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NH Medicaid Today and Tomorrow: Focusing on Value
A Research Symposium

May 31, 2017

PAP Impact on Commercial Market

Good objectives, but overall an inefficient construct with unintended consequences

1. **PAP members are not well-served in the Commercial market:**
   - PAP members have significantly different health utilization and cost
   - Traditional Commercial medical mgmt does not meet PAP member needs
   - Fragmented service model leaves gaps in care

2. **Middle-income people hurt by combining with higher-cost PAP members**
   - Until now, NH has been a success story in the individual market
   - In 2018, ~20,000 members receiving no federal subsidy will be forced to pay significantly more in order to cover ~50,000 PAP members
   - This is a shadow tax on a very small population, and will likely make individual coverage too expensive for many

3. **Double-whammy – federal 'Risk Adjustment' scheme drives premiums higher:**
   - Premiums go up not just because cost of PAP members needs to be spread over non-PAP membership
   - Risk Adjustment harms any plan that is more affordable than the market average *for any reason* (e.g., efficient providers, Bronze plan, good med mgmt)
   - Risk Adjustment volatility forces all carriers in a competitive market to increase premiums, period. Mixing two very different populations greatly magnifies this effect and drives premiums even higher

Basic Facts: PAP versus non-PAP populations

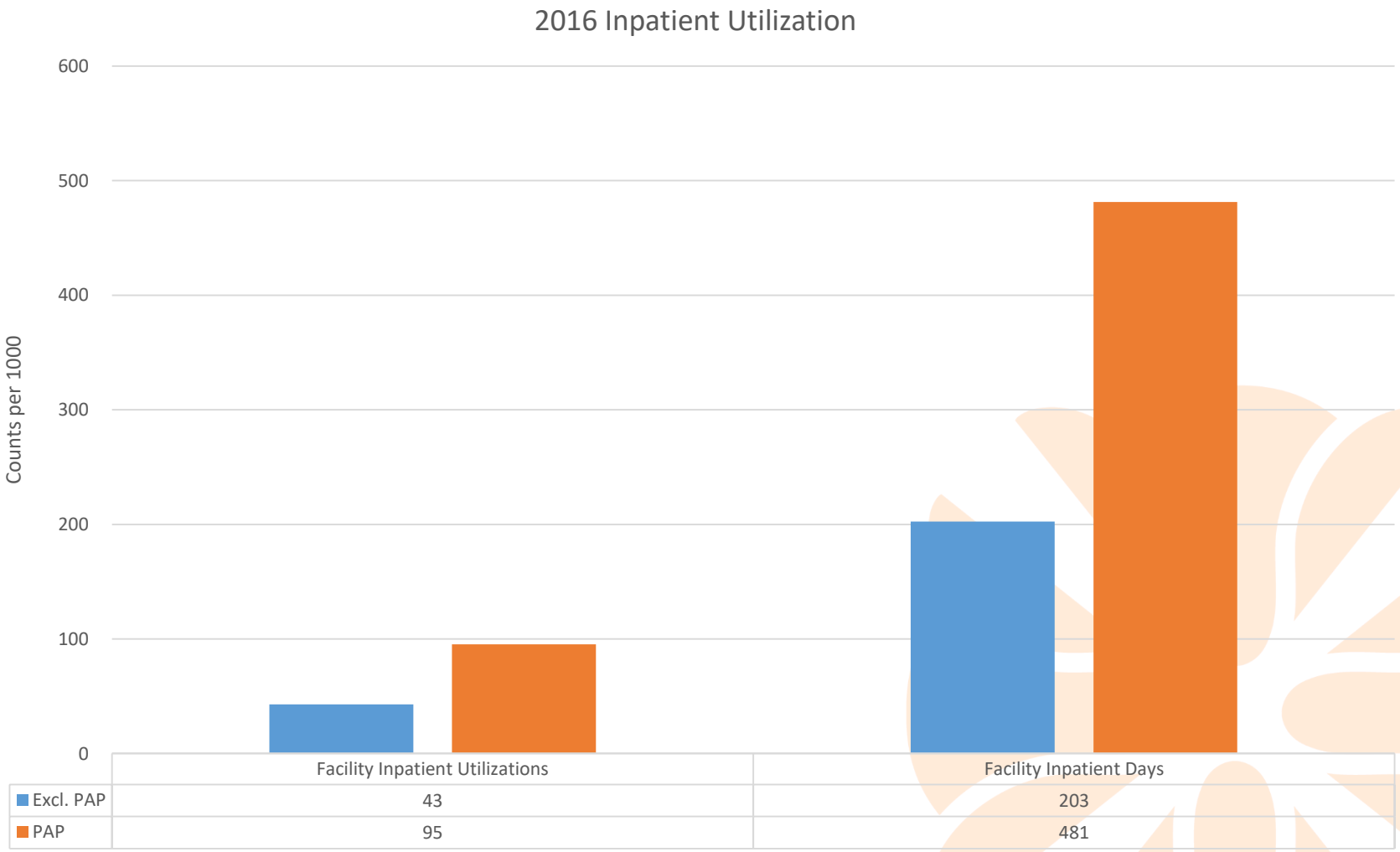
Significantly different utilization for the two groups

