



**THE GENERAL COURT
OF
NEW HAMPSHIRE
CONCORD 03301**

**CHARLES W. MORSE
PRESIDENT OF THE SENATE**

**SHAWN N. JASPER
SPEAKER OF THE HOUSE**

MEMORANDUM

Date: November 17, 2017

To: Honorable Christopher Sununu, Governor
Honorable Chuck Morse, President of the Senate
Honorable Shawn Jasper, Speaker of the House
Honorable Tammy Wright, Senate Clerk
Honorable Paul Smith, House Clerk
Michael York, State Librarian

From: Senator Jeb Bradley, Chairman

Subject: Final Report of HB 1696, 126-A:5-e - Chapter 13:12 - Laws of 2016

Pursuant to HB 1696, 126-A:5-e - Chapter 13:12 - Laws of 2016, enclosed please find the final report of the Commission to Evaluate the Effectiveness and Future of the Premium Assistance Program.

Should you have any questions or comments regarding this report, please don't hesitate to contact me.

Enclosures

cc: Committee Members

**COMMISSION TO EVALUATE THE EFFECTIVENESS AND
FUTURE OF THE
PREMIUM ASSISTANCE PROGRAM
126-A:5-e - Chapter 13:12 - Laws of 2016**

**Final Report
November 8th, 2017**

Commission Members:

Senator Jeb Bradley – Senate District 3, *Chair*
Senator Sharon Carson – Senate District 14
Senator Dan Feltes – Senate District 15
Representative Karen Umberger – Carroll 2
Representative Steve Schmidt – Carroll 6
Representative Cindy Rosenwald – Hillsborough 30
Commissioner Roger Sevigny – NH Insurance Department
Jennifer Patterson – NH Insurance Department
Commissioner Jeffrey Meyers – NH Department of Health and Human Services
Lisa Guertin – Anthem
Michael Rose – Southern New Hampshire Health
Richard Cornell – Mental Health Center of Greater Manchester
Travis Harker – NH Medical Society
Peter Burwen – Member of the NH Health Protection Program

Introduction:

In 2016 the Legislature passed House Bill 1696 which reauthorized the New Hampshire Health Protection Program, New Hampshire's Medicaid expansion program, through the end of 2018. Part of the reauthorization was the creation of this study commission, made up of legislators and stakeholders, that was tasked with evaluating the effectiveness and future of the program. The commission met many times over the course of two years, taking testimony from many affected industries and groups including state departments, private insurance carriers, hospitals, primary care providers, behavioral health services providers, substance use disorder treatment providers and members of the public. The findings and recommendations included in this report seek to guide the legislature on proposing legislation directing the future of Medicaid expansion in New Hampshire.

Charge of the Commission:

RSA 126-A:5e:

II.(a) The commission shall evaluate the effectiveness and future of the Premium Assistance Program. Specifically the commission shall:

- (1) Review the program's financial metrics.
- (2) Review the program's product offerings.
- (3) Review the program's impact on insurance premiums for individuals and small businesses.
- (4) Make recommendations for future program modifications, including, but not limited to whether the Premium Assistance Program is the most cost-effective model for the long term versus a return to private market managed care.
- (5) Evaluate non-general fund funding options for longer term continuation of the program.
- (b) Any funding solutions recommended by the commission shall not include the use of new general funds.
- (c) The commission shall solicit information from any person or entity the commission deems relevant to its study.

Summary of testimony received at Commission Meetings

September 28th, 2016

The commission met to organize and Senator Jeb Bradley was elected chair. The commission spent time setting goals for the commission and identifying stakeholders that they would like to hear from. The following were identified:

- a. The Department of Health and Human Services – Would like them to discuss demographics, cost, churn data and any other information they deem to be useful to the commission.
- b. Insurance Department - Would like them to provide information on what is happening to health insurance costs across the state.
- c. Provider Community – Would like physicians and hospitals to discuss impact on their practices.
- d. Carriers - Would like to hear what their experiences have been so far.
- e. Drug Prevention Community - Is the program successful in helping with costs of treatment and increasing access to care.
- f. Consumers – What are consumers experiencing? Is the Premium Assistance Program working well.
- g. Has the program helped to reduce costs in Corrections?
- h. Adult Dental Benefits
- i. Public Health Advocates – Is the program helping?
- j. New Hampshire Municipal Association- Has this program helped to reduce cost in the towns and cities?
- k. Department of Labor and Employment Security - who is working and who is not.
- l. Managed Care Organizations - How much health care is being provided and is it cost effective?

m. Chamber of Commerce/small business – Would like to know if the program is doing a good job at keeping the workforce healthy?

Senator Bradley suggested that the commission break the groups up into different panels and at every meeting certain groups can present and discuss the issues that the commission identifies. It was determined that it would be best to hear from the Department of Health and Human Services and the Insurance department first to best get an overview of how the program is working so far.

December 12th, 2016

The meeting started with a presentation from The Department of Health and Human Services. They testified that the program has about 50,000 people in it but it does fluctuate and people come in and out of the program. Eligibility for the program is based on income. The department testified that some of the churn, (which is when members are entering and exiting the program often having lapses in coverage) can also be based on members falling in and out of the income guidelines. Roughly 20,000 members in the program (as of 10/31/17) were employed and 25,000 did not attest to being employed. Over 100,000 people have been able to obtain coverage through the program and. Members earning above 100% of FPL are required to pay some copays for services. At the time of the presentation, the Department of Health and Human Services did not believe that copays were affecting utilization rates. The department is working on tracking more variables in the program and will be able to provide more information as the program continues to run.

Steve Ahnen, Paula Minnehan (NH Hospital Association) - Reiterated hospital support for program. The way to make sure people get the right care at the right time and place is to ensure that people have appropriate insurance coverage.. Rates of uninsurance dropped from 9% to 6%. 53% drop in uninsured hospital admissions, 46% drop in uninsured ER visits, 48% drop in uninsured outpatient service utilization. The Premium Assistance Program is necessary for substance use disorder treatment infrastructure. Steve Ahnen stated that he has not heard that hospitals are having a hard time collecting copays but he believes that many hospitals are just writing them off.

January 9th, 2017

Tyler Brannon of the NH Insurance Department, provided a briefing covering the role of the NH Insurance Department, NH Insurance Markets and Impact of the 2014 ACA changes and Premiums. The ACA established the same criteria for all states. It was requested that the Insurance Department send a link to the Committee on out of pocket costs for each bronze, silver, gold, and platinum metal levels.

Lisabritt Solsky provided an overview of the Well Sense Health Plan. Well Sense is not involved with the expanded Medicaid population, but does provide Medicaid Care Management (MCM) services for standard Medicaid. The Committee requested that Well Sense provide the actual numbers for the chart titled A Snapshot of Well Sense's Medically Frail members use of substance use disorder services and the number of people in the Bridge Program who required services.

Public Health Advocates provided testimony from several people who were receiving services. Travis Morin provided a letter from Ellie Smith who requested the legislators to realize the effectiveness of the Medicaid Expansion Program. Michelle Merritt (New Futures) provided information on what they are providing for substance use disorder treatment and will provide written testimony to the committee. She indicated 11,000 people have sought out substance abuse treatment. 107,000 have been enrolled at various times and now there are approximately 50,000 people enrolled in the program. There was an initial problem going from MCO's to the Premium Assistance Program, but most of the kinks have been worked out. Courtney Gray from the NH Provides association indicated the substance abuse program was very successful.

John Iudice, Addiction Recovery Services remarked about the importance of the expanded services provided to those dealing with addiction as the NH Health Protection Program provided expanded services.

Sue Ellen Griffin, NH Community Behavioral Health Association provided written testimony. She provided a chart showing unduplicated clients for both the Premium Assistance Program and the NH Health Protection Program.

Kristine Stoddard, Bi-state Primary Care Association provided written testimony. One key area of discussion was the steep reduction in the number of uninsured clients that are now using the Community Health Centers. There has also been an increase in the number of clients which indicates more patients are accessing necessary primary and preventive care. She indicated there was a problem with auto assignment of non-English speakers. She also stated that co-pays for those enrolled in the Premium Assistance Program have gone up, but the co-pays do not seem to be a problem. They have also seen a growth in access to substance use disorder treatment.

Greg White, Lamprey Health Care, provided written testimony describing their services and the number of clients and the percentage enrolled in commercial insurance, Medicaid, Medicare and uninsured. He indicated if the Health Protection Program and the Premium Assistance Program stopped they would not be able to continue to provide the same level of service.

Senator Bradley suggested that the commission not meet until there is more guidance from the federal government on what is going to happen to the funding for expanded Medicaid programs going forward.

June 17th 2017

Deputy Commissioner Alex Feldvebel (NH Insurance Department) and Commissioner Jeffrey Meyers (Health and Human Services) updated the commission members on The American Health Care Act (AHCA) (H.R. 1628), a bill proposed by Congress that was currently being considered.

Multiple insurance reforms are contained in the AHCA. It would eliminate the individual mandate and the employer mandate but it would keep the mandate to provide insurance to anyone who wanted to purchase it. There would be a change in the structure of the exchange subsidies after 2020 using a different calculation. This legislation would establish a market stabilization fund for the individual market and would include a \$15 billion appropriation per year (2018-2021) to create a reinsurance program in the individual market. For 2022 and beyond there would need to be a state match but there would be long term funding available for programs like reinsurance. To incentivize people to keep insurance there would be a policy stating that if you have a gap in coverage longer than 60 days there would be a 6 month period before new coverage would be effective.

This proposed federal legislation would be a large overhaul of the Medicaid program. The proposed legislation would require a Director of State Medicaid Directors be hired to oversee all the different state programs. There would also be changes to the waiver programs. Some waivers would be grandfathered, some would be expanded. The legislation includes provisions Expanding SUD treatment and Behavioral Health coverage to persons age 21-64. The legislation is subject to change but the department will provide a fiscal impact once it is available.

August 28th 2017

Commissioner Sevigny of the Insurance Department indicated his Department had hired a consulting firm Gorman Actuarial Inc. to look at the effect of the NH Premium Assistance Program and compared that to what was happening in the individual market place. Bela Gorman presented the briefing which covered the background, data sources, membership, allowed claims costs, demographics, plan design, induced demand, adjusted claims cost, impact of the Premium Assistance Program on the individual market and risk adjustment. The summary

indicated for 2016 that the Premium Assistance Program enrollees have higher morbidity than non-Premium Assistance Program enrollees. The Premium Assistance Program population is younger, enrolled in a more comprehensive plan, have higher risk scores, and greater claims cost. Gorman testified that due to changes in the market place, 2018 may look totally different than 2016.

Deborah Fournier, NH Department of Health and Human Service's Medicaid Director, provided a briefing on the Premium Assistance Program which included enrollment, length of enrolment, reasons for disenrolling, Premium Assistance Program members using substance abuse service, and federal dollars used in 2015-2017. 69% of the enrollees are under 45, 12% are considered medically frail and not part of the demonstration. The hospitals use a presumptive eligibility and patients have 30 to 60 days to enroll before they are dropped from the plan and they must renew their eligibility every 12 months. One source of churn in the program is individuals entering the program, but not completing necessary Premium Assistance Program paperwork to remain in the program. The top reason for leaving the program is income level has increased so they are no longer eligible.

September 6th, 2017

Paula Rogers from Anthem presented information on their enrollees in the Premium Assistance Program and noted that Anthem is "highly vested in making this program work." She reviewed the history of Medicaid Expansion from managed care to the Premium Assistance Program. She noted that there was much work by all stakeholders to manage the transition from the bridge program to the Premium Assistance Program. She also reviewed the elements of the non-federal share's funding approach. She mentioned the current and future issues as being placement (e.g. commercial market), funding, and effectiveness. The plan's assessment per member per month costs are likely to rise next year, and the assumption is that the funding approach for the remainder amount will need to change after next year. Anthem's costs drivers include ER use, behavioral health, substance use disorder, pharmacy (especially for Hep C and opioid agonists), loss ratio, and lagging preventive care. Administrative issues could also be addressed by carriers. She asked if the department of health and human services could provide information on Medicaid status of hospitalized inmates. A further issue raised is whether primary care physicians could be assigned to enrollees.

