Individual Market and NH Premium Assistance Program (NHPAP) 2018 Projections

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1. Introduction

The expansion of Medicaid through the Premium Assistance Program (PAP) has greatly increased membership in New Hampshire's individual health insurance market.[1] In December 2015, the month prior to the PAP phase of Medicaid expansion, New Hampshire's individual market covered 56,000 residents. In December 2016, one year after the implementation of PAP, the individual market covered 98,000 people, an increase of 42,000 members, or 75%. In April 2017, there were 109,000 New Hampshire residents covered in the individual market of which 102,000 are individual market single risk pool members and 7,000 are grandfathered and transitional members (and not included in the single risk pool for rate-setting purposes). Approximately 43,000 of individual market members were enrolled through the PAP, representing 42% of individual market single risk pool members.[2]

This is the second report produced by Gorman Actuarial (GA) to analyze the impact of including the NH PAP population within the NH individual market. The first report focused on 2016 data, which showed that while PAP enrollees are younger, they appear to have higher health care needs than the Non-PAP population, based on claims data provided to GA by the carriers. Due to the ACA's single risk pool requirement, in 2016, the inclusion of PAP members within the individual market resulted in higher average claims costs and higher premiums across the entire individual market.

There will be many market changes in the 2018 individual market and historical analyses alone may not be the best predictor of the future. Building upon the 2016 analyses, GA has developed actuarial models to explore how these market changes may impact the relationship between the PAP and Non-PAP markets in 2018. This second report summarizes findings from this modeling exercise. In addition, this report presents additional 2016 analyses requested by the NH PAP Commission on August 28, 2017.

[1] Expansion of New Hampshire's Medicaid program started in August 2014 through the Bridge Program.
[2] Annual Hearing Data (Preliminary for 2016 & 2017) supplemented with CMS reports and monthly QHP enrollment reports.

2. Individual Market Enrollment

- **26% of the NH individual market do not receive subsidies towards health insurance premiums in 2017.**

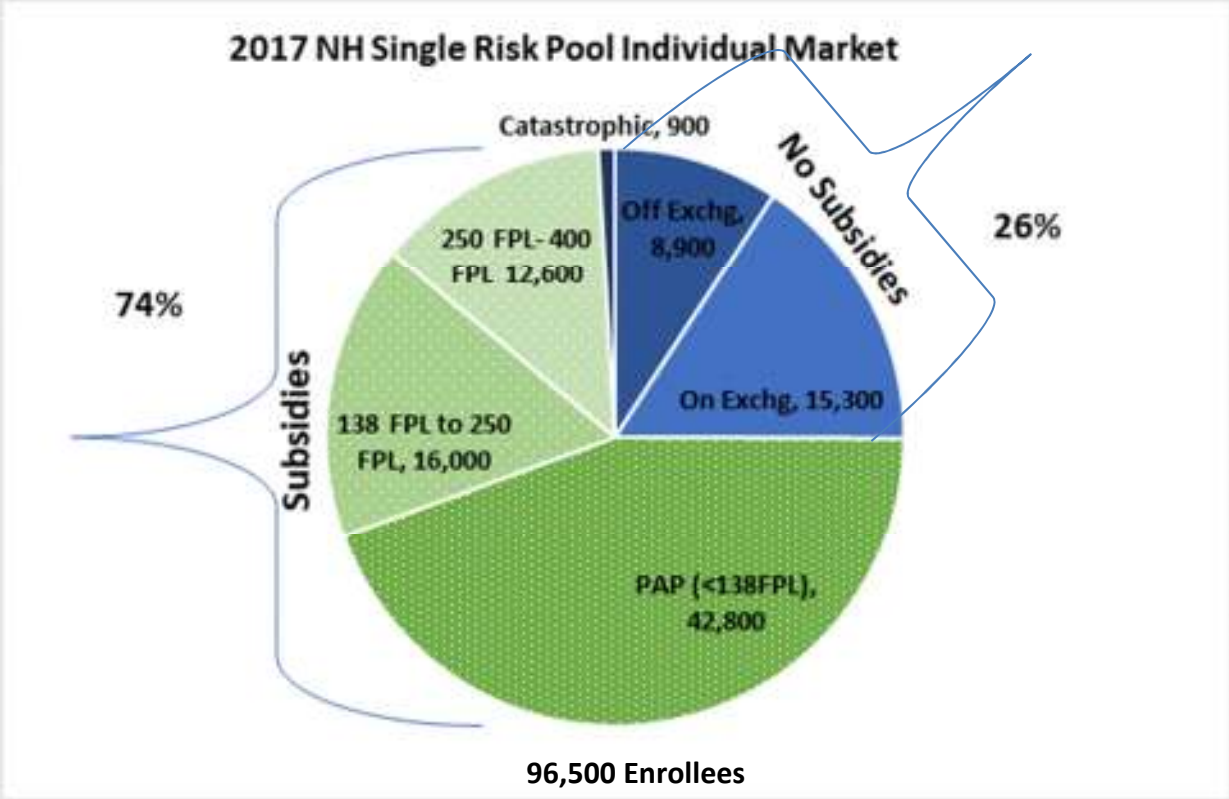

Figure 1: Estimated August 2017 Individual Market Membership[3]

As shown in **Figure 1**, 26% or 25,100 enrollees pay the full health insurance premium in NH's individual market in 2017. The PAP population, estimated at 42,800, do not pay any premiums. Approximately 28,600 enrollees receive Advanced Premium Tax Credits (APTC) of which 55% (16,000) receive Cost Sharing Reduction (CSR) subsidies. [4] This figure illustrates that the majority of the market receives some form of federal subsidy.

- **The medical expenditures of the Non-PAP enrollees earning below 200% of the Federal Poverty Level (FPL) look very similar to the medical expenditures of the PAP enrollees.**

[3] Enrollment was estimated using the QHP Monthly Enrollment Reports, CMS's 2017 Effectuated Enrollment Snapshot Report, and information received from the NH insurance carriers.
[4] Enrollees earning between 138% FPL and 250% FPL are eligible for CSR subsidies in addition to APTC.

