees contribute a portion to the cost of health insurance.<sup>37</sup>
- Merging the two markets to determine compliance with the MLR in 2011 may be seen as a precedent for merging the two markets in 2014 when the exchange becomes operational. Maryland may want to keep its options open and observe the disruptions that occur in each of these markets between now and the time the rules for the exchange need to be finalized, recognizing that there will be additional disruptions attributable to each of these markets in 2014.
  - Effective 2014, enrollees in the individual market in the exchange will have guarantee issue (GI) coverage and will no longer be subject to medical underwriting, will not be subject to rejections for insurance, and will not be subject to waiting periods before pre-existing medical conditions are eligible for coverage. All of these are currently allowed in the current Maryland voluntary individual market. In the previous chapter, we have estimated the upward pressure on premiums that will occur on gross rates in this market, which is material. The small employer group market, however, has been subject to GI since the mid 1990's with the passage of HIPAA. Furthermore, individual employees (and their dependents) are not subject to waiting periods for pre-existing conditions, except in very limited situations. As demonstrated in the previous chapter, the anticipated impact on gross premiums rates attributable to

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<sup>37</sup> The Interim Final Rules states that "regardless of whether an issuer provides rebates to enrollees directly or indirectly through a group policyholder, an issuer must take steps to ensure that each enrollee receives a rebate that is proportional to the amount of premium paid by that enrollee and that the group policyholder does not retain more of the rebate than is proportional to the amount of premium it paid. Therefore, this interim final regulation allows an issuer to delegate its rebate distribution functions to a group policyholder, but provides that the issuer remains liable for complying with all of its obligations under the statute and maintains records received from the group policyholder demonstrating that rebates were accurately distributed." <http://edocket.access.gpo.gov/2010/pdf/2010-29596.pdf>

PPACA for the small employer market is minimal. The material differences in the impact on premiums between the two markets, would cause expectations of more disruption in the individual market than in the small group market in 2014.

- As referenced in the previous chapter, the MHCC, through its oversight of the CSHBP, has established a set of comprehensive benefits that must be included in all small group policies (“floors”) as well as a maximum level of cost sharing that can be required (“ceilings”). There are no analogous “floors” or “ceilings” in the individual market. Therefore, material differences exist in the “scope” of benefits and cost sharing provisions between the two markets that create very different risk pools until 2014, where there will be mandated “floors” for both markets.
- There are many reasons why it is difficult to compare premiums in the individual market to premiums in the small group market including materially different benefits. In addition, the small group market contains a full distribution of health risks because insurers are required to accept all groups, while the individual market risk distribution leaves out many of the highest risk because insurers in the this market are allowed to medically underwrite and deny coverage to high risk individuals. However, if these two markets are going to be merged, it is important to be cognizant of the actual dollar differences in the premiums. For calendar year 2009, the annual premium per insured in the individual market was about \$2,300; the corresponding statistic for the small employer market was about \$3,900, or almost 70% higher.<sup>38</sup>
- The federal definition of “small employer” appears to differ from Maryland’s current definition, although the final rules for definitions have yet to be released. The federal definition appears to include *all employees*, including part time, temporary and/or seasonal. Maryland’s current law allows employers to exclude part time, temporary and/or seasonal employees. There will be a subset of Maryland employers that are currently defined under Maryland law as small employers that would be defined as large employers if the current federal verbiage is not modified. This may be a cause of disruption in the small employer market in 2014, which may further exacerbate the disruption that will occur in the individual market, if the individual and small group markets are merged.
- By 2014, Maryland is going to have to decide whether it wants to expand the upper limit for its small employer group from fifty employees to 100 employees. We discuss the role that self-funding may play in the expanded market in the next chapter. Suffice to say that there are real risk differences between the existing individual market, 2-50 employee market and the 51-100 employee market. A “go slow” approach would give policymakers more flexibility in assessing the underlying disruptions in each market.

### Cons of Keeping Separate

- Even though there is a low lifetime loss ratio in the individual market pre-PPACA, CareFirst (the dominant carrier in this market) has almost 90% of the premium in the individual market and 80% of the premium in the small group market. CareFirst’s annual

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<sup>38</sup> Information provided by the Maryland Insurance Administration



loss ratio for 2009 was 84% for the individual market and 81% for the small group market. When the other adjustments are made, we expect CareFirst's loss ratios for both segments to be well above the prescribed PPACA loss ratio of 80%. That makes the differences in loss ratios between the two markets less of an issue.