Sen. Carson asked why ER use was high. Ms. Rogers said they had hoped to find the cost of contracting with hospitals had evened out as uncompensated care decreased but that this had not happened. In response to a question by Rep. Rosenwald whether enrollees could be required to have a primary care physician, the members were told a waiver from the Centers for Medicaid and Medicare Services would be required.

Commissioner Meyers asked what is the scale of inappropriate ER use. The members were told by Mr. Veno from Harvard Pilgrim that 50% of visits might be

avoidable/non-emergency. Commissioner Meyers asked for the raw numbers. Ms. Rogers was asked what Anthem does to divert ER use. They have programs in other states they are examining. Commissioner Meyers stated that over 98% of Premium Assistance Program enrollees have a primary care physician. Mr. Cornell asked if there is a proactive, positive way to educate enrollees about healthcare utilization.

Matt Veno from Harvard Pilgrim said they have both Premium Assistance Program and non-Premium Assistance Program members; Premium Assistance Program members are 30% more expensive and have 5 time more ER use than non-members. Among Premium Assistance Program enrollees, 11% of ER visits involved patients without a primary care physician. There is higher rates of Hepatitis C and medication assisted treatment among Premium Assistance Program members. Harvard Pilgrim works with Benevera, a New Hampshire based care management company, on population health. Pent up medical demand is a cost driver that should ease over time.

Chris Kennedy from NH Healthy Families/ Centene said once someone gets to the ER, it's incumbent on the plans to work with that individual to change their utilization behavior. He told the commission that they don't treat their Premium Assistance Program members differently from their managed care enrollees. Sen. Feltes asked what approaches do plans have to improve case management and education. Harvard Pilgrim has good data to look for high cost enrollees. All plans are trying to hire more case managers.

Steve Ahnen from the New Hampshire Hospital Association stated that Medicaid reimburses under the level of cost. He presented data on uncompensated care and MET revenues, noting that the numbers are based on data from 2 years ago. He mentioned that there is controversy over the federal definition of uncompensated care and litigation on same. The hospitals have worked in partnership with the state and the carriers to fund the Premium Assistance Program. In response to questions, he said hospitals have no mechanism to collect a co-payment for inappropriate ER use. Sen. Feltes raised the issue of debt collection practices, and Sen. Bradley asked what incentives could be used to collect a payment from the enrollee for inappropriate ER use.

Ms. Iacopino from Wellsense spoke in support of returning the Premium Assistance Program members to managed care from the commercial market. She stated her belief that this represents the best, most efficient approach to health care for the population, and that the Gorman report supports this belief. Managed care organizations offer services such as transportation to medical appointments. They can reduce churn. 26% of their clients have an substance use disorder diagnosis, and 68% have a mental health diagnosis. Wellsense has reduced ER visits in its population.

Michele Merritt and John Udis from New Futures addressed the commission. They have no position on managed care versus the Premium Assistance Program. They noted that overdoses appear to be starting to flatten out or decline which they stated is due to the increase in access to services provide by the Premium

Assistance Program. 20,000 people have accessed substance use disorder services through the program since its inception.

Mr. Udis's substance use disorder program has been able to increase treatment capacity by 30% due to the Premium Assistance Program. He stated that mental health providers prefer to contract with commercial carriers instead of managed care organizations because of reimbursements. This may be true also for drug treatment providers as well. He testified that since drug courts require someone to have the ability to pay for treatment, eliminating the NHHPP would impact the number of individuals who were accepted into drug court programs.

Kristin Stoddard and Dr. Joann Buonamano addressed the commission, representing Bi-State Primary Care and the Goodwin Health Center. The uninsured rate at FQHCs has fallen from 20% to 14% due to the NHHPP. 80% of patients have incomes below 200% of poverty. Goodwin is now treating 2300 additional mental health patients and 200 additional SUD patients. 30% of Goodwin's pre-natal patients are addicted.

September 27th, 2016

Bela Gorman, consultant to NH Insurance Department, presented information on individual insurance market costs and premiums for the Premium Assistance Program population vs. non-Premium Assistance Program population. Dr. Harker asked if the Premium Assistance population is sicker. Her answer was yes, and she also believes the cost sharing reduction population has characteristics more like the Premium Assistance Program population than the group earning more than 400% FPL. Sen. Bradley asked what would happen if we used a better process for screening out medically frail individuals from the Premium Assistance Program. She responded that it would have an impact but no firm numbers. Arkansas has done this but they are making their screening less robust for 2018. Commissioner Myers said the Center for Medicaid and Medicare Services had not allowed us to use a screening tool so far. Only Iowa allows people to not self-attest as medically frail.

Lisa Guertin stated that Anthem had done a rough calculation and found that 36% of Anthem's Premium Assistance Program members would meet a medically frail definition. These members generated virtually all excess cost. Their costs are 3.5 times higher than non-frail. 9% of their members had a substance use disorder claim; their costs are 5.5 times higher. Anthem also looked at claims by income. Members with incomes between 100-138% FPL were not substantially higher than clients with incomes above subsidy eligibility levels; however, members with incomes below 100% FPL were substantially higher. She also noted that 10% of their members churn on and off.

Dr. Harker asked what the impact on rates might be if churn were reduced.

She thought it would be beneficial because there would be more months of premium collection. Jennifer Patterson asked if there might be a waiver opportunity to reduce churn. The commission was reminded that 37% of enrollees lose eligibility because their income becomes too high while 12% never finish the enrollment process. Jennifer Patterson stated we could do a better job managing churn, Rep. Rosenwald stated we should focus on those enrollees who do not finish enrollment because they are likely to be found eligible during a hospitalization and are, therefore, already more expensive. Deb Fournier (Department of Health and Human Services) stated that the cost analysis given by Anthem were similar to the data the department is seeing.

October 4th, 2017

Senator Bradley requested that the Department of Health and Human Services and the Insurance Department discuss the effect of the medically frail being part of the Premium Assistance Program population. Jennifer Patterson (NH Insurance Department) presented an outline to the commission of possible market stabilization options. One option was submitting a Medicaid 1115 waiver along with an 1332 Insurance waiver. She provided a handout titled "NH Insurance department Individual Market Stabilization and the Future of Premium Assistance Program" which explained the options. She indicated we would have to have an actuary do some work prior to determining cost alternatives.

Lisa Britt Solsky, Executive Director of Well Sense provided a comparison between what the MCO's provide and what the Exchange Carriers provide. She identified 12 areas that were discussed.

The Commission had a wide ranging discussion:

- a. To include differences between reimbursement rates between Medicaid and commercial insurance.
- b. A question that needs to be answered shortly is how are we going to manage the approximately 51,000 people currently in the expansion program.
- c. How do we identify the medically frail and should they all fall under the MCO's or do some of them still remain in the individual market.
- d. Substance Abuse Disorder claims are paid at the Medicare rate rather than Medicaid rate.
- e. Should there be single a high risk pool
- f. How are we managing people with in Corrections – if a person spends 24 hours in the hospital Medicaid picks up the cost – People who have served their time often fall out of the program after they leave prison.
- g. MCO's are contracted at \$358 average per member per month. This includes not only the expanded Medicaid population but also traditional Medicaid. It was noted that many of the Medicaid enrollees are children.
- h. For those that are enrolled for a short term the MCO's receive \$441.

- i. The Department of Health and Human Services pays for high cost drugs for Medicaid recipients, where the insurance companies for those in the individual market pick up these costs. The majority of drugs are for HEP C and hemophilia.
- j. Should we remove some or all of the medically frail from the individual market
- k. Is the move to MCO's a better fit for the expansion program

October 25th, 2017

John Meerschaert of Milliman (the Department of Health and Human Service's Actuarial Consultant) presented an actuarial analysis of the Premium Assistance Program. This was conducted under contract with the Department of Health and Human Services. They compared delivery in commercial insurance vs. managed care. Managed care would cost 55% less for the non-federal share, mainly due to the difference in provider reimbursement rates. This equates to a \$12.7 Million non-federal savings in 2018.

Milliman also looked at the effect of changing the "medically frail" definition. Making it looser would increase the number of these enrolled by up to 17% of the population and potentially decrease the medical cost by up to 25%. Mr. Meerschaert pointed out that the savings potential would be affected by how the carriers set their premiums and might not be the same as the potential medical cost savings.

Sen. Feltes asked if the loose definition of medically frail could be looked at relative to managed care vs. premium assistance to project cost savings. Rep. Rosenwald asked if we should look at potential net savings of moving to managed care by also incorporating the effect on premium tax and uncompensated care. Dr. Harker asked how utilization would change in managed care and how that change would affect cost. Dr. Wolf-Rosenblum asked if the results would produce a sustainable model under Medicaid reimbursement rates. Mr. Meerschaert noted that Milliman could not really address that question. Dr. Harker also expressed concerns on sustainability. Mr. Cornell also said recruiting staff is difficult. On the issue of provider reimbursement rates, Mr. Meerschaert reminded the commission that while the state is required to pay the MCOs actuarially sound rates, but the reimbursement they pay providers is not regulated by this requirement.

November 8th, 2017

Mathew Doucet from Milliman Actuarial joined us by phone to discuss further information he had put together comparing the cost of Premium Assistance

Program and managed care. He provided two slides he had used in a recent briefing and as well as two charts on Medically Frail and their impact on the individual market costs and costs of all individuals being transferred to managed care.

There are currently approximately, 33,000 Medicaid expansion people using the Premium Assistance Program and 7,000 that have self-identified as medically frail and are currently in managed care. The expanded Medicaid personnel make up 37% of the individual market place in NH. If just medically frail using the loose definition were removed from the Premium Assistance Program, the Per member per month cost per individual would drop from \$783 to \$709. It is evident that if all expanded Medicaid people were removed from the individual market the costs for remaining people would be reduced. This is because the cost associated with the expanded Medicaid population is more expensive than most of the people in the individual market place.

Michael Rose was concerned if we move everyone to Medicaid managed care the insurance tax will be reduced, DSH payments may go up and the availability of services may decline.

Jennifer Patterson indicated the Insurance Department needs to know whether or not the Premium Assistance program will continue and who is in the risk pool. There is a possibility the Insurance Department may need to request a 1332 waiver to stabilize the individual market.

Recommendations

1. The commission recommends that the New Hampshire Health Protection Program be reauthorized with the following recommendations.

2. Shift from Premium Assistance Plan to Medicaid Managed Care: The Commission recommends, with the below caveats paragraphs 3-7, that the Premium Assistance Plan members receive Medicaid Expansion through a managed care product rather than the current Premium Assistance Model. The Commission recommends this change for several reasons: to reduce premium instability in the individual health insurance market, to provide more straight forward opportunities for addressing individual market premium increases in 2019, to provide consistent benefits for all Medicaid participants, to better serve the medically frail and remove the impact of the medically frail on the individual market, and to create a larger pool of participants in order to establish a scale that will increase competition among managed care providers.

3. Provider Reimbursement Rates: The Commission recommends that the reimbursement rate shall be higher than the existing traditional Medicaid rate for providers of behavioral health care services, including substance use disorder services and mental health services, irrespective of whether or not a comparability waiver is applied for and approved. The commission further recommends that other services be considered for higher reimbursement than existing Medicaid rates.

4. Transition Period Without Lapse In Coverage: There shall be an administratively efficient transition period where Premium Assistance Plan members are shifted into managed care without any Premium Assistance Plan member losing coverage due solely to this transition, including managed care companies honoring pre-existing authorizations and plans.

5. Continuity of Care: To ensure a continuity of care, Managed Care companies shall provide effective case management to assist individuals who receive Medicaid but due to increased income levels may no longer qualify for Medicaid and will transition into the health care exchange, including, but not limited, immediately assisting in applying for coverage on the health care exchange for over-income individuals and continuing care and case management during the pendency of the application. These case management services are intended to prevent lapses in coverage for those individuals.

