June 2010

Report to the Health Care Access Bureau
Within the Massachusetts Division of Insurance

Analysis of Individual Health Coverage In Massachusetts Before and After the July 1, 2007 Merger of the Small Group and Nongroup Health Insurance Markets

OLIVER WYMAN

Dianna K. Welch, F.S.A., M.A.A.A.
Kurt Giesa, F.S.A., M.A.A.A.

MMC MARSH MERCER KROLL
GUY CARPENTER OLIVER WYMAN

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) prepared this report for the sole use of the Health Care Access Bureau of the Massachusetts Division of Insurance. Distribution to parties other than the Health Care Access Bureau does not constitute advice by Oliver Wyman to those parties. This report should not be distributed to other parties unless it is distributed in its entirety. The reliance on any aspects of this report by parties other than Health Care Access Bureau is not authorized by Oliver Wyman and is done at their own risk.

Oliver Wyman relied on a significant amount of membership and claims data submitted by the major Massachusetts health carriers in performing its analysis. In arriving at the findings, Oliver Wyman used and relied on information provided by the participating health carriers. If this information is inaccurate or incomplete, Oliver Wyman's findings and conclusions may need to be revised.

While Oliver Wyman relied on the data provided by the health plans without independent investigation or verification, Oliver Wyman reviewed the information for consistency and reasonableness. Where Oliver Wyman found the data inconsistent or unreasonable, it requested clarification. Oliver Wyman utilized generally accepted actuarial methodologies in arriving at its findings. To the extent this data is incomplete or inaccurate, Oliver Wyman's findings may need to be revised.

Contents

1

Introduction

In 2006, a comprehensive health reform law[1] (the "Massachusetts Health Reform Law") expanded access to health coverage in Massachusetts. Residents must maintain an adequate level of health coverage, called minimum creditable coverage, or face significant financial penalties. The Massachusetts Health Reform Law also combined previously separate small group and nongroup health coverage markets into one merged market (the "Merged Market") in order to make coverage more affordable to individuals.

The Merged Market[2] allows individuals to purchase the same array of products available to small employers. Rates are primarily based on the claims experience of the larger pool of small group members. The law requires that carriers who offer coverage in the Merged Market offer the same coverage to individuals as offered to small employers.

In the summer of 2009, health carriers notified the Division of Insurance (the Division) that they were experiencing spikes in utilization among individual members who were newly enrolled under the Merged Market. The health carriers indicated that more individuals were terminating coverage after having expensive medical procedures.

The Division's Health Care Access Bureau (HCAB) engaged Oliver Wyman to analyze the claims experience of individuals in the nongroup market prior to and after the merger. In order to perform this study, Oliver Wyman collected and analyzed claims data with

[1] Chapter 58 of the Acts of 2006.

[2] Note that throughout this report, when we refer to the Merged Market we also include the experience of the individuals remaining in the residual nongroup market. The experience of the individuals remaining in the residual nongroup market represents less than 2% of the total member months after the merger of the markets, and does not have a material impact on the results of the analysis. While the individuals in the residual nongroup market represent 8% of subscribers in Table 1, the member months provide a more appropriate reflection of the financial impact that these members have on the Merged Market.

dates of service from January 1, 2006 through December 31, 2006 and from January 1, 2008 to December 31, 2008, testing whether increased adverse selection may have been an unintended consequence of the merger of the nongroup and small group markets.

Major Findings

- The average number of covered individual subscribers[3] grew from 45,900 in 2006 to 107,343 in 2008.

- The percentage of individuals terminating coverage within their first year grew from 13.8% in 2006 to 24.2% in 2008.

- The Merged Market's allowed claims costs PMPM in 2008 were 3.4% higher than the small group market's allowed claims costs PMPM.[4] .

- After adjusting for higher premiums paid by individual subscribers (e.g. through group size adjustment and age factors), the cost of the merger is estimated to be 2.6% (ranging from -4.3% to 5.9% per carrier) or 1.1% to 1.6% higher than the 1.0% to 1.5% impact that had been projected prior to the merger.

- In 2006, individuals and small groups who terminated within a year had loss ratios 2.2% lower than average for the combined markets. However, in the Merged Market, the loss ratio of those terminating within a year is 8.8% higher than average. This indicates adverse selection may be occurring.

