

---

# **New Hampshire Insurance Department**

## **2012 Medical Cost Drivers**

---

**December 2013**

**Gorman Actuarial, LLC  
210 Robert Road  
Marlborough, MA 01752**

**Bela Gorman, FSA, MAAA  
Jennifer Smagula, FSA, MAAA  
Jon Camire, FSA, MAAA**

## Table of Contents

<b>Section Title</b>	<b>Page Number</b>
1. Executive Summary	5
2. Data Sources and Definitions	8
3. Overview of New Hampshire Insurance Market	9
4. Premium Trends - Unadjusted	12
5. Benefits and Benefit Buy-Down	13
6. Premium Trends - Adjusted	18
7. Components of Premium	19
7.1. Introduction	19
7.2. Medical Claims	19
7.3. Pricing Trends	27
7.4. Medical Loss Ratios	28
7.5. Administrative Expenses	30
7.6. Profit Margins	32
8. Regional and National Comparisons	35
9. Affordability Discussion	38
9.1. Carrier Cost Levers and Constraints	38
9.2. Provider Differentiation & Network Design	39
9.3. Alternative Payment Models	45
10. Conclusion	47
11. Appendix	48
11.1. Data Sources	48
11.2. Glossary of Terms	49
11.3. Limitations and Data Reliance	50
11.4. Qualifications	51

## List of Tables

<b>Table</b>	<b>Page Number</b>
TABLE 1 – UNADJUSTED EARNED PREMIUM BY MARKET SEGMENT AND YEAR _____	12
TABLE 2 – MEMBER DISTRIBUTION OF DEDUCTIBLE BY MARKET SEGMENT AND YEAR* _____	13
TABLE 3 – COST SHARING ATTRIBUTES BY MARKET SEGMENT AND YEAR* _____	14
TABLE 4 – BENEFIT BUY-DOWN BY MARKET SEGMENT _____	15
TABLE 5 – 2012 EARNED PREMIUM TRENDS BY MARKET SEGMENT _____	18
TABLE 6 – MEMBER COST SHARING PERCENTAGE BY MARKET SEGMENT _____	21
TABLE 7 – AVERAGE TARGET MEDICAL LOSS RATIOS, CARRIER RATE FILINGS _____	29
TABLE 8 – AVERAGE MEDICAL LOSS RATIOS, ACTUAL EXPERIENCE _____	29
TABLE 9 – AVERAGE TARGET EXPENSE RATIOS, CARRIER RATE FILINGS _____	31
TABLE 10 – AVERAGE EXPENSE RATIOS AND PMPM’S, ACTUAL EXPERIENCE _____	31
TABLE 11 – AVERAGE TARGET PRICING MARGINS, CARRIER RATE FILINGS _____	32
TABLE 12 – AVERAGE PROFIT MARGIN AND PMPM, ACTUAL EXPERIENCE _____	33
TABLE 13 – COMPARISON OF NATIONAL, REGIONAL AND STATE COSTS AND TRENDS _____	35
TABLE 14 – 2012 PREMIUM PMPM’S AND LOSS RATIOS BY MARKET SEGMENT – NEW ENGLAND STATES AND NATIONAL _____	37
TABLE 15 – 2012 OUTPATIENT SURGERY COST BY SITE OF PROCEDURE* _____	42
TABLE 16 – 2012 USE OF AMBULATORY SURGICAL CENTERS FOR OUTPATIENT SURGERY _____	43

## List of Figures

<b>Figure</b>	<b>Page Number</b>
FIGURE 1 – DISTRIBUTION OF NEW HAMPSHIRE HEALTH INSURANCE COVERAGE (2010 – 2011)	9
FIGURE 2 – DISTRIBUTION OF PRIVATE MARKET MEMBERSHIP (2012)	10
FIGURE 3 – FULLY-INSURED MARKET SHARE BY YEAR	11
FIGURE 4 – COMMERCIAL MEMBERSHIP BY PRODUCT, INSURED STATUS AND YEAR	16
FIGURE 5 – FULLY-INSURED SMALL GROUP MEMBERSHIP BY PRODUCT AND YEAR	17
FIGURE 6 – FULLY-INSURED LARGE GROUP MEMBERSHIP BY PRODUCT AND YEAR	17
FIGURE 7 – OBSERVED ALLOWED CLAIM TRENDS	20
FIGURE 8 – OBSERVED UTILIZATION TRENDS	22
FIGURE 9 – OBSERVED COST TRENDS	23
FIGURE 10 – HOSPITAL INPATIENT AND OUTPATIENT COMBINED AVERAGE RATE CHANGES 2012 AND 2013	24
FIGURE 11 – 2012 CLAIMS BY TYPE OF SERVICE	25
FIGURE 12 – OBSERVED TRENDS BY SERVICE CATEGORY	26
FIGURE 13 – AVERAGE MEMBER AGE BY MARKET SEGMENT	27
FIGURE 14 – AVERAGE PRICING TRENDS	28
FIGURE 15 – UNDERWRITING GAIN PERCENTAGE BY CARRIER	34
FIGURE 16 – PERCENTAGE OF MEMBERS IN SITE OF SERVICE BENEFIT DESIGNS AND TIERED NETWORK PRODUCTS BY MARKET SEGMENT AND YEAR	41
FIGURE 17 – NEW HAMPSHIRE INSURED MEMBERSHIP IN RISK ARRANGEMENTS	46

## 1. Executive Summary

In May 2010, New Hampshire passed RSA 420-G:14-a, V-VII (Chapter 240 of the laws of 2010, an act requiring public hearings concerning health insurance cost increases). This law requires the New Hampshire Insurance Commissioner to “hold an annual public hearing concerning premium rates in the health insurance market and the factors, including health care costs and cost trends that have contributed to rate increases during the prior year.” This year’s hearing was held on September 26, 2013. In addition, the law requires the Commissioner to “prepare an annual report concerning premium rates in the health insurance market and the factors that have contributed to rate increases during the prior year.” The Commissioner and the New Hampshire Insurance Department (NHID) have engaged Gorman Actuarial, LLC (GA) to assist them in preparing this third Annual Report.

The key findings from this year’s report are:

- **In 2012, average premiums in New Hampshire’s fully-insured private markets increased 1.1%. The continued movement towards plans with increased member cost sharing prevented additional premium increases of approximately 4 to 6%.**

The average 2012 premium increase was down from the 3.8% premium increase experienced in 2011, while the level of benefit buy-down remained fairly consistent year-over-year.

- **Actual healthcare claims increased 2.7% from 2011 to 2012. Average utilization declined for the third year in a row while cost trends increased slightly.**

Overall claim trends decelerated modestly from 3.3% in 2011 to 2.7% in 2012. Utilization trends continue to be negative, decreasing from -2.1% in 2011 to -3.5% in 2012. Conversely, cost trends have increased to 6.4%, an uptick from 5.6% seen in the previous two years. Therefore, while utilization trends have remained favorable, the offsetting increase in provider reimbursement levels continues to drive increasing claims.

- **In addition to premium costs, members paid on average \$1,001 in out-of-pocket cost sharing in 2012.**

The share of claims paid by members increased from 18.2% in 2011 to 20.1% in 2012 due to increases in benefit plan features such as deductibles and copayments.

➤ **Pricing trends in 2013 and 2014 continue to decline reflecting the more favorable observed claim trends in recent years.**

The 2014 New Hampshire pricing trend of 8.1% is down from 8.7% in 2013 and generally in line with national trend survey results. Pricing trends are one of several components of the resulting premium increase. In addition, there is typically a significant lag between the claims data reflected in premiums and the actual observed experience.

➤ **Carriers priced their 2012 plans such that 82.2% of premiums would go towards coverage of medical claims. Actual claims consumed only 79.5% of premiums.**

Medical loss ratios for two carriers were below the minimum thresholds set by the ACA, resulting in those two carriers paying nearly \$1.2 million in premium rebates to New Hampshire policyholders for 2012.

➤ **Actual administrative expenses increased 4.3% in 2012. This expense trend was down slightly from the 5.6% experienced in the prior year.**

While the trend is down modestly from the prior year, expenses have still increased 10.1% in two years and the percentage of premium going towards expenses has increased from 14.6% to 15.4% in that time.

➤ **Carriers continue to explore various levers to address cost drivers including benefit designs and provider reimbursement strategies.**

One particular strategy, the site of service benefit design, has shown to have a net financial savings when members are provided an incentive to use less costly settings. However, it will take a

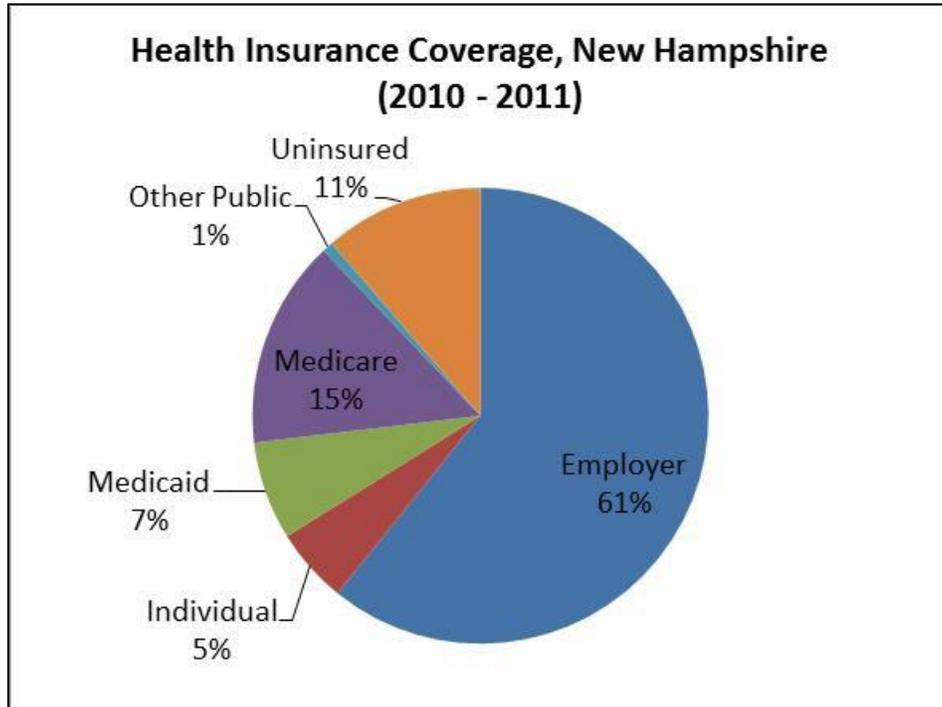
multi-faceted approach, including benefit design, provider reimbursement structures and provider networks to promote transparency and align stakeholder financial incentives with the ultimate goal of significantly impacting long term health care costs.

## **2. Data Sources and Definitions**

A number of data sources were utilized in preparing the report. This includes testimony at the annual public hearing which was conducted on September 26, 2013. In addition, GA utilized existing data and information collected by the NHID along with publicly available information. Finally, GA and the NHID asked carriers in New Hampshire to complete a questionnaire providing details not available from other data sources. This report uses only de-identified or aggregated responses to the questionnaires. Additional details on key data sources and a glossary of key terms can be found in the Appendix at the end of this report. The report contains statements that attempt to provide some prospective context to current or past trends. These statements are based on the understanding of the existing and proposed regulatory environment as of November 30, 2013. If subsequent changes are made, these statements may not appropriately represent the expected future state.

### 3. Overview of New Hampshire Insurance Market

Many different types of health insurance plans are available in New Hampshire. To put the markets in some context, Figure 1 shows the estimated distribution by type of health insurance coverage for all New Hampshire residents during 2010 - 2011<sup>1</sup>, the most recent years for which the data were available.



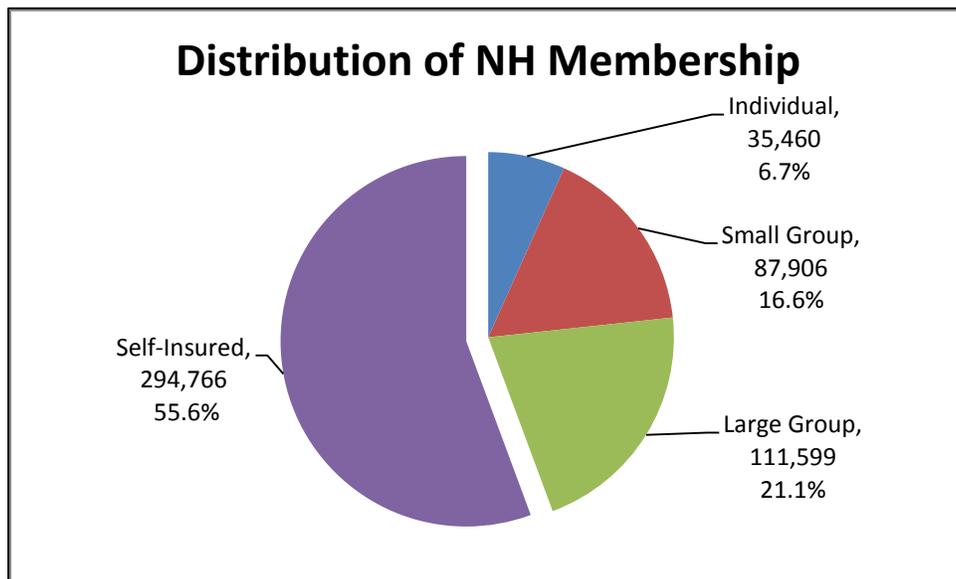
**Figure 1 – Distribution of New Hampshire Health Insurance Coverage (2010 – 2011)**

It is estimated that 11% of New Hampshire residents are uninsured. This is below the national average of 16% and ranks 12<sup>th</sup> lowest out of the 50 states.<sup>2</sup> 23% of the population receives their health coverage through public sources including Medicare and Medicaid. The Medicaid rate of 7% is the lowest of any state, and significantly below the national average of 16%. Roughly two-thirds of the market receives their coverage in the private market, either through individual insurance or employer-sponsored group insurance coverage. The 61% receiving employer-sponsored coverage is the highest of any state in the country, and is well above the national average of 49%.

<sup>1</sup> Kaiser Family Foundation: <http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=39&rgn=31>  
The data is based on an analysis of the Census Bureau's March 2010 and 2011 Current Population Surveys (CPS; Annual Social and Economic Supplements) and are restricted to the civilian (not active duty military) population. The state data represent 2-year averages. In certain segments, the survey data may not be consistent with New Hampshire state reporting.

<sup>2</sup> For residents under age 65 (unlikely to be covered by Medicare), 13% of New Hampshire residents and 18% of residents nationally are estimated to be uninsured.

Figure 2 shows the 2012 distribution of the private health insurance market membership split between self-insured coverage and fully-insured coverage by market segment. Self-insurance is a type of funding arrangement where an employer does not actually pay insurance premiums to a carrier to accept the claims risk. The employer pays only a service fee to a carrier to administer the plan, but then the employer covers the cost of claims directly. These arrangements are common among larger employers. 56% of privately insured members in New Hampshire are covered under a self-insured arrangement. Because these plans do not pay premiums, the primary focus of this report will be on the remaining 44% of privately insured members in the Individual, Small Group, and Large Group fully-insured segments.



