



COMPREHENSIVE ASSESSMENT OF ACA FACTORS THAT WILL AFFECT INDIVIDUAL MARKET PREMIUMS IN 2014

Prepared for and at the request of:

America's Health Insurance Plans

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EXECUTIVE SUMMARY

As part of the **Patient Protection and Affordable Care Act (ACA)**, a series of provisions applies to individual and small group comprehensive medical insurance plans, **effective January 1, 2014**. These provisions are anticipated to have a **potentially significant impact on current premium rates**. AHIP engaged Milliman to conduct a study to provide a comprehensive assessment and analysis of the major factors affecting private health insurance premiums in the individual health market. This report provides the results of our analysis. Its primary purpose is to **educate interested parties** about the type of changes that people may see to their current premium rates, given the ACA provisions and the sources of those changes.

Key observations from our study of premium impact include:

- Some provisions in the ACA are likely to place significant **upward pressure on premiums**, including **new taxes and fees**, **essential health benefit requirements**, limits on patient cost-sharing and related insurance market reforms. Other provisions—such as transitional reinsurance and premium subsidies—are likely to mitigate expected premium increases or otherwise make coverage more affordable, at least for **those eligible for financial assistance**. Nonetheless, **average individual market pre-subsidy premiums are anticipated to increase significantly from what standard rates are today**.
- Individuals and families with household incomes of 400% of the federal poverty level (FPL) or lower will be eligible for **prepaid tax credits (premium subsidies)** and cost-sharing reductions (CSRs) that could significantly lower their total out-of-pocket insurance costs, making coverage much more affordable. For example, our modeling indicates that subsidies will pay an average of 40% of silver plan premium in 2014 for those who are eligible for subsidies. The benefits will be even greater for those with the **lowest incomes, covering 94% of premium**. Further, bronze plan premiums could be as low as \$0 for low-income individuals, and, in some cases, older people who purchase a bronze plan will get post-subsidy premium rates less than younger people at the same income level. These subsidies will result in **significant reductions from current premium levels for many people**.
- It is important to note that the focus of this report is not only on the average change, but also on how the ACA provisions will affect individuals' premium changes depending on their age, gender, location, health status, and household income level, as well as their current health plan coverage and the new health plan they choose in 2014. The change in allowable rating characteristics (e.g., from generally uncapped attained age gender rating to a 3-to-1 unisex rating cap by age) **results in a significant amount of subsidization of older and less healthy insured people by younger, healthier insured members, compared to what is in the marketplace today**. The result of this is that cohorts such as young, healthy males could see substantial increases due to the combination of the overall rate change and the age/gender rating requirements. In comparison, the **older, less healthy individuals could see rate reductions**. Healthier older people are likely to see an overall increase, while younger, less healthy females may also see reductions in premium.
- State-by-state variation in premium impact—which is due to the ACA provisions—will be significant. Specifically, states that have less restrictive individual market rating and related regulations, which represents the vast majority of states, will likely experience greater average premium increases in the individual market (as compared to the national average). That is because moving to guaranteed

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issue and modified community rating **will likely increase participation by higher-cost individuals** (including those currently receiving coverage in state-administered high-risk pools who will likely enroll in exchange-plan coverage). Those states that currently have guaranteed issue and community rating requirements in the individual market (such as Maine, Massachusetts, New York, New Jersey, and Vermont) will likely experience lower premium increases (or perhaps may even experience premium decreases as the mandate would likely increase participation by some lower-cost individuals).

Throughout the report are estimated ranges and point estimates of the impact that each component of change may contribute in moving from a 2013 premium level to a 2014 rate. A total impact value is not presented though because of the significant variation that is likely to take place due to differences among insurers regarding their current rating and underwriting practices and strategic planning, differences in state regulations, and the uncertainties associated with potential uninsured and employee migration that affects the individual risk pool in 2014. As such, not all of the components of change presented apply uniformly to insurers or consumers.

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REPORT QUALIFICATIONS

There are several points of context that are important when considering the results presented in this paper.

1. Our analysis is a snapshot of the current individual market based upon data and information from various sources. There are numerous insurers and many health plan designs that differ from one another and that cannot be fully reflected in this analysis. The impact of ACA may be more or less pronounced for people currently covered by these other plans than illustrated in this report.
2. There will likely be many possible plan designs from which people will be able to choose. While all of them are required to have **actuarial values** that meet the ACA metallic levels, as determined by the Centers for Medicare and Medicaid Services (CMS) actuarial value calculator, some plan features and provisions will vary. In particular, plans will differ in terms of the makeup of their healthcare provider networks and the prescription drug formularies that they use.
3. **This paper looks only at the impact of ACA on premium rates**, including premium tax credit subsidies available to those with household income of 100% to 400% of FPL. The new law also provides cost-sharing reduction (CSR) subsidies to people meeting specific qualifications. Also, the richer benefit plans it mandates may reduce the out-of-pocket costs an insured member must pay in addition to the premium.
4. Our illustrations are focused on the impact to an individual and not to a family. In general, this is because **families are to be rated in 2014 and later on a per member basis and not as a family unit**, as they currently are. Federal premium subsidies will be greater for family households than for single-person households. This should be considered when thinking about the impact of ACA on family units. Other variations could occur that would be due to the mix of persons in the family unit (i.e., age, gender, single- vs. two-parent household).
5. Underlying our analysis is an assumption as to the level of migration of individuals who are currently uninsured or insured under an employer-sponsored group health plan into the individual market during 2014.
6. Our analysis assumes the healthcare delivery system in place today. The U.S. healthcare system is constantly evolving and responding to changes that are due to economic influences, regulatory changes (such as ACA), political actions, technological and pharmaceutical innovations, and business considerations. While dramatic changes in the healthcare delivery system are not anticipated over the next year, the impact to local markets could vary from these results, which would be due to such changes (e.g., consolidation of hospital systems or vertical integration of providers).

