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**State of Montana**

**Health Insurance Market Study**

**Final Report**

**December 2012**

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### Executive Summary

Leif Associates was engaged by the State of Montana Auditor's office Commissioner of Securities and Insurance ("CSI") to perform an actuarial analysis of the current Montana insurance market for individual, small group, and large group major medical health insurance coverage and the potential impacts of new federal rating requirements such as minimum loss ratios and adjusted community rating on insurance rates. Our analysis does not address self-insured or excepted benefit coverage. In addition, the analysis considers the impact of risk adjustment, risk corridors and reinsurance mechanisms on the transition to adjusted community rating. The study also provides suggestions for efficient ways to use these or other mechanisms to ease the impact on rates during the transition.

### Key Findings

The 2011 population of Montana was estimated by the US Census Bureau as 998,199 persons. Of those, 15.2% were age 65 and older. The remaining 846,500 Montana residents are the subject of this study. To secure information for the study, we conducted a survey of the largest carriers in each market.

### Individual Market

- We surveyed ten insurers plus two high-risk pools, in total providing individual coverage to about 54,000 individuals (30,000 policies). These insurers and high-risk pools represent 99.5% of the individual health insurance market as a percent of covered lives reported to the Montana CSI on the 2011 NAIC Supplemental Health Care Exhibit. Nearly 80% of the individuals are insured by the two largest insurers, Blue Cross Blue Shield and Time Insurance Company. About 94% of the lives are insured in the commercial market, with the remaining 6% covered by the state and federal high-risk pools.
- There are several components of federal reform that will affect the individual market in Montana:
  - Age rating for adults will be limited to a ratio of 3:1 by age, meaning that the highest rate cannot be more than three times the lowest rate (note, this type of notation, "3:1", is used throughout this document to refer to ratios and can be read "3 to 1"). Age ratios in Montana individual plans currently range nearly as high as 6:1 for older ages. Only 8% of the contracts were above 3:1, and for these, the average ratio was only approximately 3.6:1. Reducing the age ratio for those 8% will necessitate increased rates for younger persons.
  - Health status will no longer be allowed as a rating factor. Currently, all Montana individual health insurers use health status factors to develop a range of rates, from as low as 0.85 to a high of 3.00. Collapsing this range of rates to an overall average will result in individuals getting significant rate decreases and some increases, ranging from -63% to +15%.
  - Most of the Montana individual carriers currently use exclusionary riders, which exclude certain conditions or treatments from coverage. These riders will not be allowed in 2014. Approximately 8% of Montana's individual policies have these riders. Costs and premiums will rise by an unknown amount when they are removed.
  - Out-of-pocket costs for enrollees will be limited in 2014 to an indexed \$6,050 for individuals (\$12,100 for families). Currently approximately 22% of Montana's individual policies have out-of-pocket maximums above that level. Reducing the out-of-pocket maximums will have an upward impact on claims and premiums.
- Perhaps the most significant impact of reform is the potential migration of current high-risk pool members into the individual market.



- While only 6% of the individual market members are in the high-risk pools, their claims represent about 25% of the total market claims.
- Bringing them into the commercial individual market will increase claims by approximately 26% on a per member per month basis.
- In order to maintain the current loss ratio in the individual market, this increase in claims equates to roughly the same increase in the current average market premium.
- However, due to the influx of some portion of the currently uninsured, there is the potential that this impact will be substantially mitigated. The uninsured are estimated to number roughly three times the current individual insured market, and a large portion of these persons are expected to enter the individual market, increasing the size of the individual market substantially. However, little is known of the health status of these persons, so no estimate of the impact to claims level of the resultant market can be made.
- Their costs have previously been spread across the entire health insurance market up to a maximum of 1% of premium and supported in addition by grant funding, for a total of \$17 million in 2011.
- For years 2014, 2015 and 2016 the loss of the assessments will be offset by payments under the health care reform temporary reinsurance program which will be \$10, \$6, and \$4 billion per year nationally, respectively. HHS estimates that in 2014 reinsurance payments will result in premium decreases in the individual market of between 10 and 15 percent relative to expected premiums without reinsurance.
- Although the federal reinsurance program funding runs for only the years 2014-2016, if the funds are not fully utilized nationally, they can be carried forward.
- One final issue to note is that the state pool does not require US citizenship, but the exchanges will, so there is the possibility there are persons currently covered under the state pool who will lose coverage and be unable to replace it.
- In addition, it is anticipated that risk adjustment mechanisms (discussed in greater detail later in this report) will lessen the need for margins providing protection against the possibility of poor experience in rate setting and allow insurers to price toward an “average” risk.

### Small Group Market

- The small group market is comprised of traditional small group coverage and association group coverage. We surveyed seven insurers providing small group and association group coverage to about 55,000 individuals. These insurers represent 99.7% of the small employer and association health insurance market as a percent of covered lives reported to the Montana CSI on the 2011 NAIC Supplemental Health Care Exhibit. About 64% of the covered lives in this market are insured by Blue Cross Blue Shield, with the remaining 36% spread amongst the rest of the carriers.
- There are several components of federal reform that will affect the small group market in Montana:
  - Health status will no longer be allowed as a rating factor. Currently, all Montana small group health insurers use health status factors at the group level (employees cannot be individually rated) to develop rates within a normalized range of 0.75 to 1.25. Collapsing this range of rates to an overall average will result in groups getting significant rate decreases and increases, ranging from -32% to +48%. Approximately 30% of the market will see increases, 40% will see decreases, and 30% will remain roughly unchanged.



- Industry will no longer be allowed as a rating factor. Currently, most Montana small group health insurers use industry factors to develop rates within a range from 0.85 to 1.15. Collapsing this range of rates to an overall average will result in groups getting rate increases and decreases.
- Group size will no longer be allowed as a rating factor. Currently, most Montana small group health insurers use group size factors to develop rates. The highest reported size factors are 85% higher than the lowest factors. However, it is not possible to determine the percentage of the market at this factor as the two carriers reporting this factor did not report their group counts by group size. Small group regulation requires that this differential be 35% or less for employers with 2-50 eligible employees. For those carriers reporting count by group size, less than 1% of the groups are currently at factors that exceed the legal limit. The average differential for these groups is estimated to be roughly 38%, requiring a rate reduction of approximately 2%. The CSI is currently working with the carriers whose factors apparently violate this limit. Collapsing this range of rates to an overall average will result in groups getting rate increases and decreases.
- Out-of-pocket costs for enrollees will be limited in 2014 to an indexed \$6,050 for individuals (\$12,100 for families). Currently approximately 10% of Montana's small group and 2% of association policies have out-of-pocket maximums above that level. Reducing the out-of-pocket maximums will have some upward impact on premiums for that 12%.

### Large Group Market

- The large group market is comprised of large group coverage and the Federal Employees Health Benefit Plan, which covers approximately 34% of the lives in large group policies. We surveyed three insurers providing large group coverage to about 96,000 individuals. These insurers represent 99.3% of the large employer health insurance market as a percent of covered lives reported to the Montana CSI on the 2011 NAIC Supplemental Health Care Exhibit. About 71% of the covered lives in this market are insured by Blue Cross Blue Shield.
- The rate factor limitations, essential health benefits requirements, actuarial value metal levels and out of pocket limitations of the Affordable Care Act ("ACA") do not apply to large group policies. Many of the benefit requirements of the ACA do apply to large group policies, but will have only minimal impact since most policies are already in compliance.

### Reinsurance, Risk Adjustment, and Risk Corridors

- Reinsurance, risk adjustment, and risk corridors are risk-leveling mechanisms established in the ACA to help mitigate the initial and ongoing financial impact of guaranteed issue and the influx of previously uninsured persons and those in high-risk pools into the Exchange and the commercial market.
- Reinsurance will benefit the individual market only and will be funded through assessments on all health insurers and third-party administrators (self-funded plans) during 2014 through 2016. The total funds available nationally under this program will be \$10, \$6, and \$4 billion for the years 2014, 2015, and 2016 respectively. Montana has the option to operate a reinsurance program on its own after 2016.
- HHS estimates that in 2014 reinsurance payments will result in premium decreases in the individual market of between 10 and 15 percent relative to expected premiums without reinsurance.
- Risk adjustment and risk corridors will help maintain a healthy market place by mitigating insurance carrier losses from adverse selection by shifting funds between the carriers. However, the impact will not be immediate as the payments will come later in 2015. Nonetheless, the



programs should lessen the need for margins providing protection against the possibility of poor experience when carriers set rates for 2014 and encourage the setting of rates for “average” risk.

- The risk corridors program is temporary, effective only for three years beginning 2014. Risk adjustment is a permanent program.
- Risk adjustment charges and payments must be completed and issuers invoiced by no later than June 30 of the year following the risk adjustment year. Amounts owed will be payable in 30 days.
- Issuers are required to submit all risk corridor information to HHS by July 31 of the year following the benefit year.
- It is uncertain whether the market will be fully stabilized within the three years of operation of the two temporary programs. However as noted above, the reinsurance program can be extended by the state and the risk adjustment program is permanent.



## The Montana Individual Market

### **Market Composition and Demographics**

Of the 846,500 Montana residents below the age of 65, approximately 54,000 (6.4%) were insured in the individual market in 2011. The 2011 Montana individual insurance market consisted of ten insurance carriers (referred to as the commercial market), plus two high-risk pools that insure individuals who are rejected due to health reasons by the insurance carriers or who lost their employer group coverage and are “HIPAA eligible” for the state high-risk pool. The commercial market insures 94% of the lives, with the high-risk pools providing coverage for the remaining 6%.

We surveyed ten insurers plus two high-risk pools, in total providing individual coverage to about 54,000 individuals. These insurers and high-risk pools represent 99.5% of the individual health insurance market as a percent of covered lives reported to the Montana CSI on the 2011 NAIC Supplemental Health Care Exhibit. The following table shows the number of covered lives and the market share for each of the ten individual carriers and the two high-risk pools. The table is sorted in decreasing order of market share. It can be seen that nearly 80% of the market is insured by the two largest insurers, Blue Cross Blue Shield of Montana and Time Insurance Company.

**Table 1: 2011 Individual Market Share**

<b>Insurer</b>	<b>12/31/11 Subscribers</b>	<b>12/31/11 Covered Lives</b>	<b>Market Share</b>
<b>BCBS</b>	18,939	30,501	57%
<b>Time</b>	5,593	10,833	20%
<b>State High-Risk Pool (MCHA)</b>	2,855	2,855	5%
<b>World</b>	1,018	2,020	4%
<b>John Alden</b>	1,004	1,804	3%
<b>New West</b>	731	1,386	3%
<b>Pacific Source</b>	847	1,293	2%
<b>Mega</b>	647	1,116	2%
<b>National</b>	434	952	2%
<b>Companion</b>	332	630	1%
<b>Federal High-Risk Pool (MACP)</b>	281	281	1%
<b>Midwest</b>	40	68	0%
<b>Total</b>	<b>32,721</b>	<b>53,739</b>	<b>100%</b>

Although the insurers had policies in force at the end of 2011, not all are selling new business. Recent changes in the individual insurance market include the following:

- Pacific Source has assumed New West’s individual business. New West’s policies are being renewed as Pacific Source policies on their anniversary dates throughout the year.
- World closed their health insurance products for new sales effective 10/20/2011. Renewals ceased during 2012 and policyholders had a limited opportunity to renew with Celtic Insurance Company.
- Mega and Midwest closed their health insurance products for new sales in 2010.



## The Montana Individual Market

As noted above, there were 32,721 subscribers and 53,739 lives covered in individual policies in 2011. Thus the average contract size was 1.64. The distribution of subscribers by contract type is shown below.

**Table 2: Individual Market Distribution by Contract Type**

Contract Type	Subscriber Count	% of Subscribers
Individual Only	23,171	71%
Two Adults Only	3,297	10%
One Adult plus Child(ren)	2,660	8%
Two Adults plus Child(ren)	3,593	11%
<b>Total</b>	<b>32,721</b>	<b>100%</b>

The demographics of the insured lives are quite different between the individual commercial insurance market and the high-risk pools. Individuals covered by the commercial market have an average age of about 36, with about 34% of the lives over the age of 50. The high-risk pools have an average age of about 50, with approximately 65% of the covered lives over the age of 50. There are very few children and young adults in the high-risk pools. The age distribution of insured lives in the commercial insured market, the high-risk pools, and combined is shown in the following table.

**Table 3: Individual Market Distribution by Age**

Age Range	Insurance Market Age Distribution	High-Risk Pool Age Distribution	Combined Age Distribution
0-18	24%	3%	23%
19-25	9%	4%	9%
26-29	5%	4%	5%
30-34	7%	5%	7%
35-39	7%	5%	6%
40-44	7%	6%	7%
45-49	8%	8%	8%
50-54	10%	14%	11%
55-59	12%	21%	12%
60-64	11%	30%	12%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Avg Age</b>	<b>36.1</b>	<b>50.1</b>	<b>36.9</b>

We also studied the geographic distribution of persons covered in the individual insurance market. For this analysis, we defined the individual geographic location by county and assigned each county to one of five geographic regions. The counties and count of lives for each region are shown in the table below.



**Table 4: Individual Market Distribution by Geographic Region**

Region	Counties	Count of Lives	% of Lives
Northwest	Flathead, Lake, Lincoln, Mineral, Missoula, Ravalli, Sanders	16,613	31%
Southwest	Beaverhead, Broadwater, Deer Lodge, Gallatin, Granite, Jefferson, Lewis and Clark, Madison, Meagher, Powell, Silver Bow	14,260	27%
North Central	Blaine, Cascade, Chouteau, Glacier, Hill, Liberty, Phillips, Pondera, Toole, Teton	6,152	11%
South Central	Big Horn, Carbon, Fergus, Golden Valley, Judith Basin, Musselshell, Park, Petroleum, Stillwater, Sweet Grass, Wheatland, Yellowstone	11,100	21%
Eastern	Carter, Custer, Daniels, Dawson, Prairie, Fallon, Garfield, McCone, Powder River, Richland, Roosevelt, Rosebud, Sheridan, Treasure, Valley, Wibaux	5,614	10%
<b>Total</b>		<b>53,739</b>	<b>100%</b>

## Market Pricing

Individual insurance carriers in Montana use a variety of rating factors in establishing rates for an individual policy. The following table shows the type and frequency of use of these specific factors. The insurance carriers have been de-identified and scrambled alphabetically to protect proprietary rating strategies. The most prevalent rating factors are age, health status, and tobacco use. Gender is not allowed as a rating factor in Montana.

**Table 5: Individual Market Rating Factors**

Carrier	Age	Health Status	Tobacco Use	Household Discount	Geographic Area	Duration *
A	X	X	X	X	X	
B	X	X	X	X	X	
C	X	X				
D	X	X	X			
E	X	X				
F	X	X	X			
G	X	X	X			X
H	X	X		X		
I	X	X	X			
J	X	X	X	X		
<b>Total Count</b>	<b>10</b>	<b>10</b>	<b>7</b>	<b>4</b>	<b>2</b>	<b>1</b>

\* Use of durational adjustments in individual coverage has been determined to be non-compliant with Montana law. The CSI is working with the carrier to resolve.

