Actuarial Analysis: Impact of the Affordable Care Act (ACA) on Small Group and Individual Market Premiums in Massachusetts

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Prepared for:
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1. EXECUTIVE SUMMARY

Wakely Consulting Group (Wakely) was asked by the Massachusetts Association of Health Plans (MAHP) and Blue Cross Blue Shield of Massachusetts (BCBSMA) to analyze the impact of the market reforms introduced by the Affordable Care Act (ACA) in 2014 on the state's individual and small group markets. This report presents the results of Wakely's work. All estimates presented in this report are specific to the Commonwealth of Massachusetts and will likely be different for other states. The following components are discussed in this report:

1. Current Massachusetts regulations, rating practices and market composition for the individual (non-group) and small group markets.
2. Analysis of the impact of the ACA reforms on the small group and individual markets, including the impact of changes in benefit plan offerings, commercial insurance rating and underwriting rules and practices, assessments on insurance, and transitional reinsurance program. This analysis was completed for the following markets:
    a) Current Individual
    b) Current Small Group
    c) Commonwealth Care enrollees above the income cut-off in 2014 for MassHealth (133% FPL)

For the current merged and large group markets, we received data from the largest nine insurers in the state. The data received includes: aggregate premiums and claims, rating factors, non-benefit expenses, commissions, and current members' demographic information for 2010-11 that these plans submitted to the Massachusetts Division of Insurance in mid-2012 (DOI Data Call). We supplemented this information with publicly available rate filings and survey information. We reviewed this information for reasonability, but did not audit the information. Any errors in this data may materially impact the results of our analysis.

The following describes key results of the analysis. The full report should be referenced to fully understand the assumptions, approach and results.

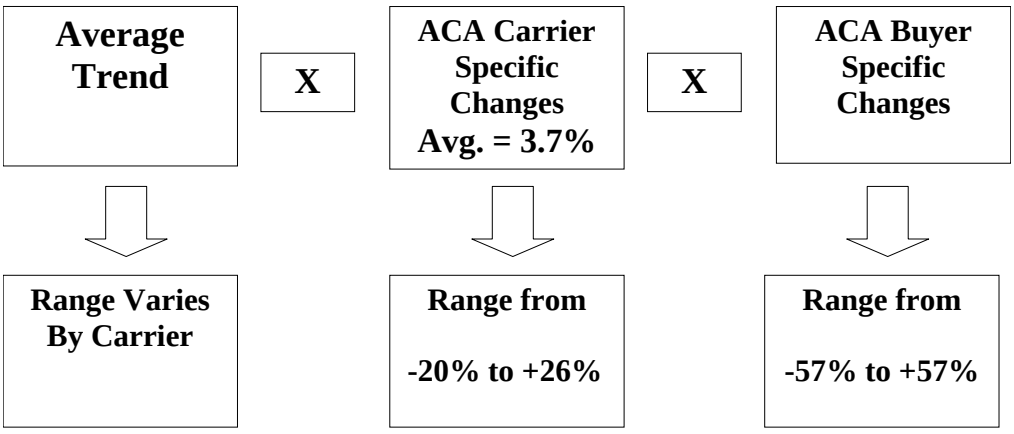
<u>Individual & Small-Group Markets</u>

As illustrated below, the product of three sets of variables will determine premium increases for 2014. First, there is "normal" annual trend, meaning the average expected change in utilization of various services and the rate of reimbursement for such services. For example, increases in the prevalence of diabetes, or its diagnosis, or compliance with treatment programs might generate increases in the use of prescription drugs to control blood sugar levels; and changes in the prices of existing drugs to control blood sugar, or the introduction of new drugs to do so, or greater reliance on generic drugs might cause

changes in the average price of such prescriptions. The sum of such changes in use and reimbursement across all covered medical services is trend. Some of these factors will vary by health plan, as they do every year, based on plan designs, contract terms, etc. Trend is listed in Table 1 as one of eight variables, but in this report, Wakely does not project an average trend for Massachusetts.

Second, there will be costs and savings generated by the ACA that apply across the merged individual and small-group market to all participating carriers, starting in 2014. These five additional sets of costs/savings attributable to the ACA are listed immediately after annual trend in Table 1 and are explained in section 3. Their values will also vary from one carrier to another. For each variable, Wakely has estimated an industrywide average and a range. Wakely's best estimate is that the carriers analyzed will fall within the range indicated. While the average of all five factors summed is a 3.7% premium increase in 2014, the range of variance from one carrier to another is actually far greater than the average industrywide increase.

Third, there will be two sets of changes under the ACA for 2014 that will vary not by carrier, but by purchaser— the individual purchasing directly or the small employer group. One set of changes is in the factors that carriers may use in rating individuals and groups. The other is for those buyers who have to increase or decrease their cost sharing for 2014 in order to comply with the new actuarial value requirements of the ACA, for bronze, silver, gold or platinum coverage. On average, Wakely estimates that neither variable will contribute toward an industrywide premium change. However, particular buyers will experience either a rate increase or decrease on account of these two factors. The range of variation can be very wide. [1]



[1] The factors shown in the following image are multiplicative. However before multiplying them, each rate change must be added to 1. For example, a Carrier change of 3.7% and a Buyer change of 5.0% would result in an 8.9% rate change. The 8.9% is calculated by multiplying 1.037 by 1.05 =1.089 and then subtracting 1.

1. The range of variation in rate changes for 2014, due to changes made by the ACA, will be broad:

   a) because of differences among carriers in claims trend, morbidity relative to prior years, the impact of risk adjustment and insurer assessments, particular issuers will experience premium changes from 2013 to 2014 that are quite different than the industry average; and

   b) because of differences among group and individual buyers in their own rating factors – age, family size, group size, participation levels, membership in cooperatives and associations -- and in the services covered and actuarial value of coverage compared with 2013, particular purchasers will experience premium changes from 2013 to 2014 that are quite different from the average.

2. Wakely has calculated a range of variation for each of seven factors, which vary based on group/individual rating characteristics and issuer offering coverage. The endpoints of the ranges illustrate the potential impact of the ACA on premiums, although it is extremely unlikely that the endpoint value of each range for all eight factors would apply to any Individual or Group Purchaser.[2]

3. Wakely estimates that premiums for the entire merged individual and group market across all issuers will increase in 2014 by approximately 3.7% (on average) due to changes required by the ACA that affect base rates, on top of the carrier's annual premium trend and buyer-specific variables. This does not include the impact of rating factor changes described above, nor does it include annual trend.

4. Wakely estimates that the average individual and small-group premium increase of 3.7% is comprised in part of a 1% increase for required coverage of pediatric dental and vision care as well as adapting the state Mental Health Parity Law to come into line with the federal requirements under the ACA; these costs will be added to both individual and small-group rates.

5. Another 2.5% increase is estimated for the relatively high morbidity of the Commonwealth Care enrollees who are expected to join the individual commercial market in 2014. While the Commonwealth Care enrollment is younger on average than the current non-group market, and therefore will be priced favorably, its age-adjusted morbidity is 20% greater than current non-

[2] Were the extremes of the range for all seven factors to apply to a particular buyer, Wakely estimates the potential range of impacts on premium is from a low of -66% to a high of +97% (plus trend); were a carrier to experience the extremes of the range for each of the five factors that apply to them, Wakely estimates a potential range of issuer premium impacts from a low of -20% to a high of +26% (plus trend).

group enrollment of comparable ages. The net increase in individual costs will be spread across premiums for the entire merged market.

6. The health insurance provider fee (premium tax) assessments, newly imposed by the ACA, will add approximately 0.8% to the costs to be funded out of premium revenues. Again, specific carriers will experience this differently because of an exemption from assessments for carriers with 80% or more of their business in Medicare and Medicaid and a higher assessment on health plans which are not tax exempt.

7. The net effect of transitional reinsurance on 2014 premiums will be to lower premiums approximately 0.6% on average across participating carriers in year-1. Such recoveries will not occur until 2015, and will vary substantially from plan to plan, but should be credited against 2014 premiums.