- Only one calculation will be needed to determine compliance if the markets are merged for MLR purposes, as opposed to two calculations.
- Some carriers may be able to comply with the MLRs if the markets are merged but not if they stay separate. Given CareFirst's dominance, Maryland would not want to do anything that would cause more carriers to leave either market. Based on the TLRs from the 2009 MIA data, 4 of the 10 carriers in Maryland would meet MLR requirement under the merged market scenario, but would not meet the MLR requirement for either the individual or small group market separately. Please remember that TLRs are only preliminary indicators of whether a rebate will ultimately be paid since PPACA provides for other adjustments that result in PLRs that are greater than the TLRs. Without additional information that is not required to be filed by the carriers until summer of 2011, the TLR is the only measure we have available.

### **Pros and Cons of Merging the Individual and Small Group Markets in the Exchanges Effective 2014**

As indicated in the introduction to this section, there are major decisions pertaining to how exchanges will operate that materially effect the pros and cons of merging the individual and small group markets. These decisions impact how much freedom employees of a specific employer will have within the exchange.

#### **Model 1—Defined Contribution**

In this model, the employer defines the dollar amount of contribution he/she is going to contribute to health coverage. This dollar amount may vary by dependent option. Each employee has the freedom to purchase from the entire array of carriers and benefit plans within the exchange. Because of this freedom, the premium for each individual will be based upon their age and dependent status. There will be no "average" rates for a group. This is similar to how the existing Utah exchange operates.

#### **Model 2—Single Source**

In this model, the employer selects the benefit plan and the carrier for the group as a whole, very similar to what occurs in the small employer market today. Because all employees are insured by a single carrier, average rates (i.e., an average single rate for all employees selecting single coverage regardless of age and an average family rate for all employees selecting family coverage regardless of age) can be created. This is how the Massachusetts exchange operates for small employers.

There are variations to each of these models, but the general concepts are the same. The defined contribution model (Model 1) provides for more freedom of choice by

employees, but that type of freedom precludes any use of group-specific average rates. Thus older employees will pay more under this model for the same benefit offered by the same carrier than they would in the single source model. The defined contributions model creates the potential for greater antiselection. The single source model (Model 2) limits choice by employees, but enables the use of average rates, which is very common for the “larger” small group, but eliminates antiselection at the employee level. The scope of this paper is not on the construction of exchanges. We are discussing this issue here only because the type of model affects the advantages and disadvantages of merging the markets.

### Pros for Combining—Both Models

- There seems to be confusion as to how self-employed “groups” of one life are to be defined for the purposes of determining whether they will be included in the small group market as of 2014. Guidance is expected regarding how owners/partners/S and C corporation owners will be counted. If the final guidance expands the lower limit to one life for the self employed, this will create the potential for selection if there are separate exchanges for individual versus small group. The self-employed will be able to choose the market that offers the lowest premium.
- Merging the two markets or keeping them separate depends largely on the ultimate rules for choice among employees in the exchange for the small group market. If the exchanges allow individual employees to choose from all the carriers and plans available (sometimes referred to as “individual choice”), then selection may be minimized by merging the two markets.
- Theoretically, a single pool could prompt the highest number of carriers participating, since it could conceivably include carriers specializing in the existing individual market as well as carriers specializing in the existing small group market, resulting in the most competition and choice for consumers. The dominance of CareFirst in each of these markets currently may make this particular consideration for Maryland less important than in some other states.
- Issues associated with reinsurance and risk adjusters may make a single exchange more functional.
- Some managed care entities that until now have focused only on those markets that did not require underwriting expertise (e.g., Medicaid or Medicare Advantage markets) may perceive a combined market as a greater business opportunity than separate markets, and may be more willing to assume the risk of expanding into the commercial sector.

### Cons

- For states such as Maryland, where the rating rules and underwriting rules have differed greatly between the two markets, there will be substantial rate disruptions as a result of complying with the reforms for each market separately. However, even more rate disruptions may occur if the markets are merged.
- As indicated previously, the current premiums in the two markets are very different for a multitude of reasons. Maryland allows medical underwriting and lets carriers reject individuals entirely on the basis of medical conditions in the individual market. This

results in lower premiums for those who can pass health underwriting. Federal law requires carriers to guarantee-issue coverage to all small employers. According to information provided by MIA, the annual premium per member for 2009 in the individually underwritten market was \$2,337. The analogous premium per member for small group was \$3,894. The difference is partly due to richer benefits, as well as the lack of medical underwriting and demographic differences, in the small group market compared to the individual market. However, a 67% differential in premiums is substantial and will exert upward pressure on the premiums in the existing individual market in 2014 if the markets are merged at that time.