## Age Slopes

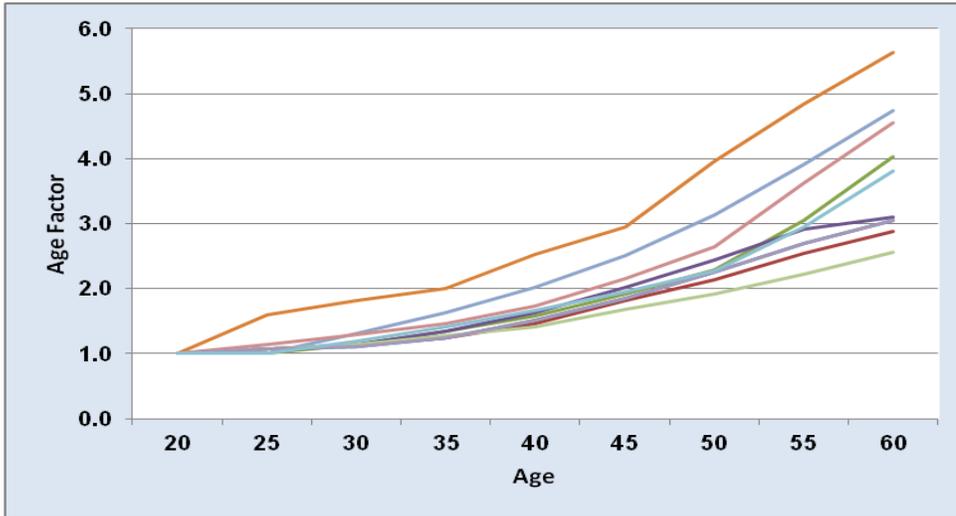
As noted above, all carriers in the individual market use age as a rating factor. The extent to which rates vary by age differs among the carriers to some extent. We examined each carrier's age factors, normalized them so that age 20 was set to 1.00 for all companies, and analyzed the age slopes. The graph below plots the age slopes for each of the carriers. It shows that the range of rate factors reaches nearly as high as 6:1 (although, as discussed below, only 5% of the market used age factors above 3:1).



## The Montana Individual Market

That means that the premium rates charged for a person in their 60's may be nearly six times the rate for a person aged 20. In 2014, the rate differential can be no more than 3.00. Currently eight of the ten carriers have factors that exceed a 3:1 ratio. Approximately 2,500 contracts (or 5% of the market) are currently at rates using factors above 3:1.

**Table 6: Individual Market Age Slope**



The following table shows the ratio of the highest to lowest age factor for each of the ten individual insurance carriers for ages 20 through 60.

**Table 7: Individual Market Age Ratios**

Carrier	Age Ratio: High to Low
A	2.9
B	4.0
C	3.1
D	3.1
E	5.6
F	4.7
G	4.6
H	2.6
I	3.1
J	3.8

As mentioned above, approximately 2,500 contracts (about 5% of the market) are currently at rates using factors above 3:1.



## Health Status

All of the carriers use health status to determine whether coverage will be denied. They also use health status to determine the health status rating factor that will be applied for the individual. Some of the carriers also use health status to determine if exclusionary riders will be added to the policy. The table below shows the prevalence of these three uses of health status.

**Table 8: Individual Market Uses of Health Status**

	A	B	C	D	E	F	G	H	I	J
<b>Rating Factors</b>	X	X	X	X	X	X	X	X	X	X
<b>Exclusionary Riders</b>	X	X		X		X	X	X	X	X
<b>Denial of Coverage</b>	X	X	X	X	X	X	X	X	X	X

The health status rating factors in use by carriers have a broad range (0.85 to 3.00), but generally average close to 1.00. The range of health status factors reported by the carriers are shown in the table below, along with their average factor weighted by enrollment and the range of potential rate changes to move all policies to the average. The values presented in the Rate Change Low column approximate the average rate decreases that will be experienced by those currently rated up for health status, and those in the Rate Change High column are the increases for those currently rated down for health status.

**Table 9: Individual Market Health Status Factors**

Carrier	Low Factor	High Factor	Weighted Average Factor	Rate Change Low	Rate Change High
A	0.85	1.80	0.98	-46%	+15%
B	0.90	1.50	1.04	-31%	+15%
C	1.00	1.40	1.08	-23%	+8%
D	0.85	1.00	0.95	-5%	+12%
E	0.90	2.00	1.00	-50%	+11%
F	0.90	1.20	1.00	-16%	+11%
G	0.90	2.00	1.01	-50%	+12%
H	1.00	3.00	1.13	-63%	+13%
I	0.85	1.00	0.95	-5%	+12%
J	1.00	1.00	1.00	0%	0%
<b>Total Range</b>	<b>0.85</b>	<b>3.00</b>		<b>-63%</b>	<b>+15%</b>



## Exclusionary Riders

Eight of the ten Montana individual carriers use exclusionary riders. Exclusionary riders are used to exclude certain health conditions or treatments from coverage under an individual policy. Exclusionary riders will not be allowed in 2014.

**Table 10: Individual Market Exclusionary Riders**

Carrier	% of Members with an Exclusionary Rider
A	11%
B	9%
D	7%
F	18%
G	15%
H	7%
I	6%
J	12%
<b>Total</b>	<b>8%</b>

## Tobacco Use

As noted above, seven of the ten individual carriers reflect tobacco use as a rating factor in individual products. Tobacco rate loadings will be allowed in 2014 up to a maximum factor of 1.50. The factors currently in use in the Montana individual market by the seven carriers are shown in the following table. Five of the seven carriers use tobacco factors that vary by age. Under the ACA, the proposed regulations would allow tobacco factors to vary by age. Three of the seven carriers are using tobacco factors that exceed the permissible 2014 rate load of 1.50. However, there are only 229 lives affected by tobacco rate loads above 1.50.

**Table 11: Individual Market Tobacco Use Factors**

Carrier ID	Low Factor	High Factor	Varies By Age
A	1.21	1.73	Yes
B	1.30	1.30	No
D	1.18	1.76	Yes
F	1.30	1.40	Yes
G	1.30	1.45	Yes
I	1.18	1.76	Yes
J	1.17	1.17	No
<b>Range</b>	<b>1.17</b>	<b>1.76</b>	



## Household Discount

Four of the carriers in the study use a household discount factor. In theory, a household discount is used to reflect the administrative efficiencies resulting from a two-person policy as compared to a one-person policy. Household discounts are a form of family rating. The only form of family rating that will be allowed in 2014 and later under the proposed federal regulation is to limit the number of children charged separately in the family rate to three.

**Table 12: Individual Market Household Discounts**

Carrier ID	How Household Discount Factor is Used	Factor
A	Both adults on the policy have a discount applied	0.90
B	Both adults on the policy have a discount applied	0.95
H	Discount applies only to rate of the second adult	0.95
J	Both adults on the policy have a discount applied	0.95

## Geographic Area

Geographic location factors are not commonly used by the individual carriers in Montana. Of the ten carriers, only two are using geographic factors. For the two carriers that use geographic factors, one uses a very narrow range while the other uses a very broad range. There was no consistency between the geographic area rating between the two carriers, neither in the areas considered nor in the relativities of the factors assigned to those areas. For this reason, we did not study geographic factors further as part of this analysis.

## Durational Rating

Durational rating will no longer be allowed in 2014 under federal law, and it has been determined by the CSI to be prohibited under current Montana law. Durational rating is rarely used in Montana. Only one carrier reported using duration as a rating factor, however it was determined by the CSI that three additional carriers were in the process of implementing the use of durational rating. The CSI is working with these carriers to resolve this.

## Other Underwriting Criteria

The individual insurance carriers also use additional characteristics to determine whether to accept or reject an applicant for individual insurance coverage. The following criteria are used by some or all of the carriers:

- Height/weight
- Tobacco usage
- Medical history
- Claims experience
- Occupation
- Hobbies/sports
- Health screening
- Predictive modeling
- Criminal history



## Market Financial Characteristics

### Market Size and Loss Ratios

Aggregate financial information for calendar year 2011 for the Montana commercial individual insurance market and the high-risk pools is shown in the following table. This table presents only a summary of the actual financial information for the current participants in the individual market and makes no adjustments for mitigating impacts.

**Table 13: Individual Market Aggregate 2011 Financial Information**

	Commercial Market	High-Risk Pools	Combined
<b>Total Earned Premium</b>	<b>\$127,763,000</b>	<b>\$17,857,000</b>	<b>\$145,620,000</b>
<b>Total Claims Incurred</b>	<b>\$102,663,000</b>	<b>\$35,123,000</b>	<b>\$137,786,000</b>
<b>Medical Loss Ratio *</b>	<b>80.4%</b>	<b>196.7%</b>	<b>94.6%</b>
<b>Total Member Months</b>	<b>611,577</b>	<b>38,126</b>	<b>649,703</b>

\* The claims, and therefore loss ratios, for the members of the high-risk pools are currently offset by assessments and grants and will be offset in the individual market by reinsurance for years 2014 through 2016. The loss ratios presented above do not reflect these offsets.

The following table shows the 2011 medical loss ratio for each individual insurance carrier, along with their premium and claims on a per member per month basis. Rebates are required by the ACA subject to specific guidelines regarding the definition of claims and the credibility of the block of business. The table below also indicates for each carrier whether rebates were paid for 2011. A total of \$1,685,000 in rebates was paid back to policyholders for 2011.

**Table 14: Individual Market Medical Loss Ratios**

Carrier	Premium PMPM	Incurred Claims PMPM	Medical Loss Ratio	Rebates Paid For 2011 (Y/N)
<b>A</b>	\$187	\$160	86%	N
<b>B</b>	\$240	\$141	59%	Y
<b>C</b>	\$248	\$228	92%	N
<b>D</b>	\$209	\$126	60%	Y
<b>E</b>	\$175	\$137	78%	N
<b>F</b>	\$240	\$183	76%	Y
<b>G</b>	\$298	\$291	98%	N
<b>H</b>	\$203	\$183	90%	N
<b>I</b>	\$226	\$139	61%	Y
<b>J</b>	\$154	\$35	23%	N
<b>Average</b>	<b>\$209</b>	<b>\$168</b>	<b>80%</b>	



As is illustrated by the entry for Carrier J in the above table, the ACA rebate requirements alone cannot guarantee achievement of the MLR targets. Augmenting these requirements with a Montana rating law could help alleviate this situation. Federal rate review standards include an analysis of target loss ratios within the legal limits. Rates for some of these insurers should be decreased by increasing their targeted loss ratio to meet the minimum MLR in the federal law. Through the risk adjustment and risk corridors programs, insurers with better experience will supplement the losses of insurers with worse experience.

### Market Product Characteristics

#### Product Type

There are no HMO products offered in the Montana individual market. The largest component of individual product types is HSA-eligible High Deductible Health Plans, which comprise about 57% of the covered lives. Another 40% of the lives are in PPO plans, with the remaining 3% in indemnity plans.

Individual plans that were sold prior to March 23, 2010 can have grandfathered status, meaning that they do not have to comply with some of the benefit requirements of the ACA. However, substantive changes to these plans after that date will result in loss of grandfathered status. Plans sold after that date must comply. The following table shows the distribution of Montana individual plans with regard to grandfathered and open or closed status.

**Table 15: Individual Market Grandfathered Status**

	% of Market
<b>Open Active Plans</b>	<b>84%</b>
<b>Closed Plans – Grandfathered</b>	<b>15%</b>
<b>Closed Plans – Non-Grandfathered</b>	<b>1%</b>

Plan designs include the cost-sharing features of deductibles, coinsurance, and maximum-out-of-pocket. Only one carrier uses office visit copays. The market average cost sharing amounts for a single policyholder are shown in the following table. There is little variation in these features between the carriers.

**Table 16: Individual Market Cost-Sharing Features**

	Market Average
<b>In-Network Deductible</b>	<b>\$4,111</b>
<b>Coinsurance Percent</b>	<b>15%</b>
<b>Maximum Out of Pocket</b>	<b>\$5,644</b>

Plans with a variety of deductibles are available in the market. The following table shows the distribution of lives within the various deductible choices. Although the ACA does not directly limit deductibles, it does indirectly through the metal plan levels and also through cost-sharing restrictions. Clearly, deductibles which exceed the cost-sharing limits discussed immediately below would not be allowed. This would affect 8% of the policies currently in force.



**Table 17: Individual Market Distribution by Deductible**

Deductible	% Distribution
\$0	0%
\$1 to \$500	0%
\$501 to \$1,000	4%
\$1,001 to \$3,000	42%
\$3,001 to \$6,000	46%
Over \$6,000	8%

Individual plans in the Montana market allow members to choose fairly high out-of-pocket maximums. The table below shows the current prevalence within the range of choices. It should be noted that in 2014, cost-sharing will not be allowed to exceed an indexed amount of \$6,050 (2012 dollars). Thus as many as 22% of currently in force policies are potentially affected by that limitation.

**Table 18: Individual Market Distribution by Out-of-Pocket Maximum**

Out-of-Pocket Maximum	% Distribution
\$0	0%
\$1 to \$1,000	1%
\$1,001 to \$2,000	0%
\$2,001 to \$6,000	77%
\$6,001 to \$12,000	16%
Over \$12,000	4%
No OOP Max/Unlimited	2%

In general, current individual plans in Montana offer most benefit categories, including prescription drug, maternity, mental health, and preventive benefits. There are a few policies (about 7% of total) that cover generic drugs only, which will likely not comply with essential benefit requirements in 2014. About 15% of the policies do not cover preventive benefits, but those are most likely the grandfathered plans noted above.

### **Impact of New Federal Requirements**

There are a number of new federal requirements that will affect the individual Montana insurance market in 2014. The ACA in 42 USC 300gg states the following:

- (1) IN GENERAL - With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market –**
  - (A) such rate shall vary with respect to the particular plan or coverage involved only by –**
    - (i) whether such plan or coverage covers an individual or family;**
    - (ii) rating area, as established in accordance with paragraph (2);**
    - (iii) age, except that such rate shall not vary by more than 3 to 1 for adults; and**
    - (iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1; and**
  - (B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not describe in subparagraph (A).**
- (2) RATING AREA. -**



***(A) IN GENERAL. – Each state shall establish 1 or more rating areas within that state for purposes of applying the requirements of this title.***

Below is an estimate of the potential impact of these requirements as well as other ACA requirements related to plan design and minimum loss ratios.

- **Impact of limiting to 3:1 age ratio**

Eight of the ten commercial insurers are using age slopes that exceed the 3:1 ratio that will be allowed in 2014. However, only about 2,500 policies (about 8% of the market) are above the 3:1 level. For those policies, the average age factor is about 3.6, necessitating a 17% average rate reduction to get to the maximum allowable 3.0 age ratio. The affected insurers have about 10,200 total policies in force, or 31% of the total policies in the market. To make up for this loss of revenue, the other 7,700 policies in these insurers would require a 5.6% rate increase.

- **Impact of eliminating health status factors**

All Montana individual carriers use health status factors in setting rates for individual policies. The health status rating factors in use by carriers have a broad range (0.85 to 3.00), but generally average close to 1.00. The range of health status factors reported by the carriers is shown in Table 9 above. While the elimination of health status factors should result in revenue neutrality for the market as a whole, there will be some extreme rate changes required to bring some policies to the average.

Approximately 53% of the policies have rates below the carrier average and will require rate increases of up to 15%. Based on the distribution of policies by factor, it appears that the average increase (for those receiving increases) would be about 11%.

Approximately 47% of the policies have rates above the carrier average and will require rate reductions of up to 63%. Based on the distribution of policies by factor, it appears that the average decrease (for those receiving decreases) would be about 8%.

