Actuaries
Risk is Opportunity.®

Design and Implementation Considerations of ACA Risk Mitigation Programs

JUNE 2012

SPONSORED BY

SOCIETY OF ACTUARIES

PREPARED BY

Adrian Clark, FSA, MAAA
James T. O'Connor, FSA, MAAA

Milliman

Table of Contents

EXECUTIVE SUMMARY

The Society of Actuaries (SOA) retained Milliman, Inc. to conduct research examining the potential implications of the risk mitigation programs—risk adjustment, reinsurance, and risk corridors—created under *The Patient Protection and Affordable Care Act, as amended* (ACA)*.*

Background: The ACA prohibits health plans from denying coverage or excluding coverage of pre-existing health conditions. It also prohibits health plans from varying premiums by gender or health status and limits premium variations by age. As a result of these provisions, health plans that enroll a relatively less healthy population could be at a greater risk of losses. This could, in turn, create incentives for health plans to avoid enrolling individuals in poor health. The ACA includes three risk mitigation programs to help ensure that health plans are more fairly compensated for the risks they bear, thereby facilitating competition based on efficient care management and quality rather than risk selection.

The three ACA programs are:

1. A permanent risk adjustment program, intended to shift funds from health plans that enroll relatively healthy populations to those that enroll relatively less healthy populations.

2. A transitional reinsurance program providing additional funds to health plans that enroll individuals with especially high medical spending.

3. A 3-year transitional risk corridor program, intended to mitigate risks associated with mispricing premiums when the estimated medical spending of potential enrollees is uncertain—the government will provide funding if a health plan's losses exceed a certain threshold and a health plan will pay the government if the health plan's gains exceed a certain threshold.

Projection Methodology: This analysis uses Milliman's Health Care Reform Financing Model (HCRFM) to analyze the impact of these risk mitigation programs in 2014-2017. Using the model's projections of enrollment and premiums, the analysis focused on loss ratios—medical claims divided by premiums—to assess the adequacy of premium income, both with and without the risk mitigation programs.

Six different scenarios were modeled, varying particular aspects of the risk adjustment method and rules applying to the Individual Market. For a baseline scenario, two additional sub-scenarios were modeled which varied the assumptions regarding premium increases. Each scenario was run for three groups of states categorized by pre-ACA regulatory restrictiveness, and the results are also presented on a nationwide level.

Key Findings from Research:

- **Risk mitigation programs appear to reduce financial risks to health plans. At the same time, overly restrictive premium rate limitations can lead to high federal risk corridor payments.**

  Risk mitigation programs help stabilize the market by adjusting overall health plan revenues to be more in line with the risks undertaken. The results suggest that the transitional risk corridor program is of particular importance, especially if the rate review process were to become overly restrictive or plans do not adequately adjust for the post-2013 population, resulting in premiums that are inadequate relative to the risk that plans are bearing.

  If the rate-setting process results in premiums that are not adequate to meet claims and expenses, federal payments under the risk corridor programs will be high to compensate partially for the inadequate premiums. The impact of inadequate rates on a health plan's financial viability should also be considered. This result stresses the need for the rate review process to not only guard against unduly high premiums, but also to ensure that premiums are not set too low. This is especially important in 2017 and beyond, after the expiration of the risk corridor program.

- **Risk mitigation programs are especially important for plans in states with less restrictive issue and rating rules prior to ACA.**

  The results vary fairly significantly between states, depending on the restrictiveness of each state's regulatory environment prior to 2014. As might be expected, plans in the most restrictive states (e.g., those that already impose significant rating and underwriting restrictions) already have relatively higher premiums, but are projected to require lower rate increases than plans in other states. Plans in states that are moving from relatively less restrictive rules to the guaranteed issue and community rating rules in 2014 are projected to have more need for the risk mitigation mechanisms, especially the risk corridors, if premiums do not incorporate anticipated adverse selection and the increase in costs that may result from the expected health status of newly enrolled members.

- **Grandfathered plans will reflect a relatively healthier population over time.**

  Prior to 2014, average premium rate increases and loss ratios tend to be higher for grandfathered business because underwriting often restricts less healthy people from changing to other coverage options. Over time, grandfathered plans are projected to become a smaller share of the overall market, with rapid migration to other plans beginning in 2014, as individuals originally in grandfathered plans move to other plans either inside or outside of an exchange. Individuals who would be eligible for lower premiums in non-grandfathered plans, either due to premium subsidies or to the introduction of premium rate restrictions related to age or health status, are more likely to change plans. As a result, individuals remaining in grandfathered plans are more likely to be younger and/or in better health, with commensurately lower premium increases and loss ratios. This effect should be recognized in the rate review process as potential premium rate reductions for grandfathered plans, and potentially as increases in trend rates observed by non-grandfathered plans.

- **The Individual Market is expected to grow rapidly starting in 2014**

  By year 2017, the total individual market enrollment is projected to almost triple. This is primarily the result of the ACA's individual mandate combined with the availability of substantial subsidies. Exchange business is expected to grow much faster than non-exchange business due to the availability of subsidies only through exchanges. Much of this increase is expected to come from individuals currently uninsured, but some enrollment is expected to come from individuals currently insured through coverage provided by employers.

**Limitations:** As with all models projecting health insurance enrollment, medical spending, and premiums, there is uncertainty regarding the results. The model's underlying assumptions, which are detailed in the report and attachments, were developed using various data sources and professional judgment. The specific results may vary under different sets of assumptions and scenarios. The projections, therefore, are not intended to be predictions of specific outcomes. Rather, they are meant to illustrate the potential impacts of the risk mitigation programs under certain scenarios. Particular caution must be exercised regarding the premium projections. Premiums can differ across years and across scenarios for several reasons, including rating rules, differences in the relative health status/utilization of the underlying insured population, differences in the age and gender distribution of the underlying insured population, varying healthcare delivery system structures, practice patterns, provider reimbursement arrangements, and the risk mitigation programs. Of course, there can also be random fluctuations.

Unless otherwise noted, care must be taken not to attribute premium changes or differences solely to any one of these factors. This analysis focuses largely on loss ratios rather than premiums in order to isolate the relationship between the underlying risk the health plans bear with respect to medical costs and the premiums received.

SCOPE OF THE REPORT

The Society of Actuaries (SOA) retained Milliman to conduct a research project examining the impact of *The Patient Protection and Affordable Care Act, as amended* (ACA), on the health insurance industry and, in particular, the impact of the three ACA risk mitigation programs. This report presents an analysis of the impact of ACA based upon specific sets of assumptions and projection methodologies applied to six scenarios chosen for modeling in consultation with the SOA Project Oversight Group (POG). Six different scenarios were modeled, varying particular aspects of the risk adjustment method and rules applying to the Individual Market. For a baseline scenario, two additional sub-scenarios were modeled which varied the assumptions regarding premium increases. Each scenario was run for three groups of states categorized by pre-ACA regulatory restrictiveness (referred throughout the report as Geographic Groups or Regulatory Environments), and the results are also presented on a nationwide level. The first scenario was analyzed under three different assumptions regarding implementation of premium rate levels and rate increases because of the sensitivity of results, particularly for the risk corridor program, depending upon the assumption for rate increases implemented during the transition years.

Milliman used its Health Care Reform Financing Model (HCRFM) to generate model projections for each of these scenarios. See Attachment A for a detailed description of this model. This report presents a summary of the results, along with a description of the projection methodology and the key assumptions underlying the projections. Detailed results are contained in the attachments to the report. The main report focuses on the impact to the individual medical market.

GENERAL RESULTS

As mentioned above, we used six different scenarios to model the impact of variations in health plan participation and product qualification in state exchanges, as well as the financial impact of risk mitigation programs. The results of those scenarios are presented later in this section of the report. A description of each scenario is presented in the next section of the report.

Our modeling indicates that a health plan's ability to maintain adequate rates is critical to an ACA objective of creating a viable and competitive health plan marketplace. Even with the risk mitigation programs in place for years 2014-2016, our model projects that some markets and health plans will experience losses beyond the capacity of the risk mitigation programs to eliminate completely. Our modeling shows that these losses may indicate the need for premium rate actions that are higher than past experience would support, at least in years 2014 and 2015. Potentially higher rate increases may be needed in 2017 after the reinsurance and risk corridor programs terminate.

As such, we first present results for Scenario 1, in which we varied the rate increase assumptions for years 2014 and later to illustrate the premium and loss ratio variability that could occur. These rate increase variations are described below.

Individual Market Results for Scenario 1 for Varying Rate Level Assumptions

Based on the underlying assumptions related to relative health status/utilization levels (of both the uninsured and the currently insured), and because of the ACA requirements for guaranteed issue, modified community rating, and elimination of pre-existing condition limitations, our modeling has indicated the possibility for adverse selection to occur, particularly in years 2014, 2015, and 2016. Such adverse selection could result in the need for health plans to increase their premium rates significantly[1]. Given the challenge to health plans and regulators to keep premiums as affordable as possible, but also adequate to maintain the financial viability of a health plan, we modeled three different rate level scenarios that examined differences in implementation of rates at differing levels relative to the adverse selection health plans may encounter:

- *Status Quo*: Reflects expected results as if the 2014 ACA reforms are not implemented. Rate increases for this scenario are uncapped.

- *Scenario 1A*: Reflects expected results for implementation of 2014 ACA reforms, does not reflect pricing for anticipated adverse selection for years 2014 and later, and assumes a 20% maximum rate increase (excluding increases for age and benefit changes).

- *Scenario 1B*: Reflects expected results for implementation of 2014 ACA reforms, includes pricing for anticipated adverse selection for years 2014 and later, but with a 20% maximum rate increase (excluding increases for age and benefit changes).

- *Scenario 1C*: Reflects expected results for implementation of 2014 ACA reforms, includes pricing for anticipated adverse selection for years 2014 and later, with no maximum rate increase.

Tables 1 – 7 provide a summary of the projected experience results by rate level scenario and category of business (i.e. grandfathered, exchange, and non-exchange, non-grandfathered business) for the Individual Medical markets for all three geographic groupings combined. Tables 8A through 8F provide similar summary data by geographic grouping, but only for all categories of business combined.

---

[1] We note that many health plans will introduce rates for new plans to be sold for 2014, which may replace plan designs currently in force. Technically these will not be considered rate increases. Since ACA requires pooling and modified community rates, we applied the 20% cap as if the new rates were relative to the prior rates for similar plans. As such, we did not distinguish between rates for new plans and those for continuing plans.

Separate detailed results by category of business for each geographic grouping are presented in Attachment C.

Enrollment

Table 1 summarizes projected enrollment of each individual market channel by projection year for the status quo scenario and each of the three rate level scenarios.

Table 1						
Results by Rate Level Scenario and Projection Year						
Individual Medical Business Only						
All Geographic Areas Combined						
Enrollment (In Thousands)						
Projection Year	**Scenario**	**Total**	**Grandfathered Business***	**Non-Grandfathered Non-Exchange Business***	**Exchange Business**	**All Non-Exchange Business**
2013	Status Quo	14,594	7,425	7,169	n/a	14,594
2014	Status Quo	14,563	5,936	8,628	n/a	14,563
2014	Scenario 1A	20,622	2,518	8,674	9,430	11,192
2014	Scenario 1B	20,628	2,485	8,513	9,630	10,998
2014	Scenario 1C	20,640	2,252	7,884	10,505	10,135
2015	Status Quo	14,535	4,789	9,746	n/a	14,535
2015	Scenario 1A	29,772	1,947	10,821	17,004	12,768
2015	Scenario 1B	29,831	1,892	10,666	17,274	12,558
2015	Scenario 1C	29,733	2,025	9,143	18,566	11,168
2016	Status Quo	14,538	3,936	10,602	n/a	14,538
2016	Scenario 1A	35,259	1,859	12,098	21,302	13,957
2016	Scenario 1B	35,314	1,789	11,942	21,583	13,731
2016	Scenario 1C	35,228	1,946	10,183	23,099	12,129
2017	Status Quo	14,534	3,286	11,247	n/a	14,534
2017	Scenario 1A	39,160	1,775	12,767	24,618	14,543
2017	Scenario 1B	39,206	1,718	12,583	24,906	14,300
2017	Scenario 1C	39,113	1,870	10,875	26,369	12,745

* For the Status Quo scenario, business issued after 2010 was placed into the non-grandfathered business column. Business issued prior to 2011 and persisting was placed in the Grandfathered Business category.

The following are notable from the projections in Table 1:

- By year 2015 the total individual market enrollment in each scenario is projected to double over what it would have been as measured by the Status Quo scenario. By year 2017, it is projected to be 2.7 times as high. This is primarily the result of the ACA's individual mandate, combined with the availability of substantial subsidies for lower income people. In addition, some people with group coverage migrate to the individual market due to their employer plans being terminated, particularly among small employers not subject to penalties. The migration of uninsured to the individual market is assumed to phase in over time, because of the time it takes to educate people about and have them respond to the changes and the phase-in of individual mandate penalties. The specific underlying phase-in assumptions are shown in Table A-3 in Attachment A.

- Due to the expansion of Medicaid eligibility, some migration from the individual market to Medicaid is projected to occur. This results in slower projected enrollment growth in the individual market in year 2014. This is not evident in Table 1. Evaluation of changes to Medicaid was outside the scope of this analysis.

- As might be expected, exchange business is projected to grow much faster than non-exchange business. By 2017, exchange business is projected to have approximately twice as many enrollees as non-grandfathered/non-exchange plans. This is primarily due to the availability of subsidies only to those who purchase coverage through an exchange. The growth in exchange enrollment is even more pronounced for Scenario 1C--higher premiums when premium increases are uncapped make subsidized coverage in the exchange preferable.

- Grandfathered business is projected to lapse very quickly from year 2013 to 2014 due to the introduction of guaranteed issue and the availability of premium subsidies to those purchasing new exchange plans. By year 2017, less than 5% of the individual market members in force in 2010 (the base year of the model) is projected to remain enrolled in a grandfathered plan. In Table 2, we see that projected average premium rates for the grandfathered business start out higher than those for non-grandfathered business, but ultimately end up lower. Similarly, Table 3 shows that projected loss ratios are lower for grandfathered business after year 2013 since healthier people are more likely to persist in such plans.

Some may expect that there would be less growth or perhaps even a reduction in enrollment in 2017 due to the end of the transitional reinsurance and risk corridor programs. While the elimination of these risk mitigation programs could result in larger rate increases to compensate health plans for their increased risk, we do not think it will have substantial impact since, as shown later, the average net reinsurance program payments received by the individual market are not very significant as a percentage of premium (about 2%). However, this impact could vary by health plan. We have assumed that once a person becomes covered, he or she will maintain coverage in order to comply with the ACA individual mandate.

Average Annual Premiums

Table 2 summarizes a comparison of average projected annual premium by rate level scenario, category of business, and projection year. It should be noted that the ratio of one year's average premium rate to the prior year's rate is not the same as the average rate increase that was implemented. These results reflect differences and annual changes in age/gender, geographic area, and benefit plan distributions, variation in health status/utilization levels, as well as the implemented rate increases.

Table 2						
Results by Rate Level Scenario and Projection Year						
Individual Medical Business Only						
All Geographic Areas Combined						
Average Annual Premiums*						
Projection Year	Scenario	Total	Grandfathered Business**	Non-Grandfathered Non-Exchange Business**	Exchange Business[+]	Exchange Business after Premium Subsidy
2013	Status Quo	$2,725	$2,890	$2,553	n/a	n/a
2014	Status Quo	$2,933	$3,233	$2,726	n/a	n/a
2014	Scenario 1A	$2,979	$3,430	$2,902	$2,929	$1,835
2014	Scenario 1B	$3,242	$3,677	$3,146	$3,214	$1,945
2014	Scenario 1C	$3,725	$4,180	$3,688	$3,654	$2,054

				Non-Grandfathered Non-Exchange Business**	Exchange Business[+]	Exchange Business after Premium Subsidy
Table 2 Results by Rate Level Scenario and Projection Year Individual Medical Business Only All Geographic Areas Combined **Average Annual Premiums***							
Projection Year	Scenario	Total	Grandfathered Business**			
2015	Status Quo	$3,170	$3,606	$2,955	n/a	n/a
2015	Scenario 1A	$3,492	$3,681	$3,427	$3,512	$1,998
2015	Scenario 1B	$3,788	$4,151	$3,691	$3,809	$2,107
2015	Scenario 1C	$4,808	$4,026	$4,907	$4,845	$2,361
2016	Status Quo	$3,493	$4,004	$3,303	n/a	n/a
2016	Scenario 1A	$4,171	$3,962	$4,088	$4,237	$2,162
2016	Scenario 1B	$4,490	$4,635	$4,388	$4,535	$2,279
2016	Scenario 1C	$5,478	$4,208	$5,591	$5,536	$2,426
2017	Status Quo	$3,897	$4,415	$3,745	n/a	n/a
2017	Scenario 1A	$4,942	$4,231	$4,868	$5,031	$2,368
2017	Scenario 1B	$5,283	$4,737	$5,212	$5,357	$2,480
2017	Scenario 1C	$6,045	$4,401	$6,158	$6,115	$2,540

* Note: Premiums reflect anticipated net risk adjustment and reinsurance payments, but not net risk corridor payments.

** For the Status Quo scenario, business issued after 2010 was placed into the non-grandfathered business column. Business issued prior to 2011 and persisting was placed in the Grandfathered Business category.

+ Before application of federal premium subsidies

Table 2 offers the following observations:

- While the projected average premiums for grandfathered business are greater than those for other business categories in year 2013 (and in every year for the Status Quo scenario), over time this reverses as less healthy people move to the guaranteed issue, standard rated market and older people move to lower rates resulting from the 3-to-1 rate slope requirement[2].

- The non-grandfathered premium would be higher than shown in Table 2 in 2014-2016 if not for the impact of the transitional reinsurance program.

- The modest differences between average premiums for exchange business and non-grandfathered/non-exchange business are due to the differing age/gender and plan mix between the two distribution channels. They are not due to health status differences since rates for the two channels are based on pooled experience and vary only by plan, age, and geographic location.

- We note that many people purchasing coverage through an exchange will qualify for federal premium subsidies, which, as shown above, reduces the premium rates they effectively pay on average. For some consumers, the subsidy will bring the personal cost of a plan down substantially, and may even be $0 for a bronze plan.

---

[2] Section 1201 of ACA amends the Public Health Service Act to require that premium rates cannot vary by age more than 3 to 1 for adults and cannot vary by gender. Many states currently allow rate variation by age and gender based upon actuarial cost differences that exceed the limitations imposed by ACA.

Loss Ratios

Table 3 summarizes the resulting loss ratios[3] across all individual market plans by rate level scenario, category of business, and projection year. Loss ratios are used to assess the adequacy of premium income by isolating the relationship between the underlying risk the health plans bear with respect to medical costs and the premiums received. Assumed target loss ratios range from 78% to 80%, varying by modeled health plan type. These levels reflect the loss ratios needed to meet or exceed the ACA MLR minimum requirement of 80%. Loss ratios exceeding these targets may indicate that premiums are inadequate for some plans to meet claims and administrative expenses.

Table 3 Results by Rate Level Scenario and Projection Year Individual Medical Business Only All Geographic Areas Combined Incurred Loss Ratios Prior to Risk Mitigation Payments						
Projection Year	Scenario	Total	Grandfathered Business*	Non-Grandfathered Non-Exchange Business*	Exchange Business	All Non-Exchange Business
2013	Status Quo	80%	86%	72%	n/a	80%
2014	Status Quo	82%	87%	77%	n/a	82%
2014	Scenario 1A	116%	82%	114%	128%	105%
2014	Scenario 1B	106%	77%	106%	116%	98%
2014	Scenario 1C	92%	69%	91%	99%	86%
2015	Status Quo	83%	87%	80%	n/a	83%
2015	Scenario 1A	113%	76%	112%	117%	107%
2015	Scenario 1B	104%	69%	105%	108%	99%
2015	Scenario 1C	81%	72%	81%	82%	80%
2016	Status Quo	83%	86%	82%	n/a	83%
2016	Scenario 1A	105%	77%	105%	107%	101%
2016	Scenario 1B	97%	68%	98%	100%	94%
2016	Scenario 1C	79%	75%	78%	79%	78%
2017	Status Quo	82%	86%	81%	n/a	82%
2017	Scenario 1A	97%	79%	97%	98%	95%
2017	Scenario 1B	91%	72%	91%	92%	89%
2017	Scenario 1C	78%	79%	78%	79%	78%

* For the Status Quo scenario, business issued after 2010 was placed into the non-grandfathered business column. Business issued prior to 2011 and persisting was placed in the Grandfathered Business category.

---

[3] Note that these loss ratios are not on a basis for determining rebates payable due to the minimum loss ratio requirements of ACA. In this report, the use of the term "loss ratio" refers to the ratio of incurred claims to earned premiums. This differs from the ACA term "medical loss ratio" or "MLR", which includes other items in its ratio such as quality improvement expenses, contract reserves changes, and taxes and regulatory assessments and fees.

As can be observed:

- Loss ratios for grandfathered business are projected to be relatively stable from one year to the next for all three of the rate level scenarios. They are lower in Scenario 1B in 2015-2017 in order to make up for some of the premium shortages for non-grandfathered business, while still exceeding the MLR minimum for all business combined.

- The loss ratios are very high in years 2014 through 2017 for non-grandfathered business, except for Scenario 1C after 2014. Scenario 1C has no limit on the rate increases implemented and can thereby keep loss ratios close to target.

- Loss ratios in Scenarios 1A and 1B are projected to decrease over time, but do not revert to target loss ratio levels. This is due to several factors, including the assumption that rate increases are capped. In addition, we have assumed that health plans will reflect in their product pricing the projected reduction in claims caused by anticipated net reinsurance payments individual carriers receive through 2016 (i.e. health plans are assumed to set lower premium rates in anticipation of receiving some reinsurance program payments for their large claims).

- Loss ratios are projected to be higher for exchange business than for non-grandfathered/non-exchange business in years 2014 and 2015 largely due to an expectation of pent-up demand in the first year of coverage from the previously uninsured, and the impact of that demand on claim costs in the first year of insurance coverage, since more of the uninsured are projected to move to the exchange channel than the non-exchange channel. The differences in loss ratios narrow over time.

The health plans are projected to receive some relief from higher-than-target loss ratios in years 2014 through 2016 from the risk mitigation programs. This can be seen in Table 4 (below), which shows the loss ratios after inclusion of the impact of the risk mitigation programs. These programs allow health plans to sustain higher loss ratios through 2016. They also allow for lower premium rates from which consumers can benefit. However, it is not likely that lower premium rates and high loss ratios evident in Scenarios 1A and 1B, which limit premium increases, would be financially sustainable after 2016 when the risk corridor program ends.

Table 4, below, summarizes the resulting loss ratios (including the impact of the risk mitigation programs) by rate level scenario, category of business, and projection year. Consistent with the previous table, these loss ratios are not on a basis that can enable the determination of rebates payable pursuant to the minimum loss ratio (MLR) requirements of ACA. MLRs include quality improvement expenses and certain reserve changes in the numerator and remove taxes and fees from the denominator.

				Non-Grandfathered		All Non-
Projection Year	**Scenario**	**Total**	**Grandfathered Business***	**Non-Exchange Business***	**Exchange Business**	**Exchange Business**
2013	Status Quo	80%	86%	72%	n/a	80%
2014	Status Quo	82%	87%	77%	n/a	82%
2014	Scenario 1A	87%	83%	87%	88%	86%
2014	Scenario 1B	84%	78%	84%	85%	83%
2014	Scenario 1C	80%	71%	80%	82%	77%
2015	Status Quo	83%	87%	80%	n/a	83%
2015	Scenario 1A	88%	77%	88%	89%	87%
2015	Scenario 1B	85%	70%	86%	86%	84%
2015	Scenario 1C	78%	73%	78%	79%	77%
2016	Status Quo	83%	86%	82%	n/a	83%
2016	Scenario 1A	87%	78%	87%	87%	86%
2016	Scenario 1B	84%	68%	85%	85%	83%
2016	Scenario 1C	78%	76%	78%	79%	77%
2017	Status Quo	82%	86%	81%	n/a	82%
2017	Scenario 1A	97%	79%	97%	98%	95%
2017	Scenario 1B	91%	72%	91%	93%	89%
2017	Scenario 1C	78%	79%	78%	79%	78%

Table title (header block):
Table 4
Results by Rate Level Scenario and Projection Year
Individual Medical Business Only
All Geographic Areas Combined
Incurred Loss Ratios Including Impact of Risk Mitigation

* For the Status Quo scenario, business issued after 2010 was placed into the non-grandfathered business column. Business issued prior to 2011 and persisting was placed in the Grandfathered Business category.

Even with the three risk mitigation programs, total adjusted loss ratios are projected to remain above the 78% to 80% targets for Scenarios 1A and 1B. This is due to the cost-sharing formula of the risk corridor program and the high loss ratios during the 2014 to 2016 period: while the federal government provides risk corridor payments when loss ratios are at least 3% greater than target, the health plan must share any excess below its target. A health plan that cannot implement adequate rates and rate increases on a timely basis may have difficulty attaining its target loss ratio, especially with the one-sided nature of the ACA MLR rebate formula (health insurers are required to provide rebates to consumers if their MLRs fall below 80%, but are not compensated if their MLRs exceed 80%).

Transitional Reinsurance Program

The reinsurance program will be funded by large group (including self-funded plans), small group, and individual markets through an assessment. The ACA requires total funding of $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016[4]. Reinsurance benefits are only available to health plans covering individual market members. The details of the program are described in Attachment A.

---

[4] Section 1341 of ACA also requires additional payments totaling $5 billion be made by health plans that do not benefit the individual market, but are paid directly to the federal government. States may also choose to levy other assessments related to the reinsurance program. The impact of these additional federal and state levies on premium rates is not reflected in our analysis.

Table 5 shows the net impact of the transitional reinsurance program on the individual market for each scenario.