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7. Our analysis is applicable to an average state that has decided to accept and implement the expansion of Medicaid offered through ACA. It assumes individuals eligible for the Medicaid expansion are insured under a Medicaid fee-for-service or managed care delivery system versus the state using Medicaid expansion dollars to purchase individual market coverage for such individuals. However, our analysis does not consider the impact of other funding changes that the federal or state governments might make to other healthcare financing programs such as Medicare or ACA.
8. This analysis requires assumptions as to future unknown events. As such, another person conducting a similar analysis could have different results, which would be due to the assumptions chosen. However, the author believes that results will be directionally similar for most health actuaries experienced in conducting such studies.
9. Because this paper shows how premiums change from 2013 premium rates, the approach presented herein differs from the rate filing forms, but is reasonably comparable.
10. The views, comments, and analyses presented in this report are those of the author and **do not represent the opinions or conclusions of Milliman, Inc.**

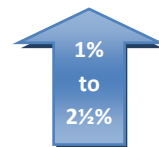
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ACA FACTORS AFFECTING INDIVIDUAL MARKET PREMIUMS IN 2014

The world in which health plan issuers are setting premiums for individual market healthcare coverage in 2014 is very different from what we have seen historically in most states. For 2014, health plan actuaries are considering an entirely new set of “building blocks” as they set their premiums. This will result in varied impacts in terms of the premium changes they will experience in 2014 based on age, geography, and other demographic features, among other factors. Some of these building blocks will lead to **increased premiums for all individuals; some will decrease premiums**. Additionally, the availability of a **premium tax credit** (premium subsidy) through exchanges will significantly lower the *out-of-pocket premium* rates many households will pay. This paper looks at expected average premium rate changes (results in individual states and for individual people may differ significantly). The following is a look at these various premium rate building blocks and the factors that will affect the premium rate charged to an individual. Please note that there is a range of potential average impact for each of the factors discussed and not all factors are applicable to a given person, insurer, or state. In particular, **some of the results shown are not applicable to states that have previously incorporated some of these reforms**. Furthermore, caution is needed when trying to combine the factors and ranges presented, as they are **not necessarily additive**.

NEW TAXES AND FEES LEADING TO INCREASED PREMIUMS

Health insurer tax. ACA imposes a new excise tax on fully insured plans, **\$8 billion** in 2014 and increasing thereafter. According to the Congressional Budget Office (CBO), this tax is likely to be passed through to the premiums charged for coverage.¹ Milliman estimates that this nondeductible tax will increase premiums in 2014 by about **2% on average**. The impact on premium is dependent on the size and tax status of the insurer and on the insurer’s expectation of the total size of the commercial market and its share of the market. Some small health plans may be exempt from this tax (not indicated in the arrow to the right). A study by Oliver Wyman corroborates this estimate (1.9% to 2.3%) in 2014.²



Health insurance exchange user fees. Under ACA, **exchanges are authorized to charge plan user fees**. For plans participating in the federally facilitated exchange (FFE), this fee is estimated to be **3.5% of exchange premium**.³ These fees spread over all of an insurer’s individual market business. Therefore, for insurers selling both through the exchange and outside the exchange, the impact of this fee will be less than 3.5% of premium. Rates for an insurer selling only through the exchange would include the full 3.5%, and rates for insurers not selling through the exchange would not include these fees. An average of 1.4% is estimated based on a projected mix of exchange and



¹ Congressional Budget Office (November 30, 2009). An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act, p. 15.

² Oliver Wyman, (October 31, 2011). Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans.

³ States that operate their own exchanges can also charge a user fee; most states have not announced what these fees will be.

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non-exchange business for 2014. States operating their own exchanges can also charge user fees, and some states have estimated per member per month (PMPM) fees as high as \$37 (Utah) and \$45 (West Virginia).⁴ Covered California, the California exchange, plans on charging 3% of premium to participating insurers.⁵

It is not yet clear how much of this fee will replace other administrative and marketing expenses that the insurer would otherwise incur. Certain marketing and distribution expenses (such as broker commissions) for exchange business should decrease because of the exchanges. However, insurers will be responsible for interfacing with the exchange, issuing the policies, and providing policyholder services and claims processing. Moreover, it is likely that there will be a significant increase in volume to health plan customer call centers—as a result of the 2014 reforms and the influx of previously uninsured individuals and families into the new marketplaces. It is also likely that the exchanges will not eliminate the need for insurers to market their products. The impact will vary by health plan, but it is very likely that the functions performed by the exchange will not entirely replace the needs of the health plan.

Transitional reinsurance assessment. ACA creates a transitional reinsurance program (described later in this paper) that is funded by insurers and third-party administrators (TPAs) selling in the group market as well as those selling in the individual market. The estimated 2014 fee to pay for this program is \$5.25 per member per month or \$63.00 per year.⁶ It will add about another 1% to 2% to the average premium rate, varying depending on the expected distribution of an insurer's metallic plans (higher for bronze plans and lower for platinum plans).

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Other ACA taxes and fees. Plans are also required to pay fees to facilitate the administration of the risk adjustment program, as well as to fund the new Patient-Centered Outcomes Research Institute (PCORI).⁷ These fees add another \$3 per year to premiums. ACA also requires new taxes on pharmaceuticals and medical devices, which may be passed through in their product pricing and that ultimately get reflected in health plan premiums. We discuss the impact related to insurers' direct administrative costs in the Market Competition section.



See the Market Competition section for discussion on administrative costs.

⁴ West Virginia Office of the Insurance Commissioner (June 11, 2012). West Virginia Health Benefit Exchange: Financial Sustainability Overview, slide 17.

⁵ Cosway, R. (March 27, 2013). Factors Affecting Individual Premium Rates in 2014. Page 21. Milliman client report to Covered California.

⁶ U.S. Department of Health and Human Services (March 2012). Final Rule: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014.

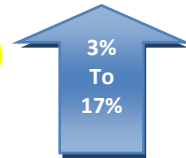
⁷ 77FR72722: PCORI fee of \$2 per enrollee; 77FR73125: In proposed Notice of Benefit and Payment Parameters, HHS estimates up to \$1 per capita fee; 77FR73191: HHS estimated plan cost of IT infrastructure for risk adjustment and reinsurance program is \$589 million; using HHS estimate of 20 million enrollees, translates to \$29.24 cost per enrollee per year.

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BENEFIT PLAN CHANGES AFFECTING PREMIUM RATES

Section 1302 of ACA addresses **minimum required benefit plan provisions** that must be included. The plan designs currently in force in the individual market often do not meet these minimum levels, both in the services that are covered and the cost sharing of the plan. On the other hand, health plans are considering plan designs that renew emphasis on managed care features, use wellness programs, or limit provider networks to create lower premium levels.

EHB buy-up. Beginning in 2014, ACA requires plans to cover a broad range of mandated **essential health benefits (EHBs)**, the scope of which is more expansive than typical individual policies sold today. In particular, covered services **will expand to include behavioral health**, maternity, outpatient prescription drugs, pediatric dental and vision, and habilitative care. While many individual plans in today's market offer coverage for some of these services, that coverage is typically very limited. Based upon the Milliman 2012 Health Cost Guidelines™, the costs for a traditional \$1,500 deductible plan with 30% coinsurance and a \$6,000 total out-of-pocket expense limit that offers no coverage for maternity (other than for complications) and no outpatient prescription drugs **would need to increase by about 15%**; if it already covered drugs (as many plans do) but not maternity, the average increase would be **3%** (more if the insurer considers the selection involved in such plans). Increases for a \$500 deductible plan with 20% coinsurance and a \$3,000 total out-of-pocket would be similar. On top of these increases, premiums would also need to increase because of **more comprehensive coverage** for the other required services noted above. We estimate that people insured through the individual market will see **rate increases averaging 3% to 17% in order to upgrade coverage to include mandated benefits.**



The impact will vary by state and health plan because various states already mandate coverage for some of these services, the EHB benchmark plans include some limitations to the benefits, and health plans include at least partial coverage for some of these benefits. Independent studies commissioned by states looked at the impact of the EHB requirements on premiums. A study for the state of Maryland⁸ estimated an impact on premium of 2% to 4% for EHB expansion. It appears that this study assumed that prescription drugs were covered adequately. An analysis for Oregon⁹ found an average increase of 5% to 7%. An average estimate of 8% has been used in this analysis.

