# Association Health Plans and Community-Rated Small Group Health Insurance in Washington State

Final Report

September 30, 2011(Updated)

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This report was developed pursuant to a contract with the Office of the Insurance Commissioner.

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*Figure 4 is updated in this copy of the final report.

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# EXECUTIVE SUMMARY

Washington State has a robust association health plan (AHP) market. Unlike many other states, Washington statute recognizes associations formed for the purpose of insurance. As a result, associations in Washington have been formed on several bases: within industry groups, across industry groups, and as creations of insurance carriers. While most AHPs offer coverage to small groups (with 50 or fewer employees), larger groups account for a growing share of AHP enrollment.

Washington State regulates AHPs as large group plans, specifically exempting them from small group rating and approval requirements. Since 1995, carriers have been able to offer "experience rated" premiums to small employers that buy AHP coverage, taking into consideration each employer's claims experience and the aggregated health history of its employees. Carriers may also use other rate factors to rate AHP coverage—such as gender and nonstandard age brackets for rate differentiation—that are prohibited in the community-rated small group market.

The asymmetric regulation of AHPs and small groups offers substantial opportunity for carriers to select risk. By rating coverage strategically and denying employers where the associations' own rules may permit, carriers can separate the risk pools for AHPs and other employer groups and can isolate high-cost small groups in community-rated coverage. As a result, premiums in the community-rated small group market might be higher for the same benefit design, discouraging some employers from offering coverage at all and driving others to offer less coverage (with more limited benefits and greater cost sharing) than they might if premiums were lower.

This report offers an analysis of the information that carriers provided in response to a data call issued by the Office of the Insurance Commissioner (OIC) as authorized in legislation amending ESBH 1714(2011), as well as other information that carriers reported in regular filings to the OIC and the U.S. Department of Labor.

## Enrollment in AHPs and Large Group or Community-Rated Small Group Plans

In 2008, approximately 491,300 Washington State residents were enrolled in AHP plans, including 227,000 enrolled through small employers and 264,300 enrolled through large employers. AHP enrollees accounted for more than one-third of total insured group coverage—16 percent in small groups with AHP coverage and 18 percent in large groups with AHP coverage. Nearly half of all insured small group enrollees (48 percent) were in AHP plans.

Small group enrollees in AHP plans predominantly included those in relatively large small groups—that is, groups of 11 to 50 workers, versus 2 to 10 workers. In 2008, these larger small groups accounted for 64 percent of total small-group enrollment in AHPs, and the smallest groups—with 2 to 10 workers—accounted for 36 percent. In contrast, larger small groups accounted for 48 percent of the community-rated small group market, while the smallest groups accounted for 52 percent.

## Trends in Enrollment

From 2005 to 2008, enrollment in AHPs increased 11 percent, while enrollment in either large group or community-rated small group insurance decreased nearly 12 percent—driving an overall decline in group coverage during this period. Most of this change occurred between 2007 and 2008, when the number of enrollees in AHPs increased 6 percent and the number of enrollees in large group or community-rated small group plans decreased nearly 11 percent.

From 2005 to 2008, large-group AHP enrollment increased much faster than small-group AHP enrollment. Large-group AHP enrollment increased more than 16 percent, while small-group AHP enrollment grew 4.5 percent. However, enrollment in both non-AHP large group and community-rated small group plans decreased faster than the increase in AHP enrollment. As a result, 87,000 fewer residents (-5.2 percent) were enrolled in any insured group coverage in 2008 than in 2005. In small groups, 67,500 fewer workers and dependents were covered overall, with 76,900 fewer workers and dependents covered in community-rated small group plans.

Corresponding to the growth in AHP enrollment, the number of carriers that wrote AHP business in Washington State increased from 11 in 2005 to 16 in 2008, as some carriers began insuring AHPs and others withdrew. In addition, the median size of AHPs grew 8 percent as associations with 500 or more enrollees became more prevalent. In 2008, AHPs with 500 or more enrollees accounted 42 percent of all AHPs.

The increase in the median size of AHPs from 2005 to 2008 coincided with an increase in the average size of AHP small groups and a decrease in the average size of small groups insured in the community-rated small group market. Even in 2005, the smallest groups accounted for a smaller share of AHP enrollment than enrollment in the community-rated small group market; by 2008, they accounted for an even lower proportion of AHP small group enrollment and a higher proportion of community-rated small group enrollment. In 2008, about 35 percent of AHP small-group enrollees were in groups with fewer than 10 lives, with 21 percent in the smallest groups of 2 to 5. In contrast, 50 percent of community-rated small group enrollees were in groups with fewer than 10 lives, with 27 percent in the smallest groups.

**Premiums and Medical Cost**

Because carriers have ample opportunity to segment risk between AHPs and community-rated small group market, it is widely supposed that small groups with AHP coverage pay lower premiums than are available to community-rated small groups. Indeed, in 2008, AHP small groups appear to have paid premiums that were substantially lower than community-rated small group premiums. On average, small groups in AHP plans paid about $246 per member month, compared with $316 per member per month in community-rated small group coverage. Adjusted for age, AHP small group premiums remained lower than community-rated small group premiums; other adjustments—for gender, location, benefit design, or burden of illness—were not possible with available data.

It is possible that much lower unadjusted average premiums for AHP small groups were related to generally narrower benefit designs (with, for example, lower limits on covered benefits or much higher cost sharing) than were available in the community-rated small group market. However, it seems more likely that lower average AHP premiums reflected better risk selection as well as the larger average size of AHP small groups compared with community-rated small groups.

From 2005 to 2008, premiums increased at a faster average rate for AHP small groups than for community-rated small groups, but remained lower for AHP small groups in all years. In both AHPs and community-rated small group plans, medical cost (defined as carrier payments for incurred claims) increased faster than premiums, but it increased fastest for small groups in AHPs.

The faster growth of average medical cost increased insurers' average medical loss ratios (calculated as total medical cost divided by total premiums) for both large and small groups in AHPs, as well as for community-rated small groups. However, in all years, the medical loss ratio for small groups in AHPs exceeded that in community-rated small groups, consistent with the larger

average size of AHP small groups. By 2008, the average medical loss ratio for small and large groups in AHPs had risen to 0.87, compared with 0.84 for community-rated small groups.

**Medical Underwriting**

Many carriers reported using health factors or claims experience to rate AHP coverage, having each applicant complete a standard health questionnaire (not requiring a physical exam) and reviewing claims histories to adjust rates at renewal. In 2008, health status was used to set rates in nearly half of all AHPs (48 percent), affecting 60 percent of AHP enrollees. Claims experience was used to set rates in nearly two-thirds of AHPs, affecting 87 percent of AHP enrollees. Just 6 percent of AHP enrollees were in a plan that used neither health factors nor claims experience to rate coverage. The number of AHPs that rated on health factors or claims experience (or both) increased from 75 in 2005 to 95 in 2008, and the number of AHP enrollees affected by these practices increased 26 percent.

Average premiums rose faster for enrollees in AHPs subject to rating on health status or claims experience, but the medical loss ratio on these plans increased much less than in AHPs where the carrier did not medically underwrite premiums. From 2005 to 2008, the average loss ratio for plans where carriers used health factors or claims experience to rate coverage increased just 4 percent. In AHPs where carriers did not medically underwrite premiums, the average medical loss ratio increased 16 percent.

**Update to 2010**

Carriers in Washington State reported lower levels of enrollment in AHPs and in community-rated small group plans in 2010 than in 2008. In 2010, estimated enrollment in AHPs was 2.5 percent less than in 2008, while enrollment in large group and community-rated small group plans dropped 11 percent. Overall, more than 35 percent of insured residents were enrolled in AHPs in 2010, compared with 33 percent in 2008.

A subset of carriers (representing 94 percent of total insured enrollment and 70 percent of AHP small group enrollment in 2008) reported more detailed information about the size of enrolled groups in both years. For these carriers, the change in enrollment from 2008 to 2010 was significant in at least two ways. First, while total enrollment dropped 11 percent, the loss of enrollment was concentrated in the large group and community-rated small group markets, not in AHPs—as also occurred from 2005 to 2008. Second, small group enrollment in AHPs increased 5 percent, while enrollment in every other category—AHP large groups, non-AHP large groups, and community-rated small groups—declined. In 2010, AHPs accounted for nearly half of these carriers' total small group enrollment (49 percent), compared with 39 percent in 2008.

As in 2008, average premiums for AHP small groups ($278) were substantially lower than for community-rated small groups ($382) in 2010, and may have increased much less since 2008. While comparison of AHP and community-rated small group premiums is complicated by the different calculations possible for 2008 and 2010, it appears that average premiums increased 6 percent for AHP small groups, compared with 21 percent for community-rated small groups.

**Future Monitoring**

Federal health reforms seem likely to transform the regulatory landscape for AHPs in Washington State and in other states that currently allow AHPs to operate under regulation that is different from the traditional market. For purposes of rate review and reporting, new federal rules include individual and small employer policies sold through associations in the rate review process—even if, as in Washington State, they are otherwise excluded from individual and small group market rules. Also with respect to the implementation of federal reform more broadly, federal regulators have expressed their view that the size of each individual employer participating in an AHP will determine whether the employer's coverage is subject to the small group or the large group rules. In addition, federal reform will redefine small groups as employer groups with 2 to 100 employees (versus the current definition of 2 to 50), potentially expanding the reach of small group market rules in AHPs as well as in the traditional market.

If embraced in Washington State, these changes could obviate many of the concerns that underlie this study. To the extent that AHP small groups are subject to the same regulations that govern the community-rated small group market, the ability of AHPs to segment risk in ways that would imperil the community-rated market is very limited. However, if Washington State wishes to continue to monitor the relationship of AHPs to the large group and community-rated small group market in coming years, more information is needed than either ESBH 1714(2011) authorized for this study or is obtained under other current reporting requirements. In particular, to understand whether AHPs are segmenting risk in ways that might destabilize the large group community-rated small group markets, it will be necessary to know in greater detail how carriers are rating AHPs—specifically, which rate factors they use, the impact on rates offered to AHP large and small groups, differences in plan designs, and the relative burden of illness in AHP large and small groups compared with that in non-AHP large groups and community-rated small groups.

In addition, to be useful to policymakers, this information must:

- Clearly include, and separately categorize, information about individuals and groups of one;
- Specifically name the AHP that is covered to allow verification of the reported data against other reporting and earlier survey information; and
- Identify which AHPs are insurer-sponsored, versus those initiated by public employer groups or private employer groups.

Finally, the information must be much more current than was required for this study, which looks back eight years and captures information only as recently as 2008.

Some of the information that is needed to understand the relationship between AHPs and the large group and community-rated small group markets will potentially be easier to obtain in future years due to efforts already underway in Washington State. For example, as of March 2011, health carriers are required to file a Revised Additional Data Statement reporting information about AHP enrollment, premiums, and medical cost for small and large groups—although, because life and disability carriers (which insured more than 15 percent of AHP enrollees in 2010) are not required to report, the information currently obtained is very incomplete. Other information needed to understand how the cost experience of AHPs differs from that in the large group and community-rated small group market might be obtained in the context of federal reforms or in parallel efforts (such as the development of an all-payer claims database) that Washington State might consider.

