IOWA'S HEALTH BENEFIT EXCHANGE: SIMULATION MODELING TO PREDICT ELIGIBLE POPULATIONS AND COST

IOWA'S CURRENT HEALTH COVERAGE MARKETPLACE: BACKGROUND RESEARCH & SIMULATION MODELING

VERSION 2
STATUS: FINAL

NOVEMBER 30, 2012

PREPARED BY:

David P. Lind BENCHMARK

Data Point Research

AND

MAGNUM ACTUARIAL GROUP

TABLE OF CONTENTS

1. Summary 6

2. Introduction 8
- **2.1 Purpose 8**
- **2.2 Data Sources 8**
- **2.3 Executive Summary 9**

3. General Background on Insurance Markets and Regulations 15
- **3.1 Competition in the Iowa Insurance Market 15**
  - 3.1.1 Loss Ratios 16
  - 3.1.2 Market Share of Insurers in Iowa 19
  - 3.1.3 Iowa Individual Insurance Market 20
  - 3.1.4 Iowa Small Group Market 23
  - 3.1.5 Iowa Large Group Market 26
  - 3.1.6 Implications of Market Share 28
  - 3.1.7 Consumer Operated and Oriented Plans (CO-OP) 28
  - 3.1.8 Iowa's New CO-OP – Midwest Members Health 29
- **3.2 Regulatory History of the Iowa Insurance Market 30**
  - 3.2.1 Individual Market Protections 31
  - 3.2.2 Small Group Market Protections 35
  - 3.2.3 Rate Review and Medical Loss Ratios 37
  - 3.2.4 Iowa Broker Compensation and Direct Sales Expenditures 37
- **3.3 Summary of Iowa's Insurance Markets and Regulations 39**

4. Assessment of Insurers offering HBE plans outside of HBE 40
- **4.1 Background 40**
- **4.2 Iowa Options 43**
  - 4.2.1 Required 43
  - 4.2.2 Not Required 44
- **4.3 What Iowa Could Do? 44**

5. Assessment of Individual and Small Group Markets Inside HBE 45
- **5.1 Overview 45**
- **5.2 Background 46**
- **5.3 Iowa Options 50**
  - 5.3.1 Exclusive – All Individual and Small Group Plans Sold Inside the Exchange 50
  - 5.3.2 Qualifying – Earning the Right to Sell Outside the Exchange 51
  - 5.3.3 Open – Allowing Carriers to Choose Sales Channels 51
- **5.4 Implications of Potential Iowa Choices 52**
- **5.5 What Could Iowa Do? 53**

6. Assessment of Approaches to Standardized Plans 54
- **6.1 Critical Assumptions 55**
- **6.2 Individual vs. Small Group Concerns 55**

6.3 Self-Insurance Concerns 56
6.4 Standardization – QHPs Inside the HBE 56
6.5 Standardization – Plans Outside the HBE (in a Non-Exclusive HBE Environment) 58
6.5.1 Uniform Standardization Inside and Outside the HBE 59
6.5.2 Standardized Within the HBE, but not Outside 59
6.5.3 Non-Standardized Within the HBE, Standardized Outside the HBE 60
6.5.4 No Standardization Inside or Outside the HBE, Other than ACA Requirements 60
6.6 What About Plan Offerings Outside the HBE that do not Provide MEC? 60
6.7 Summary of Implications of Potential Iowa Choices 61
6.8 What Could Iowa Do? 61

7. Implementation of Transitions for Reinsurance/Risk 63
7.1 Background 63
7.2 Program Interdependencies 66
7.3 Financial Projections 66
7.3.1 Purposes and Limitations 66
7.3.2 Description of the Model 66
7.3.3 Model Output – Without Any of the Three R's 71
7.4 Reinsurance 75
7.4.1 Basics 75
7.4.2 Model Output – Reinsurance Only 80
7.4.3 Iowa Reinsurance Options, Obligations, and Restrictions 82
7.4.4 Implications of Potential Iowa Reinsurance Choices 82
7.5 What Could Iowa Do? 83
7.6 Risk Corridors 84
7.6.1 Basics 84
7.6.2 Model Output – Risk Corridor Only 85
7.6.3 Model Output – Risk Corridors Combined with Reinsurance 87
7.6.4 Iowa Options, Obligations, and Restrictions 90
7.6.5 Implications of Potential Iowa Choices 90
7.7 Risk Adjustment 90
7.7.1 Basics 90
7.7.2 Iowa Options, Obligations, and Restrictions 92
7.7.3 Implications of Potential Iowa Choices 92
7.7.4 Conclusion 93

8. Implications of Merging Individual And Small Group Plans 94
8.1 Background Information on Merging the Individual and Small Group Markets 94
8.2 Potential Benefits and Concerns of Merging Markets in 2014 95
8.3 Possible Merged Market Outcomes 96
8.3.1 Potential Benefits 96
8.3.2 Potential Concerns 96
8.4 Possible Outcomes for Non-Merged Markets 97
8.4.1 Potential Benefits 97
8.4.2 Potential Concerns 97
8.5 Decisions by Other States 97
8.6 Selected Estimates and Analysis for Iowa on Merging Both Markets 99
8.6.1 Overview and Methods 99

8.7 Results **100**
8.8 Limitations and Caveats **102**
8.9 Concluding Remarks **103**

9. Reassessment of Small Employer Definition **104**
9.1 Current Iowa Status **104**
9.2 Decisions by Other States **104**
9.3 Iowa Analysis **106**
9.3.1 Potential Benefits of Changing the Small Employer Definition Before 2016 110
9.3.2 Potential Benefits of Waiting Until 2016 110
9.3.3 Implications for Iowa 110

10. Assessment of Sole Proprietors as Small Employer **111**
10.1 Overview and Background **111**
10.1.1 Number of Non-Employer Businesses 112
10.1.2 Percent Insurance Coverage for Self-Employed 112
10.1.3 Motivation for Policy Selection for Self-Employed 113
10.1.4 Health of Self Employed 113
10.1.5 Numbers of Sole Proprietors in Iowa 114
10.2 Scenarios Considered for Handling Sole Proprietors **115**
10.2.1 Scenario 1: Requiring all Sole Proprietors to Purchase Insurance Through the Small Group Market 115
10.2.2 Scenario 2: Keeping Sole Proprietors in the Individual Market 115
10.2.3 Scenario 3: Allowing Sole Proprietors the Option of Small Group or Individual Policy 118
10.3 Potential Pricing Implications of Not Merging Individual and Small Group Risk Pools **123**
10.4 Concluding Remarks on Treating Sole Proprietors Like Small Employers **125**

11. Assessment of Revision to Definition of Small Employer to be Consistent Within and Outside the HBE **126**
11.1 Definitions of Small Employer: Iowa and ACA Differences **126**
11.2 Small Employer Definition Inside and Outside of the HBE – Sole Proprietors **126**
11.2.1 Same Definitions for Small Employer In and Out of HBE – Sole Proprietors Allowed as Small Groups inside and Outside the HBE 127
11.2.2 Different Definitions for Small Employer In and Out of HBE – Sole Proprietors Allowed as Small Groups inside, but not Outside, the HBE 127
11.3 Small Employer Definition Inside and Outside of the HBE – Employer Size after 2016 ..... **128**
11.4 Keys to Success of a State Exchange **129**

12. Acknowledgments **130**

13. Glossary **131**

14. Works Cited **142**

Document Information

Document Title	< Report Title>
Version	2.0
Document Approval Date	
Author	David P. Lind Benchmark, Data Point Research Inc., and Magnum Actuarial Group
Approved By	

The master copy of this document is available on-line. Hard copies are for information purposes only and are not subject to document control.

1. SUMMARY

Under the Affordable Care Act (ACA), private insurers are required to deliver coverage to individuals and small businesses in more open and transparent insurance markets. If ACA is enacted, beginning in 2014, insurers must offer products with more comparable benefits and cost-sharing. Additionally, they would be required to provide coverage to anyone regardless of any pre-existing health conditions, allowing consumers to more easily shop for coverage. A Health Insurance Exchanges (HBE) will facilitate insurance purchasing with the hope that new competition among insurers will help to moderate premiums for individuals and small groups. The Federal government will subsidize the cost of coverage for low and moderate income individuals who buy insurance through the Exchanges.

As with all other states, Iowa will need to make many critical policy decisions to implement new insurance market rules and decide whether and how to operate Exchanges. Many of these decisions may be influenced by how competitive Iowa's insurance market is perceived to be, with the subsequent results of these decisions affecting how insurance markets operate and the cost of coverage. Because Iowa is highly concentrated with few insurers in both the Individual and Small Group markets, Iowa may lean toward using the purchasing power of an Exchange to counteract the market power of one or a few large insurers. Given the various political and economic dynamics found within Iowa, unique considerations will need to be made to avoid unintended consequences for both the Individual and Small Group markets.

When assessing the Individual and Small Group markets inside the HBE, a key decision that Iowa must address is whether the Iowa HBE should take an Exclusive, Qualifying, or Open approach. The implications stemming from each approach are far-reaching, as it will affect many inter-related issues. Requiring or not requiring carriers to offer their Qualified Health Plans (QHPs) outside the HBE would also provide potential advantages and disadvantages under each scenario. However, it is only after considering whether to standardize the health plans offered both within and outside the Exchange that a combination of choices can be generated to provide some clarity of which paths to seriously consider. This is outlined under Section 6.8 "What Could Iowa Do?"

Determining how best to develop and implement the transitional reinsurance program for the individual market is another decision to be made by Iowa. As with the HBE, Iowa will be able to either take an active role in designing and running the reinsurance program or default to a Federal option. If Iowa chooses to run its own program, the next steps would involve forming the reinsurance entity or entities and contracting with an administrator. The analysis indicates that Iowa should seriously consider running its own transitional reinsurance program, but adopt the 2014 assessment rates and reimbursement parameters.

The ACA does not dictate a timeline to merge the Individual and Small Group risk pools, which means that both markets can be merged at any time on or after 2014. Given the complexities of the various reform provisions of ACA for 2014 and beyond, Iowa may wish to experience ACA-

required changes to both markets before deciding to merge them. A preliminary analysis performed by The Urban Institute for this report shows that merging both markets would likely lead to higher premiums in the Small Group market and lower premiums in the individual market.

It is difficult to predict the change to the insurance market that would be caused by classifying organizations with 51-100 employees as small groups before the 2016 mandate. The ACA has many moving parts. The creation of a Basic Health Program (BHP) and Exchange along with the possible market disruptions from merging the individual and small market plans, defining sole proprietors as small employers, and adding organizations with 51-100 employees to the small employer definition all interact with each other with various outcomes that are most likely to be unknown.

Iowa may need to first decide whether to merge the Individual and Small Group risk pools before determining the potential impact of sole proprietors being defined as "individuals" or as "small employers." If the two risk pools are not merged, pricing differences could emerge. In either event, there does not appear to be any compelling ACA-related reason not to include sole proprietors in Iowa's definition of "small employer" and to allow them to purchase either individual or small group coverage.

Another question to be addressed by Iowa is whether to revise the definition of "small employer" outside the HBE to be consistent with the HBE definition. Successful state Exchanges have often ensured a level playing field between policies in and out of the Exchange by standardizing definitions and regulations. These common regulations and definitions reduce the potential for adverse selection.

By deciding to establish and run its own Health Benefits Exchange (HBE), there are several key considerations for Iowa to make when confronted with the eight main issues found in Milestone 7. Each issue presents unique and complex challenges in addition to the challenges of maintaining and promoting affordable coverage and competitive markets within Iowa. When factoring in the current market conditions inherent within Iowa's insurance industry, the state must carefully make decisions that will no doubt have both intended and unintended consequences for each insurance market. All issues are intertwined, accentuating the complex decisions the state must eventually address.

2. INTRODUCTION

2.1 Purpose

This report consists of an analysis of the ramifications of the Affordable Care Act (ACA) on Iowa's insurance. The purpose of this document is to help policy-makers understand the implications of this sweeping legislation. The Affordable Care Act is complex. If the Act is left intact by the U.S. Supreme Court, Iowa will have the opportunity to make broad decisions that will ultimately affect every Iowan. This report is one of a series of documents designed to inform design-makers in a politically neutral and unbiased manner.

2.2 Data Sources

Information was collected from a variety of sources including the following:

- U.S. Census Bureau data
- The State of Iowa Department of Public Health
- Centers for Disease Control and Prevention
- U.S. Department of Health and Human Services
- Research completed by David P. Lind Benchmark
- The Iowa Behavioral Risk Factor Surveillance System
- The Iowa Health Insurance Study, conducted by Data Point Research
- Iowa Workforce Development
- American Community Survey
- Kaiser State Health Facts
- Analyses conducted by other states

2.3 Executive Summary

Insurance Market and Regulations

- Iowa experiences some of the lowest health insurance rates in the country. However, given the fact that Iowa has one dominant insurer (Wellmark Blue Cross and Blue Shield of Iowa) for both the Individual and Group markets, the Iowa Insurance Division (IID) requested and received a waiver from the Department of Health and Human Services. This waiver allows an adjustment to be made to the Medical Loss Ratio (MLR) to help transition insurers in the Individual Insurance market.
- The ACA included a loan program to finance the creation of Consumer Operated and Oriented Plans (CO-OPs). The Federal government has appropriated $3.8 billion for loans to help with start-up costs, to be repaid in five years, and for loans to enable CO-OPs to meet state insurance solvency and reserve requirements, to be repaid in 15 years.
- CO-OPs are designed to foster the creation of new consumer-governed, private, nonprofit, member-governed plans that will create innovative care delivery and payment models to compete in the Individual and Small Group health insurance markets.
- The ACA includes features that promote transparency and hold insurers accountable for rate increases and how premium dollars are spent, such as Rate Review and Medical Loss Ratio.
- Starting in 2011, insurers must spend between 80-85 percent of the premium dollars they take in on health care services or health care quality improvement activities. Known as the Medical Loss Ratio insurers in the Individual and Small Group markets must meet the 80 percent MLR, while insurers in the Large Group market must meet the 85 percent MLR.

Assessment of Insurers Offering HBE Plans Outside HBE

- There are a wide range of options available for single coverage from Wellmark Blue Cross and Blue Shield of Iowa in both the Individual and Small Group markets (Tables 4.1.1 and 4.1.2).
- Premium subsidies and issuance of coverage regardless of prior or current health (i.e., guaranteed issue) are likely to make average claims costs inside the Health Benefit Exchange (HBE) higher than those outside the HBE (Section 4.2).

- Exchanges can be one of three models: Qualifying, Exclusive, or Open.
- Benefits of the Exclusive model include:
  - Invites the least adverse-selection against the HBE
  - Easiest communication with consumers
  - Least expensive to implement
- Challenges of the Exclusive model include:
  - Poses the greatest danger of carriers leaving the Iowa market
  - Offers the least choice for consumers
  - Creates a reduction of product innovation and experimentation
- Benefits of the Qualifying model include:
  - More choices for consumer
  - Risks would be spread over a wider pool;
- Allows room for product innovation and experimentation
- Challenges of the Qualifying model include:
  - Carries more potential for adverse selection against HBE;
- Carriers may leave the market;
- Benefits of the Open model include:
  - Least disruptive to market
  - Permits participate in HBE or the ability to leave the market. Carries the least danger of carriers leaving the market;
  - Allows the maximum consumer choice and insurer product innovation.
- Challenges of the Open Model:
  - Poses the greatest potential of anti-selection against HBE and pressure on rate review and product filing process;

Assessment of Individual and Small Group Markets Inside the HBE

- The availability and size of premium tax credits will depend on income level. The subsidy amounts are designed to limit how much an individual would pay out of pocket for the benchmark plan (Table 5.2.1).
- The ACA provides for a subsidy to limit an individual's maximum out-of-pocket spending on medical services, also referred to as cost-sharing assistance (Table 5.2.2).

- The majority of states are still evaluating their Exchange options. Recommendations for the states with the most HBE progress are summarized in Table 5.4.1.

Assessment of Approaches to Standardized Plans

- Standardization inside the HBE would make operations easier for the HBE, IID, and less sophisticated buyers. However, it would also be more difficult for smaller insurers. Standardization may push more sophisticated buyers outside the HBE (Section 6.3).
- There are several possible ways to standardize in and outside the HBE. These are relevant only to Qualifying and Open Models: (Section 6.4)
    - Standardization both inside and outside
        - All the benefits of standardization inside the HBE in addition to making regulators the product innovators in all possible channels (Section 6.4.1).
    - Standardization inside, not outside
        - This would offer more consumer choice combined with the potential for carriers to "game the system" to the detriment of HBE customers. Would need to anticipate and put safeguards in place (Section 6.4.2).
    - Normal ACA and State standards without complete standardization inside and out
        - This model would offer the least disruption of the current market. Additionally, it would offer the greatest consumer choice and carrier innovation. However, it would also increase pressure on the IID rate and product filing reviews to minimize "gaming the system" (Section 6.4.4).
- Not all consumers want, need, or would buy coverage that provides minimum essential coverage (Section 6.5).

Transitions for Reinsurance and Risk Adjustment

- In 2014, the ACA will bring enormous change and, without education, may bring uncertainty that could destabilize the private health insurance market (Section 7.1).
- The ACA's risk management solution consists of the "Three Rs:" transitional reinsurance, transitional risk corridors, and permanent risk adjustment (Section 7.1).
- The reinsurance program would dampen the risk of loss, but do little to dampen the potential for excessive gain.
- The risk corridor program by itself would dampen both the risk of loss and potential for excessive gain, but it could become an unintended burden on taxpayers.
- The combination if reinsurance and risk corridors could create an attractive market environment from 2014-2016, but it is not sustainable.

- The U.S. Department of Health and Human Services (HHS) will run the risk corridor program. It is recommended that Iowa run the reinsurance program. Iowa could also run the risk adjustment program, but it should adopt the HHS program (Section 7.7.4).

Implications of Merging Individual and Small Group Plans

- Of the twelve states in which recommendations were made, all have opted to keep the risk pools separate for the time being (Table 8.5.1).
- If the ACA was fully implemented in 2012,
  - The number of uninsured Iowans would drop by 113,000 (Table 8.7.1).
  - The number of Iowans with coverage through their employers would increase by 65,000 due to the SHOP Exchange (Table 8.7.1).
  - Medicaid and the Children's Health Insurance Program (CHIP), would increase by 52,000 due to the expansion of Medicaid eligibility and outreach efforts (Table 8.7.1).
  - The private Individual market would remain at about 200,000 (Table 8.7.1).
- The average age in the Small Group market would be higher than the average age in the Individual Market (Table 8.7.2).
- Over seven percent of adults covered in the individual market would be in fair or poor health, versus less than five percent in the small-group market (Table 8.7.2).
- The average health costs of those covered in the individual market would be 10 to 15 percent higher than the average health costs of those covered in the small-group market.
- A merger of the small group and individual markets would likely lead to higher premiums in the Small Group market and lower premiums in the Individual market.

Reassessment of Small Employer Definition

- Of the 17 states in which a recommendation has been made, 14 have opted to leave the Small Group between 2-50 employees until 2016, and three are leaning towards expanding to 100 employees before 2016 (Table 9.2.1).
- The 50-99 employee group market is relatively small in Iowa. The market is about nine percent of the entire group market, totaling approximately 125,000 Iowans (Table 9.3.1).
- According to the *2011 Iowa Employer Benefits Study*©, there is not a substantial difference in premiums in regards to employer size (Figure 9.3.1).
- Individual policyholders (group of one) pay 40 percent of their premium as administrative costs, whereas a policy for a group of 50-99 pays only 15 percent, and a group of more than 10,000 pays about 4.5 percent (Figure 9.3.2).

- Pricing loads for the Small Group market assume a 75 percent loss ratio (Table 9.3.2).
- More than 98,300 working Iowans are currently enrolled in employer-sponsored health coverage in firms with 51-100 employees. This is about 80 percent of those employed in organizations with 51 to 100 employees (Table 9.3.3).

Assessment of Sole Proprietors as Small Employers

- The vast majority of businesses in Iowa are self-employers with no employees (Figure 10.1.1.1).
- The vast majority of those who consider themselves self-employed (87 percent) report having health insurance coverage. This percentage is only slightly lower than those working for organizations (Figure 10.1.2.1).
- Self-employed Iowans are much more concerned about keeping down costs than their peers who work for larger organizations, most likely because they bear the cost directly. Conversely, in group plans, the employer bears the cost directly and the employee may not fully understand the impact of that cost on his or her salary (Table 10.1.3.1).
- Self-employed Iowans tend to be healthier than their counterparts who work at larger organizations in terms of missed days of work due to health (Figure 10.1.4.1).
- About 214,500 Iowans pay self-employment taxes. Of these, 169,000 sole proprietors in Iowa pay self-employment taxes but with no Federal tax ID and thus no employees (Figure 10.1.5.1).
- In Scenario 2, outlined in section 10.2.2, sole proprietors would be required to purchase insurance in the individual market if they do not have insurance through a second job, spouse, or Federal program (Figure 10.2.2.1.1).
    - Because most sole proprietors already purchase coverage in the Individual market or have coverage through their spouse, very little change is expected in the market if sole proprietors were not allowed to enter the Small Group market (Table 10.2.2.2.1).
- In Scenario 3, outlined in Section 10.2.3, sole proprietors would be given the option to purchase insurance in the Individual or Group market. The current coverage for sole proprietors is estimated to be the same as for other Scenarios (Figure 10.2.3.1.1).
    - If sole proprietors would be given the option to purchase insurance in the Individual or Group market, 90 percent of sole proprietors would obtain Individual policies (Table 10.2.3.2.1).
    - Another possibility is that roughly half of Iowa sole proprietors will opt for Individual policies, and half will opt for Small Group policies (Table 10.2.3.2.2).

- If the self-employed morbidity cost is close to 90 percent, SHOP products would be highly unlikely to have even a 2 percent pricing advantage over HBE because of small price differences (Figure 10.3.1).
- If 50 percent or more of consumers bought in the HBE, the SHOP products would not have a price advantage (Figure 10.3.2).

Assessment of Revision to Definition of Small Employer to Be Consistent Within and Outside the HBE

- If regulations for self-insurance are not held to the same standards as those mandated by the ACA, then a real potential for adverse selection becomes clear. Given the impact of this change, standardizing within and outside the Exchange as well as regulating standards for self-insured businesses seems to be necessary.
- Increasing the definition of small-employer to 100 employees in 2016 argues for immediate standardization of definitions and regulations in and out of the HBE in preparation for this significant event.

Keys to Success of a State Exchange

- Common regulations and definitions for policies in and out of the Exchange reduce the potential for adverse selection.
- A user-friendly interface to compare policies in and out of the Exchange.
- Brokers compensated equivalently for policies both in and out of the Exchange.
- Individuals, employers, and brokers need to be informed about how the Exchange works. For example, small businesses need to be aware of the tax credits towards policies in the Exchange, and sole proprietors will need to know if they can purchase on the Individual, Small Group, or both markets.

3. General Background on Insurance Markets and Regulations

This section provides background information about the insurance markets and regulations currently existing within the state of Iowa

Under the Affordable Care Act (ACA), insurers are required to provide a rebate to policyholders if the insurer's Medical Loss Ratio (MLR) is less than 80 percent for the Individual or Small Group markets or less than 85 percent for the Large Group market. In addition to claims payment for medical services, other costs used in the loss ratio may include case management services, the cost of quality improvement efforts by the insurers, and other costs related to health care services but not directly affecting those insured. The remaining 20 percent for small group or 15 percent for large group is the amount of premium that is available for the cost of administering the insurance, such as paying claims, tracking enrollment changes, commissions, and insurer profits.

Beginning September 1, 2011, states were required to review proposed premium increases by insurers and determine whether such increases are justified. For those states that do not have effective rate review procedures in place, the Federal government performs the reviews on behalf of the state. States with uncompetitive markets may want more authority to establish a prior approval rate review process, while in states where markets are less concentrated, policymakers may be more comfortable with a less rigorously regulated approach. [(1)]

Health insurance premiums are nothing more than a derivative of health care costs. As the primary driver of premiums, health care costs must also be thoughtfully addressed, specifically through the provider community. Ensuring a healthy co-existence between insurers and providers will be extremely important for a cost-effective delivery system for the future. Though beyond the scope of this analysis, it is critical to maintain a sustainable partnership between provider communities and insurers.

3.1 Competition in the Iowa Insurance Market

Insurance market competition can be measured many different ways. One common way is to measure the percentage of the market, such as the number of people enrolled or premiums written during a given time period. Another marker to assess the degree of competition within a market is the number of insurance carriers that each make up a threshold portion of the market.

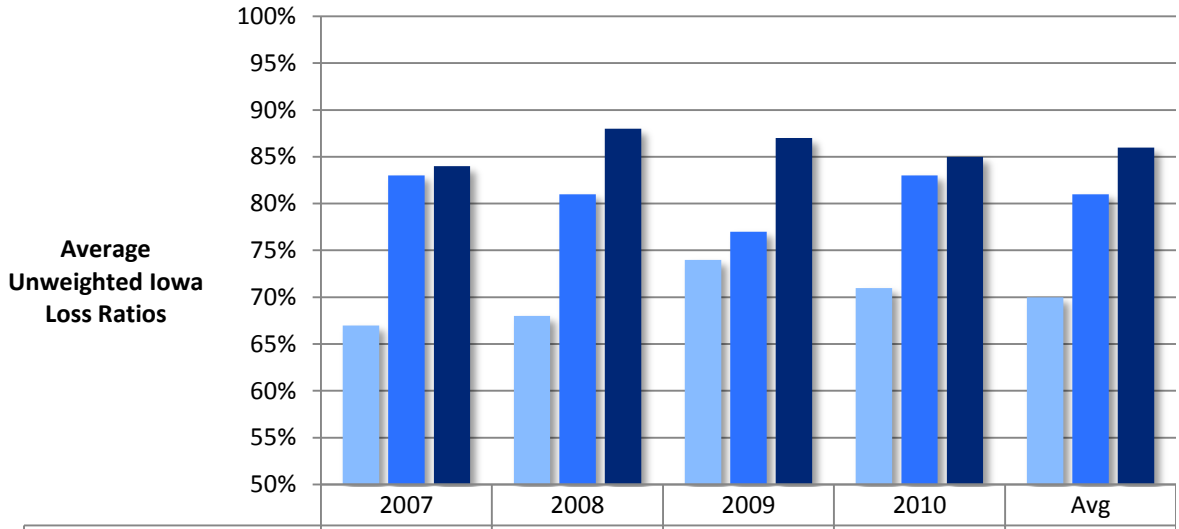
There are substantial barriers to entry in any insurance market, such as the ability to form competitive provider networks, maintaining solvency capital, and establishing brand awareness among consumers. Such barriers provide protection to the existing insurers doing business in any given market.

3.1.1 Loss Ratios

Iowa has some of the lowest health insurance rates in the country. However, given the fact that Iowa has one dominant insurer (Wellmark Blue Cross and Blue Shield of Iowa) for both the Individual and Group markets, the Iowa Insurance Division (IID) requested and received a waiver from the U.S. Department of Health and Human Services (HHS). This waiver allows an adjustment to be made to the MLR to help transition insurers in the Individual insurance market. The concern that insurers might leave the Iowa Individual market prompted Iowa to request a transitional relief beginning in 2011. The HHS's response to Iowa's request set the MLR standard for 2011 as 67 percent of premium and for 2012 as 75 percent of premium. The final standard of 80 percent will be implemented in 2013 and beyond.

Figures 3.1.1.1 and 3.1.1.2 provide a four year history of combined loss ratios for all insurers doing business in Iowa. Figure 3.1.1.1 shows loss ratios on an unweighted basis. The four year loss ratio averages are 70 percent, 81 percent and 86 percent for Individual, Small Group, and Large Group respectively.

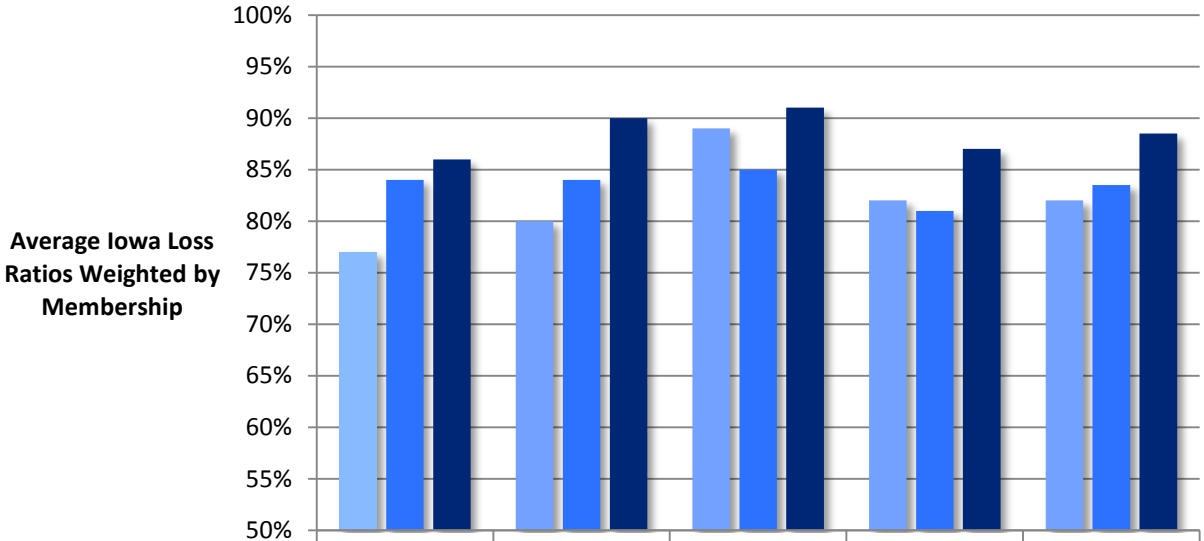
Figure 3.1.1.1. Iowa Unweighted Loss Ratios 2007-2010.



	2007	2008	2009	2010	Avg
Average Individual LR	67%	68%	74%	71%	70%
Average Small Group LR	83%	81%	77%	83%	81%
Average Large Group LR	84%	88%	87%	85%	86%

The four-year averages for the weighted loss ratios are 82 percent, 83.5 percent and 88.5 percent for Individual, Small Group, and Large Group respectively. [2] As mentioned earlier, the health insurance market in Iowa is dominated by Wellmark, Inc. in all three market categories. Due to this, the weighted loss ratios provided are very close to the Wellmark, Inc. values, despite significant differences between the other insurers.

Figure 3.1.1.2. Iowa Weighted by Membership Loss Ratios 2007-2010.



	2007	2008	2009	2010	Avg
Average Individual LR	77%	80%	89%	82%	82.0%
Average Small Group LR	84%	84%	85%	81%	83.5%
Average Large Group LR	86%	90%	91%	87%	88.5%

Tables 3.1.1.1 and 3.1.1.2 and Figure 3.1.1.3 include the breakout of loss ratios by carrier for the Individual, Small Group, and Large Group markets. [(2)] In 2010, Des Moines-based Principal Financial Group announced that it would stop selling health insurance because they do not have the resources and economies of scale to compete with players like United Healthcare and others in specific markets. Des Moines-based American Republic Insurance and World Insurance also recently withdrew from the Iowa Individual market. Such decisions are noteworthy for regulatory authorities concerned with the lack of competition within the Iowa health insurance environment.

Table 3.1.1.1. Rank of Insurers by Loss Ratio for the Individual Market (2010).

2010 ICCM Loss Ratios	
Wellmark of Iowa	87%
Wellmark Inc.	86%
Time Life	80%
American Family	80%
Coventry	65%
Golden Rule	63%
American Republic	38%

Table 3.1.1.2. Rank of Insurers by Loss Ratio for the Small Group Market (2010).

2010 Small Group Loss Ratios	
Time Life	99%
Principal	90%
Wellmark, Inc.	84%
Coventry	82%
United Healthcare River Valley	79%
Wellmark of Iowa	73%
United Healthcare	72%

Table 3.1.1.2. Rank of Insurers by Loss Ratio for the Large Group Market (2010).

2010 Large Group Loss Ratios	
American Family	99%
Wellmark Inc.	89%
United Healthcare	85%
United Healthcare River Valley	84%
Wellmark of Iowa	84%
Coventry	81%
Principal	75%

3.1.2 Market Share of Insurers in Iowa

The Individual insurance market, including coverage purchased inside and outside a Health Benefit Exchange (HBE) beginning in 2014, will play a key role in the implementation of the ACA. The current market for Individual insurance is highly concentrated in many states, and Iowa is no exception. According to the Kaiser Family Foundation analysis of 2010 insurer filings to the National Association of Insurance Commissioners (NAIC), the median market share held by the largest insurance carrier in each state was 54 percent. [(3)]

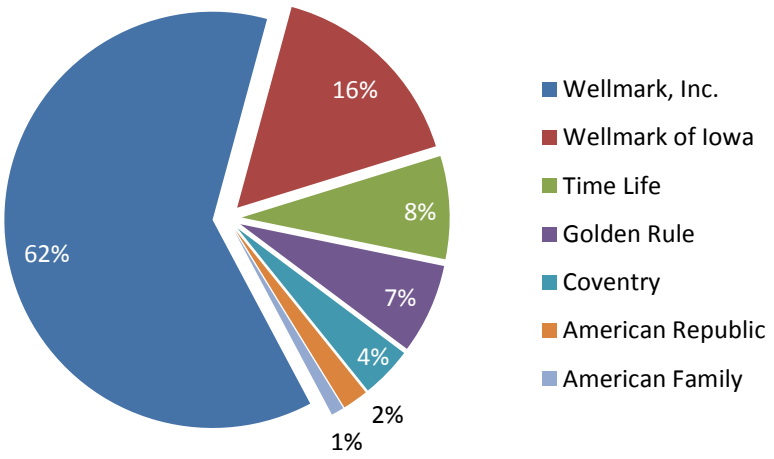
In the Small Group market (2-50 employees), Wellmark has 76 percent market share for member months and 63 percent market share for premium written. The Large Group market (51+) is also dominated by Wellmark, with 78 percent market share for member months and 77 percent market share for premium written. [(2)]

Following are a number of charts and graphs that portray the penetration of each insurer within the Iowa insurance landscape.