Percent Difference in MHI NHPAP utilization/1000 compared to NH w/o PAP (2016)						
Setting	In Network			Out of Network		
	NH PAP Only	NH w/o PAP	**% Difference**	NH PAP only	NH w/o PAP	**% Difference**
Facility Inpatient	66	34	**96%**	29	8	**258%**
Facility Outpatient	1758	1477	**19%**	406	72	**466%**
Professional	7067	5428	**30%**	766	314	**144%**
Ancillary	1383	495	**179%**	123	26	**369%**
ER Utilization	433	112	**287%**	370	52	**604%**
BH & SUD services	1660	273	**509%**	144	12	**1060%**

In 2016, the average duration of MHI NH commercial membership was **9 months**.
The MHI PAP population had an average membership of **6 months.**

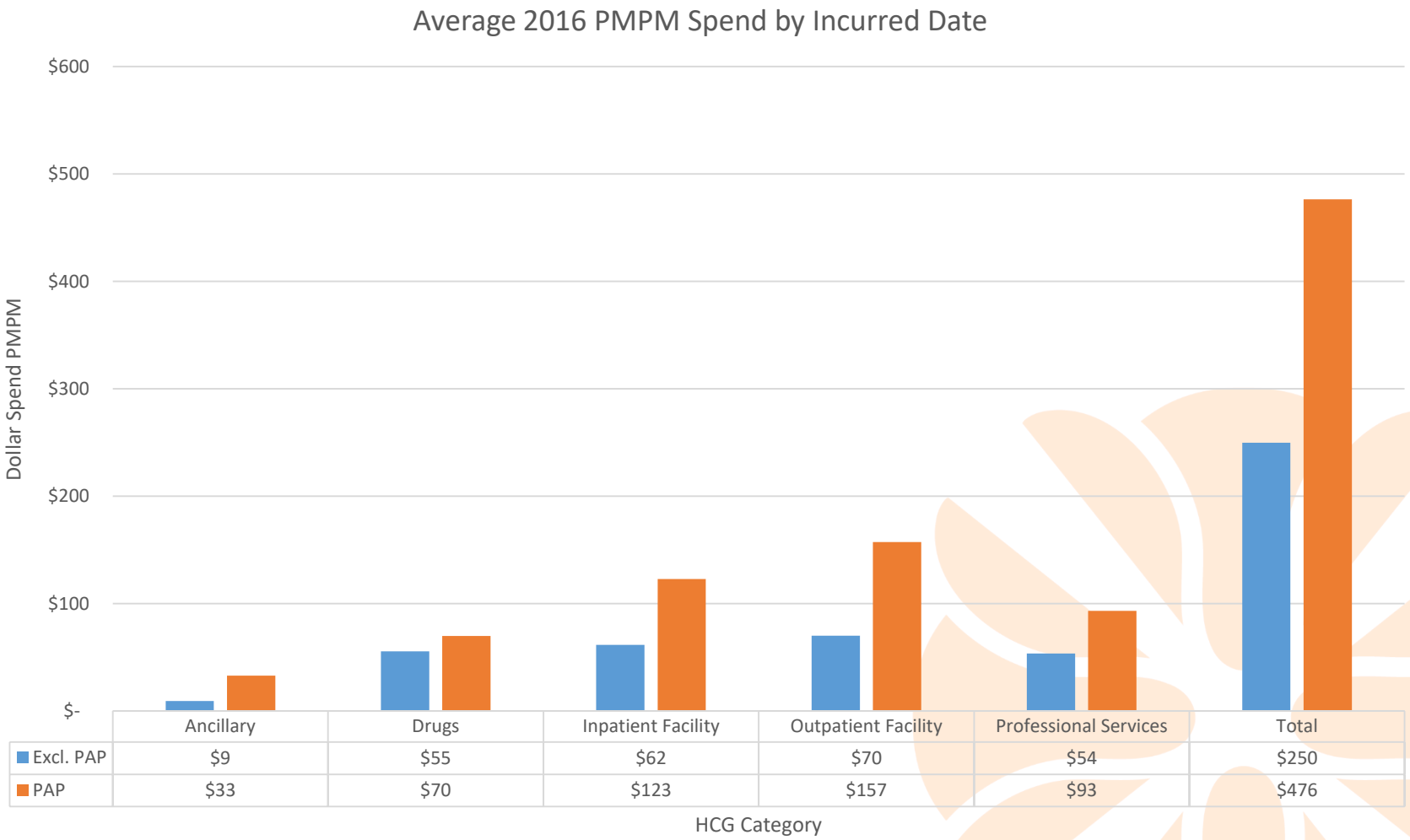
Basic Facts: PAP versus non-PAP populations

