
The Impact of the ACA on Wisconsin's Health Insurance Market

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Table of Contents

Section Title	Page Number
1. Introduction	4
2. Key Findings	4
3. Analysis of Impacts to Coverage	6
3.1. The Uninsured	7
3.2. Individual Insurance Market and the Exchange	12
3.3. Employer Sponsored Insurance	14
3.4. Contrast with No Mandate	15
4. Wisconsin Individual Market	15
4.1. Current Individual Market Premiums	16
4.2. Individual Market Rating Practices	17
4.3. Individual Market Premium Discounts/Surcharges	19
4.4. Individual Market Product Offerings	19
5. Health Insurance Risk-Sharing Plan (HIRSP)	21
6. Individual Market Premium Impacts due to ACA Reforms – Before Implementation of Tax Subsidy	22
7. Individual Market Premium Impacts due to ACA Reforms – After Implementation of Tax Subsidy	26
7.1. Catastrophic Plans	28
8. Wisconsin Small Group Market	29
8.1. Current Small Group Market Premiums	29
8.2. Small Group Market Rating Practices	30
8.3. Small Group Market Premium Discounts/Surcharges	32
8.4. Small Group Product Offerings	32
8.5. Small Group Premium Impacts due to the ACA	34
9. Merged Market Analysis	35
10. Conclusions	37
11. Appendices	38

List of Tables

Section Title	Page Number
TABLE 1 – 2009 BASELINE INSURANCE COVERAGE	6
TABLE 2 – 2016 COVERAGE EFFECTS OF THE ACA	7
TABLE 3 – ESTIMATED 2009 MONTHLY PREMIUMS PER SINGLE POLICY	16
TABLE 4 – ESTIMATED 2009 MONTHLY PREMIUMS PER FAMILY POLICY	17
TABLE 5 – WI INDIVIDUAL MARKET RATING PRACTICES BEFORE AND AFTER ACA	17
TABLE 6 – WI INDIVIDUAL MARKET 2009 PREMIUM DISCOUNTS & SURCHARGES	19
TABLE 7 – WI INDIVIDUAL MARKET ACTUARIAL VALUE RANGE	20
TABLE 8 – WI INDIVIDUAL MARKET ESSENTIAL BENEFITS ESTIMATED IMPACT	21
TABLE 9 – WI HIRSP VS. INDIVIDUAL MARKET	22
TABLE 10 – INDIVIDUAL MARKET SINGLE POLICIES	24
TABLE 11 – INDIVIDUAL MARKET FAMILY POLICIES	24
TABLE 12 – RESULTING PREMIUM CHANGES DUE TO CATEGORIES (1) THROUGH (5) BEFORE TAX SUBSIDIES	25
TABLE 13 – DISTRIBUTION OF PREMIUM IMPACTS BY AGE COHORT	25
TABLE 14 – AVERAGE PREMIUM IMPACTS BY AGE COHORT	25

TABLE 15 – SUMMARY OF “WINNERS” AND “LOSERS” BY SUBSIDY CATEGORY	26
TABLE 16 – SINGLE POLICY “WINNERS”	27
TABLE 17 – SINGLE POLICY “LOSERS”	27
TABLE 18 – FAMILY POLICY “WINNERS”	28
TABLE 19 – FAMILY POLICY “LOSERS”	28
TABLE 20 – 2009 WI SMALL EMPLOYER GROUP PREMIUMS	30
TABLE 21 – 2009 WI SMALL EMPLOYER GROUP RATING PRACTICES	31
TABLE 22 – 2009 WI SMALL EMPLOYER GROUP SURCHARGES & DISCOUNTS	32
TABLE 23 – WI SMALL GROUP MARKET 2009 DEDUCTIBLES BY ACTUARIAL VALUE	33
TABLE 24 – WI SMALL GROUP PREMIUM IMPACT	35
TABLE 25 – SMALL GROUP PREMIUM CHANGE BY GROUP SIZE	35
TABLE 26 – 2009 MARKET SHARE AND MEDICAL COSTS BY MARKET	36
TABLE 27 – MERGED MARKET PREMIUM IMPACT ANALYSIS	37
TABLE 28 – CARRIER PARTICIPATION	39
TABLE 29 – REGION DEFINITIONS	39
TABLE 30 – 2009 MARKET COMPARISON	41
TABLE 31 – RATING BANDS BY MARKET SEGMENT	42
TABLE 32 – IMPACTS OF ELIMINATION OF GENDER RATING	44
TABLE 33 – DISTRIBUTION OF PREMIUM IMPACT BY AGE COHORT	45
TABLE 34 – DISTRIBUTION OF PREMIUM IMPACT DUE TO HEALTH STATUS RATING LIMITATIONS IN THE INDIVIDUAL MARKET	45
TABLE 35 – DISTRIBUTION OF PREMIUM IMPACT DUE TO HEALTH STATUS RATING LIMITATIONS IN THE SMALL GROUP MARKET	46
TABLE 36 – IMPACT OF AGE/GENDER AND HEALTH STATUS LIMITATIONS	46
TABLE 37 – CORRELATION OF HEALTH STATUS AND AGE IN THE INDIVIDUAL MARKET	47
TABLE 38 – WI SMALL GROUP PREMIUM IMPACT DUE TO CASE SIZE	48
TABLE 39 – ACA PREMIUM ASSISTANCE CREDIT TABLE	56

1. Introduction

With the passing of the Affordable Care Act of 2010 (ACA), states will be assessing the impact of various components of the law on their insured markets. The Wisconsin Department of Health Services (DHS) has commissioned Gorman Actuarial and Dr. Jonathan Gruber to assess the impact of the ACA on the Wisconsin (WI) markets. The first phase of this analysis, performed by Gorman Actuarial, was to understand the market landscape of the existing privately insured markets. A series of three reports were produced: Individual, Small Group and Large Group 51 to 100 eligible employees. The second phase of this analysis, performed by both Gorman Actuarial and Dr. Gruber, was to understand the rating, premium and economic impacts of the ACA on the Wisconsin Market. This report presents the results of this actuarial and economic modeling. This report also includes an Appendix summarizing assumptions and approach on the various modeling and simulation exercises.

2. Key Findings

This section outlines key findings from this study. In general, there will be a significant drop in the uninsured and traditional non-group market with modest reductions in the population of the Small Group Market. In addition, we have modeled premium disruption in the Individual and Small group markets. Such disruption arises both because the existing high risk pool is folded into the individual market, because insurers are no longer allowed to health status rate their policies, and due to new restrictions regarding age rating. These result in a new subsidization of the less healthy population by the more healthy policy holders and an increased subsidization of the old policyholders by the young. It should be noted, however, that we have not modeled the impact of the Transitional Reinsurance Program for the Individual Market which could alleviate some of the premium disruption.

➤ **By 2016, the number of uninsured is projected to decrease by 340,000, or 65%. (Section 3.1, Page 7)**

Due to the individual mandate and the premium tax subsidies, the number of uninsured will drop by 340,000 leaving 180,000 uninsured. 27% of this population will receive premium tax subsidies through the exchange and 38% of this population will receive coverage through public insurance. Another 30% are covered through ESI and the remaining 5% will be unsubsidized through the exchange. In contrast, if the individual mandate is repealed, we estimate that only 62,000 uninsured would gain coverage, with 460,000 remaining uninsured.

➤ **57% of the Individual Market (91,000 members) will be eligible for tax subsidies within the exchange. (Section 7, Page 26)**

Approximately half of this population is individual policyholders. The total for tax credits to Wisconsin state residents in 2016 is \$729 million.

➤ **The Individual Market will experience premium increases as compared to pre reform premiums. (Section 7, Page 27)**

Prior to the application of tax subsidies 87% of the individual market will experience an average premium increase of 41%. The average increase for the entire Individual Market will be 30%. After the application of tax subsidies 59% of the individual market will experience an average premium increase of 31%. This is mostly due to the rating and product limitation changes, the merging of the HIRSP population into the Individual Market and the introduction of the new exchange. Approximately 40% of the current Individual Market is enrolled in benefit plans that have an actuarial value below the ACA minimum.

It should be noted that we did not model the impact of the reinsurance program in the exchange which may alleviate the premium increases. In addition, we have assumed the existing HIRSP subsidies will not be used to mitigate the premium changes in the Individual Market. If they were used, we believe the Individual Market premiums could be reduced by approximately 10%.

Please see Section 6, page 23 for an illustration of the premium impacts to Wisconsin households.

➤ **After the application of tax subsidies, 41% of the Individual Market will experience premium decreases as compared to pre reform premiums. (Section 7, Page 26)**

The average premium decrease will be 56%. 86% of this population will receive a premium tax subsidy within the Exchange. Other reasons for premium reductions are due to the rating limitations such as the 3 to 1 age band and eliminating the health status adjustment.

➤ **The merging of the Individual Market with the HIRSP Market will increase Individual Market premiums by 16%. (Section 6, Page 22 and Appendix VIII, Page 42)**

Due to higher morbidity in the HIRSP population as compared to the Individual Market, the merging of these markets results in the Individual Market subsidizing the HIRSP Market. In addition, we have assumed the existing HIRSP subsidies will not be used to mitigate the premium changes in the Individual Market. If they were used, we believe the Individual Market premiums could be reduced by approximately 10%.

➤ **53% of the Small Employer Groups will experience a premium increase as compared to pre reform premiums. (Section 8.5, Page 34)**

The average premium increase will be 15%. 47% of small groups will receive, on average, a 16% decrease. These premium changes are primarily due to the elimination of

a carrier's ability to use health status as a rating variable and the elimination of group size adjustments. There will be minimal selection as a small number of employers drop coverage, although there remains some uncertainty about employer reactions given the many forces which might impact their decision to offer insurance.

- **We estimate that in 2016 the traditional Individual Market sees an 83% decline, losing 150,000 members, while the newly reformed market will grow to 320,000 new enrollees. (Section 3.2, Page 12)**

A key tenet of reform is the movement towards a community rated individual market, mostly operating through the exchange. Individuals will be able to retain “grandfathered” policies that they held as of the passage of the ACA, but we project that very few will do so by 2016. On the other hand, the newly reformed market will end up much larger than the traditional individual market prior to reform.

3. Analysis of Impacts to Coverage

The Gruber Microsimulation Model (GMSIM) uses a combination of 2009 Current Population Survey (CPS) data and state administrative data to establish a 2009 insurance coverage baseline for the non-elderly (under 65) population. Table 1 presents this baseline.

	2009 Baseline Coverage
Employer Sponsored Insurance (ESI)	3,220,000
Small Firm ESI (2-50 Employees)	330,000
Large Group ESI	2,880,000
Individual Market Insurance	180,000
Public Insurance	750,000
Uninsured	480,000
Total	4,620,000

Table 1 – 2009 Baseline Insurance Coverage¹

Status Quo (Without ACA)

By utilizing population growth projections from the U.S Census Bureau, and insurance enrollment projections from the Congressional Budget Office (CBO), we are able to project forward from this 2009 baseline, and establish a 2016 pre-ACA status quo baseline. We focus on 2016 to allow three years for the ACA to phase in; this follows CBO assumptions on the amount of time it takes for the mandate to become fully effective. Employer sponsored insurance (ESI) would expand by 8% growing from 3.2 million individuals covered in 2009 to 3.5 million individuals in 2016 in the absence of

¹ Note: Columns may not sum due to rounding. Population estimates may vary slightly from Gorman Actuarial Market Survey Reports due to the difference in data sources.

the ACA. Both small firm ESI and large firm ESI would share in this expansion. Small firm ESI would grow by 9%, from 330,000 individuals covered in 2009 to 360,000 individuals in 2016 (following population growth). The remaining ESI population would grow by 8%, expanding from a base of 2.9 million individuals in 2009 to 3.1 million individuals by 2016. Non-group, or individual, market insurance enrollment would remain steady during this period at 180,000 individuals covered. The public insurance membership would shrink by 7% from 2009 to 2016, falling from 750,000 individuals covered to 700,000 individuals (as the economy improves). The ranks of the uninsured would grow by 8%, rising from 480,000 individuals lacking coverage to 520,000 individuals.

With ACA

By 2016, the enacting of the ACA will have had a large impact on insurance coverage in Wisconsin. The expansion of Medicaid will add an additional 170,000 individuals to the public program. The creation of the exchanges will provide a large boost to the Individual Market, in addition to siphoning off most of the traditional Individual Market enrollees. At the same time, these provisions will create a modest reduction in ESI. The net of these effects would be a significant decrease in the uninsured population of 340,000 individuals. Table 2 below summarizes the 2016 coverage effects of the ACA.

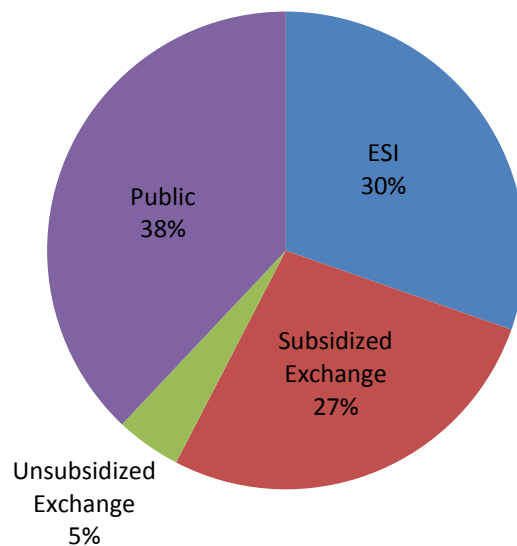
	Status Quo	With ACA	ACA Impact
Employer Sponsored Insurance (ESI)	3,470,000	3,460,000	-10,000
Small Firm ESI (2-50 Employees)	360,000	350,000	-10,000
Large Group ESI	3,110,000	3,110,000	0
Individual Market Insurance	180,000	30,000	-150,000
Exchange	0	320,000	320,000
Public Insurance	700,000	870,000	170,000
Uninsured	520,000	180,000	-340,000
Total	4,870,000	4,870,000	0

Table 2 – 2016 Coverage Effects of the ACA²

3.1. The Uninsured

Table 2 shows that the number of uninsured individuals will fall by 340,000, or 65%. It should be noted that the change in the uninsured has two components: individuals who are uninsured under the status quo and gain coverage under the ACA, and individuals who are insured under the status quo and become uninsured under the ACA. There are about 360,000 individuals in the former category, and about 23,000 individuals in the latter. In the remainder of this report, when we speak of “individuals gaining coverage”, we are referring to the 360,000 individuals in the first group. Figure 1 shows how these 360,000 individuals gain coverage.

² Note: Columns may not sum due to rounding.

Figure 1: Coverage Sources of the Previously Uninsured: 2016

Coverage for the previously uninsured is spread fairly evenly across ESI, public insurance, and the exchange. ESI covers 30%, or about 110,000, of those who are uninsured under the status quo, and then become insured under the ACA. Most of these individuals are obtaining coverage because of the individual mandate. 38%, or about 130,000 individuals who are newly gaining coverage, receive their coverage through public insurance. The remaining 32% are covered via the exchange, with 27%, or about 90,000 individuals, receiving federal subsidies, and 5%, or 20,000 individuals, paying the full cost of their Individual Market premium.

Figures 1A and 1B show the breakdown of the newly insured by income category and by age. Most of the newly insured are low income; seven in ten newly insured have incomes below two times the poverty line, and only one in eight have incomes above four times the poverty line. The distribution by age is much more even, with sizeable gains in insurance coverage in every age group.

