

NH Premium Assistance Program (NHPAP) Analysis of 2016 Data

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Introduction

- Gorman Actuarial, Inc
 - Formed in 2006
 - Lead Consultant: Bela Gorman, FSA, MAAA
 - Over 25 years of health care experience
 - Client list include state agencies in MA, ME, RI, NY, and NH
 - Worked for two largest insurers in MA
- Gorman Actuarial Relevant Engagements
 - MA Individual & Small Group Market Merger Study-2006
 - Followed by similar studies in Maine and New York
 - Post ACA, Merger studies performed for NH, NV, WI, WY, MN, TN, MA including impact of small group market and the 51-100 markets
 - Currently involved with a durational study that analyzes Medicaid Expansion populations: 3 insurance carriers, spanning 5 to 7 states, 9 different data sets

Agenda

- I. Background
- II. Data Sources
- III. Membership
- IV. Allowed Claims Costs
- V. Demographics
- VI. Plan Design
- VII. Induced Demand
- VIII. Adjusted Claims Cost
- IX. Impact of PAP on Individual Market
- X. Risk Adjustment
- XI. Summary

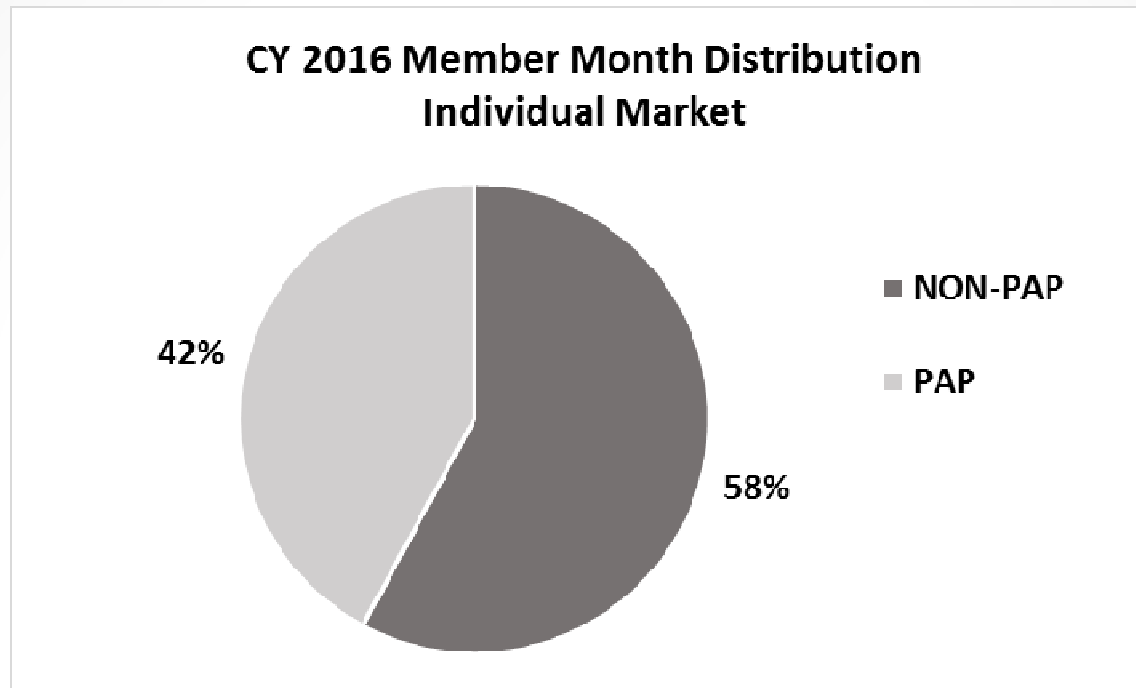
Background

- PAP program became part of NH's Individual Market in January 2016
 - Significantly increased size of Individual Market
 - Affordable Care Act's (ACA) single risk pool requirements apply:
 - Premium rates for Individual Market based on medical expenditures of the combined PAP and Non-PAP populations
 - PAP members are part of the ACA's risk adjustment program
- 2016 analysis provides historical comparisons of the enrollees within the PAP program and the Non-PAP enrollees
- Significant changes in 2018 may materially impact future comparisons of the PAP program enrollees and the Non-PAP enrollees