- Certain insureds in the individual market will see very high increases in premiums due to the elimination of gender as a rating factor, elimination of medical underwriting, compression of rating factors attributable to age, and increases in benefits. Merging these individuals with the existing small group market – whose average premium is already substantially higher – would appear to only add to the increase in premiums and potential disruption. For illustrative purposes, we “merged” the individual and small group market based upon 2009 premium levels. The resulting average premium per member per year (PMPY) reflected almost a 50% increase from the average PMPY in the individual market and about a 10% decrease from the average PMPY in the small group market. This is a “crude” estimate in that it does not take into consideration the differences in benefits and demographics, but shows the very large differences in premium levels that currently exist.
- A single pool may result in fewer total carriers and less competition if those carriers that specialize in only one of the existing separate markets choose not to participate in the new combined market.
- The markets can always be merged at a later date. It always seems easier to combine markets than to split them.
- Depending upon the final rules, there may be potential for selection for the self-employed in the small group market versus the individual market. However, this anti-selection will be minimal compared to the disruption of combining the two markets immediately. Also, the final rules could eliminate this potential before 2014.
- Another issue that Maryland needs to consider is that, beginning in 2016, the definition of small group will be expanded to include employers with up to 100 employees. States will have the option of retaining an upper limit of 50 employees for years 2014 and 2015. Expanding the upper limit of the definition of small group will disrupt the markets even further. Premiums for groups of 51 to 100 employees are generally a result of a blend of group-specific experience and “manual rates<sup>39</sup>.” “Manual rates” often differ from community rates for the small groups. It is our understanding that, when the definition of small group expands to include employers with up to 100 employees, the rates outside the exchange for these groups must also be based on community rates, using the same rates

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<sup>39</sup> “Manual rates” are average rates developed from an aggregation of some or all of a carrier’s claim experience. The rates are then adjusted to reflect the specific group’s risk characteristics including such factors as age, gender, industry, area, benefit, group size, etc. Because manual rates are used for group sizes that are not regulated, there are no limits to the magnitude of the adjustments for each of the risk characteristics other than being able to be justified actuarially. Manual rates do NOT reflect the emerging claim experience for the specific group. Manual rates are analogous to community rates except that community rates limit the types and magnitude of the risk characteristics that can be used to adjust the average rate.

for the other small groups. This will be the segment most apt to choose to self-fund when this occurs, especially groups whose current premiums are materially less than those required by modified community rating. It would seem that, at least initially, segregating individual and group exchanges would minimize these distortions as much as possible, given the structures of reforms.

- Issues associated with reinsurance and risk adjustment may make separate markets more functional.

PPACA contains three type of risk mitigation mechanism:

- Risk corridors (first three years only)
- Risk adjusters
- Temporary individual market reinsurance (first three years only)

The goal of risk corridors is to minimize the losses as well as the gains for the first three years of the exchange to encourage carriers to participate. The purpose of risk adjusters is to remove incentives for enrolling only healthy individuals in a market where medical underwriting is prohibited and the range between risk categories is artificially capped. Risk adjusters are to be applied both within and outside the exchange. Theoretically, the only impact on aggregate average gross premium rates pertaining to the first two types of risk mitigation would be the possibility of a slightly lower risk charge incorporated into the rates. There are no new funds coming into the system from external sources.

The goal of the temporary individual market reinsurance is to at least partially mitigate some of the rate shock associated with the entrance of high risk pool enrollees into the individual market. Initial costs may be higher in the individual market if more high risk pool individuals enroll than individuals with average or low risks that were previously uninsured. Also, initial costs could be higher if the average claim amount per member for high risk pool enrollees is not fully offset by the average claim amount per member for the new enrollees that were previously uninsured. This applies only to the individual market. The source for providing this reinsurance is a \$25 billion assessment on insurers and self funded plans with \$10 billion redistributed for 2014, \$8 billion redistributed for 2015 and \$4 billion redistributed for 2016. The details as to how carriers in the individual Exchange market will be reimbursed for high risk individuals are as yet, undefined, as is the amount available to each state.