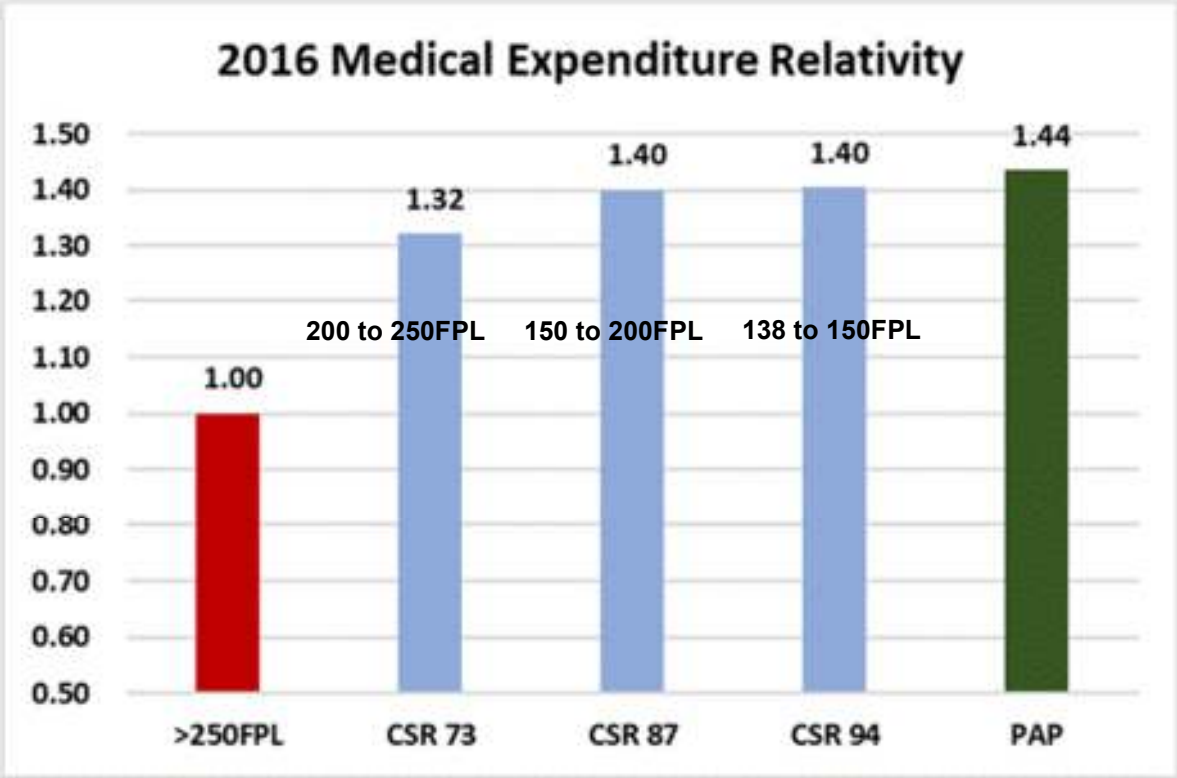

Figure 2: 2016 Individual Market Allowed Medical Expenditure Relativity[5]

As shown in **Figure 2**, the PAP population's medical expenditures per enrollee are approximately 1.44 times greater than (green bar) that of the population that earns above 250% FPL (red bar). The red bar reflects the population that receives APTC (those earning between 250% and 400% FPL) and enrollees that do not receive any subsidies. In addition, enrollees earning between 138% and 250% FPL (blue bars) have medical expenditures that on average look very similar to the PAP population as their medical expenditure relativities range from 1.32 to 1.40. Note that some of these differences could be due to utilization differences due to induced demand resulting from lower cost sharing (i.e., deductibles, co-payments, co-insurance). Generally, individuals enrolled in plans with lower cost sharing may utilize more services. PAP enrollees and those earning between 138% and 150% FPL are enrolled in Platinum equivalent plans, and those earning between 150% and 200% FPL are enrolled in Gold equivalent plans. Those earning above 200% FPL are mostly enrolled in Silver and Bronze plans.

[5] Individuals earning below 250% FPL are eligible for CSR subsidies. Those that earn between 200% and 250% FPL are eligible to enroll in a plan that has an actuarial value of 73%. Those that earn between 150% and 200% FPL are eligible to enroll in a plan that has an actuarial value of 87%. Those that earn between 138% and 150% FPL are eligible to enroll in a plan that has an actuarial value of 94%.

3. 2018 Individual Market Changes

In 2018, NH's individual market will experience significant market changes, the most noteworthy of which are the high premium rate increases, the market withdrawal of one insurer, and the withdrawal of some product offerings of another insurer.

- **At least 26,350 individual market enrollees will have to seek coverage from a different insurer or select a different product.**