# INTRODUCTION

Washington State has a robust association health plan (AHP) market. Unlike many other states, Washington allows associations to form for the purpose of insurance. As a result, associations in Washington have been formed on several bases: within industry groups (such as the Washington Education Association (WEA)), across industry groups (such as the Associated Employers Health and Welfare Trust), and as creations of insurance carriers (such as the Washington Alliance for Healthcare Insurance Trust (WAHIT)). While most AHPs offer coverage to small groups (with 50 or fewer employees), larger groups account for a large and growing share of AHP enrollment.

Washington State regulates AHPs as large group plans, specifically exempting them from small group community rating requirements.[1] Since 1995, carriers have been able to offer "experience rated" premiums to small employers that buy AHP coverage, taking into consideration each employer's claims experience and the aggregated health history of its employees.[2] Carriers may also use other rate factors to rate AHP coverage—such as gender and nonstandard age brackets for rate differentiation—that are prohibited in the community-rated small group market. One managing general agent publicly attributes the "exceptional growth" of AHPs to regulation "which favors in many ways, member controlled Association or Trust Plans over community rated medical plans" in Washington State.[3]

The definitions of the individual and group insurance markets set out in new federal rules implementing the ACA differ from the current definitions that some states, including Washington State, use to exempt AHPs.[4] In particular, the final rules governing rate review and reporting provide

[1] Because the statutory authority of Washington State agencies to regulate health plans is dependent on the type of plan, it is complex and uneven. A summary chart of the authority of, respectively, the Washington State Office of the Insurance Commissioner and the U.S. Department of Health and Human Services to oversee rates and forms is provided in Appendix A.

[2] The question of whether AHPs can rate coverage to individual employer groups based on each group's health status or claims experience was raised in 2007, when the OIC issued Technical Assistance Advisory TAA-06-07 indicating that association rates must be based on the claims experience of the entire association membership and that any rating by an association based on the health information of an individual member employer was prohibited. Two associations challenged this approach to regulating the rating practices of associations. In finding for the plaintiffs, the Spokane County Superior Court noted that Washington's statutes provide an exemption for associations from the community rating laws but do not address how the association plan should be rated. In her 2007 ruling, the Judge noted that the rating approach desired by the OIC was a policy change that should be specified by the Legislature, not the agency. On August 29, 2007, the OIC permanently withdrew the advisory.

[3] The website goes on to note that "the ability to factor industry, gender and geographical location when establishing new business rates is allowed by current regulation of member controlled Associations" and that, due to these factors, AHPs can offer "exceptionally high quality medical coverage at competitive premiums for qualifying employer groups." (See: http://www.thompsonspears.net/, accessed September 23, 2011.)

[4] Final federal rules clarifying the status of AHPs under ACA provisions regarding rate review and reporting were issued on September 6, 2011 (see: Federal Register Vol. 76, No. 172 available at: http://www.gpo.gov/fdsys/pkg/FR-2011-09-06/pdf/2011-22663.pdf, accessed September 20, 2011). While the September 6 final rule federal pertains only to specific rate review and reporting requirements, CMS has indicated its view that, for the broader purpose of implementing the ACA, "in most situations involving employment-based association coverage, the group health plan exists at the individual employer level and not the association-of-employers level. In these situations the size of each individual employer participating in the association determines whether the employer's coverage is subject for the small group or the large group rules." (See: CMS Insurance Standards Bulletin Series, September 1, 2011, available at: http://cciio.cms.gov/resources/files/association_coverage_9_1_2011.pdf.pdf, accessed September 20, 2011).

that "individual and small employer policies sold through associations will be included in the rate review process, even if a State otherwise excludes such coverage from its definitions of individual and small group market coverage." While these federal rules apply uniformly to small groups whether insured through AHPs or in the small group market, the states retain broad regulatory authority to regulate insurance products if not otherwise specified in federal law. Thus, the new federal rules do not alter Washington State's exception for AHPs with respect to either community rating or the use of rate factors that are prohibited for community-rated small groups.

The inclusion of AHPs in the federal reasonable rate review requirements means that Washington carriers that issue non-grandfathered plans to association members must file a rate justification with the U.S. Department of Health and Human Services (HHS) if a rate increase greater than 10 percent is proposed. However, Washington State's current statutory exemption of AHPs from state-level rate review means that HHS will review AHP rates, even though for purposes of this rule Washington is deemed an effective rate review state for individual and small group plans.

The asymmetric regulation of AHPs and small groups offers ample opportunity for carriers and AHPs to select favorable risk. By rating coverage strategically and denying employers where the associations' own rules may permit, carriers have the opportunity to separate the risk pools for AHP and other employer groups and isolate high-cost small groups in the community-rated market. As a result, premiums for community-rated small groups might be higher for the same benefit design, discouraging some employers from offering coverage at all and driving others to offer less coverage (with more limited benefits and greater cost sharing) than they might if premiums were lower.

In 2005, the Office of the Insurance Commissioner (OIC) conducted a survey of carriers that wrote association health plans. This survey found that approximately 248,000 Washington residents were enrolled in AHPs. In addition, roughly one-quarter of these enrollees were in plans that used member employers' health information to determine rates.

In March 2010, Washington State enacted ESBH 1714(2011), requiring insurance carriers in the state to report the volume of business they wrote, respectively, for associations and community-rated small groups in calendar years 2005 through 2008. Carriers were asked to provide information about each association plan that they wrote—including the size of employers that participated in the association plan; the number and age distribution of resident enrollees; the dollar values of premiums and medical cost; and the use of health factors or claims experience in issuing coverage to an association member, setting premiums, or both. Carriers were asked also to report the same information for their small group business, aggregated across all small groups that they covered.

Twenty-seven carriers responded to the data call—representing nearly all of the group health insurance written in Washington State. Most carriers that responded reported both AHP and community-rated small group business. The information that carriers reported was amassed in a database and checked to confirm that required information was reported, the information reported for each AHP and aggregated small group line was internally consistent, and responses were within feasible ranges. Several carriers were asked to resubmit information to correct apparent data quality problems, and the database (including carriers' original and resubmitted data for nearly all AHPs) was closed on August 31, 2011.

This report offers an analysis of the information that carriers provided in response to the data call, as well as information that carriers reported in regular filing. The latter included: (1) the carriers' annual statements reporting both company-level information and information about, respectively, individual and group health insurance business written in Washington State; (2) supplemental reports

to the OIC that report member-owned and other individual, small group, and large group business in Washington State; and (3) information reported to the federal Department of Labor by self-insured employer trusts.[5]

The report is organized in six sections. Section A offers a snapshot of the AHP and community-rated small group insurance markets in Washington State in 2008. In Section B, changes in the size and composition of these markets from 2005 to 2008 are reported.

Section C offers an analysis of AHP premiums and medical cost, compared with premiums and medical cost in the community-rated small group market. We adjust both measures for the age distribution of covered workers to partially account for the relative burden of illness in AHPs versus the community-rated small group market. However, because carriers were not required to report information about the gender and geographic location of enrollees, the scope of covered benefits, level of cost sharing, or the incidence of medical conditions, we were unable to adjust for the factors that likely drive most of any difference in premiums and medical cost.

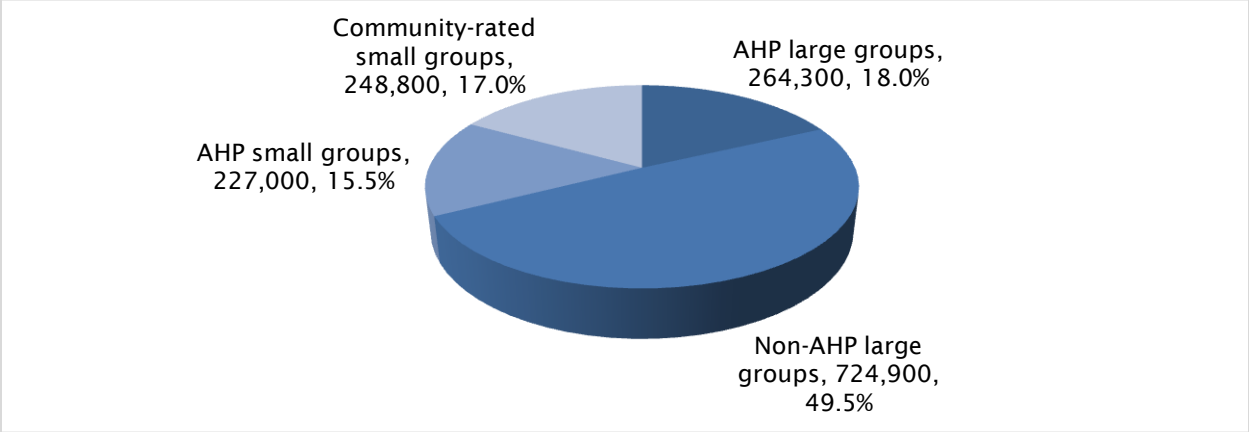
In Section D, the information that carriers reported about their use of health status and claims experience in setting premiums for AHP members is presented, and we consider differences in average premiums and medical cost that correspond to these practices. In Section E, we use carriers' 2011 additional data statements and estimates prepared by the OIC to update the survey-based analysis, comparing enrollment in AHPs and the community-rated small group market in 2008 and 2010, as well as the change in average premiums and medical cost. Finally, issues related to ongoing monitoring of AHPs are discussed in Section F.

## A. Enrollment in AHPs and Large Group or Community-Rated Small Group Plans

In 2008, approximately 491,300 Washington State residents were enrolled in AHP plans, including 227,000 enrolled through small employers (defined as groups of 2 to 50 employees) and 264,300 enrolled through large employers (defined as groups of more than 50 employees) (Figure 1). AHP enrollees accounted for more than one-third of total insured group coverage—16 percent in small groups with AHP coverage and 18 percent in large groups with AHP coverage. Nearly half of all insured small group enrollees (48 percent) and 27 percent of large group enrollees were in AHPs. (Figure 2).

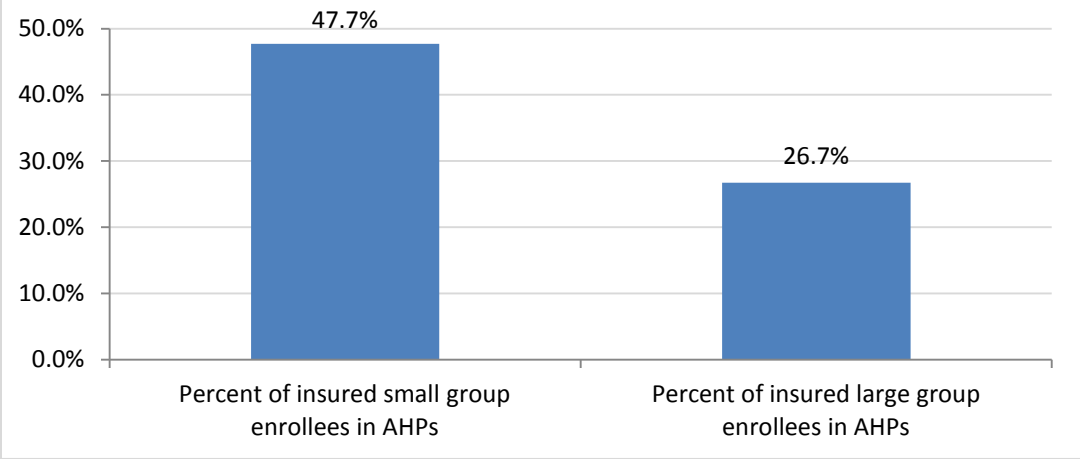
[5] Technical Appendix B provides more information on the data sources and methods used in this report.

