New Hampshire Insurance Department

2011 Medical Cost Drivers

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1. Executive Summary

Increasing health insurance premiums have been a cause for concern for many across the nation. The development of health insurance premiums is not a simple calculation. It can include a complex set of formulas and assumptions which are sometimes difficult to understand. For policymakers to develop sound policies that address premium increases, the underlying drivers must be more transparent.

Many states, including New Hampshire, have passed legislation to make health insurance premium increases more transparent. 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 new law required 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." In addition, the 2010 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 2nd Annual Report.

The key findings from this year's report are:

- **In 2011, overall premiums in the privately insured markets increased 3.8%, however if consumers had stayed in their existing plan designs, overall premiums would have increased 9.0%.**

  The 3.8% increase includes the effect of some consumers changing their benefits from the previous year, generally purchasing products with higher member cost sharing to lower their premiums. In 2011, consumers reduced their premiums by an average of 4.8% in exchange for less comprehensive coverage.

- **When establishing premiums, carriers had assumed that medical expenditures would increase 10% to 12% annually from 2010 to 2012.**

  There is a significant lag between the time when a carrier establishes premiums and the observed medical trends. Carriers must set premiums by relying on historical experience.

- **Actual medical expenditures increased 3.0% from 2010 to 2011, driven by lower utilization trends.**
  Observed medical claim trends have decreased dramatically over the past three years, from 10.9% in 2009 to its current level of 3.0% in 2011. While both cost and utilization trends have been decreasing during this time, utilization trends have experienced a larger decrease and in 2011 the utilization trend was -2.1%, the second year in a row with negative trends.

- **The overall 2013 pricing trend assumption is 8% to 9%, lower than pricing trends in recent years.**
  As observed medical claim trends decline, it is expected that this will be reflected in lower future pricing trends. The 2013 New Hampshire pricing trends are consistent with national trend survey results.[1]

- **In 2011, carriers assumed 16.7% of every premium dollar would go towards administrative expense and profit margins, and 83.3% would go towards medical benefits.**
  Actual results in 2011 were slightly more favorable for the carriers with 82.2% of premiums paying for medical claims and 17.8% remaining to cover administrative expenses and profits.

- **Actual administrative expenses increased 5.6% from 2010 to 2011 as reported by the carriers.**
  Actual administrative expense trends varied significantly by market segment. In the Individual Market segment, expenses decreased by 6.4% while in the Small and Large Group Market expenses increased by 11.9% and 3.0%, respectively.

- **Each of the largest carriers showed improved profitability in 2011 compared to 2010.**

[1] http://www.sibson.com/publications/surveysandstudies/2013trendsurvey.pdf

Profit margins increased by 2.9% overall in 2011 compared to a breakeven level in 2010. Of the four largest carriers in New Hampshire, Anthem and Cigna had the highest overall profit margins in 2011, while MVP and Harvard Pilgrim reported the largest increases to their profit margins from 2010 to 2011.

- **Carriers are employing various strategies to control costs including developing innovative benefits and provider reimbursement strategies.**
  These strategies include site of service benefit designs and provider risk-sharing contracts. However, these strategies are relatively new and more experience is needed before assessing their full impact in the market.

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 24, 2012.[2] In addition, GA utilized existing data and information collected by the NHID along with publicly available information. Finally, GA and the NHID asked several of the 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.

[2] A transcript of the hearing can be found at http://www.nh.gov/insurance/consumers/documents/2012_rate_hearing.pdf.

3. Overview of New Hampshire Insurance Market

This report will focus primarily on the New Hampshire private insurance market. To put the private market in context, Figure 1 shows the estimated distribution by type of health insurance coverage for all New Hampshire residents during 2010 - 2011[3].