3.1.3 Iowa Individual Insurance Market

Figure 3.1.3.1 and Table 3.1.3.1 show that in the Individual market for Iowa, Wellmark, Inc. and Wellmark of Iowa control about 78 percent of the market share for member months and about 84 percent of the premiums written [(2)]. Wellmark Health Plan of Iowa, Inc. offers an HMO product, and Wellmark, Inc. provides health insurance in the individual, Small Group, and Large Group markets. Together, these two entities form Wellmark Blue Cross Blue Shield.

Figure 3.1.3.1 Market Share of Individual Comprehensive Major Medical Member Months (2010).



Source: NovaRest Actuarial Consulting. NovaRest Report for the Iowa Insurance Division In support of the Annual Report to the Iowa Governor and to the Iowa Legislature.(2011)

The Kaiser Family Foundation analysis of 2010 insurer filings to the National Association of Insurance Commissioners (NAIC), using the Mark Farrah Associates Health Coverage Portal ™, provides a measurement by looking at the number of carrier plans with a market share of at least five percent. [4]

Table 3.1.3.1 Market Share of Insurers for the Individual Market based on Premium (2010).

NAIC Supplemental Health Care Market Share (Individual Market)				
Carrier	**Health Premium Earned**	**Market Share by Premium**	**Number of Covered Lives**	**Cumulative Market Share by Premium**
Wellmark Inc.	$387,723,121	83.62%	148,913	83.62%
Time Ins Co	$21,300,087	4.59%	8,196	88.21%
Golden Rule Ins Co	$15,058,608	3.25%	8,185	91.46%
Coventry Health Care of IA Inc.	$6,662,605	1.44%	5,116	92.90%
American Family Mutual Ins Co	$5,191,216	1.12%	1,482	94.02%
American Community Mutual Ins Co	$3,421,852	0.74%	462	94.76%
American Republic Ins Co	$3,223,616	0.70%	1,185	95.46%
Mega Life & Health Ins Co	$3,102,867	0.67%	909	96.13%
New York Life Ins Co	$2,670,532	0.58%	537	96.71%
46 Other Companies	$15,313,796	3.29%	7,397	100.00%
Totals	463,668,300	100%	182,382	100.00%

Another common measure of competition is the Herfindahl-Hirschman Index (HHI). The HHI measures how evenly market share is spread across a large number of insurers.

- 0-1000 = Highly Competitive Market
- 1,000-1,500 = Unconcentrated Market
- 1,500-2,500 = Moderately Concentrated Market
- 2,500 -10,000 = Highly Concentrated Market (little or no competition)

In Iowa, the HHI index for the Individual market is 7,045, which indicates a highly concentrated market environment with very little competition. Of the six states bordering Iowa (Nebraska, South Dakota, Minnesota, Wisconsin, Illinois and Missouri), only South Dakota's score came close to Iowa's. However, Iowa's score was still 20 percent higher. The national median (3,761) was almost half of the Iowa score (Table 3.1.3.2). [5]

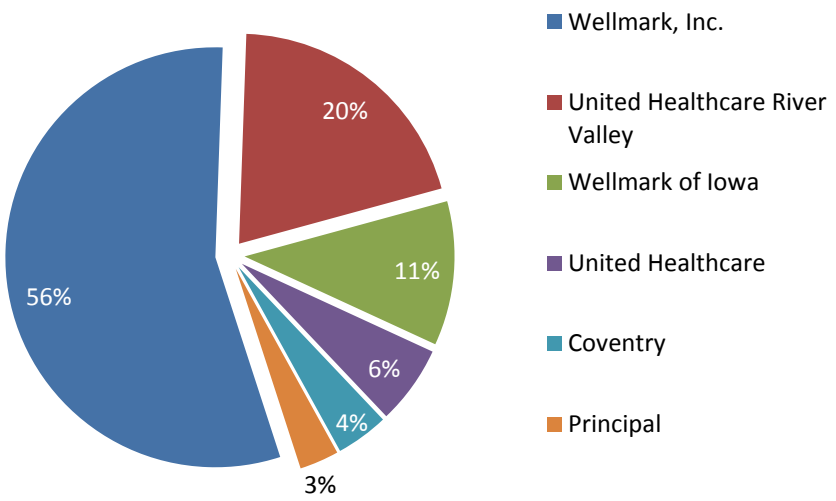
Table 3.1.3.2. Number of Insurers with More than Five Percent Market Share in the Iowa Individual Market, 2010.

	Number of Insurers with More than Five Percent Market Share	Market Share of Largest Insurer (based on enrollment)	Herfindahl-Hirschman Index (HHI)
Iowa	2	84%	7,045
South Dakota	3	75%	5,779
Minnesota	4	67%	4,788
Illinois	4	66%	4,483
Nebraska	3	64%	4,458
Missouri	5	32%	1,824
Wisconsin	6	21%	1,434
U.S. Median	**4**	**54%**	**3,761**

3.1.4 Iowa Small Group Market

According to the Kaiser Family Foundation analysis of 2010 insurer filings to the NAIC, the median market share held by the largest insurance carrier in each state was 51 percent (Table 3.1.4.2). However, Figure 3.1.4.1 shows that in the Small Group market for Iowa, Wellmark Inc. and Wellmark of Iowa control about 66 percent market share for member months [(2)] as well as about 63 percent of premium written (Table 3.1.4.1).

Figure 3.1.4.1. Iowa Market Share of Insurers for the Small Group Market (2010).



Source: NovaRest Actuarial Consulting. NovaRest Report for the Iowa Insurance Division In support of the Annual Report to the Iowa Governor and to the Iowa Legislature.(2011)

Table 3.1.4.1. Market Share of Insurers for the Small Group Market Based on Premium (2010).

NAIC Supplemental Health Care Market Share (Small Group Market: 2 - 50)				
Carrier	Health Premium Earned	Market Share By Premium	Number of Covered Lives	Cumulative Market Share by Premium
Wellmark Inc.	$364,179,410	51.84%	101,969	51.84%
UnitedHealthcare Plan of the River V	$110,201,553	15.69%	39,087	67.53%
Wellmark Health Plan of IA Inc.	$79,984,021	11.38%	18,556	78.91%
UnitedHealthcare Ins Co	$45,066,756	6.41%	13,342	85.32%
Principal Life Ins Co	$33,184,317	4.72%	12,602	90.04%
Coventry Health Care of IA Inc.	$16,072,451	2.29%	6,443	92.33%
Medical Assoc Health Plan Inc.	$14,762,172	2.10%	4,508	94.43%
Federated Mutual Ins Co	$13,453,932	1.91%	3,794	96.34%
Coventry Health & Life Ins Co	$8,632,401	1.23%	3,731	97.57%
Health Alliance Midwest Inc.	$6,991,260	1.00%	2,050	98.57%
18 Other Companies	$10,045,437	1.43%	3,702	100.00%
Totals	$702,573,710	100.00%	209,784	100.00%

The HHI measures how evenly market share is spread across a large number of insurers. In the Small Group market, Iowa scored 4,549. Only South Dakota scored higher when comparing Iowa's surrounding states. [4] The national median value is 3,595. These numbers suggest that Iowa has a highly concentrated Small Group insurance market. (Table 3.1.4.2)

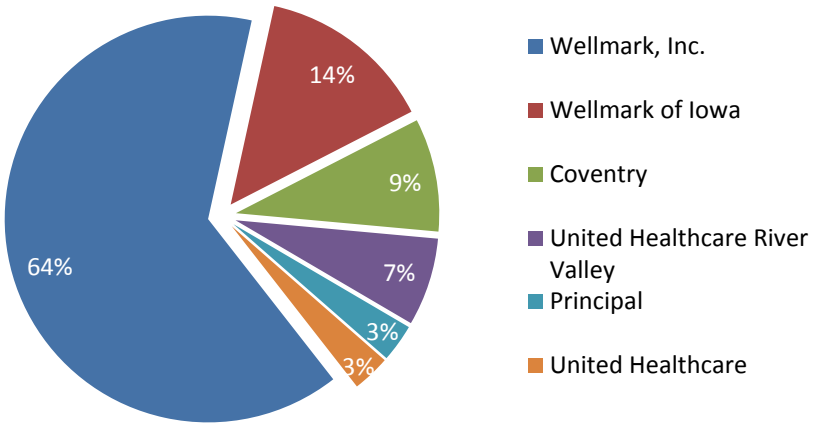
Table 3.1.4.2. Number of Insurers with More than Five Percent Market Share in the Iowa Small Group Market, 2010.

	Number of Insurers with More than Five Percent Market Share	Market Share of Largest Insurer (based on enrollment)	Herfindahl-Hirschman Index (HHI)
South Dakota	3	67%	4,961
Iowa	2	63%	4,549
Minnesota	4	53%	3,879
Illinois	4	52%	3,262
Nebraska	3	46%	2,991
Missouri	5	42%	2,386
Wisconsin	4	36%	1,716
U.S. Median	4	51%	3,595

3.1.5 Iowa Large Group Market

Based on market share for member months, Figure 3.1.5.1 shows that Wellmark, Inc. and Wellmark of Iowa control 78 percent of the large group market within Iowa, and 77 percent of the market share of premiums written (Table 3.1.5.1).

Figure 3.1.5.1. Market Share of Insurers for the Large Group Market (2010).



Source: NovaRest Actuarial Consulting. NovaRest Report for the Iowa Insurance Division In support of the Annual Report to the Iowa Governor and to the Iowa Legislature.(2011)

Table 3.1.5.1. Market Share of Insurers for the Large Group Market based on Premium (2010).

NAIC Supplemental Health Care Market Share (Large Group Market: 51+)				
	Health Premium	Market Share	Number of	Cumulative Market
Carrier	Earned	By Premium	Covered Lives	Share by Premium
Wellmark Inc.	$870,676,106	62.93%	220,362	62.93%
Wellmark Health Plan of IA Inc.	$195,955,865	14.16%	48,950	77.09%
UnitedHealthcare Plan of the River V	$95,137,108	6.88%	22,432	83.97%
Coventry Health Care of IA Inc.	$73,218,945	5.29%	24,375	89.26%
Medical Assoc Health Plan Inc.	$44,381,849	3.21%	10,946	92.47%
Principal Life Ins Co	$42,506,447	3.07%	12,579	95.54%
UnitedHealthcare Ins Co	$37,204,308	2.69%	8,103	98.23%
Coventry Health & Life Ins Co	$9,863,007	0.71%	3,418	98.94%
Health Alliance Midwest Inc.	$5,249,825	0.38%	1,606	99.32%
Avera Health Plans Inc.	$2,943,545	0.21%	889	99.53%
13 Other Companies	$6,429,217	0.46%	2,004	99.99%
Totals	**$1,383,566,222**	**100.00%**	**355,664**	**100.00%**

Source: NAIC 2010 Supplemental Health Care Market Share

3.1.6 Implications of Market Share

In general, the level of competition in Iowa is similar in the Individual and Small Group markets. In both markets, there are only two insurers that have more than a five percent share of the premium written. The Individual market is more concentrated, with Wellmark, Inc. enjoying 84 percent of the premium written, and Time Insurance Company writing just under 5 percent. Although not as pronounced as the Individual market, the Small Group market is still dominated by Wellmark at 63 percent of premium written, followed by United Healthcare at 22 percent.

The issue with Wellmark's dominance in the Iowa health insurance market was recently addressed through a report submitted to Iowa's Insurance Commissioner, Susan Voss, in October 2011. Commissioner Voss had ordered this report to determine whether Wellmark's market share adversely impacts Iowa consumers. [(6)] Baker and Daniels, a firm based in Indianapolis, was assigned to perform this examination by interviewing Iowa stakeholders.

Baker and Daniels determined that Wellmark's market share does not seem to adversely impact the following items:

- Premiums paid by Iowa consumers
- Quality or quantity of health care received by Iowa consumers
- Customer service received by Iowa consumers
- Products that Iowa consumers have to choose from

The report did, however, suggest that Wellmark's market share could potentially impact Iowa consumers by limiting their choice of health insurance companies. One sentence within this report appears to summarize the overall key conclusion: "While a number of interviewees wished for more competitors in Iowa, no one thought that Wellmark's market share adversely impacts the quantity or quality of products available to Iowa consumers."

3.1.7 Consumer Operated and Oriented Plans (CO-OP)

The ACA included a loan program to finance the creation of Consumer Operated and Oriented Plans (CO-OPs). The Federal government has appropriated $3.8 billion for loans to help with start-up costs, to be repaid in 5 years, and for loans to enable CO-OPs to meet state insurance solvency and reserve requirements, to be repaid in 15 years. The legislation provides for the loans to be awarded competitively to applicants who must not be existing issuers, trade associations whose members consist of pre-existing issuers, entities related to pre-existing issuers, predecessors of pre-existing issuer or related entity, or organizations sponsored by a state or local government.

CO-OPs are designed to foster the creation of new consumer-governed, private, nonprofit, member-governed plans that will create innovative care delivery and payment models to compete in states' Individual and Small Group health insurance markets. CO-OPs will be able to compete both inside and outside the state-based Exchanges. The Centers for Medicare and Medicaid Services (CMS) issued final rules for the CO-OP program under Section 1322 of PPACA on December 8, 2011. Although created primarily for the Individual and Small Group markets, the Final Rule confirms that many larger employers will be able to participate in CO-OPs by

permitting up to one-third of all CO-OP contracts to be purchased by such large employers. The Final Rule also states that the Section 1322 requirement that "substantially all" health insurance issued by the CO-OP is placed in the Individual and Small Group markets will be satisfied if at least two-thirds of contracts are placed in those markets.

The challenges for long-term success will depend on many market factors, including how existing competitors respond to these plans in addition to the management capabilities of the CO-OP. The key challenges will include the following:

- Developing a provider network that can compete successfully with other existing networks. There are existing "rental" provider networks that a CO-OP may wish to piggy back, however, such networks may not have the negotiating clout with health care providers within a given market, which can be detrimental to offering competitive premiums on a long term basis.
- Developing a proven administrative structure that can adapt to the complexities required to provide the many typical requirements of enrolling new members, paying claims, adjudicating claims with other payers and reporting functions.
- Accepting enrollment when the insurance Exchanges open in 2014 will be challenging.
- Implementing a sound member governance board. CO-OP members will elect board members who will need the expertise on finance, strategic planning, product development and medical management. Board members can include experts who are not plan members.
- The danger of adverse selection. In order for CO-OPs to build enrollment, they will need to set premiums low enough to attract enrollees, but high enough to cover claim costs and administration expenses. The inclusion of new enrollees who were previously uninsured creates more uncertainty and unpredictability for all insurers. New enrollees may have unmet medical needs and preexisting conditions, making it imperative the markets are protected with reinsurance and risk adjustments that are available through the ACA insurance market reforms.

3.1.8 Iowa's New CO-OP – Midwest Members Health

On February 21, 2012, the first seven ACA-created CO-OPs were announced by the U.S. Department of Health and Human Services (HHS) for having the approval to provide health coverage in eight states. [(7)] One of the states included is Iowa. The new Iowa and Nebraska CO-OP, Midwest Members Health, Inc., is sponsored by a group of business individuals with broad experiences in health insurance, health care regulation, consumer organizations, and startup ventures. Leading this venture is David Lyons, former Iowa Insurance Commissioner and now CEO of the Iowa Institute; Cliff Gold, a former senior executive with Wellmark Blue Cross and Blue Shield of Iowa, and Stephen Ringlee, a venture capitalist from Ames, IA. The CO-OP officially applied for funding in mid-October 2011 under a Federal Opportunity Announcement of the U.S. Department of Health and Human Services.

As a nonprofit health insurance issuer, Midwest Members Health has qualified for Federal loans up to $112,612,100, which provides capital for start-up costs and cover claims to maintain financial solvency. Any financial gains realized by the CO-OP must be used exclusively on behalf of its members and to re-pay the loans from the Federal government. The CO-OP program contains extensive provisions to protect against fraud, waste, and abuse. Midwest Members Health is subject to strict monitoring, audits, and reporting requirements for the length of the loan repayment period plus 10 years and must meet a series of milestones before drawing down disbursements, as described in their loan agreement.

Incorporated in Iowa, Midwest Members Health will apply for insurance licenses in both Nebraska and Iowa and begin to market products by October 2013 for a January 1, 2014 implementation date. Their news release on February 21, 2012 indicated the CO-OP "will offer plans to individuals and employers across both states utilizing a well-established broad provider network and one of the nation's leading non-profit plan administrators." In addition, "The CO-OP will work closely with physicians and health care systems to develop the innovative patient/provider programs required under the CO-OP provisions of the ACA."

The provider network is Midlands Choice, the largest network of health care providers (hospitals, physicians, and allied health practitioners) in Iowa and Nebraska not owned by an insurance company. HealthPartners, , will provide administrative and health management services to Midwest Members Health. HealthPartners is a 1.3 million member, cooperatively-governed health plan. In addition, Midwest Members Health is actively working with the Iowa Academy of Family Physicians and the Nebraska Academy of Family Physicians to develop a medical home network for its members.

Midwest Members Health intends to offer its products through agents, brokers, and via the new Health Care Exchanges that are to be established under the ACA. The membership goal of this CO-OP during the next three to seven years is between 50,000 to 80,000 members. The initial focus to gain membership is to pursue the uninsured, both the individually uninsured and those who are employed by small employers that do not offer health coverage.

3.2 Regulatory History of the Iowa Insurance Market

Each of the primary markets for private health insurance in Iowa (Individual, Small Group and Large Group) has distinct characteristics from one another, and therefore each market operates under different rules and regulations. Below is a summary of the Iowa private insurance markets.

3.2.1 Individual Market Protections

The individual health insurance market in Iowa is highly regulated to ensure the protections discussed in this section. Individual coverage is not subsidized by employers, which means the consumer pays the entire premium, resulting in this market being very price sensitive. Reforms in this market have not created major market disruptions although the Individual market remains highly concentrated. Individual market reforms began in April 1996, which included rating restrictions and portability provisions, which were slightly augmented in 1997 to comply with the Health Insurance Portability and Accountability Act (HIPAA). Table 3.2.1.1 summarizes many regulation protections in the Individual health insurance market in Iowa. [8]

Table 3.2.1.1. Protections in the Iowa Individual Insurance Market.

Protections in the Iowa Individual Insurance Market	
Guaranteed Issue (Not Applicable to HIPAA Eligible Individuals), 2011	
All Insurers Must Guarantee Issue All Products?	No
All Insurers Must Guarantee Issue Some Products?	No
Insurers of Last Resort?	No
Special Rules for Child-Only Policies?	Yes
Rate Restrictions (Not Applicable to HIPAA Eligible Individuals), 2011	
Limits on Rating?	Yes
Types of Rating Restrictions?	Rate Bands
Portability Rules (Not Applicable to HIPAA Eligible Individuals), 2011	
Elimination Riders Permitted	Yes
Definition of pre-existing condition	Prudent Person Standard
Maximum Look-Back Period (months)	60
Maximum Exclusion Period (months)	24
Credit for Prior Coverage	Yes
Individual Coverage Rules for HIPAA Eligible Individuals, 2011	
State HIPAA Approach	Alternative Mechanism
Qualifications?	HIPAA eligible
Insurer?	High Risk Pool
Are There Limits on What Can be Charged?	Yes
Are There Minimum Standards for What Must be Covered?	Yes
Standardized Plans in the Individual Market, as of March 2009	
Are Standardized Plans Required?	No
Health Insurance Subsidies in the Individual Market, as of January 2011	
Health Insurance Subsidies in the Individual Market	No
Individual Market Rescission Rules, 2010	
Rescission allowed during contestability period for reasons other than fraud	Yes
Contestability period	2 years
Grounds for rescission within contestability period	Misstatements
Grounds for rescission after contestability period	Fraudulent misstatements
State Statutory Authority to Review Health Insurance Rates, Individual Plans, 2010	
Rate Filing Required	Yes
Review Authority	Prior approval (30 day)

Table 2.3.1.2 summarizes the regulations for the Iowa High Risk Pool. (9)

Table 3.2.1.2. Regulations in the Iowa High Risk Pool.

High Risk Pools	
Iowa High Risk Pool Eligibility, January 2010	
Has High Risk Pool Program?	Yes
Pool Open Only to Medically Eligibles	No
Pool Open to HIPAA Eligibles	Yes
Pool Open to Health Coverage Tax Credit (HCTC) Eligibles	Yes
Pool Open to Medically Eligibles	Yes
Iowa High Risk Pool Programs and Enrollment, as of Dec. 31, 2010	
Has High Risk Pool Program?	Yes
Year Operational	1987
Enrollment	3,154
Iowa High Risk Pool Pre-Existing Condition Exclusion and Look Back Periods for Applicants Without Qualifying Prior Credible Coverage, as of December 31, 2009	
State High-Risk Pool Imposes a Pre-Existing Condition Exclusion Period?	Yes
Length of Waiting Period	6 months
Credit for Prior Coverage/Exceptions	Yes
Iowa High Risk Pool Plans with Medical Deductibles of $2,500 or More, Dec. 2009	
At least half of Enrollees with Deductible of $2,500 or More	Yes
Percent of Enrollees with Deductibles of $2,500 or More	57%
Iowa High Risk Pool Costs, December 2009	
Premiums Collected	$15,906,831
Non-Premium Funding	$19,192,024
Pool Costs (Claims + Admin)	$35,098,855
Total Premium Per Member	$5,318
Non-Premium Funding Per Member	$6,417
Total Cost Per Member	$11,735
Iowa High Risk Pool Sources of Funding, December 2009	
Premiums	35%
Assessments	62%
State General Fund	0%
Tax Credits	0%
Grants	3%
Interest	0%

Requirements for Iowa High Risk Pool Governing Boards, February 2009	
Majority are Representatives of Insurers/Providers	No
Total Board Members	14
Number of Consumer Members	State Law only specifies the number of individuals representing the general public
Iowa High Risk Pool Premiums (2002 - 2010), as of January 2010	
Monthly premium increased by 50% since 2002	Yes
Frequency of Premium Increases	Annual
Rates based on the following plan deductibles	$1,000
2010	$523
2009	$483
2008	$483
2007	$472
2006	$453
2005	$414
2004	Not available
2003	$346
2002	$285
Iowa High Risk Pool Covered Benefits, as of January 2010	
High Risk Pool Imposes Annual Maximum	No
Annual Maximum	No
Lifetime Benefit Maximum	$3 million
Annual Deductible Options	$1,000 - $10,000
Annual coinsurance maximum	$2,500 - $10,000
High Risk Pool Covers Prescription Drugs	Yes
Prescription Benefit Limitations and/or Exclusions	Separate Rx drug deductible of $500 or $1,000 for the higher deductible plans
Iowa High Risk Pool Assessments on Insurers to Fund High Risk Pools, as of December 31, 2009	
Commercial Health Carriers	Yes
State High-Risk Pool Rating Rules, 2010	
Statutory premium cap below 151% of standard rate	Yes
Statutory premium cap as % of standard rates	150%
Rate Variables:	
Plan Design/Age/Family Size	Yes
Gender	Yes
Smoking status	Yes

Under ACA, eligible residents of Iowa may apply for coverage through the state's Pre-Existing Condition Insurance Plan, HIPIOWA-FED. To qualify for this coverage, Iowan's must meet the following criteria:

- Be a citizen or national of the United States or residing in the United States legally.
- Have been uninsured for at least the last six months before applying for this coverage.
- Have a pre-existing condition or have been denied coverage because of a health condition.

Table 3.2.1.3 summarizes key features of the Iowa Pre-Existing Condition Insurance Plan, also known as HIPIOWA-FED. [10]

Table 3.2.1.3. HIPIOWA-FED Pre-Existing Insurance Plan.

Iowa Pre-Existing Insurance Plan (PCIP)	
Operation Decisions and Preliminary Funding Allocations	
State's Pre-Existing Condition Insurance Plan Operation Decision	State-run
Potential Allocation of Pre-X Condition Insurance Plan Funds (in millions)	$35
Enrollment as of November 30, 2011	
Number of People Enrolled and with Coverage in Effect	229
Date Coverage for Enrollees Began	September 1, 2010
Premiums for State-Operated Plans, 2011	
State-Run PCIP?	Yes
Premium Range	$156 to $765 per month
Premium Based On	Age and tobacco use
Deductible	$1,000
Out-of-Pocket Limit	Medical: $2,500
	Pharmacy: $1,000
AIDS Drug Assistance Program (ADAP) Coordination with PCIP	
ADAP Able to Enroll Clients in PCIP	N/A
Clients Enrolled in PCIP	N/A
Average Monthly Cost to ADAP per Client	N/A

3.2.2 Small Group Market Protections

In the early-to-mid 1990's, the Iowa small employer reform law promoted the availability of health insurance coverage to small employers, defined at first as employers with 2 to 25 employees, but expanded to employers of 2 to 50 lives. The core of the reforms was to ensure that any willing small employer has access to insurance coverage and can retain that insurance through subsequent renewal periods. Iowa follows the NAIC model by limiting year-to-year premium increases for any given Small Group to 15 percent above the insurer's trend, (the increase in the insurer's rates for new business).

Table 3.2.2.1 summarizes many of the regulation protections in the Small Group health insurance market in Iowa. [11]

Table 3.2.2.1. Protections in the Iowa Small Group Market.

Protections in the Iowa Small Group Market	
Guaranteed Issue, 2011	
Guarantee Issue All Products	Yes
Definition of Small Group	2 to 50
Guaranteed Issue for Self-Employed Group of One?	No
Special Rules for Groups of One?	No
Rate Restrictions, 2011	
Limits on Rating?	Yes
Types of Rating Restrictions?	Rate Bands
Pre-Existing Condition Exclusion Rules, 2011	
Federal Standard / Exceeds Federal Standard	Federal Standard
Maximum Look-Back Period (months)	6
Maximum Exclusion Period (months)	12
Credit for Prior Coverage Required?	Yes
Maximum Lapse Period Allowed (days)?	63
Iowa Statutory Authority to Review Insurance Rates, Small Group, 2010	
Rate Filing Required	Yes
Review Authority	Prior approval (30 day)
Standardized Plans in the Small Group Market, as of January 2009	
Are Standardized Plans Required?	No
Health Insurance Subsidies in the Small Group Market, as of January 2011	
Health Insurance Subsidies in the Small Group Market	No
Expanded COBRA Coverage for Small Firm Employees, 2010	
State COBRA Expansion?	Yes
Maximum Duration of Continuation Coverage (months)	9
Rating Restrictions? Percentage of Group Rate	100%
Iowa Conversion Coverage for Small Firm Employees, 2010	
Mandatory Group Conversion?	No
Rating Limits?	N/A
Restriction Against Providers Balance Billing Managed Care Enrollees, 2010	
Restriction Against Providers Balance Billing Managed Care Enrollees?	Yes
Restrictions Applies to HMOs?	Yes
Restriction Applies to Network Providers?	Yes
Restrictions Applies to PPOs?	No

3.2.3 Rate Review and Medical Loss Ratios

The ACA includes features that promote transparency and holds insurers accountable for rate increases and how premium dollars are spent. Two such features included in ACA are known as Rate Review and Medical Loss Ratio. Beginning September 1, 2011, health insurance companies must inform the public when they want to increase insurance rates for Individual or Small Group policies by an average of 10 percent or more. Should the average increase reach this threshold, the proper insurance authorities in state or Federal government will review these rate increases, also know as Rate Review. [12] In Iowa, the Iowa Insurance Division will examine the health insurer's data on each rate increase (by carrier and by market) to determine whether the increase is reasonable or not. Iowa's rate review parameters are listed in Table 3.2.3.1. [13]

Starting in 2011, insurers must spend between 80-85 percent of the premium dollars they take in on health care services or health care quality improvement activities. Known as the Medical Loss Ratio (MLR), insurers in the Individual and Small Group markets must meet the 80 percent MLR, while insurers in the Large Group market must meet the 85 percent MLR. If the MLR is not met, insurers must provide refunds to policy holders beginning in 2012.

Table 3.2.3.1. Iowa Rate Review and Rate Filings – Individual and Small Group.

Rate Review and Rate Filings - Individual and Small Group	
Rate Review Processes, 2011	
State Has Effective Rate Review Program?	Yes
Individual Market Rate Review Process	State
Small Group Market Rate Review Process	State
Number of Rate Filings Received, Reviewed, and Disapproved, Withdrawn, or Resulting in Rates Lower Than Originally Proposed, 2010	
Rate Filings Received: Individual	51
Rate Filings Reviewed: Individual	51
Rate Filings Disapproved, Withdrawn, or Resulting in Lower Rates: Individual	28
Medical Loss Ratio Adjustments, 2011	
Requested a Waiver?	Yes
Waiver Approved	Yes
Requested 2011 MLR	60%
Requested MLR Adjustments Beyond 2011	Increasing 5% each year through 2013
Approved 2011 MLR	67%
Approved MLR Adjustments Beyond 2011	75% in 2012, 80% in 2013

3.2.4 Iowa Broker Compensation and Direct Sales Expenditures

Licensed producers in Iowa such as insurance agents, brokers and consultants have a great presence and influence in both the Individual and Small Group markets. According to the

Independent Insurance Agents of Iowa, Inc., over 90 percent of Iowans access the Individual or Small Group markets through an agent or broker. [14]

Prior to the last few years, brokers in Iowa were typically paid commission as a percent of premium. However, with the escalation of health premiums in both the Individual and Small Group markets, many insurers in Iowa have changed to a flat fee per member per month arrangement. For many brokers, this new commission arrangement is considered a reduction in compensation, despite performing similar services as in the past. Comparing both commission approaches, Table 3.2.4.1 summarizes broker compensation in Iowa during 2010. In addition, expenditures for direct sales in both the Individual and Small Group markets are shown for comparison purposes. [15]

Table 3.2.4.1. Iowa Broker Compensation and Expenditures on Direct Sales, 2010.

Iowa Broker Compensation and Expenditures on Direct Sales, 2010	
Broker Compensation, 2010	
Broker Compensation ($) Per Member Per Month - Individual Market	$14.47
Broker Compensation ($) Per Member Per Month - Small Group Market	$18.42
Broker Fees (as a Percent of Premiums) in the Individual Market	6.8%
Broker Fees (as a Percent of Premiums) in the Small Group Market	6.6%
Expenditures on Direct Sales, 2010	
Direct Sales ($) Per Member Per Month - Individual Market	$0.56
Direct Sales ($) Per Member Per Month - Small Market	$1.13
Direct Sales (as a Percent of Premiums) in the Individual Market	0.3%
Direct Sales (as a Percent of Premiums) in the Small Group Market	0.4%

3.3 Summary of Iowa's Insurance Markets and Regulations

As Iowa policymakers assess the many options and considerations required to implement a state-based Exchange, they will need to examine the level of competitiveness in each insurance market as a factor in the choices to be made with respect to insurance market rules, Exchanges, and rate review. Any changes to the Iowa insurance market under the ACA may diminish and/or enhance competition. How markets change will be determined by a number of factors, including decisions by state policymakers, local political and economic issues, and business decisions made by insurers. The structure of insurance markets within Iowa determined by the decisions regarding Exchanges and rate review will ultimately determine health insurance premiums. Finally changing health delivery, coupled with cost shifting from the public programs such as Medicaid and Medicare, will greatly determine the affordability of health insurance for Iowans.

As with any regulation, there are both intended and unintended consequences. The ACA will be no exception.

4. Assessment of Insurers offering HBE plans outside of HBE

This section addresses the question of whether carriers participating in Iowa's Health Benefit Exchange (HBE) should be required to offer their Qualified Health Plans (QHPs) outside the Exchange.

- There are wide variations in QHP designs that will satisfy actuarial value requirements.
- This section is only relevant to Qualifying and Open HBE models (see Section 5).
- Reasons to offer QHP plans outside of HBE include QHP certification seal of approval outside HBE, favorable morbidity on QHPs outside HBE could help lower premiums for customers inside HBE, favorable morbidity on non-QHPs would not help lower premiums in HBE, would do little to reduce carriers' sales costs, likely some carriers would not participate in the HBE.
- Reasons not to offer include less disruption of market and potential to lose carriers and higher prices for QHP in HBE.

The rest of this section provides greater discussion of these options.

4.1 Background

The Atlantic Information Service's *Guide to Healthcare Reform* [16] defines Qualified Health Plans as "Health plans that have certifications in effect that they meet certain standards and are recognized by the Exchange in each Exchange through which they are offered (45 C.F.R. Ec. 155.0)." By definition a plan cannot be a QHP unless it is also an HBE plan.

Only QHPs may be sold on the Exchange. Section 5.2 describes the minimum requirements. Other plans could meet all those requirements, but unless the state has certified that they can be sold through its Exchange, they are not QHPs.

The four tiers of coverage are commonly referred to as the precious metal plans. Platinum plans must cover 90 percent of expected covered medical costs, Gold covers 80 percent, Silver 70 percent, and Bronze 60 percent. The inclusion of the word "covered" makes these standards tougher for plans that cover services other than "essential benefits" than those that do not.

Iowa may want to consider defining actuarial values relative to a common baseline plan to avoid this anomaly. For example, a carrier could have a plan that is identical in every respect to its Gold QHP, except with a lower deductible that increased its actuarial value to 90 percent, the requirement for the Platinum tier. Unless the carrier had applied for and received certification for that plan, it would not be a QHP. The distinction is more than a matter of semantics. For example, a true QHP would be covered under the risk corridor program discussed in Section 7.6.1, while the QHP "lookalike" would not.

There is nothing in the ACA that specifically allows or forbids a carrier from offering non-QHPs outside the Exchange. That choice is left to the states that may choose one of the three HBE models discussed in Section 5.1. By the same token, there is nothing in the ACA that specifically

allows, forbids, or requires a carrier to offer its certified QHPs outside the Exchange. If a state adopts either the Qualifying HBE or Open model, carriers could offer their QHPs outside the Exchange.

As described in the General Background discussion of Section 3.2, four carriers in the Individual market account for 94 percent of the premium and five companies, sometimes operating in two entities, account for 94 percent of Small Group premium. Wellmark Blue Cross and Blue Shield of Iowa is by far the dominant carrier, representing 84 percent of the Individual premium and 63 percent of the Small Group premium written in the market.

Each of the carriers in the market offer several plan design options. These options vary by the deductibles, coinsurance, out-of-pocket amounts, copays, and types of services covered/excluded. The options may also include various inside limits on specific benefits such as mental health, substance abuse, rehabilitation, chiropractor and home health. The vast majority of plans do not provide standard maternity benefits.