**Figure 1. Number and Percent of Enrollees in AHPs or in Large Group or Community-Rated Small Group Plans, 2008**




Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey and 2008 annual carrier statements.

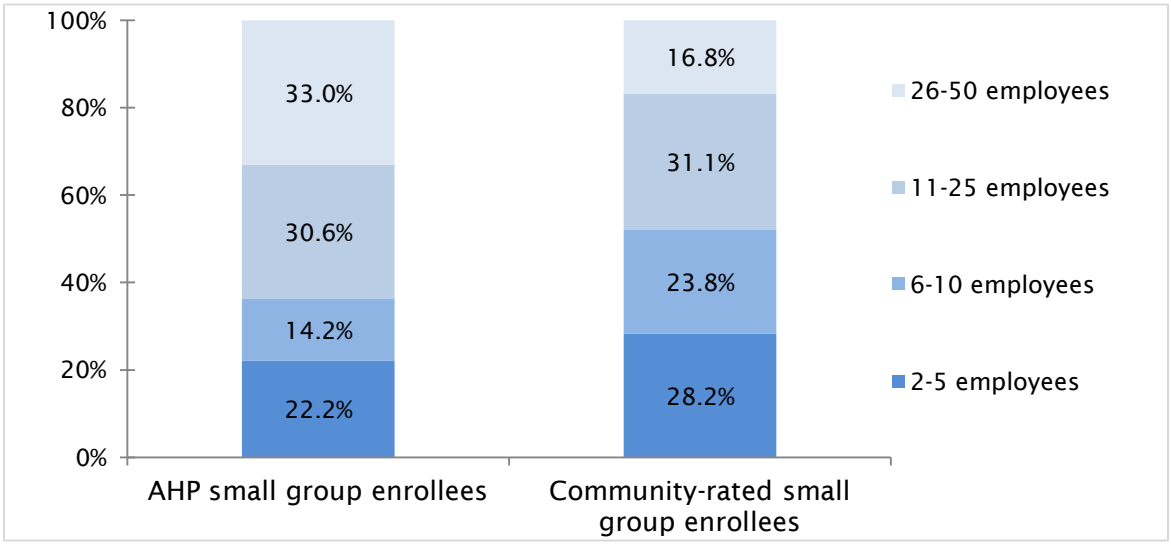
**Figure 2. Percent of Insured Small- and Large-Group Enrollees in AHPs, 2008**




Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Small group enrollees in AHPs predominantly included those in relatively large small groups—that is, groups of 11 to 50 workers, versus 2 to 10 workers.[6] In 2008, these larger small groups accounted for 64 percent of total small-group enrollment in AHPs, and the smallest groups—with 2 to 10 workers—accounted for 36 percent (Figure 3). In contrast, larger small groups accounted for 48 percent of the community-rated small group market, while the smallest groups accounted for 52 percent.

**Figure 3. Distribution of Small-Group Enrollees in AHP and Community Rated Small Group Plans by Group Size, 2008**




Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: Enrollees in AHP and non-AHP large-groups are not shown.

[6] ESBH 1714(2011) authorized the OIC to call for information on enrollment in firm sizes with 2 or more employees. Consequently, it is unclear whether carriers reported enrollment of groups of one at all, or whether they might have included either individuals or groups of one in the smallest firm size category. At least two carriers in Washington State, the Mega Life and Health Insurance Company, and Midwest National Life Insurance Company of Tennessee, explicitly market to groups of one. Enacted in 2010, S.B. 6538 clarified the definition of a group of one to be "a self-employed individual or sole proprietor who must also: (a) have been employed by the same small employer or small group for at least twelve months prior to application for small group coverage, and (b) verify that he or she derived at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year, except a self-employed individual or sole proprietor in an agricultural trade or business, must have derived at least fifty-one percent of his or her income from the trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, for the previous taxable year." (See: http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bills/Session%20Law%202010/6538-S.SL.pdf, accessed September 20, 2011.)

Among all AHP enrollees in 2008, 42 percent were in employer groups of 100 or more employees (Table 1). Twelve percent were enrolled through employer groups with 51 to 100 employees, which the federal Patient Protection and Affordable Care Act (ACA) will redefine as small groups.[7] Had this redefinition been in place in 2008, it would have categorized 58 percent of total AHP enrollment as small groups—suggesting that about half of AHP enrollees in Washington State might be drawn from the community-rated small group market when the redefinition of small groups becomes effective.

**Table 1. Distribution of Enrollees in AHPs or Community-Rated Small Groups by Group Size, 2008**

| | AHPs | | Community-rated small groups | |
|---|---|---|---|---|
| | Number of enrollees (in thousands) | Percent of enrollees | Number of enrollees (in thousands) | Percent of enrollees |
| **Total** | 491.3 | 100.00% | 248.8 | 100.00% |
| **Small Employer Groups** | 227.0 | 46.3% | 240.9 | 96.8% |
| 2-5 employees | 50.4 | 10.3% | 68.0 | 27.3% |
| 6-10 employees | 32.2 | 6.6% | 57.4 | 23.1% |
| 11-25 employees | 69.4 | 14.1% | 75.0 | 30.1% |
| 26-50 employees | 75.0 | 15.3% | 40.5 | 16.3% |
| **Large Employer Groups** | 264.3 | 53.8% | 7.9 | 3.1% |
| 51-100 employees | 57.0 | 11.6% | 7.1 | 2.8% |
| 100+ employees | 207.3 | 42.2% | 0.8 | 0.3% |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

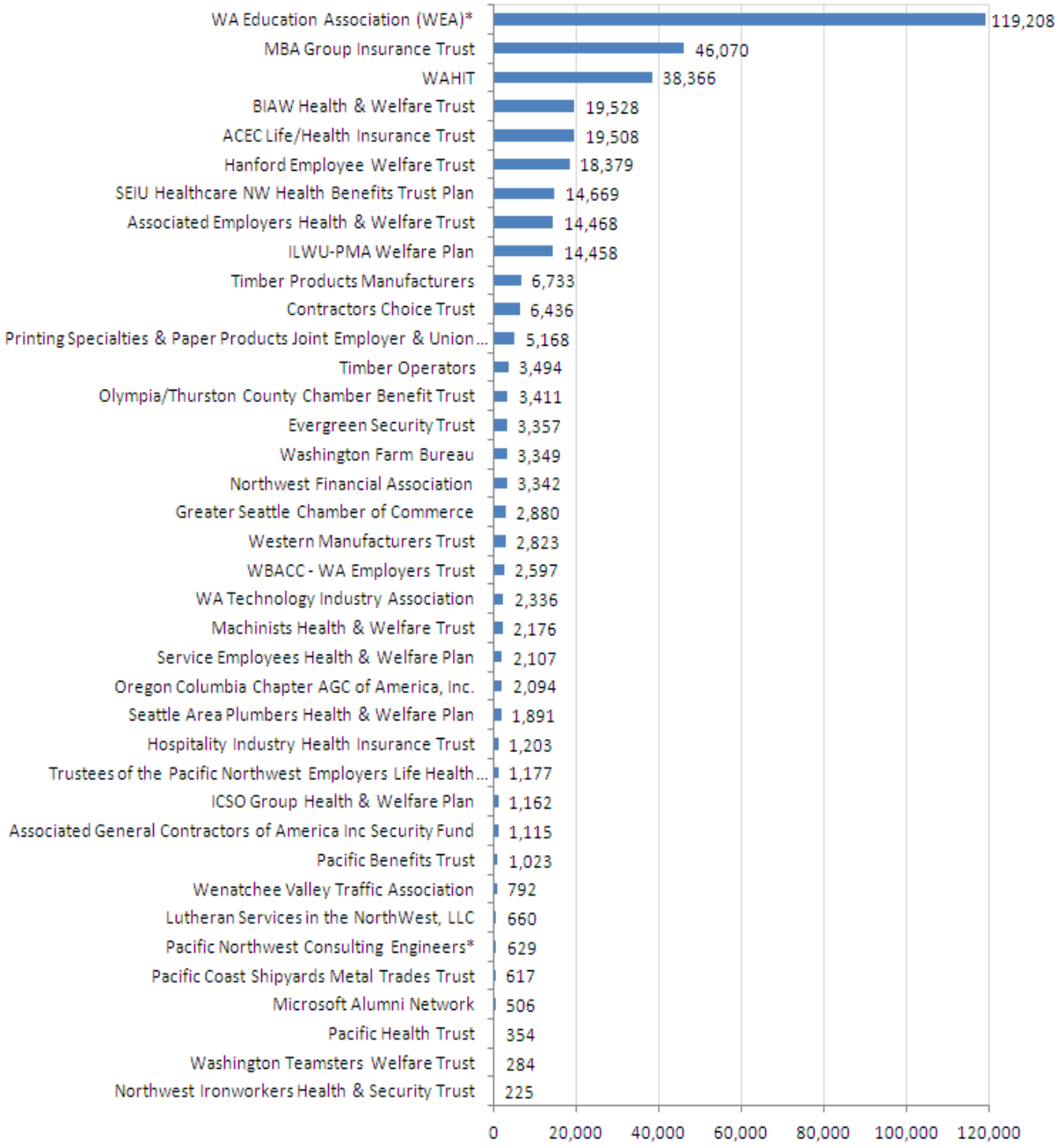
Figure 4 displays many of the AHPs that enroll small and large groups in Washington State based on public reporting to the U.S. Department of Labor. These AHPs, accounting for approximately three fourths of total AHP enrollment in Washington State in 2010, ranged from those with more than 100,000 lives to those with only a few hundred lives. By far the largest AHP, insured by Premera, was the Washington Education Association (WEA). WEA had more than 119,000 health plan enrollees in 2010 and accounted for as much as a third of total AHP enrollment. The next largest association plan was the Master Builders Association (MBA) Group Insurance Trust with approximately 46,000 enrollees, followed by the Washington Alliance for Healthcare Insurance Trust (WAHIT), a Premera-created AHP with more than 38,000 enrollees. One of the AHPs reported in Figure 4—the Timber Products Manufacturers, with about 6,700 enrollees—was self-insured.