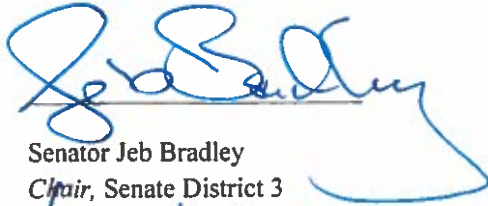
6. Reporting and Data: It is recommended that members of the Commission work with the Department of Health and Human Services, the Department of Revenue, the Insurance Department, the Legislative Budget Assistant and provider organizations to provide up to date information on possible changes to the level of uncompensated care, Premium Tax revenue and Medicaid Enhancement Tax Revenue should a managed care model be adopted for Medicaid Expansion.

7. Reauthorize for 5 Years: The Commission recommends that Medicaid Expansion be reauthorized for five years consistent with the policy of the Center for Medicaid and Medicare Services approving waivers for 5 years.

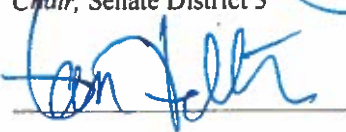
Addendums

1. Gorman Presentation August 18th, 2017
2. Gorman Presentation September 29th, 2017
3. Milliman Presentation October 25th, 2017
4. Milliman Presentation November 8th, 2017


Respectfully submitted,




Senator Jeb Bradley
Chair, Senate District 3



Senator Dan Feltes
Senate District 15




Representative Steve Schmidt
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NH Department of
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Jennifer Patterson
NH Insurance Department




Stephanie Wolf-Rosenblum
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Premium Assistance Program
Member



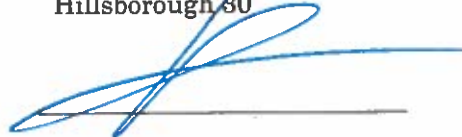
Senator Sharon Carson
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Travis Harker
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Lisa Guertin
Anthem



Richard Cornell
Mental Health Center of
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**2016 Actuarial Analysis of NH Premium
Assistance Program**

Gorman Actuarial, Inc.

August 18, 2017

Bela Gorman, FSA, MAAA
Jenn Smagula, FSA, MAAA

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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. In December 2015, the month prior to the expansion of Medicaid, 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. Approximately 43,000 of these members were enrolled through the PAP program, representing 42% of individual market single risk pool membership.¹

With a full year (2016) of data available, the state can understand how the inclusion of the NH PAP population within the individual market has impacted insurance premiums. Each year, Gorman Actuarial (GA) analyzes information for the insured markets by collecting data from the insurers through the Annual Hearing process for the New Hampshire Insurance Department (NHID). The report and Annual Hearing are presented in the fall of each year. This year, NHID has made a special request to analyze the PAP population and to produce a short report on the results to be presented in the summer. In addition, GA will be providing an additional report that models various scenarios for 2018 as the individual market landscape could be very different compared to 2016 and historical results may not be the best predictor of future effects. For example, with Minuteman's exiting of the individual market, the Non-PAP population may experience significant risk deterioration.

GA has relied on information provided by the insurance carriers. Due to the shortened timeline, GA was not able to verify and validate all data. However, most of the key information has been validated against other data sources. If the information provided is inaccurate, our findings may need to be revised. However, GA believes the results from this report are directionally correct.

¹ Annual Hearing Data (Preliminary for 2016 & 2017) supplemented with CMS reports and monthly QHP enrollment reports.

2. Individual Market Key Findings²

- **42% of the 2016 individual market consists of the PAP population.**

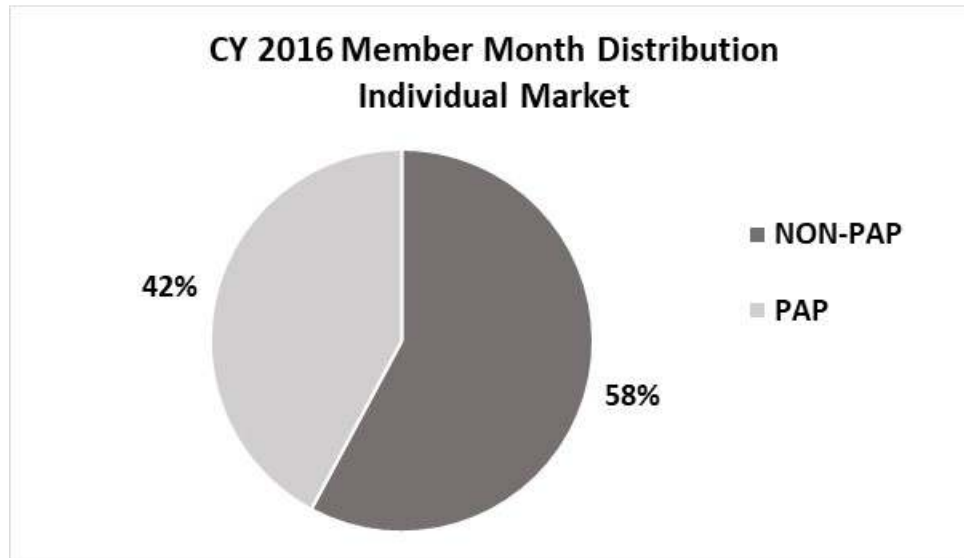


Figure 1: 2016 Individual Market Member Month Distribution

As shown in **Figure 1**, 58% of the individual market was not part of the PAP program. This distribution was calculated using member month data. The figure excludes grandfathered and transitional members which are not part of the individual market single risk pool.

² Throughout the remainder of this report, the individual market refers to the population included in the single risk pool individual market and therefore excludes grandfathered and transitional members.

- **The average PAP population's medical costs are 26% higher than the average Non-PAP population.**

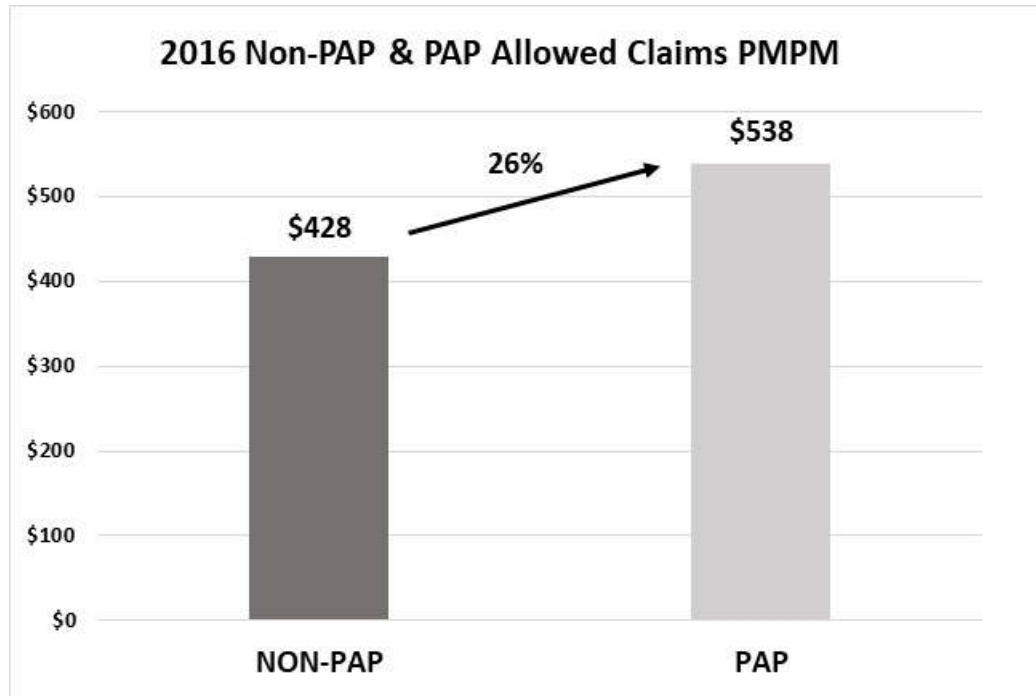


Figure 2: 2016 Non- PAP and PAP Allowed Claims PMPM

GA summarized claims costs for the PAP population and the Non-PAP population for each insurance carrier and then across the market. The claims costs include the insurer share of medical expense as well as the member cost sharing. This is referred to as the allowed claims costs. These costs were divided by member months to calculate a PMPM. As shown above, the PMPM costs for the PAP population is \$538 and for the Non-PAP population it is \$428, a difference of \$110 PMPM or 26%.

- **The PAP population is much younger than the Non-PAP population.**

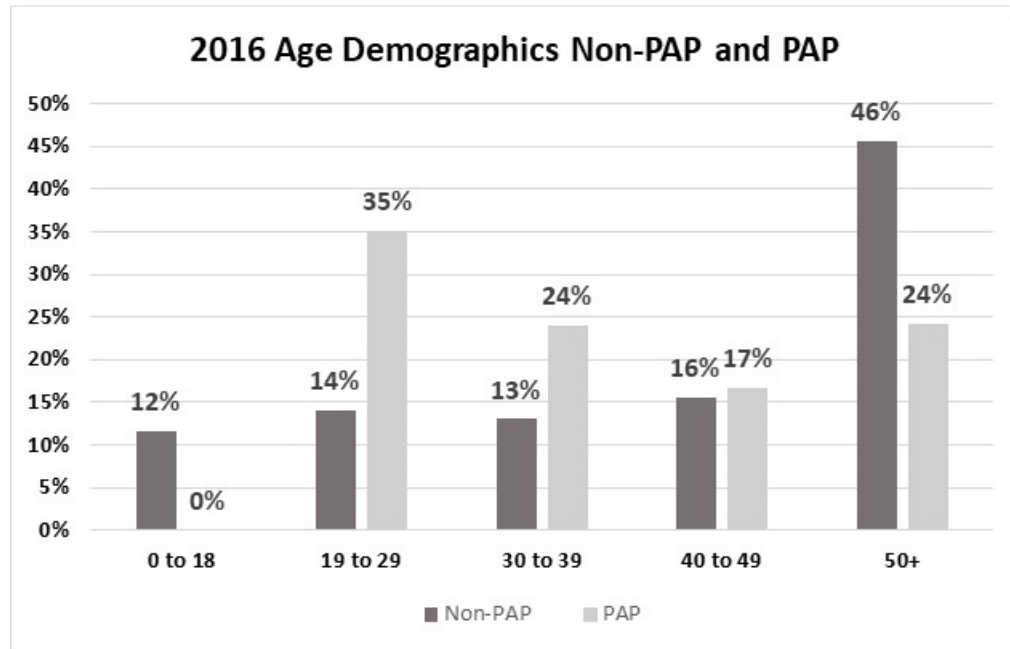


Figure 3: 2016 Non-PAP and PAP Age Demographics

As shown in **Figure 3**, there are no children enrolled in the PAP program. However, 59% of the PAP population is under the age of 40 contrasted with 39% of the Non-PAP population. 46% of the Non-PAP population is over the age of 50 compared to only 24% of the PAP population. The age differences in these two populations might suggest that observed medical costs for the PAP population should be lower than the Non-PAP population, not higher.