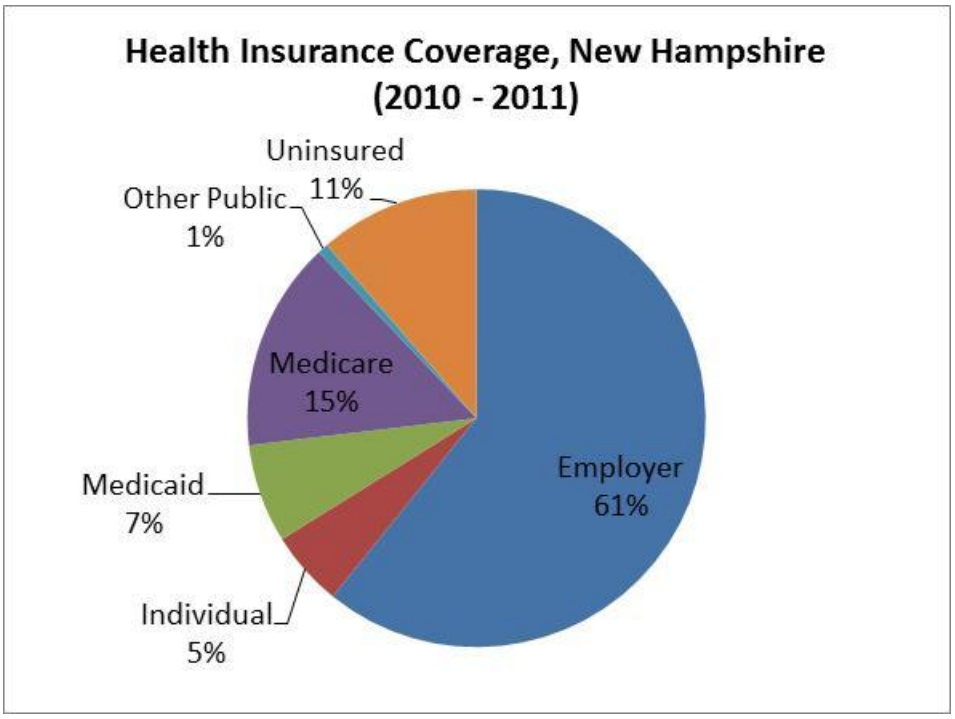

Figure 1– Distribution of Health Insurance Coverage, New Hampshire (2010 – 2011)

11% of residents (13% under age 65) are estimated to be uninsured. This is below the national average of 16% (18% under age 65) and ranks 12th lowest out of the 50 states. 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%.

Table 1 shows the 2011 private health insurance market by carrier membership both in total and split between fully-insured and self-insured members. These figures include

[3] 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.

members that receive coverage through a New Hampshire carrier.[4] They include non-residents that receive coverage through a New Hampshire employer, and exclude New Hampshire residents that receive coverage through an out-of-state employer. The estimates shown in Figure 1 represent New Hampshire residents and are not the same population shown in Table 1.

	Fully-Insured		Self-Insured		Combined	
	Members	%	Members	%	Members	%
Anthem	140,673	55.8%	139,984	45.1%	280,657	49.9%
CIGNA	16,690	6.6%	128,450	41.3%	145,140	25.8%
Harvard Pilgrim	63,045	25.0%	41,342	13.3%	104,387	18.5%
MVP	19,488	7.7%	0	0.0%	19,488	3.5%
MEGA Life & Health	3,703	1.5%	0	0.0%	3,703	0.7%
Assurant	2,834	1.1%	0	0.0%	2,834	0.5%
United	1,836	0.7%	0	0.0%	1,836	0.3%
Celtic	1,187	0.5%	0	0.0%	1,187	0.2%
Others	2,617	1.0%	932	0.3%	3,548	0.6%
Total	**252,073**	**100%**	**310,706**	**100%**	**562,780**	**100%**

Table 1 – 2011 New Hampshire Private Market Membership by Carrier[5,6]

Anthem has about half of the overall private market share, and the largest share in each segment. Cigna has about one-quarter of the market overall, with the vast majority of Cigna members in self-insured arrangements. Harvard Pilgrim has 18.5% of the overall market and 25% of the fully-insured market. MVP has 7.7% of the fully-insured marketplace and does not participate in the self-insured business. All other carriers have less than 1% of the overall market share in New Hampshire.

