Arkansas Marketplace Research

Victor A. Puleo, Jr., Ph.D., CFP®
Associate Professor of Insurance & Risk Management

John C. Bratton, Ph.D., CIC, CPCU, ASLI, ARM
Professor of Insurance & Risk Management

David Mitchell, Ph.D.
Assistant Professor of Economics

Center for Insurance Studies
University of Central Arkansas

9/14/2012

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Major Findings

The insurance market in Arkansas is highly concentrated. Our concentration is similar to Louisiana, but it higher than Missouri, Oklahoma, and Texas. It is very unclear from the literature which insurance carriers will enter the Arkansas Federally Facilitated Exchange Partnership. Carriers that might enter the exchange are: those currently in Arkansas, large and growing national carriers, and carriers in neighboring states.

Insurance Carriers in the Individual and Small Group Markets in Arkansas

Three insurance carriers provide most of the individual and small group coverage for the state of Arkansas. They are: USAble Mutual Insurance Company (Arkansas Blue Cross Blue Shield), United Health Care Insurance Company, and QCA Health Plan Inc. (QualChoice). There are many companies who provide some type of health insurance in the state of Arkansas; however, many of these do not provide comprehensive health insurance. They provide hospital indemnity, supplemental care, dental, or specified disease, CancerWise, essential core care, or accident benefit care.

Competition in Arkansas Compared to Other States

All of Arkansas could use more competition in the health insurance market. While most states have highly concentrated insurance markets, there is less competition in Arkansas than in many other states. This section of the study describes some common methods used to measure competition, an analysis of each method, and results from several studies showing the application of these measures.

Three Measures of Competition

There are several ways to measure competition. One method involves analysis of the market share of the state's largest insurer. This a measure of how much market power the largest insurer has. A larger market share means more market power. Another measure of competition is the number of carriers with more than five percent of the market. A common measure of competition used by economists is the Herfindahl Hirshman Index (HHI). The HHI measures how evenly market share is spread across a large number of carriers. HHI values range from 0 to 10,000, with a value closer to zero

indicating a more competitive market and values closer to ten thousand indicating less competition. HHI is calculated by taking the sum of squares of market share by state.

Different economists and different publications use starting data in the form of a percent instead of a whole numbers. In these cases the HHI will range from 0 to 1 instead of 0 to 10,000. It is the same analysis but with a different scale. The following table uses Department of Justice Antitrust Guidelines and shows how the HHI can be interpreted using both the whole number scale and the percentage scale (http://statehealthfacts.org).

Market Concentration	HHI Starting With Whole Numbers	HHI Starting With Percentages
Unconcentrated	(HHI below 1000)	(HHI below .1)
Moderately concentrated	(HHI between 1000 and 1800)	(HHI between .1 and .18)
Highly concentrated	(HHI above 1800)	(HHI above .18)

Source: http://www.justice.gov/atr/hmerger/11249.htm

Analysis of the Three Metrics

The following analysis compares the three previously mentioned measures of competition: (1) number of carriers with more than five percent market share, (2) market share of largest insurer, and (3) the Herfindahl Hirshman Index for Arkansas and the seven surrounding states. The Figure 1 shows the three measures of competition in the individual insurance market. Figure 2 shows the three measures for the small group market.

Insurance Competition Compared with Surrounding States:

Figure 1
Individual Insurance Market (2011)

State	Number of Carriers with more than 5% Market Share	HHI	Market Share of Largest Insurer (Enrollment)
Arkansas	**3**	**.5954**	**77%**
Louisiana	3	.5463	73%
Mississippi	4	.3299	54%
Missouri	5	.1824	32%
Oklahoma	3	.3784	59%
Tennessee	5	.2506	36%
Texas	5	.3337	56%

Source: Kaiser Family Foundation

Note: For consistency we did not change the data for Arkansas even though we know that the Kaiser Family Foundation slightly overstates the competition in the insurance market.

Figure 2 ***Small Group Insurance Market (2011)***			
State	Number of Carriers with more than 5% Market Share	HHI	Market Share of Largest Insurer (Enrollment)
Arkansas	**3**	**.3518**	**51%**
Louisiana	3	.6532	80%
Mississippi	4	.6498	80%
Missouri	5	.2386	42%
Oklahoma	5	.2672	46%
Tennessee	3	.5299	70%
Texas	4	.2429	40%

Source: Kaiser Family Foundation

Note: Our data for Arkansas is slightly different. We calculate the Herfindahl Index (HHI) to be .24.

Number Of Arkansas Carriers With More Than 5% Of The Market

Individual Market

There are only three companies in Arkansas with more than five percent of the market for individual health insurance (measured in terms of the number of people enrolled). Neighboring states have Louisiana and Oklahoma also have three carriers in this category. Texas, Missouri, and Tennessee each have five carriers in this category. Mississippi has a similar population and four carriers in the individual health market with at least five percent market share (http://www.kff.org/healthreform/upload/8242.pdf).

Small Group Market

Again, there are only three companies with market shares more than five percent for small group health insurance. The median in the U.S. is 4 companies though Arkansas ranks 32nd in population and would be expected to have fewer carriers than some more populous states (http://www.statehealthfacts.org/).

Market Share of the Largest Insurer

Individual Market

In the individual health insurance market, the largest health insurer in Arkansas has over 65% of the market. Neighboring states tend to be a bit more competitive by this measure. The largest insurer's share of the market is as follows: Louisiana 73%, Oklahoma 59%, Texas 56%, Mississippi 54%, Tennessee 36% and Missouri 32%.

Small Group Carriers

In the small group health insurance market the largest insurer in Arkansas has over 51 % of the market. Arkansas is right in the middle of its neighbors. The largest insurer's share of the market is as follows: Louisiana 80%, Mississippi 80%, Tennessee 70%, Oklahoma 46%, Missouri 42%, and Texas 40% (*Kaiser Family Foundation. "How Competitive are State Insurance Markets?").*

Herfindahl Index for Health Insurance in Arkansas

Estimates of the HHI for the health insurance market differ, sometimes dramatically. However, all the estimates show concentrated markets. While the range may differ, the order of market concentration across states tends to be very similar. (Dafny et. al.2011).

Using Kaiser Family Foundation data, Arkansas has a Herfindahl Hirschman score of 5,954 for the Individual Insurance Market. This is highly concentrated. This ranks Arkansas 44th out of 50 states and below the District of Columbia.

Our data suggests that the HHI is 2,400. (This would put Arkansas in the top ten for least concentrated. However, we suspect that the other states have the same data problem that Arkansas has. There are many carriers in health insurance that do not provide comprehensive health insurance to people under age 65, but rather provide other services.

The American Medical Association has its own data for Arkansas and estimates the HHI score for Individual Group Insurance to be 6,000. Again, that is highly concentrated. The AMA estimates the HHI for the HMO and PPO market across the states. In their 2011 study, using the combined market, Arkansas ranks 32 out of the 47 states with available data. The following chart illustrates the American Medical

Association's calculations of market concentration (HHI) for the combined HMO and PPO product markets, the HMO product markets, and the PPO product markets.

Figure 3
Comparison of HHI for Combined HMO and PPO markets, HMO markets, and PPO markets

State	HMO + PPO HHI	HMO HHI	PPO HHI
Arkansas	3686	5449	3614
Mississippi	3828	3949	3952
Missouri	1869	1739	2061
Oklahoma	3308	3768	4115
Tennessee	4008	3414	4910
Texas	2697	2016	2984
Louisiana	3451	2969	4165

Source: American Medical Association, "Competition in health insurance: A comprehensive study of U.S. markets" (2011).

When it comes to small group health insurance in Arkansas there are three carriers with more than 5% of the market. The Herfindahl Hirschman score is 3,518. This score ranks Arkansas 26th out of 49 states (The ranking is not applicable for California). Using the alternate range the score would be .3518 (Statehealthfacts.org). There are other estimates of the HHI score for the states. Using the AMA data Arkansas' Small Group Employer HHI score is .24 (Statehealthfacts.org). Using data from the Arkansas Department of Insurance we find that the HHI for individual policies is .63, and the HHI for small group policies is .3820.

Additional Carriers and Identification of Potential Barriers to their Entry

In the individual and small group insurance markets there is much uncertainty about the average risk population. This is exacerbated by numerous other ACA changes. Once carriers can see what the rules are and how the competition is working out, they will have a better idea of whether or not it would be profitable to enter the market. There are three overlapping groups of carriers who might enter the exchange.

1) Current carriers in the state of Arkansas.
2) The largest US health carriers.
3) Health carriers in neighboring states

The Top Ten Carriers in Arkansas by Market Share

Figure 4 *Individual Health Policies: (2011)*			
Name	Health Premium Earned	Market Share by Premium	Market Share by Number of Covered Lives
USAble Mutual Ins Co	185,736,252	77.47%	78.85%
United Health Company (Golden Rule Ins Co)	18,943,593	7.90%	7.71%
QCA Health Plan Inc.	7,984,547	3.33%	5.27%
Time Ins Co	5,306,788	2.21%	1.12%
Humana Ins Co	3,675,977	1.53%	1.98%
United Security Life & Health Ins Co	1,896,602	0.79%	0.31%
United Healthcare Ins Co	1,627,956	0.68%	0.26%
Coventry Health & Life Ins Co	1,340,228	0.56%	0.05%
World Ins Co	661,562	0.28%	0.09%
Freedom Life Ins Co Of America	617,224	0.26%	0.21%
		HHI with top ten carriers	**.63**

Source: Arkansas Department of Insurance

Notes for Figure 3

Several carriers were removed the Department of Insurance carrier list because they do not provide comprehensive health insurance to the under 65 market.

Golden Rule Insurance Company is a United Health Care Company

World Insurance is American Enterprise Group

American Republic Ins Co sells supplemental insurance - Short-term medical, convalescent care

Figure 5 *Small Group Market: (2011)*				
Name	Health Premium Earned	Market Share by Premium	Number of Covered Lives	Market Share by Number of Covered Lives
USAble Mutual Ins Co (includes affiliate HMO Partner Inc.)	198,567,704	52.92%	58,430	55.99%
QCA Health Plan Inc.	74,700,997	19.91%	20,593	19.73%
UnitedHealthcare Ins Co	67,467,650	17.98%	17,453	16.72%
UnitedHealthcare Ins Co of the River	8,778,994	2.34%	3,621	3.47%

Coventry Health & Life Ins Co	8,728,347	2.33%	1,977	1.89%
United Healthcare of AR Inc.	5,093,030	1.36%	701	0.67%
Principal Life Ins Co	2,434,442	0.65%	31	0.03%
Federated Mutual Ins Co	2,204,912	0.59%	365	0.35%
John Alden Life Ins Co	2,122,064	0.57%	328	0.31%
Trustmark Life Ins Co	1,838,020	0.49%	327	0.31%
Humana Ins Co	1,743,357	0.46%	241	0.23%
Aetna Life Ins Co	402,352	0.11%	13	0.01%
Time Ins Co	388,250	0.10%	131	0.13%
Madison National Life Ins Co Inc.	275,767	0.07%	41	0.04%
Standard Security Life Ins Co of NY	248,012	0.07%	54	0.05%
Companion Life Ins Co	146,416	0.04%	52	0.05%
Union Security Ins Co	78,742	0.02%	5	0.00%
18 Companies in Report	375,219,056	100%	104,363	100%
			HHI	**0.382017**

Large National Health Insurance Carriers

We believe that the most likely carriers to enter the Arkansas Exchange are the carriers who are already in the state or who have business in neighboring states. Still, some carriers are large and growing. It would make sense to invite those large and growing national carriers to participate in the Arkansas Exchange. Below are the largest health insurance companies in the country by value.