For many reasons these average impacts do not equal, but the main reason is the inherent nature of the mathematics involved in the calculation of the percentage decrease needed applied to a larger number, and the percentage increase applied to a smaller number in order to equate both to the average of the two. In other words, if all else were equal, the needed increase for those at a lower rate would exceed the decrease for those at the higher rate in order maintain mathematical equivalence.

- **Impact of eliminating exclusionary riders**

Eight of the ten Montana individual carriers use exclusionary riders. Exclusionary riders are used to exclude certain health conditions or treatments from coverage under an individual policy. Exclusionary riders will not be allowed in 2014. On average across the entire market, about 8% of individual policies have an exclusionary rider. The removal of these riders will result in increased claims and therefore increased premium rates, but we do not have sufficient information about the nature of the exclusionary riders to allow us to estimate the overall impact.

- **Impact of limiting to 150% tobacco load**

Seven of the ten individual carriers reflect tobacco use as a rating factor in individual products. Three of the seven carriers are using tobacco factors that exceed the permissible 2014 rate load of 1.50. However, only 229 lives are rated at a factor above 1.50. Reducing those rates to the 1.50 rate level would have an insignificant impact on market rates.



- **Impact of minimum loss ratio requirement**

For 2011, four individual carriers paid member rebates totaling \$1,685,051, based on having loss ratios that did not meet the minimum loss ratio requirement. This represents a reduction in premium across the whole individual commercial market of approximately 1.3%. Due to the credibility adjustment in the rebate calculation, the rebates paid do not necessarily result in each carrier having loss ratios of 80%. For years in which the carrier has less than 1000 covered lives, no rebate is paid regardless of the loss ratio. The credibility formula transitions over the first three years, and the mechanics after that point are not yet firmly established, so the impact in future years may differ from that observed in 2011.

- **Impact of plan design requirements**

Approximately 22% of individual policies currently in force have out-of-pocket maximums that exceed \$6,000, which is approximately the out-of-pocket limit that will be imposed in 2014. Lowering the out-of-pocket limit will result in some premium increases. We do not have sufficiently detailed information about current out-of-pocket maximums to allow us to make an estimate of increased cost for this change. We do not expect other benefit requirements to have a significant impact on the cost of individual plans.

- **Impact of merging the high-risk pool with the individual market**

Approximately 6% of the lives insured in the individual market are currently insured by the state and federal high risk pools. These are individuals who have been denied coverage through the individual insurance market because of health reasons, or have been eligible for individual coverage through HIPAA. The high-risk pool members have significantly higher claim costs than the rest of the individual market, which can be seen in the following table. Although the high-risk members represent only 6% of the individual market, they have about 25% of the market's claims.

Merging the high-risk pools into the individual market would increase individual market claims from \$168 PMPM to \$212 PMPM, an increase of 26%. As an offset, health insurers would no longer be required to pay the high-risk pool assessment, which has been previously spread across all health insurance carriers in all markets, up to 1% of premium. Grant money was previously available (through 2013) for funding the pools. The total outside funding for the pools for 2011 was \$17 million. Funds from the temporary reinsurance program under the ACA, which are designed to offset these higher claims, will be \$10 billion in 2014 nationally for the entire program. The portion available for Montana will depend on actual claim experience. However, HHS estimates that in 2014 reinsurance payments will result in premium decreases in the individual market of between 10 and 15 percent relative to expected premiums without reinsurance.

**Table 19: Impact of Merging High-Risk Pool into the Individual Market**

2011	Commercial Market	State High-Risk Pool	Federal High-Risk Pool	Combined Market
<b>Incurred Claims</b>	<b>\$102,663,000</b>	<b>\$27,690,000</b>	<b>\$7,433,000</b>	<b>\$137,786,000</b>
<b>Member Months</b>	<b>611,577</b>	<b>35,315</b>	<b>2,811</b>	<b>649,703</b>
<b>Claims PMPM</b>	<b>\$168</b>	<b>\$784</b>	<b>\$2,644</b>	<b>\$212</b>



- **Impact of new populations entering the individual market**

The scope of this study did not include an analysis of the impact of currently uninsured Montana residents entering the individual market. However, the uninsured are estimated to number roughly three times the current individual insured market, and a large portion of these persons are expected to enter the individual market, increasing the size of the individual market substantially. Increasing the size of the risk pool, will allow additional risk spreading and may lower rates. However, little is known of the health status of these persons, so an exact estimate of the impact to claims level of the resultant market cannot be made.



## The Montana Small Group Market

### *Market Composition and Demographics*

The Montana small group market is defined as employer groups with 50 or fewer employees and has two components: (1) traditional small groups; and, (2) association groups. Association groups are made up of employers who have joined together for business purposes and purchase insurance as a collective. Most of the employers in association groups are small employers, so for purposes of this study we have included them with traditional small groups. There are more covered lives in Montana association group coverage than in traditional small group coverage. In 2014, the small employers who currently participate in association groups will be eligible to participate in the state's Exchange, thus it is important to recognize their potential impact on the future small group market and the federal rate and benefit laws that will affect them. In general, under the ACA, laws applicable to traditional small group would also apply to association coverage issued to small employers.

We surveyed seven insurers providing small group and association group coverage to about 55,000 individuals. These insurers represent 99.7% of the small employer and association health insurance market as a percent of covered lives reported to the Montana CSI on the 2011 NAIC Supplemental Health Care Exhibit. The following table shows the number of groups, subscribers, covered lives, and market share for six small group carriers. The table is sorted in decreasing order of market share. The three largest carriers (Blue Cross Blue Shield, Allegiance, and John Alden) cover over 80% of the traditional small group market.

**Table 20: Traditional Small Group Market Share**

Insurer	12/31/11 Groups	12/31/11 Subscribers	12/31/11 Covered Lives	Market Share
<b>BCBS</b>	1,212	6,134	10,880	47%
<b>Allegiance</b>	249	2,844	4,818	20%
<b>John Alden</b>	502	2,472	3,746	16%
<b>New West</b>	326	1,585	2,501	11%
<b>Trustmark</b>	46	421	635	3%
<b>Time</b>	98	399	615	3%
<b>Total</b>	<b>2,433</b>	<b>13,855</b>	<b>23,195</b>	<b>100%</b>

The next table shows the number of associations, groups, subscribers, covered lives, and market share for four association group carriers, again sorted in decreasing order of market share. Blue Cross Blue Shield insures nearly 80% of the association group market.

**Table 21: Association Group Market Share**

Insurer	12/31/11 Associations	12/31/11 Groups	12/31/11 Subscribers	12/31/11 Covered Lives	Market Share
<b>BCBS</b>	8	2,766	13,396	24,305	78%
<b>New West</b>	3	428	2,148	3,815	12%
<b>Western</b>	2	216	1,320	2,279	7%
<b>Allegiance</b>	2	51	490	954	3%
<b>Total</b>	<b>15</b>	<b>3,461</b>	<b>17,354</b>	<b>31,353</b>	<b>100%</b>



## The Montana Small Group Market

The average small group size is 5.7 subscribers for traditional small groups and 5.0 subscribers for association group. The distribution of subscribers by contract type for traditional and association groups is similar, as is shown below.

**Table 22: Small Group and Association Distribution by Contract Type**

Contract Type	Traditional Small Group		Association Group	
	Subscriber Count	% of Subscribers	Subscriber Count	% of Subscribers
Employee Only	9,640	70%	11,504	67%
Employee + Spouse	1,387	10%	1,902	11%
Employee + Child(ren)	1,277	9%	1,807	10%
Employee + Family	1,551	11%	2,141	12%
<b>Total</b>	<b>13,855</b>	<b>100%</b>	<b>17,354</b>	<b>100%</b>

The demographics of the insured lives are nearly identical between the small group and association group markets, as can be seen in the table below.

**Table 23: Small Group and Association Market Distribution by Age**

Age Range	Small Group Market Age Distribution	Association Market Age Distribution	Combined Age Distribution
0-18	21%	23%	22%
19-25	10%	10%	10%
26-29	7%	6%	6%
30-34	8%	9%	9%
35-39	8%	8%	8%
40-44	8%	8%	8%
45-49	9%	9%	9%
50-54	11%	10%	10%
55-59	10%	10%	10%
60-64	7%	6%	7%
65+	1%	1%	1%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Avg Age</b>	<b>34.9</b>	<b>34.2</b>	<b>34.5</b>

Using the same geographic definitions as used for the individual market, the distributions of small group and association by region is shown in the table below. There is very little difference in the geographic locations of small group and association group lives. The geographic distribution is also similar to that seen in the individual market.



## The Montana Small Group Market

**Table 24: Small Group and Association Distribution by Geographic Region**

Region	Counties	Traditional Small Group		Association Group	
		Count of Lives	% of Lives	Count of Lives	% of Lives
<b>Northwest</b>	Flathead, Lake, Lincoln, Mineral, Missoula, Ravalli, Sanders	6,133	26%	8,062	26%
<b>Southwest</b>	Beaverhead, Broadwater, Deer Lodge, Gallatin, Granite, Jefferson, Lewis and Clark, Madison, Meagher, Powell, Silver Bow	7,211	32%	10,567	34%
<b>North Central</b>	Blaine, Cascade, Chouteau, Glacier, Hill, Liberty, Phillips, Pondera, Toole, Teton	3,009	13%	3,172	10%
<b>South Central</b>	Big Horn, Carbon, Fergus, Golden Valley, Judith Basin, Musselshell, Park, Petroleum, Stillwater, Sweet Grass, Wheatland, Yellowstone	4,957	21%	7,049	22%
<b>Eastern</b>	Carter, Custer, Daniels, Dawson, Prairie, Fallon, Garfield, McCone, Powder River, Richland, Roosevelt, Rosebud, Sheridan, Treasure, Valley, Wibaux	1,885	8%	2,503	8%
<b>Total</b>		<b>23,195</b>	<b>100%</b>	<b>31,353</b>	<b>100%</b>

The distribution by group size is somewhat different in association groups, with a higher percentage of groups having five or fewer employees.

**Table 25: Small Group and Association Group Size Distribution**

Group Size	Small Group Distribution	Association Distribution
<b>1-5</b>	67%	78%
<b>6-9</b>	16%	11%
<b>10-19</b>	13%	7%
<b>20-29</b>	3%	2%
<b>30-50</b>	1%	1%
<b>51+</b>		1%
<b>Total</b>	100%	100%
<b>Avg Size</b>	<b>5.7</b>	<b>5.0</b>

### **Market Pricing**

Traditional small group insurance carriers in Montana are constrained by law in the rating factors that can be used in setting rates for small employers. The following table shows the type and frequency of use of these specific factors. The insurance carriers have been de-identified and scrambled alphabetically to protect proprietary rating strategies. All carriers use age, geography, group size and health status in setting small group rates. Most also use industry, and some use a spousal rate variance. Gender is not allowed as a rating factor in Montana.



## The Montana Small Group Market

**Table 26: Small Group Rating Factors**

Carrier	Age	Geography	Group Size	Health Status	Industry	Spousal Variance
K	X	X	X	X	X	
L	X	X	X	X	X	X
M	X	X	X	X	X	X
N	X	X	X	X	X	X
O	X	X	X	X	X	X
P	X	X	X	X		
<b>Total Count</b>	<b>6</b>	<b>6</b>	<b>6</b>	<b>6</b>	<b>5</b>	<b>4</b>

Association group insurance carriers in Montana, although not required by law like traditional, use similar factors, as shown below.

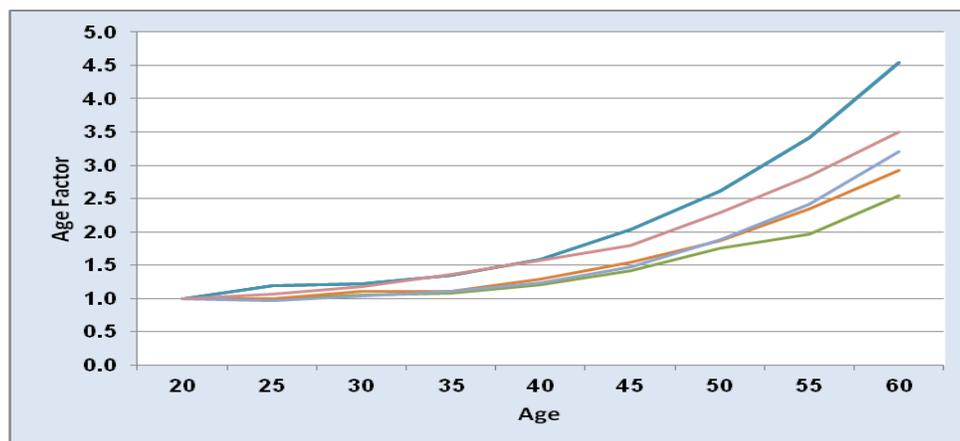
**Table 27: Association Group Rating Factors**

Carrier	Geography	Health Status	Age	Industry	Group Size
Q	X	X	X	X	X
R	X	X	X	X	
S	X	X			
T	X	X	X		
<b>Total Count</b>	<b>4</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>

### Small Group and Association Age Slopes

The small group and association group age factors do not vary as much as the individual plan factors. We examined each carrier's age factors (if provided), normalized them so that age 20 was set to 1.00 for all companies, and analyzed the age slopes for ages 20 through 60. The graph below plots the age slopes of the small group and association carriers. It shows that the range of rate factors reaches as high as 4.5:1, in contrast to the individual plan range of 6:1. Thus the impact of the 3:1 requirement in 2014 on this market is much less than on the individual market.

**Table 28: Small Group and Association Market Age Slopes**





### Small Group and Association Geographic Area Factors

The small group and association group markets use geographic location as a rating factor. Some carriers use county as the defining criteria while others use zip code. The table below shows the range of area factors used across the state by the two market types. We have normalized the factors so that the weighted average for each carrier is equal to one. Not all carriers reported on this factor, so only a subset of the carriers is shown. It can be seen from the table that the range by geographic region has the highest rate between 15% and 33% higher than the lowest rate and there is no significant difference between the small group and association group markets in the overall impact of this rating criteria. However, what cannot be seen in the table is the fact that there is essentially no consistency in the assignment of the rating areas and the relative level of rating impact within those areas between carriers. Under the proposed HHS regulation, Montana may establish from one to seven mandatory geographic rating areas, eliminating one of these sources of inconsistency.

**Table 29: Small Group and Association Geographic Rating Factors**

Market	Carrier	Low Factor	High Factor	Ratio of High to Low Factor	Geo Definition	Number of Distinct Factors
Small Group	K	0.907	1.201	1.325	County	4
	N	0.873	1.151	1.318	3-Digit Zip	9
	O	0.942	1.191	1.264	5-Digit Zip	10
	P	0.913	1.080	1.183	5-Digit Zip	8
Association	Q	0.923	1.166	1.264	5-Digit Zip	10
	R	0.890	1.179	1.325	County	4
	S	0.816	1.020	1.250	3-Digit Zip	2
	T	0.931	1.067	1.146	5-Digit Zip	10

### Small Group and Association Industry Factors

Industry is an allowable case characteristic for small group plans under Montana insurance law, but the factor for any industry may not vary from the average of the factors for all industries by more than 15%. In other words, the variation due to industry is a range of 0.85 to 1.15, so the ratio of the highest factor to the lowest is roughly 135%. Almost all of the carriers in the small group and association markets use industry as a rating factor. The range, ratio, and weighted average factors are shown below.