Relatively few carriers write most AHP coverage in Washington State. In 2008, Premera and Regence wrote nearly three-fourths of all AHP business in the state. Premera accounted for 42 percent of total insured AHP enrollment and 47 percent of AHP premiums (Table 2). Regence accounted for 34 percent of insured AHP enrollment and 33 percent of AHP premiums. Group Health and Aetna also wrote significant AHP business, but respectively, accounted for just 7 percent and less than 4 percent of insured AHP enrollment. Other carriers—including Kaiser, United

[7] States may adopt this expanded small-group definition in 2014, but must adopt it for all plan years starting in 2017.

Healthcare, and another 10 carriers—collectively covered about 13 percent insured AHP enrollees and wrote about 12 percent of AHP premiums.

**Figure 4. Selected AHPs by Number of Enrollees, 2009-2011**




Source: Mathematica Policy Research. WEA enrollment is derived from Premera's SIMBA filing (November 12, 2010). For all other associations, enrollment is reported in the association's Form 5500, submitted to the U.S. Dept. of Labor.

Notes: This figure has been updated to reflect a software correction. All data are for fiscal years beginning in calendar 2009 unless otherwise noted: *indicates enrollment in the fiscal year beginning in calendar year 2010. When reported plan enrollment exceeded reported association enrollment at the beginning and end of the year by more than 30 percent, plan enrollment was estimated as average association enrollment during the year.

**Table 2. Distribution of AHP Enrollees and Total Premiums by Major Carrier, 2008**

| | Total AHP enrollees | | Total AHP premiums | |
|---|---|---|---|---|
| | Number (thousands) | Percent | Dollars (millions) | Percent |
| **Total** | 491.4 | 100.0% | $1,739.6 | 100.0% |
| Premera | 208.7 | 42.5% | 824.4 | 47.4% |
| Regence | 168.0 | 34.2% | 578.2 | 33.2% |
| Group Health | 34.3 | 7.0% | 124.1 | 7.1% |
| Aetna | 16.9 | 3.4% | 4.8 | 0.3% |
| Kaiser | 0.8 | 0.2% | 0.3 | 0.0% |
| All other AHP carriers (n=11) | 62.6 | 12.7% | 207.8 | 11.9% |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Notes: Premera companies include Premera Blue Cross and Lifewise Health Plan of Washington. Regence companies include Asuris Northwest Health, Regence BlueShield, Regence BlueShield of Idaho, Regence Blue Shield of Oregon, Regence Health Maintenance of Oregon, and Regence Life and Health Insurance Company. Group Health companies include Group Health Options, KPS, and Group Health Cooperative.

Regence and Premera also write most community-rated small group coverage in Washington State—in 2008, nearly 84 percent (Table 3). Regence covered 57 percent of all community-rated small group enrollees in 2008, and Premera covered 26 percent. Group Health and Kaiser also wrote significant community-rated small group business (respectively covering 10 percent and 4 percent of community-rated small group enrollees), while Aetna and another 11 carriers collectively covered less than 2 percent.

**Table 3. Distribution of Community-Rated Small Group Enrollees and Total Premiums by Major Carrier, 2008**

| | Total enrollees | | Total premiums | |
|---|---|---|---|---|
| | Number (thousands) | Percent | Dollars (millions) | Percent |
| **Total** | 248.8 | 100.0% | 943.8 | 100.0% |
| Regence | 143.1 | 57.5% | 585.4 | 62.0% |
| Premera | 64.5 | 25.9% | 213.1 | 22.6% |
| Group Health | 25.9 | 10.4% | 90.0 | 9.5% |
| Kaiser | 10.7 | 4.3% | 38.6 | 4.1% |
| Aetna | 0.1 | 0.1% | 0.6 | 0.1% |
| All other community-rated small group carriers (n=11) | 4.5 | 1.8% | 16.1 | 1.7% |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Notes: Premera companies include Premera Blue Cross and Lifewise Health Plan of Washington. Regence companies include Asuris Northwest Health, Regence BlueShield, Regence BlueShield of Idaho, Regence Blue Shield of Oregon, Regence Health Maintenance of Oregon, and Regence Life and Health Insurance Company. Group Health companies include Group Health Options, KPS, and Group Health Cooperative.

## B. Trends in Enrollment

From 2005 to 2008, enrollment in AHPs increased 11 percent, while enrollment in the large group and community rated small group market decreased nearly 12 percent—driving an overall decline in group coverage during this period (Table 4). The largest change in the market occurred between 2007 and 2008, when the number of enrollees in AHPs increased 6 percent and the number of enrollees in large group and community-rated small group plans decreased nearly 11 percent.

**Table 4. Number of Enrollees in AHPs or in Large Group or Community-Rated Small Group Plans, 2005-2008**

| | All insured large and small groups enrollees | AHP large and small group enrollees | Non-AHP large group and community-rated small group enrollees |
|---|---|---|---|
| Enrollment (in thousands) | | | |
| 2005 | 1,546.1 | 441.3 | 1,104.8 |
| 2006 | 1,557.5 | 476.4 | 1,081.2 |
| 2007 | 1,550.7 | 462.8 | 1,088.0 |
| 2008 | 1,465.0 | 491.4 | 973.6 |
| Percent change, 2005-2008 | -5.2% | 11.3% | -11.9% |
| 2005-2006 | 0.7% | 7.9% | -2.1% |
| 2006-2007 | -0.4% | -2.8% | 0.6% |
| 2007-2008 | -5.5% | 6.2% | -10.5% |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: A small number of carriers were unable to report the number of AHP enrollees in 2005, but did report enrollees in other years. In these cases, 2005 enrollment was estimated by extrapolating from enrollment in 2006-2008.

From 2005 to 2008, AHP enrollment increased among both small and large groups. Small group AHP enrollment increased 4.5 percent—from 208,200 in 2005 to 217,700 in 2008 (Table 5). Large group AHP enrollment increased more than 16 percent—from 212,800 in 2005 to 247,500 in 2008.

However, enrollment in both non-AHP large groups and community-small groups declined faster than the increase in AHP enrollment. As a result, 87,000 fewer residents (-5.2 percent) were enrolled in any insured group coverage in 2008 than in 2005 (Figure 4). In small groups, 67,500 fewer workers and dependents were covered in insured plans overall, with 76,900 fewer workers and dependents covered in community-rated small group plans. In large groups, 19,500 fewer workers and dependents were covered in insured plans overall, with 54,300 fewer workers and dependents covered in non-AHP large group plans.

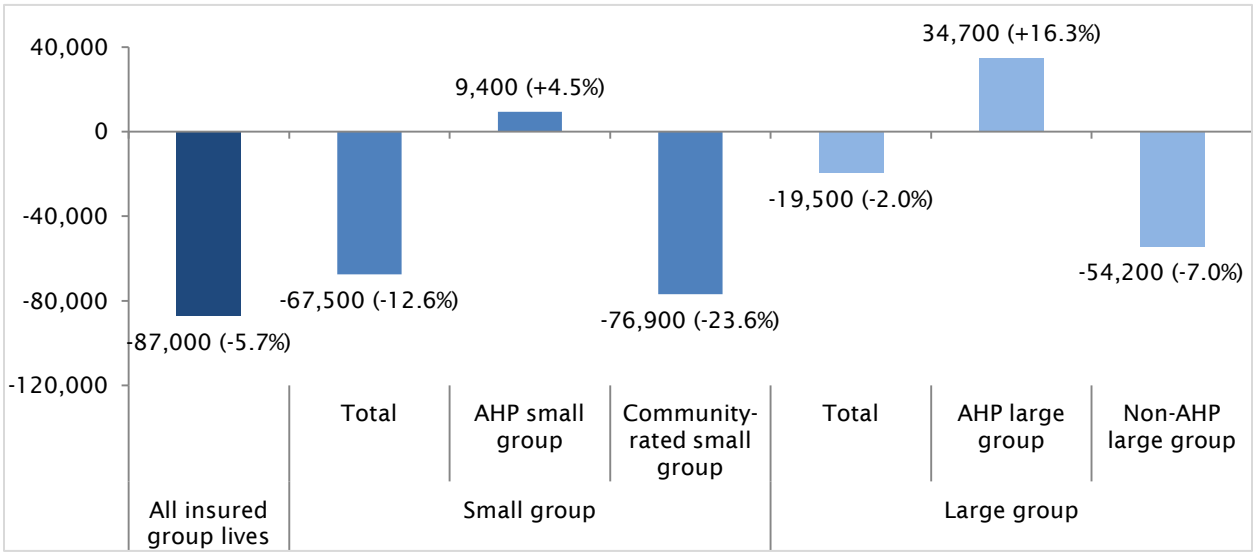
**Table 5. Number of Small- and Large-Group Enrollees in AHPs or in Large Group or Community-Rated Small Group Plans and Percent Change, 2005-2008**

| | AHP small group enrollees | Community-rated small group enrollees | AHP large group enrollees | Non-AHP large group enrollees |
|---|---|---|---|---|
| Enrollment (in thousands) | | | | |
| 2005 | 208.2 | 325.7 | 212.8 | 779.1 |
| 2006 | 213.5 | 305.6 | 236.3 | 775.5 |
| 2007 | 212.3 | 280.7 | 236.9 | 807.2 |
| 2008 | 217.7 | 248.8 | 247.5 | 724.9 |
| Percent change, 2005-2008 | 4.5% | -23.6% | 16.3% | -7.0% |
| 2005-2006 | 2.5% | -6.2% | 11.0% | -0.5% |
| 2006-2007 | -0.6% | -8.1% | 0.3% | 4.1% |
| 2007-2008 | 2.5% | -11.4% | 4.5% | -10.2% |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: A small number of carriers were unable to report the number of AHP enrollees in 2005. The tabulations in this table exclude those plans in all years.

**Figure 5. Change in Enrollment in AHPs and Large Group or Community-Rated Small Group Plans, 2005-2008**




Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: A small number of carriers were unable to report the number of AHP enrollees in 2005. A small number of carriers were unable to report the number of AHP enrollees in 2005. The tabulations in this figure exclude those plans in all years.

Corresponding to the growth in AHP enrollment, the number of carriers that wrote AHP business in Washington State increased from 11 in 2005 to 16 in 2008 (Table 6), as some carriers began insuring AHPs and others withdrew (data not shown). In addition, the number of AHPs increased from 135 in 2005 to 139 in 2008, having risen to as many as 145 AHPs in 2006. From 2005 to 2008, the median size of AHPs grew 8 percent—from 219 to 236 enrollees—as associations with 500 or more enrollees became more prevalent. In 2008, AHPs with 500 or more enrollees accounted 42 percent of all AHPs, compared with 36 percent in 2005.