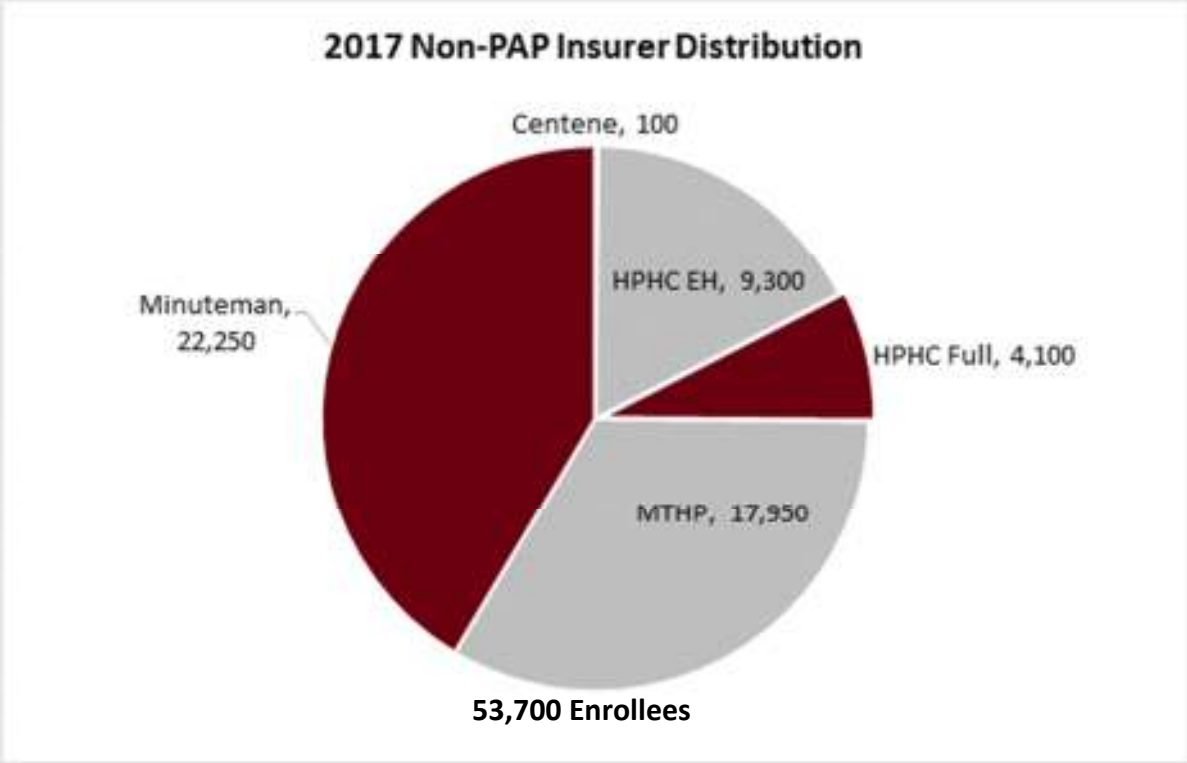

Figure 3: Estimated August 2017 Non-PAP Insurer Distribution[6]

The withdrawal of Minuteman, the 2017 market leader in the Non-PAP market, will leave 22,250 individuals seeking coverage elsewhere in 2018. Another 4,100 that are currently enrolled in Harvard Pilgrim Health Care's "full network" plan offering, which will not be offered in 2018, will also need to switch plans. The combination of these two withdrawals represents almost half of the Non-PAP market.

- **The average 2018 premium rate increase for enrollees who do not receive subsidies is estimated to be 52%.**

[6] HPHC EH stands for HPHC Elevate Health, HPHC's select network plan offering. HPHC Full stands for HPHC's full network offering.

Population	Average Rate Increase	Market Size
Unsubsidized	52%	25,100
Subsidized	Flat or negative (mostly)	28,600
PAP	0%	42,800

Table 1: 2018 Average Annual Rate Increases

GA simulated rate increases for the unsubsidized individual market. Enrollees currently enrolled in Minuteman or Harvard Pilgrim full network offerings were mapped to the plan with the lowest rate within the same metallic tier. Enrollees enrolled in all other terminated plans were generally mapped to the closest plan within the same metallic tier. As shown above, the average rate increase for enrollees that do not receive subsidies is projected to be 52% in 2018, which contrasts with generally negative or no increases for the subsidized market. Since individuals enrolled through the PAP program do not pay a premium, they do not receive a rate increase or decrease. GA further analyzed the impact to those enrollees who are currently receiving APTC. Due to the significant rate increases in 2018 and the withdrawal of Minuteman, which currently offers the second lowest cost silver plan in 2017, the APTC will increase significantly in 2018. The increase in the APTC will generally outpace the increase in the rates of many of the 2018 plan offerings. Due to this dynamic, many of the APTC enrollees will experience no change or a rate decrease. An illustrative example is described below.

APTC ILLUSTRATIVE EXAMPLE

Enrollee Description: Age 50, 200%FPL

The annual income for this enrollee is $24,120. According to the Affordable Care Act, this individual is required to pay 6.34% of his income on health insurance. This equates to $1,529 a year or $127 a month.

50 Year Old, 200 FPL	2017	2018	Change in Premium Dollars	% Change
Scenario 1				
Age Adjusted 2nd Lowest Costing Silver Premium	$375	$643	$268	71.5%
Member Premium if enrolled in 2nd Lowest Costing Silver	$127	$127	$0	0.0%
Advanced Premium Tax Credit (APTC)	$248	$516	$268	108.1%
Scenario 2				
Age Adjusted "More Expensive" Silver Plan Premium	$464	$697	$233	50.2%
("More Expensive" Silver plan)-(2nd lowest costing silver plan)	$89	$54	-$35	-39.3%
Actual Member Premium	$216	$181	-$35	-16.2%

Scenario 1: Individual enrolled in 2nd lowest costing silver plan

In 2017, the age adjusted 2nd lowest cost silver plan premium is $375. The monthly member share of the premium is $127 and the APTC is $248 (which is the difference between $375 and $127). In 2018, the age adjusted 2nd lowest cost silver plan premium increases to $643 a month, an increase of $268 or 71.5%. The individual continues to pay $127 a month. The APTC jumps to $516 a month, an increase of $268 or 108.1%

Scenario 2: Individual enrolled in a more expensive silver plan

If this individual chooses to enroll in a more expensive plan, the silver plan premium is $464 and the individual must pay the difference between this more expensive plan and the 2nd lowest cost silver plan ($464-$375=$89) in addition to $127. In 2017, this member will pay $216 a month.
In 2018, the renewal rate for the more expensive plan is $697, a $233 increase or 50.2%. This individual must pay the difference between this more expensive plan and the 2nd lowest cost silver plan ($697-643=$54) in addition to the $127. This member will pay $181 a month. This is a $35 decrease or 16.2% decrease from this member's 2017 premium rate.