- **The PAP age factor is 17% lower than the Non-PAP age factor.**

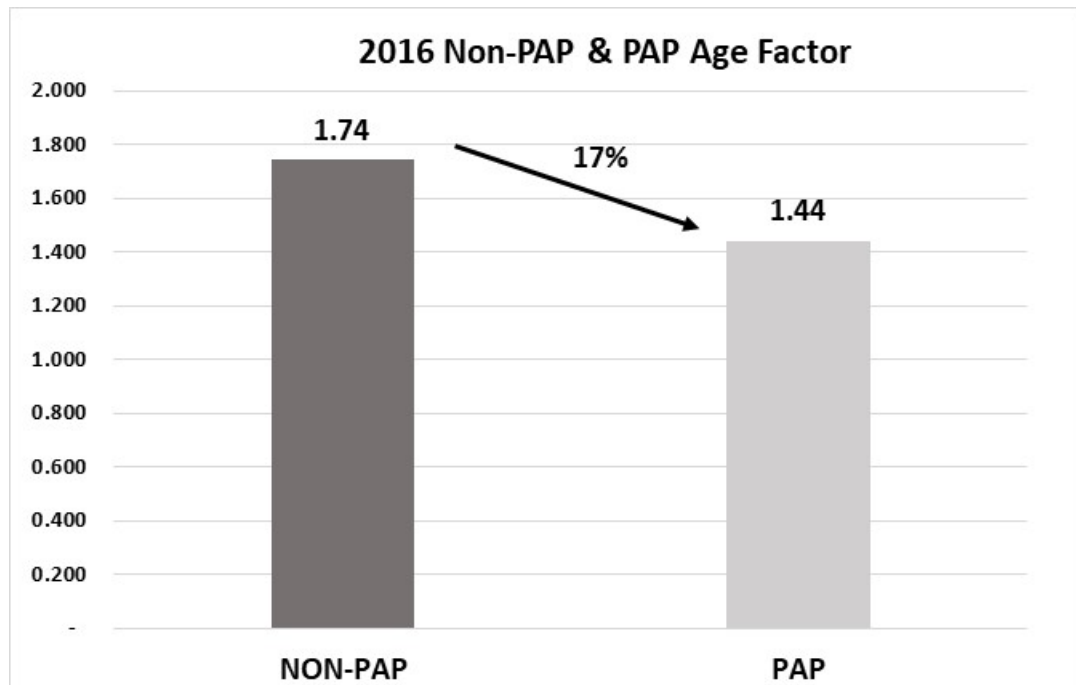


Figure 4: 2016 Non-PAP and PAP Age Factor

GA received age demographics from each insurer and applied these demographics to the 2016 federal age factors. Age factors are used to adjust premiums to cover the higher expected medical costs of an older population. The higher the age factor, the older the population and the greater the expected medical costs. As shown, the age factor of the Non-PAP population is 1.74 and the age factor of the PAP population is 1.44.

- **35% of the Non-PAP On Exchange population are enrolled in Bronze plans while all of the PAP population is enrolled in Platinum equivalent plans.**

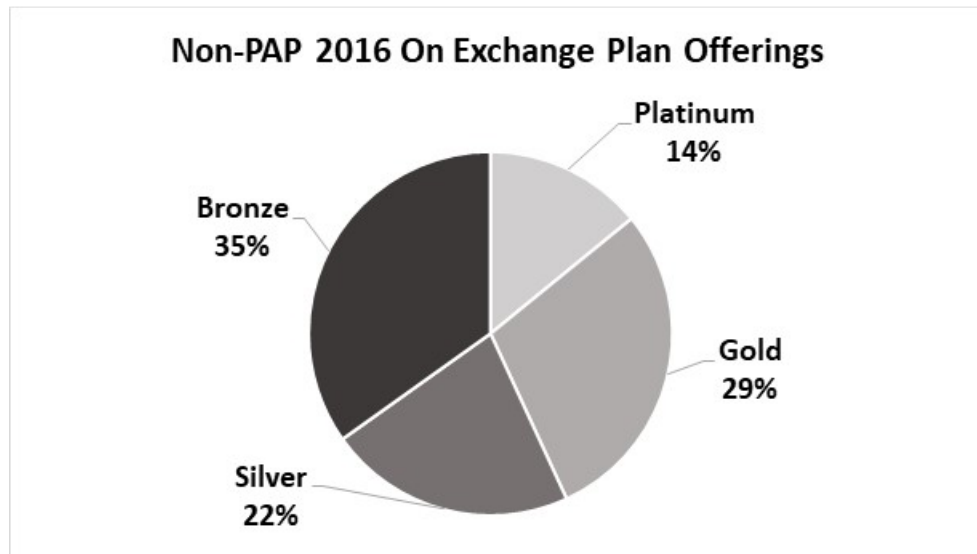


Figure 5: 2016 Non-PAP On Exchange Plan Offerings

For this analysis, GA has assumed the metallic tier distribution for the Non-PAP population enrolled through the exchange represents the distribution for the entire Non-PAP population.³ As shown, 35% of the Non-PAP population are enrolled in Bronze plan offerings, 22% in the Silver, 29% in Gold and 14% in Platinum. This distribution reflects those individuals who receive subsidies to enroll in more comprehensive plan designs.⁴ PAP enrollees are all enrolled in Platinum equivalent plans.⁵ Since PAP enrollees are enrolled in more comprehensive plans, the lower member cost sharing has less influence on enrollee behavior and utilization of health care services. Therefore, PAP enrollee's medical costs may be higher due to induced demand.

³ GA has performed sensitivity analyses on this assumption and overall premium impacts are not materially different.

⁴ Using federal reports, GA was able to calculate the number of members who receive cost sharing reduction subsidies (CSR) by the three metallic tier offerings (actuarial value of 0.73, 0.87, or 0.94).

⁵ PAP members are enrolled in silver plans with cost sharing reduction subsidies such that the actuarial value of the plan is either .94 or 1.00.

- **Non-PAP population's induced demand factor is 1.05 as compared to the PAP population at 1.15.**

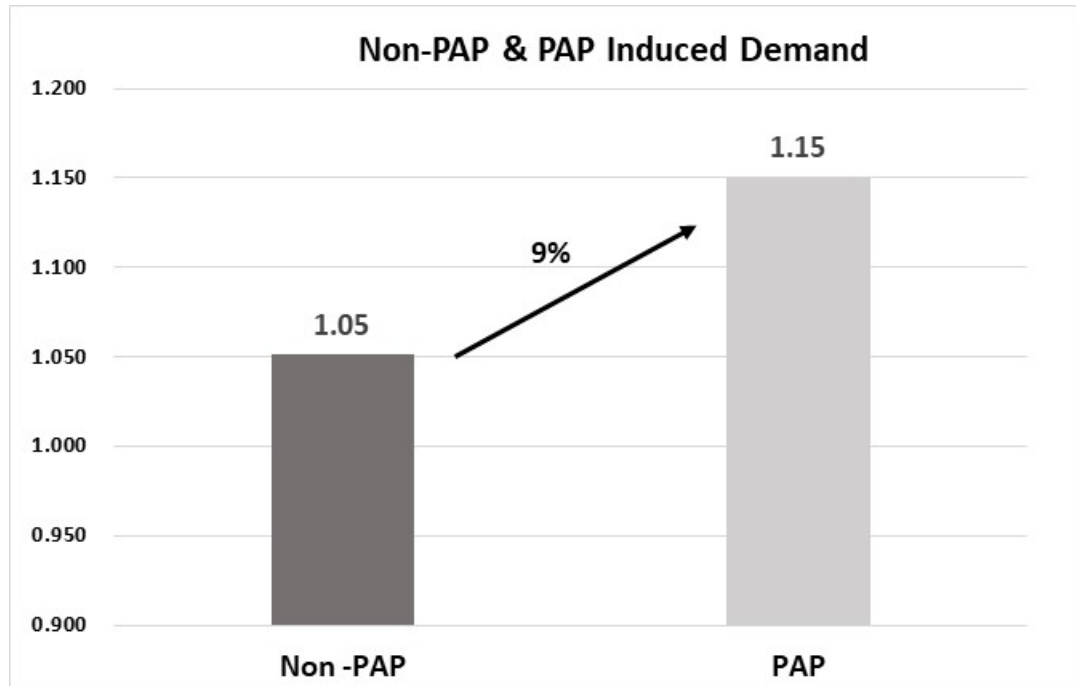


Figure 6: 2016 Non-PAP and PAP Induced Demand Factors

Generally, when populations are enrolled in plan offerings with low member cost sharing, utilization of services is greater. This is referred to as induced demand. Since PAP members are enrolled in more comprehensive plan offerings as compared to the Non-PAP population, medical costs for this population are expected to be higher. Using the induced demand factors from the federal risk adjustment model, the PAP population's medical expenses are expected to be 9% higher than the Non-PAP population (1.15/1.05) strictly due to differences in plan designs.

- **After adjusting for age and induced demand, the PAP population's medical costs are 39% higher than the Non-PAP population's medical costs.**

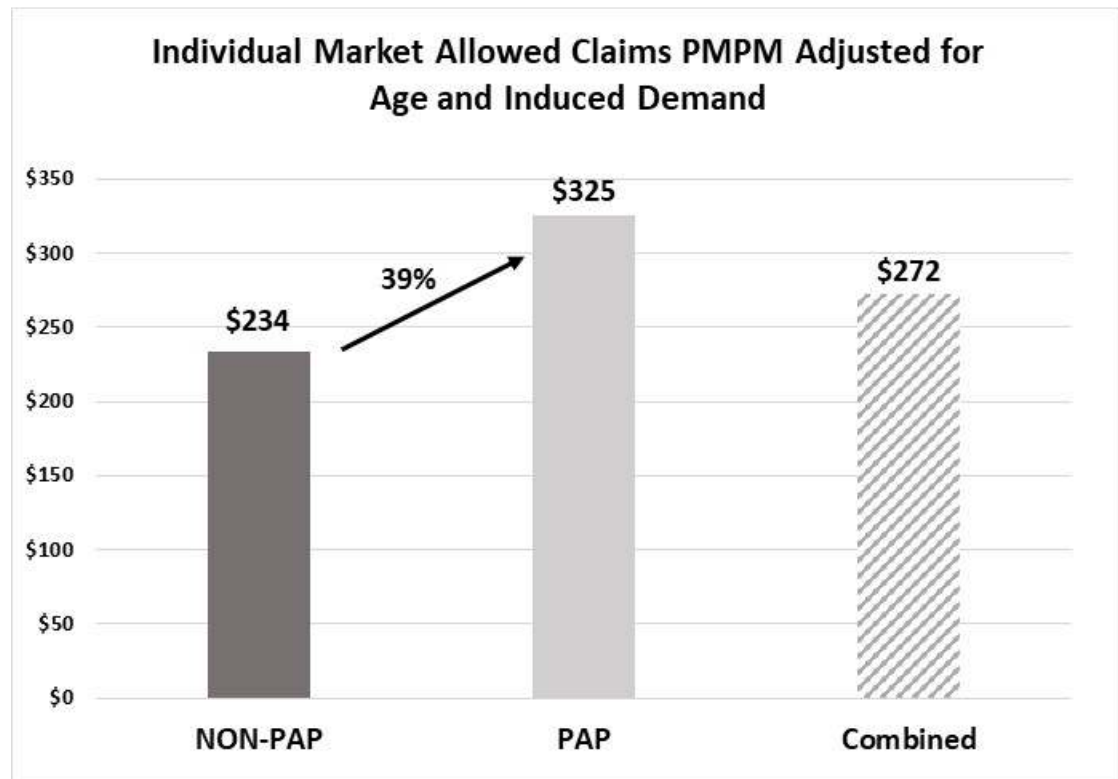


Figure 7: 2016 Non-PAP and PAP Allowed Claims PMPM Adjusted for Age and Induced Demand

Since the age demographics of each population (PAP vs. Non-PAP) are so different, the medical costs are adjusted for age. That is, if both populations had a similar age distribution, how would their medical costs compare. Similarly, since the plan designs of each population are also diverse, the medical costs are adjusted for induced demand. That is, if both populations were enrolled in similar benefits how would their medical costs compare. As shown in the figure above, the PAP population's age and benefit adjusted allowed claims⁶ PMPM is \$325, compared to the Non-PAP population's medical costs of \$234 in CY 2016. This represents a 39% difference.

⁶ By using allowed claims rather than paid claims, the analysis already reflects the member cost sharing differences.

➤ **If the PAP population was excluded from the individual market, CY 2016 adjusted claims costs would decrease 14%.**

Premium rates are based on medical claim costs of the entire individual market single risk pool. These medical costs are then projected into the future. Since insurers can rate for age and benefits, the medical costs are also adjusted for both. In order to understand the impact to medical claim costs of excluding the PAP population within the single risk pool, we compared the age and induced demand adjusted allowed claims ⁷PMPM of the Non-PAP population (\$234) to the age and induced demand adjusted allowed claims PMPM of the combined population (\$272) in CY 2016. The difference between these two costs is 14%⁸. Therefore, adjusted medical claim costs in the individual market would be approximately 14% lower if the PAP population was excluded from the individual market in CY 2016 which in turn would have a downward impact on premium.