**Table 6. Number of AHP Carriers, Number of AHPs, and AHP Enrollment, 2005-2008**

| | Number of carriers writing AHP business[a] | Number of AHPs | Median enrollees per AHP | Percent of AHPs | | | |
|---|---|---|---|---|---|---|---|
| | | | | 2-50 enrollees | 51-99 enrollees | 100-499 enrollees | 500+ enrollees |
| 2005 | 11 | 135 | 219 | 32.6% | 5.9% | 25.2% | 36.3% |
| 2006 | 15 | 145 | 247 | 33.8% | 2.8% | 23.4% | 40.0% |
| 2007 | 15 | 141 | 214 | 34.0% | 5.7% | 22.7% | 37.6% |
| 2008 | 16 | 139 | 236 | 30.2% | 6.5% | 20.9% | 42.4% |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Notes: A small number of carriers were unable to report the number of AHP enrollees in 2005, but did report enrollees in other years. In these cases, 2005 enrollment was estimated by extrapolating from enrollment in 2006-2008.

[a] Carriers owned by a common parent are combined. Parent companies include Premera, Regence, Group Health, Aetna, Health Net, and United Healthcare.

The increase in the median size of AHPs from 2005 to 2008 coincided with an increase in the average size of small groups in AHPs and a decrease in the average size of community-rated small groups. Even in 2005, a lower share of AHP enrollment was in the smallest groups, compared with enrollment in the community-rated small group market. Groups with fewer than 10 lives accounted for 44 percent of AHP small-group enrollment, with 32 percent in the smallest groups (with 2 to 5 lives) (Table 7). In contrast, 45 percent of community-rated small group enrollment was in groups with fewer than 10 lives, with 25 percent in the smallest groups.

**Table 7. Group Size Distribution of Small-Group Enrollment in AHPs and Community-Rated Small Group Plans, 2005-2008**

| | Total small group enrollees (thousands) | Percent of small-group enrollees in groups of: | | | |
|---|---|---|---|---|---|
| | | 2-5 | 6-10 | 11-25 | 25-50 |
| **AHPs** | | | | | |
| 2005 | 208.2 | 32.3% | 11.3% | 29.6% | 26.8% |
| 2006 | 213.5 | 27.9% | 12.9% | 29.1% | 30.1% |
| 2007 | 212.3 | 24.3% | 13.1% | 30.2% | 32.4% |
| 2008 | 217.7 | 20.8% | 13.8% | 31.2% | 34.1% |
| **Community-rated small groups** | | | | | |
| 2005 | 325.7 | 24.6% | 20.2% | 28.3% | 19.8% |
| 2006 | 305.6 | 25.0% | 21.0% | 29.2% | 18.6% |
| 2007 | 280.7 | 25.9% | 22.5% | 30.4% | 17.2% |
| 2008 | 248.8 | 27.3% | 23.1% | 30.1% | 16.3% |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Notes: Plans that did not report enrollment in 2005 are excluded from this table. As a result, change in the small and large group markets does not sum to total change. In addition, AHPs and community-rated small group plans for which enrollment by group size were not reported are included in the "total enrollees "column but not in other columns.

By 2008, very small groups accounted for an even lower proportion of AHP small group enrollment and a higher proportion of community-rated small group enrollment. About 34 percent

of AHP small-group enrollees were in groups with fewer than 10 lives, with 21 percent in the smallest groups of 2 to 5. In contrast, 50 percent of community-rated small-group enrollees were in groups with fewer than 10 lives, with 27 percent in the smallest groups.

## C. Premiums and Medical Cost

Because carriers are able to use pricing to segment risk between the AHP and community-rated small group market, it is widely supposed that AHP small groups pay lower premiums than are available to community-rated small groups. In this section, we explore these differences, although the analysis is substantially hindered by the highly aggregated nature of the data insurers were asked to report. In particular, carriers were not asked to report differences in premiums and medical cost within either AHPs or the community-rated small group market. Therefore, to the degree that carriers vary premiums by group size, we are unable to account for that variation.[8]

Attempting to work around this weakness in available data, we look at two alternative measures of average small group premiums and medical cost in AHPs: (1) the weighted average across all AHPs that included small groups (in effect assuming that each is the same across small and large groups in the same AHP); and (2) the average in "small group-focused AHPs", where more than 50 percent of total enrollment was in small groups. Both are compared to average premiums and medical cost in the community-rated small group market. We further adjust premiums and medical cost for the minor differences in the reported average age of insured employees. However, we were unable to adjust either measure for other major sources of differences in premiums and medical costs that ultimately were more important than the minor differences in enrollee age. These other sources include not only the smaller average size of groups in the community-rated small group market compared with those in AHPs, but also the prevalent benefit designs and the relative burden of illness in AHP small groups and community-rated small groups, and differences in gender, industry, geographic location, or other factors that carriers might use set AHP premiums.

### Unadjusted Average Premiums and Medical Cost

In 2008, AHP small groups appear to have paid premiums that were, on average, substantially lower than community-rated small group premiums. This difference is apparent, whether looking at the weighted average premium in AHPs that included small groups or the average premium in small group-focused AHPs. On average, small groups in AHP plans paid $246-$247 per member month for coverage, compared with $316 per member per month in community-rated small group coverage (Table 8). In contrast, large groups in AHPs paid average premiums ($340-$366) that were higher than community-rated small-group premiums—likely reflecting broader benefits, lower cost sharing, or both in AHPs that included predominantly large groups.

It is possible that the much lower average AHP small group premiums were related to narrower benefit design (with, for example, lower limits on covered benefits or higher cost sharing) than were available to community-rated small groups. However, it seems more likely that AHP benefits were at least competitive with those in the community-rated small group market, and that lower AHP

[8] In addition, carriers were not asked to report association membership fees; those amounts, if any, may not be reflected in the AHP premium data.

premiums reflected better risk selection as well as the larger average size of AHP small groups compared with community-rated small groups.

**Table 8. Unadjusted Premiums and Medical Cost for Community-Rated Small Groups, and AHP Small and Large Employer-Focused Groups, 2005-2008**

| | Community-rated small groups | AHP small groups, average across large and small groups in the AHP | AHP large groups, average across large and small groups in the AHP | Average in small group-focused AHPs | Average in large group-focused AHPs |
|---|---|---|---|---|---|
| **Average earned premiums** | | | | | |
| 2005 | $275 | $204 | $272 | $206 | $285 |
| 2006 | $282 | $215 | $291 | $217 | $306 |
| 2007 | $294 | $233 | $315 | $234 | $336 |
| 2008 | $316 | $246 | $340 | $247 | $366 |
| Annual change | | | | | |
| 2005-2006 | 2.5% | 5.3% | 6.9% | 5.5% | 7.3% |
| 2006-2007 | 4.2% | 8.3% | 8.3% | 7.7% | 9.7% |
| 2007-2008 | 7.6% | 5.5% | 7.9% | 5.5% | 8.9% |
| 2005-2008 average | 4.8% | 6.4% | 7.7% | 6.2% | 8.6% |
| **Average medical cost** | | | | | |
| 2005 | $207 | $158 | $235 | $160 | $251 |
| 2006 | $223 | $178 | $248 | $181 | $260 |
| 2007 | $242 | $193 | $272 | $193 | $293 |
| 2008 | $267 | $214 | $296 | $215 | $319 |
| Annual change | | | | | |
| 2005-2006 | 7.4% | 13.0% | 5.3% | 13.4% | 4.0% |
| 2006-2007 | 8.7% | 8.3% | 9.9% | 6.8% | 12.6% |
| 2007-2008 | 10.1% | 11.1% | 8.8% | 11.3% | 8.6% |
| 2005-2008 average | 8.8% | 10.8% | 8.0% | 10.5% | 8.4% |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Notes: Plans not reporting enrollment in 2005 are excluded in all years. Premiums and medical cost for small and large groups enrolled in AHPs are calculated as the weighted average per member per month for all groups in an AHP that included small and large groups, respectively. Small group-focused AHPs are AHPs where more than half of the members were in groups of 2-50 employees. Large group-focused AHPs are AHPs where more than half of the members were in groups with more than 50 employees. Medical cost is defined as carrier payments for incurred claims.

From 2005 to 2008, average premiums increased at a faster rate for AHP small groups than for community-rated small groups, but remained lower for AHP small groups in all years. In the last year of this period, from 2007 to 2008, average AHP small group premiums increased more slowly (6 percent) than community-rated small-group premiums (8 percent), while AHP large group premiums increased somewhat faster (8 to 9 percent).

In both AHPs and community-rated small group plans, medical cost—defined as carrier payments for incurred claims—increased faster than premiums, but it increased fastest for AHP small groups. From 2005 to 2008, average medical cost increased at an average annual rate of 11 percent in AHP small groups, compared with 9 percent in community-rated small groups and 8 percent in AHP large groups.

The faster growth of average medical cost increased insurers' average medical loss ratios (calculated as total medical cost divided by total medical premiums) for both large and small groups in AHPs, as well as for community-rated small groups. However, in all years, the medical loss ratio for small groups in AHPs exceeded that for community-rated small groups. By 2008, the average medical loss ratio for small and large groups in AHPs had risen to 0.87, compared with 0.84 for community-rated small groups (Table 9).[9]

**Table 9. Unadjusted Weighted Average Medical Loss Ratios for AHP Small Groups, Community-Rated Small Groups, and AHP Large Groups, 2005-2008**

| | AHP small groups | Community-rated small groups | AHP large groups |
|---|---|---|---|
| 2005 | 0.772 | 0.754 | 0.865 |
| 2006 | 0.827 | 0.791 | 0.852 |
| 2007 | 0.828 | 0.825 | 0.865 |
| 2008 | 0.872 | 0.844 | 0.872 |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: Plans not reporting enrollment in 2005 are excluded in all years. Premiums and medical cost for small and large groups enrolled in AHPs are calculated as the weighted average per member per month for all groups within an AHP that includes small and groups, respectively. Medical loss ratios are calculated as medical cost per premium dollar; medical cost is defined as carrier payments for incurred claims. Medical loss ratios for non-AHP large-group plans are not shown.

## Age-Adjusted Premiums and Medical Cost

The results of age-adjusting premiums and medical cost are reported in Table 10. Two aspects of this analysis are noteworthy. First, the average age of enrollees in each segment of the insured market—AHP small groups, community-rated small groups, and AHP large groups—is similar and quite young, ranging from 34 to 36 years of age in all years. Compared with community-rated small groups, AHP enrollees (in either small or large groups) were slightly younger in all years. Moreover, from 2005 to 2008 the average age in AHP small and large groups declined more (-1.3 percent and -1.1 percent, respectively) than that in community-rated small groups (-0.9 percent). Nevertheless, the differences (apparent in the age-related expected cost adjustment factor) were small.

Second, adjusted only for age, both premiums and medical cost for AHP small groups increased faster than for community-rated small groups—a result that might well not hold if more detailed analysis of benefit designs, in particular, had been possible. Relative to AHP large groups, age-adjusted premiums for AHP small groups grew more slowly, but age-adjusted medical cost grew faster. The anomalous character of these results relative to the more intuitive patterns we observed without adjustment strongly suggests that much more detailed information—such as the gender and geographic location of enrollees, benefit design and cost sharing, and the relative burden of illness—

[9] The higher medical loss ratio for AHP small groups is consistent with the larger average size of AHP small groups compared with community-rated small groups. Indeed, calculated for the smallest AHP small groups (with 2 to 25 lives), the medical loss ratio in 2008 was 0.83, compared with 0.92 among AHP groups with 26 to 100 lives (data not shown).

is needed to understand relative premiums and medical cost in AHPs and in non-AHP large group and community-rated small group plans.