- Oliver Wyman estimates the cost of the additional adverse selection in the Merged Market is in the range of 0.5% to 1.5%. Consideration should be given to creating pre-existing condition provisions, waiting periods, or open enrollment periods for individuals to reduce the adverse selection in the Merged Market. In addition, strengthening the individual mandate would help to alleviate the adverse selection in the Merged Market.

- There were 1,272 high-cost individual subscribers terminating coverage within six months in 2008 compared to 364 in 2006; this is an increase of 249%. If high-cost individuals who terminated within one year were not covered in the Merged Market, the Merged Market loss ratio would have improved by 0.7 percentage points.

---

[3] This only includes coverage issued directly by health carriers to individuals eligible to purchase coverage under M.G.L. c. 176M or M.G.L. c. 176J and does not include persons enrolled in subsidized Commonwealth Care or Young Adult Plans newly developed and offered through the Commonwealth Health Insurance Connector Authority ("Connector").

[4] Allowed claims represent the total payments made to providers, including both the amount paid by the health insurer and the cost sharing paid by the members.

- If an open enrollment period were in place, and the proportion of individuals dropping coverage within a year returned to 2006 levels, it is estimated that the Merged Market loss ratio would improve by approximately 1.2%.[5]

[5] This also assumes that individuals who maintain coverage for the full twelve months instead of dropping coverage, have claims consistent with "low-cost" claimants during the additional months of coverage.

2

Changes in the Merged Small Group/Nongroup Market

Prior to the merger of the guarantee issue markets for nongroup and small group business, health carriers in each market were permitted by statutes[6] to impose either a pre-existing condition limitation or a waiting period on new enrollees.[7] These laws were intended to safeguard against adverse selection.

Following the merger of the markets, health carriers continue to be permitted to impose pre-existing condition limitations and waiting periods,[8] but are now required to apply them in the same manner for both small groups and individuals. This change has created an administrative problem for the health carriers. Although health carriers always applied waiting periods or pre-existing limitations for individuals, they did not generally apply them for small employers, due to the administrative burden of doing so. Consequently, when the markets were merged, health carriers stopped applying waiting periods or pre-existing condition limitations to individuals. Now individuals now become covered from the effective date of purchase for all services.

Studies performed prior to the merger of the markets estimated that individual coverage rates would decrease by 15% and small employer rates would increase by between 1.0% to 1.5% of premium.[9] These studies did not, however, consider the unintended consequence of the elimination of pre-existing condition and waiting periods for individuals. This analysis examines claims experience for individuals in 2006 under the nongroup market and in 2008 under the Merged Market to determine whether there has

[6] M.G.L. c. 176M applied to nongroup coverage; M.G.L. c. 176J applies to small group coverage.

[7] Both the pre-existing condition limitation and the waiting period were limited to a six-month period, with credit toward the six months for any prior creditable coverage not separated by more than a 63-day gap in coverage.

[8] The length of the waiting period under the merged market was reduced to a four-month period.

[9] Gorman Actuarial, LLC, et al., "Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets" (Dec. 26, 2006).

been changed behavior that is leading to increases in claims costs in 2008 compared to 2006.

3

Analysis of All Individuals in the Merged Market

For calendar years 2006 and 2008, health carriers submitted the number of individual and small group subscribers who terminated in their first year of coverage (listed by the number of months of coverage before termination) and the number who terminated beyond one year. In addition, the health carriers submitted data showing the total payments made to providers on behalf of each group of individuals.

The following Table 1 shows the number of individual subscribers and small groups by their duration of coverage. Note that in identifying subscribers and small groups, we included a six-month look-back and look-forward period for each calendar year. For example, subscribers and small groups shown in the 2006 column include subscribers and small groups who had coverage during 2006, but in determining the duration of coverage, we considered the period between July 1, 2005 and June 30, 2007. Subsequent tables showing financial metrics such as premium, claims, and loss ratios reflect only the subscribers' and small groups' experience during the relevant calendar year.