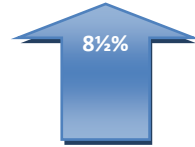
Individuals get improved benefits that are due to the EHB requirements, which could reduce out-of-pocket costs, but at a higher pre-subsidy premium level. Some insured people might not value or want to pay for this extra coverage they are getting, but **under the ACA they do not have a choice.** For some individuals receiving a premium subsidy, there may be no additional cost for the enhanced benefits.

⁸ Oliver Wyman & Mercer (June 16, 2011). Potential Impact of the Affordable Care Act on the Current Individual and Small Group Markets.

⁹ Wakely Consulting Group (July 31, 2012). Actuarial Analysis: Impact of the Affordable Care Act (ACA) on Small Group and Individual Market Premiums in Oregon.

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Actuarial value minimum requirement. As part of the EHB requirements, plans must also meet new tests of **minimum actuarial value (AV)**—the percentage of covered costs that must be paid by the health plan. The minimum AV allowed beginning in 2014 is **60% for a bronze plan**. In order to be eligible for the cost-sharing reduction (CSR) benefit offered by ACA, people with household incomes less than 250% of FPL need to purchase a silver plan with a 70% AV (they would also receive substantial premium subsidies to afford the rich plan). A recent study by Jon Gabel published in *Health Affairs*¹⁰ found that **more than half (51%) of the plans sold in the individual market today would not meet minimum requirements for bronze coverage**, with 12% of plans having an AV of 35% to 49%—far below bronze level standards. For plans already above the minimum 60% AV, there would be no impact. Only plans currently below that level would be impacted by this requirement. Based on this research, people affected by the 60% AV standard would see premium rate increases averaging about 15%. Overall, the market would average an **8.5% premium increase** based on the actuarial value distribution in the *Health Affairs* published study.



Some states looked at the overall average impact the AV requirements would have on plan premiums in their state:

- An analysis for Oregon found that the AV requirement will lead to only an average 2% increase in premiums.¹¹
- The estimated increase in a Gruber/Gorman Minnesota study is 4%.¹²
- The Maryland study referred to above estimated a 6% impact that is due to the AV requirement.
- A Milliman study¹³ conducted for the Ohio Department of Insurance estimated a state average AV of 55% for the individual market, which is lower than the overall averages shown in the Gabel study and the Gruber/Gorman Minnesota study. It implies an average 9% increase to get to a bronze plan.
- A study done for the Maine Bureau of Insurance¹⁴ indicated an average AV of only 45%, with about 80% of insured policyholders below 55%. Those with plans less than a 60% AV in Maine would need about a 60% rate increase to get to the 60% AV; an average 50% would be needed statewide.

The distribution of plans affects the overall average impact to the market, but, at least for both the Gabel study (with data from **California**, Florida, Michigan, Pennsylvania,

¹⁰ Gabel, J. et al. (2012). More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014. *Health Affairs* 31 No. 6.

¹¹ Peper, J. et al. (July 31, 2012). Actuarial Analysis: Impact of the Affordable Care Act (ACA) on Small Group and Individual Market Premiums in Oregon. Wakely Consulting Group. Retrieved April 2, 2013, from <http://www.cbs.state.or.us/ins/consumer/federal-health-reform/wakely-aca-actuarialanalysis-20120731.pdf>.

¹² Todd-Malmlov, A. (January 11, 2013). Updated Gruber and Gorman Analysis of ACA and Exchange Impact on Minnesota. Minnesota Health Insurance Exchange. Retrieved April 2, 2013, from <http://mn.gov/commerce/insurance/images/ATF-2013-01-11GruberGormanUpdatePresentation.pdf>.

¹³ Milliman (August 31, 2011). Assisting With the First Year of Planning for Design and Implementation of a Federally Mandated American Health Benefit Exchange. Client Report to the Ohio Insurance Department.

¹⁴ Gorman Actuarial, Smalgula, J., & Gruber, J. (May 31, 2011). The Impact of the ACA on Maine's Health Insurance Markets. Maine Bureau of Insurance.

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and Utah) and the Gruber/Gorman Minnesota study, the average increase for those below the 60% required AV threshold is **15%**.

It should be noted, though, that as with the EHB moving up to a minimum 60% AV provides a **richer benefit plan to the insured** and perhaps less out-of-pocket costs if they happen to have a claim.

Benefit design/managed care/provider network. Health plans are in the process of designing and developing the benefit plans that they will sell in 2014, both through the exchange and outside of the exchange. Design features related to **provider networks and managed care provisions** are independent of meeting EHB and AV requirements discussed above. Some of the developing designs could be priced **5% to 10% lower** for 2014 premiums than they would without these features. Not all insurers will be able to make such reductions and some may even need to raise rates in certain localities **if providers gain more negotiating leverage through consolidation.**



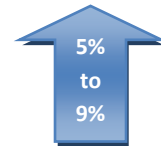
One recurring theme is the introduction (or reintroduction) of greater managed care through plan design. Plans may strengthen care management provisions. Some may make **nondiscriminatory wellness programs** available (note individual market plans cannot provide **premium discounts for participation in wellness programs as group plans can**). The features that seem to be most widely considered are the design of the provider network and the design of the outpatient prescription drug formulary to be used for a given plan.

While ACA has rules concerning the breadth of the provider network that can be used for a plan, health plans have considerable flexibility in the determination of which providers will be included in a plan's provider network(s). In order to compete on the exchange with a plan that would offer a more affordable premium, many health plans are developing **"high-value networks"** that limit the number of providers included in the network to those that provide quality care **at a lower-cost than the "broader networks" that they currently offer.** Provider network differentiation will allow for a lower premium rate for those people who are less concerned with **which providers** are on the **preferred list** and yet still make available a broader network plan to consumers who want more choice in preferred providers. It is not clear how extensive these changes will be, particularly for 2014, given the time it takes to construct a provider network and negotiate price. Also, not all insurers will be able to modify their networks in this manner. **Some provider-owned health plans are obligated to include all of their affiliated providers.** Others have already negotiated the lowest payment rates possible. Furthermore, **healthcare provider consolidation may make it more difficult to negotiate further reductions in payment rates,** as the balance of negotiating leverage shifts or intensifies in local areas. However, some new health plans entering the individual market are seeking to secure more competitive payment rates from their networks.