[4] These figures do not include members in the New Hampshire Health Plan state high risk pool or the Federal Pre-existing Condition Insurance Program (PCIP). As of December 2011, those plans reported 2,556 and 302 New Hampshire members, respectively.

[5] 2011 NAIC Supplemental Health Care Exhibit (SHCE) filings with the following adjustments:

- Excluded Anthem Federal Employee Program and Blue Card host members
- Included Health Plans, Inc. members with Harvard Pilgrim (not included in SHCE)

[6] The self-insured membership may be underreported as the SHCE is not a required filing for third party administrators or other entities that do not write fully-insured individual or group business in any state.

4. Premium Trends - Unadjusted

GA examined fully insured premium trends both on 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 2. These premium PMPM's are based on calendar year averages which include a mixture of policy anniversaries throughout the year. For example, for an account that purchased coverage effective in July 2010, the first six months of their premium is allocated to 2010, while the last six months is allocated to 2011. These premiums also reflect changes in mix of business. For example, if a carrier increases it share of business in higher age groups which generally have higher premiums, this will be reflected in premium trends. Finally, the unadjusted premium will also reflect a change in benefits. For example, if an employer group increases their deductible, their relative premium would decrease which would be reflected in the unadjusted premium. Therefore, overall premium trends do not necessarily represent premium rate increases seen by policyholders or employer groups. The Individual Market premium PMPM's are substantially lower than the Group Market PMPM's due to the existence of health underwriting in the Individual Market, which tends to drive a healthier risk pool, and due to the higher average levels of cost sharing which will be discussed in Section 5. The Individual Market experienced the lowest percentage change in unadjusted premium trends at -1.8%, while the Small Group and Large Group Markets experienced trends of 4.2% and 5.4% respectively. The overall 2011 premium trend in the fully-insured market is 3.8%.

Unadjusted Earned Premium PMPM			
	2010	**2011**	**% Change**
Individual	$295	$290	-1.8%
Small Group	$404	$421	4.2%
Large Group	$411	$433	5.4%
Total Fully-Insured	$397	$413	3.8%

Table 2 – Unadjusted Earned Premium PMPM by Market Segment and Year[7]

[7] Source: 2011 and 2012 NHID Carrier Questionnaire

5. Benefits and Benefit Buy-Down

When analyzing premium changes and medical trends, it is important 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 2010 and 2011 New Hampshire Supplemental Reports, we were 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 key attributes reported in the Supplemental Report include deductibles, coinsurance, office visit copays and member out-of-pocket maximums. Table 3 displays a distribution of membership by deductible level for each of the three fully-insured market segments in CY 2010 and CY 2011. There has been some shift in each of the market segments to higher deductible plans. In the Individual Market, where a very small amount of members are in plans with less than a $1,000 deductible, the percentage of members with a deductible greater than $3,000 has increased from 36.3% in 2010 to 40.4% in 2011. In the Small Group and Large Group Markets, where members have lower deductibles on average as compared to the Individual Market, the percentage of members with a deductible greater than $3,000 has increased from 20.5% to 37.3% in the Small Group Market and from 14.0% to 26.4% in the Large Group Market. As shown, from 2010 to 2011 it appears that the Group Markets experienced a larger shift to higher deductible plans as compared to the Individual Market. This may be due to prevalence of benefit buy-downs prior to 2010 in the Individual Market.

	Individual		Small Group		Large Group	
Deductible	**2010**	**2011**	**2010**	**2011**	**2010**	**2011**
$0	0.2%	0.0%	3.9%	1.7%	20.2%	19.0%
$1 - $500	0.0%	0.0%	1.8%	0.4%	4.5%	3.1%
$501 - $1,000	0.5%	0.4%	11.1%	3.2%	15.1%	9.0%
$1,001 - $1,500	29.0%	26.1%	21.7%	18.8%	17.6%	15.7%
$1,501 - $3,000	33.9%	33.0%	41.2%	38.4%	28.6%	26.8%
$3,001 - $5,000	2.9%	2.4%	13.7%	29.6%	10.1%	21.4%
greater than $5,000	33.4%	38.0%	6.8%	7.7%	3.9%	5.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 3 – Distribution of Membership by Deductible Levels by Market Segment and Year[8, 9]

[8] Source: NH Supplemental Report Data. Excludes plans with no cost sharing. The NH Supplemental Report Data includes membership that is based on both NH situs and NH residents.