Inpatient utilization significantly higher for PAP population



Basic Facts: PAP versus non-PAP populations

Higher utilization means higher cost – PAP population costs almost double non-PAP



	Ancillary	Drugs	Inpatient Facility	Outpatient Facility	Professional Services	Total
Excl. PAP	$9	$55	$62	$70	$54	$250
PAP	$33	$70	$123	$157	$93	$476

Conclusion #1: PAP Members Not Served Well in the Commercial Market

Different needs mean different service model, and Commercial mkt does not have it

Few Examples:

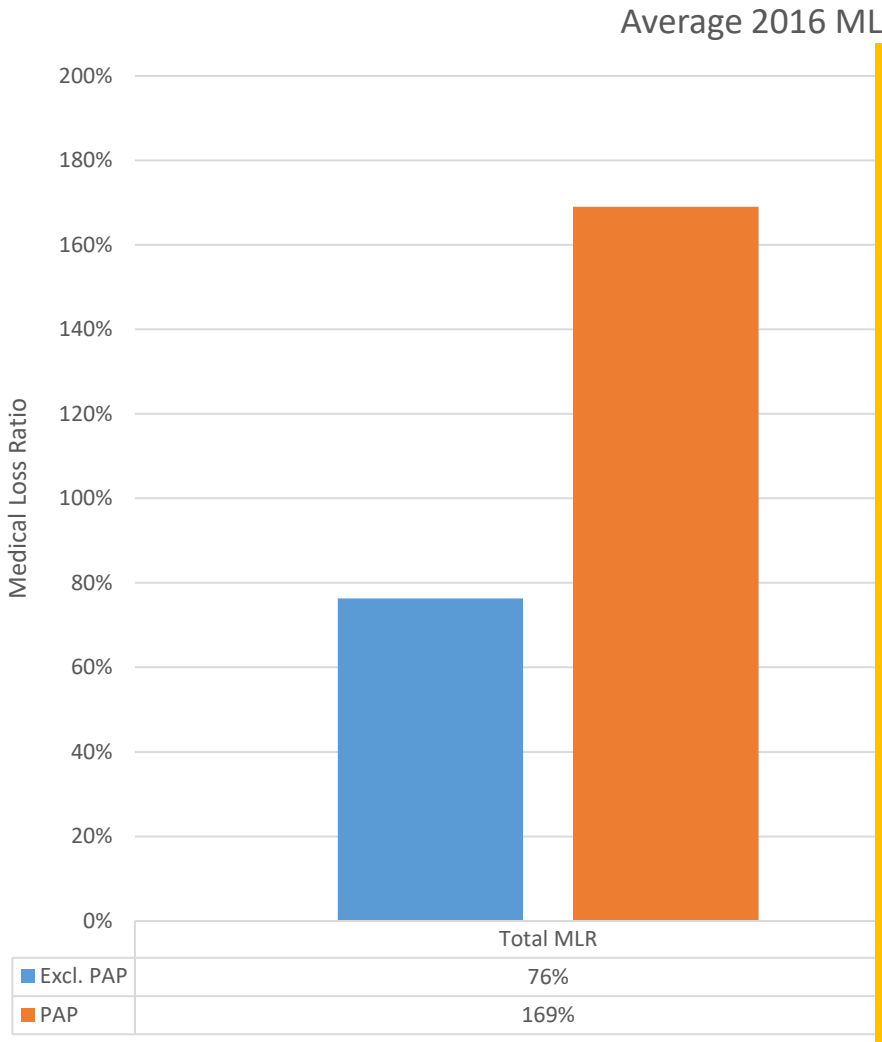
1. **Delivery of non emergent care:**
   PAP members were required to have PCPs in Medicaid. Commercial populations can not have this requirement. Many MHI PAP members are now using ERs for their non emergent care. *Redirection activities are more intensely needed for the MHI PAP population.*