Figure 6

Largest Health Insurance Companies by Value (Fortune 500)

Company	Revenue in $ Millions	Profits $ Millions	In Arkansas?
UnitedHealth Group	101,862.00	5,142.00	Yes
WellPoint	60,710.70	2,646.70	No
Humana	36,832.00	1,419.00	Yes
Aetna*	45,966.50	2,528.80	Yes
Cigna	21,998.00	1,327.00	Yes
Health Net	11,901.00	72.1	No
Amerigroup	6,318.40	195.6	No
WellCare Health Plans	6,106.90	264.2	No
Centene	5,340.60	111.2	No
Molina Healthcare	4,769.90	20.8	No

Issue date: May 21, 2012

Source: money.cnn.com
*Aetna includes Coventry Health Care

Potential Barriers To Entry

Without knowing the eventual rules, there are five barriers to entry by carriers in both the small group market and the individual health market.

1) Uncertainty
2) Adverse Selection
3) County by County versus State Wide Participation
4) Churning
5) Medical Loss Ratio

Uncertainty

A very large barrier to insurer participation is that the carriers do not know the rules and regulations that will be in place. They will want to know those rules so they can decide what sort of products to offer, whether to join, and whether or not enrollees will be able to game the system. It is also very hard to know how large the market will be. The expectation is that the individual exchange market will be large but many expect that the small business exchange may be small. Not only are the forecasts for small business exchange participation small, but also they are varying and uncertain (Blavin et al. 2012)

Adverse Selection

Adverse selection is a very real problem for carriers within the exchanges. California's early exchange, PacAdvantage, went well without subsidies until adverse selection lead to carrier defections and eventually forced the exchange to close (Kingsdale 2012) One study found that limiting firms' ability to stay in grandfathered plans reduces adverse selection (Eibner et. al 2012). Limiting grandfathered plans does, however, conflict with the promise of ACA. Carriers will have strong incentives to encourage relatively healthy enrollees.

Select Counties

Despite Arkansas having an "any willing provider" law, many Arkansas carriers offer services in a few counties only. If the exchange rules require carriers to participate in every county, those carriers may opt out. It might be better to encourage carriers to participate in any county where they already offer services.

Churning

Churning or the movement in and out of the exchange within a given year is costly to carriers and difficult for the insured. The insured can lose certain types of coverage as well as have to repay certain types of tax incentives. Churning normally occurs when a person gains or loses a job pushing them into or out of the exchange. This is already a problem in Medicaid and SCHIP. Having a Basic Health Plan for people who are below 200% of the federal poverty level might help. There would still be some churn between those people who move in and out of the 200% FPL each year, but it would be less since some of those people would be in employer insurance programs anyway. Alternatively, some of the exchange plans could serve Medicaid.

Medical Loss Ratio

Under the Patient Protection and Affordable Care Act (ACA) a minimum loss ratio of 80% is prescribed for insurance sold to individuals and in small employer plans. Large plans with 101 or more employees have a minimum loss ratio of 85%. In Arkansas the preliminary data suggests that many carriers are not currently meeting this requirement. Other states have gotten temporary waivers from Health and Human Services in order for their carriers to come into compliance.

Figure 7
Arkansas 2011 Individual Comprehensive Health Coverage
Preliminary Medical Loss Ratio

Name	Domicile	Health Premium Earned	Preliminary Medical Loss Ratio	Number of Covered Lives
USAble Mutual Ins Co	AR	185,736,252	0.859	90,711
Golden Rule Ins Co	IN	18,943,593	0.846	8,865
QCA Health Plan Inc.	AR	7,984,547	0.824	6,061
Time Ins Co	WI	5,306,788	0.802	1,285

Humana Ins Co	WI	3,675,977	0.652	2,274
United Security Life & Health Ins Co	IL	1,896,602	1.417	351
United Healthcare Ins Co	CT	1,627,956	1.021	301
Coventry Health & Life Ins Co	DE	1,340,228	0.76	62
World Ins Co	NE	661,562	0.554	105
Mid West National Life Ins Co of TN	TX	654,875	0.619	218
Freedom Life Ins Co Of America	TX	617,224	0.358	236

Source: Arkansas Insurance Department

Figure 8
Arkansas 2011 Small Group Coverage
Preliminary Medical Loss Ratio

	Name	Preliminary Medical Loss Ratio
1	USAble Mutual Ins Co (Arkansas Blue Cross Blue Shield)	0.728
	HMO Partners Inc (Arkansas Blue Cross Blue Shield)	0.746
2	QCA Health Plan Inc	0.867
3	UnitedHealthcare Ins Co	0.786
4	UnitedHealthcare Ins Co of the River	0.889
5	Coventry Health & Life Ins Co	0.935
6	United Healthcare of AR Inc	0.728
7	Principal Life Ins Co	1.265
8	Federated Mutual Ins Co	0.601
9	John Alden Life Ins Co	0.684
10	Trustmark Life Ins Co	0.539
	Top Ten by Health Premium in Report. See Table 4	

Source: Arkansas Insurance Department

Who Will be Eligible to Buy in the Exchange?

Exchanges are designed for people who don't have insurance through their employer, Medicaid, or Medicare. The Patient Protection and Affordable Care Act (PPACA) encourages states to expand Medicaid to include all individuals with income

up to 133% of the federal poverty line qualify for coverage, including adults without dependent children. There will be a sliding subsidy for people who make up to 400% of the federal poverty level. Figure 8 below shows that the FPL a single person is over $44,000. The FPL for a family of four is $92,200. The median household income in Arkansas is $39,267. Most uninsured people in Arkansas would probably be eligible for some sort of subsidy.

Figure 9

2012 Federal Poverty Guidelines for the 48 Contiguous States and DC and Household Income in Arkansas.

Household size	100%	133%	150%	200%	300%	400%
1	$11,170	$14,856	$16,755	$22,340	$33,510	$44,680
2	15,130	20,123	22,695	30,260	45,390	60,520
3	19,090	25,390	28,635	38,180	57,270	76,360
4	23,050	30,657	34,575	46,100	69,150	92,200
5	27,010	35,923	40,515	54,020	81,030	108,040
6	30,970	41,190	46,455	61,940	92,910	123,880
7	34,930	46,457	52,395	69,860	104,790	139,720
8	38,890	51,724	58,335	77,780	116,670	155,560
For each additional person, add	$3,960	$5,267	$5,940	$7,920	$11,880	$15,840

Source: U.S. Department of Health and Human Services: http://aspe.hhs.gov/poverty/12poverty.shtml - thresholds

Household Income and Size	Arkansas	National
Persons per household, 2006-2010	2.5	2.59
Median income	$21,274	$27,334
Median household income 2006-2010	$39,267	$51,914

Source: http://quickfacts.census.gov/qfd/states/05000.html

Using the "Small Area Income and Poverty Estimates" from the Census Bureau we are able to take the expected number of uninsured in each county by income level. The first column is the county name. The next three columns show the number of uninsured people below different FPLs. The last two columns represent the market for the insurance exchange. The first column is the number of uninsured people in each county who make between 138% and 400% of the FPL. The last column shows the market for if Medicaid or a Medicaid product were extended to cover up to 200% of the FPL. The reason to limit the market to the group of people who earn between 200 and 400 percent of the FPL is that extending Medicaid would reduce the churn into and out of this market.

Figure 10
Potential Size of the Insurance Exchange Market by County

County	Number Uninsured below 400% FPL	Number Uninsured below 200% FPL	Number Uninsured below 138% FPL	Eligible for the Market: 138%-400%	Eligible for the Market: 200%-400%
Arkansas County, Arkansas	2,643	1,851	1,281	1,362	1,362
Ashley County, Arkansas	3,263	2,307	1,653	1,610	1,610
Baxter County, Arkansas	5,419	3,766	2,632	2,787	2,787
Benton County, Arkansas	33,132	21,779	14,960	18,172	18,172
Boone County, Arkansas	5,447	3,839	2,729	2,718	2,718
Bradley County, Arkansas	2,163	1,624	1,228	935	935
Calhoun County, Arkansas	842	577	406	436	436
Carroll County, Arkansas	5,364	3,948	2,792	2,572	2,572
Chicot County, Arkansas	1,943	1,471	1,071	872	872
Clark County, Arkansas	4,041	3,031	2,279	1,762	1,762
Clay County, Arkansas	2,456	1,730	1,201	1,255	1,255
Cleburne County, Arkansas	3,782	2,641	1,859	1,923	1,923
Cleveland County, Arkansas	1,282	872	613	669	669
Columbia County, Arkansas	3,323	2,380	1,722	1,601	1,601
Conway County, Arkansas	2,993	2,089	1,492	1,501	1,501
Craighead County, Arkansas	14,789	10,614	7,752	7,037	7,037
Crawford County, Arkansas	9,244	6,451	4,518	4,726	4,726
Crittenden County,	8,080	5,894	4,377	3,703	3,703

Arkansas					
Cross County, Arkansas	2,867	2,007	1,427	1,440	1,440
Dallas County, Arkansas	1,253	909	641	612	612
Desha County, Arkansas	2,205	1,652	1,218	987	987
Drew County, Arkansas	3,055	2,253	1,649	1,406	1,406
Faulkner County, Arkansas	13,815	9,296	6,564	7,251	7,251
Franklin County, Arkansas	2,770	1,989	1,404	1,366	1,366
Fulton County, Arkansas	1,760	1,314	958	802	802
Garland County, Arkansas	14,433	10,222	7,304	7,129	7,129
Grant County, Arkansas	2,352	1,562	1,073	1,279	1,279
Greene County, Arkansas	5,966	4,152	2,926	3,040	3,040
Hempstead County, Arkansas	4,125	3,087	2,264	1,861	1,861
Hot Spring County, Arkansas	4,711	3,476	2,514	2,197	2,197
Howard County, Arkansas	2,547	1,915	1,381	1,166	1,166
Independence County, Arkansas	5,075	3,618	2,586	2,489	2,489
Izard County, Arkansas	2,207	1,671	1,250	957	957
Jackson County, Arkansas	2,853	2,088	1,524	1,329	1,329
Jefferson County, Arkansas	11,728	8,643	6,420	5,308	5,308
Johnson County, Arkansas	4,128	3,043	2,175	1,953	1,953
Lafayette County, Arkansas	1,316	979	718	598	598
Lawrence County, Arkansas	2,624	1,906	1,385	1,239	1,239
Lee County, Arkansas	2,104	1,594	1,208	896	896
Lincoln County, Arkansas	2,567	1,842	1,371	1,196	1,196
Little River County, Arkansas	1,747	1,236	854	893	893
Logan County, Arkansas	3,260	2,279	1,586	1,674	1,674
Lonoke County, Arkansas	8,725	5,898	4,203	4,522	4,522
Madison County, Arkansas	2,762	1,999	1,441	1,321	1,321
Marion County, Arkansas	2,299	1,715	1,229	1,070	1,070
Miller County, Arkansas	6,640	4,714	3,420	3,220	3,220
Mississippi County, Arkansas	7,135	5,174	3,795	3,340	3,340
Monroe County, Arkansas	1,345	989	722	623	623
Montgomery County, Arkansas	1,596	1,137	815	781	781
Nevada County, Arkansas	1,438	1,051	763	675	675
Newton County, Arkansas	1,448	1,087	788	660	660
Ouachita County, Arkansas	3,322	2,378	1,697	1,625	1,625

Perry County, Arkansas	1,531	1,098	791	740	740
Phillips County, Arkansas	3,039	2,284	1,695	1,344	1,344
Pike County, Arkansas	1,892	1,359	977	915	915
Poinsett County, Arkansas	4,043	2,961	2,118	1,925	1,925
Polk County, Arkansas	3,364	2,427	1,721	1,643	1,643
Pope County, Arkansas	9,695	7,082	5,169	4,526	4,526
Prairie County, Arkansas	1,362	954	668	694	694
Pulaski County, Arkansas	46,096	31,592	21,884	24,212	24,212
Randolph County, Arkansas	2,872	2,081	1,491	1,381	1,381
St. Francis County, Arkansas	4,430	3,342	2,499	1,931	1,931
Saline County, Arkansas	11,101	6,979	4,716	6,385	6,385
Scott County, Arkansas	2,031	1,515	1,093	938	938
Searcy County, Arkansas	1,365	1,056	772	593	593
Sebastian County, Arkansas	21,044	14,858	10,553	10,491	10,491
Sevier County, Arkansas	3,712	2,783	2,027	1,685	1,685
Sharp County, Arkansas	2,769	2,077	1,506	1,263	1,263
Stone County, Arkansas	2,074	1,561	1,137	937	937
Union County, Arkansas	5,782	4,089	2,974	2,808	2,808
Van Buren County, Arkansas	2,344	1,679	1,207	1,137	1,137
Washington County, Arkansas	33,244	23,228	16,424	16,820	16,820
White County, Arkansas	11,935	8,426	6,081	5,854	5,854
Woodruff County, Arkansas	1,241	907	656	585	585
Yell County, Arkansas	4,398	3,203	2,269	2,129	2,129

Source: http://smpbff1.dsd.census.gov/TheDataWeb_HotReport/servlet/HotReportEngineServlet?reportid=545e06bb0f97b3bd627572849bda2ce9&emailname=saeb@census.gov&filename=sahie09_county.hrml

If the Arkansas Federally Facilitated Exchange Partnership eligibility is set up for uninsured who make between 138%- 400% of the Federal Poverty Level, there would be 213,482 people eligible for participation.