Figure 1A: Newly Insured By Income

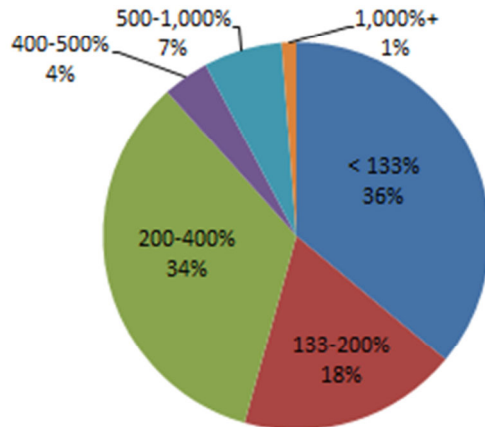
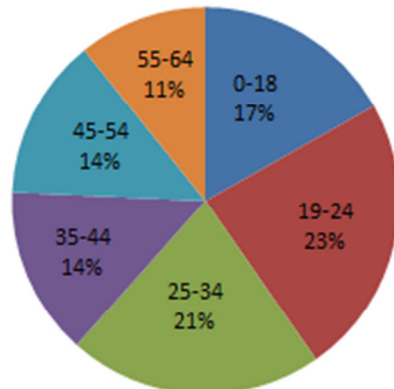
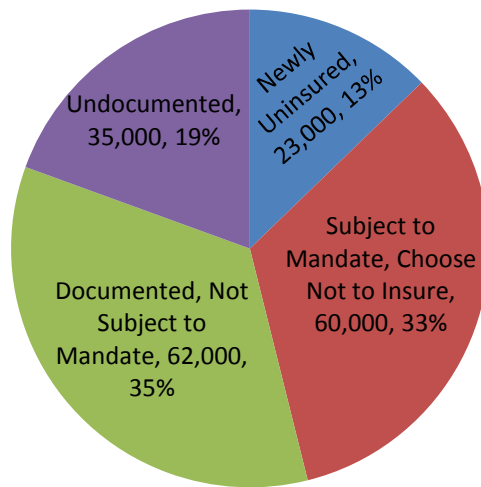


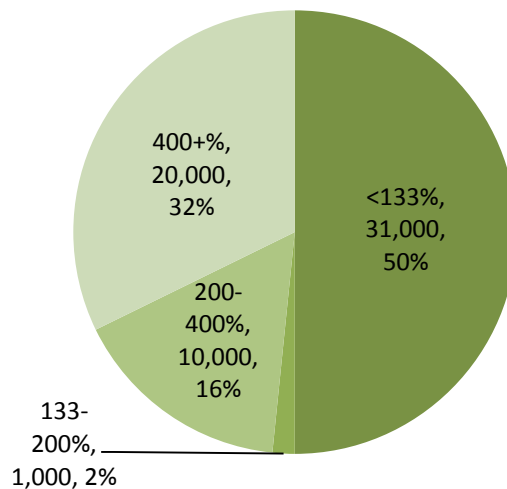
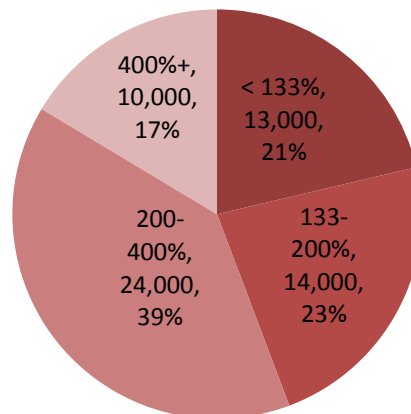
Figure 1B: Newly Insured By Age



Despite the decrease in the number of uninsured, there will still be around 180,000 uninsured individuals in 2016. Figure 2 shows the breakdown of those remaining uninsured.

Figure 2: Remaining Uninsured: 2016

Of the approximately 180,000 remaining uninsured individuals, 19% are undocumented immigrants. The coverage provisions of the ACA are explicitly denied to undocumented immigrants, so there is little reason to believe that the ACA will improve insurance coverage in this population. As previously mentioned, there are about 23,000 individuals who were insured in the status quo, and after the implementation of the ACA went uninsured. These newly uninsured make up 13% of the remaining uninsured, and are predominantly former ESI enrollees who had their offer discontinued by their employer. The remaining 68% of individuals uninsured even after the implementation of the ACA can be split into two categories, those who are exempt from the mandate (because their income is below the individual tax filing threshold or because insurance costs more than 8% of their income) and those that are subject to the mandate and still choose to remain uninsured. There are 62,000 individuals in the exempt group and 60,000 in the group choosing to ignore the mandate. This group of holdouts is quite small with respect to total state population. The entire group of 122,000 only represents 3% of the non-elderly population in 2016. In Figures 3a and 3b, we examine the income distribution of the two groups in order to better understand them.

Figure 3a: Remaining Uninsured Not Subject to Mandate by % of FPL**Figure 3b: Remaining Uninsured Subject to Mandate by % of FPL**

Looking first at Figure 3a, those not subject to the individual mandate, we see that half of the individuals in this category make less than 133% of FPL. This is to be expected as there are no financial penalties for breaking the mandate if household income is less than the tax filing threshold. These individuals are all eligible for Medicaid, but many of them decline it (as they do today) without a requirement for enrollment. More interesting are the groups above 133% of FPL, as we can learn a bit about the affordability of the exchange and ESI from these groups. If household income is greater than the tax filing

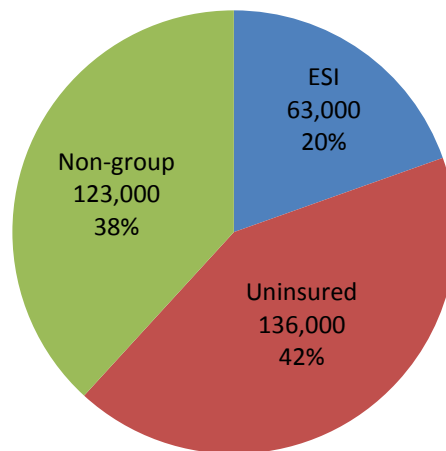
threshold, the only way an individual can be exempted from the mandate is if insurance is “unaffordable”, which is defined as costing more than 8% of income. We see very few individuals exempt from the mandate between 133-200% of FPL, which correspond to the highest levels of exchange subsidies. As income rises and subsidies decrease, more individuals become mandate exempt, and remain uninsured. There are 10,000 exempt remaining uninsured between 200-400% of FPL. Once we get to 400% of poverty and the full phase-out of exchange subsidies, we see another bump in exempt uninsured individuals (those for whom insurance costs more than 8% of their income), with 20,000 individuals in this category.

The group that is subject to the mandate includes people that by definition have an affordable insurance option, and an income that is at least larger than the tax filing threshold. This group also does not have a particularly strong trend with regard to income. Perhaps the only lesson to be learned is that as income rises so does the probability of being insured. The over 400% of FPL population, despite comprising over 40% of the total state population, represents only 17% of the remaining uninsured which ignore the mandate. It is still important to remember that even though there are some who refuse to insure regardless of the incentives, they are a tiny fraction of the state population. The entire group of 60,000 individuals that are ignoring the mandate only make up 1% of the 2016 Wisconsin non-elderly population.

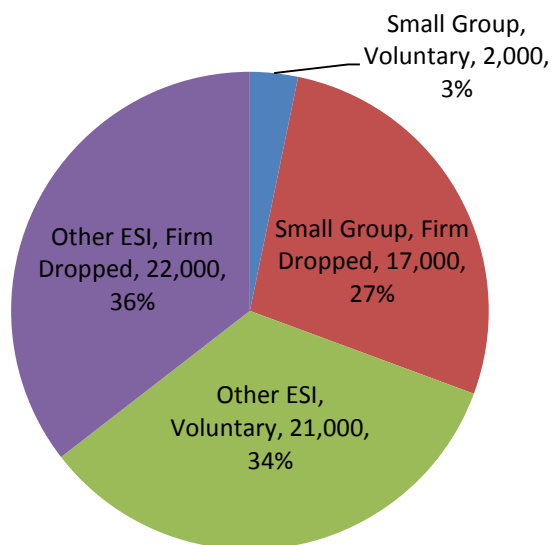
3.2. Individual Insurance Market and the Exchange

By 2016, individuals desiring non-group insurance can participate in one of three different markets. The first is to stay in the traditional Individual Market by maintaining their “grandfathered” plan (which was held in 2010). Individuals in this market will be able to retain non-community rated insurance policies, but they will not be eligible for the new tax credits. This market will decline substantially by 2016, however, as very few individuals maintain consistent Individual Market coverage for that long a period. The second is to move to the new insurance exchanges, which are community rated and provide federal subsidies for those who are eligible. The third is to move to the newly reformed market, but to purchase a policy outside of the exchange. This may be attractive for non-subsidized individuals if there are a wider variety of health plan choices available outside the exchange.

We estimate that the traditional Individual Market sees an 83% decline, losing 150,000 members, while the newly reformed market will grow to 320,000 new enrollees. Figure 5 below presents the status quo coverage sources of the exchange population.

**Figure 5: Status Quo Coverage Sources of the Exchange Population:
2016**

The largest group moving to the exchange is those who would be uninsured absent the ACA. They make up 42% of the exchange representing 140,000 individuals. Next, is the existing non-group population which makes up 38% of the exchange, representing 123,000 individuals. The status quo ESI population makes up the remaining 20% of the exchange, representing 60,000 individuals switching from ESI to the exchange.

Figure 6: Individuals Moving From ESI to the Exchange: 2016

3.3. Employer Sponsored Insurance

As previously mentioned, ESI will experience a small net decline in enrollment, although there will be larger gross flows within the employer-sponsored insurance population. There will be 10,000 fewer Wisconsin residents covered via ESI due to the effects of the ACA. This represents less than a 1% decline in ESI enrollment. There are a few reasons for the small magnitude of this effect. The first is that the full effects of the ACA will take a few years to manifest themselves. Exchange enrollment is expected to phase-in over the first 3 to 4 years of the ACA, so 2016 impacts on ESI enrollment will be somewhat muted. The second major reason is that firms will not fully take up the incentives provided by the ACA to drop coverage. This is due to the employer mandate codified in the ACA. Firms with 50 or more employees will face fines if they do not offer adequate, affordable policies to their employees. These fines partially offset the financial incentives to drop coverage and shift employees to the nascent exchange. In addition, the presence of the individual mandate provides an incentive for individuals to pressure employers to maintain ESI coverage. Since insurance coverage is mandatory at the individual level as well, employees will desire the security provided by the ESI plans they are already enrolled in. Furthermore, evidence from the recent health insurance reform in Massachusetts suggests that most firms will not drop coverage, even with the presence of a viable alternative like the exchange. It is not clear how relevant this experience is for Wisconsin given the differences in the two states, but it further confirms the conclusions from our analysis (and CBO's) that show small effects on employers.

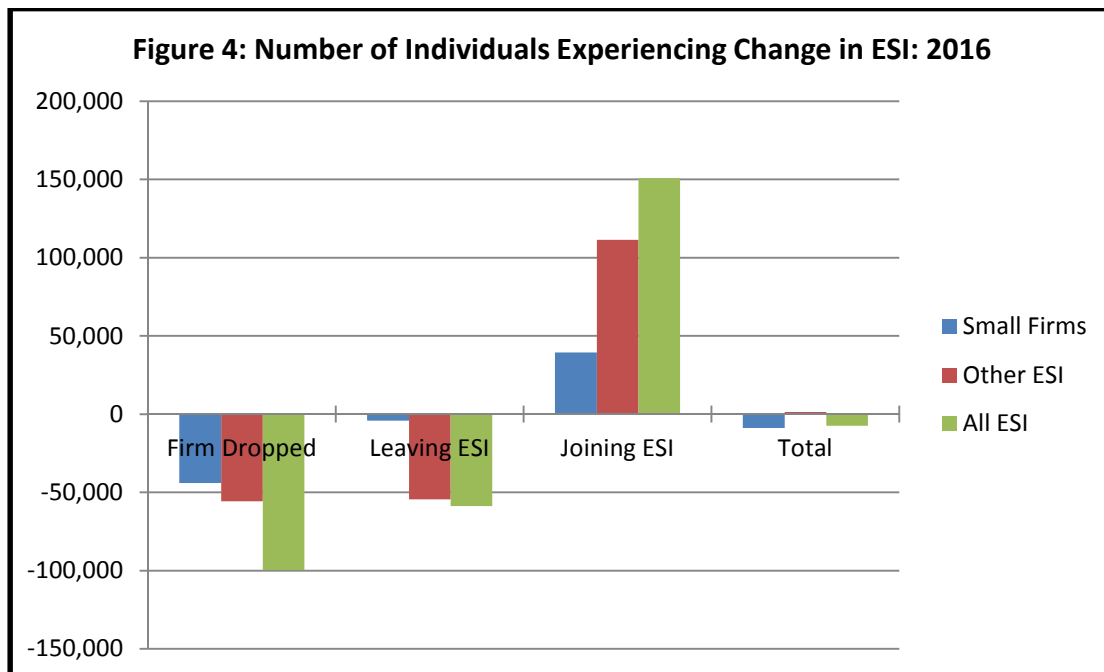


Figure 4 summarizes the flow in and out of ESI in 2016. In this figure we divide the ESI movements into three categories: those dropped by their firm; those who voluntarily leave employer-sponsored insurance to move to the exchange, Medicaid, or even to become uninsured; and those who join employer-sponsored insurance either due to

changing prices, the individual mandate, or the expansion of dependent coverage to young adults. The last set of bars shows the very small overall net effects.

As with those in the non-group market, those in the Small Group Market may end up in one of three places. The first is to retain their existing “grandfathered” small group coverage in the existing (non-community) rating environment. The second is to purchase through the new SHOP exchange, which is the only channel through which they can avail themselves of small group tax credits. The third is to purchase in the new community rated market, but outside the SHOP exchange. As before, we assume that most small firms will no longer be grandfathered by 2016, but we do not explicitly model how many are in or out of the SHOP exchange. We estimate that 60,000 persons covered by small group insurance remain grandfathered, and that 285,000 move into the newly reformed market (inside and outside the exchange).

3.4. Contrast with No Mandate

For comparison purposes, we also estimated the impact of the ACA without the individual mandate. These estimates are less precise because we do not have the experience of Massachusetts to assist in guiding the modeling. When we remove the mandate provision, we estimate that the number of uninsured covered is 62,000. This means that only one fifth as many people would receive coverage as compared to the full ACA implementation, where 340,000 individuals gain coverage. Without the mandate, there would be 460,000 remaining uninsured individuals versus only 180,000 remaining uninsured individuals with the mandate. This small net coverage effect is partly because there is a much larger erosion of employer-sponsored insurance without the mandate to incentivize enrollment among those offered ESI: employer-sponsored insurance falls by 128,000 persons. This is a huge increase in ESI erosion compared with the full ACA scenario that only shows a 10,000 individual decrease in ESI enrollment. After the implementation of the full ACA, there will be 3,460,000 individuals enrolled in ESI, but without the mandate there will be only 3,340,000 individuals enrolled in ESI.

4. Wisconsin Individual Market

We define Wisconsin’s current Individual Market as individuals (this includes single policyholders and family households) that purchase insurance on their own in the private insured market. This excludes the individuals enrolled in Wisconsin’s Health Insurance Risk-Sharing Plan (HIRSP) and individuals enrolled in Wisconsin’s public programs such as Medicaid. We have estimated that as of Year End 2009, there were approximately 160,000 individuals enrolled within Wisconsin’s Individual Market, and an additional 15,500 members enrolled within Wisconsin’s HIRSP³. These estimates are based on results from a survey conducted by Gorman Actuarial on behalf of the

³ The HIRSP population is approximately 19,000 as of January 2011, per http://www.hirsp.org/pdfs/report_enrollment.pdf. This increase in membership may further impact premiums in the Individual Market.

Wisconsin Office of the Commissioner of Insurance and the Wisconsin Department of Health Services to the major insurance carriers in the market. Additional information on this population as well as general methodology can be found in Gorman Actuarial's report, "Market Summary for Wisconsin's Individual Health Insurance Market", dated November 22, 2010 (Individual Market Summary Report).

4.1. Current Individual Market Premiums

For the Wisconsin Individual Market Study, GA collected CY 2009 premium data for single policies and family policies. A detailed description of GA's data collection and aggregation methods can be found in the Appendix. Table 3 below shows estimated monthly 2009 premiums for single policies within the Wisconsin Individual Market. Note that these premiums reflect the various discounts and surcharges that carriers use to set premiums as well as varying benefit levels. We have shown premiums by age cohort and by region. Region definitions are consistent with our market study and can be found in the Appendix.