8. Other changes either are not material or Wakely lacked the data needed to quantify them.

Table 1

	Best Estimate of Market Rate Impact	Range of Impacts by Issuer	Range of Impacts due to Buyer Characteristics	Cumulative Impact of Issuer and Buyer Characteristics
Trend	Varies by Carrier	Varies by Carrier	n/a	Varies by Carrier
Essential Benefits Requirement	1.0%	0.25% to 2.0%	n/a	0.25% to 2.0%
Morbidity Changes (due to Comm Care Entrants)	2.5%	1.6% to 3.4% [2]	n/a	1.6% to 3.4% [2]
Health Insurer Provider Fee (Premium Tax)	0.8%	0% to 2.1%	n/a	0% to 2.1%
Reinsurance Program	-0.6%	-8.0% to 1.5%	n/a	-8.0% to 1.5%
Risk Adjustment	0.0%	-15% to +15%	n/a	-15% to +15%
Rate Factor Limitations (Age Slope Limited to 2:1, tobacco, geography, removal of previously used factors)	0.0%	0.0%	-55% to +50% [1]	-55% to +50% [1]
AV Requirements (min Bronze level and +/-2% tolerance)	0.0%	0.0%	-4.6% to +4.6%	-4.6% to +4.6%
Total	**3.7% plus trend**			

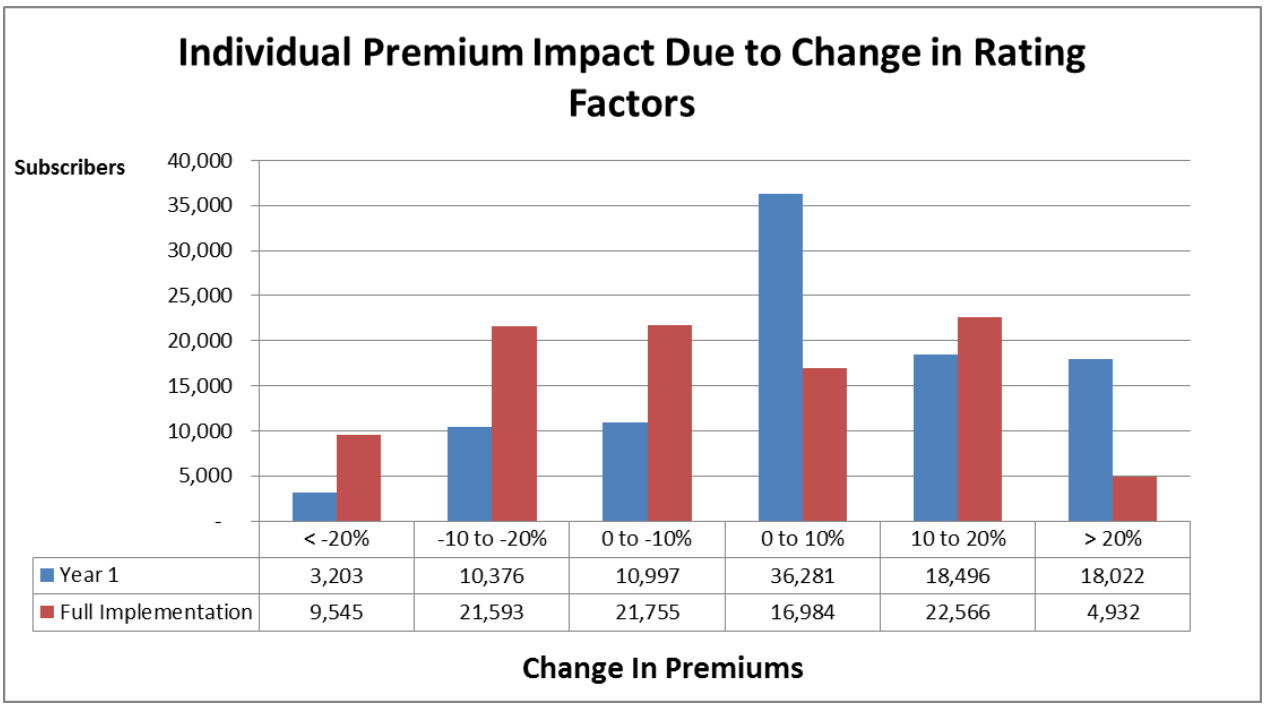
[1] Group and individual specific variations are significant. See Section 5 for more details on the distribution of changes for the issuer and buyer.
[2] The listed morbidity change is not the range by carrier, rather a range of the overall impact to the market. Actual changes by carrier are more significant for issuers that currently offer coverage primarily to Commonwealth Care.

Individual

While the average premium increase is 3.7% across the merged market, not only will this differ from carrier to carrier, but the impact of the ACA's changes will vary considerably by individual household. The range of variations due to rate factor limitations in 2014, on top of the 3.7% average increase and issuer specific changes, is depicted in the bar chart below. Note that these impacts apply to both those currently rated as individuals and as sole proprietors, and include the removal of the industry and group size factors as they currently apply to sole proprietors. Note as well that, as the chart's title indicates, this table excludes the impact of trend and the 3.7% average market wide impact of ACA changes, so

that the actual increase or decrease in premiums received by any particular buyer in one of the intervals depicted would shift to the right, for the added cost of trend plus the average 3.7% ACA impact.

Chart 2



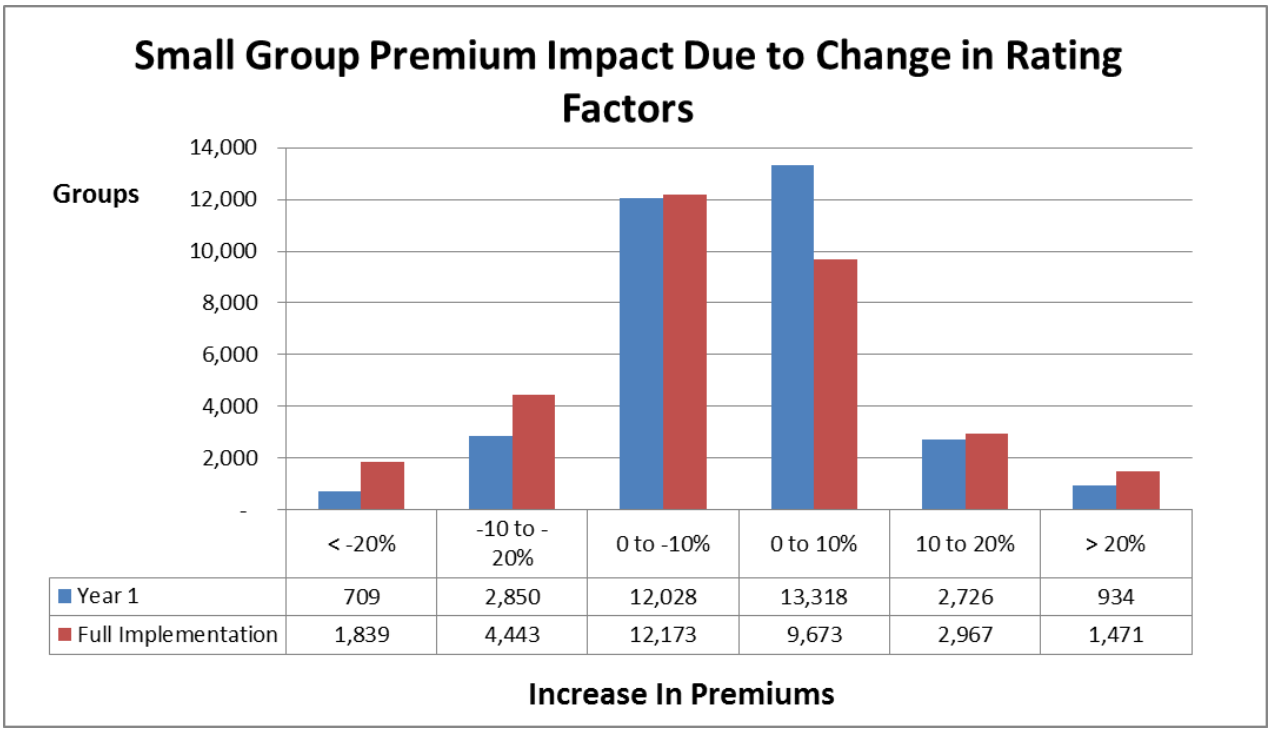
	< -20%	-10 to -20%	0 to -10%	0 to 10%	10 to 20%	> 20%
Year 1	3,203	10,376	10,997	36,281	18,496	18,022
Full Implementation	9,545	21,593	21,755	16,984	22,566	4,932

Another change is that under the ACA, families will be rated by age not only for the subscriber, as is current practice with some issuers, but for his/her spouse and each dependent (up to a maximum of three dependents below age 21). Slightly over half of individuals will see an increase or decrease in their rates of more than +/-10% due to these changes in rating rules. In 2014, more than 3/4ths of individual buyers will experience some increase in premiums due purely to changes affecting their particular rating factors, on top of trend and the average 3.7% overall increase. It is difficult to predict how the changes in premium rates will affect individual's choices regarding coverage options.

Small Group

While we expect a 3.7% increase in premiums on average across the merged market, not only will the impact of the ACA changes vary by carrier, but they will also vary considerably by specific employer group. Because of list rating (effective at the start of each group's plan year in 2014), plus changes to other allowable rating factors and practices that will be phased in between 2014 and 2016, some groups will see significant changes to their rates. When fully phased-in (2016), cumulative rate increases or decreases exceeding +/-10% due to these changes will impact nearly one in three small groups.

Chart 3



The results for each component of the analysis are included below. Please see individual sections of the report for descriptions of our method, assumptions, data and inherent limitations with our estimates. Estimates of the impact of healthcare reform provisions are inherently uncertain because of the large number of forces affecting the insurance market, including actions by consumers and health plans.

1.1 Data Reliance

The analysis in this report is primarily based on data provided by the carriers via the DOI survey tool. The survey collected 2010 and 2011 information on commercial individual, small group, and large group lines of business. For the purpose of this report, we only used the 2011 individual and small group data. The information gathered by the survey includes, but is not limited to:

1. A description of rating methodology and factors, including: age factors, area factors, group size factors, industry factors, participation and other rating factors where applicable.

2. Aggregate earned premium, allowed claims, subscriber and member counts by group type (individual, small, large)

3. A subscriber age distribution by policy type (individual, individual + spouse, individual + child(ren), family). Ages ranged from 0 to 64+ in intervals of one year.

4. A total member month age distribution with same ranges and intervals as subscriber distribution.

5. A summary of subscribers and member months by geographic region.

6. Various statistics at the individual group level, including: number of subscribers and members in the group, group type, earned premium, allowed and paid claims, actuarial value (compared to the carrier's richest benefit plan), zip code, industry code, participation adjustment (if applicable), effective and termination dates.