[9] 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

Table 4 shows the average deductible, member coinsurance percentage, office visit copay and member out-of-pocket limit by year. The average deductibles in the Individual Market increased $172 while the deductibles in the Small Group and Large Group Markets increased $362 and $286, respectively.

	Individual		Small Group		Large Group	
	2010	2011	2010	2011	2010	2011
Average Deductible	$3,167	$3,339	$1,985	$2,347	$1,419	$1,706
Average Coinsurance	15.0%	13.6%	3.5%	2.8%	4.5%	4.5%
Average Copay	$10	$10	$22	$23	$22	$23
Average OOP Maximum	$4,180	$4,783	$2,488	$2,858	$2,452	$2,849

Table 4 – Cost Sharing Attributes by Market Segment and Year[10]

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 medical costs covered by the health plan for a standard population.[11] The higher the actuarial value, the more comprehensive, or the richer, the benefit plan design. The lower the actuarial value, the more the 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. Actuarial value models use data such as claims distributions and utilization data. The underlying data of a model may vary across geographies due to local cost differences and practice patterns variations. Actuarial value calculations may also vary from one carrier to another within the same state.

In order to calculate overall actuarial values by market segment, Gorman Actuarial relied on two methodologies. The first method calculated actuarial values using our internal pricing model and the cost sharing attributes from the NH Supplemental Report Data. The second method used the actuarial values reported by each carrier in the NH Supplemental Report Data.[12, 13] Figure 2 displays premium reductions due to benefit buy-down in 2011 for each fully-insured market segment based on the average of the actuarial values derived from these two methodologies. The Small Group Market experienced the largest benefit buy-down at 6.4% and the Individual Market experienced

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percentage, the highest in-network office visit copay and the maximum member out-of-pocket limit for in-network services.

[10] 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.

[11] 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
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.

[12] Ibid.

[13] GA made adjustments in cases where benefit buy-down generated by carrier reported actuarial values did not appear reasonable.

the least at 2.5%. Overall, we estimate that in 2011, premium reductions due to benefit buy-down were 4.8%.