Data Sources

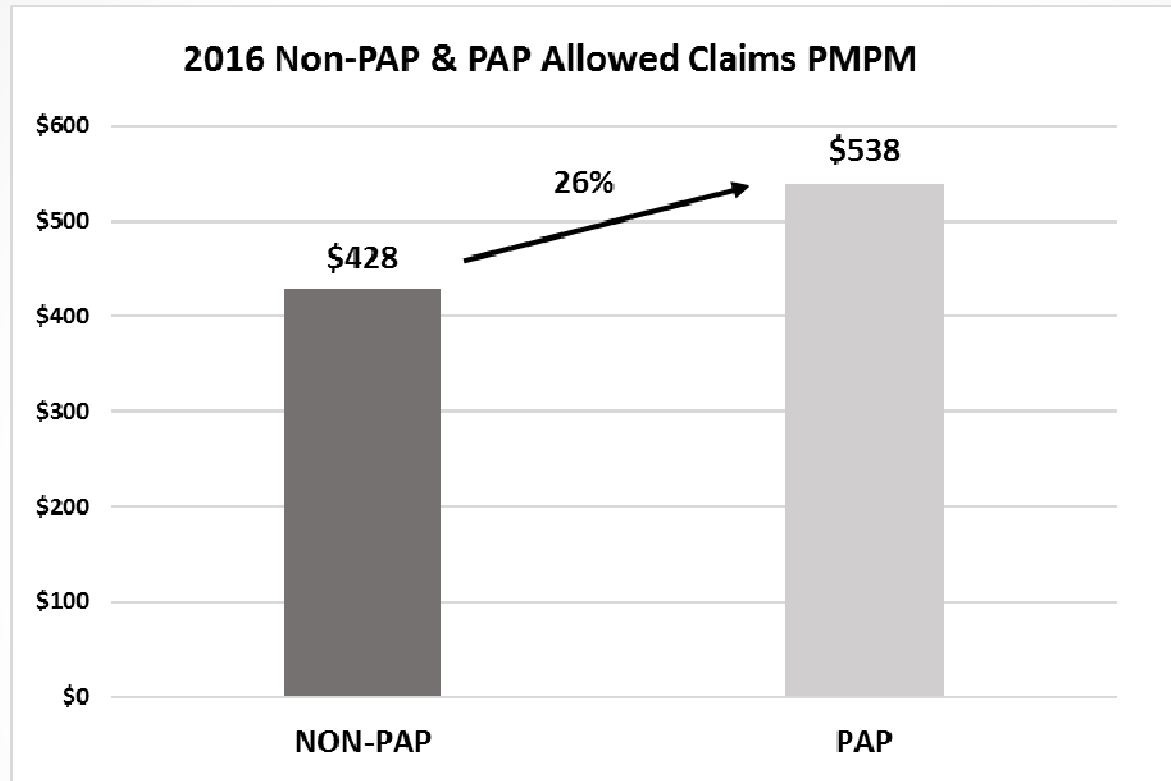
- Annual Hearing Process
 - Data Request & Supplemental Data Request
 - Requests have been designed and enhanced by Gorman Actuarial (GA) to collect PAP enrollee data separately from Non-PAP enrollee data
 - Data first received between June 30th and mid-July
 - GA still reviewing and checking insurer data
 - Most of the Claims Data has been validated
 - ACA Risk Adjustment Reports
 - Each insurer provided their ACA risk adjustment reports to GA
 - GA aggregated results

2016 Membership



- For CY 2016, 42% of the Individual Market (single risk pool) was enrolled in the PAP program
- As of March 2017, there were 102K enrollees in the Individual Market
- In addition, there were approximately 7,000 grandfathered and transitional enrollees, which are not part of the Individual Market (single risk pool)