	Table 5 Transitional Reinsurance Program Individual Medical Market Benefits and Contributions (Assessments) by Projection Year within State Regulatory Grouping ($ billions)								
	Reinsurance Benefits			**Reinsurance Contributions from Individual Market**			**Net Reinsurance Subsidy from Group Markets**		
Scenario	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
1A	$10.0	$6.0	$4.0	$1.3	$1.1	$0.8	$8.7	$4.9	$3.2
1B	$10.0	$6.0	$4.0	$1.3	$1.1	$0.8	$8.7	$4.9	$3.2
1C	$10.0	$6.0	$4.0	$1.3	$1.1	$0.8	$8.7	$4.9	$3.2

	Total Individual Market Claims before Mitigation			**Ratio of Net Reinsurance Subsidy to Total Benefits**		
Scenario	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
1A	$71.1	$117.3	$153.8	12%	4%	2%
1B	$71.1	$117.8	$154.6	12%	4%	2%
1C	$70.8	$115.9	$152.1	12%	4%	2%

The net reinsurance subsidy ratio shown above is an indication of the claim relief the individual market is projected to receive. This subsidy can allow for premium rates to be set lower than they might otherwise be in anticipation of large claims. This can help stabilize premiums for consumers during the three years when the most market disruption is expected to occur. Each year when the reinsurance funds decline and then in 2017 when the program has ended, benefit trends will increase due to the effect of claims leveraging each year through the reduction of reinsurance subsidies. This trend leveraging needs be recognized by health plans and regulators alike in setting premium rates. See Attachment A for additional discussion on the reinsurance program. The ratio to total benefits shown above is an approximation for the impact on the numerator of the loss ratio.

Risk Adjustment Program

Table 6 shows the amount of money transferred each year through the risk adjustment program. This program is a "zero-sum game" in that the total amounts paid by health plans into the risk adjustment pool are received by other health plans each year. These scenarios are based upon a prospective model approach. A "concurrent" approach, which the HHS has indicated it will use for the federal model, is assumed for Scenario 5. The results for Scenario 5 are compared to those for Scenario 1 later in the report, and more information on how the two risk adjustment approaches differ is provided in Attachment A.

Table 6 Permanent Risk Adjustment Program Individual Medical Market (millions)								
	Dollars Transferred				**Transferred as a % of Total Benefits**			
Scenario	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
1A	$742	$786	$1,047	$1,504	1.0%	0.7%	0.7%	0.8%
1B	$748	$772	$1,179	$1,537	1.1%	0.7%	0.8%	0.8%
1C	$748	$989	$1,188	$1,458	1.1%	0.9%	0.8%	0.8%
	As a % of Benefits of Health plans Receiving				**As a % of Benefits of Health plans Paying**			
Scenario	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
1A	2.0%	1.9%	1.5%	1.8%	2.2%	1.0%	1.3%	1.5%
1B	2.0%	1.8%	1.4%	1.5%	2.2%	1.0%	1.6%	1.8%
1C	1.9%	2.0%	2.1%	2.0%	2.3%	1.5%	1.2%	1.3%

The risk adjustment program is permanent. It is intended to make health plans indifferent to the health status of the people they insure, although it is not likely to perfectly equalize the risks presented. The goal of this program is to stabilize a competitive marketplace in which health plans compete on plan features and services rather than on avoidance of high risk individuals. This is beneficial to consumers, particularly those with high-cost health conditions, as it is more likely to give them continued choice of health plans.

The modeled results shown in Table 6 indicate relatively minor cash flow transfers each year as a percentage of benefits. However, these results may be more or less significant to any particular health plan and are very dependent on the distribution of covered members by health status, age, and gender among the various health plans. The modeled distribution is the result of a plan choice algorithm and related assumptions that influence a person's choice of health plan. This algorithm is described in Attachment A and its key related assumptions are detailed in Attachment B. The choice parameters include a comparison of each health plan's premium rates (after premium subsidies), the health plan's brand awareness among consumers, consideration of loyalty to the health plan under which the person is currently covered, and their likelihood to shop for new coverage. These parameters vary based on the age, gender, health status, and income level of each person. In addition, the risk adjustment program results are sensitive to the risk adjuster methodology used. The above results are based upon a prospective methodology; a concurrent methodology would produce somewhat different results, as illustrated later in the report. However, even within a given general methodology such as a prospective method, there are variations in application of the methodology, particularly with respect to new entrants and when their true health status may be able to be reflected in the risk adjustment calculation. Our prospective method assumes no knowledge of a new entrant's health status in the year first enrolled in the plan and applies only an age/gender factor to these people. It applies the risk scores based upon average market premiums rather than on a plan tier basis. Our model risk adjustment methodology is discussed in Attachment A. Results could vary if underlying health plan assumptions differ or the calculation methodology differs.

Risk Corridor Program

The 3-year transitional risk corridor program, modeled after the Medicare Advantage program, provides health plans some protection against pricing risk due to the unknown mix of enrollees who might purchase coverage from them. If a health plan's loss ratio for qualified plans, after adjustment for the reinsurance and risk adjustment programs, is higher than its target level, the government shares in the excess loss via a payment to the health plan, and if the adjusted loss ratio ends up lower than target, the health plan pays the government some of the windfall. The program is described more fully in Attachment A.

Table 7 shows the projected net impact of the risk corridor program for Scenarios 1A, 1B, and 1C. A positive dollar amount in the table indicates the amount that the federal government will need to pay to the health plans and a negative amount is the amount that health plans will need to pay the federal government. Only Scenario 1C results in a payment to the government when all states are combined. As will be illustrated in the next section, this varies considerably by state regulatory grouping for each scenario.

Table 7 Risk Corridor Program Individual Medical Market Aggregate Net Payments by Projection Year within Rate Level Scenario (millions)		
Year	Scenario	Total All States
2014	Scenario 1A	$9,115
2014	Scenario 1B	$6,419
2014	Scenario 1C	$ 994
2015	Scenario 1A	$21,063
2015	Scenario 1B	$16,517
2015	Scenario 1C	($ 980)
2016	Scenario 1A	$23,321
2016	Scenario 1B	$17,695
2016	Scenario 1C	($ 1,850)

The results highlight the interaction between the rate review process and the risk corridors. If the rate review process is overly restrictive and results in premiums that are not adequate to meet claims and expenses, federal payments under the risk corridor programs will be high to partially compensate for the inadequate premiums.

Individual Market Results for Scenario 1 by Geographic Grouping for Varying Rate Level Scenarios

The previous section of this report showed results for Scenario 1 by category of business (i.e. grandfathered, exchange and non-grandfathered/non-exchange). Tables 8A through 8F provide results for Scenario 1 under the three groupings of states with respect to rate increase assumptions, as described earlier.

Enrollment by State Grouping

		Enrollment (000 omitted)			Yearly Change in Enrollment		
Projection Year	**Scenario**	**Most Restrictive**	**Average Restrictive**	**Least Restrictive**	**Most Restrictive**	**Average Restrictive**	**Least Restrictive**
2013	Status Quo	1,474	5,004	8,117			
2014	Status Quo	1,471	5,003	8,089	0%	0%	0%
2014	Scenario 1A	1,766	6,641	12,215	20%	33%	50%
2014	Scenario 1B	1,763	6,642	12,223	20%	33%	51%
2014	Scenario 1C	1,765	6,649	12,226	20%	33%	51%
2015	Status Quo	1,467	5,001	8,067	0%	0%	0%
2015	Scenario 1A	2,460	9,623	17,689	39%	45%	45%
2015	Scenario 1B	2,461	9,627	17,743	40%	45%	45%
2015	Scenario 1C	2,464	9,649	17,621	40%	45%	44%
2016	Status Quo	1,473	5,015	8,050	0%	0%	0%
2016	Scenario 1A	3,053	11,402	20,805	24%	18%	18%
2016	Scenario 1B	3,056	11,395	20,863	24%	18%	18%
2016	Scenario 1C	3,057	11,420	20,752	24%	18%	18%
2017	Status Quo	1,471	5,025	8,037	0%	0%	0%
2017	Scenario 1A	3,578	12,699	22,883	17%	11%	10%
2017	Scenario 1B	3,582	12,682	22,942	17%	11%	10%
2017	Scenario 1C	3,577	12,712	22,824	17%	11%	10%

Table 8A
Results by Rate Level Scenario by Geographic Area
Individual Business
By Geographic Area
All Business Combined

The most restrictive regulatory states represent approximately 10% of the total individual insured population in year 2013 and drop slightly to 9% by 2017. It should be noted that we have assumed gradual entry of the uninsured population into the commercial insured markets over several years (see Table A-3 in Attachment A or Table B-12 in Attachment B for the assumed phase-in factors); these phase-in factors vary by geographic grouping and are lower in year 2014 for the most restrictive states. This results in the slower projected growth rate for these states. It also explains the slower projected growth rate in 2014 for the average restrictive area compared to the least restrictive.

Average Annual Premium Changes by State Grouping

Table 8B shows results for average premium changes for each geographic grouping through year 2018. Readers should note that these are changes in average premiums in force and not necessarily the rate increases implemented. In addition to rate increases, they are impacted by changes in age, gender, and plan mix, which differ somewhat for each projection year, each geographic grouping, and each scenario. These increases also reflect base claims trend of 7.5% each year plus deductible leveraging impact.

		Annual Change in Avg. Premium			Cumulative Avg. Premium Relativities		
Table 8B — Results by Rate Level Scenario by Geographic Area — Individual Business — By Geographic Area — All Business Combined							
Projection Year	**Scenario**	**Most Restrictive**	**Average Restrictive**	**Least Restrictive**	**Most Restrictive**	**Average Restrictive**	**Least Restrictive**
2013	Status Quo				1.00	1.00	1.00
2014	Status Quo	5.7%	8.2%	8.2%	1.06	1.08	1.08
2014	Scenario 1A	10.1%	11.9%	13.0%	1.10	1.12	1.13
2014	Scenario 1B	20.9%	21.1%	23.0%	1.21	1.21	1.23
2014	Scenario 1C	20.9%	32.7%	52.6%	1.21	1.33	1.53
2015	Status Quo	5.4%	8.4%	9.2%	1.11	1.17	1.18
2015	Scenario 1A	17.0%	18.1%	17.7%	1.29	1.32	1.33
2015	Scenario 1B	11.9%	18.2%	18.8%	1.35	1.43	1.46
2015	Scenario 1C	13.1%	31.9%	33.0%	1.37	1.75	2.03
2016	Status Quo	9.8%	9.8%	10.5%	1.22	1.29	1.31
2016	Scenario 1A	17.1%	19.2%	19.2%	1.51	1.57	1.59
2016	Scenario 1B	12.1%	18.9%	19.5%	1.52	1.70	1.75
2016	Scenario 1C	11.5%	13.1%	14.4%	1.52	1.98	2.32
2017	Status Quo	12.5%	11.3%	11.3%	1.38	1.43	1.45
2017	Scenario 1A	10.8%	19.3%	19.5%	1.67	1.88	1.89
2017	Scenario 1B	9.6%	18.1%	19.0%	1.66	2.01	2.08
2017	Scenario 1C	8.8%	10.2%	10.2%	1.66	2.18	2.56

While average premiums are currently considerably higher in the most restrictive state grouping than in the other two groupings, the changes in average premiums are projected to be lower in the most restrictive states than in the other two state groupings, in part because some ACA reforms are already in force in those markets and hence have little projected impact during the full transition to the ACA. As a result, premium differences across the geographic groupings narrow over time. The cumulative average premium relativities in Table 8B illustrate that cumulative increases through 2017 needed in Scenario 1C for average states are 31% higher (2.18/1.66 -1) than the most restrictive state grouping, and those for the least restrictive state grouping are 54% higher (2.56/1.66 -1).

Loss Ratios by State Grouping

Table 8C presents the projected incurred loss ratios for each geographic grouping, both before and after the impact of the risk mitigation programs.

		Loss Ratios before Risk Mitigation			Loss Ratios after Risk Mitigation		
Table 8C **Results by Rate Level Scenario and Geographic Area** Individual Business By Geographic Area **All Business Combined**							
Projection Year	**Scenario**	**Most Restrictive**	**Average Restrictive**	**Least Restrictive**	**Most Restrictive**	**Average Restrictive**	**Least Restrictive**
2013	Status Quo	80%	80%	80%	80%	80%	80%
2014	Status Quo	83%	81%	81%	83%	81%	81%
2014	Scenario 1A	92%	111%	128%	81%	86%	89%
2014	Scenario 1B	84%	103%	118%	78%	82%	87%
2014	Scenario 1C	83%	94%	94%	78%	79%	80%
2015	Status Quo	86%	82%	82%	86%	82%	82%
2015	Scenario 1A	86%	107%	126%	81%	87%	91%
2015	Scenario 1B	81%	100%	115%	79%	84%	88%
2015	Scenario 1C	81%	80%	82%	79%	78%	79%
2016	Status Quo	88%	82%	82%	88%	82%	82%
2016	Scenario 1A	80%	100%	117%	79%	86%	90%
2016	Scenario 1B	79%	93%	107%	79%	83%	87%
2016	Scenario 1C	79%	79%	79%	79%	78%	78%
2017	Status Quo	86%	81%	81%	86%	81%	81%
2017	Scenario 1A	78%	92%	108%	78%	92%	108%
2017	Scenario 1B	79%	86%	99%	79%	86%	99%
2017	Scenario 1C	79%	78%	79%	79%	78%	79%

As might be expected, for the most restrictive states, not only are the projected rate changes generally lower than in other states (see Table 8B), but also the projected loss ratios are much more stable for each of the scenarios. While some adverse selection is projected in the most restrictive states, particularly in year 2014, there is considerably more in the other two state groupings. As a result, health plans operating in the most restrictive states are expected to receive lower risk corridor payments than health plans in the other states, especially when pricing does not incorporate adverse selection and/or premium increases are capped, as illustrated in Table 8D below. Premiums in the most restrictive states already reflect, in part, a high risk population.

The risk mitigation programs are projected to help stabilize the loss ratio results during years 2014 through 2016, but as the table above shows, in year 2017, when the transitional reinsurance and risk corridor programs are no longer in effect, the loss ratios in the least restrictive regulatory environment are much higher than target for Scenarios 1A and 1B, but meet target for Scenario 1C. The loss ratios for average restrictive states are slightly above target.

The premium rates underlying Table 8B are reflective of a target loss ratio of 78% to 80% for each of the geographic areas. However, actual experience in the most restrictive states, as measured by 2010 Supplementary Healthcare Exhibits, indicates considerably higher loss ratios. We have assumed that insurers will price at lower target levels than those experienced, resulting in higher premiums. If regulators restrict such increases, then premiums will be lower than modeled, and the loss ratios shown in Table 8C (above) will be higher. Chart 1 shows the relationships between average rate changes shown in Table 8B and loss ratios shown in Table 8C for Scenario 1C. Charts for the other two scenarios are included in Attachment C.

CHART 1
Accumulated Changes in Average Premium from Year 2013
and Annual Loss Ratios by Regulatory Grouping
Scenario 1C
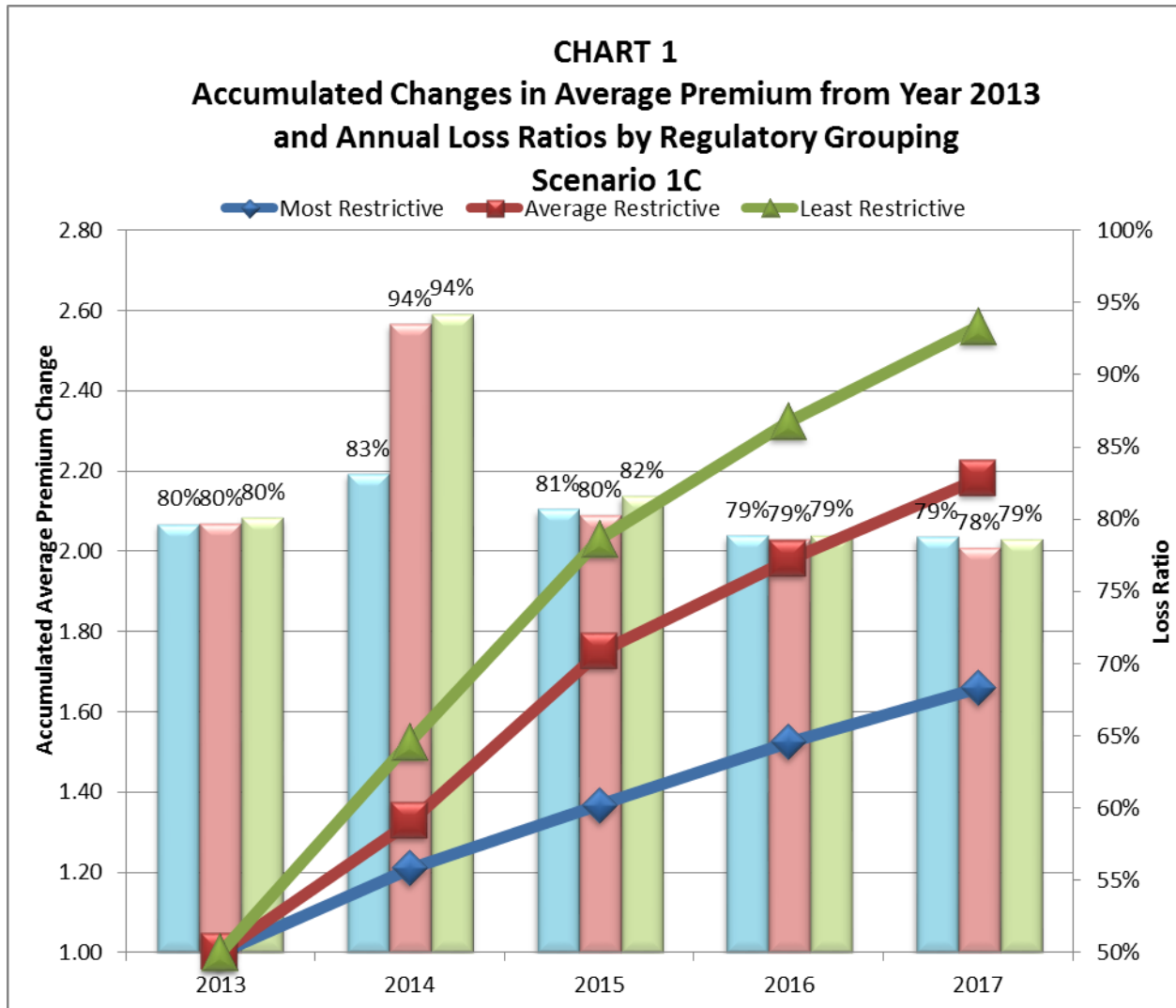
Transitional Risk Corridor Results by State Grouping

Table 8D presents the aggregate net payments from the risk corridor program by regulatory environment. The federal government is projected to pay significant amounts each year under Scenarios 1A and 1B (in which rate increases are restricted), but receives funds under Scenario 1C after 2014. The projected effect of the risk corridor program varies considerably by regulatory environment. The most restrictive states are projected to be required to pay the government, while the less restrictive states are projected to receive funds from the government in all but Scenario 1C in which health plans can price to their target loss ratios. When premium increases are limited, the least restrictive states are projected to receive considerable funds relative to the other state groupings because they are most affected by the ACA reforms.

Table 8D				
Transitional Risk Corridor Program **Results by Rate Level Scenario and Geographic Area** **Individual Business** **Aggregate Net Payments* by Projection Year** **within Rate Level Scenario and State Regulatory Grouping** (millions)				
Year	**Scenario**	**Most Restrictive State Grouping**	**Average Restrictive State Grouping**	**Least Restrictive State Grouping**	**Total All States**
2014	Scenario 1A	$ 85	$1,874	$7,156	$9,115
2014	Scenario 1B	($429)	$1,231	$5,618	$6,419
2014	Scenario 1C	($450)	$ 285	$1,159	$ 994
2015	Scenario 1A	$ 244	$5,086	$15,733	$21,063
2015	Scenario 1B	($242)	$3,789	$12,970	$16,517
2015	Scenario 1C	($273)	($528)	($179)	($980)
2016	Scenario 1A	($145)	$5,338	$18,128	$23,321
2016	Scenario 1B	($384)	$3,746	$14,333	$17,695
2016	Scenario 1C	($340)	($ 610)	($900)	($1,850)

* A positive number indicates payments from the federal government to the health plans, while a negative number indicates amounts to be paid by health plans to the federal government under the risk corridor program.

Transitional Reinsurance Program by State Grouping

The transitional reinsurance program is projected to impact loss ratios after risk mitigation, and in turn, helps stabilize premium rates for consumers. Table 8E summarizes the net reinsurance results for each of Scenarios 1A, 1B, and 1C.

Table 8E **Transitional Reinsurance Program** **Results by Rate Level Scenario and Geographic Area** **Individual Business** **Benefits and Contributions (Assessments) by Projection Year within State Regulatory Grouping**									
	Most Restrictive State Grouping			**Average Restrictive State Grouping**			**Least Restrictive State Grouping**		
Scenario	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
Individual Market Reinsurance Benefits ($ billions)									
1A	$1.3	$0.8	$0.5	$3.4	$2.1	$1.4	$5.3	$3.2	$2.1
1B	$1.3	$0.8	$0.5	$3.4	$2.1	$1.4	$5.3	$3.2	$2.1
1C	$1.3	$0.8	$0.5	$3.4	$2.1	$1.4	$5.3	$3.2	$2.1
Individual Market Reinsurance Contributions ($ billions)									
1A	$0.1	$0.1	$0.1	$0.4	$0.4	$0.3	$0.7	$0.6	$0.5
1B	$0.1	$0.1	$0.1	$0.4	$0.4	$0.3	$0.7	$0.6	$0.5
1C	$0.1	$0.1	$0.1	$0.4	$0.4	$0.3	$0.7	$0.6	$0.5
Individual Market Net Reinsurance Subsidy from Other Markets ($ billions)									
1A	$1.2	$0.7	$0.4	$3.0	$1.7	$1.1	$4.5	$2.6	$1.6
1B	$1.2	$0.7	$0.4	$3.0	$1.7	$1.1	$4.5	$2.5	$1.6
1C	$1.2	$0.7	$0.4	$3.0	$1.7	$1.1	$4.5	$2.6	$1.6
Individual Market Total Claims before Mitigation ($ billions)									
1A	$10.7	$16.4	$22.3	$21.6	$35.7	$46.8	$38.8	$65.2	$84.7
1B	$10.7	$16.2	$22.0	$21.6	$35.9	$47.1	$38.9	$65.7	$85.5
1C	$10.7	$16.3	$22.1	$21.6	$35.5	$46.5	$38.6	$64.2	$83.6
Ratio of Individual Market Net Reinsurance Subsidy to Total Individual Market Benefits									
1A	11%	4%	2%	14%	5%	2%	12%	4%	2%
1B	11%	4%	2%	14%	5%	2%	12%	4%	2%
1C	11%	4%	2%	14%	5%	2%	12%	4%	2%

The results above indicate little variation in net reinsurance impact by scenario and geographic grouping. The results as a percentage of individual market benefits are highly dependent on the influx of new insureds each year. The uninsured are projected to phase in over time, starting slowly in 2014 and building up quickly to the ultimate change factor levels by year 2017. The decreasing percentages

of net reinsurance payments are due to a combination of this phase-in of uninsureds and the reduction of the amounts required by ACA to be contributed to the program (i.e. $10 billion in year 2014, $6 billion in 2015, and $4 billion in 2016). The funding was allocated among the three state groupings based upon members covered in the individual and commercial group markets (including self-funded plans and grandfathered business). The funding can only be used for eligible claims of non-grandfathered individual members.

Risk Adjustment Program by State Grouping

Table 8F summarizes the risk adjustment results for each of Scenarios 1A, 1B, and 1C.

Table 8F Permanent Risk Adjustment Program Individual Medical Market (millions)											
Dollars Transferred											
	Most Restrictive State Grouping				**Average Restrictive State Grouping**				**Least Restrictive State Grouping**			
Scenario	2014	2015	2016	2017	2014	2015	2016	2017	2014	2015	2016	2017
1A	$68	$ 80	$130	$314	$173	$219	$300	$360	$500	$487	$616	$830
1B	$60	$130	$257	$210	$216	$158	$246	$359	$473	$483	$676	$968
1C	$77	$ 68	$170	$234	$178	$292	$284	$373	$493	$629	$734	$851
Transferred as a % of Total Individual Market Benefits											
	Most Restrictive State Grouping				**Average Restrictive State Grouping**				**Least Restrictive State Grouping**			
Scenario	2014	2015	2016	2017	2014	2015	2016	2017	2014	2015	2016	2017
1A	0.6%	0.5%	0.6%	1.1%	0.8%	0.6%	0.6%	0.6%	1.3%	0.7%	0.7%	0.8%
1B	0.6%	0.8%	1.2%	0.7%	1.0%	0.4%	0.5%	0.6%	1.2%	0.7%	0.8%	0.9%
1C	0.7%	0.4%	0.8%	0.8%	0.8%	0.8%	0.6%	0.7%	1.3%	1.0%	0.9%	0.8%
As a % of Individual Market Benefits of Health Plans Receiving											
	Most Restrictive State Grouping				**Average Restrictive State Grouping**				**Least Restrictive State Grouping**			
Scenario	2014	2015	2016	2017	2014	2015	2016	2017	2014	2015	2016	2017
1A	1.1%	1.6%	1.5%	2.8%	1.0%	2.1%	2.0%	2.0%	3.4%	1.9%	1.3%	1.5%
1B	1.0%	2.6%	2.7%	2.0%	1.3%	1.1%	1.3%	1.3%	3.4%	2.1%	1.3%	1.5%
1C	1.3%	1.1%	2.0%	1.9%	1.1%	1.9%	1.4%	1.7%	3.1%	2.2%	2.6%	2.2%
As a % of Individual Market Benefits of Health Plans Paying											
	Most Restrictive State Grouping				**Average Restrictive State Grouping**				**Least Restrictive State Grouping**			
Scenario	2014	2015	2016	2017	2014	2015	2016	2017	2014	2015	2016	2017
1A	1.5%	0.7%	1.0%	1.9%	3.6%	0.9%	0.9%	0.9%	2.1%	1.2%	1.6%	1.8%
1B	1.4%	1.2%	2.0%	1.2%	4.0%	0.7%	0.9%	1.2%	1.9%	1.1%	2.1%	2.5%
1C	1.7%	0.7%	1.3%	1.5%	3.6%	1.4%	1.1%	1.1%	2.2%	1.8%	1.3%	1.4%

The results shown in Table 8F show some variation by state grouping. As mentioned earlier during the discussion of the nationwide results (see the discussion following Table 6), the risk adjustment flow of funds is highly dependent on how health plans position themselves relative to each other in the marketplace and how people perceive each health plan. The fact that the results differ from one state grouping to another is primarily indicative of differences between the health plans participating in a particular state grouping. The change within a state grouping from one year to another is due to movement on a guaranteed issue basis by individuals of varying risk scores based upon the plans and rates being offered in that year. Again, this membership migration from one health plan to another is dependent on numerous factors specific to each individual, including age, gender, health status, income level, brand loyalty, brand awareness, eligibility for federal premium subsidies, and, of course, the relative premium rates being offered for each plan. Where the percentages relative to benefits incurred for those health plans receiving risk adjustment payments are greater than that for those paying, it is indicative that less healthy risks are concentrated in fewer health plans and possibly those with the greatest membership. Where the relationship is reversed, there are a few carriers with healthy membership providing risk adjustment payments to the other health plans with greater than average health risk scores.