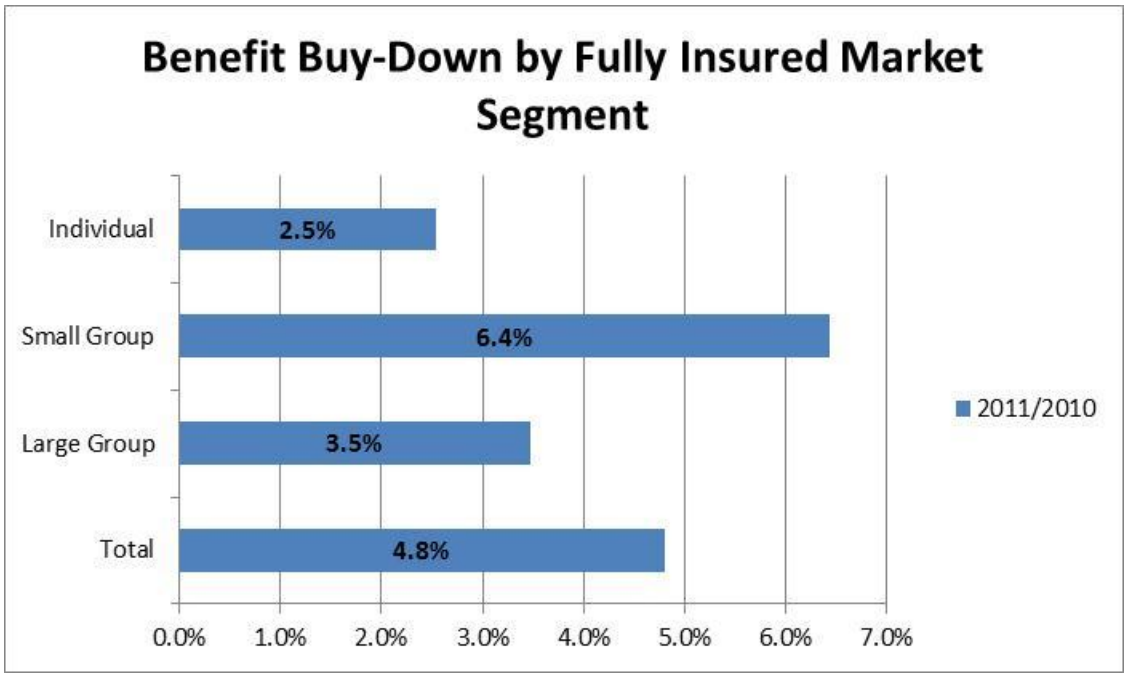

Figure 2– Benefit Buy-Down by Market Segment

The U. S. Department of Health and Human Services (HHS) released proposed ACA regulations related to actuarial value and a draft federal actuarial value calculator for comment in November 2012.[14, 15] It is recommended that in future reports the federal actuarial value calculator be used to determine overall actuarial values by market segment. These actuarial values can then be used to track benefit buy-down over time.[16]

In addition to benefit buy-down, other trends in product offerings can influence premium trends. Figure 3 displays the percentage of New Hampshire private market membership by product and insured status for 2010 and 2011. This includes all market segments. There has been little shift between these two years. The proportion of total fully-insured members has decreased slightly from 46% to 45%, while the proportion of the combined PPO and Indemnity population has increased slightly from 42% to 44%.

[14] http://www.ofr.gov/OFRUpload/OFRData/2012-28362_PI.pdf
[15] http://cciio.cms.gov/resources/regulations/index.html
[16] While the benefit buy-down shown in this report will most likely be different than what will eventually be generated by the federal calculator, we believe the information provided in this section is a more standardized approach than what has been used in the past and can be used to provide directional information.