Single Policies	Billed Premium PSPM						Total
	Milwaukee	Northeastern	Northern	Southeastern	Southern	Western	
0-17	\$117.07	\$104.11	\$107.40	\$120.41	\$130.49	\$112.07	\$115.43
18-24	\$102.05	\$93.95	\$102.74	\$106.46	\$107.98	\$97.82	\$101.77
25-29	\$116.58	\$108.84	\$121.29	\$123.10	\$121.58	\$116.44	\$117.78
30-34	\$143.59	\$130.92	\$140.52	\$155.81	\$150.13	\$135.27	\$143.11
35-39	\$177.20	\$154.40	\$165.32	\$176.51	\$172.01	\$149.14	\$166.18
40-44	\$204.36	\$175.98	\$191.89	\$207.45	\$198.70	\$181.69	\$193.06
45-49	\$246.49	\$205.57	\$212.51	\$240.90	\$242.61	\$211.97	\$225.52
50-54	\$306.13	\$249.65	\$265.17	\$296.25	\$291.00	\$260.52	\$275.14
55-59	\$349.20	\$296.30	\$313.20	\$346.27	\$341.89	\$302.13	\$320.99
60-64	\$397.16	\$328.58	\$352.09	\$393.95	\$379.85	\$345.90	\$361.03
65+	\$375.03	\$319.43	\$355.71	\$456.17	\$364.47	\$414.74	\$378.95
Average	\$204.77	\$201.05	\$227.45	\$224.51	\$218.08	\$210.56	\$213.76

Table 3 – Estimated 2009 Monthly Premiums Per Single Policy

On average, single policy holders paid approximately \$214 per month in 2009 or \$2,568 annually. Approximately 1.9% of the single policies are in "child-only" policies. As expected, premiums increase with age. Premiums for single policies are highest in the Northern and Southeastern regions. This is primarily driven by the demographics and area rating factors for these two regions.

Table 4 shows 2009 monthly premiums for family policies. We have summarized the data by family size and by region. As mentioned in the market study report, family premiums are typically an aggregation of premiums established for each member within the family. Generally, the higher the family size the higher the premium. Note that the premiums shown reflect the various discounts and surcharges that carriers use to set premiums.

Family Policies	Billed Premium PSPM						
Family Size	Milwaukee	Northeastern	Northern	Southeastern	Southern	Western	Total
2	\$396.56	\$399.75	\$436.09	\$432.92	\$424.15	\$402.96	\$415.49
3	\$414.77	\$375.57	\$441.19	\$434.56	\$463.51	\$395.89	\$419.92
4+	\$522.92	\$440.61	\$516.74	\$510.74	\$527.59	\$444.82	\$490.00
Average	\$441.33	\$408.92	\$459.70	\$462.13	\$468.75	\$415.19	\$440.61

Table 4 – Estimated 2009 Monthly Premiums Per Family Policy

On average, policy holders paid approximately \$441 per month in 2009 or \$5,292 annually. As expected, premiums increase with family size. However these increases are modest. Further investigation reveals that family policies with family sizes of 2 are older and therefore have higher surcharges due to age. Premiums for families are highest in the Southern region. This is primarily driven by richer plan designs in the Southern region.

4.2. Individual Market Rating Practices

Due to Wisconsin's limited regulatory oversight, pricing for this segment varies significantly across carriers. In CY 2014, we believe carriers will be required to limit their rating practices for non-grandfathered business which will cause pricing disruption in the market. Individuals who have retained their grandfathered status will be allowed to be rated as they are today. However, it may be difficult to retain grandfathered status due to HHS's requirements. Table 5 summarizes the rating practices that occur currently in the Individual Market and also outlines which practices will be limited or not allowed in CY 2014. Since there is so much variation in rating practice today, GA calculated average rating practices among the carriers it surveyed. Additional information on the variation can be found in the Individual Market Summary Report.

	Rating Practices Before and After ACA	
	CY 2009	CY 2014
Age/Gender	5.1 to 1 Rate Band for adults	No Gender Allowed; 3 to 1 band for adults
Tobacco	30% Surcharge	50% surcharge
Geography	1.12 to 1 Rate Band	Regions defined by State, no rating limitations
Health UW	1.77 to 1 Rate Band	Not Allowed
Spousal	-8.5% Discount	Not Allowed
Exclusionary Riders	Excludes Benefits based on conditions	Not Allowed

Table 5 – WI Individual Market Rating Practices Before and After ACA

Below we provide a brief description of each of the rating practices highlighted in Table 5.

Age/Gender - All carriers surveyed currently use some form of age and gender rating when setting policy premiums. This means that carriers will surcharge premiums for older individuals and discount premiums for younger individuals. In addition, carriers will typically surcharge premiums for females and discount premiums for males for ages less than 55 and surcharge premiums for males and discount premiums for females for ages over 55. We have estimated that on average, for adults, the highest rate due to

age/gender is 5.1 times higher than the lowest rate due to age/gender. In 2014, for non-grandfathered plans, carriers will no longer be allowed to gender rate and age adjustments will need to be within a 3 to 1 band for adults, meaning that a premium rate cannot be greater than 3 times the lowest rate due to age. This results in the younger demographics subsidizing a greater portion of the older demographic's premium.

Tobacco - Most carriers surveyed collect information on tobacco use. Of the carriers that collect tobacco information, 8% of the market reports using tobacco with an average surcharge of 30%. In CY 2014, health plans will be able to charge up to a 50% surcharge for tobacco use. This may result in an increase in premiums for individuals who use tobacco.

Geography - Most carriers apply a geography adjustment when setting premiums for the Individual Market. We have estimated that on average, the highest rate due to geography is 1.12 times the lowest rate. From the Individual Market Study, we found that on average, the Milwaukee and Southeastern region premiums are surcharged and all other region's premiums are discounted. In CY 2014, per the ACA, the state will be required to define rating regions⁴.

Health Underwriting - Most carriers in the Wisconsin Individual Market today apply a health underwriting adjustment. The practice varies from carrier to carrier and takes many forms, such as applying new business discounts or applying durational adjustments. Some carriers classify individuals into risk classes when they first apply for insurance using a medical questionnaire. Each risk class is then surcharged or discounted. Individuals at certain carriers stay within their risk class upon renewal, while other carriers may reevaluate the member's risk class each year. Those that do not use a health underwriting adjustment still health underwrite to accept or deny applicants. We have estimated that on average the highest rate is 1.77 times the lowest rate due to health underwriting. In 2014, carriers will not be able to health underwrite non-grandfathered business. This results in the healthier members subsidizing a greater portion of the less healthy members' premium.

Spousal - Approximately half of the carriers surveyed apply a spousal discount to the premium. For these carriers the average discount is 8.5%. We believe that in CY 2014, for non-grandfathered business, carriers will no longer be able to apply a spousal discount.

Exclusionary Riders – Several carriers also use exclusionary riders as a form of health underwriting. This is the practice of excluding benefits for specific conditions for a policy upon review of a health questionnaire. Approximately 6.5% of the market has an exclusionary rider attached to their policy. Some common exclusionary riders across carriers appear to be back disorders, asthma, arthritis, and acne. This practice will no longer be allowed in CY 2014.

⁴ Section 2701(a)(2)(A) of the ACA

4.3. Individual Market Premium Discounts/Surcharges

Every premium charged in the Individual Market is comprised of various components due to the rating discounts and surcharges used by insurance carriers as indicated in Section 4.2.

Table 6 shows the distribution of surcharges and discounts due to age/gender and health status for the Individual Market. For example, 11% of the Individual Market received a 32% premium discount due to age/gender and 8.1% of the Individual Market received a 35% surcharge due to age/gender. Note that the health status discounts and surcharges are less variable than the age/gender discounts and surcharges.

Surcharge/Discounts	Age/Gender		Health Status	
	% Distribution	Average Surcharge/Discount	% Distribution	Average Surcharge/Discount
<-50%	0.7%	-60%	0.0%	0%
-50% to -25%	11.0%	-32%	0.5%	-28%
-25% to 0%	45.1%	-12%	62.8%	-12%
0% to 25%	30.7%	10%	24.3%	10%
25% to 50%	8.1%	35%	10.0%	36%
50% to 75%	2.5%	60%	2.4%	52%
75%+	1.8%	105%	0.0%	88%
Total	100.0%	0.0%	100.0%	0.0%

Table 6 – WI Individual Market 2009 Premium Discounts & Surcharges

4.4. Individual Market Product Offerings

In addition to the rating factors described in section 4.2, premiums also reflect the benefits and cost sharing of the plan purchased by the policyholder. Policyholders purchasing more comprehensive benefits will be charged higher premiums. In order to understand the value of the benefits purchased, we have calculated an actuarial value for every member within the Individual Market. At a high level, the actuarial value represents the average percent of medical expenses that would be paid by an insurance carrier. The higher the actuarial value, the more comprehensive or the richer the plan design. The lower the actuarial value, the more the member pays in member cost sharing. We have estimated the average actuarial value for the Wisconsin Individual Market to be approximately 0.67. That is, approximately 67% of medical expenses will be paid for by the insurance carrier and 33% of medical expenses will be paid for by the member, on average. This contrasts with the Wisconsin Small Group Market where the average actuarial value is 0.76.

The majority (77%) of the Wisconsin Individual Market is enrolled in Preferred Provider Organization (PPO) plans with a deductible and coinsurance. Approximately 97% of all

members have some form of a deductible on their policy. There are approximately 50 to 60 deductible levels offered in the market today. For those individuals that have a deductible, we have calculated the average single policy deductible to be approximately \$2,900 and the average family policy deductible to be \$7,500. In the truest form, this means that insurance coverage does not begin until a single policyholder has spent \$2,900 out of pocket on medical expenses or \$7,500 for family policies. However, there are exceptions as some products exclude benefits like preventive services from the deductible. From the market survey, we have estimated that approximately 54% of members have their deductible apply to preventive services. Additional information on the distribution of deductibles is found in the Individual Market Summary Report.

In CY 2014, we have assumed that the minimum actuarial value allowed in the market will be 0.60⁵. We have calculated that approximately 38% of the market is currently enrolled in products that have an actuarial value of less than 0.60. Table 7 shows average deductibles by ranges of actuarial values. In CY 2014, products offered in the exchange will be classified into four product categories, Platinum, Gold, Silver, and Bronze with corresponding actuarial values of 0.90, 0.80, 0.70, and 0.60. For illustrative purposes, we have grouped the Individual Market members into the four product categories assuming existing products with an actuarial value of 0.55 to 0.65 would be considered Bronze, 0.66 to 0.75 would be Silver, 0.76 to 0.85 would be Gold and above 0.85 would be Platinum. The average deductible decreases significantly as the actuarial value increases, with an overall average of \$3,275 (combined single and family policyholders.)

Actuarial Value Range (Prior to HCR)	Member Distribution	Average AV	Average In-Network Single Deductible
Less than 0.55	12.8%	0.47	\$7,509
BRONZE (0.55 to 0.65)	28.0%	0.58	\$4,528
SILVER (0.66 to 0.75)	31.8%	0.69	\$2,473
GOLD (0.76 to 0.85)	20.6%	0.80	\$1,225
PLATINUM (greater than 0.85)	6.9%	0.89	\$430
Total	100.0%	0.67	\$3,275

Table 7 – WI Individual Market Actuarial Value Range

In addition to varying cost sharing elements, members' benefits also vary. We have highlighted three which we believe will be a part of the essential benefit definition in CY 2014: pharmacy benefit, behavioral health benefit, and maternity benefit. Approximately 21% of the Wisconsin Individual Market membership did not have the pharmacy benefit in CY 2009. We estimate that adding the pharmacy benefit will increase premiums for these members 10% to 15%. Approximately 98% of the market does not have the maternity benefit. The 2% of the current market that chooses to purchase the maternity benefit (women ages 18-44) pay premiums that are higher by 70% to 100%. When we model the effect of requiring all policies to include the maternity benefit, it has the effect

⁵ As stated within the ACA, Bronze level benefits are at 0.60 Actuarial Value.

of increasing premiums 1% to 3% for the entire market. Those 2% that previously paid a surcharge see steep reductions in their premiums, while the other 98% see an increase. Finally, we observed that many members do not purchase the behavioral health benefit. We estimate that adding the behavioral health benefit will increase premiums 5% to 7% for these members. It should also be noted that essential benefits are part of the actuarial value calculation, but actuarial value also includes cost sharing elements. Therefore, a plan design may have a low actuarial value due to a high deductible but still include coverage for all essential benefits. On the other hand, a plan design could have a high actuarial value due to a low deductible but still not cover all essential benefits, such as maternity.

	Estimated % of Members without Coverage	Estimated Premium Impact for Members without this Coverage
Pharmacy	21%	10% - 15%
Behavioral Health	Exact Estimate Unknown, but assume majority does not	5% - 7%
Maternity	98%	1% - 3%

Table 8 – WI Individual Market Essential Benefits Estimated Impact

5. Health Insurance Risk-Sharing Plan (HIRSP)

Wisconsin's HIRSP serves as a safety net for residents who have been denied health insurance coverage due to their health status or who have lost their employer sponsored insurance. Premiums in the plan are subsidized using funds from insurer assessments and provider contributions. Generally, products and premiums offered through HIRSP are comparable to products and premiums offered in the Wisconsin Individual Market. As of YE 2009, GA estimated that there were 15,500 individuals enrolled in HIRSP.

Table 9 compares the HIRSP population to the Individual Market. The Individual Market is approximately ten times the size of the HIRSP. The average age of HIRSP is 52 as compared to 35 for the Individual Market. This is largely due to the predominant adult population in HIRSP. In CY 2009, approximately 9% of the HIRSP population did not utilize any benefits as compared to 41% of the Individual Market. Therefore, the HIRSP members are higher utilizers of medical care than the Individual Market. Finally, when we compare CY 2009 Allowed Claims per member per month (PMPM), the HIRSP population's average medical costs are almost four times the Individual Market. These statistics are not surprising since many of these individuals were denied coverage in the Individual Market due to their health status. In CY 2014, Wisconsin's HIRSP will most

likely be merged with the Individual Market. This will have a significant premium impact on the existing Individual Market as this market will subsidize the high risk individuals of the HIRSP. This is discussed further in Section 6.

	WI HIRSP	WI Individual Market
Estimated Members YE 09	15,500	160,000
Average Age	52	35
% of Members with no claims in CY 2009	9.0%	41.0%
Estimated Allowed Claims PMPM	\$940.93	\$245.71

Table 9 – WI HIRSP vs. Individual Market

6. Individual Market Premium Impacts due to ACA Reforms – Before Implementation of Tax Subsidy

There are many changes that will take place in CY 2014 that will affect premiums within the Individual Market. Some changes will affect just portions of the Individual Market and others will affect the Market as a whole. We have focused our modeling and assumptions on the five categories of change listed below. These premium impacts are shown prior to the implementation of the federal tax subsidy. There will be a portion of the Individual Market that will be eligible for these subsidies. We have shown the results including the tax subsidy in Section 7. Additional information on methodology can be found in the Appendix.

- (1) **The impact of rating limitations:** As outlined in Section 4.2, Wisconsin insurance carriers will no longer be able to rate this market using their current rating methodologies. The rating requirements set forth within the ACA will force carriers to cross subsidize premiums across age demographics, gender, and health status. This in effect will create “winners & losers”. That is, some members will receive rate increases and some will receive rate decreases. However, we believe the rating limitation changes alone will not affect overall premiums.
- (2) **The impact of product limitations:** While the essential benefits coverage has yet to be defined, we believe benefits such as pharmacy, maternity and behavioral health will be included. This will affect a portion of the market as indicated in Section 4.4. In addition, we believe that the minimum actuarial value allowed in 2014 will be 0.60. This will require some members within the market to “buy up” and will therefore result in premium increases. Finally, the practice of exclusionary riders will no longer be allowed. We have estimated the premium impact due to product limitations to the entire Individual Market to be **6% to 7%**.
- (3) **The impact of merging the Wisconsin HIRSP with the Individual Market:** In CY 2014, we have assumed that the Wisconsin HIRSP and the Individual Market

will be one rating pool. In addition, we have assumed the provider subsidies and insurer assessments used specifically to subsidize the HIRSP population will no longer exist. If these subsidies were applied to the combined Individual and HIRSP Market we believe premiums could be reduced by approximately 10%. In the absence of these subsidies, we estimate that merging the HIRSP Market with the existing Individual Market will increase overall premiums for the Individual Market by **16%**.