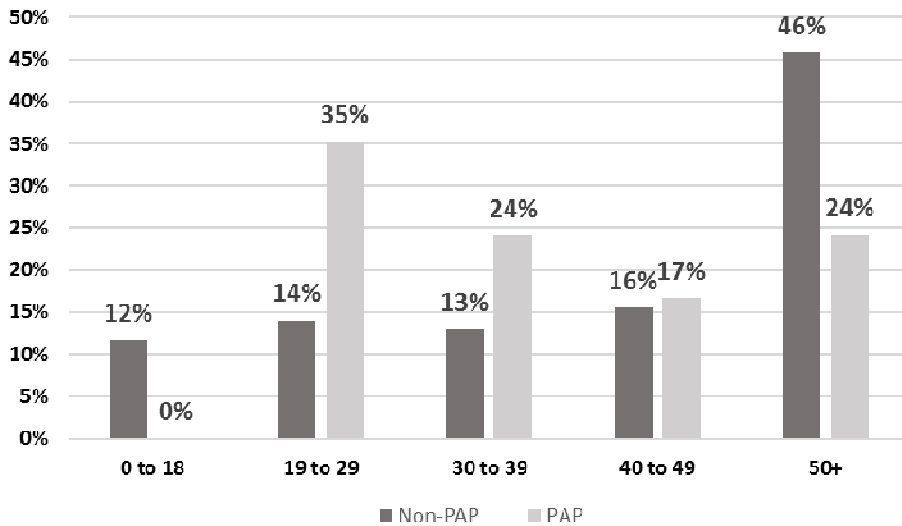
2016 Claims Costs



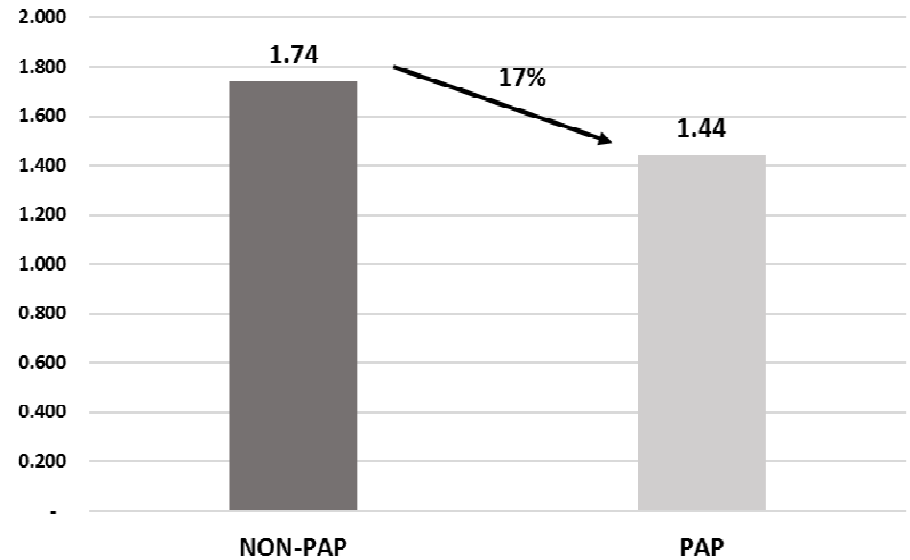
- PAP medical & pharmacy expenditures were 26% **higher** than Non-PAP
- Calculated based on allowed claims (includes member cost sharing and insurer payments) per member per month
- Differences can be due to factors such as age, plan design (i.e., induced demand), and health status