**Table 30: Small Group and Association Industry Factors**

Market	Carrier	Low Factor	High Factor	Ratio of High to Low Factor	Weighted Average Factor
Small Group	K	0.900	1.210	1.344	1.036
	N	0.961	1.150	1.197	1.035
	O	0.900	1.150	1.278	1.021
Association	Q	0.900	1.150	1.278	0.995
	R	0.900	1.210	1.344	1.017



## The Montana Small Group Market

The industries generally receiving the highest factors are listed:

- Oil and Gas Drilling
- General Contractors
- Motor Vehicle Dealers
- Physicians, Hospitals, and Other Health Services
- Legal Services
- Social Services
- Taxi Services
- Bars
- Entertainment Industry

### Small Group and Association Health Status Factors

In Montana for traditional small group, adjustments in rates for claims experience, health status, and duration of coverage may not be charged to individual employees or dependents, but must be applied uniformly to all members of the group. For groups with similar case characteristics and plan designs, rates may not vary from the index rate by more than 25%. The total variation allowed is therefore 67% (range is from 75% to 125% of index rate,  $1.25 \div .75 = 1.67$ ).

While association groups are not subject to the rate factor limitations, it appears that there is little difference in rating practices from traditional small group. In the table below, each carrier is listed with the range of the factors being used along with an estimate of the weighted average of the factors and the range of rate change that would likely result from the elimination of the use of health status factors. The values presented in the Rate Change Low column approximate the maximum rate decreases that will be experienced by those currently rated up the maximum possible for health status, and those in the Rate Change High column are the maximum increases for those currently rated at the minimum for health status.

Note, in order to facilitate the display of this information, the factor ranges have all been normalized to reflect a minimum factor of 0.75.

**Table 31: Small Group and Association Health Status Factors**

Market	Carrier	Low Factor	High Factor	Estimated Wtd Avg Factor	Rate Change Low *	Rate Change High *
Small Group	K	0.75	1.25	1.110	-11.2%	+48.0%
	N	0.75	1.25	0.930	-25.6%	+24.1%
	O	0.75	1.25	0.954	-23.7%	+27.2%
	P	0.75	1.25	1.051	-15.9%	+40.1%
Association	Q	≤ 0.75	≥ 1.25	0.846	-32.3%	+12.8%
	R	≤ 0.75	≥ 1.25	0.955	-23.6%	+27.4%
	S	≤ 0.75	≥ 1.25	0.973	-22.2%	+29.7%
	T	≤ 0.75	≥ 1.25	1.049	-16.1%	+39.8%

\* These values represent the endpoints of the potential ranges of rate changes. Actual results are expected to fall within these ranges.

### Small Group and Association Group Size Factors

Group size factors are also used by many carriers in the small group and association group markets. The factors are largest for the smallest groups, as can be seen in the following table. For purposes of this table, the carrier factors have been normalized so that the group size 50 factor is 1.00 for all carriers.



## The Montana Small Group Market

Current Montana small group regulation requires that this differential be 35% or less for employers with 2-50 eligible employees. The CSI is working with carriers operating outside of the legal range to ensure compliance. Group size will no longer be allowed as a rating factor beginning 2014.

**Table 32: Small Group and Association Group Size Factors**

Group Size	Factor Range
1-2	1.28 – 1.85
3-5	0.98 – 1.35
6-9	0.96 – 1.28
10-25	0.96 – 1.23
26-50	1.00 – 1.06

### Market Financial Characteristics

#### Market Size and Loss Ratios

Aggregate financial information for calendar year 2011 for the Montana small group and association health insurance market is shown in the following table.

**Table 33: Small Group and Association Aggregate 2011 Financial Information**

	Total
Total Earned Premium	\$212,224,000
Total Claims Incurred	\$161,579,000
Total Admin and Profit	\$50,645,000
Medical Loss Ratio	76.1%
Total Member Months	620,768

The following table shows the 2011 medical loss ratio for each small group and association group insurance carrier, along with their premium and claims on a per member per month basis. Small group and association business has been combined for carriers selling both. Rebates are required by the ACA subject to specific guidelines regarding the definition of claims and the credibility of the block of business. The table below also indicates for each carrier whether rebates were paid for 2011. A total of \$882,000 in rebates was paid back to policyholders for 2011.

**Table 34: Small Group and Association Market Medical Loss Ratios**

Carrier	Premium PMPM	Incurred Claims PMPM	Medical Loss Ratio	Rebates Paid For 2011 (Y/N)
K	\$323	\$193	60%	Y
L	\$333	\$238	72%	Y
M	\$342	\$194	57%	N
N	\$386	\$274	71%	N
O	\$360	\$277	77%	N
P	\$341	\$267	78%	N
S	\$344	\$258	75%	Y
<b>Average</b>	<b>\$342</b>	<b>\$260</b>	<b>76%</b>	



## The Montana Small Group Market

As is illustrated by the entry for Carrier M in the above table, the ACA rebate requirements alone cannot guarantee achievement of the MLR targets. Augmenting these requirements with a Montana rating law could help alleviate this situation.

### Market Product Characteristics

#### Product Type

The largest component of small group product types is PPO plans, which comprise about 77% of the covered lives. The next largest segment is HSA-eligible High Deductible Health Plans, with about 16% of the covered lives. The remaining 7% are in HMO or indemnity plans.

Small group plans that were sold prior to March 23, 2010 can have grandfathered status, meaning that they do not have to comply with some of the benefit requirements of the ACA. Plans sold after that date must comply. The following table shows the distribution of Montana small group and association plans with regard to grandfathered and open or closed status.

**Table 35: Small Group and Association Grandfathered Plans**

	% of Market
Open Active Plans	93%
Closed Plans – Grandfathered	7%

Plan designs include the cost-sharing features of deductibles, office visit copays, coinsurance, and maximum-out-of-pocket. The market average cost sharing amounts for a single policyholder are shown in the following table. These plan designs are more generous for association groups than for traditional groups.

**Table 36: Small Group and Association Average Market Cost-Sharing Features**

	Small Group Market	Association Market
In-Network Deductible	\$2,763	\$1,742
Office Visit Copay	\$27	\$2
Coinsurance Percent	24%	26%
Maximum Out of Pocket	\$4,790	\$3,033

Plans with a variety of deductibles are available in the market. The following table shows the distribution of lives within the various deductible choices.

**Table 37: Small Group and Association Market Distribution by Deductible**

Deductible	Small Group	Association
\$0	0%	0%
\$1 to \$500	25%	22%
\$501 to \$1,000	22%	31%
\$1,001 to \$3,000	38%	35%
\$3,001 to \$6,000	14%	12%
Over \$6,000	1%	0%



## The Montana Small Group Market

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The majority of small group and association plans have out-of-pocket maximums that fall between \$2,000 and \$6,000. Again, it should be noted that in 2014, cost-sharing will not be allowed to exceed an indexed amount of \$6,050 (2012 dollars). Thus as many as 10% of small group and 2% of association group members currently in force policies are potentially affected by that limitation as shown in Table 38.



**Table 38: Small Group and Association Market Distribution by Out-of-Pocket Maximum**

Out-of-Pocket Maximum	Small Group	Association
\$0	0%	0%
\$1 to \$1,000	2%	1%
\$1,001 to \$2,000	21%	20%
\$2,001 to \$6,000	67%	77%
\$6,001 to \$12,000	8%	2%
Over \$12,000	2%	0%
No OOP Max/Unlimited	0%	0%

In general, current small group and association plans in Montana cover all benefit categories, including prescription drug, maternity, mental health, and preventive benefits. These policies will likely not require much revision to comply with essential benefits in 2014.

### ***Impact of New Federal Requirements***

There are a number of new federal requirements that will affect the small group Montana insurance market in 2014. Below is an estimate of the potential impact of these requirements.

- **Impact of limiting to 3:1 age ratio**

Most of the carriers in the small group market use age factors that are already in compliance with the 3:1 age ratio limitation that will go into place in 2014. This change is expected to have only a minimal effect on the small group rates.

- **Impact of eliminating health status factors**

All Montana small group carriers use health status factors in setting rates for small group policies. The health status rating factors in use by carriers are limited to a range of 0.75 to 1.25 by current state law. The range of health status factors reported by the carriers is shown in Table 31 above. While the elimination of health status factors should result in revenue neutrality for the market as a whole, there will be some extreme rate changes required to bring some policies to the average.

The survey did not provide enough detail to allow us to determine the percent of policies that fall above and below the average factor, but we were able to determine that in order to maintain revenue neutrality while eliminating the health status factors, a range of rate changes from -32% to +48% would be required.

- **Impact of eliminating industry factors**

Most Montana small group carriers use industry factors in setting rates for small group policies. The range of industry factors reported by the carriers is shown in Table 30 above. While the elimination of industry factors should result in revenue neutrality for the market as a whole, some sizeable rate reductions and increases are likely, since there is currently up to a 35% rate difference between the highest and lowest factors.



- **Impact of eliminating group size factors**

Many Montana small group carriers use group size factors in setting rates for small group policies. The range of group size factors reported by the carriers is shown in Table 32 above. While the elimination of group size factors should result in revenue neutrality for the market as a whole, some sizeable rate reductions and increases are likely, since there is currently up to a 85% rate difference between the highest and lowest factors.

- **Impact of minimum loss ratio requirement**

For 2011, three small group carriers paid member rebates totaling \$882,000, based on having loss ratios that did not meet the minimum loss ratio requirement. This represents a reduction in premium across the whole small group market of approximately 0.4%. However, after adjusting for the rebates paid, the loss ratio for the entire market is 76.5%, still shy of the MLR requirement by 3.5%. Part of this difference is due to valid MLR adjustments, such as Health Care Quality Improvement expenses, but part is also due to the action of the credibility adjustment in the MLR rebate calculation. Therefore, rate review, requiring pricing toward a target of an MLR of 80%, is still critical in combination with the rebate mechanism to ensure that the target loss ratio is achieved and maintained.

- **Impact of plan design requirements**

Approximately 10% of traditional small group policies and 2% of association group policies have out-of-pocket maximums that exceed \$6,000, which is approximately the out-of-pocket limit that will be imposed in 2014. Lowering the out-of-pocket limit will result in some premium increases. We do not have sufficiently detailed information about current out-of-pocket maximums to allow us to make an estimate of increased cost for this change. We do not expect other benefit requirements to have a significant impact on the cost of small group plans.

- **Impact of new populations entering the small group market**

The scope of this study did not include an analysis of the impact of currently uninsured Montana small employers entering the small group market. However, it should be noted that there are additional small employer tax credits available through the SHOP exchange which may incentivize additional small employers to enter the market.



## The Large Group Market

### **Market Composition and Demographics**

The Montana large group market is defined as employer groups with more than 50 employees. The rating requirements of ACA previously discussed in this report affect the individual and small group markets but not the large group market. Large groups will not be eligible to purchase coverage through the Exchange. Starting in 2016, federal law will redefine large group employers as those with more than 100 employees.

The large group segment is a major component of the health insurance market in Montana. This study focuses only on those large employers that are fully insured. It does not address self-insured employer health benefit programs.

We surveyed three insurers providing large group coverage to about 96,000 individuals. These insurers represent 99.3% of the large employer health insurance market as a percent of covered lives reported to the Montana CSI on the 2011 NAIC Supplemental Health Care Exhibit. The following table shows the number of groups, subscribers, covered lives, and market share for three large group carriers. We have also identified separately the Federal Employee Health Benefit Plan (FEHBP), due to its large size and very different demographics. The table is sorted in decreasing order of market share.

**Table 39: Large Group Market Share**

Insurer	12/31/11 Groups	12/31/11 Subscribers	12/31/11 Covered Lives	Market Share
<b>BCBS</b>	80	18,178	35,810	37%
<b>BCBS - FEHBP</b>	1	14,368	31,859	34%
<b>New West</b>	20	7,362	14,639	15%
<b>Allegiance</b>	105	7,967	13,672	14%
<b>Total</b>	<b>206</b>	<b>47,875</b>	<b>95,980</b>	<b>100%</b>

The average large group size is 232 subscribers if including the FEHBP and 163 if excluding the FEHBP. The distribution of subscribers by contract type for FEHBP and other large groups is very different, as can be seen in the table below. Only 40% of employees in large groups cover dependents, whereas in FEHBP over 60% of employees cover dependents.

**Table 40: Large Group Distribution by Contract Type**

Contract Type	Large Groups		FEHBP	
	Subscriber Count	% of Subscribers	Subscriber Count	% of Subscribers
<b>Employee Only</b>	20,043	60%	5,375	37%
<b>Employee + Spouse</b>	5,165	15%		
<b>Employee + Child(ren)</b>	2,975	9%		
<b>Employee + Family</b>	5,324	16%	8,993	63%
<b>Total</b>	<b>33,507</b>	<b>100%</b>	<b>14,368</b>	<b>100%</b>

The demographics of the insured lives are very different between the FEHBP and other large groups, as can be seen in the table below. The FEHBP members are about six years older on average, with 19% of the members being over the age of 65.



## The Montana Large Group Market

**Table 41: Large Group Market Distribution by Age**

Age Range	Large Group Market Age Distribution	FEHBP Market Age Distribution	Combined Age Distribution
0-18	22%	20%	21%
19-25	10%	7%	9%
26-29	6%	4%	5%
30-34	7%	4%	6%
35-39	7%	5%	6%
40-44	8%	5%	7%
45-49	9%	7%	8%
50-54	10%	8%	10%
55-59	10%	10%	10%
60-64	8%	11%	9%
65+	3%	19%	9%
<b>Total</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>Avg Age</b>	<b>38.2</b>	<b>44.4</b>	<b>40.3</b>

All surveyed carriers currently use the same age slope for large group as they use in the small group market. The rating requirements under the ACA which will limit the age ratio to 3:1 do not apply to large group. It is unknown whether the carriers will maintain the existing age slopes for large group, or for simplicity sake, match them to the new slopes required for individual and small group.

Using the same geographic definitions as used for the individual and small group markets, the distributions of large group and FEHBP members by region is shown in the table below. There is very little difference in the geographic locations of the large groups.

**Table 42: Large Group Distribution by Geographic Region**

Region	Counties	Large Group		FEHBP	
		Count of Lives	% of Lives	Count of Lives	% of Lives
<b>Northwest</b>	Flathead, Lake, Lincoln, Mineral, Missoula, Ravalli, Sanders	15,165	24%	8,674	27%
<b>Southwest</b>	Beaverhead, Broadwater, Deer Lodge, Gallatin, Granite, Jefferson, Lewis and Clark, Madison, Meagher, Powell, Silver Bow	21,139	33%	8,496	27%
<b>North Central</b>	Blaine, Cascade, Chouteau, Glacier, Hill, Liberty, Phillips, Pondera, Toole, Teton	9,388	14%	5,619	18%
<b>South Central</b>	Big Horn, Carbon, Fergus, Golden Valley, Judith Basin, Musselshell, Park, Petroleum, Stillwater, Sweet Grass, Wheatland, Yellowstone	14,581	23%	6,423	20%
<b>Eastern</b>	Carter, Custer, Daniels, Dawson, Prairie, Fallon, Garfield, McCone, Powder River, Richland, Roosevelt, Rosebud, Sheridan, Treasure, Valley, Wibaux	3,848	6%	2,647	8%
<b>Total</b>		<b>64,121</b>	<b>100%</b>	<b>31,859</b>	<b>100%</b>



## The Montana Large Group Market

The distribution of groups and members by group size is shown in the table below. While half of the groups have 75 or fewer subscribers, those groups include only 8% of the large group lives. Two-thirds of the lives are in the 5% of groups that have more than 500 employees.