**Table 10. Age-Adjusted Premiums and Medical Cost for AHP Small Groups, AHP Large Groups, and Community-Rated Small Groups, 2005-2008**

| | Enrollees (in thousands) | Average age | Age-related expected cost adjustment factor | Adjusted medical cost per member per month | Adjusted premiums per member per month |
|---|---|---|---|---|---|
| **AHP small groups** | | | | | |
| 2005 | 207.6 | 34.47 | 0.98 | 160 | 208 |
| 2006 | 221.5 | 34.64 | 0.98 | 180 | 219 |
| 2007 | 220.0 | 34.13 | 0.97 | 198 | 240 |
| 2008 | 229.9 | 33.98 | 0.97 | 219 | 252 |
| Percent change 2005-2008 | 10.7% | -1.4% | -1.0% | 36.9% | 21.2% |
| Average annual change | 2.6% | -0.4% | -0.3% | 8.2% | 4.9% |
| **AHP large groups** | | | | | |
| 2005 | 237.8 | 34.91 | 1.00 | 218 | 251 |
| 2006 | 245.9 | 35.25 | 1.02 | 241 | 284 |
| 2007 | 228.6 | 34.75 | 1.01 | 281 | 325 |
| 2008 | 253.2 | 34.52 | 1.01 | 293 | 335 |
| Percent change 2005-2008 | 6.5% | -1.1% | 1.0% | 34.4% | 33.5% |
| Average annual change | 1.6% | -0.3% | 0.2% | 7.7% | 7.5% |
| **Community-rated small groups** | | | | | |
| 2005 | 325.7 | 35.95 | 1.00 | 208 | 276 |
| 2006 | 305.6 | 36.48 | 1.02 | 218 | 276 |
| 2007 | 280.7 | 35.51 | 1.01 | 239 | 290 |
| 2008 | 248.8 | 35.64 | 1.01 | 265 | 313 |
| Percent change 2005-2008 | -23.6% | -0.9% | 1.0% | 27.4% | 13.4% |
| Average annual change | -6.5% | -0.2% | 0.2% | 6.2% | 3.2% |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: Medical cost is defined as carrier payments for incurred claims.

## D. Medical Underwriting

Many carriers reported using health factors or claims experience to rate AHP coverage, having each applicant complete a standard health questionnaire (not requiring a physical exam) and reviewing claims histories to adjust rates at renewal. In 2008, health status was used to set rates in nearly half of all AHPs (48 percent), affecting 60 percent of AHP enrollees. Claims experience was used to set rates in nearly two-thirds of AHPs, affecting 87 percent of AHP enrollees (Table 11). Just 6 percent of AHP enrollees were in a plan that used neither health factors nor claims experience to rate coverage.

In AHPs that were rated based on either health factors or claims experience, average medical cost was much higher ($270 to $274 per member per month) than in those that used neither to set rates ($130). However, the very low average premium among AHPs that used neither health status or claims experience to rate coverage was driven by just a few large plans in this category, and may reflect plan designs with higher cost sharing than was common in either AHPs or the community-rated small group market.

**Table 11. Use of Health Factors or Claims Experience to Set AHP Premiums, 2008**

| | Number of AHPs | Percent of AHPs | Number of enrollees (thousands) | Percent of AHP enrollees | Medical cost per member per month |
|---|---|---|---|---|---|
| **All AHPs** | 138 | 100.0% | 491.4 | 100.0% | $257 |
| Health factors used | 66 | 47.8% | 294.1 | 59.8% | $274 |
| Claims experience used | 87 | 63.0% | 427.2 | 86.9% | $270 |
| Neither health factors nor claims experience used | 43 | 31.2% | 29.0 | 5.9% | $130 |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Notes: Medical cost is defined as carrier payments for incurred claims. Because some carriers reported using both health factors and claims experience to rate coverage, percentages may not add to 100%.

The number of AHPs that rated on health factors or claims experience increased from 75 in 2005 to 95 in 2008, and the number of AHP enrollees affected by these practices increased 26 percent (Table 12). While average premiums rose faster for enrollees in AHPs subject to rating on health status or claims experience, the medical loss ratio in these plans increased much less than in AHPs where the carrier did not medically underwrite premiums. From 2005 to 2008, the average loss ratio in AHPs where carriers used health factors or claims experience to rate coverage increased just 4 percent (from 0.836 to 0.873). In AHPs where carriers did not medically underwrite premiums, the average medical loss ratio increased 16 percent.

**Table 12. Number of Plans, Average Premiums, and Medical Loss Ratios in AHPs That Use Health Factors or Claims Experience to Set Premiums and Percent Change, 2005-2008**

| | Number of plans | Number of enrollees (thousands) | Premiums per member per month | Average medical loss ratio |
|---|---|---|---|---|
| **Carrier uses health factors or claims experience to rate association members** | | | | |
| 2005 | 75 | 367.9 | $254 | 0.836 |
| 2006 | 97 | 435.1 | $266 | 0.840 |
| 2007 | 97 | 429.1 | $292 | 0.849 |
| 2008 | 95 | 462.3 | $304 | 0.873 |
| Percent change, 2005-2008 | 26.7% | 25.7% | 19.8% | 4.3% |
| **Carrier does not use health factors or claims experience to rate association members** | | | | |
| 2005 | 59 | 73.3 | $156 | 0.749 |
| 2006 | 47 | 41.3 | $135 | 0.770 |
| 2007 | 43 | 33.7 | $145 | 0.803 |
| 2008 | 43 | 29.0 | $149 | 0.870 |
| Percent change, 2005-2008 | -27.1% | -60.4% | -4.7% | 16.2% |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey.

Note: Medical loss ratios are calculated as medical cost per premium dollar; medical cost is defined as carrier payments for incurred claims.

## E. Update to 2010

Responding to new reporting requirements in March 2011, carriers in Washington State reported lower levels of enrollment in either AHPs or in community-rated small group plans in 2010 than they had reported for 2008, in response to the OIC data call. While inferences drawn from comparison of separate data sources should always be considered with caution, the data reported for 2010 appear to indicate a continuation of some trends observed from 2005 to 2008. These changes occurred in the context of a significant drop in total insured group coverage, which in all states has been an important result of the economic recession.

In 2010, estimated enrollment in AHPs was 2.5 percent less than in 2008, while enrollment in non-AHP large group and community-rated small group plans had dropped nearly 11 percent (Table 13). Overall, about 35 percent of insured residents were enrolled in AHPs, compared with 33 percent in 2008.

**Table 13. Enrollment in AHPs and Large Group or Community-Rated Small Group Plans and Percent Change, 2008 and 2010 (estimated)**

| | Total insured coverage | AHP large and small groups | Non-AHP large groups and community-rated small groups |
|---|---|---|---|
| Enrollment (in thousands) | | | |
| 2008 | 1,465.0 | 491.3 | 973.7 |
| 2010 | 1,348.5 | 479.2 | 839.3 |
| Percent change 2008-2010 | -8.0% | -2.5% | -10.7% |
| Percent of enrollees | | | |
| 2008 | 100.0% | 33.5% | 66.5% |
| 2010 | 100.0% | 35.5% | 64.5% |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey, carrier information reported in the revised additional data statement, and OIC estimates. Non-AHP large-group enrollment includes PEBB enrollees.

Table 14 provides estimates of the change in small- and large-group enrollment, respectively, in AHP and large group or community-rated small group coverage for a subset of carriers that reported information about the size of enrolled groups to the OIC in the March 2011 Revised Additional Data Statement. These carriers represented about 94 percent of total enrollment in insured health plans, 84 percent of total AHP enrollment, and 70 percent of AHP small group enrollment in 2008.[10]

For these carriers, the change in enrollment from 2008 to 2010 was significant in at least two ways. First, while their total enrollment dropped 11 percent, the loss of enrollment was concentrated in non-AHP large group and community rated small group plans, not in AHPs—as also occurred

[10] The relatively low proportion of AHP small group enrollees that these carriers represent reflects the impact of exempting life and disability carriers (including United HealthCare, Aetna, Mega Life and Health Insurance Company, Health Net Life Insurance Company, the National Life Insurance Company of Tennessee, and others) from filing the Additional Data Statement in March 2011.

from 2005 to 2008. As a result, AHP enrollment accounted for 34 percent of their total business in 2010, compared with 30 percent in 2008.

**Table 14. Selected Carriers' Enrollment in AHP and Large Group and Community-Rated Small Group Plans by Group Size, and Percent Change, 2008 and 2010**

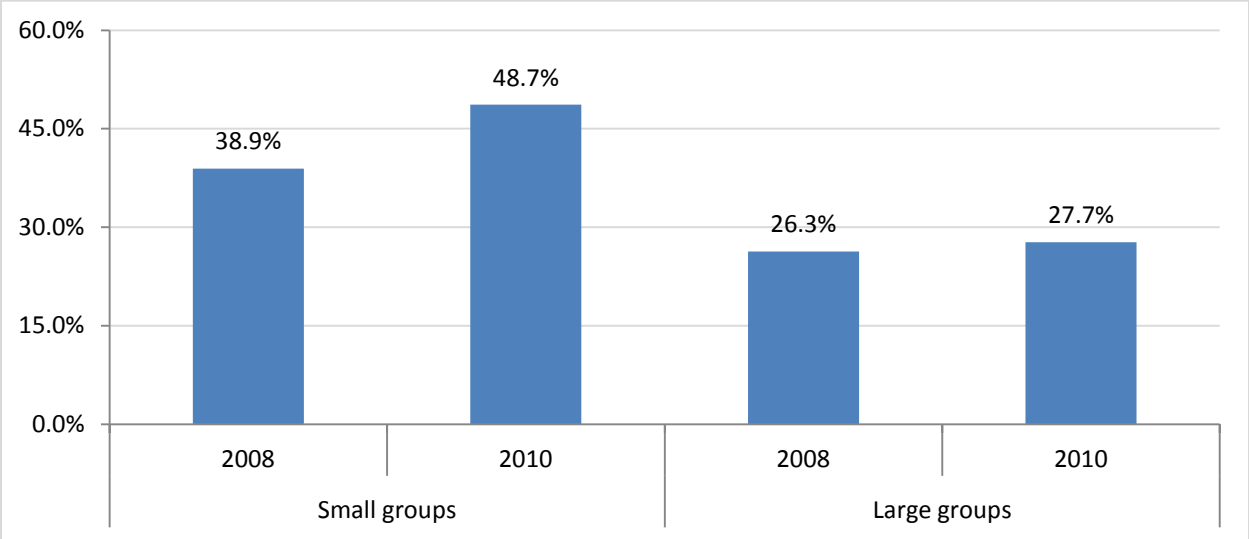
| | | AHP coverage | | | Non-AHP coverage | | |
|---|---|---|---|---|---|---|---|
| | Total | Total | Small groups | Large groups | Total | Community-rated small groups | Non-AHP large groups |
| **Enrollment (in thousands)** | | | | | | | |
| All carriers, 2008 | 1,464.9 | 491.2 | 227.0 | 264.3 | 973.6 | 248.8 | 724.9 |
| Selected carriers | | | | | | | |
| 2008 | 1,380.0 | 413.7 | 156.3 | 257.4 | 966.3 | 245.0 | 721.3 |
| 2010 | 1,221.4 | 409.0 | 164.1 | 245.0 | 812.4 | 173.2 | 639.1 |
| Percent change | -11.5% | -1.1% | 5.0% | -4.8% | -15.9% | -29.3% | -11.4% |
| **Percent of enrollees** | | | | | | | |
| All carriers, 2008 | 100.0% | 33.5% | 15.5% | 18.0% | 66.5% | 17.0% | 49.5% |
| Selected carriers | | | | | | | |
| 2008 | 100.0% | 30.0% | 11.3% | 18.6% | 70.0% | 17.8% | 52.3% |
| 2010 | 100.0% | 33.6% | 13.4% | 20.1% | 66.5% | 14.2% | 52.3% |
| **Percent of enrollees by source of coverage** | | | | | | | |
| All carriers, 2008 | --- | 100.0% | 46.2% | 53.8% | 100.0% | 25.6% | 74.4% |
| Selected carriers | | | | | | | |
| 2008 | --- | 100.0% | 37.8% | 62.2% | 100.0% | 25.4% | 74.6% |
| 2010 | --- | 100.0% | 40.1% | 59.9% | 100.0% | 21.3% | 78.7% |