Subscribers by Duration of Coverage

Table 1: Individual Subscribers and Small Groups by Duration at Termination

	Individual Subscribers				Small Groups	
		2008				
Duration at Termination	2006	Pre-Merger Products	Post-Merger Products	Total	2006	2008
1 month	569		4,254	4,254	1,860	1,900
2 months	682		3,676	3,676	2,243	2,046
3 months	642		3,036	3,036	2,655	2,373
4 months	563		2,363	2,363	2,064	1,732
5 months	524		2,020	2,020	2,116	1,882
6 months	528		1,828	1,828	2,264	1,983
7 months	511	23	1,666	1,689	1,822	1,624
8 months	512	40	1,410	1,450	1,640	1,484
9 months	484	50	1,321	1,371	2,309	1,943
10 months	473	83	1,143	1,226	1,695	1,639
11 months	470	110	1,132	1,242	1,842	1,708
12 months	384	116	1,734	1,850	4,136	4,617
>12 months	12,203	10,523	8,533	19,056	42,414	58,574
1 - 6 months	3,508	N/A	17,177	17,177	13,202	11,916
7 - 12 months	2,834	422	8,406	8,828	13,444	13,015
<= 12 months	6,342	422	25,583	26,005	26,646	24,931
Terminated Total	18,545	10,945	34,116	45,061	69,060	83,505
Active	27,355	14,320	47,962	62,282	130,086	117,978
Grand Total	45,900	25,265	82,078	107,343	199,146	201,483

As indicated in the highlighted section of Table 1, there were substantial changes in the purchase of products between 2006 and 2008.

- Among small employers, the number of active groups decreased from 130,086 in 2006 to 117,978 in 2008. The number of small groups who enrolled and then terminated within 12 months declined from 26,646 to 24,931.

- Among individuals, there is a significant increase in the number of individual subscribers in force for one year or less; this represents people "jumping" into and out of coverage.

    - Individual subscribers active at the end of the year grew from 27,355 in 2006 to 62,282 in 2008; this is an increase of 128%.

- Individual subscribers who enrolled and terminated their coverage within 12 months of enrollment rose from 6,342 in 2006 to 26,005 in 2008; this is an increase of 310%.
- Individual subscribers who enrolled and terminated their coverage within six months of enrollment rose from 3,508 in 2006 to 17,177 in 2008; this is an increase of 390%.
- The proportion of individual subscribers remaining active for one year or less grew from 13.8% in 2006 to 24.2% in 2008.

Although a fair amount of churning[10] may be expected within a guaranteed issue market, there appears to be significantly more churning as a result of the markets' merger and the elimination of waiting periods and pre-existing condition limitations.

Claims Costs by Duration of Coverage

Table 2, below, shows allowed claims experience per member per month (PMPM). The 2006 claims were trended forward two years at an annual rate of 5.51% so that the small group claims PMPM in 2006 could be compared to the small group claims PMPM in 2008.

Table 2: Allowed PMPM by Duration at Termination

	Individual				Small Group		Individual and Small Group Combined	
		2008						
Duration at Termination	2006*	Pre-Merger Products	Post-Merger Products	Total	2006	2008	2006	2008
1 month	$645		$400	$400	$495	$339	$531	$379
2 months	424		322	322	391	266	399	301
3 months	478		441	441	256	298	304	373
4 months	417		449	449	285	246	313	358
5 months	452		404	404	268	325	303	364
6 months	512		470	470	289	256	326	358
7 months	552	$127	428	427	304	269	353	344
8 months	590	138	431	431	354	241	407	334
9 months	493	50	468	467	299	240	326	335
10 months	529	777	438	439	322	296	359	353
11 months	412	955	407	409	332	411	346	410
12 months	448	292	338	338	322	334	326	334
>12 months	593	582	543	556	348	345	372	365
1 - 6 months	470	N/A	420	420	295	283	330	356
7 - 12 months	499	579	407	407	321	322	339	346
<= 12 months	489	579	412	412	317	315	337	349
Terminated Total	572	582	470	490	343	341	366	362
Active	505	569	466	487	351	352	359	362
Grand Total	$524	$573	$467	$488	$350	$350	$360	$362

* 2006 PMPMs were trended to 2008 at an annual rate of 5.51%

- In aggregate, small group claims costs in 2008 post-merger were $350 PMPM; the Merged Market claims costs were $362 PMPM. Therefore, the Merged Market's claims costs in 2008 were 3.4% higher than the small employers' claim costs.

[10] Churning is generally defined as individuals enrolling and then terminating coverage.