⁷ Using allowed claims for both populations eliminates the cost sharing differences between the two populations. Adjusting for induced demand eliminates the utilization differences due to cost sharing for the two populations.

⁸ GA modeled this with and without the catastrophic population, and the results were nearly the same.

3. Additional Analyses

Gorman Actuarial also analyzed claims costs and risk adjustment reports for the Non-PAP and PAP populations to understand whether the 39% difference in age and benefit adjusted medical costs could be due to other factors such as morbidity differences.

- **The PAP population's inpatient facility medical expenses are approximately 50% greater than the Non-PAP Population, however, pharmacy costs are approximately the same between the two populations.**

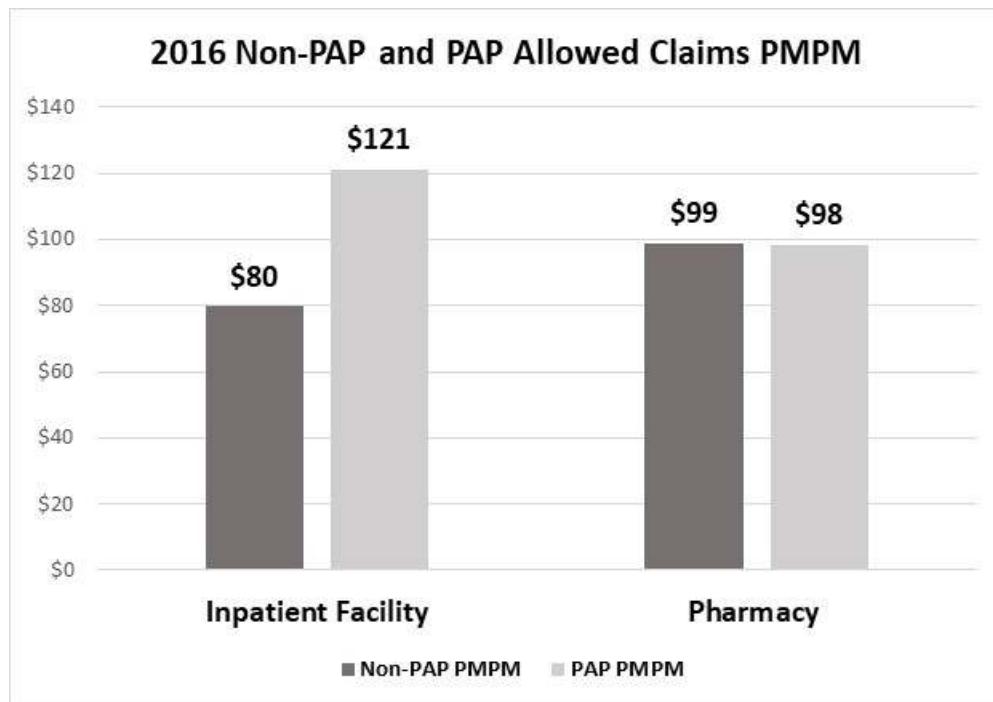


Figure 8: 2016 Non-PAP and PAP Inpatient Facility and Pharmacy Claims

A review of inpatient claims PMPMs indicate that the PAP population may be a higher risk population as compared to the Non-PAP population.⁹ Pharmacy expenditures are essentially the same for both populations.

⁹ Inpatient expenses do not include emergency department visits, unless that visit resulted in an inpatient admission.

- **The risk score for PAP plans is 27% higher than the risk score of Non-PAP plans.**

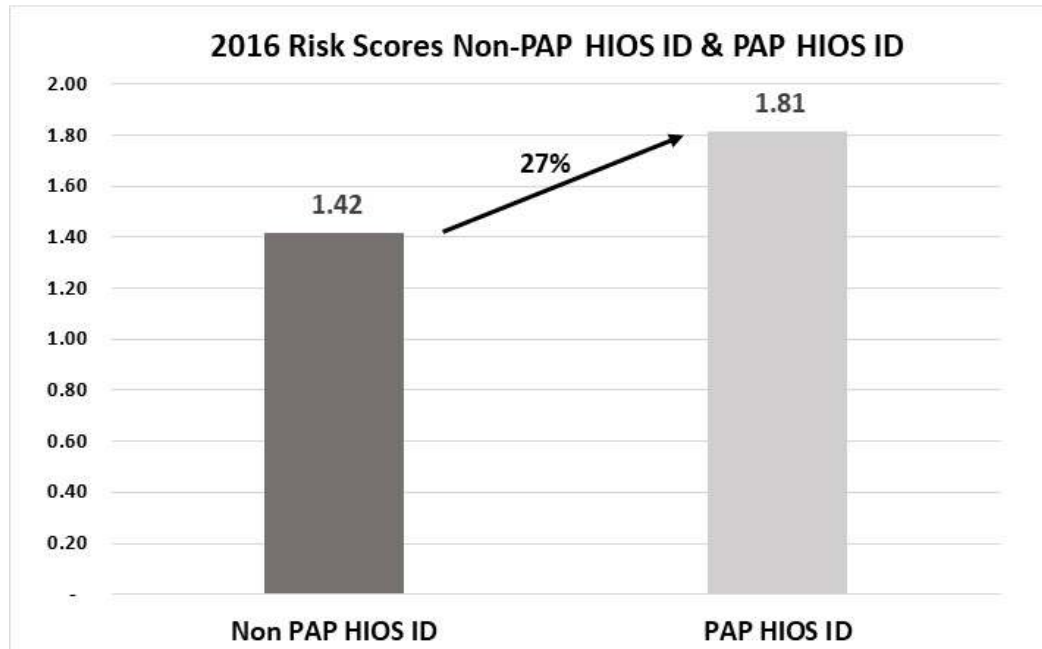


Figure 9: 2016 Plan Level Risk Scores

GA received the federal risk adjustment reports from each insurance carrier. Each report provides a plan liability risk score by HIOS ID, which allowed GA to aggregate these scores across insurance carriers. Each insurer's product portfolio offers a plan that is designed for the PAP population. However, this plan offering is offered to the entire individual market, including PAP and Non-PAP enrollees. GA has estimated that 82% of enrollees within the PAP plan offerings are actual PAP enrollees. Using this information, GA determined that the average risk score for enrollees in Non-PAP plans is 1.42 while the average risk score for enrollees in PAP plans is 1.81, representing a 27% difference.

- **\$41 million was transferred from Non-PAP plans to PAP plans in 2016 through the federal risk adjustment program.**

The federal risk adjustment program transfers payments from plan offerings with members that are less healthy than average (i.e., higher risk) to plan offerings whose members are healthier than average (i.e., lower risk). We analyzed the risk transfers from Non-PAP plans to PAP plans. There was \$41 million dollars transferred from Non-PAP HIOS plan ID's to PAP HIOS plan ID's based on the federal risk adjustment reports.

4. Considerations and Limitations

Gorman Actuarial prepared this draft 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.

The purpose of this draft report is to provide stakeholders preliminary information on the impact of the PAP population on the single risk pool individual market. This report provides analysis based on historical information using 2016 data. In the next six weeks, GA will be analyzing newly submitted rate filings and developing a model to understand how the PAP population may influence the premiums of the overall market in 2019. Due to the dynamic health care environment, the markets are constantly changing. Analyses of historical data may not provide a clear direction for the future. The influence of premium rate increases, insurers exiting the market and insurers withdrawing certain plan offerings will likely impact the overall makeup of the individual market. These items need to be considered when understanding how the PAP population will impact the overall risk pool in 2019.

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, 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.

5. 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.

6. 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. All indicators suggest that this population may have a higher morbidity than the Non-PAP population. However, further analysis needs to be performed to understand whether this higher morbidity may be due to other factors such as the different enrollment patterns of the PAP and Non-PAP populations. The state should consider conducting a durational study which would examine turnover rates and health care claims costs by duration of enrollment. Due to the changing health care environment, historical analyses may not provide a clear direction for the future. For example, with Minuteman's exiting of the individual market, the Non-PAP population may experience significant risk deterioration and therefore the difference in medical claim costs between the Non-PAP and PAP populations may not be as large in future years. The New Hampshire individual market will continue to undergo changes from 2016 to 2018 and these changes need to be considered when analyzing the impact of the PAP population on the future market.

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

Gorman Actuarial, Inc.

September 29, 2017

**Bela Gorman, FSA, MAAA
Jenn Smagula, FSA, MAAA**

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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.**

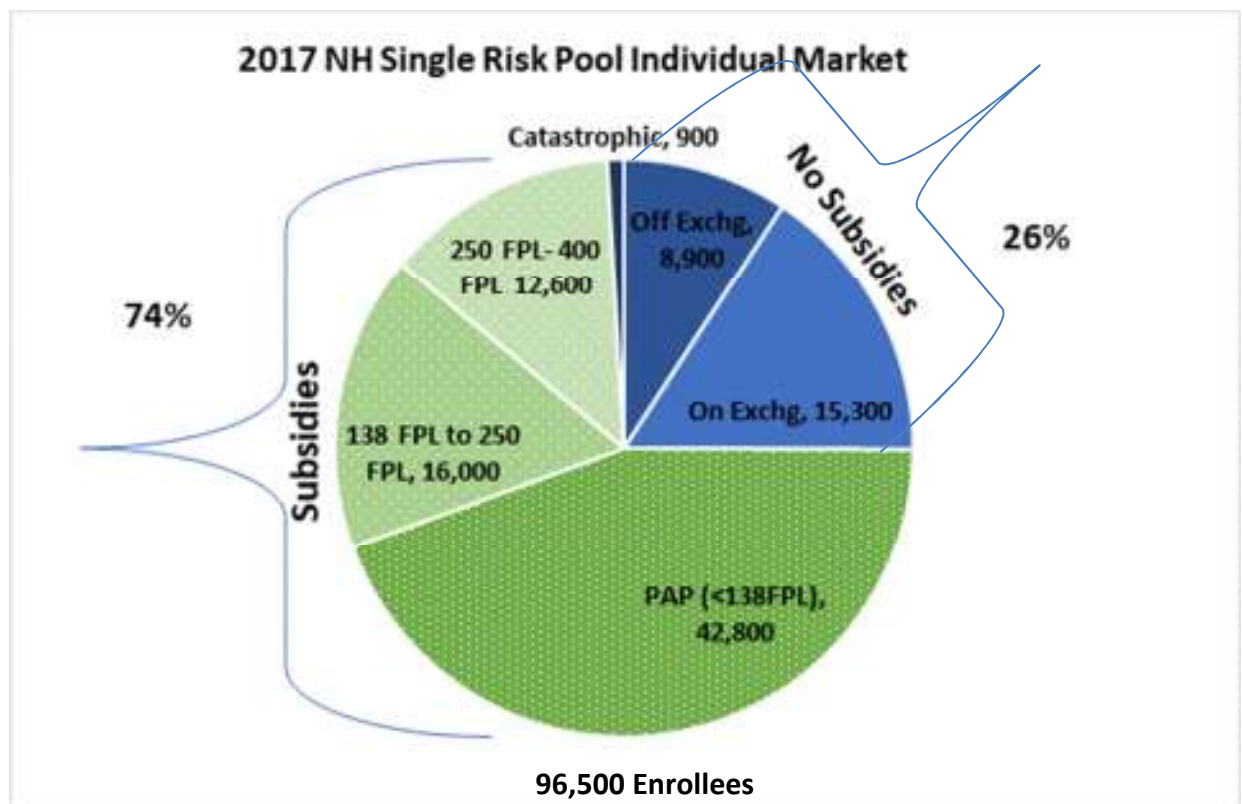


Figure 1: Estimated August 2017 Individual Market Membership³

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.