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RISING HEALTHCARE COSTS

Outside of new requirements under ACA, a driver of premium increases will continue to be **increasing medical costs**, which in turn drive up the cost of healthcare coverage. According to the Health Care Cost Institute (HCCI), healthcare spending for those under 65 who were covered by employer-sponsored, private health plans grew 4.6% in 2011, an increase over the 2010 change.¹⁵ The Milliman Medical Index for 2012 indicated an expected average increase in healthcare costs of 6.9% over 2011 levels.¹⁶ While higher than the general rate of inflation, recent health cost trends have been considerably lower than historical experience (often double-digit increases). Some of this lower trend has been attributed to the recently struggling economy and its high unemployment rate. Some believe that the high public focus on healthcare reform has helped rein in cost increases. It is unclear whether trends will again accelerate as the economy improves, as our **insatiable demand for healthcare services** increases because of the greater availability and more comprehensive health insurance coverage, and as our national focus shifts from healthcare to another sector of the economy. Increased demand for services generally results in higher costs if the supply for those services (providers) or improved efficiency does not keep pace with demand.



We anticipate that **healthcare cost base trends** will continue at about a **4% to 7%** annual level during 2014, with deductible leveraging adding about 1%-2% additional points to trend.¹⁷

¹⁵ Health Care Cost Institute (September 2012). Health Care Cost and Utilization Report: 2011.

¹⁶ Milliman (May 2012). 2012 Milliman Medical Index.

¹⁷ Deductible leveraging occurs when the cost of services increases from one year to the next, but the deductible and copays remain the same. For example, if services cost \$10,000 in 2013 and increase to \$11,000 in 2014 (a 10% increase), a plan with a \$1,000 deductible would pay a benefit of \$9,000 in 2013 and \$10,000 in 2014 (an 11% increase).

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CHANGES IN RISK POOL COMPOSITION/ADVERSE SELECTION

Beginning in 2014, individuals will have **guaranteed access to coverage**. This is currently the case in the small group market, but individual market insurers in most states currently require applicants to be healthy enough to pass the insurer's **medical underwriting standards** before issuing coverage and allowing currently insured members to upgrade coverage to richer benefits. This is a significant change to the individual market, especially because the guaranteed availability is accompanied by prohibitions against limiting benefits due to **pre-existing conditions**, guaranteeing **premium grace periods as long as 90 days** for many insured members, and varying premium rates due to health status or claims experience. To limit the potential for adverse selection, the exchanges will have an **open enrollment period** from October 2013 through March 2014. In the remainder of 2014, enrollment is only available for individuals with a **qualifying event**, including at their current policy renewal date. Coverage will be made even more accessible thanks to significant premium and cost-sharing **subsidies** that ACA makes available to assist low- and moderate-income people. The combination of these ACA provisions is likely to result in **many new entrants into the individual health marketplace**, as well as marked movement among those already in the market. It is noteworthy that, even with open enrollment period restrictions, insurers still anticipate significant exposure to **adverse selection** due to several forces that will influence choice during 2014.



Following is a discussion of various sources of **potential adverse selection** that will impact premium rates. Please note that these factors are not all independent from one another, and, as such, the impact percentages shown are **not necessarily additive or multiplicative** for estimating an overall impact. They are not all applicable to states that already have guaranteed issue and adjusted community rating in place.

New market entrants and guaranteed access to coverage. There are five distinct groups of new people entering the market whose presence will impact premium rates, which will be due to their having average health status levels that differ from those exhibited by the current individual market:

1. **The currently uninsured:** Many will be less healthy than those currently in the individual market, while others will be healthier. However, it is more likely that the unhealthy people will take advantage of the guaranteed access to insurance coverage sooner than healthy people will, particularly in 2014 when the individual mandate penalties are quite small compared to the cost of unsubsidized coverage. Less healthy people are also more likely to learn about the new insurance opportunities sooner than healthier people due to their exposure to healthcare providers and greater sensitivity to the need for coverage.
2. **Current state high-risk program and federal preexisting conditions insurance plan (PCIP) members/COBRA and group conversion enrollees:** The individual market will now also be open to those currently covered through state high-risk programs, as well as those in federal PCIPs. While they are relatively few in

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number, they have very high claim costs¹⁸ that they will bring with them to the individual insurance pool. Optum/Lewin in its analysis for the Society of Actuaries estimated that the combined PCIP and state high-risk program members would have average claim costs of about \$24,000 for year 2014.¹⁹ For PCIP programs members specifically, every state operating its own PCIP program had a claim ratio of greater than 180% (not including claims incurred but not yet paid), with some states over 1,000%. Collectively, the federally-run PCIPs had a claim ratio of 669% (not including claim incurred by not yet paid). All states combined had a claims ratio of 581% before administrative expenses and not including claims incurred but not yet paid.²⁰ These higher than expected costs led to a suspension of the PCIP program on March 2, 2013.

This group of people also includes those currently with either COBRA or group conversion coverage. They also exhibit high costs and poor health status. While COBRA premiums may be higher or lower than what the person will be able to find in the individual market, it is more likely that people with group conversion plans will be able to find richer coverage at more affordable rates in the individual marketplace.

3. Employees and dependents of employer groups: While large employers will be subject to penalties if they do not offer minimum, affordable health coverage, small employers are not subject to any such penalties. Employees and dependents who are eligible for an "affordable"²¹ group plan are not eligible for premium or benefit subsidies in the individual market. Certain small employers may introduce strategies for the benefit of lowering their costs and perhaps that of their employees, which could affect the individual market. These decisions will be dependent on many factors, including the relationship that exists between premium rates for small group coverage and individual market exchange rates. Small employers receiving large rate increases that are due to the small group rating reforms may also decide to terminate their plans if they feel the cost has become unaffordable. The impact of these terminations on the individual market is uncertain and depends on the strategic planning and actions that employers take.
4. Part-time employees: Employers that currently offer a health plan to their part-time employees (defined as working less than 30 hours per week on average), may decide to drop part-time eligibility if it is believed that these employees can get better and less costly coverage through the subsidies offered through the

¹⁸ NASCHIP (2011/2012). Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis. Based on 2010 data, high-risk program members incurred about three times the average claim levels of the individual market. The federal PCIP high-risk program has experienced even higher relative levels.

¹⁹ Optum/Lewin, Haught, R. & Ahrens, J. (March 2013). Cost of the Future Newly Insured under the Affordable Care Act (ACA); Table B-17 composited. Society of Actuaries.