Recommendations to the State Insurance Commissioner

Health benefits exchange planning in Arkansas is ahead of planning efforts in most other states. However, feedback from this carrier study indicates the primary reason for delaying final decisions on whether to participate in, and products to offer

on, the Arkansas FFE Partnership is the uncertainty surrounding final plan management design and operation. Survey findings from the Carrier Study, in response to selective decision points related to open market vs. active purchaser decisions that will shape the Arkansas FFE Partnership, were presented to the Arkansas FFE Partnership Plan Management Advisory Committee on August 3, 2012. Carriers prefer a more open-market approach. The Plan Management Advisory Committee's final recommendations to the Arkansas FFE Partnership Steering Committee were in alignment with feedback received from the carriers. We believe this recommendation, if implemented, will be viewed positively by carriers and may encourage participation in the Arkansas FFE Partnership.

The purpose of the PPACA is to make health insurance affordable to large numbers of currently uninsured individuals. The number of uninsured Arkansans by county is well documented. Success of the Arkansas' FFE Partnership will be measured by the reduction in the number of uninsured Arkansans. This will be accomplished through enrolling individuals in qualified health insurance plans offered on the exchange. Many of these individuals will be eligible for premium tax credits and cost-sharing reductions. The increased number of insured lives by county could serve as an alternative measure of success of the Arkansas FFE Partnership. We recommend the Department of Insurance begin requiring health insurers offering comprehensive health insurance plans in Arkansas to begin reporting the number of insured lives by county beginning in 2013 to serve as the pre-2014 benchmark for exchange assessment purposes.

The size of the uninsured population, and the percentage of the population uninsured, varies significantly by county in Arkansas. The number of carriers offering comprehensive health insurance plans also varies by county. Some counties have only two health insurance carriers providing comprehensive health insurance plans. Those counties with significantly higher uninsured populations may be eligible for significantly higher premium tax credits with which to purchase health insurance through the exchange. We have provided preliminary information on the potential size of the uninsured population eligible for subsidies by county broken down by income levels. More research is needed is needed in this area. Detailed information on the number of individuals eligible for premium tax credits by county could be used to attract carriers to those underserved counties and increase the health insurance plans available through the exchange in those counties.

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PART II – CARRIER SURVEY

Survey Overview

Description

This survey was undertaken to determine the extent of the health insurance market in Arkansas and to gather information regarding issuers plans to participate in the Arkansas Federally-Facilitated Exchange (FFE) Partnership.

Methodology

Market share information was obtained from the Arkansas Department of Insurance and from the Insurance Departments of each of the seven states adjacent to Arkansas (Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas). Two survey instruments were designed to gather information about each issuers participation in the individual and small group health insurance markets – one for issuers operating in Arkansas and one for issuers operating in adjacent states but not in Arkansas.

Respondent Metrics

During the initial planning stage for the survey, the authors were provided with 2010 market share reports for individual and small group health insurers in Arkansas. After discussions with the leadership of the Arkansas Health Benefits Exchange Partnership the decision was made to survey the top ten individual health insurance issuers and the top ten small group health insurance issuers in Arkansas.

The first step in the process was to update the information based upon 2011 data. There are 45 issuers on the Arkansas Department of Insurance 2011 list of Individual Comprehensive Health Coverage providers. The top ten issuers on that list account for 97.16% of the Arkansas market. There are 18 issuers on the 2011 list of Small Group Employer Comprehensive Health Coverage providers. The top ten issuers on that list account for 98.64% of the Arkansas Market. Because several issuers are active in both the individual and small group markets this resulted in the selection of 17 issuers.

Market share information was obtained from the Insurance Departments of each of the seven states adjacent to Arkansas (Kentucky, Louisiana, Mississippi, Missouri, Oklahoma, Tennessee, and Texas). Issuers with five percent or more market share in any of those states but not already included were added to the study. From these issuers, any whose service area does not include Arkansas, i.e., Blue Cross Blue Shield plans and Tennessee Farm Bureau, were removed. This resulted in the addition of three insurers for a total of 20 issuers in the study (Appendix I).

The initial survey was distributed on June 25, 2012. As of July 23, 2012 seventeen issuers have responded to the survey. It has been determined that two of the companies not responding provide supplemental health plans only. Those companies have been removed from the study. One carrier, that does issue comprehensive health insurance in some states, but not Arkansas, has not responded to the survey.

Of the seventeen issuers that have responded, two companies provide supplemental plans only, two issuers withdrew from comprehensive health coverage market nationwide, and one issuer no longer writes individual or small group comprehensive health coverage in Arkansas.

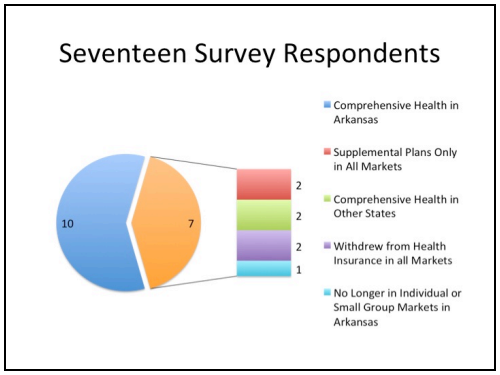


Figure 11

Twelve issuers provided usable answers to the survey questions. Ten of those providing answers to the survey currently issue health insurance coverage in Arkansas and two issue health insurance coverage in one or more of the seven adjacent states, but not in Arkansas (Figure 1).

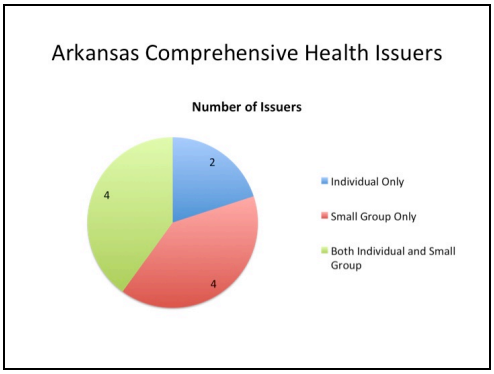


Figure 12

Of the ten companies currently issuing health coverage in Arkansas, two participate in the individual market only, four participate in the small group market only, and four participate in both individual and small group markets (Figure 2). Of the two companies surveyed that issue health coverage in one or more adjacent states, one participates in the individual market only and one participates only in the small group market.

The six companies currently in the individual health market in Arkansas, and the one company currently in the individual market in an adjacent state, were asked how likely they are to participate in the Arkansas Individual FFE Partnership.

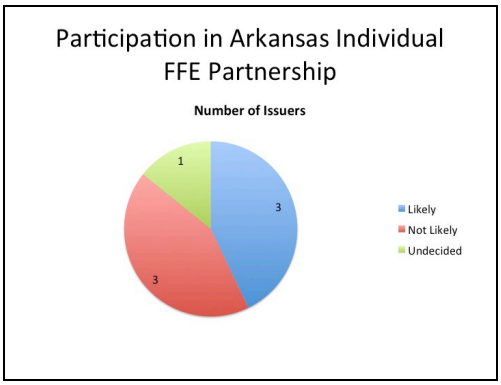


Figure 13

Three issuers answered that they are "likely" to participate, three issuers answered "not likely" to participate, and the one respondent - that does not currently

participate in the Arkansas market - indicated "no decision to date" on participation (Figure 3).

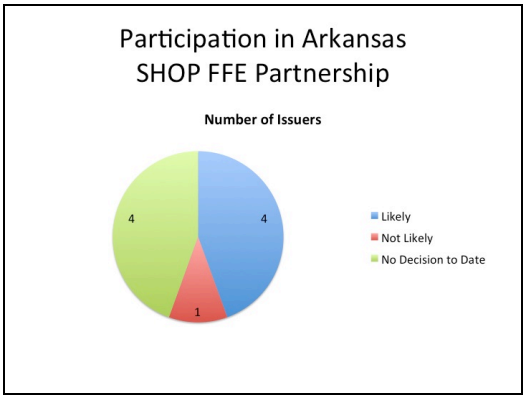


Figure 14

The eight companies currently in the small group market in Arkansas, and the one company currently in the small group market in an adjacent state, were asked how likely they are to participate in the Arkansas Small Business Health Options Program (SHOP) FFE Partnership. Their responses indicate that four issuers currently participating in the Arkansas market are "likely" to participate, one issuer currently participating in the Arkansas market is "not likely" to participate, and four issuers, including one not currently in the Arkansas market, have made "no decision to date" (Figure 4).

Survey Questions

The surveys included questions about:

- Geographic distribution of individual and small group products,
- Likelihood of participation in the Arkansas FFE Partnership,
- Barriers to participation in the Arkansas FFE Partnership,
- Considerations that would positively influence participation in the Arkansas FFE Partnership,
- Plans likely to be offered on the Arkansas FFE Partnership,
- Factors that might influence issuer's decision to participate in the exchange.

Survey Responses

The information that follows includes each question in the survey and a graphical depiction of the responses to each survey question. Additional comments provided by respondents, if any, are included after each graph.

Section I - Individual Health Insurance

The first section of the survey includes questions about each issuer's participation in the individual comprehensive health insurance market.

1. In how many of Arkansas' 75 counties do your organization currently offer individual health insurance policies (under age 65 market)?

- Individual health in all 75 counties (6 responses)
- Small group health only (4 responses)
- Not currenting issuing health insurance in Arkansas (2 responses)

2. Which of the following best describes the immediate future plans of your organization to offer individual health insurance policies (under age 65 market) in Arkansas' 75 counties?

- No plans to change (11 responses)
- No decision on issuing individual health in Arkansas

3. What are the primary considerations that influenced your company's decision with respect to the previous question?

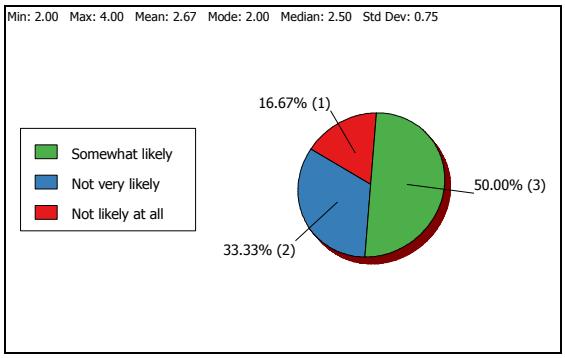
- Already in all 75 counties (6 responses)
- Not in individual market (5 responses)

4. If not offering individual health insurance policies in all counties, what might make expanding into additional counties in Arkansas attractive to your company?

- The respondents issuing individual health in Arkansas report operating in all 75 counties

Section II - AR FFE Partnership Individual Exchange

5. Is your organization likely to apply to be a QHP issuer and offer individual health insurance plans in the Arkansas FFE Partnership for the initial plan year 2014?



6. What factor(s) will/did your company consider in determining whether or not to participate in the Arkansas FFE Partnership individual exchange?