**Table 43: Large Group Size Distribution**

Group Size *	% of Groups	% of Members		
		Non-FEHBP	FEHBP	Combined
0-50	29%	4%	0%	3%
51-75	22%	8%	0%	5%
76-100	17%	8%	0%	6%
101-150	12%	8%	0%	5%
151-200	7%	8%	0%	5%
201-300	5%	8%	0%	5%
301-500	3%	7%	0%	5%
501+	5%	48%	100%	66%
<b>Total</b>	100%	100%	100%	100%
<b>Avg Size</b>		<b>163</b>	<b>14,368</b>	<b>232</b>

\* In order to maintain consistency with the remainder of the survey, group size was defined as the number of covered employees and not as the total eligible employees. This is the reason there are large groups reported above with group size less than 51.

### Market Pricing

Large group insurance carriers in Montana carriers use age, geography, group size, and sometimes industry in setting large group rates. Gender is not allowed as a rating factor in Montana. The following table shows the type and frequency of use of these specific factors. The insurance carriers have been de-identified and scrambled alphabetically to protect proprietary rating strategies.

**Table 44: Large Group Rating Factors**

Carrier	Age	Geography	Group Size	Health Status	Industry
U	X	X		X	X
V	X	X	X	X	
W	X	X	X	X	X
<b>Total Count</b>	<b>3</b>	<b>3</b>	<b>2</b>	<b>3</b>	<b>2</b>

Due to the small number of carriers in the large group market, we are not showing details about these factors by carrier. However, our analysis revealed that the rating factors were generally similar to those used in the small group market.



## Market Financial Characteristics

### Market Size and Loss Ratios

Aggregate financial information for calendar year 2011 for the Montana large group health insurance market is shown in the following table.

**Table 45: Large Group Aggregate 2011 Financial Information**

	Total
<b>Total Earned Premium</b>	<b>\$391,660,000</b>
<b>Total Claims Incurred</b>	<b>\$363,244,000</b>
<b>Total Admin and Profit</b>	<b>\$28,416,000</b>
<b>Medical Loss Ratio</b>	<b>92.7%</b>
<b>Total Member Months</b>	<b>1,179,052</b>

The following table shows the 2011 medical loss ratio for each large group insurance carrier, along with their premium and claims on a per member per month basis. Rebates are required by the ACA subject to specific guidelines regarding the definition of claims and the credibility of the block of business. No rebates were paid back to large group policyholders for 2011. The MLR required for large group under the ACA is 85%, but the application of the credibility adjustment may limit rebates, particularly in the first year of the program.

**Table 46: Large Group Market Medical Loss Ratios**

Carrier	Premium PMPM	Incurred Claims PMPM	Medical Loss Ratio	Rebates Paid For 2011 (Y/N)
<b>U</b>	\$315	\$258	82%	N
<b>V</b>	\$342	\$323	95%	N
<b>W</b>	\$309	\$303	98%	N
<b>Average</b>	<b>\$332</b>	<b>\$308</b>	<b>93%</b>	

## Market Product Characteristics

### Product Type

The largest component of large group product types is PPO plans, which comprise about 66% of the covered lives. The next largest segment is HMO plans with 18%, followed closely by HSA-eligible High Deductible Health Plans with 14% of the covered lives. The remaining 2% are in indemnity plans. All plans are reported to be open and non-grandfathered.

Plan designs include the cost-sharing features of deductibles, office visit copays, coinsurance, and maximum-out-of-pocket. The market average cost sharing amounts for a single policyholder are shown in the following table. Large group plans tend to be more generous than individual or traditional small group plans, but are similar to association group plans.



## The Montana Large Group Market

**Table 47: Large Group Market Average Cost-Sharing Features**

Large Group Market	
In-Network Deductible	\$1,732
Office Visit Copay	\$10
Coinsurance Percent	30%
Maximum Out of Pocket	\$3,106

Plans with a variety of deductibles are available in the market. The following table shows the distribution of lives within the various deductible choices.

**Table 48: Large Group Market Distribution by Deductible**

Deductible	Large Group Market
\$0	0%
\$1 to \$500	19%
\$501 to \$1,000	36%
\$1,001 to \$3,000	34%
\$3,001 to \$6,000	10%
Over \$6,000	1%

The majority of large group plans have out-of-pocket maximums that fall between \$2,000 and \$6,000. Again, it should be noted that in 2014, cost-sharing will not be allowed to exceed an indexed amount of \$6,050 (2012 dollars). Thus approximately 4% of large group members currently in force are potentially affected by that limitation.

**Table 49: Large Group Market Distribution by Out-of-Pocket Maximum**

Out-of-Pocket Maximum	Large Group Market
\$0	0%
\$1 to \$1,000	1%
\$1,001 to \$2,000	20%
\$2,001 to \$6,000	75%
\$6,001 to \$12,000	4%
Over \$12,000	0%
No OOP Max/Unlimited	0%

In general, current large group plans in Montana cover all benefit categories, including prescription drug, maternity, mental health, and preventive benefits. These policies will likely not require much revision to comply with essential benefits in 2014.

### ***Impact of New Federal Requirements***

The rate factor limitations of the ACA apply only to individual and small group policies. Large group policies will only be affected by minimum loss ratio and plan design requirements. Below is an estimate of the potential impact of these requirements. Since the passage of HIPAA in 1997, health status discrimination against individual employees and dependents has not been allowed.



## The Montana Large Group Market

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- **Impact of minimum loss ratio requirement**

Loss ratios are generally higher for large group policies than for individual or small group policies. The loss ratio threshold for large group policies is 85%. For 2011, none of large group carriers paid member rebates. We do not believe the minimum loss ratio requirement will have a measurable impact on the large group market.



### The Three Rs

The three Rs are reinsurance, risk adjustment, and risk corridors. These are risk-leveling mechanisms established in the ACA to help mitigate the initial and ongoing financial impact of guarantee issue and the influx of previously uninsured persons or those in high-risk pools into the Exchange and the commercial market. Below is a table which summarizes the key elements of the three Rs. More details are provided in the following paragraphs.

	Reinsurance	Risk Adjustment	Risk Corridors
<b>Purpose</b>	Provides funding to issuers that incur high claims costs for enrollees	Transfers funds from lower risk plans to higher risk plans	Limits issuer losses and gains
<b>Time Period</b>	2014 - 2016	Permanent	2014 - 2016
<b>Markets</b>	Individual	Individual and Small Group	Individual and Small Group
<b>Inside or Outside the Exchange</b>	Both	Both	Exchange Only
<b>Amount of Funding Nationally</b>	2014: \$10 Billion 2015: \$6 Billion 2016: \$4 Billion	None. Funds shifted between carriers.	Unknown
<b>Source of Funding</b>	Per capita contribution of entire insurance market, including TPAs (self-funded plans)	Required to be cost neutral	Federal government, if payments exceed charges

### Reinsurance

#### Background

The reinsurance program under the ACA is a temporary program that will operate from 2014 through 2016. The reinsurance program is intended to protect health plans operating in the individual market both inside and outside the Exchange from the financial impact of large claims resulting from the initial influx of uninsured persons and those previously insured in state and federal high-risk pools. It will not replace traditional reinsurance such as is currently purchased by health insurers to protect against exceptionally large claims. It will instead temporarily supplement traditional reinsurance coverage to provide additional protection due to the expected impact of pent up demand from the new populations entering the individual insurance market.

A state that does not establish a state-based Exchange is allowed to administer the reinsurance program. The reinsurance program will be administered by HHS if the state elects not to administer it. States can contract with or establish a reinsurance administrator subject to certain standards. States can establish contracts with multiple reinsurance administrators, but their geographic coverage areas must be distinct and together cover the entire state. States can continue a reinsurance program beyond 2016.

#### How Reinsurance Will Work

Reinsurance payments are based on a proportion of an issuer’s claim costs that are above an attachment point and below a reinsurance cap for the applicable benefit year. The attachment point is the threshold dollar amount after which the issuer is eligible for reinsurance payments, while the reinsurance cap is the



dollar limit at which point an issuer is no longer eligible for reinsurance payments. The attachment point, coinsurance rate, and reinsurance cap are calculated based on an issuer's total costs for an individual enrollee in a given calendar year.

All health insurance issuers, and third-party administrators (TPAs) on behalf of self-insured group health plans, will submit contributions to support reinsurance payments to issuers that cover high-cost individuals in non-grandfathered individual market plans. By statute, the aggregate national contributions for reinsurance payments are \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016. Additional collections will be made for a US Treasury contribution and administrative expenses. Contributions will be on a per capita basis and will be collected from TPAs by HHS. The 2014 contribution rate proposed by HHS is \$5.25 per month per enrollee.

No later than November 15 of benefit years 2014, 2015, and 2016, a contributing entity must submit to HHS an annual enrollment count of the average number of covered lives of reinsurance contribution enrollees for each benefit year. Within 15 days of submission of the annual enrollment count or by December 15, whichever is later, HHS will notify each contributing entity of the reinsurance contribution amounts to be paid based on the annual enrollment count. A contributing entity must remit contributions to HHS within 30 days after the date of the notification of contributions due for the applicable benefit year.

HHS will collect reinsurance contributions on behalf of all states from both health insurance issuers and self-insured group health plans in the aggregate using a national contribution rate from all health insurance issuers in all states. Reinsurance funds will be collected and paid out annually to minimize the costs of administering the program and the burden on contributing entities. Instead of allowing a state establishing its own reinsurance program to modify, via a state notice of benefit and payment parameters, the data collection frequency for issuers to receive reinsurance payments, all states will be required to use the annual payment schedule set forth by HHS.

HHS will allocate and distribute the reinsurance contributions collected under the national contribution rate based on the need for reinsurance payments, regardless of where the contribution was collected.

HHS proposes a distributed data approach for reinsurance payments. In this approach, the required data will be collected and stored by issuers. Issuers will map their data into a common data format and place the data on a server that is owned by the issuer. Under the proposed approach, HHS would run software on the data by remotely accessing the issuer's server.

Reinsurance payments are based on claims incurred and paid by an issuer for an enrollee in a given calendar year subject to the national reinsurance parameters. Reinsurance payments may not exceed available contributions. HHS intends to prorate payments based on available funds at the national level. Any remaining funds due to an issuer will be paid at the end of the benefit year, subject to the availability of funds, during an annual reconciliation. Any reinsurance eligible claims not paid in full as part of the annual payment reconciliation will not be applied to future benefit years. However, if contributions exceed payments in a given year, the remaining funds may be carried over to the following year.

## ***Risk Adjustment***

### **Background**

Risk adjustment is a permanent program beginning in 2014 intended to protect health plans operating in the individual and small group markets from the financial consequences of attracting a higher than average health risk. Health plans both inside and outside the Exchange will be required to participate in the risk adjustment program.



A state that does not establish a state-based Exchange is not allowed to administer the risk adjustment program. The risk adjustment program will be administered by HHS if a state does not establish a state-based Exchange.

Risk adjustment applies to any health insurance coverage offered in the individual or small group market with the exception of grandfathered health plans, Medicare Advantage or Medicare Prescription Drug Plans, contracts with state Medicaid agencies to provide Medicaid benefits, and coverage solely for excepted benefits (accident only, dental or vision, specific disease, hospital indemnity, Medicare supplement plans, and so forth).

The risk adjustment program does not have external funding. It is funded within the insurance industry by shifting funds from insurance carriers with lower risk populations to those with higher risk populations.

### **How Risk Adjustment Will Work**

A risk adjustment model will be used to calculate individual risk scores for each covered individual. The individual risk scores will be used to develop the plan average actuarial risk, which in turn will be used for the calculation of payments and charges for risk adjustment covered plans. It is expected that insurers will be required through the rate review process to set rates reflecting an “average” risk score with the expectation of possible risk adjustment contributions or distributions.

HHS has developed a federal risk adjustment model that they will use to administer the risk adjustment program in states that do not administer their own program. Only states approved to operate an Exchange that choose to operate their own risk adjustment program can elect an alternate methodology. The federal risk adjustment model is expected to be released in late 2012 or early 2013.

Data regarding the demographic and health status of enrollees is needed in order to operate a risk adjustment model. Information about the health status of enrollees is based on medical diagnoses contained in medical claims or encounter records. HHS proposes to use a distributed approach to data collection. In the distributed approach, the required data will be collected and stored by issuers. Issuers would be required to map their data into a common data format and place the data on a server that is owned by the issuer. Under the proposed approach, HHS would remotely access the issuer’s server, run the data through the risk adjustment software, calculate the risk scores and plan average risk, and provide the information back to the issuer.

Beginning in 2014, HHS proposes to conduct a six-stage data validation program when operating risk adjustment on behalf of a state: (1) sample selection; (2) initial validation audit; (3) second validation audit; (4) error estimation; (5) appeals; and, (6) payment adjustments. States that run their own risk adjustment program are not required to adopt this HHS data validation methodology.

Under the risk adjustment program, payments will be transferred from issuers with relatively lower risk populations to issuers with relatively higher risk populations. HHS has proposed a payment transfer methodology. The proposed payment transfer formula is based on the state average premium for an applicable market. The formula applies a set of cost factor adjustments to the state average premium so that it will better reflect plan liability. Adjustments are made for the following cost factors: plan average risk score, actuarial value, permissible rating variation (such as age, tobacco, and family composition), geographic cost differences, and induced demand. The state average premium is multiplied by these factors to develop the plan premium estimates used in the payment transfer formula.

Under the proposed method, risk adjustment transfers are calculated at the risk pool level. Each state will have a risk pool for all of its metal-level plans combined. Catastrophic plans will be a separate risk pool. Individual and small group market plans will either be pooled together or treated as separate risk pools depending on whether the state merges these two markets. Payment transfers are aggregated at the issuer level. The payment methodology will need to be balanced so the payments to plans with higher



risk are equal to the charges to plans with lower risk. The balancing of charges and payments will be performed within a state and within a risk pool.

HHS will not remit payments to issuers until after receipt of amounts owed by issuers in a given state. Charges will be invoiced prior to processing issuer payments. The calculation of charges and payments must be completed and issuers invoiced no later than June 30 of the year following the risk adjustment year. Amounts owed will be payable in 30 days.

### **Risk Corridors**

#### **Background**

The risk corridor program is a temporary program intended to limit the gains and losses of carriers offering qualified health plans inside the Exchange. Like reinsurance, it will be in place for three years, beginning in 2014.

Risk corridors encourage health insurance issuers to offer plans through the Exchanges in the first three years of their operation by ensuring that all issuers share the risk associated with initial uncertainty in the pricing of qualified health plans. Risk corridors act as an after-the-fact adjustment to premiums based on the health insurance issuer's experience. They are designed to protect Qualified Health Plan (QHP) issuers in the individual and small group market against inaccurate rate setting.

#### **How Risk Corridors Will Work**

Due to uncertainty about the population during the first years of Exchange operation, plans may not be able to predict accurately their risk, and their premiums may reflect costs that are ultimately much lower or much higher than predicted, as reflected in overall profitability. For these plans, risk corridors are designed to shift cost from plans that overestimate their risk to plans that underestimate their risk. Issuers with allowable costs that are less than 97% of their target amount will remit charges for a percentage of those savings to HHS, while issuers with allowable costs greater than 103% of the target amount will receive payments from HHS to offset a percentage of those losses.