The DOI survey data was provided to us by the following carriers:

- Blue Cross Blue Shield of Massachusetts
- Boston Medical Center HealthNet Plan
- CeltiCare Health Plan
- Fallon Community Health Plan
- Harvard Pilgrim Health Care
- Health New England
- Neighborhood Health Plan
- Network Health
- Tufts Health Plan

The DOI surveys were provided but were incomplete for Fallon Community Health Plan and Health New England. Due the lack of rating information, these carriers were excluded from our analysis of premium impact due to changes in allowable rating factors.

In addition to the DOI survey data, we received the following from each carrier:

1. A summary of members (as of 12/31/12) by market (Commonwealth Care, Commonwealth Choice, non-Connector individual and small group, and fully-insured large group). Commonwealth Care membership was broken out by those who will be eligible for Medicaid in 2014 and those who will be eligible for commercial insurance and federal subsidies.

2. Center for Health Information and Analytics (CHIA) risk adjustment summaries by insurer. The summaries include risk scores and risk transfer information by metallic level for commercial individual, small group, and large group business. For this report, we only analyzed the individual and small group information in our risk transfer assumptions.

3. Publically available quarterly rate filings for 2012 through 2013 Q2.

All of the data provided to us was checked for general reasonableness but was not audited nor validated for accuracy.

1.2 Limitations, Disclosures, and Key Assumptions

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

1. Our analysis was completed with 2010/2011 detailed market information, only partially updated by 2012 and 2013 filings. Even in the absence of ACA changes, the market will change significantly over the course of three to six years (2011 to 2014/ 2016). The values included in this report are estimates and could vary significantly.

2. Rates, especially in 2014 through 2016, depend on how health plans *predict* costs will change under the ACA reforms and population expansions, and how premiums are set, not necessarily on how costs actually change.

3. We have not projected any changes to rates based on issuers' strategy decisions on risk in 2014. Prospective changes in cost only reflect the actuarial result based on demographics of the market and the change in rating based on regulatory factors. How each issuer will react and implement rates in light of the changing conditions may vary from that assumed in this paper. We do not have access to and therefore have not included any such strategy decisions.

4. We have not modeled any changes to the rates due to risk corridor program.

5. We have not modeled any changes to rates due to emerging experience, projected change in contracts, different area factors, etc.

6. We have not modeled any changes to employee costs due to changes in employer contributions. The analysis focuses on the average premium for the group, not each subscriber costs within the group.

7. Also, while most decisions regarding the exchange and the insurance market have been decided, some state and federal regulations and guidance are still pending. Pending decisions, regulations and guidance may significantly impact premiums and product offerings.

8. Rate changes for individual households and small groups (and other financial incentives) may drive individuals and employers to make unanticipated decisions around coverage. The behavior of individual members and employers is difficult to predict.

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

10. Any reference in this report to the number of groups or subscribers having specific rate increases or decreases is based on simulated outcomes. Efforts were made to align these outcomes with merged market group and subscriber summaries. The reader should not rely any subcategory of groups or subscribers without considering its relativity to the total merged market.

11. Any adjustment to costs and premiums resulting from revised contracting post-ACA was not considered. Reduced contract costs might result from eliminating the level of uncompensated care for uninsured residents or increases in contracting may be necessary because of provider capacity limits. In addition, increased contract costs might also result for some carriers who have historically only been part of the CommCare market and are entering the broader merged market.

12. We have assumed that associations or "cooperatives" consisting of small employer groups are part of the participating carriers' small-group risk pool and will continue to be so even as they are integrated into the new small group market.

13. We assume Massachusetts will move forward with Medicaid expansion.

14. There may be changes to the level of assessments, such as an assessment by the Massachusetts Health Connector ("the Connector") to fund operations of the exchange. We have not assumed any changes to the assessments in our analysis.

15. More individuals may opt to enroll in catastrophic plans which have less restrictive cost-sharing requirements than the existing metallic levels. The impact of these plans on the estimates of the ACA changes is not expected to be significant, but would lower the premium increase estimates.

16. We did not receive any data indicating the grandfather status of benefit designs. The analysis assumes that the number of grandfathered plans in Massachusetts is insignificant and will not impact the overall results.

17. No impact on premiums was assumed for the application of symmetrical risk corridors to the individual market.

2. OVERVIEW OF MASSACHUSETTS MERGED MARKET

The Massachusetts non-group and small-group markets were merged on July 1, 2007, as part of the State's landmark healthcare reform under Chapter 58 of the Massachusetts General Laws of 2006. Since then, the small-group market (size 1 to 50 employees, including sole proprietorships) has held relatively steady, and the commercial non-group market has more than doubled in size to some 86,000 lives. Almost half of the non-group enrollment is in the Connector's unsubsidized Commonwealth Choice commercial insurance program, whereas virtually the entire small-group market is outside the Connector. Existing rules for the merged market in Massachusetts have many similarities in principle to market reforms under the ACA; indeed, Massachusetts is commonly acknowledged as the model for national reform of non-group and small-group coverage in Title I of the ACA. However, there are important differences between state and federal reform in the structure of the exchanges, required benefits, and rating rules that, as Massachusetts comes into compliance with the ACA, will affect premium rates for the market as a whole and for some buyers in particular.

2.1 Current Rating & Underwriting Practices

Massachusetts currently allows rate variation for individual households based on:

- age
- family size
- geographic rating region
- group size
- wellness
- industry factor (for those individuals who are sole proprietors)

In general, there are no rate variations allowed on individual or group premiums for gender and health status. Rating actions are required to be filed and approved by the state prior to implementation, and carriers typically file new rates quarterly.

All rating variables noted above for use in rating individual households, except group size and SIC factor, will be allowed under the ACA for individuals and small groups, but how some of these rating factors can be applied under the ACA will change significantly. While smoking factors are not currently utilized in the Massachusetts individual market, they will be allowed under ACA. However, the Massachusetts Division of Insurance has set the rating band for tobacco use in 2014 at 1:1, meaning that tobacco use will not be a rating factor for 2014. Because of challenges associated with self-reported data and the cost of testing for smoking, it is not clear if issuers will employ a smoking adjustment later, if allowed by the Division to do so.

Carriers in the merged market are currently allowed to use the following rating factors for small groups, and most small employers are rated according to these factors:

1. Age: a 2-to-1 rating band applies to all ages, 1-64+. This is more restrictive than the 3-to-1 rating band imposed by the ACA; and Massachusetts is expected to retain 2-to-1. All carriers in the merged market are required to apply this rating factor, both for individual and group pricing. Assuming an index rating of 1, a 2-to-1 rating band means that the minimum age rating factor is .67 and the maximum is 1.33 (twice the minimum).
2. Contract size and composition: rates are composited by tiers and most carriers use single, 2-adults, adult-plus-child, and family tiers. All carriers in the merged market apply this rating factor, both for individual and group pricing.
3. Standard industry code (group and sole proprietors only): all health plans in the small group market, except for one of the smaller plans, employ industry rating. Variation for industry is allowed only within the 2-to-1 rating band.
4. Participation (group only): small-group carriers generally require a minimum participation rate, typically that everyone in a group of five or fewer employees participate, and 75% of those in larger groups participate. One of the larger carriers uses group participation as a rating variable for groups that do not meet these threshold participation levels. Variation for industry is allowed only within the 2-to-1 rating band.
5. Geographic rating regions: there are seven rating regions in the state, and health plans that serve multiple rating regions typically employ regional rating for both individual and group pricing. A geographic rate adjustment factor ranging from 0.80 to 1.20 is allowed, outside the 2-to-1 rating band.
6. Group size: all small-group carriers factor in group size, generally distinguishing between groups of five or fewer and larger groups; sole proprietorships are also underwritten as group insurance. A group size factor ranging from 0.95 to 1.10 is allowed outside the 2-to-1 rating band.
7. Wellness programs (group only): since 2012, the Connector has been allowed to give a premium credit (15%), funded by the State, to small employers in its Business Express program for participation in its wellness program. There is negligible participation in this program. Since April 2012, cooperatives have also been formed by the Massachusetts Retailers Association, several Chambers of Commerce and other business associations, under which participating carriers can give participating small employers a modest discount off standard premiums. These cooperatives cover several thousand lives. In addition, health plans are allowed to rate for tobacco use, but do not currently do so.
8. Lastly, current regulation restricts total annual rate increases to a 15% upper limit (rate bumper) for any group or individual.

For small groups, a number of common rating practices will either be entirely eliminated or modified in 2014 (as of the start of each group's plan year), or they will be phased out by 2016.[3]

2.2 Market Composition

Nine insurers make up nearly 100% of the Massachusetts merged market. There are other smaller insurers in the market, but our analysis focuses on the nine insurers with the largest market share.

Of some 200,000 Commonwealth Care enrollees, as of year-end 2012, nearly half are at or below 133% of FPL and therefore are expected to qualify for MassHealth in 2014. The remaining 103,089 Commonwealth Care enrollees are expected to qualify for advance premium tax credits (APTCs) through the Connector in 2014. Commonwealth Care is currently served by five licensed carriers, but its experience is isolated from the commercial non-group risk pool, and its premiums are separately set through the Connector's annual bid process. As of January 1, 2014, those Commonwealth Care enrollees who do not qualify for MassHealth will presumably enter the commercial individual and small-group merged market risk pool. This represents a substantial influx to that market, exceeding the entire non-group commercial enrollment in 2013. Seventy percent of these Commonwealth Care enrollees are almost evenly split between Network Health (35,430) and BMC HealthNet Plan (38,183), with smaller numbers for Neighborhood Health Plan (18,394), CeltiCare (8,924), and Fallon Community Health Plan 2,158.