- The Merged Market's claims costs were expected to be higher than the small group market's claims costs by 1.0% to 1.5%. While the 3.4% increase is higher than projected,
  - part of the increase in claims costs is due to the higher average age of the members covered in the individual market.[11] (Older individuals pay higher premiums than younger individuals [within regulatory limits] so, a portion of the increased claims costs that is due to higher age is paid by the individuals and does not need to be spread across all those in the Merged Market.[12] Only the portion of the increased claim costs that are not charged directly to the individuals through higher premium rates must be spread over the entire Merged Market). The expected increase of 1.0% to 1.5% reflected the impact of this higher premium.
  - part of the difference can be attributed to the unintended consequences of the removal of waiting periods and pre-existing conditions from individuals.
- Regarding those who terminated coverage within a year, 2008 small group claims costs were $315 PMPM and Merged Market claims costs were $349 PMPM. The Merged Market's claims costs for those terminating within a year are 10.6%[13] higher than those who terminate within a year from the small group market.
- For individuals, PMPM claims costs declined from 2006 to 2008 for nearly all durations of coverage. The average cost for individuals PMPM in 2008, even when terminating early, is lower than it was in the pre-merger, nongroup market.
- Claims costs for individuals terminating within a year are significantly higher than the claims costs for the small group market. Combining these higher claims costs with the increased volume of those terminating early results in added cost to the small group market.

Loss Ratio by Duration of Coverage

In order to understand the portion of the 3.4% increase in claims costs that results in higher premiums for small groups, it is necessary to analyze the loss ratios of the small group market and the Merged Market. Loss ratios adjust for the impact of the difference in the premiums that are paid by individuals and small groups, and therefore isolate the portion of the increased claims costs that are spread over the entire Merged Market.

---

[11] Welch, Dianna, prepared for Massachusetts Division of Health Care Finance and Policy, Premium Levels and Trends in Private Health Insurance Plans; http://www.mass.gov/Eeohhs2/docs/dhcfp/r/cost_trends_files/part2_premium_levels_and_trends.pdf

[12] In the Merged Market, the increased premium that may be charged due to higher than average age is limited by regulation 211 CMR 66. Therefore, to the extent that older individuals may not be charged the full cost of their age-related claims, there is a portion of the age-related costs that is spread over the entire Merged Market.

[13] The 10.6% increase is calculated from un-rounded PMPM amounts (not shown).

Health carriers have had loss ratios[14] close to 90% over the past few years in the Massachusetts market.[15] The following table shows the loss ratios for the small group market and the Merged Market, normalizes that ratio to 1.00 for each market, and calculates the relative loss ratios for all durations of coverage.

Table 3: Loss Ratios by Duration at Termination

	Small Group		Individual and Small Group Combined	
Duration at Termination	2006	2008	2006	2008
	Loss Ratio			
1 - 6 months	68.3%	71.5%	77.8%	97.1%
7 - 12 months	83.7%	86.2%	86.7%	95.2%
<= 12 months	81.2%	84.1%	85.0%	95.6%
> 12 months	86.5%	84.2%	88.9%	87.9%
Terminated Total	85.7%	84.2%	88.3%	89.1%
Active	86.2%	86.1%	86.7%	87.6%
Grand Total	86.2%	85.7%	86.9%	87.9%

	Ratio of Loss Ratio by Duration at Termination to Grand Total Loss Ratio			
1 - 6 months	0.793	0.834	0.895	1.105
7 - 12 months	0.972	1.005	0.997	1.083
<= 12 months	0.942	0.981	0.978	1.088
> 12 months	1.004	0.982	1.022	1.000
Terminated Total	0.994	0.982	1.015	1.014
Active	1.001	1.004	0.997	0.997
Grand Total	1.000	1.000	1.000	1.000

- In 2008, the small group market experienced a loss ratio of 85.7%. In 2008, the Merged Market loss ratio was 87.9%. This indicates that the merger of the market increased the loss ratio by 2.6% (0.879 / 0.857 – 1). This is also the increase in premium that is necessary for carriers to charge small groups in aggregate in order

[14] Claims incurred divided by premium revenue earned.

[15] Welch, Dianna, prepared for Massachusetts Division of Health Care Finance and Policy, Premium Levels and Trends in Private Health Insurance Plans; http://www.mass.gov/Eeohhs2/docs/dhcfp/r/cost_trends_files/part2_premium_levels_and_trends.pdf

to achieve their target loss ratios. This is 1.1% to 1.6% more than the predicted increase of 1.0% to 1.5%.

