New Hampshire Market Study Key Findings

Prepared for New Hampshire Insurance Department

September 2012

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1. Introduction

With the passing of the Affordable Care Act of 2010 (ACA), states will need to assess the impact of various components of the law on their health insurance markets. States will be faced with several policy decisions regarding their markets. Policy decisions range from whether to change group size definitions in the Small Group Market to deciding the future of the state's high risk pool. The New Hampshire Insurance department has engaged Gorman Actuarial to develop an actuarial model to analyze the impact of various policy decisions on the New Hampshire Markets. This model will then be handed off to the Department for their use. This document highlights the key findings from the output of the model using Gorman Actuarial's baseline assumptions.

2. Baseline Assumptions

- Medicaid expansion to 138% FPL.
- Small Group Market in CY 2014 defined as 1 to 50 eligible employees.
- NH High Risk Pool and PCIP program are part of the Individual Market in CY 2014.
- Medium level take-up assumptions of the Uninsured. For the purpose of this model, we define medium level take-up assumptions as 59% take-up insurance with 41% remaining uninsured by CY 2016.[1]
- Uninsured claims expenditures will be similar to the existing Small Group market.[2]
- No pent-up demand for the newly insured population.[3]

[1] Urban Institute estimates 37% of NH's uninsured will remain uninsured. Gorman Actuarial targeted 40% to 45% remaining uninsured as their baseline estimates. Buettgens, Holahan, Caroll "Health Reform Across the States:Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid", March 2011

[2] The level of medical expenditure for the newly insured is not known, so we do not know how it will compare to the existing insured population. Since New Hampshire's Individual Market is currently health underwritten, it is unlikely that the newly insured's medical expenditures will resemble the Individual Market in a guaranteed issue environment. For baseline estimates, we have assumed that the uninsured medical expenditures will resemble costs within NH's Small Group Market, similar to the assumption made by the Kaiser Family Foundation study: "Exchange enrollee per capita health spending might look similar to health spending among Americans currently insured through an employer." Kaiser Family Foundation, "A Profile of Health Insurance Exchange Enrollees", March 11, 2011

[3] Studies for pent-up demand show varied results. Li-Wu Chen, Wanqing Zhang, Jane Meza, Roslyn Fraser, MA, "Pent-up Demand: Health Care Use of the Uninsured Near Elderly", Economic Research Initiative on the Uninsured Working Paper Series,July 2004
Schimmel, Jody. "Pent-Up Demand and the Discovery of New Health Conditions after Medicare Enrollment" Paper presented at the annual meeting of the Economics of Population Health: Inaugural Conference of the American Society of Health Economists, TBA, Madison, WI, USA, Jun 04, 2006
K. Goldsteen, R.L. Goldsteen, "Demand For Medical Services Among Previously Uninsured Children: The Roles of Race and Rurality", South Carolina Rural Health Research Center, Arnold School of Public Health, University of South Carolina, October 2002
Amy Finkelstein et. al., "The Oregon Health Insurance Experiment: Evidence from the First Year"

3. Baseline Membership

- **As of CY 2011, we estimate 42,000 Individual Market members, 121,000 Small Group Market members, and 130,000 uninsured.**
  New Hampshire's uninsured rate of the nonelderly population is estimated at 11.6% which is much lower than the national average at 18%.

	2011 Baseline
Individual Market	42,000
High Risk Pool/PCIP	4,000
Fully Insured Small Group Market	121,000
Fully Insured 51 to 99	48,000
Fully Insured Large Group 100+	124,000
Medicare	195,000
Medicaid	132,000
Self Insured Group	481,000
Other	37,000
Uninsured	130,000
Total New Hampshire Membership	1,314,000

Table 1 – Estimated NH Market as of 12/31/2011[4]

- **We estimate 48,000 Fully Insured Large Group 51-99 members. In CY 2016, this market will be required to be part of the Small Group Market.** In CY 2016, the ACA requires states to define their Small Group Market up to 100 employees. This will be a change for New Hampshire as their current definition for Small Group Market is 1 to 50 employees[5]. In addition for the purpose of defining the Small Group Market, the definition of employee will change from "eligible employee" to the federal definition[6], which includes each full-time, part-time and seasonal employee.