**Figure 2 – Distribution of Private Market Membership (2012)<sup>3,4</sup>**

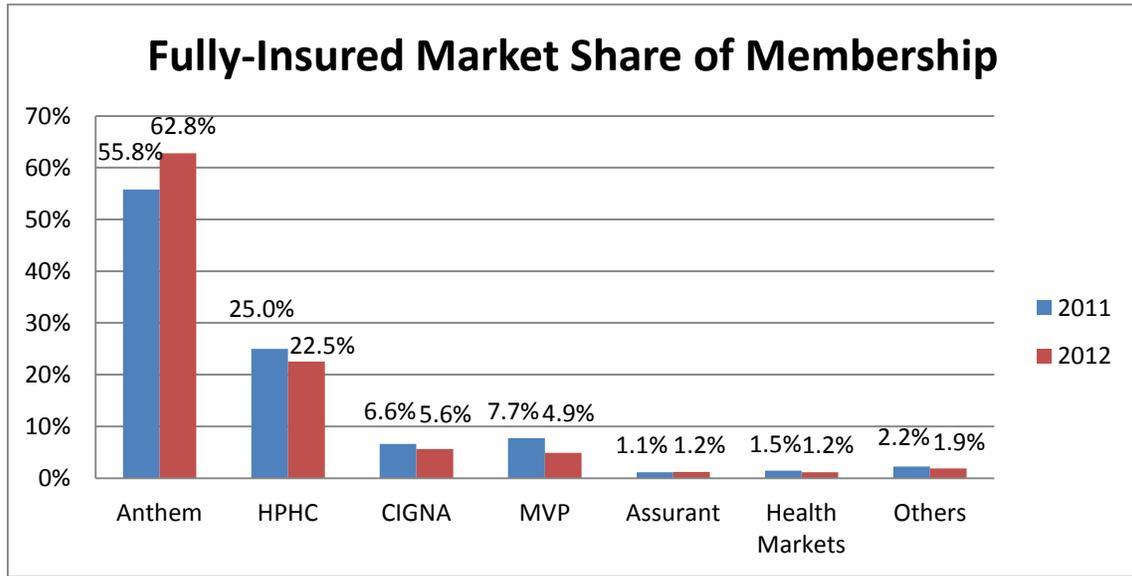
Figure 3 shows each carrier's share of members in the combined fully-insured markets. Anthem, with 63% of the overall share of members, is the largest carrier in each market segment. They are also the only major carrier in the state to increase their share in the last year. Harvard Pilgrim is the second largest carrier with a 23% overall share, and about one-third of the fully-insured Large Group Market. Cigna has just a 6% share of the fully-insured markets, but maintains a substantial market presence in New Hampshire with more than 40% of the self-insured market. MVP's member share declined to 5% of the fully-insured marketplace in 2012, and they have recently announced plans to withdraw from the New Hampshire market.<sup>5</sup> All other carriers have less than 2% of the overall fully-insured market share in New Hampshire.

<sup>3</sup> 2012 NAIC Supplemental Health Care Exhibit filings with the following adjustments:

- Excluded Federal Employee Program, Blue Card host members
- Included Health Plans, Inc. members

<sup>4</sup> The Supplemental Health Care Exhibits include out-of-state residents covered by a New Hampshire based plan, but exclude New Hampshire residents covered by an out-of-state health plan.

<sup>5</sup> <https://swp.mvphealthcare.com/wps/portal/mvp/shared/aboutus/pressreleases> - October 15, 2013 press release - MVP Announces Intention to Concentrate Resources in VT and NY



**Figure 3 – Fully-Insured Market Share by Year<sup>6</sup>**

<sup>6</sup> 2012 Supplemental Health Care Exhibit filings excluding Federal Employee Program members

## 4. Premium Trends - Unadjusted

Similar to last year's report, fully insured premium trends were analyzed on both an unadjusted and benefit-adjusted basis. The unadjusted basis examines earned premium PMPM trends based on information provided by each carrier as displayed in Table 1. These premiums reflect actual average premium rates paid in each market and can be influenced by factors such as the demographic mix of the membership and the changing level of benefits covered under each plan. For example, if an employer group increases their deductible, their relative premium would decrease which would be reflected in the unadjusted premium. Therefore the unadjusted premium trends do not fully reflect the increased cost of insurance borne by the average member including changes in out-of-pocket cost sharing.

Unadjusted Earned Premium PMPM			
	2011	2012	% Change
<b>Individual</b>	\$290.25	\$304.50	4.9%
<b>Small Group</b>	\$420.88	\$431.34	2.5%
<b>Large Group</b>	\$433.41	\$435.47	0.5%
<b>Total Fully-Insured</b>	\$412.53	\$417.10	1.1%

**Table 1 – Unadjusted Earned Premium by Market Segment and Year<sup>7</sup>**

The Individual Market premium PMPM's remain well below the Group Market PMPM's. The Individual Market plans have higher average levels of member cost sharing and the use of health underwriting (which will no longer be permitted for ACA-compliant plans beginning in 2014) leads to a generally healthier risk pool. In 2012, the Individual Market experienced the highest percentage change in unadjusted premium trends at 4.9%, while the Small Group and Large Group Markets experienced trends of 2.5% and 0.5% respectively. In last year's report, the pattern of increases was opposite by market, with the highest premium trends in the Large Group market and lowest increases in the Individual Market. The overall 2012 premium trend across all of the fully-insured markets is 1.1%, down from 3.8% in the prior year.

<sup>7</sup> Source: 2012 and 2013 NHID Carrier Questionnaires

## 5. Benefits and Benefit Buy-Down

When analyzing premium changes and medical trends, it is helpful to understand what portion of the change is due to cost changes from the carrier and what portion of the change is due to a change in benefits purchased. For example, a policyholder could receive a premium increase of 15%. However, this 15% increase could reflect a 20% increase from the carrier, and a 5% decrease because the policyholder purchased benefits which reflect higher cost sharing. “Benefit buy-down” is the process of selecting a plan with reduced benefits or higher member cost-sharing as a way to mitigate premium increases.

Using data provided by carriers for the 2011 and 2012 New Hampshire Supplemental Reports, Gorman Actuarial was able to analyze the change in benefits between these two time periods. Health insurance plan designs can have many different member cost sharing attributes. The Supplemental Report captures data for a subset of key cost sharing attributes including deductibles, coinsurance, office visit copays and member out-of-pocket maximums. Table 2 displays a distribution of membership by deductible level for each of the three fully-insured market segments in CY 2011 and CY 2012. Similar to last year’s analysis, there continues to be movement in each of the market segments toward health plans with higher deductibles. The Large Group markets appear to have experienced the greatest amount of shift towards higher deductibles, where 44% of the Large Group Market had deductibles of \$3,000 or more in 2012 compared to 27% in 2011.

Deductible	Individual		Small Group		Large Group	
	2011	2012	2011	2012	2011	2012
\$0	0.0%	0.4%	1.6%	0.0%	18.2%	4.6%
\$1 - \$499	0.0%	0.0%	0.2%	0.0%	1.8%	1.3%
\$500 - \$999	0.0%	0.8%	2.6%	0.0%	6.1%	4.7%
\$1,000 - \$1,499	35.0%	26.2%	19.0%	14.7%	16.5%	12.4%
\$1,500 - \$2,999	34.3%	31.4%	38.5%	34.2%	30.4%	32.5%
\$3,000 - \$4,999	1.7%	5.2%	30.5%	43.4%	23.2%	37.6%
greater than or equal to \$5,000	29.0%	36.0%	7.6%	7.7%	3.9%	6.8%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

**Table 2 – Member Distribution of Deductible by Market Segment and Year<sup>8,9,10</sup>**

Table 3 shows the average deductible, member coinsurance percentage, office visit copay and member out-of-pocket limit for 2011 and 2012. The average deductible in the Large Group Market increased the most at \$589 while the Individual Market increased \$552,

<sup>8</sup> Source: NH Supplemental Report Data. Excludes plans with no cost sharing.

<sup>9</sup> The Supplement Report Data has a limited number of cost sharing and plan attributes. This information is limited to the highest individual in-network deductible, the highest in-network member coinsurance percentage, the highest in-network office visit copay and the maximum member out-of-pocket limit for in-network services.

<sup>10</sup> The data from the NH Supplemental Survey was limited to a subset of carriers in 2012 while the data used in the 2011 report included all market participants. The 2011 data in this report has been updated to reflect a similar subset of carriers compared to 2012 in order to be consistent across years reported.

followed by a much smaller increase in the Small Group Market of \$233. The Individual Market continues to have the largest average deductible levels and average out-of-pocket maximums compared to the other market segments.

	Individual		Small Group		Large Group	
	2011	2012	2011	2012	2011	2012
<b>Average Deductible</b>	\$2,639	\$3,191	\$2,355	\$2,588	\$1,750	\$2,338
<b>Average Coinsurance</b>	10.9%	9.4%	2.5%	2.5%	\$0	\$0
<b>Average Copay</b>	\$12	\$12	\$23	\$24	\$23	\$25
<b>Average OOP Maximum</b>	\$3,744	\$4,157	\$2,845	\$3,127	\$2,649	\$3,098

**Table 3 – Cost Sharing Attributes by Market Segment and Year<sup>11,12</sup>**

Based on the information submitted in the Supplemental Report, approximately 39% of the Individual Market members are in grandfathered plans as of 2012 compared to only 2% in the Small Group Market. In 2014, the highest deductible levels in the Individual New Hampshire Marketplace (the new state healthcare exchange) will be \$5,750.<sup>13,14</sup> Approximately 18% of non-grandfathered Individual members are in plans with deductibles greater than \$5,750 in 2012 and may need to choose plans with lower deductibles in 2014.

There are different ways to calculate benefit buy-down. One method is to calculate the change in actuarial value between two time periods. Actuarial value is defined in simple terms as the share of total medical costs covered by the health plan for a standard population.<sup>15</sup> The higher the actuarial value, the more comprehensive, or the richer, the benefit plan design. The lower the actuarial value, the more the average member generally pays for benefits through member cost sharing. For the same benefit plan design, there can be significant variation in estimated actuarial value due to differences in the assumptions used.

Gorman Actuarial relied on several methodologies to review benefit buy-down in this year's report. Similar to last year, we calculated actuarial values using GA's internal

<sup>11</sup> Source: NH Supplemental Report Data. Excludes plans with no cost sharing. Average out-of-pocket maximum also excludes plans with no out-of-pocket maximum. The 2011 data from this year's report was updated to reflect not match to last year's report because a smaller subset of carriers was available in the 2012 data

<sup>12</sup> The data from the NH Supplemental Survey was limited to a subset of carriers in 2012 while the data for 2011 included all market participants. The 2011 data in this table has been updated to reflect a similar subset of carriers compared to 2012 in order to be consistent across years reported.

<sup>13</sup> [http://www.nh.gov/insurance/consumers/documents/nh\\_mktpic\\_indvplns.pdf](http://www.nh.gov/insurance/consumers/documents/nh_mktpic_indvplns.pdf).

<sup>14</sup> This is based on the Bronze metal level and does not include catastrophic plans.

<sup>15</sup> In the New Hampshire Supplemental Reporting Bulletin "actuarial value" is defined as a factor representative of the relative value of the benefits being reported against a standardized set of benefits. The standardized set of benefits is defined as the four plans that ceding carriers must use to adjudicate claims for purposes of the reinsurance pool. See the 2012 NH Supplemental Reporting Bulletin:

[http://www.nh.gov/insurance/media/bulletins/2012/documents/sup\\_rept\\_bull-2012.pdf](http://www.nh.gov/insurance/media/bulletins/2012/documents/sup_rept_bull-2012.pdf)

Note that this definition of actuarial value is different than what is used in this report. Instead of comparing to a standardized set of benefits, the actuarial values are calculated relative to a plan with no cost sharing.

pricing model and the limited cost sharing attributes from the NH Supplemental Report Data. Gorman Actuarial also reviewed the actuarial values reported by each carrier in the NH Supplemental Report Data,<sup>16</sup> and the change in the percentage of member cost sharing reported by carriers in the 2013 Carrier Questionnaire. The results of these analyses generated a range of benefit buy-down estimates for each market segment in 2011 and 2012.<sup>17</sup> Table 4 displays a range of estimated premium reductions due to benefit buy-down in 2011 and 2012 for each fully-insured market segment based on the results of these methodologies. Across the entire fully-insured market in 2012, the estimated range of premium reductions due to benefit buy-down is 4 to 6%, which is consistent with the range buy-down experienced in 2011. In 2012 the Large Group Market experienced the largest benefit buy-down impact, in the range of 5 to 7%. This elevated level of buy-down is consistent with the increase in deductibles and the lower unadjusted premium increase noted above. The level of benefit buy-down in the Individual Market has increased approximately two percentage points from 2011 to 2012, while the level of buy-down in the Small Group Market has declined by a similar amount.

	<b>2011 Benefit Buy-Down Range</b>	<b>2012 Benefit Buy-Down Range</b>
<b>Individual</b>	2% to 4%	4% to 6%
<b>Small Group</b>	5% to 7%	3% to 5%
<b>Large Group</b>	3% to 5%	5% to 7%
<b>Total</b>	4% to 6%	4% to 6%

**Table 4 – Benefit Buy-Down by Market Segment**

The U. S. Department of Health and Human Services (HHS) released a federal actuarial value calculator in February 2013.<sup>18</sup> The goal of the calculator is to determine the metallic tier actuarial value for products offered in the Individual and Small Group Markets. While this tool provides a standardized method for calculating actuarial values, given its specific purpose and the assumptions and data used in the calculator, it may not be appropriate for other uses. The NHID and New Hampshire carriers should continue to explore the use of the federal actuarial value calculator or other tools for the purpose of standardizing actuarial values in the future.