2. **Transportation:**
   PAP members use 911 ambulance services more frequently and less appropriately than commercial members. *This is requires unique medical management initiatives.*

3. **Housing:** Homelessness is rare in MHI NH commercial population. A lack of housing for some MHI PAP member makes care coordination challenging. PAP members with substance disorders and infections must be kept in hospitals for months. *This is a medical management challenge that is unique to MHI PAP members.*

Conclusion #2: Middle-income Population Will See Significant Premium Increases

Unintended consequence of PAP/Commercial combination



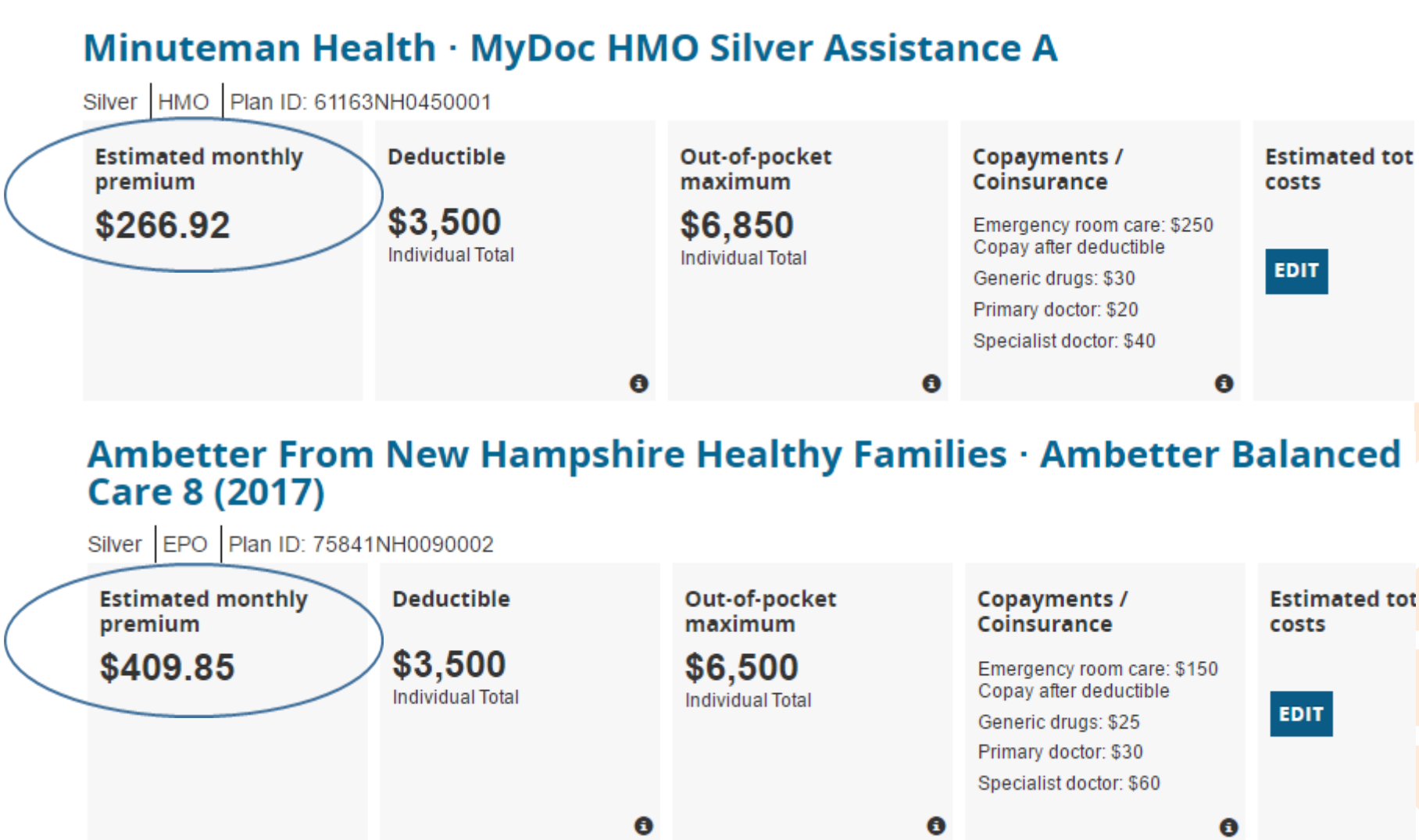
Situation

- 'MLR' means 'Medical Loss Ratio'
- This is total medical claims as a percentage of premiums
- PAP population MLR is *over double* that for the non-PAP population

Result

- Currently, one premium must be set for two very different populations
- Approximately half of the non-PAP members receive a federal subsidy to purchase coverage
- The remaining half must fully pay premiums out of their own pockets
- Very high increases appear likely for 2018 due to combined PAP / non-PAP pool

Conclusion #2 (continued)
Ambetter premiums reflect PAP-only population; market will rise to match Ambetter



Conclusion #3: Double-whammy of Federal Risk Adjustment Harms Both Populations

Combining PAP and non-PAP into one risk pool amplifies volatility and increases prices

		9%	91%				
		PAP-only Risk Pool	non-PAP Risk Pool	Combined Risk Pool		Weighted Avg Risk Pool	Difference
Claims		$ 507.10	$ 265.10	$ 287.10		$ 287	$ 0
Risk Adjustment		$ 46.20	$ 57.20	$ 95.70		$ 56	$ 39
NBE		$ 112.20	$ 85.80	$ 96.80		$ 88	$ 9
Total		$ 665.50	$ 408.10	$ 479.60		$ 431	$ 48
2017 rate	$ 357						
2018 increase		86%	14%	34%		21%	

- Combining PAP and non-PAP risk pools drives premium higher than a simple weighted average would imply. (YES, this sounds crazy)
- The Risk Adjustment component is greatly amplified – almost doubles – by combining such very different risk pools
- 38% of the 2018 premium increase is due solely to Risk Adjustment component of a single risk pool
- **If in two separate pools, *total spend across PAP and non-PAP would be lower***

NOTE: The above data is disguised. This information is important competitively. Actual numbers are *worse* than that shown above.