[3] Letter from Gary Cohen, Deputy Administrator and Director, CCIIO, to Commissioner Joseph Murphy, Massachusetts Division of Insurance (April 5, 2013).

Table 4: Insurers and Members in the Massachusetts Comm Care and Merged Markets

	December 31, 2012 Membership					
	Comm Care		Merged Market		Total Ind and SG	
Market Enrollment	M'Caid Eligible	Non M'Caid Eligible	Individual	Small Group	Total	% of Total
BCBS	0	0	31,089	218,117	249,206	29%
BMCHP	33,310	38,183	348	69	71,910	8%
Celtic Care	11,129	8,924	364	29	20,446	2%
Fallon	2,004	2,158	7,281	41,725	53,168	6%
Harvard Pilgrim	0	0	17,457	160,307	177,764	21%
HNE	0	0	2,117	24,047	26,164	3%
Neighborhood	12,304	18,394	19,987	26,653	77,338	9%
Network Health	36,210	35,430	0	0	71,640	8%
Tufts	0	0	7,799	91,102	98,901	12%
TOTAL	94,957	103,089	86,442	562,049	846,537	100%

The non-group market is currently served by the Connector (37,731 enrollees) and directly by carriers enrolling members outside the Connector (48,711). Over half of direct enrollees are in BCBSMA (26,000). In combination with its non-group enrollment through the Connector (5,089), BCBSMA serves over one-third of the total non-group market -- 31,089 of 86,442. Other significant carriers for the commercial non-group membership, in and out of the Connector, are Harvard Pilgrim Health Care, Neighborhood Health Plan, and Fallon Community Health Plan.

With the addition of some 100,000 Commonwealth Care enrollees not eligible for MassHealth to the 86,000 or so existing individual commercial enrollees, BCBSMA's share of non-group enrollment could fall substantially, to about 15% - 20%. The shares of non-group commercial enrollment in 2014 for BMC HealthNet Plan, Network Health and Neighborhood Health Plan could well equal or exceed BCBSMA's share. Harvard Pilgrim Health Care's commercial non-group enrollment is also material. This development, as of January 1, 2014, will represent a significant increase in the size of the commercial non-group segment and a significant dispersion of non-group commercial market share among five major carriers. Because of the very different position of these five carriers in Commonwealth Care and the merged commercial markets, and the differences in risk scores for Commonwealth Care and

commercial enrollees, the five carriers will likely experience considerably different transitional rate impacts in 2014.

The small-group market enrolls almost entirely outside the Connector. Across the state, BCBSMA accounts for some 40% of this enrollment. Harvard Pilgrim Health Care (2nd) and Tufts Health Plan (3rd) account for most of the rest of the statewide small-group market (45%), although Fallon Community Health Plan and Health New England each account for substantial shares of small-group enrollment in their core service areas of central and western Massachusetts, respectively.

3. OVERVIEW OF ACA CHANGES

The ACA puts into place comprehensive reforms that improve access to affordable health coverage, establish new consumer protections for patients, and provide new ways to bring down costs while improving the quality of health care in the U.S. Beginning January 1, 2014, the ACA will affect all state health care programs and cause significant shifts in funding. Massachusetts will benefit from being a state that expanded health care access prior to the ACA, enabling the Commonwealth to utilize existing infrastructure to reduce costs and increase federal support. The Commonwealth will receive significant new federal revenue that will help to support the state's ongoing health care reform and cost containment efforts. The ACA will help Massachusetts build upon the gains made by the Commonwealth toward universal coverage since 2006 under chapter 58.

The market rules effective January 1, 2014, under the ACA do differ significantly from current practice in Massachusetts, and will require a series of changes in rating individual buyers and small groups. Based on a recent decision by CMS, some of these changes can be phased in during the first two years of national reform (2014 and 2015), to take full effect only in 2016. Where new rules are replacing current practice over time, existing (non-ACA-compliant) practices will be given only 2/3rds of their previous weight in 2014, 1/3rd in 2015, and will be prohibited in 2016. For example, group size is not an allowed rating factor under the ACA, so only 2/3rds of the rate adjustment attributed to this factor by a carrier in 2013 will be allowed in setting premiums for groups with plan years starting in 2014; only 1/3rd of the rate adjustment previously attributable to this factor will be allowed in group rates that start in 2015.

Rating rules in the merged market will change considerably as a result of the ACA. Effective at the start of plan years beginning after December 31, 2013 i.e., as of January 1st, 2014 for individual enrollment and, for small employers, on the group's anniversary date in 2014, the following changes to existing rating practices will be fully effective:

1. In Massachusetts, health plans generally rate based on the age of the subscriber (or spouse, if older), but under the ACA rating factors will apply to each individual in a family unit, except that families with more than three dependent children under 21 will only be rated for three such dependents. Thus, for example, a family of two adults and one child will be rated significantly less than a family with two adults of the same age, plus four children, one of whom is over 20. If the two families make up a group, each will be rated the same, but the list rating for all six lives for the second family raises family rates for the group. This change will take full effect in 2014.

2. In Massachusetts, health plans generally rate for age within a band that applies to children as well as adults i.e., from ages 1 to >64, and ranges as much as 6-to-1; carriers then truncate household premiums to fit within the 2-to-1 allowable rating factor for age -- but under the ACA, the state's 2-to-1 rate band will apply to adults only (21-to >64), and children will have a separate factor. This change will take full effect in 2014.

3. Definition of small group. In Massachusetts, sole proprietorships were considered small groups, but under the ACA "groups of 1" will be classified as individual coverage, effective in 2014. Of course, they remain part of the merged market, so remain in each carrier's unified risk pool, but lose immediately in 2014 all aspects of group rating, such as size, industry, etc.

4. Minimum participation requirements for group coverage. Health plans generally require 100% participation for groups of five or less, and 75% for small groups above this threshold; under the ACA, health plans may continue to use participation, except that they must issue policies to small groups, without regard to minimum participation requirements between November 15th and December 15th of each year. This change will take full effect in 2014.

Effective beginning in 2014 for groups, the following rating practices will be phased out 1/3rd in 2014, 2/3rds in 2015, and eliminated altogether for 2016:

1. Group size. In Massachusetts, health plans generally rate mini-groups (1-to-5 lives) higher than other small groups, but group size is not an allowable rating factor under the ACA.
2. Industry. Health plans generally give a credit or a surcharge to rates for standard industry codes with generally healthier or sicker employees, respectively. Industry rating is not allowed under the ACA.
3. Participation. Some carriers will increase rates rather than turn down a group for a low participation rate, but this will be phased out under the ACA.
4. Wellness. In Massachusetts, the Connector and group purchasing cooperatives are allowed to give a wellness credit for participating employers that meet defined criteria, but the amount and criteria for the credits will change, and they will no longer be confined to cooperatives or association groups.

As explained above, rating by age will apply to individuals. Moreover, the 2-to-1 constraint on age rating will apply to each individual. This contrasts with the current practice of most carriers, which use a far wider age-rating band -- as much as 6-to-1 for each subscriber -- and then truncate the age factor for individual buyers or the entire group at 2-to-1. As of 2014, the age rating factors are prescribed by the state and limit the 21-64+ factors to be within a 2-to-1 band, with a separate child rate (outside of the 2-to-1 band).

To see how this can impact group rating, consider a group with three employees, Abe (40), Bob (40), and Carol (56), where the issuer might rate them 1.0 (Abe), 1.0 (Bob), and 2.0 (Carol). (At an index rate of 2, Carol's rate is twice Bob and Abe's, and about four times the rate for a 22-year old.) Summed and divided by three, the group's age rating under the current rating method would be 1 + 1 + 2 = 4, divided by 3 = 1.33. This rate fits within the 2-to-1 limit around an average of 1, even though Carol's rate does not fit within the 2-to-1 rating band. As of 2014, the health plan must rate this same group something like this: 1.0 + 1.0 + 1.2 = 3.2, for an average rating factor across all three employees of 1.067.

Table 5: Example of Current versus New Market Rules for Age Rating Small Groups

Single Employees	Current Age Rating	New Market Rules	Delta
Abe (40)	1	1	0
Bob (40)	1	1	0
Carol (56)	2	1.2	.8
TOTAL	4 divided by 3 = 1.33	3.2 divided by 3 = 1.067	.26

Another major change affecting rates in 2014 will be the dispersal of some 100,000 Commonwealth Care enrollees into non-group commercial insurance. The Commonwealth's Health Connector mainly insures individual buyers:

1. Some 200,000 adults with household incomes below 300% of FPL who are either fully or partially subsidized under the State's Medicaid section 1115 waiver, and who are enrolled in five health plans, four of which also participate in MassHealth; and
2. Some 35,000 Commonwealth Choice individuals and families (plus about 5,000 lives in small employer groups) who as direct purchasers pay for their own coverage and choose among nine commercial carriers.