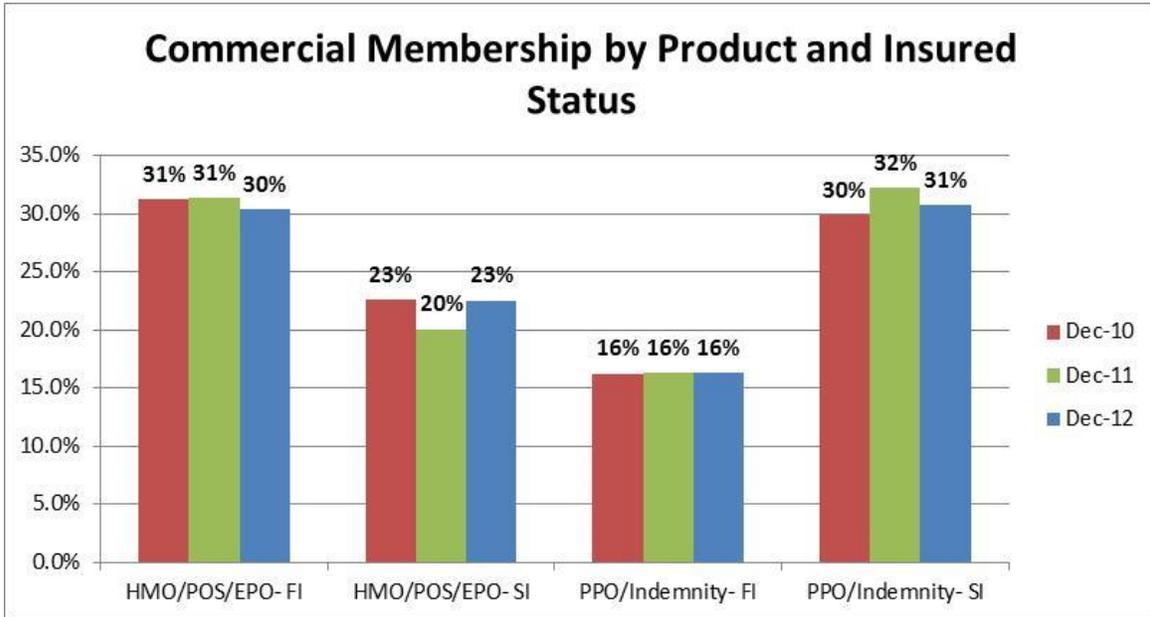
While benefit buy-down has continued to impact premium trends in New Hampshire, the product offerings in New Hampshire have remained fairly stable over the past three years. Figure 4 displays the percentage of New Hampshire private market membership by product and insured status for year ending December 2010, 2011 and 2012. This includes all market segments. Many have suggested that there will be significant shifts to

<sup>16</sup> Ibid.

<sup>17</sup> There are limitations in each of the methodologies employed to calculate benefit buy-down. In addition, the data from the NH Supplemental Survey was limited to a subset of carriers in 2012 while the data for 2011 included all market participants. Thus a range of benefit buy-down is shown for 2012 and 2011.

<sup>18</sup> <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/av-calculator-final.xlsx>

the self-insured market as a way for employers to avoid some of the requirements of the ACA. However, the data do not indicate that this trend has begun in New Hampshire. It will be interesting to track this information in the future, especially when the 51 to 100 Market is defined as the Small Group market in 2016 and beyond. The proportion of the combined PPO and Indemnity population has decreased slightly from 48% to 47%.<sup>19</sup>



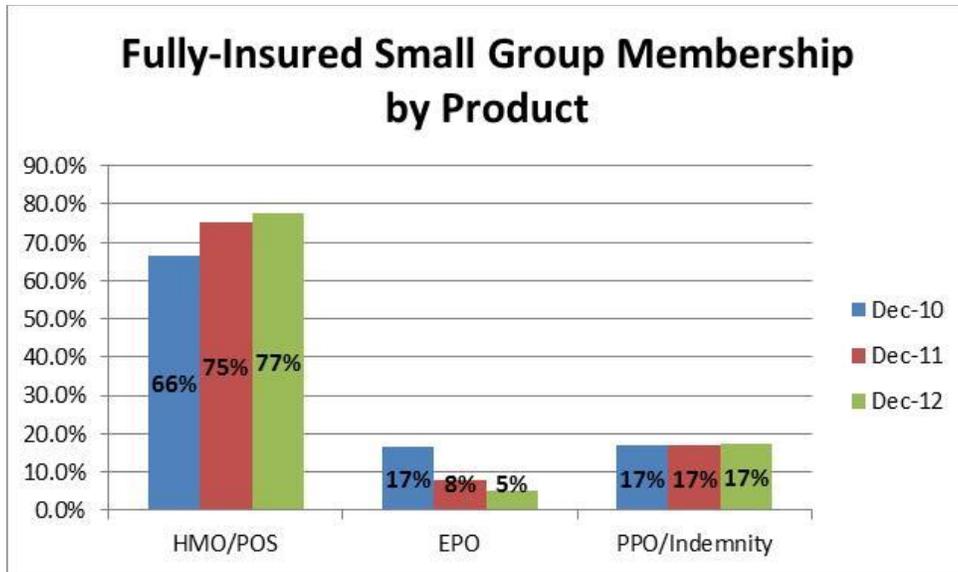
**Figure 4 – Commercial Membership by Product, Insured Status and Year<sup>20, 21</sup>**

Within the fully-insured Small Group and Large Group Markets, there have been some shifts among products. Figure 5 shows that in the Small Group Market the proportion of members in HMO/POS products increased steadily over the past three years, offset by a decrease in EPO (exclusive provider organization). Figure 6 shows that Large Group Market membership in HMO/POS products increased in 2011 but has remained very stable in 2012.

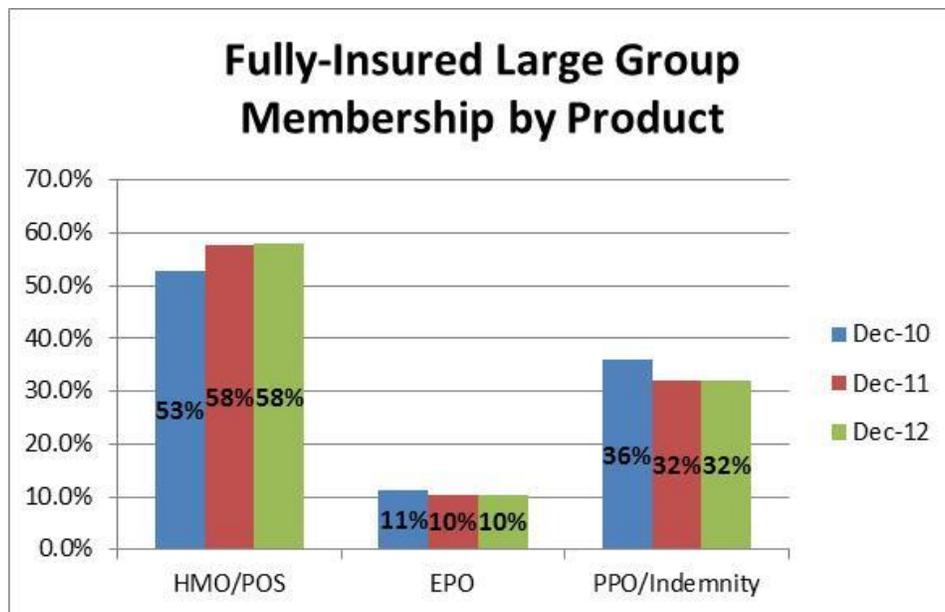
<sup>19</sup> The 2011 and 2010 data are based on information from the 2013 Carrier Questionnaire and may differ slightly from the information presented in last year’s report.

<sup>20</sup> Source: 2013 Carrier Questionnaire

<sup>21</sup> The data source for this figure in last year’s report was the 2011 and 2010 Supplemental Report Data.



**Figure 5 – Fully-Insured Small Group Membership by Product and Year<sup>22, 23</sup>**



**Figure 6 – Fully-Insured Large Group Membership by Product and Year<sup>24, 25</sup>**

<sup>22</sup> Source: 2013 Carrier Questionnaire

<sup>23</sup> The data source for this figure in last year’s report was the 2011 and 2010 Supplemental Report Data.

<sup>24</sup> Source: 2013 Carrier Questionnaire

<sup>25</sup> The data source for this figure in last year’s report was the 2011 and 2010 Supplemental Report Data.

## 6. Premium Trends - Adjusted

There are several key drivers of the unadjusted premium trend. One is the impact of benefit changes on premium trends. As consumers buy down to benefit plans with higher out-of-pocket cost sharing, the premiums do not increase as rapidly as they would have if the benefits had not been reduced. Using the benefit buy-down ranges calculated in Section 5, we can recalculate each market's estimated premium trends to demonstrate the trends after adjusting for benefit changes. This is referred to as benefit-adjusted premium trends. Table 5 shows the unadjusted and benefit-adjusted premium trends for each market segment in 2011. In each market, because of the impact of benefit buy-down, the adjusted trends are higher than the unadjusted trends. For example, if small employers did not change their current benefit levels, in 2012 the Small Group Market would have experienced average premium increases in the range of 6% to 8% (benefit-adjusted premium trend). However, since small employers did "buy-down" in 2012, the actual premium increase experienced in 2011 was 2.5% (unadjusted premium trend). On a benefit-adjusted basis, overall premiums in the fully-insured market increased 5% to 7% in 2012 compared to an unadjusted premium trend of 1.1%. In 2011, the unadjusted overall premium trend in the fully-insured market was 3.8% and the unadjusted premium trend was 8% to 10%. In 2012, the highest premium trends on both an unadjusted and adjusted basis were in the Individual Market, while in 2011, the Individual Market had the lowest unadjusted and adjusted premium trends.

<b>Earned Premium PMPM Trends</b>		
	<b>Unadjusted</b>	<b>Adjusted</b>
<b>Individual</b>	4.9%	9% to 11%
<b>Small Group</b>	2.5%	6% to 8%
<b>Large Group</b>	0.5%	6% to 8%
<b>Total Fully-Insured</b>	1.1%	5% to 7%

**Table 5 – 2012 Earned Premium Trends by Market Segment<sup>26</sup>**

<sup>26</sup> Unadjusted premium trends represent actual premium trends as reported by the carrier. Benefit-adjusted premium trends are calculated to reflect the premium trends assuming no benefit changes.

## 7. Components of Premium

### 7.1. Introduction

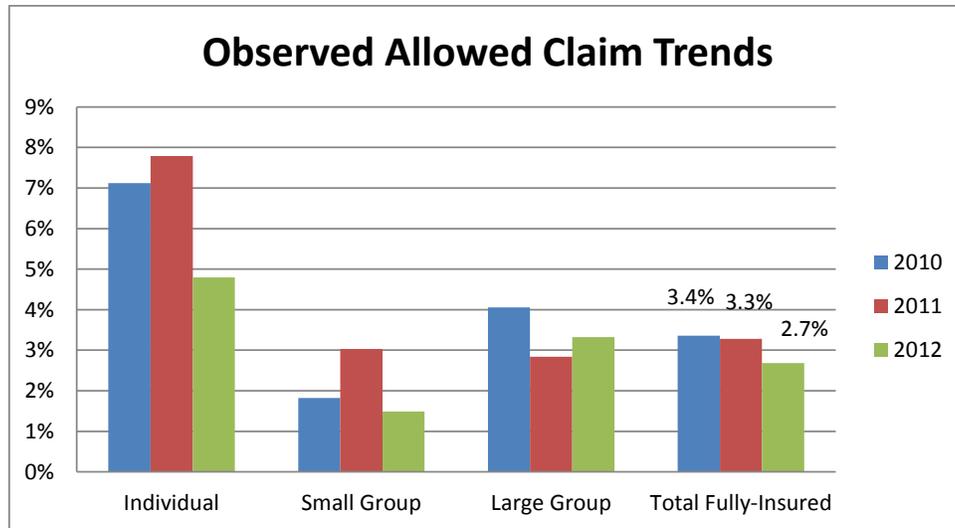
This section explores the trends and drivers of each component of premium – claims, expenses and profits – in terms of how they impacted 2012 premium rate levels and actual 2012 results. It is important to remember that carriers must file premium rates several months in advance of the beginning of the period for which the rates are effective. This can lead to some lag between pricing assumptions, which are heavily influenced by past experience, and actual results seen in the projected period for which the premium rates are effective.

### 7.2. Medical Claims

Medical expenses, or claims, are the largest contributor to health insurance premiums, and the increase in claim costs has been the largest driver of the increase in premiums over time. Figure 7 shows the annual allowed claim trends by market segment. Allowed claims are the sum of the claim amounts paid by the carriers and the payments paid by the members through cost-sharing, such as deductibles and copayments. Across all fully-insured markets in 2012, the average allowed claim trends were down slightly to 2.7%. Decreases in the Individual and Small Group Markets are partially offset by a modest increase in the Large Group Market. Overall these New Hampshire trends are below trends seen nationally in the Segal Health Plan Cost Trend Survey.<sup>27</sup> However, the year-over-year pattern of the results in New Hampshire are consistent with those seen on a national basis where 2012 national medical trends were down slightly on both HMO and PPO products and at or near the lowest levels seen in the history of the survey dating back to 2002. Section 8 of this report has additional regional and national trend comparisons.

<sup>27</sup> <http://www.sibson.com/publications/surveysandstudies/2014trendsurvey.pdf>

Table 4: Selected Medical, Rx Carve Out and Dental Trends: 2002 – 2012 Actual and 2013-2014 Projected



**Figure 7 – Observed Allowed Claim Trends<sup>28</sup>**

While allowed trends have remained relatively stable overall in the last couple years, the share of claims covered by members through out-of-pocket cost sharing continues to increase due to benefit buy-down. Table 6 shows the percentage of allowed claims paid for by members out-of-pocket. Overall the member cost sharing percentage increased from 18.2% in 2011 to 20.1% in 2012. That level of cost sharing equates to average annual out-of-pocket spending of \$1,001 per member in 2012 above and beyond the premium cost, an increase of \$95 per member compared to 2011. The Health Care Cost Institute (HCCI) reported national average annual cost sharing in 2012 of \$768 per member, which was 16.3% of allowed claims.<sup>29</sup> Consistent with lower premiums and benefit levels, the New Hampshire Individual Market has the highest cost sharing at 30.0% of claims in 2012. The pattern of the change in the cost sharing by market segment shown below is opposite of the changes seen in the premiums in Table 1, and reflects the consumer trade-off between higher up-front premiums or higher member cost sharing. Where the Large Group Market had the lowest average premium increase, that market has the largest increase in member cost sharing. The Individual Market had the highest increase in average premiums, but a much more modest increase in cost sharing percentage.

<sup>28</sup> 2013 Carrier Questionnaire – weighted average by allowed claim amounts in the corresponding year.

<sup>29</sup> <http://www.healthcostinstitute.org/files/2012report.pdf> - HCCI 2012 Health Care Cost and Utilization Report. Their report analyzed employer-sponsored insurance and members under age 65 only. In New Hampshire, the average cost sharing in Group markets only was \$992, marginally different than the \$1,001 average for all fully-insured markets.