- The 2.6% increased cost is the aggregate cost to the small group market across all carriers. The cost varies by carrier and ranges from -4.3% to 5.9%.[16] There were two carriers with a negative (favorable) cost to the small group, indicating that these two carriers experienced favorable selection among individuals resulting in lower Merged Market loss ratios than small group loss ratios.

- Active members in the Merged Market generally have a relative loss ratio of 0.997 while those terminating within one year have a relative loss ratio of 1.088. This means that the active members subsidize some of the costs tied to those individuals who terminate within one year.

- In 2006, those that terminated coverage after one year or less had loss ratios that were less than the average both in the small group market and in the combined small group and nongroup markets. In the combined small group and nongroup markets, the relative loss ratio was 0.978. However, in the Merged Market, the relative loss ratio of those terminating after one year or less is 1.088, despite small groups continuing to perform better than average at those durations, indicating that only the individuals are exhibiting adverse selection at the short durations.

Initial Conclusions When Looking at All Individuals

- The number of individuals holding coverage for short periods of time has increased significantly since the merger.
- The increased number of individuals who terminated after short durations, combined with their higher claims costs relative to small group claims costs, increases costs in the Merged Market.

- When comparing the claims cost PMPM of individuals terminating within a year in the 2006 nongroup market and individuals terminating within a year with Post-Merger products in 2008, the claims cost did not go up. Assuming the population stayed the same, the absence of waiting periods does not appear to cause a significant change in the relative costs of individuals in the Merged Market. However, the population and product mix did not stay the same. The Division and Oliver Wyman decided to examine further the individuals covered in both markets in the next section of this report.

[16] One outlier impact of 27.5% is not shown in the range and was experienced by a very small carrier without a credible block of Merged Market business.

4

Analysis of High-Cost and Low-Cost Individuals

In order to examine potential differences between the individuals who terminated within their first year of coverage both before and after the market merger, the data was further stratified. Plans supplemented their initial data submissions to split membership and claims data between those individuals who were high-cost users of care (claims costs of $1000 or more per month) and those who were low-cost users of care (claims costs of less than $1000 per month). This was intended to determine whether there were different coverage trends between the two populations.

High-Cost Individuals

As illustrated in Table 4, the number of high-cost individual subscribers increased substantially from 2006 to 2008.

Table 4: High-Cost Individual Subscribers by Duration at Termination

	Individual			
		2008		
Duration at Termination	2006*	Pre-Merger Products	Post-Merger Products	Total
1 month	60		224	224
2 months	62		226	226
3 months	71		232	232
4 months	57		215	215
5 months	61		182	182
6 months	53		193	193
7 months	58	2	173	175
8 months	53	4	150	154
9 months	46	5	140	145
10 months	63	9	111	120
11 months	42	17	106	123
12 months	36	15	137	152
>12 months	1,487	1,528	1,063	2,591
1 - 6 months	364	N/A	1,272	1,272
7 - 12 months	298	52	817	869
<= 12 months	662	52	2,089	2,141
Terminated Total	2,149	1,580	3,152	4,732
Active	3,932	2,162	5,023	7,185
Grand Total	6,081	3,742	8,175	11,917

- There were 2,141 high-cost individual subscribers terminating coverage within twelve months in 2008 compared to 662 in 2006; this is an increase of 223%.
- There were 1,272 high-cost individual subscribers terminating coverage within six months in 2008 compared to 364 in 2006; this is an increase of 249%.
- The total number of active high-cost subscribers increased from 3,932 in 2006 to 7,185 in 2008; this is an increase of 83%.
- High-cost subscribers increased most quickly among those who terminated coverage within six months of enrollment.

Table 5: Allowed PMPM of High-Cost Individuals by Duration at Termination

	Individual			
		2008		
Duration at Termination	2006*	Pre-Merger Products	Post-Merger Products	Total
1 month	$4,340		$5,074	$5,074
2 months	3,927		3,054	3,054
3 months	3,276		3,834	3,834
4 months	2,612		3,622	3,622
5 months	2,748		3,279	3,279
6 months	3,863		3,212	3,212
7 months	3,586		2,877	2,878
8 months	4,750		3,107	3,107
9 months	3,388		3,406	3,406
10 months	3,089	1,525	2,897	2,881
11 months	2,583	2,473	3,139	3,132
12 months	3,306	2,317	2,308	2,309
>12 months	3,333	2,926	3,122	3,048
1 - 6 months	3,270	N/A	3,507	3,507
7 - 12 months	3,432	2,076	2,904	2,901
<= 12 months	3,373	2,076	3,129	3,127
Terminated Total	3,340	2,922	3,126	3,078
Active	2,382	2,634	2,406	2,462
Grand Total	$2,641	$2,721	$2,630	$2,653

* 2006 PMPMs were trended to 2008 at an annual rate of 5.51%

- Average PMPM claims costs of high-cost individuals with coverage for six months or less rose from $3,270 to $3,507 per month, or by 7%. This compares to a 7% decrease in the PMPMs for all individuals.