Commonwealth Care is currently outside the regulated commercial insurance market, operating in effect as a self-funded pool. As of 2014, the 200,000 or so Commonwealth Care lives will disperse into MassHealth – those at or below 133% of FPL – or commercial health plans subsidized by (a) advance premium tax credits (APTCs), (b) cost-sharing reductions (CSRs,) and (c) a new State "wrap-around" program to prevent enrollees with 133% to 300% of FPL from bearing more cost than they would have under Commonwealth Care. Some 100,000 enrollees from Commonwealth Care will be added to the 86,000 or so existing individual enrollees in commercial insurance.

The expansion of subsidy eligibility, from 300% of FPL under c. 58 to 400% of FPL under the ACA, plus the burst of outreach effort in anticipation of 2014 will likely further increase non-group enrollment. In addition, the definition of small-group will change from 1-50 lives to 2-50 lives as of January 1, 2014, further swelling non-group enrollment. However, this move of some enrollment from small-group to individual enrollment does not impact the risk profile of a carrier's merged market enrollment.

Modest increases in benefits will also commence on January 1, 2014, for non-grandfathered plans. In the individual market, prescription drug coverage will be required for catastrophic plans—it is currently optional for those under 26—and pediatric dental and vision benefits will be added. In addition, the limits currently allowed on visits per year (24) and other services for non-biologically-based mental

health conditions will be disallowed.[4] On the other hand, more individuals will qualify for, and may opt for, catastrophic coverage in 2014 than currently qualify for "Young Adults Plans" (< age 26), and the cost-sharing for catastrophic coverage under the ACA will be greater than currently applies to Young Adult Plans. In summary, benefit increases and cost-sharing reductions in Massachusetts' individual and small-group market will be modest.

Finally, the restriction on rate increases for any one group or non-group buyer to no more than 15% from one year to the next -- so-called "rate bumpers" – created by chapter 288 will no longer apply.[5]

[4] Bulletin 2013-12; Changes to Mental Health Benefit. Division of Insurance (April 1, 2013)

[5] Wakely does not have the data needed to analyze the impact of eliminating rate bumpers on overall rates, but its impact on particular groups for which manual rating calls for increases exceeding 15% is obvious.

4. ANALYSIS OF FACTORS IMPACTING 2014 PREMIUM

4.1 Health Insurer Provider Fee (Premium Tax)

The IRS has issued proposed regulations (REG-118315-12) for implementing the annual fee on the health insurance industry that is scheduled to take effect in 2014. The industry-wide fee was enacted as part of the ACA and is allocated among insurers based on market share.

The total fee for the entire industry starts at $8 billion in 2014 and will increase annually until 2018, when it will be indexed for inflation. The fee is allocated based on market share among all insurers with "aggregate net premiums written" over $25 million. It is treated as an excise tax and is not deductible for federal corporate tax purposes. Aggregate net premiums written is generally calculated after discounting a percentage of the net premiums under $50 million. The first $25 million in premiums is not included, and tax-exempt entities exclude 50% of all aggregate net premiums written (see tables).

Table 6: Health Insurer Provider Fee National Contribution Requirements

Year	Statutory Health Insurer Provider Fee Amount (in $B)
2014	$8.0
2015	$11.3
2016	$11.3
2017	$13.9
2018	$14.3
2019	$14.3
2020	$14.3
2021	$16.5
2022	$19.1
2023	$22.1

Table 7: Health Insurer Provider Fee National Contribution Requirements

Aggregate Net premiums Written	For Profit	Tax-Exempt (non-excluded)
< $25 million	0%	0%
$25 to $50 million	50%	25%
>$50 million	100%	50%

Covered entities

The fee is generally imposed on all entities engaged in the business of providing health insurance. However, the statute provides the following specific exclusions:

- Employers who self-insure employee health risks
- Governmental entities
- A voluntary employees' beneficiary association (VEBA) established under Section 501(c)(9) unless it is established by an employer to provide health coverage benefits for employees
- A nonprofit corporation that does not benefit a private shareholder or individual, does not attempt to influence legislation or carry on propaganda, and receives at least 80% of gross revenues for government programs that target low-income, elderly or disabled populations

Estimated Impact

Wakely developed estimates of the insurer fee and its impact on Massachusetts premiums. On average, we expect that the health insurer provider fee will range between 0% and 2.1% of premium in 2014, depending on the issuer, with an average of 0.8% overall. This estimate assumes that carriers will pass the entire amount of tax through as premium increases, and that taxable companies will also pass the additional expense due to the non-deductibility through to the premium. Because the average impact of the insurer fee on premium rates depends on the proportion of tax-exempt premiums, and Massachusetts has a high proportion of not-for-profits, the average impact of the health insurer provider fees on premium rates in Massachusetts is less than the national average. The table below summarizes Wakely's estimates.

Table 8: Wakely Estimates of Insurer Fee Premium Impacts in Massachusetts

Year	Min Adjustment	Max Adjustment	Average
2014	0.6%	2.1%	0.8%
2015	0.8%	2.7%	1.0%
2016	0.7%	2.5%	0.9%

4.2 Impact of Essential Health Benefits

The ACA requires that all benefit plans cover services for essential health benefits, some of which are excluded in the current market. Based on the services enumerated in the ACA, the essential health benefits will include, but are not limited to, the following categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management, and
10. Pediatric services, including oral and vision care

Due to Massachusetts State mandates[6], there are relatively few essential health benefit requirements that we expect to increase premiums for 2014. We estimate a maximum 2.0% impact to premiums due to the following essential benefit plan changes:

- Pediatric dental
- Pediatric vision
- Expansion of the state's mental health parity to comply with the Mental Health Parity and Addiction Equity Act of 2008 as required under the ACA
- Addition of pharmacy coverage to the catastrophic plans for young adults

The minimum premium impact is a small 0.25% under the assumptions that pediatric dental is not offered by the QHP, and more aggressive pricing assumptions are used for mental health/substance and vision.

The table below summarizes the minimum, best estimate, and maximum premium adjustments for EHB to the average market rates. We expect the rate impacts for each issuer to be within that range.

[6]See website: http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/ma-state-required-benefits.pdf

Table 9: Essential Health Benefit Impact

Minimum	Best Estimate	Maximum
0.25%	1.0%	2.0%

This impact will be seen immediately in 2014, and will not have a phase-in period.

4.3 Impact of Transitional Reinsurance Program

The reinsurance program under the ACA is a temporary program that will operate from 2014 through 2016. The reinsurance program is intended to stabilize individual premiums by offering reinsurance for high cost claimants. States that establish an exchange may operate the reinsurance program or they may allow HHS to operate the program.

The ACA includes the following nationwide requirements for reinsurance assessments to fund the reinsurance program as well as to contribute to the US Treasury[7]:

Table 10: Reinsurance Assessments

Year	Reinsurance Program[8] (in $B)	US Treasury (in $B)	Total Assessment (in $B)
2014	$10.0	$2.0	$12.0
2015	$6.0	$2.0	$8.0
2016	$4.0	$1.0	$5.0

Per the final regulation of the HHS Notice of Benefit and Payment Parameters for 2014, the assessment on issuers and self-insurers in 2014 will be $5.25 PMPM. The analysis for Massachusetts is a bit different than most states because of the merged market element. Generally, the impact is shown separately for the individual market versus the small group market. In Massachusetts, the impact on the overall premium of the merged market depends on the amount of individual membership versus the total membership in the merged market.

[7] The US Treasury contributions are to fund the retiree subsidy program.
[8] In addition to the reinsurance amount listed here, there are additional administrative amounts to operate the program estimated to be 0.2% of the cost of the reinsurance payments, which we have not included in the analysis.

Given that the population that is assessed is different than the population that benefits from the program, we calculated that the break-even ratio of the transitional program occurs in 2014 when there are 9.4 members assessed to every member in the individual market. In any given pool of membership, if the ratio of assessed members to individual members is less than this ratio, the average premium rate will decline (the program will result in a savings). If the ratio of assessed members to individual members is higher than this ratio, the average market rate will increase (the program will result in a cost). Note, this program results in a "cost" nationally due to the funding the administrative expenses and contributions to the US treasury are over and above the benefits that will be paid.

The estimated ratio of assessed members to individual members for the Massachusetts merged market is 5.1:1, indicating that the average rate for the merged market will decline by 0.6% as a result of the transitional reinsurance program in 2014. Because the program's biggest impact is in 2014, the subsequent years of 2015 and 2016 will see increases in costs relative to the prior year. However the impact relative to the 2013 year is still negative in each of 2015 and 2016. Our estimate of the annual change in average premium for the merged market (relative to 2013 premiums) is shown in the following table.

Table 11: Impact of Transitional Reinsurance Program

Year	Change in Average Merged Market Premium (Relative to 2013)
2014	-0.6%
2015	-0.5%
2016	-0.3%

4.4 Impact of Single Risk Pool

The adjusted community rating rule in the ACA requires that issuers must consider all members of their small group and individual plans part of a single risk pool, including members in small group and individuals plans both inside and outside the exchange. The premiums for each group in the insurer's pool will be based on the average experience of that insurer's entire pool, adjusted for the rating variation factors that the ACA permits. This is already the case in Massachusetts. For Massachusetts, the main change to its current market is that part of the Commonwealth Care enrollment (133% - 300% FPL) will qualify for APTCs through the Health Connector and, as of 2014, will enter the individual commercial insurance market.