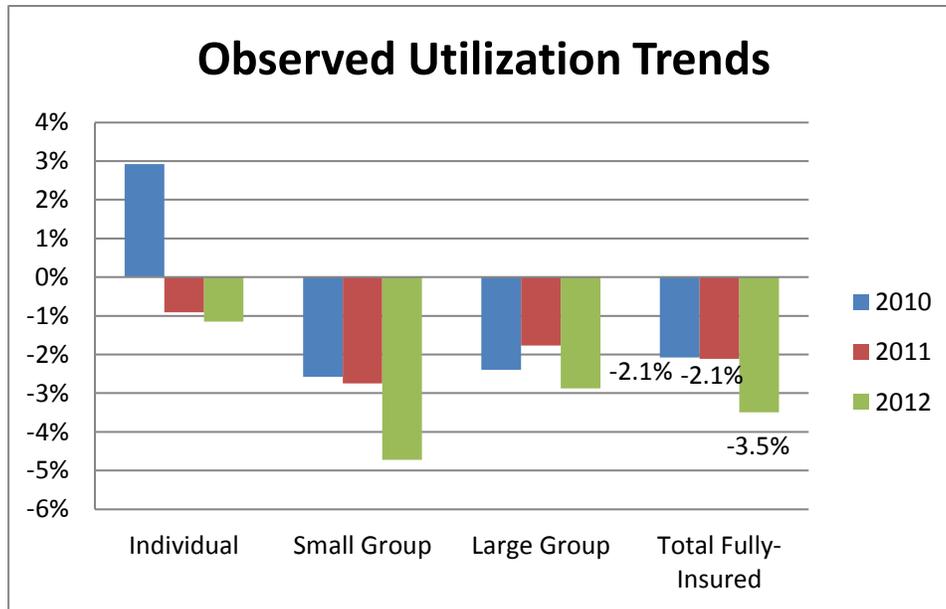
<b>Member Cost Sharing Percentage by Market Segment</b>			
	<b>2011</b>	<b>2012</b>	<b>Change</b>
<b>Individual</b>	29.6%	30.0%	0.4%
<b>Small Group</b>	21.2%	22.3%	1.1%
<b>Large Group</b>	13.7%	16.3%	2.6%
<b>Total Fully-Insured</b>	18.2%	20.1%	1.9%

**Table 6 – Member Cost Sharing Percentage by Market Segment<sup>30</sup>**

Claim trends can be separated into two distinct categories: Utilization and Cost. Utilization is simply the number of services provided (e.g. admissions to a hospital, visits to a specialist, prescriptions filled). Cost trends are a combination of the change in unit price of specific services, the change in claim severity of the total basket of services provided, and the change in mix of providers being used. Claim severity is often driven by the availability of new treatments or technology that contributes to an overall change in claim costs. A typical example of an increase in claim severity is when a patient receives an MRI rather than an X-ray to diagnose an injury. The utilization of services may still be one service and the unit price of an X-ray and the unit price of an MRI may not have changed. However the overall cost of claims has increased because the patient received a more expensive service.

Figure 8 and Figure 9 isolate the utilization and the cost components of the allowed trends. With negative trends the last three years, utilization has been the major driver of the overall deceleration in claim trends in recent years. Across all markets, 2012 utilization trends were -3.5% with further favorable development in every market segment compared to prior year.

<sup>30</sup> 2013 Carrier Questionnaire

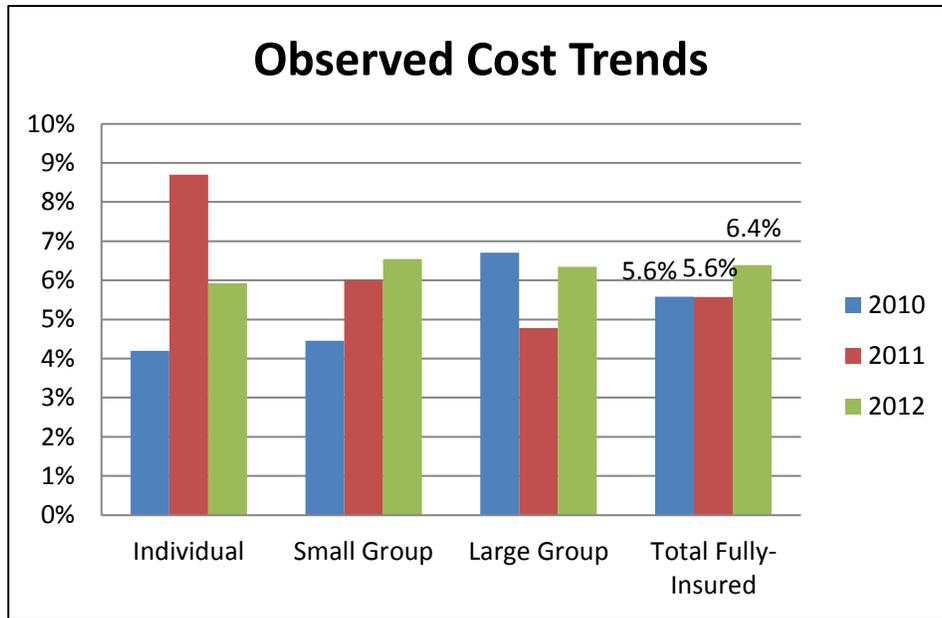


**Figure 8 – Observed Utilization Trends<sup>31</sup>**

While utilization trends remain favorable, the offsetting increase in provider reimbursement levels continue to drive premium increases overall. Figure 9 shows the 2012 cost trends across all fully-insured markets at 6.4%, slightly higher than the 5.6% trend experienced in the two prior years. The cost trends by market segment, which have shown more volatility in previous years, have coalesced in the 5.9% to 6.5% range for 2012. The average negotiated provider contract rates increased consistently between 4% and 5% over the last three years.<sup>32</sup> The remaining 1% to 2% of the overall cost trends appear to have been driven by the mix of providers and the severity of services. That means that over the past few years, members have been utilizing more expensive providers and more expensive services adding 1% to 2% to overall medical expenditures.

<sup>31</sup> 2013 Carrier Questionnaire – weighted average by allowed claim amounts in the corresponding year.

<sup>32</sup> 2012 and 2013 Carrier Questionnaire - weighted average by allowed claim amounts in the corresponding year



**Figure 9 – Observed Cost Trends<sup>33</sup>**

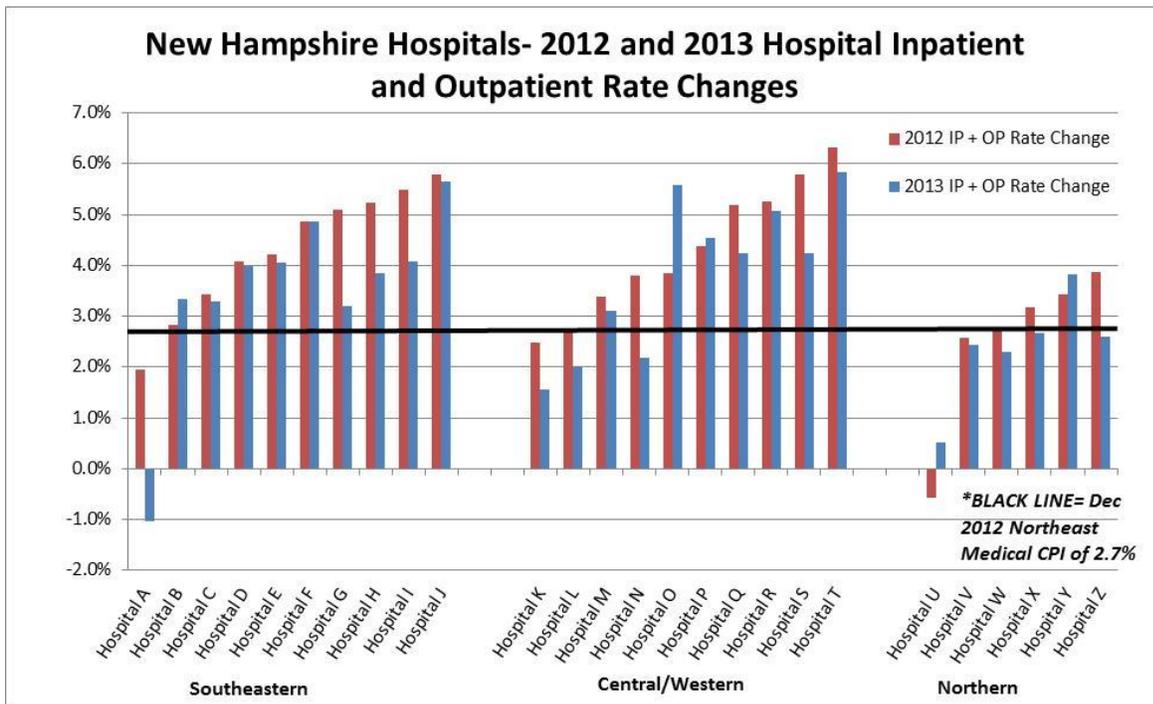
The variation of hospital payment rates and the level of rate changes over time continue to be areas of concern in regards to future health care cost trends. As cited in last year's report, there were several studies commissioned by the NHID related to understanding the variation in prices paid to hospitals including the "Analysis of Price Variations in New Hampshire's Hospitals" by the University of Massachusetts Medical School (UMMS)<sup>34</sup> and "The Costs of NH's Health Care System: Hospital Prices, Market Structure, and Cost Shifting" by the New Hampshire Center for Public Policy Studies (NHCPPS)<sup>35</sup>. The study by the UMMS concludes that there is wide variation in commercial prices paid to New Hampshire hospitals even after adjusting for case mix while the NHCPPS report states that New Hampshire's hospital prices demonstrate significant variation that is not necessarily explained by patient morbidity, quality of care, or payer mix. Data in the NHCPPS report from 2009 shows that the lowest paid hospital for inpatient services was paid 31% below the state average while the highest paid hospital for inpatient services was paid 29% more than the average. The differences are even wider for outpatient hospital services, where the lowest paid hospital for outpatient services was paid 32% below the state average while the highest paid hospital for outpatient services was paid 65% more than the average. The NHCPPS report also demonstrates that based on hospital price data from 2005 to 2009, high cost hospitals generally tend to hold their position as high costs hospitals over time while low cost hospitals tend to remain low cost hospitals over time.

<sup>33</sup> 2013 Carrier Questionnaire – weighted average by allowed claim amounts in the corresponding year

<sup>34</sup> <http://www.nh.gov/insurance/lah/documents/umms.pdf>

<sup>35</sup> <http://www.nh.gov/insurance/reports/documents/nhcpps.pdf>

In addition to these analyses on historic provider payment rate relativities, carriers provided their 2012 and 2013 projected inpatient and outpatient hospital unit cost changes by facility. Figure 10 displays the combined inpatient and outpatient unit cost changes by facility across all reporting carriers for both the 2012 (in red) and the 2013 (in blue). The single dark black line represents the 2012 Northeast Medical Consumer Price Index (CPI) of 2.7%.<sup>36</sup> The vast majority of hospitals (21 out of 26) have unit price changes above Northeast Medical CPI and nearly half of all these facilities had average unit cost increases above 4% in 2012. Looking beyond just one year, 17 out of 26 hospitals received average unit price increases above 2.7% in both 2012 and 2013. This includes every hospital except one in the Southeastern region, and most hospitals in the Central/Western region.



**Figure 10 – Hospital Inpatient and Outpatient Combined Average Rate Changes 2012 and 2013<sup>37</sup>**

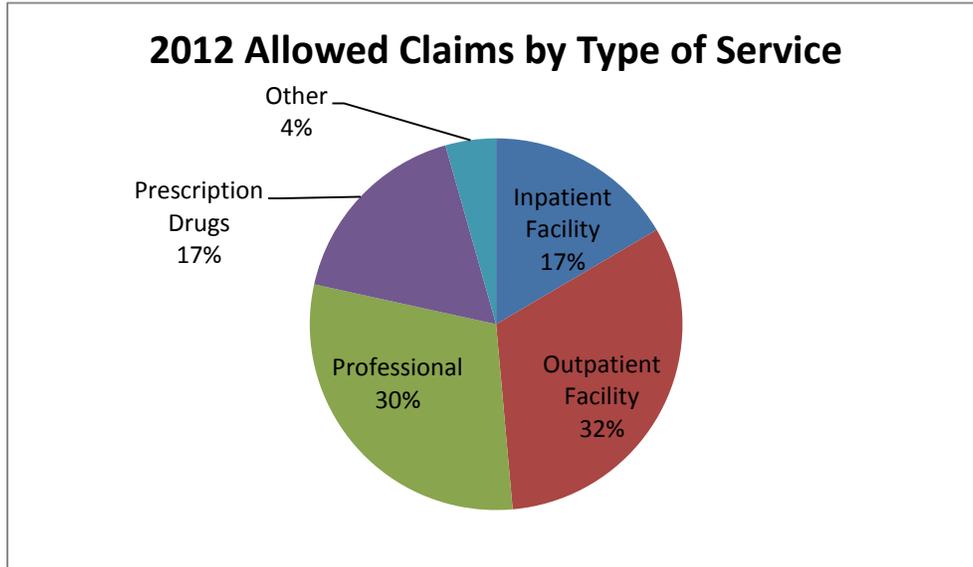
Claim payments can also be segmented by the type of service that is being covered. Figure 11 shows the distribution of 2012 allowed claim payments across all fully-insured markets by the various types of service. Slightly less than half of all claims were paid to a facility such as a hospital or ambulatory surgical center to cover

<sup>36</sup> <http://www.bls.gov/cpi/cpid1212.pdf>

The Northeast is defined as Connecticut, Maine, Massachusetts, New Hampshire, New York, New Jersey, Pennsylvania, Rhode Island and Vermont. The CPI for Medical Care is based on both medical care services (professional services, hospital and related services and health insurance) and medical care commodities (medicinal drugs, medical equipment and supplies.) For more information on how Medical CPI is calculated, see <http://www.bls.gov/cpi/cpifact4.htm>.

<sup>37</sup> 2013 Carrier Questionnaire – weighted average across all reporting carriers.

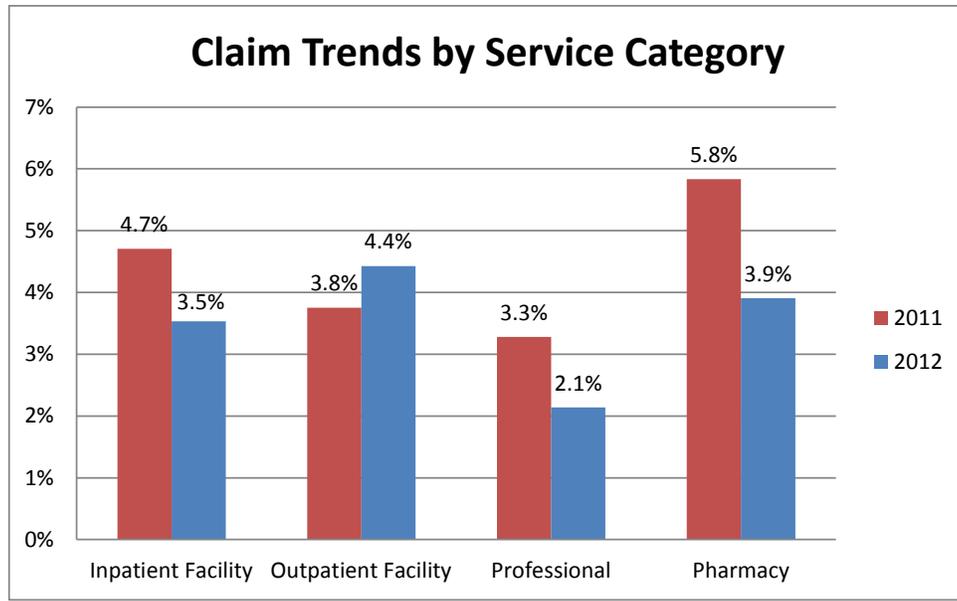
inpatient or outpatient care. Professional care such as office visits to a physician or therapist accounted for 30% of total claims, while prescription drugs represented 17% of payments. The remaining 4% of claims consists of other payments that don't easily fit into the four primary categories, such as durable medical equipment like wheelchairs, and non-fee-for-service payments, such as capitation payments and quality incentives.