If a subsidized member is not enrolled in the second lowest cost silver plan, when the increase in APTC is greater than the increase in the renewal rate, the enrollee will experience a rate decrease. This will happen for less expensive Bronze plans as well. There are instances where a subsidized member will experience a rate increase when the renewal rate increase is higher than the increase in APTC. However, due to the large APTC increase, this will happen infrequently.

- **Premiums for enrollees that do not receive subsidies will be much higher than those enrollees that receive APTC.**

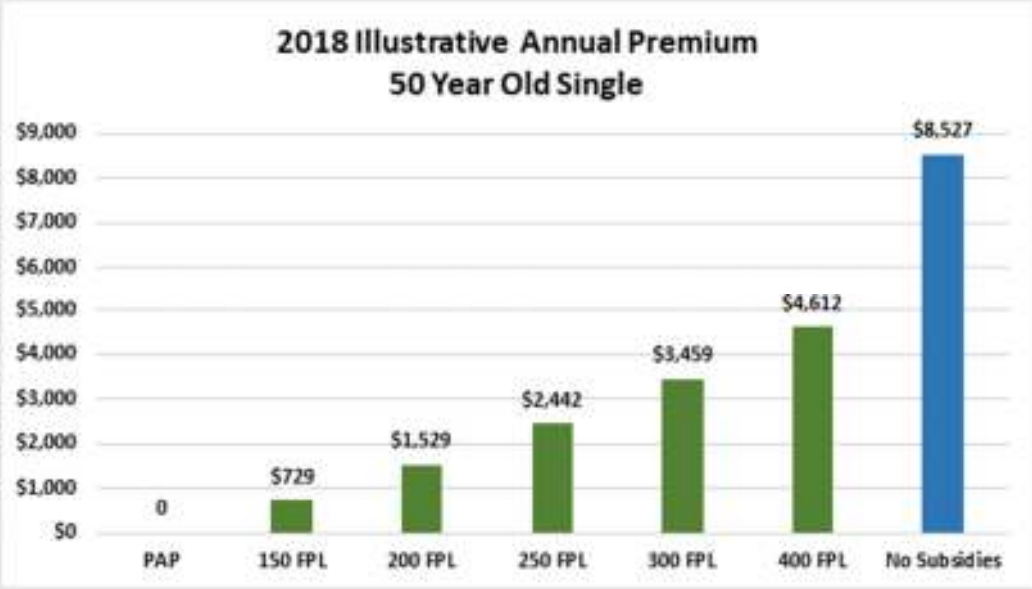

Figure 4: 2018 Individual Market Premiums – Single Policy

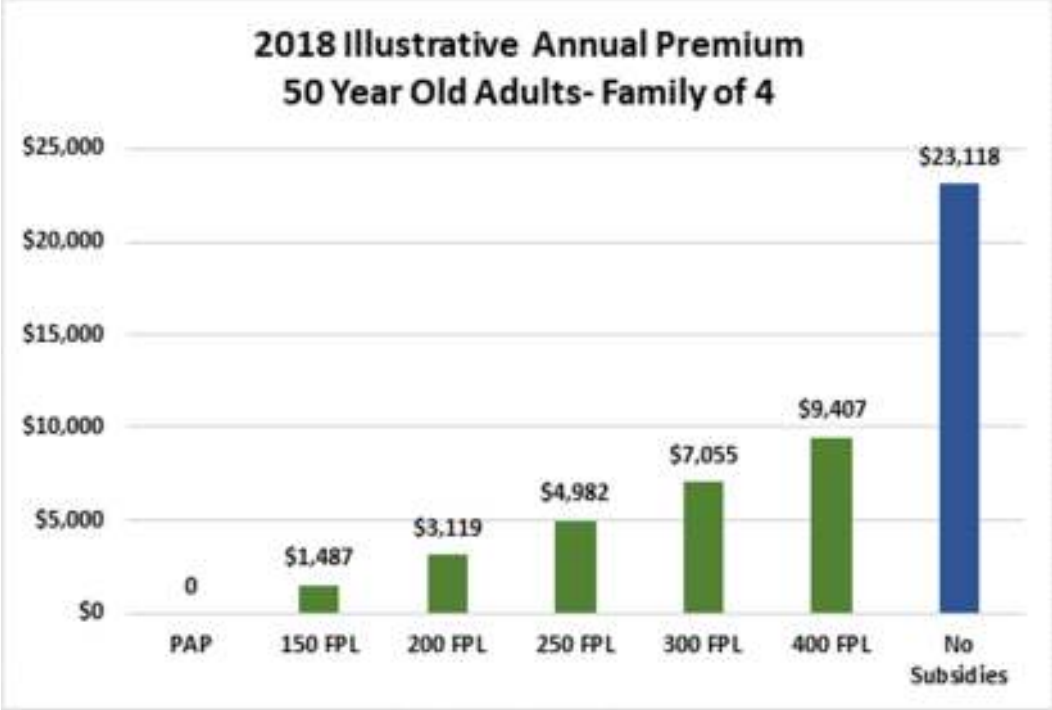

Figure 5: 2018 Individual Market Premiums – Family of Four

As shown above, for a single policy, the PAP population pays $0 premiums, the APTC population highlighted in green pays between $729 a year and $4,612 a year depending on their income. The non-subsidized individual pays $8,527 a year, which is almost 12 times more than the enrollees earning 150% FPL. These charts assume the age of the adult enrollee is 50 and that the APTC enrollees are enrolled in the 2nd lowest cost silver plan. It also assumes the enrollees in the non-subsidized market are enrolled in the plan with the median rate among silver plan offerings. Also note that those earning between 150% FPL and 200% FPL are eligible for CSR subsidies and are eligible to enroll in a platinum/gold equivalent plan. A similar pattern is shown for family policies, however, the differential between the non-subsidized and subsidized market is much greater.[7]

[7] Since the Federal Poverty Level (FPL) for a family of 4 is two times the single household FPL, the premium differentials of the non-subsidized market and the subsidized market are greater for family policies.