The interaction of these three programs is unknown at this time. We do know that the temporary individual market reinsurance applies only to the individual market. It may be prudent to defer merging of the individual and small group markets until the impacts of these programs, as well as the impacts of premium subsidies available in the individual market, are better understood.

## Pros and Cons of Merging Unique to Each Exchange Model

### **Model 1 - Defined Contribution**

#### Pros for Merging Individual and Small Employer Market

- This model really transforms the small employer market into an environment that more closely resembles the individual market.
- Combining the markets would maximize the number of enrollees in the pool which should result in more stable and predictable results than in separate markets.
- Individuals leaving groups and/or joining groups would be able to retain their coverage within the Exchange.

#### Cons for Merging Individual and Small Employer Market

- The risks associated with individual coverage differ from those associated with group coverage. If exchanges effectively convert group coverage into individual coverage, there will be more adverse selection as individuals choose benefit plans that maximize their perceived, specific economic well-being. Keeping the markets separate, at least initially, may minimize this impact to the extent that there may be different selection patterns between the individual and small group. By this we mean if there is more selection within the small group block resulting from this model, leading to higher rates for comparable plans, the higher rates would not need to be born by members in the individual block.
- May encourage small employers to drop support of insurance altogether because the presence of premium subsidies for individuals may be highlighted more in a combined market.
- If more small employers drop coverage, the costs to taxpayers will increase because more individuals will be eligible for subsidies.

### **Model 2 - Single Source**

#### Pros for Merging Individual and Small Employer Market

- Combining the markets would maximize the number of enrollees in the pool which, theoretically, should result in more stable and predictable results than in separate markets.

#### Cons for Merging Individual and Small Employer Market

- Care must be taken to retain as much employer-sponsored coverage (with the corresponding employer contributions) as possible, or the costs of premium subsidies will be far higher than anticipated. Currently, employers with fewer than 51 employees are not subject to any penalty for dropping health care coverage or for choosing not to provide it. One way of retaining the “glue” to hold employer groups together is to base the premiums for an employer group in the exchange on the average age for that employer group, as opposed to assigning a different rate to each individual employee. Requiring all employees in the group to have the single plan selected by the employer (as

## Potential Impact of the ACA on the Current Individual and Small Group Markets

Massachusetts has done) will further minimize selection. Incorporating these rules would seem to favor separate markets.<sup>40</sup>

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<sup>40</sup> Massachusetts currently allows group size as a rating factor in the state's merged market. Thus, it is difficult to compare the rates for any particular group to the analogous rates individuals could have purchased on an individual basis. Massachusetts recently required that all employees within a single employer group purchase the single plan selected by the employer, if purchased through the exchange. Outside of the exchange, each carrier can determine how much product choice to allow within a single employer group.

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## **Erosion in the Small Group Market**

In previous sections we have identified some of the factors that may result in erosion in the small group market. The purpose of this chapter is to consider factors that have not been discussed in previous sections.

### **Self-Insurance**

Before PPACA, self-insured plans were subject to considerably less regulation than fully insured plans. Major advantages to self-insured plans included greater flexibility in designing benefit plans, reduced administrative expenses, avoidance of state-mandated benefits, and the ability to capture favorable claims experience.<sup>41</sup> Many of these advantages will disappear with the implementation of PPACA – most significantly, flexibility in benefit design. However, there are still several advantages for self-insured plans.

One of the major advantages to self-insuring is the avoidance of the annual health insurance plan fee. This fee will be assessed to health insurers based on their market share of net premiums written, but will not apply to self-insured plans. The fee will begin in 2014 and will be equal to \$8 billion across all health insurance plans. The amount will increase to \$14.3 billion in 2018. After that, it will increase based on the rate of premium growth in the preceding calendar year. It is expected that this fee will be a pass-through to insureds in the form of additional premium. Since self-insured plans are not subject to this fee, it will be advantageous for an organization to self-insure.<sup>42</sup>

A secondary advantage is that self-insured plans are not subject to PPACA's MLR requirements. While most self-insured plans may run at a loss ratio that is greater than

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<sup>41</sup> International Foundation of Employee Benefit Plans, Inc., "Health Care Reform: What Employers Are Considering – Survey Results May 2010."

<sup>42</sup> Mulvey, Janemarie, "Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)."

the minimum required, self-insured plans will also reap the administrative cost savings of not having to report MLR experience and not needing to calculate and distribute rebates.