Tables 4.1.1 and 4.1.2 below show the wide range of options available (single coverage) [17] from Wellmark and its competitors.

Table 4.1.1. Individual Wellmark Offered in Iowa.

	Blue Advantage	Blue Advantage HSA-Qualified	Alliance Select	Blue Basics	Blue Priority HSA-Qualified
Deductible	$1,500 - $4,000	$1,900 - $3,000	$500 - $9,500	$3,000-$5,000	$1,700 - $5,400
Coinsurance	30% - 50%	0%	10% - 40%	50%	0% - 20%
Out-of-Pocket	$4,500 - $12,000	$2,900 - $4,000	$1500 - $10,500	$5,000 - $7,000	$1,700 - $5,400
Office Visits	Copay Options	Deductible/Coinsurance	Copay Options	Copay Options	Deductible/Coinsurance
ER	Deductible/Coinsurance	Deductible/Coinsurance	$100 - $175	$150	Deductible/Coinsurance
Rx Deductible	$200 Brand	Medical Deductible	$0-$200 Brand	NA	Medical Deductible
Rx Copay	$5/$30/$55/50%	$5/$30/$55/50%	$8/30/45	$8 Generic-only	100% coverage or $8/35/50

Table 4.1.2. Small Group Wellmark Plans Offered in Iowa.

	Alliance Select	Blue Choice	Blue Access	Blue Advantage	Blue Priority HSA-Qualified or HRA
Deductible	$250 - $5,000	$500 - $3,000	$500 - $3,000	$500 - $3,000	$1,500 - $5,000
Coinsurance	10% - 30%	20%	20%	30%	0%
Out-of-Pocket	$1000 - $10,000	$1,000 - $6,000	$1,500 - $9,000	$1,500 - $9,000	$3,000 - $10,000
Office Visits	Copay Options	Copay Options	Copay Options	Copay Options	Deductible/Coinsurance
ER	Copay Options	$200	$200	$200	Deductible/Coinsurance
Rx Deductible	$0 to $200 Brand	$100 Brand	$100 Brand	$100 Brand	$0 - $100 Brand
Rx Copay	$10/25/40 - $8/35/50/85	$8/35/50/85	$8/35/50/85	$8/35/50/85	$8/35/50/85 or Deductible/Coinsurance

Note the tables above illustrate in-network benefits only. The HMO plans will not have an out-of-network benefit. For the other plans, the out-of-network penalties vary, and may include additional deductibles, coinsurance, or out-of-pocket amounts.

Some of the plan options illustrated above, even when adding the essential benefits coverage, may not meet the actuarial value requirements of a QHP. A good example of this would be the high-deductible health plans which accompany a Health Savings Account (HSA). These plans will have lower premiums due to the higher cost-sharing.

Plans outside the HBE may be QHP (i.e. same plan as offered inside the HBE) or non-QHP. Some non-QHP may meet the definitions of Minimum Essential Coverage (MEC) for a purchaser to satisfy the individual mandate, and some may not meet these definitions.

Individuals who qualify for the subsidies will most likely go through the Exchange to purchase coverage. Those that do not qualify for any subsidy may purchase coverage either inside or outside the Exchange, depending on the combination of price and plan options that best meet their personal needs.

The limited two-year small business tax credit as noted in Section 5.2 may provide little incentive for Small Groups (< 50 employees) to purchase inside the SHOP Exchange. Employers will consider the availability of plan options, premium levels, contribution levels, or even if self-funding is a more desirable alternative. If an employer forgoes coverage for employees, those employees will most likely behave as described above for individuals in the market.

4.2 Iowa Options

Section 5 introduces terms for three potential models Iowa from which Iowa must choose one for its HBE and Shop Exchange - Exclusive, Qualifying, and Open. The Section 4 question of whether Iowa should require insurers to offer their QHPs outside the Exchanges has different relevance under each model:

- Exclusive - Insurers cannot offer Individual or Small Group major medical products outside the Exchange, in which case the Section 4 issue would be irrelevant.
- Qualifying - Insurers must offer QHPs in the Exchange to write any Individual or Small Group major medical in Iowa, in which case the Section 4 issue would be relevant for all insurers.
- Open - Insurers can choose which channels they use for their Iowa Individual and Small Group major medical. For those carriers that chose to use the Exchanges and other channels the Section 4 issue would be relevant; for carriers that chose either only the Exchanges or only outside channels it would be irrelevant.

4.2.1 Required

The ACA requires carriers in the Exchange to offer at least one Silver and Gold level QHP and to charge the same rates if they offer these QHPs outside the Exchange. There would be nothing in this choice that would prevent carriers from offering non-QHPs outside the Exchange. Section 5.3 discusses that possibility.

The potential advantages of requiring carriers to offer their QHPs outside the HBE include:

- Consumers who prefer to buy outside the Exchange, perhaps to obtain more complete services of an agent, would have access to the products that had earned the Exchange's seal of approval.
- The anticipated lower morbidity costs of the non-Exchange population could help lower QHP premium rates.

The potential disadvantages of requiring carriers to offer their QHPs outside the HBE include:

- There would be two distinct risk pools for products being sold outside the HBE. The non-QHP part of the pool would not have to support any of the anticipated higher morbidity costs of the Exchange population. The carriers could create pricing differentials that would be greater than could be explained by differences in benefits design.
- Carriers have been trying for years to find ways to lower their distribution costs. Some may view HBEs as a convenient way to address that problem. Requiring carriers to offer their QHPs alongside non-QHPs offered outside the Exchange could force them to put more money into higher cost channels they had been hoping to scale back.
- Some carriers might decide not to participate in the HBE if participating would force them to sell their QHPs outside the Exchange.

4.2.2 Not Required

Potential advantages of not requiring carriers to sell their QHPs outside the HBE include:

- It minimizes disruption of the current non-Exchange marketplace.
- It would provide more flexibility for carriers to rationalize their distribution costs.
- It would avoid possible objections to participating in the HBE.

Potential disadvantages of not requiring carriers to offer their QHPs outside the HBE include:

- Buyers who want a QHP seal of approval might be forced to buy through the Exchange instead of a trusted agent.
- QHP premium rates could be based primarily on the anticipated higher morbidity cost of Exchange buyers, which may result in higher premiums.

4.3 What Iowa Could Do?

The issues discussed in Sections 4 through 6 are so intertwined that the discussion of a package of choices Iowa could make to balance the various considerations will be deferred until the end of Section 6.

5. Assessment of Individual and Small Group Markets Inside HBE

This section addresses the structure of a potential Iowa Health Benefits Exchange (HBE) model.

Iowa has the choice of enacting three Health Benefits Exchange (HBE) models - Exclusive, Qualifying or Open.

- Exclusive – Least anti-selection against HBE; easiest communications with unsophisticated buyers; least expensive to implement; greatest danger of carriers leaving Iowa market; least choice for consumers; reduction of product innovation and experimentation.
- Qualifying - Participate in HBE or leave the market. More potential for anti-selection against HBE; more choices for consumer can be a blessing or a curse; still likely carriers would leave the market; wider experience pool over which to spread risks; allows room for product innovation and experimentation.
- Open – Least disruptive to market; greatest potential of anti-selection against HBE and pressure on rate review/product filing process; least danger of carriers leaving the market; maximum consumer choice and insurer product innovation.

Selection of an HBE model is only one of several inter-related choices in implementing the ACA. At least one state has chosen each model

In addition, premium subsidies and guaranteed issue are likely to make average claims costs inside HBE higher than outside. The rest of this section provides further detail of these items.

5.1 Overview

This section discusses the implications of adopting one of three models for markets within the HBE:

- ***Exclusive*** *Model:* In this model, the HBE would be the only channel through which Individual and Small Group insurance can be purchased or sold in Iowa.
- ***Qualifying*** *Model*: In this model, every carrier must earn the right to sell Individual and Small Group insurance outside of the Exchange.
- ***Open*** *Model*: In this scenario, the HBE would be one of several channels through which carriers could choose to market Individual and Small Group insurance.

These terms were coined to support the discussions in this report and are not common industry terms. Other reports have used the terms mandatory and voluntary to describe similar concepts, but those terms are potentially misleading and do not encompass all of the possibilities. This section will address only non-grandfathered Individual and Small Group major medical, not grandfathered plans, Large Group major medical, or other forms of health insurance (such as limited benefits, short-term, self-funded) Iowa might allow.

5.2 Background

The purpose of an HBE is to increase the number of those insured by providing an efficient marketplace for consumers and Small Groups to compare and purchase affordable, high quality health insurance.

The ACA and the U.S. Department of Health and Human Services (HHS) use the phrase Qualified Health Plan" (QHP) as its seal of approval for high quality. Only QHPs, as certified by the HBE, may be sold on the Exchange. The minimum requirements for a QHP under ACA are:

- Provide coverage for an essential benefits package. The HBE will be able to define essential benefits subject to rules set by HHS.

  The law defines the benefits to be covered, but does not define the specific cost-sharing requirements. These benefits include the following: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services, laboratory, and preventive and wellness, and pediatric services. The definition of these benefits would be based on the state's benchmark plan:

  1. One of the three largest Small Group plans in the state by enrollment
  2. One of the three largest State employee health plans by enrollment
  3. One of the three largest Federal employee health plan options by enrollment
  4. Largest HMO plan offered in Iowa's commercial market enrollment

  If Iowa does not select one of the above, HHS proposes the default will be the Small Group plan with the largest enrollment in the state. If Iowa adheres to the HHS guidelines and suggestions, the benchmark plan is likely to be a richer, more expensive benefit package than what is commonly purchased in the Individual market. For example, most individual plans today do not cover maternity, but it is included as a covered benefit in the essential benefits package.

- Fit within one of four tiers of coverage based on actuarial value.

  According to HHS guidelines, a QHP must offer at least one QHP in the Silver and Gold coverage level and offer a child-only plan (< age 21) at the same levels of coverage. In addition, a catastrophic plan can be offered, but only to those under age 30.

  With the implementation of an Exchange, a significant percentage of individuals and families will be purchasing coverage for the first time, or at a minimum, for the first time in a number of years. This is because they will no longer have to successfully pass medical underwriting and many can receive premium subsidies if they purchase a QHP through the HBE. The ACA and HHS regulations refer to these subsidies as premium tax credits. The availability and size of these credits will depend on income level. The subsidy amounts are designed to limit how much someone would pay out of pocket for the benchmark plan, the second lowest cost Silver plan available in the Exchange, and are illustrated in Table 5.2.1.

Table 5.2.1. FPL and Tax Credit.

Income Range (as percentage of FPL)	Limit on Baseline Plan Premium, Net of Credit (as percentage of Income)
Up to 133%	2%
133% to 150%	3.00% to 4.00%
150% to 200%	4.00% to 6.30%
200% to 250%	6.30% to 8.05%
250% to 300%	8.05% to 9.50%
300% to 400%	9.5%

Although this table looks relatively simple, the actual rules are quite complicated and currently require subsidy calculators such as that offered by the Kaiser Family Foundation online. [(18).]

In addition, the ACA provides for a subsidy to limit a person's maximum out-of-pocket spending on medical services, referred to as cost-sharing assistance. Those subsidies are outlined in Table 5.2.2 (based on the 2011 HSA limit).

Figure 5.2.2. FPL and Out of Pocket Spending.

Income Range (as percentage of FPL)	Limit on Out of Pocket Spending (as percentage of HSA limit)
100% to 200%	1/3
200% to 300%	1/2
300% to 400%	2/3
Above 400%	100%

For small employers with less than 25 employees, average wages less than $50,000, and at least 50 percent employer contributions, there is a Small Business Tax Credit (SBTC) available if coverage is purchased through the SHOP Exchange. Beginning in 2014, this amount can be up to 50 percent of employer contributions (35 percent for tax-exempt businesses), which is available for two years. This is a sliding scale, with full credit for employers with less than 10 employees and an average wage of $25,000. There is no requirement or penalty for employers with less than 50 employees to offer health insurance coverage. If an employer does not offer coverage, employees have the option of entering the Individual market or Medicaid (if qualified) within the HBE with potential eligibility for the individual subsidies as noted above, purchase coverage outside the HBE, or may go without insurance.

Past experience has shown (both in Medicaid expansions and State and Federal high risk pools) that uninsured individuals have much higher morbidity, on average, than the current insured population. High risk pools commonly experience average claims costs per member five times higher than commercially underwritten insured members with the benefits and demographics.

Several factors are likely to make average per member claims costs higher in the Exchange than outside, if the Exchange is not Exclusive, regardless of any other HBE-related choices Iowa could make:

- The average income of HBE members most likely will be lower than that of people who obtain insurance outside an Exchange. People with lower incomes who are not eligible for Medicaid will be attracted to the HBE due to premium subsidies and cost-sharing assistance if they buy a QHP through an Exchange. Numerous public health studies have shown positive correlations between income level and health status.
- The availability of subsidies also means that HBEs will almost certainly attract more people who have not previously been able to afford insurance, potentially leading to a large influx of previously uninsured and potentially less-healthy consumers.
- Iowa complies with Health Insurance Portability and Accountability Act (HIPAA) access regulations requiring carriers to offer Basic and Standard plans within their portfolio. These plans are set at defined multiples of the carrier's lowest priced plan (174.1 percent for the basic plan, 202.8 percent of the standard plan). Many insured under these plans in 2014 will be able to purchase coverage at a much lower price than they are currently paying, with likely eligibility for ACA subsidies. This subset of the insured marketplace also exhibits a much higher average claims cost than the commercial medically underwritten market.
- People who would not qualify for subsidies, already own Individual policies, and are pleased with their health insurance situations will have little incentive to jump to the Exchange. This population will be relatively healthy because its members passed medical underwriting.

The issues surrounding the decision of whether to make the Iowa insurance market Exclusive to the HBE, Qualifying, or Open depend on whether the state decides that maximizing choice or spreading the premium load as evenly as possible is the preferred scenario.

5.3 Iowa Options

5.3.1 Exclusive – All Individual and Small Group Plans Sold Inside the Exchange

One possible scenario is that the HBE could be the Exclusive sales channel for Individual and Small Group major medical insurance requiring mandatory participation in the HBE for any carrier wanting to sell Individual and Small Group major medical insurance in the state of Iowa.

Potential benefits of having both markets entirely inside the Exchange include:

- If the QHP certification process is designed intelligently and applied thoughtfully, consumers would gain a new level of assurance that they were purchasing high quality health insurance.
- If the media and online presence of the HBE is well-designed, comparison shopping and self-education would become far easier.
- Forcing all insurance into the HBE would ensure a large consumer base and could reduce acquisition costs, with commensurate reductions in premium rates.
- Bringing more previously insured (and medically underwritten) and higher income members into the HBE would lower overall average HBE claims costs, reducing premium rates for those least able to afford them.
- A larger pool with a broader risk base would enhance the HBE's long-term price stability and viability.
- Higher income members are more likely to maintain coverage, so forcing them into the Exchange would enhance its long-term membership stability.

The downsides to having both markets entirely inside the HBE include:

- Exchange requirements could drive smaller carriers out of the market, leaving only a few large carriers serving the Individual and Small Group markets.
- Assuming only four carriers in the Individual market, Wellmark might be the only one offering a Platinum level because the next three might decide that they could not compete in the face of the adverse-selection traditionally experienced by richer benefits plans combined with Wellmark's provider discount advantages. The Iowa Insurance Division (IID) rate review process typically looks at rate requests across the entire pool of benefits options, not at the detailed option level. That situation would leave consumers and Small Groups willing to pay for richer benefits exposed to potential price-gouging.
- Consumers and Small Groups would have few options given the few carriers.
- The constraints of operating in an Exchange may discourage experimenting with new ideas and technologies.
- The number of national carriers may be limited as they incur additional administrative expenses to support Iowa-specific plans.

5.3.2 Qualifying – Earning the Right to Sell Outside the Exchange

Another option Iowa could consider is to require carriers, per the HHS guidelines, to offer at least one QHP in the Silver and Gold coverage levels to qualify to sell insurance outside the HBE.

As discussed previously, morbidity inside the HBE is more likely to be costlier than outside the HBE. Requiring participation on the HBE would result in a wider spread of the higher morbidity population, and potentially lower premiums. Carriers would still have the flexibility to experiment with new plan ideas outside the HBE to potentially attract lower morbidity populations to help mitigate their experience pools.

However, while the qualifying requirement does not seem as restrictive as an Exclusive HBE channel, it would be more likely to offer a large carrier such as Wellmark an advantage due to economies of scale. Smaller carriers may be driven out of the market as they may not be able to afford to comply with the onerous HBE requirements for only a few plan offerings as there would be less scale over which to spread expenses. In that event, few carriers would be left to serve the market.

5.3.3 Open – Allowing Carriers to Choose Sales Channels

An Open Exchange approach would allow any carrier whose plans certified as QHP by the HBE to offer them inside and outside the HBE.

Potential benefits in having an Open Exchange include:

- Preserves the current insurance market, with less disruption. Maintains and encourages competition in the market, with a wide variation of plan offerings allowed.
- Smaller carriers will not be required to take on the onerous burdens of HBE compliance and regulations, thus keeping their administrative expenses lower, preserving their viability in the market and maintaining competition.
- Greater consumer and Small Group choice of plan designs and prices. Fewer consumers may opt out of the market and pay the penalty, and fewer Small Groups may opt out of coverage or consider self-funding, if they are able to select a plan that more closely meets their insurance needs and price range.
- Allows greater flexibility for carriers to create innovative products to differentiate themselves and steer risk selection.

Potential downsides to having an Open Exchange include:

- Adverse-selection is a major concern in that a potentially large portion of consumers and Small Groups may be drawn outside the Exchange leaving the Exchange with a significant portion of the low income subsidized population with higher morbidity and higher resulting premiums.
- Since insurers would be required to maintain one risk pool for rating, they may be wary of allowing the low-income and previously uninsured population into their risk-pool.

- While there will be reinsurance, risk corridors, and risk adjusters to offset adverse selection, they may not perfectly offset the additional risk for those carriers participating in the HBE.

5.4 Implications of Potential Iowa Choices

There are no precedents providing a clear path to the ideal approach. Utah and Massachusetts operate Exchanges that are part of an Open market. Both situations are unique, with both successes and failures, although the ACA requirements may present opportunities to correct the problems for them going forward.

The majority of states are still evaluating their Exchange options. Each state is unique with respect to their current levels of competition and insurance plan and rate regulations, and may differ significantly from Iowa. A summary of each state's progress can be found at Kaiser's Health Reform web site [(19)]. The recommendations for the four states with the most progress are summarized in Table 5.4.1.

Table 5.4.1. Comparison of States with Established Exchanges.

State	Decision/Recommendation (Not Final)	Type	Date
Connecticut	The HBE will limit the number of plans offered through the HBE. Carriers participating in the HBE must offer both Silver and Gold level plans to both individuals and small employers. Plans offered within the HBE must charge the same premium as when offered outside the HBE.	Open	3/15/2012
Maryland	Carriers should be required to offer products in the HBE if revenues exceed an annual premium revenue threshold, to be defined by the Maryland Insurance Administration in consultation with the HBE. Carriers offering a catastrophic plan outside the HBE should be required to participate in the HBE.	Qualifying	2/22/2012
Vermont	Insurance plans for Small Groups and Individuals should only be sold through the HBE so as to increase HBE sustainability and promote payment reforms.	Exclusive	2/6/2012
Washington	Insurers may not offer any Individual or Small Group health benefit plan outside the HBE unless they also offer a Silver and Gold level Individual or Small Group QHP in the HBE. Insurers may not offer a Bronze level plan outside the HBE unless the carrier offers the same plan through the HBE.	Qualifying	3/15/2012

Section 6.4 discusses how the Qualifying model, in conjunction with imposing certain product standardization requirements, could preserve much of what was appealing about the Exchange concept to the ACA's authors, while allowing a wide range of consumer choice outside the Exchange.

Although structurally this report deals with one of Iowa's decision points in isolation from the others, in practice Iowa should consider them an inter-related package. While a tentative decision may be made on this question first, the decision may need to be revisited as the other issues and their implications are analyzed.

5.5 What Could Iowa Do?

The issues discussed in Sections 4 through 6 are so intertwined that the discussion of a package of choices Iowa could make to balance the various considerations will be deferred until the end of Section 6.

6. Assessment of Approaches to Standardized Plans

This section addresses the implications of differing plan standardization choices. All products in all states are standardized in the sense that they must cover the state's benefits mandates. All Qualified Health Plans (QHPs) will be standard in covering Essential Health Benefits (EHB) and meeting specified actuarial value requirements. Medicare Supplement plans are standardized because there is a defined set of allowable benefits options, except in two states, and within each option, all carriers' plan benefits are identical. This section will discuss the issues surrounding possible approaches to the most extreme form standardization.

There are a number of issues to consider about plan standardization.

- Concerns to be addressed through standardization are more significant for Individual than Small Group markets.
- Standardization inside the Health Benefit Exchange (HBE) would make operations easier for the HBE, Iowa Insurance Division (IID), and less sophisticated buyers. However, it would also be more difficult for would-benew Navigators (agents or others providing health care information) and smaller insurers. Standardization may also push more sophisticated buyers outside the HBE.
- Four possible combinations involving standardization outside the HBE (relevant only to Qualifying and Open models).
    1. Standardization inside and outside - All the charms benefits of standardization inside the HBE plus making regulators the product innovators in all possible channels.
    2. Standardization inside, not outside - More consumer choice combined with potential for carriers to game the system to the detriment of HBE customers. Would need to anticipate and put safeguards in place.
    3. Standardization outside, not inside – Wouldn't make sense.
    4. Normal Affordable Care Act (ACA) and state standards without full-blown standardization in both channels – Least disruption of current market; greatest consumer choice and carrier innovation; increased pressure on IID rate and product filing reviews to minimize gaming the system.
- Not all consumers want, need, or would buy coverage that provides minimum essential coverage.
- The path through these choices must consider the inter-relationships between the issues and balance choice and innovation with simplicity and affordability in the HBE. There may be more than one viable path.

The rest of this section will examine these elements more closely.

6.1 Critical Assumptions

Because many specific regulations and interpretations of those regulations have not yet been decided, it is necessary to make assumptions about the likely outcomes to frame a useful review and analysis of the options that are available to Iowa. We will assume the following:

- QHPs must include coverage of Essential Health Benefits. All plans sold in HBEs must be QHPs, so it is clear that all QHPs must meet EHB requirements.
- Minimum Essential Coverage (MEC) is the required level of coverage necessary for individuals and families to avoid individual mandate penalties. The U.S. Department of Health and Human Services (HHS) has not yet defined MEC other than to say that it must be a state-approved major medical plan. Some observers, e.g., the Kaiser Family Foundation have suggested that the Bronze level (60 percent actuarial value) is the lowest level of coverage that will meet the MEC requirement. This discussion will assume that outcome.
- MEC refers to the services that are covered and overall cost sharing but not the specific levels of cost sharing built into a plan such as the deductible.
- Although the ACA defines the metal categories as exact percentages of expected medical costs, we will assume that states will have some leeway. For example, Bronze plans may be defined as reimbursing between 60-69 percent of expected medical costs, as opposed to exactly 60 percent.

6.2 Individual vs. Small Group Concerns

The issues surrounding standardization are more important for Individual than Small Group because:

- Obtaining the premium subsidies will probably be the primary reason most people purchase Individual coverage in the HBE. There will not be a similar incentive in the Small Group market.
- Adverse selection is more of a concern for the individual market in that insurers could use benefit design to steer the higher income, healthier people away from the HBE with lower cost/lower actuarial value plans not offered in the HBE. Those plans, on average, would have a better risk profile than the ones offered in the HBE. That situation would eventually be detrimental to HBE customers, many of whom must buy in the HBE to obtain subsidies.

In contrast, in the Small Group market:

1. There are no premium subsidies.
2. Adverse selection is less of a concern in that the decision maker is the employer whose primary interest is likely to be the total cost of providing insurance for all employees, not whether one particular benefits design best matches his or her health issues.

There is a Small Business Tax Credit (SBTC) that will help a limited number of Small Groups that employ low income employees for the first two years of the Exchange. Most observers feel this credit will do little to encourage Small Group employers to buy through the SHOP Exchange. However, a successful Small Group SHOP Exchange will most likely be shaped by administrative efficiencies found in the SHOP Exchange, versus what employers encounter outside the Exchange. That is not to say that many of the standardization possibilities for Individual could be implemented for Small Group as well. Typically purchasers of Small Group products are more sophisticated than Individual purchasers, so the simplification of choices that standardization would create is less important to them.

6.3 Self-Insurance Concerns

One product design issue does pose a significant risk for the Small Business Health Options Program's (SHOP Exchange) role with small employers with a workforce less healthy than average: the potential proliferation of Small Group self-insurance offerings by insurance carriers. This would be troublesome to the SHOP Exchange and to employers left in the fully-insured pool because primarily healthy groups would choose to self-insure. Iowa should consider this adverse selection issue as it designs its SHOP Exchange to avoid having the fully insured pool, inside or outside of the SHOP Exchange, become more heavily weighted with high cost groups.

6.4 Standardization – QHPs Inside the HBE

This section will discuss the potential impacts of standardizing the QHPs within the HBE, an issue that is relevant whether Iowa chooses an Exclusive, Qualifying or Open marketplace.

As the ACA stands today, insurers will be required to offer QHPs in the HBE that fall into four differing metal categories, differing by the percentage of actuarial value a given plan will reimburse. While one school of thought would be that this is enough standardization, the reality is that there could be significant plan differences by company within a given metal category. A Kaiser Family Foundation white paper titled *What the Actuarial Values in the Affordable Care Act Mean* describes a study in which it commissioned three prominent actuarial firms to identify plans that would meet the various precious metal actuarial value targets. [(20)] The paper concludes by saying that they found "potential for substantial variation in plan design meeting the actuarial value thresholds in the law, suggesting that the terms of coverage could vary significantly across insurers."

Potential benefits of applying an additional level of standardization to QHPs offered in the HBE include:

- Easier comparison shopping for the consumer. If all plans within a given metal category are exactly the same, the consumer can easily choose the lowest priced option or possibly choose the company within a given range of prices that best suits them.

- Some consumers in the HBE may have limited financial acumen in understanding the value of the various coverage options offered to them. Standardizing the plan options from each insurer will produce fewer choices for the applicant, and hopefully reduce the confusion that the consumers may feel when choosing a QHP.
- Creation of Iowa-authored consumer guides would be simplified.
- Building the HBE infrastructure, along with the insurer's connections to it, would be simplified.
- Insurers with structural cost advantages, better network discounts and/or lower administrative costs could offer the lowest premiums. This could lead to more sales within the HBE for insurers, which could continue to lower expense margins, and ultimately, premiums.
- Development and marketing costs should be lower for all insurers, since sales materials will not have to focus on product differences between the insurers.
- By requiring all insurers to offer the same plans within the HBE, it minimizes the potential for insurers to design plans within the HBE designed with the intent of attracting low-risk consumers.
- Administrative/Actuarial work within the Iowa Insurance Division should be lessened, as they would not have to scrutinize benefit differences between plans.
- The need for Navigators (agents) to support buyers in the HBE would be lessened, due to uniformity of the plan choices. This could lead to lower costs, and ultimately, lower premiums.

Some of the downsides to standardizing plans offered within the Exchange:

- Consumer choice will be limited with a one-size fits all approach. Consumers will not have any ability to choose from varying product options within a given metal category that may be a better fit for them or their company.
- Smaller insurers who can't obtain similar discounts with providers or those who do not have enough size to reduce fixed administrative costs may be squeezed from the marketplace, resulting in even less consumer choice.
- Insurers would no longer be able to reduce their benefit plans at the time of renewal as a way to minimize cost increases. Using standardized plans, the HBE to tweak the standardized plan within a given metal category. Alternatively, the stakeholder could move to a lower metal category, which may be a much greater reduction in coverage than they desire.
- One metal plan may shift to another. For example, a plan could have an actuarial value of 65 percent today, but could increase to 70 percent in a couple of years. Small employers may have a policy of maintaining a certain metal category as part of its employee benefits program. If the actuarial value sufficiently, the employer may prefer to maintain the original tier level simply by raising the deductible. If QHPs were standardized, the appropriate deductible might not be available and the employer

would be faced with the choice of modifying its benefit program or switching plans/carriers.

- Insurers may be unable to offer plans that would be well received by the public due to restrictions on benefit offerings.
- Customers may have fewer options to choose from due to the standardized nature of the benefits.
- There would be no room for innovation or experimentation of plan designs within the HBE, as the role of product designer would be performed by the HBE.
- The need for Navigators would be decreased, reducing or eliminating a possible income stream needed by agents to make a living.

6.5 Standardization – Plans Outside the HBE (in a Non-Exclusive HBE Environment)

This section is not relevant if Iowa decides to establish an Exclusive HBE environment.

The ACA sets only two requirements for plans that are offered outside of the HBE:

- Plans that are identical to ones sold inside the HBE must be sold at the same premiums as inside the HBE.
- To allow consumers to avoid paying penalties for not complying with the coverage mandate, they must purchase Minimum Essential Coverage (MEC). Some knowledgeable observers expect that MEC requirements will include a minimum 60 percent actuarial value (with the exception of catastrophic plans that may be purchased by those under the age of 30). If HHS chooses not to make that decision, Iowa could do so and enforce it in the IID rate review process.

As mentioned earlier, the HBE will almost certainly have higher morbidity costs inside than outside of the HBE. That should be taken into consideration when making decisions of what the state of Iowa allows outside the HBE.

Most individuals between 138-250 percent of theFederal Poverty Level (FPL) will likely purchase insurance at the Silver metal level or higher through the HBE to take advantage of the premium and cost sharing subsidies available to them. People between 250-399 percent of FPL will be only eligible for premium subsidies but will still be likely to purchase coverage within the HBE. Individuals and families who are not eligible for subsidies will have much less incentive to purchase coverage through the HBE.

The factor that probably will have the biggest effect on rates in the single Individual risk pool will be the number of people who elect to pay the penalty rather than purchase insurance. Some of these will be low-income consumers who feel they can't afford health insurance even with the premium subsidies. Most of the rest will likely be people who feel that they are healthy and wealthy enough to self-insure.

Requiring a higher minimum actuarial value than HHS requires would be counter-productive because it would drive away the healthy and wealthy who prefer catastrophic protection, but at

as low of a cost as possible. To avoid leaving that segment with no catastrophic coverage options, Iowa would have to allow carriers to sell policies that do not meet the MEC requirements outside its HBE.

There are four possible scenarios if Iowa does not create an Exclusive HBE: uniform standardization inside and outside the HBE, standardization inside but not outside the HBE, standardization outside but not inside the HBE, and no standardizations beyond ACA requirements.

6.5.1 Uniform Standardization Inside and Outside the HBE

Insurers could sell in either channel and consumers could buy from any insurer through either channel, with the only distinction between plans being the metal tier. Insurers would not be able to offer plans outside the Exchange that they did not offer inside of the HBE.

The potential advantages and disadvantages of requiring the exact same offering inside or outside of the HBE are the same ones discussed in the section that discussed standardization within the HBE, with the following two exceptions:

- It would completely take away the ability of the consumer to decide what is best for them and puts the power fully in the hands of the regulators, who may not be able to fully understand the breadth of consumer needs in the marketplace.
- By requiring insurers to offer exactly the same plans in both channels, it would prevent insurers from using plan design differences to impact risk selection in one channel versus the other.

6.5.2 Standardized Within the HBE, but not Outside

Standardization of plans offered inside the HBE would maximize the potential benefits the ACA's authors intended in the Exchange concept, but at the cost of limiting consumer choice and private market innovation within the HBE environment.

Preserving existing channels (the non-HBE channel) would support choice and innovation, and just as importantly, minimize market disruption.

However, it is important to point out that this approach would increase the risk that insurers would look for, and find, ways to "game" the system, to the detriment of HBE consumers. While it is beyond the scope of this report to attempt to identify all the possibilities and potential counter-measures, some of them could include:

- Insurers may decide to not sell within the HBE, to avoid the higher morbidity risk most observers expect to occur within the HBE. As a counter measure, Iowa could simply require insurers offering plans outside of the HBE to also offer plans within the HBE.
- Insurers may decide to offer only low cost/lower actuarial value plans outside the HBE, pulling all the healthy and wealthy in that direction. Requiring insurers wanting to sell outside the HBE to allow plans within the HBE would at least ensure they couldn't rely entirely on skimming those with the least risk.

- Broker and agent commissions may be more attractive outside of the HBE than the Navigator fees paid inside the HBE, which would ensure that similar plan designs with similar pricing would be sold primarily outside the HBE. Medical Loss Ratio (MLR) rebate rules would act as a brake on this concern.
- Premium differences between plans within and outside the HBE will need to be scrutinized closely to ensure that insurers do not set premiums in such a way to discourage HBE insureds and encourage non-HBE insureds.

6.5.3 Non-Standardized Within the HBE, Standardized Outside the HBE

This scenario is unlikely from a regulatory and political sense, but is included here to ensure all possible combinations are mentioned.

One of the potential benefits of standardization is that it simplifies choices and makes it easier to educate someone who doesn't understand how health insurance works. The HBE will have many inexperienced first-time buyers evaluating the choices and will provide less person to person assistance than agents have provided historically. Therefore, it would be unwise to exclude standard practices within the HBE.

6.5.4 No Standardization Inside or Outside the HBE, Other than ACA Requirements

This scenario could be the best option to minimize the disruption to the current insurance marketplace and, as a result, could be the most attractive environment in terms of enticing carriers to participate in both the HBE and outside of the HBE. Plans within the Exchange would still be required to be QHPs, which would provide some protection in terms of benefits and minimum standards for plan offerings. The HBE also would likely benefit from a wider range of product options available from a greater number of insurers than the three preceding options.

Insurers would be rewarded for innovative plan. Consumers would have more flexibility to purchase coverage that matches more closely with their perceived needs.

However, there would be some risks included with this approach. Consumers, particularly in the HBE, may not be able to differentiate between all the plan options available to them, and may not be able to decipher which plan is best for them. Unfettered, it would give insurers opportunities to use plan design to shape self-selection in ways that could be detrimental to HBE customers, especially in terms of adverse selection and increasing premiums.

