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# ***Report on Merging the Individual and Small Group Markets***

Prepared by PwC for  
Covered California

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*November 9, 2018*



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We performed a limited review of the data for reasonableness and consistency and believe that the overall data are reasonable.

If there are material errors or omissions in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Differences between the historical base data and future experience depends on unknown changes in policy and programs, and on the extent to which future experience conforms to the assumptions made in the report and by the reader. It is certain that actual impact of merging the individual and small group markets will not conform exactly to the results presented in the report.

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The results in this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely upon these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

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This document has been prepared pursuant to an engagement between PwC and Covered California and is intended solely for the use and benefit of Covered California and the California legislature and not for reliance by any other person.

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# Executive Summary

The Patient Protection and Affordable Care Act (ACA) required changes to the individual and small group health insurance markets beginning in 2014. As part of those changes, the ACA gave states the option to merge the individual and small group markets rather than maintaining separate risk pools. The purpose was to allow states to combine the markets to create larger risk pools that might better stabilize premiums and improve economies of scale.

The California State Legislature has asked Covered California to report to the Legislature on issues and considerations related to combining California's individual and small group markets into a single risk pool. PwC was engaged by Covered California to prepare this report, examining the advantages and disadvantages of merging the California individual and small group markets, including the impact on individual and small group premium rates.

This report and analysis summarizes PwC's observations and findings related to a merger of the individual and small group markets into a single risk pool.

## Market Overview

*The Individual and Small Group markets in California are both large, stable, and generally provide robust health plan options. They share common market and rating rules, but have significant differences in enrollee risk characteristics, available benefit and network options, and product selections.*

The Individual and Small Group markets in California are both large, stable, and generally provide robust health plan options. They share common market and rating rules, but have significant differences in enrollee risk characteristics, available benefit and network options, and product selections.

Both markets are roughly the same size at approximately 2 million enrollees, and are relatively stable despite federal actions altering the impact of the ACA. Both markets have robust health plan participation, although there are areas where low income individual enrollees have limited or no choice of health plans.

Both markets share similar market and rating rules -- guaranteed issue/renewability, no pre-existing condition exclusions, no health status rating, standardized rating formulas and age factors, EHB coverage, metal tiers, no annual or lifetime limits, same rating regions.

Each market has significantly different risk characteristics -- small group enrollees average 15%-20% lower risk (as measured by risk score) than individual enrollees. The markets also differ in product standardization, types of product and network offerings

Small groups tend to choose more generous benefit plans (near Gold on average) than individual market enrollees (Silver on average) due to factors such as low income subsidies tied to Silver plans, high

premiums that are fully borne by unsubsidized individuals, and contributions from employers for health coverage.

## Merged Market Policy Options

*There are a range of potential state policy options related to a merger of the individual and small group markets.*

There are a range of potential state policy options related to a merger of the individual and small group markets. Limiting the scope to combining each issuer's claims experience in the two markets for premium calculations would be the least disruptive option. This allows issuers to continue to use market specific adjustment factors to calculate the final premium. This is consistent with the assumptions underlying the report.

Expanding the scope - for example, requiring issuers to participate in both markets, to offer the same products and network options in both markets, requiring the same open enrollment periods in both markets, or requiring that rates be the same in both markets - would be significantly more disruptive.

## Premium Impacts

*Based on modeling of premiums using 2019 rate filings, merging the markets into a single risk pool is estimated to decrease individual market premiums by an average of 10% and increase small group premiums by an average of 11%.*

Based on modeling of premiums using 2019 rate filings, merging the markets into a single risk pool is estimated to decrease individual market premiums by an average of 10% and increase small group premiums by an average of 11%.

The effective subsidization of the individual market by the small group market if the markets were merged into a single risk pool has increased significantly from 2017 to 2019. The estimated increases to small group rates are 3.9% , 7.8%, and 10.8% based on 2017, 2018, and 2019 rate filings, respectively. This is primarily due to deterioration in the individual risk pool as a result of federal actions impacting the ACA that issuers anticipated in their pricing.

If markets were merged, the impact on 2019 rates would vary considerably among issuers due to differences in the relative size and risk of their enrollment in each market.

- *Issuers in both markets:* 2019 individual market premiums would decrease 5% to 16%, and small group market premiums would increase 4% to 65%. In response, health plans may change market participation, product and network offerings, and pricing assumptions.
- *Issuers in only one market:* rates are not expected to change significantly due to merging the markets, except for the projected impact on risk adjustment transfers in a single merged risk pool.

- The additional uncertainty caused by merging the markets may cause issuers to use more conservative pricing assumptions, resulting in higher premiums for both markets than the modeled results, at least temporarily.

The increases and the projected variation in rate increase to small groups are significant enough that they may have destabilizing effects on the small group market. Small group employers are less likely to offer health coverage to their workers and are often very price sensitive. If combined with more conservative pricing assumptions from the health plans, small group market shifts may occur relatively quickly. While this would be particularly disruptive to the small group market, it would challenge issuers in both markets.

## Regional Premium Variations

*Merging the markets would cause additional short-term premium volatility as issuers change to a single set of geographic rating factors for the merged market. It is not expected to have any material impact on the dynamic of higher premiums in Northern California versus Southern California.*

Merging the markets would cause additional short-term premium volatility as issuers change to a single set of geographic rating factors for the merged market. It is not expected to have any material impact on the dynamic of higher premiums in Northern California versus Southern California.

Issuers use geographic rating factors to reflect differences in healthcare delivery costs among the state's rating regions. In a merged market, issuers that operate in both markets would need to combine the geographic cost factors used in each market into a single set of factors

## Impacts to Consumers

*Consumers in the individual market would likely see significant reductions in premiums, although the reduction in consumer costs would be mostly experienced by unsubsidized enrollees. For subsidized enrollees, reductions in premiums would largely accrue to the federal government. Small employers and their employees would see premium costs increase.*

Consumers in the individual market would likely see significant reductions in premiums, although the reduction in consumer costs would be mostly experienced by unsubsidized enrollees. Small employers and their employees would see premium costs increase.

Subsidized enrollees are largely insulated from rate changes, and much of the benefit of lower individual premiums would accrue to the federal government through lower premium subsidy payments.

Reductions in premium costs for both subsidized and unsubsidized individual enrollees may be sufficient to attract new and lower risk enrollees to purchase coverage, which could improve the average risk mix in the individual market

Consumers may see wide variations in premium changes by issuer after markets are merged. Small group enrollees may

see fewer products or network options offered by their employers due to increases in premiums. Merging the markets is not expected to have any impact on the number of counties that have only a single health plan option for which low income enrollees can receive subsidies.

## *Lessons from Other States*

*The three states that have adopted a merged Individual and Small Group market have characteristics (e.g. very small size) that limit their relevance to California. A number of states studied the impact of merging the Individual and Small Group markets, but did not proceed due to increases in small group premiums that were considered unacceptable and risked creating instability in both markets.*

In reviewing experiences with other states that have implemented a merged market, none had similar size or stability in both markets as compared to California.

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## *Concluding Observations*

The individual and small group markets in California are both large and relatively stable at this time with sufficient issuer participation that most participants in these markets have a choice among a number of carriers and products. Issuers have adapted to provide products that meet the different needs of each. If the markets were merged, premiums for small groups would increase substantially while individual premiums would decrease, due to the subsidization of the higher risk individual pool by the lower risk small group pool. In order to save on premium costs, small employers are likely to offer lower cost products or more limited networks to enrollees, reduce contributions, move toward alternative funding arrangements that remove them from the risk pool (e.g., self funding), or stop offering coverage to employees altogether. All of these actions are detrimental to small group employees and employers, as well as to a merged risk pool.

Decreases in individual market premiums may encourage additional individuals to purchase insurance, particularly those who are most price sensitive such as younger and healthier individuals. This would positively impact the risk pool. However, since the federal government provides subsidies to a large percentage of enrolled individuals and the subsidies are based on premiums, subsidized enrollees are not expected to realize much of the benefit. Instead, the premium decreases largely accrue to the benefit of the federal government in the form of reduced premium subsidy costs. Only individuals who do not receive subsidies would receive the full benefit of the premium reductions.



In the short term, if the markets were merged there are clear winners and losers and a substantial amount of uncertainty. While merging the markets would create a larger risk pool, the separate California individual and small group risk pools are sufficiently large and stable. There is no evidence that a merged market would lead to reductions in health plan administrative costs due to economies of scale or reductions in duplication of resources. There is also no specific evidence that merging the markets would reduce or increase the number market participants or the level of competition, though the change may cause some companies to reconsider their market strategy.

Rather, the clear negative impacts to small employers due to premium increases will heighten uncertainty that may be disruptive to the small group market. Though the long term impacts of merging the markets cannot be predicted, there is strong evidence that in the short term merging the markets would have very significant impacts to premiums, and those changes would be highly destabilizing to both markets.

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# Introduction

## Background

The Patient Protection and Affordable Care Act (ACA) required changes to the individual and small group health insurance markets beginning in 2014. As part of those changes, Section 1312(C)(3) of the ACA gave states the option to merge the individual and small group markets rather than maintaining separate risk pools. The purpose was to allow states to combine the markets to create larger risk pools that might better stabilize premiums and improve economies of scale.

The California State Legislature has asked Covered California to report to the Legislature on issues and considerations related to combining California's individual and small group markets into a single risk pool. PwC was engaged by Covered California to prepare this report, examining the advantages and disadvantages of merging the California individual and small group markets, including the impact on individual and small group premium rates.

Currently, the individual and small group markets in California are separate and most, but not all, policies sold to individuals and small groups meet the requirements of the ACA reforms. The legislation requires some common market rules and benefit design across both markets:

- Require benefit plans to cover the ten essential health benefits
- Require benefit plans to meet minimum annual out of pocket limits and “metal level” actuarial value requirements<sup>1</sup>
- Prohibit pre-existing condition exclusions
- Prohibit health status underwriting
- Limit rating factors to age, geography and smoking status
- Require use of the federal age band relativity pricing factors, with a ratio limited to 3:1 (or an other approved set of factors)
- Require use of the same geographic rating regions. California established 19 rating regions.
- Require issuers to meet 80% minimum Medical Loss Ratio (MLR) thresholds or return the difference to members or employers as rebates.

Despite the common requirements, significant differences in premiums exist between the individual and small group markets. This is primarily due to differences in the population risk characteristics that drive healthcare costs. In a merged market, California's individual and small group markets would be combined into a single risk pool. As a result, each population would experience a change in premiums as one population subsidizes the other.

Only ACA-compliant plans are included in the issuers' single risk pool rate development and risk transfers. Compliant plans may be purchased on-exchange, through the Covered California marketplace and Covered California for Small Business (CCSB), or off-exchange, direct from the

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<sup>1</sup> Actuarial value and metal level refers to the expected percentage of healthcare costs the plan will pay. Actuarial values are 60% for Bronze, 70% for Silver, 80% for Gold and 90% for Platinum.

issuer or through brokers and general agents. Non-compliant plans<sup>2</sup> are rated separately and are not included in Centers for Medicare and Medicaid Services (CMS) risk transfer calculations. Over time, the percentage of individual and small group enrollees in non-compliant plans has declined, and currently approximately 90% of enrollees are in compliant plans<sup>3</sup>.

Risk adjustment is the only remaining premium stabilization program of the “3Rs” that were implemented in the early years of the ACA healthcare reforms.<sup>4</sup> The ACA prohibits issuers from adjusting premium rates to reflect enrollee health status, and risk adjustment is the mechanism that accounts for differences in the relative health status of each issuer’s enrollees through a transfer of funds between issuers<sup>5</sup>. To calculate each issuer’s transfer amount, CMS evaluates healthcare risk data submitted by the issuers throughout the year.

Exhibit 1 presents a comparison of CMS’ summary risk measures for California’s individual and small group markets for 2017 calendar year. It highlights that while the population size is similar in both markets, there are substantial differences in benefit selection and underlying risks. While the average 2017 individual market risk score is 17% higher than the small group risk score, the average individual market premium is lower due to enrollees’ tendency to select leaner benefits and plans with narrower networks relative to small group enrollees.

**Exhibit 1**  
**2017 Enrollment and Premiums for California**

Topic	Individual	Small group
Population size (member months)	2 Million Members (24.8 Million MM)	2 Million Members (24.0 Million MM)
Average metal level (actuarial value)	Silver (0.694 <sup>6</sup> )	near Gold (0.769)
Average risk score	1.306	1.115
Average premium PMPM	\$440.39	\$452.25

*Source: Center for Consumer Information & Insurance Oversight, CMS. Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year, Released July 9, 2018*  
<https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/>

This report and analysis assumes that the scope of a merger of the individual and small group markets into a single risk pool is limited to the calculation of premium rates (and ancillary risk adjustment

<sup>2</sup> California enacted restrictions on the renewal of individual and small group insurance policies that were not ACA-compliant. These plans are called “grandfathered plans” and “grandmothered plans”. Specifically, a grandfathered plan is a policy purchased on or before March 23, 2010 that may not include some rights and protections provided under the Affordable Care Act. Plans may lose grandfathered status if they are changed such that benefits are reduced or costs to consumers increase, such as any increase in a cost-sharing percentage or elimination of benefits to diagnose and treat a particular condition. Over time, the number of grandfathered plans has declined. As of the end of 2017, grandfathered plans enrolled 11% of the individual market and 10% of the small group market. Grandmothered plans are non-grandfathered health plans that were subject to a Federal Health and Human Services transition policy allowing insurers in the individual and small group markets to renew policies noncompliant with certain ACA insurance market reforms. These plans typically became effective after the March 2010 passage of the ACA, but before many of the ACA provisions went into effect. California required grandmothered plans to terminate at the end of 2015.