4. Modeling Results

- **By year end 2018, the individual market will lose 5,300 to 13,200 members due to the premium rate increases, the market withdrawal of Minuteman and other product offerings, and the weakening of the individual mandate.**

Modeling Results	PAP	Subsidized	No Subsidies	Total	Membership Loss
Baseline	42,800	28,600	25,100	96,500	
Low Estimate	42,800	28,600	19,800	91,200	-5,300
Best Estimate	42,800	28,600	14,900	86,300	-10,200
High Estimate	42,800	28,600	11,900	83,300	-13,200

Table 2: 2018 Projected Membership

GA made several assumptions to estimate projected 2018 membership in the individual market. First, GA assumes that the PAP market remains fairly stable in market size. Since this segment does not pay premium, the only real disruption will be with the market withdrawal of Minuteman and HPHC's full network. GA has assumed that PAP enrollees will choose a different insurer or will be auto-enrolled into another insurer and not exit the market. Second, GA has assumed the subsidized market will also remain fairly stable in market size. Many in this segment will experience rate decreases or no increase. Finally, GA assumes that the unsubsidized market will change in size due to the market disruptions. Using rate filings and membership reports, GA developed a model to simulate 2018 enrollment. Termination rate assumptions were based on the renewal rate increase and the 2017 insurance carrier.[8] GA varied its termination rates to perform sensitivity analyses and to develop a range of results.

- **The projected loss of healthier members in the unsubsidized market will lead to higher average claims costs in the individual market in 2018.**

[8] GA has assumed that Minuteman enrollees are more likely to exit the market as compared to Matthew Thornton and HPHC enrollees.

Modeling Results	Individual Market Claims Increase
Baseline	
Low Estimate	3%
Best Estimate	5%
High Estimate	6%

Table 3: 2018 Individual Market Average Claims Cost Increase

GA utilized results shown in Figure 2 by insurance carrier to simulate resulting claims costs for the individual market after the projected membership losses in 2018.[9] The results indicate that average individual market claims will increase 3% to 6% in 2018. This increase in claims is outside of normal cost and utilization trends. This result will lead to higher premiums in the individual market.

- **Excluding the PAP members from the individual market single risk pool will have a downward impact on 2019 premiums. The 2018 average adjusted medical expenditures would decrease 10% to 12%.**

Exclusion of PAP from Market	Individual Market Adjusted Claims Impact
2016 Baseline	-14%
2018 Low Estimate	-12%
2018 Best Estimate	-11%
2018 High Estimate	-10%

Table 4: 2018 Medical Expenditure Impact

As highlighted in the August report, GA found that the PAP population's age and benefit adjusted allowed claims PMPM are 39% higher than the Non-PAP population's adjusted medical claims costs. In 2016, if the PAP population had not been part of the individual market single risk pool, overall adjusted claims costs would have been reduced by 14%.[10] With the market disruptions in 2018, the risk pool of the Non-PAP market is projected to deteriorate. However, it will continue to have lower medical expenditures than the PAP market. As shown in the table above, excluding the PAP market from the individual

[9] GA assumes that the claims relativity of the subsidized members between 250 and 400FPL are between 1.00 and the claims relativity for the CSR73 members. GA also assumes that those individuals that exit the market are healthier than those individuals that remain.
[10] https://www.nh.gov/insurance/reports/documents/08-28-17-ga-nh-pap-analysis-final.pdf

market single risk pool would have had a downward impact on overall premium rates as average 2018 individual market adjusted claims would have decreased 10% to 12%.

5. Utilization Statistics

- **In 2016 admissions rates for the PAP population were 60% higher than the Non-PAP population.**

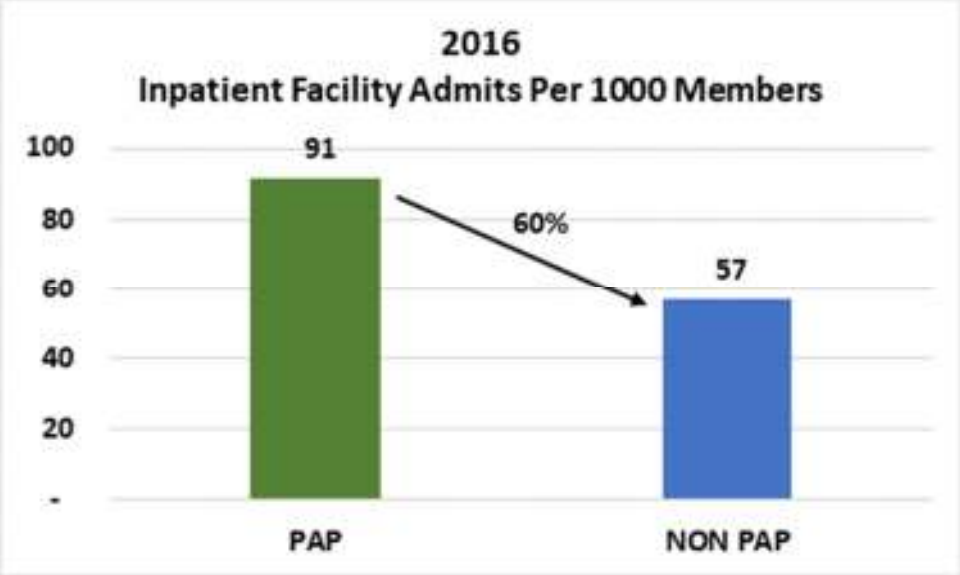

Figure 6: 2016 PAP and Non-PAP Inpatient Utilization

- **In 2016 prescriptions per member per year for the PAP population were 36% higher than the Non-PAP population.**