6.6 What About Plan Offerings Outside the HBE that do not Provide MEC?

It is important to point out that there likely will be insurers who will want to offer, and customers who would like to purchase, health plans that do not meet MEC requirements, as defined by HHS and Iowa. While these plans would probably not account for a large part of the overall marketplace (and none of the Exchange market), many high income people may want them available. This segment would include people who today buy plans with deductibles over

the Health Savings Account (HSA) High Deductible, Health Plan limits even though that means they cannot take advantage of the tax benefits of an HSA. Those benefits are far greater than the penalties they would pay for failing to comply with the individual mandate.

Some actuaries have estimated that Individual premium rates will increase 55-85 percent, e.g., Milliman in its study for the Ohio Exchange. [21] The Wisconsin Department of Insurance has estimated the increase will be over 35 percent. The projections used to discuss the three ACA financial risk management programs set a best estimate of 47 percent, with 25th through 75th percentile estimates of 35-58 percent (See Table 7.3.2.4). Many, if not most, Exchange customers would be receiving premium subsidies. The relatively small number of people who want only pure catastrophic coverage might understandably resent being denied that opportunity.

6.7 Summary of Implications of Potential Iowa Choices

There are several considerations for Iowa when making the choice of whether to standardize or not and where to do so:

- The amount of regulation and political risk the state of Iowa wants to adopt.
- The amount of plan design choice Iowa ultimately allows in its marketplace.
- The importance of having many plan options (low standardization) versus fewer plan options (high standardization).
- Balancing the needs of some consumers who would benefit from having standardization to understanding the options presented to them versus those consumers who value having considerable choice in the market.
- Taking additional steps, as necessary, to mitigate adverse selection between the HBE and the non-HBE business.
- The impact of the choices on the broker/agent community. In the HBE, the Navigators will play a similar role as brokers/agents today, although it is undetermined if the compensation will be commensurate with what agents may receive outside of the HBE.

6.8 What Could Iowa Do?

The discussions in Sections 4 through 6 demonstrate how inter-related these questions are. Reasonable people will disagree about the best combination of choices, but all would agree that the choices should be internally consistent. With that said, one possible path could be:

- Require any carrier who wants to sell Individual and/or Small Group major medical in Iowa to participate in the HBE. Some small insurers would probably drop out of the market, but they represent no more than six percent of the current total premium.
- Create a standard census and baseline benefits plan against which all carriers would calculate actuarial value.
- Require all carriers to offer all their QHPs in any channel in which they sell Individual or Small Group major medical.

- Define a set of standard QHPs that all carriers must offer.
- Allow carriers to certify and offer other QHPs that meet the ACA and Iowa HBE standards.
- Define MEC to include a minimum 60 percent actuarial value.
- Allow carriers operating outside the HBE to market catastrophic major medical plans with less than a 60 percent actuarial value, provided that they cover all essential health benefits with limits not any more restrictive than those allowed for QHPs.
- Require carriers to calculate, certify to, and disclose the actuarial value of all major medical plans.
- Require carriers to certify whether, to the best of their knowledge and belief, plans meet the ACA and Iowa standards for MEC.
- Set reasonable and prudent minimum specific stop loss levels based on group size for self-funded groups.
- Require carriers to allow Individuals and Small Groups to change plans only once during an annual open enrollment period, except under extraordinary circumstances.

7. Implementation of Transitions for Reinsurance/Risk

This section investigates the transitional programs designed to help insurance carriers manage the uncertainty inherent in implementing the Affordable Care Act (ACA). In 2014, the ACA will bring enormous change and uncertainty that could destabilize the private health insurance market. The Three R's are the ACA's risk management solution - transitional reinsurance, transitional risk corridors, and permanent risk adjustment. Without such mechanisms, the carriers' risk of loss and potential for excessive gains in 2014 would be unacceptably high, even for a company as big as Wellmark.

- The reinsurance program by itself would dampen the risk of loss but do little to dampen the potential for excessive gain.
- The risk corridor program by itself would dampen both the risk of loss and potential for excessive gain, but could become an unintended burden on taxpayers.
- The combination of reinsurance and risk corridors could create an attractive market environment from 2014-2016, but is not sustainable.
- The U.S. Department of Health and Human Services (HHS) has not announced details of the risk adjustment program, an exceedingly complex issue.
- HHS will run the risk corridor program. Iowa can and should seriously consider running the reinsurance program. Iowa could also run the risk adjustment program, but should instead adopt the HHS program.

This section discusses these three programs that the ACA mandates with the establishment of Health Benefit Exchanges (HBEs) in 2014. The common objective of these programs is to promote market and price stability in a post-2013 environment that will be marked with critical uncertainties. As with HBEs, Iowa should take an active role in designing and running these programs.

7.1 Background

Absent a judicial or legislative change, the ACA calls for a second round of change to the health insurance landscape in 2014. These changes include:

- The individual coverage mandate.
- The elimination of individual health status assessments as a tool to make underwriting decisions and set premium rates, i.e., guaranteed issue.
- Restrictions on the use of other factors known such as age and sex to set premium rates.
- Expanded benefits mandates.
- Premium subsidies for for some consumers in Qualified Health Plans (QHPs) sold through Health Benefits Exchanges.

Collectively, these changes are likely to bring large numbers of new participants into the private health insurance market. Many of these individuals will have serious and costly health conditions that had forced them to pay premium rates about five times what carriers charge reasonably healthy people, the local market Standard Risk Rate (SRR); made it impossible to obtain coverage through the private market at any cost; or driven them into high risk pools. Payers in the private market will reasonably expect their average claims costs per participant will increase significantly. However, insurance companies will no longer be able to deny coverage or charge higher premium rates for this group. The only recourse for the carriers will be to spread the expected additional costs over their entire pool of participants.

Predicting those additional costs is not an exact science, so carriers will be concerned about several critical uncertainties:

- The mix of standard and high risks in the pool of new participants.
- The possibility that the pool of high risk, new participants will not be evenly distributed among the carriers.
- The average claims costs for the pool of new high risk participants the carriers traditionally have not insured.
- The possibility that a few new members in need of extremely expensive treatment could overwhelm the actuarial expectations of any given carrier, particularly the smaller ones.

Traditional health insurers and self-funded plans concerned with these kinds of uncertainties have purchased commercial reinsurance that transferred the financial risks and rewards of insuring fluctuations from actuarial expectations to entities more able and willing to absorb them. Very large carriers traditionally have made limited use of commercial reinsurance because they had the financial resources to absorb fluctuations and did not want to pay for the reinsurers' administrative costs and profit targets. With the elimination of lifetime limits, even very large carriers might have considered reinsurance for multi-million dollar claims. However, commercial reinsurance may no longer be a viable way for carriers to hedge these uncertainties because of the ACA's Medical Loss Ratio (MLR) rebate rules.

The ACA established rules are designed to ensure that, over the long term, carriers spend at least 80 percent of Individual and Small Group premiums on the healthcare treatment costs. If a carrier does not meet that target, it must refund excess premiums to its customers. These rules do not allow carriers to include the costs of and reimbursements from commercial reinsurance in the rebate calculation. The ACA's authors imposed that restriction at the recommendation of the NAIC, which felt that including reinsurance-related financial transactions in the MLR rebate calculation could open the door for gaming the system. The MLR rebate rules neutralize the risk transfer formerly available via commercial reinsurance.

A second way that the MLR rebate rules will add to carrier concerns over the uncertainties created by 2014 changes is that rebates must be calculated at the company/business line/state level. Previously, payers could use higher than expected margins in some segments to offset the losses in others. Under the ACA, much of the favorable experience in some states will be

returned to customers as rebates, while carriers must absorb all the losses associated with states that have unfavorable experience. In effect, these rules can turn even the largest private payer into a collection of smaller entities, each with limited profit potential, but unlimited loss potential.

The ACA's authors recognized that without some protection from these uncertainties, some insurance companies might abandon the market and the remaining companies would be forced to charge premium rates with high safety margins that would defeat the objective of making health insurance available to more people at more affordable rates.

To promote premium stability in the Individual and Small Group markets, the ACA calls for establishing the following three programs, commonly referred to as the Three R's:

- Temporary reinsurance program
- Temporary risk corridor program
- Ongoing risk adjustment program

Table 7.1.1 summarizes the regulations published in the Federal Register [22] regarding these programs:

Table 7.1.1. Summary of the Three R's.

Program	Reinsurance	Risk corridors	Risk adjustment
What	Provides funding to issuers that incur high claims costs for enrollees.	Limits issuer losses (and gains)	Transfers funds from lower risk plans to higher risk plans.
Program Operation	State option to operate, regardless of whether the State establishes an Exchange.	HHS	State option to operate if the State establishes an Exchange.
Who Participates	All issuers and third party administrators on behalf of group health plans contribute funding; non-grandfathered individual market plans (inside and outside the Exchange) are eligible for payments.	Qualified health plans	Non-grandfathered individual and small group market plans, inside and outside the Exchange.
Why	Offsets high cost outliers	Protects against inaccurate rate-setting.	Protects against adverse selection.
When	Throughout the year	After reinsurance and risk adjustment.	Before June 30 of the calendar year following the benefit year.
Time Frame	3 years (2014–2016)	3 years (2014–2016)	Permanent.

The rest of this section will describe the basics of how each of these three programs addresses the uncertainties that could de-stabilize the market, including options, obligations, and restrictions facing Iowa; and the issues Iowa should consider in making its choices. This section will not address the administrative and disclosure requirements, a subject outside the scope of this report.

Before discussing each program, this section will also:

- Describe how design and implementation decisions on one program can materially affect another.
- Present and discuss "directionally correct" financial projections that illustrate how the programs could address the market stability objective and the potential implications of certain decisions.

7.2 Program Interdependencies

As described in Table 7.1.1, the reinsurance program "provides funding for issuers that incur high claims costs for [individual] enrollees." Having a disproportionately large or small number of members with high claims can be the primary reason an issuer incurs the losses or gains that the risk corridor program is designed to limit. Consequently, decisions that affect the degree of protection provided under the reinsurance program will also affect the level and direction of risk corridor funds flow.

The risk adjustment program transfers funds from lower risk plans to higher risk plans. Presumably, a higher risk plan will have more high claims cost enrollees than a lower risk plan. If the risk adjusters work well, they will provide "before the fact" financial relief that will partially overlap the reinsurance program. The purpose of the risk corridor program is to protect against inaccurate rate-setting. There can be several reasons for inaccurate rate-setting, including limited data, uncertainty in the face of unprecedented change, poor actuarial work, conscious marketing decisions, and failure to use or limitations on the use of factors known to be highly correlated with claims costs. Better, more complete risk adjusters, would also reduce the level and direction of risk corridor funds flow.

HHS has not yet decided if the reinsurance and risk adjustment programs may operate wholly or partially independently. If the risk adjustment formulas take into account past claims experience on individual members, not a certainty at this point, prior reinsurance reimbursements could affect future risk adjustments. In any event, the calculation of a carrier's risk corridor funds flow will take into account reimbursements it has received from and payments it has made to the reinsurance and risk adjustment programs.

7.3 Financial Projections

7.3.1 Purposes and Limitations

This sub-section introduces the financial projections created to support the discussions of the reinsurance and risk corridor programs. It is not yet possible to model the risk adjustment because HHS has not announced specific design proposals and the range of possibilities is so broad.

7.3.2 Description of the Model

The model simulates and projects the range of potential 2014 behavior of a simplified version of the Iowa Individual market with and without two of the Three R's. It is not possible, at this point, to model the risk adjustment program.

The Iowa Individual market is highly concentrated in Wellmark. Table 7.3.2.1 compares the market profile from Table 3.2.3.1 with the simplified model profile:

Table 7.3.2.1. 2010 vs. 2014 Market Profile Estimates

	2010 Iowa Individual Market Profile				Model Pre-2014 Market Profile		
	Covered Lives	Market Share by Covered Lives	Cumulative Market Share by Covered Lives		Members	Share	Cumulative Share
Wellmark	148,913	81.6%	81.6%		150,000	87.4%	87.4%
Company A	8,196	4.5%	86.1%		7,200	4.2%	91.6%
Company B	8,185	4.5%	90.6%		7,200	4.2%	95.8%
Company C	5,116	2.8%	93.4%		7,200	4.2%	100.0%
All Others	11,972	6.6%	100.0%		0	0.0%	100.0%
Total	182,382	100.0%			171,600	100.0%	

The actual 2010 Iowa Individual market was more concentrated than Table 7.3.2.1 suggests because many, perhaps half, of the "All Others" companies' covered lives have limited benefits or supplemental coverage Individual policies that are not subjects of the HBE or Three R discussion. The model market profile is a good approximation of the 2014 starting point. The model looks at Wellmark and Company A, assuming that companies A, B, and C will behave identically. [(23)]

One of the natural starting points for any discussion about preserving the post-2013 stability of the private health insurance market is a simple question: How many of the current 360,000 uninsured Iowans are likely prospects for buying private health insurance? Table 7.3.2.2 shows two steps in developing the baseline estimate used throughout this report. The two steps involve estimating the size of two populations whose members will not be likely prospects:

- There are approximately 89,000 non-citizens under age 65 living in Iowa. Of those, 43,000 do not have health insurance. According to the current rules, non-citizens will not be eligible for ACA premium subsidies or cost sharing assistance. Therefore, the projections assume these individuals are not likely prospects for private health insurance. Of the current 360,000 uninsured Iowans, 317,000 are citizens eligible for some form of assistance.
- Iowa citizens with household incomes below 138 percent of the FPL will be eligible for Medicaid. In 2010, 26.7 percent of Iowans qualified for Medicaid based on this income requirement. The projections in this report assume that 26.7 percent of uninsured Iowa citizens have household incomes less than 138 percent of the FPL and would therefore obtain coverage through Medicaid. Using these figures, **about 232,000 Iowans will be likely new prospects for private health insurance.**

Table 7.3.2.2. Current and Future Coverage Overview

Population	Number/Percentage
2010 Iowa Population with Private Insurance	1,930,000
2010 Iowa Population with Individual Coverage	214,000
2010 Iowa Uninsured	360,000
2010 Iowa Non-Citizens	89,000
2010 U.S. Non-Citizens % Uninsured	48.3%
2010 Iowa Uninsured Non-Citizens	43,000
2010 Uninsured Iowa Citizens	317,000
Estimated 2010 Iowa % <=% FPL	26.7%
2010 Iowa Medicaid Eligible in 2014	85,000
2014 Iowa New Private Health Insurance Prospects	232,000

The model assumes that everyone currently in the Individual market maintains coverage but may change carriers. That means the projected net growth in the Individual market is equal to the new previously-uninsured entrants. For each of the four carriers, the projected 2014 enrollment will be:

$$\begin{aligned} &Carrier\ Health\ Co\ Projected\ 2014\ Enrollment \\ &\quad = Pre - 2014\ Enrollment + Pickup\ of\ Other\ Carriers\ Lapses \\ &\quad + Enrollments\ of\ Previously\ Uninsureds - Carrier\ \ Health\ Co\ Lapses \end{aligned}$$

The sum of all four carriers' projected enrollments must equal the assumed total new previously uninsured members. The average claims costs for these new previously insured entrants, many of whom could not pass medical underwriting (the high risk group) will be much higher than for the current members (the standard risk group), who had passed some form of underwriting. Experience with state high risk pools has shown that the average high risk claims costs can be five times the standard risk pools. We have assumed roughly 4.80 higher.

The simulation model makes probabilistic assumptions for the critical uncertainties for the carriers. These concerns drove the creation of the Three R's. The major uncertainties and the range of assumptions are presented in Table 7.3.2.3.

Table 7.3.2.3. Simulation Assumptions

Question Behind the Assumption	Best Estimate	High Estimate	Low Estimate
What percent of the projected 232,000 new prospective private health insurance members will buy individual?	60%	20%	80%
What percent of new Individual market participants will be high risk compared to the average profile of the current 214,000 Individual members?	30%	10%	50%
What percent of all pre-2014 Individual market participants will change carriers? They will not have to pass underwriting and they will not be able to preserve their pre-2014 rates by staying with their current carrier.	25%	15%	40%
What percent of the available prospect pool, new participants and competitors' lapsed, will each of the smaller companies be able to obtain?	25%	10%	33%
What percent of its pre-2014 enrollment will each smaller company lose to a competitor?	25%	10%	50%

When the model assumes that 10 percent to 50 percent of new Individual market participants will be high risk, it means that it assumes 10 percent to 50 percent will have the average cost per member typical of a state high risk pool. The remaining 50 percent to 90 percent will have the average cost per member of a commercial population, meaning they will be considered standard risks. The model also assumes that current commercial members, who started in the standard risk pool, will always have standard risk morbidity costs. As shown in Figure 7.3.3.2, the assumed potential combinations of new and current participants could result in carriers having a 2014 high risk component from a low as 5 percent to as high as 20 percent, with the best estimate in the 10 percent to 14 percent range. [(23)]

Although there are no explicit lapse and sales assumptions for Wellmark, the assumptions in Table 7.3.2.3, combined with the constraint that all members must be in one of the four companies, define what those assumptions must be.

Based on these assumptions, Table 7.3.2.4 projects a wide range of possibilities for what the 2014 Iowa Individual market will look like. [23] The percent increase in 2014 Per Member Per Year (PMPY) claims costs is a good indicator of how much individual carriers might increase premium rates in 2014.

Table 7.3.2.4. Estimated 2014 Iowa Market

Percentile	Percent Individual Market Growth	Percent Increase in 2014 PMPY Claims Cost	2014 Wellmark Market Share
5%	50.3%	22.5%	72.3%
10%	55.8%	27.0%	74.1%
15%	59.3%	30.0%	75.2%
20%	62.2%	33.2%	76.1%
25%	65.0%	36.0%	76.7%
30%	67.6%	38.0%	77.4%
35%	70.1%	40.2%	78.0%
40%	72.1%	42.7%	78.7%
45%	74.1%	44.7%	79.3%
50%	76.0%	46.8%	79.7%
55%	78.4%	49.7%	80.2%
60%	80.6%	52.4%	80.7%
65%	82.6%	54.1%	81.2%
70%	85.1%	55.7%	81.9%
75%	88.0%	58.4%	82.5%
80%	90.2%	60.6%	83.2%
85%	92.4%	64.3%	83.8%
90%	95.2%	68.0%	84.6%
95%	98.4%	47.5%	79.5%

Percentile	Percent Individual Market Growth	Percent Increase in 2014 PMPY Claims Cost	2014 Wellmark Market Share
Average	75.8%	47.5%	79.5%

The other important assumptions concern the carriers' targets for loss ratios and pre-tax profit margins shown in Table 7.3.2.5. [23]

Table 7.3.2.5. Assumed Loss Ratio and Profit Margins

Company	Loss Ratio Target	Profit Margin Target (pre-tax, before MLR Rebates)
Wellmark	83%	3.75%
Company A	80%	3.75%

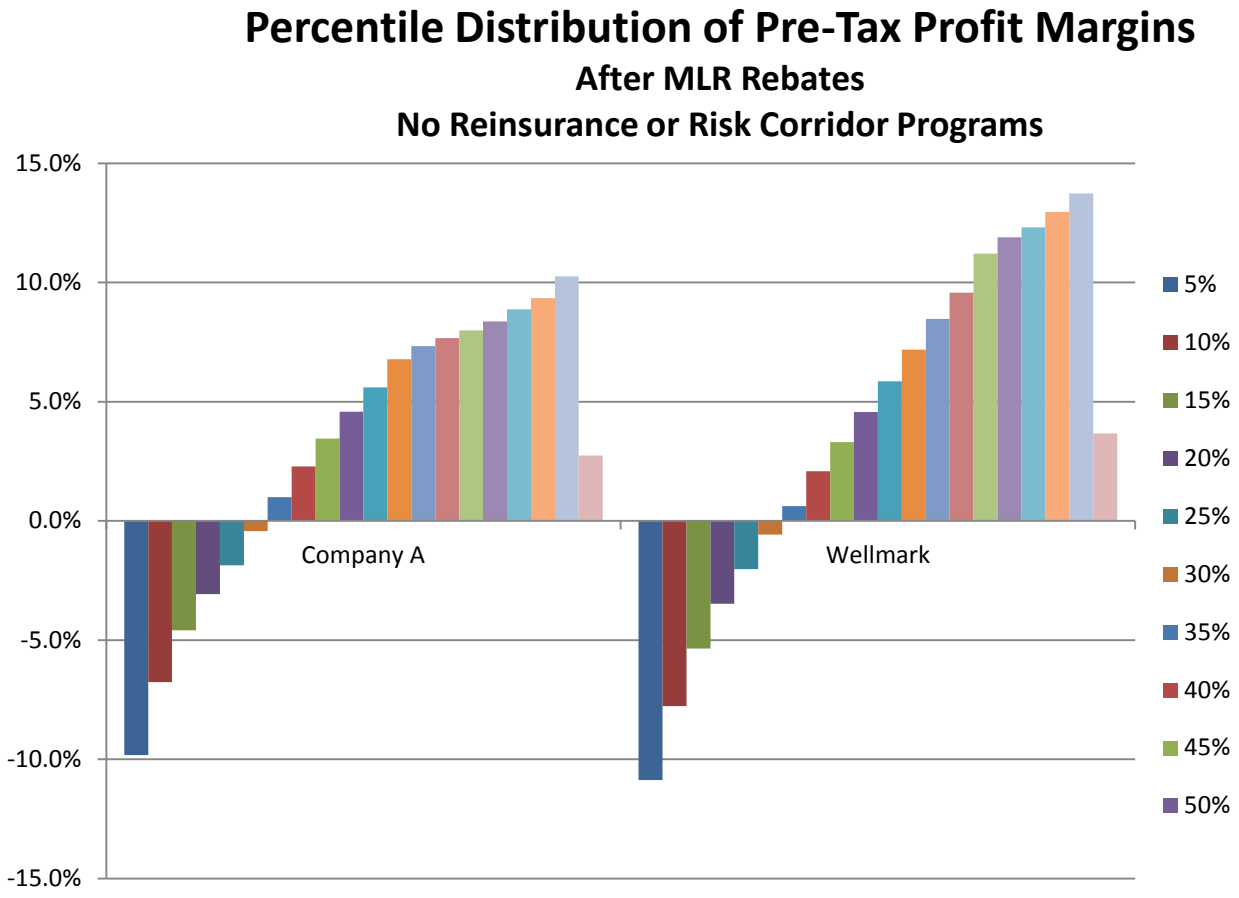
The Wellmark assumptions are representative of the targets the company described in its latest Individual rate filing. Company A's assumptions are based on actuarial judgment that, being smaller, Wellmark's competitors will need lower loss ratios, but that they will not drop their targets below 80 percent to avoid questions within the rate review process.

7.3.3 Model Output – Without Any of the Three R's

The carriers' major concerns center around how all this change and uncertainty could affect their profitability. How bad could the losses become? What is the probability of loss? The model projects the probabilistic range of the profit margins for Wellmark and Company A, pre-tax profits after MLR rebates as a per cent of premium, under all four possible combinations of reinsurance and risk corridor.

These ranges are based purely on statistical uncertainty, assuming that the underlying pricing is perfect and would produce exactly the targeted results if a company had an infinite number of members. In practice, most companies have statistically modest numbers of members and no pricing is ever perfect. Figure 7.3.3.1 shows the probability distribution and the average of the projected margins for Wellmark and Company A with no reinsurance or risk corridor mechanisms. These, and subsequent projections, were based on 1,000 random trials that included the full range of possible outcomes weighted by their respective probabilities. [23]

Figure 7.3.3.1. Percentile Distribution of Pre-Tax Profit Margins after MLR Rebates with no Reinsurance or Risk Corridor Programs



Both companies would probably be content with their projected average margin, but both would probably be concerned that there would be a 25 percent probability of loss, with distinct possibilities of losses over 5 percent of premium. However, consumer advocates and regulators would point to the 45 percent probability that profit margins would be at least 5 percent. The Three R's were created to address both concerns. The discussions of the reinsurance and risk corridor programs will use similar charts to show how those programs might dampen this uncertainty.

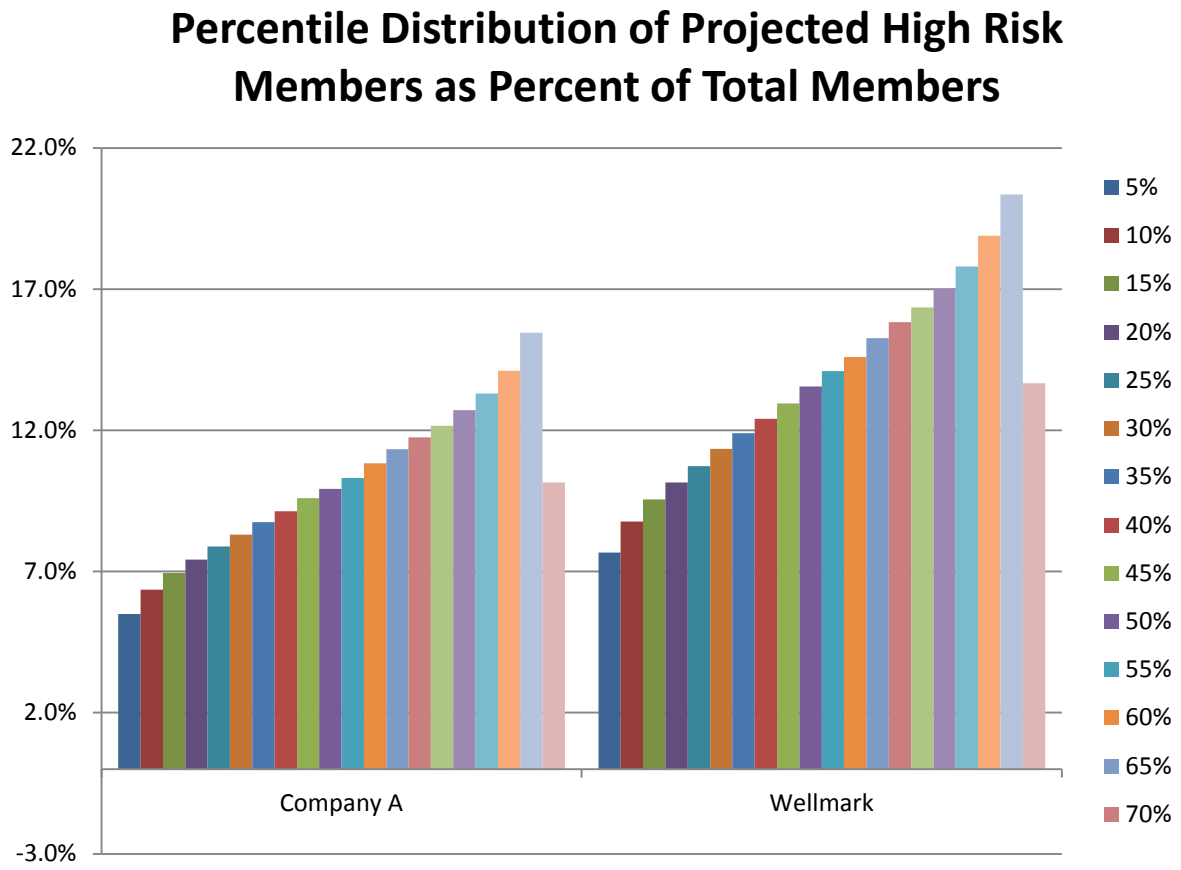
There are several potentially surprising aspects of this projection that deserve comment.

- The average margin over 1,000 random trials was below the 3.75 percent target of both companies because of the effects of projected MLR rebates. The target was for margins before MLR rebates, which depend on the projected loss ratio. Several of the variable assumptions can combine to produce a wide range of loss ratios. The MLR rebate rules force companies to give back money when loss ratios are low and to absorb the losses when they are high. The average margin includes instances where low loss ratios forced the companies to rebate excess premiums. As will be demonstrated in

subsequent sub-sections, the temporary reinsurance and risk corridor programs will mitigate this asymmetry from 2014 through 2016.

- The average projected margin for Wellmark is slightly higher than for Company A. Wellmark's target loss ratio is 3 percent higher than Company A's. Statistically, that would mean Wellmark will not be forced to pay rebates as often and, when they do, the rebates will be smaller.
- Wellmark's range is more extreme than Company A's. This projection seems counter-intuitive because statistics suggest that a larger sample size will have smaller variances. The explanation for this seeming anomaly is subtle and related to the highly concentrated nature of the Iowa Individual market, which consists essentially of one very large carrier and three smaller. In 2014, a large number of new members will enter the market. They will have much higher morbidity costs than the current pool. Each company will absorb some of these new entrants, but the model assumes that it is almost impossible for the three smaller carriers to absorb them all. Instead it assumes that there is a range of possible new participant acquisition for each of the three smaller companies that is commensurate with their current relative size. Because all the new market entrants must go with one of the four carriers, the model first projects how many will choose one of the three smaller carriers and the rest will go with Wellmark. This aspect of the model reflects Wellmark's heritage as the carrier of last resort. The new entrant pool has more high risks than the current pool. If a company absorbs a disproportionate number of new participants, its new risk pool will have a higher percentage of high risk. That, in turn, will create more extreme variability in projected margins. Figure 7.3.3.2 shows that the model does expect Wellmark to end up with a higher share of high risk members. [23]

Figure 7.3.3.2. Percentile Distribution of Projected High Risk Members as Percent of Total Members.



The wide range of possibilities for both companies may be surprising. These percentages will depend on the combined effect of several outcomes, each with a high degree of uncertainty.

- The number of new participants to the market.
- The percentage of these new entrants that have substantially higher claims costs than the insurers' current customer base.
- The percentage of the new participant pool the carrier acquires.

These types of concerns greatly concern carriers and caused the ACA's authors to order the creation of the Three R's.

7.4 Reinsurance

7.4.1 Basics

The transitional ACA reinsurance program has been designed to address carrier concerns that with the advent of guaranteed issue and premium subsidies in 2014, a handful of very large claims from new members could have a devastating effect on their Individual business. The program is similar to commercial specific stop loss reinsurance traditionally purchased by smaller carriers and self-funded group plans. It will cover all non-grandfathered Individual plans written inside or outside the HBE, but not cover Small Group or Large Group, and is scheduled to expire at the end of 2016. Although it will not cover the Small Group or Large Group markets, both will pay assessments for high claims protection of the Individual market.

The protection provided to the carriers will be defined by three moving parts – the *attachment point,* the *coinsurance rate,* and the *reinsurance cap*. Each carrier will keep track of all claims paid annually for each member. When the total paid covered benefits exceed the attachment point, the reinsurance entity will reimburse the carrier for the excess of the total paid over the attachment point multiplied by the coinsurance rate, subject to a limit on the annual reinsurance reimbursement for an individual, i.e., the reinsurance cap.

Per Member Per Month (PMPM) assessments on Iowa health insurers and self-funded plans will provide the funds for the reimbursements and program administration. HHS regulations have set nationwide 2014 targets of $10 billion for the program, decreasing to $6 billion in 2015, and $4 billion in 2016. In 2010, Iowa represented 1.1 percent of the nationwide private health insurance market, as measured by members, which suggests that its 2014 reinsurance program budget under the Federal program would be about $110,000,000.

It is extremely difficult to predict average PMPY claims costs under this type of program with precision, even for a large pool of people. Those claims costs will exhibit high trend rates because of the financial leverage created by attachment points that typically measure hundreds of thousands of dollars. It is entirely possible that the reinsurance premiums collected will not be sufficient to pay for 100 percent of program costs. There are no provisions for supplemental assessments after each year's PMPM rates have been announced. Consequently, the regulations allow programs to make up the difference by equitably reducing the reimbursements. Some programs may consider scaling back the initial reimbursements and making additional year-end payments if there is money available. Excess funds can be rolled forward to pay for the following years' costs. The regulations are vague about what should happen to any excess funds when the program ends in 2016.

HHS, not the states, will collect assessments on self-funded plans regardless of whether a state or HHS runs the state's reinsurance program.

Each year HHS will announce the three program reimbursement parameters and the nationwide PMPM assessment rate. States that have taken on responsibility for the reinsurance program can change the parameters and increase, but not decrease, the assessment rate.

HHS regulations call for states to eliminate their high risk pools or modify them to coordinate with the reinsurance program. It is likely that the reinsurance program attachment point will be set so high that an insurer experiencing a disproportionately large number of new members similar to those found in a high risk pool would still face devastating financial consequences without any of the other Three R's.

The ACA's authors and the HHS reported that the transitional reinsurance program would be continued beyond 2016 because:

- The industry would have had ample time to gauge the impact of the anticipated huge pool of new entrants.
- HHS and the states would have ample time to tune another one of the Three R's – the risk adjusters. ACA's authors' belief in the efficacy of the risk adjusters also contributed to the planned declining targets for reinsurance assessments.

Some health insurance actuaries believe that some form of reinsurance for high amount claims would always be necessary to stabilize the private health insurance market in any state with multiple carriers.

7.4.1.1 Financial Projections

As with the overview financial projections, these should be directionally correct, but not sufficiently precise for actual rate-setting purposes. HHS is devoting significant resources to the following three questions.

- With the designated limits on aggregate national assessments, what are rough estimates of the PMPM assessments that would be borne by all health insurers and self-insured plans?
- How much reinsurance protection could those assessments buy?
- How much would this protection dampen the potential for extreme losses that concern Individual and Small Group issuers?

The design of the funding mechanism sets up uncertainty about the appropriate initial nationwide assessment rate and a reason the nationwide rate may not be appropriate for Iowa for the same set of plan parameters HHS announces. Assessments collected from all health carriers and self-funded plans must provide enough money to cover the reinsurance reimbursements to the Individual carriers. Ideally, the assessments should use up the entire assessment budget. The formulas for assessment and affordable reimbursement rates are shown:

$$PMPM\ Assessment\ Rate = Assessments\ Budget\ \div Total\ Market\ Members$$
$$= PMPM\ Assessment\ Rate\ \times Total\ Market\ Members$$

$$Average\ PMPM\ Reinsurance\ Reimbursement$$
$$= Assessments\ Budget\ \div Individual\ Market\ Members$$
$$= PMPM\ Affordable\ Assessment\ Rate\ \times Total\ Market\ Member$$

To have a balanced budget:

$$PMPM\ Affordable\ Assessement\ Rate$$
$$= \%\ of\ Total\ Members\ in\ Individual\ Market$$
$$\times Average\ PMPM\ Reimbursement\ Rate$$

The selection of the three program coverage parameters will determine the affordable average PMPM reinsurance reimbursement. The only known quantities in this program are the annual nationwide assessment budgets. To avoid over-spending the $10 billion 2014 budget, it will be necessary to accurately project the size of the 2014 private market. Most observers expect the Individual market to grow more than other segments, but the exact rate is not certain, so neither is the set of program coverage parameters that would balance the budget. Table 7.4.1.1.1 shows a range of plausible assessment rates using the same potential new 2014 private health members developed in Figure 7.3.2.1.[(23)(24)]

Table 7.4.1.1.1. Plausible Assessment Rates.