2016 Age Demographics

2016 Age Demographics Non-PAP and PAP



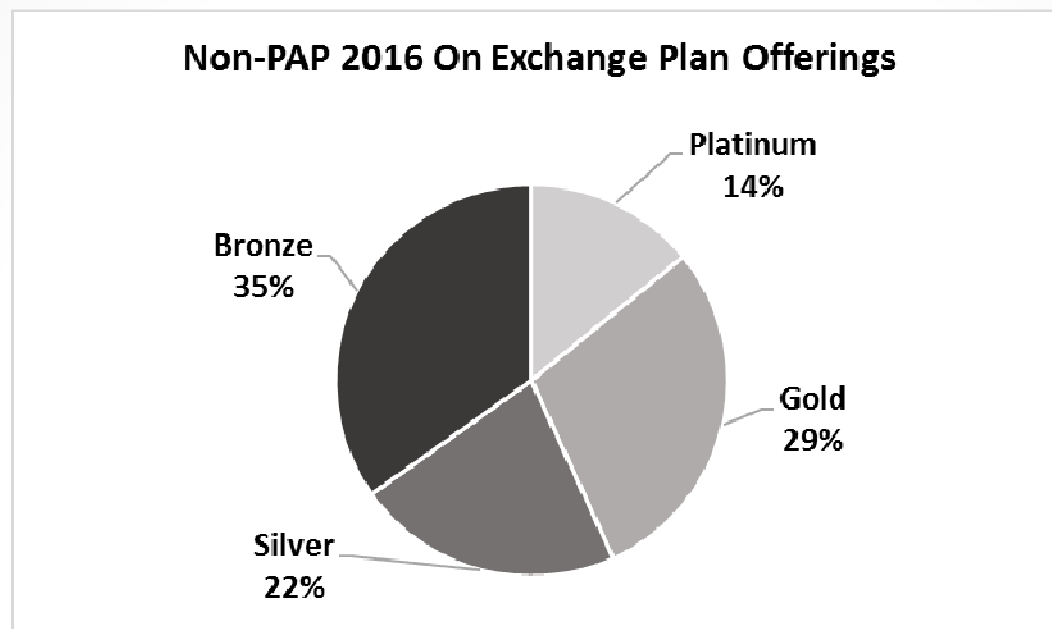
2016 Non-PAP & PAP Age Factor



- PAP population is *younger* than Non-PAP population
 - Avg. Age is 38 for PAP vs. 43 for Non-PAP
 - 35% of PAP between 19-29 vs. 14% of Non-PAP;
 - 24% of PAP age 50+ vs. 46% of Non-PAP

- Non-PAP age factor is 17% higher than PAP
 - Based on age alone, expect Non-PAP claims costs to be higher than PAP claims costs