²⁰ The Center for Consumer Information & Insurance Oversight (CCIIO); Pre-Existing Condition Insurance Plan Data as of December 31, 2012; Retrieved on April 9, 2013 from <http://ccio.cms.gov/resources/files/pcip-expenditures-12-31-2012.pdf>

²¹ "Affordable" means that cost of self-only coverage of the plan may not exceed 9.5% of an employee's household income.

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individual market exchanges for eligible individuals.

5. **Early retirees**: Similarly, employers that currently sponsor retiree health plans may choose to terminate the plans and have their early retirees get an individual market health plan. Because many of the retirees may have reduced incomes, they may qualify for **subsidies** through the exchange.

Our modeling indicates that the resulting mix of these new entrants with the individual market members currently in force will increase **risk scores by 0% to 23%**, varying by state, where the low end is reflective of some states that already have guaranteed issue and modified community rating requirements and the high end states that have few current restrictions.

Adverse selection related to plan choice, single risk pool, and renewal timing.

Discussed above was the potential impact of currently uninsured people and others entering into the individual market and changing the risk composition of the market. ACA changes also create new opportunities for people currently insured in the individual market. The impact from these current members emanates from four different sources as ACA gets implemented: 1) annual plan choice; 2) elimination of durational rating; 3) elimination of premium variation based on **health status**; and 4) renewal dates different than the ACA January 1, 2014, effective date. Combined, these factors **increase rates by an average of 15% to 30%**. Each is discussed below.

1. **Plan choice**. One of the criticisms of the current individual marketplace is that some insured members may become **“stuck” in their coverage once they develop medical conditions**. The development of conditions after they get coverage may prevent them from being able to move from one health plan to another. Even within the insurer with which they have coverage, they **may only be able to downgrade benefits; they cannot upgrade to a richer plan without underwriting approval**. ACA changes this dynamic and allows such individuals to choose **any plan during each open enrollment** or special enrollment period according to what their anticipated healthcare costs are going to be for the year. Those expecting little in the way of healthcare costs for the year could downgrade benefits to reduce their premiums, and **those expecting to need healthcare services could upgrade to richer coverage**. This is also applicable to new market entrants who will **opt for the level of coverage most in line with their expected utilization**. The number of choices will be considerably greater than those typically available to employees of employer groups. Furthermore, it appears that each family member may be able to choose a plan that differs from that of other family members based upon each of their expected healthcare needs for the year. The ACA requirement that a **child-only plan** be made available for each plan offered makes this “split-contract” behavior all the more likely.

This adverse selection will increase the overall cost of the single experience risk pool because such **adverse selection cannot be reflected in premium rates by benefit plan level**. While the ACA risk adjustment program will help redistribute these extra costs among the various health plans and insurers, it does nothing to **lower the total costs related to such adverse selection**.

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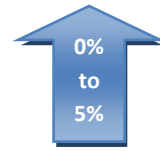
2. Elimination of durational rating. The 2013 claims experience pool for each individual market insurer consists of members of varying coverage duration (i.e., years since the coverage became effective). Due to medical underwriting, there is a **pattern of increasing morbidity factors by duration**. In 2014, **insurers will no longer be able to vary rates based upon policy duration**. The approach to durational rating varies by insurer. For insurers who use durational rating, their 2014 base rates will need to increase by the anticipated loss of revenue that they otherwise would have earned from the durational premium rate-ups. Many insurers do not ostensibly use durational rating, but rather **close off blocks of older business to new sales every few years and then rate the closed blocks separately**. Other insurers do not use any form of durational rating, but already use aggregate rating based upon a single experience pool. The Society of Actuaries sponsored a research study²² conducted by Milliman in which it estimated the impact of durational selection and wear off. Analysis of the study supports the expectation of durational underwriting wear off in 2014 and the need to adjust premium rates for combining experience of **older blocks of business with that of more recently issued insured members**.
3. Elimination of underwriting premium rate-ups and preexisting condition exclusions. ACA will also no longer allow an insurer to vary premium rates based upon the **health status** or **claims experience** of an applicant or current member. Further, insurers will no longer be able to sell policies with **pre-existing condition exclusions**. As such, insurers will need to adjust their 2014 premium rates to recoup the lost revenue collected today because premiums currently are allowed to vary by health status. Further, **insurers will see higher claims costs in 2014 because pre-existing condition exclusions will be eliminated**. At the same time, individuals who currently pay a higher premium due to having a medical condition will see a **reduction in 2014 because of this change, while others will see their premiums increase**.
4. Renewal date shift. The final market and rating regulation released by HHS at the end of February **made clear that individual policies can stay in place until their scheduled renewals in 2014** instead of requiring all individual plans to convert to an ACA-compliant EHB plan on January 1, 2014. This may have the effect of healthier and younger male members persisting with their existing coverage until their 2014 renewals, while less healthy, female, and older members may be able to get lower rates for similar or better coverage by **lapsing their pre-ACA coverage and purchasing new coverage**. There are also likely to be some healthy and younger people who are eligible for premium subsidies who will also lapse early if they can find a subsidized premium rate lower than that of their current coverage. This shift will require a **net increase in the risk pool morbidity level** for 2014, which will be based upon the expected renewal distribution of members throughout the year.

²²Wachenheim, L. (October 2006). Variation by Duration in Individual Health Medical Claims. Society of Actuaries.

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PENT-UP DEMAND

With the influx of uninsured flowing into the individual healthcare market in 2014, the general expectation is that utilization of services will temporarily surge, as those who previously did not have coverage will now have coverage for the first time and seek preventive care or treatment for minor health issues that they otherwise would not. Consistent with other studies,^{23,24,25,26} our modeling indicates that claims in the 2014 individual market may be 0% to 5% higher due to previously uninsured people's pent-up demand. This is dependent on a number of factors, including the number of uninsured entering the market in 2014 relative to already insured members.



²³Damler, R. (August 2009). Experience under the Healthy Indiana Plan: The short-term cost challenges of expanding coverage to the uninsured. Milliman.

²⁴Finkelstein, A. et al. The Oregon Health Insurance Experiment: Evidence from the First Year.

²⁵State Health Access Data Assistance Center (SHADAC, August 2005). Health Care Services Among the Newly Insured. Arizona Health Care Cost Containment System (AHCCCS).

²⁶Wakely Consulting Group (July 31, 2012). Actuarial Analysis: Impact of the Affordable Care Act (ACA) on Small Group and Individual Market Premiums in Oregon.

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MARKET COMPETITION

The introduction of individual exchanges and their lure to health plans of increased market share, which is due to the exclusive availability of premium and cost-sharing subsidies through the exchanges, **may create a more competitive individual market.** Health plans are currently setting strategies as to how best to offer relatively attractive pricing on the exchange. It appears that this is largely being done through product design and provider network configuration (discussed earlier in this paper). However, in light of the potential distribution and underwriting expense reductions discussed below, coupled with the protections offered through the ACA risk corridor program, some health plans may be willing to offer lower premiums, while others will likely take a more conservative approach given the level of uncertainty that exists with the new marketplaces. A range of an average 5% reduction to no reduction is expected for the impact of market competition. This is in addition to the benefit design/managed care/provider network changes discussed earlier.