- If high-cost individuals terminating within 12 months were not in the Merged Market pool in 2008, the loss ratio of the Merged Market would have been reduced by 0.7 percentage points (data not shown).

- High-cost individuals have high loss ratios by definition. However, among high-cost individuals, those with short durations of coverage have significantly higher loss ratios than all high-cost individuals combined. In 2006, high-cost individuals

with coverage for 12 months or less had loss ratios 51.7% higher than average. In 2008, the analogous differential was 61.9% (Table 6).

Table 6: Ratio of High Cost Individual Loss Ratio by Duration at Termination to Grand Total High Cost Individual Loss Ratio

	Individual			
		2008		
Duration at Termination	2006	Pre-Merger Products	Post-Merger Products	Total
1 - 6 months	1.562		1.520	1.752
7 - 12 months	1.493	1.023	1.340	1.539
<= 12 months	1.517	1.023	1.408	1.619
> 12 months	1.234	1.058	1.146	1.043
Terminated Total	1.276	1.058	1.256	1.199
Active	0.898	0.975	0.894	0.916
Grand Total	1.000	1.000	1.000	1.000

Table 7 shows that the proportion of enrollment in individual coverage for durations of one year or less that is attributable to high-cost claimants has increased from 2006 to 2008, by 38%. At the same time, the proportion of claims increased by over 127%.

Table 7: High Cost Individuals by Duration of Coverage as Percent of All Individuals, All Durations

2006

Duration of Coverage	Subscribers	Member Months	Premium	Allowed Claims
≤ 6	0.8%	0.2%	0.2%	1.2%
≤ 12	1.4%	0.5%	0.6%	3.3%
All Terminated	4.7%	2.9%	4.0%	18.6%
Active	8.6%	7.9%	11.0%	35.8%
Total	13.3%	10.8%	15.0%	54.5%

2008

Duration of Coverage	Subscribers	Member Months	Premium	Allowed Claims
≤ 6	1.2%	0.4%	0.4%	3.1%
≤ 12	2.0%	1.2%	1.2%	7.5%
All Terminated	4.4%	3.1%	4.3%	19.5%
Active	6.7%	6.9%	10.1%	34.9%
Total	11.1%	10.0%	14.4%	54.5%

Ratio (2008 / 2006)

Duration of Coverage	Subscribers	Member Months	Premium	Allowed Claims
≤ 6	1.491	2.323	2.084	2.683
≤ 12	1.380	2.282	1.903	2.278
All Terminated	0.939	1.057	1.061	1.049
Active	0.780	0.875	0.924	0.974
Total	0.836	0.924	0.961	1.000

Low-Cost Individuals

Table 8 summarizes the number of low-cost individual subscribers.

Table 8: Low-Cost Individual Subscribers by Duration at Termination

	Individual			
		2008		
Duration at Termination	2006*	Pre-Merger Products	Post-Merger Products	Total
1 month	509		4,039	4,039
2 months	620		3,463	3,463
3 months	571		2,821	2,821
4 months	506		2,165	2,165
5 months	463		1,848	1,848
6 months	476		1,655	1,655
7 months	452	21	1,504	1,525
8 months	459	36	1,268	1,304
9 months	438	45	1,191	1,236
10 months	410	74	1,039	1,113
11 months	428	93	1,029	1,122
12 months	347	101	1,604	1,705
>12 months	10,691	8,995	7,485	16,480
1 - 6 months	3,145	N/A	15,991	15,991
7 - 12 months	2,534	370	7,635	8,005
<= 12 months	5,679	370	23,626	23,996
Terminated Total	16,370	9,365	31,111	40,476
Active	23,415	12,155	42,954	55,109
Grand Total	39,785	21,520	74,065	95,585

- The number of low-cost individuals terminating in less than six months increased from 3,145 in 2006 to 15,991 in 2008, an increase of over 400%.