**Figure 11 – 2012 Claims by Type of Service<sup>38</sup>**

Figure 12 presents the observed allowed claim trends by the four major types of service categories across all fully-insured markets. All service categories experienced a decrease in trends in 2012 compared to 2011 except Outpatient Facility, which is also the largest segment of claims.

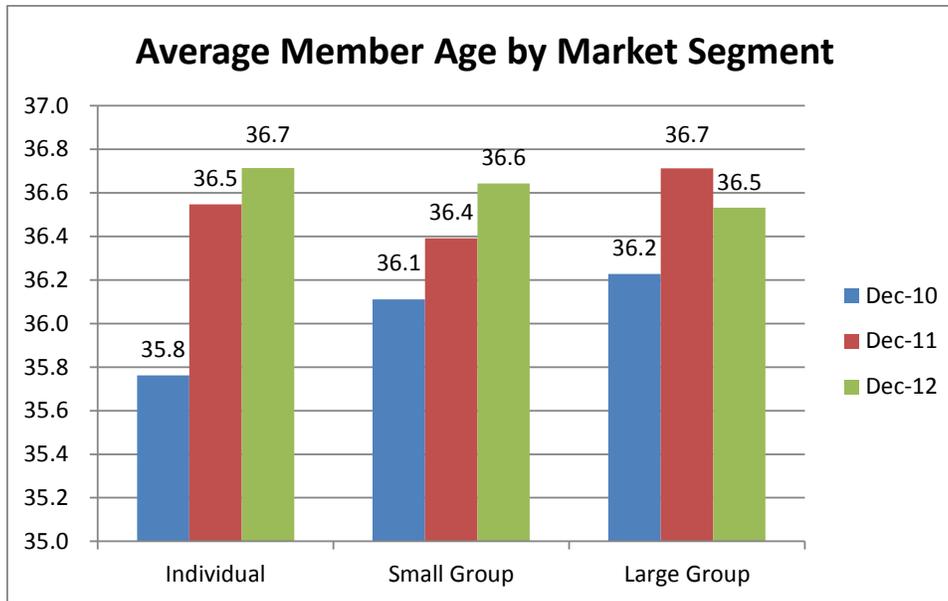
<sup>38</sup> 2013 Carrier Questionnaire



**Figure 12 – Observed Trends by Service Category<sup>39</sup>**

Age is an important factor used in the rating process, so isolating age demographics can be insightful in understanding claim trends over time. Figure 13 shows average member age across each market segment as of December in 2010, 2011 and 2012. As of December 2012, the average age of each of the market segments is in a rather tight range of 36.5 to 36.7. While the age demographics across markets are similar in 2012, the change over the past two years is generally consistent with the allowed claim trend patterns observed during that time. The Individual Market showed significantly greater aging between 2010 and 2011, and claims trends were higher in that Market over those periods. As aging has leveled off in the Individual Market, claims trends have come more in line with those observed in the Group Markets.

<sup>39</sup> 2013 Carrier Questionnaire – weighted average by allowed claim amounts. The total Fully-Insured trend for the “Other” service category was -0.9%.



**Figure 13 – Average Member Age by Market Segment<sup>40</sup>**

### 7.3. Pricing Trends

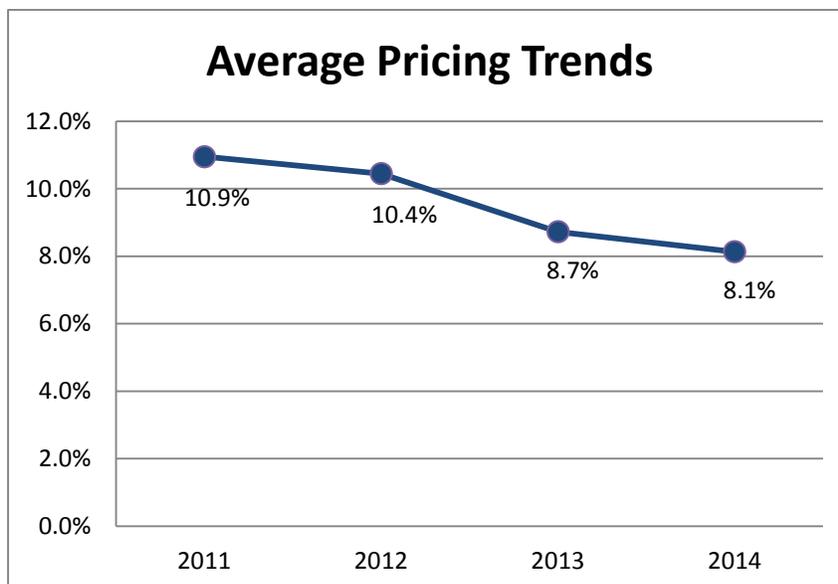
In the introduction to Section 7, we noted that there can be some disconnect between historical trends and the trend assumptions used in pricing. Section 7.2 focused on observed historical claim trends. In Section 7.3, we will examine the assumed claim trends used in pricing for the past couple years.

Figure 14 shows average pricing trends in New Hampshire across all fully-insured markets from 2011 through 2014. Figure 7 showed fairly consistent observed claim trends from 3.4% in 2010 down to 2.7% in 2012. As this experience has emerged, pricing trends have declined in each of the most recent pricing periods. Although observed utilization trends have emerged at negative levels over the past few years, carriers in New Hampshire have not assumed ongoing utilization decreases in their pricing. This approach is consistent with national surveys of carrier pricing trends. The 2014 Segal Health Plan Cost Trend Survey<sup>41</sup> reported average projected 2014 trends of 7.0% to 8.0% in total, including assumed utilization increases of 2.2% to 2.3% on non-pharmacy claims. Overall the average 2014 pricing trend in New Hampshire of 8.1% is consistent with the upper end of this national trend survey.

<sup>40</sup> 2013 Carrier Questionnaire

<sup>41</sup> <http://www.sibson.com/publications/surveysandstudies/2014trendsurvey.pdf>

Table 1 - 2014 Projected Medical (Actives and Retirees < age 65) with Pharmacy excluding FFS / Indemnity plan, Table 2 – Components of 2013 and 2014 Projected Trends for Hospital Services and Physician Services



**Figure 14 – Average Pricing Trends<sup>42</sup>**

## 7.4. Medical Loss Ratios

In health insurance, the medical loss ratio is a measure of the percentage of each premium dollar used to pay for medical expenses. The remainder of each premium dollar is available to cover administrative expenses and contribute to profit margins or surplus. Carriers establish target loss ratio assumptions during their pricing process. Given the rates filed, this is the expected portion of premium dollars needed to pay projected claims. Table 7 shows the average target loss ratios by market segment in 2011 and 2012. The 2012 target medical loss ratio was 82.6%. Therefore, on average, carriers expected 17.4% of the premium rate to cover administrative expenses and to contribute to profits. The Group segments showed relatively minor decreases in their target loss ratios. The Individual Market target loss ratio dropped from 70.0% to 68.0%, driving the overall average fully-insured target down by 0.5 percentage points compared to 2011. In subsequent sections, we will explore expenses and margin in more detail.

<sup>42</sup> Average pricing trends are based on Carrier Questionnaire responses in 2012 and 2013. Carrier responses by market segment were weighted by paid claim amounts in 2012.

<b>Medical Loss Ratios in Rating Assumptions by Market Segment</b>			
	<b>2011</b>	<b>2012</b>	<b>Change</b>
<b>Individual</b>	70.0%	68.0%	-2.0%
<b>Small Group</b>	82.9%	82.8%	-0.1%
<b>Large Group</b>	84.9%	84.5%	-0.4%
<b>Total Fully-Insured</b>	83.1%	82.6%	-0.5%

**Table 7 – Average Target Medical Loss Ratios, Carrier Rate Filings<sup>43</sup>**

Table 8 shows the average actual medical loss ratios by market segment. These ratios represent a rather simple calculation of claims divided by premium, consistent with the targets shown in Table 7. The average experienced loss ratio across all fully-insured markets declined from 82.2% to 79.5%, which represents the second straight year with a drop of roughly three percentage points in total. The average medical loss ratios in all markets declined, led by a 3.3 percentage point drop in the Large Group Market. This was driven primarily by the lower than expected observed claim trends in 2012 compared to pricing trend assumptions.

<b>Actual Medical Loss Ratios by Market Segment</b>			
	<b>2011</b>	<b>2012</b>	<b>Change</b>
<b>Individual</b>	66.0%	65.0%	-1.0%
<b>Small Group</b>	82.0%	80.3%	-1.7%
<b>Large Group</b>	84.8%	81.5%	-3.3%
<b>Total Fully-Insured</b>	82.2%	79.5%	-2.7%

**Table 8 – Average Medical Loss Ratios, Actual Experience<sup>44</sup>**

The Affordable Care Act (ACA) established Minimum Medical Loss Ratio (MLR) standards on a nationwide basis starting in 2011. The national minimum medical loss ratios are 80% in the Individual and Small Group (2 – 50 eligible lives) markets, and 85% in the Large Group (greater than 50 eligible lives) market. The medical loss ratio formula used in determining whether a carrier satisfied the minimum requirements is a more complex calculation process than those shown above in Table 7 and Table 8. The ACA allows for a number of technical adjustments to both the premium revenue (i.e. subtracting state and federal taxes, assessments and fees) and claim costs (i.e. adding administrative expenses used to improve health care quality) and also for credibility where carriers have low market membership.

Carriers that experience medical loss ratios below the standards are required to provide premium rebates to policyholders for the amounts below the minimum threshold. To prevent significant disruptions in the Individual Market, at the request

<sup>43</sup> 2012 & 2013 Carrier Questionnaire: weighted average by market membership

<sup>44</sup> 2013 Carrier Questionnaire

of the New Hampshire Insurance Department, the Department of Health and Human Services (HHS) granted a waiver for the New Hampshire Individual Market allowing the loss ratio standard to grade up from 72% in 2011 to 75% in 2012 to 80% for 2013 and beyond.<sup>45</sup> Although the ACA MLR calculation includes technical adjustments not included in the target loss ratios shown in Table 7, it is still surprising to see the target loss ratio for the Individual Market declining by two percentage points in Table 7 at a time when minimum loss ratio standards are increasing in that market segment by three percentage points.

Based on 2012 experience, most New Hampshire carriers were compliant with the minimum loss ratio standards. Of the \$504 million in rebates payable nationwide, \$1.17 million was payable based on carrier experience in New Hampshire.<sup>46</sup> While still just 0.2% of national rebates, this represents a sizeable increase from the \$79,000 in rebates paid based on 2011 experience. In the Large Group Market, Cigna must pay total premium rebates of \$673,453 to 13,004 members (\$52 per member or approximately 0.9% of premiums). In the Individual Market, Time Insurance Company (a subsidiary of Assurant) must pay premium rebates of \$497,882 to 2,404 members (\$207 per member or approximately 6.3% of premiums).<sup>47</sup>

## 7.5. Administrative Expenses

As indicated above, carriers filed premium rates in 2012 expecting 17.4% of the premium to pay for administrative expenses and to contribute to profit margins. The administrative expense premium charge is generally developed by analyzing actual carrier administrative expenses. Carriers incur administrative costs from a variety of sources such as employee compensation, vendor costs for health management programs, broker commissions and other marketing costs, maintenance of real estate and technology assets, and federal and state assessments and taxes. Just as claims are viewed relative to premium in the medical loss ratio, the administrative expense ratio is defined as administrative expenses divided by premium.

Table 9 shows the average administrative expense ratios assumed in rate filings by market segment. The overall expense ratio across the fully-insured markets increased modestly from 14.1% in 2011 to 14.4% in 2012. Therefore, on average, carriers charged 14.4% of the premium rate for administrative expenses in 2012. The modest overall increase was driven by the Group Markets while the Individual Market expense target declined. It is typical to see lower expense ratios in the Large

<sup>45</sup> [http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/nh\\_mlr\\_adj\\_declearter.pdf](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/nh_mlr_adj_declearter.pdf)

<sup>46</sup> <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2012-mlr-rebates-by-state-and-market.pdf>

<sup>47</sup> <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2012-mlr-issuer-rebates-06042013.pdf>

The calculation of rebates as a percent of premium is based on earned premium for that company and market segment as reported on the 2012 Supplemental Health Care Exhibit.

Group Market relative to the Individual Market. With relatively lower premiums in the Individual Market, allocated fixed expenses may be a higher percentage of costs. In addition, some variable expenses tend to be more efficient in the Group Markets than the Individual Market. This is one reason why the ACA Minimum Loss Ratio standard is higher in the Large Group Market (85%) than in the Small Group and Individual Markets (80%).

<b>Expense Ratios in Rating Assumptions by Market Segment</b>			
	<b>2011</b>	<b>2012</b>	<b>Change</b>
<b>Individual</b>	20.4%	19.8%	-0.7%
<b>Small Group</b>	14.9%	15.1%	0.2%
<b>Large Group</b>	12.7%	13.1%	0.3%
<b>Total Fully-Insured</b>	14.1%	14.4%	0.3%

**Table 9 – Average Target Expense Ratios, Carrier Rate Filings<sup>48</sup>**

Table 10 shows the actual expense ratios and expense PMPM costs experienced by market segment in 2011 and 2012. Across all fully-insured markets, the actual total administrative expense PMPM as reported by carriers increased by 4.3% to \$64.03. Since this was above the overall premium trend of 1.1%, the actual expense ratios increased 0.5 percentage points from 14.9% in 2011 to 15.4% in 2012. Since 2010, average administrative expenses have increased 10.1%.

<b>Actual Expense Ratios and PMPM's by Market Segment</b>			
<b>Expense Ratio</b>	<b>2011</b>	<b>2012</b>	<b>Change</b>
<b>Individual</b>	21.9%	22.3%	0.4%
<b>Small Group</b>	15.3%	15.3%	0.0%
<b>Large Group</b>	13.5%	14.1%	0.6%
<b>Total Fully-Insured</b>	14.9%	15.4%	0.5%
<b>Expense PMPM</b>	<b>2011</b>	<b>2012</b>	<b>% Change</b>
<b>Individual</b>	\$63.53	\$67.84	6.8%
<b>Small Group</b>	\$64.49	\$66.03	2.4%
<b>Large Group</b>	\$58.50	\$61.42	5.0%
<b>Total Fully-Insured</b>	\$61.41	\$64.03	4.3%

**Table 10 – Average Expense Ratios and PMPM's, Actual Experience<sup>49</sup>**

Through 2012, ACA requirements have not had a substantive effect on administrative expenses. Going forward, there will be new ACA-driven fees and

<sup>48</sup> 2012 & 2013 Carrier Questionnaire: weighted average by market membership

<sup>49</sup> 2012 & 2013 Carrier Questionnaire

assessments that will increase administrative expenses in all markets. Two of the more impactful new assessments include the Health Insurers Provider Fee<sup>50</sup> and the Transitional Reinsurance Assessment.<sup>51</sup> The Health Insurers Provider Fee is a new excise tax starting in 2014 that will assess \$8 billion industry-wide and increase each year after that. The cost to each carrier will vary based on their size and tax status. The Transitional Reinsurance program will help offset the expected increase in costs due to higher morbidity of new entrants moving into the Individual Market from 2014 to 2016. The program will be funded with an industry-wide assessment starting at \$5.25 PMPM in 2014, which is expected to decline each year before being eliminated in 2017.