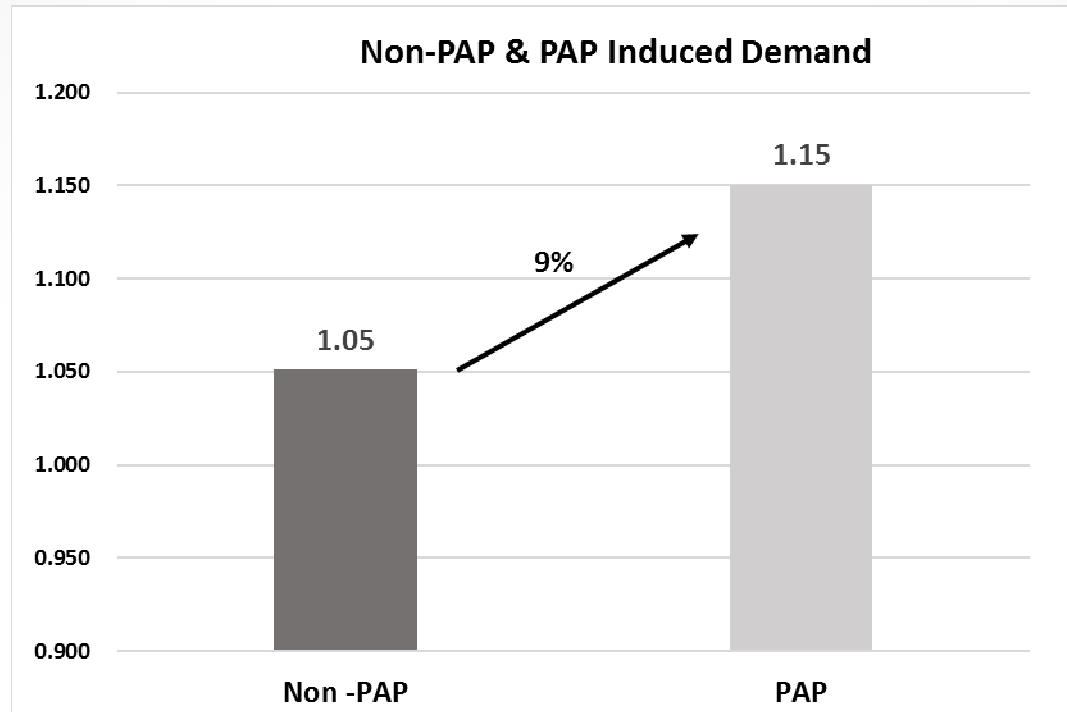
2016 Plan Design Differences



Note: Assuming on and off exchange distribution the same

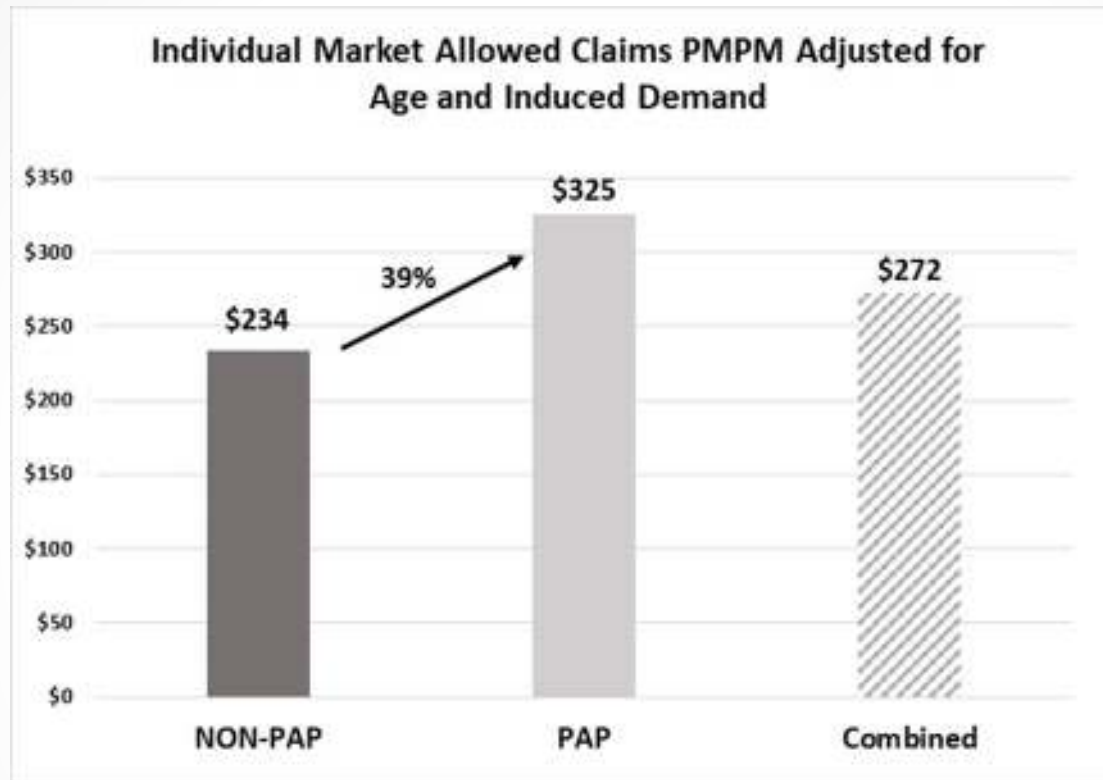
- 100% of PAP population enrolled in **Platinum Equivalent** plans, whereas 57% of Non-PAP enrolled in Bronze and Silver
- Non-PAP distribution reflects cost sharing reduction (CSR) plans
- Enrollment in Platinum plans suggest greater utilization of health care services
 - Less barriers to care due to lower cost sharing
 - Induced demand effect

2016 Induced Demand



- PAP's induced demand "factor" is 9% *higher* than the Non-PAP population
- Suggests that the PAP population's claims costs are expected to be 9% higher than Non-PAP due to induced demand differences
- Induced demand factors are those used in federal risk adjustment methodology