- Ability to effectively compete
- Any restrictions on local plans versus the OPM plans that advantage the OPM plans to the detriment of the local plans.
- As a company we have not made the decision on if or how we would participate in any exchanges.
- Ease of doing business with the exchange
- How the exchange is structured and the specific rules for exchange operation.
- Individual market opportunity
- It will be very difficult for a small insurance carrier to continue beyond 2014 given the current rate and MLR restrictions.
- It would be premature to commit that we will participate in any Exchange.
- Not in the individual market. (2 responses)
- Organizational priorities
- Regulatory environment
- Relevant to its decision will obviously be any rules which are promulgated concerning the Federal-State Partnership model for Exchanges, as well as factors which generally apply in deciding whether to do business in any given market currently.

- Requirements that all metallic levels be offered
- Specific rules for exchange operation
- Structure of the exchange
- The costs and processes used to determine if a plan is qualified.
- The degree to which rates approved for the exchange allow coverage of the additional administrative costs and burdens associated with interacting with the exchange
- The degree to which rates approved for the exchange allow coverage of the various fees the ACA applies to issuers.
- The degree to which rates approved for the exchange allow reasonable margins.
- The opportunity to expand market share penetration and to fulfill organization's mission.
- The restrictions on local plans versus the OPM plans that advantage the OPM plans to the detriment of the local plans
- The restrictions on product offerings
- The restrictions on product offerings or requirements that all metallic levels be offered.
- We are currently in the process of determining our approach to operating in Exchanges across the country.
- We have not made a decision on participation in any exchanges.

7. What do you see as the three top barriers to participation in the Arkansas FFE Partnership individual exchange

- Ability to develop the product features that consumers want at prices they are willing to pay. Ability to secure and maintain rates that support medical costs and administrative costs associated with required benefit designs and rules for participation in the exchange.
- Additional administrative costs and processes associated with new exchange interactions, enrollment, billing, disenrollment, customer service.
- Additional regulatory restrictions
- Cost of participation
- Lack of ability to effectively compete
- Lack of clarity on exchange rules and design prior to exchange start-up.
- Low potential membership opportunity

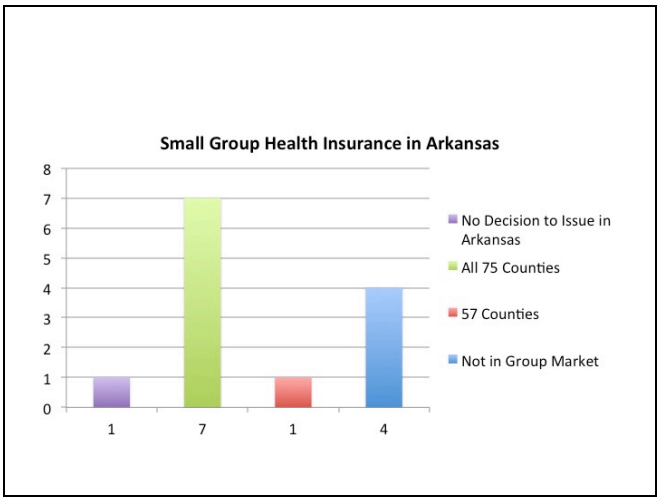
- Medical Loss Ratio
- No preexisting conditions
- How the FFE will actually operate and be governed/administered for issuers that offer QHP products.
- Potential for adverse selection
- Rate review restrictions
- Scope of essential benefit plans being cost prohibitive

8. What are the top three considerations that would positively influence your company to offer individual health insurance plans on the Arkansas FFE Partnership exchange?

- Ability to develop the product features that consumers want at prices they are willing to pay.
- Ability to secure and maintain rates that support medical costs and administrative costs associated with required benefit designs and rules for participation in the exchange.
- Administrative ease of integration and administration
- Allow pre-existing conditions limitations
- Ample potential membership
- Clarity on exchange rules and product design prior to exchange start-up.
- Flexibility to offer limited provider networks
- Flexibility to select specific markets for participation
- Minimal additional regulatory burdens placed on plans during the initial phases of exchange startup and operation.
- Remove MLR
- Remove rate review
- Strong ability to compete in market
- Structure of reinsurance risk adjustment set-up to protect from adverse selection

Section III - Small Group Health Insurance

9. In how many of Arkansas' 75 counties do your organization currently offer small group (less than 50 employees) health insurance policies?



10. Which of the following best describes the immediate future plans of your organization with respect to small group health insurance policies (less than 50 employees) in Arkansas' 75 counties?

No plans to change the number of counties in which insurance is provided.

11. What are the primary considerations that influenced your company's decision with respect to the previous question?

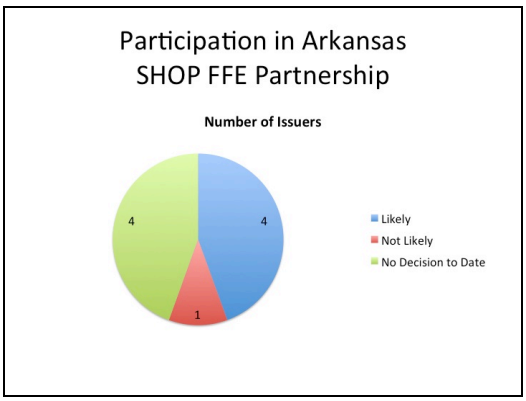
- It is the mission of the organization to offer health benefit options to all Arkansans
- No longer in the small group market in Arkansas.
- Small group coverage is the strategy we employ in all states where we offer health coverage.
- We currently can offer small group health insurance in all 75 counties.
- We do not actively participate in the small group market.
- We market health and life insurance products to individuals and families.

12. If not offering small group health insurance policies in all counties, what might make expanding into additional counties in Arkansas attractive to your company?

- No plans to change the number of counties in which insurance is provided.

Section IV- AR FFE Partnership SHOP Exchange

13. Is your organization likely to apply to be a QHP issuer and offer small group health insurance plans in the Arkansas FFE Partnership Small Business Health Options Program (SHOP) exchange for the initial plan year 2014?



14. What factor(s) will/did your company consider in determining whether on not to participate in the Arkansas FFE Partnership SHOP exchange?

- We are in the process of determining our approach to operating in Exchanges. As such, it would be premature to commit that we will participate in any Exchange. Relevant to its decision will obviously be any rules which are promulgated concerning the Federal-State Partnership model for Exchanges, as well as factors which generally apply in deciding whether to do business in any given market currently.

15. What do you see as the three top barriers to participation in the Arkansas FFE Partnership SHOP exchange? (Please identify at least three in the space below - Use the "TAB" key to open additional answer boxes.)

- Clarity of rules and requirements
- Cost of participation

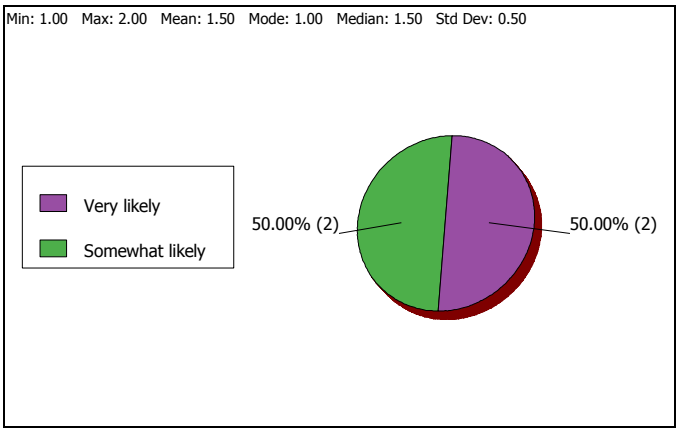
- Flexibility in product design to suit the consumer demands.
- Potential for adverse selection and cannibalization of current business
- Rates and allowed margins
- Scope of essential benefit plans being cost prohibitive.
- Smooth transition into the new market place.
- Lack of clarity on exchange rules and design prior to exchange start-up. Particularly how the FFE will actually operate and be governed/administered for issuers that offer QHP products.

16. What are the top three considerations that would positively influence your company to offer small group health insurance plans on the Arkansas FFE Partnership SHOP exchange? (Please identify at least three in the space below - Use the "TAB" key to open additional answer boxes.)

- Ability to develop the product features that consumers want at prices they are willing to pay.
- Ability to secure and maintain rates that support medical costs and administrative costs associated with required benefit designs and rules for participation in the exchange.
- Additional administrative costs and processes associated with new exchange interactions, enrollment, billing, disenrollment, customer service.
- Flexibility to offer limited provider networks.
- Flexibility to select specific markets for participation.
- Structure of reinsurance risk adjustment set-up to protect from adverse selection.

Section V - AR FFE Partnership General

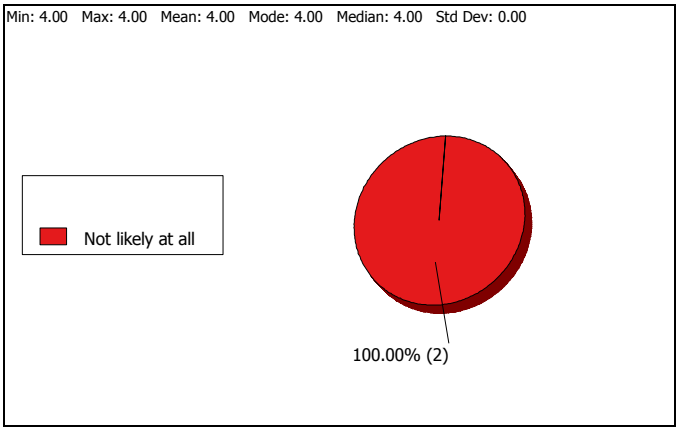
17. Is your organization likely to offer QHPs through the Arkansas FFE Partnership Exchange in all of your current service areas?



18. What most influenced the decision from the previous question?

- As a company we have not made the decision on if or how we would participate in any exchanges.

19. Is your organization likely to participate in the Arkansas FFE Partnership in new service areas?



20. What most influenced the decision from the previous question?

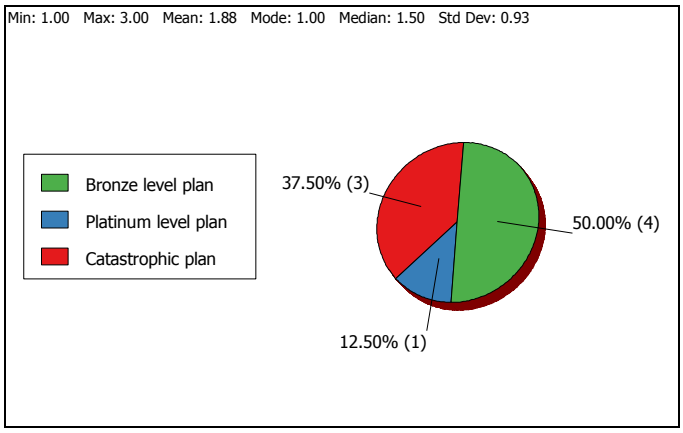
We currently offer products in all 75 counties. (3 responses)

Section VI - Qualified Health Plans

Instructions Provided To Respondents

Issuers participating in the Arkansas FFE Partnership must agree to offer at least one silver level plan and one gold level plan on the exchange. Issuers that participate in the Arkansas FFE Partnership can also offer bronze level plans, platinum level plans, and catastrophic plans to qualified individuals.

21. If you chose to participate in the Arkansas FFE Partnership, which of the following other plans is your organization likely to consider offering on the Arkansas FFE Exchange? Select all that apply.



22. Any specific comments about the choices in the previous question?

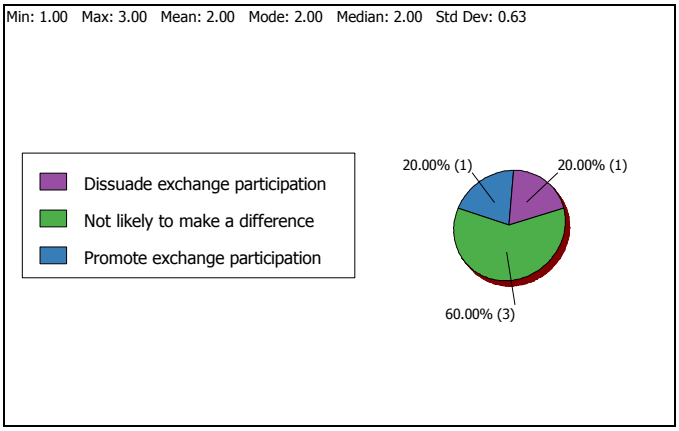
- Limitations to underwriting under PPACA create adverse selection for Platinum level plan.
- Until the states determine Essential Health Benefits and define plan requirements, it is premature to determine additional offerings beyond those required.
- We are undecided with respect to a platinum product.