## 7.6. Profit Margins

In last year's report, we briefly discussed that carriers put margin into their pricing to cover explicit profit expectations, but also as a margin against adverse risk. The risk margin tends to increase in smaller blocks of business due to higher volatility of results and lower credibility of the experience on which pricing assumptions are based.

Table 11 shows the average pricing margins by market segment in rate filings for 2011 and 2012. Consistent with the smaller market size, the Individual Market in New Hampshire has much higher pricing margins than the Group Markets. Pricing margins remained essentially flat in the Group Market segments from 2011 to 2012, but increased from 9.6% to 12.2% in the Individual Market. On average across all fully-insured markets, carriers charged 3.1% of premiums for profit and risk margin in 2012.

Pricing Margin in Rating Assumptions by Market Segment			
	2011	2012	Change
<b>Individual</b>	9.6%	12.2%	2.6%
<b>Small Group</b>	2.2%	2.1%	-0.1%
<b>Large Group</b>	2.4%	2.4%	0.0%
<b>Total Fully-Insured</b>	2.8%	3.1%	0.3%

**Table 11 – Average Target Pricing Margins, Carrier Rate Filings<sup>52</sup>**

Table 12 shows the actual profit margins by market segment experienced in 2011 and 2012. Profit margin, in this exhibit, is defined as the percentage of premium remaining when you subtract out claims and expenses (100% minus Medical Loss Ratio minus Expense Ratio). Overall profit margins in the fully-insured markets increased from 2.9% to 5.2%. The increased profit margins in 2012 are generally

<sup>50</sup> <https://www.federalregister.gov/articles/2013/03/04/2013-04836/health-insurance-providers-fee>

<sup>51</sup> <http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf>

<sup>52</sup> 2012 and 2013 Carrier Questionnaires – weighted average by market membership

consistent with the reduced medical loss ratio driven by the recent favorable claim trends, particularly utilization, at a level below pricing assumptions.

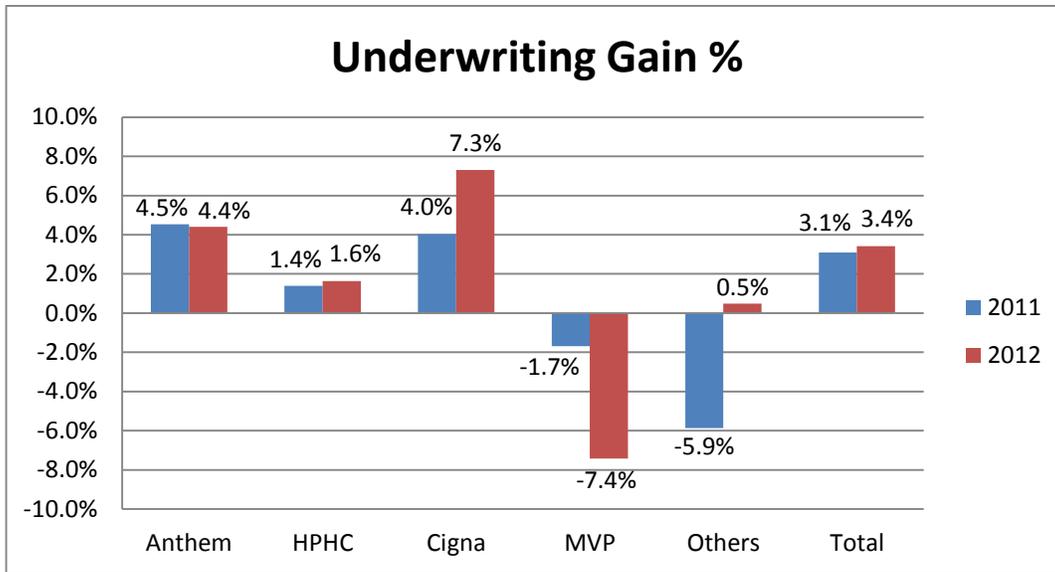
<b>Actual Profit Margins by Market Segment</b>			
<b>Profit Margin %</b>	<b>2011</b>	<b>2012</b>	<b>Change</b>
<b>Individual</b>	12.2%	12.7%	0.6%
<b>Small Group</b>	2.6%	4.3%	1.7%
<b>Large Group</b>	1.7%	4.4%	2.7%
<b>Total Fully-Insured</b>	2.9%	5.2%	2.3%
<b>Profit PMPM</b>	<b>2011</b>	<b>2012</b>	<b>\$ Change</b>
<b>Individual</b>	\$35.29	\$38.73	\$3.44
<b>Small Group</b>	\$11.12	\$18.75	\$7.63
<b>Large Group</b>	\$7.39	\$19.29	\$11.91
<b>Total Fully-Insured</b>	\$11.96	\$21.57	\$9.61

**Table 12 – Average Profit Margin and PMPM, Actual Experience<sup>53</sup>**

Beginning in 2010, the NAIC began requiring carriers to file Supplemental Health Care Exhibits with their annual statements. These new filings provide a greater level of detail at the state and market level than had previously been available from public filings. These exhibits can provide another view of margins in the private New Hampshire market in total and by carrier.

Figure 15 shows the underwriting gain percentage (the operating profit margin) by carrier and in aggregate for the combined Individual, Small Group and Large Group Markets from the 2011 and 2012 Supplemental Health Care Exhibits. The Total underwriting gain percentage increased modestly from 3.1% in 2011 to 3.4% in 2012. In total dollars, the 2012 underwriting gain was \$47.5 million on premiums of \$1.39 billion. Anthem and Harvard Pilgrim essentially maintained their gain percentage from 2011 to 2012. Cigna's underwriting gain percentage increased from 4.0% to 7.3% while the underwriting loss for MVP grew from 1.7% to 7.4%.

<sup>53</sup> 2012 & 2013 Carrier Questionnaire



**Figure 15 – Underwriting Gain Percentage by Carrier<sup>54,55,56</sup>**

<sup>54</sup> 2011 & 2012 Supplemental Health Care Exhibits. Underwriting Gain/Loss (Part 1, Line 11) divided by Health Premiums Earned (Part 1, Line 1.1).

<sup>55</sup> 2012 Underwriting Gain and Premium by Carrier:

Anthem: \$41.4M gain on \$940M premium

Harvard Pilgrim: \$4.7M gain on \$284M premium

Cigna: \$5.4M gain on \$75M premium

MVP: \$4.2M loss on \$56M premium

Others: \$0.2M gain on \$32M premium. Others include Assurant, Aetna, HealthMarkets, United, Celtic and several other carriers with less than \$1 million of health premiums in New Hampshire.

<sup>56</sup> The data requirements in the carrier questionnaires and the Supplemental Health Care Exhibits were not identical and therefore the total underwriting gain percentage in Figure 15 shows a lower gain in 2012 than the aggregated carrier questionnaire results shown in Table 12. The largest variance is the inclusion of the experience of the Federal Employees Program (FEP) in the Supplemental Health Care Exhibits. FEP business was specifically excluded from the carrier questionnaire because it functions quite differently than a typical fully-insured account. In an effort to reconcile this difference, GA has calculated an estimated total underwriting gain percentage excluding the impact of FEP. With this adjustment, the total underwriting gain percentage for 2012 increased to 4.8% compared to 3.4% without the adjustment. The 4.8% UW gain is more in line with the 5.2% profit margin shown in Table 12.

## 8. Regional and National Comparisons

Along with the deeper dive into New Hampshire trends, it is useful to examine how insurance costs and trends in the state compare to regional and national levels. The NAIC requires detailed financial statements to be filed annually by all insurance carriers.<sup>57</sup> From these filings, the NAIC produces a summary of all health insurance carrier filings aggregated at the state and national level. Table 13 shows a comparison of New Hampshire results to the New England region and national results.

	National	New England	New Hampshire
<b>2011 Premium PMPM</b>	\$311.35	\$413.26	\$401.50
<b>2011 Claims PMPM</b>	\$261.80	\$352.14	\$329.70
<b>2011 Medical Loss Ratio</b>	84.1%	85.2%	82.1%
<b>2012 Premium PMPM</b>	\$318.19	\$423.42	\$408.16
<b>2012 Claims PMPM</b>	\$271.60	\$364.13	\$331.18
<b>2012 Medical Loss Ratio</b>	85.4%	86.0%	81.1%
<b>% Change in Premium PMPM</b>	2.2%	2.5%	1.7%
<b>% Change in Claims PMPM</b>	3.7%	3.4%	0.4%

**Table 13 – Comparison of National, Regional and State Costs and Trends<sup>58</sup>**

New Hampshire premium PMPM in 2012 is 28% higher than the national level, yet 3.6% below the regional PMPM. The New Hampshire claims PMPM is 22% above the national level, but 8.7% below the regional mark. Although the variances are worth noting, it is difficult to assess relative affordability without understanding more about contributing factors, such as the relative differences in the demographic profile or health status of the insured populations and the relative actuarial value of medical benefits provided.

New Hampshire premium and claim trends from 2011 to 2012 are more closely aligned with the national and regional trends. New Hampshire premium PMPM increased 1.7% in 2012, within one percentage point of the regional and national premium trends. New Hampshire claims PMPM increased only marginally at 0.4%, more significantly below the 3.4% and 3.7% claim trends observed in the regional and national averages, respectively. The 2012 national claim trend from the NAIC analysis is consistent with

<sup>57</sup> The results from the aggregated NAIC filings do not fully reconcile to the data provided in the carrier questionnaires used earlier in the report. The NAIC filings include all New Hampshire carriers, including those that were not asked to respond to the 2013 Carrier Questionnaire. In addition, there may be minor differences in certain definitions or exclusions of certain types of business between the NAIC filing and the Carrier Questionnaire.

<sup>58</sup> The loss ratio calculation is claims divided by premium. They do not include any of the adjustments allowed in the ACA loss ratio formula used for rebate purposes, which can increase the result by several percentage points. See Section 7.4 for more discussion of loss ratios.

the 3.8% trend reported by HCCI in their 2012 report. New Hampshire claims trends have been consistently below the regional and national comparisons over the last few years. With claim trends increasing at a lower trend rate than premiums, New Hampshire loss ratios have decreased over time. In 2012, the New Hampshire loss ratio of 81.1% was 4.9 and 4.3 percentage points below the regional and national loss ratios, respectively.

Table 14 presents the 2012 NAIC data in a more detailed form. In this table the premium PMPM and medical loss ratio are shown for the Individual and Group Markets separately for each state in New England along with the total regional and national averages. New Hampshire average premium PMPM is 42% and 25% above the national averages in the Individual and Group Markets, respectively. However, in the Individual Market, the average New Hampshire premium PMPM of \$303.83 is below all the other New England states and 21% below the regional average. These results are similar to the patterns seen in 2011. New Hampshire is the only New England state that allowed health underwriting in the Individual Market in 2012, so this lower premium is likely reflective of a relatively healthier risk pool. However the New Hampshire loss ratio, the best indicator of relative value for each premium dollar, is only 65.0%, roughly 27 percentage points below the average Individual Market loss ratio in New England (91.7%) and 21 points below the next lowest state loss ratio (85.9% in Connecticut). It is reasonable to conclude that at least a portion of the loss ratio differential between the Individual Market in New Hampshire and the other New England states is due to more aggressive regulation in states outside of New Hampshire as well as market differences such as the merged Individual and Small Group Market for rating in Massachusetts. As was discussed in Section 7.5, the ACA Minimum Loss Ratio requirements will require carriers in the New Hampshire Individual Market to increase their loss ratios in 2013 or pay additional premium rebates back to policyholders. By comparison, there is much more consistency in the premiums and loss ratios in the Group Markets across the New England states. The average New Hampshire premium PMPM of \$424.12 for the Group Markets is just 1.1% below the regional average of \$428.71, and the New Hampshire loss ratio for the Group Markets of 82.9% is much more in line to the regional average of 85.3%.

	Individual Market		Group Markets	
	Premium PMPM	Loss Ratio	Premium PMPM	Loss Ratio
NH	\$303.83	65.0%	\$424.12	82.9%
CT	\$309.43	85.9%	\$463.22	80.6%
ME	\$398.00	97.5%	\$427.37	84.7%
MA	\$412.88	93.9%	\$425.48	86.7%
RI	\$360.80	93.9%	\$409.65	86.7%
VT	\$388.52	95.2%	\$372.57	88.4%
New England	\$386.79	91.7%	\$428.71	85.3%
National	\$213.72	85.4%	\$340.62	85.4%

**Table 14 – 2012 Premium PMPM's and Loss Ratios by Market Segment – New England States and National<sup>59</sup>**

<sup>59</sup> The loss ratio calculation is claims divided by premium. They do not include any of the adjustments allowed in the ACA loss ratio formula used for rebate purposes, which can increase the result by several percentage points. See Section 7.4 for more discussion of loss ratios.

## 9. Affordability Discussion

### 9.1. Carrier Cost Levers and Constraints

Although recent years have shown a deceleration in the increase of health insurance premiums in New Hampshire and across the country, affordability of health insurance is still a major concern. The burden of addressing affordability of health care services is one that is shared by many stakeholders including hospitals, physicians, employers, consumers, regulators as well as life science and pharmaceutical companies. However, because much of the public views health care financing through the lens of insurance premiums and the out-of-pocket costs driven by their plan's benefit design, insurance carriers tend to be at the center of the discussion when it comes to affordability.

As we have discussed in previous sections, there are several factors that drive the cost of insurance including administrative costs and margins. However, the main cost component of health insurance in all markets is the cost of claims. With ACA MLR regulations limiting the level of administrative costs and margins, it is clear that managing the cost of claims is tantamount to controlling premiums. As the trend analysis in Section 7 shows, the claims cost is driven by two primary factors: utilization and cost of services. Utilization is driven primarily by a member's health and treatment decisions made with their health care providers. The cost component is more readily controlled by insurance carriers as the price for providing health care services can be negotiated with providers.

Insurance carriers have four basic levers to differentiate their plans and address cost drivers through product design:

- (1) Benefits - which services are covered?
- (2) Network - which providers are included?
- (3) Provider Payment Models - how will providers be compensated for various services?
- (4) Cost Sharing - what costs will the member be responsible for?

While each of these plan attributes can be utilized to reduce premiums, they also tend to attract criticism from negatively impacted stakeholders, which vary based on the approach.

Until 2014, carriers in the New Hampshire Individual Market had the additional lever of medical underwriting to determine who was eligible to even purchase coverage. By excluding sicker patients with known conditions, claim costs in underwritten markets were much lower as evidenced by the significantly lower premiums and claims in the New Hampshire Individual Market than the Group Markets in 2012. With ACA regulations eliminating medical underwriting and

guaranteeing eligibility to all regardless of health status beginning in 2014, that pricing lever will be removed going forward.