The risk corridors program will be based on the ratio of a QHP health plan's total costs, other than administrative costs, to its total premiums, reduced by the administrative costs.

To support the risk corridors program calculations, issuers will submit data needed to determine actual performance relative to the target amounts, to be collected in standard formats specified by HHS. Issuers will be required to submit data related to actual premium amounts collected, including premium amounts paid by parties other than the enrollee and specifically, advance premium tax credits paid by the government. Issuers will be required to submit allowable cost data to calculate the risk corridors in a format to be specified by HHS and the allowable costs will be reduced for any direct and indirect remuneration received. The allowable costs will be reduced by the amount of any cost-sharing reductions received from HHS. Risk adjustment and reinsurance will be regarded as adjustments to allowable costs for purposes of determining risk corridors amounts.

For a plan with allowable costs in excess of 103% but not more than 108% of the target, HHS will pay the issuer 50% of the amount in excess of 103% of the target amount. For a plan with allowable costs that exceed 108% of the target amount, HHS will pay the issuer an amount equal to 2.5% of the target amount plus 80% of the amount in excess of 108% of the target amount.

For a plan with allowable costs below 97% but greater than 92% of the target, HHS will charge the issuer an amount equal to 50% of the difference between 97% of the target amount and the actual value of allowable costs. For a plan with allowable costs below 92% of the target amount, the issuer will remit charges to HHS in an amount equal to 2.5% of the target amount plus 80% of the difference between 92% of the target amount and the actual value of allowable costs.



An issuer is required to submit all risk corridor information to HHS by July 31 of the year following the benefit year. The first submission will be July 31, 2015.

### ***Impact of the 3Rs on the Montana Insurance Market***

Reinsurance, risk adjustment, and risk corridors are risk-leveling mechanisms established in the ACA to help mitigate the initial and ongoing financial impact of guaranteed issue and the influx of previously uninsured persons and those in high-risk pools into the Exchange and the individual and small group commercial markets.

#### **Reinsurance**

HHS estimates that the reinsurance program will result in premiums in the national individual market that are 10-15% lower than they would have been without the program.

Two significant changes to the reinsurance program as embodied in the HHS Premium Stabilization Rule (March 23, 2012) were proposed by HHS in their Notice of Premium and Benefit Parameters for 2014 (November 30, 2012).

Under the previous rule, funds collected on behalf of a state would be distributed to benefit issuers for their operations within that same state. Under the proposed rule, the funds are distributed nationally, so this program is no longer balanced within a given state. Since the contributions are on a per capita basis, but the distributions are based upon a claim-based reinsurance formula, it is likely that states with higher per capita claim costs will benefit, while those with lower claims will subsidize them.

Under the previous rule, contributions and payments would be made throughout out the year, while under the proposed rule there would be one annual settlement, with HHS providing notice to the issuers by no later than June 30 of the year following the benefit year. Under the original version of the program, payments into the individual market were expected to begin mid-2014. However, under the proposed program, this date is moved out a year to mid-2015.

#### **Risk Adjustment**

The impact of the risk adjustment mechanism will not be seen until mid-2015, when the first risk adjustment charges and payments are made. The program is required to be revenue neutral and essentially amounts to a shifting of funds between carriers within a market. The risk adjustment will occur separately in the individual and small group markets (unless the state decides to merge those two markets). The impact of this program on the Montana market is unknown at this time.

#### **Risk Corridors**

Similarly, the risk corridor mechanism will not have an impact until after mid-2015. It will help carriers operating in the Exchange by correcting for loss ratios that fall outside a plus or minus 3% range from target. Its purpose is to encourage carriers to offer products in the Exchange and give them time to get appropriate product pricing in place. The impact of this program on the Montana market is unknown at this time.



### **Study Methodology**

The carriers included in the survey were selected jointly by the CSI and Leif Associates and include all of the significant writers of comprehensive major medical health insurance in Montana.

The survey was designed to capture information about information regarding the product characteristics currently allowed in Montana and that will be impacted by the new federal requirements.

The survey was distributed to the selected carriers in April of 2012 and requested information for calendar year 2011. In performing our analysis, the information from the survey was augmented with information from the 2011 NAIC Supplemental Health Care Exhibits filed by the carriers with the CSI.

A copy of the survey is attached to this report as an appendix.

The information from the surveys and NAIC exhibits was compiled and analyzed, then used as the basis of this report.



**Appendix A – The Survey Document**

**State of Montana**  
**Health Insurance Market Study - Instructions**

**Background**

One of the tasks of the federal grant the State of Montana received for the study of a health insurance exchange in Montana was to perform a market survey related to the current private insurance market. The State of Montana has retained Leif Associates to conduct this analysis on their behalf.

**Important Info**

We are studying the following segments of the Montana insurance market: Individual, Small Group, Large Group and Bona Fide Association.

***"Bona Fide Association" for this purpose are only those bona fide association plans, requiring membership in the bona fide association, that don't otherwise fall into the Individual, Small or Large Group segments.***

\*If your bona fide association business is rated just as you would rate any other individual in Montana (except that bona fide association membership is required), then please consider that as Individual for purposes of this survey.

\*If your bona fide association business is rated just as you would rate any other small group in Montana (as subject to Small Group rating laws), then please consider that as Small Group for purposes of this survey.

\*If you treat your bona fide association business as a single large group and rate it the same as you would rate any other large group, then please consider that as Large Group for purposes of this survey.

\*If you rate employer groups within a bona fide association differently from other groups in the same Bona Fide Association and not as true small groups (subject to Small Group rating laws), then please consider that as bona fide association for purposes of this survey.

This survey is specific to calendar year **2011** information only. Point in time numbers should be as of **12/31/2011**.

We are focused on ALL fully insured major medical Montana business, including open and closed blocks.

Do not include non-major medical business, such as dental, life, supplement AD&D, hospital indemnity, etc. But do include hospital/surgical plans.

Please put your answers in the cells highlighted in yellow in this Excel file and return to us by **5/21/12**. We are not requesting additional documentation.

**Definitions**

Bona Fide Association = bona fide association business, requiring membership in a bona fide association, rated not as true individual, small group or large group business. Do NOT include MEWAs as part of this survey.

Geographic Regions = by county as follows:

Northwest - Lincoln, Sanders, Mineral, Missoula, Ravalli, Flathead and Lake.

Southwest - Granite, Powell, Lewis and Clark, Meagher, Broadwater, Jefferson, Silver Bow, Deer Lodge, Beaverhead, Madison and Gallatin.

N Central - Glacier, Toole, Liberty, Hill, Blaine, Phillips, Pondera, Teton, Chouteau and Cascade.

S Central - Judith Basin, Fergus, Petroleum, Wheatland, Golden Valley, Musselshell, Park, Sweet Grass, Stillwater, Carbon, Yellowstone, and Big Horn.

Eastern - Valley, Daniels, Roosevelt, Sheridan, Garfield, McCone, Richland, Dawson, Prairie, Wibaux, Rosebud, Custer, Fallon, Treasure, Powder River, and Carter.

Incurred date = The date the member received the medical service.

Members = Count of all enrolled, including dependents.

Paid date = The date the claim was paid by the carrier.

Subscribers = Count of the primary enrolled, such as employees under group coverage or primary policy holder for individual coverage - excludes dependent counts.

**Contact Information**

For questions, please contact Elizabeth Leif, Nic Ramey or Melanie Maddocks at Leif Associates.

Elizabeth Leif, FSA can be reached at 303-294-0994 or ejleif@Leif.net.

Nic Ramey, ASA can be reached at 303-294-0994 or nramey@Leif.net.

Melanie Maddocks can be reached at 303-294-0994 or melanie@Leif.net.

**State of Montana  
Health Insurance Market Study - Individual**

**FILL IN YELLOW CELLS ONLY**

	Example	Response
1.01	Number of subscribers as of 12/31/11: 5,000	
1.02	Number of members as of 12/31/11: 10,000	
1.03	Number of member months in 2011: 120,000	
	Average Family Size 2.00	
	Average Length of Enrollment 12.00	

1.04 Number of members as of 12/31/11 by age:

Example		Response	
Age	Count	Age	Count
0-18	200	0-18	
19-25	1,000	19-25	
26-29	1,000	26-29	
30-34	1,000	30-34	
35-39	1,000	35-39	
40-44	1,000	40-44	
45-49	1,000	45-49	
50-54	1,000	50-54	
55-59	1,000	55-59	
60-64	1,000	60-64	
65+	800	65+	
Total Members	10,000	Total Members	0

1.05 Number of subscribers as of 12/31/11 by family size/contract type, based on how sold/recorded in your system:

Example		Response	
Contract Type	Count	Contract Type	Count
Individual Only	1,000	Individual Only	
2 Adults Only	1,000	2 Adults Only	
1 Adult + Child(ren)	1,000	1 Adult + Child(ren)	
Family	2,000	Family	
Total Subscribers	5,000	Total Subscribers	0

1.06 Number of members by geographic region (see instructions for definition of each region):

Example		Response	
Geography	Count	Geography	Count
Northwest	2,500	Northwest	
Southwest	2,500	Southwest	
N Central	0	N Central	
S Central	2,500	S Central	
Eastern	2,500	Eastern	
Total Members	10,000	Total Members	0

1.07 Rating characteristics - Only check if you have Montana factors that vary based on this criteria. For example:

- If you have a single statewide geography factor, then do NOT select geography as a rating characteristic.
- Only select tobacco if you have a definitive rating impact based on tobacco usage only.
- Only select spousal rate variance if rates for the spouse vary whether applying by self or with another adult.

Example		Response	
Plan Design	X	Plan Design	X
Age	X	Age	X
Gender		Gender	X
Geography	X	Geography	X
Tobacco		Tobacco	X
Duration		Duration	X
Wellness		Wellness	X
Spousal Rate Variance		Spousal Rate Variance	X







1.17 Plan variances - 1.07 indicates that you rate based on plan design, please tell us approximately how many plans you offer and members on each type as of 12/31/11.

Example			Response		
Plan Type	Count of Plans	Member Count	Plan Type	Count of Plans	Member Count
Open Active Plans	50	9,000	Open Active Plans		
Closed Plans - Grandfathered	10	500	Closed Plans - Grandfathered		
Closed Plans - Non-Grandfathered	10	500	Closed Plans - Non-Grandfathered		
Total	70	10,000	Total	0	0

1.18 Durational rating impacts - 1.07 indicates that you rate based on duration, please provide those impacts and members impacted by each as of 12/31/11. If more space is needed, provide separately.

Example			Response		
Duration	Rating Impact	Member Count	Duration	Rating Impact	Member Count
Initial Year	1.0000	6,000			
1st Year Renewal	1.1000	1,000			
2nd Year Renewal	1.2000	500			
3rd Year Renewal	1.3000	500			
4th Year Renewal	1.4000	500			
5th Year Renewal	1.5000	500			
6th Year Renewal	1.6000	500			
7th Year Renewal	1.7000	500			
Total		10,000	Total		0

1.19 Gender rating impacts - 1.07 indicates that you rate based on gender, please provide those impacts and members impacted by each as of 12/31/11. If more space is needed, provide separately.

Example			Response		
Gender	Rating Impact	Member Count	Gender	Rating Impact	Member Count
Male	0.9000	3,500			
Female	1.2000	3,500			
Children	1.0000	3,000			
Total		10,000	Total		0

1.20 Wellness rating impacts - 1.07 indicates that you rate based on wellness, please provide those impacts and members impacted by each as of 12/31/11. If more space is needed, provide separately.

Example			Response		
Wellness	Rating Impact	Member Count	Wellness	Rating Impact	Member Count
None	1.0000	8,500			
Tobacco Prevention	0.9500	500			
Weight Management	0.9500	500			
Diabetes Management	0.9500	500			
Total		10,000	Total		0

1.21 Exclusionary Riders - 1.08 indicates that you use exclusionary riders, please provide more information along with count of 12/31/11 members affected. If more space is needed, provide separately.

Example		Response	
Type of Exclusionary Rider	Member Count	Type of Exclusionary Rider	Member Count
Without an exclusionary rider	8,000	Without an exclusionary rider	
Disease Specific Rider	500	Disease Specific Rider	
Treatment Specific Rider	500	Treatment Specific Rider	
Non-Specific Rider	1,000	Non-Specific Rider	
Total	10,000	Total	0

1.22 For claims incurred in calendar year 2011, please tell us the following:

Example		Response	
Claim Responsibility	Dollars	Claim Responsibility	Dollars
Plan Share	\$8,000,000	Plan Share	
Member Share*	\$1,000,000	Member Share*	
Total Allowed	\$9,000,000	Total Allowed	\$0

\*Member share = deductibles, copays, coinsurance (NOT premium, balance billing, etc.)

1.23 For your membership as of 12/31/11, please tell us the count by general plan type:

Example		Response	
Plan Type	Member Count	Plan Type	Member Count
HMO	8,000	HMO	
PPO	500	PPO	
Fee for Service	1,000	Fee for Service	
HDHP Qualified	500	HDHP Qualified	
Total	10,000	Total	0

1.24 For those on an individual policy (no dependents) as of 12/31/11, please report the average plan features: This should be based on plan design for in-network benefits, not actual average amounts paid by the insured.

Example		Response	
In-Network Plan Feature	Average	In-Network Plan Feature	Average
Deductible	\$1,500	Deductible	
Office Visit Copay	\$35	Office Visit Copay	
Coinsurance % (Member Share)	20%	Coinsurance % (Member Share)	
Out of Pocket Maximum	\$5,000	Out of Pocket Maximum	

1.25 For those on a policy containing dependents as of 12/31/11, please report the average plan features: This should be based on plan design for in-network benefits, not actual average amounts paid by the insured.

Example		Response	
In-Network Plan Feature	Average	In-Network Plan Feature	Average
Deductible	\$3,000	Deductible	
Office Visit Copay	\$35	Office Visit Copay	
Coinsurance % (Member Share)	20%	Coinsurance % (Member Share)	
Out of Pocket Maximum	\$10,000	Out of Pocket Maximum	

1.26 For your members as of 12/31/11, please quantify the number of members by in-network deductible. This should be based on plan design, not actual average amounts paid by the insured.

Example		Response	
In-Network Deductible	Member Count	In-Network Deductible	Member Count
\$0 (or no deductible)	5,000	\$0 (or no deductible)	
\$1 - \$500	1,000	\$1 - \$500	
\$501 - \$1,000	1,000	\$501 - \$1,000	
\$1,001 - \$3,000	1,000	\$1,001 - \$3,000	
\$3,001 - \$6,000	1,000	\$3,001 - \$6,000	
Over \$6,000	1,000	Over \$6,000	
Total	10,000	Total	0

1.27 For your members as of 12/31/11, please quantify the number of members by Out of Pocket Max, including deductible. This should be based on plan design, not actual average amounts paid by the insured.

Example		Response	
Out of Pocket Maximum (including deductible)	Member Count	Out of Pocket Maximum (including deductible)	Member Count
\$0	5,000	\$0	
\$1 - \$1,000	1,000	\$1 - \$1,000	
\$1,001 - \$2,000	1,000	\$1,001 - \$2,000	
\$2,001 - \$6,000	1,000	\$2,001 - \$6,000	
\$6,001 - \$12,000	1,000	\$6,001 - \$12,000	
Over \$12,000	500	Over \$12,000	
No OOP Max/Unlimited	500	No OOP Max/Unlimited	
Total	10,000	Total	0

1.28 For your members as of 12/31/11, please quantify the number of members having the following available benefits. This should be based on availability in plan design, not actual usage by the insured.