Population	Number/Percentage
2010 Iowa Population with Private Insurance	1,930,000
2010 Iowa Population with Individual Coverage	214,000
2010 Iowa Uninsured	360,000
2010 Iowa Non-Citizens	89,000
2010 U.S. Non-Citizens % Uninsured	48.3%
2010 Iowa Uninsured Non-Citizens	43,000
2010 Uninsured Iowa Citizens	317,000
Estimated 2010 Iowa % <=% FPL	26.7%
2010 Iowa Medicaid Eligible in 2014	85,000
2014 Iowa New Private Health Insurance Prospects	232,000

% of Prospects Taking Private Insurance	None	20%	40%	60%	80%	100%
2014 Private Market Size	1,930,000	1,976,000	2,023,000	2,069,000	2,116,000	2,162,000
2014 Assessment Budget	$110,000	$110,000	$110,000	$110,000	$110,000	$110,000
2014 PMPM Iowa Allowable Assessment	$4.75	$4.64	$4.53	$4.43	$4.33	$4.24
2014 PMPY Allowable Assessment	$57.00	$55.66	$54.38	$53.16	$51.99	$50.87

% Growth Coming from Individual Market	Allowable Average PMPY Reinsurance Reimbursement					
0%	$513.82	$513.82	$513.82	$513.82	$513.82	$513.82
25%	$513.82	$487.37	$463.51	$441.87	$422.17	$404.15
50%	$513.82	$463.51	$422.17	$387.60	$358.27	$333.06
75%	$513.82	$441.87	$387.60	$345.20	$311.16	$283.24
100%	$513.82	$422.17	$358.27	$311.16	$275.01	$246.38

In today's market, assuming no new entrants, an annual per member assessment of $57.00 on each of the 1,930,000 private market members would fund the $110,000,000 budgeted for reinsurance reimbursements to the Individual market regardless of its size. If spread over only the current 214,000 Individual market members, the program could afford to pay an average of $513.82 per member.

If the total market size increased in 2014, the program would spread its $110,000,000 over a larger number; hence, the assessment per member could be smaller. However, if the Individual market size increased, the affordable reinsurance reimbursement per member would also decrease.

The examples used throughout the rest of the report assume that 80 percent of the new private market prospects will buy insurance and, of those, 75 percent will buy Individual. At that level, the assessment rate would be $51.99 per member and the affordable reimbursement rate $311.16 per member. The objective becomes finding the combination of attachment point, coinsurance rate, and reinsurance cap that will produce exactly the right amount of reimbursements. Based on the purely illustrative, but representative, assumptions used by Magnum Actuarial Group, the $311.16 per member affordable reimbursement rate corresponds roughly to a $1 million attachment point, 80 percent coinsurance, and $2.5 million reinsurance cap.

The same calculations based on nationwide numbers would have produced similar assessment and affordable reimbursement rates. That suggests that unless Iowa believes its use of medical services and charge levels per unit of service are materially different than the nationwide average, it would be reasonable to rely on HHS's 2014 assessments and program reimbursement parameters.

Table 7.4.1.1.1 shows that as an industry, the average assessments paid by Individual insurers are likely to be far less than the reimbursements they receive. That means that from 2014 through 2016, the Large Group market will be subsidizing the Individual market.

7.4.2 Model Output – Reinsurance Only

In the analysis of how a reinsurance program could dampen results volatility, the model used assumptions consistent with the highlighted 2014 allowable reinsurance premium and coverage parameters. Figure 7.4.2.1 and 7.4.2.2 [23] compare both companies' projected pre-tax profit margin profitability with none of the R's and with only reinsurance.

Figure 7.4.2.1. Company A Percentile Distribution of Pre-Tax Profit Margins after MLR Rebates Comparing No R's and Reinsurance Only.

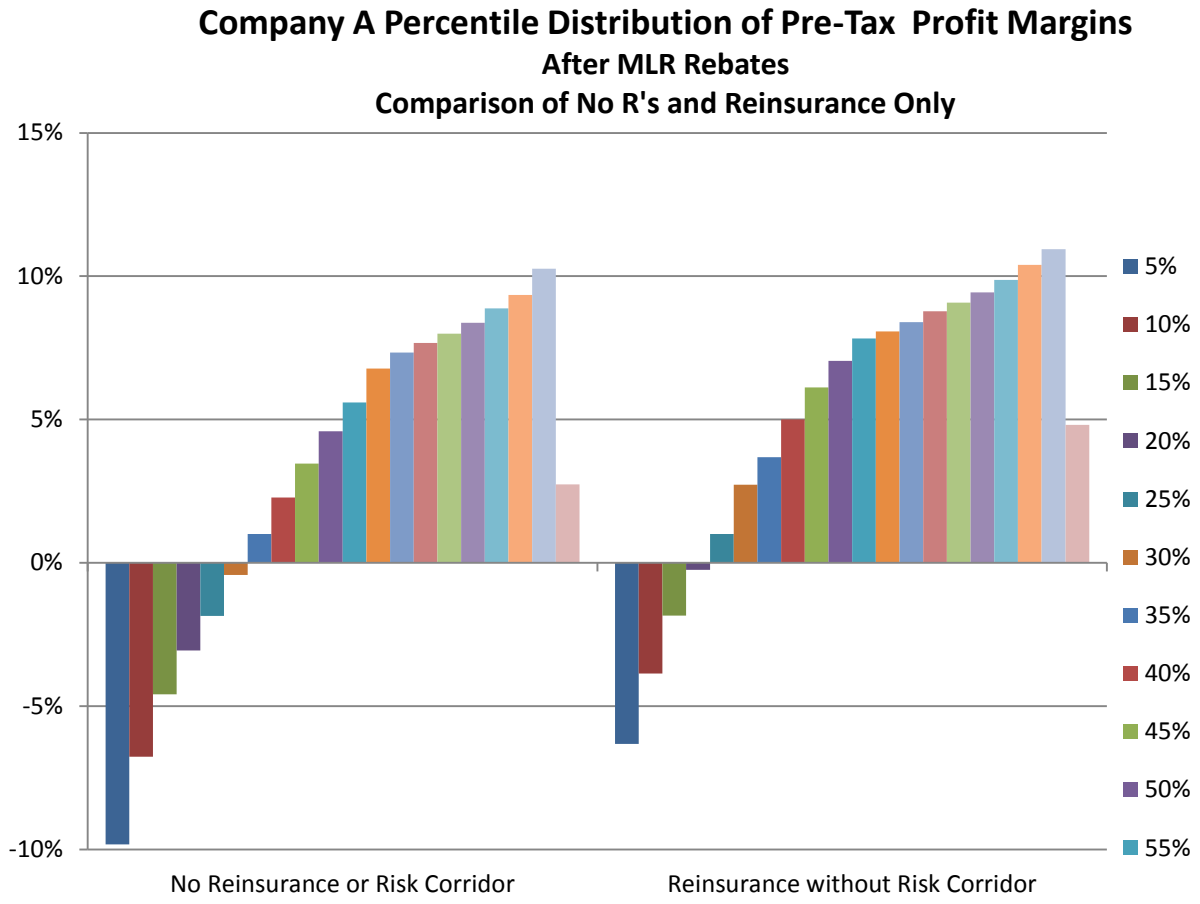
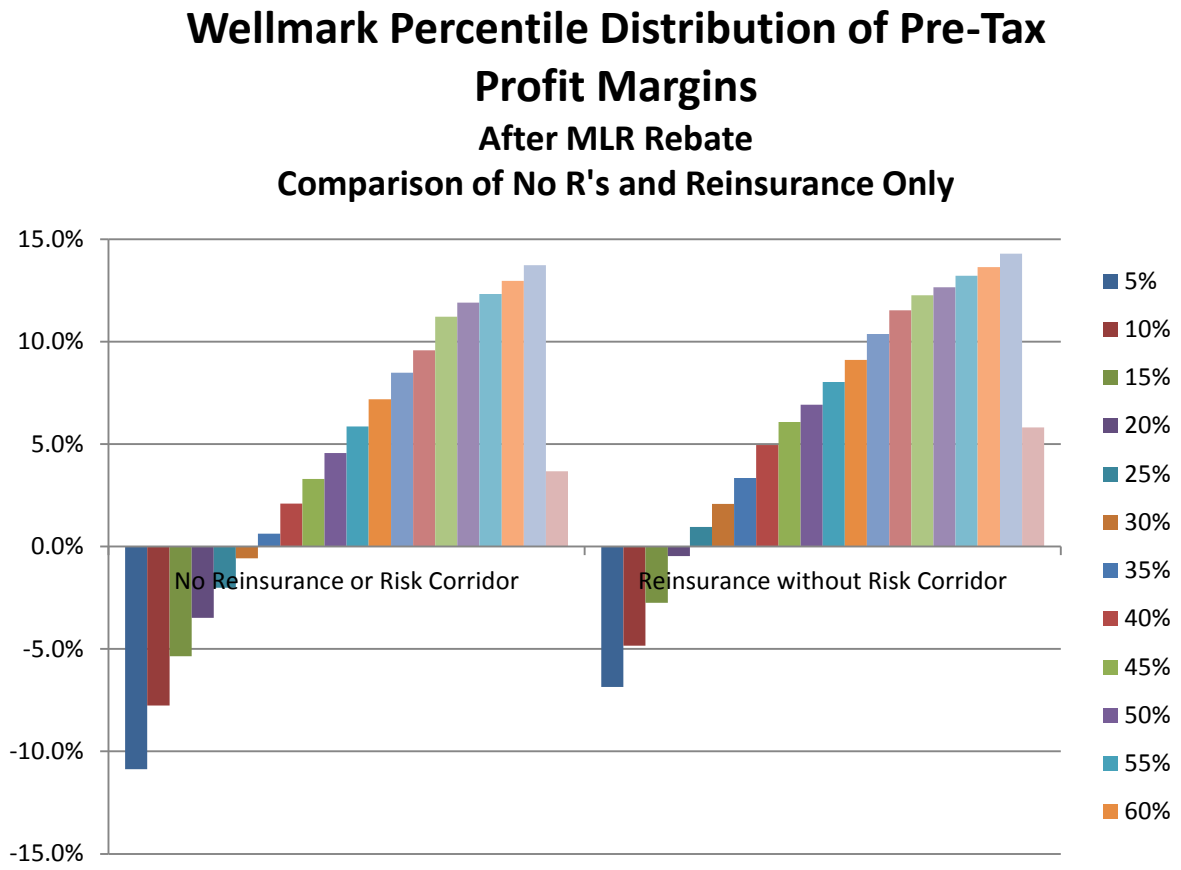


Figure 7.4.2.2. Wellmark Percentile Distribution of Pre-Tax Profit Margins after MLR Rebates Comparing No R's and Reinsurance Only.



Several aspects of these comparisons jump out:

- The average profit margins for both companies are higher with reinsurance than without and higher than their common 3.75 percent targets because they are both enjoying the benefit of having the Large and Small Group markets subsidize their reinsurance.
- The reinsurance program has made both companies' loss tail shorter, the desired result. That's because high losses are usually associated with several very large claims which the reinsurance program helps absorb.
- The difference in the profit tail is smaller because when margins after reinsurance reimbursement are high, it's usually because there's not much work for the reinsurance to do.

7.4.3 Iowa Reinsurance Options, Obligations, and Restrictions

Iowa can elect to run the program or default to a Federal program, even if it establishes and runs its own HBE. The reinsurance programs could, but would not have, to be run by the HBE.

If Iowa chose to run its own reinsurance program, its options, obligations, and restrictions would include:

- Creating the legislative or regulatory authority.
- Establishing the reinsurance entity or entities. These entities must be non-profit. If Iowa chose to establish multiple entities, there must not be any geographic overlap.
- Like a high risk pool, the reinsurance entity can contract with a for-profit company that would provide administration. Commercial carriers who have been in the specific stop loss business are possibilities.
- The contract with any administrative entity must extend far enough beyond 2016 to ensure that the entity completes all activity associated with claims incurred before the end of 2016.
- Making annual decisions concerning:
  - ✓ Additions to the nationwide PMPM assessments announced by HHS. (States would not be allowed to charge and collect lower assessments.)
  - ✓ Modifications to the three basic plan parameters – attachment point, coinsurance rate, and reinsurance cap.
  - ✓ Rules for handling deficient or excessive assessments.
- Monitoring the activities of the reinsurance entity and its administrator.

7.4.4 Implications of Potential Iowa Reinsurance Choices

Iowa's first choice must be whether to run its own program or default to the Federal program because having a reinsurance program that complies with HHS regulations is mandatory. If it chooses to run its own program, the next choices would involve forming the reinsurance entity (or entities) and contracting with an administrator. After that, the decisions will involve ongoing financial and operational issues, which are beyond the scope of this report.

The potential advantages of defaulting to the Federal program:

- Avoiding the time, costs, and public debate that establishing and running an Iowa program would entail.
- Realizing economies of scale by relying on the technical expertise of Federal staff and contractors to run a new. This program would have some similarities to the high risk pools, but the process for setting high risk pool premium rates involves determining the average rates being charged for similar coverage in the public market. There is no public market for the kind of coverage provided by the reinsurance program. Much more technically sophisticated actuarial modeling would be required, with a smaller pool of actuaries having the requisite experience. The Federal program is likely to have

access to far more useful actuarial data to support the plan design and assessment setting process.

- Iowa would not have to develop new capabilities or deal with problems for a program that is scheduled to last for only three years.

The potential advantages of creating and running an Iowa program:

- Freedom to set the three coverage parameters, which could be an important tool for shaping the kind of private individual health insurance market the State hopes to have. If Iowa wants to encourage many active smaller carriers, it could set the attachment points lower and increase assessments above the HHS level. If it wants to have only larger carriers and plans owned by systems, which have greater ability to absorb larger claims, it could set the attachment point higher.
- Freedom to coordinate premium rates with coverage parameter decisions and Iowa's anticipated large claims experience relative to nationwide averages and market segment mix. The discussion of the financial projections illustrated how differences could cause a program that was right for nationwide averages to be either under-funded or overly restrictive for Iowa. The Iowa reinsurance budget would start at $110,000,000 in 2014 and decrease under the HHS program due to the ACA limitations. Seemingly small differences could mean real money to the carriers the program is intended to protect.
- Freedom to set rules for handling of deficient or excessive reinsurance assessments.
- Ability to form the reinsurance entity (or entities) and choose the third party administrator, which would create the potential to keep those jobs in Iowa.
- Increased ability to hold the reinsurance entity accountable for performance.
- Creation of an infrastructure that could continue the existing or modified reinsurance program after 2016 if Iowa felt that was necessary to maintain market stability.
- The level at which HHS or a state sets the attachment point will have a major impact on the next of the Three R's – the risk corridor program.

AW START

7.5 What Could Iowa Do?

A game plan that could provide some of the advantages of both choices could be:

- Commit to running the program, form the entity, and engage the administrator.
- Use the Federal assessment rate and program parameters for 2014. Iowa could spend more money and time on actuarial work similar to, but more extensive than the modeling done to support this report. The output of such an effort is not likely to be more reliable because Iowa's actuaries wouldn't have relevant Iowa data.
- With a year of actual Iowa experience, review results using the Federal parameters and decide whether to engage actuaries to set program parameters based on Iowa experience.

- Repeat the process for 2016.
- Decide whether the risk adjustment program provides enough stability to drop the reinsurance program or to continue an Iowa-run reinsurance program beyond 2016.

7.6 Risk Corridors

7.6.1 Basics

The transitional ACA risk corridor program has been designed to address carrier concerns that could materially underprice their post-2013 business due to the uncertainties created by having an unpredictable mix of medically underwritten and guaranteed issue members, new restrictions on traditional pricing structures, margin squeeze created by MLR rebate rules, and rate reviews. The program is somewhat similar to commercial aggregate stop loss reinsurance frequently purchased by self-funded group plans, but with some critical differences. It will cover QHPs sold inside or outside the HBE, but HHS has said that it may clarify this standard in future rulemaking or guidance.

The risk corridor program will take money from carriers whose allowable costs are below 97 percent of target costs and send money to carriers whose allowable costs are above 103 percent of target. This flow will be entirely between HHS and QHP issuers. Although the states will not be party to the risk corridor money flow, their decisions concerning rate reviews, the reinsurance program, and the risk adjustment program will have a huge impact on how much is flowing in each direction.

The critical definitions and formulas are:

$$\boldsymbol{Target\ Costs} = Premiums\ Earned - Allowable\ Administrative\ Costs$$

Premiums Earned includes both payments made by members to acquire coverage and premium tax credits, i.e. premium subsidies, made on behalf of members.

Allowable Administrative Costs means total costs for administration and operations, excluding the cost of quality improvement activities permitted to be included as part of incurred claims in the numerator of the MLR calculation, but including the various tax items subtracted from premiums in the denominator of the MLR calculation and the carrier's target pre-tax profit margin. There is a cap of 20 percent of earned premium on these costs, but the various tax items are exempt in comparing actual costs against the 20 percent cap.

$$\begin{aligned}\boldsymbol{Allowable\ Costs} \\ &= Payments\ Made\ for\ Medical\ Treatment \\ &+ Costs\ of\ Quality\ Improvement\ Activities \\ &+ Reinsurance\ Payments\ Made - Reinsurance\ Reimbursements\ Received \\ &\pm\ Risk\ Adjustments\end{aligned}$$

This definition is essentially the same as the MLR definition of incurred claims without the change in contract reserves. All payments will be assigned to the calendar year in which the service was provided or the cost incurred.

Like the reinsurance program, the risk corridor program is scheduled to expire at the end of 2016 because the ACA's authors and HHS felt that:

- The industry would have had ample time to gauge the impact of the anticipated huge pool of new entrants.
- HHS and the states would have ample time to tune another one of the Three R's – the risk adjusters.

Many health actuaries would agree that if the risk adjustment program works well and the prospective rate review programs are fair and reasonable, the risk corridor program might add little value after 2016.

7.6.2 Model Output – Risk Corridor Only

Figures 7.6.2.1 and 7.6.2.2 compare both companies' projected pre-tax profit margins with the risk corridor program only and without any of the other Three R's. [23] These simulations were simplified by the assumption that both companies only had one Individual QHP that would be subject to the risk corridor calculation. In practice, there would be a separate calculation for each plan, if a company had more than one.

Figure 7.6.2.1. Company A Percentile Distribution of Pre-Tax Profit Margins after MLR Rebates Comparing No R's and Risk Corridor Only.

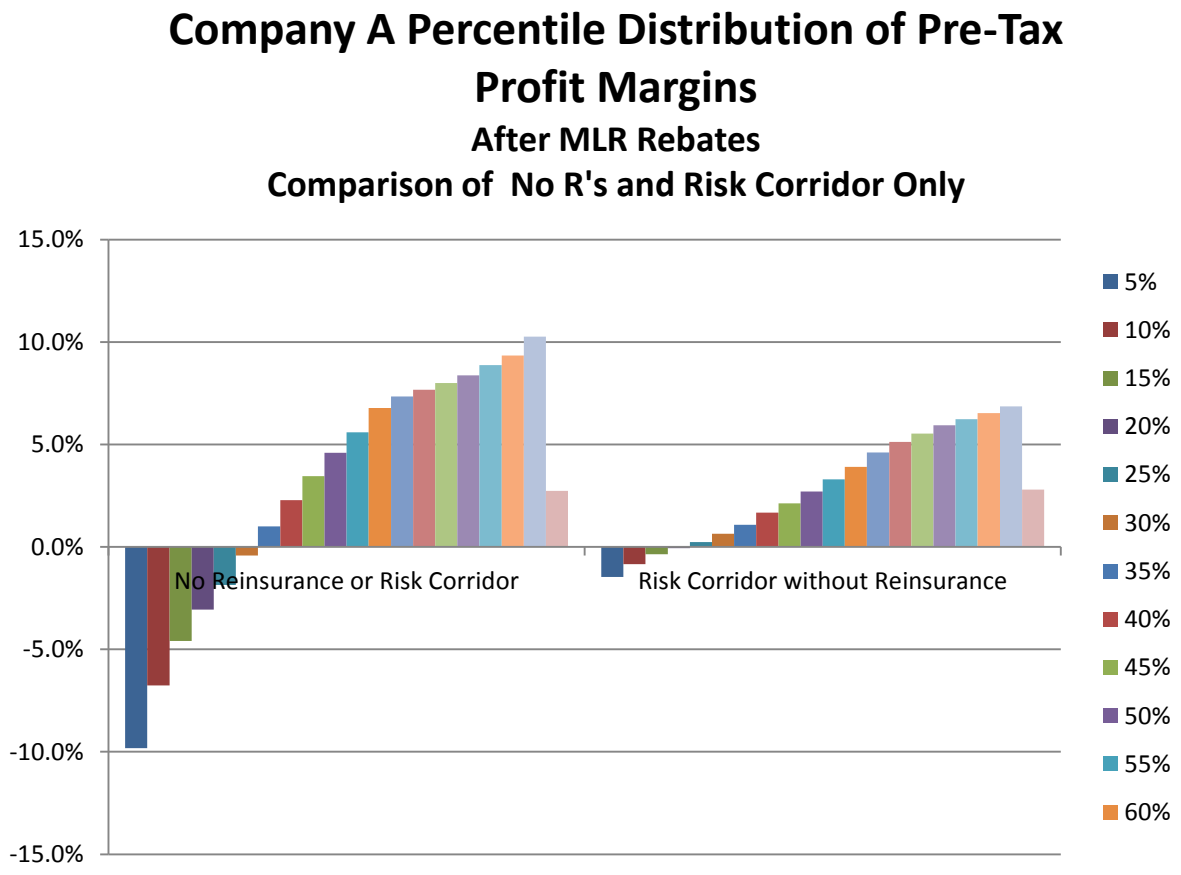
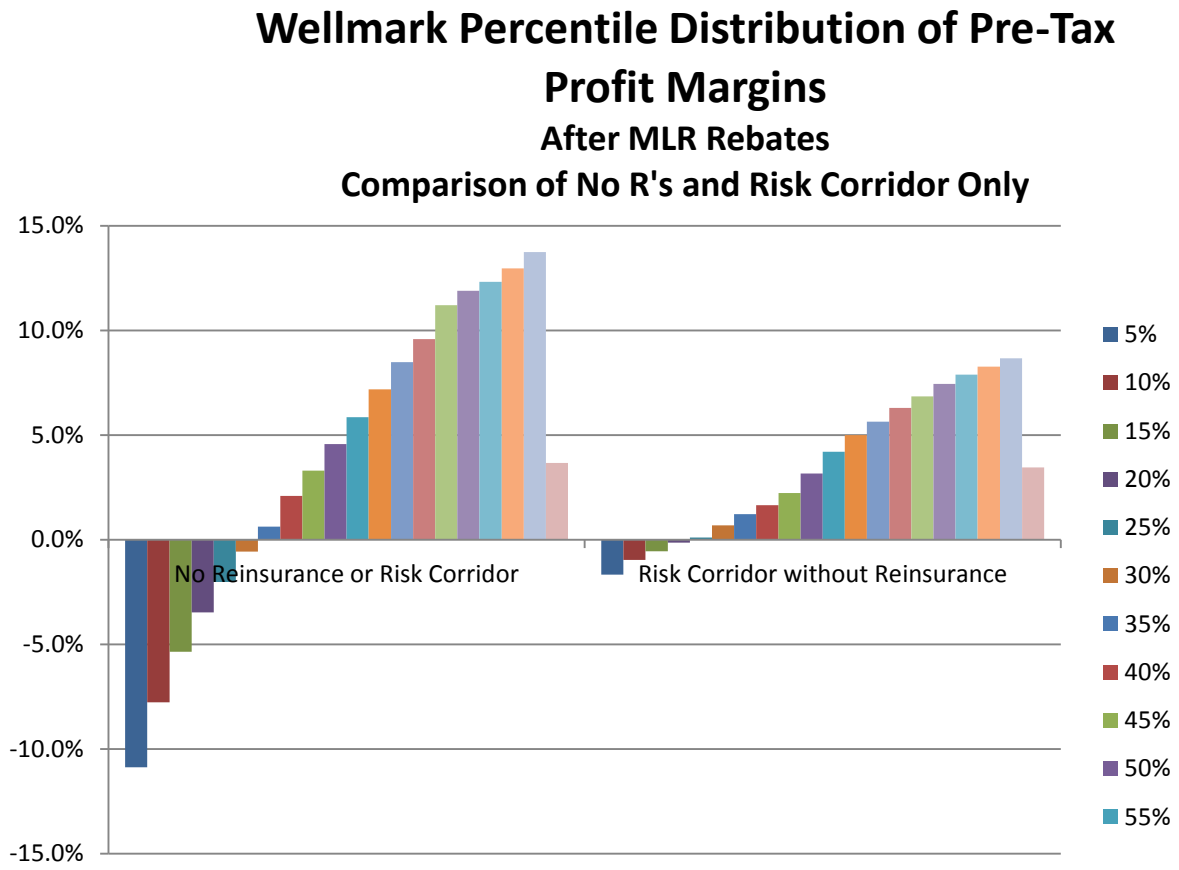


Figure 7.6.2.2. Wellmark Percentile Distribution of Pre-Tax Profit Margins after MLR Rebates Comparing No R's and Risk Corridor Only.



The risk corridor program dramatically flattens the highs and the lows. Several differences jump out of a comparison of these charts to those demonstrating the effects of the reinsurance (Figures 7.4.2.1 and 7.4.2.2):

- The risk corridor program compresses the loss end of the distribution far more than the reinsurance program because it partially covers all claims-related sources of loss, not just disproportionate numbers of very large claims. Higher than expected use of services and unit costs for services can also drive high losses, both possibilities that could affect large and small claims.
- The risk corridor program compresses, not stretches, the profit end of the distribution because it was designed to take back part of the profits over a specified threshold.
- Unlike the reinsurance program, the risk corridor program does not increase the average profit margin of either company because it doesn't provide huge subsidies from other parts of the private health insurance market.

At first glance, it might appear that making this program a permanent part of the health insurance landscape would solve many problems, even without the reinsurance program. Carriers' margins would be fairly stable within a socially acceptable range and the long term average would represent a decent return on capital.

However, the program structure has two potential flaws:

- There is no guarantee that the program would be a zero sum game. If, for example, every carrier underpriced its business by more than three percent, HHS would have to make risk corridor payments to every carrier. With no payments coming in from profitable carriers, the only funding source would be Federal tax revenues. It is entirely possible that payments HHS receives will not be sufficient to fund obligations.
- Companies required to make risk corridor payments may well view that they were being forced to pay to help keep competitors in business by subsidizing prices intentionally set too low to build market share. Their competitors' cost accounting practices could become an easy target because they affect the calculations of allowable administrative costs and target costs; hence, the amount accompany will receive or be required to pay under the program. Cost accounting is not a precise science. HHS' regulations call for reviewing the cost accounting, but it is likely companies could and would find ways to game the system particularly since the calculations must be done at a granular level. Companies that felt their competitors were abusing the program might, understandably, put enormous pressure on HHS to police that alleged abuse.

Living with those exposures for three years might be an acceptable price to pay for the planned reforms.

7.6.3 Model Output – Risk Corridors Combined with Reinsurance

Figures 7.6.3.1 and 7.6.3.2 below compare both companies' projected pre-tax profit margin profitability margins with the combination of the risk corridor and reinsurance programs and without any of the Three R's. [23]

Figure 7.6.3.1. Company A Percentile Distribution of Pre-Tax Profit Margins after MLR Rebates Comparing No R's and Reinsurance and Risk Corridor.

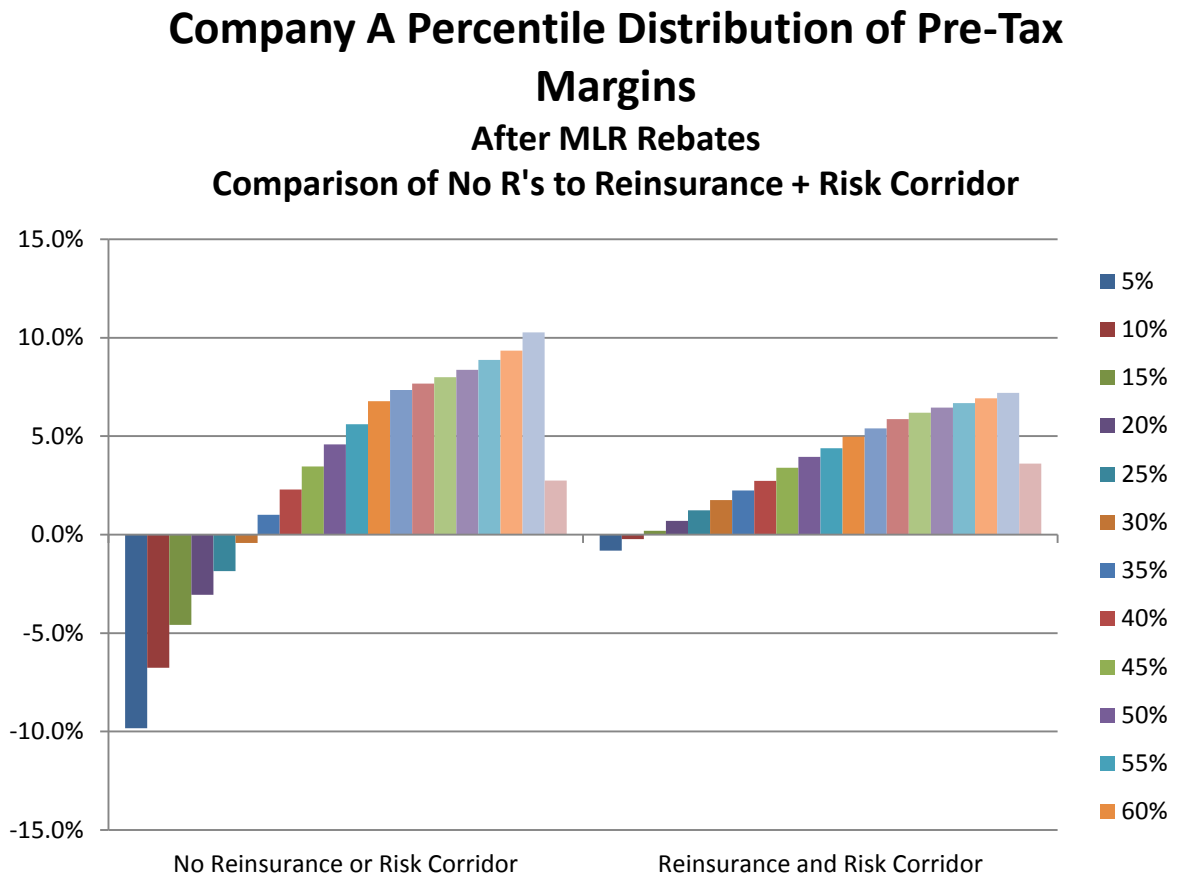
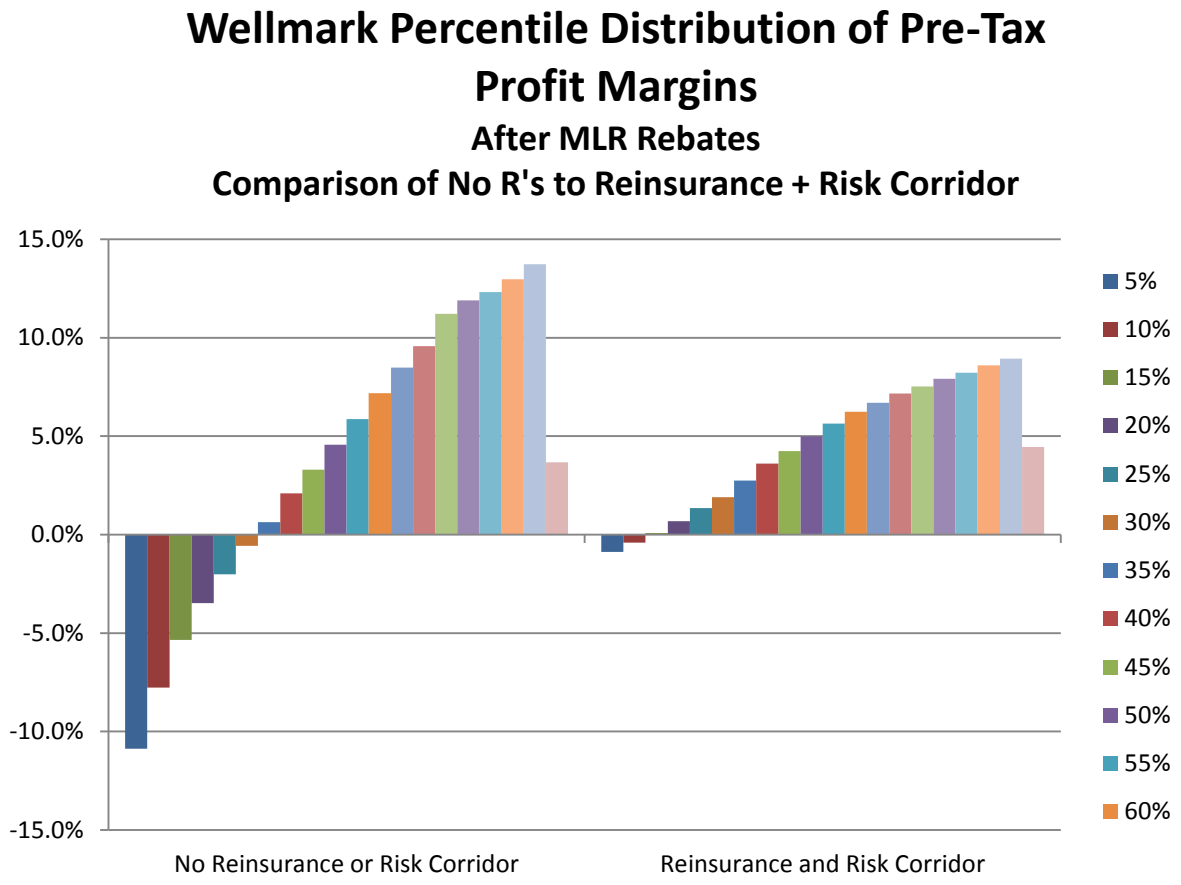


Figure 7.6.3.2. Wellmark Percentile Distribution of Pre-Tax Profit Margins after MLR Rebates Comparing No R's and Reinsurance and Risk Corridor.