While not eliminating other pricing levers, ACA regulations, when they are fully implemented, will significantly impact carriers' ability to differentiate benefit plans and minimize costs in many other ways. Essential health benefit regulations require Individual and Small Group benefit plans to broadly cover the vast majority of common healthcare services. Starting in 2014, ACA-compliant plans cannot exclude benefits such as pharmacy or maternity services<sup>60</sup>. With respect to cost sharing, carriers are also no longer able to impose annual or lifetime dollar limits on covered care. Most preventive care must be covered with no cost sharing to the member at all. Limits on deductibles and out-of-pocket maximums as well as actuarial value and minimum value requirements limit the financial liability to which a member can be exposed. For these reasons, many of the lowest premium benefit plans currently offered in the Individual and Small Group markets in New Hampshire are not ACA-compliant and may eventually no longer be available.

Even with the cost sharing constraints imposed by the ACA, carriers in the Individual and Small Group market will continue to offer a variety of benefit plans with different cost sharing options across a relatively broad spectrum. Platinum plans (actuarial values between 0.88 and 0.92) will feature relatively low member cost sharing, but higher monthly premiums. Bronze plans (actuarial values between 0.58 and 0.62) from the same carrier may have premiums 30-50% below Platinum plans, but members are likely to have much higher deductibles and overall out-of-pocket cost exposure. While these plan options will continue to offer consumers a choice in terms of higher up front premium payments or higher out-of-pocket cost when care is needed, these high and low option benefit designs will most likely not differ materially from the type of market that exists today, and will not address the fundamental affordability issue with the cost of healthcare.

## 9.2. Provider Differentiation & Network Design

The one major pricing lever for carriers that the ACA left essentially unconstrained is their provider networks. Given other constraints and market dynamics, it is evident that carriers in New Hampshire and many other states across the country are exploring multiple options to impact premiums through network design and provider differentiation.

In last year's report, both Tiered Network options and Site of Service benefit designs were discussed. While there are different types of tiered network plans, they are typically built on a broad network, but offer significant member cost sharing incentives when members choose services from a lower cost network of providers. Site of service benefit designs offered in New Hampshire typically provide

<sup>60</sup> These ACA plan requirements may not apply to grandfathered and otherwise exempted plans that may continue to be offered in New Hampshire. They will apply to new plans effective January 1, 2014 or later.

significant financial incentives to members to choose lower cost facilities for outpatient surgery or laboratory services. The discussion below describes how tiered network and site of service benefit designs function from a member perspective.

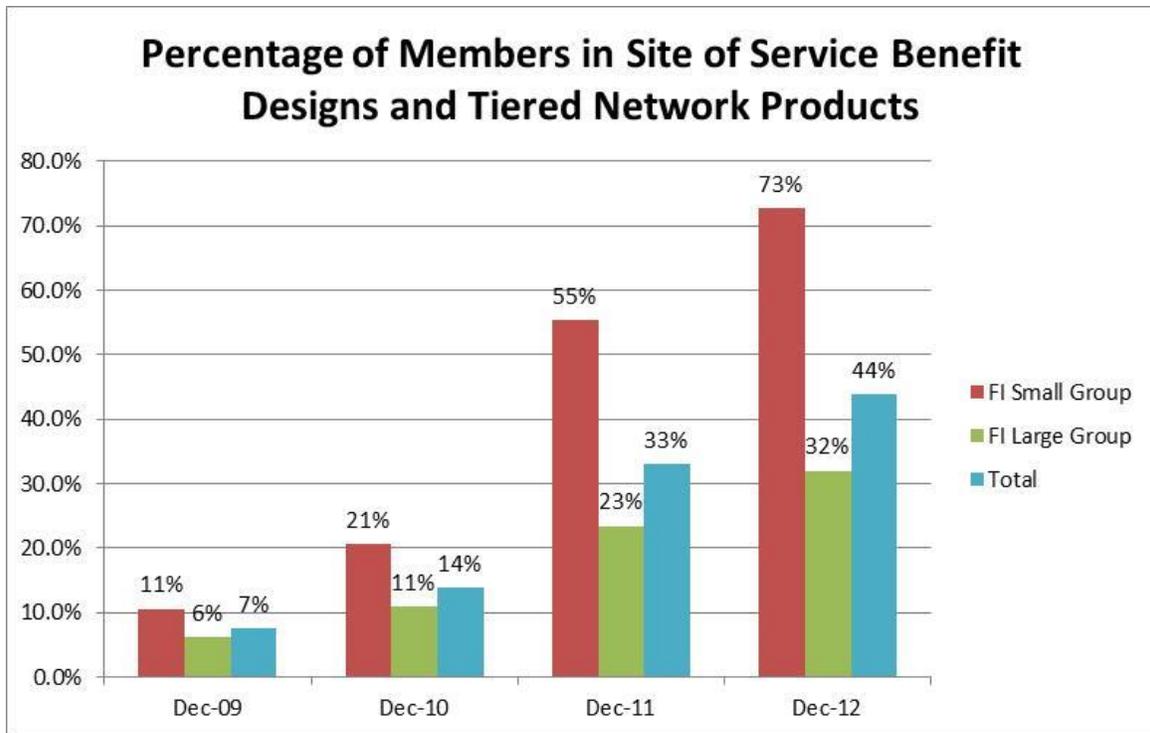
In a tiered network product, hospital A is considered Tier 1 and hospital B is Tier 2. The hospitals are typically placed into tiers based on both cost and quality metrics. If a member chooses to use hospital A for a certain service, the deductible is \$250 and the coinsurance is 5% up to the member's out-of-pocket limit. If the member chooses to use hospital B for that same service, the deductible is \$1,000 and the coinsurance is 15% up to the member's out-of-pocket limit. Therefore, when a member chooses hospital A over hospital B, their out-of-pocket costs will be significantly less.

With a site of service benefit design, if a member has an outpatient surgery at a hospital, the cost sharing is \$1,000. But if that member has the same outpatient surgery at an ambulatory surgical center (ASC), the cost sharing is \$75. The member has the choice of having the surgery done at the hospital and pay \$1,000 or at the ASC and pay \$75.

While neither tiered network plans nor site of service benefit designs prohibit a member from choosing their preferred provider, they introduce some limited cost transparency by exposing the member to a significant financial decision. Insurance carriers expect collective member behavior to change, which will ultimately reduce claims costs, and therefore carriers are able to reduce premiums. These types of plans continue to gain popularity in New Hampshire. Figure 16 illustrates the growth in membership in these types of plans in recent years. As of December 2012, 44% of the members across the entire fully-insured market are in either site of service benefit designs or tiered network products. The growth has been in the site of service benefit options while membership in tiered network products has decreased slightly. In the Small Group Market, the percentage of members in the site of service benefit designs and tiered network products has increased from 11% as of December 2009 to 73% as of December 2012. Site of service benefit designs have become the standard option in the Small Group Market for some carriers. Their prevalence has also increased in the Large Group Market where the percentage of members in site of service benefit designs and tiered network products have increased from 6% as of December 2009 to 32% in December 2012.<sup>61</sup> As referenced in the hearing from 2011, the average price differential for the site of service benefit option is in the upper single digits compared to a plan offering without the site of service benefit option for at least one carrier.<sup>62</sup>

<sup>61</sup> According to the carriers surveyed, these options were not offered in the Individual Market through 2012.

<sup>62</sup> [http://www.nh.gov/insurance/consumers/documents/2012\\_rate\\_hearing.pdf](http://www.nh.gov/insurance/consumers/documents/2012_rate_hearing.pdf)



**Figure 16 – Percentage of Members in Site of Service Benefit Designs and Tiered Network Products by Market Segment and Year<sup>63</sup>**

To understand the value proposition of the site of service benefit designs, data were collected for the top outpatient surgeries by total spend over a two year time period.<sup>64</sup> These data were separated into two categories: members in plans with the site of service benefit option and members in plans without the site of service benefit option. The surgeries included GI endoscopy, colonoscopy and knee arthroscopy. Table 15 below shows the average allowed costs for each of these surgeries at a hospital outpatient setting and at an ambulatory surgical center (ASC). In addition, the table includes net costs for these surgeries. Allowed costs include member cost sharing while net costs are the true costs to the insurance carrier. As shown, the average allowed cost for specific surgeries is significantly lower at ASC's compared to hospital outpatient settings. For example, for a specific type of GI Endoscopy, the average allowed cost in 2012 was \$4,103 at a hospital outpatient site compared to \$1,789 at an ambulatory surgical center. For this surgery, costs at an ASC are \$2,314 or 56% lower than costs at a hospital outpatient setting.<sup>65</sup> As dictated by the benefit design structure, the member cost sharing for the surgery when performed at an ASC compared to a hospital outpatient setting is much lower. For the GI Endoscopy, the member pays \$82 per surgery on average at an ASC compared to

<sup>63</sup> Source: 2013 NHID Carrier Questionnaire

<sup>64</sup> In addition to outpatient surgery, the site of service benefit design also has an incentive for members to choose lower cost facilities for laboratory services, but for the purpose of the analysis in this report the focus is on outpatient surgery services.

<sup>65</sup> Based on data for members with a site of service benefit option.

\$1,074 on average at a hospital outpatient site. Even when factoring in this lower member cost sharing, the difference in the net cost per surgery is still significant. For the GI endoscopy, the insurance carrier pays \$3,029 if the surgery is at a hospital outpatient site and \$1,706 if it is performed at an ASC. The net savings is \$1,323 or 44% if this surgery is performed at an ASC. Similar results can be found when analyzing data for colonoscopies and knee arthroscopies. In total for all outpatient surgeries, the average net cost differential is \$2,646 per surgery between outpatient hospital sites compared to ambulatory surgical centers.

Site of Service Data CY 2012						
	Allowed Cost per Surgery		Net Cost per Surgery		Member Cost Sharing per Surgery	
	Outpatient	Ambulatory	Outpatient	Ambulatory	Outpatient	Ambulatory
	Hospital	Surgical Centers	Hospital	Surgical Centers	Hospital	Surgical Centers
<b>GI Endoscopy:</b>	\$4,103	\$1,789	\$3,029	\$1,706	\$1,074	\$82
<i>\$ Difference</i>		-\$2,314		-\$1,323		-\$991
<i>% Reduction</i>		56%		44%		92%
<b>Colonoscopy:</b>	\$3,505	\$2,128	\$3,201	\$2,099	\$304	\$29
<i>\$ Difference</i>		-\$1,378		-\$1,102		-\$275
<i>% Reduction</i>		39%		53%		90%
<b>Knee Arthroscopy:</b>	\$6,888	\$3,358	\$5,890	\$3,270	\$998	\$88
<i>\$ Difference</i>		-\$3,530		-\$2,620		-\$910
<i>% Reduction</i>		51%		44%		91%
<b>Total All Outpatient Surgeries:</b>	\$6,052	\$2,649	\$5,216	\$2,570	\$835	\$78
<i>\$ Difference</i>		-\$3,403		-\$2,646		-\$757
<i>% Reduction</i>		56%		51%		91%

**Table 15 – 2012 Outpatient Surgery Cost by Site of Procedure<sup>66, 67</sup>**

Table 15 clearly illustrates that there is a net financial savings when members are encouraged to use the less costly setting. Table 16 shows that members have positively responded to these incentives. Members in a site of service products use ambulatory surgical centers 46% percent of the time for GI endoscopies compared to 33% of the time for members not in site of service products. There are similar increases in the use of ambulatory surgical centers for other top outpatient procedures as well. Across all outpatient surgeries, members use ambulatory surgical centers 33% of the time compared to 25% of the time for members that do not have a site of service benefit design.

<sup>66</sup> Source: 2013 NHID Carrier Questionnaire

<sup>67</sup> GI Endoscopy is CPT 43239. Colonoscopy is CPT codes 45380, 45385 and 45378. Knee Arthroscopy is CPT code 29881. These five CPT codes comprise approximately 19% of outpatient surgery spending at either an outpatient hospital or ASC. The “Total All Outpatient” line represents all outpatient surgeries including the five CPT codes referenced above.

<b>Site of Service Data CY 2012</b>			
<b>% Use of Ambulatory Surgical Centers</b>			
	<b>Members in Site of Service Option</b>	<b>Members NOT in Site of Service Option</b>	<b>Difference</b>
<b>GI Endoscopy:</b>	46%	33%	<b>13%</b>
<b>Colonoscopy:</b>	45%	31%	<b>14%</b>
<b>Knee Arthroscopy:</b>	52%	41%	<b>11%</b>
<b>Total All Outpatient</b>			
<b>Surgeries:</b>	33%	25%	<b>9%</b>

**Table 16 – 2012 Use of Ambulatory Surgical Centers for Outpatient Surgery<sup>68</sup>**

The site of service benefit designs alone are not enough to address the entire affordability issue, but they have proven to gain traction in the market and they are impacting member behavior by shifting care to lower cost providers. In addition, carriers stated at the hearing that site of service benefit designs are having a favorable impact when it comes to contract negotiations with hospitals, as hospitals are concerned about losing volume to ambulatory surgical centers and are therefore willing to renegotiate outpatient hospital rates.

While the site of service products have increased in market popularity, criticism has come from the hospitals citing the fact that shifting care outside of hospitals leads to less coordinated care and fragmentation of the health care system. It is difficult to find data to quantify this concern. In addition, hospitals have expressed concern that the site of service benefit designs specifically target certain higher margin services like certain outpatient surgeries and if the volume of these higher margin services decreases then the hospitals will need to make up that margin on other services. The median operating margin across all New Hampshire acute care hospital systems between FY 2008 and FY 2011 has been fairly consistent so it is unclear as to whether the site of service products have significantly impacted overall hospital margins as of yet.<sup>69</sup>

A relatively new concept, with similarities to tiered networks and site of service benefit plans that has gained some traction in the large employer market is the use of reference pricing. With this concept, plans set a maximum cost (the “reference price”) that the plan will pay for specific procedures, and then provide members with a list of the cost of those procedures by facility. A member that chooses a facility with a cost above the reference price must pay the difference out of pocket. A Health Affairs study<sup>70</sup> that examined the CalPERS experience using reference pricing for knee and hip replacement surgeries showed a substantial member shift to hospitals below the reference price. A potentially even more impactful outcome was

<sup>68</sup> Source: 2013 NHID Carrier Questionnaire

<sup>69</sup> Source: Audited financial statements summarized by the New Hampshire Hospital Association.

<sup>70</sup> <http://content.healthaffairs.org/content/32/8/1392.full>

that many hospitals with costs above the reference price in years before the plan was implemented significantly reduced their prices in an effort to avoid being disadvantaged and losing market share in this type of plan for these services. The reference pricing concept, as described here, may be limited to the large employer self-insured market due to regulatory constraints on maximum member cost sharing in the Individual and Small Group Markets. Regardless, the ability of full cost transparency to change provider prices (when the member is fully exposed to the costs) is something to be noted.