Individual Market Results – Varying Exchange/Risk Mitigation Scenarios

As mentioned earlier, in addition to a status quo scenario, we modeled five different scenarios varying by several criteria: the number of health plans that participate in and outside of the exchanges; plan requirements for the exchanges; the presence of an ACA Basic Health Program; and the risk adjuster method used. These scenarios are described in Table 11 of this report. Table 9 summarizes the results of each of these five scenarios, along with the status quo scenario, for all modeled individual health plans combined. These are all reflective of a rate level scenario in which premium rates are based only on the prior year's experience without adjustment for anticipated adverse selection and capped at 20% per year (as was previously described for Scenario 1A).

Table 9 Results by Exchange/3Rs Scenario and Projection Year Individual Business All Geographic Areas Combined All Health Plans Combined							
Projection Year	Scenario	Enrollment (000)	Premium ($millions)	Average Premium	Loss Ratio w/o Risk Mitigation	Loss Ratio w/ Risk Mitigation	Net Risk Mitigation ($millions)
2013	Status Quo	14,594	$39,764	$2,725	79.9%	79.9%	n/a
2014	Status Quo	14,563	$42,708	$2,933	81.6%	81.6%	n/a
2014	Scenario 1	20,622	$61,431	$2,979	115.7%	86.7%	$17,831
2014	Scenario 2	20,619	$60,439	$2,931	115.5%	86.7%	$17,381
2014	Scenario 3	20,614	$61,486	$2,983	115.3%	86.6%	$17,629
2014	Scenario 4	18,140	$55,309	$3,049	113.5%	85.8%	$15,321
2014	Scenario 5	20,641	$61,683	$2,988	115.1%	86.6%	$17,585
2015	Status Quo	14,535	$46,070	$3,170	82.7%	82.7%	n/a
2015	Scenario 1	29,772	$103,965	$3,492	112.8%	87.8%	$25,995
2015	Scenario 2	29,795	$102,154	$3,429	112.5%	87.8%	$25,173
2015	Scenario 3	29,828	$104,350	$3,498	112.1%	87.7%	$25,542
2015	Scenario 4	25,790	$92,286	$3,578	110.7%	87.2%	$21,672
2015	Scenario 5	29,731	$104,226	$3,506	112.2%	87.7%	$25,509
2016	Status Quo	14,538	$50,779	$3,493	83.2%	83.2%	n/a
2016	Scenario 1	35,259	$147,084	$4,171	104.6%	86.5%	$26,502
2016	Scenario 2	35,278	$144,088	$4,084	104.6%	86.7%	$25,742
2016	Scenario 3	35,321	$147,598	$4,179	104.0%	86.4%	$26,049
2016	Scenario 4	30,237	$129,172	$4,272	103.0%	86.1%	$21,780
2016	Scenario 5	35,202	$147,502	$4,190	104.0%	86.4%	$25,950
2017	Status Quo	14,534	$56,631	$3,897	82.3%	82.3%	n/a
2017	Scenario 1	39,160	$193,513	$4,942	97.0%	97.0%	$0
2017	Scenario 2	39,167	$189,479	$4,838	97.1%	97.1%	$0
2017	Scenario 3	39,214	$194,049	$4,948	96.6%	96.6%	$0
2017	Scenario 4	33,541	$169,632	$5,057	95.7%	95.7%	$0
2017	Scenario 5	39,119	$194,111	$4,962	96.7%	96.7%	$0

Net risk mitigation reflects the sum of the net reinsurance and risk corridor transfer payments received by the health plans. The risk adjustment program payments net to zero ($0) since the program is designed such that payments from the program equal contributions into the program each year.

The results do not vary significantly by scenario, except for Scenario #4, which includes the presence of an ACA Basic Health program. The enrollment in the Basic Health Program is not included in the results shown above, which explains why it has lower enrollment and total premium revenue than the other scenarios.

Another of the differences between these scenarios is the risk adjustment methodology that is used. All the scenarios except for Scenario 5 use a prospective methodology. Scenario 5 uses a concurrent methodology. The difference between these methods is described in Attachment A. Table 10 presents a comparison of the payment transfer results for Scenarios 1 and 5, which are identical except for their risk adjustment method.

Table 10 Permanent Risk Adjustment Program Individual Medical Market Comparison of Prospective Method (Scenario 1) to Concurrent Method (Scenario 5) (millions)								
	Dollars Transferred				**Transferred as a % of Total Benefits**			
Scenario	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Scenario 1	$742	$786	$1,047	$1,504	1.0%	0.7%	0.7%	0.8%
Scenario 5	$775	$1,111	$1,317	$1,687	1.1%	1.0%	0.9%	0.9%
	As a % of Benefits of Health plans Receiving				**As a % of Benefits of Health plans Paying**			
Scenario	**2014**	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Scenario 1	2.0%	1.9%	1.5%	1.8%	2.2%	1.0%	1.3%	1.5%
Scenario 5	3.1%	2.5%	1.7%	1.9%	1.7%	1.5%	1.7%	1.7%

The results show only some minor variation. While the concurrent method resulted in less dollars being transferred in year 2014 than the prospective method, the opposite is true for subsequent years. The reader should however not draw a general conclusion that this will always be the case. It is dependent on our model assumptions and the risk adjustment formulas being used, as described in Attachment A.

SCENARIOS MODELED

Initial Scenarios

In addition to a status quo scenario that assumed the ACA reforms for 2014 and beyond do not go into effect, the following five scenarios were modeled for the analyses presented in this report. Each was modeled separately by three Regulatory Environments (Most Restrictive States, Average Restrictive States, and Least Restrictive States). The states in each Regulatory Environment are summarized in Table B-2 of Attachment B. For Scenario 1, we also modeled three rate level scenarios. The other scenarios reflect only the "A" rate increase assumptions (i.e. rate increases based only on prior experience without adjustment for anticipated adverse selection and with a 20% annual maximum).

Tables 11 and 13 present the various scenarios selected for modeling. Table 11 lists characteristics that are common to all the scenarios. Table 13 shows those characteristics that vary among the six scenarios. There are countless potential scenarios that could be modeled, but there are also realistic limitations on the number of scenarios that can reasonably be modeled due to time, budget, and presentation constraints. The scenarios tested were chosen to measure specific incremental changes to certain characteristics of the reformed health insurance industry.

Assumptions common to all scenarios include the following:

Table 11	
COMMON SCENARIOS CHARACTERISTICS	
Scenario Characteristic	**All Scenarios***
1. **Individual/SG Markets**	Separate markets and exchanges
2. **Premium Rate Development**	
a. Rate Levels	Based on Past Experience Only
b. Rate Increase Caps	20%
c. Rate Reduction Limits	0%
3. **Reinsurance Program**	
a. Payment Method	Based on Actual Incurred Claims
b. Contribution Method	Allocated per member
c. Attachment Point	$50,000
d. Coinsurance	20%
e. Benefit Cap	None
4. **Risk Corridor Calculation**	
a. Calculation Method	Target MLR = 1- Admin Load
b. Application	Each QHP in or out of Exchange
5. **Modeled Health Plan Types**	See Attachment B for a listing of health plan types
6. **Plans Offered by each Health Plan**	See Attachment B for a listing of plan types being modeled
7. **Geographic Area Splits**	3 Separate areas: 1) Most Restricted States; 2) Average Restricted States; and, 3) Least Restrictive States. Table B-2 in Attachment B shows which states have been assigned to each area grouping.

*   The Reinsurance Program and Risk Corridor program do not apply to the Status Quo scenario.

Several of the above characteristics are further described as follows:

1. **Individual/SG Markets**: States are allowed to keep their individual and small group markets as separate markets or as merged markets. A key aspect of a merged market is that premium rates

would be based on the pooled experience of both a health plan's individual business and small group business. This could result in different premium rates than if the markets were not merged, which in turn can affect the dollars of subsidy a person might receive since the premium rates for the second lowest Silver plan might be higher or lower than that of a non-merged market. A merged market can also have implications about a health plan's ability to manage its rates for MLR purposes since rate determination is pooled, but MLR rebate determination is based on the separate experience of each of the two markets. However, given our limitations in the number of scenarios that were feasible to run, we have only run scenarios reflecting separate markets since it is our understanding that most states will keep the markets separate.

2. **Premium Rate Development**: The premium rate development algorithm of the model determines each subsequent year's premium rates based upon the prior year's claims experience. In years 2014 and later, the experience of all the individual products is pooled to determine the premiums for each plan. No provision for future adverse selection is reflected in any of these five initial scenarios. The resulting rate changes are also limited to no more than 20% per year. These are assumptions that significantly affect the sensitivity of the results, as will be shown by varying these restrictions for Scenario #1, as described earlier in the report.

3. **The Reinsurance Program**: ACA introduces a transitional reinsurance program for years 2014 through 2016. HHS has issued a final rule that indicates that the funding will be based on member counts and benefits will be based on claim dollars, irrespective of whether the claimant had a specific condition. Attachment A provides additional description of the reinsurance program.

   States will have considerable flexibility in determining the cost-sharing provisions of the program in terms of the attachment point, coinsurance, out-of-pocket limit, and benefit cap. For this report, a $50,000 attachment point with 20% coinsurance without cap is assumed for all scenarios. However, it should be noted that the reinsurance program is not intended to replace the excess-of-loss reinsurance health plans purchased in today's marketplace. In particular, the total program is funded only up to $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. Traditional reinsurance currently used by many health plans will continue to be needed due to the transitional nature of this program and the limited amount of coverage available through the ACA program.

4. **The Risk Corridor Program**: The transitional risk corridor program, which also is in effect from year 2014 to 2016, has a formula that is replicated in the model. We assume the target claims are consistent with minimum MLR levels. The formula is applied on a QHP level consistent with the final regulation. We have assumed that only plans sold outside of the exchange that have a corresponding plan sold within the exchange are QHPs, along with all plans sold through the exchange.

5. **Modeled Health Plan Types:** The Milliman health care reform model has the feature of being able to simulate the competitive marketplace among health plans. We have modeled nine different types of health plans that typically operate in the individual marketplace. The characteristics of these health plan types vary in terms of their current approaches to medical underwriting, the level of provider discounts they receive, the expense and risk loads they reflect in their premium rates, and their rating methodologies. See Attachment B for various assumptions used for the health plan types.

6. **Description of Plans Offered by Each Health Plan:** We have also modeled health plan types differently in terms of their strategies for exchange participation and plans to be offered within and outside of the exchange starting in year 2014. The plans modeled each represent one of the metal tiers. Some health plan types offer all of them; others are selective as to which of the four metal plans they offer and may vary offering between what is sold in the exchange and outside of the exchange. See Table B-18 in Attachment B for the details assumed.

7. **Geographic Area Splits:** We characterized each state as being more restrictive, less restrictive, or at an average regulatory level for the individual market. These characterizations were based on research we prepared and on our judgment. They are reflective of our assessment of the states based upon each state's regulatory environment as of 2010. Others might categorize the states differently than we have for this study. The three geographic groupings of states are listed in the following table.

Table 12	
STATE REGULATORY GROUPINGS	
Regulatory Environment*	**States**
MR - Most Restrictive	MA, ME, NJ, NY, VT
AR - Average Restrictive	AL, CT, DE, FL, IA, ID, KS, KY, LA, MI, MN, MS, MT, NE, NH, NM, NV, OR, PA, RI, SC, SD, UT, WA
LR - Least Restrictive	AK, AR, AZ, CA, CO, DC, GA, HI, IL, IN, MD, MO, NC, ND, OH, OK, TN, TX, VA, WI, WV, WY

* based on the regulatory environment of the individual market

Table 13 shows key characteristics that differentiate the scenarios.

Table 13 SCENARIOS MODELED						
Scenario Characteristic	**Status Quo**	**Scenario 1**	**Scenario 2**	**Scenario 3**	**Scenario 4**	**Scenario 5**
1. **Basic Health Plan**	None	None	None	None	Yes	None
2. **Exchange Rules**						
a. Health Plan qualification	N/A	Open	Restricted	Open	Open	Open
b. Product limits	N/A	Any QHP	Each metal	Each metal	Any QHP	Any QHP
3. **Modeled Health Plan Count**	9	9	9	9	9	9
a. In Exchange Only	N/A	3	1	2	3	3
b. Outside Exchange Only	9	1	6	2	1	1
c. Both in and out	N/A	5	2	5	5	5
4. **Risk Adjuster Method**	None	Prospective	Prospective	Prospective	Prospective	Concurrent

Each row in the table is further described as follows:

1. **Basic Health Plan**: the Basic Health Plan is an option offered by ACA to each state. The program is for people between 138% of the Federal Poverty Level (FPL) and 200% FPL. It is intended to be a bridge between Medicaid and the individual exchange for those people who tend to move in and out of Medicaid eligibility. The state receives 95% of the premium and benefit subsidies that the BHP members would have qualified for if they were in the federally subsidized exchange. Scenario #4 reflects adoption of the BHP. In all other respects, it is identical to Scenario #1.

2. **Exchange Rules**: This is intended to characterize the type of exchange that a state might develop. An "open exchange" is one in which any willing health plan can market its plans through the exchange with relatively few restrictions. A "restricted exchange" is one that requires an increased

level of qualification criteria to be met before allowing a health plan to participate in the exchange. Fewer health plans are expected to participate in a restricted exchange.

Exchanges may also have certain requirements regarding what plans a health plan must offer. We have reflected those that allow any qualified health plan (QHP) the health plan chooses to be marketed through the exchange. Other exchanges could conceivably require a health plan to offer each type of metal tier[5] plan if it wishes to participate on the exchange. This restriction could affect the number of health plans willing to participate on the exchange. Scenarios #2 and #3 differ from Scenario #1 in these respects.

3. **Modeled Health Plan Count**: Based on the health plan qualifications described in row 2a, we have varied the number of health plans in the model as to whether they sell their products only through the exchange, only outside of the exchange, or through both in and outside of the exchange.

4. **Risk Adjuster Method**: As of the date of when our scenarios were determined, there had been no decision by HHS as to what methodology should be used for the Risk Adjustment program required by ACA to be implemented. Our scenarios use a prospective method, except for Scenario #5 which uses a concurrent method, but is identical to Scenario #1 in all other respects. A description of the "prospective" and "concurrent" methods is presented in Attachment C.

Additional Scenarios

In addition to the five reform scenarios indicated above, we also ran what we refer to as a "status quo" scenario. This scenario reflects the situation under the assumption that none of the future ACA reforms are implemented. This scenario allows us to measure the impact of the ACA reforms in any given projection year. This scenario provides a baseline projection against which changes due solely to the implementation of ACA can be measured.

In reviewing the preliminary results of the projections, we found that the key assumptions resulting in the most variability of the risk adjustment programs, particularly the risk corridor program, were the health plans' assumptions as to the level of rate increase needed, their requests for rate increases, and the approvals of the filed rate changes. Depending on the level of market disruption that a health plan takes into account in its rate development process and the subsequent approval of such requested rates, the risk mitigation programs may not be adequate to ensure that plans are being compensated for the risk that they actually end up bearing. The market disruption may result from adverse selection, the level of expected claims for the currently uninsured population, the volatility of a health plan's membership (switching to other plans), competitors' strategic reactions (e.g. rates and marketing approaches), and other key assumptions in pricing. This led us to add several additional scenarios related to differing rate level assumptions, as discussed earlier, for Scenario 1. The rate level scenarios illustrated are the following:

- *Status Quo*: Reflects expected results as if the 2014 ACA reforms are not implemented. Rate increases for this scenario are uncapped.

- *Scenario 1A*: Reflects expected results for implementation of 2014 ACA reforms, no anticipated adverse selection for years 2014 and later, and a 20% maximum rate increase (excluding increases for age and benefit changes).

- *Scenario 1B*: Reflects expected results for implementation of 2014 ACA reforms, includes pricing for anticipated adverse selection for years 2014 -2016, but with a 20% maximum rate increase (excluding increases for age and benefit changes).

- *Scenario 1C*: Reflects expected results for implementation of 2014 ACA reforms, includes pricing for anticipated adverse selection for years 2014 - 2016, with no maximum rate increase.

---

[5] "Metal tier" plan refers to a health plan with one of the levels of coverage defined by §1302(d)(1) of ACA. Four levels of coverage are described in this section of the law and described as Bronze, Silver, Gold, and Platinum.

SIMPLIFYING ASSUMPTIONS

The following are certain simplifying assumptions used in the projection system model:

1. Assumes that employer groups in excess of 100 employees are all insured through a single health plan. This assumption was made in recognition that the focus of the analysis was on the small group and individual markets which are the ones most affected by the ACA reforms.

2. Requires that all movements and change decisions occur either at the end of a projection year or at the beginning of a projection year. No changes within the year are assumed to occur.

3. Does not explicitly reflect the impact of the minimum loss ratio requirement of ACA. This is implicitly reflected by the choice of pricing targets for the affected lines of business.

4. Changes in job status are not projected.

5. Changes in employer size are not included, other than for deaths.

6. Assumes only one plan is offered by a given employer.

7. Does not permit an employee to switch to spouse's coverage from own employee's coverage, or vice versa, due to data and assumption limitations.

8. Assumes there is no movement from between the self-funded group market to a fully insured arrangement and vice versa. The system can model such movements, but such change factors were not available to model such movements.

9. Uses a fixed set of up to five plan benefit designs for all the health plans within a market. These have been chosen to represent the actuarial values required for each of the ACA metal plans, even for projection years prior to 2014. As such, the projection results do not capture any rate increases due to having to move from a non-qualified plan to one that meets the minimum 60% actuarial value requirement.

10. Excludes the cost and impact of supplemental and ancillary coverages such as mini-meds, LTC, disability income, accident, cancer and critical illness plans.

11. Makes no provision for reflecting the presence and impact of HSA and HRA accounts and contributions made to such accounts by employers and individuals.

12. Does not allow individual family members to switch to a non-family plan, except for those newly eligible for Medicare or reaching the child dependent limiting age. However, it does allow for individual family members to separate from the family in market switching scenarios.

13. Is not an econometric model. The number of employers is assumed to be constant (i.e. new employers offset business failures). Also, while the number of employees for a given employer may change due to deaths and other assumptions, the system does not model fluctuations in employee sizes due to business reasons.

14. Does not reflect the impact of ACA on Medicare Advantage and Medicare Part D plans, nor does it model the impact on Medicaid, other than movement to Medicaid due to new expanded eligibility rules effective in year 2014. Does not reflect the potential for individuals to switch between individual and Medicaid as economic status changes. This is also true of the Basic Benefit Plan modeled in Scenario #4.

15. Does not reflect SHOP Exchange employee choice.

16. Does not reflect the impact of MLR waivers granted to certain states.

17. Does not reflect the potential range of take-up factors that may be experienced in some states, caused by the range of individual economic conditions, the range of products offered in the market, and other factors.

18. Does not reflect delivery system issues, such as provider access.

LIMITATIONS, CAVEATS AND RELIANCE

It should be noted that the choice of scenarios was constrained by available time and budget. Our results do illustrate the potential impact on premiums, enrollment, and other key metrics of variations in some key assumptions, but they do not represent the full range of possible outcomes. This is also partially attributable to our current incomplete knowledge of the ultimate choices that will be made by regulators, as well as choices made by health plans, employers, providers, and citizens.

The results of our analysis are projections, not predictions, and they are dependent upon the set of assumptions that is used. The results are likely to vary if a different set of assumptions is used. It is very likely that future experience will not exactly conform to these projected results. We have conducted limited sensitivity testing of our results to changes in assumptions. As expected for as complex a system as we are attempting to model, changes in some assumptions can produce significant changes in results, due to the interrelationships of factors influencing the results. It is possible that actual results will be outside the range we have shown.

We have relied on various sources for data and information upon which the underlying assumptions have been developed. In many cases there has not been adequate experience data upon which to develop assumptions, and we have had to rely on judgment.

The analyses are based upon our understanding and interpretation of ACA and its related regulations. At the time we did the analyses for this report, the government had not issued final regulations related to many of the reforms to be effective starting in the year 2014. Furthermore, interim regulations issued are likely to be amended in some fashion in the future. We also note that states will be allowed some flexibility in varying certain aspects of the 3Rs, Exchange operations and requirements, and other provisions of ACA, which may impact results differently than what has been presented. Note that the authors are not attorneys, and that Milliman does not provide legal advice to clients.

Milliman advises reader not to take any action solely in reliance on this report. Any of the results presented could prove to be different for any one state or health plan.

ACKNOWLEDGMENTS

The authors would like to acknowledge and thank the Society of Actuaries for the opportunity to conduct this study on its behalf. We also wish to recognize and thank the SOA Project Oversight Group (POG) and the SOA staff members for their active participation in the design of the study and for the considerable time and effort they dedicated in reviewing the report and its results and in providing helpful feedback and suggestions that made the report all the more valuable to its readers.

Attachment A

ABOUT THE HCRFM

Introduction

The Milliman Health Care Reform Financing Model (HCRFM) was developed by Milliman, Inc. (Milliman) to assist clients with an assessment of the potential impact of a particular health care reform requirement to be evaluated. The creation of HCRFM is the result of a collaborative effort among numerous Milliman consultants in various Milliman offices. The HCRFM models the potential costs and movements of individuals and the interaction between competing medical cost payers and providers within and between the various insurance markets that comprise the U.S. health care system for a given proposed health care financing scheme.

Modeling includes provision for:

- Seriatim projection of each census record, including differentiation by age, gender, income status, and health status. For these projections, we have used a random sample of 10% of a census file which represents all 300 million people in the United States.

- Twelve (12) different market segments, each with its own set of demographic, change factor, health care cost, and premium rate determination assumptions. The market segments being used are the following:

Table A-1
MARKET SEGMENT MODELED
1. Individual
2. State/Federal High Risk Programs
3. Uninsured
4. Small Group : 1 - 10 employees
5. Small Group : 11 - 25 employees
6. Small Group : 26 - 50 employees
7. Group : 51 - 100 employees
8. Group : 101 - 999 employees
9. Group: 1000+
10. Medicaid
11. Medicare
12. Basic Health Program

While we are modeling 12 different markets, our focus is almost entirely on the individual market, which is subject to the risk mitigation programs. Some people in other markets move out of those markets into one of the other markets, including the individual market place. Others in the individual market may move into one of the other markets. In particular, there is considerable movement from the uninsured market into the individual market and the Medicaid market. People in the commercial markets who become Medicare eligible are assumed to move to the Medicare market. See Attachment A for a listing of the assumed movement factors from one market to another.

- Nine (9) different health plan types within each commercial market segment were modeled. These are characterized as shown in Table A-2.

Table A-2
HEALTH PLAN TYPES MODELED
1. Single State Health plan
2. National Health plan group #1
3. National Health plan group #2
4. HMO/Local Health plan #1
5. HMO/Local Health plan #2
6. Local/Regional Health plan #1
7. Local/Regional Health plan #2
8. Non-Profit COOP*
9. Multi-State OPM Plan*

* New health plans entering in year 2014

- Up to 5 different benefit plan designs per health plan within each market segment for grandfathered plans; up to another 5 for exchange plans, and up to 5 more for non-grandfathered/non-exchange plans. The plans chosen reflect the metallic plans offered by each health plan type for each of these categories.

- This model includes results from 2010 through 2017. We show results from 2013 through 2017.

- Change algorithms applied to each individual and employer group in the census.   Change algorithms used are in two basic types: 1) likelihood to change from one market to another; and, 2) likelihood to change from one health plan/plan combination to another within a market.

- Morbidity projection based on a correlated stochastic process, including provision for alternative probability distributions. This feature allows a particular person to have either improving or deteriorating health status from one year to the next. The randomness of such change is controlled though a correlation factor to the original health status and the prior year health status of each person. We are using a 0.90 correlation factor for this model (i.e. allows up to only 10% random variation from one year to the next).

- Measurement of the impact of the ACA risk mitigation programs, including options on the methodology to be used for each program.

Switching (Change Factor) Process

The switching process develops the probability of an individual switching from his current market segment or current insurance plan into each available competing market segment or to a different insurance plan within his current market, including the likelihood of remaining in his current market segment and plan. Plan movement is based on the premium variance between current and possible alternative market segment plans, adjusted by elasticity factors related to the individual's health status, current insured status, income level, and other characteristics at that time.   Similarly, movement to a new market is based upon selected characteristics of the individual or employer.

Market Switching

Movement from the uninsured market is based upon change factors that Milliman developed through research on certain programs such as health reform in Massachusetts and Maine's Dirigo project, along with our judgment. Assumed movement varied by age, gender, income level, health status, and the market to which each uninsured person would change. It was assumed that a currently uninsured individual would stay uninsured, move to the Medicaid market, or obtain

coverage in the individual market (or Basic Health Plan for Scenario #4). However, in recognition of the relatively low initial penalties or incentive to change their uninsured status in year 2014 to purchase a health plan, we have assumed that our change factors to the Individual Medical Market from the Uninsured market are graded in over time as penalties grow. We have assumed the following phase-in multipliers of our uninsured person change factors to the individual market:

TABLE A-3 PHASE-IN OF MARKET CHANGE FACTORS UNINSURED TO INDIVIDUAL			
Projection Year	Most Restrictive	Avg. Restrictive	Least Restrictive
2014	0.25	0.40	0.45
2015	0.50	0.70	0.75
2016	0.75	0.85	0.90
2017	1.00	1.00	1.00

These phase-in assumptions have a significant impact on the results of our analysis. We note that we have developed these phase-in factors based solely on judgment. These factors were not applied to movement to the Medicaid market since this decision would either not cost or be relatively low cost to newly eligible uninsured people to get their new coverage. We have assumed that 100% of those newly eligible for either program move to that program in 2014.

Plan Switching

In addition to the individual characteristics mentioned above, the plan switching process makes provision to reflect:

- Brand awareness of a given insurance health plan and other intangibles (e.g. quality of provider network, health plan's distribution systems, etc.)

- Brand loyalty is a measure of the increased likelihood of a person to stay with their current health plan due to their satisfaction (or dissatisfaction) with the health plan.