These projections make the Individual market look like a great business from 2014 through 2016. It appears that the probability of loss would be small, and even then the losses would be small. The expected profit margins would be a healthy four percent of revenue. However, there are four potential issues:

- Large and Small Group plan sponsors are subsidizing the Individual market through the reinsurance program, a situation they won't tolerate indefinitely.
- U.S. taxpayers are unknowingly protecting Individual carriers against willful or accidental inadequate pricing through the risk corridor program.
- The risk corridor program's exposure to deliberately self-serving cost accounting could increase the cost of the program to taxpayers and/or put HHS in the middle of disputes between competing companies.
- These financial projections dealt only with statistical uncertainty, assuming that carriers all have perfect data that they interpreted and used perfectly. The inevitable data imperfections magnify the statistical uncertainties.

7.6.4 Iowa Options, Obligations, and Restrictions

There are none because HHS owns the entire program.

7.6.5 Implications of Potential Iowa Choices

Iowa's reinsurance program choices could affect the cash flowing through the risk corridor *program*. Lower attachment points combined with higher coinsurance rates and reinsurance caps would reduce the frequency and size of losses, reducing risk corridor payments to carriers. More extensive reinsurance coverage would increase the frequency and size of higher margins, increasing risk corridor payments from carriers.

7.7 Risk Adjustment

7.7.1 Basics

Although HHS regulations and ACA-related literature have definitions for various related terms containing the words risk adjustment, it's probably best to start with a broader, more conceptual discussion of the term than to jump right into its specific meaning in the context of the ACA.

Broadly speaking, risk adjustment in the health care arena is any process used to attempt to predict the claims costs, medical expenses, or intensity of medical service usage of one person or a group of people. A complete risk management process requires data, a model, and methodology. Table 7.7.1.1 describes three practices common in the private health insurance business:

Table 7.7.1.1. Common Industry Risk Adjustment Practices.

Industry Practice	Data	Baseline
Group experience rating	Last year's loss ratio, perhaps with adjustments for non-recurring events	Last year's premium rates
Small group rate card or manual	Insured demographics, broad consideration of individual employee history	Base rates
Individual preferred risk discounts or substandard loads	Detailed applicant health history	Standard risk rates (SRR) for plan chosen, area, age, and sex

The ACA envisions something different and more complex than any of these practices. HealthCare.gov says that "*The primary goal of the risk adjustment program is to better spread the financial risk borne by health insurance issuers …by transferring funds from plans that enroll the lowest risk individuals to plans that enroll the highest risk individual. Thus, the risk adjustment program is intended to reduce or eliminate premium differences among plans based solely on favorable or unfavorable risk selection in the Individual and Small Group markets."*

The ACA risk adjustment process will determine the amount and direction of the transfer for non-grandfathered major medical plans, inside or outside the HBE. HHS has not set the specifics of it risk adjustment process. States can default to the Federal program or create their own, subject to HHS review and approval.

Although HHS has described few specifics about the mechanics of its process, it has announced goals and conditions any approved program must meet:

- A permanent, not transitional program.
- Must be budget neutral, unlike the transitional risk corridor program.
- Weighted average of individual risk scores determined by model.
- Factors in model may include, but not limited to, demographic, diagnostic, and utilization factors.
- Accurately explain cost variation within a given population.
- Choose risk factors that are clinically meaningful to providers.
- Encourage favorable behavior and discourage unfavorable behavior. Limit gaming.
- Use data that is complete, high in quality and available in a timely fashion.
- Provide stable risk scores over time and across plans.
- Minimize administrative burden.
- Easy for stakeholders to understand and implement.
- Distributed data collection approach, i.e., insurers submit data, in prescribed form without personal health information (PHI), to HHS or the state.

This is a daunting list for a subject as complex as risk adjustment. HHS published a 94 page paper titled *Risk Adjustment Implementation Issues* [(25)] in which it requested public comment on a long series of technical questions.

The American Academy of Actuaries response was 17 pages long. As of April 2012 www.regulations.gov had received and published over 1,000 comments, some of them quite long and impassioned.

The ACA's authors invested the undefined risk adjustment program with heavy expectations. It aspires to neutralize the effects of anti-selection sufficiently to:

- Make carriers comfortable with the 2017 elimination of the reinsurance and risk corridor programs.
- Eliminate explicit forms of risk selection and subtle forms of risk steerage as the basis of competition between carriers and replace it with quality and efficiency.

Many actuaries are skeptical. Actuaries who have worked in the Individual market believe that no risk adjustment program will ever beat a well-conceived and well-executed medical underwriting process. Their experience has typically been that all risk adjustment processes under-predict high risk populations and over-predict low risk populations.

7.7.2 Iowa Options, Obligations, and Restrictions

Iowa can adopt the Federal program or build and run an alternative program, subject to HHS review and certification. Building the program would involve:

- Creating the legislative or regulatory authority.
- Creating the responsible not-for profit entity.
- Obtaining and implementing the risk adjustment model by either
  - ✓ Acquiring, modifying, calibrating, and implementing one of several commercial models , or
  - ✓ Creating a new model.

In either event, the process would require a large team of highly trained, specialized, and expensive statisticians, clinicians, and actuaries.

- Building the infrastructure to gather and process the enormous amounts of data necessary to perform the calculations.
- Periodically re-calibrating the model.

7.7.3 Implications of Potential Iowa Choices

With these factors in mind, Iowa should adopt the Federal program, not build and run its own.

7.7.4 Conclusion

Iowa must make two immediate decisions concerning the Three R's

- Temporary Reinsurance Program: This report suggests that Iowa establish and run its own Reinsurance Program, with strong consideration given to using the HHS 2014 program parameters for the first year. Each year, Iowa can revisit its experience to determine whether modifying the HHS parameters would be appropriate. Before 2017, Iowa should closely examine how well the risk adjustment program is achieving its objectives to determine whether it would be prudent to drop the reinsurance program as scheduled under the ACA.
- Permanent Risk Adjustment Program: This report suggests that Iowa default to the HHS program, the direction most, but not all, states appear to be leaning because of two daunting technical hurdles:
    - Creating, calibrating, validating, and obtaining HHS approval for the risk adjustment model and methodology.
    - Building and maintaining the data collection and processing infrastructure to apply the approved methodology.

  Before 2017, Iowa should look at its experience under the HHS program to determine whether there are compelling reasons to create its own risk adjustment program.

8. Implications of Merging Individual And Small Group Plans

Specific to this section of the report, the Affordable Care Act (ACA) gives states the option to combine the Individual and the Small Group market risk pools to allow each state flexibility to tailor the Health Benefit Exchange (HBE) to the given population within both markets. The ACA does not require a timeline for states to merge these markets, which most likely will be helpful for states to determine whether other ACA-required provisions (i.e. guarantee-issue, Federal subsidies, etc.) will impact these markets before considering merging them.

This section provides analysis of whether to merge the Individual and Small Group health insurance markets for rating purposes and provides an analysis of a merger on premiums.

Sections 8 through 11 all deal with questions related to merging the current Small Group market with other market segments. There are two ways of thinking about merging segments for pricing. One would be to merge their claims experience for pricing purposes, but allow carriers to reflect other expense differences, which depend primarily on group size, in their pricing. The other would require merging all expenses - claims, administration, and marketing. The pricing implications differ considerably. In both sections, we will assume that merging would mean the regulations would be changed to require pooling both claims and non-claims expenses in pricing.

8.1 Background Information on Merging the Individual and Small Group Markets

Section 1312 of the ACA requires each state to make many changes in their private health insurance regulations. Although the ACA provides an overview framework for insurance regulation, each state is allowed discretion with various components of this law. [27]

For example, states are required to have individual direct-pay insurance enrollees be members of a single risk pool both inside and outside the state's health insurance Exchange. In a similar fashion, ACA requires that Small Group insurance share the same risk pool, both inside and outside of the Exchange.

Even though risk pools are shared, benefit plans and premium costs inside and outside the Exchange will not necessarily be the same. Insurance companies can use the merged risk pool experience as the basis for premium development and then subsequently make actuarial adjustments for the benefit plans sold within each market, factoring in other costs such as broker compensation and other retention and market-specific administration expenses.

Currently, Iowa does not merge the Individual with the Small Group market. Doing so will most assuredly impact the two markets beyond the other provisions also included under ACA. Both grandfathered plans and self-insured plans are exempt from being included in merged pools.

8.2 Potential Benefits and Concerns of Merging Markets in 2014

It is important to articulate that determining the result of merging both risk pools will be difficult.

1. We currently lack critical data and knowledge about human behavioral decisions once the new healthcare law is implemented in 2014. The insurance products offered both inside and outside the Exchange along with the associated costs of those products will greatly affect the buying behaviors in both markets.
2. The presence of the optional Basic Health Program (BHP) for those deemed eligible will impact the enrollment and subsequent risks within the Exchange pool(s).
3. The Federal subsidy for premium assistance brings another variable to influence purchasing behaviors for qualified individuals under 400 percent of the Federal Poverty Level (FPL).
4. Finally, the ACA has created three programs to promote premium stability in the Individual and Small Group markets – Risk Adjustment, Reinsurance, and Risk Corridors. The Reinsurance and Risk Corridor programs are only temporary, as both are set to expire after 2016, while the Risk Adjustment method is perhaps considered the most important and complex. The effectiveness of these programs will not be determined until the markets have had time to operate.

Iowa has a dominant insurance company in both highly-concentrated markets. Making a hasty decision to merge both markets without understanding how each market has been initially impacted with other ACA-required provisions may bring unintended consequences not desired by the state and the major stakeholders, such as insurance companies and its customers. In short, there is a significant amount of uncertainty and complexity when predicting enrollment and plan costs when merging both markets in Iowa given the variables mentioned above.

This section will first address the potential benefits and concerns of merging both markets in 2014. Based on many assumptions, the section will then make educated estimates to each market should they be merged in 2014.

8.3 Possible Merged Market Outcomes

8.3.1 Potential Benefits

Iowans who currently are unable to obtain individual insurance coverage due to pre-existing medical issues will be among the first entrants in the newly-created guaranteed issue Individual market. In addition, Iowans who are under the 400 percent FPL will qualify for Federal subsidies to help offset the premium costs of insurance coverage. By merging both risk pools, the theoretical benefits may include the following:

- Merged markets may create a larger population risk pool in which to spread the overall healthcare costs. A larger risk pool may reduce premium volatility, administrative costs, and perceived differences between the products and their costs offered within both markets.
- Merged markets may be perceived by both Individual and Small Group participants with product options easier to understand.
- Merged markets may provide continuity of coverage and possibly avert provider disruption when insureds move between Individual and Small Group coverages.
- Merging both risk pools may decrease premium costs for the Individual market based on the preliminary analysis provided by The Urban Institute (found later in this section).

8.3.2 Potential Concerns

Merging both markets may lead to uncertainties and unpredictability in the actions of carriers and employers.

- If merging the two markets increases the Small Group premiums, small employers may conclude the market is too burdensome and consequently exit the market by making one of the following decisions:
    1. No longer offer health insurance coverage.
    2. Move to a defined contribution approach, whereby the employer provides each employee with a specific subsidy to purchase their own insurance policy.
    3. Move to self-insure their health plan. Such exits may adversely impact the remaining risk pool due to the potential adverse selection issues (healthier employers exit the Small Group market).
- Merging both markets may cause short-term instability in premium rates, health benefit plans, and carrier earnings.
- Merging both markets may cause less flexibility for insurance carriers when responding to the differing needs of both markets, such as service and benefit preferences.
- Having merged both markets prior to 2017 may pose new challenges to larger employer groups (100+) who may be allowed to participate in the Iowa insurance market.

- Other carriers not currently in the Iowa market may avoid entry due to preconceived notions that merged markets will be more burdensome and not worth the effort to participate.
- It may be difficult for the state to merge both risk pools and implement procedures and administrative systems for ongoing regulatory control and oversight.

8.4 Possible Outcomes for Non-Merged Markets

8.4.1 Potential Benefits

By leaving the markets as they are, better information may be available to plan a future merger of markets.

- For the initial years of reform beginning in 2014, premiums for the Small Group market may likely be more predictable and perhaps lower than they would be in a merged market.
- By not initially merging the two risk-pool markets, the state could possibly avoid unnecessary, potentially de-stabilizing action in the early years of reform.
- Planning a formal actuarial study sometime after 2014 could help assure that key data needed for analysis is captured during the early years of reform operation (before attempting to merge the two risk pools).
- Smaller employers may be less likely to exit the Small Group market due to having more stable premiums.

8.4.2 Potential Concerns

By not merging the markets as soon as possible, the following risks are possible.

- Premium costs for individuals who are not eligible for tax credits will likely be higher than they would be in a merged market.
- Having different plans and markets could reduce continuity of coverage and provider disruption when insureds move between Individual and Small Group coverage.
- Continuing uncertainty regarding a potential market merger.

8.5 Decisions by Other States

Many other states are confronted with the same question of merging their separate risk pools for 2014 and beyond. Table 8.5.1 presents an overall summary of some available state recommendations to date. It is very important to note that the situation is very fluid and these recommendations may not be final. Also, each state has unique risk pools that may or may not be similar to Iowa's two markets. Of the twelve states in which recommendations were made, all have opted to keep the risk pools separate for the time being, allowing them time to observe the impact of other reform provisions scheduled to be implemented in 2014. By deferring their decision, a more informed decision can conceivably be made.

Table 8.5.1. Status of Merging Both Risk Pools by State.

State	Decision/Recommendation (Not Final)	Potential Impact	
		Individual	Small Group
California	Keep the risk pools separate and revisit at a later date Institute of Health Policy Solutions	Great Uncertainty	Great Uncertainty
Colorado	Keep the risk pools separate and revisit at a later date Colorado Health Benefit Exchange (Feb. 12, 2012)	Great Uncertainty	Great Uncertainty
Connecticut	A draft recommendation to keep risk pools separate for now Mercer	Decrease 2%	Increase 4%
Illinois	Keep the risk pools separate and revisit at a later date Health Management Associates / Wakely Consulting Group	Increase Significantly	Decrease Minimally
Indiana	Keep the risk pools separate and revisit at a later date Milliman	Decrease 1 - 2%	Increase 4 - 6%
Maine	Keep the risk pools separate and revisit at a later date Gorman/Gruber	Decrease 9%	Increase 12%
Maryland	Keep the risk pools separate and revisit at a later date State of Maryland	Great Uncertainty	Great Uncertainty
Ohio	Keep the risk pools separate and revisit at a later date Milliman	Decrease 3 - 7%	Increase 4 - 8%
Rhode Island	Keep the risk pools separate and revisit at a later date Urban Institute	Great Uncertainty	Great Uncertainty
Virginia	Keep the risk pools separate and revisit at a later date Urban Institute	Premiums Decrease	Premiums Increase
Washington	Keep the risk pools separate and revisit at a later date Milliman	Decrease 5%	Increase 10 - 15%
Wisconsin	Keep the risk pools separate and revisit at a later date Gorman/Gruber	Increase 31%	Decrease 12%

8.6 Selected Estimates and Analysis for Iowa on Merging Both Markets

The following report on merging the two Iowa markets was generated for this section by Mr. Fredric Blavin (Research Associate) and Mr. Matthew Buettgens (Senior Research Associate) of The Urban Institute. The information found in Overview and Methods, Results and Limitations and Caveats sections come directly from the memorandum (dated April 20, 2012) authored by both individuals. Both authors have granted permission for this memorandum to be published within this section.

8.6.1 Overview and Methods

The analysis provided in this section comes from the Urban Institute's national Health Insurance Policy Simulation Model (HIPSM) to estimate the coverage effects of health reform among the nonelderly population in Iowa and to provide guidance on how merging the Individual and Small Group insurance markets would impact premiums in both markets. [28]

The core of the national model is two years of the Current Population Survey's Annual Social and Economic Supplement (CPS), matched to several other national datasets, including the Medical Expenditure Panel Survey – Household Component. HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The HIPSM model simulates the main coverage provisions of the Affordable Care Act as if they were fully implemented in 2011 and compare results to the 2011 HIPSM baseline without implementation of these reforms.

The modeling assumptions in HIPSM were developed to be consistent with the key components of the ACA and do not reflect any policy decisions from the state of Iowa. For the main coverage results below, the following assumptions were made:

- The full implementation of ACA insurance market regulations, Exchange, premium subsidy and cost-sharing schedules, individual mandate criteria.
- The ACA employer assessment levels and exemption criteria.
- The private Individual and Small Group markets would not be pooled together in computing premiums. To assess the potential premium effects of a market merger, the HIPSM model analyzed some of the observable characteristics of private Individual and Small Group enrollees under this split market scenario.
- Small groups are defined as those with up to 100 full-time-equivalent workers. This is the definition that must be used beginning in 2016 to determine eligibility for the Small Business Health Options Program or SHOP Exchange.
- Premiums are rated up to the maximum limits of the law, namely, 3 to 1 rating on age and 1.5 to 1 rating on tobacco use.
- The essential health benefits package is to be that of a typical employer-sponsored plan.

- Tax credits for low-wage firms with up to 25 employees in the SHOP Exchange.
- Income groups defined by modified adjusted gross income (MAGI).
- Medicaid eligibility at 138 percent of the Federal Poverty Level (FPL).
- The integrated "no-wrong-door" interface for the Exchanges, Medicaid, and the Children's Health Insurance Program (CHIP) would assess eligibility for Medicaid and CHIP, but would not automatically enroll those found eligible. This is consistent with the final regulations regarding the Exchange issued by the U.S. Department of Health and Human Services (HHS). Automatic enrollment would be a state option.
- IowaCare eligibility is eliminated for adults with MAGI above 138 percent FPL.
- The Basic Health Program option is not implemented.
- The individual mandate is in effect as enacted in the law.

8.7 Results

The Table 8.7.1 shows the current distribution of health insurance coverage in Iowa and how that would change if the ACA was fully implemented in the current year. [28]

Table 8.7.1. Health Insurance Coverage of the Nonelderly in Iowa.

	Without the ACA			With the ACA		
	Number	%		Number	%	Difference
Employer	1,646,000	63%		1,711,000	65%	65,000
Private	206,000	8%		201,000	8%	-5,000
Public	422,000	16%		474,000	18%	52,000
Uninsured	341,000	13%		228,000	9%	-113,000
Total	*2,612,000*	*100%*		*2,612,000*	*100%*	

There are some notable changes:

- The number of uninsured Iowans declines by 113,000, from 341,000 to 228,000. Other states would experience larger percent changes in the uninsured, but a larger share of Iowans currently have coverage through their employers (63 percent) compared to most other states (58 percent nationally).
- The number of Iowans with coverage through their employers would increase by 65,000, inside or outside the SHOP Exchange. This would be due mainly to the increased demand for coverage under the individual mandate.

- Public coverage (primarily Medicaid and CHIP) increases by 52,000 due to the expansion of Medicaid eligibility and outreach efforts.
- The private Individual market, where individuals and families purchase coverage directly from insurers, would remain at about 200,000. However, there would be notable movement both into and out of this market. On the one hand, the individual mandate and premium subsidies in the Exchange for those without access to Employer Sponsored Insurance (ESI) would bring new enrollees to the Individual market. On the other hand, some individuals will leave the private Individual market and will gain coverage through an ESI plan, while others will gain coverage through Medicaid/CHIP e.g., some adults in the private Individual market would become newly eligible for Medicaid and the no-wrong-door interface would detect CHIP eligibility among some children currently enrolled in family policies in the Individual market.

When examining the age and health status - two factors that are correlated strongly with health care costs — enrollees in the Small Group and private Individual markets under the ACA provide insight into the potential effects of merging these two markets (Table 8.7.2) [28].

Table 8.7.2. Characteristics of Enrollees in the Small Firm and Individual Markets, Post-ACA Implementation

Market Under the ACA	Average Age	Percent of Adults in Fair or Poor Health
Small Group ESI	36	4.8%
Private Individual	33	7.2%

The HIPSM model found that:

- The average age in the Small Group market would be higher than in the Individual market (36 versus 33). This difference in the age distribution should be qualified by noting that the older adults in the Small Group market are more likely to be workers, and would thus tend to be healthier than non-working older adults.
- More than seven percent of adults covered in the Individual market would be in fair or poor health, versus just under five percent in the Small Group market. Those in fair or poor health have much higher health care costs than those in better health.
- Overall, assuming the same standard benefit package in both markets, the average health costs of those covered in the Individual market would be 10 to 15 percent higher than the average health costs of those covered in the Small Group market. Thus, a merger of the Small Group and Individual markets would likely lead to higher premiums in the Small Group market and lower premiums in the Individual market.

8.8 Limitations and Caveats

The main limitation of this analysis is that it only suggests how premiums could be affected by a market merger, but does not formally compare a split market scenario with a merged markets scenario. It is important to note, however, that estimating the actual premium change under a merged markets scenario is complicated and beyond the scope of this work. A complete analysis of a market merger would highlight HIPSM's dynamic model process: The market merge would affect premiums, which would in turn change many decisions about whether or not to enroll in Small Group or private Individual coverage. That would change the average health costs of covered lives, leading to further changes in premiums.

The Urban Institute recently published results at the national level that makes this comparison and found merging the Small Group and Individual markets would result in 1.7 million more people nationwide participating in the Exchanges and 1.0 million more people being insured overall because of lower premiums in the private Individual market. [29] However, these estimates vary from state-to-state and more decisive conclusions related to this policy choice can only be drawn from a more rigorous modeling exercise.

The Urban Institute has also conducted more comprehensive analyses for other states, including New York, Massachusetts, Missouri, and Virginia. For each of these states, the HIPSM model produced state-specific models that involve a more detailed construction of each state's baseline. [30] These models allow a comparison of the coverage and cost implications (for individuals and households, employers, and the state and Federal government) of various policy options available to the state, such as merging the Individual and Small Group markets, defining Small Group at 50 or 100 workers, and implementation of the Basic Health Program.

In contrast to the national model, the state-specific HIPSM models are based on the CPS observations for that particular state. To increase sample size and smooth out behavior, records from the region are used as well, but with a much lower weight. The data are reweighted to achieve state-specific population targets and enrollment targets in a set of categories for which the state might have particular data of interest. The Urban Institute research staff is also working on integrating HIPSM with the American Community Survey (ACS) to produce detailed sub-state coverage and cost estimates. [31] The ACS has a far larger sample size than the data used here. This model would provide the capacity to produce the coverage and cost implications of policy reform within Iowa by county or Congressional district.

Two policy options open to Iowa could substantially impact these results:

- *The future of the IowaCare program for those above 138 percent of poverty*. For these estimates, the assumption is that the program is discontinued, with current enrollees moving to the Exchange or ESI. However, the program could also be converted into a Basic Health Program, which would be entirely Federally funded. There would be potential state savings and further analysis would be necessary to assess the effect of a BHP on private Individual premiums in Iowa.
- *The "no wrong door" interface.* The state must decide whether a full eligibility determination for Medicaid and CHIP will be done in real time and whether or not those

found eligible would be automatically enrolled. This would affect not only adults gaining eligibility through the expansion, but also many children eligible for CHIP who are not currently enrolled. The Urban Institute finds that with automatic enrollment, costs in the private Individual market would be lower than the estimates presented above.

8.9 Concluding Remarks

The ACA does not dictate a timeline to merge the two risk pools, which means that both the Individual and Small Group markets can be merged at any time on or after 2014. Given the complexities of the various reform provisions of ACA for 2014 and beyond, Iowa may wish to experience ACA-required changes to both markets before deciding to merge them. After assessing the post-Exchange health market sometime beyond 2014, Iowa can then make a more informed decision by analyzing concrete data for each given market before making a decision to merge them sometime later.

It also may be advisable to seek stakeholder input on this particular topic after objective data and any unforeseen details have been revealed after the impacts of the ACA-required provisions occur in 2014 and beyond. Merging the markets sooner, rather than later, may prematurely provide yet another layer of complexity to Iowa's insurance markets.

9. Reassessment of Small Employer Definition

The Affordable Care Act (ACA) requires that the small employer definition include all rating groups up to 100 employees by January 1, 2016. However, states have the option to keep the small employer definition up to 50 through 2015. Because the existing insurance rules, population, health status and carrier competitiveness vary across the nation, each state must assess its own situation.

This section provides analysis of whether to change the statutory definition of "small employer" from including up to an average of more than fifty employees to up to an average of not more than one hundred employees prior to January 1, 2016.

In both instances, there would be two ways to merge these markets for pricing purposes. One would be to merge their claims experience while allowing carriers to reflect other expense differences, which depend primarily on group size, in their pricing. The other would require merging all expenses, claims, administration, and marketing. The pricing implications differ considerably. In both sections, we will assume that the regulations would be changed to require pooling both claims and non-claims expenses in pricing.

9.1 Current Iowa Status

Currently, Iowa defines Small Groups as those containing 2-50 employees. Policies in this group are guarantee issue, as they are required to be by Federal law. Iowa does not offer standardized plans (24 states do), nor Small Group subsidies (13 states do).

Groups of one in Iowa do not have a guarantee issue. Iowa does not require individual Small Group standardized plans (12 states do) and provides no individual subsidy (13 states do). [32] States that currently offer standardized plans and subsidies would presumably have fewer factors to consider than states like Iowa when considering a change in the small employer definition.

9.2 Decisions by Other States

A number of other states are grappling with the same question in regards to reassessing the small employer definition before 2016. Table 9.2.1 presents a review of some available state decisions. Please note that the situation is very fluid and these decisions are not final. Of the 17 states in which a recommendation has been made, 14 have opted to leave the Small Group between 2-50 until 2016 and three are leaning towards expanding to 100 before 2016.

Table 9.2.1. Status of Small Group Definition by State

State	Decision/Recommendation
Alabama	Do not expand Small Group to 100 prior to 2016 Alabama Health Insurance Exchange Study Commission Recommendations
California	Do not expand Small Group to 100 prior to 2016 Small Employer "SHOP Exchange Issues, Institute for Health Policy
Colorado	Do not expand Small Group to 100 prior to 2016 Policy Questions for the Colorado Health Benefit Exchange Board of Directors
Connecticut	Do not expand Small Group to 100 prior to 2016 Connecticut Health Insurance Exchange Board
Georgia	Do not expand Small Group to 100 prior to 2016 Insurance Markets Subcommittee Report for Georgia Health Insurance Exchange Advisory Committee
Hawaii	Do not expand Small Group to 100 prior to 2016 State of Hawaii SB2434
Maine	Do not expand Small Group to 100 prior to 2016 Recommendations Regarding the Maine Health Benefits Exchange from the Advisory Committee on Maine's Health Insurance Exchange
Maryland	Do not expand Small Group to 100 prior to 2016 State of Maryland SB0238
Minnesota	Do not expand Small Group to 100 prior to 2016 Small Group Health Insurance Market Working Group report to State of MN.
Mississippi	Do not expand Small Group to 100 prior to 2016 State of Mississippi HB1220
Montana	Expand Small Group to 100 prior to 2016 State of Montana HB124
Ohio	Do not expand Small Group to 100 prior to 2016 State of Ohio HB412
South Carolina	Do not expand Small Group to 100 prior to 2016 State of South Carolina H3738
Vermont	Expand Small Group to 100 prior to 2016

State	Decision/Recommendation
	http://hcr.vermont.gov/sites/hcr/files/RJL%20Final%20Integration%20Report%20Act%2048%20Exchange.
Virginia	Do not expand Small Group to 100 prior to 2016 State of Virginia HB464
Washington	Do not expand Small Group to 100 prior to 2016 Planning Washington's Health Benefit Exchange
Wisconsin	Expand Small Group to 100 prior to 2016 State of Wisconsin S273

A Minnesota report asked actuaries from Minnesota's Small Group market carriers to analyze the impact to the market. Because employers in that category are self-insured or uninsured, there is no information on how many may enter the market from self-funding or uninsured status. Likewise, if rates increased, there is little information regarding how many may elect to self-fund for better rates. Lacking further information, carrier actuaries in their professional judgment estimated that 10 percent of the groups that are fully insured would leave the fully-insured market. [33]

9.3 Iowa Analysis

The 50-99 group market is relatively small in Iowa. Table 9.3.1 shows the market is about nine percent of entire group market, totaling approximately 125,000 Iowans. [34] [35]

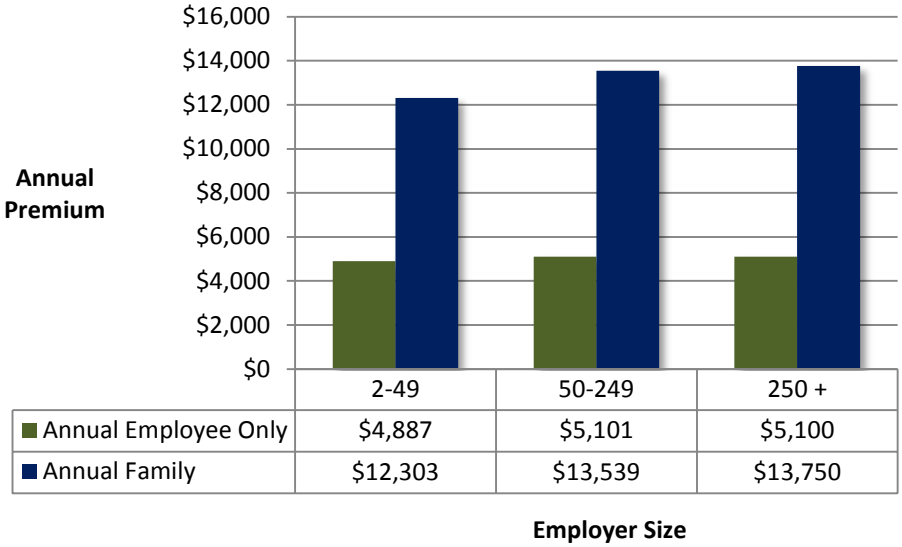
Table 9.3.1. Employees by Firm Size.

Firm Size	Number of Firms	Number of Employees	Percent of Market with Sole Proprietors	Percent of Market without Sole Proprietors
Sole Proprietor	NA	169,000	12.5%	NA
1-49 Employees	56,819	389,796	28.8%	32.9%
50-99 Employees	1,809	125,719	9.3%	10.6%
100+ Employees	1,689	668,913	49.4%	56.5%

According to the *2011 Iowa Employer Benefits Study*©, there is not a substantial difference in premiums in regards to employer size. On average, single coverage premiums for employers with less than 50 employees are four percent less than single premiums found in organizations of 250 or more. Rates for family annual premium are 10 percent less in firms under 50 employees.

Premiums paid by the smaller employers appear to be comparable to their larger counterparts, but this does not portray the major problems confronted by Iowa small employers. Smaller employers in Iowa receive higher premium increases and are forced to make more dramatic changes to the plan designs to help mitigate these annual increases. Because of this, employers with fewer than 50 employees require their employees to pay considerably higher deductibles when compared to larger organizations. Some carriers in the Small Group market do not offer the full range of benefit options available to larger groups because of fears about anti-selection. On an equal benefits basis, 2 to 49 employee prices are higher, if carriers are even willing to offer them the same benefits (Figure 9.3.1).

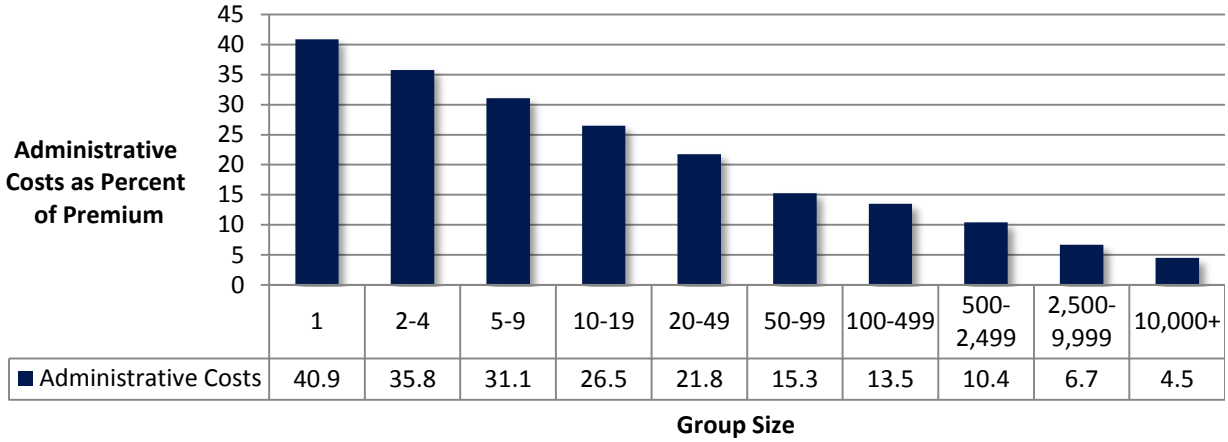
Figure 9.3.1. Annual Premium by Firm Size



	2-49	50-249	250 +
Annual Employee Only	$4,887	$5,101	$5,100
Annual Family	$12,303	$13,539	$13,750

A report by the Lewin Group finds that administrative costs are directly related to group size. Figure 9.3.2 shows that an Individual policyholder (group of one) pays 40 percent of premium as administrative costs whereas a policy for a group of 50-99 pays 15 percent and a group of more than 10,000 pays about 4.5 percent. [37]

Figure 9.3.2. Administrative Costs as a Percent of Premium by Group Size



	1	2-4	5-9	10-19	20-49	50-99	100-499	500-2,499	2,500-9,999	10,000+
Administrative Costs	40.9	35.8	31.1	26.5	21.8	15.3	13.5	10.4	6.7	4.5

These charges also reflect what the carrier cost accounting indicates the administration and marketing costs actually have been. However, the ACA's Medical Loss Ratio (MLR) rebate and prospective rate review rules have changed what how much carriers can charge for non-claims expense and profits. The companies have been working diligently to reduce their cost structures so they can live with the new rules. Iowa, for example, now requires carriers filing Individual and Small Group rate requests to demonstrate that the proposed rates are likely to generate at least an 80 percent MLR, the level below which a company would have to pay rebates. For most companies, the ACA-defined 80 percent MLR would be equivalent, roughly to a 75 percent loss ratio. At that level, a carrier would be allowed about 25 percent of premium for profit and expenses, including premium tax, high risk pool assessments, and the cost of quality improvement activities.