- The high number of low-cost individuals indicates that relatively healthy members are also dropping coverage and therefore are not contributing a full year of premium to the overall risk pool.

- There are reasons for both high-cost and low-cost subscribers to maintain individual coverage for a short period of time, including a move out of state or obtaining employer-sponsored coverage. However, we believe it is unlikely that

these reasons can explain the increase in the proportion of subscribers that are dropping coverage.

- We estimated the impact on the Merged Market of employing an annual open enrollment period. Assuming that a portion (consistent with 2006 levels) of those that drop coverage will continue to do so for reasons such as those mentioned above, and the remainder keep their coverage for a full 12 months, we estimate that the 2008 Merged Market loss ratio would be reduced from 87.9% to 86.8%, a reduction of 1.3%.[17]

Conclusions about High-Cost and Low-Cost Individuals

- The proportion of high-cost, short duration individuals has increased since the merging of the markets, indicating increased adverse selection. The high-cost, short duration individuals have loss ratios significantly higher than all high-cost individuals combined, resulting in increased costs to the Merged Market. In order to address this, consideration should be given to either establishing separate pre-existing condition limitation/waiting periods or creating an open enrollment period specific to individuals.

- The proportion of low-cost, short duration individuals has increased since the merging of the markets, despite the penalties associated with the individual mandate for coverage. These low-cost short duration individuals have loss ratios lower than the remainder of those covered yet they negatively impact the overall experience of the pooled market because they terminate within the first year without paying a full year of premium. In order to address this, consideration should be given to strengthening the penalties in place now to increase the impact of the individual mandate.

[17] This analysis assumes that the loss ratio during the additional months of coverage will be 53.1%, consistent with the 2008 loss ratio of low-cost individuals.

[page intentionally left blank]

Appendix A

List of Participating Carriers

- Aetna Health Inc.
- Aetna Life Insurance Company
- Assurant Health (John Alden Life Insurance Company, Time Insurance Company and Union Security Insurance Company)
- Blue Cross and Blue Shield of Massachusetts, Inc.
- Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
- ConnectiCare of Massachusetts, Inc.
- Fallon Community Health Plan, Inc.
- Fallon Health and Life Assurance Company, Inc.
- Harvard Pilgrim Health Care, Inc.
- HPHC Insurance Company, Inc.
- Health New England, Inc.
- Mid-West National Life Insurance Company of Tennessee
- Neighborhood Health Plan, Inc.
- The MEGA Life and Health Insurance Company
- Tufts Associated Health Maintenance Organization, Inc. (d/b/a/ Tufts Health Plan)
- Tufts Insurance Company
- UnitedHealthcare of New England, Inc.
- UnitedHealthcare Insurance Company

Appendix B

Methodology

Oliver Wyman's initial analysis of the data revealed issues with several of the datasets provided. After further investigation by Oliver Wyman and the carriers, some of the datasets were re-run and sent to Oliver Wyman.

After all of the revised datasets were received, the carriers' data was aggregated to reflect the entire study population. From the aggregated data, Oliver Wyman was able to produce several analyses and summary statistics by duration of coverage as described in this report. Summary statistics that were reviewed included member months, loss ratios, and per member per month (PMPM) allowed claims costs. Changes in allowed claim costs from 2006 to 2008 can be attributed to changes in the nature of the markets, as well as normal medical and prescription drug claim trend. In order to remove the impact of normal claim trend, we trended the 2006 claim data forward two years at an annual trend rate of 5.51%. 5.51% was chosen as the trend, because it resulted in the 2006 small group PMPM being equal to the 2008 small group PMPM. The small group market was chosen as the basis for this calculation because it was the most stable of the populations in the study during that time.

We also reviewed several additional statistics, such as paid to allowed ratios and distribution of allowed claims by type of service. Since these statistics did not exhibit noticeable patterns, they were not communicated in this report.

Finally, as noted in the report the participating carriers were asked to provide additional individual market data, separating the individuals into high cost and low cost claimants. The process for analyzing the additional data was the same as the original analysis. The datasets were analyzed for reasonableness. Some of the datasets were re-run. Similar analyses were performed on the revised datasets as was done with the original datasets.

OLIVER WYMAN

411 East Wisconsin Avenue, Suite 1600
Milwaukee, WI 53202-4419
1 414 223 7989