<sup>3</sup>2017 CDI and DMHC Enrollment Report

<sup>4</sup>The ACA established the “3Rs” - Risk corridors, Reinsurance, and Risk Adjustment - to help protect health insurance companies against unpredictable losses or unmanageable risk selection, and to stabilize consumer’s premiums in the early years of the law’s coverage provisions. Risk corridors and Reinsurance were temporary programs in place for the first three years (2014-2016 benefit years). Risk Adjustment is a permanent program.

<sup>5</sup> Issuers with enrollees with below average risk pay into the risk pool and the funds are distributed to issuers with enrollees with higher than the average risk. The amount of payer funds transfer is equal to the amount of receiver funds transfer.

<sup>6</sup> The average includes individuals enrolled in subsidized Cost-Sharing Reduction (CSR) plans at the 73, 87, and 94% levels

transfers) using a single risk pool comprised of issuers' combined experience of the two markets. U.S. Department of Health and Human Services (HHS) provides guidance in the Federal Uniform Rate Review Instructions<sup>7</sup> to issuers for the development of premium rates in states with a single (merged) risk pool. That guidance is the basis for the estimated premium impacts presented in this report.

The state could also consider other policy elements in a merger of markets, such as requiring issuers to offer the same products and networks in both markets or requiring health plans to offer coverage in both markets. And, in response to recent actions initiated by the Federal government, states may consider imposing an individual mandate, establishing a reinsurance program, or revising legislation on short-term limited duration (STLD) and association health plans (AHP).

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<sup>7</sup> "2018 Unified Rate Review Instructions Rate Filing ... - CMS.gov." 1 Jan. 2017, <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Unified-Rate-Review-URR-Reporting-Requirements-for-Single-Risk-Pool-Plans-OMB-0938-1141-Final-2018-URR-Instructions-Parts-I-II-and-III-.PDF>. Accessed 25 Sep. 2018.

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# *Current Market Assessment*

Though market and rating rules are largely consistent, the individual and small group markets are significantly different in several respects. Each of these markets varies in the number of participating issuers, particularly in certain regions. There are substantial differences in the variety of health plan benefit designs, in the breadth of provider networks offered in the markets, the underlying risk of the populations, and how issuers market and distribute coverage to enrollees. Despite the challenges since the implementation of the ACA, both markets in California have become more stable as issuers, consumers, and employers adapted to the new rules.

## *California Small Group Market*

California operates its own state based individual health exchange, known as Covered California, which is considered one of the most successful individual health insurance marketplaces in the country. Covered California contracted with 11 health plans for 2014, its first year of operation, and for 2019 it continues to offer coverage through 11 health plans. It has aggressively encouraged enrollment through extensive marketing and outreach. It is one of the largest exchanges in the country with approximately 1.4 million individual members and has had among the lowest annual premium rate increases of any state.<sup>8</sup>

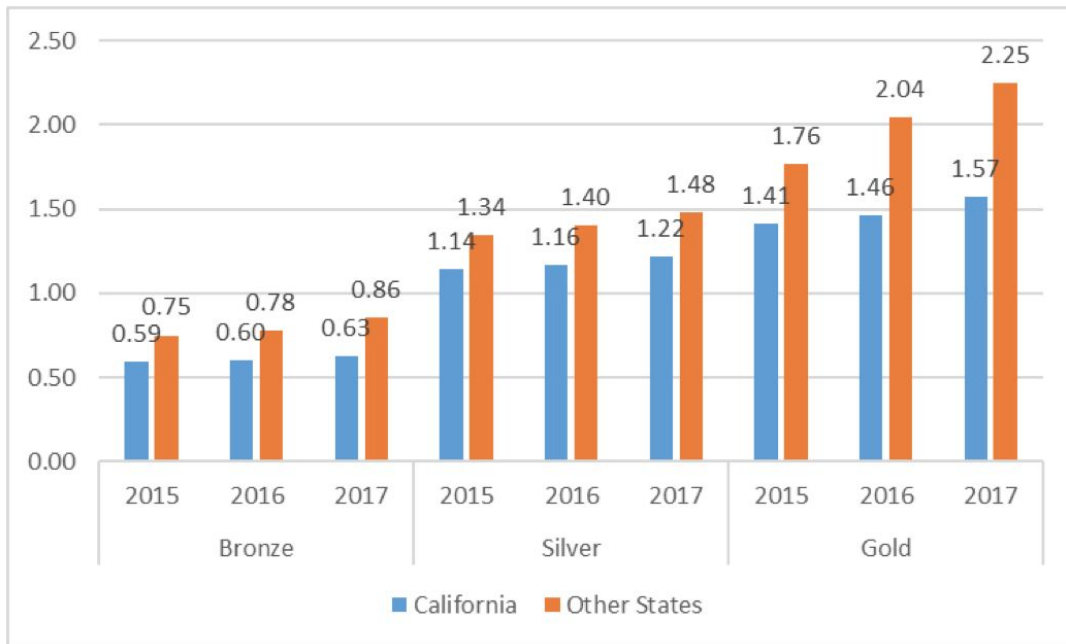
Covered California requires issuers to offer standardized benefit designs, which are mirrored throughout the individual market. Current rules require issuers to offer similar plans off-exchange as they do on-exchange, and at the same premium cost, before new plan designs can be added to off-exchange offerings. As of the end of 2017, there are about 600,000 additional individual members who enrolled in off-exchange plans. In total, California's Individual market covers over two million people and has among the healthiest risk mixes in the country.<sup>9</sup>

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<sup>8</sup> "National vs. California Comparison: Detailed Data ... - Health Affairs."  
<https://www.healthaffairs.org/doi/10.1377/hblog20180710.459445/full/>. Accessed 25 Sep. 2018.

<sup>9</sup> "National vs. California Comparison- Health Affairs."

**Exhibit 2**  
**Individual Market Risk Scores By Metal Level**  
**California Versus Other States<sup>10</sup>**



Source: *National vs. California Comparison- Health Affairs.* and *"Wakely National Risk Adjustment Reporting (WNRAR) | Wakely."* <https://www.wakely.com/services/product/wakely-national-risk-adjustment-reporting-wnrar>. Accessed 25 Sep. 2018.

The open enrollment period for 2018 coverage offered consumers a choice of 11 health insurance companies, with over 80% of consumers having a choice of three or more health plans<sup>11</sup>. Total on-exchange enrollment only declined by -2.3% compared to declines averaging -3.8% in states with federally facilitated marketplaces<sup>12</sup>. These positive signs remain true for the 2019 benefit year with all 11 health insurance companies returning, 96% of consumers able to choose from at least two health insurance companies, and 82% of consumers able to choose from three or more insurance companies.

<sup>13</sup>

## **California Small Group Market**

California is one of four states that expanded the definition of small group (initially 1-50 employees) to include firms with up to 100 employees, effective for plan renewals after January 1, 2016. There is a competitive small group health insurance market in California, with 10 health plans offering products either regionally or statewide, from both national and local issuers. Small group health plans must be ACA compliant, meeting essential health benefit design and actuarial value metal level benefit design. Any small group policy must be available to a group of any size, from 2 to

<sup>10</sup> "National vs. California Comparison- Health Affairs." and "Wakely National Risk Adjustment Reporting (WNRAR) | Wakely." <https://www.wakely.com/services/product/wakely-national-risk-adjustment-reporting-wnrar>. Accessed 25 Sep. 2018.

<sup>11</sup> "Insurer Participation on ACA Marketplaces, 2014-2018 | The Henry J ...." 10 Nov. 2017, <https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/>. Accessed 25 Sep. 2018.

<sup>12</sup> Burton, R. et al. What Explains 2018's Marketplace Enrollment Rates? Urban Institute; June 20, 2018.

<sup>13</sup> Covered California. Covered California's Health Insurance Companies and Plan Rates for 2019. Preliminary Rates, August 16, 2018. <https://www.coveredca.com/individuals-and-families/getting-covered/health-insurance-through-covered-california/>

100 employees, and use the same geographic and age premium adjustment pricing factors. The total small group market is estimated to cover slightly more than 2 million members<sup>14</sup>.

Covered California for Small Business (CCSB), the small group health exchange, offers standardized benefit designs under an employee individual choice model. The employee choice model was implemented in 2014, and allows small businesses to offer employees a choice of a single metal tier plan across multiple insurance issuers. Since 2015, small businesses have also have the option to offer two contiguous coverage levels.<sup>15</sup> Though CCSB enrollment has grown recently to nearly 50,000 enrollees, it represents a small share of the small group market.

In contrast to the individual market, there is no requirement for issuers to offer small group plan designs that mirror the CCSB benefit design in the off exchange market. CalChoice, a private small group exchange, offers a different mix of issuers and plan designs than CCSB, and has approximately 320,000 members.<sup>16</sup> Together, these two small group exchanges enroll 15%-20% of the small group market.

The majority of the small group market has plan designs that are ACA compliant, but vary across issuers in specific benefit design and provider network options. If the employer group meets size and participation requirements, groups may still have a choice of plans, either with multiple offerings from the same issuer, or a choice of plans from competing issuers. These are sold directly by issuers through their sales staff, and through broker, and general agent distribution channels.

## *Similarities and Differences*

Today, California's individual and small group market risk pools are both near equal size and are relatively stable, but have marked differences. Understanding how the two markets compare to each other helps frame key considerations when assessing the impacts of merging the two markets.

### *Market participation*

While there are a large number of health insurance issuers in California, the individual and small group insurance markets are both highly concentrated. As of 2017, the three largest health insurers, Kaiser, Anthem Blue Cross, and Blue Shield of California, enrolled an estimated 80% of the individual market and over 75% of the small group market.<sup>17</sup> Market share and rank vary substantially across the geographic regions, and some regional and local plans, such as Molina, Sharp, and Western Health Advantage may have significant market share in their home geographies. Exhibit 3 below illustrates California health plan's individual and small group market share as of December 2017.

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<sup>14</sup>DMHC and CDI enrollment report for 2017

<sup>15</sup> "Employee Choice - Health Affairs." 18 Sep. 2014, <https://www.healthaffairs.org/doi/10.1377/hpb20140918.841228/full>. Accessed 25 Sep. 2018.

<sup>16</sup> "Enrolling in a Private Health Exchange: a Good Idea for 2017 - My ...." <https://www.mycalchoice.com/enrolling-private-health-exchange-good-idea-2017/>. Accessed 25 Sep. 2018.

<sup>17</sup> 2018 DMHC and CDI enrollment reports.

**Exhibit 3**  
**2017 Enrollment and Market Share by Health Plan**

	<b>Individual</b>		<b>Small Group</b>	
	<b>Enrollees (in thousands)</b>	<b>Market Share</b>	<b>Enrollees (in thousands)</b>	<b>Market Share</b>
Blue Shield of California	636	32%	526	26%
Kaiser	562	28%	683	33%
Anthem Blue Cross	380	19%	372	18%
Health Net	164	8%	99	5%
Molina Healthcare	139	7%	0	0%
United Healthcare	0	0%	183	9%
Aetna	0	0%	60	3%
Sharp Health Plan	32	2%	30	1%
Western Health Advantage	15	<1%	56	3%
CCHP	12	<1%	2	<1%
Sutter Health Plan	2	<1%	32	2%
Others	48	2%	0	<1%
<b>Total</b>	<b>1,990</b>		<b>2,043</b>	

*Source: CA DMHC and CDI 2017 Enrollment Summary Reports; Excludes self-funded lives and grandfathered plans  
 Anthem Individual enrollment prior to January 1, 2018 withdrawal from most of the state regions. Individual  
 market share estimated to be 5-7% in 2018*

**Premium rate setting**

The Unified Rate Review Template is required to be used by issuers to prepare and submit rates to regulators for all non-grandfathered plans in the individual and small group markets. The rating formula applied in the URRT, the 19 California rating regions, and the federal age factors are the same for each market.

Issuers are allowed to use different geographic cost factors, which reflect variations in provider cost and healthcare delivery, in each market. Additionally, issuers may vary pricing assumptions such as trend between the two markets, and they may vary rating factors such as administration and distribution cost loads and cost sharing factors.

While the rate setting processes for the individual and small group markets are very similar, there are some differences that need to be considered. Exhibit 4 below summarizes these differences:

**Exhibit 4**  
**Premium Rate Setting Cycle Differences between Individual and Small Group Markets**

<b>Individual</b>	<b>Small Group</b>
<ul style="list-style-type: none"> <li>• Rates are effective January 1</li> <li>• Rates are set once a year leading up to calendar year open enrollment</li> </ul>	<ul style="list-style-type: none"> <li>• Policies can be effective at any point in time and premium rates are guaranteed for 12 months</li> <li>• Rates are allowed to be adjusted quarterly for new and renewing groups</li> </ul>

The URR Instructions provide guidance for handling these differences in a merged market so they are not a barrier to rate setting.



Further detail on premium rate setting can be found in section titled Estimated Premium Impacts.

**Risk Mix**

Due to differences in the composition of the populations covered in the individual and small group markets (see Exhibit 5), there are differences in the underlying risk and cost of the populations. For benefit years 2014 to 2016, the California individual market risk score has been consistently higher than the small group market risk score. This is consistent with the experience of most other states.

Small group enrollees are typically actively working and receive premium contributions from their employer. As a result, they are more likely to enroll in coverage and represent a relatively good risk mix. California’s expansion of the small group definition up to 100 employees increased the size of the population base and may have improved the risk mix.

In the individual market, higher income (over 400% federal poverty level) enrollees pay the entire premium. These individuals tend to be relatively price sensitive and those that purchase coverage tend to be higher than average risk. Lower income individuals, especially young and healthy individuals are also very price sensitive, and even with subsidies those who are younger and healthier tend to forego healthcare coverage.<sup>18</sup>

The tendency for lower risk individuals not to enroll, and conversely, the tendency for higher risk individuals to enroll is known as adverse selection, and it leads to higher premiums. Adverse selection is a threat to any risk pool, and if not adequately controlled it may lead to a death spiral of high rate increases to cover the worsening risk.