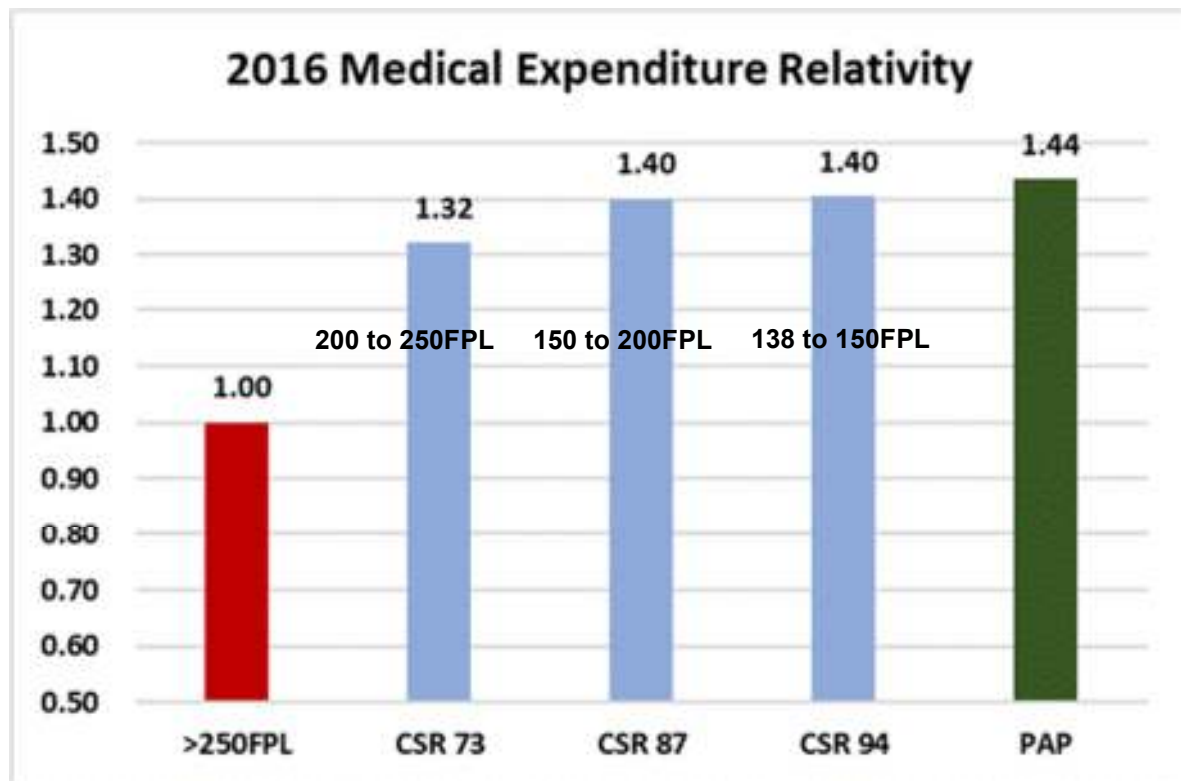


Figure 2: 2016 Individual Market Allowed Medical Expenditure Relativity⁵

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.**

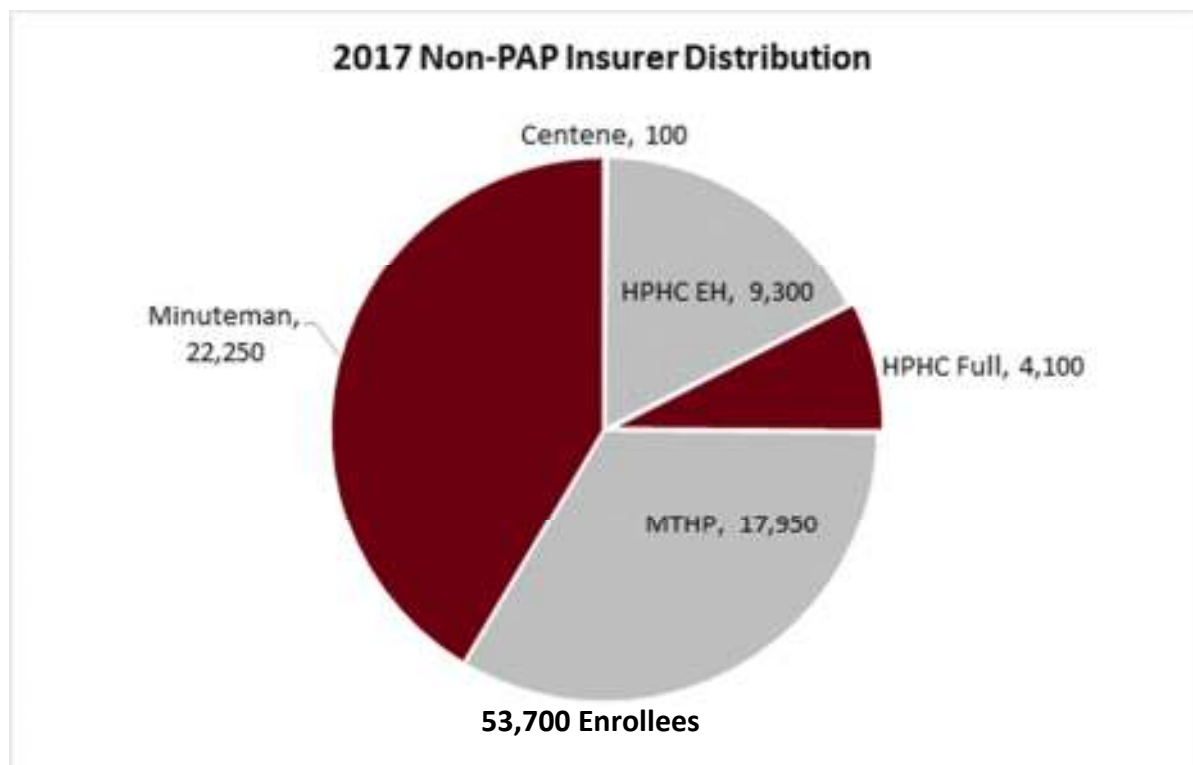


Figure 3: Estimated August 2017 Non-PAP Insurer Distribution⁶

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 HPCH EH stands for HPCH Elevate Health, HPCH's select network plan offering. HPCH Full stands for HPCH'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-\$464=\$233) 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.

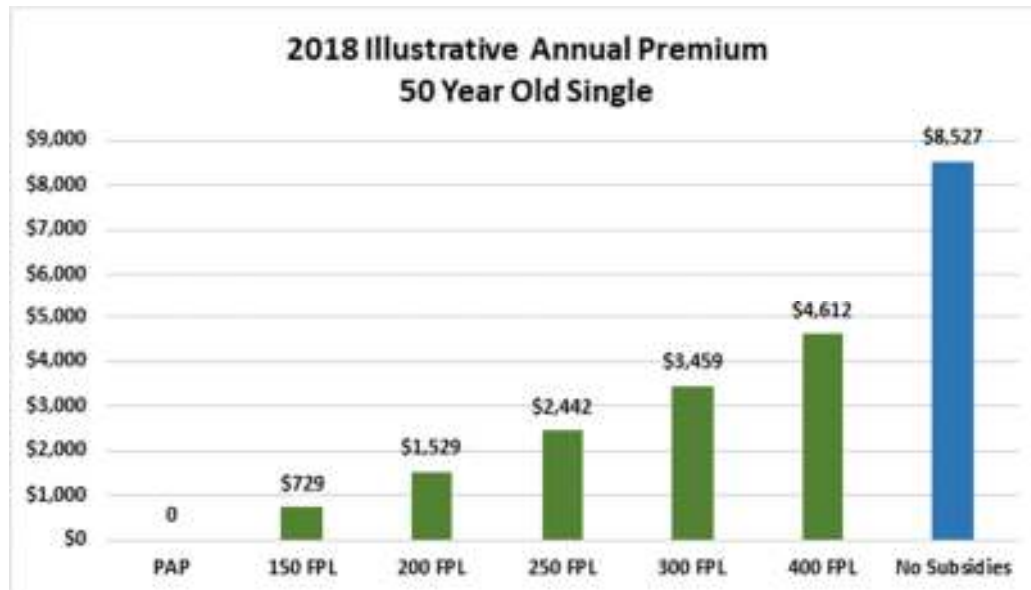


Figure 4: 2018 Individual Market Premiums – Single Policy

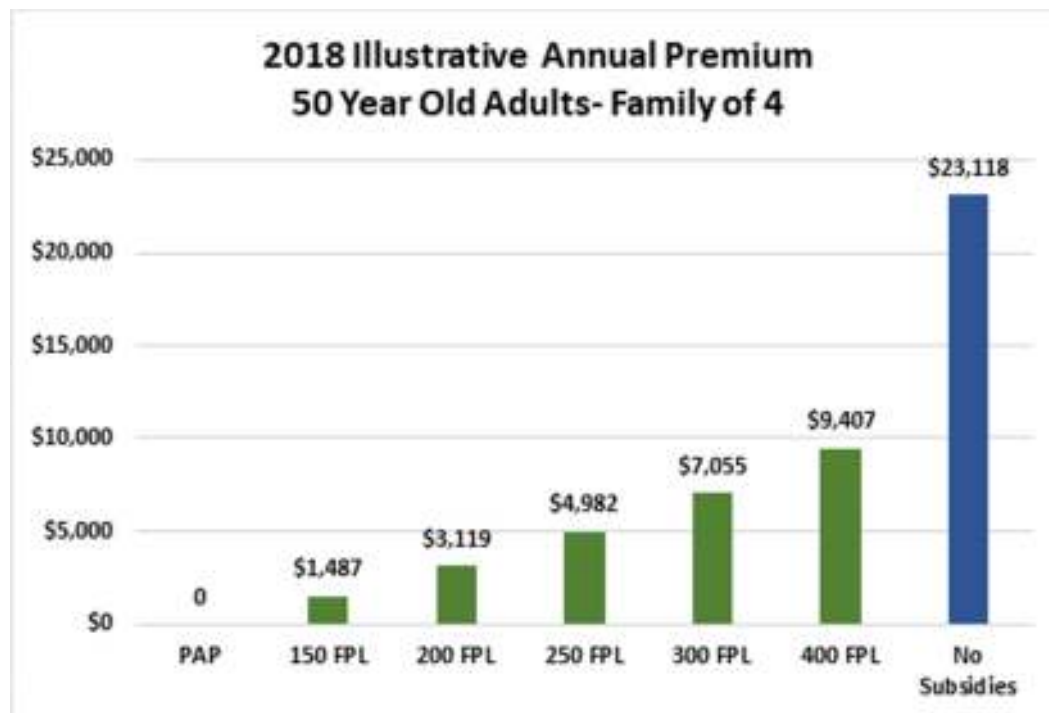


Figure 5: 2018 Individual Market Premiums – Family of Four

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.