Assuming that carriers, other than Wellmark, would price the entire Small Group market to a 75 percent loss ratio, the pricing changes in the various size segments would be as shown in Table 9.3.2. It is possible, but not likely, that if Iowa merged the 50 to 99 segment into Small Group, the non-Wellmark companies might find that their actual costs in the newly merged Small Group segment were less than 25 percent and would then price more aggressively. Wellmark already prices to a higher loss ratio.

Table 9.3.2. Segment Size Expense Loads

Segment Size	Current Expense Loads	Merged Post-ACA Rate Changes
2-4	35.8%	-14.4%
5 to 9	31.1%	-8.1%
10-19	26.5%	-2.0%
20-49	21.8%	4.3%
50-99	15.3%	12.9%

In addition to the number of lives in each employer size and existing premium cost, the number of people electing to take coverage is important in any analysis. Table 9.3.3 show that in firms with 51-100 employees, about 79 percent enroll in employer-sponsored health coverage. In the end, 98,355 working Iowans are currently enrolled in employer-sponsored health coverage in firms with 51-100 employees. Those 98,355 Iowans represent 8.3 percent of the total employer-sponsored market (7.2 percent if sole proprietors are included).

Table 9.3.3. Estimates of the Number of Working Iowans with Employer-sponsored Health Coverage

	Business with 50 or Fewer Employees	Businesses with 51 to 100 Employees
Working Iowans	531,300	125,700
Percent of employers currently offering employer-sponsored health insurance	59.9%	98.9%
Number of working Iowans working in firms that offer employer-sponsored health insurance	318,250	124,300
Percent of working Iowans who work in firms offering employer-sponsored health insurance and are not covered by a spouse's insurance or otherwise opt	76.7%	79.1%
Number of working Iowans who work in firms offering employer-sponsored health insurance and are not covered by a spouse's insurance or otherwise opt out	244,098	98,355

9.3.1 Potential Benefits of Changing the Small Employer Definition Before 2016

The benefits of moving the small employer definition up to 100 in 2014 may result in the following:

- Lower premiums in the 10 to 49 segment by merging a segment with actual expenses of about 13.5 percent with a segment whose actual expenses are 21.8 percent to 35.8 percent but are constrained to charge no more than 25 percent.
- Maximize participation in HBE by increasing the potential size of the risk pool.
- Increase market stability by incorporating a segment with less potential for anti-selection.

9.3.2 Potential Benefits of Waiting Until 2016

The primary benefit of waiting to move the upper limit of the small employer definition to 100 when required in 2016 would be mitigating additional market disruption in the face of all the other ACA-related changes between now and the end of 2016.

9.3.3 Implications for Iowa

The following summary may indicate Iowa would be better served by waiting to change the definition of small employers to 100 until 2016:

- MLR rebate and prospective rate review rules should force significant rate reductions in the Small Group market as currently defined. Any further reductions in 2 to 50 prices made possible by merging it with 51 to 100 are much smaller and uncertain at best.
- Rates in the 51 to 100 segment would likely increase by roughly 13 percent. At this point, the 51 to 100 segment seems to be about 40 percent of the size of the 2 to 50 segment. Rate increases of that magnitude would drive some fully insured groups to self-funding and they would likely be the healthier lower cost groups. That would diminish the potential for decreasing rates in the 2 to 50 segment.
- The potential benefits seem small and uncertain when weighed against adding one more source of market disruption that is not absolutely necessary.

Changes to the insurance market caused by classifying firms with 51-100 employees to the Small Group market before it is mandated in 2016 is difficult to predict. The ACA has many moving parts and the creation of a Basic Health Program, Health Benefit Exchange (HBE), and possible market disruptions from merging the Individual and small market plans, defining sole proprietors as small employers, and adding firms with 51-100 employees to the small employer definition all interact with each other and implementing different combinations might present varying unintentional outcomes.

10. Assessment of Sole Proprietors as Small Employer

This section provides analysis of the impact of sole proprietors being defined as individuals or as small employers with respect to the Iowa implementation of the Affordable Care Act (ACA). Sole proprietors are organizations that essentially fuse the company and person into one entity under tax laws. As such, sole proprietors could be considered individuals and thus obtain insurance through the Individual market and Health Benefits Exchange (HBE), or they could be considered small businesses and obtain insurance through the Small Group market and Small Business Health Options Program (SHOP).

10.1 Overview and Background

Currently, almost one quarter of U.S. states allow self-employed non-employers to be considered as a "group of one" and allowed within the Small Group market. [38] Thus, the idea of self-employed individuals moving into the group market is not novel. The adverse-selection issues that have made the concept of group of one unpopular to commercial insurers in the Small Group market will become irrelevant in 2014 when the ACA requires insurers to accept all applicants on a guaranteed issue basis at rates that do not depend on health status.

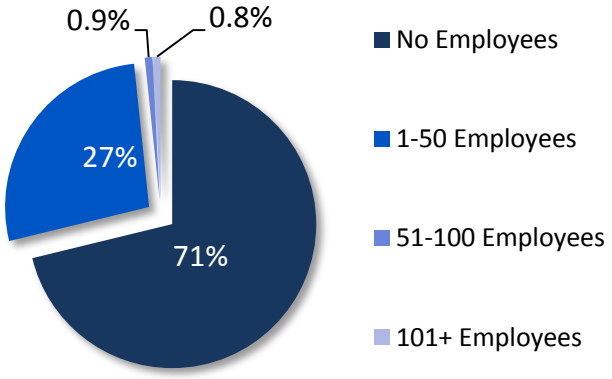
In the Sec. 1421 of Part II – Small Business Tax Credit (SBTC), the ACA states that self-employed and sole proprietors would not be eligible for small business tax credits regardless of whether Iowa insurance law would allow groups of one.

HHS regulation 155.710(b)(1) says that one of the eligibility criteria for SHOP eligibility is that a business is a small employer, so Iowa would be able to give the self-employed and sole proprietors SHOP access by amending its definition of Small Group to include groups of one and setting its HBE and SHOP rules appropriately.

10.1.1 Number of Non-Employer Businesses

The vast majority of businesses in Iowa are self-employers with no employees (Figure 10.1.1.1). (34)

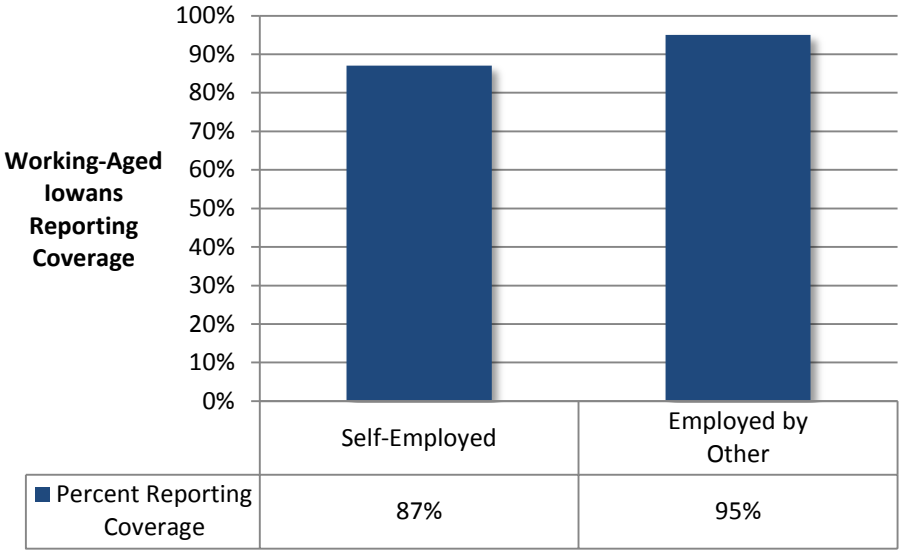
Figure 10.1.1.1. Percent of Iowa Organizations by Size.



10.1.2 Percent Insurance Coverage for Self-Employed

The vast majority of those who consider themselves self-employed (87 percent) report having health insurance coverage, and this value is only slightly lower than those working for organizations. (39)

Figure 10.1.2.1. Percent Covered by Insurance for Self-Employed versus Employed by Other.



10.1.3 Motivation for Policy Selection for Self-Employed

In order to understand how self-employed Iowans would react to new options in health care due to the ACA, one must understand the motivation for current policy selection. Self-employed Iowans are much more concerned about keeping down costs than their peers working in larger organizations, most likely because they bear the cost directly; whereas, in group plans, the employer bears the cost directly and the employee does not fully understand the impact of that cost on his or her salary (Table 10.1.3.1). For example, 80 percent of self-employed would select a plan with a high deductible to keep costs down, compared to only 64 percent of those at larger organizations. When considering the behavior of self-employed Iowans, clearly cost is a major motivating factor even potentially at the expense of their own health (e.g., making fewer doctor visits). [39]

Table 10.1.3.1. Iowan's Choice of Options to Control Health Care Costs.

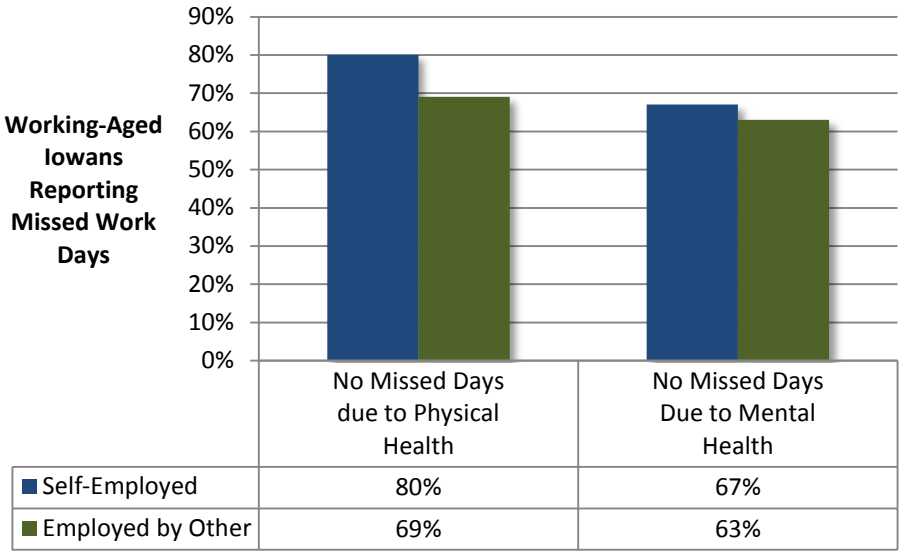
	Self Employed	Employed by Others
Use clinics staffed by nurses and P.A.s instead of doctors	74.5%	75.1%
Pick policy with higher deductible	80.0%	64.4%
Pick higher co-pay for visits and Rx	78.2%	58.8%
Make fewer doctor visits	52.2%	43.5%
Choose policy with fewer participating doctors and hospitals	40.0%	38.4%

10.1.4 Health of Self Employed

Assessment of the impact of self-employed Iowans entering an insurance market requires an understanding of the health of these individuals in order to assess a change in risk. Self-employed Iowans tend to be healthier than their counterparts who work at larger organizations in terms of missed days of work due to health (Figure 10.1.4.1). [39] An analysis of factors associated with Iowans reporting being in very good health showed that being self-employed was associated with good health as much as education, high income, and having quit smoking. [39]

As discussed in the Section 7 descriptions of modeling of the 2014 Iowa Individual market, the average morbidity costs for the pool of people who decide whether and what insurance to buy for themselves will be much higher than it had been before the ACA required guaranteed issue. That pool will include the self-employed and sole proprietors. The results of the self-reported health assessment cited above suggest that the self-employed portion of the whole pool may have lower morbidity costs than the rest of the pool.

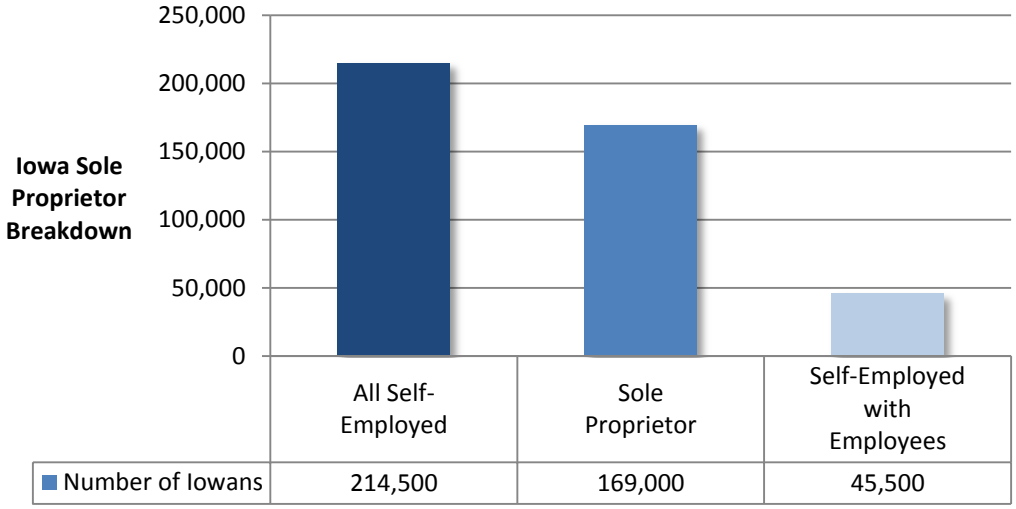
Figure 10.1.4.1 Health Measures of Self-Employed versus Employed by Other



10.1.5 Numbers of Sole Proprietors in Iowa

In 2008-2009, Iowa had an average of 214,500 people filing taxes as self-employed. Of these, the vast majority (169,000) were sole proprietorships with no employees as inferred through not reporting a Federal tax identification number. [35] For the remainder of the report, when we discuss the self-employed we are referring to the entire group of 214,500 Iowans who pay self-employment taxes, and when we discuss sole proprietors we are referring specifically to the 169,000 sole proprietors in Iowa who pay self-employment taxes but with no Federal tax ID and thus no employees (See Figure 10.1.5.1).

Figure 10.1.5.1 Number of Sole Proprietors in Iowa.



10.2 Scenarios Considered for Handling Sole Proprietors

For the remainder of this section, three scenarios will be considered:

Scenario 1 - Requiring all sole proprietors to purchase insurance through the Small Group market.

Scenario 2 - Requiring all sole proprietors to purchase insurance through the Individual market.

Scenario 3 - Allowing sole proprietors to choose a policy from either the individual or Small Group market

If Iowa decides to merge the Individual and Small Group risk pools as described in Section 8, the prices for essentially identical products from the same insurer should also be essentially identical whether purchased in the Individual HBE or SHOP. If not, pricing differences could emerge. There is not likely to be significant differences between the Individual and Small Group Qualified Health Plans (QHPs) from any given carrier because of the precious metal actuarial value requirements. However, it is entirely possible that some carriers might choose to offer the Platinum tier to Small Groups, but not individuals.

10.2.1 Scenario 1: Requiring all Sole Proprietors to Purchase Insurance Through the Small Group Market

The first scenario considered is one in which all sole proprietors would be required to purchase insurance in the Small Group market. This requirement would only take effect if the sole proprietor does not have coverage through an additional employer, a spouse, or a Federal program (e.g., Medicaid). The potential price-related benefits and concerns for this scenario would be relevant only if Iowa did not merge the Individual and Small Group markets.

This option would appear to make all sole proprietors ineligible for premium tax credits and cost sharing assistance because according to Healthcare.gov, to be eligible a person "*must not have access to health insurance through an employer,"* unless "*the employer plan does not cover at least 60 percent of covered benefits on average or the employee share of the premium exceeds 9.5% of the employee's income."*

That shortcoming would appear to make this scenario not feasible, so this report will not discuss it further.

10.2.2 Scenario 2: Keeping Sole Proprietors in the Individual Market

The second scenario considered is one in which all sole proprietors would be required to purchase insurance in the Individual market, and is the "business as usual" option. This requirement would only take effect if the sole proprietor does not have coverage through an additional employer, a spouse, or a Federal program (e.g., Medicaid). The potential price-related benefits and concerns for this scenario would be relevant only if Iowa did not merge the Individual and Small Group markets.

Some potential benefits of this option would be:

- This scenario represents essentially "business as usual," and therefore would have minimal impact on the markets as ACA regulations are implemented.
- Keeping the large number of typically healthier, self-employed within the Individual market would broaden the risk pool of the HBE and thus reduce costs within the Exchange.
- Once established, there would be no concerns about future large-scale movement between Individual and Small Group markets due to premium changes over time, thereby quickly stabilizing the markets after the change is made.
- No need to draft policies regarding minimum duration of holding a policy in order to reduce movement between Individual and Small Group markets.

Some potential concerns with this option would be:

- A relatively large number of healthy self-employed would not enter the Small Group market, thereby making the SHOP Exchange considerably smaller, less healthy, more expensive, and potentially unattractive for small businesses looking for insurance that would then opt to purchase outside of the SHOP Exchange.
- There is a greater possibility that the self-employed and sole proprietors would not have access to higher tier level QHPs.
- The self-employed and sole proprietors would not have access to plans from carriers that sell Small Group, but not Individual.

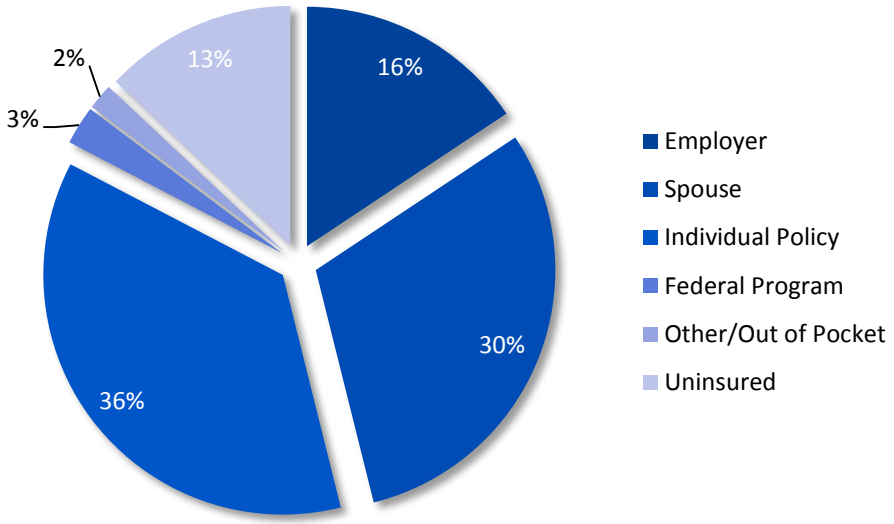
We make several assumptions for Scenario 2, including:

- Sole proprietors with coverage through a spouse will retain this coverage, especially given the increase in quality of employer policies due to the ACA.
- Sole proprietors with coverage through a Federal Program (e.g., Medicaid) will continue to obtain coverage in this manner. In fact, more Iowans will qualify for this option given the proposed expansion of Medicaid.

10.2.2.1 Percentage and Type of Coverage for Sole Proprietors

In this scenario, sole proprietors, would be required to purchase insurance in the individual market if they do not have insurance through a second job, spouse, or Federal program. Our estimates of current coverage for sole proprietors are the same as for Scenario 1, and are presented again below (Figure 10.2.2.1.1). [39]

Figure 10.2.2.1.1 Source of Coverage for Self-Employed.



10.2.2.2 Estimate of Number of Sole Proprietors Moving Into the Individual Market Under Scenario 2

Because most sole proprietors already purchase coverage in the Individual market or have coverage through their spouse, we expect very little change in the market if sole proprietors were not allowed to enter the Small Group market (Table 10.2.2.2.1).

Table 10.2.2.2.1 Percent of Number of Sole Proprietors Entering Small Group Market Under Scenario 1

Current Coverage of Sole-Proprietor	Current Number of Sole-Proprietors	Number not Entering Any Market	Number Entering Individual Market
Spouse	51,460	51,460	
Federal Needs-Based Plan	4,411	4,411	
Employer (Self) Policy	26,465		26,465
Individual Policy	61,753		61,753
Other/Out of Pocket	2,941		2,941
Currently Uninsured	21,970		21,970
Total	**169,000**	**55,871**	**113,129**

10.2.3 Scenario 3: Allowing Sole Proprietors the Option of Small Group or Individual Policy

The third scenario considered is one in which sole proprietors would be given the option of purchasing in either the Individual or Small Group market. Again, sole proprietors with current coverage through an additional employer, a spouse, or a Federal program (e.g., Medicaid) would be given the option of keeping their current coverage.

This option provides the most flexibility for sole proprietors which would likely be a strong selling-point. However, this scenario also provides for the highest degree of uncertainty in terms of how it would affect markets and individual behaviors.

Some potential benefits of this option would be:

- Increased flexibility for sole proprietors in selecting policies that fit their needs.
- Competition for the typically healthier sole proprietors' business may drive down policy costs in both Individual and Small Group markets.

Some potential concerns with this option would be:

- Potentially large fluctuations in composition of Small Group and Individual markets as sole proprietors determine the best policy, leading to market instability and reduced viability of the Individual and small-businesses Exchanges.
- May require a complex set of rules regarding how often a sole proprietor can change policies in order to minimize movement between markets. For example, to require a policy selection to remain in effect for a minimum of three years before a new policy

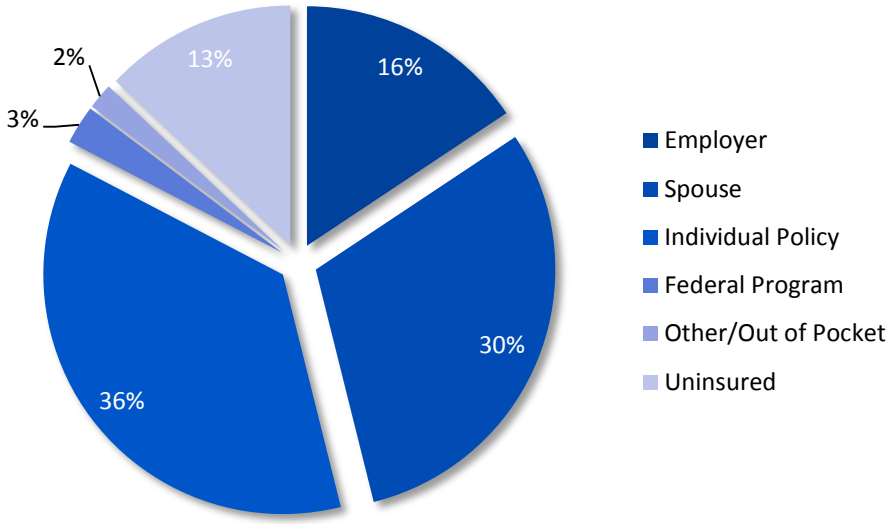
could be selected, except on the case of a defined set of circumstances, e.g., a change in family composition, move to another state, or loss of a network provider.

- Insurance companies may be able to control the market by driving sole proprietors towards either Individual or Small Group policies, thereby jeopardizing the viability of the separate Exchanges. Merging the Individual and Small Group risk pools would make using price to drive sole proprietors in either direction virtually impossible. The IID's rate review process which forces carriers to demonstrate that rates are unlikely to cause loss ratios to drop below the equivalent of an 89 percent MLR, would make it very difficult even in an unmerged market.

10.2.3.1 Percentage and Type of Coverage for Sole Proprietors

In this scenario, sole-proprietors would be given the option to purchase insurance in the Individual or Small Group market. Our estimates of current coverage for sole proprietors are the same as for Scenarios 1 and 2, and are presented again below (Figure 10.2.3.1.1). [39]

Figure 10.2.3.1.1 Source of Coverage for Self-Employed



10.2.3.2 Estimate of Number of Sole Proprietors Moving Into the Individual Market Under Scenario 3

Unfortunately, behavior of individual sole proprietors is difficult to assess with confidence without knowing specifics of how the ACA will be implemented within Iowa as well as the impact of this implementation on policy premiums across both Individual and Small Group markets.

We make additional assumptions based on current behaviors of sole proprietors that may provide insight into future behavior under Scenario 3. These assumptions are:

- Sole proprietors with coverage through a spouse will retain this coverage, especially given the increase in quality of employer policies due to the ACA.
- Sole proprietors with coverage through a Federal Program (e.g., Medicaid) will continue to obtain coverage in this manner if they remain eligible based on income guidelines. In fact, more Iowans will qualify for this option given the proposed expansion of Medicaid.
- Sole proprietors currently without insurance will select policies based on the perceived cost/benefit/quality of the given carrier. Even with credits towards a policy in the HBE or SHOP Exchange, sole proprietors without current insurance are still likely to have restricted funds to put towards a policy.
- Small Group policies will become less expensive due to increased competition, but will continue to be more expensive than Individual policies, unless Iowa merges the Individual and Small Group risk pools. The specifics of the relation between the two markets will be nearly impossible to predict until more details of the ACA are determined, but this comparison is likely to hold true under any contingency.

We will present two possibilities for the impact of Scenario 3. One possibility is that most sole proprietors will opt for Individual insurance. This may occur for several reasons, including initially high costs for group of one Small Group insurance, people sticking with what they know and continuing to obtain Individual insurance, as well as potentially not being aware that under Scenario 3 that they now have the option of a Small Group policy. The estimates for Scenario 3 considering this possibility are shown in Table 10.2.3.2.1, and reflect 90 percent of sole proprietors obtaining individual policies.

Table 10.2.3.2.1 Sole Proprietors Entering Markets Under Scenario 3: 90 Percent Individual

Current Coverage of Sole-Proprietor	Total Number of Sole-Proprietors	Number not Entering Any Market	Number In Small Group Market	Number In Individual Market
Spouse	51,460	51,460		
Federal Program	4,411	4,411		
Employer (Self) Policy	26,465		2,647	23,818
Individual Policy	61,753		6,760	54,993
Other/Out of Pocket	2,941			2,941
Currently Uninsured	21,970			21,970
Total	**169,000**	**55,871**	**9,407**	**103,722**

Another possibility is that roughly half of Iowa sole proprietors will opt for Individual policies, and half will opt for Small Group policies. This may occur if initial competition for the healthier sole proprietor pool drives initial costs down and group of one policies begin to approach the costs of Individual policies. Additionally, sole proprietors would need to be given the appropriate information about the possibility of Small Group policies as group of one, either directly or through a broker. The estimates for Scenario 3 considering this possibility are shown in Table 10.2.3.2.2, and reflect 50 percent of sole proprietors obtaining Individual policies and 50 percent obtaining Small Group policies.

Table 10.2.3.2.2 Sole Proprietors Entering Markets Under Scenario 3: 50 Percent Individual

Current Coverage of Sole-Proprietor	Total Number of Sole-Proprietors	Number not Entering Any Market	Number In Small Group Market	Number In Individual Market
Spouse	51,460	51,460		
Federal Program	4,411	4,411		
Employer (Self) Policy	26,465		13,233	13,233
Individual Policy	61,753		30,877	30,877
Other/Out of Pocket	2,941			2,941
Currently Uninsured	21,970			21,970
Total	**169,000**	**55,871**	**44,109**	**69,020**

10.2.3.3 Market Movement Concerns under Scenario 3

Any potential price-related benefits and concerns for this scenario would be relevant only if Iowa did not merge the Individual and Small Group markets. Otherwise, from the consumers' perspective, the primary benefit would likely be the ability to choose from a broader range of offerings from a broader range of carriers.

A major concern with Scenario 3 is that, without restrictions, sole proprietors could frequently move between the Individual and Small Group Exchanges as policy costs change. If they were allowed to do so, the impact would be an increase in market volatility as well as the real possibility of adverse selection leading to more healthy individuals ending up in one market and unhealthier ending up in the other Exchange. Both of these outcomes would undermine the long-term viability of the Exchanges, suggesting that Scenario 3 would require legislation, restrictions, or guidelines for how often and when sole proprietors can change policies. Predicting this behavior depends upon a number of factors, most of which are unknown at this time are including:

- Restrictions regarding movement between the Individual to the Small Group Exchanges.
- Restrictions regarding movement in and out of the Exchanges.
- Initial offerings of policies within the Individual HBE and SHOP Exchanges.
- Uncertainty of premiums based on risk profiles within and outside the Exchanges.
- Whether or not policies offered outside of the Exchanges are required to follow the same guidelines as those offered within the Exchanges.

- Ease of finding and comparing policies given the online portal to the Exchanges, including comparison to policies outside the Exchange.

10.3 Potential Pricing Implications of Not Merging Individual and Small Group Risk Pools

Quantification of the potential impact because the potential morbidity cost difference of the self-employed and sole proprietor pool under guaranteed issue is purely speculative. However, it is possible to estimate whether it would be big or small using projections of the size of different segments based on several assumptions:

- There are currently 182,382 people in the Individual market, 61,153 covered under policies owned by someone who is self-employed. That latter group is part of the 113,129 sole proprietors projected to have purchased Individual or Small Group in 2014 (Tables 10.2.2.2.1).
- There are currently 209,230 people in the Small Group market (See Table 3.1.4.1).
- In 2014, 90 percent of the 232,000 of the projected new prospects from the currently uninsured pool (Table 7.3.3.2) will take private health insurance, about 209,000. Of those, about 21,970 will come from the currently uninsured self-employed population, leaving about 187,030 from the currently uninsured who are unemployed and employees of companies. The projection model assumes that 93,515 (50 percent) will take Individual coverage and 46,758 (25 percent) will take Small Group and the same number Large Group.
- The average morbidity costs of the entire new self-employed pool, which includes the formerly uninsured and uninsurable, will be some multiple less than 100 percent of the new Other Individual and Small Group pools.

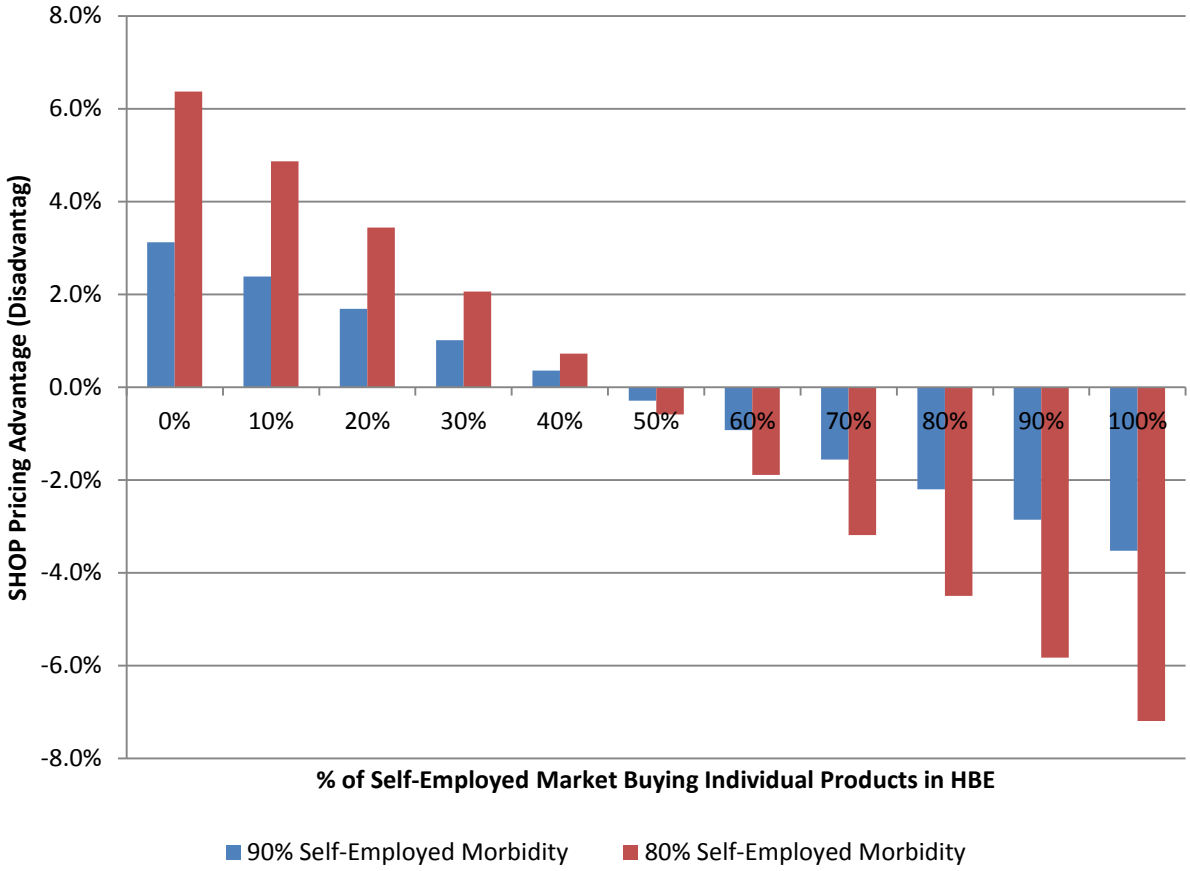
Figure 10.3.1 shows the pricing advantage or disadvantage the SHOP would have based on variations of two assumptions:

- The average morbidity cost of the self-employed population is either 90 percent or 80 percent of the rest of the population. Actuarial experience and the comparison of self-reported sick days in Figure 10.1.4.1 suggest that it is far likelier to be less than or equal to 90 percent, but there is no data available to quantify the difference reliably.
- The percentage of self-employed buying Individual products ranges from 0-100 percent. As noted earlier, it should not be zero because that would mean that no sole proprietors had been eligible for or taken advantage of premium credits for buying QHP in the HBE. It would reach 100 percent only if the rules did not give sole proprietors access to the SHOP Exchange.

If the self-employed morbidity costs is close to 90 percent, SHOP products would be highly unlikely to have even a two percent pricing advantage over HBE because that would mean that over 25 percent of self-employed buyers were ineligible for premium subsidies and/or had found the benefit design and small pricing differences more compelling (Figure 10.3.1). If 50 percent or more bought in the HBE, the SHOP products would never have a pricing advantage. Iowa

should be concerned with SHOP pricing advantages only if it truly believes that average self-employed morbidity costs are at least 20 percent less than for the rest of the population.