Policy Recommendations
By focusing on each populations needs, total costs can go down while care improves

1. **Separate PAP and non-PAP risk pools**
   Option A: Re-constitute Bridge program. More cost-effective option
   Option B: Create separate risk-adjusted pools for PAP and non-PAP; both are technically in the commercial market and all commercial carriers are still in. Could be easier to get approved

2. **Fix Risk Adjustment volatility**
   Option A: Suspend RA for 2018 to avoid massive premium increases. Feds are reportedly changing for 2019 anyway due to shortcomings
   Option B: At least make RA more predictable by capping payouts. Would lower increases, but not as much as Option A

3. **Paying to cover PAP population – covering the state portion of PAP costs**
   After taking the steps above, the total cost of PAP will have decreased significantly. Then, to pay for what costs remain:
   Option A: Assess each carrier a flat percentage of all insured premiums
   Option B: Assess hospitals a cost-sharing fee since they have fewer uninsured

Minuteman recommends doing Option A for all three categories. The 'B' options would all work as well, but have a less positive impact

Policy Recommendations
What will not fix the problem

1. **High risk pools will not solve the core problems**
   - Costs are only a part of the problem; premium volatility is driven by federally imposed Risk Adjustment
   - Protecting insurers against highest-cost cases can decrease insurer accountability in managing those cases; overall costs can climb
   - Funding the shortfall in high-risk pools is another cost to be met

2. **Changing plan designs or benefit coverage levels also will not solve core problems**
   - Financially, these are rounding errors compared to the risk pools and RA issues

3. **Canceling coverage for current PAP population would create more problems**
   - This population is incurring costs regardless whether we cover them through PAP or Bridge or 'uninsured'. They go to the ER no matter what
   - The better question is how we can most effectively and efficiently deliver the best clinical and financial outcome
   - Suddenly canceling PAP without another plan would negatively affect the whole market