Section VII - Factors Impacting FFE Partnership Exchange Participation

Instructions Provided To Respondents

To help us gain a better understanding of how different factors might influence your company's decisions about FFE Partnership Exchange participation in Arkansas, please rate how each of the following factors might affect your company's decisions.

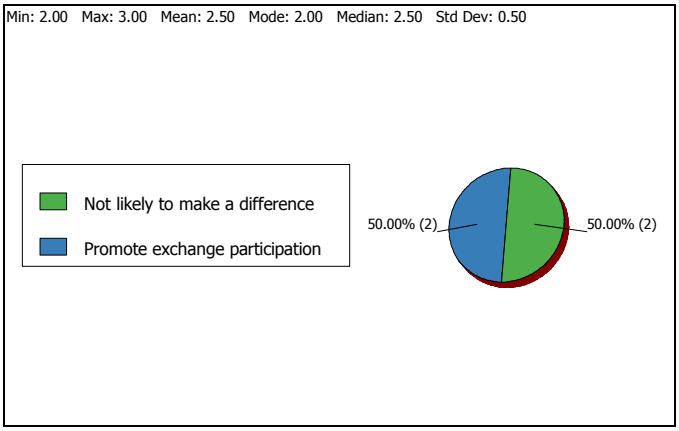
23. The expected number of participants in the individual exchange



24. Please provide a brief explanation for the selection you chose for the previous question

- We are unlikely to know how many there will be before deciding to participate.
- We prefer that the market offer a sizable pool of consumers to ensure that a balanced marketplace exists.
- We would be dissuaded from participation if there were a low number of participants and persuaded to participate if there were a high number of participants.

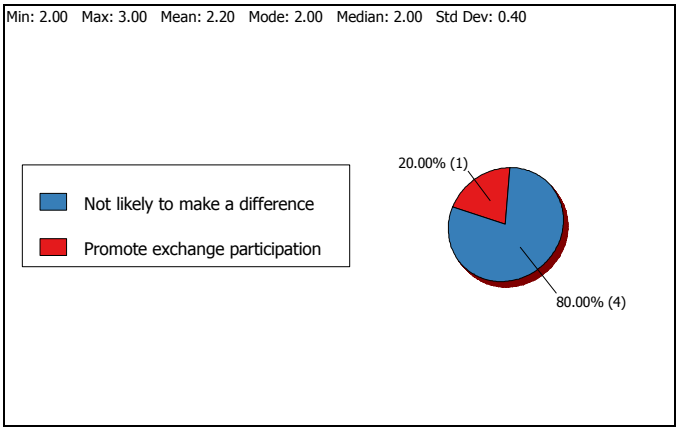
25. The expected number of participants in the Small Business Health Options Program (SHOP) exchange



26. Please provide a brief explanation for the selection you chose for the previous question

- Small group is not an area of growth or focus.
- We are unlikely to know how many there will be before deciding to participate. (3 responses)
- We would be dissuaded from participation if there were a low number of participants and persuaded to participate if there were a high number of participants.

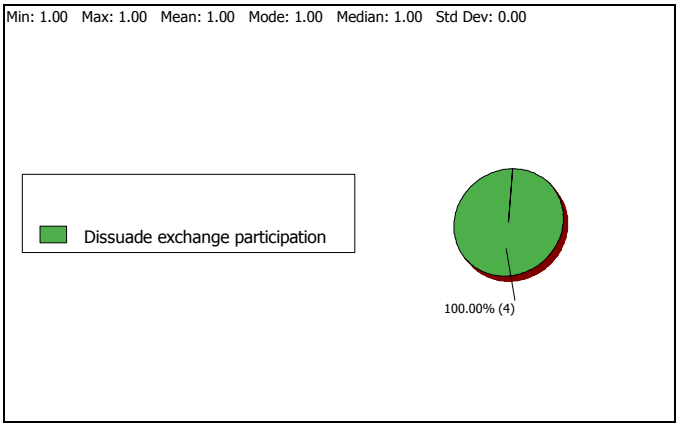
27. The addition of 275,000 newly eligible Medicaid recipients under managed care contracts



28. Please provide a brief explanation for the selection you chose for the previous question

- Changing the Arkansas Medicaid program to managed care could affect our participation.
- Opportunity to attract members who move in and out of Medicaid.
- We do not participate in the Medicaid marketplace.

29. The DHHS required accreditation by NCQA or URAC for FFE Partnership Exchange Participation

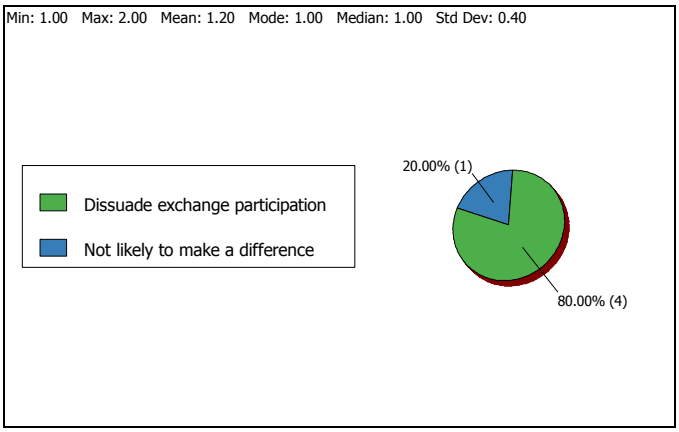


30. Please provide a brief explanation for the selection you chose for the previous question

- FEHBP program does not require accreditation. Of limited value because market drives quality of carriers.
- High cost for accreditation.
- One of the reasons that very few local plans in the Arkansas market have chosen to pursue accreditation is that our markets have not placed value on accreditation by NCQA or URAC, particularly when faced with even minor premium increases associated with the accreditation process.
- Two domestic carriers in the market do not have this and market does not require.
- We are not an HMO so we do not have many of the services that these accreditations deal with. Until they clarify how the will do accreditation for true insurance companies we cannot determine how we will respond.
- We do conduct HEDIS/CAPHS surveys of our HMO product lines annually.

- We feel that the exchanges should take advantage of and require accreditation from existing organizations rather than creating new requirements.

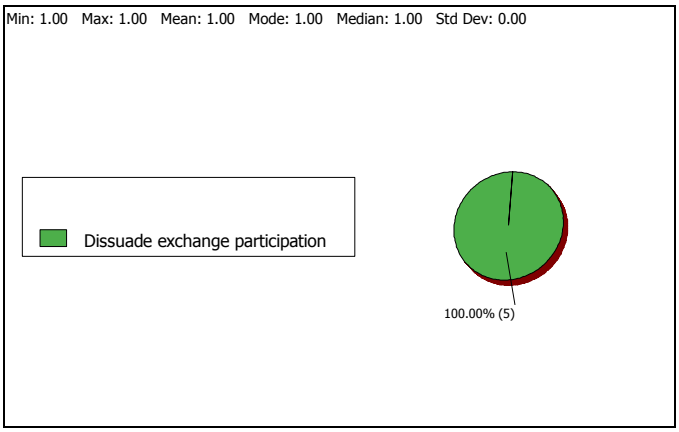
31. Possibility of Statewide coverage requirement for participating QHP issuers



32. Please provide a brief explanation for the selection you chose for the previous question

- Allowing localized product variations may better address special needs areas of the state better than attempting to create a one size fits all exchange product.
- Carriers should have flexibility to choose where to do business in the state as we do today.
- There is some potential value to having localized networks of high performing providers even in rural areas in order to keep medical costs and premiums lower than would be available with statewide network requirements.
- To the extent that medical costs vary by geographic area, requiring plans, even those with state wide coverage to continue to offer statewide coverage or networks may be counter competitive.
- We would want to participate in areas of the state where we could effectively compete.

33. Requiring participating QHP issuers to offer all metallic level plans



34. Please provide a brief explanation for the selection you chose for the previous question

Carriers should have flexibility to choose product offerings in the state as we do today.

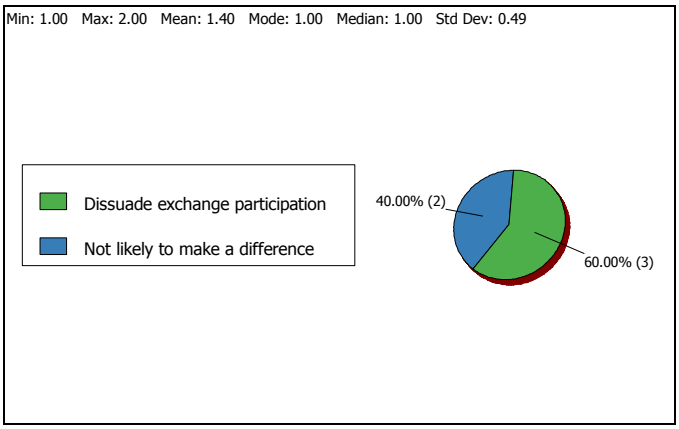
If the volume of the participation for a particular plan metallic level is not sufficient, the issuer may not be able to made the plan viable in the long term.

Product design and approval costs money and time.

Product design and approval costs money and time. If the volume of the participation for a particular plan metallic level is not sufficient, the issuer may not be able to make the plan viable in the long term.

We want to be able to participate based upon our ability to effectively compete and for some states that may not be by offering all metallic levels.

35. Limitation on the number of plans sold by a QHP issuer at each metallic level



36. Please provide a brief explanation for the selection you chose for the previous question

Market competition is better for all participants.

Since the individual exchange is all about individual products, one would expect consumers to respond better to having choices that might fit their needs rather than the Henry Ford approach of "You can have any color you want, as long as it is black".

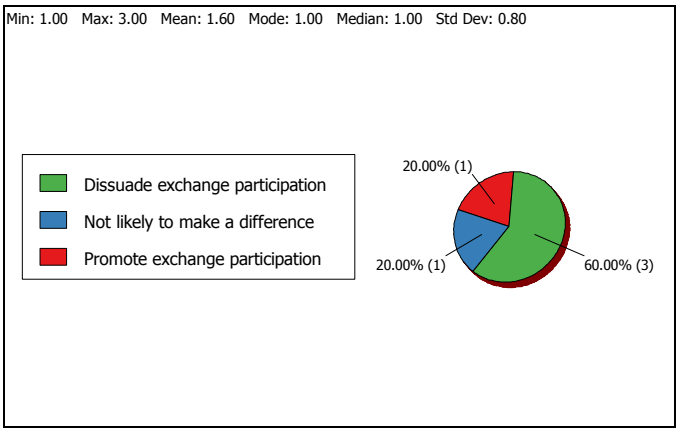
The best approach likely would be to allow any bronze plan (of example) that fulfills EHBs so as to allow the plan structure that fits a consumer's needs.

The individual exchange is all about individual products. One would expect consumers to respond better to having choices that might fit their needs.

We would want to be able to offer enough choice to compete but also want the state to ensure that the choices are not so vast that the marketplace becomes confusing for the consumer.

While limiting may create simplicity, it also makes it harder to customize individual products for particular life stages or economic situations.