The impact of the Commonwealth Care membership entering the merged commercial risk pool depends on the amount of members and their relative morbidity (on an age-normalized basis) compared to the existing merged small group and individual market. Overall, some 100,000 new commercial lives from Commonwealth Care enrollees should represent 12% to 16% of the merged market in 2014, and they

will add covered lives with a morbidity about 20% higher than in the existing merged market, as shown in the table below:

Table 12: Impact of CommCare Membership Entering the Merged Market

Description	Low Estimate	Best Estimate	High Estimate
Percentage of CommCare membership moving to the merged market as compared to the total market	12%	14%	16%
CommCare morbidity as a percent of the existing merged market	1.15	1.2	1.25
Impact to merged market premiums	1.6%	2.5%	3.4%

However, as these CommCare lives are currently concentrated in four carriers, which have relatively little commercial membership, their transition will have an outsized impact on these four and much less impact on the other five carriers.

4.5 Impact of Risk Adjustment Requirements

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

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

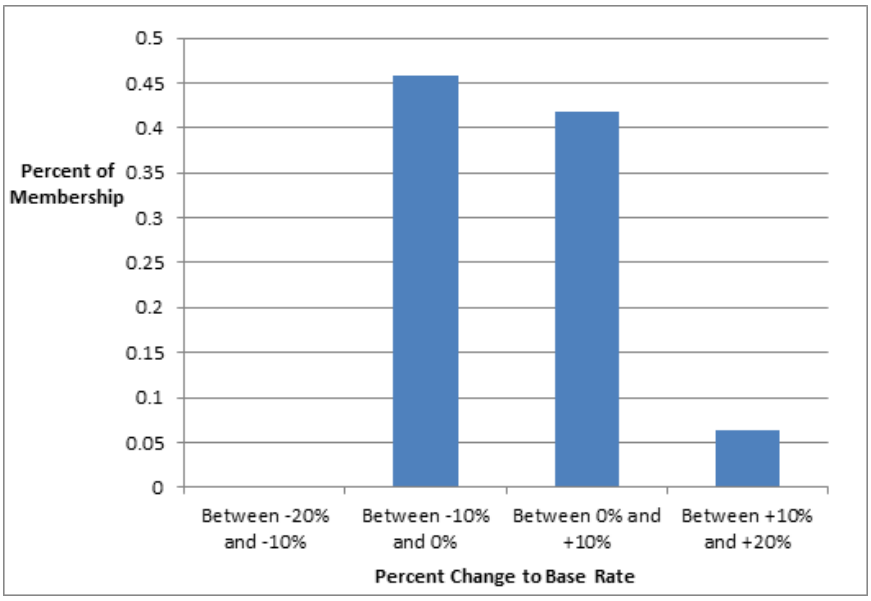
Based on the risk adjustment mechanism, revenue for a carrier will either be increased or decreased based on whether the risk for a carrier is higher or lower, respectively, than the average -- after accounting for allowable rating factors (most notably age). The risk adjustment mechanism may help mitigate adverse selection among carriers, as additional revenue can be expected from the risk adjustment mechanism if higher-than-average-risk membership enrolls. The additional revenues should curb a plan's incentive to select the healthiest of employer groups when using adjusted community rating.

The implications of risk adjustment for rate setting is that the index rates should be set based on a 1.0 population. Because issuers with the lowest risk membership will subsidize those issuers with the highest risk membership, setting the premium rates at a 1.0 risk will best protect the issuer from unanticipated risk transfers that might affect overall profitability. To assist issuers in this regard, CHIA has provided for an assessment of each carrier's risk, compared to the market, in a risk adjustment study performed by Milliman.

Based on this study, we have estimated the range of impacts to existing issuer premiums. Note, this impact is in addition to the overall impact of the single risk pool described in the prior section. The

remaining impact of the risk adjustment will vary by carrier, but will be premium neutral to the overall market. The distribution of premium impacts by health plan is shown in the following table.

Chart 13 – Distribution of Change in Rates by Issuer Due to Risk Adjustment Implementation



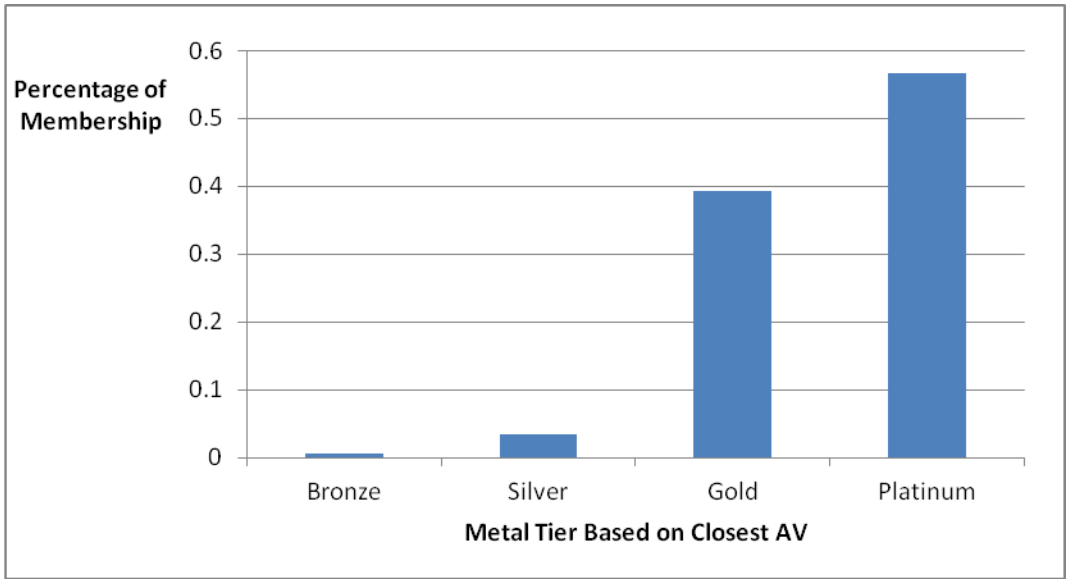
Note that we have excluded a couple of outlier carrier impacts from our graph, as we suspect they are impacted by data issues that we were not able to test as part of this project. The remaining impacts shown in Chart 13 reflect the raw outputs from the study. Actual impacts to various issuers will likely incorporate anticipated changes to coding that could result in premium impacts different than those shown above.

4.6 Impact of AVC Requirements

Beginning in 2014 there will be four primary levels of plan designs that may be offered, varying by their actuarial value (AV). The four plans are: Bronze at 60% AV, Silver at 70%, Gold at 80% and Platinum at 90%. All individual and small group benefit plans must be within two percentage points of these AVs in 2014. Nationally, all issuers participating in both the individual and small group markets will be required to offer at least one plan at the Silver level and one at the Gold level. In addition, most states will mirror these requirements in the market outside of the exchange.

The table below shows the 2011 distribution of Massachusetts members mapped to the closest metal AV levels, per the DOI survey. This does not include the Commonwealth Care membership, most of which is expected to be in Silver plans with cost-sharing reductions (CSRs).

Chart 14 – Distribution by Metal Tier



Because Massachusetts already has a requirement for Minimum Creditable Coverage under chapter 58 that matches the minimum 60% AV requirement of small groups and individual coverage under the ACA, we do not expect the AV requirement to have any significant overall impacts to premiums in 2014.

However, every group or individual for which the current benefit design is not within the allowed two percentage point tolerance of the AV requirements will have some impact as the coverage must be either enriched or reduced so that the AV is within the required ranges. The impact of this AV change on any particular purchaser could be as much as approximately +/- 4.6% impact to premium.[9] Our assumption is that the net overall impact of bringing the current benefit plans into AV compliance is insignificant, assuming a similar number of increased and decreased benefit designs.

4.7 Factors with No Average Market Impact

No other changes due to the ACA are expected to have an impact on premiums after 2013. Specifically, Wakely considered the following factors unchanged for Massachusetts:

[9] Maximum impact will be felt for members where current AV levels equal 65%. Premium impact will be 68%/65%-1 = 4.6%. Note that the AVs in 2014 will be calculated using the federal AV calculator and may result in small variations in AV different than those prior to 2014.