The ACA requirement of guaranteed issue, elimination of health condition rating, and introduction of exchanges will result in certain areas of expense reduction. Most expenses supporting medical underwriting will be eliminated and **potentially lower broker and agent commissions** will result because of sales through the exchanges. The 2011 supplemental healthcare exhibits indicate that the nationwide individual **average commission** in the individual market as a percentage of premiums was **5%**. Exchanges may result in further reducing these expenses by 1.5% to 2.5% of premium. The **elimination of medical underwriting** would **lower expenses** about another **1%**. Insurers who gain market share will also be able to spread fixed expenses over more membership, which could help lower the expense ratio. However, because much more **claim activity is also expected** in the new marketplace, insurers may need to increase their claims settlement staffs. In addition, plans will need to develop and maintain a new information technology infrastructure to support the transmission of claims data for the **risk adjustment and reinsurance programs**, as well to support data and information interfaces with the exchanges. **Compliance, accounting, legal, and actuarial expenses** are likely to increase, at least for 2014. These added costs will offset some of the expense reductions for commissions and underwriting. So the **net reduction in expenses** might range from **0.5% to 1.5% of premium.**

However, individual market operations lost money on average in 2010 and 2011.²⁷ As such, these expense reductions may allow insurers to only avoid future losses in this market, and therefore the reductions may not affect premiums on average, particularly given the uncertainties insurers face in 2014. However, some insurers may be in a position to lower premiums. These expense savings are reflected as contributing to the market competition impact estimate of up to a 5% premium reduction shown above.

²⁷ Based on a compilation of companies' supplemental healthcare exhibits for 2010 and 2011. Underwriting losses were -1.1% of earned premium in 2011 and -0.4% in 2010.

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Additionally, the exchanges may attract health plans previously only serving the Medicaid population. Medicaid health plans entering the individual market may be focused on insuring individuals who were previously Medicaid-eligible or have income levels below 250% FPL. If these plans are able to secure competitive provider reimbursement rates, they may also attract other consumers.

Note that an insurer's pricing strategy may differ based upon the approach that the state exchange takes in its oversight of the market. The 0% to 5% reduction estimate does not include the impact of health plans introducing high value network products, which limit the number of hospitals and other providers from which insured members can obtain services at maximum reimbursement levels. These high-value network plans in some cases will also be coupled with more targeted managed care and disease management programs, which were discussed earlier in this paper.

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TRANSITIONAL REINSURANCE PROGRAM SUBSIDY

The transitional reinsurance program (ACA §1341) reimburses individual market health plans for 80% of the cost of claims amounts between \$60,000 and \$250,000. Total required funding in 2014 is \$10 billion. If the full \$10 billion is paid out in 2014, net claim costs could be reduced by 6% to 15%, depending on the rate of influx of uninsured and those currently with employer-sponsored insurance into the individual market and the exposure of current in-force members who qualify for benefits under the reinsurance program in 2014.



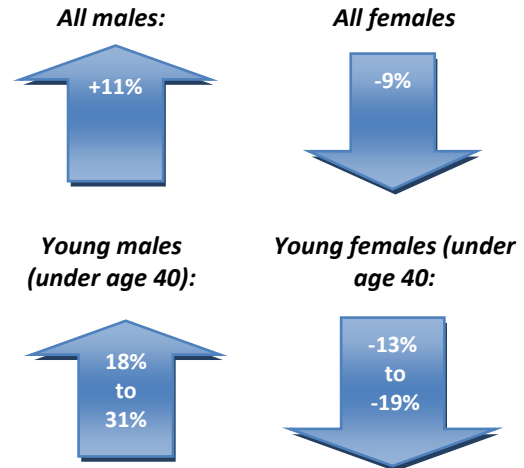
Health plans will likely assess a number of factors and balance a number of considerations in reducing premium rates for this subsidy. These considerations include: 1) the number of new individual market enrollees into their plans is uncertain; 2) as 2014 renewals will be staggered throughout the year, fewer members will qualify for the reinsurance benefit; 3) states not electing the Medicaid expansion offered by ACA may inadvertently dilute the reinsurance funding and result in higher insured claims expenses, and, 4) the transitional nature of the reinsurance program and the reduction in available subsidy over the three years. Because of these concerns, health plans may be reluctant to lower rates too much as the subsidies diminish and then totally go away after 2016. As such, the reduction impact on premium rates is expected to be in the 6% to 12% range for calendar year 2014.

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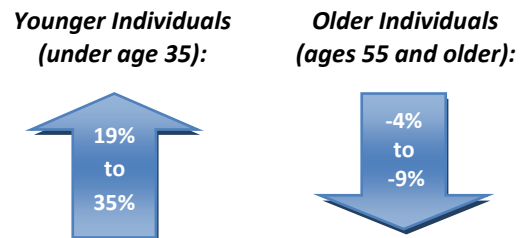
FACTORS WITH VARIED IMPACT

ACA includes other requirements that will also impact premiums of an individual, depending on the individual's age, gender, health status, income level, where they live, and the type of coverage they have today. **Clearly, younger or healthier males who are in low premium, high deductible plans today will see significant pre-subsidy premium increases.** Those who are older or less healthy will likely see their premiums decrease as all individuals are brought together into a single risk pool.

Unisex rating. While some states currently require unisex rating for the individual market, most allow sex-distinct rating. Evidence is overwhelming that healthcare costs and utilization vary significantly by gender, particularly at young ages, even when maternity costs are excluded. However, ACA requires that all health plans be rated on a **unisex** basis beginning in 2014. This change has a very significant impact on pre-subsidy premium rates, particularly for younger people. Based upon a fairly typical rate slope used in the market, young females under age 40 can expect to see premium rates decrease by 13% to 19%, while young males will see pre-subsidy premiums increase by 18% to 31%. At older ages, the premium rate differentials decrease and become fairly nominal after age 55. Based on the distribution modeled, for states that allow gender-distinct rates, adult male rates increase by 11% and female rates decrease by 9% on average. Rates were modeled such that the same revenue is generated.



Age band compression. ACA places new limits on how much premiums can vary based on age, which will increase pre-subsidized premiums for younger individuals and families, while lowering premiums for older individuals. The impact is dependent on the age distribution expected for 2014 and the current rate slopes being used. An analysis we conducted on over a dozen distributions using a unisex age slope of 4.5-to-1 indicates that the age rating restrictions (after adjustment to unisex rates) will impact premiums on average as follows:



Age Range Avg.