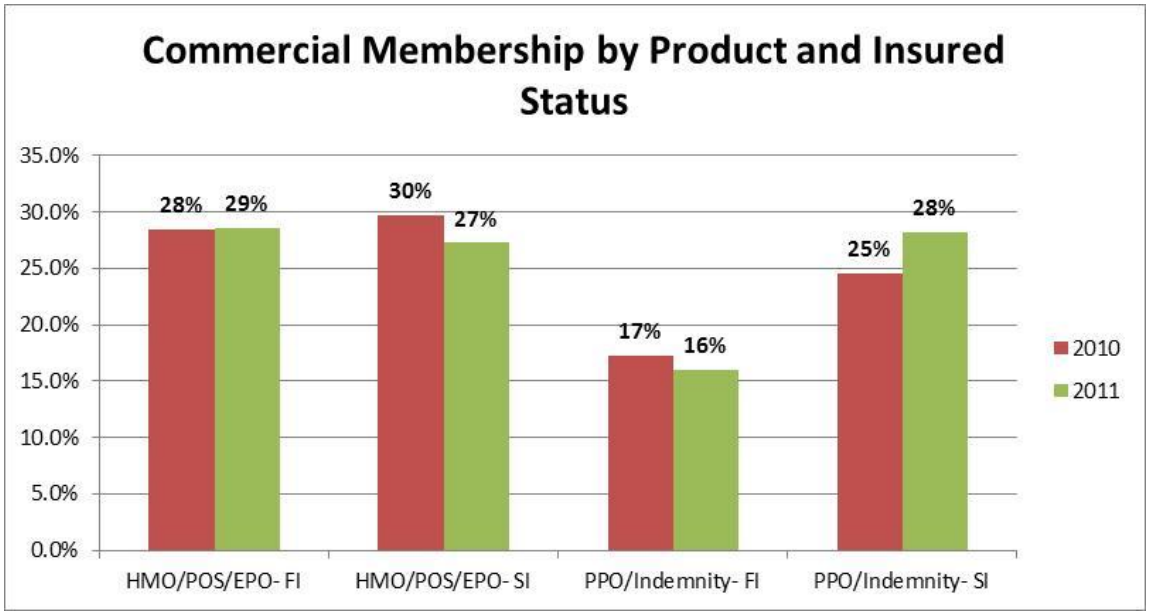

Figure 3– Commercial Membership by Product, Insured Status and Year[17]

Within the fully-insured Small Group and Large Group Markets, there have been shifts among products. Figure 4 shows that in the Small Group Market the proportion of members in HMO/POS products increased, offset by a decreases in EPO (exclusive provider organization) and PPO/Indemnity products. Figure 5 shows that in the Large Group Market, a similar effect is occurring in that the proportion of members in HMO/POS products increased while the proportion of members in PPO products decreased. These shifts vary by carrier.

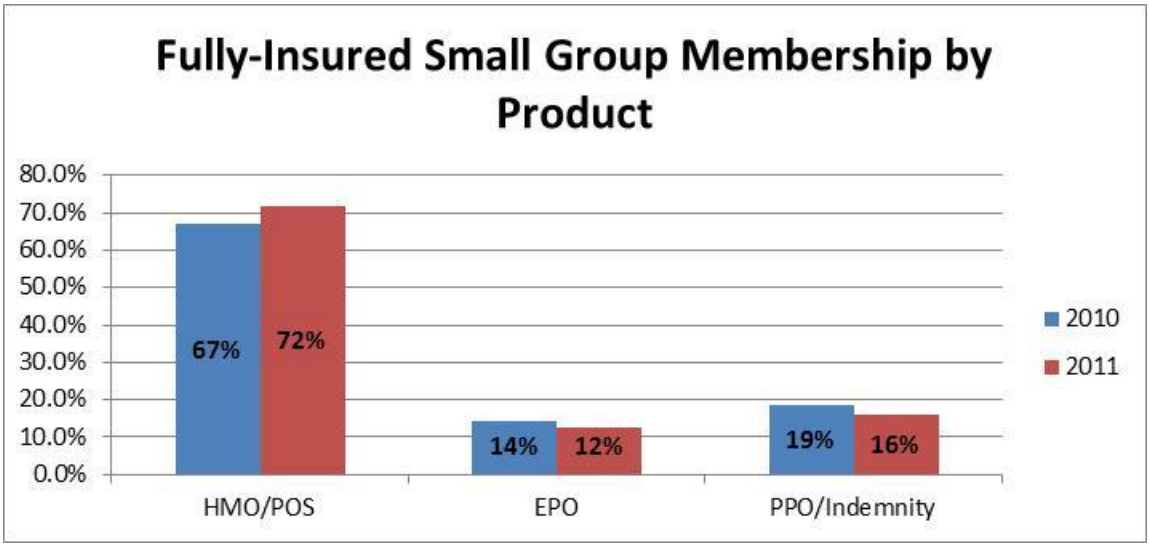

Figure 4– Fully-Insured Small Group Membership by Product and Year[18]

[17] Source: NH Supplemental Report Data
[18] Source: NH Supplemental Report Data