**Exhibit 5  
Drivers of Risk Mix Differences between Individual and Small Group Markets**

Individual	Small Group
<ul style="list-style-type: none"> <li>• Composed of workers without employer sponsored coverage, those who are older and not working, and those who may have chronic or disabling conditions and may not be working</li> <li>• 47% do not get premium subsidies and pay full cost</li> <li>• 53% are lower income (&lt;400% FPL) receive premium subsidies to purchase health insurance on-exchange<sup>19</sup></li> <li>• Of those with premium subsidies, 75% are eligible (&lt;250% FPL) for assistance to reduce deductible and</li> </ul>	<ul style="list-style-type: none"> <li>• Generally composed of actively working individuals and their dependents – on average younger than the individual market</li> <li>• Receive contributions from employer to help cover premium costs</li> <li>• Issuers require minimum group participation which reduces adverse selection</li> <li>• California is one of four states to expand definition of Small Group to include employers with 51-100 employees; larger pool may improve risk mix <sup>21</sup></li> </ul>

<sup>18</sup> "Identifying And Fixing The Individual Market's Central ... - Health Affairs." <https://www.healthaffairs.org/doi/10.1377/hblog20180727.541089/full/>. Accessed 25 Sep. 2018.

<sup>19</sup> Covered California enrollment report, DMHC and CDI enrollment report

<p>copayment/coinsurance cost sharing requirements.<sup>20</sup></p> <ul style="list-style-type: none"> <li>California Individual market has a state average risk score of 1.306 in 2017</li> </ul>	<ul style="list-style-type: none"> <li>California small group state average risk score of 1.115 in 2017.</li> </ul>
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**Enrollment and Distribution**

The way consumers purchase coverage differs between the individual market and small group market. Whether they are purchased directly from an insurance carrier or through a broker or third party, the costs associated with marketing and selling these products varies. For example, small groups often utilize brokers to purchase health coverage for employees, and those brokers are able to help place other types of coverage for a group. Individuals on the other hand enroll directly with the exchange or healthplan so marketing and education is key. Exhibit 6 below outlines some of these differences.

**Exhibit 6  
Consumer Outreach and Enrollment Differences between Individual and Small Group Markets**

Individual	Small Group
<ul style="list-style-type: none"> <li>Limited Open Enrollment Period (OEP) for the next calendar year. In CA, this will be October 15, 2018 to January 15, 2019 for CY 2019.</li> <li>Special Enrollment Period (SEP), outside of OEP, limited to “life events” (e.g., loss of coverage, marriage, birth of a child). Must enroll within 60 days of life event</li> <li>Ability to purchase plans online or with assistance of call center counselor, navigator, or broker agent</li> <li>Covered CA has historically budgeted significant funds for marketing and outreach.</li> <li>Issuers have been able to reduce their individual distribution costs through lowering payments to insurance agents and brokers<sup>22</sup></li> </ul>	<ul style="list-style-type: none"> <li>No restricted Open Enrollment Period. Small groups enroll and renew throughout the calendar year</li> <li>Employers typically leverage a broker to assist with purchase. May also use broker to purchase other benefits and payroll services.</li> <li>Less reliance on marketing and outreach as products are often sold through brokers or other general agents,</li> <li>Commissions are higher than in the individual market - about 5-6% of premium<sup>25</sup></li> </ul>

<sup>21</sup> Although California expanded its definition of “small group” in 2016, there is no evidence that group in the expanded definition joined the small group market. Some groups from 51-100 employees may have gone self-insured, excluding them from the market risk, or made other adjustments (i.e., add headcount) to exclude them from the market.

<sup>20</sup> Covered California enrollment report

<sup>22</sup> "Marketing Matters - California's Health Benefit Exchange - Covered ...."  
[http://hbex.coveredca.com/data-research/library/coveredca\\_marketing\\_matters\\_9-17.pdf](http://hbex.coveredca.com/data-research/library/coveredca_marketing_matters_9-17.pdf). Accessed 25 Sep. 2018.

<ul style="list-style-type: none"> <li>• Broker agent commissions are typically lower for individual market - about 1.5% of premium or a flat PMPM rate<sup>23</sup>. Some issuers have discontinued or reduced commissions for SEP enrollments<sup>24</sup></li> </ul>	
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**Networks**

Due to variation in the risk and the price sensitivity of each market, the underlying provider networks for the various plans tend to differ between the two markets. Small groups are looking for more flexibility in network options, and due to employer demands, issuers have kept broader networks in place for their small group products and offer broad and narrow HMO and PPO provider networks. In the individual market, issuers use networks as a lever to reduce costs resulting in narrower networks for individual consumers. On the Covered California exchange, only two issuers offer a PPO product, one statewide and the other limited to southern California.<sup>26</sup>

<sup>25</sup> "Agent Commission Structure - Covered California." 1 Dec. 2017, <https://www.coveredca.com/agents/PDFs/Agent-commission-schedule.pdf>. Accessed 26 Sep. 2018.

<sup>23</sup> "Marketing Matters - Covered California"

<sup>24</sup> California Marketplace May Require Insurers To Pay Agent Commissions

Chad Terhune - <https://khn.org/news/california-marketplace-may-require-insurers-to-pay-agent-commissions/>

<sup>26</sup> Covered California. Covered California's Health Insurance Companies and Plan Rates for 2019. Preliminary Rates, August 16, 2018.

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# Estimated Premium Impacts

## Introduction

In a merger of the individual and small group markets into a single risk pool, each issuer would calculate premiums using the combined experience of all of their non-grandfathered individual and small group enrollees. Due to differences in the underlying risks of these two population groups, combining their experience means that enrollees in both groups would experience a change in premium rates. In addition, issuers that only operate in one of the two markets would need to evaluate their premium rates because of changes in the calculation of risk adjustment transfers under a merged market as well as potential premium changes of competitors.

## Methodology

To estimate the changes in premiums from merging the markets, data were collected from publicly available individual and small group rate filings for rates effective in 2017, 2018, and 2019. The rate filings are submitted to the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) using the Federal Unified Rate Review Template (URRT), which standardizes much of the rate development process and facilitates comparisons between issuers. In addition to data from the URRTs, information contained in Supplemental Rate Review Templates (SRRTs) and actuarial memorandum submitted with the rate filings were used in the analysis.

The Unified Rate Review Instructions provide rate development direction to issuers in states with merged (combined) markets. That guidance and URRT formulas were used with data obtained from the rate filings to calculate merged market premiums for several issuers representing majority of enrollment in both markets. These calculations form the basis for the findings in this section.

## Estimating Premium Impact Using Market Adjusted Index Rate

The premium rate offered to each consumer reflects the benefit plan selected and allowable rating factors such as enrollee age and geography. The calculation of a consumer's premium rate can be summarized using the following formula:

$$\begin{aligned} \text{Consumer premium rate} &= \\ &\text{Market Adjusted Index Rate (used for all of issuer's products in the market)} \\ &\quad \times \\ &\text{Product specific factors (actuarial value, provider network, administrative} \\ &\quad \text{and distribution costs)} \\ &\quad \times \\ &\text{Geographic cost factor (calibrated to 1.0 average for issuer)} \\ &\quad \times \\ &\text{Age factor (calibrated to 1.0 average for issuer)} \end{aligned}$$

The “market adjusted index rate” is calculated by each issuer for each market, and it is reported in each issuer’s rate filings. It represents the issuer’s projected market average healthcare costs per member per month (PMPM) before the application of cost sharing and adjusted to reflect the estimated statewide average market risk.<sup>27</sup>

The market adjusted index rate is the base multiplier rate used to determine premiums for every benefit plan offered by the issuer in the market. Thus, the premium impact from merging the markets can be estimated by comparing an issuer’s market adjusted index rate in a merged market to the issuer’s market adjusted index rate for the individual and small group markets.

### *Calculation of Merged Market Adjusted Index Rates*

For each issuer participating in both the individual and small group markets, the merged market adjusted index rate was calculated taking the average of the issuer’s individual and small group market adjusted index rates, weighted by projected member months, both as reported in the issuer’s rate filings. To aggregate market adjusted index rates across issuers, projected member month weighting was applied in a similar manner.

The projected risk adjustment transfer embedded in the market adjusted index rate can have a significant impact on an issuer’s premium rates and is discussed in more depth below. Estimation of risk adjustment transfers is complex, and estimating the impacts on risk adjustment under a merged market is beyond the scope of this engagement. Merged market adjusted index rates were not calculated for issuers that operate in only one market since the only impact to their rates would be due to the effects on risk adjustment transfers in the combined market. For the purposes of these calculations, an issuer’s projected risk adjustment transfer in a merged market was assumed to equal the sum of the issuer’s projected risk adjustment transfers in the individual and small group markets.

Although the adjustments may be recalibrated under a merged market, the methodology used in this analysis assumes all adjustments that are applied to the market adjusted index rate do not change if the markets are merged.

### *Data*

Publicly available data from 2017, 2018, and 2019 individual and small group rate filings were extracted and summarized for the health plans representing the largest market share in each market - Kaiser, Blue Shield of California, Anthem, Health Net, United Healthcare, Molina Healthcare, and Aetna. Combined, the selected health plans make up over 90% of enrollment in both the individual and small group markets as illustrated in Exhibit 3, 2017 Enrollment and Market Share by Health Plan.

### *Assumptions and Limitations*

While these calculations provide a reasonable basis for projecting the impact on premiums, there are significant limitations in the ability to precisely estimate premium impacts due to a merged market. This is partly because the rate filings do not all contain complete information, but also because the actions of issuers cannot be precisely predicted. In addition, the following assumptions and limitations apply to these estimated premium impacts:

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<sup>27</sup>The market adjusted index rate also includes the issuer’s exchange fees.

- No changes in issuers' projected enrollment, market share, or rating factors are assumed to occur as a result of merging the markets.
- Projected risk adjustment transfers are a material component of many issuers' premium rates. Incomplete information, as well as the complicated nature of risk adjustment transfer calculations limits the ability to accurately estimate impacts to issuer projected risk adjustment transfers. The rate filings and actuarial memorandum include the issuer's estimate of the net transfer. For calculation purposes, the issuer's projected risk adjustment transfers in a merged market were assumed to equal the sum of the separate individual and small group projected risk adjustment transfers.
- Geographic cost factors (GCFs) are developed by each issuer to vary premium rates by regions based on differences in provider costs. These GCF differences reflect issuer contracted rates, provider networks and utilization of the enrolled population. Merging markets requires each issuer to consolidate its GCFs into a single set used for both markets. Issuers may adjust the merged GCFs in ways that cannot be predicted.
- Merging individual and small group markets may affect an issuer's pricing assumptions. For example, issuer may modify their GCFs to be more competitive in certain regions in a merged market.
- Merging individual and small group markets may affect an issuer's decision to participate in one or both markets. For calculation purposes, no change in issuer participation were assumed.
- Individuals and small groups will shop for lower premium rates or may drop from the market if they receive a significant premium increase due to merging the markets. Consumers and employers shopping for lower premiums would likely shift enrollment into lower value health benefit plans and would dampen the effective average rate increases. To the extent individuals and small groups drop coverage, risk mix would be expected to deteriorate and premium rate increases could be greater.

Despite these limitations, these calculations form a reasonable basis for quantifying impacts on rates due to merging the markets.

## Findings

### *Premium Impacts (Market Adjusted Index Rate)*

Exhibit 7 shows a summary of the average market adjusted index rates calculated for each market for the issuers included in the analysis. It shows market adjusted index rates that have increased at a much faster rate in the individual market than the small group market, and as a result the individual market adjusted index rate increased from 8% higher than small group in the 2017 rates to 23% higher in the 2019 rates. For comparison, Covered California reported average rate increases of: 12.5% in 2018 (excluding the CSR surcharge) and 8.7% in 2019 for its individual plans, and increases of 5.6% in 2018 and 4.6% in 2019 for its small group plans<sup>28</sup>.

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<sup>28</sup> Covered California. Covered California's Health Insurance Companies and Plan Rates for 2019. Preliminary Rates, August 16, 2018.

**Exhibit 7**  
**2017 - 2019 Average Market Adjusted Index Rates**  
**For Select Issuers**

		Individual	Small Group	Merged
Projected Member Months (in millions)	2017	24.9	23.9	48.7
	2018	21.0	24.0	45.0
	2019	21.2	24.5	45.7
Market Adjusted Index Rate	2017	\$492	\$457	\$475
	2018	\$541	\$464	\$500
	2019	\$600	\$487	\$540
% Change in Market Adjusted Index Rate	2017-18	10.0%	1.5%	5.3%
	2018-19	10.9%	5.0%	8.0%

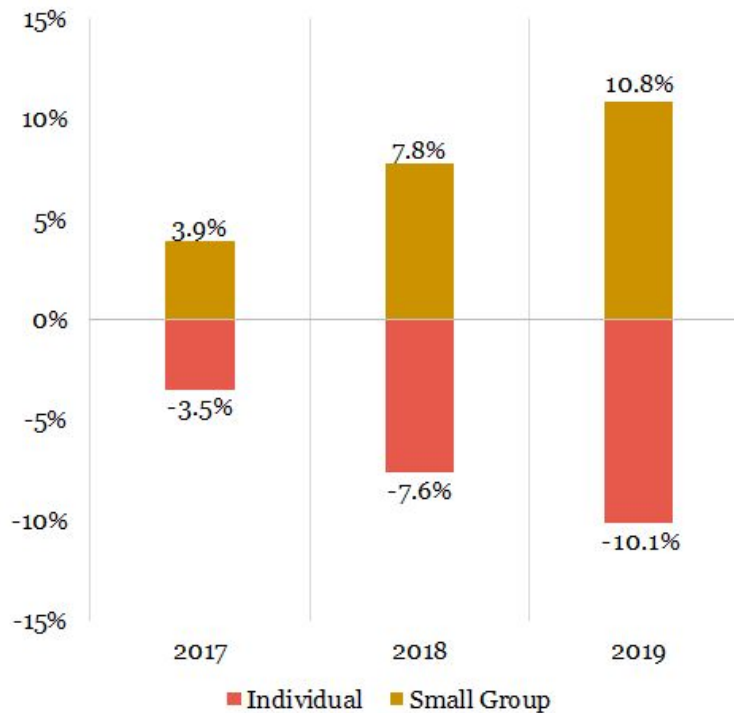
*Source: 2017 - 2019 CA DMHC and CDI Rate Filings*

The excess increases in individual market premiums compared to small group can be attributed predominantly to federal policy decisions that have eliminated some of the foundational elements of the ACA, particularly the elimination of the individual mandate penalty.<sup>29</sup>

The ratio of the merged market adjusted index rate to the individual and small group market adjusted index rate provides the estimated impact on rates due to merging the markets into a single risk pool. The resulting changes in premiums are shown in Exhibit 8.