Ages 21-29: +28%

Ages 30-34: +17%

Ages 35-39: +10%

Ages 40-49: -5%

Ages 50-59: -6%

Ages 60-64: -9%

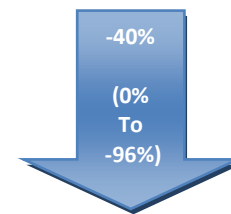
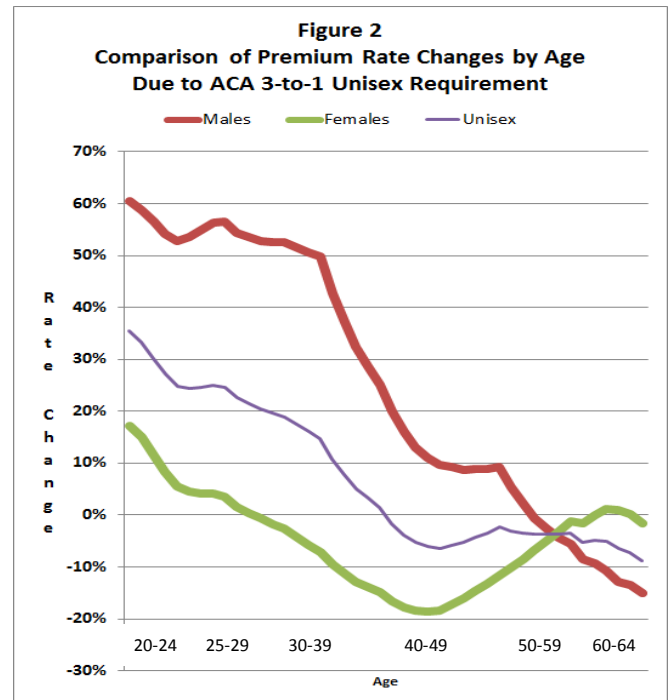
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Keep in mind that these are changes from a unisex rate table due only to implementation of the **3-to-1 age compression** using HHS age factors. The combination of the ACA unisex requirements and required 3-to-1 age factors are shown in the chart in Figure 2.

As can be seen, **young males age 25 to 36 will see rate increases in excess of 50%**, while females 25 to 29 will see an average net rate increase of 4%. However, females aged 35 to 59 will see rate decreases up to 18%. **Males aged 55 and older will see rate decreases up to 15%.**

I have also looked at a premium rate schedule in which the female rates were already less than 3-to-1. The older females for this plan will have a rate increase instead of a rate decrease because the regulation does not allow a health plan to continue to use a rate slope less than 3-to-1 unless a state requires it.

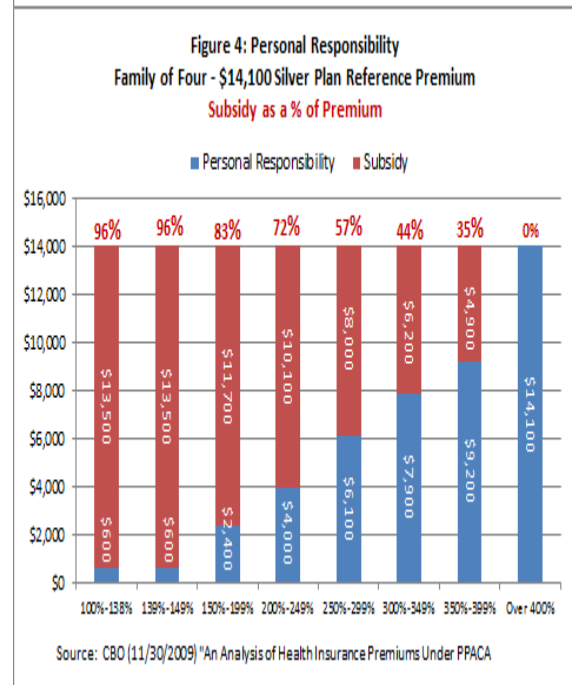
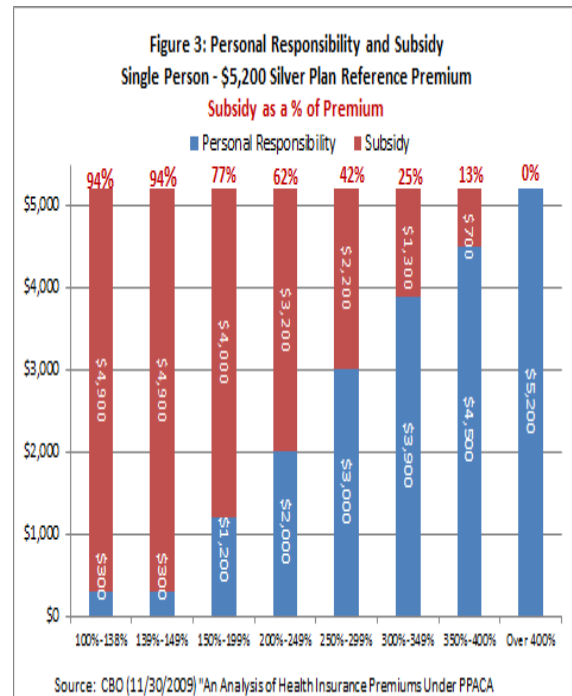
Premium and benefit subsidies. A hallmark provision of ACA is the availability of premium subsidies (prepaid tax credits) and cost-sharing reductions (CSR) for low- and middle-income people **who do not have access to affordable employer-sponsored insurance.** The CBO estimates that the **average subsidy** per subsidized enrollee (both tax credits and CSRs) will be **\$5,510** in 2014.²⁸ The premium subsidies equal the excess of the premium for the second-lowest-priced silver plan over a specific percentage of an individual's household income, which ranges from 2% for those in households 100% to 133% of FPL up to **9.5%** for those in the 301% to 400% FPL range. Our modeling indicates that this averages in 2014 to about 40% of the silver plan premium for the individual market, a very substantial benefit, making insurance much more affordable than it otherwise would be. For those opting for a bronze plan, the average subsidy would reduce premium rates even more. For some people in the lower income levels, no premium would need to be paid. However, by choosing a bronze plan rather than a silver plan, individuals with household incomes under 250% FPL would lose access to available cost-sharing subsidies (CSRs) associated with the purchase of silver-level exchange plans, which may be more cost-effective for them to purchase.



²⁸ Congressional Budget Office (February 2013). Effects of the Affordable Care Act on Health Insurance Coverage—February 2013 Baseline, Table 3.