- (4) **The impact of the new exchange market:** In CY 2014, with the introduction of the individual mandate and the tax subsidies provided within the exchange, there will also be new Individual Market entrants. These new Individual Market members will come primarily from the uninsured and to a lesser extent from employer sponsored insurance. These new members will have an impact on the existing Individual Market premiums and the magnitude of the impact will depend on how their risk profile compares to the risk profile of the Individual Market. This last modeling exercise was performed by Dr. Gruber using his microsimulation model (GMSIM). Neither we nor Dr. Gruber have incorporated in our modeling the impact of the risk adjustment, reinsurance, and risk corridor programs that are mandated by the ACA, which may mitigate premium changes due to the law. In the absence of these programs, we find that premiums for the entire Individual Market may increase an additional **13%**.
- (5) **Managed Competition Effect:** The introduction of an exchange and corresponding tax subsidies provides insurers with a membership growth opportunity. Insurers may strive to achieve efficiencies which may lead to lower premiums within the exchange. Dr. Gruber has assumed a 7.5% reduction in premiums due to this effect, which follows the efficiencies assumed by the CBO in their analysis (and is consistent with evidence from the benefits of managed competition in the Wisconsin state employees program).

Table 10 and Table 11 illustrate the change in premium to individual market policyholders, on average, prior to the application of the premium tax subsidies⁶. Table 10 illustrates the impacts to premiums for single policyholders. We have shown two age cohorts: those between the ages of 19 and 29 and those between the ages of 55 and 64. All premium numbers shown are in 2009 dollars and are annual amounts. As shown, the younger demographic will experience higher rate increases as compared to the older demographic. Also shown in Table 10 are the estimated average out of pocket expenses paid by the two age cohorts⁷.

⁶ CY 2014 premiums do not include annual premium trends; however they do include all impacts due to the ACA as described in this section, including the impact of the new exchange market and the managed competition effect.

⁷ Average out of pocket expenses prior to reform were estimated using CY 2009 estimated actuarial value and CY 2009 premium. Average out of pocket expenses post reform were estimated using CY 2014 actuarial values and CY 2009 premium. CY 2014 actuarial values assume anyone with an actuarial value

Age Cohort	Out of Pocket			Out of Pocket			Total Change
	Premium Before Reform	Expense Before Reform	Total Before Reform	Premium After Reform	Expense After Reform	Total After Reform	
19-29	\$ 1,229	\$ 402	\$ 1,631	\$ 1,796	\$ 381	\$ 2,178	34%
55-64	\$ 3,986	\$ 1,874	\$ 5,860	\$ 4,157	\$ 1,672	\$ 5,829	-1%

Table 10 – Individual Market Single Policies

Table 11 illustrates changes in premium for family policyholders prior to the application of the premium tax subsidies. As shown, the premium change is less for family sizes of 2. This due to an older demographic in family sizes of 2. Also shown in Table 11 are the estimated average out of pocket expenses, by family size.

Family Size	Out of Pocket			Out of Pocket			Total Change
	Premium Before Reform	Expense Before Reform	Total Before Reform	Premium After Reform	Expense After Reform	Total After Reform	
2	\$ 4,986	\$ 2,317	\$ 7,303	\$ 6,150	\$ 2,024	\$ 8,174	12%
3	\$ 5,039	\$ 2,202	\$ 7,241	\$ 6,973	\$ 1,957	\$ 8,930	23%
4+	\$ 5,860	\$ 2,668	\$ 8,528	\$ 8,556	\$ 2,356	\$ 10,912	28%

Table 11 – Individual Market Family Policies

To help understand how a typical family in the Individual Market will be impacted, we can provide an example. Let's examine the case of a family of four earning greater than 400% FPL, who will be ineligible for the premium tax subsidy. This family has an annual household income of \$88,200. As shown in Table 11, they pay \$5,860 in annual premiums and \$2,668 in out of pocket costs, resulting in a total expenditure of approximately \$8,500. In 2014, absent premium trend, this family will experience a 28% increase in their health care costs and will have an annual expenditure of approximately \$11,000.

Table 12 shows the distribution of premium changes from the combined effects discussed above. For example, prior to tax subsidies, 41% of the market will receive a premium increase that is higher than 50%. Overall premiums will increase 30% on average prior to tax subsidies. Once again, these estimates do not include any offsetting impact from risk adjustment, risk corridors, and reinsurance that are mandated by the ACA, nor do they account for potential offsets to premium increases from redirecting the existing assessment that finances the HIRSP.

less than 0.60 in CY 2009 is brought up to a benefit package that has an actuarial value of 0.60. These out of pocket expenses are imputed and may not reflect actual out of pocket expenses incurred in CY 2009.

Premium Impact	Distribution of Members
less than -50%	0.2%
-50% to -26%	1.4%
-25.9% to -11%	5.5%
-10.9% to 0%	5.5%
0.1% to 10%	4.9%
10.1% to 25%	10.3%
25.1% to 50%	31.0%
more than 50%	41.3%
Total	100.0%

Overall Average Premium Increase	30%
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Table 12 – Resulting Premium Changes Due to Categories (1) through (5) Before Tax Subsidies

Table 13 shows the distribution of premium impacts by age cohort. For example, 54% of the members receiving greater than a 50% premium increase are age 29 and under.

Individual Market Members	Age Cohort						
Premium Impact	0-17	18-29	30-39	40-49	50-59	60+	Total
less than -50%	0%	2%	2%	0%	10%	85%	100%
-50% to -26%	3%	5%	5%	3%	30%	54%	100%
-25.9% to -11%	13%	23%	7%	7%	18%	33%	100%
-10.9% to 0%	1%	25%	7%	8%	24%	36%	100%
0.1% to 10%	2%	5%	4%	6%	40%	43%	100%
10.1% to 25%	4%	16%	10%	14%	41%	15%	100%
25.1% to 50%	23%	24%	11%	19%	19%	3%	100%
more than 50%	26%	28%	16%	21%	9%	1%	100%

Table 13 – Distribution of Premium Impacts by Age Cohort

Table 14 shows the average premium impacts by age cohort. These premium impacts are also separated into its components showing the impacts due to age, gender, health status, benefits, high risk pool and exchange. We have also shown the corresponding category for these changes as it relates to what was outlined previously in this Section. As shown, the average premium change for members between ages 18 and 29 is 42%. The largest two components of this premium change is due to the age rating changes (14%) and for the impact of the High Risk Pool and the introduction of the exchange (22%).

		Age Cohort						
Category	Premium Impacts Due to:	0-17	18-29	30-39	40-49	50-59	60+	Total
1	% Due to Age	15%	14%	15%	13%	-5%	-25%	0%
1	% Due to Gender	-1%	0%	1%	0%	-1%	1%	0%
1	% Due to Health Status	1%	0%	1%	0%	-1%	-2%	0%
2	% Due to Benefits	5%	2%	2%	3%	4%	5%	7%
3,4,5	% Due to HRP & Exchange	22%	22%	22%	22%	22%	22%	22%
	Total Average Premium Impact	48%	42%	45%	43%	19%	-5%	30%

Table 14 – Average Premium Impacts by Age Cohort

7. Individual Market Premium Impacts due to ACA Reforms – After Implementation of Tax Subsidy

As described in Section 6, many changes will take place in CY 2014 that will impact what a consumer will pay in the Individual Market. Approximately 57% of the Individual Market will be eligible for federal premium tax subsidies that will be offered through the exchange. This subsidy will be based on one's income and increases as income decreases. We modeled the effect of the tax subsidy on the Individual Market. Most of our modeling was performed using actual data on the Individual Market received from the insurance carriers, but insurance carriers do not capture income information. With assistance from Dr. Gruber, we have assigned income categories to our existing Individual Market data. In addition, we assigned exchange premiums to each of our Individual Market records. These exchange premiums were provided by Dr. Gruber and are adjusted for the federal subsidies. Note that, once again, our results do not account for any further reduction in premiums from state risk adjustment/reinsurance or from redirecting the high risk pool assessment.

We begin, in Table 15, by summarizing our results. We first divide the Individual Market into those who see post-subsidy premium reductions ("winners") and those who see post-subsidy premium increases ("losers"). Within each of these groups, we then further divide the winners and losers into those who are and are not eligible for subsidies in the exchange. Overall, we find that 41% of the market will pay less as compared to pre-reform premiums. Their average premium reduction is 56%. The 59% that pay more experience an average increase of 31%. Note that the premium estimates shown are in 2009 dollars. The results show that there is a wide variation in premium impacts as depending on an individual's income status, rating factors and plan design.

Single and Family Policies	"Winners"				"Losers"			
	% Dist.	Average Annual Premium Before 2014 Impacts	Average Annual Premium After Exchange	Premium Change	% Dist.	Average Annual Premium Before 2014 Impacts	Average Annual Premium After Exchange	Premium Change
Eligible for Subsidy (<400% FPL)	35.2%	\$ 3,620	\$ 1,343	-62.9%	21.8%	\$ 2,019	\$ 2,608	29.2%
Not Eligible for Subsidy (>400% FPL)	5.5%	\$ 5,704	\$ 4,167	-26.9%	37.6%	\$ 3,775	\$ 5,042	33.6%
Total	40.7%	\$ 3,879	\$ 1,716	-55.8%	59.3%	\$ 3,085	\$ 4,042	31.0%

Table 15 – Summary of "Winners" and "Losers" by Subsidy Category

Table 16 through Table 19 provide additional information on the impact of premium tax subsidies on the Individual Market. We first divide the data into single policyholders (Table 16 and Table 17) and family policyholders (Table 18 and Table 19). Within single and family, we further divide the results into "Winners" and "Losers". Note that "winners" includes those that see reductions due to tax subsidies and also those who see reductions due to rating rule changes. Similarly "losers" are comprised of two

populations; those who receive premium tax subsidies but whose premiums are still higher than pre reform premiums and those that see premium increases due to rating rule changes. In addition, we have categorized the single policies by age and family policies by family size.

Table 16 shows that 19.2% of the market is single policyholders that will experience, a 58% average reduction in premiums as compared to pre reform premiums. The premium reductions are more significant at the lower ages due the lower incomes in this demographic which results in higher premium tax subsidies. Table 17 shows that 21% of the market is single policyholders that will experience 29% average premium increase as compared to pre-reform premiums. Here, premium increases are greater for the age 19-49 age cohort, which is primarily due to the future rating limitations.

Single Policies "Winners"						
Age Category	% Distribution of Total Members	Average Annual Premium Before 2014 Impacts	Average Monthly Premium Before 2014 Impacts	Average Annual Premium After Exchange	Average Monthly Premium After Exchange	Premium Change
19-29	7.2%	\$ 1,410.19	\$ 117.52	\$ 461.96	\$ 38.50	-67%
30-39	1.5%	\$ 2,357.05	\$ 196.42	\$ 982.33	\$ 81.86	-58%
40-49	2.3%	\$ 2,949.51	\$ 245.79	\$ 1,137.50	\$ 94.79	-61%
50-59	4.3%	\$ 4,102.22	\$ 341.85	\$ 1,730.28	\$ 144.19	-58%
60+	4.0%	\$ 4,772.94	\$ 397.75	\$ 2,561.32	\$ 213.44	-46%
Total	19.2%	\$ 3,109.24	\$ 259.10	\$ 1,300.45	\$ 108.37	-58%

Table 16 – Single Policy “Winners”

Single Policies "Losers"						
Age Category	% Distribution of Total Members	Average Annual Premium Before 2014 Impacts	Average Monthly Premium Before 2014 Impacts	Average Annual Premium After Exchange	Average Monthly Premium After Exchange	Premium Change
19-29	7.6%	\$ 1,227.83	\$ 102.32	\$ 1,711.91	\$ 142.66	39%
30-39	3.7%	\$ 1,635.09	\$ 136.26	\$ 2,375.86	\$ 197.99	45%
40-49	3.7%	\$ 2,285.16	\$ 190.43	\$ 3,218.73	\$ 268.23	41%
50-59	4.4%	\$ 3,071.98	\$ 256.00	\$ 3,832.60	\$ 319.38	25%
60+	2.0%	\$ 3,458.35	\$ 288.20	\$ 3,844.83	\$ 320.40	11%
Total	21.4%	\$ 2,117.62	\$ 176.47	\$ 2,727.71	\$ 227.31	29%

Table 17 – Single Policy “Losers”

Table 18 and Table 19 show premiums and premium changes for family policies after applying the tax subsidies received through the exchange, once again divided into Winners and Losers. Table 18 shows that 21.3% of market is family policy members who will experience an average premium reduction of 54% as compared to pre reform premiums. Table 19 shows that 38.1% of the market is family policy members who will experience an average premium increase of 33%. The premium change increases as family size increases. This is due to the age demographics of the family policies, where the family policies with two members are typically older than policies with a larger family size.

Family Policies "Winners"						
Family Size	% Distribution of Total Members	Average Annual Premium Before 2014 Impact	Average Monthly Premium Before 2014 Impacts	Average Annual Premium After Exchange	Average Monthly Premium After Exchange	Premium Change
2	7.6%	\$ 5,657	\$ 471.42	\$ 2,759	\$ 229.92	-51%
3	3.2%	\$ 5,957	\$ 496.42	\$ 2,512	\$ 209.33	-58%
4	10.5%	\$ 7,181	\$ 598.42	\$ 3,220	\$ 268.33	-55%
Total	21.3%	\$ 6,187	\$ 515.58	\$ 2,861	\$ 238.42	-54%

Table 18 – Family Policy “Winners”

Family Policies "Losers"						
Family Size	% Distribution of Total Members	Average Annual Premium Before 2014 Impact	Average Monthly Premium Before 2014 Impacts	Average Annual Premium After Exchange	Average Monthly Premium After Exchange	Premium Change
2	11.5%	\$ 4,357	\$ 363.08	\$ 5,454	\$ 454.50	25%
3	7.1%	\$ 4,640	\$ 386.67	\$ 6,253	\$ 521.08	35%
4	19.5%	\$ 5,405	\$ 450.42	\$ 7,619	\$ 634.92	41%
Total	38.1%	\$ 4,776	\$ 398.00	\$ 6,342	\$ 528.50	33%

Table 19 – Family Policy “Losers”

7.1. Catastrophic Plans

In 2014 exchanges will offer catastrophic plans to those individuals that meet the eligibility requirements as stated in the ACA. Many of these individuals will be between the ages of 18 and 30. Dr. Gruber has estimated that there will be 22,000 individuals enrolled in these catastrophic plans within the exchange. We have not explicitly modeled

the impact of these individuals on the Individual Market risk pool, however we believe including these individuals would result in an overall premium decrease of up to 3%.

8. Wisconsin Small Group Market

Gorman Actuarial also performed an analysis on the Wisconsin Small Group Market and provided a Small Group Market Study which emphasized current rating practices in the Small Group Market. We have estimated that as of year-end 2009, there were approximately 330,000 members, 170,000 subscribers and 25,000 employer groups in the Wisconsin Small Group Market. Below, we provide a brief overview of the Small Group Market and also the premium change implications due to the ACA.

8.1. Current Small Group Market Premiums

Data collected from the insurers included premiums paid by the employer group to the insurance carrier. This premium will include premiums paid by the employer group and employee contributions (i.e. the portion of the premium paid by the employee.) Insurance companies generally do not collect contribution information and therefore have no information regarding what portion of the premium is paid by the employer versus the employee. Thus the information presented in this report represents total premiums that are charged by the insurance carrier. The Kaiser Family Foundations' HRET Survey of Employer-Sponsored Health Benefits indicates that nationally in 2010 covered workers on average contribute 19% of the premium for single coverage and 30% of the premium for family coverage.⁸ This contribution will vary by state and employer group size, among other variables.