- **Approximately 6% of the Small Group Market is "groups of 1". The ACA defines the Small Group Market as 2 to 50 employees and sole proprietors are included within the Individual Market.** It is our

[4] Baseline estimates based on NHCHIS, Supplemental Data, CPS and estimates for the self-insured. Other may reflect state employees and out of area employees.
[5] We used the current New Hampshire definition of employee and market segment for our modeling and analyses.
[6] CCIIO Technical Guidance Memorandum 2011-004, July 18, 2011

understanding that New Hampshire can maintain their definition of small group as 1 to 50. If this happens, sole proprietors may have the choice of going to the Small Group Market or to the Individual Market through the federally facilitated exchange. If premiums and product offerings are markedly different, this choice may cause some selection. For example, richer benefit offerings in the Small Group Market may cause sole proprietors seeking comprehensive coverage to purchase through the Small Group Market.

- **Limited information exists on New Hampshire's self-insured market**. Gorman Actuarial had to estimate the size of the self-insured market based on various data sources. In the future HHS may be a resource to understand the size of New Hampshire's self-insured market as HHS will be collecting assessments for the Temporary Individual Market Reinsurance Program from the self-insured market.

4. Individual Market

- **Individual Market premiums may increase 40% due to the merging of the high risk pool and the Individual Market**. There are approximately 4,000 high risk pool members, of which 13% are PCIP members and 87% are state high risk pool members. The estimated morbidity of all high risk pool members is 5.7. That is, high risk pool members cost on average 5.7 times more than an Individual Market member. Merging the PCIP program with the Individual Market increases premiums 27% with the remaining 13% increase due to the merging of state high risk pool members. We estimate that members of the PCIP program are on average 27 times more costly than the average current Individual Market member.

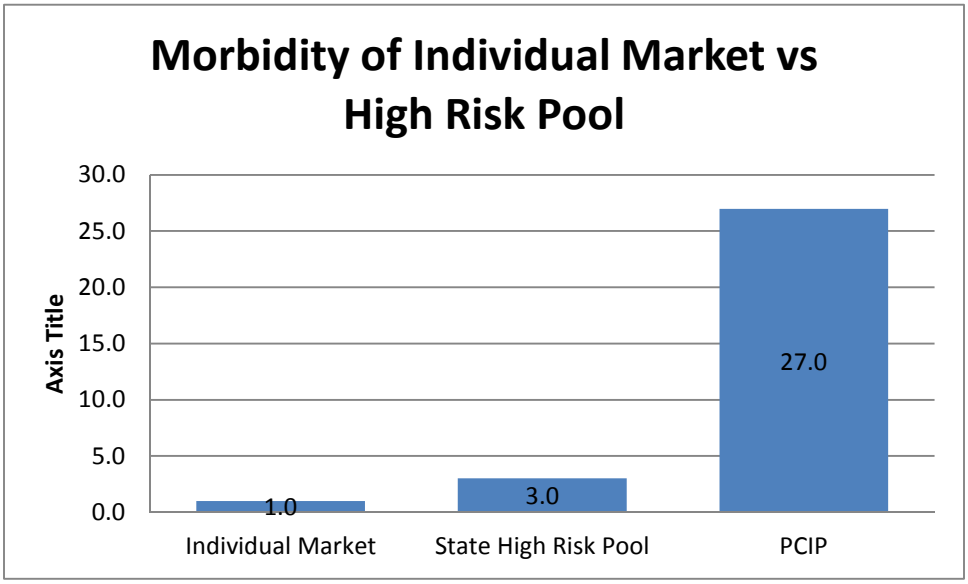

Figure 1 – Morbidity Comparisons

- **The ACA's Temporary Individual Market Reinsurance Program may reduce premiums 9% in CY 2014 and 3% in CY 2016.** The ACA establishes a transitional reinsurance program from 2014 to 2016. This program is designed to mitigate some of the cost uncertainty in the Individual Market that will have many new entrants during this time. Both the fully-insured and self-insured markets will be assessed to fund a new not-for-profit reinsurance entity that will help pay benefits for higher cost members in non-grandfathered Individual Market plans. The initial CY 2014 federal baseline will target assessments of $10 billion nationally with targets declining to $6 billion in CY 2015, and $4 billion in CY 2016.