- Massachusetts adopted a tobacco rating factor of 1:1;

- Minimum Loss Ratio is already well above the requirements of the ACA and the give-backs by Massachusetts carriers began in 2011, so no new rate impact is projected for 2014 and beyond;

- Pent-up demand is expected not to be the factor that it may be in other markets because the market reforms (guaranteed issue and renewal), subsidies for lower-income individual coverage, and an employer mandate have been in place since 2007; and

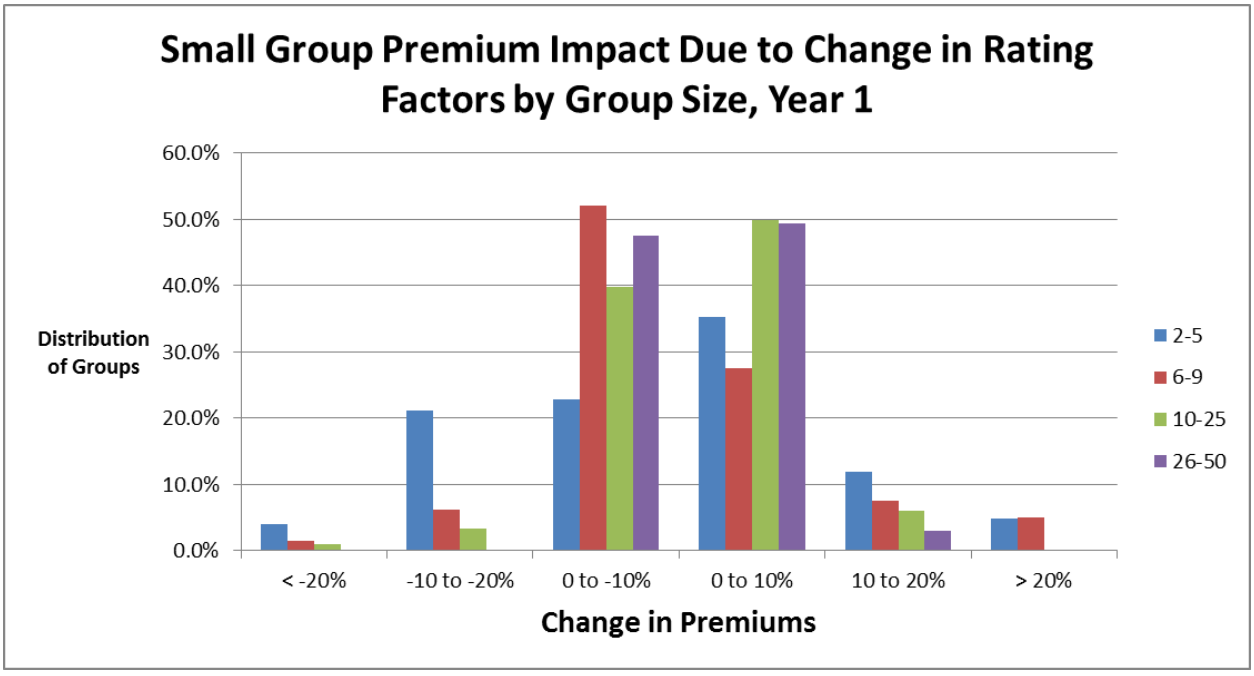
- Geographical rating factors used by carriers in the past are all within the limits prescribed by the ACA.

5. IMPACT ON SPECIFIC HOUSEHOLDS AND SMALL GROUPS

As described above, a series of changes to current rating practices will soon take effect, either fully in 2014, or to be phased-in for 2016. Some of these changes in rating will have little, if any, measureable impact on the claims experience of the merged market in aggregate, but the change to list-billing for each member of a family will affect particular household rates in the individual market significantly; and multiple rating changes will affect rates for particular employers and employees in the small group segment. Specifically, the elimination of the group size, industry and the cooperative rating factors, and the change in application of age rating will affect rates for particular households and groups.

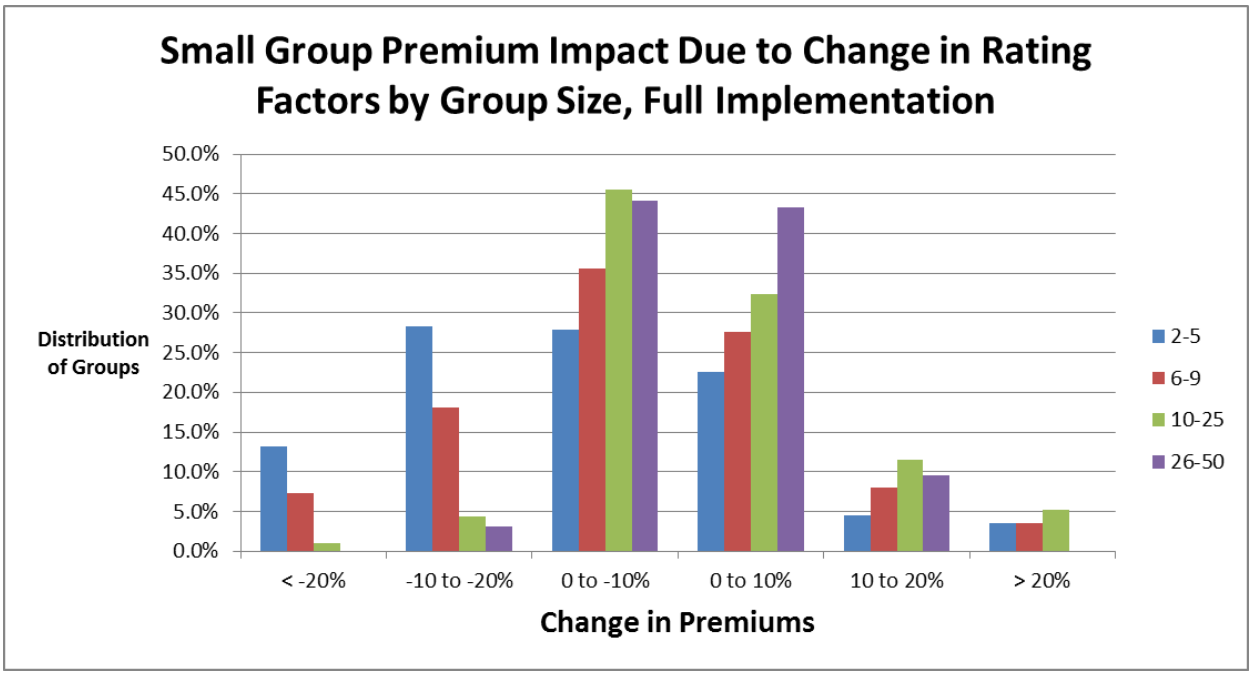
For example, the elimination of group size as a rating factor will tend to lower rates for the smallest groups, which have been "rated up," and slightly raise rates for larger groups. Carriers will be allowed to phase-out group size as a rating factor over two years. Thus, we see below that slightly more of the smallest groups (< 10) than of the larger groups will experience a rate decline in excess of 20% for year-1.

Chart 15



Even more groups will experience a significant change in premiums due to changes in rating factors once the rating factor changes are fully implemented. At that point, the smallest groups (2-5) will benefit the most from premium reductions, while more of the largest groups (>25) will experience premium increases.

Chart 16



While more than 20% of groups with 10-25 lives and 10% of groups with more than 25 FTEs will experience a rate change of more than +/-10%, the percentages are higher for smaller groups: over 30% of those with 6-9 lives and about 50% of those with 2-5 employees will experience increases or decreases exceeding +/-10% because of the new rating factors. The large rate changes are not symmetrical: smaller groups will experience rate decreases than will larger groups.

Because the rate decreases are going disproportionately to smaller groups -- with less premium revenue per group than larger groups -- slightly more groups overall will experience decreases than increases because of changes to rating methods. With full implementation, *twice as many groups* will see rate decreases of at least 10% as will see rate increases in excess of 10%. However, *the number of employees in groups* seeing rate increases and groups seeing rate decreases will be far closer to even.

On the other hand, the group market will be more stable than the individual market. Relatively fewer groups will experience premium swings on account of new rating rules than will households in the individual market. This is especially true in year-1, while some rating changes are being phased-in. In 2014, 3/4ths of the small groups will experience a swing of less than 10% up or down, and even by full implementation of rating changes, only slightly more will experience such a swing. Chart 17a summarizes the distribution of small group premium changes due to rating factors by number of groups and Chart 17b summarizes these changes by number of subscribers.