Reference pricing, site of service benefit options and tiered networks attempt to use different forms of a “carrot and stick” approach to network differentiation and transparency. And while they all show some potential to change behaviors and reduce premiums, the greatest lever a carrier has to control the cost of their claims is in selecting cost efficient providers to include in its network. Since the HMO backlash in the 1990’s, it is relatively common practice for carriers in New Hampshire and across the country to include nearly all hospitals and physician groups in their broadest commercial provider networks. By acquiescing to the market acceptance of this “100% network” trend, carriers have given up considerable leverage to use provider competition to negotiate more favorable unit costs from providers. The documented result has been average unit cost trends that consistently exceeded Northeast Medical CPI in the past several years.

In recent years, carriers have revived the idea of contracting with a more limited network of providers. By not contracting with all of the providers in a region, the carrier is able to negotiate more favorable terms in return for offering greater volume of its members to the provider. Since many carriers offer both broad and narrow network products, they know the terms of the standard contracts with all providers, and they are able to select specific providers and negotiate terms with the intent to achieve a targeted premium reduction.

In New Hampshire, both Anthem and Harvard Pilgrim have recently launched products with less than their full commercial network. Anthem is offering plans in the Individual Market through the new Health Exchange based on their Pathway network, which includes 16 of the state’s 26 acute care hospitals and a reduced number of physician groups (since many groups in the state are affiliated with hospitals and contract with carriers as a combined entity). Harvard Pilgrim is offering plans in the Small and Large Group Markets on their Elevate Health network, which includes five New Hampshire hospitals and 400 primary care physicians. By contracting with a more limited group of providers, Anthem has said premiums will be approximately 25% below what they could have offered had the same benefit designs been offered on a broad network.<sup>71</sup> Harvard Pilgrim has said the Elevate Health plans reflect “double-digit” premium savings relative to comparable full network plans.<sup>72</sup>

<sup>71</sup> <https://www.anthem.com/health-insurance/about-us/pressreleasedetails/NH/2013/1404>

<sup>72</sup> [https://www.harvardpilgrim.org/pls/portal/docs/PAGE/BROKER/PRODUCT\\_INFO/ELEVATE/ELEVATE-EMPLOYER-BROCHUREV2.PDF](https://www.harvardpilgrim.org/pls/portal/docs/PAGE/BROKER/PRODUCT_INFO/ELEVATE/ELEVATE-EMPLOYER-BROCHUREV2.PDF)

Anthem is the only carrier offering Individual Market plans in the New Hampshire Exchange in 2014, therefore the announcement that those plans will use their Pathway network has been met with much criticism regarding patient disruption and access. New Hampshire is hardly alone in seeing the rise of these plans. Narrow network plans are appearing in all regions of the country and offered by many different carriers, particularly in the exchange markets where members are expected to be very price driven.<sup>73</sup>

### 9.3. Alternative Payment Models

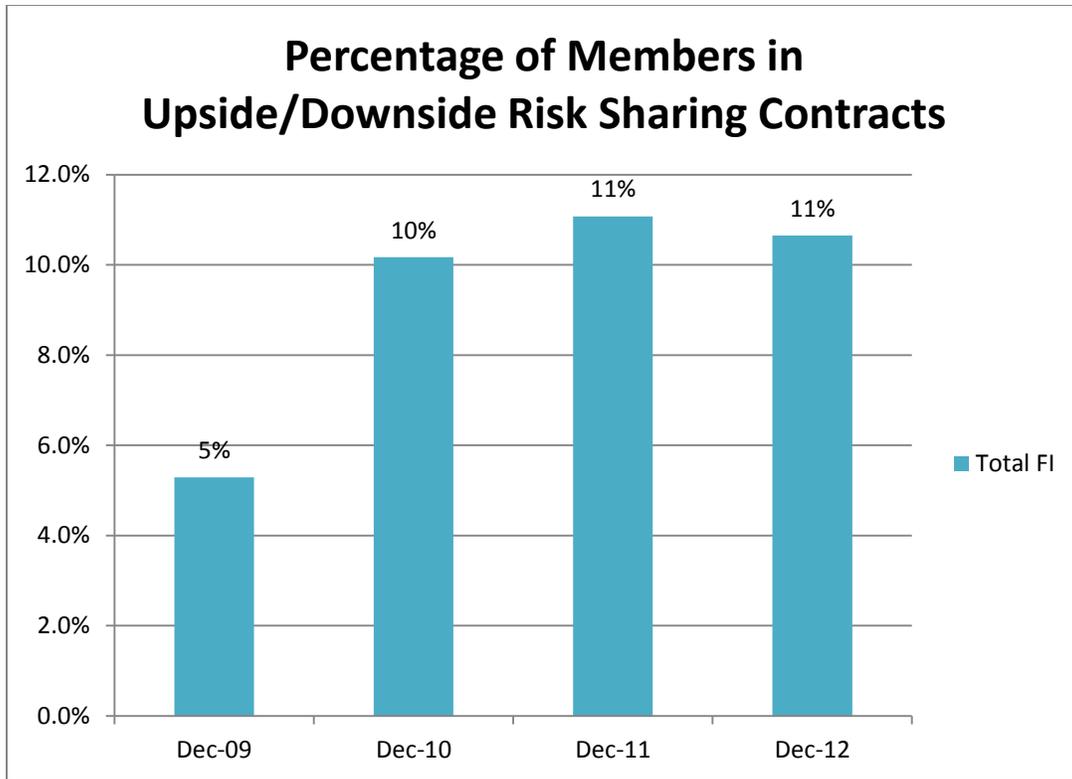
Provider payment reform continues to be an area of great discussion in New Hampshire and across the country. Both insurance carriers and providers are engaged in evaluating opportunities to migrate away from typical fee-for-service models to pay-for-performance or risk sharing models. The aim of these payment reform efforts is to better align financial incentives between the insurance carriers and the providers, to reduce unnecessary utilization, improve overall quality of care to patients, and to ultimately reduce costs to the overall health care system. Last year's report provided some background on common types of risk sharing arrangements. The variations of alternative payment strategies continue to grow. Some models include only upside risk, which involves potential incentive rewards but no potential financial penalties. Other models include both upside and downside financial risk, where the provider shares in both potential gains and losses depending on their performance often relative to a benchmark or a network of peers. Examples of these arrangements currently employed in New Hampshire include:

- Patient Centered Primary Care Homes: At least two carriers in New Hampshire are working with primary care physicians to improve care coordination and outcomes by providing data, tools and then financial incentives to the provider groups for meeting certain cost and quality metrics. These arrangements generally represent upside risk only to the provider.
- Accountable Care Organizations: At least two carriers have established accountable care type models with provider systems including Dartmouth Hitchcock and the Granite Health System. In one case, this arrangement is centered around sharing information with providers related to gaps in care and pharmacy compliance and it does not represent any financial risk sharing. In another case, the arrangement represents more of a true risk sharing arrangement where the provider shares in both upside and downside risk.

Figure 17 shows the percentage of members in New Hampshire associated with providers in a risk sharing arrangements with both upside and downside risk. Over the last few years, the penetration of these arrangements has leveled off at 10% to 11%. While upside only payment models represent progress towards greater provider-carrier alignment and can be a starting point for risk sharing, upside only

<sup>73</sup> [http://www.nytimes.com/2013/09/23/health/lower-health-insurance-premiums-to-come-at-cost-of-fewer-choices.html?pagewanted=all&\\_r=0](http://www.nytimes.com/2013/09/23/health/lower-health-insurance-premiums-to-come-at-cost-of-fewer-choices.html?pagewanted=all&_r=0)

arrangements may not create enough financial incentive to drive lasting behavior change and provider engagement. The relatively small size of some of the providers in New Hampshire may prohibit their ability to accept significant risk on their contracts and their ability to negotiate these arrangements on their own.



**Figure 17 – New Hampshire Insured Membership in Risk Arrangements<sup>74</sup>**

While shifting providers away from fee-for service payments is generally viewed as one of the critical ingredients to addressing overall health care affordability, these changes generally target unnecessary utilization and quality of care issues while not addressing the underlying cost of providing the care. If payment model reforms are not paired with initiatives to address unit cost trends and provider price disparities, the ability to meaningfully impact long-term health care affordability will be limited. One speaker at the annual hearing likened addressing health care costs to the “balloon theory” where “if you press one place and try to solve the problem, another problem pops up on the other side of the balloon.”

<sup>74</sup> Source: 2013 NHID Carrier Questionnaire

## 10. Conclusion

The primary directive for this report is to discuss and analyze the health insurance premium rate increases and the factors driving the increases in the previous year. In summary, 2012 was a year in which New Hampshire premium trends on a market-wide basis were 1.1%, the lowest level in recent history. While this is certainly a favorable outcome, driven by reductions in utilization, there continue to be areas that call for additional focus in order to keep the cost of insurance from spiking if favorable utilization does not continue. In particular, provider unit cost trends continue to outpace inflation, as they have for several years. And beyond the premium cost, benefit designs continue to shift additional out-of-pocket cost sharing to the members.

In 2012 and 2013, we have seen the New Hampshire insurance carriers continue to refine and push strategies to address premium affordability and improve cost transparency to the consumer. These initiatives include reforms in provider payment models, benefit designs, and, more recently, provider network designs. Even as these reforms have shown the ability to reduce the cost of insurance, the criticism that these initiatives have garnered indicates a need for a broader conversation regarding the shared goals of the New Hampshire health insurance marketplace and all of its stakeholders. As was discussed at the annual hearing, the NHID may be able to play a convening role for this discussion, but sustainable success will require the engagement of the carriers and providers, other state agencies and branches of government, employers and public health advocates, and of course the consumers themselves. At the close of the annual hearing, Insurance Commissioner Roger Sevigny summed up the ongoing need for this collective dialogue on the affordability of health insurance in the state: “New Hampshire needs to decide where we want to be, what we want to pay, and what we are willing to withstand to pay what we want to pay.”

## 11. Appendix

### 11.1. Data Sources

A brief summary of the key data sources used in the development of this report is included below. While GA did review the data for reasonableness, and used care in evaluating and analyzing the data from each source, Gorman Actuarial does not provide any warranties as to the accuracy of the data as reported by the carriers or as aggregated by the NHID or the NAIC.

- Carrier Questionnaire:** The NHID and Gorman Actuarial developed a survey that required quantitative and other explanatory details on carrier experience in New Hampshire. The questionnaire asked carriers to provide details on historical financial results, trends, pricing assumptions, membership, benefit plans, and strategic initiatives to address premium cost drivers. Only aggregated or de-identified information from the carrier questionnaires was used within this report. Some results shown in prior year reports may have been revised based on updated results from this year's responses to the carrier questionnaire.
- Supplemental Report Data:** This data submitted by carriers to the NHID to support the development of the annual "Supplemental Report of the Health Insurance Market in New Hampshire"<sup>75</sup>. Carriers and Third-Party Administrators must submit this data to NHID by July 15 for the previous calendar year. While the 2012 Supplemental Report has not yet been released, the data that has been collected was used in the development of this report.
- NAIC Supplemental Health Care Exhibits (SHCE):** Beginning in 2010, this was a new annual filing requirement used to assist state and federal regulators in tracking and comparing financial results, particularly elements that make up the medical loss ratio, of healthcare businesses as reported in the annual financial statements. A separate exhibit is required annually in each state in which a carrier has written any premium or has any claims or reserves in the Individual, Small Group or Large Group fully-insured Comprehensive Major Medical Markets.
- NAIC Statistical Compilation of Annual Statement Information for Health Insurance Companies:** This report includes aggregated data from

<sup>75</sup> The 2011 Supplemental Report ([http://www.nh.gov/insurance/reports/documents/2011\\_nh\\_id\\_suprpt.pdf](http://www.nh.gov/insurance/reports/documents/2011_nh_id_suprpt.pdf)) includes a more detailed description of the data in its Appendix.

annual statements of the individual companies filing the health annual statement blank. Certain data is provided only at the total national level. Other data is presented by state as well. New England regional calculations were based on the aggregated results reported for Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

## 11.2. Glossary of Terms

- **ACA:** Affordable Care Act of 2010
- **Actuarial Value:** For purposes of this report, “actuarial value” is defined as the share of medical costs covered by the health plan for a standard population.
- **Benefit-Adjusted Premium Trend:** The premium trend recalculated to assume no changes in benefits from year to year.
- **Benefit Buy-Down:** The process of selecting a plan with reduced benefits or higher member cost-sharing as a way to mitigate premium increases.
- **Cost Trend:** For purposes of this report, “cost trend” represents the combination of the change in the unit price of specific services, the change in the claim severity of the total basket of services provided, and the change in mix of providers being used.
- **EPO:** Exclusive Provider Organization; a type of health plan with a defined network of providers, but unlike an HMO, the member may not be required to select a Primary Care Physician or receive referrals to Specialists within the network.
- **Fully-Insured Plan:** A health plan in which an insurance carrier receives a premium payment in return for covering all claims risk associated with the enrollees.
- **HMO:** Health Maintenance Organization; a type of health plan that employs medical management techniques such as a defined provider network, Primary Care Physician selection and Specialist referral requirements.
- **NAIC:** National Association of Insurance Commissioners
- **NHID:** New Hampshire Insurance Department
- **Per Member Per Month (PMPM):** A common method of expressing healthcare financial data that normalizes for the size of the membership pool. Dollars are divided by member months to calculate the PMPM value.
- **POS:** Point-of-Service plan; a type of health plan similar to an HMO, but with the option to self-refer to providers outside of the HMO network, typically with increased levels of member cost sharing
- **PPO:** Preferred Provider Organization; a type of health plan that employs a network of preferred providers, but does not limit a member from seeking

care at any provider. Typically the member cost sharing will be lower when care is provided within the preferred network.

- **Pricing Trend:** An assumption used in setting premium rates that represents the expected increase in future claims costs.
- **Self-Insured Plan:** A health plan in which an employer does not actually pay insurance premiums to a carrier to accept the claims risk. The employer pays only a service fee to a carrier to administer the plan, but then the employer covers the cost of claims for their enrollees directly.
- **Unadjusted Premium Trend:** The actual percentage increase in premium PMPM's as reported by carriers.
- **Utilization Trend:** The change in the number of services provided. Examples of the types of metrics used to calculate utilization includes the number of admissions to a hospital, the number of visits to a specialist physician or the number of pharmacy prescriptions filled.

### 11.3. Limitations and Data Reliance

Gorman Actuarial prepared this report for the use of 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 healthcare, health insurance markets and financial modeling so as not to misinterpret the information presented. The report addresses certain provisions of the Affordable Care Act, but is not intended to act as an official or comprehensive interpretation of the legislation itself.

Analysis in this report was based on data provided by the New Hampshire Insurance Department, carriers in the New Hampshire health insurance markets, the NAIC 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 is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

The report contains statements that attempt to provide some prospective context to current or past trends. These statements are based on the understanding of the existing and proposed regulatory environment as of November 30, 2013. If subsequent changes are made, these statements may not appropriately represent the expected future state.

## **11.4. Qualifications**

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