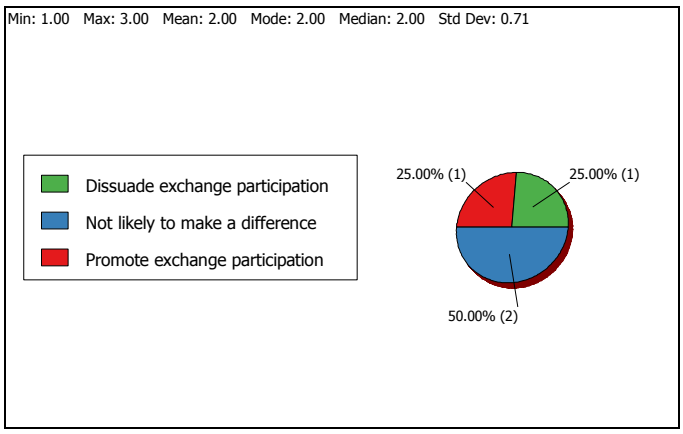
37. Offering a Medicaid-like Basic Health Plan (BHP) option



38. Please provide a brief explanation for the selection you chose for the previous question

- A Basic Health Plan significantly reduces the size of the Exchange since it is outside the exchange (like Medicaid). The exchange only serves as an enrollment tool and therefore only those 200%-400% are subsidized if rates are high enough to actually create a subsidy.
- Provides broader range of product offerings to increase market share.
- We do not have an interest in participating in a Basic Health Plan.

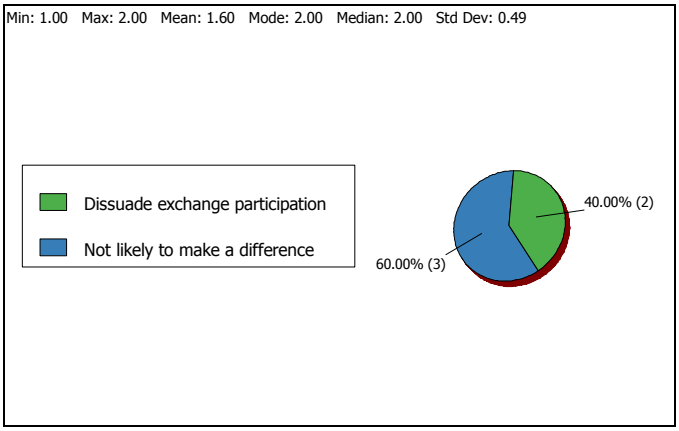
39. The DHHS required Quality Improvement reimbursements/incentives designed to improve quality of patient outcomes



40. Please provide a brief explanation for the selection you chose for the previous question

- Even though the response was not likely to dissuade, if the requirements are too onerous and create too much cost without creating real value to consumers, then the requirements would dissuade participation.
- Through a partnership with healthcare professionals, employers, legislators, regulators and carriers, we can achieve the objectives of access to quality healthcare at reasonable costs.
- We support the use of incentives for healthcare professionals that are tied to outcomes.

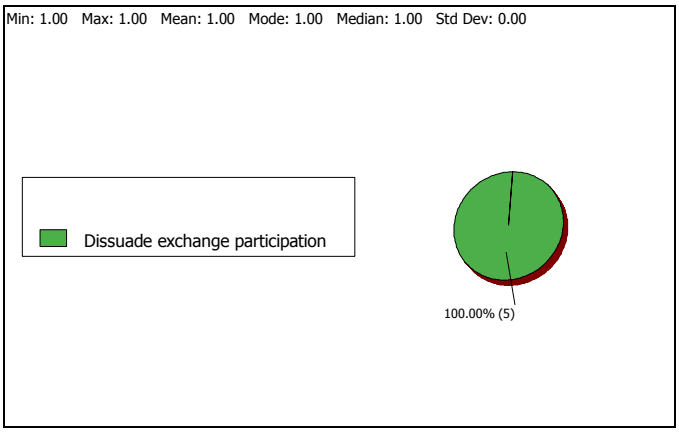
41. QHP cost sharing standards (deductibles, coinsurance, and copayments)



42. Please provide a brief explanation for the selection you chose for the previous question

- Carriers should have flexibility to set cost sharing.
- The law is pretty specific on cost sharing standards and actuarial values. To the extent the state places additional constraints beyond the federal requirements, it would dissuade an insurer from offering products on the exchange.

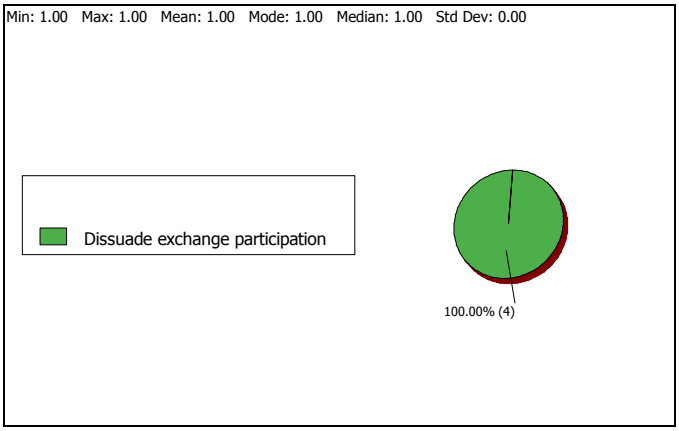
43. A competitive bidding process for participating QHP issuers



44. Please provide a brief explanation for the selection you chose for the previous question

- A winner take all, would likely discourage smaller plans from bidding, would likely introduce more insurer churn, particularly if contracts were longer term, and might have an impact on plan customer service levels and quality improvement programs.
- All carriers currently operating in good standing should be able to participate on the exchange assuming they meet the minimum QHP requirements without having to go through a bid process.
- Companies with large market and should not be put in a position to buy added market share.
- If the process were similar to the Medicare Advantage approach, there might be different outcomes for the bidding process. However, that process also has resulted in carriers entering/exiting the market on a more frequent basis. This is counterintuitive to the stated need to attract additional carriers to the state.
- This depends on how the bidding process would operate.
- To the degree that bidders mispriced or underbid to get the business, consumers and providers could be affected relative to payments and claims processing.

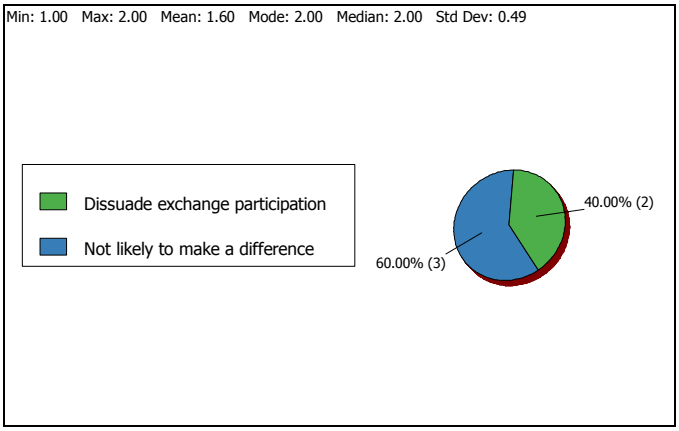
45. Mandatory participation requirement in the small group (or SHOP) FFE Partnership Exchange



46. Please provide a brief explanation for the selection you chose for the previous question

- Each company should have the option to choose to sell in either or both the individual and SHOP exchange.
- Flexibility to offer individual, small group or both should exist.
- Generally speaking requiring a company to participate in a market where they do not already have capabilities, does not work well.
- The small group market is not an area of focus and a requirement that we participate in this market does not fit with our business objectives.
- This is counterintuitive to the stated need to attract additional carriers to the state.
- We feel that carriers should be able to compete in the markets where they can add and demonstrate value to the consumer.

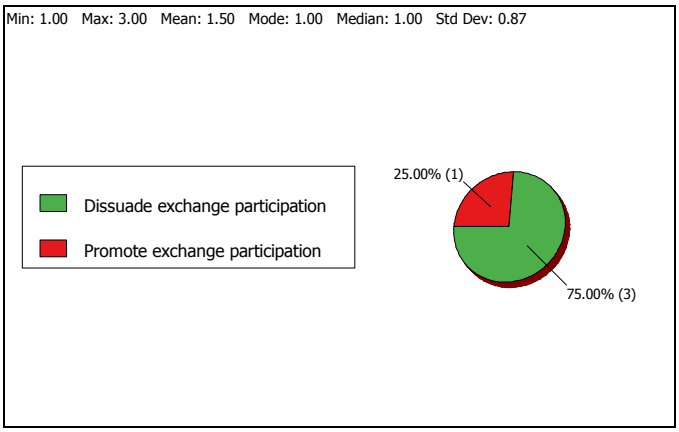
47. Allowing employers with more than 50 employees to participate in the FFE Partnership SHOP Exchange in the initial plan year 2014



48. Please provide a brief explanation for the selection you chose for the previous question

- The intent of the exchanges is to provide a marketplace for individuals and small employers to purchase healthcare coverage at a reasonable cost.
- This might increase the size of the SHOP market but will not be a critical aspect in determining if we would participate in the SHOP.
- This would allow brokers to push higher risk groups into the Exchange.
- We feel that the states should establish their exchanges for individuals and small employers.
- We recommend limiting the exchanges to the individual and small group market since the dynamics of these two markets differ dramatically from the large employer market.

49. A combined risk pool for the FFE Partnership individual and SHOP exchanges



50. Please provide a brief explanation for the selection you chose for the previous question

- A state could consider combining the pools after the evaluation of the experience in those markets.
- Due to the dynamics of the different markets, the experience of each should be kept separate.
- The state could unintentionally create a situation where the individual market rates end up higher than planned and limit participation due to the expense.
- This would force those carriers with experience or comfort with one or the other to choose to play in both. If they are uncomfortable with either then they will do neither.
- Would better mitigate adverse risk selection by combining risk pools.

51. Other factors, not previously mentioned, that might affect your company's decisions to participate in the exchange

- For not-for-profit carriers the margins are less but are not zero as capital is still required to support being a risk-assuming business and must be provided as a portion of the premiums collected.
- Any new carrier(s) of either kind will be constrained to these realities and the more directed the market is the harder it will be to come to Arkansas rather than some other place.
- For publicly traded or otherwise for profit carriers there has to be a margin to pay for the capital for those companies to be in business.

- One of the stated goals for the exchange is to attract additional carriers to offer on the exchange. This survey is the first effort we have seen to understand what might help with this effort.

52. Please provide a brief explanation of any factors mentioned in the previous question that might affect your company's decisions to participate in the exchange

Section VIII - Other

53. Are there specific Arkansas plan management or consumer characteristics that would be considered barriers/promoters to your company's participation in the Arkansas FFE Partnership?

- There are selected regions of the state that have poorer risk profiles tied to lifestyle choices.

54. Please provide any additional feedback your organization feels may be valuable to Arkansas as it continues to explore implementation of Arkansas-operated plan management and consumer assistance functions under the Federally-facilitated Health Benefits Exchange Partnership Model.

- A closely directed FFE that goes beyond the level of free market that the ACA provides is unlikely to yield the winning combination of attractive product and price.

APPENDIX I

Issuers Surveyed

Aetna Life Insurance Company
American Family Life Assurance Company of Columbus
Colonial Life & Accident Insurance Company
Connecticut General Life Insurance Company (CIGNA)
Coventry Health & Life Insurance Company
Federated Mutual Insurance Company
Golden Rule Insurance Company
HMO Partners, Inc
Humana Insurance Company
John Alden Life Insurance Company
Mega Life & Health Insurance Company
Metropolitan Life Insurance Company
New York Life Insurance Company
Principal Life Insurance Company
QCA Health Plan Inc
Time Insurance Company
United Security Life & Health Insurance Company
UnitedHealthcare Insurance Company
UnitedHealthCare of Arkansas
USAble Mutual Insurance Company

APPENDIX II

Arkansas Qualified Health Plan Selection Criteria Decision Matrix

Item	Require	Do Not Require	Comment
Quality Criteria		X	See pp. 14 - 15
Statewide Offerings		X	See pp. 14 - 15
Enhanced Network Adequacy Standards			
SHOP Participation		X	See pp. 19 - 20
Adopt AR Payment Improvement Method			
TBD Delivery System Reforms			
Selective Contracting and Price Negotiations		X	See pp. 18 – 19
Streamlining Plan and Benefit Designs		X	See pp. 18
Piloting New Delivery System and Reimbursement Strategies			
Basic Health Plan (BHP)		X	See p. 17
Web Based Tools to Drive Value-Oriented Decisions			
Recruiting new entrants to the market			

The decision matrix has been completed to reflect the feedback from issuers in response to selective decision points related to open market vs. active purchaser decisions that will shape Arkansas' Federally Facilitated Partnership Exchange and potentially impact issuer participation.