- **In CY 2014, we estimate approximately 11,500 newly insured will enter the Individual Market, increasing Individual Market premiums an additional 6%.** Due to the premium tax subsidies and the mandate, we estimate 11,500 uninsured will join the Individual Market. We have estimated that their costs and morbidity will increase premiums of the overall Individual Market by 6%.

- **We estimate that the ACA's Medical Loss Ratio (MLR) requirement will reduce premium in CY 2014 by 6%.** The MLR requirement will initially put downward pressure on premium rates as carriers price their products to a federal medical loss ratio requirement of 0.80.

- **We estimate that the ACA's minimum Actuarial Value (AV) requirement will increase overall premiums by 2%.** Beginning in CY 2014, the ACA will require that all Individual and Small Group benefit plans cover a set of "essential benefits". The ACA will also require that all plan designs (excluding catastrophic plans) provide benefits at a minimum actuarial value of 0.60 ("Bronze" level). Member cost sharing will be limited to the caps placed on Health Savings Account (HAS) qualified plans, which is $6,250 per individual policy or $12,500 per family policy for CY 2013.[7]

- **Prior to federal premium tax subsidies the overall Individual Market premiums will increase by 30% in CY 2014.** Table 2 highlights the various components of the premium change to the overall Individual Market. This excludes the impact of premium tax subsidies.

[7] These limits will likely be slightly higher for 2014.

CY 2014	Premium Impact
Individual Market	
HRP/PCIP	40%
Newly Insured	6%
Reinsurance	-8%
Minimum Actuarial Value	2%
Medical Loss Ratio Requirement	-6%
Cumulative CY 2014	30%

Table 2 – CY 2014 Individual Market Premium Changes before Subsidies

- **Prior to federal premium tax subsidies, in CY 2014 66% of the Individual Market will receive premium increases greater than 30%.** As shown in the table below, the average increase for these individuals is 57%. This is due to the 30% overall increase coupled with the elimination of health status adjustment and banding the age factor to 3 to 1. These individuals will typically be younger and healthier. Those who receive premium decreases will typically be older and less healthy.

CY 2014 Premium Change	% Distribution	Premium Change
Less than -20%	2.0%	-22%
-20% to -10%	1.9%	-15%
-10% to 0%	1.3%	-5%
0 to 10%	19.6%	5%
10% to 20%	6.7%	16%
20% to 30%	2.9%	26%
30%+	65.5%	57%
Grand Total	100.0%	30%

Table 3 – CY 2014 Individual Market Premium Changes by Premium Change Cohort before Subsidies

- **In CY 2014, after the application of federal premium tax subsides, the Individual Market will experience a 9% premium decrease overall. 34% of the market will receive on average a 63% premium decrease.** Most of the individuals who are receiving a premium decrease earn below 400% of the federal poverty level (FPL). However, even after the subsidies, 30% of the market will still experience significant increases, averaging 57%. These individuals are higher income, younger, and healthier.

CY 2014 Premium Change After Subsidies	% Distribution	Premium Change
Less than -20%	34.0%	-63%
-20% to -10%	2.8%	-15%
-10% to 0%	2.2%	-5%
0 to 10%	13.8%	5%
10% to 20%	4.5%	16%
20% to 30%	13.3%	26%
30%+	29.5%	57%
Total	100.0%	-9%

Table 4 – CY 2014 Individual Market Premium Changes by Premium Change Cohort after Subsidies

- **By CY 2016, we estimate 68,000 Individual Market members and the cumulative premium change prior to premium tax subsidies is 34%.** We have estimated that 11,500 Individual Market members will drop coverage due to high costs or because they are transitioning to the expanded Medicaid program. We also estimate an additional 21,000 newly insured members will join the market (this is in addition to the 11,500 that we estimate will join in CY 2014).