Table 20 shows estimated CY 2009 premiums for Wisconsin small employer groups. The table summarizes information by group size, which is defined by the number of employees or subscribers enrolled. For example, groups with less than 5 employees have an estimated average monthly premium of \$1,790 or an annual premium of \$21,478. Note again that this premium includes the employer group contribution as well as the employee contribution. In addition, we show a premium per member per month (PMPM) so that one can compare premiums by group size. This shows that premium PMPMs decrease as group size increases. Premiums are about 24% higher for smaller groups as compared to the largest groups. This is to be expected since there are group size surcharges in the market today and generally smaller groups have higher health status factors and higher age/gender factors as compared to larger groups⁹. We also show actuarial value by group size which shows that plan designs do not vary significantly by group size.

⁸ Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2010.

⁹ Gorman Actuarial Wisconsin Small Group Market Study

Group Size (Employees)	Distirbution of Groups	Avg Group Size (Employees)	Avg Premium Per Employer Group Per Month		Avg Annual Premium Per Employer Group PMPM	Actuarial Value
less than 5	56.9%	3.0	\$1,790	\$21,478	\$387.47	0.77
6 to 9	18.2%	7.3	\$3,896	\$46,753	\$343.84	0.77
10 to 25	19.8%	15.2	\$8,074	\$96,888	\$327.98	0.76
26 to 50	5.1%	34.6	\$18,472	\$221,667	\$311.76	0.75
Total	100.0%	7.8	\$4,273	\$51,273	\$339.07	0.76

Table 20 – 2009 WI Small Employer Group Premiums

8.2. Small Group Market Rating Practices

The current definition of the Small Group Market in Wisconsin is defined as two to fifty employees. Note that the ACA defines the Small Group Market as one to fifty employees. Therefore in CY 2014, sole proprietors or self-employed individuals may have the option to purchase insurance through the Small Group Market. Health insurance carriers do not currently collect working status information for their policy holders. Therefore, we cannot determine what proportion of the Individual Market is comprised of sole proprietors. In 2014 sole proprietors may purchase insurance through the Small Group Market, however if pricing is higher in the Small Group Market, we would expect few to migrate. Generally, sole proprietors have a lower morbidity than the rest of the Individual Market. Therefore, if Wisconsin experiences a significant migration of sole proprietors to the Small Group Market, the existing Individual Market risk pool will worsen.

In today's market, health plans are allowed to adjust premiums for health status and other case characteristics such as age, gender, geography, and case size. Rating restrictions currently exist for the health status adjustment in that rates cannot vary by +/-30% of the midpoint for policies with similar "case characteristics" and benefits. In addition, upon renewal, health status adjustments cannot increase by more than 15%. There are no current rate restrictions for adjustments to the rate for other case characteristics. The surcharges and discounts to premiums due to these case characteristics beyond health status adjustments are therefore limitless and results in a wide variation in premiums.

In CY 2014, we believe carriers will be required to limit their rating practices for non-grandfathered business and that this will cause some pricing disruption in the market. Table 21 summarizes the rating practices that occur currently in the Small Group Market and also outlines which practices will be limited or not allowed. Given the amount of variation in rating practices today, GA calculated average rating practices among the carriers it surveyed. Additional information on the variation can be found in the Small Group Market Summary Report.

	Rating Practices	
	CY 2009	CY 2014
Age/Gender	7.3 to 1 Rate Band	No Gender Allowed; 3 to 1 for adults
Geography	1.5 to 1 Rate Band	Regions defined by State, no rating limitations
Health UW	1.857 to 1 Rate Band	Not Allowed
SIC	Included in Health UW	Not Allowed
Duration	Included in Health UW	Not Allowed
Group Size	1.2 to 1	Not Allowed

Table 21 – 2009 WI Small Employer Group Rating Practices

Below we provide a brief description of each of the rating practices highlighted in Table 21.

Age/Gender - All carriers surveyed currently use some form of age and gender rating when setting policy premiums. This means that carriers will surcharge premiums for older individuals and discount premiums for younger individuals. In addition, carriers will typically surcharge premiums for females and discount premiums for males for ages less than 55 and surcharge premiums for males and discount premiums for females for ages over 55. The surcharge or discount is based on the average demographics of the employer group. Depending on the employer group's demographics, some members may be rated with a surcharge while other members may be rated with a discount and these effects may offset each other when combined across the entire demographics of that employer group. We have estimated that on average, the highest rate due to an employer group's age/gender surcharge can be 7.3 times higher than the lowest rate due to a group's age/gender discount. In 2014, for non-grandfathered plans, carriers will no longer be allowed to gender rate and age adjustments used for each subscriber or member will need to be within a 3 to 1 band for adults, meaning that a premium rate cannot be greater than 3 times the lowest rate due to age. Note that this means that the 3 to 1 age band restriction applies to the subscriber or member age factors, rather than the composite group age factors. This results in the younger employer groups subsidizing a greater portion of the older employer group's premium.

Geography - Most carriers apply a geography adjustment when setting premiums for the Small Group Market. We have estimated that, on average, the highest rate due to geography is 1.5 times the lowest rate. In CY 2014, states will be required to define rating regions.

Health Underwriting - All carriers in the Wisconsin Small Group Market today apply a health underwriting adjustment. The practice varies from carrier to carrier and takes many forms, such as applying new business discounts or applying durational adjustments. Some carriers administer medical health questionnaires for new business and then use claims experience and/or risk adjustment tools to calculate health status adjustments on renewal. In addition, some carriers use SIC (Industry) adjustments when rating small employer groups. According to Wisconsin rating requirements, all health status adjustments must fall within a 1.857 rating band or +/-30%. In CY 2014, this practice will no longer be allowed.

Group Size Adjustment - All carriers charge a group size adjustment. The overall average rating band for group size in CY 2009 is 1.2. The average group size adjustment decreases as the group size increases. In 2014, carriers will not be able to apply a group size adjustment to premiums of non-grandfathered business.

8.3. Small Group Market Premium Discounts/Surcharges

Like the Individual Market, every group premium charged in the Small Group Market is comprised of various components due to the rating discounts and surcharges used by insurance carriers as indicated in Section 8.2. Table 22 shows the distribution of surcharges and discounts due to age/gender and health status for the Small Group Market. For example, 0.7% of the Small Group Market received a 60% premium discount due to age/gender and 1.8% of the Small Group Market received a 105% surcharge due to age/gender.

	Age/Gender		Health Status	
	%	Average Surcharge/ Discount	%	Average Surcharge /Discount
Surcharge/Discounts	Distribution		Distribution	
<-50%	0.7%	-60%	0.0%	0%
-50% to -25%	11.0%	-32%	0.5%	-28%
-25% to 0%	45.1%	-12%	62.8%	-12%
0% to 25%	30.7%	10%	24.3%	10%
25% to 50%	8.1%	35%	10.0%	36%
50% to 75%	2.5%	60%	2.4%	52%
75%+	1.8%	105%	0.0%	88%
Total	100.0%	0.0%	100.0%	0.0%

Table 22 – 2009 WI Small Employer Group Surcharges & Discounts

8.4. Small Group Product Offerings

In addition to the rating factors described in section 8.2, premiums also reflect the benefits and cost sharing of the plan chosen by the employer group. Groups purchasing more comprehensive benefits will be charged higher premiums. In order to understand the value of the benefits purchased, we have calculated an actuarial value for every group within the Small Group Market. We employed the same methodology used in the Small Group Market which is discussed in further detail in the Appendix. We have estimated the average actuarial value for the Wisconsin Small Group Market to be approximately 0.76. That is, approximately 76% of medical expenses will be paid for by the insurance carrier and 24% of medical expenses will be paid for by the member on average. This contrasts with the Wisconsin Individual Market where the average actuarial value is 0.67.

The Small Group Market is split between HMO (Health Maintenance Organization), PPO (Preferred Provider Organization) and POS (Point of Service) products. 60% of the members are in POS products, 21% in PPO products, 16% in HMO and the remainder in other product types. Approximately 86% of members in the Small Group Market have a deductible. There are an estimated 40 deductible levels offered in the market today, which contrasts with 50 to 60 in the Individual Market. For members that have a deductible, we have calculated the average single policy deductible to be approximately \$1,500 and the average family policy deductible to be \$3,200. In the truest form, this means that insurance coverage does not begin until a single policyholder has spent \$1,500 out of pocket on medical expenses and \$3,200 for family policies. However, there are exceptions as some products exclude benefits like preventive services from the deductible. From the market survey, we have estimated that for the members with a deductible, approximately 33% have their deductible apply to preventive services. For detailed analysis on the distribution of deductibles in the Small Group Market, please refer to the Small Group Market Study Report.

In CY 2014, we have assumed the minimum actuarial value allowed in the market will be 0.60. We have calculated that less than 6% of the members in the Small Group Market are currently enrolled in products with less than a 0.60 actuarial value. Table 23 below shows average deductibles by ranges of actuarial values for CY 2009. For illustrative purposes, we have grouped the Small Group Market members into the four product categories assuming existing products with an actuarial value of 0.55 to 0.65 would be considered Bronze, 0.66 to 0.75 would be Silver, 0.76 to 0.85 would be Gold and above 0.85 would be Platinum.. The average deductible decreases significantly as the actuarial value increases, with an overall average of \$1,505 (combined single and family policyholders).

Actuarial Value Range (Prior to HCR)	Member Distribution	Average AV	Average In-Network Single Deductible
Less than 0.55	0.1%	0.47	\$7,243
BRONZE (0.55 to 0.65)	7.8%	0.56	\$4,656
SILVER (0.66 to 0.75)	30.6%	0.67	\$2,363
GOLD (0.76 to 0.85)	28.8%	0.76	\$1,215
PLATINUM (greater than 0.85)	32.7%	0.89	\$242
Total	100.0%	0.76	\$1,505

Table 23 – WI Small Group Market 2009 Deductibles by Actuarial Value

In addition to varying cost sharing elements, member benefits also vary. We believe in CY 2014 the definition of essential benefits will include pharmacy coverage, maternity coverage and coverage for behavioral health services, among other items. More than 98% of the Small Group Market currently has pharmacy benefits. While not specifically reported in the survey, it is our understanding upon review of summary of benefit

descriptions that the vast majority of the Small Group Market also has coverage for maternity and behavioral health services.

8.5. Small Group Premium Impacts due to the ACA

Like the Individual Market, there are many changes that will take place in CY 2014 that will affect Small Group premiums. We have focused our modeling on three categories of change which are listed below. Please note that this modeling exercise is performed on the total small group premium which includes the employer and employee portions of the premium. Additional information on methodology and assumptions can be found in the Appendix.

- (1) **The impact of rating limitations:** As outlined in Section 8.2, Wisconsin insurance carriers will no longer be able to rate this market using their current rating methodologies. The rating requirements set forth within the ACA will force carriers to cross subsidize premiums across age demographics, gender, health status and group size. This in effect will create “winners & losers”. That is, some groups will receive rate increases and some will receive rate decreases. We have modeled the impact of these rating implications to show the variation in rate changes. While specific groups will receive increases or decreases, the overall total premium will not be affected by these rating limitation changes. Note that we were unable to model the impact of the rating restrictions on age and gender due to data limitations. However, unlike the Individual Market where the age/gender changes had a large impact on premiums, we believe the impact will be more muted in the Small Group Market because age/gender factors are based on the average for an employer group.
- (2) **The impact of product limitations:** While the essential benefits coverage has yet to be defined, we have assumed that the minimum actuarial value allowed in 2014 will be 0.60. This will require some members within the market to “buy up”, resulting in premium increases. Since there are few small group employers below 0.60, the overall premium impact is negligible.
- (3) **The impact of the new exchange market:** In CY 2014, with the introduction of tax subsidies there will be a portion of small employers that drop coverage to have their employees seek coverage within the Individual Market exchange. We believe the employers that drop coverage will typically have younger and healthier demographics since they will most likely fall into the “loser” category described in item (1) above. Dr. Gruber’s modeling results estimate that approximately 5% of the small group members drop coverage. We have modeled the selection impact of this to be an approximate 1% increase in premiums. At the same time, Dr. Gruber’s modeling suggests that there will be an offsetting expansion in small group coverage as previously eligible individuals enroll in their employers’ plans due to the individual mandate. We have not modeled this

offsetting potential positive selection from this effect. This will lead us to overstate the premium changes (both up and down) due to the new exchange pool.

Table 24 shows the resulting premium changes due to the impact of rating, product limitations and selection impact. Approximately 47% of small employer groups (37% of members) will see a decrease and 53% of small employer groups (63% of members) will see an increase. Approximately 14% of small employer groups will experience an average premium reduction of 31% while nearly 10% of groups will experience an average premium increase of 30%. The majority of the rate changes are due to the elimination of health status as a rating factor in CY 2014.

Premium Impact	Member Distribution	Group Distribution	Average Rating Impact
less than -25%	8.4%	14.2%	-30.8%
-25% to -11%	12.9%	15.5%	-16.9%
-10.9% to 0%	15.9%	16.9%	-4.3%
0.1% to 10%	21.6%	19.6%	6.4%
10.1% to 25%	31.4%	25.0%	18.0%
more than 25%	9.9%	8.9%	30.1%
Total	100.0%	100.0%	1.3%

Table 24 – WI Small Group Premium Impact

Table 25 shows premium changes by group size. As expected, premiums decrease for smaller groups and increase for larger groups. This is due to the elimination of group size adjustments and also because smaller groups generally have higher health status factors and older demographics. Once again, these changes reflect only the premium increases from employer exits, and not the potentially offsetting premium decreases from increased employee participation due to the mandate.

Premium Impact	Group Size				Total
	Less than 5	6 to 9	10 to 25	26 to 50	
Average Premium Impact	-6.0%	-1.1%	3.0%	7.6%	1.3%
% of Members by Group Size	19.4%	16.7%	39.4%	24.5%	100.0%
% of Groups	56.9%	18.2%	19.8%	5.1%	100.0%

Table 25 – Small Group Premium Change by Group Size

9. Merged Market Analysis

GA modeled the premium impact of four merged market scenarios:

- (1) Merge Individual Market and Small Group Market
- (2) Merge Individual Market, HIRSP and Small Group Market
- (3) Merge Small Group Market and Large Group Market (51 to 100 Employees)

(4) Merge Individual Market, HIRSP, Small Group Market and Large Group Market
(51 to 100 Employees)

We modeled the premium impact using 2009 data. Table 26 shows estimated 2009 market share for each of the markets analyzed. As shown, we estimate by year end 2009 there were 160,000 Individual Market members, 15,500 Wisconsin HIRSP members, 332,000 Small Group Market Members and 221,000 Large Group Market (51 to 100 Employees) Members. In addition to market share, Table 26 also shows allowed claims PMPM. These allowed medical expenses include expenses paid by the insurer as well as by the member in the form of member cost sharing. As shown, allowed claims PMPMs are highest for the HIRSP followed by Large Group (51 to 100), Small Group, and then the Individual Market.

Market	Estimated		Allowed Claims
	Market share	% Distribution	PMPM
Individual Market	160,000	22.0%	\$245.71
WI HIRSP	15,500	2.1%	\$940.93
Small Group	332,000	45.6%	\$378.06
Large Group 51 to 100 EES	221,000	30.3%	\$447.94
Total	728,500	100.0%	\$382.17

Table 26 – 2009 Market Share and Medical Costs by Market

Table 27 shows results of our merged market analysis on total premium. In addition to market share and claims costs, we also reviewed demographic information such as age, gender, and geography, along with plan design information for each market. It should also be noted that the premium changes modeled were based on 2009 data and assumes merging of markets prior to CY 2014, therefore these results do not include the ACA impacts detailed in Sections 6 and 8.3. Scenario 1 shows that if the Individual Market and Small Group Market merged, premiums for the Individual Market would increase 31%. Due to the tight underwriting practices currently in place in the Individual Market as well as the existence of the HIRSP, it is not surprising that the Individual Market is subsidizing the Small Group Market in this Scenario. Scenario 2 shows similar results as Scenario 1 with the inclusion of the HIRSP. Scenario 3 focuses on changing the definition of the Small Group Market to include up to 100 employees. As shown, the premium changes are relatively small with the Small Group Market slightly subsidizing the Large Group Market (51 to 100). This is due to the similarities between these two markets. Finally Scenario 4 shows the premium changes to each market if all markets were combined.