<sup>29</sup> The individual mandate requires individuals to purchase a health insurance policy, or face a tax penalty. The purpose of the individual mandate is to encourage low risk individuals to buy health insurance, as they help preserve a healthy risk mix which helps slow the rate of premium growth. At the end of 2017, Congress passed the Tax Cuts and Jobs Act of 2017 that included elimination of the individual mandate penalty, which will take effect January 1, 2019. Issuers reflected the expected deterioration in risk in their 2019 individual rates, but the increases were less than many anticipated. There is anecdotal evidence is that some insurers anticipated the change in policy and included some expected deterioration in risk in their 2018 individual rates, reducing the impacts on 2019 rates. While there may be some impact to the small group market, expert opinion is that the effects will be minimal.

**Exhibit 8**  
**Estimated Change in Statewide Average Premiums**  
**Due to Merging the Markets**  
**For Select Issuers**



*Source: 2019 DMHC and CDI Rate Filings*

As shown in Exhibit 8, merging the markets is estimated to decrease individual market rates and increase small group rates by approximately offsetting percentages. The graph also demonstrates the impact that the deterioration of the individual market risk pool, as projected by issuers, would have on small group employers if the markets were merged into a single risk pool.

Though the graph shows premium impacts that increase significantly each year, future premium impacts would depend on future federal or state policy changes that affect market risk or other significant changes that impact the number and risk of enrollees in each market (such as economic disruptions). To the extent a change creates imbalances in the relative size of California’s individual and small group markets or increases the premium differential, the approximately equal and opposite effects on premium would change.

Analysis indicates that for issuers operating in both markets, rate decreases for individuals would range from 5% to more than 16%, compared to the statewide average decrease of approximately 10%. Conversely, small group rate increases would range from 4% to more than 65%, compared to the statewide average increase of approximately 11%. The range in issuer results is due primarily to differences in the relative sizes, risk, and costs of each issuer’s individual and small group enrollees. Similar calculations performed by issuers could lead them to make changes in pricing assumptions or influence their decision to participate in one or both markets.

Although the calculation of a merged market adjusted index rate assumes no effect on single market issuers, risk adjustment transfers are expected to impact merged market rates as the market risk scores would include both members from individual and small group markets. Estimating these



impacts is beyond the scope of this analysis, though risk adjustment considerations are discussed in the following section.

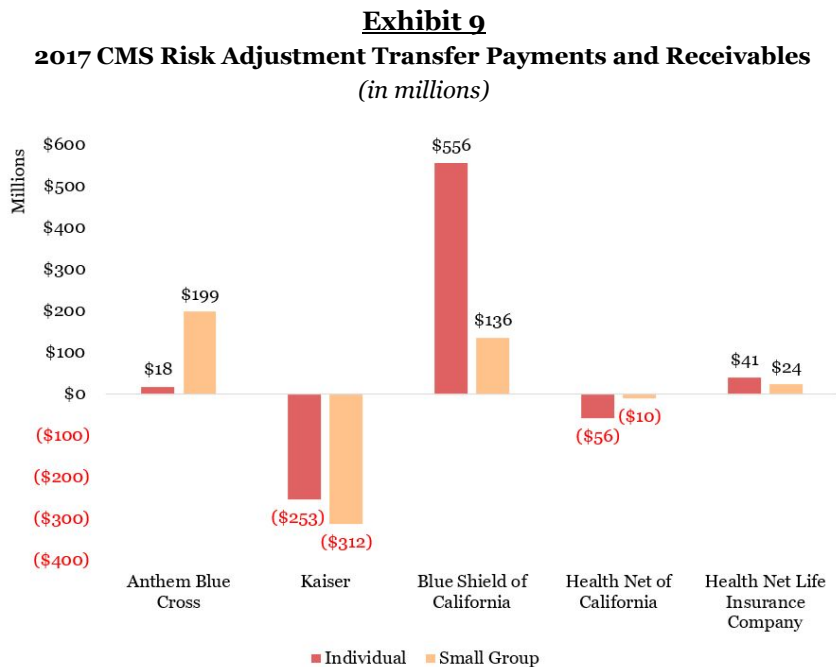
## Factors Adding Uncertainty and Variation in Premium Rates

### Effects of a Market Merger on Risk Adjustment Payments and Receipts to Plans

The ACA established a permanent risk adjustment program to transfer payments from issuers with relatively healthier populations to issuers with relatively sicker populations, thereby reducing incentives for issuers to avoid higher risk enrollees. Transfer payments are calculated separately within each risk pool - individual, small group, and catastrophic. A merged market would combine the individual and small group risk pools, with catastrophic members remaining as a separate risk pool.<sup>30</sup>

Given the limitations in available data with respect to each issuer's relative risk, it is not possible to estimate the impact that merging the markets would have on each issuer's risk adjustment transfers. Even for issuers that operate in a single market, merging the markets would affect their total risk adjustment transfers due to changes in the overall market risk. While issuers would likely develop their own models to predict risk adjustment transfers in a merged market, discussions with issuers indicate that the significant amount of uncertainty would lead them to be conservative in their premium estimates, at least in the initial years of merging the markets.

To evaluate the impact of risk transfers on premium rate development, risk transfer data from CMS and premiums from rate filings were analyzed. Due to differences in risk mix and enrollment between the individual and small group markets, an issuer operating in both markets may have large differences in transfer amounts by market (see Exhibit 9 below).

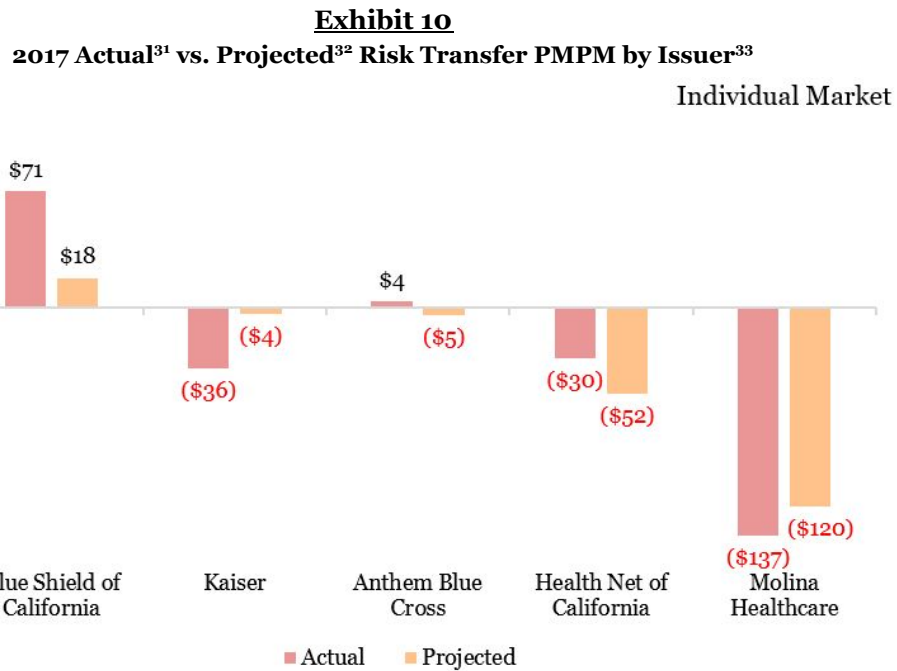


Source: Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year

<sup>30</sup> Patient Protection and Affordable Care Act 2.1010.2013 at 15418

Each issuer projects its expected risk transfer payment or receivable and reflects that impact in each year's premium rates. Transfer payments are a function of each issuer's risk relative to the statewide average, and each issuer must estimate their risk relative to their competitors without complete information, which invariably results in some differences.

Using rate filing data from DMHC and risk adjustment transfer payments published by CMS, the projected risk transfers included in each issuer's 2017 premiums were compared against their actual risk transfers for the 2017 plan year. Exhibit 10 shows that issuers have projected risk adjustment transfers with varying degrees of accuracy.

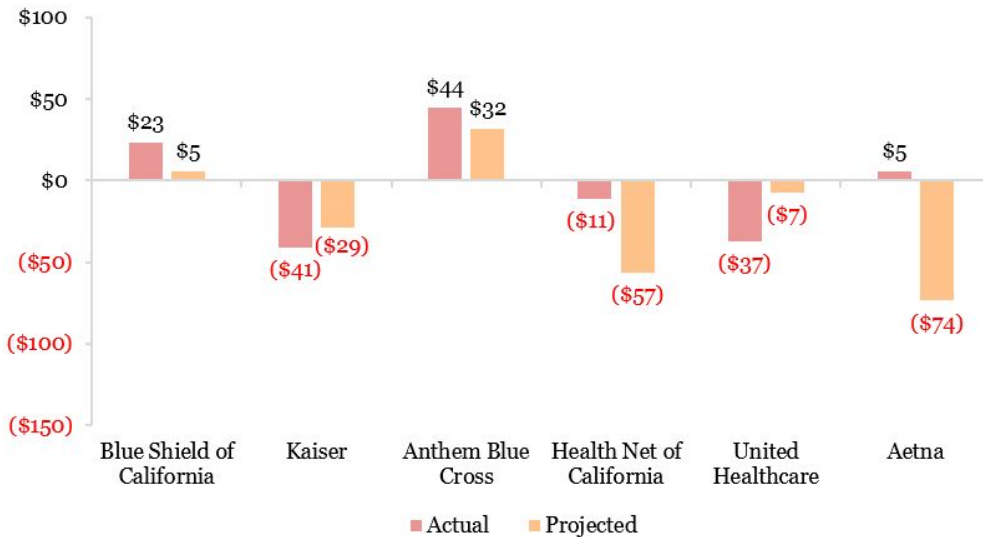


<sup>31</sup> Actual transfer PMPM is calculated by taking the 2017 risk adjustment transfer payment or receivable published by CMS and dividing it by the 2017 experience period member months from each issuer's 2019 DMHC URRT

<sup>32</sup> Projected transfer PMPM is calculated by taking the projected 2017 risk adjustment transfer amount and dividing it by the projected 2017 total premiums, both of which are included in each issuer's 2017 DMHC URRT

<sup>33</sup> For comparison purposes by issuer, HIOS ID filed in DMHC was matched against HIOS ID in 2017 CMS Risk Adjustment Transfer Payment report

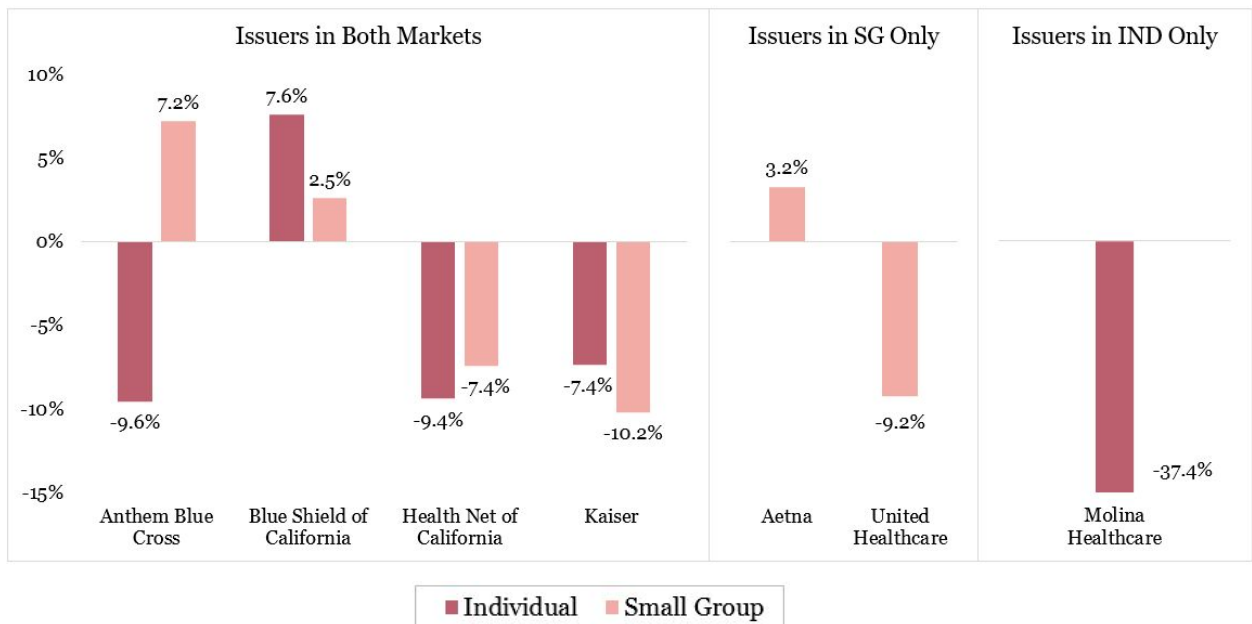
### Small Group Market



Sources: 2017, 2019 DMHC Rate Filings; Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year

To demonstrate how material risk transfers are to issuer premiums, the projected risk adjustment transfers were converted to a percent of premium (see Exhibit 11). As the chart indicates, the transfer amounts may represent a significant percentage of the premium revenue issuers receive for enrollees.