5. Uninsured Market

- **There are approximately 130,000 uninsured non-elderly individuals in New Hampshire.** 63% of the uninsured are working adults and 25% are considered not part of the labor force.

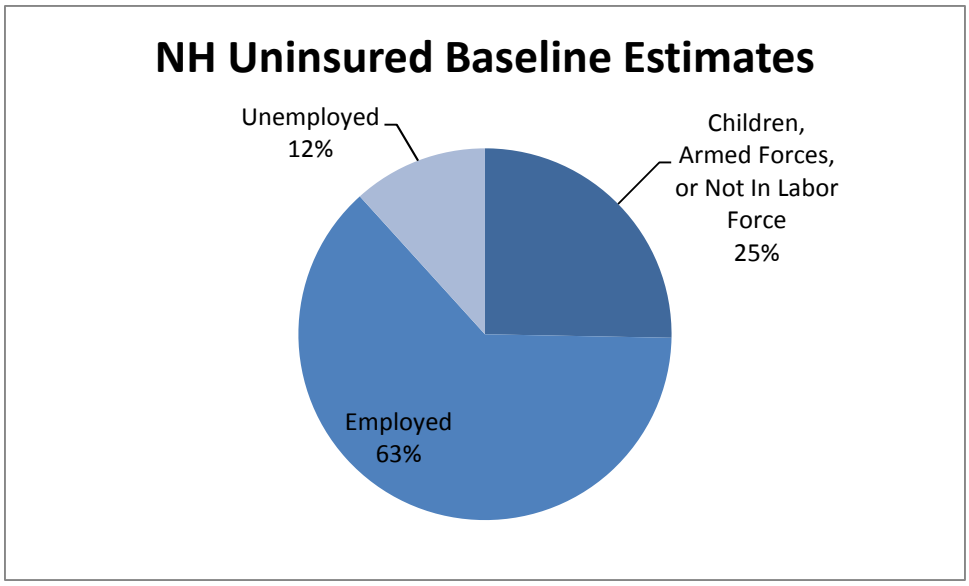

Figure 2 – Uninsured Distribution

- **58% of the uninsured are eligible for premium tax subsidies based on their income.** Approximately 26% of the uninsured have income levels below 138% FPL. Another 24% of the uninsured will not be eligible for subsidies.

Income Category	Uninsured
Below 100%	17%
100% to Below 125%	6%
125% to Below 150%	7%
150% to Below 200%	11%
200% to Below 250%	11%
250% to Below 300%	9%
300% to Below 350%	9%
350% to Below 400%	7%
400% and above	24%

Table 5 – Uninsured Income Distribution

- **59% of NH's uninsured are between the ages of 19 and 44 as compared to 38% of NH's Individual Market.** 10% of the uninsured are children as compared to 20% of the Individual Market. (Note that the Individual Market comparisons here exclude the high risk pool.)