ANNOTATED BIBLIOGRAPHY

American Academy of Family Physicians. (2011). "Health Insurance Exchanges: Variation in State Efforts." Government Relations Division. Washington, D.C. March, 2011. http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/state/statehcr/aafpexchangesbrief.Par.0001.File.tmp/AAFP%20Exchanges%20--%20March%202011.pdf

This paper lists the different structures and types of exchanges selected on a state-by-state basis. Failed exchange examples and highlights of each program are provided, along with current (as of 2011) exchanges.

American Medical Association. 2011. "Competition in Health Insurance: A comprehensive study of U.S. markets-2011 Update." Chicago, IL.

Provides estimates of the Herfindahl index for PPO's and HMO's across forty-eight states and the District of Columbia.

Bisgaier, Joanna; MSW and Karen V. Rhodes, MD, "Auditing Access to Specialty Care for Children with Public Insurance," *The New England Journal of Medicine*, 364:24, June 16, 2011. http://www.nejm.org/doi/pdf/10.1056/NEJMsa1013285

This is a study of clinics in Cook County, Illinois examining the disparity of care offered to pediatric patients on the basis of differing insurance status. They concluded that there was a disparity of outpatient service care between children with public vs. private insurance. They recommended that policy interventions were necessary to ensure equal access to health care. They also mention that reimbursement levels strongly influence provider decisions on accepting public insurance.

Blavin F, Blumberg LJ, Buettgens M, Holahan S., McMorrow, S. "How choices in exchange design for states could affect insurance premiums and levels of coverage. *Health Affairs.* 2012 31:2290-2989.

A very large barrier to insurer participation is that the carriers do not know the rules and regulations that will be in place. They will want to know those rules so they can decide what sort of products to offer, whether to join, and whether or

not enrollees will be able to game the system. It is also very hard to know how large the market will be. The expectation is that the individual exchange market will be large but many expect that the small business exchange may be small. Not only are the forecasts for small business exchange participation small, but they are varying and uncertain.

Boies, Kimberly Cogdell. "Using the Flexibility of the Affordable Care Act to Reduce Health Disparities by Creatively Structuring Health Insurance Exchanges." Journal of Civil Rights and Development. Volume 26, Issue 1. 2011. St. John's University. http://www.stjohns.edu/academics/graduate/law/journals_activities/jcred/issues/26_1.stj

This article is intended to provide a strategy for increasing health equity through the use of health insurance exchanges, by examining the strategy and policies of Massachusetts. The paper closes by making recommendations on the format and governance of the exchanges, and some recommended incentives and their outcomes.

Buettgens, M. and C. Carroll (2012). Eliminating the Individual Mandate: Effects on Premiums, Coverage, and Uncompensated Care. Washington, D.C., Urban Institute for the Robert Wood Johnson Foundation. http://www.healthreformgps.org/wp-content/uploads/rwjf-individualmandates.pdf

This is an updated article based on recent survey data and updated state trends. In it, they examine the effects of eliminating the individual mandate. It points out that the current non-group market in New York is a prime example of what could happen, while noting that New York's market does not subsidize coverage in the exchanges the way the ACA does. Points out that outreach at the beginning of the market implementation will be important because if too few people sign up then adverse selection will be a serious problem.

Bunce, Victoria C. "Health Insurance Mandates in the States 2011." The Council for Affordable Health Insurance. 2012. http://www.cahi.org/cahi_contents/newsroom/article.asp?id=1039

This paper charts the total mandates for health care policies by state. It also includes a listing of the most and least popular mandates. This is only the executive summary, but they mention the full article is available by emailing them.

Burkhauser, R. V., Lyons, S., & Simon, K. (2011). "An Offer You Can't Refuse: Estimating the Coverage Effects of the 2010 Affordable Care Act" (pp. 40): Employment Policies Institute. http://epionline.org/studies/110715_EPI_AnOfferYouCantRefuse_Final.pdf

This paper uses current literature to make approximate calculations regarding the effects of the ACA on the overall share of workers covered by employer-sponsored health insurance (ESI). It is primarily focused on the employment effects (likely small) and ESI crowd-out effects (possibly much more significant). Two contrasting examples are provided for illustration. One assumes little behavioral change and another assumes more fully realized participation by employers and employees under a broader definition of the affordable coverage rule.

California Health Benefit Exchange (2012).. "The California Path to Achieving Effective Health Plan Design and Selection and Catalyzing Delivery System Reform." May 18, 2012. http://www.healthexchange.ca.gov/BoardMeetings/Documents/May%2022,%202012/HBEX-QHPStakeholderReport_5-18-12.pdf

This is a very thorough paper addressing California's health plan design with the added benefit of having input from various stakeholder groups. They were asked questions on topics like the optimal number of plans, plan selection criteria, and even how to catalyze health care system reform. Affordability was considered by most to be the most important part of the program. Pages four and five highlight the paper's key findings.

California Pan-Ethnic Health Network (2010). "Equity Through Implementation: Ensuring health reform meets the needs of California's diverse communities." California Pan-Ethnic Health Network: 2. http://www.cpehn.org/pdfs/Implementing%20Reform.pdf

This is a short breakdown of the changes in eligibility for California's expanded health care system under the new legislation. It also lists 4 recommendations to ensure equity of coverage across the demographic barriers. These seem remarkably similar to the ones already listed in several of the Arkansas committee meetings though.

Cunningham, Peter J. (2011) *State Variation in Primary Care Physician Supply: Implications for Health Reform Medicaid Expansions*, Center for Studying Health System Change, Research Brief No. 19. March 2011. http://www.rwjf.org/files/research/72046.pdf;

This study was designed to show the state variation in Medicaid primary care physicians by taking into account the overall supply, the proportion that accept Medicaid patients, and the number of nonelderly Medicaid enrollees in the state. It mentions that states like Arkansas that already have low numbers of primary care physicians could see as much as 38% enrollment expansion in Medicaid. Most of the new enrollees will be adults. The percent increase in Medicaid enrollment is expected to be almost four times larger than the percent increase in primary care physician supply.

Dafny, Leemore; David Dranove; Frank Limbrock; and Fiona Scott Morton (2011) "Data Impediments to Empirical Work on Health Insurance Markets," *The B.E. Journal of Economic Analysis & Policy*: Vol. 11: Iss. 2 (Contributions), Article 8. Available at: http://www.bepress.com/bejeap/vol11/iss2/art8

This article points out that there are a wide variety of estimates for insurance competition. However, all the estimates show highly concentrated markets across the states.

Dorn, S. "State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Goals." Washington, D.C., Urban Institute for the Association of Community Affiliated Plans http://www.rwjf.org/files/research/66488.pdf

This paper discusses ways in which states can use the PPACA to help meet their individual policy goals. These include reforming health insurance to function

more like a traditional market, slowing cost growth, increasing quality, increasing coverage and access, and finally, reducing budget deficits.

Dorn, S., M. Buettgens, et al. (2011). "Using the basic health program to make coverage more affordable to low-income households: a promising approach for many states." Washington, D.C., Urban Institute for the Association of Community Affiliated Plans http://www.urban.org/UploadedPDF/412412-Using-the-Basic-Health-Program-to-Make-Coverage-More-Affordable-to-Low-Income-Households.pdf

This paper is a simulation showing how implementing the Basic Health Program will affect national and state level insurance coverage. They concluded that moving adults from Medicaid to the BHP would realize significant state savings while only minimally reducing the number of participants in the exchange. The discussion section also mentions consumer effects, costs to Medicaid beneficiaries and states, federal funding, exchange size, and exchange risk level.

Dunn, Dennis; David Lewandowski; and Gary Pickens, 92010) *The Influence of Reform on Local Coverage and Utilization,* White paper, Thompson Reuters, (Sept.) http://www.knightmarketing.com/_/pdf/TR-Healthcare-Reform-White-Paper.pdf

This paper outlines the features of healthcare reform that pertain to insurance coverage and utilization projections, reviews the industry's best general estimates of insurance coverage effects for the whole country, presents methods for estimating insurance coverage changes in a particular market, and discusses the next steps for utilization trending. These changes are tracked on a year-by-year basis in several included tables. Finally, it shows how to estimate market specific volumes for a particular procedure.

Dunn, D. and L. MacCracken (2011). "Onset of Healthcare Reform: Managing New Demands," Thomson Reuters http://img.en25.com/Web/ThomsonReuters/Onset_of_Healthcare_Reform_090811.pdf

This paper focuses primarily on first identifying and defining the consumer, then moves on to show the market growth, and then addresses the growing need for

improved care delivery models and staff planning in the health care community. They conclude by mentioning the need to engage consumers, plan for appropriate capacity, the need to strategize with physicians, deliver new care models, manage population health through preventative measures, and integrate community needs with the total market and patient information.

Duggan, M. and Kocher, B. 2010 "The Economics, Opportunities, and Challenges of Health Insurance Exchanges." *Economists' Voice*, (December). https://bepp.wharton.upenn.edu/files/?whdmsaction=public:main.file&fileID=1647

This article explains how the exchanges build on the current market by altering incentives for individuals, employers, and insurers. It explains the key functions of the exchanges, their economic benefit potential, points out two key weaknesses, and a few key issues for the exchanges. It concludes by stating that the success of the exchanges will depend largely on the efficacy of their execution and support.

Edwards, Randy. 2010 "Access." *Hospital and Health Networks*. (August). http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/08AUG2010/1008HHN_Coverstory&domain=HHNMAG.

This short paper focuses primarily on things like the administrative aspect of the new healthcare reform laws. It makes basic statements about expanded access leading to additional patients, but cautions against making permanent expansion until the numbers are better understood. It also suggests planning for these expansions now, and not later. The Massachusetts model's fiscal issues are mentioned and then the model is examined in more detail. The article suggests using alternative staffing and operations and process modifications to help meet the increased demand.

Eibner, Christine E., et al. 2009. "Controlling Health Care Spending in Massachusetts: An Analysis of Options." Division of Health Care Finance and Policy. Boston, Massachusetts. (August). http://www.mass.gov/eohhs/docs/dhcfp/r/pubs/09/control-health-care-spending-rand-08-07-09.pdf

This is a very thorough paper addressing many conceivable issues for the Massachusetts health care plan. It provides twenty-one different options to help reduce the amount of health care spending. They examine two primary methods, with the first being lowering cost on a per-unit basis, and the second being a reduction in volume of services provided.

Elmendorf, Douglas. (2009) "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act." Washington, DC: Congressional Budget Office. (Nov. 30). http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf

This is a lengthy analysis by the Congressional Budget Office discussing how Health Insurance premiums are expected to react under the new legislation. It gives three broad categories for premium effect analysis. The first category is the difference in amount of coverage purchased. Second is the price variation for a given set of coverage for a given group of enrollees. Third is the variation in individuals purchasing from a given insurance market.

Farnham, Jennifer, and Dorothy Gaboda. "Helping New Jersey Families Coordinate Transitions and Maintain Coverage When Changing Health Plans." Rutgers Center for State Health Policy. March, 2012. http://www.cshp.rutgers.edu/Downloads/9240.pdf

This paper examines how to coordinate the transition between the various types of coverage and health care plans in New Jersey. This could be particularly informative as a significant percentage of Arkansans are likely to "transition" between plans at some point during the year. Smoothing the transitions between plans would allow a continuous flow of services and prevent gaps in insurance coverage.

Federal Trade Commission and the Department of Justice (2004). "Improving Health Care: A Dose of Competition." Report by the Federal Trade Commission and the Department of Justice. (July). http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf

The joint report addresses the current role of competition in health care and examines how antitrust enforcement should work to protect and encourage that competition. Focuses on information asymmetries in health care and health care insurance, barriers to provider markets, the inefficient and distortionary effects of licensing, and the way that mandates can reduce competition. Most favored nation clauses can be anti-competitive.