Premium Change	Individual Market	Small Group Market	Large Group Market (51 to 100)
Scenario 1 - Merge Individual Market and Small Group Market	+31%	-12%	
Scenario 2 - Merge Individual Market, HIRSP and Small Group Market	+38%	-7%	
Scenario 3 - Merge Small Group Market and Large Group Market (51 to 100)		+4%	-7%
Scenario 4 - Merge Individual Market, HIRSP, Small Group Market and Large Group Market (51 to 100)	+45%	-2%	-13%

Table 27 – Merged Market Premium Impact Analysis

As shown from our results, the Individual Market is very different than the Small and Large Group (51-100) Markets and any policy to include this market with the others will cause some significant premium disruption. The results in Wisconsin are quite different as compared to results in states with guaranteed issue and community rating such as New York and Massachusetts. In these states, merging the markets shows that the group markets tend to subsidize the individual market.

In CY 2014 and beyond the composition of the Individual Market will change and the state may want to revisit merging markets when there is more information on this new market.

10. Conclusions

By CY 2016, with the introduction of public insurance expansions, premium tax subsidies, the small firm tax credit, the Individual Market and SHOP exchanges, the individual mandate, and the various rating reforms, approximately 340,000 uninsured will become insured. In addition, approximately 41% of the Individual Market will experience premium decreases as compared to pre reform premiums. Many within the Individual Market will also be required to enroll in more comprehensive benefit packages. However, there will also be significant premium increases in the Individual Market with an estimated 59% of the market experiencing average premium increases of 30%, even after accounting for tax subsidies. This is primarily due to healthier members subsidizing a greater portion of the less healthy members' premium and the younger demographics subsidizing a greater portion of the older demographic's premium.

Our modeling does not account for two factors that may mitigate the impacts on the individual market. The first is reinsurance, risk adjustment, and risk corridor programs that are explicitly designed to spread risks and should lead to a mitigation of both the premium increases and decreases that we model. The second is the existing HIRSP provider and insurer assessments which will be "freed up" when the HIRSP is merged into the broader reformed non-group market; reusing these funds to mitigate rate

increases could lower rates by roughly 10% in the reformed market. Alternatively, Wisconsin could wait to understand how the Individual Market Transitional Reinsurance Program would mitigate these increases before committing these funds to the Individual Market.

Due to the rating reforms, the Small Group Market will also experience premium disruption. However, Dr. Gruber's modeling indicates that member migration will be minimal. Therefore, this market will experience minimal adverse selection.

To mitigate the premium shocks in CY 2014, Wisconsin may want to consider gradually moving towards rating regulation by introducing age band limitations and eliminating the ability to use health status and gender within the Individual and Small Group Markets.

Finally, since the markets are so diverse, it does not seem appropriate to merge the Individual and Small Group Markets before CY 2014. Wisconsin may want to revisit this approach once it understands the composition and size of the Individual Market in CY 2014 and beyond.

11. Appendices

I. Data Collection and Aggregation

After conducting phone calls with many of the carriers in the Wisconsin insured markets, Gorman Actuarial (GA) developed a survey instrument that would capture data for each member in the Individual, Small Group and Large Group Markets. Data collected include fields such as age, geography, claims, premium, plan design information, and rating factors. A list of carriers that participated in this study is found below. Due to the complexity of the market, some carriers had difficulty providing information in the format required. We also found a large amount of variation in how carriers operate and report data. Some common issues included multiple member records within one dataset, incorrect premium reporting and incorrect plan design reporting. One carrier did not provide member level data and only provided group level detail for the Small Group and Large Group Markets. There was a considerable amount of communication between GA and the carriers to ensure that GA was interpreting the information received correctly. As a result, some carriers had to supply supplementary data sets. Once the data sets were "scrubbed", a master database was developed which combined all the carrier data sets into a single database for each market. The database for each market, along with additional information from the carriers (e.g. plan summary descriptions, rating factors and rating methodology) was used to perform the market studies as well as analysis for this report. The timeline for the data collection process took some carriers four weeks and others twenty weeks to complete.

GA estimates that almost 100% of the Individual Market, 73% of the Small Group Market, and 79% of the Large Group Market (51 to 100) was surveyed. Membership estimates in this report are adjusted to reflect the membership of the whole market.

II. Carrier Participation

Gorman Actuarial surveyed 17 entities in the Wisconsin Health Insurance Market, as described in Table 28.

Individual Market	Small Group Market	Large Group Market
Physicians Plus	Physicians Plus	Physicians Plus
Anthem BCBS	Anthem BCBS	Anthem BCBS
Compcare	Compcare	Compcare
Security	Security	Security
Unity	Unity	Unity
Dean	Dean	Dean
WPS Ins. Corp.	WPS Ins. Corp.	WPS Ins. Corp.
WPS Health Plan Inc.	WPS Health Plan Inc.	WPS Health Plan Inc.
Humana	Humana	Humana
Golden Rule	UnitedHealthcare Insurance Co.	UnitedHealthcare Insurance Co.
Assurant	United Healthcare of Wisconsin	United Healthcare of Wisconsin
		Principal
HIRSP		Health Tradition Health Plan
		WEA Trust

Table 28 – Carrier Participation

III. Region Definitions

Milwaukee	Northeastern	Northern	Southeastern	Southern	Western
Milwaukee	Brown	Ashland	Jefferson	Adams	Barron
	Calumet	Bayfield	Kenosha	Columbia	Buffalo
	Door	Florence	Ozaukee	Crawford	Burnett
	Fond du Lac	Forest	Racine	Dane	Chippewa
	Green Lake	Iron	Walworth	Dodge	Clark
	Kewaunee	Langlade	Washington	Grant	Douglas
	Manitowoc	Lincoln	Waukesha	Green	Dunn
	Marinette	Marathon		Iowa	Eau Claire
	Marquette	Oneida		Juneau	Jackson
	Menominee	Portage		Lafayette	La Crosse
	Oconto	Price		Richland	Monroe
	Outagamie	Sawyer		Rock	Pepin
	Shawano	Taylor		Sauk	Pierce
	Sheboygan	Vilas		Vernon	Polk
	Waupaca	Wood			Rusk
	Waushara				St. Croix
	Winnebago				Trempealeau
					Washburn

Table 29 – Region Definitions

IV. Premium Data

For the Individual Market, GA collected CY 2009 annual premium data and monthly billed premium for each subscriber. GA defines subscriber as the contract holder for each policy. For the Small Group Market, GA collected CY 2009 annual premium and

monthly billed premium for each employer group. Note that the premiums in the Small Group Market include both the employer and employee portion of the premium. Insurance companies generally do not collect contribution information and therefore have no information regarding what portion of the premium is paid by the employer versus the employee. Due to data integrity issues discovered with the monthly billed premium data, all premium information used in our analysis and reports are based on the annual premium data.

For the Individual Market, most carriers rate each member on a policy separately and calculate a member specific premium. Then these member premiums are aggregated at the policyholder level. Thus, for family policies in the Individual Market, we received member specific rating factors but premiums were aggregated at the subscriber level. In our report family policies are defined as a policy with more than one member. For the premium and ACA analyses it was necessary to disaggregate the subscriber premiums for family policies to a member level. This was achieved by using the relativities between the member specific rating factors for each member on a policy. It was necessary to do some scrubbing of the data in cases where a subscriber record had more than one premium or in cases where a subscriber record had no premium provided. These instances were relatively small and the handling of these records does not significantly impact the overall results.

For the Small Group market, most carriers start with a base rate and then apply a series of adjustments to calculate the final group rate. These adjustments are calculated by analyzing the characteristics of the group in its entirety. For example, an average age/gender adjustment, an area adjustment, a health status adjustment, a benefit relativity adjustment and other applicable adjustments are applied to the base rate. The base rates are then stratified into the various policy types, such as Single, Dual, Employee plus Child(ren), and Family. Each employee within a policy type for a given employer group will receive the same rate.

V. Plan Design

Plan design information including product type, deductible, coinsurance, member out-of-pocket maximums, copays, and pharmacy coverage was collected for each member surveyed in the Individual Market, Small Group and Large Group Markets. Additional information was collected for the Individual Market members including maternity coverage and exclusionary riders. Please refer to the Market Landscape Reports for details on the plan designs offered in each of these markets.

Most plan designs have different deductibles and member out-of-pocket maximums for single policyholders versus family policyholders where family deductible and out-of-pocket maximum is usually twice the amount of the single policyholder deductible and out-of-pocket maximum. In most cases, carriers reported the single policyholder deductible and out-of-pocket maximum for all members regardless of family status, but there were a few carriers that reported deductibles specific to the family status of that particular member. In order to report consistently, we adjusted these family specific deductibles and out-of-pocket maximums to the single policyholder level by dividing by

two. Additional scrubbing was necessary for the plan design information included ensuring all coinsurances represented the member portion, rather than the plan portion, and ensuring that the out-of-pocket maximums included the deductible.

GA developed a pricing model to calculate a high level actuarial value for every member in the Individual, Small Group, and Large Group Markets. Actuarial value is a measure of the average proportion of medical expenses paid by a health plan for a given plan design. It is usually expressed on a scale of 0.00 to 1.00 where a 0.00 equates to a plan that pays for nothing and a 1.00 equates to a plan that pays for all medical expenses. In other words, the higher the actuarial value the richer the plan design and the less expected member out of pocket expenses. Information on a plan's deductible, coinsurance, member out-of-pocket maximum, and pharmacy coverage was used in the calculation of the actuarial value. Note that there are other cost sharing components such as office visit copays, emergency room copays and pharmacy specific cost sharing that will impact the actuarial value that we did not take into account. We do not feel this will have a material impact given the smaller portion of total expenditure for these types of services and given that many plans in Wisconsin have deductibles that cover most medical services and some plans also include pharmacy costs in their deductibles. Table 30 shows a high level comparison of the differences in actuarial value and plan design for the Individual, Small Group and Large Group (51 -100) Markets.

	Overall Actuarial Value	Average In- Network Deductible
Individual Market	0.67	\$3,275
Small Group Market	0.76	\$1,505
Large Group Market (51 - 100)	0.76	\$1,422

Table 30 – 2009 Market Comparison

VI. HIRSP

The HIRSP is a population whose medical expenses are partially subsidized therefore it would not be appropriate to directly compare HIRSP allowed claims to the Individual Market allowed claims. We were also provided a Usual & Customary field (U&C) for the HIRSP members. It was determined through discussions with Amie Goldman, CEO of the Wisconsin HIRSP Authority, that this U&C field is comparable to the allowed claims field in the Individual Market. This U&C field is what was used in our analysis of the HIRSP population.

VII. Rating Practices

GA collected actual rating data from the insurance carriers for each member. This rating data consisted of the surcharges and discounts the insurance carriers would apply to a premium due to rating characteristics such as age/gender, health status, and geography. Additional market specific attributes were also collected. For example, in the Individual Market, rating information related to tobacco use, durational adjustments and spousal adjustments were also collected. In the Small Group Market, additional rating

information was collected related to industry factors (SIC) and case size adjustments. Rating information was also collected for the Large Group Market 51 -100 employees, but after review of the data, GA determined that due to the complexity and variation in rating there was not a meaningful way to summarize or use the rating information for this market segment. Each rating characteristic was normalized to 1.00 for each insurance carrier using member months as weights and outliers were removed. GA then analyzed the surcharges and discounts by carrier and in total to calculate average rating bands. Table 31 shows the overall average rating bands for both the Individual and Small Group Markets.

	Individual Market	Small Group Market
Age/Gender	5.1	7.3
Tobacco Use	1.3	n/a
Geography	1.1	1.5
Health Status	1.8	1.857
Case Size	n/a	1.2

Table 31 – Rating Bands by Market Segment

VIII. Premium Impacts due to the ACA

The analysis of the rating, premium and economic impacts of ACA involves an integrated approach using both actuarial modeling and economic microsimulation modeling. The actuarial modeling was performed by GA. This modeling utilizes claims, premium, membership, rating and plan design data collected from the insurance carriers that participate in the Wisconsin Insured Markets. The first phase of the project involved a comprehensive survey of insurance markets in Wisconsin that gathered detailed data for the Individual, Small Group and the 51-100 portion of the Large Group Market. Additional data were also collected for the Wisconsin HIRSP market segment. Using these data, GA developed actuarial models that analyzed the change in premium for each member in the Individual Market and for each group in the Small Group Market due to the following changes:

- A. Rating Limitations
- B. Product Limitations
- C. Merging of the HIRSP and Individual Market
- D. Impact of the New Exchange Market on the Individual Market and Small Group Markets

A. Actuarial Modeling- Rating Limitations

The rating rules in ACA that impact the Wisconsin Markets in CY 2014 are as follows¹⁰:

1. Carriers will no longer be allowed to gender rate.
2. Carriers will have to age rate within a 3 to 1 age band for adults.
3. Carriers will no longer be able to health status or industry rate.
4. Carriers will be allowed to surcharge for tobacco use up to 50%

¹⁰ In 2014, the ACA (section 2705) allows group health plans to reduce premiums by 30% for wellness programs, and the Secretary of HHS has the ability to expand the reduction to 50%.

5. Carriers will no longer be allowed to rate for Case Size (i.e. Group Size)

We were able to model items 1-4 for the Individual Market and have detailed our methodology and results below. In the Small Group market, we were unable to model items 1 and 2 due to data limitations. Item 4 is also not modeled for Small Group as information on tobacco use is not currently collected in the Small Group Market. We have described our methods on calculating the impact of eliminating health status and case size rating below for Small Group. None of these items were modeled for the Large Group 51-100 Market due to data limitations and the complexity of rating larger groups.

The rating rule limitations described above only apply to non-grandfathered policies and products. For the portion of the modeling described in this section, we have assumed all members are in non-grandfathered products.

We have assumed that when an insurance carrier changes their rating methodology or rating factors, the carrier's overall revenue target will be the same before and after the rating change. These rating changes will result in some policyholders experiencing a decrease in premiums, "winners", and some policyholders experiencing an increase in premium, "losers" but the overall impact on total premium is zero.

Each of the rating impacts stated above were modeled at the member or group level using actual CY 2009 data collected through the survey process described above and further detailed in the series of Market Landscape reports. Age, gender, health status, smoking and case size rating factors were collected (where applicable) for all members and groups surveyed. The new rating limitations were applied to the member level or employer group level data and the percent premium impacts were calculated based on the difference between the original rating factors and the new rating factors as specified under ACA. In cases where rating factors are eliminated under ACA (e.g. gender, health status and case size) the new rating factor is essentially 1.0.

- 1. Carriers will no longer be allowed to gender rate.**
- 2. Carriers will have to age rate within a 3 to 1 age band for adults.**

All carriers surveyed currently gender rate. In general, female rating factors are anywhere from 5% to 30% greater than male rating factors between the ages of 18 and 54 while at age 55 male rating factors are greater than female rating factors. This is directly linked the cost differential assumed between females and males: At younger ages, females typically incur more costs while at older ages, males incur more costs. Our modeling assumes that carriers will no longer be able to differentiate premiums based on gender in CY 2014. Therefore in CY 2014, we expect females up to age 54 to experience a decrease in their premiums while males will experience an increase. At ages 55 and older, males will experience a relative decrease in their premiums while females will experience an increase. Most carriers do not differentiate premiums by gender for children therefore there is minimal impact on members less than age 18. Table 32 shows a summary of the impacts of the elimination of gender rating by age cohort for the

Individual Market. The impact to males up to age 54 is an increase in premium ranging from 2.3% to 14.7%. Note that the overall premium impact from this change is zero, since, depending on the age cohort, males are subsidizing females or vice versa.