Source: Mathematica Policy Research analysis of carrier data reported in the 2011 survey and carrier information reported in the revised additional data statement.

Note: Selected carriers are those that reported 2010 enrollment in March 2011. These carriers are Asuris Northwest Health, Group Health Cooperative, Group Health Options, KPS Health Plans, Kaiser Foundation Health Plans of the Northwest, Lifewise Health Plan of Washington, PacifiCare of Washington, Premera Blue Cross, Regence Blue Shield, Timber Products Manufacturers Association, Western Grocers Employee Benefit Trust, Providence Health Plans, Regence Blue Shield of Idaho, Regence Blue Shield of Oregon, and Health Net Health Plan of Oregon. Non-AHP large-group enrollment includes PEBB enrollees.

Second, small group enrollment in AHPs increased 5 percent, while enrollment in every other category—AHP large groups, non-AHP large groups, and community-rated small groups—declined. In 2010, AHPs accounted for nearly half of these carriers' total small group enrollment (49 percent), compared with 39 percent in 2008 (Figure 6). AHPs also accounted for a greater share of their large group business in 2010 (28 percent) than in 2008 (26 percent).

**Figure 6. Selected Carriers' AHP Enrollment as a Percent of their Total Small and Large Group Enrollment, 2008 and 2010**




Source: Mathematica Policy Research analysis of carrier survey data for 2008 and carrier information reported in the revised additional data statement.

Note: Selected carriers are those that reported 2010 enrollment in March 2011. These carriers are Asuris Northwest Health, Group Health Cooperative, Group Health Options, KPS Health Plans, Kaiser Foundation Health Plans of the Northwest, Lifewise Health Plan of Washington, PacifiCare of Washington, Premera Blue Cross, Regence Blue Shield, Timber Products Manufacturers Association, Western Grocers Employee Benefit Trust, Providence Health Plans, Regence Blue Shield of Idaho, Regence Blue Shield of Oregon, and Health Net Health Plan of Oregon. Non-AHP large-group enrollment includes PEBB enrollees.

As in 2008, Premera and Regence were the largest AHP carriers in 2010, followed by Group Health. Premera insured 45 percent of AHP enrollees in 2010, compared with 42 percent in 2008 (Table 15). Group Health companies also reported greater AHP enrollment in 2010, and accounted for a larger share of total AHP enrollment (9 percent) than in 2008 (7 percent). In contrast, the Regence companies that reported detailed enrollment data in March 2011 had lower AHP enrollment, and accounted for a somewhat smaller share of all AHP enrollees in 2010 (29 percent) than in 2008 (33 percent).

**Table 15. Total AHP and Community-Rated Small-Group Enrollment by Carrier, 2008 and 2010 (estimated)**

| | 2008 | | | | 2010 | | | |
|---|---|---|---|---|---|---|---|---|
| | AHP (thousands) | Percent of total AHP | Community-rated small group (thousands) | Percent of total community-rated small group | AHP (thousands) | Percent of total AHP | Community-rated small group (thousands) | Percent of total community-rated small group |
| Total | 491.4 | 100.0% | 248.8 | 100.0% | 479.2 | 100.0% | 173.2 | 100.0% |
| Premera Blue Cross | 208.7 | 42.5% | 64.5 | 25.9% | 216.5 | 45.2% | 12.4 | 7.2% |
| Regence | 164.7 | 33.5% | 143.1 | 57.5% | 141.3 | 29.5% | 113.6 | 65.6% |
| Group Health | 34.3 | 7.0% | 25.9 | 10.4% | 45.1 | 9.4% | 34.6 | 20.0% |
| All other carriers | 84.0 | 17.1% | 15.3 | 6.1% | 77.8 | 16.2% | 12.6 | 7.3% |

Source: Mathematica Policy Research analysis of carrier survey data for 2008, carrier information reported in the revised additional data statement, and OIC estimates. Non-AHP large-group enrollment includes PEBB enrollees.

Notes: In this table, Regence includes Asuris Northwest Health, Regence Blue Shield, Regence Blue Shield of Idaho, and Regence Blue Shield of Oregon, but excludes Regence Health Maintenance of Oregon and Regence Life and Health Insurance Company in both 2008 and 2010. Premera includes Premera Blue Cross and Lifewise Health Plan of Washington. Group Health includes Group Health Cooperative, Group Health Options, and KPS Health Plans.

In contrast to its growing AHP enrollment, Premera appeared to shed most of its community-rated small group business from 2008 to 2010. Having reported 64,500 community-rated small-group enrollees in 2008, it reported just 12,400 in 2010. Regence also reported many fewer community-rated small-group enrollees in 2010 (113,600) than in 2008 (143,100), but ultimately held a much larger share of the community-rated small group market (66 percent, compared with 58 percent in 2008). In contrast to both Premera and Regence, Group Health reported greater community-rated small group enrollment in 2010. In 2010, Group Health accounted for 20 percent of the community-rated small group market, compared with 10 percent in 2008.

Table 16 presents average monthly premiums and medical cost in AHP small and large groups among carriers that reported in March 2011. As in 2008, average premiums for AHP small groups in 2010 ($278) were substantially lower than for community-rated small groups ($382), and may have increased much less since 2008. While comparison of AHP and community-rated small group premiums is complicated by the different calculations possible for 2008 and 2010, it appears that average premiums increased 6 percent for AHP small groups, compared with 21 percent for community-rated small groups.[11]

[11] In 2010, carriers reported separately the premiums earned and medical costs incurred by small and large groups within each AHP. In contrast, the OIC data call asked carriers to report total premium earned and medical costs incurred by AHP in 2008, for enrolled groups of all sizes, and it was necessary to calculate average premiums and medical costs for 2008 across small and large groups in the same AHP. Because actual AHP small group premiums and medical costs may have been higher than the average within an AHP (due to the inclusion of larger groups in the

**Table 16. Selected Carriers' Average Premiums, Medical Cost, and Medical Loss Ratios for AHP Large and Small Groups and Community-Rated Small-Groups, 2008 and 2010**

| | AHP small groups | AHP large groups | Community-rated small groups |
|---|---|---|---|
| **Average premiums per member per month** | | | |
| All carriers, 2008 | $247 | $337 | $316 |
| Selected carriers | | | |
| 2008 | $262 | $338 | $317 |
| 2010 | $278 | $381 | $382 |
| Percent change 2008-2010 [a] | 6.2% | 12.7% | 20.8% |
| **Average medical cost per member per month** | | | |
| All carriers, 2008 | $214 | $294 | $267 |
| Selected carriers | | | |
| 2008 | $224 | $295 | $267 |
| 2010 | $244 | $343 | $315 |
| Percent change 2008-2010 [a] | 9.0% | 16.6% | 18.0% |
| **Average medical loss ratio** | | | |
| All carriers, 2008 | 0.868 | 0.875 | 0.844 |
| Selected carriers | | | |
| 2008 [a] | 0.854 | 0.872 | 0.844 |
| 2010 | 0.877 | 0.903 | 0.824 |

Source: Mathematica Policy Research analysis of carrier survey data for 2008 and carrier information reported in the revised additional data statement.

Notes: Selected carriers are those that reported 2010 enrollment in March 2011. These carriers are Asuris Northwest Health, Group Health Cooperative, Group Health Options, KPS Health Plans, Kaiser Foundation Health Plans of the Northwest, Lifewise Health Plan of Washington, PacifiCare of Washington, Premera Blue Cross, Regence Blue Shield, Timber Products Manufacturers Association, Western Grocers Employee Benefit Trust, Providence Health Plans, Regence of Blue Shield Idaho, Regence Blue Shield of Oregon, and Health Net Health Plan of Oregon. Because the average premium and medical cost estimates are rounded, the reported percent changes and medical loss ratios may differ slightly from those calculated directly from the table.

[a] 2008 estimates are the AHP-wide weighted average among AHPs that include small groups, while 2010 values were reported for small and large groups separately. Consequently, the percentage change estimates may be overstated for AHP small groups and understated for AHP large groups for the same benefit design, and the implied change in the medical loss ratios for both AHP small groups and AHP large groups may be overstated.

*(continued)*

calculation), the percentage change calculations for AHP small groups may be overstated for the same benefit design. Alternatively, if AHP small groups systematically bought lower-benefit options than AHP large groups, the percentage change may be overstated. Conversely, the calculated change for AHP large groups may be conservative for the same benefit design, or potentially overstated if AHP large groups systematically enrolled in higher-benefit options.

In 2010, the average medical loss ratio was 0.88 among AHP small groups and 0.82 for community-rated small groups. These compare with the federal minimum medical loss ratio of 0.85, applicable to the community-rated small group market as of January 1, 2011.

## F. Future Monitoring

AHPs are a significant source of coverage in Washington State. Because Washington State allows associations to be formed for the purpose of insurance and exempts them from small group market rules, there is ample opportunity for either carriers or the AHPs themselves to select relatively low-risk employer groups into AHPs and leave higher-risk groups in the large group or community-rated small group markets.

However, federal health reforms seem likely to transform the regulatory landscape for AHPs in Washington State and in other states that currently allow AHPs to operate under regulation that is different from the traditional market. First, for purposes of rate review and reporting, new federal rules include individual and small employer policies sold through associations in the rate review process—even if, as in Washington State, they are otherwise excluded from individual and small group market rules. Second, with respect to the implementation of federal reform more broadly, federal regulators have expressed their view that the size of each individual employer participating in the association will determine whether the employer's coverage is subject to the small group or the large group rules. Finally, federal reform will redefine small groups as employer groups with 2 to 100 employees (versus the current definition of 2 to 50), potentially expanding the reach of small group market rules in AHPs as well as their reach into the current large group market.