Figure 10.3.1. Percent of Self-Employed Buying Individual Products in HBE.



10.4 Concluding Remarks on Treating Sole Proprietors Like Small Employers

The more important choice for Iowa is whether to merge the Individual and Small Group risk pool for pricing purposes. Merged or not, there does not appear to be any compelling ACA-related reason not to include sole proprietor in Iowa's definition of small employer, and therefore allow them to purchase either Individual or Small Group.

11. Assessment of Revision to Definition of Small Employer to be Consistent Within and Outside the HBE

This section addresses the decision regarding how to define small employers in and outside of a state Health Benefits Exchange (HBE). A concern regarding the viability of the Small Business Health Options Program (SHOP) Exchange is whether or not to regulate policy offerings outside the HBE in a similar manner as within the Exchange (e.g., state rating rules). One issue within this context is whether or not to regulate the definition of what constitutes a small employer outside of the Exchanges in the same manner as will be implemented within the Exchange.

11.1 Definitions of Small Employer: Iowa and ACA Differences

The current definition of a small employer in Iowa with respect to Small Group market is at least two and no more than 50 employees. This definition is similar to that allowed by the Affordable Care Act (ACA) for small employer until 2016 of one to 50 employees. In 2016, the HBE will include employers up to 100 employees.

Although very similar, two significant differences between the ACA and Iowa definitions of small employer are clear:

1. ***Sole proprietors as Small Employers.*** The ACA definition (1-50 employees) currently appears to allow sole proprietors to be considered small employers, whereas the Iowa definition (2-50 employees) does not include sole proprietors as small employers. The impact of whether or not sole proprietors should be considered in the Individual or Small Group market is discussed elsewhere. Given estimates of 169,000 sole proprietors in Iowa, this impact of this difference would likely be immediate and significant.
2. ***Size of Small Employer after 2016.*** In 2016, the ACA and Iowa definitions would be considerably different as the HBE would then allow employers up to 100 to enter the SHOP HBE. Legislation would certainly have to be enacted to address this serious differential at that time.

11.2 Small Employer Definition Inside and Outside of the HBE – Sole Proprietors

Before 2016, the main difference between the Iowa and ACA definitions of small employer is with respect to how sole proprietors are defined. In general, sole proprietors tend to be healthier than other Iowans, and there may be considerable competition for this population of Iowans both within and outside of the HBE. The ACA appears to allow states the option of having sole proprietors be considered either as individuals or as small employers given their 1-50 definition of small employer. With 169,000 sole proprietors in Iowa, this decision could have significant impact on the viability of the SHOP HBE.

For this report, we will consider only the scenario in which Iowa opts to allow sole proprietors to enter the Small Group market. If they are required to stay in the Individual market (and there does not appear to be a compelling reason to do so), then the ACA and Iowa definitions of small employer will be effectively identical (until 2016). Consideration of all scenarios for sole proprietors appears in Section 10.

11.2.1 Same Definitions for Small Employer In and Out of HBE – Sole Proprietors Allowed as Small Groups inside and Outside the HBE

In this scenario, sole proprietors could purchase Individual or Small Group policies within and outside of the HBE.

Successful prior state Exchanges have often ensured a level playing field between policies in and out of the Exchange by standardizing definitions and regulations, and this standardization is considered a best practice [36]. A level playing field would allow all policies to compete for the typically healthier sole proprietors, thereby lowering costs inside and outside the HBE.

Another best practice that has been predictive of successful state Exchanges is a well-designed, user-friendly web interface to compare policies [36]. Having the same definitions and regulations inside and outside the HBE would allow for easy, direct comparison of policies inside with those outside the Exchange.

One potential drawback to this standardization is that all policies will offer essentially the same package of benefits, and thereby may provide fewer options for coverage that are unique for a sole proprietor. However, this also represents one of the main benefits of the ACA – policies will have a minimum standard, will be easier to compare against each other, and will have to compete mainly on cost. Thus, this drawback is minor in comparison to the broader benefits of the ACA.

11.2.2 Different Definitions for Small Employer In and Out of HBE – Sole Proprietors Allowed as Small Groups inside, but not Outside, the HBE

In this scenario, sole proprietors could purchase either Individual or Small Group policies within the HBE, but outside of the HBE sole proprietors would only be eligible for individual policies. Thus, in this scenario Iowa has opted to allow sole proprietors the option of purchasing on either market within the Exchange.

The benefits of allowing different definitions within and outside the HBE are based mainly on providing a selection-bias towards the HBE, such as if sole proprietors could be attracted to Small Group policies inside the HBE, then the SHOP HBE would have a larger proportion of healthier sole-proprietors. A larger HBE with more healthy members would make its policies less expensive and have a larger group to spread risk, making the SHOP Exchange more viable. However, the downside of this particular option is that, although benefitting the HBE, this represents adverse selection for policies outside the HBE, and may drive up costs of policies outside the HBE.

The main concern for allowing *any* difference in definitions or regulations within and outside the HBE is adverse selection. In this case, adverse selection is when healthy individuals select policies outside the Exchange, leaving less-healthy, riskier individuals in the HBE and thereby increasing premiums. Although difficult to predict exactly how this may occur under ACA, adverse selection has been a major issue in prior Exchanges, including the failed PacAdvantage of California in which common regulations were applied in and out of the Exchange, but insurers were allowed to charge different rates for the same plans in and out of the Exchange driving employers with healthy employees into the healthier, and thus cheaper market outside the Exchange [(36)]. This issue might be best addressed by merging the Individual and Small Group risk pools, forbidding rate differentials for essentially identical plans, and enforcing those provisions through the IID rate and product filing review process.

Another concern about having different definitions in and out of the HBE is that of ease-of-comparison for consumers. Successful prior Exchanges have had user-friendly, on-line, easy-to-understand interfaces that allowed consumers to easily compare policies in terms of cost and features. [(36)] Allowing different definitions for policies in and out of the Exchange may make selection difficult as the details could be different. For example, a sole proprietor looking at Small Group policies in the Exchange may have difficulty comparing these policies to the individual policies offered outside the Exchange since only Individual policies would be available outside the HBE.

11.3 Small Employer Definition Inside and Outside of the HBE – Employer Size after 2016

In 2016 employers with up to 100 employees will be allowed into the Exchange. This change will be significant as these employers will be able to select between many options including being self-insured. Some states, notably California, are already looking to control the growing trend towards self-funding in the 10 to 49 employee market. If regulations for self-insurance are not held to the same standards as those mandated by the ACA, then a real potential for adverse selection becomes clear. Given the impact of this change, standardizing within and outside the Exchange as well as regulating standards for self-insured businesses seems to be necessary. Thus, the increase of small-employer up to 100 employees in 2016 argues for immediate standardization of definitions and regulations in and out of the HBE in preparation for this significant event.

11.4 Keys to Success of a State Exchange

Several successful and failed prior state Exchanges have provided key elements for consideration of development of a successful Exchange: [38]

- Common regulations and definitions for policies in and out of the Exchange reduce the potential for adverse selection.
- A user-friendly interface to compare policies in and out of the Exchange.
- Brokers need to be compensated equivalently for policies in and out of the Exchange, otherwise they become a mechanism of adverse selection.
- Individuals, employers, and brokers need to be informed about how the Exchange works; otherwise lack of knowledge can work against a successful Exchange. For example, small businesses need to be aware of the tax credits towards policies in the Exchange, and sole proprietors will need to know if they can purchase on the Individual, Small Group, or both markets.

12. ACKNOWLEDGMENTS

David P. Lind of David P. Lind Benchmark and Andrew Williams of Data Point Research, Inc. wish to thank CSG Government Solutions, Inc. for their support and guidance during the analysis and this report. Their coordination efforts between this and the other reports in this series were particularly useful. In addition, we are grateful to have the assistance and expertise of Magnum Actuarial Group for their comments, analysis, and input to this report. We also wish to thank the Urban Institute for their analysis on merging both the Individual and Small Group markets.

Finally, we would like to thank the committed individuals at Iowa's Insurance Division for their guidance, support, and dedication to serving Iowa with the vision and insight needed to protecting consumers by effectively and efficiently providing a fair, flexible and positive regulatory environment

13. GLOSSARY

This section contains a list of selected terms and abbreviations used in the document.

ACA Affordable Care Act	Health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The legislation includes a long list of health-related provisions that began taking effect in 2010 and will continue to be rolled out over the next four years. Key provisions are intended to extend coverage to millions of uninsured Americans, to implement measures that will lower health care costs and improve system efficiency, and to eliminate industry practices that include rescission and denial of coverage due to pre-existing conditions. Generally considered to refer to two separate acts, the PPACA and HCERA.(40)
ACS American Community Survey	The American Community Survey is a large, continuous demographic survey conducted by the U.S. Census Bureau that will eventually provide accurate and up-to-date profiles of America's communities every year. Questionnaires are mailed to a sample of addresses to obtain information about households - that is, about each person and the housing unit itself. The survey produces annual and multi-year estimates of population and housing characteristics and produces data for small areas, including tracts and population subgroups. (24)
Actuarial Equivalent	A health benefit plan that offers similar coverage to a standard benefit plan. Actuarially equivalent plans will not necessarily have the same premiums, cost sharing requirements, or even benefits; however, the expected spending by insurers for the different plans will be the same.(42)
Actuarial Value	A measure of the average value of benefits in a health insurance plan. It is calculated as the percentage of covered expenses a health insurance plan expects to pay for a standard population, using standard assumptions and taking into account cost-sharing provisions. Placing an average value on health plan benefits allows different health plans to be compared. The value only includes expected benefit costs paid by the plan and not premium costs paid by the enrollee. It also represents an average for a population, and would not necessarily reflect the actual cost-sharing experience of an individual.(42)
Attachment Point	In a commercial stop loss program and the ACA transitional reinsurance program, the amount of claims on an individual that the direct writer must pay before the reinsurance program begins providing reimbursements.

Adverse Selection (also known as Anti-Selection or Self-Selection	People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool. (42)
BHP Basic Health Program	The Basic Health Program (BHP) is an optional coverage program under the Patient Protection and Affordable Care Act (ACA) that allows states to use Federal tax subsidy dollars to offer subsidized coverage for individuals with incomes between 139-200% of the Federal Poverty Level (FPL) who would otherwise be eligible to purchase coverage through state Health Insurance Exchanges. States can use the BHP to reduce the cost of health insurance coverage for these low-income consumers, a highly price-sensitive population with high rates of no insurance. Depending on how it is designed, the BHP also can help consumers to maintain continuity among plans and providers as their income fluctuates above and below Medicaid levels. (43)
BLS Bureau of Labor Statistics	The Bureau of Labor Statistics of the U.S. Department of Labor is the principal Federal agency responsible for measuring labor market activity, working conditions, and price changes in the economy. Its mission is to collect, analyze, and disseminate essential economic information to support public and private decision-making. As an independent statistical agency, BLS serves its diverse user communities by providing products and services that are objective, timely, accurate, and relevant. (44)
BRFSS Behavioral Risk Factor Surveillance System	The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors. BRFSS was established in 1984 by the Centers for Disease Control and Prevention (CDC); currently data are collected monthly in all 50 states. More than 350,000 adults are interviewed each year, making the BRFSS the largest telephone health survey in the world. States use BRFSS data to identify emerging health problems, establish and track health objectives, and develop and evaluate public health policies and programs. Many states also use BRFSS data to support health-related legislative efforts. (45)
CBO Congressional	The Congressional Budget Office produces independent, nonpartisan, timely analysis of economic and budgetary issues to support the Congressional budget process. CBO analyses do not make policy recommendations, and

Budget Office	each report and cost estimate discloses our assumptions and methodologies. All CBO employees are appointed solely on the basis of professional competence, without regard to political affiliation. (46)
CDC Centers for Disease Control	The Centers for Disease Control is a Federal Agency that seeks to create the expertise, information, and tools that people and communities need to protect their health – through health promotion, prevention of disease, injury and disability, and preparedness for new health threats by monitoring health, detecting and investigate health problems, conducting research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, and promote healthy behaviors.(47)
CHIP Children's Health Insurance Program	Enacted in 1997, CHIP is a Federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The Federal government matches state spending for CHIP but Federal CHIP funds are capped.(42)
Coinsurance Rate	In a major medical plan, the percentage of covered charges in excess of the deductible the plan will pay. In the transitional reinsurance program, the percentage of an individual's claims in excess of the attachment point the program will reimburse.
Consumer-Directed Health Plan	A health plan that encourages consumer awareness about health care costs and provides incentives for consumers to consider costs when making health care decisions. Usually these plans carry high deductibles along with a savings account for health care services. The two types of savings accounts are Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs).(42)
CO-OP Consumer Operated and Oriented Plan	The Affordable Care Act calls for the establishment of the Consumer Operated and Oriented Plan (CO-OP) Program, which will foster the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the Individual and Small Group markets. (48)
Copayment	A fixed dollar amount paid by an individual at the time of receiving a covered health care service from a participating provider. The required fee varies by the service provided and by the health plan.(42)

Cost Sharing Assistance	Subsidies to limit out-of-pocket spending by individuals meeting defined income requirements, 100% to 400% of FPL.
CPS Current Population Survey	The Current Population Survey (CPS), sponsored jointly by the U.S. Census Bureau and the U.S. Bureau of Labor Statistics (BLS), is the primary source of labor force statistics for the population of the United States. The CPS is the source of numerous high-profile economic statistics, including the national unemployment rate, and provides data on a wide range of issues relating to employment and earnings. The CPS also collects extensive demographic data that complement and enhance our understanding of labor market conditions in the nation overall, among many different population groups, in the states and in substrate areas. [24]
Deductible	A feature of health plans in which consumers are responsible for health care costs up to a specified dollar amount. After the deductible has been paid, the health insurance plan begins to pay for health care services. (42)
Employer Health Care Tax Credit	An incentive mechanism designed to encourage employers, usually small employers, to offer health insurance to their employees. The tax credit enables employers to deduct an amount, usually a percentage of the contribution they make toward their employees' premiums, from the Federal taxes they owe. These tax credits are typically refundable so they are available to non-profit organizations that do not pay Federal taxes.(42)
Employer Mandate	An approach that would require all employers, or at least all employers meeting size or revenue thresholds, to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of their employees.(42)
ERISA Employee Retirement Income Security Act	Federal Legislation enacted in 1974 to protect workers from the loss of benefits provided through the workplace. ERISA does not require employers to establish any type of employee benefit plan, but contains requirements applicable to the administration of the plan when a plan is established. The requirements of ERISA apply to most private employee benefit plans established or maintained by an employer, an employee organization, or both.(42)
Essential Benefits Package	A package of benefits set by HHS that insurers will be required to offer under the Exchanges.

FPL Federal Poverty Level	The Federal government's working definition of poverty that is used as the reference point to determine the number of people with income below poverty and the income standard for eligibility for public programs. The Federal government uses two different definitions of poverty. The U.S. Census poverty threshold is used as the basis for official poverty population statistics, such as the percentage of people living in poverty. The poverty guidelines, released by the U.S. Department of Health and Human Services (HHS), are used to determine eligibility for public programs and subsidies. For 2008, the Census weighted average poverty threshold for a family of four was $22,025 and HHS poverty guideline was $21,200.(42)
Grandfathered Health Plan	As used in connection with the Affordable Care Act: A group health plan that was created — or an individual health insurance policy that was purchased — on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered.(49)
Group Insurance	Health insurance that is offered to a group of people, such as employees of a company.
Guaranteed Issue	Guaranteed issue is a requirement that a health plan must allow qualified individuals to enroll in health coverage regardless of health, age, gender, or other factors that might predict use of health services (such as a pre-existing health condition).
HBE Health Care Benefits Exchange	A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Exchanges will offer a choice of health plans that meet certain benefits and cost standards. Starting in 2014, Members of Congress will be getting their health care insurance through Exchanges and eligible people will be able buy your insurance through Exchanges too.(49)
HCERA Health Care and Education Reconciliation Act	The Health Care and Education Reconciliation Act of 2010 (HCERA) was enacted in March 2010 and along with the Patient Protection and Affordable Care (PPACA) enacted earlier in the same month are together referred to as the Affordable Care Act (ACA).

HHS U.S. Department of Health and Human Services	The Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS represents almost a quarter of all Federal outlays, and it administers more grant dollars than all other Federal agencies combined. HHS' Medicare program is the nation's largest health insurer, handling more than 1 billion claims per year. Medicare and Medicaid together provide health care insurance for one in four Americans. (50)
High Deductible Health Plan	Health insurance plans that have higher deductibles (the amount of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services), but lower premiums than traditional plans. Qualified high-deductible plans that may be combined with a health savings account must have a deductible of at least $1,200 for single coverage and $2,400 for family coverage in 2011.(42)
HIPSM Health Insurance Policy Simulation Model	The Health Insurance Policy Simulation Model (HIPSM) is a detailed microsimulation model of the health care system. It estimates the cost and coverage effects of proposed health care policy options and is designed for quick-turn around analysis of policy proposals — from novel health insurance offerings and strategies for increasing affordability to state-specific-proposals. (28)
HMO Health Maintenance Organization	A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require enrollees to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness. (49)
HRA Health Reimbursement Account	A tax-exempt account that can be used to pay for current or future qualified health expenses. HRAs are established benefit plans funded solely by employer contributions, with no limits on the amount an employer can contribute. HRAs are often paired with a high-deductible health plan, but are not required to do so.(42)
HSA Health Savings Account	A tax-exempt savings account that can be used to pay for current or future qualified medical expenses. Employers may make HSAs available to their employees or individuals can obtain HSAs from most financial institutions. In order to open an HSA, an individual must have health coverage under an HSA-qualified high deductible health plan. These HSA-qualified high-deductible health plans must have deductibles of at least $1,200 for an

	individual and $2,400 for a family in 2011. (42)
IDPH Iowa Department of Public Health	The Iowa Department of Public Health (IDPH) is a unit of State government that partners with local public health, policymakers, health care providers, business and many others to fulfill a mission of promoting and protecting the health of Iowans.(51)
Issuer	Under the Affordable Care Act, a qualified health insurance issuer is an organization that is organized as a non-profit, member corporation under state law and where substantially all the activities consist of the issuance of qualified health plans in the individual and small group markets in each state in which it is licensed to issue such plans, and was not in existence on July 16, 2009 or not sponsored by any governmental unit; satisfies certain governance requirements; uses profits to reduce premiums, increase benefits or improve health care delivery; follows state laws in the industry; and does not begin business in a state until that state has market reforms in place.(52)
IEBS Iowa Employer Benefits Study	The **Iowa Employer Benefits Study**© is a comprehensive statistical review of Iowa employee benefits that is a key resource for employers and policy makers in Iowa. Survey results provide Iowa employers with reliable, relevant, and customized information.(36)
Individual Insurance Market	The market where individuals who do not have employer-based group coverage purchase private health insurance.
IWD Iowa Workforce Development	Iowa Workforce Development is an agency of the State of Iowa that contributes to the economic security of Iowa's workers, businesses and communities through a comprehensive statewide system of employment services, education and regulation of health, safety and employment laws.(34)
JCT Joint Committee on Taxation	The Joint Committee on Taxation is a nonpartisan committee of the United States Congress, originally established under the Revenue Act of 1926. The Joint Committee operates with an experienced professional staff of economists, attorneys, and accountants, who assist members of the majority and minority parties in both houses of Congress on tax legislation.(55)
Loss Ratio	The ratio of incurred claims to earned premiums.

Medicaid	Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a Federal entitlement program that provides health and long-term care coverage to certain categories of low-income Americans. States design their own Medicaid programs within broad Federal guidelines. Medicaid plays a key role in the U.S. health care system, filling large gaps in the health insurance system.(42)
Medicare	Enacted in 1965 under Title XVII of the Social Security Act, Medicare is a Federal entitlement program that provides health insurance coverage to 45 million people, including people age 65 and older, and younger people with permanent disabilities, end-stage renal disease, and Lou Gehrig's disease.(42)
Minimum Essential Coverage (MEC)	Under ACA, the required level of coverage for individuals and families to be able to avoid individual mandate penalties. HHS has not yet defined MEC other than it must be a state-approved major medical plan.
MLR Medical Loss Ratio	A term defined in ACA closely related to, but usually not the same as the loss ratio. Used to calculate MLR rebates.
MLR Rebates	Refunds of excess premiums made to insureds if a carrier's MLR for a given line of business in a state is less than that state's MLR threshold.
Morbidity	The incidence or prevalence of a disease or of all diseases in a population.
NAIC	The National Association of Insurance Commissioners.
Out-of-Pocket	A yearly cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium cost.(42)
Part D Medicare	A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan (Part D) or a Medicare Advantage Plan (MAP) that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.(49)
PPACA Patient Protection and	The Patient Protection and Affordable Care Act (PPACA) was enacted in March 2010, and along with the Health Care and Education Reconciliation Act (HCERA) enacted earlier in the same month are together referred to as

Affordable Care Act	the Affordable Care Act (ACA).
PPO Preferred Provider Organization	A type of health plan that contracts with healthcare providers, such as hospitals and doctors, to create a network of participating providers. Consumers pay less out-of-pocket if they use providers that belong to the plan's network. Consumers can use doctors, hospitals, and providers outside of the network for an additional cost.(49)
Premium Tax Credits	Premium subsidies available to individuals meeting certain income requirements, 138% to 400% of FPL, that buy QHP through the HBE.
QCEW Quarterly Census of Employment and Wages	The Quarterly Census of Employment and Wages (QCEW) program of the U.S. Bureau of Labor Statistics (BLS) publishes a quarterly count of employment and wages reported by employers covering 98 percent of U.S. jobs, available at the county, MSA, state and national levels by industry.(56)
QHP Qualified Health Plans	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.(49)
Reinsurance	**General Definition** A risk transfer mechanism whereby one entity takes responsibility for a defined portion of the insurance risk from another entity. **ACA Definition** A temporary risk management program whereby an entity makes per member assessments on all health plans, including self-funded, to reimburse insurers for a defined portion of an individual's claims in excess of a defined threshold in a given calendar year. A form of what is referred to a specific stop loss in the commercial market.
Reinsurance Cap	The annual limit on the reimbursements for an individual's claims under the transitional reinsurance program.
Risk Adjustment	**General Definition** Any one of a class of processes insurers use to predict claims or medical

	services for an individual or a population. Typically takes the form of a baseline cost multiplied by a calculated factor. **ACA Definition** A permanent program under which a middleman entity receives funds from plans that have lower risk populations and uses them to compensate plans with higher risk populations. Required to be self-funding. Details not defined by HHS as of 4/27/2012.
Risk Corridor	An ACA temporary risk management program designed to reimburse QHP carriers for a defined portion of losses in excess of a defined threshold and to confiscate a defined portion of profits in excess of a defined threshold. Not necessarily self-funding.
SAHIE Small Area Health Insurance Estimates	The U.S. Census Bureau's Small Area Health Insurance Estimates (SAHIE) program produces estimates of health insurance coverage for states and all counties. In July 2005, SAHIE released the first nation-wide set of county-level estimates on the number of people without health insurance coverage for all ages and those less than 19 years old. .In October 2011, SAHIE released 2008 and 2009 estimates of health insurance coverage by age, sex, race, Hispanic origin, and income categories at the state-level and by age, sex, and income categories at the county-level.(57)
SBTC Small Business Tax Credit	Tax credits available to businesses with less than 25 employees, an average annual wage of $50,000, and employer contributions of 50 percent, that purchase through the SHOP.
SHADAC State Health Access Data Assistance Center	The University of Minnesota's State Health Access Data Assistance Center (SHADAC) is funded by The Robert Wood Johnson Foundation to help states monitor rates of health insurance coverage, understand factors associated with access to care, and to utilize data for implementation of health reform.(58)
Self-Insured Plan	A plan where the employer assumes direct financial responsibility for the costs of enrollees' medical claims. Employers typically contract with a third-party administrator or insurer to provide administrative services for the plan.
SHOP Small Business Health Option	State health insurance Exchanges that will be open to small businesses up to 100 employees.(42)

Program	
Small Group Market	Firms with 2-50 employees can purchase health insurance for their employees through this market, which is regulated by states.

14. Works Cited

1. **U.S. Department of Health and Human Services.** Rate Review. *healthcare.gov.* [Online] http://www.healthcare.gov/law/features/costs/rate-review/.

2. **NovaRest Actuarial Consulting.** *NovaRest Report for the Iowa Insurance Division: In Support of the Annual Report to the Iowa Governor and Iowa Legislature.* 2011.

3. **Kaiser Family Foundation.** *How Competitive are State Health Insurance Markets?* 2011.

4. **National Association of Insurance Commisioners.** *Supplemental Health Care Exhibit.* 2010.

5. **Kaiser Family Foundation.** Individual Insurance Market Competition, 2010. *statehealthfacts.org.* [Online] 2010. http://www.statehealthfacts.org/comparemapreport.jsp?rep=101&cat=7.

6. **Baker and Daniels.** *Market Conduct Examination of Wellmark Inc. and Wellmark Health Plan of Iowa, Inc.* 2011.

7. **U.S. Department of Health and Human Services.** New Loan Program Helps Create Customer-Driven Non-profit Health Insurers. *healthcare.gov.* [Online] 2012. http://www.healthcare.gov/news/factsheets/2012/02/coops02212012a.html.

8. **Kaiser Family Foundation.** Iowa: Protections in Individual Insurance Markets . *statehealthfacts.org.* [Online] 2011. http://www.statehealthfacts.org/profileind.jsp?cat=7&sub=87&rgn=17&cmprgn=1.

9. —. Iowa: High Risk Pools. *statehealthfacts.org.* [Online] 2011. http://www.statehealthfacts.org/profileind.jsp?cat=7&sub=89&rgn=17&cmprgn=1.

10. —. Iowa: Pre-Existing Condition Insurance Plans . *statehealthfacts.org.* [Online] 2011. http://www.statehealthfacts.org/profileind.jsp?cat=7&sub=187&rgn=17&cmprgn=1.

11. —. Iowa: Protections in Small Group Markets. *statehealthfacts.org.* [Online] 2011. http://www.statehealthfacts.org/profileind.jsp?cat=7&sub=86&rgn=17&cmprgn=1.

12. **U.S. Department of Health and Human Services.** Fighting Unreasonable Health Insurance Premium Increases. *HealthCare.gov.* [Online] 2011. http://www.healthcare.gov/news/factsheets/2011/05/ratereview05192011a.html.

13. **Kaiser Family Foundation.** Medical Loss Ratio Adjustments, 2011. *statehealthfacts.org.* [Online] 2011. http://www.statehealthfacts.org/comparetable.jsp?ind=940&cat=17.

14. **Skow, Bob.** Independent Insurance Agents of Iowa, Inc. March 26, 2012. Email communication.

15. **Kaiser Family Foundation.** Iowa: Individual and Small Group Markets. *statehealthfacts.org.* [Online] 2011. http://www.statehealthfacts.org/profileind.jsp?cat=17&sub=176&rgn=17.

16. **Fernald, Francie and Brown, Jill.** *A Guide to Health Insurance Reform.* s.l. : Atlantic Information Services, Inc, 2012.

17. **Wellmark, Inc.** Compare all Iowa Health Plans. *Wellmark.* [Online] http://www.wellmark.com/Plans/Individual/IowaSimplyBlue/IASimplyBlueComparePlans.aspx.

18. **Kaiser Family Foundation.** Health Reform Subsidy Calculator. *Health Reform Source.* [Online] 2012. http://healthreform.kff.org/SubsidyCalculator.aspx.

19. —. State Health Exchange Profiles. *Health Reform Source.* [Online] 2012. http://healthreform.kff.org/State-Exchange-Profiles-Page.aspx.

20. —. What the Actuarial Values in the Affordable Care Act Mean. *Kaiser Family Foundation.* [Online] 2011. http://www.kff.org/healthreform/8177.cfm.

21. **Milliman, Inc.** *Assist with the First Year of Planning for Design and Implementation of a Federally Mandated American Health Benefit Exchange.* 2011.

22. **U.S.Department of Health and Human Services.** Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment. s.l. : U.S Governement Printing Office, March 23, 2012. Vol. 77, 57. 45 CFR Part 153.

23. **Magnum Actuarial Group.** Internal Information and Actuarial Simulations. 2012.

24. **U.S. Census Bureau.** Current Population Survey (CPS). *U.S. Census Bureau web site.* [Online] http://www.census.gov/cps/.

25. **Center for Consumer Information and Insurance Oversight.** *Risk Adjustment Implementation Issues.* 2011.

26. **Risk Adjustment Network.** Risk adjustment and risk selection in five European countries. *Risk Adjustment Network.* [Online] http://www.riskadjustment.net/index.php?p=1.

27. **U.S. Department of Health and Human Services.** Patient Protection and Affordable Care Act; Establishment of Exchanges. 59 *45 CFR Parts 155, 156, and 157.* March 27, 2012. Vol. 77.

28. **Urban Institute.** The Urban Institute's Health Microsimulation Capabilities. *The Urban Institute web site.* [Online] http://www.urban.org/publications/412154.html.

29. *How Choices in the Exchange Design for States Could Affect Insurance Premiums and Levels of Coverage.* **Blavin, F., Buettgens, M. and and Roth, J.** 2, February 2012, Health Affairs, Vol. 31, pp. 290-298.

30. **Dorn, Stan, Buettgens, Matthew and and Carrol, Caitlin.** *Using the Basic Health Program to MakeCoverage More Affordable to Low-Income Households: A Promsing Approach for Many States.* The Urban Institute. 2011.

31. **Buettgens, Matthew and Carrol, Caitlin.** *The ACA Basic Health Program in Washington State.* The Urban Institute. Forthcoming.

32. **Kaiser Family Foundation.** Iowa: Health Insurance and Managed Care. *statehealthfacts.org.* [Online] http://www.statehealthfacts.org/profileind.jsp?cat=7&rgn=17.

33. **Small Group Health Insurance Market Working Group.** *Report to the Minnesota Health Care Access Commission.* 2010.

34. **Iowa Workforce Developement.** Quarterly Census of Employment and Wages. *iowaworkforve.org.* [Online] http://www.iowaworkforce.org/lmi/empstat/aboutqcew.html.

35. **Iowa Department of Revenue, Tax Research and Policy Analysis Section.** Determination of Sole Proprietors Using Tax Filing Status. 2008-2009 Tax Data. Personal Communication.

36. **David P. Lind Benchmark.** *2011 Iowa Employer Benefits Study.* 2012.

37. **Collins, Sara, et al., et al.** *How Health Care Reform can Lower the Costs of Insurance Administration.* s.l. : The CommonWealth Fund, 2009.

38. **Gardiner, Terry and Perera, Isabel.** *SHOPping Around: Setting up State Health Care Exchanges for Small Business: A Roadmap.* American Progress and Small Business Majority. 2011.

39. **University of Iowa Healthier Workforce Center for Excellence (HWCE).** *Iowans Speak Out on Their Health - The Rural-Urban Divide.* Real Iowans Research Initiative. 2011.

40. **healthinsurance.org, LLC.** Health Insurance Glossary. *healthinsurance.org.* [Online] http://www.healthinsurance.org/glossary/.

41. **U.S. Census Bureau.** American Fact Finder Glossary. *American Fact Finder web site.* [Online] http://factfinder2.census.gov/help/en/american_factfinder_help.htm#glossary/glossary.htm.

42. **Kaiser Family Foundation.** Glossary of Key Health Reform Terms. *Health Reform Source web site.* [Online] http://www.kff.org/healthreform/upload/7909.pdf.

43. **Bachrach, Deborah, et al., et al.** The Role of the Basic Health Program in the Coverage Continuum: Opportunities, Risks, and COnsiderations for States. *Health Reform Source.* [Online] March 2012. http://www.kff.org/healthreform/upload/8283.pdf.

44. **U.S. Department of Labor Bureau of Labor Statistics.** About BLS. *Bureau of Labor Statistics web site.* [Online] http://www.bls.gov/bls/infohome.htm.

45. **Centers for Disease Control and Prevention.** About the BRFSS. *Behavioral Risk Factor Surveillance System web site.* [Online] http://www.cdc.gov/brfss/about.htm.

46. **Congressional Budget Office.** Overview. *Congressional Budget Office web site.* [Online] http://www.cbo.gov/about/overview.

47. **Centers for Disease Control and Prevention.** About CDC: Vision, Mission, Core Values and Pledge. *Centers for Disease Control and Prevention web site.* [Online] http://www.cdc.gov/about/organization/mission.htm.

48. **The Center for Consumer Information and Insurance Oversight.** Consumer Operated and Oriented Plan Program. *Centers for Medicare & Medicaid Services web site.* [Online] http://cciio.cms.gov/programs/coop/index.html.

49. **U.S. Department of Health and Human Services.** Glossary. *Healthcare.gov.* [Online] http://www.healthcare.gov/glossary/index.html.

50. —. about HHS. *U.S. Department of Health and Human Services web site.* [Online] http://www.hhs.gov/about/.

51. **Iowa Department of Public Health.** What We Do - Promote and Protect the Health of Iowans. *Iowa Department of Public Health web site.* [Online] http://www.idph.state.ia.us/WhatWeDo/.

52. **Internal Revenue Service.** Notice 2011-23: Request for Comments Regarding Application of § 501(c)(29) of the Internal. *Internal Revenue Service web site.* [Online] http://www.irs.gov/pub/irs-drop/n-11-23.pdf.

53. **David P. Lind Benchmark.** About Us. *David P. Lind Benchmark web site.* [Online] http://www.dplindbenchmark.com/about-us/.

54. **Iowa Workforce Development.** About Iowa Workforce Development. *Iowa Workforce Development web site.* [Online] http://www.iowaworkforce.org/policy/files/about.htm.

55. **Joint Committee on Taxation.** About Us. *Joint Committee on Taxation web site.* [Online] http://www.jct.gov/about-us/overview.html.

56. **U.S. Department of Labor, Bureau of Labor Statistics.** Quarterly Census of Employment and Wages. *Bureau of Labor Statistics web site.* [Online] http://www.bls.gov/cew/.

57. **U.S. Census Bureau.** Small Area Health Insurance Estimates. *U.S. Census Bureau web site.* [Online] http://www.census.gov/did/www/sahie/index.html.

58. **State Health Access Data Assistance Center.** About SHADAC. *State Health Access Data Assistance Center web site.* [Online] http://www.shadac.org/content/about-shadac.