- Health plan claims expectations (premium underwriting) versus employer and individual's claims expectations (benefit worthiness

- Benefit relativities of the various available plans

- The differences in rates between the plans and the current plan rate

The probability of choosing a plan design of a particular health plan (including the current plan) is set in direct proportion to the propensity of choosing a given insurer/plan combination, which is determined by the following formula:

Pr (P, C) = Propensity of choosing Plan P of Insurer C = IF x BF x BW x [1/(1+RI –INFL)] x BR

where:

IF – *Incumbent (Inertia) Factor* – A measure of the inertia of the family to change insurer or plan of coverage. The incumbent factor must be between zero and 1. The IF applies to the Current Health plan and Plan. All other potential quotes are assigned an IF equal to (1-IF) / (# of quotes).

Incumbent factors are looked up from elasticity tables specified in the assumptions. Within this assumption, tables for looking up the inertia to stay with the current health plan are specified. The table values to look up this inertia factor may vary by the following characteristics:

- o Rate increase (measured after application of employer contributions and federal subsidies)
- o Primary insured's multiple of the federal poverty level (FPL)
- o Average health status of family using current and previous year's health status.
- o Age of the Primary
- o Gender of the Primary
- o Year
- o Market code

Different incumbent factor tables can be used for different projection years. We have used incumbent factor tables that vary by projection year, rate increase level, health status, age/gender, and income level.

BF – *Brand Factor* – A ratio of the potential health plan's brand awareness compared to the brand awareness of the current health plan's brand name. A ratio less than 1.0 indicates a movement to a new brand is less likely; a ratio greater than 1.0 that migration is more likely. This is a combination of the Brand Loyalty factor and the Brand Awareness factor assigned to each health plan type.

BW – *Benefit Worthiness* – A ratio of the insured's claims expectations compared to the Health plan's claims expectations.

RI – *Rate Increase* – The ratio of this year's premium quoted for the potential plan less subsidy to last year's premium charged less last year's subsidy of the current plan.

BR – *Benefit Relativity* – The ratio of the benefit value of the plan being switched to relative to the current plan. However, the system limits the extent of these differences through the use of switch tolerance limits. We have assumed limits of 10% on the high side and 15% on the low side.

INFL – *Inflation Indicator* - The annual inflation rate or other appropriate indicator. This dampens the impact of the rate increase to the amount of the rate increase in excess of the indicator.

The following table provides an illustration of the change process. This example is not specific to any particular health plan or plans used in the SOA model.

		Health Plan 1	Health Plan 2	Health Plan 3	Health Plan 4	Health Plan 5	Total
Table A-4 MILLIMAN HEALTH CARE REFORM PROJECTION MODEL **Individual Switching Process** **Example**							
STEP 1: Calculate probabilities of switching to each health plan/plan for a given individual/family							
Incumbent Factor	IF	0.700	0.075	0.075	0.075	0.075	
Brand Factor	BF	1.000	1.250	1.050	0.800	0.950	
Benefit Worthiness	BW	0.900	1.050	1.075	1.050	1.000	
Rate Increase	RI	0.150	0.120	0.100	0.100	0.180	
Inflation Indicator	INFL	0.050	0.050	0.050	0.050	0.050	
Benefit Relativity	BR	1.000	1.050	0.900	1.100	1.000	
Minimum Rate Increase		0.100	n/a	n/a	n/a	n/a	
Benefit Relativity	BRT High	0.100	0.100	0.100	0.100	0.100	

Table A-4 MILLIMAN HEALTH CARE REFORM PROJECTION MODEL Individual Switching Process Example							
		Health Plan 1	**Health Plan 2**	**Health Plan 3**	**Health Plan 4**	**Health Plan 5**	**Total**
Tolerance – High							
Benefit Relativity Tolerance – Low	BRT Low	0.150	0.150	0.150	0.150	0.150	
STEP 2: Sum and normalize switching probabilities							
Switching Propensity	SP	0.573	0.097	0.073	0.066	0.063	0.871
Normalized Switching Probability	SPN	0.658	0.111	0.083	0.076	0.072	1.000
Accumulated Probability		0.658	0.769	0.852	0.928	1.000	
STEP 3: Select random number to see what health plan is selected							
e.g. if random number selected is 0.23, the employer stays with the incumbent since 0.23 is less than 0.658.							
e.g. if random number selected is 0.98, the employer moves to Health plan 5 since 0.98 is greater than 0.928.							
e.g. if random number selected is 0.70, the employer moves to Health plan 2 since 0.70 is between 0.658 and 0.769.							

Expansion of the Small Group Market to 100 Employees

The values shown in this report reflect the recognition that the definition of a small group will by law be expanded to 100 or fewer employees starting in the year 2016. States have the prerogative to change the definition before this date, but our projection assumes that all states will wait until year 2016. This should be kept in mind when reviewing the results and movements for small group and large group from year 2015 to 2016.

Health Care Cost Projections

Health care costs for each modeled member are calculated each projection year based on:

- Trended claim costs

- The individual's assigned health status and market utilization factor for the projection year, using a correlated stochastic probability algorithm

- The plan benefit richness

- The health plan cost-sharing provisions (deductible, coinsurance, copayments, out-of-pocket limits)

Health Status and Market Utilization Factors

As mentioned above, a starting health status and market utilization factor (health status factor) was assigned to each census record. An initial health status (morbidity index) is assigned to each individual census record through use of a stochastic modeling routine specific to the market of the individual. Based upon Milliman research of the various lines of health insurance business, the uninsured, and government programs (markets), we balance to an overall average health status and utilization factor within each market. The target levels by market are:

Table A-5 Average Health Status/Market Utilization Factors by Geographic Grouping and Market			
Market	**Most Restrictive**	**Average Restrictive**	**Least Restrictive**
Individual	1.231	0.920	0.806
High Risk	2.500	2.500	2.500
Uninsured	1.091	1.133	1.149
SG : 1 - 10 EEs	1.293	1.058	1.131
SG : 11 - 25 EEs	1.067	0.996	1.099
SG : 26 - 50 EEs	1.059	1.013	1.105
Group : 51 – 100	1.024	0.944	0.974
Group : 101 - 999	1.024	0.961	0.965
Group: 1000+	0.991	0.962	1.055

Note that because the geographic groupings for all markets are defined by the rating restrictions in each state's individual market, the relative health status/utilization factors in the small and large group markets will not exhibit the same relative health status as calculated in the individual market. In other words, the least restrictive geographic grouping will not have the lowest group health status/utilization of the three geographic areas. A different combination of states represent the most, average, and least restrictive state groupings for the group business since current group regulations differ from individual regulation in many states in terms of their restrictions.

The HCRFM system allows changes to each person's health status/utilization factor each year through application of a correlated stochastic process which is related to each person's starting and prior year health status. The correlation coefficient controls how much random change is allowed each year. A correlation coefficient of zero (0) means that there is no relationship to the previous year's morbidity level (other than both continue to be related to the initial level), whereas a correlation coefficient of one (1) would result in each year's morbidity level being equal to the starting level (i.e. no change in factor). For these scenarios, we have used a correlation coefficient of 0.90.

The choice of correlation coefficient directly affects the ACA Part 5 risk mitigation programs since it is a determinant of the probability that a person will have a large claim and is the key element involved in determining the risk adjustment calculations.

ACA Risk Mitigation Programs

ACA contains three programs intended to stabilize the individual and small group markets following the implementation in year 2014 of guaranteed issue with no pre-existing condition limitations and strict limitations on a health plan's ability to rate according to the inherent actuarial value of the risks that it insures. These programs are:

- the transitional reinsurance program for individual markets in each state (Section 1341);
- transitional risk corridors for plans in individual and small group markets (Section 1342); and
- risk adjustment (Section 1343).

These programs are described in Part 5 of Subtitle D of Title I of ACA and are therefore collectively known as the Part 5 programs. All three programs are effective in 2014. The first two programs are temporary and terminate after 2016.

Transitional Reinsurance Program

The transitional reinsurance program is temporary, running for three years beginning January 1, 2014, and applies reimbursement to individual market health plans only, although it is funded by health plans selling insured coverage in the group and/or individual markets as well as by third party administrators (TPAs) servicing self-funded employer group plans. The ACA originally charged the Secretary of Health and Human Services (the Secretary) with identifying criteria for determining high-risk individuals, based on a list of 50 to 100 conditions that are "indicative of individuals with pre-existing high-risk conditions," or a comparable method recommended by the American Academy of Actuaries. A final rule issued by HHS on March 16th indicates that eligibility will be based upon actual claim levels rather than a condition list. States will be responsible for determining the benefit provisions of the program (attachment point, health plan coinsurance, out-of-pocket limit, and/or benefit cap). Grandfathered plans are excluded from receiving reimbursement from the program.

The transitional reinsurance program is funded via a levy on the commercial insurance blocks of all health plans, with nationwide levy amounts totaling $10 billion for 2014; $6 billion for 2015; and $4 billion for 2016. In addition to these amounts, which are intended to fund the reinsurance payments, the act specifies additional amounts ($2 billion in 2014 and 2015, and $1 billion in 2016) which are to be included in a levy. The levy is apportioned among all health plans and third-party administrators of self-funded business, with each company's assessment reflecting its "…fully insured commercial book of business for all major medical products and the total value of all fees charged by the issuer and the cost of coverage administrated by the issuer as a third-party administrator." The ACA allows for states to add additional assessments. For the claims funding, this method is intended to be a zero-sum program.

We have estimated the share of these direct program levies (contributions) for each state grouping based upon member distribution. This is consistent with the final regulation issued by HHS on March 16th. Table A-6 shows the amounts assumed for nationwide and for each state grouping.

Table A-6a MILLIMAN HEALTH CARE REFORM PROJECTION MODEL Allocation of Transitional Reinsurance Assessments ($ millions)				
Projection Year	Nationwide	Most Restricted	Average Restricted	Least Restricted
2014	$10,000	$1,268	$3,449	$5,283
2015	$ 6,000	$ 761	$2,069	$3,170
2016	$ 4,000	$ 507	$1,379	$2,113

Table A-6b MILLIMAN HEALTH CARE REFORM PROJECTION MODEL Transitional Reinsurance Assessments per Assessed Member				
Projection Year	Nationwide	Most Restricted	Average Restricted	Least Restricted
2014	$62.46	$65.10	$63.83	$61.01
2015	$36.00	$38.12	$36.85	$35.01
2016	$23.30	$24.72	$23.85	$22.64

Table A-6c				
MILLIMAN HEALTH CARE REFORM PROJECTION MODEL				
Transitional Reinsurance Assessments				
as a Percentage of Assessed Premium Equivalents				
Projection Year	**Nationwide**	**Most Restricted**	**Average Restricted**	**Least Restricted**
2014	1.36%	1.54%	1.37%	1.36%
2015	0.72%	0.79%	0.73%	0.72%
2016	0.42%	0.45%	0.43%	0.42%

We have assumed that all funds will be distributed on claims incurred during the same year in which the levied amounts are collected. We have reflected only the claims funding of the program and have not included the impact of the additional Federal assessments that do not support the program directly or any additional state assessments that could be levied.

Table A-7, below, shows both the benefits and assessments ("Contributions") for the individual market by scenario, year and regulatory environment. It also presents the ratio of the reinsurance subsidy (i.e. benefits of the program less contributions to the program) to total benefits incurred each year.

The model has assumed that 100% of the nationwide assessments ($10 billion, $6 billion, and $4 billion) are distributed to the individual market in the same year as it is assessed. Given that the modeled scenarios in this analysis all assumed the same attachment point ($50,000), coinsurance (20%), and benefit cap (none), the benefits are the same for all five scenarios.

Table A-7								
TRANSITIONAL REINSURANCE PROGRAM								
INDIVIDUAL MEDICAL MARKET								
CONTRIBUTIONS (ASSESSMENTS) BY MARKET AND PROJECTION YEAR WITHIN STATE GROUPING								
(billions)								
	Most Restrictive State Grouping			**Average Restrictive State Grouping**			**Least Restrictive State Grouping**		
Scenario	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
Individual Market Reinsurance Benefits									
1	$1.3	$0.8	$0.5	$3.4	$2.1	$1.4	$5.3	$3.2	$2.1
2	$1.3	$0.8	$0.5	$3.4	$2.1	$1.4	$5.3	$3.2	$2.1
3	$1.3	$0.8	$0.5	$3.4	$2.1	$1.4	$5.3	$3.2	$2.1
4	$1.3	$0.8	$0.5	$3.4	$2.1	$1.4	$5.3	$3.2	$2.1
5	$1.3	$0.8	$0.5	$3.4	$2.1	$1.4	$5.3	$3.2	$2.1
Individual Market Reinsurance Contributions									
1	$0.1	$0.1	$0.1	$0.4	$0.4	$0.3	$0.7	$0.6	$0.5
2	$0.1	$0.1	$0.1	$0.4	$0.4	$0.3	$0.7	$0.6	$0.5
3	$0.1	$0.1	$0.1	$0.4	$0.4	$0.3	$0.7	$0.6	$0.5
4	$0.1	$0.1	$0.1	$0.4	$0.3	$0.2	$0.7	$0.5	$0.4
5	$0.1	$0.1	$0.1	$0.4	$0.4	$0.3	$0.7	$0.6	$0.5

Table A-7 TRANSITIONAL REINSURANCE PROGRAM INDIVIDUAL MEDICAL MARKET CONTRIBUTIONS (ASSESSMENTS) BY MARKET AND PROJECTION YEAR WITHIN STATE GROUPING (billions)									
	Most Restrictive State Grouping			**Average Restrictive State Grouping**			**Least Restrictive State Grouping**		
Scenario	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**	**2014**	**2015**	**2016**
Individual Market Total Claims before Mitigation									
1	$10.7	$16.4	$22.3	$21.6	$35.7	$46.8	$38.8	$65.2	$84.7
2	$10.5	$16.0	$21.8	$21.2	$35.0	$45.8	$38.1	$63.9	$83.1
3	$10.7	$16.4	$22.2	$21.4	$35.5	$46.6	$38.8	$65.2	$84.7
4	$9.8	$14.9	$20.0	$18.8	$31.1	$40.4	$34.1	$56.2	$72.6
5	$10.7	$16.4	$22.2	$21.5	$35.6	$46.7	$38.8	$64.9	$84.5
Ratio of Individual Market Reinsurance Subsidy to Total Benefits									
1	11%	4%	2%	14%	5%	2%	12%	4%	2%
2	11%	4%	2%	14%	5%	2%	12%	4%	2%
3	11%	4%	2%	14%	5%	2%	12%	4%	2%
4	12%	5%	2%	16%	6%	3%	14%	5%	2%
5	11%	4%	2%	14%	5%	2%	12%	4%	2%

The net subsidy to the Individual market from the Group market as a percentage of Individual market incurred benefits is also shown above in Table A-7. It shows an 11% to 14% ratio in 2014, but then the ratio falls the following years to 4% to 6% in 2015 and 2% to 3% in 2016. This percentage reduction is not only a result of decreasing total contributions to the program from the group market, but also due to the phase-in assumptions for bringing the uninsured into the individual marketplace (see Table A-3).

Risk Adjustment Program

The risk adjustment program is a permanent program that will be carried out under the criteria and methods established by the Secretary, in consultation with states. The criteria and methods may be similar to those utilized under Medicare Part C or D. Using risk adjustment, revenue will be shifted from health plans with lower than average actuarial risk members (i.e., healthier enrollees) to those with higher than average actuarial risk members (i.e., sicker enrollees). Such adjustments apply to plans in the individual and small group markets, but do not apply to grandfathered plans.

The two risk adjustment methods currently used in the Medicare, Medicaid, and commercial medical insurance markets can be classified as either concurrent method or prospective. Each method offers certain advantages over the other. HHS will use a concurrent method as the federal approach to implementing the risk adjustment program, but will allow states to use an alternate method of their choosing, subject to HHS approval. This analysis modeled both methods to assess their difference in impact.

A concurrent risk adjustment method develops relative health status factors for every member in the population. These health status factors represent the relative expected resource use for members for the same period for which the input data was gathered. For example, a common concurrent risk adjustment methodology would be to use ICD9 diagnosis data from CY2011 to estimate members' relative health status in CY2011.

A prospective risk adjustment method, on the other hand, develops relative health status factors applicable to a future period based on historical data. A common prospective risk adjustment methodology would be to use ICD9 diagnosis data from CY2011 to estimate members' relative health status in CY2012.

The HCRFM is an annual calendar year based projection system. As such, it does not model activity that occurs on a monthly or quarterly basis. So, while the risk adjustment factors may get revised during the year (e.g. on a quarterly basis), our projection reflects only a single factor per person each year. An individual's health status is assumed to remain unchanged during the year. The HCRFM also ignores timing differences, such as the elapsed time between data collection and the determination of final risk scores.

In addition to calculating the projected actual payments that a health plan may need to pay or will receive, the system also estimates what these payments or receipts will be at the end of the prior projection year for the purpose of setting premium rates for the current year. Because the current year results are not necessarily known at the time, such estimation is based on the members in force and the plan experience in the prior year. This creates a potential mismatch between the impact of the risk mitigation programs as reflected in the premium rates to be charged during the year and the actual net payments the health plan will need to pay or will receive.

For the calculation of prospective risk scores, we used individuals with 12 months of eligibility in our research database. As a result, the factors do not need to be weighted by member months (i.e. partial year exposures).

The formulas we have used are one approach to calculating the risk adjustment payments. There are other potential approaches that could be used. While HHS will use a concurrent method, it has not yet released the calculation model it will employ. Each state may adapt its own approach within guidelines. Our method was useful given the annual projection period methodology being employed by the HCRFM. The following are the basic formulas used by HCRFM in calculating these values for the prospective method.

PROSPECTIVE METHOD

$Actual\ Dollar\ Impact\ of\ Risk\ Adjuster\ Program\ (CY)$

$$= \left[\frac{\left(\frac{\sum_{i \in Plan(CY)} HS(PY)_i}{Plan\ Exposure\ (CY)}\right)}{\left(\frac{\sum_{j \in Pool(CY)} HS(PY)_j}{Pool\ Exposure\ (CY)}\right)} - 1\right] \times Average\ Benefit(CY)\ of\ Pool \times PlanExposure(CY)$$

$Predicted\ Per\ Exposure\ Dollar\ Impact\ of\ Risk\ Adjuster\ Program\ (NY)$
$= Predicted\ RiskAdjuster$

$$= \left[\frac{\left(\frac{\sum_{i \in Plan(CY)} HS(CY)_i}{Plan\ Exposure\ (CY)}\right)}{\left(\frac{\sum_{j \in Pool(CY)} HS(CY)_j}{Pool\ Exposure\ (CY)}\right)} - 1\right] \times Average\ Benefit(CY)\ of\ Pool\ Trended\ to\ Next\ Year$$

where, $\sum_{i \in Plan(CY)} HS(CY)_i$ is the population-weighted sum of the risk scores (or health status factors) for the current year, over the members in force in the plan. It is divided by the current year exposure of members (Plan Exposure (CY)) to derive the plan's average risk adjustment factor. The same is done for the determinant pool (i.e. the entire non-grandfathered business in the individual market and separately for the entire small group market). CY represents the current year; PY the prior year; and NY is the next year. Average Benefit (CY) represents the average incurred claims of the pool in the current year.

CONCURRENT METHOD

$Actual\ Dollar\ Impact\ of\ Risk\ Adjuster\ Program\ (CY)$

$$= \left[\frac{\left(\frac{\sum_{i \in Plan(CY)} HS(CY)_i}{Plan\ Exposure\ (CY)}\right)}{\left(\frac{\sum_{j \in Pool(CY)} HS(CY)_j}{Pool\ Exposure\ (CY)}\right)} - 1\right] \times Average\ Benefit(CY)\ of\ Pool \times PlanExposure(CY)$$

$$Predicted\ Per\ Exposure\ Dollar\ Impact\ of\ Risk\ Adjuster\ Program\ (NY)$$
$$= Predicted\ RiskAdjuster$$
$$= \left[\frac{\left(\frac{\sum_{i\,\in Plan(CY)} HS(NY)_i}{Plan\ Exposure(CY)} \right)}{\left(\frac{\sum_{j\,\in Pool(CY)} HS(NY)_j}{Pool\ Exposure(CY)} \right)} - 1 \right] \times Average\ Benefit(CY)\ of\ Pool\ Trended\ to\ Next\ Year$$

where, $\sum_{i\,\in Plan(CY)} HS(CY)_i$ is the population-weighted sum of the risk scores (or health status factors) over the members in force in the plan. It is divided by the current year exposure of members (Plan Exposure (CY)) to derive the plan's average risk adjustment factor. The same is done for the determinant pool (i.e. the entire non-grandfathered business in the individual market and separately for the entire small group market). CY represents the current year; PY the prior year; and NY is the next year. Average Benefit (CY) represents the average incurred claims of the pool in the current year.

For the purpose of setting premium rates for the next year, the predicted amount per exposure is subtracted from the trended experience claims being used to determine the premium rates and divided by the target loss ratio. The model allows for ad hoc adjustments to these calculated premium rates to reflect the anticipation of any changes the pricing actuary may want to include, although for these projections no ad hoc adjustments were assumed.

These formulas assume knowledge of the health status of all enrollees in a health plan's portfolio of plans, including new members to the plan. This may not be the case for the prospective method when the actual methodology prescribed by HHS is implemented. New members may be assigned only an average risk score rather than their actual score for this method. We have not tested how results might change if the prospective method were to be implemented on this basis.

Transitional Risk Corridor Program

The transitional risk corridor program for the individual and small group markets mirrors that established by the Medicare Modernization Act for Medicare Part D. Health plans retain 100% of gains or losses for qualified health plans with allowable costs (described below) within 3% of target (i.e., 97% of target to 103% of target). Health plans retain 50% of gains or losses for the next 5% band (92% of target through 97% of target, and 103% of target to 108% of target). Outside that range, health plans retain 20% of gains or losses. The target amount defined as the total amount of premiums, including any premium subsidies under any government program, less the administrative costs of the plan (limited to 20% of premium). The allowable costs compared to target are total non-administrative costs, reduced for any payments received under the other two ACA risk mitigation programs. This program is effective for qualified health plans for calendar years 2014, 2015, and 2016 and applied on a plan-by-plan basis.

ACA specifies only one method for this program, although the interpretation of what plans are eligible and how the target and allowable claims are determined could differ. The HCRFM system determines the ins and outs by plan for this program after application of the other two risk mitigation programs. We have interpreted ACA to indicate that this program, unlike the other two, is not a zero-sum result, and the Federal government will either pay out or collect any differences from target levels. This program does not have a direct impact on the premium rate setting process.

We have illustrated the projected results of the risk corridor program in the Results section of this report (see Tables 7 and 8D).

Premium Setting Process

Premium rates for each plan are a function of the plan's past trended experience, the target loss ratio for the plan, the impact of pooling the plan's experience with that of other plans in the pool, and any ad hoc rate increases assumed to be implemented for the plan. The model allows the user to choose the experience period over which the premiums will be determined, either the most recent year or the last two years before the pricing period. The two years can be weighted differently by health plan and plan

as to the impact. Each plan of a health plan can be assigned a pool of other plans. For pooled plans, the rates will be determined based upon the combined experience of all the plans included in the pool. There can be multiple pools used by any given health plan. Experience can be pooled across health plans and across markets if desired. A base rate or community rate is determined and then the plan's age/gender factors (age factors only after 2014 for non-grandfathered plans) are applied to the base rate to determine the rate to charge to the individual. If still allowed, an individual may have also been assigned an underwriting rate-up factor due to his/her health status. Ad hoc rate increases can also be reflected by year for each plan.

The model used for this report assumed rate setting is based upon pooled experience between exchange and non-grandfathered non-exchange plans of a health plan. Effectively, since exchanges are introduced in year 2014, the pooling between exchange and non-exchange plans only begins in 2014 and later. We have assumed pooled plans consider only the current year's experience in determining premium rates for the next year.

The basic premium formula is:

Premium Rate(t) = {∑ [(Wt$_{t-2}$ x Claims Experience$_{t-2}$ + Wt$_{t-1}$ x Claims Experience$_{t-1}$)/(Wt$_{t-2}$ + Wt$_{t-1}$)] x (1+ Trend$_t$) / (1 − Load$_t$)} x AdHoc$_t$ x Age/Sex Factor

where Wt$_t$ is the weight to assign to the claims experience of year t.

We employed different rate level scenarios, as follows:

- *Status Quo*: Reflects expected results as if the 2014 ACA reforms are not implemented. Rate increases for this scenario are uncapped.

- *Scenarios 1A, 2 - 5*: Reflects expected results for implementation of 2014 ACA reforms, no anticipated adverse selection for years 2014 and later, and a 20% maximum rate increase (excluding increases for age and benefit changes).

- *Scenario 1B*: Reflects expected results for implementation of 2014 ACA reforms, pricing for anticipated adverse selection for years 2014 and 2015, but with a 20% maximum rate increase (excluding increases for age and benefit changes).

- *Scenario 1C*: Reflects expected results for implementation of 2014 ACA reforms, pricing for anticipated adverse selection for years 2014 and 2015, with no maximum rate increase.

We also limited base rate reductions to no more than 0%.

Attachment B

Key Underlying Assumptions

Milliman, Inc.

Key Underlying Assumptions

CENSUS

A. *Used U.S. MEPS and U.S. Census data (March 2010) coupled with market research data for demographic and insurance splits of the baseline U.S. census data*

1. Member counts by age, gender, and family composition

2. Family size

3. Line of business

4. Employer size

B. *Distribution of population by geographic grouping and market*

	Table B-1A DISTRIBUTION OF POPULATION BY GEOGRAPHIC GROUPING AND MARKET (IN THOUSANDS)			
Market	**Most Restrictive**	**Average Restrictive**	**Least Restrictive**	**Grand Total**
Individual	1,489	5,018	8,134	14,641
High Risk	3	101	153	257
Uninsured	4,620	15,673	29,206	49,499
SG : 1 - 10 EEs	1,264	2,753	4,254	8,271
SG : 11 - 25 EEs	1,088	3,159	4,875	9,122
SG : 26 - 50 EEs	1,021	3,181	5,405	9,607
Group : 51 – 100	1,132	2,912	4,612	8,656
Group : 101 - 999	3,964	9,035	16,102	29,101
Group: 1000+	10,117	29,038	44,792	83,947
Medicaid	7,869	17,328	29,934	55,132
Total Non-Medicare	**32,569**	**88,197**	**147,467**	**268,233**
Medicare	5,338	15,792	21,868	42,998
Total	**37,907**	**103,989**	**169,336**	**311,232**

Table B-1B shows the percentage distribution of the population shown above within each geographic area.