If embraced in Washington State, these changes could obviate many of the concerns that underlie this study. To the extent that AHP small groups are subject to the same regulations that govern the community-rated small group market, the ability of AHPs to segment risk in ways that would imperil the community-rated market is very limited. In states that have long regulated AHPs at the participating employer level (for example, Colorado, Massachusetts, and New Jersey), AHPs are believed to be an insignificant component of the small group market; future analysis of data reported nationally for the first time in 2011 may well bear out that perception.

If Washington State wishes to continue to monitor the relationship of AHPs to the large group and community-rated small group markets in coming years, more information is needed than either ESBH 1714(2011) authorized for this study or is obtained under other reporting requirements. In particular, to understand whether AHPs are segmenting risk in ways that might destabilize the large group community-rated small group markets, it will be necessary to know in greater detail how carriers are rating AHPs—specifically, which rate factors they use, the impact on rates offered to AHP large and small groups, differences in plan designs, and the relative burden of illness in AHP large and small groups compared with that in non-AHP large groups and community-rated small groups. In addition, to be useful to policymakers, this information must:

- Clearly include, and separately categorize, information about individuals and groups of one;
- Specifically name the AHP that is covered to allow verification of the reported data against other reporting and earlier survey information; and
- Identify which AHPs are insurer-sponsored, versus those initiated by public employer groups or private employer groups.

Finally, the information must be much more current than was required for this study, which looks back eight years and captures information only as recently as 2008.

Some of the information that is needed to understand the relationship between AHPs and the large group and community-rated small group markets will potentially be easier to obtain in future years due to efforts already underway in Washington State. For example, as of March 2011, health carriers are required to file a Revised Additional Data Statement, reporting information about AHP enrollment, premiums, and medical cost for small and large groups, respectively. However, because life and disability carriers are not required to report, the information currently obtained is very incomplete. The OIC estimates that the life and disability insurers that were exempted from reporting in 2011 accounted for more than 15 percent of AHP enrollees in 2010.

Other information needed to understand how AHPs differ from the large group and community-rated small group markets might be obtained in the context of federal reforms, or in parallel efforts that many other states have undertaken and that Washington State might consider. For example, differences in benefit design might be captured by requiring carriers to use the standard actuarial rules to determine plan tiers in the health insurance exchange, extended to all plans offered to AHPs and community-rated small groups. In addition, an all-payer claims database (such as many other states are assembling) could be extremely useful for understanding the relative burden of illness in AHPs and the large and community-rated small group markets, if carriers are further required to provide coding that links individual identification codes to policy identification codes. As in other states, such a database could also be useful in understanding many other aspects of health care delivery, costs, and financing in Washington State.

# APPENDIX A: SUMMARY OF STATUTORY AUTHORITY TO REGULATE HEALTH INSURANCE RATES AND FORMS

The statutory authority of the OIC to review carriers' rates and forms varies by both the type of carrier and the type of plan. For health carriers (called health care service contractors, or HCSCs) and HMOs, the OIC has authority to require carriers to file rates and forms, require prior approval of forms for small groups, and disapprove rates.

For AHPs, the OIC can require prior approval of both rates and forms only for disability carriers. For all other carriers that write AHP business, the OIC has authority to require filing of rates and forms, but can review only forms, and cannot disapprove either rates or forms.

Under federal rules issued September 6, 2011, HHS will review non-disability carriers' AHP small-group rates in Washington State, as well as MEWA small-group rates.

**Table A.1. Rate and Form Review Authority in Washington State, Effective 2011**

| | Washington State Office of the Insurance Commissioner (OIC) | | | | | U.S. Department of Health and Human Services (HHS) |
|---|---|---|---|---|---|---|
| **Carrier and plan type** | **Prior Approval (group sizes 1-50)** | **File, review, and possible disapproval** | **File and review** | **File and use** | **Use** | **Review (group sizes 2-50)** |
| HMOs – community rated | Forms | Rates | | | | |
| Health Care Service Contractors (HCSCs) – community rated | Forms | Rates | | | | |
| Disability carriers, including AHPs | Rates<br>Forms | | | | | |
| Non-disability carriers, including AHPs | | | Forms | Rates | | Rates |
| MEWAs | | | | | Forms | Rates |

Source: Washington State Office of the Insurance Commissioner.

# APPENDIX B: DATA AND METHODS

## A. Data

The analysis in this report relies on data reported to the Washington Office of the Insurance Commissioner (OIC) and the federal Department of Labor. Each data source is described below.

- **Data reported to the Office of the Insurance Commissioner in compliance with ESBH 1714(2011).** In 2010, 37 carriers that wrote AHP or small group business in Washington State between 2005 and 2008 responded to a request for information issued by the Washington OIC as authorized by ESBH 1714(2011). Carriers were asked to provide information about each association plan that they wrote—including the number and size of employers that participated in the plans; the number and age distribution of resident employees or individuals enrolled in the plans; the dollar values of premiums and medical cost; and the use of health factors or claims experience in issuing coverage, setting premiums, or both. In addition, they were asked to report the same information for their community-rated small group business as a whole.

- **Annual Statement: Exhibit of Premiums, Enrollment and Utilization (2005-2008).** The OIC provided annual statements for each carrier that filed as a comprehensive health insurance company and reported business in Washington. Information about the number of members and member months, health premiums earned, and the claims incurred in each year for group plans was extracted from the Exhibit of Premiums, Enrollment and Utilization for 2005-2008 (rows 6, 15, and 18).

- **Additional Data Statement Filing.** The OIC also provided the Additional Data Statement Form for the Year Ending December 31, 2010 for all carriers, other than life and disability carriers, that wrote community-rated small group or AHP coverage in Washington. Information on net premium income, claims incurred (total hospital and medical), and total members at the end of the current year were extracted for small group contracts, and large group contracts.

- **Form 5500, Annual Return/Report of Employee Benefit Plan.** The OIC provided links to Form 5500 information submitted to the U.S. Department of Labor reporting the number of people enrolled in association plans in 2009, 2010, and 2011 and the insured or self-insured status of the plans.

- **State Insurance Management & Business Application (SIMBA).** Created to provide a tool for OIC staff to complete the day to day business of the agency, SIMBA is used to collect and manage data related to licensing of producers and companies, cases and orders submitted against companies and/or producers; revenue received from licensees (taxes, licensing fees, etc); rates and forms filings. SIMBA consists of an internal component used by OIC staff and an online component used by OIC customers. The OIC estimates of life and disability carriers' AHP enrollment in 2010 were based on the carriers' April 2011 NAIC filing (which reported their national AHP and MEWA business) cross-referenced to SIMBA.

## B. Methods

### 1. Data cleaning and verification

The information that carriers reported in response to the OIC data call as authorized by ESBH 1714(2011) was amassed in a database and checked to confirm that the required information was reported, the information reported for each AHP and aggregated small group line was consistent, and responses were within feasible ranges. Premiums per member month were analyzed, and extreme outlier lines of data (specifically, reporting premiums of less than $100 or greater than $2,000 per member month) were excluded from the analysis. Mathematica confirmed the stability of the reported trends by reproducing the calculations, eliminating all years of data for any AHP where at least one year of data was excluded as an outlier; this analysis confirmed that the elimination of outliers did not skew the reported results.

Most carriers reported the number of members enrolled during the year, and the distribution of those members by group size. However, for a small number of association plans, carriers were unable to report 2005 enrollment. When reporting trends in total AHP enrollment over time, Mathematica estimated 2005 enrollment for those plans by extrapolating from reported 2006-2008 enrollment. However, because the data were insufficient to estimate small and large group enrollment for these plans, they were excluded in all years for analyses of enrollment change by group size. AHPs not reporting 2005 enrollment were dropped from analyses of average premiums and medical cost only in the 2005.

All plans reported in the data call were classified into the following analysis categories:

- **Carrier.** Carriers commonly owned by a single company were combined under the parent company for the purpose of counting the number of carriers writing AHP or other large group or community-rated small group business over time. Six companies (Asuris Northwest Health, Regence BlueShield, Regence Life And Health Insurance Company, Regence BlueShield of Idaho, Regence Blue Shield of Oregon, and Regence Health Maintenance of Oregon) were classified as Regence. Three companies (Group Health Cooperative, Group Health Options, and KPS Health Plans) were classified as Group Health" Aetna, UnitedHealthcare, and HealthNet each reported two separate lines of business that were combined under their respective parent names.
- **Number of small-group and large-group enrollees.** Within each plan, the number of enrollees in group sizes of 2 to 50 were summed to arrive at total small-group enrollees, and the number in group sizes of 51 or more were summed to arrive at total large-group enrollees.
- **Small group or large group focus.** Association health plans were classified as being small group or large group focused if more than 50 percent of their enrollment was comprised of small groups (size 2 to 50) or large groups (sized 51 and above), respectively.
- **AHP size.** Association health plans were categorized into size class using total enrollment, including both small and large group enrollees.
- **Large group enrollment, premiums, and medical cost** were estimated as total group enrollment, earned premiums, and incurred claims reported in each year on the 2005-

2008 Annual Statements minus the small group and association plan numbers reported in the OIC data call.

## 2. Describing Trends in the AHP and Small Group Market

From the data call database, we calculated trends in enrollment, annual incurred claims, and annual net earned premiums for the AHP and community-rated small group market. We also calculated the share of the small group market that enrolled in AHPs and community-rated plans. In addition, data from carriers' annual statements for 2008 were used to assess the size of the non-AHP large group market in Washington state.

In addition, we analyzed the distribution of enrollees in the AHP and small group market based on employer size (2-5, 6-10, 11-25, 26-50, 51-100, 100+). Lastly, we analyzed data reported on the percentage of enrollees for whom plan rates were adjusted for health factor or claims experience reasons. Carriers also reported if they deny coverage based on health factors. However, as only one carrier in one year (2007) reported denying a limited number of plans we did not include analysis of this data.

## 3. Age Adjustment

To develop the adjustment factors to compare premiums and claims, four cost-by-age tables were developed and then simplified and blended into the following unisex age factors:

| <20 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65+ |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 1.25 | 1.5 | 1.7 | 1.85 | 1.85 | 2.25 | 2.75 | 3.5 | 4.25 | 6 |

Member-weighted averages were used to develop a relative cost factor for the entire study population and for each sub-population studied. The weighted average cost factor for the full population was 2.023.

## 4. Analysis of 2010 Data

To assess changes in the market from 2008 to 2010, per member per month premiums, medical loses, and carriers' shares of the AHP and other large group and community-rated small group market were calculated using data from the OIC data call database (for 2008) and carriers' additional data statement fillings (for 2010). In addition, OIC provided estimates of 2010 AHP and other large group and community-rated small group enrollment for life and disability carriers that are not required to file the additional data statement.

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