Chart 17a

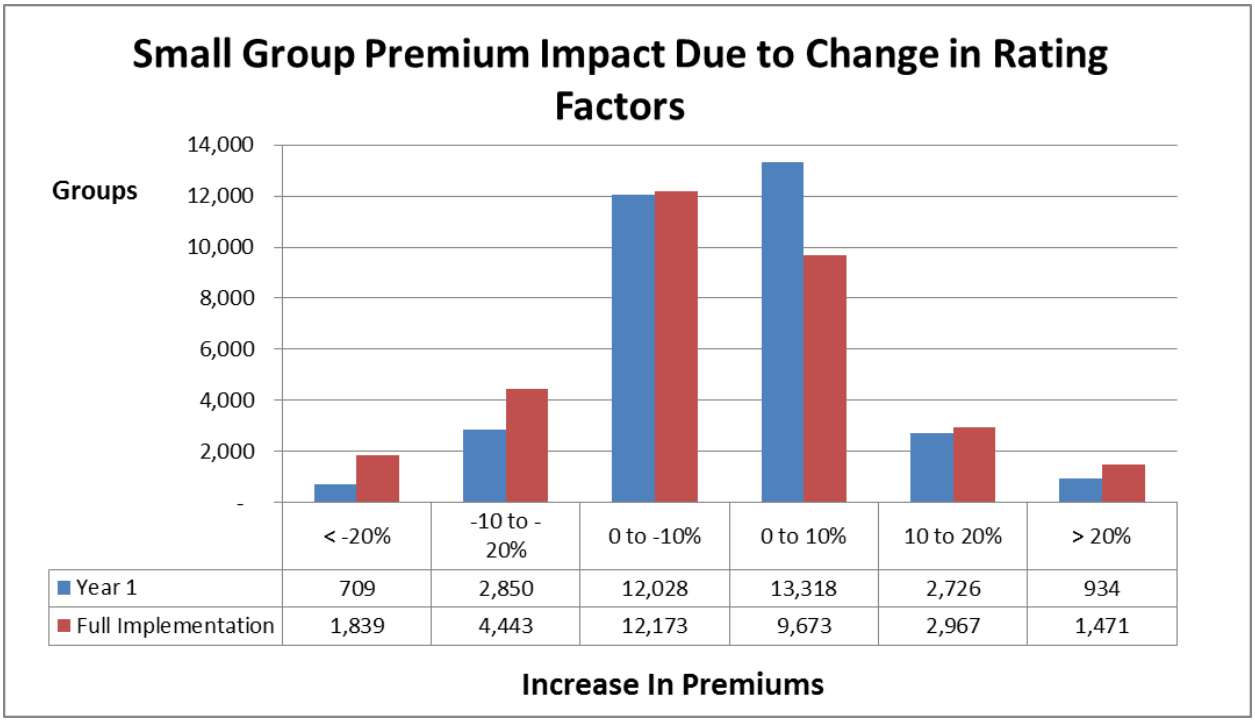
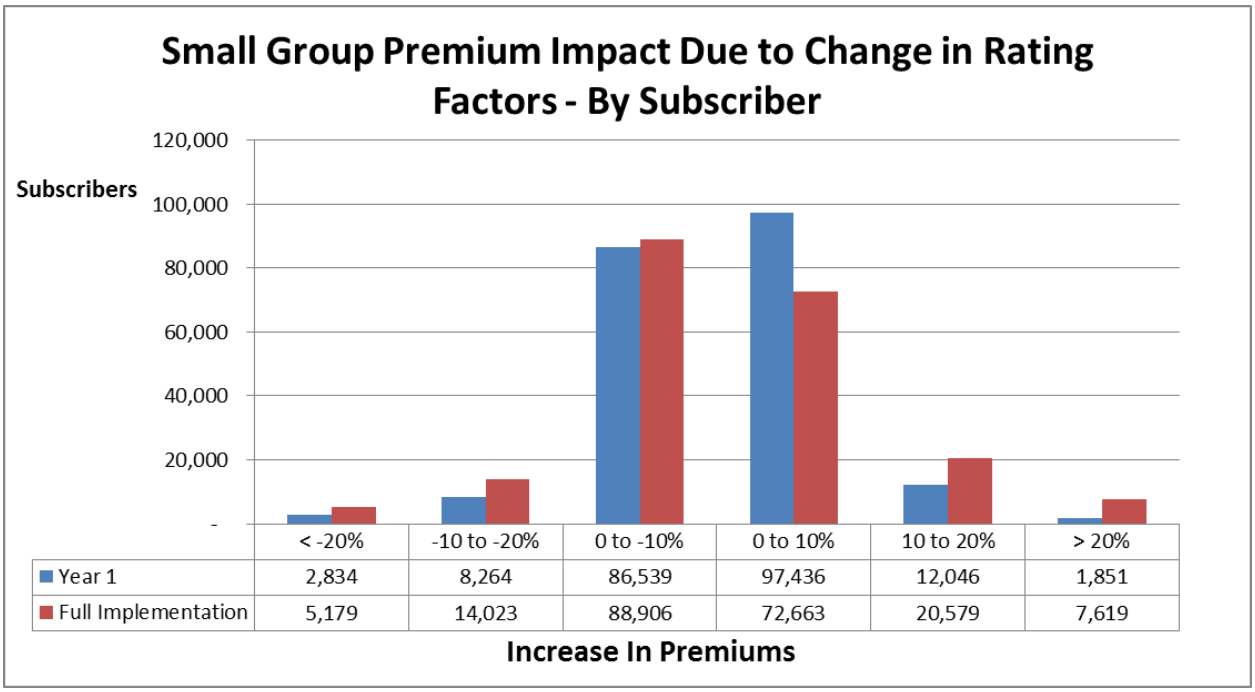
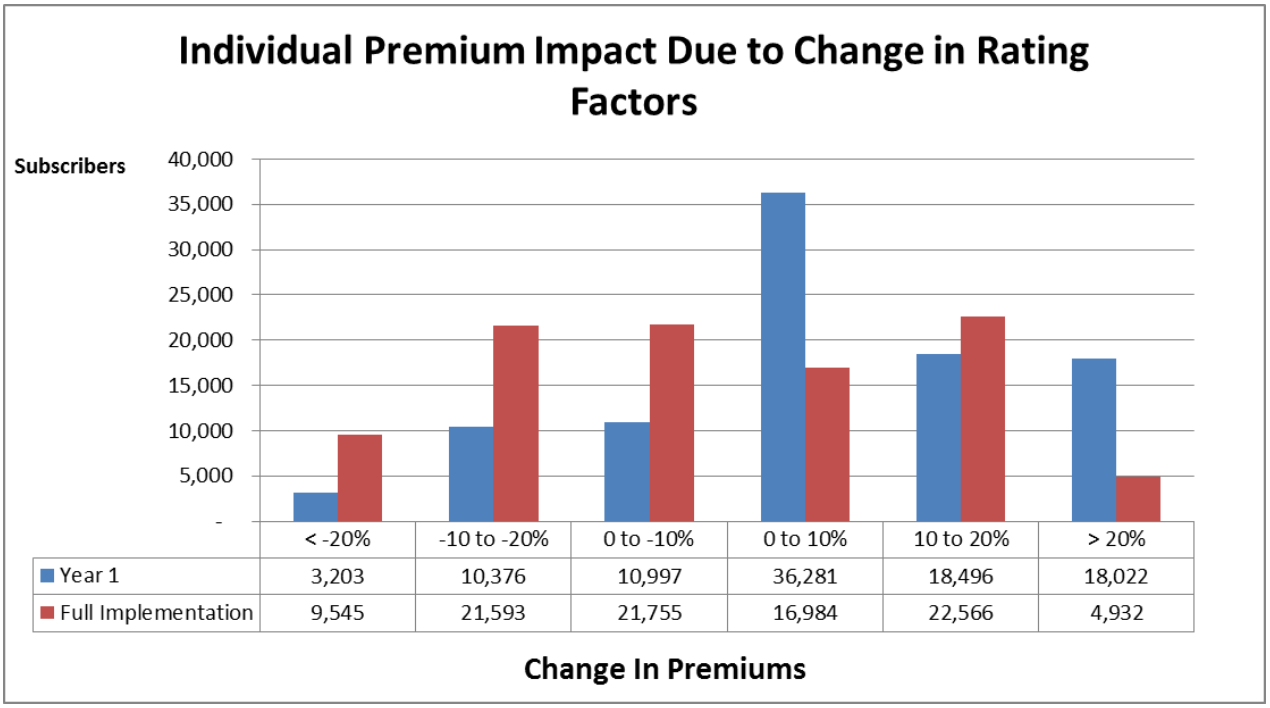


Chart 17b



By contrast, a majority of individual buyers will experience an immediate rate swing up or down in excess of 10%. And the rate increases will be far more prevalent than rate decreases.

Chart 18



5.1 Methodology of Estimating Distribution of Individual and Small Group Impacts

In order to calculate the full impact to premiums due to the change in allowable rating factors (including 2:1 age rating), we needed to price each carrier's existing individual and small group policies using their own rating methodology and factors and then re-price the same policies under the ACA compliant rating methodology. To accurately price the existing policies, we needed each carrier's subscriber and member census data. The DOI survey data outlined in the Data section, gave us snap shots of the census data in aggregate, but not at the group level. Therefore we used the distributions included in the surveys and simulated census data to replicate the unique composition of policies for each carrier. When compiling our distributions, we only considered the characteristics of active policies (policies that termed during the year were excluded). Our simulated values included:

1. Group size - ranging from 1 to 50.
2. Policy type – Including: Individual, Individual + Spouse, Individual + Child(ren), Family
3. Subscriber Age – Ranging from 1 to 65
4. Dependent Age – Children range from 1 to 20, Spouse range from 21 to 65
5. Family Size – Ranging from 3 to 8.
6. Industry
7. Participation (where applicable)
8. Percent of individuals who are sole proprietors.

Each carrier has its own small group rating methodology and rating factors. When pricing under the pre-ACA rating environment, we followed the methodology outlined by each carrier in its survey response. We note that the carriers apply age factors and pricing conversion factors differently, and this was

incorporated into our analysis. Once the simulated data was priced under both pricing environments, we then made a revenue neutral adjustment to each carrier's post-ACA index rate such that all carriers were collecting the same amount of revenue under both methodologies. Therefore, the analysis assumes that the effect on premiums due to the change in allowable rating factors for the merged market in aggregate will be 0%. However, some individuals and small groups will see significant increases or decreases in premiums.

The DOI survey data provided to Wakely only included rating factors and aggregate census data for merged market and large group business; it did not include Commonwealth Care data and rating factors. Given that the Commonwealth Care sector is its own, separate risk pool, and that it is clear that the rating factors and methodology applicable to the merged market were not applicable to the Commonwealth Care market, we felt it was appropriate to exclude the Commonwealth Care members (including those whom will be part of the merged market in 2014) from the analysis of the effect on premiums due to the change in allowable rating factors.

6. CONCLUSION

Wakely's best estimate is that the ACA will increase premiums across carriers and buyers in the merged individual and small-group market in 2014 by 3.7%, on average. The amount of 3.7% for costs associated with the ACA is in addition to normal trend and masks considerable variation. Rate changes will vary considerably from individual carrier to carrier and for particular group/individual purchasers, depending on each carrier's particular circumstances. Wakely estimates the range of potential variation to be between -20% and +26% by issuer and potentially well in excess of this wide range for particular individual or group purchasers.