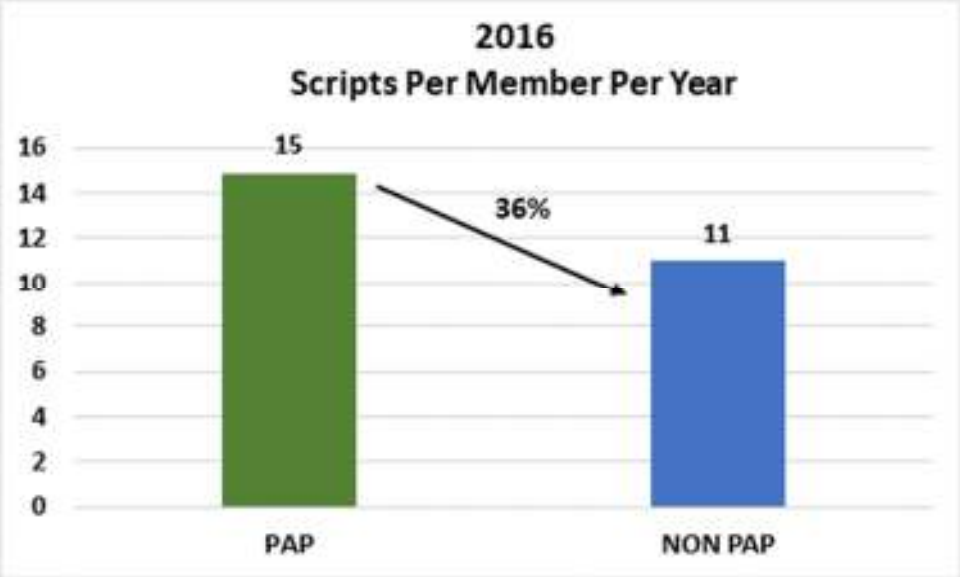

Figure 7: 2016 PAP and Non-PAP Pharmacy Utilization

PAP enrollment processes vary considerably from the Non-PAP market. Analyses from insurers indicate that PAP enrollees may come in and out of the program more than once within a 12-month period. As a PAP enrollee's income changes, they may self-report the change, which can trigger eligibility redetermination. This is different from the Non-PAP market as enrollees are generally locked into the market for 12 months and eligibility is determined during annual open enrollment. This movement within the PAP program can lead to adverse selection and more instability in the market. In addition, presumptive eligibility rules apply where a PAP enrollee can enroll at the hospital and then follow up later with a full application into the program. The higher number of hospital admissions for the PAP market indicates that presumptive eligibility is occurring. The different enrollment processes between the PAP and Non-PAP markets contribute to the risk pool differences (and higher claims costs) between these two populations.

6. PAP & Substance Use Disorder (SUD)

- **In 2016, approximately 10% of PAP enrollees had a substance use disorder.[11]**

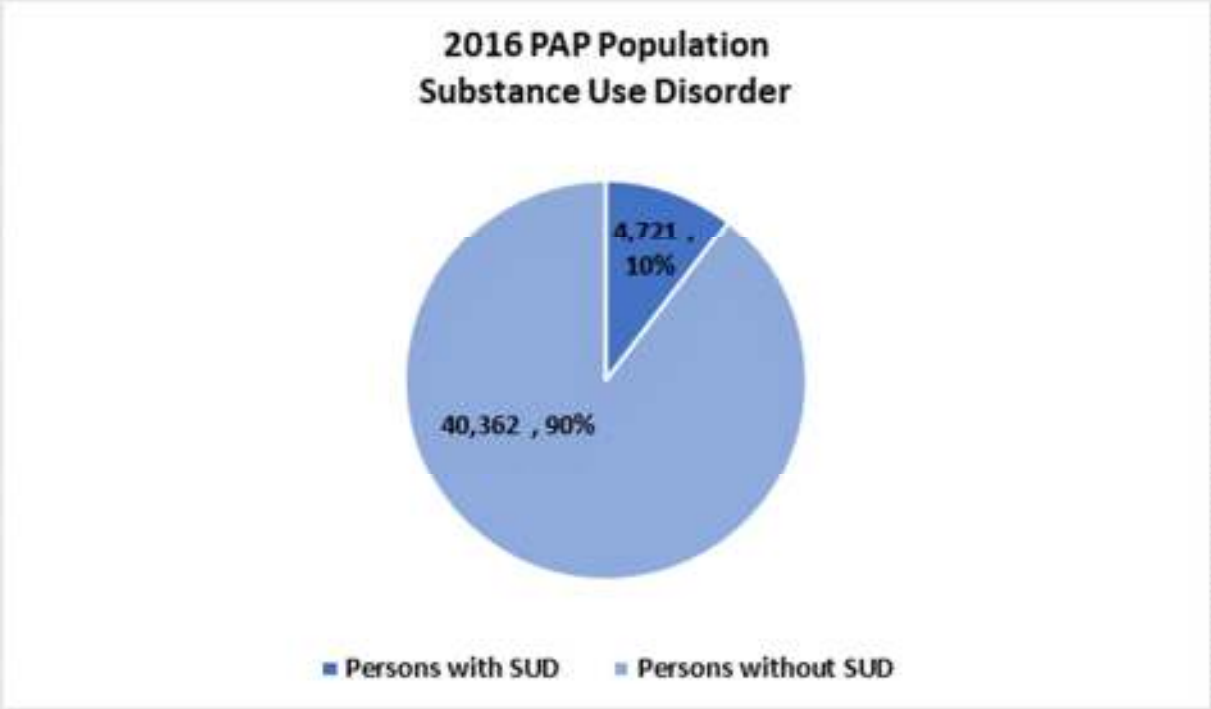

Figure 8: 2016 PAP persons with SUD

GA received detail claims data from NH's Department of Health and Human Services (DHHS) for the PAP program. The data includes anyone who was enrolled in the PAP program in 2016.[12] The analysis indicates that 10% of the PAP enrollees had a primary diagnosis of an SUD. This compares to a 2012 analysis performed for commercial members in Massachusetts showing 1.2% of commercial members using a SUD service and 4.9% of Massachusetts Medicaid members using a SUD service.[13] While the time periods and methodology are different, directionally it appears that the NH PAP market has a higher proportion of enrollees with a SUD than other insured markets.