Additionally, while insured plans will not be able to discriminate in favor of highly compensated individuals as of 2011, self-insured plans that wish to be non-qualified plans do not have this restriction. Non-qualified, self-insured plans may offer different benefit plans to highly compensated individuals, but will not receive favorable tax treatment. Qualified, self-insured plans will continue to be subject to ERISA's non-discrimination rule if they wish to remain qualified and receive favorable tax treatment.

Self-insured plans enjoy the cash-flow advantages of only having to fund claims when they are actually paid – compared with a fully insured plan, where the employer must “pre-fund” the claims by paying a premium. This will not change. Self-insured plans also are exempted from state-specific mandated benefits, which become very important for employers operating in multiple states. So, some of the reasons for becoming self-insured will remain, and there may be more reasons for some larger groups to reconsider self-insuring (to avoid some of the new fees).

Maryland has already adopted rating reforms (specifically, adjusted community rating) for the small employer market. In Maryland, small group premiums cannot vary by aggregate morbidity of the group. Therefore, before PPACA, there was already a large incentive for “healthy” small employer groups to self-insure, rather than pay presumably higher premiums for small group coverage. Beginning in 2014 under PPACA, premiums may not vary by health status or gender, may vary by a maximum 3:1 ratio for age, and may vary by a maximum 1.5:1.0 ratio for tobacco. There are provisions for credits attributable to wellness programs. Other factors, including industry and group size, can no longer be used (but are not currently allowed in Maryland anyway).

As currently written, PPACA provides for only two types of dependent tiers: single and family. Most small group carriers use either three-tier or four-tier dependent options (Three-tier: employee only, employee plus one, and employee plus two or more dependents. Four tier: employee only, employee and spouse, single parent, and family.) We know of some carriers that use per-member rating to develop premiums, so that a family of five would pay more than a family of four. The PPACA premium restrictions will cause cross-subsidization in most states<sup>43</sup>. We expect the impact of these changes to be smaller for Maryland, since the state already has restrictions on morbidity rating.

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<sup>43</sup> By cross-subsidization we mean that the premiums for some “units” will be higher than required purely from an actuarial perspective to subsidize the premiums for some “units” that will be lower than required from a purely actuarial perspective. For example, if there is only a two tier dependent option, those “families” comprised of two adults will have the same premiums as a families of two adults and three children; younger people (and groups) will be subsidizing the premiums of older people (and groups) because of the 3:1 rating limitations attributable to age; and healthier individuals (and groups) will be subsidizing sicker individuals (and groups) because of the elimination of underwriting and the inability to vary rates based upon individual morbidity (or average group morbidity). Because Maryland's existing rating and underwriting rules in the small group market are similar to those required under PPACA, there will be less disruption in the small employer market here than in other states. There will be disruption in the Maryland individual market which currently does not require the cross-subsidization present in the existing small group market.



Since Maryland's existing rating rules are so similar to PPACA's 2014 rules for the small group market, there are no *new* incentives driving groups with 50 or fewer employees to elect self-funding. The major difference may be greater efforts among carriers to actively market "self-funded" products to this group size. The target market would be groups with younger, healthier individuals ("preferred groups") who are currently subsidizing older, sicker groups. Retention of these "preferred groups" is critical to the viability of insurance pools over the long run.

Self-funding may be a viable option for some preferred groups because what constitutes a "self-funded" plan is rather ambiguous under ERISA. Since reinsurance is not covered under PPACA, it may be possible to design a "self-funded" product with ultimate costs equal to or less than the fully insured premiums, as the self-funded carriers would be able to base the rates for any reinsurance on factors not allowed under PPACA (such as gender, age, or medical status).

Maryland has tried to define what constitutes a "self-funded" plan by defining what constitutes stop-loss premiums. Section 15-129 defines stop loss as insurance that has no less than a \$10,000 specific attachment point and no less than a 115% aggregate stop-loss attachment point.<sup>44</sup>

Any levels lower than these prescribed amounts would be defined as "insurance" under Maryland law and not "reinsurance." Several years ago, Maryland was sued over a similar previous statute and lost the case. The Appeals Court ruled that ERISA pre-empted the previous Maryland law.<sup>45</sup> It is our understanding that Section 15-129 has not yet been tested in court.