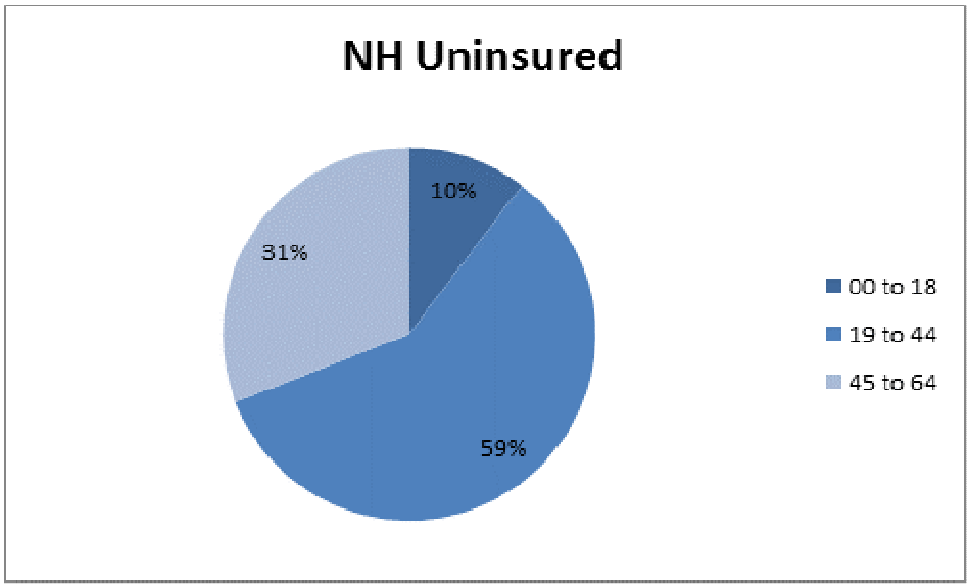

Figure 3 – Uninsured Age Distribution

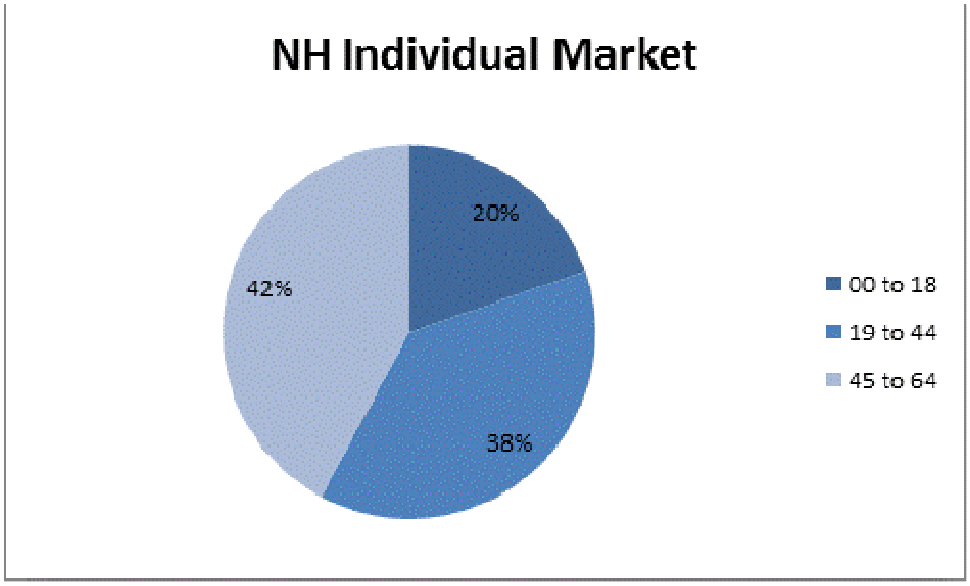

Figure 4 – Individual Market Age Distribution

- **NH's uninsured appear to have higher morbidity than the current Individual Market**. As shown, 98% of the Individual Market reports either Excellent, Very Good, or Good health status as compared to 92% of the Uninsured. (The Individual Market below excludes the high risk pool.)

Self Reported health Status	Uninsured	Individual Market
Excellent	29%	55%
Very good	34%	35%
Good	29%	8%
Fair	7%	1%
Poor	2%	1%

Table 6 – Self Reported Health Status

- **By 2014, we estimate 57% of the current uninsured will remain uninsured decreasing to an estimated 41% by 2016.** In 2016, we estimate that 25% of the uninsured will purchase insurance in the Individual Market and 21% will purchase through the employer market. 13% will enroll in the expanded Medicaid program.