Key Underlying Assumptions

Table B-1B				
DISTRIBUTION OF POPULATION BY GEOGRAPHIC GROUPING AND MARKET				
Market	**Most Restrictive**	**Average Restrictive**	**Least Restrictive**	**Grand Total**
Individual	4.6%	5.7%	5.5%	5.5%
High Risk	0.0%	0.1%	0.1%	0.1%
Uninsured	14.2%	17.8%	19.8%	18.5%
SG : 1 - 10 EEs	3.9%	3.1%	2.9%	3.1%
SG : 11 - 25 EEs	3.3%	3.6%	3.3%	3.4%
SG : 26 - 50 EEs	3.1%	3.6%	3.7%	3.6%
Group : 51 – 100	3.5%	3.3%	3.1%	3.2%
Group : 101 - 999	12.2%	10.2%	10.9%	10.8%
Group: 1000+	31.1%	32.9%	30.4%	31.3%
Medicaid	24.2%	19.6%	20.3%	20.6%
Total Non-Medicare	100.0%	100.0%	100.0%	100.0%

The states included in each of the regulatory groupings are shown in the Table B-2. They were categorized based upon our view of the business environment for the individual comprehensive medical market. We recognize that some states might be categorized differently by others and the groupings would differ for the group markets.

Table B-2	
STATE REGULATORY GROUPINGS	
Regulatory Environment*	**States**
MR - Most Restrictive	MA, ME, NJ, NY, VT
AR - Average Restrictive	AL, CT, DE, FL, IA, ID, KS, KY, LA, MI, MN, MS, MT, NE, NH, NM, NV, OR, PA, RI, SC, SD, UT, WA
LR - Least Restrictive	AK, AR, AZ, CA, CO, DC, GA, HI, IL, IN, MD, MO, NC, ND, OH, OK, TN, TX, VA, WI, WV, WY

* based on the regulatory environment of the individual market

Key Underlying Assumptions

C. *Distribution of population by federal poverty level*

The following tables show the distribution of the population by federal poverty level (FPL). The distributions vary by geographic grouping. Note that we have assumed the same distribution by FPL for both Small Group and Large Group due to data limitations.

Table B-3A DISTRIBUTION OF POPULATION BY FEDERAL POVERTY LEVEL* NATIONWIDE (ALL GEOGRAPHIC GROUPINGS COMBINED)						
FPL	Individual	High Risk	Small Group	Large Group	Uninsured	Total
<139%	23.9%	17.9%	4.9%	4.9%	40.1%	14.6%
139% - 149%	2.2%	1.6%	0.9%	0.9%	3.7%	1.7%
150% - 199%	10.2%	9.7%	5.8%	5.8%	13.7%	8.0%
200% - 299%	18.2%	15.5%	17.2%	17.2%	18.1%	17.5%
300% - 399%	12.9%	13.1%	16.5%	16.6%	9.9%	14.7%
400%+	32.5%	42.2%	54.7%	54.6%	14.5%	43.6%
All	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

* Based upon U.S. Census data. Percentage may not add to 100.0% due to rounding.

Table B-3B DISTRIBUTION OF POPULATION BY FEDERAL POVERTY LEVEL* MOST RESTRICTIVE GEOGRAPHIC GROUPING						
FPL	Individual	High Risk	Small Group	Large Group	Uninsured	Total
<139%	27.0%	20.9%	4.2%	4.2%	32.0%	10.8%
139% - 149%	2.1%	1.9%	0.6%	0.6%	3.1%	1.1%
150% - 199%	8.1%	4.8%	4.3%	4.3%	12.6%	6.0%
200% - 299%	18.0%	16.4%	13.7%	13.7%	18.0%	14.8%
300% - 399%	11.0%	10.6%	13.7%	13.7%	12.2%	13.2%
400%+	33.8%	45.3%	63.5%	63.5%	22.1%	54.0%
All	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

* Based upon U.S. Census data. Percentage may not add to 100.0% due to rounding.

Key Underlying Assumptions

Table B-3C						
DISTRIBUTION OF POPULATION BY FEDERAL POVERTY LEVEL*						
AVERAGE RESTRICTIVE GEOGRAPHIC GROUPING						
FPL	Individual	High Risk	Small Group	Large Group	Uninsured	Total
<139%	24.0%	19.9%	5.0%	5.0%	40.0%	14.2%
139% - 149%	2.8%	2.2%	1.0%	1.0%	3.7%	1.7%
150% - 199%	11.2%	9.6%	6.2%	6.2%	13.5%	8.2%
200% - 299%	18.2%	14.6%	18.1%	18.1%	18.5%	18.2%
300% - 399%	13.0%	13.3%	17.3%	17.3%	9.6%	15.3%
400%+	30.8%	40.3%	52.3%	52.3%	14.7%	42.4%
All	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

* Based upon U.S. Census data. Percentage may not add to 100.0% due to rounding.

Table B-3D						
DISTRIBUTION OF POPULATION BY FEDERAL POVERTY LEVEL*						
LEAST RESTRICTIVE GEOGRAPHIC GROUPING						
FPL	Individual	High Risk	Small Group	Large Group	Uninsured	Total
<139%	23.3%	16.5%	5.0%	5.0%	41.5%	15.6%
139% - 149%	1.8%	1.3%	0.9%	0.9%	3.8%	1.7%
150% - 199%	10.1%	9.9%	5.8%	5.8%	14.0%	8.2%
200% - 299%	18.3%	16.0%	17.5%	17.5%	17.8%	17.6%
300% - 399%	13.2%	12.9%	16.8%	16.8%	9.8%	14.7%
400%+	33.3%	43.3%	54.0%	54.0%	13.1%	42.1%
All	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

* Based upon U.S. Census data. Percentage may not add to 100.0% due to rounding.

D. **_Distribution by Health Plan type based upon statutory annual statement information_**

1. From 2010 Annual Statement data, we identified various types of health plans and health insurance carriers selling comprehensive medical business. We categorized them into seven different health plan types for purposes of modeling movement of insureds among health plans.

2. Distribution of population by type of health plan being assumed is shown in the following tables.

Key Underlying Assumptions

Table B-4A INSURED POPULATION DISTRIBUTION BY HEALTH PLAN TYPE NATIONWIDE (THOUSANDS)				
Health Plan Type	**Individual**	**Small Group**	**Large Group**	**Total Under 65**
1. Health Plan Type 1	8,346	12,662	61,120	82,129
2. Health Plan Type 2	1,431	4,555	13,098	19,085
3. Health Plan Type 3	1,552	4,335	17,158	23,046
4. Health Plan Type 4	374	830	7,277	8,480
5. Health Plan Type 5	690	1,502	10,759	12,950
6. Health Plan Type 6	1,722	1,769	4,561	8,052
7. Health Plan Type 7	526	1,347	7,730	9,603
8. High Risk Pools				257
9. Uninsured				49,499
10. Medicaid				55,132
11. Medicare				42,998
Total – All Health Plan Types	**14,641**	**27,000**	**121,703**	**311,232**

Table B-4B INSURED POPULATION DISTRIBUTION BY HEALTH PLAN TYPE MOST RESTRICTIVE GEOGRAPHIC GROUPING (THOUSANDS)				
Health Plan Type	**Individual**	**Small Group**	**Large Group**	**Total Under 65**
1. Health Plan Type 1	832	1,265	5,045	7,142
2. Health Plan Type 2	197	914	3,200	4,311
3. Health Plan Type 3	31	275	1,573	1,880
4. Health Plan Type 4	97	262	802	1,161
5. Health Plan Type 5	161	194	753	1,108
6. Health Plan Type 6	104	222	1,192	1,517
7. Health Plan Type 7	67	242	2,649	2,958
8. High Risk Pools				3
9. Uninsured				4,620
10. Medicaid				7,869
11. Medicare				5,338
Total – All Health Plan Types	**1,489**	**3,374**	**15,213**	**37,907**

Key Underlying Assumptions

Table B-4C INSURED POPULATION DISTRIBUTION BY HEALTH PLAN TYPE AVERAGE RESTRICTIVE GEOGRAPHIC GROUPING (THOUSANDS)				
Health Plan Type	Individual	Small Group	Large Group	Total Under 65
1. Health Plan Type 1	2,934	4,676	23,218	30,829
2. Health Plan Type 2	463	1,248	2,691	4,402
3. Health Plan Type 3	581	1,423	4,884	6,888
4. Health Plan Type 4	106	220	1,927	2,253
5. Health Plan Type 5	241	700	5,759	6,700
6. Health Plan Type 6	585	515	1,248	2,348
7. Health Plan Type 7	107	311	1,257	1,675
8. High Risk Pools				101
9. Uninsured				15,673
10. Medicaid				17,328
11. Medicare				15,792
Total – All Health Plan Types	5,018	9,092	40,984	103,989

Table B-4D INSURED POPULATION DISTRIBUTION BY HEALTH PLAN TYPE LEAST RESTRICTIVE GEOGRAPHIC GROUPING (THOUSANDS)				
Health Plan Type	Individual	Small Group	Large Group	Total Under 65
1. Health Plan Type 1	4,580	6,721	32,857	44,158
2. Health Plan Type 2	771	2,393	7,208	10,372
3. Health Plan Type 3	940	2,637	10,701	14,278
4. Health Plan Type 4	171	348	4,548	5,067
5. Health Plan Type 5	287	609	4,247	5,143
6. Health Plan Type 6	1,033	1,033	2,121	4,186
7. Health Plan Type 7	352	794	3,824	4,970
8. High Risk Pools				153
9. Uninsured				29,206
10. Medicaid				29,934
11. Medicare				21,868
Total – All Health Plan Types	8,134	14,534	65,506	169,336

Key Underlying Assumptions

E.   ***Plan type distribution***

The following tables display the assumed initial distribution of plan types within line of business assigned to the census for each geographic grouping and nationwide. Plan type assumptions are discussed later in this attachment. Target plan type distributions within line of business are summarized below for health plans offering all five plan designs. The distributions are slightly different for those offering fewer than the five plans. Variations by geographic grouping are reflective of health plan types assumed and not actual differences in plan design distributions.

Table B-5A NATIONWIDE INSURED POPULATION DISTRIBUTION BY PLAN TYPE WITHIN MARKET			
Plan Type	**Individual**	**Small Group**	**Large Group**
1. Platinum	4.9%	10.1%	10.7%
2. Gold	13.7%	27.0%	10.3%
3. Silver	26.1%	34.4%	13.4%
4. Bronze	26.6%	15.2%	7.6%
5. NQ	28.6%	13.2%	0.0%
6. SF	0.0%	0.0%	58.0%
Total – All Plan Types	100.0%	100.0%	100.0%

Table B-5B MOST RESTRICTIVE GEOGRAPHIC GROUPING INSURED POPULATION DISTRIBUTION BY PLAN TYPE WITHIN MARKET			
Plan Type	**Individual**	**Small Group**	**Large Group**
1. Platinum	4.9%	10.2%	10.7%
2. Gold	13.8%	26.9%	10.2%
3. Silver	26.4%	34.6%	18.6%
4. Bronze	26.8%	15.2%	10.4%
5. NQ	28.2%	13.1%	0.0%
6. SF	0.0%	0.0%	50.2%
Total – All Plan Types	100.0%	100.0%	100.0%

Key Underlying Assumptions

Table B-5C			
AVERAGE RESTRICTIVE GEOGRAPHIC GROUPING			
INSURED POPULATION DISTRIBUTION BY PLAN TYPE WITHIN MARKET			
Plan Type	**Individual**	**Small Group**	**Large Group**
1. Platinum	4.9%	10.1%	9.9%
2. Gold	13.7%	27.1%	9.9%
3. Silver	26.1%	34.4%	11.7%
4. Bronze	26.6%	15.2%	6.7%
5. NQ	28.7%	13.2%	0.0%
6. SF	0.0%	0.0%	61.8%
Total – All Plan Types	100.0%	100.0%	100.0%

Table B-5D			
LEAST RESTRICTIVE GEOGRAPHIC GROUPING			
INSURED POPULATION DISTRIBUTION BY PLAN TYPE WITHIN MARKET			
Plan Type	**Individual**	**Small Group**	**Large Group**
1. Platinum	4.9%	10.1%	11.2%
2. Gold	13.7%	26.9%	10.6%
3. Silver	26.1%	34.4%	13.3%
4. Bronze	26.6%	15.3%	7.5%
5. NQ	28.7%	13.3%	0.0%
6. SF	0.0%	0.0%	57.4%
Total – All Plan Types	100.0%	100.0%	100.0%

F. *Health status levels assigned to each census record are based on a random assignment by line of business correlated to average to the line of business nationwide average based upon internal Milliman research (see later in this attachment for more detail on the development of health status factors)*

G. *Births, Immigration, Medicare Eligibility, and Deaths*

1. Births: New births each year are assumed to equal the number of newborns in our 2010 census data.

2. Immigration: We have not included population growth due to immigration.

3. Medicare Eligibility: We assume people move into the Medicare market in the year they attain age 65. We do not reflect any Medicare eligibility for those under age 65 who might qualify as disabled.

Key Underlying Assumptions

4. Deaths: Deaths are projected to occur at the end of each projection year based upon a U.S. standard mortality table.

Change Factor Assumptions

Change factors are key assumptions regarding the projected impact of the ACA reforms. There is little empirical data supporting these assumptions. Milliman has conducted research on various programs that converted to a guaranteed acceptance basis and developed various change factors through observations of these other programs. Following are the various change factor assumptions used in this projection. They do not vary by scenario.

A. Group Employers Plan Termination Factors

Some employers may be motivated to terminate their health plans and send their employees to the individual market. This is particularly true for groups of 50 or fewer employees since they are not subject to any penalties for not sponsoring a plan. Table B-6 presents the assumed termination rates. It is assumed that these terminations occur only in years 2014 and 2015. This results in sending their employees to the individual market to choose a plan, either through the Exchange or outside of the Exchange. No correlation is assumed between the health plan carrier they had under their group plan and the one that they choose in the individual market. All employees will choose a plan in the year the employer terminates the group plan.

TABLE B-6 GROUP PLAN TERMINATION ASSUMPTIONS BY REGULATORY GROUPING IN 2014 AND 2015			
Group Size	**Most Restrictive**	**Average Restrictive**	**Least Restrictive**
SG : 1 - 10 EEs	10% / 10%	15% / 15%	20% / 15%
SG : 11 - 25 EEs	10% / 5%	10% / 10%	15% / 10%
SG : 26 - 50 EEs	5% / 2%	5% / 5%	10% / 5%
Group : 51 – 100	2% / 1%	3% / 3%	5% / 3%
Group : 101 - 999	1% / 0%	1% / 0%	1% / 1%
Group: 1000+	0% / 0%	0% / 0%	0% / 0%

B. Medicaid Crowd-Out from the Individual or Group Markets

Medicaid crowd-out is the opportunity of employees and individuals who are in income levels (i.e. FPL ≤ 138%) that make them eligible for Medicaid expansion to move from their current coverage or uninsured status to the Medicaid program. The following crowd-out factors have been assumed. The higher the factor, the more likely the person will leave their current plan and enroll in Medicaid.

TABLE B-7 MEDICAID CROWD-OUT FACTORS				
	Health Status Factor			
Age/Gender	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
All < 18	86%	88%	89%	91%
Females 18 – 44	81%	83%	84%	86%
Females ≥ 45	77%	80%	81%	83%
Males ≥ 17	77%	80%	81%	83%

These factors do not vary by market or regulatory groupings.

Key Underlying Assumptions

C. Individual Plan Switching Factors (Incumbency/Inertia Factors)

The following are the incumbency or inertia factors used for plan switching. The application of these factors is discussed in the section in Attachment A on plan switching. The factors vary by projection year, the rate increase being presented by the incumbent plan, the individual's health status factor, and the individual's income level (see Table B-3 for the income levels). The lower the factor, the more likely the employer will shop to switch its plan.

This first table of factors was used for projection year 2014 and 2015. These are lower factors than for other years due to the likelihood of more interest in comparing one's current plan with the introduction of exchanges, guaranteed issue, and other new reforms.

Table B-8 INDIVIDUAL PLAN SWITCHING INCUMBENCY/INERTIA FACTORS							
Projection Years 2014 and 2015							
	Income Level 1				**Income Level 2**		
Rate Increase	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
< 10%	70.0%	73.7%	73.7%	73.7%	70.0%	73.7%	73.7%	73.7%
10%-20%	68.5%	72.1%	73.7%	73.1%	68.6%	72.3%	73.7%	73.1%
20%-30%	65.4%	69.0%	72.1%	71.8%	65.9%	69.5%	72.5%	72.0%
30%-40%	60.2%	63.9%	67.8%	69.8%	61.3%	64.9%	68.7%	70.2%
40%-50%	49.9%	53.6%	59.3%	65.7%	52.1%	55.7%	61.1%	66.5%
	Income Level 3				**Income Level 4**		
Rate Increase	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
< 10%	70.0%	73.7%	73.7%	73.7%	70.0%	73.7%	73.7%	73.7%
10%-20%	68.7%	72.4%	73.7%	73.2%	68.9%	72.6%	73.7%	73.2%
20%-30%	66.2%	69.9%	72.7%	72.2%	66.7%	70.4%	73.2%	72.4%
30%-40%	62.0%	65.6%	69.3%	70.5%	63.0%	66.7%	70.1%	70.9%
40%-50%	53.5%	57.2%	62.3%	67.1%	55.7%	59.3%	64.1%	67.9%
	Income Level 5				**Income Level 6**		
Rate Increase	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
< 10%	70.0%	73.7%	73.7%	73.7%	70.0%	73.9%	73.7%	73.7%
10%-20%	69.2%	72.9%	73.7%	73.3%	69.6%	73.2%	73.7%	73.5%
20%-30%	67.5%	71.2%	73.7%	72.7%	68.7%	72.4%	73.7%	73.2%
30%-40%	64.8%	68.4%	71.6%	71.6%	67.2%	70.9%	73.6%	72.6%
40%-50%	59.3%	62.9%	67.0%	69.4%	64.3%	67.9%	71.2%	71.4%

The next table of factors was assumed for years prior to 2014 since they are likely to have less disruption, but will still see some movement in anticipation of 2014.

Key Underlying Assumptions

Table B-9							
INDIVIDUAL PLAN SWITCHING INCUMBENCY/INERTIA FACTORS							
Projection Years prior to 2014							
	Income Level 1				**Income Level 2**			
Rate Increase	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
< 10%	71.3%	75.0%	75.0%	84.6%	71.3%	75.0%	75.0%	84.6%
10%-20%	69.7%	73.4%	75.0%	84.6%	69.8%	73.6%	75.0%	84.6%
20%-30%	66.5%	70.3%	73.4%	84.6%	67.0%	70.8%	73.8%	84.6%
30%-40%	61.3%	65.0%	69.0%	84.6%	62.4%	66.1%	69.9%	84.6%
40%-50%	50.8%	54.5%	60.4%	84.6%	53.0%	56.7%	62.2%	84.6%
	Income Level 3				**Income Level 4**			
Rate Increase	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
< 10%	71.3%	75.0%	75.0%	84.6%	71.3%	75.0%	75.0%	84.6%
10%-20%	70.0%	73.7%	75.0%	84.6%	70.1%	73.9%	75.0%	84.6%
20%-30%	67.4%	71.1%	74.1%	84.6%	67.9%	71.6%	74.5%	84.6%
30%-40%	63.1%	66.8%	70.5%	84.6%	64.1%	67.9%	71.4%	84.6%
40%-50%	54.5%	58.2%	63.4%	84.6%	56.7%	60.4%	65.2%	84.6%
	Income Level 5				**Income Level 6**			
Rate Increase	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
< 10%	71.3%	75.0%	75.0%	84.6%	71.3%	75.0%	75.0%	84.6%
10%-20%	70.4%	74.2%	75.0%	84.6%	70.8%	74.6%	75.0%	84.6%
20%-30%	68.7%	72.5%	75.0%	84.6%	69.9%	73.7%	75.0%	84.6%
30%-40%	65.9%	69.7%	72.8%	84.6%	68.4%	72.2%	74.9%	84.6%
40%-50%	60.3%	64.0%	68.2%	84.6%	65.4%	69.2%	72.4%	84.6%

The next table of factors was assumed for years later than 2015 since they are likely to have the least amount of disruption. Given the uncertainty regarding how people will shop for new coverage after 2015, we have set these factors to be much higher than the previous sets of factors, reflecting less movement from one plan to another.

Key Underlying Assumptions

Table B-10							
INDIVIDUAL PLAN SWITCHING INCUMBENCY/INERTIA FACTORS							
Projection Years Later Than 2015							
	Income Level 1				**Income Level 2**		
Rate Increase	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
< 10%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%
10%-20%	91.9%	92.0%	92.4%	93.2%	92.1%	92.2%	92.6%	93.3%
20%-30%	87.8%	88.1%	89.3%	91.6%	88.4%	88.7%	89.8%	91.9%
30%-40%	80.9%	81.5%	84.0%	89.0%	82.3%	82.8%	85.1%	89.5%
40%-50%	67.1%	68.3%	73.5%	83.7%	69.9%	71.1%	75.7%	84.8%

	Income Level 3				**Income Level 4**		
Rate Increase	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
< 10%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%
10%-20%	92.3%	92.4%	92.7%	93.4%	92.5%	92.6%	92.9%	93.4%
20%-30%	88.9%	89.1%	90.1%	92.1%	89.6%	89.8%	90.6%	92.3%
30%-40%	83.2%	83.7%	85.8%	89.9%	84.6%	85.1%	86.9%	90.4%
40%-50%	71.9%	72.9%	77.1%	85.6%	74.8%	75.7%	79.3%	86.7%

	Income Level 5				**Income Level 6**		
Rate Increase	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
< 10%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%
10%-20%	92.9%	92.9%	93.2%	93.6%	93.4%	93.4%	93.5%	93.8%
20%-30%	90.7%	90.8%	91.5%	92.7%	92.2%	92.3%	92.6%	93.3%
30%-40%	87.0%	87.3%	88.6%	91.3%	90.2%	90.4%	91.1%	92.6%
40%-50%	79.6%	80.3%	83.0%	88.5%	86.3%	86.7%	88.1%	91.1%

D. Uninsured Switching to Individual Market

The following are the switching probabilities that an uninsured person will move into the individual market. These probabilities vary by age, gender, income level, and health status. The higher the factor, the more likely the uninsured individual will move to the individual market and purchase an individual plan. We have not assumed that any uninsured will move into the Small Group or Large Group markets.

Key Underlying Assumptions

	Table B-11 UNINSURED SWITCHING PROBABILITIES TO INDIVIDUAL MARKET							
	All Projection Years							
	Income Level 1				**Income Level 2**			
Age/Sex	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
All < 20	0.0%	0.0%	0.0%	0.0%	28.4%	31.7%	33.7%	34.9%
Males 20-35	0.0%	0.0%	0.0%	0.0%	12.4%	13.9%	14.8%	15.3%
Males > 35	0.0%	0.0%	0.0%	0.0%	28.4%	31.7%	33.7%	34.9%
Females 20+	0.0%	0.0%	0.0%	0.0%	28.4%	31.7%	33.7%	34.9%
	Income Level 3				**Income Level 4**			
Rate Increase	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
All < 20	65.6%	68.7%	69.4%	71.1%	55.3%	57.2%	57.4%	59.4%
Males 20-35	28.7%	30.1%	30.4%	31.1%	24.2%	25.1%	25.1%	26.0%
Males > 35	65.6%	68.7%	69.4%	71.1%	55.3%	57.2%	57.4%	59.4%
Females 20+	65.6%	68.7%	69.4%	71.1%	55.3%	57.2%	57.4%	59.4%
	Income Level 5				**Income Level 6**			
Rate Increase	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**	**< 0.75**	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
All < 20	37.6%	38.0%	38.3%	39.8%	20.6%	20.6%	21.2%	21.2%
Males 20-35	16.5%	16.6%	16.8%	17.4%	9.0%	9.0%	9.3%	9.3%
Males > 35	37.6%	38.0%	38.3%	39.8%	20.6%	20.6%	21.2%	21.2%
Females 20+	37.6%	38.0%	38.3%	39.8%	20.6%	20.6%	21.2%	21.2%

In recognition of relatively low penalties or incentive to change their uninsured status in year 2014 to purchase a health plan, we have assumed that the above change factors to the Individual Medical Market are graded in over time as penalties grow and people become more aware of their responsibilities under ACA. We have assumed the following phase-in multipliers of our change factors:

TABLE B-12 PHASE-IN OF MARKET CHANGE FACTORS UNINSURED TO INDIVIDUAL			
Projection Year	**Most Restrictive**	**Avg. Restrictive**	**Least Restrictive**
2014	0.25	0.40	0.45
2015	0.50	0.70	0.75
2016	0.75	0.85	0.90
2017	1.00	1.00	1.00

Therefore, for example, instead of a very healthy male age 40 in FPL5 in an average restrictive state having a probability of 37.6% of moving to the individual market, his probability of moving in year 2014 is 0.40 x 37.6% = 15.0%. The probability of the remaining very health age 40 uninsured males moving to the individual market in 2015 is 0.70 x 37.6% = 26.3% instead of 37.6%.

Key Underlying Assumptions

E. Uninsured Switching to the Medicaid Market

The following are the switching probabilities that an uninsured person will move into the Medicaid market. These probabilities vary by age, gender, income level, and health status. Only people in FPL1 (FPL < 138%) qualify for expanded Medicaid coverage.

The following change probability factors have been assumed. The higher the factor, the more likely the person will enroll in Medicaid. We have not specifically reflected the impact of the ability of medical providers to auto-enroll a Medicaid eligible uninsured patient.

Table B-13 MEDICAID CHANGE PROBABILITY FACTORS				
Age/Gender	**Health Status Factor**			
	< 0.75	**0.75 - 1.10**	**1.10 - 1.70**	**> 1.70**
All < 18	86%	88%	89%	91%
Females 18 – 44	81%	83%	84%	86%
Females ≥ 45	77%	80%	81%	83%
Males ≥ 17	77%	80%	81%	83%

Health Plan Characteristics

A.   *Brand Awareness and Brand Loyalty*

Health plan types were ranked in regard to individuals' and employers' relative brand perception and loyalty of each Health Plan, and each was assigned a brand awareness and brand loyalty factor. Brand awareness and brand loyalty factors are used in the plan switching decision algorithm used in the model within each market. Factors above 1.0 reduce the propensity to change coverage at a given level of rate increase. Factors below 1.0 increase the propensity to change coverage at a given level of rate increase. We have assigned brand awareness and brand loyalty factors to each health plan type. These are proprietary to Milliman and not shown in this report, but they have been reviewed by the POG.