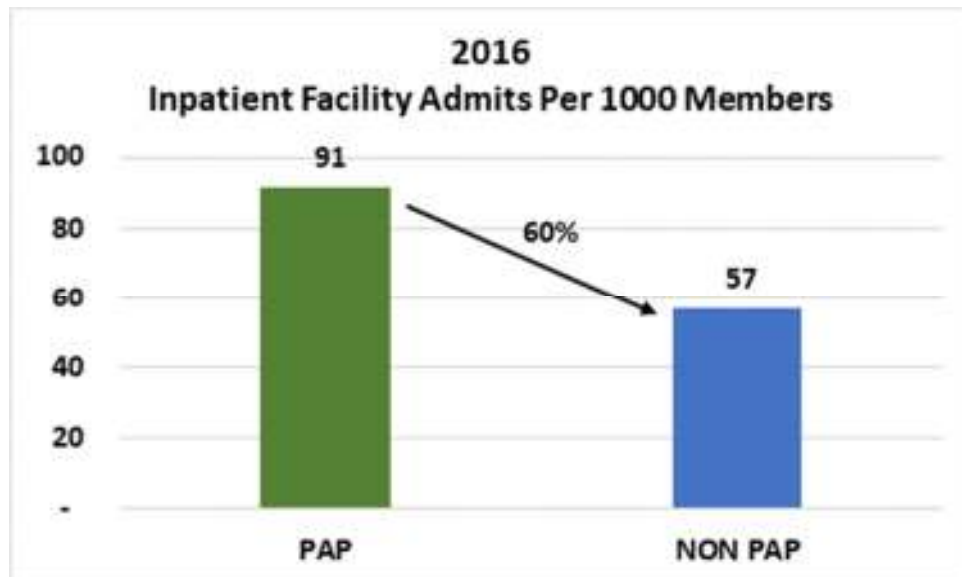


Figure 6: 2016 PAP and Non-PAP Inpatient Utilization

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

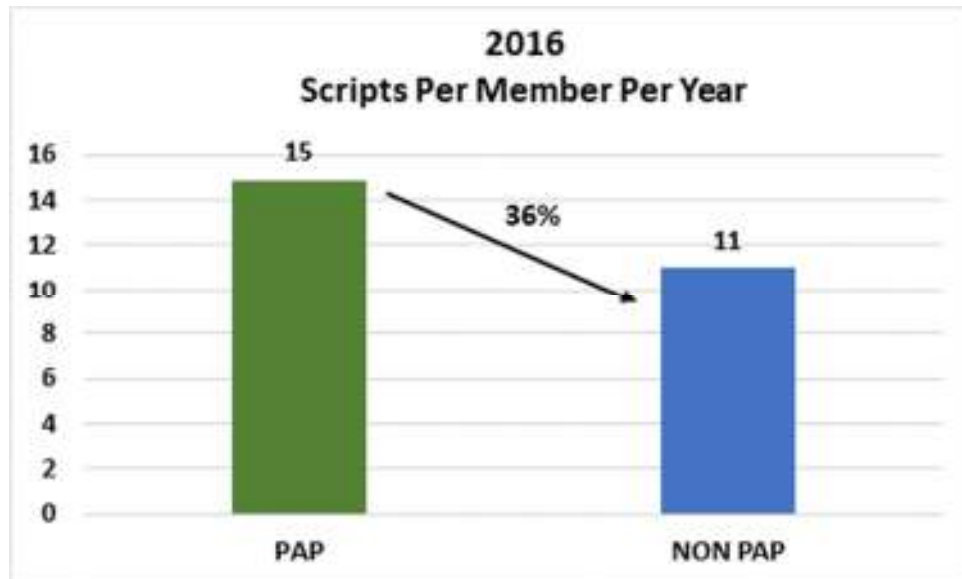


Figure 7: 2016 PAP and Non-PAP Pharmacy Utilization

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

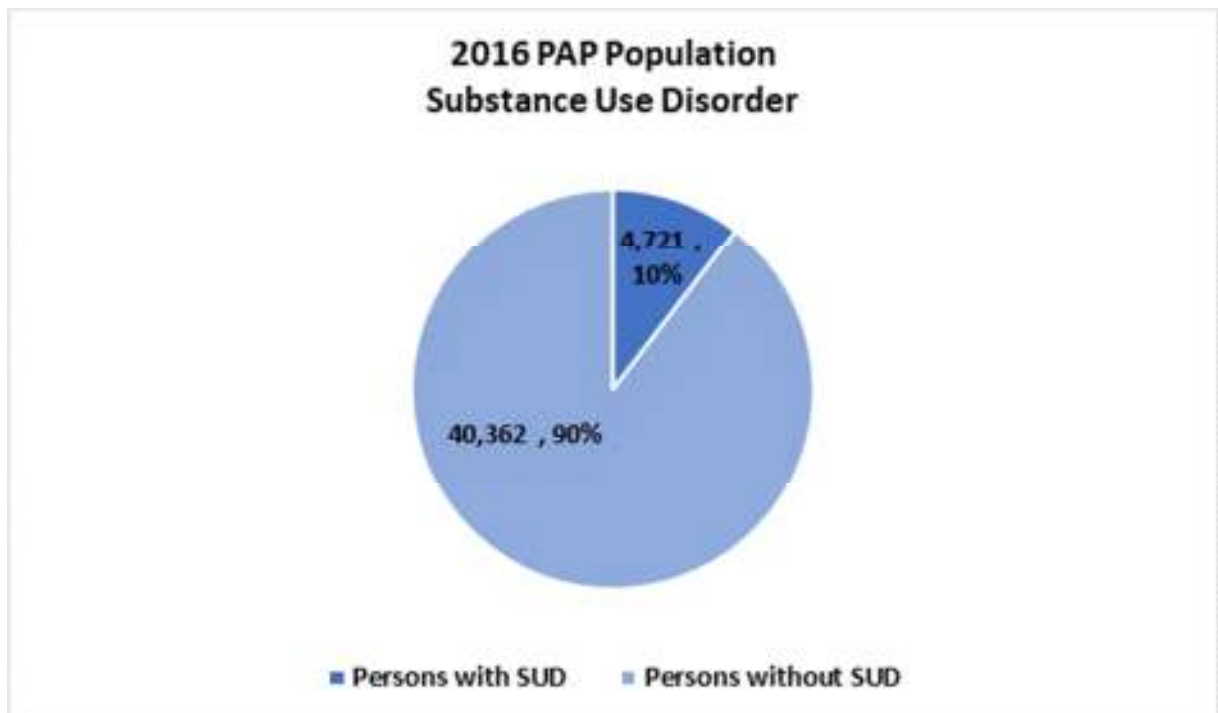


Figure 8: 2016 PAP persons with SUD

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.**

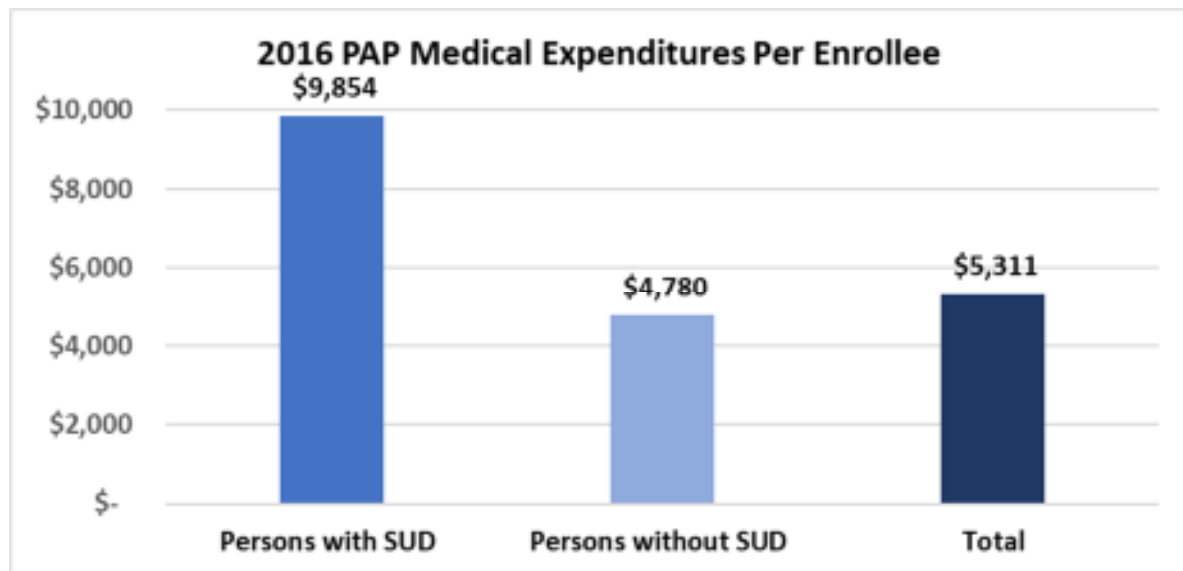


Figure 9: 2016 PAP Annual Allowed Medical Expenditures per enrollee

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).**

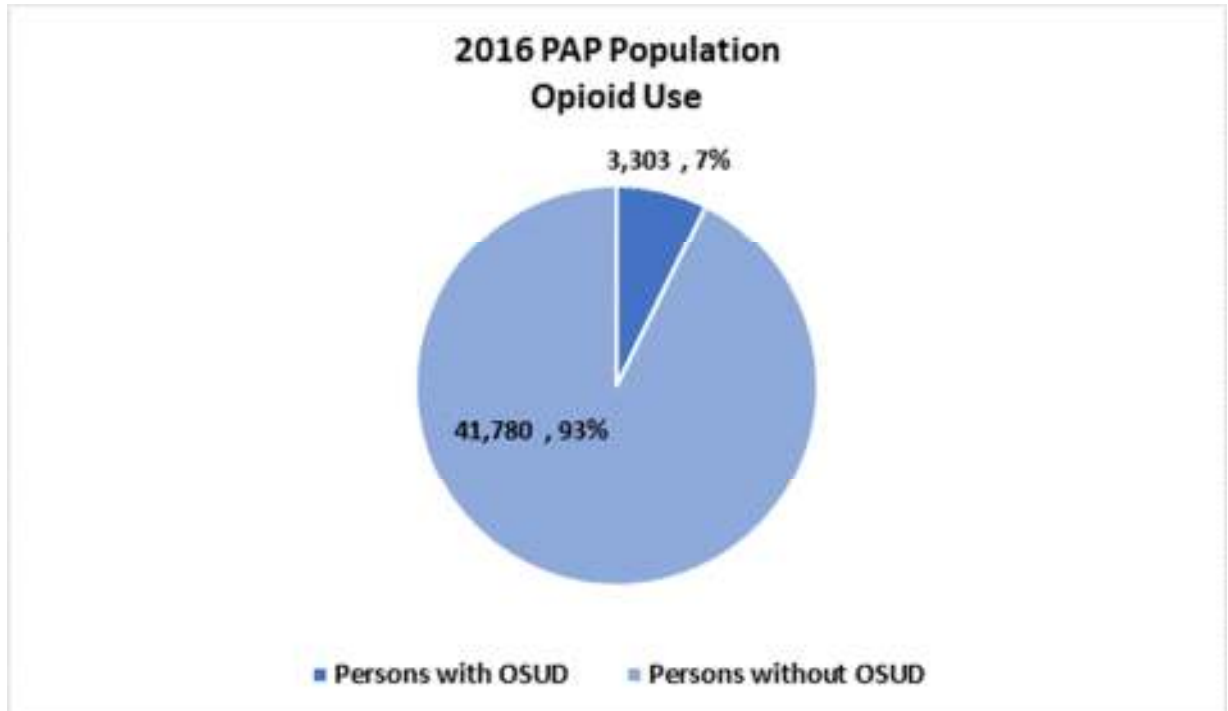


Figure 10: 2016 PAP Enrollees with OSUD

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.**

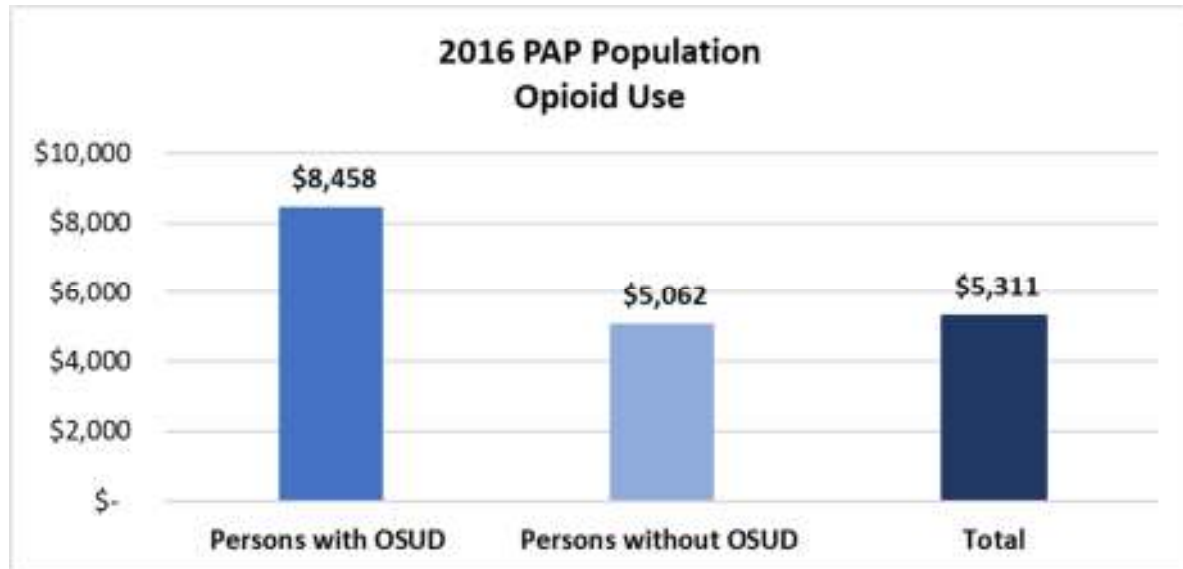


Figure 11: 2016 PAP Annual Allowed Medical Expenditures per enrollee

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.