Age Category	% Membership Distribution		% Impact from Elimination of Gender Rating	
	Females	Males	Females	Males
0-17	9.5%	9.8%	0.0%	0.0%
18 - 29	10.9%	12.7%	-6.8%	8.6%
30 - 34	2.6%	3.3%	-9.7%	13.1%
35 - 39	2.9%	3.3%	-10.6%	14.7%
40 - 44	3.7%	4.0%	-9.2%	12.1%
45 - 49	4.5%	4.9%	-6.1%	7.4%
50 - 54	4.6%	4.9%	-2.1%	2.3%
55 - 59	4.6%	4.2%	2.2%	-1.8%
60+	5.8%	3.8%	6.7%	-5.4%
Total	49.1%	50.9%		

Table 32 – Impacts of Elimination of Gender Rating

While carriers will be allowed to differentiate rates by age in CY 2014, the difference in rates for adults (18 years of age and older) will need to be within a 3 to 1 rating band. In other words, no premium rate can be more than three times another premium rate due to age. There are currently no rating restrictions on age and gender rating in the Wisconsin Markets and as a result the current overall rating band is approximately 5 to 1 in the Individual Market and 7 to 1 in the Small Group Market. There are many approaches carriers may employ to shrink their age band down to 3 to 1. For our modeling purposes we took the approach that mitigated the impact to the youngest adults, essentially setting the age factors for older members at three times the lowest current age factor for adults. The revenue shortfall was then spread across the whole population. As a result of the 3 to 1 age band restriction in Wisconsin, older members in general will experience a premium decrease while younger members in general will experience a premium increase. In the Individual Market, 74% of members will receive a premium increase as a result of age and gender rating changes (“losers”) and their average age is 28.6. The remaining 26% of the members will receive a premium decrease as a result of age and gender rating changes (“winners”) and the average age for these members is 54.5. We have modeled a greater number of individuals receiving premium increases as compared to those that are receiving premium decreases. The “winners” in this exercise are those individuals who, today, typically pay larger premiums which results in a greater number of “losers” to make up the revenue shortfall. Table 33 shows the distribution of percent premium impacts due to age and gender rating changes by age cohorts for the Wisconsin Individual Market. For example, 5.5% of the Individual Market will experience premium impacts of -50% to -26% strictly due to age and gender changes and of these members, 77% of them are 60 years old or greater.

Individual Market Members	Age Cohort							% Distribution of Premium Impact
Premium Impact	0-17	18-29	30-39	40-49	50-59	60+	Total	
-50% to -26%	0.0%	0.1%	0.0%	0.1%	23.0%	76.7%	100.0%	5.5%
-25.9% to -11%	0.0%	0.0%	0.0%	1.0%	49.3%	49.6%	100.0%	10.3%
-10.9% to 0%	0.0%	5.9%	19.6%	16.9%	51.3%	6.3%	100.0%	10.6%
0.1% to 10%	20.5%	24.9%	13.4%	21.6%	19.1%	0.4%	100.0%	24.2%
10.1% to 25%	40.5%	27.1%	4.6%	18.1%	9.5%	0.1%	100.0%	35.0%
25.1% to 50%	0.0%	37.0%	33.1%	29.7%	0.0%	0.2%	100.0%	14.5%
								100.0%

Table 33 – Distribution of Premium Impact by Age Cohort

3. Carriers will no longer be able to health status or industry rate

All carriers in the Small Group Market and all but two carriers in the Individual Market currently rate using health status. The overall rating band for health status is 1.8 in the Individual Market. There is a band of 1.857 (+/-30%) required by law in the Small Group Market, and we found all carriers to be within this band after some minimal scrubbing of the data and removing outliers. Under ACA in CY 2014, health status rating will no longer be allowed, therefore members and groups who currently benefit from lower premiums due to their favorable health status will see an increase in their premiums while members and groups who currently experience higher premiums due to their less favorable health status will see a decrease in their premiums. Approximately, 64% of Individual Market members and 63% of Small Group Market members will experience a premium increase due to the elimination of the health status adjustment. Table 34 shows detail of the health status changes for the Individual Market and Table 35 shows detail of the health status changes for the Small Group Market.

Premium Impact	% Member Distribution	Average Premium Impact
less than -25%	3.9%	-34.2%
-25% to -11%	4.8%	-17.8%
-10.9% to 0%	26.9%	-3.8%
0.1% to 10%	44.9%	3.5%
10.1% to 25%	18.3%	14.8%
more than 25%	1.2%	34.0%
Total	100.0%	0.0%

Table 34 – Distribution of Premium Impact due to Health Status Rating Limitations in the Individual Market

Premium Impact	% Member Distribution	% Group Distribution	Average Premium Impact
less than -25%	8.6%	12.1%	-30.5%
-25% to -11%	12.7%	13.6%	-17.7%
-10.9% to 0%	15.5%	15.3%	-5.3%
0.1% to 10%	23.1%	20.1%	5.1%
10.1% to 25%	35.4%	31.4%	17.1%
more than 25%	4.7%	7.5%	30.5%
Total	100.0%	100.0%	0.0%

Table 35 – Distribution of Premium Impact due to Health Status Rating Limitations in the Small Group Market

Overall the elimination of health status will have a smaller impact on premiums than the age and gender changes in CY 2014 in the Individual Market. This is directly related to the fact that health status rating bands currently in practice are less than the age/gender rating bands (2 to 1 for health status versus 5 to 1 for age/gender.) In addition, there is less variation in current health status adjustments compared to age/gender adjustments. Table 36 compares the distribution of health status adjustments to age/gender adjustments and further illustrates this point.

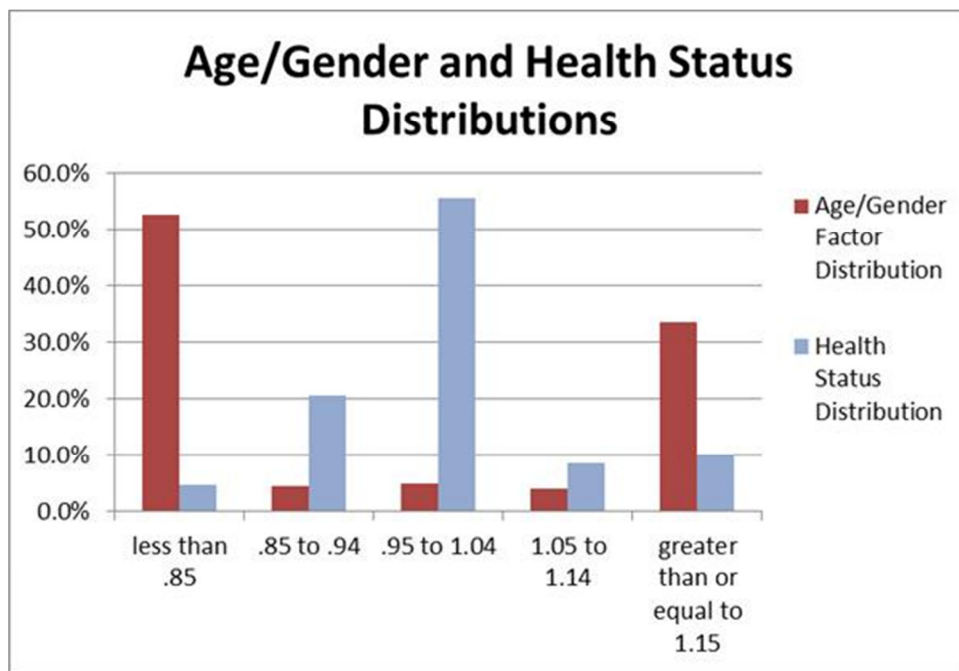


Table 36 – Impact of Age/Gender and Health Status Limitations

In the Individual Market we did additional analysis to understand how health status is correlated with age. While there is not a perfect correlation, for members above the ages of 35 as the age increases the health status also increases. At ages less than 35, this

relationship does not necessarily hold true and there is a spike in the health status for members between the ages of 18 and 24. This may be related to the fact that among younger demographics, only those who need insurance and therefore have worse morbidity (i.e. higher health status adjustments) are more likely to enroll than those with better morbidity (i.e. lower health status adjustments.) See Table 37 for more detail.

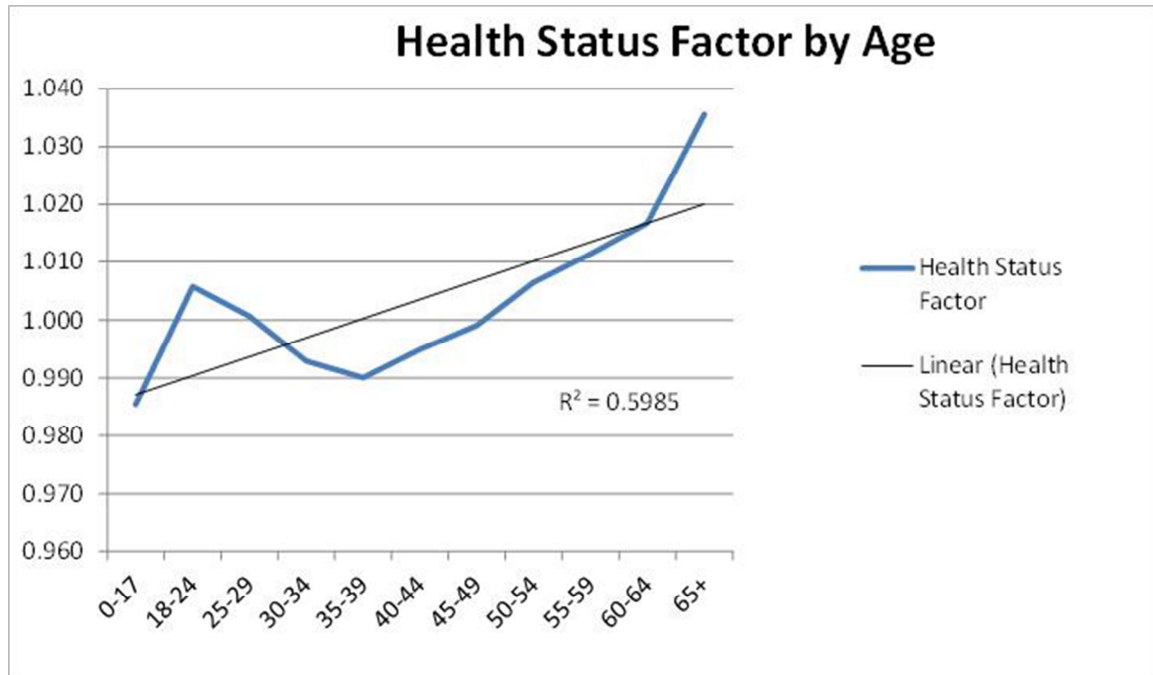


Table 37 – Correlation of Health Status and Age in the Individual Market

4. Carriers will be allowed to surcharge for smoking up to 50%

The average rating surcharge currently used for smokers is 30% in the Wisconsin Individual Market. The ACA states that carriers will be allowed to surcharge smokers up to 50%. Our modeling assumes that carriers will surcharge smokers the full 50% in CY 2014. Of the eleven carriers surveyed in the Individual Market, all but one collect information on member tobacco use. Of the carriers that collect information on tobacco use, 8% of members report using tobacco. The change in smoking surcharge was modeled to have a net effect of zero, but again there will be winners and losers. Approximately 19% of the market will get a premium increase as a result of the change in the smoking surcharge while 80% of the market will experience a premium decrease. The remaining 1% of the market is represented by the carrier who does not currently rate based on smoking and therefore no impact was modeled.

5. Carriers will no longer be allowed to rate for Case Size (i.e. Group Size)

All carriers in the Small Group Market charge an adjustment for case size or group size. In general, the case size adjustments charged increase as the size of the group decreases.

The average rating factor for case size was 1.04 for groups with less than 6 employees and 0.98 for groups with between 26 and 50 employees. In 2014, carriers will not be able to apply a case size adjustment to premiums of non-grandfathered business. Therefore, in general, larger groups will experience premium increases and smaller groups will experience premium decreases as a result of this limitation. Again, while this change was modeled to have an overall zero premium impact, approximately 59% of members and 32% of groups will receive an increase while 41 of members and 68% of groups will receive a decrease. Table 38 shows additional details on this change.

Premium Impact	% Member Distribution	% Group Distribution	Average Premium Impact
less than -25%	0.1%	0.3%	-35.8%
-25% to -11%	3.3%	10.8%	-17.2%
-10.9% to 0%	37.7%	56.8%	-2.3%
0.1% to 10%	58.8%	32.1%	2.8%
10.1% to 25%	0.2%	0.1%	11.0%
more than 25%	0.0%	0.0%	n/a
Total	100.0%	100.0%	0.0%

Table 38 – WI Small Group Premium Impact due to Case Size

B. Actuarial Modeling- Product Limitations

In CY 2014, we have assumed the minimum actuarial value will be 0.60 which would equate to a Bronze product offering. In the Individual Market, 38% of members have an actuarial value less than 0.60 while in the Small Group Market, only 6% of members have an actuarial value less than 0.60. In addition to cost sharing restrictions, in CY 2014 there will be a set of essential benefits that must be covered. Three key benefits expected to be included in the definition of essential benefits are pharmacy, behavioral health and maternity. The Individual Market is expected to be impacted by the essential benefits definition given that 21% of members do not have pharmacy benefits and 98% does not have maternity benefits, while the Small Group Market should see less of an impact given its more comprehensive coverage. It should be noted that essential benefits has not yet been defined in detail. The Individual Market currently also has some carriers that apply exclusionary riders to its policies. An exclusionary rider is a provision in a health care policy that excludes or limits coverage for a specific condition. This will no longer be allowed beginning in 2014. The overall impact to premiums as a result of these product limitations is 6% to 7% in the Individual Market and negligible in the Small Group Market.

C. Merging of the HIRSP and Individual Market

Since premiums are based on estimated medical costs for a population, the impact of merging various markets would increase average medical costs for one segment and decrease medical costs for another segment. This leads to one market segment

subsidizing the other. To estimate the impact of merging the HIRSP population with the Individual Market, we analyzed allowed claims costs, paid claims costs, plan design distributions, age/gender distributions and geography distributions of each market respectively. In addition, we analyzed respective market share. Allowed claims include medical and pharmacy claims as well as member cost sharing. For the HIRSP population, we used the U&C field for an allowed claims proxy. We calculated CY 2009 allowed claims per member per months (PMPM) and paid claims PMPMs for both populations. We then adjusted the claims costs for the corresponding benefits, age demographic and geographic distribution within each market. These adjustments were calculated using actuarial models to determine actuarial value, age factor, and a geographic factor. We then compared these adjusted claims to understand relative morbidity. We have estimated that the HIRSP's morbidity is 2 to 3 times that of the current Wisconsin Individual Market. Based on this analysis, we have estimated the overall premium impact of merging these two markets to the Individual Market to be 16%. This premium impact does not consider the provider and insurer assessments used for the current HIRSP. In CY 2009, these assessments totaled \$53M.¹¹ We estimate that these assessments could reduce Individual Market premiums by 10%.

D. Impact of the New Exchange Market on the Individual Market and Small Group Markets

For the Individual Market, Gorman Actuarial relied on Dr. Gruber and his microsimulation model to understand the impact of the new exchange pool on the Individual Market. GA provided Dr. Gruber data for the Wisconsin Individual and Small Group Markets. Data included claims costs, premiums, actuarial value and demographic information for every member or small group. Dr. Gruber calibrated his models to this data and then provided GA with relative costs and demographic information for the newly insured, existing Individual Market, and Small Group Market. Based on this data, GA estimated that the premium impact of the new exchange pool on the Individual Market is approximately 13%. For the Small Group Market, GA developed a selection model by reviewing the average claims costs for employer groups grouped by premium impact. The analysis showed that employer groups receiving premium decreases were on average higher costing than those receiving premium increases. This is not surprising since the elimination of health status adjustment would decrease premiums for employers with higher risk and increase premiums for employer groups with lower risk. GA relied on the output of Dr. Gruber's model for employer group terminations. Based on this analysis, GA has estimated a premium impact of 1% due to employers exiting the market.