B.   *Provider Discounts*

1.   Discount factors vary by provider service type (i.e. inpatient facility, outpatient facility, physician/professional, Rx, and other) and health plan type.

2.   Source of discounts was based upon proprietary Milliman nationwide research.

C.   *Administrative Expense/Profit Loading*

1.   Administrative expense/profit loadings are equal to 1 – (incurred claims/reported premium)

2.   The load can vary by calendar year. We have assumed a different load for year 2010 from 2011 and later due to the potential actions Health Plans are taking in order to meet the new MLR requirements starting in 2011.

3.   Assumptions by health plan type within state regulatory grouping are summarized in the following table:

Key Underlying Assumptions

Table B-14 ADMINISTRATIVE EXPENSE / PROFIT LOADING INDIVIDUAL MEDICAL MARKET 2010 LEVEL / 2011+ LEVEL			
Health Plan	**Most Restrictive**	**Average Restrictive**	**Least Restrictive**
1. Health Plan Type 1	5%/20%	21%/20%	26%/20%
2. Health Plan Type 2	5%/21%	21%/21%	26%/21%
3. Health Plan Type 3	5%/21%	21%/21%	26%/21%
4. Health Plan Type 4	5%/21%	21%/21%	26%/21%
5. Health Plan Type 5	5%/21%	21%/21%	26%/21%
6. Health Plan Type 6	5%/21%	21%/21%	26%/21%
7. Health Plan Type 7	5%/21%	21%/21%	26%/21%
8. Non-Profit Coop	5%/21%	21%/21%	26%/21%
9. OPM Multi-State Plan	5%/20%	21%/20%	26%/20%

D.   ***Health Plan Underwriting Criteria prior to Year 2014***

These assumptions are applicable only for the average and least restrictive state groupings. The most restrictive state grouping was assumed to require guaranteed issue and no health status rating in all years.

1.   Accept/Reject Criteria – Individual Medical Business

Table B-15 ACCEPT / REJECT UNDERWRITING CRITERIA INDIVIDUAL MARKET AVERAGE AND LEAST RESTRICTIVE STATE GROUPINGS*		
Health Plan	**Maximum morbidity level accepted for coverage**	**Experience period analysis and weighting****
1. Health Plan Type 1	3.00	Last 2 years 60/40
2. Health Plan Type 2	2.50	Last 2 years 50/50
3. Health Plan Type 3	2.00	Last 2 years 60/40
4. Health Plan Type 4	3.00	Last 2 years 50/50
5. Health Plan Type 5	2.00	Last 2 years 60/40
6. Health Plan Type 6	2.00	Last 2 years 70/30
7. Health Plan Type 7	1.50	Last 2 years 80/20
8. Non-Profit Coop	N/A	N/A
9. OPM Multi-State Plan	N/A	N/A

 * No limit on morbidity level in the Most Restrictive State Grouping

 ** Note that this analysis is the basis for the Health Plan portion of the Benefit Worthiness component of the plan switching formula.

Key Underlying Assumptions

2. Substandard Rating Methodology

Table B-16 SUBSTANDARD UNDERWRITING RATING CRITERIA INDIVIDUAL MARKET AVERAGE AND LEAST RESTRICTIVE STATE GROUPINGS*		
Health Plan	**Percentage of Excess Morbidity for Rate Up**	**Maximum Rate-Up**
1. Health Plan Type 1	80%	100%
2. Health Plan Type 2	90%	100%
3. Health Plan Type 3	100%	150%
4. Health Plan Type 4	60%	50%
5. Health Plan Type 5	70%	100%
6. Health Plan Type 6	80%	150%
7. Health Plan Type 7	90%	200%
8. Non-Profit Coop	N/A	N/A
9. OPM Multi-State Plan	N/A	N/A

* No limit on morbidity level in the Most Restrictive State Grouping

Plan Assignments and Designs – Commercial Individual and Group Business

A.   *Modeled plans designs will be limited to 5 types*

All health plans offer identical plan designs, although not all plans will be offered by each health plan (this is done for ease of comparing movements)

B.   *Commercial plan designs and their actuarial values*

Table B-17 COMMERCIAL PLAN DESIGNS AND ACTUARIAL VALUES		
Plan	**Plan Abbrev.**	**Actuarial Value**
Platinum	P	91%
Gold	G	81%
Silver	S	71%
Bronze	B	61%
Non-Qualified	NQ	51%

Key Underlying Assumptions

C.   *Plans assumed to be offered by each modeled health plan*

Table B-18 PLANS OFFERED BY MODELED HEALTH PLANS INDIVIDUAL MARKET IN AND OUT OF EXCHANGE			
Modeled Health Plan	**Pre-Reform**	**In Exchange**	**Out of Exchange**
1. Health Plan Type 1	P, G, S, B, NQ	P, G, S, B	P, G, S, B
2. Health Plan Type 2	P, G, S, B, NQ	P, G, S, B	P, G, S, B
3. Health Plan Type 3	G, S, B, NQ	G, S, B	P, G, S, B
4. Health Plan Type 4	P, G, S	P, G, S	P, G, S
5. Health Plan Type 5	G, S, B	G, S, B	None
6. Health Plan Type 6	P, G, S, B, NQ	G, S, B	P, G, S, B
7. Health Plan Type 7	S, B	None	S, B, NQ
8. Non-Profit Coop	None	G, S, B	None
9. OPM Multi-State Plan	None	P, G, S, B	None

Initial Claim Costs

A.   *Initial health care costs for each plan were set through use of the Milliman Health Cost Guidelines (HCGs) Rating Model reflective of nationwide cost levels. These were balanced to the control levels determined through research.*

B.   *Initial health care costs are billed level costs by the following service splits*

   1.   Inpatient facilities

   2.   Outpatient facility

   3.   Physician/professional

   4.   Outpatient prescription drugs

Provider discounts are applied to these billed health care costs at the health plan level to determine the allowed cost levels for the plan. Plan cost-sharing provisions are applied on an individually insured basis each year.

C.   *Health Status/Utilization Adjustment Factors by Market and Geographic Grouping*

Average health status/utilization adjustment factors by market are a very critical assumption for these projections. They affect the levels of adverse selection that could take place due to the various health care reforms to be implemented in year 2014. Of key interest is the relationship between the uninsured market levels and those of the individual market.

Key Underlying Assumptions

Table B-19 Average Health Status/Utilization Adjustment Factors by Geographic Grouping and Market			
Market	**Most Restrictive**	**Average Restrictive**	**Least Restrictive**
Individual	1.231	0.920	0.806
High Risk	2.500	2.500	2.500
Uninsured	1.091	1.133	1.149
SG : 1 - 10 EEs	1.293	1.058	1.131
SG : 11 - 25 EEs	1.067	0.996	1.099
SG : 26 - 50 EEs	1.059	1.013	1.105
Group : 51 – 100	1.024	0.944	0.974
Group : 101 - 999	1.024	0.961	0.965
Group: 1000+	0.991	0.962	1.055

These assumptions are based on research conducted by Milliman, including self-reported health status results of the U.S. Census Bureau 2010 Current Population Survey (CPS), relative claim costs by state and market reported by health plans in 2010 annual statement filings, as well as other proprietary data of Milliman. These have been set relative to our nationwide estimates for the large group market. Note that the Most Restrictive state grouping has healthier uninsured than the other two groupings and that their individual insured health status is much higher than their uninsured population and that of the individual markets for the other two groupings.

D.   Health Status Factor Relativities by Health Plan Type for the Individual Market

Table 20 HEALTH STATUS RELATIVITY FACTORS BY HEALTH PLAN TYPE INDIVIDUAL MARKET			
Health Plan Type	**Most Restrictive**	**Average Restrictive**	**Least Restrictive**
Health Plan Type 1	1.030	1.100	1.100
Health Plan Types 4 and 5	1.010	1.050	1.050
Other Plans	1.000	1.000	1.000
High Risk Programs	2.500	2.500	2.500

* Will be set to reproduce Table 1 relativities

These factors recognize that some health plan types have higher average risk scores than other types due to a combination of regulatory and underwriting influences.

E.   Claims Trend Assumptions

The following annual base trend rates are assumed. These are applied to healthcare costs prior to application of plan cost-sharing provisions.

Key Underlying Assumptions

Table B-21	
CLAIMS TREND ASSUMPTIONS	
INDIVIDUAL MEDICAL AND GROUP COMMERCIAL BUSINESS	
Calendar Year	**Total Trend**
2011	6.0%
2012 and Later	7.5%

Premium Structure and Methodology

A.   ***Premium age/gender rating factor curves***

Premium rates in the individual and small group lines of business were in part determined based upon sets of designated age/gender curves. These curves are restricted to a 3-to-1 ratio for adult rates beginning on 1/1/2014, but prior to 2014 steeper slopes were used. We did not assume smoker-nonsmoker differentials nor lower rates for approved wellness programs.

B.   ***Federal Subsidies***

Federal subsidies are calculated in accordance with our understanding of the ACA formulas for each census record based upon the family income level and the cost for the second lowest silver plan being modeled. These subsidies are subtracted from the premium being offered by each health plan during the plan switching process.

Attachment C

Projection Results – Rate Level Scenarios

C-1: Individual Business Only: All Geographic Areas Combined -
Scenarios 1A, 1B, and 1C

C-2: Individual Business Only: Most Restrictive State Grouping -
Scenarios 1A, 1B, and 1C

C-3: Individual Business Only: Average Restrictive State Grouping -
Scenarios 1A, 1B, and 1C

C-4: Individual Business Only: Least Restrictive State Grouping -
Scenarios 1A, 1B, and 1C

Society of Actuaries

Design and Implementation Considerations of ACA Risk Mitigation Programs

Attachment C1

Individual Business Only

All Geographic Areas Combined

<table>
<tr><td colspan="7">Table C1-1
Results by Exchange/Non Exchange and Projection Year
Individual Business
All Geographic Areas Combined
Enrollment
(thousands)</td></tr>
<tr>
<th>Projection Year</th>
<th>Scenario</th>
<th>Total</th>
<th>Grandfathered Business</th>
<th>Non-Grandfathered Non-Exchange Business</th>
<th>Exchange Business</th>
<th>All Non-Exchange Business</th>
</tr>
<tr><td>2013</td><td>Status Quo</td><td>14,594</td><td>7,425</td><td>7,169</td><td>n/a</td><td>14,594</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>2014</td><td>Status Quo</td><td>14,563</td><td>5,936</td><td>8,628</td><td>n/a</td><td>14,563</td></tr>
<tr><td>2014</td><td>Scenario 1A</td><td>20,622</td><td>2,518</td><td>8,674</td><td>9,430</td><td>11,192</td></tr>
<tr><td>2014</td><td>Scenario 1B</td><td>20,628</td><td>2,485</td><td>8,513</td><td>9,630</td><td>10,998</td></tr>
<tr><td>2014</td><td>Scenario 1C</td><td>20,640</td><td>2,252</td><td>7,884</td><td>10,505</td><td>10,135</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>2015</td><td>Status Quo</td><td>14,535</td><td>4,789</td><td>9,746</td><td>n/a</td><td>14,535</td></tr>
<tr><td>2015</td><td>Scenario 1A</td><td>29,772</td><td>1,947</td><td>10,821</td><td>17,004</td><td>12,768</td></tr>
<tr><td>2015</td><td>Scenario 1B</td><td>29,831</td><td>1,892</td><td>10,666</td><td>17,274</td><td>12,558</td></tr>
<tr><td>2015</td><td>Scenario 1C</td><td>29,733</td><td>2,025</td><td>9,143</td><td>18,566</td><td>11,168</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>2016</td><td>Status Quo</td><td>14,538</td><td>3,936</td><td>10,602</td><td>n/a</td><td>14,538</td></tr>
<tr><td>2016</td><td>Scenario 1A</td><td>35,259</td><td>1,859</td><td>12,098</td><td>21,302</td><td>13,957</td></tr>
<tr><td>2016</td><td>Scenario 1B</td><td>35,314</td><td>1,789</td><td>11,942</td><td>21,583</td><td>13,731</td></tr>
<tr><td>2016</td><td>Scenario 1C</td><td>35,228</td><td>1,946</td><td>10,183</td><td>23,099</td><td>12,129</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>2017</td><td>Status Quo</td><td>14,534</td><td>3,286</td><td>11,247</td><td>n/a</td><td>14,534</td></tr>
<tr><td>2017</td><td>Scenario 1A</td><td>39,160</td><td>1,775</td><td>12,767</td><td>24,618</td><td>14,543</td></tr>
<tr><td>2017</td><td>Scenario 1B</td><td>39,206</td><td>1,718</td><td>12,583</td><td>24,906</td><td>14,300</td></tr>
<tr><td>2017</td><td>Scenario 1C</td><td>39,113</td><td>1,870</td><td>10,875</td><td>26,369</td><td>12,745</td></tr>
</table>

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment C1
Individual Business Only

All Geographic Areas Combined

Table C1-2 **Results by Exchange/Non Exchange and Projection Year** Individual Business All Geographic Areas Combined Premium Revenue ($ millions)						
Projection Year	**Scenario**	**Total**	**Grandfathered Business**	**Non-Grandfathered Non-Exchange Business**	**Exchange Business**	**All Non-Exchange Business**
2013	Status Quo	39,764	21,461	18,303	n/a	39,764
2014	Status Quo	42,708	19,192	23,517	n/a	42,708
2014	Scenario 1A	61,431	8,636	25,172	27,623	33,808
2014	Scenario 1B	66,870	9,139	26,777	30,955	35,916
2014	Scenario 1C	76,875	9,412	29,076	38,387	38,488
2015	Status Quo	46,070	17,267	28,803	n/a	46,070
2015	Scenario 1A	103,965	7,169	37,082	59,714	44,251
2015	Scenario 1B	113,007	7,853	39,364	65,791	47,217
2015	Scenario 1C	142,966	8,152	44,862	89,952	53,014
2016	Status Quo	50,779	15,759	35,020	n/a	50,779
2016	Scenario 1A	147,084	7,364	49,455	90,266	56,818
2016	Scenario 1B	158,567	8,292	52,405	97,870	60,697
2016	Scenario 1C	192,986	8,189	56,929	127,867	65,119
2017	Status Quo	56,631	14,508	42,123	n/a	56,631
2017	Scenario 1A	193,513	7,511	62,146	123,857	69,657
2017	Scenario 1B	207,129	8,137	65,583	133,409	73,720
2017	Scenario 1C	236,457	8,229	66,972	161,257	75,200

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment C1
Individual Business Only

All Geographic Areas Combined

Table C1-3 **Results by Exchange/Non Exchange and Projection Year** Individual Business All Geographic Areas Combined Incurred Loss Ratios						
Projection Year	**Scenario**	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	80%	86%	72%	n/a	80%
2014	Status Quo	82%	87%	77%	n/a	82%
2014	Scenario 1A	116%	82%	114%	128%	105%
2014	Scenario 1B	106%	77%	106%	116%	98%
2014	Scenario 1C	92%	69%	91%	99%	86%
2015	Status Quo	83%	87%	80%	n/a	83%
2015	Scenario 1A	113%	76%	112%	117%	107%
2015	Scenario 1B	104%	69%	105%	108%	99%
2015	Scenario 1C	81%	72%	81%	82%	80%
2016	Status Quo	83%	86%	82%	n/a	83%
2016	Scenario 1A	105%	77%	105%	107%	101%
2016	Scenario 1B	97%	68%	98%	100%	94%
2016	Scenario 1C	79%	75%	78%	79%	78%
2017	Status Quo	82%	86%	81%	n/a	82%
2017	Scenario 1A	97%	79%	97%	98%	95%
2017	Scenario 1B	91%	72%	91%	92%	89%
2017	Scenario 1C	78%	79%	78%	79%	78%

All Geographic Areas Combined

Table C1-4						
Results by Exchange/Non Exchange and Projection Year						
Individual Business						
All Geographic Areas Combined						
Incurred Loss Ratios Including Impact of Risk Mitigation						
Projection Year	**Scenario**	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	80%	86%	72%	n/a	80%
2014	Status Quo	82%	87%	77%	n/a	82%
2014	Scenario 1A	87%	83%	87%	88%	86%
2014	Scenario 1B	84%	78%	84%	85%	83%
2014	Scenario 1C	80%	71%	80%	82%	77%
2015	Status Quo	83%	87%	80%	n/a	83%
2015	Scenario 1A	88%	77%	88%	89%	87%
2015	Scenario 1B	85%	70%	86%	86%	84%
2015	Scenario 1C	78%	73%	78%	79%	77%
2016	Status Quo	83%	86%	82%	n/a	83%
2016	Scenario 1A	87%	78%	87%	87%	86%
2016	Scenario 1B	84%	68%	85%	85%	83%
2016	Scenario 1C	78%	76%	78%	79%	77%
2017	Status Quo	82%	86%	81%	n/a	82%
2017	Scenario 1A	97%	79%	97%	98%	95%
2017	Scenario 1B	91%	72%	91%	93%	89%
2017	Scenario 1C	78%	79%	78%	79%	78%

All Geographic Areas Combined

				Non-Grandfathered		
Table C1-5						
Results by Exchange/Non Exchange and Projection Year						
Individual Business						
All Geographic Areas Combined						
Average Annual Premiums						

Projection Year	Scenario	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	Exchange Business after Subsidy
2013	Status Quo	$2,725	$2,890	$2,553	n/a	n/a
2014	Status Quo	$2,933	$3,233	$2,726	n/a	n/a
2014	Scenario 1A	$2,979	$3,430	$2,902	$2,929	$1,835
2014	Scenario 1B	$3,242	$3,677	$3,146	$3,214	$1,945
2014	Scenario 1C	$3,725	$4,180	$3,688	$3,654	$2,054
2015	Status Quo	$3,170	$3,606	$2,955	n/a	n/a
2015	Scenario 1A	$3,492	$3,681	$3,427	$3,512	$1,998
2015	Scenario 1B	$3,788	$4,151	$3,691	$3,809	$2,107
2015	Scenario 1C	$4,808	$4,026	$4,907	$4,845	$2,361
2016	Status Quo	$3,493	$4,004	$3,303	n/a	n/a
2016	Scenario 1A	$4,171	$3,962	$4,088	$4,237	$2,162
2016	Scenario 1B	$4,490	$4,635	$4,388	$4,535	$2,279
2016	Scenario 1C	$5,478	$4,208	$5,591	$5,536	$2,426
2017	Status Quo	$3,897	$4,415	$3,745	n/a	n/a
2017	Scenario 1A	$4,942	$4,231	$4,868	$5,031	$2,368
2017	Scenario 1B	$5,283	$4,737	$5,212	$5,357	$2,480
2017	Scenario 1C	$6,045	$4,401	$6,158	$6,115	$2,540

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment C1
Individual Business Only

All Geographic Areas Combined

Table C1-6 **Results by Exchange/Non Exchange and Projection Year** Individual Business All Geographic Areas Combined **Change in Average Premium Each Year**						
Projection Year	**Scenario**	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	Exchange Business after Subsidy
2013	Status Quo	0%	0%	0%	n/a	n/a
2014	Status Quo	8%	12%	7%	n/a	n/a
2014	Scenario 1A	9%	19%	14%	15%	-28%
2014	Scenario 1B	19%	27%	23%	26%	-24%
2014	Scenario 1C	37%	45%	44%	43%	-20%
2015	Status Quo	8%	12%	8%	n/a	n/a
2015	Scenario 1A	17%	7%	18%	20%	9%
2015	Scenario 1B	17%	13%	17%	18%	8%
2015	Scenario 1C	29%	-4%	33%	33%	15%
2016	Status Quo	10%	11%	12%	n/a	n/a
2016	Scenario 1A	19%	8%	19%	21%	8%
2016	Scenario 1B	19%	12%	19%	19%	8%
2016	Scenario 1C	14%	5%	14%	14%	3%
2017	Status Quo	12%	10%	13%	n/a	n/a
2017	Scenario 1A	18%	7%	19%	19%	10%
2017	Scenario 1B	18%	2%	19%	18%	9%
2017	Scenario 1C	10%	5%	10%	10%	5%

Society of Actuaries

Design and Implementation Considerations of ACA Risk Mitigation Programs

Attachment C1

Individual Business Only

All Geographic Areas Combined

Table C1-7						
Results by Exchange/Non Exchange and Projection Year						
Individual Business						
All Geographic Areas Combined						
Accumulated Change in Average Premium from 2013						
Projection Year	**Scenario**	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	Exchange Business after Subsidy
2013	Status Quo	1.00	1.00	1.00	n/a	n/a
2014	Status Quo	1.08	1.12	1.07	n/a	n/a
2014	Scenario 1A	1.09	1.19	1.14	1.15	0.72
2014	Scenario 1B	1.19	1.27	1.23	1.26	0.76
2014	Scenario 1C	1.37	1.45	1.44	1.43	0.80
2015	Status Quo	1.16	1.25	1.16	n/a	n/a
2015	Scenario 1A	1.28	1.27	1.34	1.38	0.78
2015	Scenario 1B	1.39	1.44	1.45	1.49	0.83
2015	Scenario 1C	1.76	1.39	1.92	1.90	0.92
2016	Status Quo	1.28	1.39	1.29	n/a	n/a
2016	Scenario 1A	1.53	1.37	1.60	1.66	0.85
2016	Scenario 1B	1.65	1.60	1.72	1.78	0.89
2016	Scenario 1C	2.01	1.46	2.19	2.17	0.95
2017	Status Quo	1.43	1.53	1.47	n/a	n/a
2017	Scenario 1A	1.81	1.46	1.91	1.97	0.93
2017	Scenario 1B	1.94	1.64	2.04	2.10	0.97
2017	Scenario 1C	2.22	1.52	2.41	2.40	0.99