**Exhibit 11**  
**2019 Projected Risk Transfer Payments as % of Projected Premium**



Source: 2019 Rate Filings

The key takeaway is that risk adjustment constitutes a material component of the projected premium rates and must be carefully considered in a merged market scenario. The analysis indicates that there is significant variability in 1) risk adjustment amounts each year and 2) accuracy of issuer risk transfer

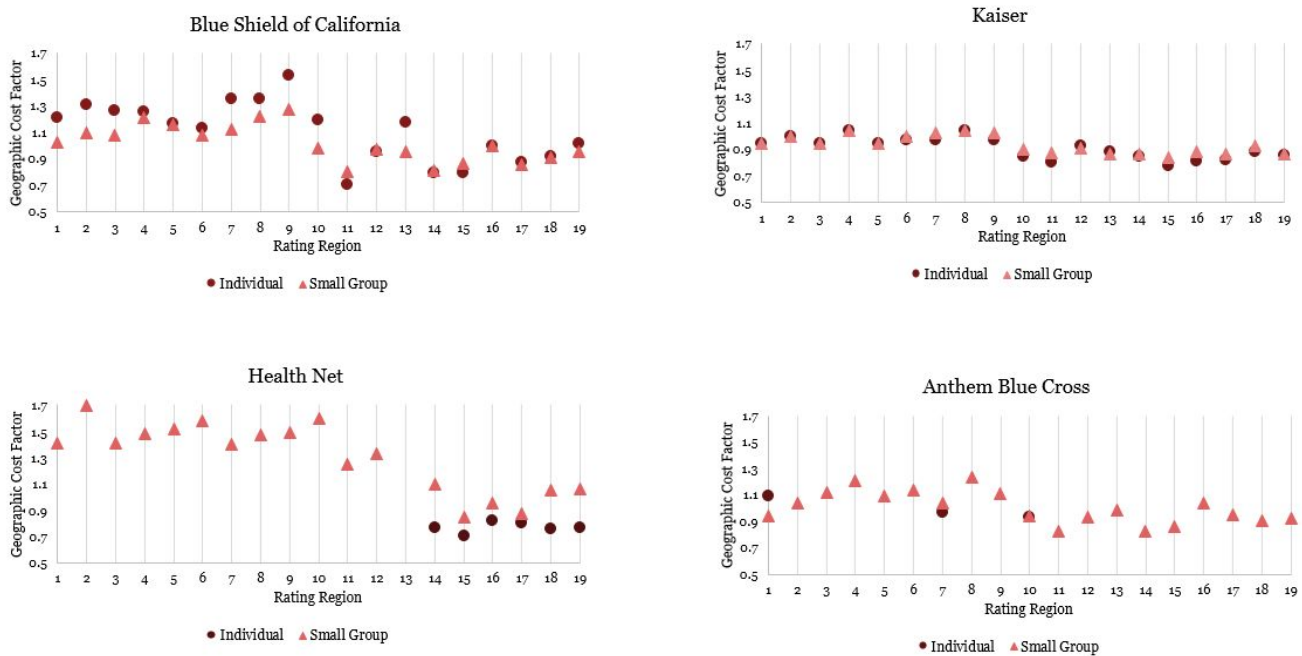
estimates. Estimation and projection of expected risk adjustment transfers under a merged market would introduce further uncertainty.

## Geographic Cost Factors

Geographic cost factors (GCFs) are used to calculate premiums for each region. They reflect geographic differences in the costs of delivering care, and they vary widely among the 19 rating regions in California. Issuers can establish separate GCFs for each market, however, 45CFR 156.80 (d)(3) requires issuers in states with merged markets to establish a single set of GCFs to reflect the combined risk pool.

Exhibit 12 shows the GCFs from the 2019 rate filings of the four insurers that operate in both markets.

**Exhibit 12**



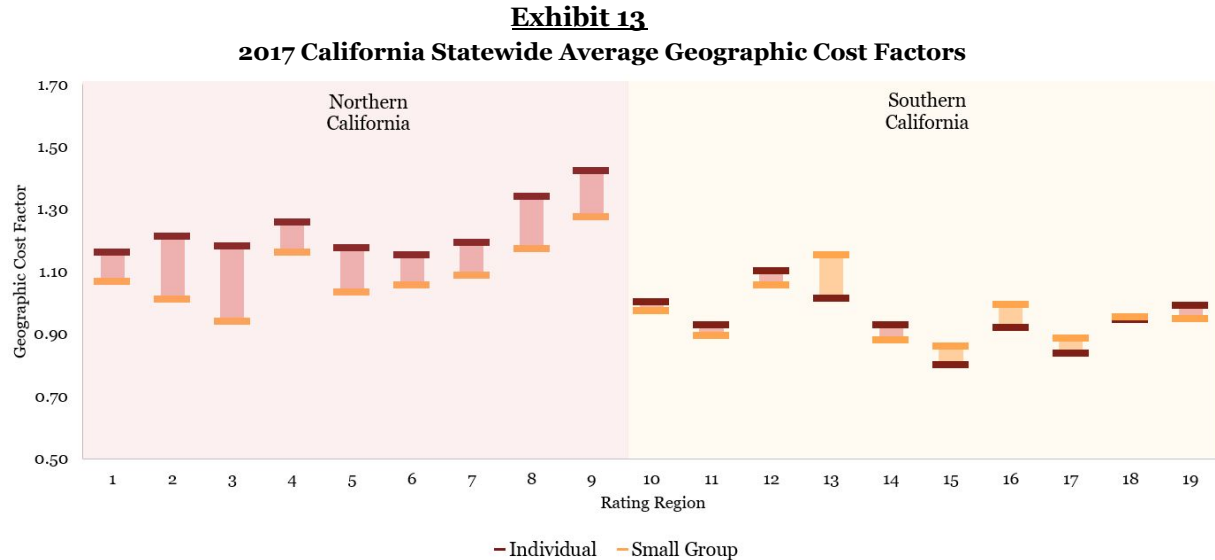
### **Projected 2019 Geographic Cost Factors by Issuer**

*Source: 2019 DMHC Rate Filings*

As shown in these charts, in some cases there are large differences in the GCFs used by issuers in each market. Each issuer would need to consolidate its GCFs to reflect regional cost differences in the merged market. GCFs are determined by each issuer and should be driven by network and care delivery costs. Additionally, issuers may adjust GCFs to increase market competitiveness. As a result, drawing conclusions on how issuers will merge their individual and small group GCFs by region is challenging.

Regional differences in costs can be substantial. For example, Covered California reported that the average 2018 individual market premium in Northern California was nearly 32% higher than the premium for the same person living in Southern California, and premiums were as much as 78%

higher when comparing the San Francisco region to the Los Angeles region<sup>34</sup>. Merging the individual and small group markets is unlikely to significantly change this dynamic. However, a comparison of the statewide average GCF in 2017 (see Exhibit 13) suggests that consolidating the individual and small group GCFs could result in a slight reduction in the difference between Northern and Southern California premiums. Since issuers have considerable liberty in setting their GCFs to align with their pricing strategy and product and network offerings, it is difficult to predict how issuers will adjust their GCFs in a merged market.



Source: Appendix B to 2017 Benefit Year Risk Adjustment Summary Report - HHS Risk Adjustment Geographic Cost Factor

## Summary

Based on our analysis and assuming no major changes in these markets, merging the individual and small group risk pools would have almost equal and opposite effects on each market’s statewide average premiums. The calculation of a merged market adjusted index rate indicates that on average, the projected 2019 individual market rates would decrease by approximately 10% while the small group market rates would increase by approximately 11%. Due to differences in risk mix, market participation, and product offerings, each issuer’s individual and small group premiums differ and may vary significantly outside of the statewide averages.

While the merged market adjusted index rate provides a reasonable basis for quantifying impacts on rates, it does not incorporate all the factors that are applied to develop premium rates. This assumes those issuer specific factors, such as risk adjustment transfers and geographic cost factors, which can materially impact each issuer’s premium development, do not substantially change compared to current values. Due to the complex nature of these adjustments and the significant latitude issuer’s have in generating these factors, it is difficult to predict how issuers would react under a merged market.

<sup>34</sup> This would generally hold true for Off-exchange rates as well because of the requirement for issuers to offer the same standardized benefit design Off-Exchange and for issuers that participate in the Covered California market to offer the Off-Exchange plan at the same premium as On-Exchange.

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# *Impact on consumers*

Changes to premiums will impact customers in different ways, depending on their current markets. Merging the markets would create an initial rate shock for some small groups, while the individual market would see premium reductions, primarily impacting unsubsidized individuals. These changes in premiums could reduce the number of people enrolling in health coverage across the two markets, impacting the stability of the merged market. While it is impossible to predict the precise impact on consumers, utilizing market knowledge and gathering additional viewpoints can provide a foundation to better understand the wide range of possible impacts. The issues described below are some of the key consumer impacts that arose through research and were highlighted in interviews done with health plan.

## *Premium rates*

Under a merged market, changes in premiums would impact individual and small group differently. Because both segments are price sensitive, individuals and small group employers would mostly shop around for options during the initial years of the merged market.

Generally, individual premiums are expected to decrease while small group premiums are expected to increase. A significant portion (62%) of the individual market is supported by premium subsidies (described in more detail in the following section), which is calculated based on the premium of the second lowest priced silver plan. These premium subsidies can be significant for some individuals, resulting in small monthly payments. As the premiums are reduced, these subsidized premiums will likely remain similar, limiting the impact on these consumers. As a result, only the unsubsidized population will realize the full impact of reduced premiums due to merging the two risk pools. On the other hand, the small group market will likely experience the negative impact of rate shocks. To maintain their budgets, small group employers may buy down benefits, consider limited network products, or exit the market.

## *Insurer Choices*

Based on our assumptions that the merged market would only impact the pricing of the individual and small group risk pools, little change in consumers' options is anticipated for the individual market. The individual market might see a slight increase in enrollment as unsubsidized individuals sign up for health insurance. However, effects would most likely be dampened by the removal of the individual mandate in 2019, and the premium reductions may not be sufficient to encourage substantial new entrants in the individual market.

The small group market would most likely be negatively impacted as insurers re-consider their participation in California's merged market. Under the merged market, small groups may experience a rate shock, which may discourage small employers from offering coverage. Additionally, the market risk score used in the risk transfer calculation will include higher risk scores from the individual market once the markets are merged. For insurers that currently participate only in the small group market, their risk score transfer may be adversely impacted, leading them to potentially re-evaluate their geographic offerings.

Given the unpredictability of how consumers will react to a merged market, insurers may opt to re-evaluate their geographic options immediately, potentially leaving consumers with fewer insurer options than in the market today.

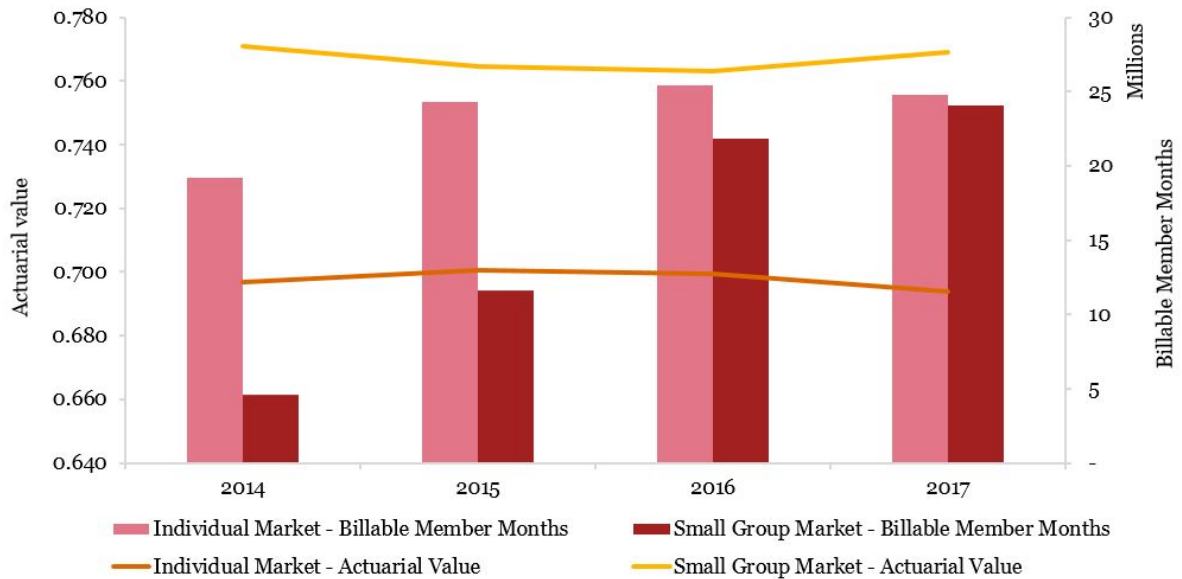
### Benefit Design

Both markets require benefit plans to be ACA compliant and to have actuarial values consistent with federally defined metal tiers. The average actuarial value of plans in individual and small group market is plotted below (Exhibit 14). The graph clearly indicates that benefit plans purchased by small group members are more generous (gold and silver tiers) compared to plans purchased by individuals (silver and bronze plans).

A year over year comparison confirms that individuals consistently enroll in less rich plans compared to small groups which have maintained a higher actuarial value. Some of this effect may be due to employer’s contribution to medical premium, which prevents employees from feeling the full impact of the premiums, and thus are able to afford higher metal tier plans.