Example			Response		
Plan Benefit	Via Plan or Rider	Member Count	Plan Benefit	Via Plan or Rider	Member Count
Generic Rx Only	Rider	1,000	Generic Rx Only		
Generic and Brand Rx	Rider	1,000	Generic and Brand Rx		
Maternity	Plan	10,000	Maternity		
Non-Severe Mental Health	Plan	10,000	Non-Severe Mental Health		
Severe Mental Health	Plan	10,000	Severe Mental Health		
Preventive	Plan	10,000	Preventive		

**State of Montana**  
**Health Insurance Market Study - Small Group**

**FILL IN YELLOW CELLS ONLY**

	Example	Response
2.01	Number of employer groups as of 12/31/11:	350
2.02	Number of subscribers as of 12/31/11:	5,000
2.03	Number of members as of 12/31/11:	10,000
2.04	Number of member months in 2011:	120,000
	Average Members per Group	28.57
	Average Family Size	2.00
	Average Length of Enrollment	12.00

2.05 Number of members as of 12/31/11 by age:

Example		Response	
Age	Count	Age	Count
0-18	200	0-18	
19-25	1,000	19-25	
26-29	1,000	26-29	
30-34	1,000	30-34	
35-39	1,000	35-39	
40-44	1,000	40-44	
45-49	1,000	45-49	
50-54	1,000	50-54	
55-59	1,000	55-59	
60-64	1,000	60-64	
65+	800	65+	
Total Members	10,000	Total Members	0

2.06 Number of subscribers as of 12/31/11 by family size/contract type, based on how sold/recorded in your system:

Example		Response	
Contract Type	Count	Contract Type	Count
Employee Only	1,000	Employee Only	
Employee + Spouse	1,000	Employee + Spouse	
Employee + Child(ren)	1,000	Employee + Child(ren)	
Employee + Family	2,000	Employee + Family	
Total Subscribers	5,000	Total Subscribers	0

2.07 Number of Employer Groups and members by geographic region (based on employer location & see instructions for definition of each region):

Example			Response		
Geography	Groups	Members	Geography	Groups	Members
Northwest	100	2,500	Northwest		
Southwest	100	2,500	Southwest		
N Central	0	0	N Central		
S Central	100	2,500	S Central		
Eastern	50	2,500	Eastern		
Total	350	10,000	Total	0	0

2.08 Number of Employer Groups, Subscribers, and Members by Group Size:

Example				Response			
Group Size	Groups	Subscribers	Members	Group Size	Groups	Subscribers	Members
1-5	145	580	1,160	1-5			
6-9	100	900	1,800	6-9			
10-19	0	0	0	10-19			
20-29	50	1,200	2,400	20-29			
30-50	50	2,000	4,000	30-50			
51+	5	320	640	51+			
Total	350	5,000	10,000	Total	0	0	0

- 2.09 Rating characteristics - Only check if you have Montana factors that vary based on this criteria. For example:  
 -If you have a single statewide geography factor, then do NOT select geography as a rating characteristic.  
 -Only select tobacco if you have a definitive rating impact based on tobacco usage only.  
 -Only select spousal rate variance if rates for the spouse are NOT the same as that of the employee.

Example	
Plan Design	X
Age	X
Gender	
Geography	X
Industry	
Duration	
Group Size	
Tobacco	
Wellness	
Spousal Rate Variance	

Response	
Plan Design	X
Age	X
Gender	X
Geography	X
Industry	X
Duration	X
Group Size	X
Tobacco	X
Wellness	X
Spousal Rate Variance	X

- 2.10 Health Status/Underwriting Risk in Rating/Issuance - Please check how you use underwriting for small group applications.

Example	
Don't underwrite or consider health status in review of application	
For determination of a rating impact (higher or lower)	X
For application of Exclusionary Riders	X
For potential denial of coverage	X

Response	
Don't underwrite or consider health status in review of application	
For determination of a rating impact (higher or lower)	X
For application of Exclusionary Riders	X
For potential denial of coverage	

- 2.11 Underwriting Specifics - 2.10 indicates that you do underwrite, please select the types of factors considered in your underwriting process. For 'Other' please provide more information separately.

Example	
Height	X
Weight	X
Tobacco Usage	X
Claims Experience	
Hobbies/Sports	
Medical History - Self	X
Med History - Family	
Predictive Modeling	
Health Screen	
Credit Rating	
Occupation	
Criminal History	
Other	X

Response	
Height	
Weight	
Tobacco Usage	
Claims Experience	
Hobbies/Sports	
Medical History - Self	
Med History - Family	
Predictive Modeling	
Health Screen	
Credit Rating	
Occupation	
Criminal History	
Other	

- 2.12 Subscriber age slopes - 2.09 indicates that you rate based on age, please provide your age groupings and factors for primary subscribers (not spouses or dependents). If more space is needed, provide separately. If you have multiple slopes, please report on the one with the MOST members in 2011.

Example	
Age	Factor
0	0.7550
1-9	0.5000
10-19	0.6520
20-29	1.4000
30-39	1.4500
40-49	1.5000
50-59	1.5550
60-64	1.6500
65+ Plan Primary	1.7500
65+ Medicare Primary	0.9250

Response	
Age	Factor





2.19 Industry rating factors - 2.09 indicates that you rate based on industry, please provide the particular codes for those receiving the highest of the factors listed in 2.18. Otherwise, provide your entire industry table separately.

Example	
Highest Industry Rating Impact	Industry or SICs
1.1500	111-140, 4141, 5993, 8011, 9311

Response	
Highest Industry Rating Impact	Industry or SICs

2.20 Experience/health status factors - 2.10 indicates that you underwrite for rating purposes, please provide those impacts along with count of 12/31/11 groups, subscribers, and members affected. If more space is needed, provide separately.

Minimum Rating Factor	0.75
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Minimum Rating Factor	1.00
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Example			
Health Status Factor	Group Count	Subscriber Count	Member Count
0.75	50	1,250	2,500
0.76-0.90	75	1,250	2,500
0.91-1.10	100	1,500	3,000
1.11-1.24	75	500	1,000
1.25	50	500	1,000
Total	350	5,000	10,000

Response			
Health Status Factor	Group Count	Subscriber Count	Member Count
1.00			
1.01-1.2			
1.21-1.47			
1.48-1.66			
1.67			
Total	0	0	0

2.21 Plan variances - 2.09 indicates that you rate based on plan design, please tell us approximately how many plans you offer and number of groups on each type as of 12/31/11.

Example		
Plan Type	Count of Plans	Group Count
Open Active Plans	50	300
Closed Plans - Grandfathered	5	25
Closed Plans - Non-Grandfathered	5	25
Total	60	350

Response		
Plan Type	Count of Plans	Group Count
Open Active Plans		
Closed Plans - Grandfathered		
Closed Plans - Non-Grandfathered		
Total	0	0

2.22 Durational rating impacts - 2.09 indicates that you rate based on duration, please provide those impacts and number of groups impacted by each as of 12/31/11. If more space is needed, provide separately.

Example		
Duration	Rating Impact	Group Count
Initial Year	1.0000	175
1st Year Renewal	1.1000	50
2nd Year Renewal	1.2000	25
3rd Year Renewal	1.3000	25
4th Year Renewal	1.4000	25
5th Year Renewal	1.5000	25
6th Year Renewal	1.6000	15
7th Year Renewal	1.7000	10
Total		350

Response		
Duration	Rating Impact	Group Count
Total		0



2.27 For claims incurred in calendar year 2011, please tell us the following:

Example	
Claim Responsibility	Dollars
Plan Share	\$8,000,000
Member Share*	\$1,000,000
Total Allowed	\$9,000,000

Response	
Claim Responsibility	Dollars
Plan Share	
Member Share*	
Total Allowed	\$0

\*Member share = deductibles, copays, coinsurance (NOT premium, balance billing, etc.)

2.28 For your membership as of 12/31/11, please tell us the count by general plan type:

Example	
Plan Type	Member Count
HMO	8,000
PPO	1,000
Fee for Service	500
HDHP Qualified	500
Total	10,000

Response	
Plan Type	Member Count
HMO	
PPO	
Fee for Service	
HDHP Qualified	
Total	0

2.29 For those on an EE only policy (no dependents) as of 12/31/11, please report the average plan features:  
This should be based on plan design for in-network benefits, not actual average amounts paid by the insured.

Example	
In-Network Plan Feature	Average
Deductible	\$1,500
Office Visit Copay	\$35
Coinsurance % (Member Share)	20%
Out of Pocket Maximum	\$5,000

Response	
In-Network Plan Feature	Average
Deductible	
Office Visit Copay	
Coinsurance % (Member Share)	
Out of Pocket Maximum	

2.30 For those on a policy containing dependents as of 12/31/11, please report the average plan features:  
This should be based on plan design for in-network benefits, not actual average amounts paid by the insured.

Example	
In-Network Plan Feature	Average
Deductible	\$3,000
Office Visit Copay	\$35
Coinsurance % (Member Share)	20%
Out of Pocket Maximum	\$10,000

Response	
In-Network Plan Feature	Average
Deductible	
Office Visit Copay	
Coinsurance % (Member Share)	
Out of Pocket Maximum	

2.31 For your members as of 12/31/11, please quantify the number of members by in-network deductible.  
This should be based on plan design, not actual average amounts paid by the insured.

Example	
In-Network Deductible	Member Count
\$0 (or no deductible)	5,000
\$1 - \$500	1,000
\$501 - \$1,000	1,000
\$1,001 - \$3,000	1,000
\$3,001 - \$6,000	1,000
Over \$6,000	1,000
Total	10,000

Response	
In-Network Deductible	Member Count
\$0 (or no deductible)	
\$1 - \$500	
\$501 - \$1,000	
\$1,001 - \$3,000	
\$3,001 - \$6,000	
Over \$6,000	
Total	0

2.32 For your members as of 12/31/11, please quantify the number of members by Out of Pocket Max, including deductible.  
This should be based on plan design, not actual average amounts paid by the insured.

Example	
Out of Pocket Maximum (including deductible)	Member Count
\$0	5,000
\$1 - \$1,000	1,000
\$1,001 - \$2,000	1,000
\$2,001 - \$6,000	1,000
\$6,001 - \$12,000	1,000
Over \$12,000	500
No OOP Max/Unlimited	500
Total	10,000

Response	
Out of Pocket Maximum (including deductible)	Member Count
\$0	
\$1 - \$1,000	
\$1,001 - \$2,000	
\$2,001 - \$6,000	
\$6,001 - \$12,000	
Over \$12,000	
No OOP Max/Unlimited	
Total	0

2.33 For your members as of 12/31/11, please quantify the number of members having the following available benefits. This should be based on availability in plan design, not actual usage by the insured.

Example		
Plan Benefit	Via Plan or Rider	Member Count
Generic Rx Only	Rider	1,000
Generic and Brand Rx	Rider	1,000
Maternity	Plan	10,000
Non-Severe Mental Health	Plan	10,000
Severe Mental Health	Plan	10,000
Preventive	Plan	10,000

Response		
Plan Benefit	Via Plan or Rider	Member Count
Generic Rx Only		
Generic and Brand Rx		
Maternity		
Non-Severe Mental Health		
Severe Mental Health		
Preventive		

**State of Montana**  
**Health Insurance Market Study - Large Group**

**FILL IN YELLOW CELLS ONLY**

- 3.01 Number of employer groups as of 12/31/11:
- 3.02 Number of subscribers as of 12/31/11:
- 3.03 Number of members as of 12/31/11:
- 3.04 Number of member months in 2011:
- Average Members per Group
- Average Family Size
- Average Length of Enrollment

Example
125
10,000
20,000
240,000
160.00
2.00
12.00

Response

- 3.05 Number of members as of 12/31/11 by age:

Example	
Age	Count
0-18	400
19-25	2,000
26-29	2,000
30-34	2,000
35-39	2,000
40-44	2,000
45-49	2,000
50-54	2,000
55-59	2,000
60-64	2,000
65+	1,600
Total Members	20,000

Response	
Age	Count
0-18	
19-25	
26-29	
30-34	
35-39	
40-44	
45-49	
50-54	
55-59	
60-64	
65+	
Total Members	0

- 3.06 Number of subscribers as of 12/31/11 by family size/contract type, based on how sold/recorded in your system:

Example	
Contract Type	Count
Employee Only	2,000
Employee + Spouse	4,000
Employee + Child(ren)	2,000
Employee + Family	2,000
Total Subscribers	10,000

Response	
Contract Type	Count
Employee Only	
Employee + Spouse	
Employee + Child(ren)	
Employee + Family	
Total Subscribers	0

- 3.07 Number of Employer Groups and members by geographic region (based on employer location & see instructions for definition of each region):

Example		
Geography	Groups	Members
Northwest	25	5,000
Southwest	0	0
N Central	35	5,000
S Central	40	5,000
Eastern	25	5,000
Total	125	20,000

Response		
Geography	Groups	Members
Northwest		
Southwest		
N Central		
S Central		
Eastern		
Total	0	0

- 3.08 Number of Employer Groups, subscribers, and members by Group Size:

Example			
Group Size	Groups	Subscribers	Members
0-50	2	30	60
51-75	75	4,785	9,570
76-100	42	3,360	6,720
101-150	2	250	500
151-200	1	175	350
201-300	1	250	500
301-500	1	400	800
501+	1	750	1,500
Total	125	10,000	20,000

Response			
Group Size	Groups	Subscribers	Members
0-50			
51-75			
76-100			
101-150			
151-200			
201-300			
301-500			
501+			
Total	0	0	0

- 3.09 Rating characteristics - Only check if you have Montana factors that vary based on this criteria. For example:  
 -If you have a single statewide geography factor, then do NOT select geography as a rating characteristic.  
 -Only select tobacco if you have a definitive rating impact based on tobacco usage only.  
 -Only select spousal rate variance if rates for the spouse are NOT the same as that of the employee.

Example	
Plan Design	X
Age	X
Gender	
Geography	X
Industry	
Duration	
Group Size	
Tobacco	
Wellness	
Spousal Rate Variance	

Response	
Plan Design	X
Age	X
Gender	X
Geography	X
Industry	X
Duration	X
Group Size	X
Tobacco	X
Wellness	X
Spousal Rate Variance	X

- 3.10 Health Status/Underwriting Risk in Rating/Issuance - Please check how you use underwriting for large group applications.

Example	
Don't underwrite or consider health status in review of application	
For determination of a rating impact (higher or lower)	X
For application of Exclusionary Riders	X
For potential denial of coverage	X

Response	
Don't underwrite or consider health status in review of application	
For determination of a rating impact (higher or lower)	X
For application of Exclusionary Riders	X
For potential denial of coverage	

- 3.11 Underwriting Specifics - 3.10 indicates that you do underwrite, please select the types of factors considered in your underwriting process. For 'Other' please provide more information separately.

Example	
Height	X
Weight	X
Tobacco Usage	X
Claims Experience	
Hobbies/Sports	
Medical History - Self	X
Med History - Family	
Predictive Modeling	
Health Screen	
Credit Rating	
Occupation	
Criminal History	
Other	X

Response	
Height	
Weight	
Tobacco Usage	
Claims Experience	
Hobbies/Sports	
Medical History - Self	
Med History - Family	
Predictive Modeling	
Health Screen	
Credit Rating	
Occupation	
Criminal History	
Other	

- 3.12 Subscriber age slopes - 3.09 indicates that you rate based on age, please provide your age groupings and factors for primary subscribers (not spouses or dependents). If more space is needed, provide separately. If you have multiple slopes, please report on the one with the MOST members in 2011.