2016 Adjusted Allowed Claims

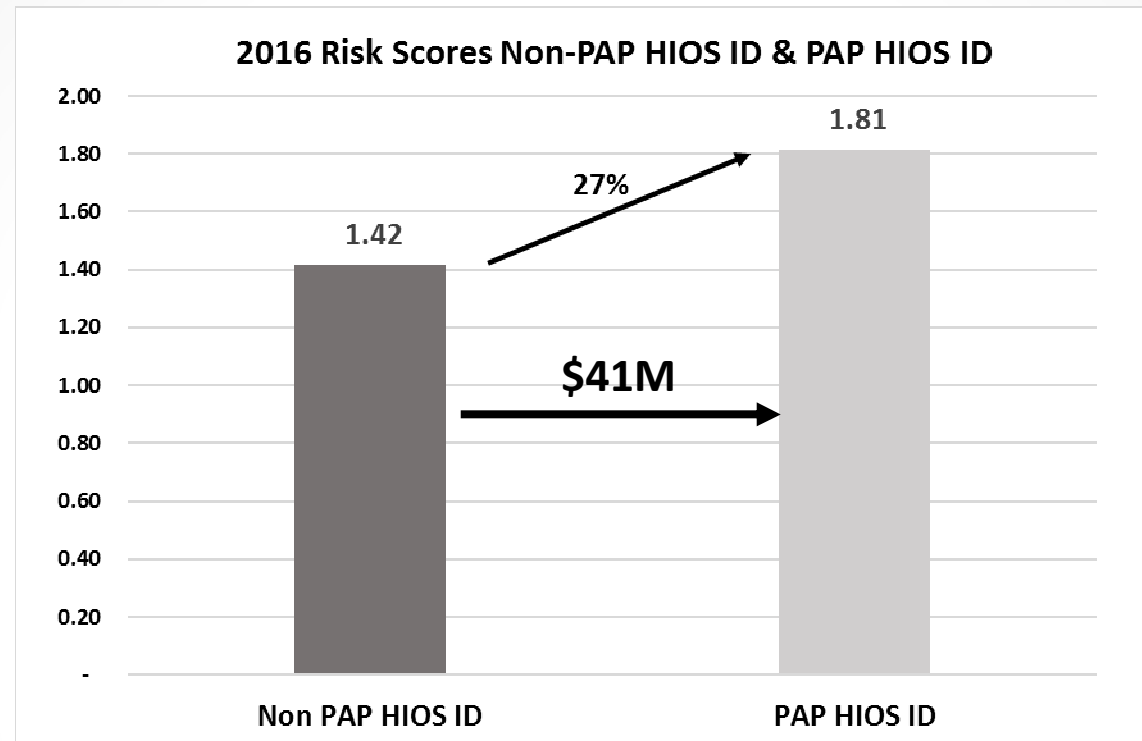


- After adjusting for age and induced demand:
 - PAP's adjusted claims expenditures are 39% **higher** than the Non-PAP adjusted claims expenditures

Impact of PAP on Individual Market

- Non-PAP's adjusted 2016 allowed claims are \$234 PMPM and the combined PAP and Non-PAP population's adjusted allowed claims are \$272 PMPM
- If PAP population was not part of Individual Market, overall adjusted medical expenditures would **decrease** 14% , which would have a downward impact on premiums
- Impact may be very different in 2018
 - Minuteman exiting the market
 - HPHC withdrawing full network plan and reducing service area
 - Significant premium increases in the market
 - Loose individual mandate enforcement
 - Price sensitive “healthy” individuals may exit the market, which could reduce the claims costs gap between PAP and Non-PAP populations.

2016 Risk Adjustment



Note: Approximately 82% of enrollees within PAP plan offerings are PAP enrollees

- Enrollees within the PAP plan offerings risk score is 27% *higher* than enrollees in the Non-PAP plan offerings
- **\$41 million** was transferred from Non-PAP plans to PAP plans in 2016 through the federal risk adjustment program.

Summary

- For 2016, all indicators suggest that PAP enrollees have *higher* morbidity than Non-PAP enrollees.
- Key features of PAP population:
 - Younger
 - Enrolled in more comprehensive plans
 - Higher risk scores
 - Greater claims costs
- Due to changes in the market, 2018 may look very different from 2016
 - Model the impact of individuals exiting the Non-PAP market
 - Must also model the impact of churn in the PAP market
 - The impact of these changes could impact the relationship between the PAP and Non-PAP populations