The erosion of the small employer pool attributable to healthier groups electing self-funding may be further exacerbated if a state chooses to implement the PPACA premium restrictions and change in small group definition (from group size of 50 or less to group size 100 or less) earlier than the 2016 date specified by PPACA; currently the rates for these large groups are often developed using a combination of emerging experience and manual rates with no limitations on factor values. We would expect the groups in this size category who have high claim costs to remain in the fully insured market because they will benefit financially from the limitations on rating factors, while the groups who have low claim costs will have financial incentives to self-insure.

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<sup>44</sup> Code of Maryland, Section 15-129. "Specific attachment point" refers to the level of claims that must be incurred for each member before the stop-loss insurance will start to reimburse claims. "Aggregate stop-loss attachment point" refers to the percentage of expected claims *for the group as a whole* that must be incurred before the stop-loss insurance will start to reimburse claims.

<sup>45</sup> American Medical Security Incorporated vs. Bartlett III.

Under the PPACA rating requirements, the low-cost groups subsidize the high-cost groups. But if a substantial number of low-cost groups elect to self-insure, they will not be in the insurance pool and there will not be sufficient premiums to subsidize the high-cost groups. This will cause the average premium in the insured pool to increase beyond any normal trend increase. This could result in another “slice” of the healthiest groups electing to self-insure, driving the premiums for the remaining groups in the insured pool even higher.

HIPAA requires guarantee issue (GI) for all small employers, and we have not identified anything in PPACA eliminating HIPAA’s GI provision.<sup>46</sup> Therefore, it would seem possible that a small employer could switch from being self-insured to fully insured when they recognize the existence of (or the potential for) large claims. Once the large claims were paid, the group could once again become self-insured. There may be some administrative complications to doing this, but it appears that PPACA would not present any regulatory barriers to prevent this.

## Associations

To date, there has been little focus on how PPACA may affect associations. For the purpose of complying with the MLR requirements, the National Association of Insurance Commissioners (NAIC) has recommended that associations be classified in the same market segment (i.e., individual, small group, or large group) that they currently use for these programs. Some associations may simply set up different associations for each member type (i.e., one association for individuals, one for small employers and another one for large employers). Many states classify associations as groups. However, whether they are “large” groups or “small” groups can become nebulous from a regulatory perspective. Some states that classify associations as groups do not oversee any group rates (for small *or* large groups). Before PPACA, the distinction was unnecessary. Some states have a special classification for associations – recognizing that they are groups for the purposes of rating, but that they are not large groups in the traditional sense. Other states require associations consisting of small groups to follow their small group rating laws, although there may be some flexibility in comparisons with non-association plans.

States have generally asserted regulatory authority over surplus requirements for self-funded associations, known as MEWAs (multiple employer welfare arrangements).<sup>47</sup> We are not aware of any PPACA provisions that would affect this process or impose additional restrictions, although many of the provisions still need to be fully vetted.

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<sup>46</sup> Under HIPAA, carriers operating in the small employer market must issue policies to any small employer at any time. If the employees can demonstrate continuous coverage, of which self-funding is recognized as coverage, then, with few exceptions, there will be no waiting periods attributable to pre-existing conditions resulting for the new fully insured policy. This creates an environment where small employers could self fund until they became aware of a large claim, purchase insurance for the duration of the claim and return to self funding.

<sup>47</sup> Kofman, Mila, Eliza Bangit and Kevin Lucia. “MEWAs: The Threat of Plan Insolvency and Other Challenges.” The Commonwealth Fund. March 2004.

## Co-ops

PPACA provides for the creation of not-for-profit co-ops through the creation of grant funds. It is conceivable that some associations could morph themselves into co-ops using some of this seed money. It is unclear at this time whether the capital requirements for these co-ops will be similar to capital requirements for HMOs and insurance carriers. If the requirements are lower for co-ops, they will be at greater risk of insolvency.

## Use of Section 125 Plans to Enable Employees to Purchase Coverage

Section 125 plans are cafeteria plans in which employees can choose between two or more benefits. All contributions to Section 125 plans are excluded from taxable income. This benefits both the employee and the employer. If a Section 125 plan is used, the employee can deduct the employee contribution amount from taxable income, which effectively allows him or her to realize tax savings through these “pre-tax” contributions. In addition, since the taxable employee income is lower, the employer realizes savings from reduced FICA taxes, for employees whose wages are below the Social Security taxable wage base. Therefore, an employer may opt to increase an employee’s wage to allow him or her to purchase medical coverage rather than the employer purchasing the medical coverage directly.