Accumulated Changes in Average Premium from Year 2013 and Annual Loss Ratios by Regulatory Grouping Scenario 1A
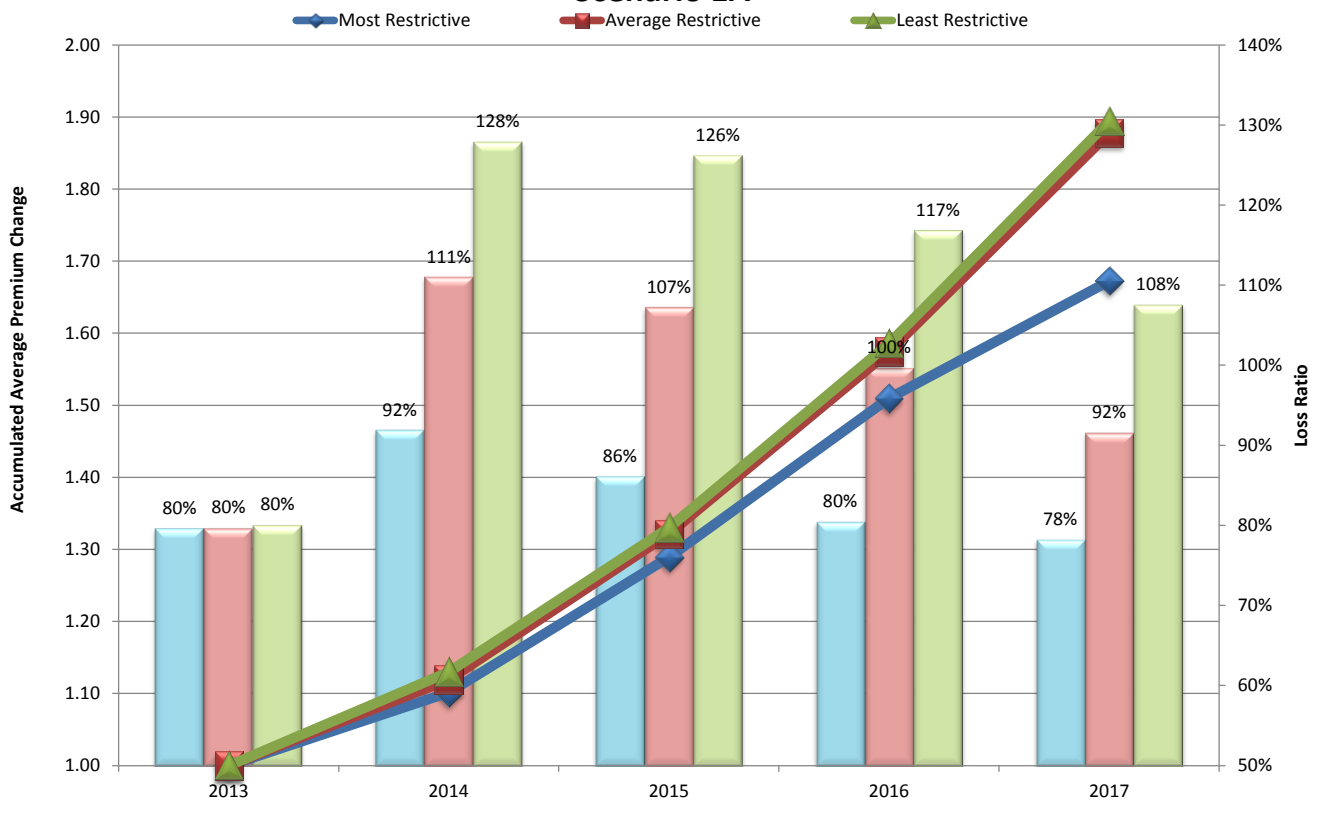
Accumulated Changes in Average Premium from Year 2013
and Annual Loss Ratios by Regulatory Grouping
Scenario 1B
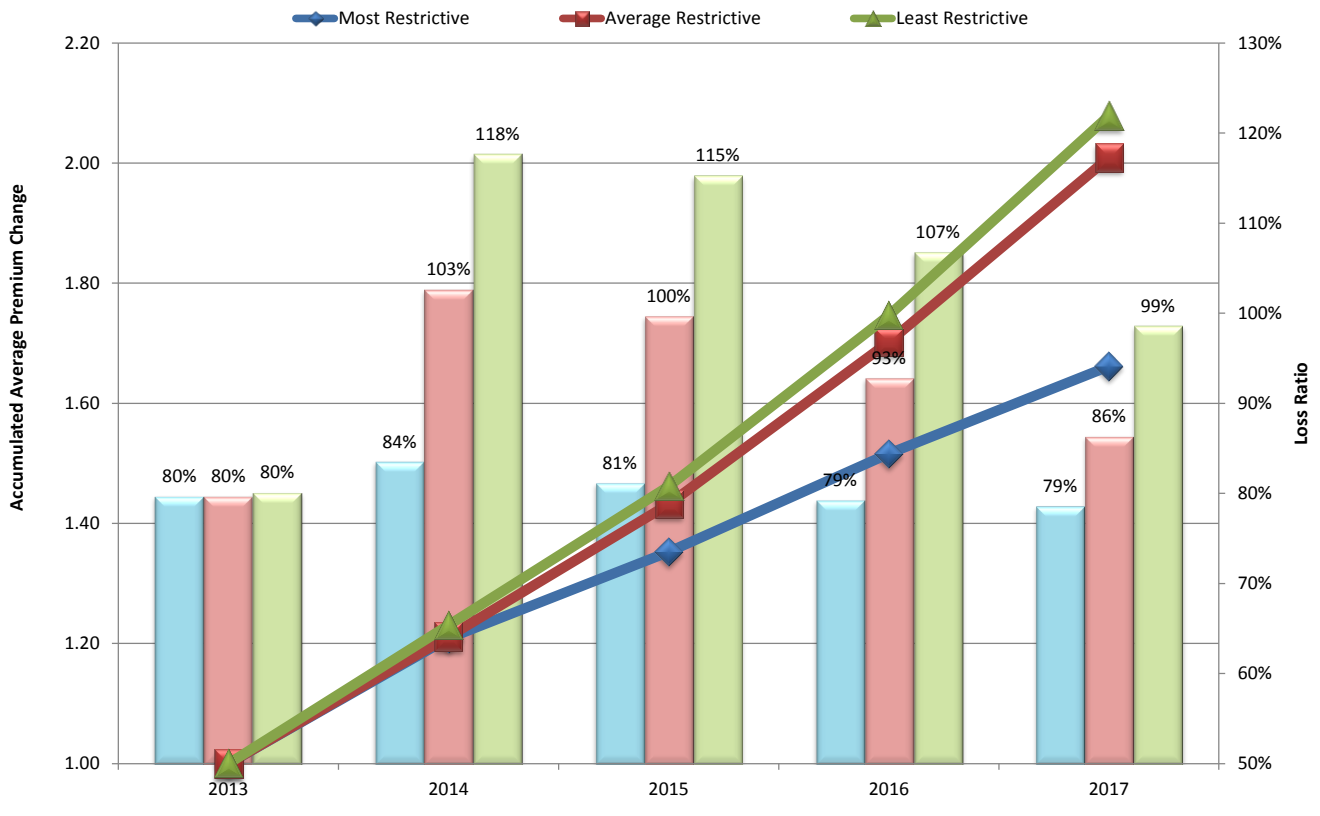
Accumulated Changes in Average Premium from Year 2013
and Annual Loss Ratios by Regulatory Grouping
Scenario 1C
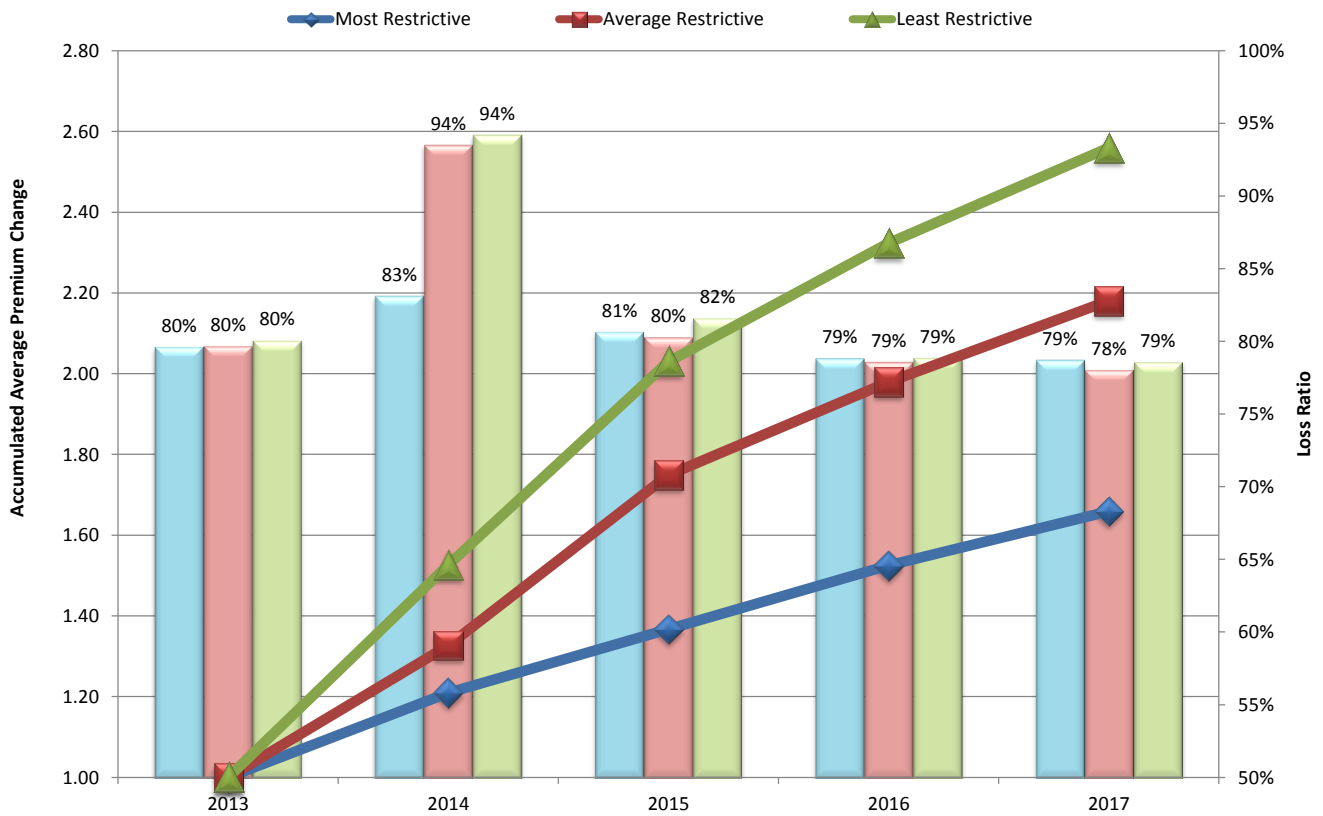
Society of Actuaries

Design and Implementation Considerations of ACA Risk Mitigation Programs

Attachment C2

Individual Business Only

Most Restrictive States Only

				Non-Grandfathered		
Projection Year	**Scenario**	**Total**	**Grandfathered Business**	**Non-Exchange Business**	**Exchange Business**	**All Non-Exchange Business**
2013	Status Quo	1,474	751	723	n/a	1,474
2014	Status Quo	1,471	589	882	n/a	1,471
2014	Scenario 1A	1,766	212	657	897	869
2014	Scenario 1B	1,763	214	608	941	821
2014	Scenario 1C	1,765	209	603	953	812
2015	Status Quo	1,467	461	1,006	n/a	1,467
2015	Scenario 1A	2,460	146	704	1,610	850
2015	Scenario 1B	2,461	147	671	1,642	818
2015	Scenario 1C	2,464	147	677	1,640	824
2016	Status Quo	1,473	364	1,110	n/a	1,473
2016	Scenario 1A	3,053	134	779	2,140	913
2016	Scenario 1B	3,056	137	770	2,149	907
2016	Scenario 1C	3,057	137	766	2,154	903
2017	Status Quo	1,471	292	1,180	n/a	1,471
2017	Scenario 1A	3,578	124	866	2,588	989
2017	Scenario 1B	3,582	126	857	2,599	983
2017	Scenario 1C	3,577	126	851	2,600	978

Table C2-1
Results by Exchange/Non Exchange and Projection Year
Individual Business
Most Restrictive States Only
Enrollment
(thousands)

Most Restrictive States Only

				Table C2-2		
				Results by Exchange/Non Exchange and Projection Year		
				Individual Business		
				Most Restrictive States Only		
				Incurred Loss Ratios		
Projection Year	**Scenario**	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	80%	92%	64%	n/a	80%
2014	Status Quo	83%	94%	73%	n/a	83%
2014	Scenario 1A	92%	88%	85%	98%	86%
2014	Scenario 1B	84%	88%	76%	87%	80%
2014	Scenario 1C	83%	88%	77%	86%	80%
2015	Status Quo	86%	93%	81%	n/a	86%
2015	Scenario 1A	86%	82%	83%	88%	82%
2015	Scenario 1B	81%	86%	78%	82%	80%
2015	Scenario 1C	81%	82%	79%	81%	80%
2016	Status Quo	88%	94%	84%	n/a	88%
2016	Scenario 1A	80%	80%	78%	81%	79%
2016	Scenario 1B	79%	84%	77%	80%	78%
2016	Scenario 1C	79%	80%	78%	79%	78%
2017	Status Quo	86%	93%	83%	n/a	86%
2017	Scenario 1A	78%	82%	77%	78%	78%
2017	Scenario 1B	79%	82%	77%	79%	78%
2017	Scenario 1C	79%	81%	78%	79%	79%

Most Restrictive States Only

	Table C2-3					
	Results by Exchange/Non Exchange and Projection Year					
	Individual Business					
	Most Restrictive States Only					
	Incurred Loss Ratios Including Impact of Risk Mitigation					
Projection Year	**Scenario**	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	80%	92%	64%	n/a	80%
2014	Status Quo	83%	94%	73%	n/a	83%
2014	Scenario 1A	81%	89%	78%	81%	81%
2014	Scenario 1B	78%	89%	75%	77%	79%
2014	Scenario 1C	78%	88%	75%	77%	79%
2015	Status Quo	86%	93%	81%	n/a	86%
2015	Scenario 1A	81%	82%	80%	82%	81%
2015	Scenario 1B	79%	87%	78%	79%	80%
2015	Scenario 1C	79%	83%	78%	79%	79%
2016	Status Quo	88%	94%	84%	n/a	88%
2016	Scenario 1A	79%	80%	78%	80%	79%
2016	Scenario 1B	79%	84%	78%	79%	79%
2016	Scenario 1C	79%	80%	78%	79%	78%
2017	Status Quo	86%	93%	83%	n/a	86%
2017	Scenario 1A	78%	82%	78%	78%	78%
2017	Scenario 1B	79%	82%	77%	79%	78%
2017	Scenario 1C	79%	81%	78%	79%	79%

Most Restrictive States Only

Table C2-4
Results by Exchange/Non Exchange and Projection Year
Individual Business
Most Restrictive States Only
Change in Average Premium Each Year

Projection Year	Scenario	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	Exchange Business after Subsidy
2013	Status Quo	0.0%	0%	0%	n/a	n/a
2014	Status Quo	5.7%	16%	1%	n/a	n/a
2014	Scenario 1A	10.1%	30%	17%	15%	-44%
2014	Scenario 1B	20.9%	30%	33%	27%	-42%
2014	Scenario 1C	20.9%	31%	34%	27%	-42%
2015	Status Quo	5.4%	16%	4%	n/a	n/a
2015	Scenario 1A	17.0%	15%	22%	19%	4%
2015	Scenario 1B	11.9%	14%	13%	14%	0%
2015	Scenario 1C	13.1%	15%	13%	16%	6%
2016	Status Quo	9.8%	17%	11%	n/a	n/a
2016	Scenario 1A	17.1%	13%	18%	18%	2%
2016	Scenario 1B	12.1%	16%	12%	12%	4%
2016	Scenario 1C	11.5%	13%	12%	12%	-1%
2017	Status Quo	12.5%	15%	15%	n/a	n/a
2017	Scenario 1A	10.8%	9%	11%	11%	7%
2017	Scenario 1B	9.6%	12%	11%	10%	4%
2017	Scenario 1C	8.8%	10%	10%	9%	4%

Most Restrictive States Only

					Table C2-5	
				Results by Exchange/Non Exchange and Projection Year		
				Individual Business		
				Most Restrictive States Only		
				Accumulated Change in Average Premium from 2013		

Projection Year	Scenario	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	Exchange Business after Subsidy
2013	Status Quo	1.00	1.00	1.00	n/a	n/a
2014	Status Quo	1.06	1.16	1.01	n/a	n/a
2014	Scenario 1A	1.10	1.30	1.17	1.15	0.56
2014	Scenario 1B	1.21	1.30	1.33	1.27	0.58
2014	Scenario 1C	1.21	1.31	1.34	1.27	0.58
2015	Status Quo	1.11	1.34	1.05	n/a	n/a
2015	Scenario 1A	1.29	1.49	1.43	1.37	0.58
2015	Scenario 1B	1.35	1.48	1.51	1.45	0.58
2015	Scenario 1C	1.37	1.51	1.51	1.47	0.62
2016	Status Quo	1.22	1.56	1.17	n/a	n/a
2016	Scenario 1A	1.51	1.68	1.69	1.62	0.59
2016	Scenario 1B	1.52	1.71	1.69	1.63	0.60
2016	Scenario 1C	1.52	1.71	1.70	1.64	0.61
2017	Status Quo	1.38	1.81	1.35	n/a	n/a
2017	Scenario 1A	1.67	1.83	1.87	1.81	0.63
2017	Scenario 1B	1.66	1.91	1.87	1.78	0.63
2017	Scenario 1C	1.66	1.87	1.86	1.78	0.63

Society of Actuaries

Design and Implementation Considerations of ACA Risk Mitigation Programs

Attachment C3

Individual Business Only

Average Restrictive States Only

Table C3-1						
Results by Exchange/Non Exchange and Projection Year						
Individual Business						
Average Restrictive States Only						
Enrollment						
(thousands)						
Projection Year	**Scenario**	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	5,004	2,544	2,460	n/a	5,004
2014	Status Quo	5,003	2,051	2,952	n/a	5,003
2014	Scenario 1A	6,641	864	2,777	3,000	3,641
2014	Scenario 1B	6,642	855	2,752	3,035	3,607
2014	Scenario 1C	6,649	812	2,584	3,253	3,396
2015	Status Quo	5,001	1,664	3,337	n/a	5,001
2015	Scenario 1A	9,623	667	3,465	5,490	4,132
2015	Scenario 1B	9,627	661	3,450	5,517	4,111
2015	Scenario 1C	9,649	756	2,995	5,897	3,752
2016	Status Quo	5,015	1,376	3,639	n/a	5,015
2016	Scenario 1A	11,402	639	3,863	6,900	4,502
2016	Scenario 1B	11,395	636	3,856	6,903	4,492
2016	Scenario 1C	11,420	724	3,366	7,329	4,090
2017	Status Quo	5,025	1,156	3,869	n/a	5,025
2017	Scenario 1A	12,699	613	4,070	8,016	4,683
2017	Scenario 1B	12,682	614	4,059	8,009	4,673
2017	Scenario 1C	12,712	694	3,615	8,404	4,308

Average Restrictive States Only

Projection Year	Scenario	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
**Table C3-2** **Results by Exchange/Non Exchange and Projection Year** Individual Business Average Restrictive States Only Incurred Loss Ratios
2013	Status Quo	80%	84%	74%	n/a	80%
2014	Status Quo	81%	85%	77%	n/a	81%
2014	Scenario 1A	111%	80%	109%	123%	102%
2014	Scenario 1B	103%	74%	103%	112%	95%
2014	Scenario 1C	94%	69%	93%	101%	87%
2015	Status Quo	82%	85%	80%	n/a	82%
2015	Scenario 1A	107%	74%	107%	112%	101%
2015	Scenario 1B	100%	68%	100%	103%	95%
2015	Scenario 1C	80%	76%	80%	81%	79%
2016	Status Quo	82%	84%	81%	n/a	82%
2016	Scenario 1A	100%	76%	99%	102%	96%
2016	Scenario 1B	93%	72%	92%	95%	90%
2016	Scenario 1C	79%	78%	78%	79%	78%
2017	Status Quo	81%	83%	81%	n/a	81%
2017	Scenario 1A	92%	78%	92%	92%	90%
2017	Scenario 1B	86%	77%	86%	87%	85%
2017	Scenario 1C	78%	79%	78%	78%	78%

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment C3
Individual Business Only

Average Restrictive States Only

				Non-Grandfathered		
Table C3-3						
Results by Exchange/Non Exchange and Projection Year						
Individual Business						
Average Restrictive States Only						
Incurred Loss Ratios Including Impact of Risk Mitigation						

Projection Year	Scenario	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	80%	84%	74%	n/a	80%
2014	Status Quo	81%	85%	77%	n/a	81%
2014	Scenario 1A	86%	82%	86%	87%	85%
2014	Scenario 1B	82%	76%	82%	85%	80%
2014	Scenario 1C	79%	71%	79%	82%	77%
2015	Status Quo	82%	85%	80%	n/a	82%
2015	Scenario 1A	87%	75%	87%	88%	85%
2015	Scenario 1B	84%	69%	85%	86%	82%
2015	Scenario 1C	78%	77%	76%	79%	76%
2016	Status Quo	82%	84%	81%	n/a	82%
2016	Scenario 1A	86%	77%	86%	87%	85%
2016	Scenario 1B	83%	73%	83%	84%	82%
2016	Scenario 1C	78%	78%	77%	78%	77%
2017	Status Quo	81%	83%	81%	n/a	81%
2017	Scenario 1A	92%	78%	90%	93%	89%
2017	Scenario 1B	86%	77%	85%	88%	84%
2017	Scenario 1C	78%	79%	77%	79%	77%

Average Restrictive States Only

Table C3-4						
Results by Exchange/Non Exchange and Projection Year						
Individual Business						
Average Restrictive States Only						
Change in Average Premium Each Year						
Projection Year	**Scenario**	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	Exchange Business after Subsidy
2013	Status Quo	0.0%	0%	0%	n/a	n/a
2014	Status Quo	8.2%	11%	8%	n/a	n/a
2014	Scenario 1A	11.9%	19%	17%	16%	-28%
2014	Scenario 1B	21.1%	29%	27%	25%	-23%
2014	Scenario 1C	32.7%	39%	40%	37%	-23%
2015	Status Quo	8.4%	10%	9%	n/a	n/a
2015	Scenario 1A	18.1%	8%	20%	20%	10%
2015	Scenario 1B	18.2%	9%	20%	20%	10%
2015	Scenario 1C	31.9%	-5%	37%	36%	18%
2016	Status Quo	9.8%	10%	11%	n/a	n/a
2016	Scenario 1A	19.2%	6%	20%	20%	8%
2016	Scenario 1B	18.9%	3%	20%	20%	9%
2016	Scenario 1C	13.1%	7%	13%	13%	4%
2017	Status Quo	11.3%	9%	13%	n/a	n/a
2017	Scenario 1A	19.3%	7%	20%	20%	9%
2017	Scenario 1B	18.1%	1%	19%	19%	8%
2017	Scenario 1C	10.2%	8%	10%	10%	4%

Average Restrictive States Only

				Non-Grandfathered		
Projection Year	Scenario	Total	Grandfathered Business	Non-Exchange Business	Exchange Business	Exchange Business after Subsidy
2013	Status Quo	1.00	1.00	1.00	n/a	n/a
2014	Status Quo	1.08	1.11	1.08	n/a	n/a
2014	Scenario 1A	1.12	1.19	1.17	1.16	0.72
2014	Scenario 1B	1.21	1.29	1.27	1.25	0.77
2014	Scenario 1C	1.33	1.39	1.40	1.37	0.77
2015	Status Quo	1.17	1.22	1.18	n/a	n/a
2015	Scenario 1A	1.32	1.28	1.40	1.39	0.79
2015	Scenario 1B	1.43	1.41	1.52	1.50	0.85
2015	Scenario 1C	1.75	1.31	1.92	1.86	0.91
2016	Status Quo	1.29	1.35	1.31	n/a	n/a
2016	Scenario 1A	1.57	1.36	1.68	1.67	0.85
2016	Scenario 1B	1.70	1.44	1.82	1.80	0.92
2016	Scenario 1C	1.98	1.40	2.17	2.11	0.95
2017	Status Quo	1.43	1.47	1.48	n/a	n/a
2017	Scenario 1A	1.88	1.46	2.02	2.00	0.93
2017	Scenario 1B	2.01	1.47	2.16	2.14	1.00
2017	Scenario 1C	2.18	1.51	2.38	2.33	0.99

Table C3-5
Results by Exchange/Non Exchange and Projection Year
Individual Business
Average Restrictive States Only
Accumulated Change in Average Premium from 2013

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment C4
Individual Business Only

Least Restrictive States Only

Table C4-1						
Results by Exchange/Non Exchange and Projection Year						
Individual Business						
Least Restrictive States Only						
Enrollment						
(thousands)						
Projection Year	**Scenario**	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	8,117	4,130	3,987	n/a	8,117
2014	Status Quo	8,089	3,295	4,794	n/a	8,089
2014	Scenario 1A	12,215	1,442	5,240	5,534	6,682
2014	Scenario 1B	12,223	1,416	5,153	5,653	6,570
2014	Scenario 1C	12,226	1,231	4,696	6,299	5,927
2015	Status Quo	8,067	2,664	5,403	n/a	8,067
2015	Scenario 1A	17,689	1,134	6,651	9,904	7,786
2015	Scenario 1B	17,743	1,083	6,545	10,114	7,629
2015	Scenario 1C	17,621	1,121	5,470	11,029	6,592
2016	Status Quo	8,050	2,197	5,853	n/a	8,050
2016	Scenario 1A	20,805	1,085	7,457	12,263	8,542
2016	Scenario 1B	20,863	1,017	7,316	12,531	8,332
2016	Scenario 1C	20,752	1,085	6,051	13,616	7,136
2017	Status Quo	8,037	1,838	6,199	n/a	8,037
2017	Scenario 1A	22,883	1,038	7,832	14,013	8,870
2017	Scenario 1B	22,942	977	7,667	14,297	8,645
2017	Scenario 1C	22,824	1,050	6,409	15,365	7,459

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment C4
Individual Business Only

Least Restrictive States Only

Table C4-2
Results by Exchange/Non Exchange and Projection Year
Individual Business
Least Restrictive States Only
Incurred Loss Ratios

Projection Year	Scenario	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	80%	85%	74%	n/a	80%
2014	Status Quo	81%	85%	78%	n/a	81%
2014	Scenario 1A	128%	79%	126%	145%	115%
2014	Scenario 1B	118%	73%	117%	131%	107%
2014	Scenario 1C	94%	62%	94%	101%	87%
2015	Status Quo	82%	85%	80%	n/a	82%
2015	Scenario 1A	126%	75%	124%	133%	117%
2015	Scenario 1B	115%	64%	115%	122%	107%
2015	Scenario 1C	82%	66%	82%	83%	80%
2016	Status Quo	82%	84%	81%	n/a	82%
2016	Scenario 1A	117%	76%	115%	121%	111%
2016	Scenario 1B	107%	60%	107%	111%	100%
2016	Scenario 1C	79%	72%	79%	79%	78%
2017	Status Quo	81%	84%	80%	n/a	81%
2017	Scenario 1A	108%	79%	106%	110%	104%
2017	Scenario 1B	99%	65%	98%	101%	95%
2017	Scenario 1C	79%	77%	78%	79%	78%

Least Restrictive States Only

	Table C4-3					
	Results by Exchange/Non Exchange and Projection Year					
	Individual Business					
	Least Restrictive States Only					
	Incurred Loss Ratios Including Impact of Risk Mitigation					
Projection Year	**Scenario**	**Total**	**Grandfathered Business**	**Non-Grandfathered Non-Exchange Business**	**Exchange Business**	**All Non-Exchange Business**
2013	Status Quo	80%	85%	74%	n/a	80%
2014	Status Quo	81%	85%	78%	n/a	81%
2014	Scenario 1A	89%	81%	90%	91%	88%
2014	Scenario 1B	87%	75%	89%	89%	85%
2014	Scenario 1C	80%	63%	81%	83%	77%
2015	Status Quo	82%	85%	80%	n/a	82%
2015	Scenario 1A	91%	77%	91%	92%	89%
2015	Scenario 1B	88%	65%	90%	90%	86%
2015	Scenario 1C	79%	67%	78%	80%	77%
2016	Status Quo	82%	84%	81%	n/a	82%
2016	Scenario 1A	90%	77%	90%	90%	89%
2016	Scenario 1B	87%	60%	88%	88%	85%
2016	Scenario 1C	78%	72%	78%	79%	77%
2017	Status Quo	81%	84%	80%	n/a	81%
2017	Scenario 1A	108%	79%	106%	110%	104%
2017	Scenario 1B	99%	65%	98%	101%	95%
2017	Scenario 1C	79%	77%	78%	79%	78%

Least Restrictive States Only

Table C4-4 Results by Exchange/Non Exchange and Projection Year Individual Business Least Restrictive States Only Change in Average Premium Each Year						
Projection Year	Scenario	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	Exchange Business after Subsidy
2013	Status Quo	0%	0%	0%	n/a	n/a
2014	Status Quo	8%	11%	8%	n/a	n/a
2014	Scenario 1A	13%	21%	19%	17%	-19%
2014	Scenario 1B	23%	31%	28%	28%	-15%
2014	Scenario 1C	53%	59%	61%	59%	-6%
2015	Status Quo	9%	11%	10%	n/a	n/a
2015	Scenario 1A	18%	7%	19%	20%	10%
2015	Scenario 1B	19%	18%	20%	20%	10%
2015	Scenario 1C	33%	-4%	37%	36%	16%
2016	Status Quo	11%	10%	12%	n/a	n/a
2016	Scenario 1A	19%	8%	20%	20%	9%
2016	Scenario 1B	19%	17%	20%	20%	9%
2016	Scenario 1C	14%	1%	15%	15%	3%
2017	Status Quo	11%	10%	13%	n/a	n/a
2017	Scenario 1A	19%	7%	20%	20%	10%
2017	Scenario 1B	19%	0%	20%	20%	10%
2017	Scenario 1C	10%	1%	10%	10%	5%

Least Restrictive States Only

Table C4-5						
Results by Exchange/Non Exchange and Projection Year						
Individual Business						
Least Restrictive States Only						
Accumulated Change in Average Premium from 2013						

Projection Year	Scenario	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	Exchange Business after Subsidy
2013	Status Quo	1.00	1.00	1.00	n/a	n/a
2014	Status Quo	1.08	1.11	1.08	n/a	n/a
2014	Scenario 1A	1.13	1.21	1.19	1.17	0.81
2014	Scenario 1B	1.23	1.31	1.28	1.28	0.85
2014	Scenario 1C	1.53	1.59	1.61	1.59	0.94
2015	Status Quo	1.18	1.24	1.19	n/a	n/a
2015	Scenario 1A	1.33	1.29	1.42	1.40	0.89
2015	Scenario 1B	1.46	1.54	1.54	1.54	0.93
2015	Scenario 1C	2.03	1.53	2.21	2.17	1.09
2016	Status Quo	1.31	1.37	1.33	n/a	n/a
2016	Scenario 1A	1.59	1.39	1.70	1.68	0.97
2016	Scenario 1B	1.75	1.80	1.84	1.84	1.01
2016	Scenario 1C	2.32	1.54	2.53	2.49	1.12
2017	Status Quo	1.45	1.50	1.50	n/a	n/a
2017	Scenario 1A	1.89	1.49	2.03	2.02	1.06
2017	Scenario 1B	2.08	1.81	2.21	2.21	1.11
2017	Scenario 1C	2.56	1.56	2.79	2.75	1.17

Attachment D

Projection Results – Exchange/3Rs Scenarios

D-1: Individual Business Only: All Geographic Areas Combined -
Scenarios 1 – 5 and Status Quo

D-2: Individual Business Only: Most Restrictive State Grouping -
Scenarios 1 – 5 and Status Quo

D-3: Individual Business Only: Average Restrictive State Grouping -
Scenarios 1 – 5 and Status Quo

D-4: Individual Business Only: Least Restrictive State Grouping -
Scenarios 1 – 5 and Status Quo

Milliman, Inc.