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However, it should be noted that, while ACA provides premium subsidies to help low- and moderate-income Americans purchase insurance, **millions of other people will not be eligible for subsidies.** According to the Congressional Budget Office (CBO), more than 40% of people purchasing coverage in the individual market today would be ineligible for premium subsidies. Further, as shown in the charts in Figures 3 and 4, the amount of the subsidy declines significantly as incomes rise.²⁹ For example, single persons with incomes between 250% and 300% of FPL would receive subsidies sufficient to cover 42% of the cost of the second-lowest-cost silver plan. Those with incomes between 350% and 400% of FPL would receive subsidies sufficient to cover just 13% of the premium. For a family of four these percentages are 57% and 35%. The subsidies for families will be greater than those for a single person as a percentage of premiums. Subsidies will cover a greater percentage of bronze plan premiums than shown in the figures.

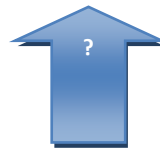


²⁹ Congressional Budget Office (November 30, 2009). An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act.

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Geographic rating. Health plans will no longer be able to define their own geographic rating areas, as they can in today's marketplace. The **geographic areas will be defined by states** or the federal fallback metropolitan statistical area (MSA) rule. The number of rating zones will be limited to one more than the number of MSAs in the state. Some states could set fewer zones. They can be defined only by MSAs, counties, or **3-digit ZIP Codes**.

**Lower Cost to
Higher Cost Zones:**



**Higher Cost to
Lower Cost Zones:**



Health plans will still be able to set their own geographic area factors for each rating zone, provided they are actuarially justified. This will impact premiums rates to the extent that the new rating areas will differ from those currently being used by health plans, which is highly likely. These impacts will vary by geographic area and health plan. Some people will see rate increases that are due to this change, while others will see their rates drop. The regulations do not allow for any type of transition for the changes. While the net impact over the entire state should be zero given a static population, rate changes (up or down) could be significant for those living in zones that get changed. There is too much variation by plan to evaluate the potential premium impact of this new ACA rule or even the number of people that will be affected by this change.

It should also be noted for individuals who receive a premium subsidy tax credit, out-of-pocket premiums are somewhat insulated from the impact of geographic rating, as an individual's premium expense for the second-lowest-cost silver plan will be capped at a defined percentage of income, regardless of the overall premium rate. For the population eligible for premium subsidies, geographic rating will mostly impact the federal government's cost rather than out-of-pocket premiums.

Thus, for certain individuals, particularly those younger or healthier, several more layers of costs will be added to premiums in 2014. Percentage reductions for older and sicker people will be lower than the increases for the young and healthy.

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OTHER CONSIDERATIONS

Catastrophic plan. ACA allows insurers to offer a “catastrophic plan” to people under age 30 and to anyone who is exempt from the individual mandate because of not being able to find affordable coverage or who is eligible for a hardship exemption. The catastrophic plan has an actuarial value less than 60% (it has been estimated to have a 57% AV), but enrollees are not eligible for a tax credit (premium subsidy), even if their household income is less than 400% of FPL. However, unlike the metallic plans, the pricing for the catastrophic plan can be adjusted to reflect the age mix and experience of those expected to purchase the plan, and it is in its own risk pool for risk adjustment purposes. These exceptions will allow lower pre-subsidy premium rates for this plan more than is likely to be available for the bronze plans.

While the ACA allowance of a catastrophic plan offers a lower-priced option to young and other eligible people, by effectively pulling it out of the single risk pool and making it more attractive to young people who tend to be the healthiest in the population, it increases the morbidity levels left in the single metallic plan risk pool and thereby will result in even higher premium rates for the metallic plans. The size of this impact is dependent on the percentage of the population that opts for the catastrophic plan instead of purchasing a bronze plan. Based upon the Milliman 2012 HCGs, if all of the adults under age 30 were to purchase a catastrophic plan, the metallic plan premiums would need to increase by almost 4%. Due to the availability of premium subsidies for metallic plans, this is not likely. However, those opting for catastrophic plans will likely be healthier on average than the twenty-somethings opting for metallic plans.

Risk mitigation. To mitigate adverse selection and pricing risk for issuers, ACA included three strategies: a transitional reinsurance program to partially reimburse plans for high-cost enrollees; a permanent risk adjustment program aimed at moving funds from plans with lower risk (and lower costs) to plans with higher risks (and higher costs); and a temporary risk corridor program.

The impact of the reinsurance program was discussed earlier. In theory, programs such as risk adjustment are designed to allow plans to price assuming they will get an average number of sick and healthy enrollees. The risk adjustment program may impact rates on a specific health plan basis, but over time will result in premium rates moving closer toward one another. The risk adjustment program may have little or no impact on the market premium rates as a whole. However, entering 2014, there remains much more uncertainty than in the current rating environment. The risk corridor program was created to help reduce the financial impact of mispricing that is due to the uncertainty. The overall goal of the risk mitigation is to encourage insurers to provide their best estimate premiums and limit the risk charges a health plan might otherwise include to account for potential adverse uncertainty. However, these programs will not be able to rectify all differences in actual plan risk, and insurers will need to balance risk mitigation program challenges with the remaining uncertainty as they set their 2014 premiums.³⁰

³⁰ National Association of Insurance Commissioners, Health Insurance and Managed Care (B) Committee (June 27, 2012). Rate Review White Paper.

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CONCLUSION

Insurers are facing an environment for 2014 that will be radically different than what we see today. Many new ACA requirements are guaranteed to increase health insurance premiums prior to the application of the premium tax credit subsidy. Additional requirements will further increase premiums for many, particularly younger or healthier individuals. An additional concern is that, when faced with high premiums, younger and healthier individuals may choose to forgo purchasing health insurance until they need it, which will only serve to increase costs for all other individuals in the healthcare system. The premium and cost-sharing subsidies available through ACA exchanges, along with the individual mandate requirement, should help assure their greater participation in the single risk pool. The ACA requirements are also likely to result in significantly lower out-of-pocket premium rates for individuals currently unable to afford insurance or individuals who struggle to pay insurance premiums on a monthly basis. Many of these individuals may have chronic health conditions, be near Medicare eligibility, or have limited financial resources. For the individual insurance market risk pool to remain a stable market in 2014 and beyond, it is vital that young and healthy individuals enter and remain in the insurance market in addition to individuals with an immediate need for healthcare services.

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RELIANCE AND LIMITATIONS

This analysis was prepared for America's Health Insurance Plans (AHIP) to provide illustrations regarding the potential impact of certain provisions of the Patient Protection and Affordable Care Act (ACA) on current premium rates. The analysis is not intended for other purposes.

In performing this analysis, I relied on data and information from various sources. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

I performed a limited review of the data used directly in this analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this assignment.

It is important to note that the actual premiums charged in 2014 will not necessarily reflect the estimates in this report. Instead, 2014 individual premiums are being determined now. They will depend significantly on how insurers expect costs to change under ACA. Differences between the estimates presented in this paper and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is highly likely that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Values were not normalized to account for the impact of influences that may be insurer-specific, including items such as provider network arrangements, distribution of business, risk pools, and market strategies. Assumptions used were intended to be reflective of the average nationwide market.

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