A Section 125 group health plan must be “non-discriminatory” per ERISA and IRS Code-HIPAA Section 2702. Health status rating factors cannot be used. Rating factors that would disqualify a plan as a non-discriminatory plan include health status, medical conditions, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability factors.

Currently, the use of one or more of these health status rating factors is permitted in the individual market in most states. Because of this, Section 125 plans are not used as a vehicle for small employers to purchase individual insurance, since the plans available for purchase are likely discriminatory plans.

Beginning in 2014 under PPACA, health status rating factors will not be allowed for any health plans, with the exception of tobacco use. With this change, we expect that in 2014 many health plans will meet the definition of “non-discriminatory” under the Section 125 requirements. Since non-discriminatory plans will be available in 2014, Section 125 plans may be a vehicle that small employers can use to enable employees to purchase individual coverage beginning in 2014.

## **Possible Use of Section 125 Plans Under PPACA**

Although employers and employees may benefit financially from using a Section 125 plan, it remains unclear whether the use of Section 125 plans will increase significantly under PPACA. Individual coverage cannot be purchased on a Section 125 plan through an exchange. However, an employee will probably be able to purchase coverage using a Section 125 plan outside of an exchange. The inability of some employees and/or

dependents to pass health underwriting is removed as a barrier under reforms. So, employers may view the combination of a one time increase in salary, with the possibility of employees being able to pay for health premiums using pre-tax dollars in some instances, as additional incentives to drop sponsorship of health plans.

### **Small-Employer Considerations in Funding Coverage through Increased Salaries and a Section 125 Plan versus Employer-Sponsored Coverage**

Several considerations will affect whether a small employer chooses a Section 125 plan or traditional employer-sponsored coverage to provide health insurance for their employees. There are both financial and non-economic considerations.

As discussed previously, employers should see FICA tax savings through the use of a Section 125 plan for employees whose wages are beneath the Social Security taxable wage base. In addition, the employer-paid premiums under employer-sponsored coverage may need to be increased to meet the minimum benefit and out-of-pocket cost requirements. Section 125 plans are favorable under both of these considerations. However, the costs of purchasing the same insurance plan in the individual market (via a Section 125 plan) and the small-employer market may differ – and will likely be greater in the individual market, as high-risk individuals will be included in this market beginning in 2014. Also, certain small, low wage employers may be able to take advantage of the small employer health insurance tax credit.<sup>48</sup>

Employers will also need to consider several non-financial impacts. First, there is the employee marketing impact of providing employer-sponsored coverage versus a Section 125 plan. For example, the employer will need to assess whether a group health plan is more effective in retaining current employees and attracting future employees. There are also hidden costs associated with employees' managing their own Section 125 individual plans, such as employee time spent managing the plan. Also, with a Section 125 plan, it may be desirable to contribute a lesser amount to an employee who will receive a subsidy in the exchange. However, this may raise issues of discriminatory compensation practices and may reduce an employer's flexibility in employee compensation levels.

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<sup>48</sup> To receive a tax credit, the employer's average annual wage must be below \$50,000 and the percentage of health premiums paid by the employer must be at least 50%. For employers that meet these criteria, the credit is calculated as follows.

- The base tax credit varies by year and organization status. The base tax credit for 2010 to 2013 is 35% of premium for small employers and 25% of premium for tax-exempt organizations. These amounts increase beginning in 2014 to 50% of premium for small employers and 35% of premium for tax-exempt organizations.
- The base credit is reduced by a factor times the base tax credit if the average annual wage is greater than \$25,000. The factor is equal to a fraction, the numerator of which is equal to the amount by which the average annual wage exceeds \$25,000 and the denominator of which is equal to \$25,000.
- The base credit is also reduced by a factor times the base tax credit if the number of full-time employees (FTEs) exceeds 10. The factor is equal to a fraction, the numerator of which is equal to the number of FTEs in excess of 10 and the denominator of which is equal to 15.

The total reduction is equal to the sum of the reductions for the average annual wage and number of FTEs. This sum may result in a credit that is equal to \$0 for some employers with fewer than 25 FTEs and an average annual wage less than \$50,000.

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These non-financial impacts need to be weighed against the financial impacts when choosing between a Section 125 plan and employer-sponsored coverage.