Example	
Age	Factor
0	0.7550
1-9	0.5000
10-19	0.6520
20-29	1.4000
30-39	1.4500
40-49	1.5000
50-59	1.5550
60-64	1.6500
65+ Plan Primary	1.7500
65+ Medicare Primary	0.9250

Response	
Age	Factor





3.19 Industry rating factors - 3.09 indicates that you rate based on industry, please provide the particular codes for those receiving the highest of the factors listed in 2.18. Otherwise, provide your entire industry table separately.

Example	
Highest Industry Rating Impact	Industry or SICs
1.1500	111-140, 4141, 5993, 8011, 9311

Response	
Highest Industry Rating Impact	Industry or SICs

3.20 Experience/health status factors - 3.10 indicates that you underwrite for rating purposes, please provide those impacts along with count of 12/31/11 groups, subscribers, and members affected. If more space is needed, provide separately.

Average Factor	1.000
----------------	-------

Average Factor	1.250
----------------	-------

Example			
Experience / Health Status Factor	Group Count	Subscriber Count	Member Count
<=0.75	10	2,500	5,000
0.76-0.90	25	2,500	5,000
0.91-1.10	50	3,000	6,000
1.11-1.24	25	1,000	2,000
>=1.25	15	1,000	2,000
Total	125	10,000	20,000

Response			
Experience / Health Status Factor	Group Count	Subscriber Count	Member Count
<=0.94			
0.95-1.13			
1.14-1.38			
1.39-1.55			
>=1.56			
Total	0	0	0

3.21 Plan variances - 3.09 indicates that you rate based on plan design, please tell us approximately how many plans you offer and number of groups on each type as of 12/31/11.

Example		
Plan Type	Count of Plans	Group Count
Open Active Plans	20	100
Closed Plans - Grandfathered	2	25
Closed Plans - Non-Grandfathered	0	0
Total	22	125

Response		
Plan Type	Count of Plans	Group Count
Open Active Plans		
Closed Plans - Grandfathered		
Closed Plans - Non-Grandfathered		
Total	0	0

3.22 Durational rating impacts - 3.09 indicates that you rate based on duration, please provide those impacts and number of groups impacted by each as of 12/31/11. If more space is needed, provide separately.

Example		
Duration	Rating Impact	Group Count
Initial Year	1.0000	25
1st Year Renewal	1.1000	25
2nd Year Renewal	1.2000	25
3rd Year Renewal	1.3000	25
4th Year Renewal	1.4000	25
5th Year Renewal	1.5000	0
6th Year Renewal	1.6000	0
7th Year Renewal	1.7000	0
Total		125

Response		
Duration	Rating Impact	Group Count
Total		0



3.27 For claims incurred in calendar year 2011, please tell us the following:

Example	
Claim Responsibility	Dollars
Plan Share	\$8,000,000
Member Share*	\$1,000,000
Total Allowed	\$9,000,000

Response	
Claim Responsibility	Dollars
Plan Share	
Member Share*	
Total Allowed	\$0

\*Member share = deductibles, copays, coinsurance (NOT premium, balance billing, etc.)

3.28 For your membership as of 12/31/11, please tell us the count by general plan type:

Example	
Plan Type	Member Count
HMO	16,000
PPO	2,000
Fee for Service	1,000
HDHP Qualified	1,000
Total	20,000

Response	
Plan Type	Member Count
HMO	
PPO	
Fee for Service	
HDHP Qualified	
Total	0

3.29 For those on an EE only policy (no dependents) as of 12/31/11, please report the average plan features:  
This should be based on plan design for in-network benefits, not actual average amounts paid by the insured.

Example	
In-Network Plan Feature	Average
Deductible	\$1,500
Office Visit Copay	\$35
Coinsurance % (Member Share)	20%
Out of Pocket Maximum	\$5,000

Response	
In-Network Plan Feature	Average
Deductible	
Office Visit Copay	
Coinsurance % (Member Share)	
Out of Pocket Maximum	

3.30 For those on a policy containing dependents as of 12/31/11, please report the average plan features:  
This should be based on plan design for in-network benefits, not actual average amounts paid by the insured.

Example	
In-Network Plan Feature	Average
Deductible	\$3,000
Office Visit Copay	\$35
Coinsurance % (Member Share)	20%
Out of Pocket Maximum	\$10,000

Response	
In-Network Plan Feature	Average
Deductible	
Office Visit Copay	
Coinsurance % (Member Share)	
Out of Pocket Maximum	

3.31 For your members as of 12/31/11, please quantify the number of members by in-network deductible.  
This should be based on plan design, not actual average amounts paid by the insured.

Example	
In-Network Deductible	Member Count
\$0 (or no deductible)	10,000
\$1 - \$500	2,000
\$501 - \$1,000	2,000
\$1,001 - \$3,000	2,000
\$3,001 - \$6,000	2,000
Over \$6,000	2,000
Total	20,000

Response	
In-Network Deductible	Member Count
\$0 (or no deductible)	
\$1 - \$500	
\$501 - \$1,000	
\$1,001 - \$3,000	
\$3,001 - \$6,000	
Over \$6,000	
Total	0

3.32 For your members as of 12/31/11, please quantify the number of members by Out of Pocket Max, including deductible.  
This should be based on plan design, not actual average amounts paid by the insured.

Example	
Out of Pocket Maximum (including deductible)	Member Count
\$0	10,000
\$1 - \$1,000	2,000
\$1,001 - \$2,000	2,000
\$2,001 - \$6,000	2,000
\$6,001 - \$12,000	2,000
Over \$12,000	1,000
No OOP Max/Unlimited	1,000
Total	20,000

Response	
Out of Pocket Maximum (including deductible)	Member Count
\$0	
\$1 - \$1,000	
\$1,001 - \$2,000	
\$2,001 - \$6,000	
\$6,001 - \$12,000	
Over \$12,000	
No OOP Max/Unlimited	
Total	0

3.33 For your members as of 12/31/11, please quantify the number of members having the following available benefits. This should be based on availability in plan design, not actual usage by the insured.

Example		
Plan Benefit	Via Plan or Rider	Member Count
Generic Rx Only	Rider	2,000
Generic and Brand Rx	Rider	2,000
Maternity	Plan	20,000
Non-Severe Mental Health	Plan	20,000
Severe Mental Health	Plan	20,000
Preventive	Plan	20,000

Response		
Plan Benefit	Via Plan or Rider	Member Count
Generic Rx Only		
Generic and Brand Rx		
Maternity		
Non-Severe Mental Health		
Severe Mental Health		
Preventive		

**State of Montana**  
**Health Insurance Market Study - Bona Fide Associations**

**FILL IN YELLOW CELLS ONLY**

	Example	Response
4.00	Number of associations as of 12/31/11	
4.01	Number of employer groups as of 12/31/11:	
4.02	Number of subscribers as of 12/31/11:	
4.03	Number of members as of 12/31/11:	
4.04	Number of member months in 2011:	
	Average Members per Employer Group	
	Average Family Size	
	Average Length of Enrollment	

4.05 Number of members as of 12/31/11 by age:

Example	
Age	Count
0-18	200
19-25	1,000
26-29	1,000
30-34	1,000
35-39	1,000
40-44	1,000
45-49	1,000
50-54	1,000
55-59	1,000
60-64	1,000
65+	800
Total Members	10,000

Response	
Age	Count
0-18	
19-25	
26-29	
30-34	
35-39	
40-44	
45-49	
50-54	
55-59	
60-64	
65+	
Total Members	0

4.06 Number of subscribers as of 12/31/11 by family size/contract type, based on how sold/recorded in your system:

Example	
Contract Type	Count
Employee Only	1,000
Employee + Spouse	1,000
Employee + Child(ren)	1,000
Employee + Family	2,000
Total Subscribers	5,000

Response	
Contract Type	Count
Employee Only	
Employee + Spouse	
Employee + Child(ren)	
Employee + Family	
Total Subscribers	0

4.07 Number of Employer Groups and members by geographic region (based on employer location & see instructions for definition of each region):

Example		
Geography	Groups	Members
Northwest	50	2,500
Southwest	0	0
N Central	70	2,500
S Central	80	2,500
Eastern	50	2,500
Total	250	10,000

Response		
Geography	Groups	Members
Northwest		
Southwest		
N Central		
S Central		
Eastern		
Total	0	0

4.08 Number of Employer Groups and Members by Employer Group Size:

Example			
Employer Group Size	Employers	Subscribers	Members
1-5	60	110	220
6-9	65	390	780
10-19	50	600	1,200
20-29	0	0	0
30-50	50	1,500	3,000
51-75	10	600	1,200
76-100	5	400	800
101-150	5	525	1,050
151-200	5	875	1,750
201-300	0	0	0
301-500	0	0	0
501+	0	0	0
Total	250	5,000	10,000

Response			
Employer Group Size	Employers	Subscribers	Members
1-5			
4-9			
10-19			
20-29			
30-50			
51-75			
76-100			
101-150			
151-200			
201-300			
301-500			
501+			
Total	0	0	0







4.19 Industry rating factors - 4.09 indicates that you rate based on industry, please provide the particular codes for those receiving the highest of the factors listed in 2.18. Otherwise, provide your entire industry table separately.

Example	
Highest Industry Rating Impact	Industry or SICs
1.1500	111-140, 4141, 5993, 8011, 9311

Response	
Highest Industry Rating Impact	Industry or SICs

4.20 Experience/health status factors - 4.10 indicates that you underwrite for rating purposes, please provide those impacts along with count of 12/31/11 groups, subscribers, and members affected. If more space is needed, provide separately.

Average Factor	1.000
----------------	-------

Average Factor	1.250
----------------	-------

Example			
Experience / Health Status Factor	Group Count	Subscriber Count	Member Count
<=0.75	25	1,250	2,500
0.76-0.90	50	1,250	2,500
0.91-1.10	100	1,500	3,000
1.11-1.24	50	500	1,000
>=1.25	25	500	1,000
Total	250	5,000	10,000

Response			
Experience / Health Status Factor	Group Count	Subscriber Count	Member Count
<=0.94			
0.95-1.13			
1.14-1.38			
1.39-1.55			
>=1.56			
Total	0	0	0

4.21 Plan variances - 4.09 indicates that you rate based on plan design, please tell us approximately how many plans you offer and number of groups on each type as of 12/31/11.

Example		
Plan Type	Count of Plans	Group Count
Open Active Plans	20	200
Closed Plans - Grandfathered	2	50
Closed Plans - Non-Grandfathered	0	0
Total	22	250

Response		
Plan Type	Count of Plans	Group Count
Open Active Plans		
Closed Plans - Grandfathered		
Closed Plans - Non-Grandfathered		
Total	0	0

4.22 Durational rating impacts - 4.09 indicates that you rate based on duration, please provide those impacts and number of groups impacted by each as of 12/31/11. If more space is needed, provide separately.

Example		
Duration	Rating Impact	Group Count
Initial Year	1.0000	50
1st Year Renewal	1.1000	50
2nd Year Renewal	1.2000	50
3rd Year Renewal	1.3000	50
4th Year Renewal	1.4000	50
5th Year Renewal	1.5000	0
6th Year Renewal	1.6000	0
7th Year Renewal	1.7000	0
Total		250

Response		
Duration	Rating Impact	Group Count
Total		0



4.27 For claims incurred in calendar year 2011, please tell us the following:

Example	
Claim Responsibility	Dollars
Plan Share	\$8,000,000
Member Share*	\$1,000,000
Total Allowed	\$9,000,000

Response	
Claim Responsibility	Dollars
Plan Share	
Member Share*	
Total Allowed	\$0

\*Member share = deductibles, copays, coinsurance (NOT premium, balance billing, etc.)

4.28 For your membership as of 12/31/11, please tell us the count by general plan type:

Example	
Plan Type	Member Count
HMO	8,000
PPO	1,000
Fee for Service	500
HDHP Qualified	500
Total	10,000

Response	
Plan Type	Member Count
HMO	
PPO	
Fee for Service	
HDHP Qualified	
Total	0

4.29 For those on an EE only policy (no dependents) as of 12/31/11, please report the average plan features:  
This should be based on plan design for in-network benefits, not actual average amounts paid by the insured.

Example	
In-Network Plan Feature	Average
Deductible	\$1,500
Office Visit Copay	\$35
Coinsurance % (Member Share)	20%
Out of Pocket Maximum	\$5,000

Response	
In-Network Plan Feature	Average
Deductible	
Office Visit Copay	
Coinsurance % (Member Share)	
Out of Pocket Maximum	

4.30 For those on a policy containing dependents as of 12/31/11, please report the average plan features:  
This should be based on plan design for in-network benefits, not actual average amounts paid by the insured.

Example	
In-Network Plan Feature	Average
Deductible	\$3,000
Office Visit Copay	\$35
Coinsurance % (Member Share)	20%
Out of Pocket Maximum	\$10,000

Response	
In-Network Plan Feature	Average
Deductible	
Office Visit Copay	
Coinsurance % (Member Share)	
Out of Pocket Maximum	

4.31 For your members as of 12/31/11, please quantify the number of members by in-network deductible.  
This should be based on plan design, not actual average amounts paid by the insured.

Example	
In-Network Deductible	Member Count
\$0 (or no deductible)	5,000
\$1 - \$500	1,000
\$501 - \$1,000	1,000
\$1,001 - \$3,000	1,000
\$3,001 - \$6,000	1,000
Over \$6,000	1,000
Total	10,000

Response	
In-Network Deductible	Member Count
\$0 (or no deductible)	
\$1 - \$500	
\$501 - \$1,000	
\$1,001 - \$3,000	
\$3,001 - \$6,000	
Over \$6,000	
Total	0

4.32 For your members as of 12/31/11, please quantify the number of members by Out of Pocket Max, including deductible.  
This should be based on plan design, not actual average amounts paid by the insured.

Example	
Out of Pocket Maximum (including deductible)	Member Count
\$0	5,000
\$1 - \$1,000	1,000
\$1,001 - \$2,000	1,000
\$2,001 - \$6,000	1,000
\$6,001 - \$12,000	1,000
Over \$12,000	500
No OOP Max/Unlimited	500
Total	10,000

Response	
Out of Pocket Maximum (including deductible)	Member Count
\$0	
\$1 - \$1,000	
\$1,001 - \$2,000	
\$2,001 - \$6,000	
\$6,001 - \$12,000	
Over \$12,000	
No OOP Max/Unlimited	
Total	0

4.33 For your members as of 12/31/11, please quantify the number of members having the following available benefits. This should be based on availability in plan design, not actual usage by the insured.

Example		
Plan Benefit	Via Plan or Rider	Member Count
Generic Rx Only	Rider	1,000
Generic and Brand Rx	Rider	1,000
Maternity	Plan	10,000
Non-Severe Mental Health	Plan	10,000
Severe Mental Health	Plan	10,000
Preventive	Plan	10,000

Response		
Plan Benefit	Via Plan or Rider	Member Count
Generic Rx Only		
Generic and Brand Rx		
Maternity		
Non-Severe Mental Health		
Severe Mental Health		
Preventive		