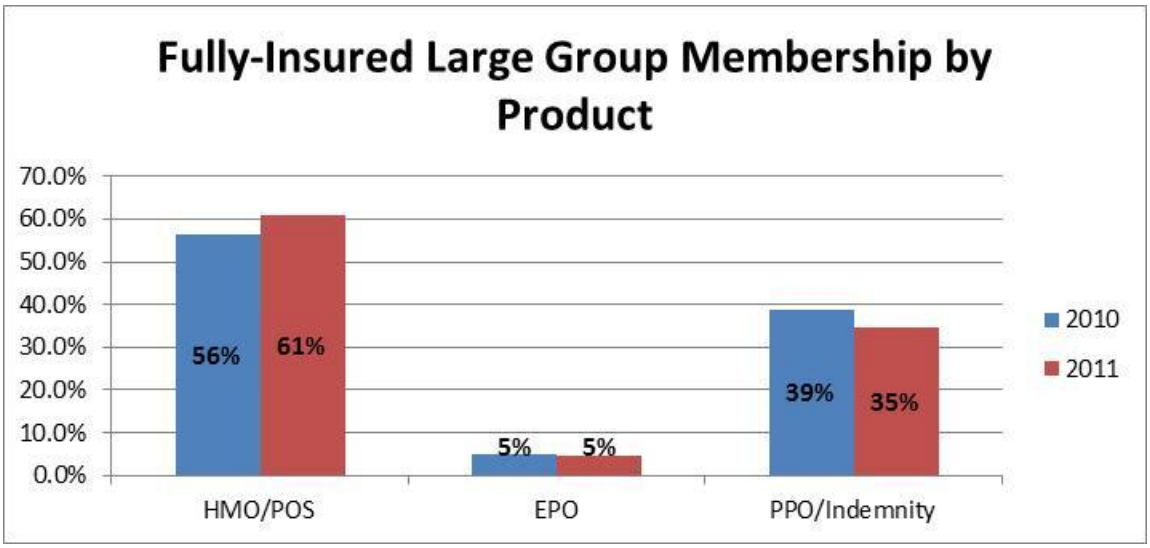

Figure 5– Fully-Insured Large Group Membership by Product and Year[19]

[19] Source: NH 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 will not increase at the same rate as if no benefit plan change was made. Using the benefit buy-downs calculated in Section 5, we can recalculate each year's 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-downs, the adjusted trends are higher than the unadjusted trends. For example, if small employers did not change their current benefit levels, in 2011 the Small Group Market would have experienced average premium increases of 11.3% (benefit-adjusted premium trend). However, since small employers did "buy-down" in 2011, the actual premium increase experienced in 2011 was 4.2% (unadjusted premium trend). On a benefit-adjusted basis, overall premiums in the fully-insured market increased 9.0% in 2011 compared to an unadjusted premium trend of 3.8%. This difference in trends varies by market segment.

Earned Premium PMPM Trends		
	Unadjusted	Adjusted
Individual	-1.8%	0.8%
Small Group	4.2%	11.3%
Large Group	5.4%	9.1%
Total Fully-Insured	3.8%	9.0%

Table 5 – Unadjusted and Benefit-Adjusted Earned Premium PMPM by Market Segment and Year[20]

[20] 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

Carriers set premium rates to pay for anticipated future claims, expenses and profits. However premiums are typically established well in advance of the rate effective date. Therefore there is a timing lag between the drivers of actual experience, and the development of assumptions and trends used in the premium rate development or pricing process. In Section 7, we will explore the trends and drivers of each component of premium – claims, expenses and profits – with a focus on their impact in driving 2011 premium rate levels and actual 2011 results.

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. Table 6 shows the paid claim PMPM's by market segment in 2010 and 2011. Across all fully-insured markets, the paid claims PMPM was essentially unchanged. The Individual and Large Group Markets had PMPM increases which are offset by a decrease in the Small Group Market. Consistent with the difference in premium PMPM's in Table 2, the Individual Market paid claim PMPM's are substantially lower than the Group Markets due to higher average levels of member cost sharing and the existence of health underwriting in the Individual Market which drives a healthier risk pool

Paid Claim PMPM's by Market Segment			
	2010	2011	% Change
Individual	$184.52	$191.43	3.7%
Small Group	$353.31	$345.28	-2.3%
Large Group	$357.09	$367.44	2.9%
Total Fully-Insured	$339.31	$339.12	-0.1%

Table 6 – Paid Claim PMPM's by Market Segment, Actual[21]

Table 6 is based only on the paid claim amounts which are covered by the carriers. In contrast, Figure 6 shows the annual allowed claim trends by market segment. Allowed claims is the sum of the claim amounts paid by the carriers and the payments paid by the members through cost-sharing, such as deductibles and copays. While allowed trends can also be influenced by factors such as changing demographics, the paid trends, like the unadjusted premium trends, can be further skewed by shifts in benefit levels that increase member cost sharing and reduce the

[21] 2012 Carrier Questionnaire

amount covered by insurance. Therefore allowed claim trends provide a more stable and comprehensive view of the change in the cost of providing care in the system.