As noted above, under a merged market, some health insurers may revise their networks and/or benefit designs, depending on how consumers react to premium rates change in the individual and small group markets. When looking at the two markets, it is important to consider that the subsidized enrollees would not experience the full impact of a rate decrease resulting in these individuals remaining in similar plans. There could be a small number of individuals who do not receive subsidies that may consider alternative plans as a result of premium relief from the merged market. The small group market would see a larger increase in premiums, which may encourage benefit buy downs to keep costs flat. This behavior may result in the average actuarial value of small groups plans shifting toward that of the individual market and leaving employees with higher out-of-pocket costs.

**Exhibit 14**  
**2017 California Statewide Actuarial Value**



Source: Appendix A to 2017 Benefit Year Risk Adjustment Summary Report - HHS Risk Adjustment Program State-Specific Data

## *Provider Network*

As mentioned previously, the rate shock to the small group market may encourage benefit buydowns. Small group employers may explore more limited network products reducing employee's access to providers within the network. Conversely, unsubsidized individuals may explore plans with wider networks after the premium reduction.

It should be noted, that the healthiest small groups would probably be the first to leave the market, leading to additional premium increases for the remaining groups. This dynamic has the potential to encourage further adverse selection and deterioration of the small group risk profile. For certain issuers looking to revamp their small group offerings, market churn may create opportunities through competition for small groups looking for the lowest cost options. However, for most, it would introduce instability that would threaten their ability to maintain their small group book of business.

Conversations with health plans echoed a number of these impacts, with issuers noting that reactions from consumers are difficult to predict and may cause reactions from health plans that could impact consumers further. Ultimately these impacts may cause the market to destabilize.



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# *Potential Market Impacts*

A wide range of issues must be considered when looking at merging the individual and small group markets. These include differences in current market structures (i.e., rate setting, risk mix, participation) as well as potential changes in policy that have been proposed. The considerations described in below are an effort to describe some of the advantages and disadvantages of merging the markets and how they might impact the decision whether to merge California's individual and small group market.

## *Premium rate setting*

The definition of merged market used in this report assumes issuers can continue to use the same rating practices as are in place today - such as trends, geographic factors and differences in underlying products. As a result, issuers would likely continue to utilize these factors to maintain different rates in their book of business for individual and small group policies for similar products. That said, the combination of two markets may cause some issuers to reconsider rate setting practices. This could lead to changes in how rating factors and other assumptions are developed in a merged market scenario, creating additional volatility.

State Legislative changes, if implemented, may also have a significant impact, such as requiring the same rate schedule in both markets. In the individual market, rates are based on the issuer experience claims history with “one shot” for setting premium. These rates are projected two years in the future and are only valid for the calendar year in which they apply. In contrast, the small group allows a quarterly rate setting process which allows issuers to incorporate new data and make corrections or adjustments over the rating period. While rates may change quarterly, once a small group is enrolled, rates are locked in for a 12 month period.

If the markets were merged and small group rates were required to be filed annually, it would likely result in higher premiums for small group participants as issuers attempted to hedge market fluctuations. If small groups were still allowed to enroll on a rolling basis, it could create opportunities for arbitrage or incentives for groups to renew near year end before new rates are filed. Small groups would make an effort to take advantage of current year rates by renewing off-cycle which may cause rates to continue to rise. One possible way to combat this would be to require groups to enroll during a specified enrollment period, like the individual market, which would prevent early renewals. However, this could have a negative impact on overall enrollment in the small group market causing groups to seek coverage elsewhere. Exhibit 15 below summarizes some of the premium rate setting considerations that would need to be weighed in the decision of whether to merge the individual and small group markets.

Currently, premium subsidies, in the form of Advance Premium Tax Credits (APTCs) are available to individuals and families with incomes up to 400% of the Federal Poverty Level. The amount of APTC an individual receives is dependent on their household income and is calculated as a percent of the second lowest cost Silver plan. For the 2019 benefit year, this range is \$16,754 to \$48,560 for an individual and \$34,638 to \$100,400 for a family of four. The APTCs can be applied in advance, that is, they can be directed to the insurance company and used by the member to reduce each monthly

premium, or as a credit, where the member pays the full monthly premium and claims repayment when filing their annual tax return. The amount of subsidy varies with family size and income level, decreasing as incomes increase. The majority of people enrolled through the exchanges are lower income, and subsidy eligible members find the APTC covers about 85% of the cost of the monthly premium.

Since merging the markets would lower statewide individual market premiums by approximately 10% (see Exhibit 8 titled “Estimated Change in Statewide Average Premiums Due to Merging the Markets”), the APTC paid by the federal government to California consumers is also expected to decrease by the same percent. In California, the average monthly APTC is \$452 per eligible individual. Merging the markets may lower this amount to approximately \$406<sup>35</sup>.

**Exhibit 15**  
**Advantages and Disadvantages of Merging the Markets Related to**  
**Premium rate setting**

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>Rate setting processes are generally similar for individual and small group, so merging the markets would not require substantial changes to issuers’ rate setting processes</li> </ul>	<ul style="list-style-type: none"> <li>Merging the markets would create an initial rate shock for some participants, primarily small group enrollees, which could reduce numbers of people with health coverage</li> <li>Changes to the risk pools could create difficulty for issuers to price in the new market resulting in conservative (higher) rates initially</li> </ul>

### *Risk mix*

Risk mix is an indicator of the relative health and expected cost of a population. Risk mix directly impacts claims cost, which in turn, impacts premiums. Poor risk mix (less healthy population) can lead to rapid increase in premiums, which may encourage lower risk members (healthier population) to leave the market. Improved risk mix helps to stabilize premiums and encourages members to remain insured and new members to purchase coverage.

Prior to ACA, issuers in the individual market could deny coverage or charge higher premiums on the basis of health status or pre-existing conditions. And in small group, issuers could impose waiting periods or charge higher premiums to groups with employees with pre-existing conditions. Under the ACA, these types of underwriting and rating is no longer allowed. Members with chronic and other pre-existing conditions are “guaranteed issue” and can not be charged different premiums or otherwise treated differently on the basis of health status. These changes in market rules have contributed to higher risk in the individual market and, to a lesser extent, in the small group market, and CMS analysis indicates the California small group risk pool has substantially lower risk than the individual risk pool.

<sup>35</sup> Source: Kaiser Family Foundation – Estimated Total Premium Tax Credits Received by Marketplace Enrollees. Kaiser Family Foundation analysis of data from February 2018 Effectuated Enrollment Snapshot, Centers for Medicaid and Medicare Services (CMS), June 2, 2018.

Currently, total enrollment in the California individual and small group markets is estimated to be similar at 2.3 to 2.4 million members in each market. This suggests, that on average, a combined risk pool would have a risk mix that is roughly an average of the two pools. However, this balance could be upset by different enrollment losses or gains as individuals and employers react to premium changes. In general enrollment losses would likely lead to a more unfavorable risk mix as healthy individuals (good risks) would be the first to exit the market, while growth in enrollment would likely lead to the addition of healthy individuals/groups which can improve risk.

The changes in the merged risk pool mix would have substantially different impacts by issuer due to differences in enrollment mix by market and differences in population risk. For issuers predominantly in the individual market, the risk score is more likely to be above the merged market score. For issuers predominantly in the small group market, their risk score is more likely to be below the merged market score.

A deterioration in combined risk mix over time may occur if a substantial number of small groups seek other sources of coverage or drop coverage in response to higher rates caused by higher risk individual enrollees. An improvement in risk mix over time could occur as individual rates go down due to the addition of healthier, small group enrollees into their risk pool.

If the risk mix deteriorates, there is potential for member migration from one market to the other, most likely small group to individual, as employers drop coverage and/or employees decline the offer of coverage. If the risk mix improves by attracting healthier individual members due to lowering/slowing the rate of individual premium increases, the merged market could expand coverage while maintaining small group participation.

**Exhibit 16**  
**Advantages and Disadvantages of Merging the Markets Related to Risk Mix**

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>Merging the markets could improve the risk mix of the individual market. Reductions in the individual market premiums would encourage healthier individuals to enroll, thereby increasing healthcare coverage for those in the individual market.</li> </ul>	<ul style="list-style-type: none"> <li>Addition of the individual market will lead to an increase in premiums for small group.</li> <li>Over time this issue may be exacerbated if small groups drop coverage or move to self-funding in reaction to higher rates</li> </ul>

## ***Market competition***

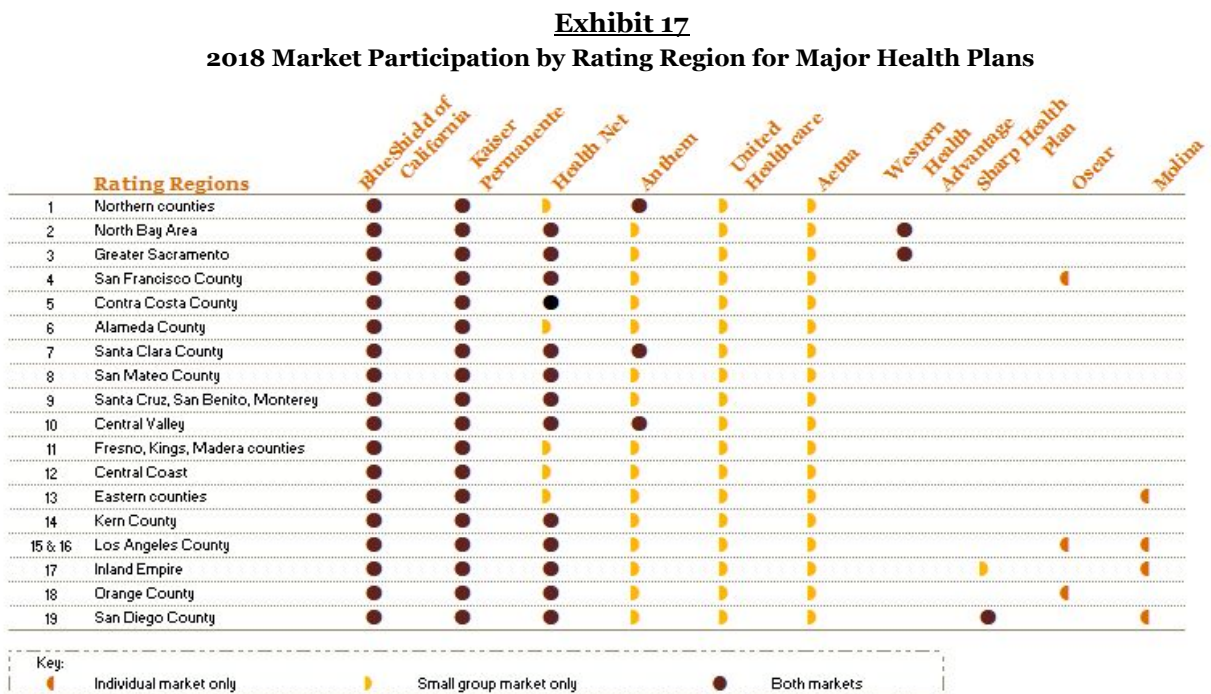
Market competition can be assessed based on the number of issuers who offer products to the same groups in a region, known as carrier choice. In the individual and small group market, issuers compete on price of plan and the underlying network options that are available. For small group a third dimension, plan design option, is a greater factor as the small group market currently has more flexibility than the standardized plan options available in the individual market. These components allow an issuer to offer products that meet the needs of the market and do so in a way that is priced in a financially sustainable way.

## Issuer participation

Many issuers have strategically selected the regions and markets in which they are participating today. A decision to participate in a market may be based on the issuers available products and how they will meet the needs of that market, or the ability to price those products in such a way that attracts healthy individuals/groups and does not cause year over year losses.

Currently, significant differences in issuer participation exist in each market and by region. The Covered California individual exchange has required participating issuers to offer products in all the carrier licensed service areas, This held true until the 2018 benefit year when Anthem Blue Cross exited the majority of the rating regions and now limits new sales to less than half of the state counties, most of which are in the least populated areas of the state.

Exhibit 17 below is a distribution of issuers for individual and small group market by rating region for the largest issuers with more than 90% of the merged market's enrollment:



Effective January 1, 2018

Source: Robert Wood Johnson Foundation- HIX Compare Datasets 2014 to 2018. <https://www.hixcompare.org/>

Merging the markets may cause issuers to rethink their product strategy and where they participate to remain financially viable. If issuers are able to price competitively, grow enrollment and gain good risk, many would continue to participate. However, if they cannot, they may exit the market. This effect is likely to be felt more in the small group market as premiums would go up and employers may look for other options to find cheaper coverage. Overall market competition will rely heavily on whether enrollment and the risk pool remains stable, grows, or declines.

The initial years of a merged market may be difficult for issuers to accurately price for the merged risk pool. As a result, premiums may be more conservative (higher), leading to lower membership retention or membership growth. If other requirements were to be implemented, there would be

more market disruption and more likely be a change in participation. As issuers assess market participation, premiums, and overall choices, individuals and small groups may be impacted.

### Network Options and Benefits

Network offerings can also be a differentiator for issuers. For the individual market, and to some extent the small group, plans have been standardized making it easier for consumers to compare benefit plans. Limiting the provider network to the most cost effective providers allows issuers to more competitively price benefit plans. In the individual market where consumers are more price sensitive, issuers have offered narrow networks, which have enabled premiums to be kept lower. Small groups however, are typically more interested in broader networks that allow employees more flexibility.

In a merged market, the networks currently offered to each market may need to be adjusted in order to minimize premium increases and retain enrollment. Small groups would most likely experience increased premiums (see Estimated Premium Impacts section of the report). Therefore, they would be especially sensitive to premiums developed under a merged risk pool and may turn to alternative products to keep cost down. The small group market currently demands access to a wider array of benefit options. While plans in the individual market are more standardized, there is additional flexibility around deductibles and out of pocket costs in the small group market that can differentiate options. For small group, these variations in plans make it difficult to narrow down the premium impact as issuers can change design as well as networks to keep cost down.