IX. Merged Markets

We performed a merged market analysis assuming that markets would merge prior to CY 2014. We considered the following scenarios:

- (1) Merge Individual Market and Small Group Market
- (2) Merge Individual Market, HIRSP and Small Group Market
- (3) Merge Small Group Market and Large Group Market (51 to 100 Employees)

¹¹ WI HIRSP 2009 Annual Report

(4) Merge Individual Market, HIRSP, Small Group Market and Large Group Market
(51 to 100 Employees)

Our approach to this analysis is much like our approach for analyzing the impact of merging the HIRSP market with the Wisconsin Individual Market. We analyzed allowed claims costs, paid claims costs, plan design distributions, age/gender distributions and geography distributions of each market respectively. In addition, we analyzed respective market share. Allowed claims include medical and pharmacy claims as well as member cost sharing. We calculated CY 2009 allowed claims per member per months (PMPM) and paid claims PMPMs for both populations. We then adjusted the claims costs for the corresponding benefits, age demographic and geographic distribution within each market. These adjustments were calculated using actuarial models to determine actuarial value, age factor, and a geographic factor. We then compared these adjusted claims to understand relative morbidity. We have estimated that the Small Group Market's morbidity is 50% to 60% higher than the current Wisconsin Individual Market. In addition, we have estimated that the Large Group Market 51 to 100 morbidity is 10% to 15% higher than the current Wisconsin Small Group Market. Based on this analysis, we have estimated the premium impacts of merging the various markets. See Table 27 in the main body of the report for the results of this analysis.

X. Income and Tax Subsidy Assignments for Individual Market

Dr. Gruber provided distribution of FPL by age cohort for single policies and distribution of FPL by age cohort and family size (Family Size 2, 3 and 4+) for members that are in family policies. For the family data there are a few caveats, namely that certain age cohorts could not be broken out by family size due to data constraints. Specifically:

- Age cohorts 19-24 and 55-59 could only be provided for Family Size 2 and 3+
- Age cohort 60-64 could only be provided for Family Size 2+

For this analysis the Wisconsin Individual Market membership was separated into single policies and family policies. The family policies were categorized into policies with either 2 members, 3 members or 4+ members.

A. Single Policies

To assign FPL level to each member in the Wisconsin Individual Market, GA used a random number assigned to the member to determine which FPL cohort the member is in. Based on the random number, the member was assigned to one of the five following FPL cohorts:

- 1) < 133%
- 2) 133-200%
- 3) 200-300%
- 4) 300-400%
- 5) > 400%

Members in FPL cohorts 1 through 4 are subsidized, and those in FPL cohort 5 are unsubsidized.

The assigned FPL distribution matches the distribution provided by Dr. Gruber, based on the age of the member. Using the member's assigned FPL level, the corresponding annual amount that the member would be required to pay (based on their age and subsidy level) was assigned from a table provided by Dr. Gruber. Then, this annual "pay" amount was compared to the "post reform" annual premium we estimated for the member. If the "pay" amount is lower, then we assume that this member will be receiving subsidies within the exchange. If higher, we assume this member does not receive subsidies. We also assign the member as either a "winner" or "loser", depending on whether the member pays less than what they were paying pre-reform (winner), or more (loser). Using the age cohort, FPL level and winner/loser designation we have created exhibits that show the distribution of members as compared to all of the single policies and the average percentage change in premium, comparing what the member will pay after the introduction of the exchange to what they were paying before.

B. Family Policies

The methodology for assigning FPL to members in the Individual Market who are in family policies was similar to the methodology used for single policy members. Additionally, the FPL level was assigned based on the number of members in the policy in addition to the age of the subscriber. The following family size cohorts are used:

- Family Size 2
- Family Size 3
- Family Size 4+

Again we used a random number assigned to the subscriber to determine the policyholder FPL level based on the policyholder's age. The assigned FPL distribution matches the distribution provided by Dr. Gruber, based on the age and family size of the subscriber. After assigning the FPL level to the policyholder, the amount the policyholder would be required to pay (based on the policyholder age, FPL and family size) was assigned from tables provided by Dr. Gruber. This annual "pay" amount was compared to the family premium (PSPY) "post reform". If the "pay" amount is lower, then we assume that this policyholder will be receiving subsidies within the exchange. If higher, we assume this policyholder does not receive subsidies. We also assign the family policy as either a "winner" or "loser", depending on whether the policyholder pays less than what they were paying pre-reform (winner), or more (loser). Using the age cohort, FPL level, family size and winner/loser designation we have created exhibits that show the distribution of members as compared to all of the family policies and the average percentage change in premium, comparing what the policy will pay after the introduction of the exchange to what they were paying before.

C. Random Trials

This method of assigning FPL was performed many times for both the single policyholders and the family policyholders, to determine if the results vary based on the randomness of members being assigned to FPL cohorts. The results were consistent among trials, with the percent distribution of members and subscribers nearly identical, and the percentage change in premium varying only slightly between trials.

XI. Overview of the Gruber Microsimulation Model (GMSIM)

The results presented in Section 3 are based on modeling performed using the microsimulation model described in this appendix. There are two major components to the Gruber Microsimulation Model (GMSIM): the “premod” which is the baseline dataset, and the GMSIM model itself which produces the simulation results.

The premod is primarily based on data from the 2005 Current Population Survey (CPS), which provides the individual level data on about 40,000 non-elderly individuals and household units. The 2005 CPS is used as the base data source because it is the latest year that respondents were asked about employer sponsored insurance (ESI) offering. We use later year versions of the CPS to update all income and demographic measures.

In the CPS we are only interested in the non-elderly population (under age 65). Individuals aged 65 and older are primarily covered by the Medicare system and do not participate in traditional insurance markets, thus we exclude them from our simulation. We also exclude individuals covered through the TRICARE military health system, as they also do not participate in traditional insurance markets. The observations in the CPS are weighted such that one observation may represent many thousand actual people. For the purpose of our analysis we begin by sorting people onto one of four pre-reform insurance categories: ESI, non-group, public, or uninsured. In the pre-reform state, the observation’s entire weight is placed in one category (when we run the simulation we relax this assumption and allow weights to be spread across insurance categories). We also create health insurance units (HIU) to replace the CPS household definitions. The CPS groups households based on residence, but this is not ideal for a health insurance simulation model. We create the HIUs to represent groups of people who would make insurance decisions together. Generally speaking spouses are grouped together and children are grouped with parents.

To supplement the CPS data, which does not include information on health expenditure or insurance premiums, we use data from the Medical Expenditure Panel Survey (MEPS). From MEPS we have the distribution of individual annual expected health spending sorted by self-reported health status and age, which we then impute to our CPS observations and then refer to as “truecost”. To set pre-reform non-group premiums, we first model actuarial value under the assumption that as income rises households will purchase higher value insurance. We then set premiums based on the individual’s truecost, a fixed load, and a variable load that reflected the relative cost of the individual’s age group. To set ESI premiums, we first model actuarial value based on the assumption that firms with higher average wages will provide higher value insurance. We then use MEPS data to impute the distribution of ESI premiums (both single and family plans) sorted by firm size. Premiums are adjusted by a health cost index that reflects the relative health of the firm’s employees, firm size averages, and state averages. We use additional MEPS data to compute the employer-employee split of the premium. We use data from the Kaiser Family Foundation (KFF) to set public insurance program spending and eligibility, as well as the federal/state funding split.

To improve the accuracy of our pre-reform estimations of the non-group and small group markets in Wisconsin, we utilize data provided by Gorman Actuarial. GA provided us with individual level data on annual claims and plan premium and actuarial value. We first use this data to adjust our estimated distribution of “truecost” or annual expected health spending to match the distribution of claims paid by Wisconsin insurers in the data provided by GA. Next, we match the distribution of insurance products in these markets. We begin by grouping together plans with similar actuarial value, which we then refer to as a “product”. Then we group the enrollees into sub-population cells determined by the enrollee’s age, sex, and claims cost. We find the distribution of “product” market share and average premium and actuarial value for each “product” in each age, sex, and claims population group. We then assign individuals from our CPS dataset to products, matching the distribution of enrollment and premium spending that we observe in the GA data. At the end of this process, our estimation of the Wisconsin non-group and small group markets much more closely reflects the actual Wisconsin marketplace.

To model firm behavior, it is important to understand that firms make decisions based on the firm wide aggregate effects of a policy. To mimic this in GMSIM, we construct “synthetic firms” which are meant to reflect the demographics of actual firms. The core of this computation comes from Bureau of Labor & Statistics (BLS) data providing the earnings distribution of co-workers for individuals of any given earnings level, for various firm sizes and regions of the country. Using these data, we randomly select individuals in the same firm size/region/health insurance offering cell as a given CPS worker in order to statistically replicate the earnings distribution that the BLS data would predict for that worker. These 99 workers then become the co-workers in a worker’s synthetic firm.

To project our premod forward for future year analysis we use a variety of income and health cost inflation rates, as well as population projections from the Census Bureau, and insurance growth rates from the Congressional Budget Office (CBO). We use CBO’s projections for GDP growth to inflate income measures. We use a flat 6% growth rate to inflate health care costs following the CBO. We grow the overall population based on Census Bureau projections of population growth by age and sex. We also adjust the relative size of insurance categories using growth rates supplied by CBO.

To begin the policy simulation process, we first consider firm reactions to policy changes. We do this because 90% of private health insurance is provided by employers, giving them great influence in insurance markets. To model firm behavior, we assume that the firm’s decision-making reflects the aggregation of worker characteristics and preferences. To model these preferences we compute “pseudo-takeups”, which are the firm’s prediction of worker reactions to policy changes. We then average these reactions across the firm. There are three ways that we allow firms to react to policy changes and their predictions of worker behavior: change in ESI offering, change in the premium contribution split, and change in the spending on the total ESI premium. We also consider the size of the firm, as small firm behavior is more sensitive to policy changes. We assume that total worker compensation remains constant, so firm increases in ESI

spending are offset with wage reductions and decreases in spending are offset with increases in wages.

We model changes in ESI offering by considering the incentives to offer insurance provided by policy. We consider each policy component separately and compute an “offer pressure” that reflects the influence of the policy component on the firm’s decision to offer or not offer insurance. Therefore policies that provide viable alternatives to ESI coverage reduce the likelihood that the firm offers ESI. For example, the introduction of individual exchanges or expansion of Medicaid would reduce the likelihood that a firm offers insurance. Additionally, policies that subsidize alternative sources of insurance reduce the likelihood that a firm will offer insurance. Subsidies or penalties for not offering insurance raise the probability of offering insurance. If there is a mandate policy, it will result in a positive offer pressure. Since individuals will be required to take up a form of insurance if they are uninsured and many will prefer ESI over other insurance types, this will reduce the likelihood that the firm drops coverage. The decision to offer insurance is the most direct method by which firms react to policy changes.

We utilize a similar framework to firm offering when considering contribution shift and spending decisions. In this process, we consider each policy component’s impact of the contribution decision and spending decision, and then aggregate the individual components to get the final contribution and spending change. The contribution and spending decisions are more subtle methods for firms to influence worker behavior. Policies that provide or subsidize alternative forms of insurance will cause firms to reduce their contribution to the ESI premium and reduce spending on the premium. This works as an indirect influence on workers to move to these alternatives. Conversely, when ESI is subsidized or firms are penalized for not providing coverage, firms will increase their contribution or spend more on the policy. All of these reactions will increase with the size of the subsidy or penalty. When firms change the total spending on the ESI premium, half of the spending increase goes to purchasing a higher actuarial value product, and half goes to buying unobservably better coverage (i.e purchasing from a more reliable or higher reputation carrier).

After determining the firm response, we move on to estimate the reactions of individuals to the policy changes. When considering individual reactions, we use a hierarchy of insurance desirability. ESI is most desirable, followed by individual exchanges, then traditional non-group insurance, and last is public insurance. To decide between the insurance options we use “takeup” equations to determine the probability that an individual will move to a certain insurance type. Generally speaking, these equations are of the form:

$$\text{Takeup} = (\text{Constant} + \text{Elasticity} \times \% \text{ Price Change} \times \text{Income Effect}) \times \text{Income Adjustment}$$

The constant is a term that reflects the individual’s health and the desirability of the insurance option. The elasticity determines the responsiveness of individuals to price changes. These are determined, to the greatest extent possible, by a survey of the health

economics literature. The price change measures the change in price from the pre-reform state to the post-reform state, and is adjusted for changes in the actuarial value of the plan. The income effect measures the level of the price change relative to income. This is important because price changes have diminishing returns to movement. That is to say that as the price change becomes large in dollar terms its impact on movement gets progressively weaker. The income effect also picks up the assumption that price changes are less important as income rises. Finally, the income adjustment reflects the assumption that takeup of insurance will fall at the final cost of insurance rises relative to income. After we compute the takeup probabilities for all the possible insurance movements, we apply any regulatory apparatus. For example, individuals with an ESI offer may be barred from moving to the individual exchange. After making the regulatory changes, we adjust the probabilities for overlap such that the sum of the movement probabilities and the probability of remaining on the pre-reform insurance category equals 100%.

By this point we have predicted the probability of the individual making all possible insurance choices. We now relax the assumption that each individual observation can only be on one insurance type. We use the movement probabilities as the share of the individual's weight that is moved to the relevant insurance category. For example, an observation might have a total weight of 1,000 and in the pre-reform state is uninsured. Pre-reform, we say this observation represents 1,000 uninsured individuals. Now in the Post-reform world, we have concluded there is a 50% probability that this observation will continue to be uninsured, and a 50% probability that this observation will be covered by public insurance. We now say that this observation represents 500 uninsured individuals and 500 individuals covered by public insurance.

At this point we have computed what we call the voluntary movement: the movement that occurs as a result of individual and firm decisions. The next step is to apply any additional regulatory apparatus that affects movement such as an individual mandate or an auto-enrollment process. To make these adjustments, we move a portion of the observation's post-reform uninsured weight to a pre-determined insurance destination. The insurance destination represents the most likely source of insurance coverage for the person. The portion of the post-reform uninsured weight that is shifted depends on the insurance destination, and is calibrated to produce results in line with CBO estimates. We also have the capability to restrict the movement of undocumented immigrants. Utilizing data provided by Dr. Jeffery Passel of the Pew Hispanic Center, we are able to identify likely undocumented immigrants in the data, and to adjust or restrict their movement.

After considering the regulatory apparatus, we have finished the movement section of the model. To conclude the modeling process we finalize cost changes for individuals, firms, and governments. The first step in this process is to reset premiums in any exchanges that have been created. Exchanges will charge premiums that reflect the underlying risk of the overall pool, instead of the individual as in traditional non-group markets. To model the premiums that will be charged in the new exchanges we collaborate with Gorman Actuarial to determine the effect of ACA regulations and exchange population

characteristics on premiums. This is an iterative process where we complete a model run and then GA provides premium effects, which we feed back into the model until the premiums and populations stabilize. For the initial run, we estimate exchange premiums by using the existing non-group and half of the existing uninsured population (selected randomly). In the subsequent iterations, we use data from GA to predict an exchange premium that is either higher or lower than the pre-reform premium based on the regulatory impacts of the ACA and the underlying cost of the exchange population. We then calculate changes in the following measures for individuals: premiums, out-of-pocket spending, regulatory penalties, wages, and taxes. For firms we calculate changes in: ESI spending, payroll taxes, and regulatory penalties. For governments, both state and federal, we calculate changes in: public insurance spending, subsidies (both for individuals and firms), tax revenues, and revenues from regulatory penalties.

XII. ACA Premium Assistance Credit Table

Table 39 is taken from Section 1402 of the ACA and shows the maximum premium percentage by income level.

"In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 133%	2.0%	2.0%
133% up to 150%	3.0%	4.0%
150% up to 200%	4.0%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

Table 39 – ACA Premium Assistance Credit Table