New Hampshire Commission to Evaluate the Effectiveness and Future of the Premium Assistance Program

Actuarial Analysis of the Premium Assistance Program

John D. Meerschaert, FSA, MAAA
October 25, 2017

Agenda

- Introductions
- Cost comparison of the Premium Assistance Program population under two scenarios
 - Status quo: Coverage in the Health Insurance Marketplace
 - Alternative delivery system: Coverage in the Medicaid Care Management program
- Discussion of the impact of modifying the medically frail definition
- Questions

Introductions

- Milliman is an independent global consulting firm that employs the largest number of health actuaries in the US
- We have worked with NH DHHS for over 10 years providing rate setting and other financial analyses for the Medicaid program, including:
 - Medicaid Care Management (MCM) program
 - New Hampshire Health Protection Program (NHHPP)
 - Bridge Program (Sept 2014 – Dec 2015)
 - Medically Frail population
 - Premium Assistance Program (PAP)
- The DHHS Commissioner asked us to provide cost estimates for the PAP population under alternative scenarios

Cost Comparison – PAP vs. MCM Program

Cost Comparison – PAP vs. MCM Program

- We estimated the cost of the PAP population under two scenarios for CY 2018:
 - Status quo: Coverage in the Health Insurance Marketplace
 - Based on CY 2018 premiums, CSR payments, and funding of the deductible
 - Alternative delivery system: Coverage in the MCM program
 - Based on CY 2016 PAP claims from the New Hampshire Comprehensive Health Care Information System (CHIS) data
 - Repriced to prevailing Medicaid fees and other adjustments made to reflect the MCM delivery system
 - Trended to CY 2018
 - Includes an allowance for MCO administrative costs, margin, and premium tax

Cost Comparison – PAP vs. MCM Program

New Hampshire Department of Health and Human Services
Comparison of Estimated CY 2018 Cost for Premium Assistance Program Population
Health Insurance Marketplace vs. MCM Program

	Health Insurance Marketplace ¹	MCM Program ²	Difference
Estimated PMPM Cost	\$783.56	\$347.44	(\$436.12)
CY 2018 Federal Medical Assistance Percentage	94%	94%	0%
Federal Share PMPM	\$736.55	\$326.59	(\$409.95)
State Share PMPM	\$47.01	\$20.85	(\$26.17)
Estimated Average Enrollment	40,168	40,168	N/A
Annual Federal Funding (in millions)	\$355.0	\$157.4	(\$197.6)
Annual State Funding (in millions)	\$22.7	\$10.0	(\$12.7)

¹ Includes premiums, CSR payments, and funding of the deductible

² Includes claims repriced to Medicaid fees and an allowance for MCO administrative costs, margin, and premium taxes

Cost Comparison – PAP vs. MCM Program

New Hampshire Department of Health and Human Services
Comparison of Estimated State Funding for Premium Assistance Program Population
Health Insurance Marketplace vs. MCM Program
Based on CY 2018 Cost Estimates and Future FMAP¹

Calendar Year	Projected FMAP	Health Insurance Marketplace (State Funds in millions)	MCM Program (State Funds in millions)	Difference
2018	94%	\$22.7	\$10.0	(\$12.7)
2019	93%	26.4	11.7	(14.7)
2020+	90%	37.8	16.7	(21.1)

¹ All expenditure estimates are based on CY 2018 cost estimates and are intended to only show the impact of reductions in the projected FMAP for the expansion population in 2019 and 2020. The impact of changes to the underlying cost of the PAP population are not included in these estimates.

Cost Comparison – PAP vs. MCM Program

- The largest driver of savings under the MCM program delivery system is lower provider reimbursement
 - CMS disallowed the use of the higher NHHPP fee schedule effective August 15, 2017
- Repricing PAP claims at Medicaid fee schedules results in significant cost savings compared to PAP reimbursement levels:
 - Hospital inpatient = 64% savings
 - Hospital outpatient = 48% savings
 - Professional and other service = 50% savings
 - Community mental health center = 26% savings

Medically Frail Definition – Impact on PAP

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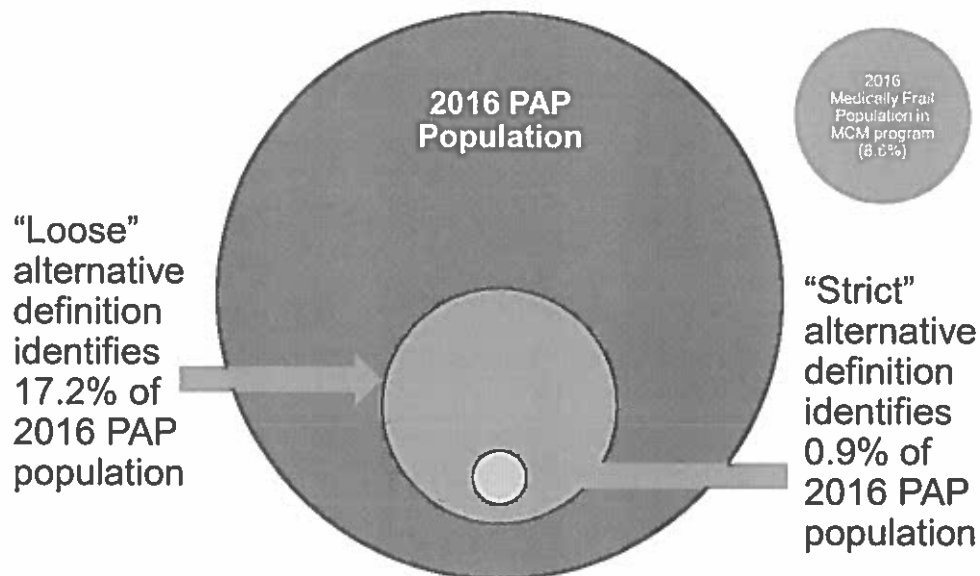
Medically Frail Definition – Impact on PAP

- Medically frail individuals cannot enroll in the PAP
- Currently, individuals can self-identify as medically frail by answering the following question:
 - “Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc.) or live in a medical facility or nursing home?”
- In 2016, 8.6% of the population who otherwise met the enrollment criteria for the PAP identified as medically frail and could not enroll in the PAP
 - Medically frail percentage has risen to 12.6% as of September 2017
- These individuals were enrolled in the NHHPP Medically Frail program and served by Medicaid MCOs
- We model the impact of changing the criteria for medically frail identification to include certain behavioral health (BH) and substance use disorder (SUD) diagnosis codes

Medically Frail Definition – Impact on PAP

- Clinicians grouped the BH and SUD diagnosis codes into categories
 - Chronic: The condition persists for a long time, is difficult to cure, or is constantly recurring
 - Disabling: The condition is one where all, or almost all, individuals are disabled when diagnosed with the condition
- We used this information to develop alternative definitions of medically frail
 - Strict: An individual has a diagnosis that is very likely to be both chronic and disabling
 - Loose: An individual has a diagnosis that is less likely to be both chronic and disabling
- Note that the alternative definitions do not consider other potential indicators of medical frailty (like chronic medical conditions)
 - Other reasonable definitions are possible
- We modeled the estimated impact using CY 2016 PAP claims data

Medically Frail Definition – Impact on PAP



Medically Frail Definition – Impact on PAP

New Hampshire Department of Health and Human Services
Comparison of Estimated CY 2016 Medical Cost for Premium Assistance Program Population
Impact of Removing Medically Frail Individuals Under Alternate Scenarios

	PAP Enrollee PMPM	% Newly Identified Medically Frail	Newly Identified Medically Frail PMPM
Current Definition	\$500.56	N/A	N/A
Expanded Definition - Strict	\$487.54	0.93%	\$1,885.24
Expanded Definition - Loose	\$372.18	17.20%	\$1,118.38

PAP Enrollee Medical Cost Reduction

Expanded Definition - Strict	-2.6%
Expanded Definition - Loose	-25.6%

Medically Frail Definition – Impact on PAP

- Other important considerations when evaluating potential changes to the medically frail definition:
 - How are potential members prospectively identified as medically frail?
 - How do the carriers react to a change and how does that translate to future premium rates?
 - PAP program costs are based on premiums, not medical cost
 - How much will it cost to cover the newly identified medically frail population in the MCM program?
 - What is the net financial impact on New Hampshire that results from a change?
 - PAP program cost
 - Medically Frail rate cell cost in the MCM program
 - How are other policy goals impacted?
- The total impact of a definition change is uncertain without exploring these questions in more detail

Caveats and Limitations

- This document is designed to provide DHHS with estimates related to the PAP population under certain scenarios. This information may not be appropriate for other purposes.
- This information should not be relied upon by anyone other than DHHS. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This information assumes the reader is familiar with the New Hampshire Medicaid program.
- It is certain that actual experience will not conform exactly to the assumptions used in these estimates. Actual amounts will differ depending on policy changes, medical trend, premium levels, enrollment levels, and other changes to the health care delivery system.
- In preparing this document, we relied on information from DHHS, the CHIS data, and other information. We accepted this information without audit but reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate.
- This presentation and its use is subject to the contract between DHHS and Milliman signed on June 14, 2017.



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Questions

Cost Comparison – PAP vs. MCM Program

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Cost Comparison – Medically Frail Definition Expansion

New Hampshire Department of Health and Human Services Comparison of Estimated CY 2018 Cost for Premium Assistance Program Population Health Insurance Marketplace vs. MCM Program Medically Frail Definition Expansion – Loose Alternative Delivery System							
	Status Quo ¹	Health Insurance Marketplace ^{1,2}	Medically Frail in MCM Program ³	Total	Difference for Remaining Health Insurance Marketplace	Difference for Medically Frail in MCM Program	Total Difference
Estimated FMAP Cost	\$783.56	\$709.41	\$756.98	\$717.59	(\$74.15)	(\$26.58)	(\$65.97)
CY 2018 Federal Medical Assistance Percentage	94%	94%	94%	94%	0%	0%	0%
Federal Share PMPM	\$736.55	\$666.84	\$711.56	\$674.54	(\$69.70)	(\$24.98)	(\$62.01)
State Share PMPM	\$47.01	\$42.56	\$45.42	\$43.06	(\$4.45)	(\$1.59)	(\$3.96)
Estimated Average Enrollment	40,168	33,257	6,911	40,168	N/A	N/A	N/A
Annual Federal Funding (in millions)	\$355.0	\$266.1	\$59.0	\$325.1	(\$27.8)	(\$2.1)	(\$29.9)
Annual State Funding (in millions)	\$22.7	\$17.0	\$3.8	\$20.8	(\$1.8)	(\$0.1)	(\$1.9)

¹ Includes premiums, CSR payments, and funding of the deductible

² Assumes a premium reduction of 25.6% for the PAP portion of the total premium

³ Includes claims re-priced to Medicaid fees and an allowance for MCO administrative costs, margin, and premium taxes

Cost Comparison – Medically Frail Definition Expansion

New Hampshire Department of Health and Human Services Comparison of Estimated State Funding for Premium Assistance Program Population Health Insurance Marketplace vs. MCM Program (in millions) Based on CY 2018 Cost Estimates and Future FMAP ¹ Medically Frail Definition Expansion – Loose				
Calendar Year	Projected FMAP	Status Quo	Alternative Delivery System	Difference
2018	94%	\$22.7	\$20.8	(\$1.9)
2019	93%	26.4	24.2	(2.2)
2020+	90%	37.8	34.6	(3.2)

¹All expenditure estimates are based on CY 2018 cost estimates and are intended to only show impact reductions in the projected FMAP for the expansion population in 2019 and 2020. The impact of changes to the underlying cost of the PAP population are not included in these estimates.

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