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### **Actions to Consider**

To maintain a viable market, it will be important to establish policies that minimize the chances of people dropping coverage when they do not anticipate the need for services and then re-enrolling when they think they will need them (what we refer to as “just-in-time insurance”). MHCC may want to consider the following public policies in order to minimize this type of selection at both the individual and small-group levels. Due to the many uncertainties associated with PPACA, MHCC would need to seek its own legal advice to determine whether these public policies would be permissible after reforms.

- Maintain equal rating inside and outside the exchange.
- Maintain a single annual open enrollment period that applies to all carriers, both inside and outside the exchange. Even if the exchange sets an annual open enrollment, adverse selection could persist if carriers outside the exchange allow open enrollment at a different time. The more open enrollment periods that exist in the market, and the longer the open enrollment periods last, the more likely it will be that relatively healthy people and groups will drop coverage, knowing that they can secure coverage just before they need it.<sup>49</sup>
- Do not allow benefit changes except at open enrollment.
- Limit new, initial coverage to Bronze-level coverage, unless the applicant (either individual or small group) had prior coverage.
- Do not allow people or groups to increase benefits by more than one coverage tier at a time. For example, if someone initially purchased Bronze coverage, they could move to Silver coverage the following open enrollment period, but not Gold or Platinum coverage.

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<sup>49</sup> It is not known at this time whether carriers outside the exchange will still be required to continuously guarantee-issue to small employers as a result of HIPAA. If that is the case, the potential for anti-selection will be greatly increased. It is unclear at this time whether restricting enrollment only to the specified periods is consistent with PPACA, although a precedent has been set regarding child-only policies.

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- If the defined contribution exchange model is adopted, limit the choices to a single level, such as Bronze, or to adjacent levels, such as Bronze and Silver, for each employer.
- Consider not allowing large employers (more than 100 employees) to move their entire group into the exchange beginning in 2017. Only those groups whose premiums outside the exchange are higher than those within the exchange will elect to enroll.
- Actively enforce the definitions of reinsurance in the small group market until they are deemed pre-empted by ERISA.

The preceding list focuses on issues that can minimize selection. A study just released by the Blue Cross Blue Shield of Massachusetts Foundation identifies the following eight lessons learned to date following Massachusetts' reform:<sup>50</sup>

1. *Ongoing stakeholder engagement.* Involve all health care stakeholders as quickly as possible to identify common ground, and continue to keep them involved.
2. *Strong, centralized coordination among government agencies.* Create processes that facilitate cooperation and accountability among the various agencies.
3. *Close coordination between Medicaid and the new public programs to maximize enrollment and retention.* Identify processes that will facilitate enrollment eligibility determination for various programs and subsidies and maintain continuity of care and coverage for all citizens as income levels change and eligibility changes.
4. *Intense, statewide effort to enroll currently uninsured.* Develop multiple approaches of outreach, enrollment and retention activities to facilitate enrollment of the uninsured.
5. *Awareness and understanding among individuals and businesses of their responsibilities as well as available subsidies and potential penalties.* Develop a comprehensive, ongoing communication program using both public and private sources.
6. *Understand that there will still be some uninsured and underinsured.* Safety-net systems must still be maintained.
7. *Continuous feedback from consumers, providers, employers and other stakeholders.* Track impacts on reforms and adjust policies, processes and operations as needed.
8. *Cost control.* Advocate for health system reforms that will reduce the cost of health care while expanding coverage and care.

The final statement is probably the most critical in the long term. Massachusetts has discovered that expanding coverage does not result in lower costs, as the state had initially hoped. The very high costs have resulted in cutbacks for certain eligible classes. Massachusetts Governor Deval Patrick has indicated that controlling health care costs will be a top priority for his second term in office. He has submitted legislation that would expand the use of alternative provider reimbursement methods (such as global

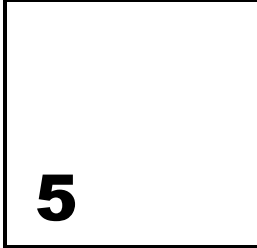
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<sup>50</sup> Raymond, Alan G., "Lessons From Implementation of Massachusetts Health Reform." Blue Cross Blue Shield of Massachusetts Foundation. March 2011.

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payments and bundled payments); accelerate the formation of accountable care organizations and other integrated models; expand state oversight into premium increases and underlying provider payment rates; “redirect” the system of malpractice in favor of “apology and prompt resolution” as a means to minimize defensive medicine; create a new state office to encourage and test ways to control health care costs; and create an advisory council of stakeholders and consumers to monitor how payment reform is implemented.





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