[11] For this analysis, enrollees with a primary substance use diagnosis were defined to have a substance use disorder. (SUD) SUD diagnoses as defined by https://www.buppractice.com/node/2633.
[12] The number of people that were in the PAP market anytime in 2016 was 45,083. This number reflects churn and will be higher than the count of people at one point in time.
[13] http://www.chiamass.gov/assets/Uploads/SUD-REPORT.pdf

- **In 2016, PAP enrollees with an SUD had medical claims expenditures that were more than two times as large as expenditures for PAP enrollees without an SUD.**

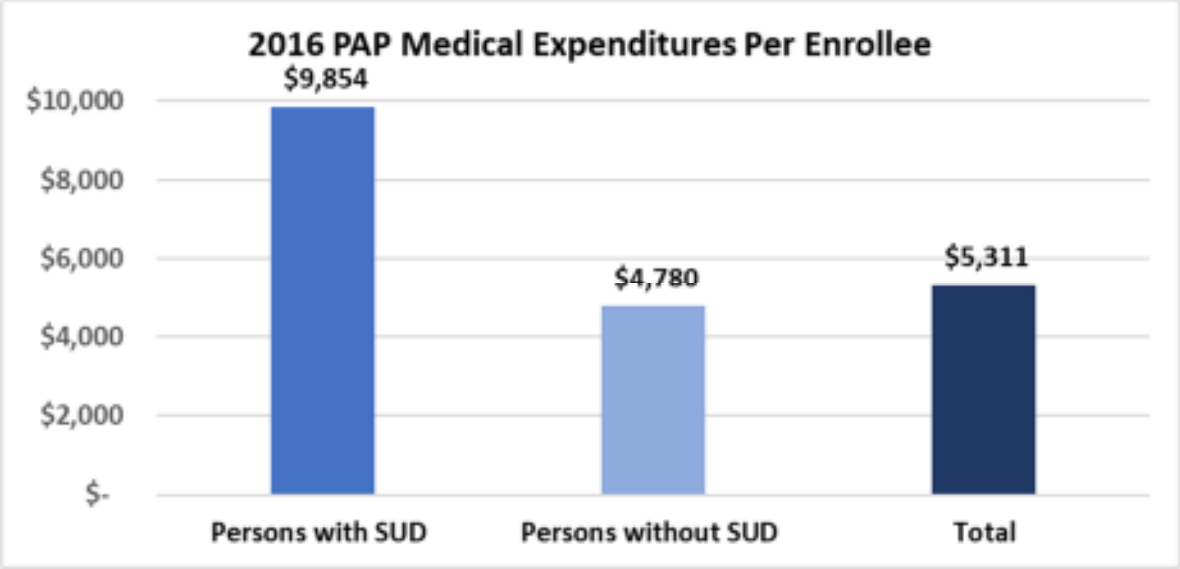

Figure 9: 2016 PAP Annual Allowed Medical Expenditures per enrollee

As shown in the figure above, enrollees with an SUD had average annual medical expenditures of $9,854. These medical expenditures include all medical expenditures, not just SUD-related medical expenditures. This contrasts with those enrollees without an SUD, which had average annual medical expenditures of $4,780. This suggests that enrollees with an SUD likely have other chronic conditions and illnesses and are generally much less healthy (in this case two times less healthy) than their counterparts (those without an SUD).

- **In 2016, approximately 7% of PAP enrollees had an opioid substance use disorder (OSUD).**

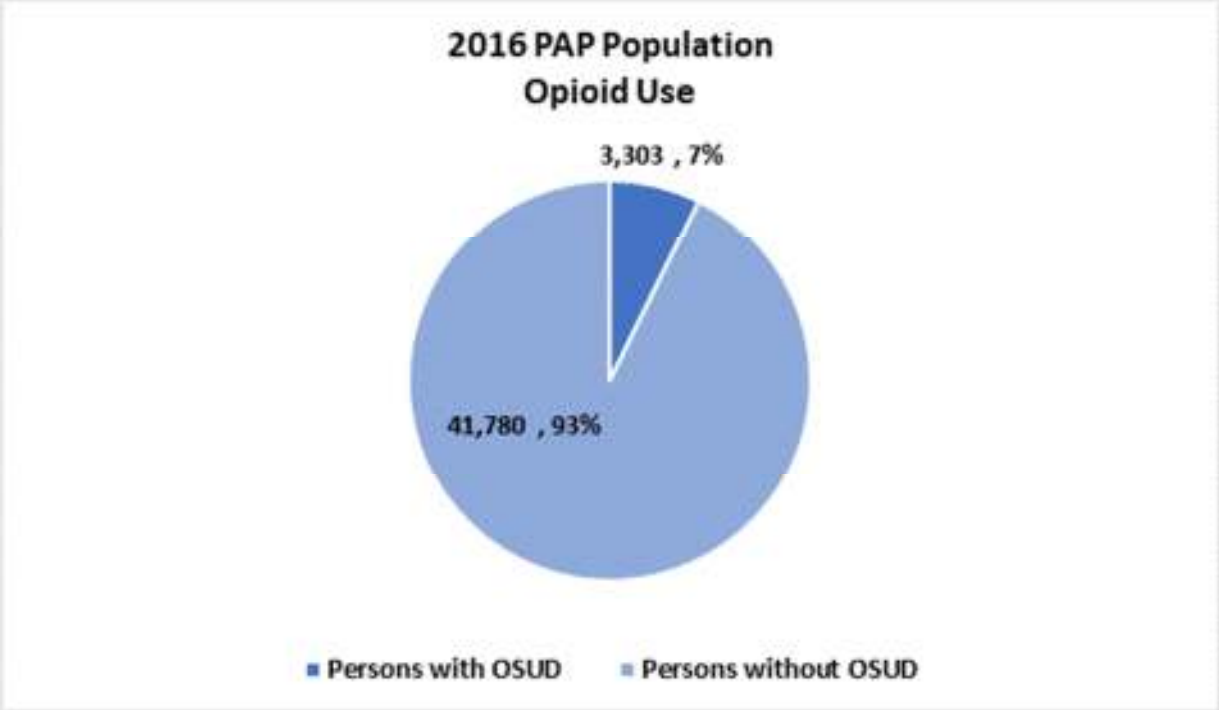

Figure 10: 2016 PAP Enrollees with OSUD

As shown in the figure above, 7% of PAP enrollees had an OSUD, which represents 70% of those enrollees with an SUD. This compares to a 2014 NH analysis that showed 0.5% of New Hampshire's fully insured commercial market had an OSUD.[14] While the time periods and methodology are not the same, these results indicate that the PAP market has a much higher proportion of OSUD than NH's insured commercial market enrollees.