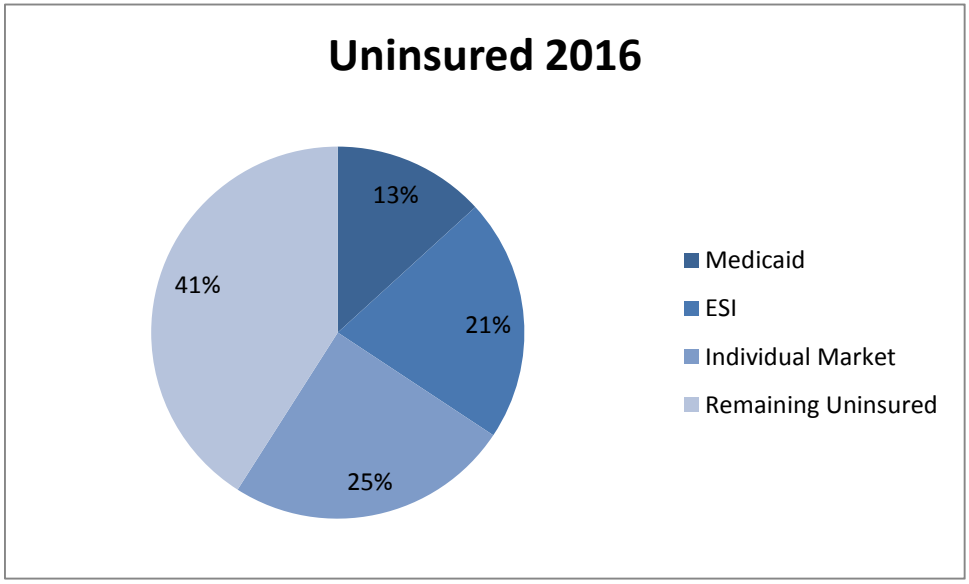

Figure 5 – Estimated Insured Status by 2016 of Current Uninsured

- **Half of the remaining uninsured either seek waivers or choose to remain uninsured and pay the penalty**. Individuals can seek waivers from the Individual mandate if the bronze level premium is greater than 8% of their income. In addition, there will be some individuals who choose to pay the penalty in 2016 which is the maximum of $675 or 2.5% of income.

6. Small Group Market

- **There are approximately 120,000 members in the NH Small Group Market**. We estimate an additional 48,000 members are in the 51-99 market. When the markets are combined, the Small Group Market will be 71% of the combined market.

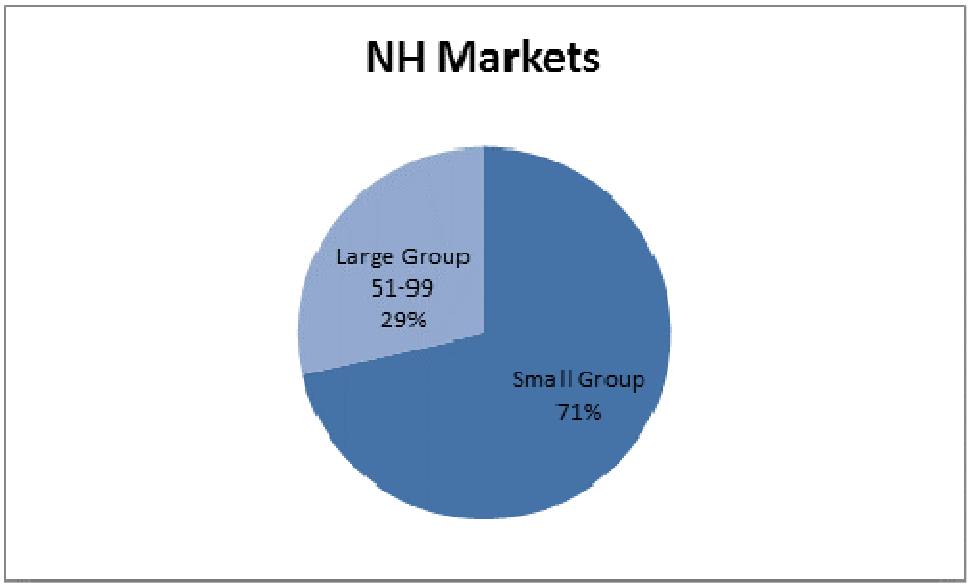

Figure 6 – NH Market Sizes

- **6% of the Small Group Market is groups of 1.** 53% of the small group market membership is in groups that have less than 9 eligible employees.