If a merged market required issuers to offer the same plan designs in both markets, small group plans would lose the flexibility employers are looking for. Small groups are looking for richer benefits (i.e., silver and gold plans) with broader networks, while the individual market, offers more low cost benefits (i.e., silver and bronze plans) with narrower networks. If the same plans were required in both markets, small groups would be subject to leaner benefits and narrower networks in order to keep costs low, which would reduce the product flexibility they have today. As a result issuers may reconsider participation in the small group market, which would impact market competition.

**Exhibit 18**  
**Advantages and Disadvantages of Merging the Markets Related to Competition and Issuer Participation**

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>● Based on the definition of merged market used, there is unlikely to be a significant change in the current mix of products in the individual or small group market - however improved risk and lower costs may allow more products to be offered to individuals over time</li> <li>● Reductions in individual premiums may lead to increased enrollment and improved risk. This may result in increased competition in the market as more issuers can price competitively</li> </ul>	<ul style="list-style-type: none"> <li>● Potential for carriers to drop out due to complexities in pricing new risk pool or increased losses</li> <li>● Increased barrier to entry for new issuers as new risk pool is unknown and potentially unstable in initial years</li> <li>● Some issuers may have difficulty pricing the new merged risk resulting in less profitability or increased difficulty in entering new markets</li> <li>● Issuers who have strategically selected markets to participate in, may reevaluate these strategies in light the new risk and may ultimately exit in some capacity</li> </ul>

## Economies of scale

As insurers adjust their processes to conform with a merged market (such as premium development and risk adjustment calculations), there may be short term increases in their administrative costs. Over the longer term, there are unlikely to be material cost savings due to economies of scale gained from merging the markets since few insurer administrative processes have activities that are distinct by market. For example, claims processing, customer service, and network management activities are similar for each market and would not change if the markets were merged. Other activities that do differ, such as sales and marketing, would continue to differ after the markets were merged.

### **Exhibit 19**

#### **Advantages and Disadvantages of Merging the Markets Related to Economies of scale for plan management functions**

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>There may be marginal reductions in administrative costs due to economies of scale by combining administrative functions</li> </ul>	<ul style="list-style-type: none"> <li>Cost savings are likely to be very limited since many of the expenses (e.g., commissions) would still exist in a merged market</li> </ul>

## Regulatory Changes

While there has not been a major overhaul of the ACA, there have been a number of changes that have impacted the individual and small group markets. Some of the most notable changes include the tax reform bill that eliminated the individual mandate penalty, regulations to encourage the expansion of Association Health Plans and short-term, limited duration insurance, and the termination of cost-sharing reduction payments. Some of these changes are limited or prohibited in California due to current or new state laws. However, those changes that will apply in California, such as the repeal of the individual mandate, will have a direct impact on the current individual and small group markets. In a merged market, changes that would have only impacted one market, would now apply to the other market. Future regulatory changes intended to target only one market may be more difficult or not possible in a merged market.

### **Exhibit 20**

#### **Advantages and Disadvantages of Merging the Markets Related to Regulatory Changes**

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>None identified</li> </ul>	<ul style="list-style-type: none"> <li>Once merged, regulatory changes that predominantly affect one market (e.g., AHPs primarily affect small groups), would impact the other market since the pools are combined</li> <li>Regulatory changes primarily targeted at one market (e.g., Individual reinsurance) may need to be reconsidered in the context of the merged market</li> </ul>

## Single plan counties

The number of participating carriers vary significantly between the individual and small group market. In the 2018 individual on-exchange market 29 out of 58 counties have only 1 or 2 issuers. These counties represent approximately 11%<sup>36</sup> of the total California population, suggesting these counties are some of the least densely populated. Low income enrollees in these regions who are eligible for premium subsidies have fewer options in the choice of issuers. For the small group, all counties have 7 to 9 issuers, leading to more competition among the small group risk pool. The map below (Exhibit 21) illustrates the number of individual and small group insurers by county for plan year 2018:

**Exhibit 21**  
**Number of Individual On -Exchange Insurers by County in 2018**



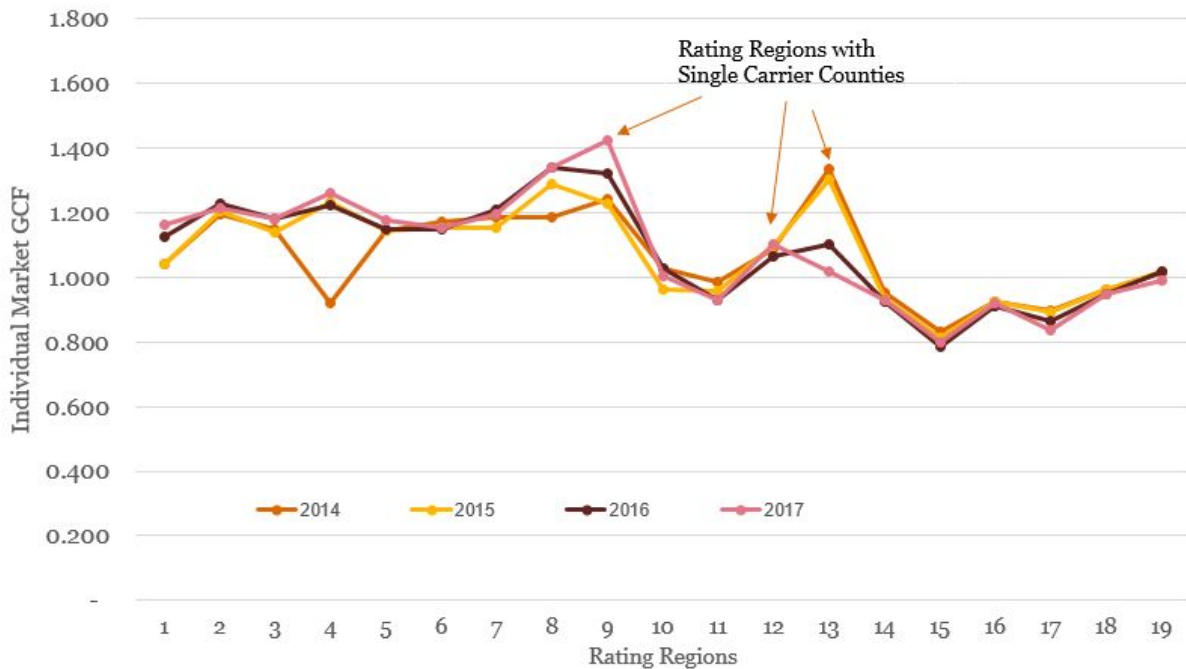
Source: Robert Wood Johnson Foundation- HIX Compare Datasets 2014 to 2018  
<https://www.hixcompare.org/>

In the individual on exchange market, Blue Shield California is the only insurer in Monterey, San Benito, San Luis Obispo, and Santa Barbara counties, which are coastal counties located in rating regions 9 and 12, plus Mono and Inyo along the eastern border in rating region 13. Counties with only two carriers could be considered at risk of having only a single carrier in the future. Dual carrier counties are located across rating regions 1, 11, and 12. In these counties, both Blue Shield and Kaiser or Anthem plans are offered.

<sup>36</sup> Based on 2017 population data for ages <65 from data.ca.gov

Based on CMS published California’s geographic rating factors between 2014 to 2017 (see Exhibit 22 below), premiums in rating regions with single carrier counties appear to be more volatile relative to other rating regions. Merging individual and small group market may stabilize the geographic cost factors, and consumer premiums in these regions.

**Exhibit 22**  
**2014-2017 California Statewide Geographic Cost Factors**



Source: CMS Risk Adjustment Summary

However, these counties may continue to face challenges in maintaining more than one health plan due to access issues or lack of financial stability of the product<sup>37</sup>. Under the merged market, the individual premiums for issuers participating in both markets would most likely decline which may further discourage participation in these regions.

### Market stability

Each market has grown to a similar size and is relatively stable despite federal efforts to repeal or curtail key pieces of the ACA. Merging the markets could have some destabilizing effects due to the increase in premiums felt by small employers, who are likely to consider other options if faced with significant increases in coverage costs. In the long term, market stability cannot be predicted, but would depend heavily on issuer participation and the ability to attract good risks into the market.

<sup>37</sup> "Anthem's Retreat Leaves Californians With Fewer Choices, More Worries" 2 Aug. 2017, <https://californiahealthline.org/news/anthems-retreat-leaves-californians-with-fewer-choices-more-worries/>. Accessed 26 Sep. 2018.



**Exhibit 23**  
**Advantages and Disadvantages of Merging the Markets Related to**  
**Market Stability**

<b>Advantages</b>	<b>Disadvantages</b>
<ul style="list-style-type: none"><li>• The combined market should be marginally more stable than each market separately, once the transition period is complete</li></ul>	<ul style="list-style-type: none"><li>• The individual and small group markets in CA are currently relatively stable in most regions, and merging the markets may cause temporary destabilization statewide</li><li>• Destabilizing issues in one market would automatically affect the other market if they are merged</li></ul>

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# *Findings from Other States*

To date, only two states, Massachusetts and Vermont, operate a merged individual and small group market. Washington D.C. operates a modified merged market; all individual and small group health plans must be offered through DC Health Link (there are no off-exchange plans), but health plans submit separate rates for individual and small group plan offerings.

## *States that elected not to implement a merged market*

Most states did not implement a merged market. Several states conducted studies between the passage of the ACA and the implementation of the Exchanges in 2014. At that time, overall uncertainty as multiple policy changes took effect was cited as a reason to avoid further disrupting the status quo by merging the markets. In particular, states where guaranteed issue was not present in both markets expected that reform to drive unpredictable morbidity changes in the individual market, posing challenges to pricing and market stability.

Several years following the implementation of guaranteed issue, states are able to retrospectively observe the impact of this and other key reforms, making overall uncertainty a less relevant consideration. However, some regulatory uncertainty still exists as changes related to the individual mandate penalty and association health plans take effect.

Among some states that elected not to merge, the response of small groups to changes in the market was a major consideration. Generally, guaranteed issue was expected to increase the morbidity, and therefore premiums, in the individual market as people who did not previously have access to coverage enrolled. By merging the risk pools, the small group markets were expected to effectively subsidize the individual market, offsetting the appeal of cost reductions for individuals with increases for small businesses. In North Carolina, this risk was added to existing concerns about a fragile small group market with low projected enrollment as tax credits expired in 2016.<sup>38</sup>

The implications for carrier competition were considered in certain states, although interpretations varied as to whether the result would be an advantage, disadvantage, or irrelevant for the overall health of the market. An analysis for the State of New Jersey assessed the level of competition in both markets. The study did not anticipate any competition benefit as the same carriers already participated in both markets.<sup>39</sup> Some states observed that the effect could work either way -- instead of bringing more carriers into the market, a merge could drive carriers out, depending on the nature and extent of new requirements.

## *States that have implemented a merged market*

Only Massachusetts, Vermont, and the District of Columbia have implemented some form of a merged market. Each geography had unique circumstances that limit the applicability of their

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<sup>38</sup> Planning and Establishing the North Carolina Healthcare Benefit Exchange. Webinar for TAG Meeting #2. January 23, 2012. NC TAG 2 Webinar Presentation.pdf Accessed 25 Sep. 2018

<sup>39</sup> Cantor, Joel C. Combining New Jersey's Individual and Small-Group Health Insurance Risk Pools. New Jersey Combined Risk Pools 2011 9140.pdf Accessed 25 Sep. 2018

experience to California's market. Additionally, both Massachusetts and D.C. rely on exceptions to some ACA provisions in order to maintain the health and stability of their markets.

## Massachusetts

The Massachusetts merged individual and small group health insurance market pre-dates passage and implementation of the ACA. Massachusetts passed legislation in April 2006 establishing a state exchange (Commonwealth Health Insurance Connector Authority), as well as other reform provisions such as variation of premium and cost sharing by income level. Subsequently, Massachusetts merged its individual and small group markets in July of 2007. The decision was aided by the assessment that the merge would reduce individual premiums much more than it would increase small group premiums. It was estimated that the merge would decrease individual rates by 15% and increase small group rates by 1.0-1.5%.<sup>40</sup> The following circumstances contributed to mitigating the rate increase to small group premiums upon merging:

- **Relative size of the markets:** the individual market was fairly small (10% of the merged market), which enabled it to be absorbed into the merged market with minimal rate shock to small groups. This was despite morbidity of individual market estimated to be 30-40% higher than small group.
- **Pre-existing similarities between the markets:** prior to merging the markets, Massachusetts implemented a number of reforms to expand access to affordable insurance. Guaranteed issue was required in both markets and health underwriting was prohibited. Plan design and benefit coverage were similar as carriers were required to offer the same products in each market.<sup>41</sup>
- **Low morbidity of the uninsured population:** at the same time that the markets were merged, Massachusetts' individual mandate took effect, driving many uninsured to join the risk pool. Additionally, the state provides premium subsidies for enrollees with income up to 300% of the federal poverty line in addition to federal premium tax credits. The uninsured population in Massachusetts was younger and wealthier than the U.S. average and expected to have lower morbidity. Estimates of the resulting premium impact ranged from a 3% decrease to a 6% increase.<sup>42</sup>

Retrospective analysis found that the estimated premium impacts were fairly accurate, with small group premiums increasing by 2.6%.<sup>43</sup> In order to maintain stability and avoid rate shocks for small groups, Massachusetts has continued operating its market with exceptions from standard ACA provisions. Most notably, small group rates can be updated quarterly and can reflect certain rating factors beyond those specified by the ACA.<sup>44</sup>

Overall, in Massachusetts, the individual and small group markets had fundamental structural similarities to post-ACA markets (i.e. guaranteed issue, individual mandate, and no medical underwriting) that positioned it differently from states that were grappling with implementing reforms while considering a merged market. However, there were also some unique circumstances

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<sup>40</sup> Update on Massachusetts Health Care Financing Reform. Health Watch Issue No. 57 - January 2008. MAMergedMarket\_2008.pdf Accessed 25 Sep. 2018

<sup>41</sup> Commonwealth of Massachusetts Request for a State Innovation Waiver Under Section 1332 of the Affordable Care Act. SIW-MA1332-Phase-1-Waiver-Application-Narrative-020216.pdf Accessed 25 Sep. 2018

<sup>42</sup> Gorman Actuarial, LLC. Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets. December 26, 2006. MASS Indiv \_ Small Gr[ finalreport-12-26.2006.pdf Accessed 25 Sep. 2018

<sup>43</sup> Gorman Actuarial, LLC. Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets. December 26, 2006. MASS Indiv \_ Small Gr[ finalreport-12-26.2006.pdf Accessed 25 Sep. 2018

<sup>44</sup> Merging the Individual and Small Group Health Insurance Markets: A Report to the Governor and Maryland General Assembly. December 1, 2016. Maryland\_2016.pdf Accessed 25 Sep. 2018

that drove the decision to merge markets -- principally the size of the individual market which enabled it to be easily absorbed -- and exceptions to ACA requirements remain in place. Analysis suggests that if rating factors were made to be ACA-compliant, small group premiums may increase by a significant amount, posing risks to market stability.<sup>45</sup>

## Vermont

Vermont began to examine the implications of merging the individual, small group and association markets prior to the passage of the ACA.<sup>46</sup> Under the auspices of the Vermont Health Care Reform Commission, the state engaged consultants and stakeholders to analyze the state health insurance market. Legislative Act 48 passed in 2011 established Green Mountain Care and directed the agency to examine design and transition to a universal single payer model for health care delivery. The merged market option was revisited as the state began planning for the individual and small group exchanges required under the ACA. At the time, it was considered an interim step until the universal coverage plan could be implemented and remained in place when the state single payer option was abandoned.