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment D1
Individual Business Only

All Geographic Areas Combined

Table D1-1 Results by Exchange/Non Exchange and Projection Year Individual Business All Geographic Areas Combined Enrollment (thousands)						
Projection Year	Scenario	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	14,594	7,425	7,169	n/a	14,594
2014	Status Quo	14,563	5,936	8,628	n/a	14,563
2014	Scenario 1	20,622	2,518	8,674	9,430	11,192
2014	Scenario 2	20,619	2,506	11,421	6,692	13,927
2014	Scenario 3	20,614	2,509	9,021	9,084	11,530
2014	Scenario 4	18,140	2,303	7,981	7,856	10,284
2014	Scenario 5	20,641	2,511	8,665	9,465	11,176
2015	Status Quo	14,535	4,789	9,746	n/a	14,535
2015	Scenario 1	29,772	1,947	10,821	17,004	12,768
2015	Scenario 2	29,795	1,924	15,270	12,601	17,194
2015	Scenario 3	29,828	1,937	11,467	16,424	13,403
2015	Scenario 4	25,790	1,814	10,073	13,903	11,888
2015	Scenario 5	29,731	1,950	10,763	17,018	12,713
2016	Status Quo	14,538	3,936	10,602	n/a	14,538
2016	Scenario 1	35,259	1,859	12,098	21,302	13,957
2016	Scenario 2	35,278	1,833	17,315	16,130	19,148
2016	Scenario 3	35,321	1,844	12,847	20,631	14,690
2016	Scenario 4	30,237	1,737	11,330	17,169	13,067
2016	Scenario 5	35,202	1,862	12,024	21,317	13,885
2017	Status Quo	14,534	3,286	11,247	n/a	14,534
2017	Scenario 1	39,160	1,775	12,767	24,618	14,543
2017	Scenario 2	39,167	1,744	18,386	19,037	20,130
2017	Scenario 3	39,214	1,761	13,547	23,906	15,307
2017	Scenario 4	33,541	1,665	12,072	19,803	13,738
2017	Scenario 5	39,119	1,778	12,700	24,641	14,478

All Geographic Areas Combined

		Table D1-2				
		Results by Exchange/Non Exchange and Projection Year				
		Individual Business				
		All Geographic Areas Combined				
		Premium Revenue				
		($ millions)				
Projection Year	**Scenario**	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	39,764	21,461	18,303	n/a	39,764
2014	Status Quo	42,708	19,192	23,517	n/a	42,708
2014	Scenario 1	61,431	8,636	25,172	27,623	33,808
2014	Scenario 2	60,439	8,580	32,942	18,917	41,522
2014	Scenario 3	61,486	8,610	26,202	26,674	34,812
2014	Scenario 4	55,309	8,048	23,629	23,632	31,677
2014	Scenario 5	61,683	8,608	25,250	27,825	33,858
2015	Status Quo	46,070	17,267	28,803	n/a	46,070
2015	Scenario 1	103,965	7,169	37,082	59,714	44,251
2015	Scenario 2	102,154	7,071	52,151	42,932	59,222
2015	Scenario 3	104,350	7,149	39,337	57,864	46,486
2015	Scenario 4	92,286	6,807	35,137	50,342	41,944
2015	Scenario 5	104,226	7,162	37,021	60,043	44,183
2016	Status Quo	50,779	15,759	35,020	n/a	50,779
2016	Scenario 1	147,084	7,364	49,455	90,266	56,818
2016	Scenario 2	144,088	7,290	70,302	66,496	77,592
2016	Scenario 3	147,598	7,338	52,537	87,723	59,875
2016	Scenario 4	129,172	7,096	47,060	75,015	54,157
2016	Scenario 5	147,502	7,368	49,350	90,784	56,718
2017	Status Quo	56,631	14,508	42,123	n/a	56,631
2017	Scenario 1	193,513	7,511	62,146	123,857	69,657
2017	Scenario 2	189,479	7,430	88,776	93,273	96,206
2017	Scenario 3	194,049	7,508	65,933	120,608	73,440
2017	Scenario 4	169,632	7,305	59,581	102,747	66,885
2017	Scenario 5	194,111	7,557	62,090	124,465	69,646

Society of Actuaries

Design and Implementation Considerations of ACA Risk Mitigation Programs

Attachment D1

Individual Business Only

All Geographic Areas Combined

				Table D1-3 Results by Exchange/Non Exchange and Projection Year Individual Business All Geographic Areas Combined Incurred Loss Ratios		
Projection Year	**Scenario**	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	80%	86%	72%	n/a	80%
2014	Status Quo	82%	87%	77%	n/a	82%
2014	Scenario 1	116%	82%	114%	128%	105%
2014	Scenario 2	115%	82%	117%	128%	110%
2014	Scenario 3	115%	82%	114%	127%	106%
2014	Scenario 4	113%	82%	113%	125%	105%
2014	Scenario 5	115%	81%	113%	128%	105%
2015	Status Quo	83%	87%	80%	n/a	83%
2015	Scenario 1	113%	76%	112%	117%	107%
2015	Scenario 2	112%	77%	114%	116%	110%
2015	Scenario 3	112%	77%	113%	116%	107%
2015	Scenario 4	111%	78%	112%	114%	107%
2015	Scenario 5	112%	77%	112%	116%	106%
2016	Status Quo	83%	86%	82%	n/a	83%
2016	Scenario 1	105%	77%	105%	107%	101%
2016	Scenario 2	105%	78%	106%	106%	104%
2016	Scenario 3	104%	78%	105%	106%	101%
2016	Scenario 4	103%	78%	105%	104%	101%
2016	Scenario 5	104%	78%	104%	106%	100%
2017	Status Quo	82%	86%	81%	n/a	82%
2017	Scenario 1	97%	79%	97%	98%	95%
2017	Scenario 2	97%	79%	99%	97%	97%
2017	Scenario 3	97%	79%	97%	97%	96%
2017	Scenario 4	96%	80%	97%	96%	95%
2017	Scenario 5	97%	79%	97%	98%	95%

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment D1
Individual Business Only

All Geographic Areas Combined

Table D1-4						
Results by Exchange/Non Exchange and Projection Year						
Individual Business						
All Geographic Areas Combined						
Incurred Loss Ratios Including Impact of Risk Mitigation						
Projection Year	**Scenario**	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	80%	86%	72%	n/a	80%
2014	Status Quo	82%	87%	77%	n/a	82%
2014	Scenario 1	87%	83%	87%	88%	86%
2014	Scenario 2	87%	83%	87%	88%	86%
2014	Scenario 3	87%	83%	87%	87%	86%
2014	Scenario 4	86%	84%	86%	86%	85%
2014	Scenario 5	87%	83%	87%	87%	86%
2015	Status Quo	83%	87%	80%	n/a	83%
2015	Scenario 1	88%	77%	88%	89%	87%
2015	Scenario 2	88%	78%	88%	89%	87%
2015	Scenario 3	88%	78%	88%	88%	87%
2015	Scenario 4	87%	79%	88%	88%	86%
2015	Scenario 5	88%	78%	88%	88%	87%
2016	Status Quo	83%	86%	82%	n/a	83%
2016	Scenario 1	87%	78%	87%	87%	86%
2016	Scenario 2	87%	79%	87%	87%	86%
2016	Scenario 3	86%	78%	87%	87%	86%
2016	Scenario 4	86%	79%	87%	86%	86%
2016	Scenario 5	86%	79%	87%	87%	86%
2017	Status Quo	82%	86%	81%	n/a	82%
2017	Scenario 1	97%	79%	97%	98%	95%
2017	Scenario 2	97%	79%	98%	98%	97%
2017	Scenario 3	97%	79%	97%	97%	96%
2017	Scenario 4	96%	80%	96%	97%	94%
2017	Scenario 5	97%	79%	97%	98%	95%

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment D2
Individual Business Only

Most Restrictive States Only

| | | | | Non-Grandfathered | | |
Projection Year	Scenario	Total	Grandfathered Business	Non-Exchange Business	Exchange Business	All Non-Exchange Business
Table D2-1						
Results by Exchange/Non Exchange and Projection Year						
Individual Business						
Most Restrictive States Only						
Enrollment						
(thousands)						
2013	Status Quo	1,474	751	723	n/a	1,474
2014	Status Quo	1,471	589	882	n/a	1,471
2014	Scenario 1	1,766	212	657	897	869
2014	Scenario 2	1,763	212	831	720	1,043
2014	Scenario 3	1,764	213	685	866	898
2014	Scenario 4	1,602	202	633	767	835
2014	Scenario 5	1,766	212	657	897	869
2015	Status Quo	1,467	461	1,006	n/a	1,467
2015	Scenario 1	2,460	146	704	1,610	850
2015	Scenario 2	2,469	144	971	1,354	1,115
2015	Scenario 3	2,465	148	749	1,568	897
2015	Scenario 4	2,204	144	697	1,362	842
2015	Scenario 5	2,458	147	699	1,613	845
2016	Status Quo	1,473	364	1,110	n/a	1,473
2016	Scenario 1	3,053	134	779	2,140	913
2016	Scenario 2	3,061	132	1,084	1,845	1,215
2016	Scenario 3	3,064	136	838	2,090	974
2016	Scenario 4	2,693	135	783	1,775	918
2016	Scenario 5	3,052	136	778	2,138	914
2017	Status Quo	1,471	292	1,180	n/a	1,471
2017	Scenario 1	3,578	124	866	2,588	989
2017	Scenario 2	3,586	119	1,178	2,290	1,296
2017	Scenario 3	3,586	126	923	2,537	1,049
2017	Scenario 4	3,142	125	865	2,152	990
2017	Scenario 5	3,577	126	871	2,579	998

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment D2
Individual Business Only

Most Restrictive States Only

				Non-Grandfathered		
Projection Year	**Scenario**	**Total**	**Grandfathered Business**	**Non-Exchange Business**	**Exchange Business**	**All Non-Exchange Business**
2013	Status Quo	80%	92%	64%	n/a	80%
2014	Status Quo	83%	94%	73%	n/a	83%
2014	Scenario 1	92%	88%	85%	98%	86%
2014	Scenario 2	92%	88%	86%	101%	87%
2014	Scenario 3	91%	88%	85%	97%	86%
2014	Scenario 4	91%	88%	84%	98%	85%
2014	Scenario 5	92%	88%	85%	98%	86%
2015	Status Quo	86%	93%	81%	n/a	86%
2015	Scenario 1	86%	82%	83%	88%	82%
2015	Scenario 2	86%	83%	81%	89%	82%
2015	Scenario 3	86%	83%	83%	87%	83%
2015	Scenario 4	85%	83%	80%	88%	81%
2015	Scenario 5	86%	84%	84%	88%	84%
2016	Status Quo	88%	94%	84%	n/a	88%
2016	Scenario 1	80%	80%	78%	81%	79%
2016	Scenario 2	81%	81%	78%	83%	78%
2016	Scenario 3	80%	81%	78%	81%	79%
2016	Scenario 4	80%	82%	78%	81%	78%
2016	Scenario 5	80%	81%	78%	81%	79%
2017	Status Quo	86%	93%	83%	n/a	86%
2017	Scenario 1	78%	82%	77%	78%	78%
2017	Scenario 2	79%	84%	78%	79%	79%
2017	Scenario 3	79%	83%	78%	79%	79%
2017	Scenario 4	79%	83%	77%	79%	78%
2017	Scenario 5	78%	81%	78%	78%	79%

Table D2-2
Results by Exchange/Non Exchange and Projection Year
Individual Business
Most Restrictive States Only
Incurred Loss Ratios

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment D2
Individual Business Only

Most Restrictive States Only

Projection Year	Scenario	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
**Table D2-3**
**Results by Exchange/Non Exchange and Projection Year**
Individual Business
Most Restrictive States Only
**Incurred Loss Ratios Including Impact of Risk Mitigation**
2013	Status Quo	80%	92%	64%	n/a	80%
2014	Status Quo	83%	94%	73%	n/a	83%
2014	Scenario 1	81%	89%	78%	81%	81%
2014	Scenario 2	81%	89%	79%	82%	81%
2014	Scenario 3	81%	89%	79%	80%	81%
2014	Scenario 4	80%	89%	77%	80%	81%
2014	Scenario 5	82%	89%	80%	81%	83%
2015	Status Quo	86%	93%	81%	n/a	86%
2015	Scenario 1	81%	82%	80%	82%	81%
2015	Scenario 2	81%	84%	79%	82%	80%
2015	Scenario 3	81%	84%	80%	82%	80%
2015	Scenario 4	81%	84%	79%	81%	80%
2015	Scenario 5	82%	84%	81%	81%	82%
2016	Status Quo	88%	94%	84%	n/a	88%
2016	Scenario 1	79%	80%	78%	80%	79%
2016	Scenario 2	80%	81%	78%	80%	79%
2016	Scenario 3	79%	81%	78%	79%	79%
2016	Scenario 4	79%	83%	78%	79%	79%
2016	Scenario 5	79%	81%	79%	79%	79%
2017	Status Quo	86%	93%	83%	n/a	86%
2017	Scenario 1	78%	82%	78%	78%	78%
2017	Scenario 2	79%	84%	78%	79%	79%
2017	Scenario 3	79%	83%	79%	78%	79%
2017	Scenario 4	79%	83%	78%	79%	78%
2017	Scenario 5	78%	81%	79%	78%	79%

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment D3
Individual Business Only

Average Restrictive States Only

	Table D3-1					
	Results by Exchange/Non Exchange and Projection Year					
	Individual Business					
	Average Restrictive States Only					
	Enrollment					
	(thousands)					
Projection Year	Scenario	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	5,004	2,544	2,460	n/a	5,004
2014	Status Quo	5,003	2,051	2,952	n/a	5,003
2014	Scenario 1	6,641	864	2,777	3,000	3,641
2014	Scenario 2	6,641	862	3,636	2,143	4,498
2014	Scenario 3	6,638	861	2,881	2,896	3,742
2014	Scenario 4	5,805	783	2,538	2,484	3,321
2014	Scenario 5	6,650	863	2,776	3,011	3,639
2015	Status Quo	5,001	1,664	3,337	n/a	5,001
2015	Scenario 1	9,623	667	3,465	5,490	4,132
2015	Scenario 2	9,631	661	4,869	4,102	5,530
2015	Scenario 3	9,625	664	3,647	5,314	4,311
2015	Scenario 4	8,315	616	3,220	4,479	3,836
2015	Scenario 5	9,622	668	3,441	5,513	4,109
2016	Status Quo	5,015	1,376	3,639	n/a	5,015
2016	Scenario 1	11,402	639	3,863	6,900	4,502
2016	Scenario 2	11,403	631	5,523	5,249	6,153
2016	Scenario 3	11,404	634	4,076	6,694	4,710
2016	Scenario 4	9,764	593	3,619	5,553	4,211
2016	Scenario 5	11,390	639	3,835	6,916	4,474
2017	Status Quo	5,025	1,156	3,869	n/a	5,025
2017	Scenario 1	12,699	613	4,070	8,016	4,683
2017	Scenario 2	12,699	603	5,879	6,217	6,482
2017	Scenario 3	12,707	606	4,295	7,805	4,901
2017	Scenario 4	10,869	570	3,852	6,447	4,422
2017	Scenario 5	12,698	611	4,038	8,049	4,649

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment D3
Individual Business Only

Average Restrictive States Only

Table D3-2						
Results by Exchange/Non Exchange and Projection Year						
Individual Business						
Average Restrictive States Only						
Incurred Loss Ratios						

Projection Year	Scenario	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	80%	84%	74%	n/a	80%
2014	Status Quo	81%	85%	77%	n/a	81%
2014	Scenario 1	111%	80%	109%	123%	102%
2014	Scenario 2	111%	80%	113%	122%	106%
2014	Scenario 3	110%	81%	110%	120%	103%
2014	Scenario 4	109%	80%	109%	118%	102%
2014	Scenario 5	110%	80%	109%	122%	101%
2015	Status Quo	82%	85%	80%	n/a	82%
2015	Scenario 1	107%	74%	107%	112%	101%
2015	Scenario 2	107%	76%	109%	111%	105%
2015	Scenario 3	107%	75%	107%	110%	102%
2015	Scenario 4	106%	75%	107%	109%	102%
2015	Scenario 5	107%	76%	106%	111%	101%
2016	Status Quo	82%	84%	81%	n/a	82%
2016	Scenario 1	100%	76%	99%	102%	96%
2016	Scenario 2	100%	77%	100%	102%	98%
2016	Scenario 3	99%	77%	99%	101%	96%
2016	Scenario 4	99%	78%	99%	100%	97%
2016	Scenario 5	99%	78%	98%	101%	96%
2017	Status Quo	81%	83%	81%	n/a	81%
2017	Scenario 1	92%	78%	92%	92%	90%
2017	Scenario 2	92%	78%	92%	92%	91%
2017	Scenario 3	91%	78%	92%	92%	90%
2017	Scenario 4	91%	79%	92%	91%	90%
2017	Scenario 5	91%	79%	91%	92%	90%

Average Restrictive States Only

				Non-Grandfathered		
Projection Year	**Scenario**	Total	Grandfathered Business	Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	80%	84%	74%	n/a	80%
2014	Status Quo	81%	85%	77%	n/a	81%
2014	Scenario 1	86%	82%	86%	87%	85%
2014	Scenario 2	86%	82%	86%	87%	85%
2014	Scenario 3	86%	83%	86%	87%	85%
2014	Scenario 4	85%	82%	85%	85%	84%
2014	Scenario 5	86%	82%	86%	87%	85%
2015	Status Quo	82%	85%	80%	n/a	82%
2015	Scenario 1	87%	75%	87%	88%	85%
2015	Scenario 2	87%	77%	87%	88%	86%
2015	Scenario 3	87%	77%	87%	88%	85%
2015	Scenario 4	86%	76%	87%	87%	85%
2015	Scenario 5	87%	77%	87%	88%	85%
2016	Status Quo	82%	84%	81%	n/a	82%
2016	Scenario 1	86%	77%	86%	87%	85%
2016	Scenario 2	86%	78%	86%	87%	85%
2016	Scenario 3	86%	77%	86%	86%	85%
2016	Scenario 4	86%	78%	86%	86%	85%
2016	Scenario 5	86%	78%	86%	86%	85%
2017	Status Quo	81%	83%	81%	n/a	81%
2017	Scenario 1	92%	78%	90%	93%	89%
2017	Scenario 2	92%	78%	91%	93%	90%
2017	Scenario 3	91%	78%	90%	92%	89%
2017	Scenario 4	91%	79%	89%	92%	88%
2017	Scenario 5	91%	79%	90%	93%	89%

Table heading:

Table D3-3
Results by Exchange/Non Exchange and Projection Year
Individual Business
Average Restrictive States Only
Incurred Loss Ratios Including Impact of Risk Mitigation

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment D4
Individual Business Only

Least Restrictive States Only

				Table D4-1		
				Results by Exchange/Non Exchange and Projection Year		
				Individual Business		
				Least Restrictive States Only		
				Enrollment		
				(thousands)		
Projection Year	**Scenario**	**Total**	**Grandfathered Business**	**Non-Grandfathered Non-Exchange Business**	**Exchange Business**	**All Non-Exchange Business**
2013	Status Quo	8,117	4,130	3,987	n/a	8,117
2014	Status Quo	8,089	3,295	4,794	n/a	8,089
2014	Scenario 1	12,215	1,442	5,240	5,534	6,682
2014	Scenario 2	12,216	1,432	6,955	3,829	8,387
2014	Scenario 3	12,212	1,435	5,455	5,322	6,890
2014	Scenario 4	10,734	1,319	4,809	4,606	6,128
2014	Scenario 5	12,226	1,436	5,232	5,558	6,668
2015	Status Quo	8,067	2,664	5,403	n/a	8,067
2015	Scenario 1	17,689	1,134	6,651	9,904	7,786
2015	Scenario 2	17,695	1,119	9,430	7,146	10,549
2015	Scenario 3	17,739	1,125	7,070	9,543	8,195
2015	Scenario 4	15,271	1,053	6,156	8,061	7,209
2015	Scenario 5	17,651	1,135	6,623	9,893	7,758
2016	Status Quo	8,050	2,197	5,853	n/a	8,050
2016	Scenario 1	20,805	1,085	7,457	12,263	8,542
2016	Scenario 2	20,814	1,071	10,708	9,035	11,779
2016	Scenario 3	20,853	1,074	7,933	11,846	9,006
2016	Scenario 4	17,779	1,010	6,928	9,842	7,938
2016	Scenario 5	20,760	1,087	7,410	12,263	8,497
2017	Status Quo	8,037	1,838	6,199	n/a	8,037
2017	Scenario 1	22,883	1,038	7,832	14,013	8,870
2017	Scenario 2	22,882	1,021	11,330	10,530	12,351
2017	Scenario 3	22,922	1,029	8,329	13,564	9,358
2017	Scenario 4	19,530	970	7,356	11,204	8,326
2017	Scenario 5	22,845	1,040	7,791	14,013	8,832

Society of Actuaries
Design and Implementation Considerations of ACA Risk Mitigation Programs
Attachment D4
Individual Business Only

Least Restrictive States Only

Table D4-2 Results by Exchange/Non Exchange and Projection Year Individual Business Least Restrictive States Only Incurred Loss Ratios						
Projection Year	**Scenario**	**Total**	**Grandfathered Business**	**Non-Grandfathered Non-Exchange Business**	**Exchange Business**	**All Non-Exchange Business**
2013	Status Quo	80%	85%	74%	n/a	80%
2014	Status Quo	81%	85%	78%	n/a	81%
2014	Scenario 1	128%	79%	126%	145%	115%
2014	Scenario 2	128%	80%	130%	144%	121%
2014	Scenario 3	128%	80%	127%	144%	116%
2014	Scenario 4	126%	80%	125%	141%	115%
2014	Scenario 5	127%	79%	124%	144%	114%
2015	Status Quo	82%	85%	80%	n/a	82%
2015	Scenario 1	126%	75%	124%	133%	117%
2015	Scenario 2	126%	76%	127%	133%	121%
2015	Scenario 3	125%	76%	125%	132%	118%
2015	Scenario 4	123%	77%	125%	129%	117%
2015	Scenario 5	125%	75%	124%	132%	116%
2016	Status Quo	82%	84%	81%	n/a	82%
2016	Scenario 1	117%	76%	115%	121%	111%
2016	Scenario 2	117%	77%	117%	121%	114%
2016	Scenario 3	116%	77%	116%	120%	111%
2016	Scenario 4	115%	77%	116%	118%	111%
2016	Scenario 5	116%	77%	114%	121%	110%
2017	Status Quo	81%	84%	80%	n/a	81%
2017	Scenario 1	108%	79%	106%	110%	104%
2017	Scenario 2	108%	78%	108%	110%	106%
2017	Scenario 3	107%	79%	106%	109%	104%
2017	Scenario 4	106%	78%	106%	107%	104%
2017	Scenario 5	107%	79%	106%	110%	103%

Least Restrictive States Only

Table D4-3						
Results by Exchange/Non Exchange and Projection Year						
Individual Business						
Least Restrictive States Only						
Incurred Loss Ratios Including Impact of Risk Mitigation						

Projection Year	Scenario	Total	Grandfathered Business	Non-Grandfathered Non-Exchange Business	Exchange Business	All Non-Exchange Business
2013	Status Quo	80%	85%	74%	n/a	80%
2014	Status Quo	81%	85%	78%	n/a	81%
2014	Scenario 1	89%	81%	90%	91%	88%
2014	Scenario 2	89%	82%	90%	91%	89%
2014	Scenario 3	89%	82%	90%	91%	88%
2014	Scenario 4	89%	83%	89%	90%	88%
2014	Scenario 5	89%	82%	90%	91%	88%
2015	Status Quo	82%	85%	80%	n/a	82%
2015	Scenario 1	91%	77%	91%	92%	89%
2015	Scenario 2	91%	77%	92%	92%	90%
2015	Scenario 3	91%	77%	91%	92%	89%
2015	Scenario 4	90%	78%	91%	91%	89%
2015	Scenario 5	91%	76%	91%	92%	89%
2016	Status Quo	82%	84%	81%	n/a	82%
2016	Scenario 1	90%	77%	90%	90%	89%
2016	Scenario 2	90%	78%	90%	91%	89%
2016	Scenario 3	89%	77%	90%	90%	89%
2016	Scenario 4	89%	78%	90%	90%	88%
2016	Scenario 5	89%	77%	90%	90%	89%
2017	Status Quo	81%	84%	80%	n/a	81%
2017	Scenario 1	108%	79%	106%	110%	104%
2017	Scenario 2	108%	78%	107%	111%	105%
2017	Scenario 3	107%	79%	107%	109%	104%
2017	Scenario 4	106%	78%	105%	108%	102%
2017	Scenario 5	107%	79%	106%	109%	104%