Group Size	% of Members
Groups Of 1	6%
Groups Of 2	11%
Groups Of 3-4	14%
Groups Of 5-9	22%
Group Of 10-25	33%
Groups Of 26-50	14%

Table 7 – Group Size Distribution

- **By 2016, 14,000 newly insured will join NH's Small Group Market.** The Individual Mandate will encourage those uninsured that are offered insurance to take-up insurance. We estimate these newly insured have morbidity that is 10% to 15% higher than the existing Small Group Market. This will increase small group premiums overall by 1%.

- **In CY 2014, groups of 1 will experience average premium changes of -40% and larger small groups will experience average premium changes of 9%.** The ACA will no longer allow group size adjustments and will require age factors to be within a 3 to 1 band. This results in lower premiums for small groups and higher premiums for large groups.

Market Segment	SG (1-50) Market Share	Average Premium Change	Allowed Claims PMPM	Paid Claims PMPM
Groups Of 1	5%	-40%	$ 609	$ 515
Groups Of 2	11%	-12%	$ 484	$ 410
Groups Of 3-4	14%	-4%	$ 405	$ 333
Groups Of 5-9	22%	2%	$ 376	$ 307
Group Of 10-25	34%	9%	$ 369	$ 301
Groups Of 26-50	14%	9%	$ 383	$ 318
SubTotal (1-50)	100%	1%	$ 401	$ 331

Table 8 – Premium Change by Group Size

- **If NH's small group definition changes from 1 to 50 to 2 to 50, premiums would decrease 3%.** The ACA excludes sole proprietors from the small group market. If NH uses the same definition, sole proprietors would be required to purchase insurance through the Individual Market. Current claims costs for the sole proprietors in the Small Group Market are 50% to 60% higher than the rest of the small group market.

- **Premiums for the Large Group 51-99 market will increase 5% when Small Group is defined up to 100.** We estimate that the 51-99 Market morbidity is somewhat better than the existing Small Group Market and there will be a cross subsidization of the markets. Small Group Market premiums may decrease 2%.

- **Smaller Groups may exit the market to take advantage of the premium tax subsidies in the Exchange**. We believe the smaller groups in the Small Group Market will consider leaving the market so that their employees may take advantage of the premium tax subsidies in the Exchange. Assuming that half of the 2 to 9 market exits, overall premiums in the Small Group Market could improve by approximately 0.5%. This is due to the 2 to 9 groups having higher morbidity than the rest of small group.

- **Larger Groups may exit the market to take advantage of the cost savings in the self-insured market.** We have modeled the effect of lower costing groups in the 51 to 99 market exiting the market. We have defined lowest costing as groups with lower than average medical expenditures. This could increase Small Group 1 to 99 premiums 2% to 4%.

7. Conclusions

New Hampshire has a relatively low uninsured rate. We estimate that by 2016, the uninsured will be reduced by 60% and that the Individual Market will grow approximately 50%. For those not eligible for premium tax subsidies, premium increases will be significant. The Small Group Market may see an influx of newly insured members that may increase premiums slightly. Expanding the small group definition up to 100 employees will increase premiums for the 51 to 99 Market and decrease premiums for the 1 to 50 Market. This could result in small employers dropping coverage to go to the self-insured market causing a moderate deterioration of the risk pool.

8. Appendix

8.1. Limitations and Data Reliance

Gorman Actuarial prepared this report solely for the use of the New Hampshire Insurance Department (NHID). 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 this information herein. This report should only be distributed in its entirety.

Any user of this report must possess a reasonable level of expertise and understanding of healthcare, health insurance markets and financial modeling so as not to misinterpret the information presented. The report addresses certain provisions of the Affordable Care Act, but is not intended to act as an official or comprehensive interpretation of the legislation itself.

Analysis in this report was based on data provided by the NHID as well as information from CPS and MEPS. 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 is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

The assumptions and projections included in this report are based on our understanding of the ACA and the associated regulations as of the report date. Future regulatory and legislative actions may materially change the impact of the ACA and invalidate certain assumptions or projections presented in this report. Therefore this report should be considered time-sensitive and results may change as new information becomes available.

8.2. Qualifications

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