The merge was expected to decrease premiums overall in Vermont and increase consumer choice.<sup>47</sup> The following circumstances were the backdrop for the decision:

- **Size of the market and growth of Association Health Plans:** as of 2009, the individual and small group markets were very small (about 9,000 enrollees for individual and 20,000 for small group). Association plans were in a separate risk pool that included small and large groups, with enrollment of about 96,000 in 2007 and growing.<sup>48</sup> Merging was one way to bring about stability by increasing the size of the risk pool. Additionally, since Association plans tended to have lower premium rates, bringing them into the Exchange was expected to result in premium decreases for both the individual and small group markets.
- **Concentrated market share:** the market in Vermont was highly concentrated, resulting in limited competition and consumer choice. In 2007, 98.4% of the individual market share belonged to just two carriers, Blue Cross and Blue Shield and MVP Health Plan.<sup>49</sup> The merge was expected to bring consumers additional choice by bringing more carriers and plan options into the individual market and
- **Pre-existing similarities between the markets:** Vermont had a history of guaranteed issue in both markets, with the exception of some exclusions for pre-existing conditions prior to the ACA. Additionally, pure community rating was required, with no variation for demographic factors by non-profit insurers and limited variation for for-profit insurers. No grandfathered plans were permitted as of the end of 2013. As such, the morbidity of the individual market was easier to determine.

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<sup>45</sup> Oliver Wyman. Report to the Massachusetts Division of Insurance: The Projected Impact on Health Insurance Premiums in the Merged Individual/Small Group Market with the Implementation of Federal Rating Rules that Restrict the Use of Massachusetts Rating Factors. MA rating factors\_oliver-wyman-052013\_o.pdf Accessed 25 Sep. 2018

<sup>46</sup> Wicks, Elliott, Merging the Individual, Small-Group, and Association Markets in Vermont. Prepared for the Vermont Health Care Reform Commission. Health Management Associates, January 2009. [http://hcr.vermont.gov/sites/hcr/files/VT\\_Merger\\_Final\\_Report%201-09.pdf](http://hcr.vermont.gov/sites/hcr/files/VT_Merger_Final_Report%201-09.pdf) Accessed 25 Sep. 2018

<sup>47</sup> Robert Wood Johnson Foundation. Analyzing Vermont's Health Insurance Market. January 9, 2013. Analyzing VT Health Insurance Market - Jan 2013 RWJF.pdf Accessed 25 Sep. 2018

<sup>48</sup> Wicks, Elliott, Merging the Individual, Small-Group, and Association Markets in Vermont. Prepared for the Vermont Health Care Reform Commission. Health Management Associates, January 2009. [http://hcr.vermont.gov/sites/hcr/files/VT\\_Merger\\_Final\\_Report%201-09.pdf](http://hcr.vermont.gov/sites/hcr/files/VT_Merger_Final_Report%201-09.pdf) Accessed 25 Sep. 2018

<sup>49</sup> Wicks, Elliott, Merging the Individual, Small-Group, and Association Markets in Vermont. Prepared for the Vermont Health Care Reform Commission. Health Management Associates, January 2009. [http://hcr.vermont.gov/sites/hcr/files/VT\\_Merger\\_Final\\_Report%201-09.pdf](http://hcr.vermont.gov/sites/hcr/files/VT_Merger_Final_Report%201-09.pdf) Accessed 25 Sep. 2018

The merge in Vermont established one risk pool with a consistent set of benefit packages and premiums. The definition of small groups was kept to those with fewer than 50 lives until 2016 in order to make the transition more gradual.<sup>50</sup> In the prior years, all individual and small group enrollment is required to go through the Exchange. In 2018, off-exchange sales were permitted. Early 2018 figures place enrollment at 23,000 subsidized individuals, 11,000 unsubsidized individuals, and 45,000 small group members.<sup>51</sup>

### *District of Columbia*

In the District of Columbia, the small size of the market led to considerations vastly different from the circumstances of California. Merging was a way to maintain stability in such a small risk pool and streamline administrative functions. Premium impacts of a 3.5-4.2% decrease for individuals and a 2.8%-3.6% increase for small groups were anticipated, with no significant impacts on enrollment. Only about 7% of the population was uninsured in 2012, so the morbidity of the individual market was largely understood.<sup>52</sup>

While operating a merged market for administrative purposes, D.C. continues to rely on exceptions to the standard ACA definition and provisions. For instance, carriers may make quarterly updates to small group rates and are not required to offer the same plans in both markets. Most notably, issuers may adjust the index rate separately for individuals and small groups.<sup>53</sup>

**Exhibit 24**  
**Results of Merging the Markets in Other States**

State/District	Rationale	Circumstance	Result
Massachusetts	Reduction to individual premium rates, resulting in more affordable coverage	Small individual market; pre-existing similarities between markets; individual mandate in effect; low morbidity of the uninsured	Moderate increase in small group rates
Vermont	Increase options, reduce volatility, and decrease premiums in the individual and small group markets	Small market overall; guaranteed issue in place; no individual mandate	Additional options and benefit packages available to consumers; incorporation of AHP members into Marketplace
District of Columbia	Administrative efficiency and stability	Very small market; low uninsured rate	Financially sustainable market with sufficient flexibility for small groups

<sup>50</sup> Robert Wood Johnson Foundation. Analyzing Vermont’s Health Insurance Market. January 9, 2013. Analyzing VT Health Insurance Market - Jan 2013 RWJF.pdf Accessed 25 Sep. 2018

<sup>51</sup> "Health Coverage Map - Vermont Health Connect." 11 Jul. 2018, [http://info.healthconnect.vermont.gov/sites/hcexchange/files/Health\\_Coverage\\_Map-2018Q1.pdf](http://info.healthconnect.vermont.gov/sites/hcexchange/files/Health_Coverage_Map-2018Q1.pdf). Accessed 26 Sep. 2018.

<sup>52</sup> District of Columbia Insurance Market Structure Recommendations. Presentation to the District of Columbia Health Benefits Exchange Executive Board. August 21, 2012. MarketRecPresentation.pdf Accessed 25 Sep. 2018

<sup>53</sup> Merging the Individual and Small Group Health Insurance Markets: A Report to the Governor and Maryland General Assembly. December 1, 2016. Maryland\_2016.pdf Accessed 25 Sep. 2018

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# *Concluding Observations*

It is not possible to predict the outcome of merging the individual and small group markets, and so the decision on whether or not to do so will need to be weighed against the goals California has for these markets. Based on PwC's review of the potential advantages and disadvantages of merging these markets, the legislature should consider impacts on the premiums and enrollment in each market and how those would impact market stability in the short and long term. These concluding observations are based on the current market environment, and should be reevaluated if there are significant changes in market conditions.

Currently both the individual and small group markets in California remain relatively stable. The markets are similar in size with approximately 2 million enrollees in each market. As a result these markets are sufficiently credible to be rated independently. In recent years, issuers have also adapted to provide products to both of these markets that meet the different needs of each. As a result, merging the markets could be disruptive in the short term. Issuers have strategically selected markets today, and have identified the products and offerings to meet the needs of each market. In the short term, issuers may need to make additional investments to administrative and actuarial functions to update enrollment and claim systems as well as refine premium rate setting to reflect the merged market.

Based on the premium analysis, merging the markets would result in significant decreases to individual premiums. However, due to premium subsidies, many individuals are insulated from changes in premium, and only the unsubsidized population will receive the full benefit of the premium reduction. Nevertheless, the reduced premium could have positive impacts on the risk pool since it could encourage younger and healthier individuals to enroll in coverage.

If the markets were merged, premiums for small groups would increase significantly. This would be particularly disruptive to small employers due to the potentially substantial increases in premium costs, may impact the products offered to small employers as issuers look toward more cost competitive options, and may also encourage employers to reduce benefits, explore alternative coverage options (e.g., self funding with stop-loss), or drop coverage altogether in order to reduce costs.

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# *Appendix*

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# *Impact on administrative functions*

Administrative functions were reviewed based on the definition of merged market as only merging the risk pool for the individual and small group market. Under that assumption, it is likely that most administrative functions will essentially remain the same as today. This section highlights some of the major administrative practices within issuers and how a merged risk pool may impact those functions.

## *Rating practices*

Currently in California, individual rates are filed annually and effective for the calendar year, while small group rates are filed quarterly and remain in effect for 12 months. The small group quarterly submissions contain rate changes beyond any scheduled trend increases for subsequent quarters in the same calendar year.<sup>54</sup> Under a merged market scenario, if the State regulator authority permits, small group rates would most likely continue to be filed quarterly. This would help prevent rate arbitrage for small groups renewing mid-year.

Administrative costs may increase in during the early implementation of the merged market, as insurers adapt their rating process and practices to the reflect the combined risk pools. However, in the long term, differences in rating practices between the two markets will have minimal impact on administrative costs.

## *Plan billing practices*

The plan billing practices would most likely remain unchanged under a merged market. While the market adjusted index rate for both would be identical under a merged market scenario, the plan premium would continue to vary between the two risk pools due to differences in actuarial value, network, and administrative costs. Separate premium grids will still be loaded, resulting in no change in administrative functions.

## *Provider billing practices*

The provider billing practices would most likely remain unchanged under a merged market scenario. Based on plan interviews, the provider billing practices are dependent on network, contract terms and and product type rather than the members' risk pool.

## *Enrollment, marketing, and outreach*

It is unlikely the costs related to enrollment, marketing, and outreach would change in a merged market. Covered California is expected to maintain a robust marketing and outreach budget as well as support community navigators and a consumer and agent call center. These exchange efforts create benefit awareness for the the issuers that sell to the individual market. Both markets also use brokers and general agents, particularly employers in the small group market. Issuers would continue to use

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<sup>54</sup> 2018 Unified Rate Review Instructions.



the same distribution channels and offer variations in products for the individual coverage or group coverage. Given the distribution channels would likely remain the same, the enrollment process would also remain unchanged.

However, if new regulations were to require any changes in enrollment periods or pathways (e.g., Exchange website and call center, Navigator/enrollment counselors, brokers and general agents, health insurers), then the administration costs associated could vary significantly.

### *Risk mix*

These administrative process would remain the same regardless of member's risk profile. There are a multitude of external forces that could impact the risk mix once the market merges.

One short term impact risk mix would impact administrative function would be pricing and financial reporting. The instability in the market may increase administrative resources needed to estimate risk adjustment transfers required for pricing and financial reporting.

### *Administrative Costs*

Based on plan interviews, minimal economies of scale are expected. The two markets would continue to operate and be identified separately for reporting purposes. Initial costs may be required to modify technological platforms such as rating models to combine the two risk pools. However, in the long term, the difference between issuers operating in separate or merged markets is not expected to be material.

### *Benefits*

There are unlikely to be significant impacts to the benefits offered in the merged market and thus minimal impact on the administration of those benefits. Some efficiencies may have been achieved already given similarities in the requirements for benefits and four to five years of experience (e.g., essential health benefits, metallic tiers). Currently, individuals enroll in more silver and bronze plans while small group participants typically elect gold and silver plans. Changes in premiums and the rate of premium changes or other factors would drive changes in enrollment. If there is a requirement to add lower cost benefit options for small groups, such as Health Savings Account compatible high deductible plans, there may be new administrative functions related to benefits. Overall, it is unlikely there would be a significant change in a merged market.

### *Network*

Similar to benefit choices, the underlying network choice and provider contract terms for products in small groups and individual differ. Small group has more broad network Preferred Provider Organization PPO products, while the individual market products are more likely Health Maintenance Organization, or have been narrowed, even for the PPO products, in order to maintain affordability.

During plan interviews, several plan representatives stated that provider network contracts may have to be reevaluated under a merged market, particularly in regard to the small group market. They are concerned that small employers may look for cheaper options in reaction to rising premiums and products that restrict or buy down network products may become more attractive. Reevaluating and renegotiating provider contracts would add to administrative costs, especially in the initial years of a merged market. Additionally, if the same networks were required in a merged market, that could add to the administrative costs to negotiate and support from an administrative perspective.

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