Fish-Parcham, Cheryl. "Rate Review: Holding Health Plans Accountable for Your Premium Dollars." Families USA Brief. April, 2010. http://www.familiesusa.org/assets/pdfs/health-reform/rate-review.pdf

This article examines the process of rate reviews in various states and then explains how national health care reform will help strengthen the process. Five lessons are outlined, and then a small section on how the reform addresses those lessons is included. The paper concludes that the efforts made by federal policy makers will help protect consumers from unfair rate hikes and provide needed oversight of health insurance premium prices.

Fish-Parcham, Cheryl. "Selecting Plans to Participate in an Exchange." Families USA Brief. February, 2010.

http://www.familiesusa2.org/assets/pdfs/health-reform/Selecting-Plans-for-Exchanges.pdf

This article discusses issues like how active a state should be in selecting exchange plans, federal exchange plan requirements, and other possible considerations. It then gives a list of some of the more current state exchanges and a brief discussion of their highlights.

Garthwaite, Craig L. *The Doctor Might See You Now: The Supply Side Effects of Public Health Insurance Expansions*, NBER Working Paper Series, Working Paper 17070, May 2011. http://apps.olin.wustl.edu/cres/research/calendar/files/GarthwaiteCraig.pdf

This study examines the implementation of the State Children's Health Insurance program on physician behavior. Physicians showed a decrease in the amount of

time spent with patients, but increased their participation in the expanded program. The decrease in hours spent with patients was found to come from shorter office visits. PPACA may change the nature of patient interactions with physicians, with registered nurses and physician assistants taking care of the more basic medical services.

Gorman Actuarial, LLC; DeWeese Consulting, Inc.; Hinckley, Allen & Tringale LP. (2006). "Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets," http://www.mass.gov/ocabr/docs/doi/legal-hearings/nongrp-smallgrp/finalreport-12-26.pdf

This December 2006 paper on the 2006 Massachusetts health care insurance reform law, St. 2006, c.58 is a commissioned study of the impact of merging the Massachusetts small group and non-group rating pools into a single market. It uses claims data to provide financial and demographic information on the effects of the legislation across the state. It identifies potential issues, shows trends, and provides analysis of the findings. Paper also provides a number of reinsurance scenarios.

Greaney, Thomas L. (2011) "The Affordable Care Act and Competition Policy: Antidote or Placebo?" *Oregon Law Review* 89:3, pp. 785-810. http://www.antitrustinstitute.org/sites/default/files/Greaney.pdf

This is an article from the Oregon Law Review that examines whether or not the affordable care act will address many of the nation's health care issues. Section IV is of specific interest and directly addresses obstacles to improving competitiveness in the health care markets.

Hacker, Jacob S., (2009) "Healthy Competition: How to Structure Public Health Insurance Plan Choice to Ensure Risk-Sharing, Cost Control, and Quality Improvement." University of California Berkeley School of Law., (April). http://www.ourfuture.org/files/Hacker_Healthy_Competition_FINAL.pdf

This paper stipulates that creating a level playing field requires that the same rules be enacted for private and public plans, risk adjustment must protect plans

from being competitively disadvantaged if they enroll a less healthy group of people, and regional pricing must allow private and public plans to compete within regions on the same terms, rather than having the public plan compete on a national basis with regionally based private plans. It then offers suggestions for making those stipulations more realistic and competitive.

Hamilton, Charlaine M., "Establishing California's Health Insurance Exchange under the Affordable Care Act: Governance and Operating Model." http://csusdspace.calstate.edu/bitstream/handle/10211.9/1402/Hamilton%20Thesis%20%28Print%29.pdf?sequence=8

This master's thesis examines several alternatives for the formation and governance of California's exchange program. They are then compared on the basis of avoiding adverse selection, facilitating competition, and enhancing the consumer experience.

Jost, Timothy Stoltzfus. (July 2010) Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues, Commonwealth Fund. http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf

This article addresses the shortcomings of previous attempts to create health insurance exchanges, explains the key issues to overcome them, analyzes the ACA's provisions addressing said shortcomings, and discusses further policy options. Some points made by the authors include the necessity of increasing competition among insurers with a focus on value and price, enrolling the highest amount of consumers possible, and creating employer-friendly exchanges.

Kingsdale, J. and Bertko, J. 2010 "Insurance Exchanges Under Health Reform: Six Design Issues for the States." *Health Affairs* 29: 6: 1158–1163 http://www.insurance.wa.gov/consumers/reform/documents/Kingsdale2010.pdf.

This article addresses what they consider the six most important design issues for states to consider when creating their health care exchanges. These issues are organization and governance, rating rules, adjusting premiums for risk selection,

the range of benefit options, bidding to provide benefit packages, and protecting the public. They conclude that without attracting and serving customers well, the exchange will fail to accomplish its mission to spread coverage and stabilize the health insurance market.

Krueger, A. B. and I. Kuziemko (2011). "The Demand for Health Insurance Among Uninsured Americans: Results of a Survey Experiment and Implications for Policy" NBER**:** pages 2-4. http://www.princeton.edu/~kuziemko/gallup_ik_25feb2011.pdf

This article uses a survey experiment to assess whether a sample group of uninsured Americans would be willing to pay for a health care plan. The results are then used to estimate coverage expansion under the ACA. Their results showed price elasticity larger than many previous studies. The results showed that directly subsidizing the purchase of a private health care plan would significantly shrink the uninsured population (60% take the plan at an annual premium of $2,000). Their results suggest that under-estimation of potential coverage rates is possible if elasticity rates from previous papers are used.

The Lewin Group (2009). *The Health Benefits Simulation Model (HBSM): Methodology and Assumptions*, (March 31). http://www.lewin.com/~/media/lewin/site_sections/clients/hbsmsummary.pdf

This paper defines and explains the criteria used in the HBSM Model. This model is designed to simulate and analyze the results of health reform proposals. This is their explanation of the general components of the model, with specific studies receiving further explanation in their respective documentation.

The Lewin Group (2010). *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers*, Staff Working Paper #11, June 8, 2010. http://www.lewin.com/publications/publication/409/

This article gives a brief overview of the PPACA and its impact on state and local governments, private employers, National Health Spending, and Hospital and Physician Income. Using their HBSM, they have estimated the impact of the

PPACA out through 2029. They do mention assuming full implementation of the act and that enrollment fully matures in 2011.

McAndrew, Claire Health Coverage in Connecticut: How Will Health Reform Help? http://www.familiesusa.org/assets/pdfs/health-reform/state-gains-2010/connecticut.pdf

This article uses Connecticut's current health coverage system to point out ways in which the current health care industry is failing consumers. They then discuss the primary ways that health care reform addresses those shortcomings.

McAndrew, C. and K. Stoll (2010). A Helping Hand for Small Businesses, Families USA; Small Business Majority: 12. http://www.familiesusa.org/assets/pdfs/health-reform/Helping-Small-Businesses.pdf

This article discusses the aspects of the ACA that affect small business efforts to insure their employees. According to the information listed, Arkansas is one of 11 states where more than 90% (94.2% specifically) of small businesses will be eligible to receive a tax credit in 2010. 13,000 of those small businesses in Arkansas are expected to be eligible for the maximum premium tax credits available in 2010.

McBride, Timothy D., et al. "Federal Employees Health Program Experiences Lack of Competition in some Areas, Raising Cost Concerns for Exchange Plans." *Health affairs* 31.6 (2012): 1321-8. *ABI/INFORM Complete; ProQuest Research Library.* Web. 13 Aug. 2012

This study examines the Federal Employees Health Benefits Program, because it somewhat resembles the structures created by the recently passed legislation. They looked at plan availability and enrollment and found that while plans were widely available, enrollment was highly concentrated in a few primary providers. This was even more prevalent in more rural locations. As would be expected, areas with more competition had lower premiums.

Missouri Foundation for Health (2012). "Bending the Health Care Cost Curve in Missouri". http://www.mffh.org/mm/files/BendingtheCurveReport.pdf

This report examines six scenarios that could help contain growing health care costs while improving health care quality. State government would see much of the savings outlined in the report and, in many cases; savings would extend to private employers and households.

Ormond, Barbara A. and Randall R. Bovbjerg, (2012) *Assuring Access to Care under Health Reform: The Key Role of Workforce Policy*, The Urban Institute, (October). http://www.rwjf.org/pr/product.jsp?id=73579

This paper focuses on improving patient access to health care under the ACA. No concrete recommendations are given, just the general suggestion to attempt to match changes to local cultures and regulatory practices.

Patient Centered Primary Care Collaborative. (2012). "Using State Insurance Exchanges to Drive Better, More Cost Effective Care." Washington, D.C., April, 2012. http://www.pcpcc.net/files/using_state_insurance_exchanges.pdf

This paper explores the concept of using the Patient Centered Medical Home model to help improve cost savings and improve health system delivery in state exchanges. It provides several examples based on current state practices that help illustrate how these improvements can be realized.

Schoen, Cathy; Jennifer L. Nicholson, and Sheila D. Rustgi, (2009) "Paying the Price: How Health Insurance Premiums Are Eating up Middle-Class Incomes," The Commonwealth Fund, (Aug.). http://www.commonwealthfund.org/~/media/Files/Publications/Data%20Brief/2009/Aug/1313_Schoen_paying_the_price_db_v3_resorted_tables.pdf

This study analyzes the effect that rising health insurance premiums have had on middle-class incomes. They mention that if health reforms were able to slow growth premiums by just one percentage point in all states, by 2020 employers and families together would save $2,571 per premium for family coverage. To

ensure affordability, they say that it is crucial that the reforms enacted address long-term growth in health care costs.

Sherrill, A. and J. E. Dicken (2011). Health Care Coverage: Job Lock and the Potential Impact of the Patient Protection and Affordable Care Act. Washington D.C., United States Government Accountability Office: 32. http://www.gao.gov/assets/590/586973.pdf

A paper from the Governmental Accountability Office that examines the phenomenon of "job lock", where employees stay in jobs they might have otherwise left due to the health care coverage provided by their employer. PPACA was suggested to potentially reduce the occurrence of said "job lock". This paper provides expert research and opinions to back both sides of the argument.

State Health Access Data Assistance Center. (2010). "Health Insurance Exchanges: Implementation and Data Consideration for States and Existing Models for Comparison." Robert Wood Johnson Foundation. (October). http://www.shadac.org/files/shadac/publications/IssueBrief23.pdf

This paper compares the more successful state models from Massachusetts, Utah, Connecticut, and Washington. There is also a brief section on ways the ACA attempts to address the concept of adverse selection. Provides a useful table to compare the different state programs.

Sullivan, J. and K. Stoll (2010). Lower Taxes, Lower Premiums, Families USA: 12. http://familiesusa.org/assets/pdfs/health-reform/Premium-Tax-Credits.pdf

This paper examines the effect of the premium tax credits provided by the ACA. It gives figures for the number of total individuals that will be eligible for the new tax credits in 2014. It also points out that while 2/3 of the people eligible for the tax credits have incomes at or above two times the poverty level, 56% of the available dollars will be targeted to lower-income families. They point out who will benefit most from the tax credit, and conclude that the reform will provide added economic certainty for many working families.

Weisman, Robert (2010) "2 Insurers Again Seek Double-digit Increases: Earlier Rejections Still Under Appeal," *Boston Globe,* June 3, 2010. http://www.boston.com/business/healthcare/articles/2010/06/03/mass_health_insurers_seek_double_digit_increases_again/

This is a news article mentioning that several of the largest health insurers in Massachusetts are requesting double digit increases in their premium rates. The health care companies blamed their deficits on rate-caps, which they said caused market chaos.

White, Chapin. *Promoting Healthy Competition in Health Insurance Exchanges: Options and Trade-offs*. National Institute for health care Reform, Policy Analysis No.6, November 2011. http://www.nihcr.org/Healthy-Competition.pdf

This is an excellent paper that addresses the trade-offs that federal and state governments will have to address when determining the structures of their exchanges and the products contained within. The first trade-off they mention is between simplicity and flexibility. Several charts and tables provided serve to further illustrate exactly how the various trade-offs affect different aspects of the marketplace and marketplace competition.