[14] https://www.nh.gov/insurance/consumers/documents/021916_nhid_analysis_2014_sud_claims.pdf

- **In 2016, PAP enrollees with an OSUD had medical claims that were 1.67 times higher than PAP enrollees without an OSUD.**

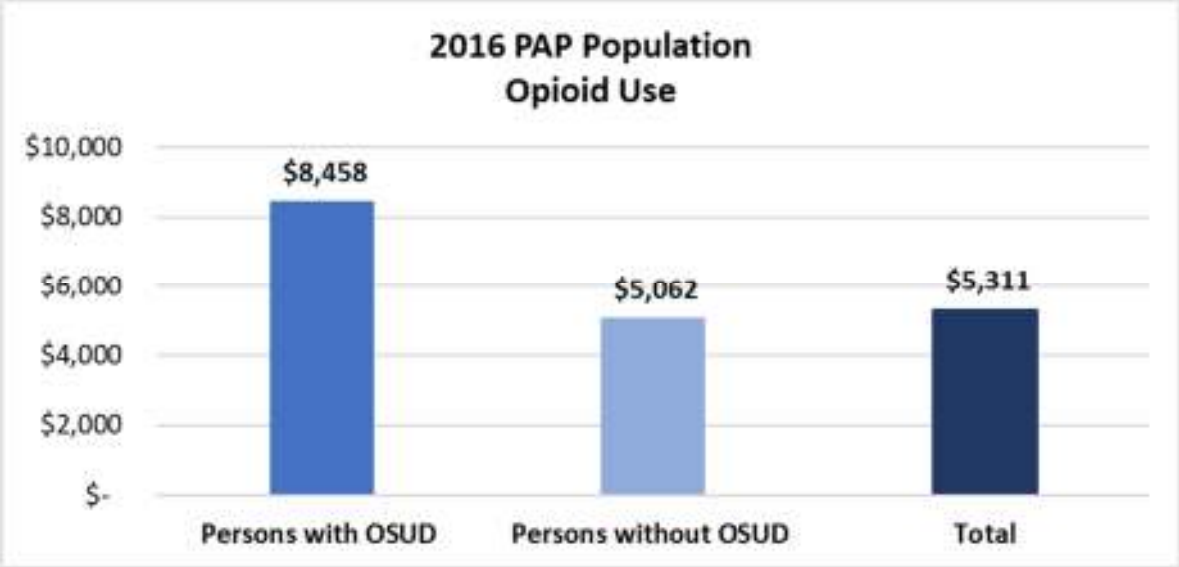

Figure 11: 2016 PAP Annual Allowed Medical Expenditures per enrollee

As shown in the figure above, enrollees with an OSUD had average annual medical expenditures of $8,458. These medical expenditures include all medical expenditures, not just OSUD-related medical expenditures. This contrasts with enrollees without an OSUD, which had average annual medical expenditures of $5,062. These differences in average annual medical expenditures are similar to the patterns observed for individuals with SUD. That is, individuals with an OSUD likely have other chronic conditions and illnesses present driving their higher medical expenditures.

7. Considerations and Limitations

Gorman Actuarial prepared this report for use by the New Hampshire Insurance Department. While we understand that this report may be distributed to third parties, Gorman Actuarial assumes no duty or liability to any third parties who receive the information herein. This report should only be distributed in its entirety.

Users of this report must possess a reasonable level of expertise and understanding of health care, health insurance markets and financial modeling so as not to misinterpret the information presented.

Analyses in this report are based on data provided by the New Hampshire Insurance Department, New Hampshire Department of Health and Human Services, insurers in the New Hampshire health insurance markets, and other public sources. Gorman Actuarial has not audited this information for accuracy. We have performed a limited review of the data for reasonableness and consistency. If the underlying data are inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

8. Qualifications

This study includes results based on actuarial analyses conducted by Bela Gorman and Jennifer Smagula, both of whom are members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They both meet the qualification standards for performing the actuarial analyses presented in this report.

9. Conclusions

An analysis of 2016 data indicates that the PAP population has higher medical expenditures, which impacts the overall individual market risk pool. If this population was not included in the single risk pool, GA projects that adjusted medical claim costs would have been lower by approximately 14% in CY 2016. Projections performed for 2018 indicate that the rate shocks and market disruptions will cause enrollees to exit the market. These enrollees will most likely be the non-subsidized, healthier population. Because of this shift in membership, GA has projected that average medical costs in the individual market may increase 3% to 6%, which will have an upward impact on 2019 premium rates. While the risk pool of the Non-PAP market is projected to deteriorate, it will continue to have lower medical expenditures than the PAP population. Excluding the PAP members from the individual market single risk pool would have reduced 2018 projected average medical expenditures 10% to 12%, which would have a downward impact on 2019 premium rates.

The State of NH may wish to consider exploring options to improve the PAP risk pool by adopting enrollment processes that can limit churn. In addition, the state could explore analyzing the PAP enrollees with a substance use disorder (SUD) further to understand how best to serve this population. PAP enrollees have a higher prevalence of SUD and opioid substance use disorder (OSUD) diagnoses compared to commercial Non-PAP populations, and average annual medical expenditures for enrollees with SUD are significantly higher than enrollees without SUD. Finally, given that the individual market will be experiencing significant market disruptions in 2018, NH may want to explore a reinsurance program for the individual market to mitigate further disruptions in 2019 and beyond.