Across all fully-insured markets in 2011, the average allowed claim trends were 3.0%, a slight decrease from 3.2% in 2010. 2011 trends in the Individual and Small Group Markets were up less than one percentage point compared to 2010 trends, but were offset by a one percentage point decline in Large Group trends from 2010. All three markets remained significantly below the trends seen in 2009. On a national basis, the Segal Health Plan Cost Trend Survey indicated 2011 trends were the lowest reported in the past eleven years.[22]

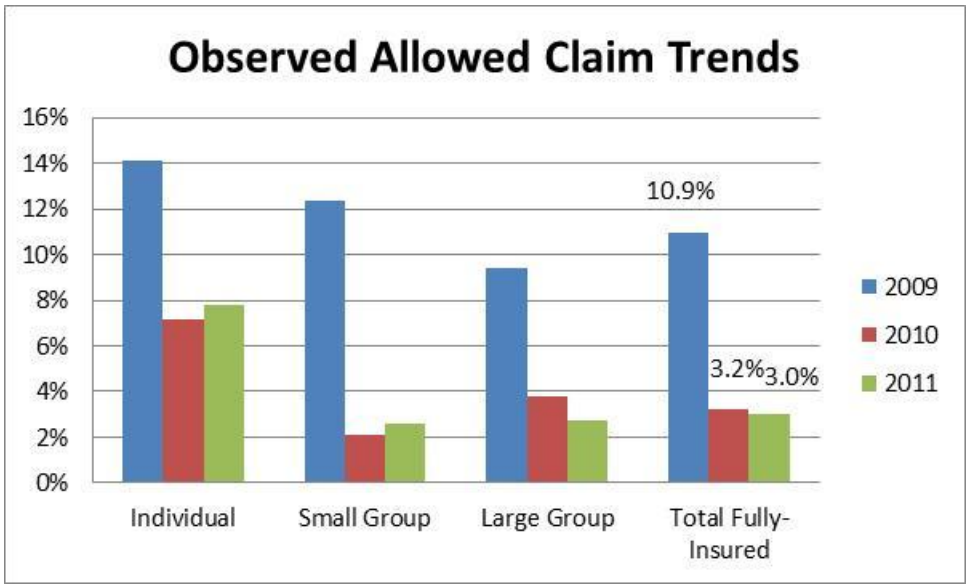

Figure 6– Observed Allowed Claim Trends[23]

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. 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 higher cost service.

[22] http://www.sibson.com/publications/surveysandstudies/2013trendsurvey.pdf
Table 4: Selected Medical, RX Carve Out and Dental Trends: 2001 – 2011 Actual and 2012-2013 Projected

[23] 2012 Carrier Questionnaire – weighted average by paid claim amounts in the corresponding year.

Figure 7 and Figure 8 isolate the utilization and the cost components of the allowed trends. With negative trends the last two years, clearly utilization has been the major driver of the overall reduction in claim trends since 2009. As utilization trends are negative, the offsetting increase in provider reimbursement levels continue to drive premium increases overall. Across all markets, 2011 utilization trends were consistent with 2010 levels at -2.1%. As seen in the total trends, both years were well below 2009 levels. The 2011 utilization trend in the Individual Market showed a significant drop from 2010, while the Group Markets had more modest shifts. During the September 24th hearing, the participating carriers all commented that overall utilization in 2011 had been more favorable than assumed in pricing. While the carriers provided some insight into the services driving their favorable utilization trends, there was little consistency among the carrier reasons on which to draw broader conclusions.

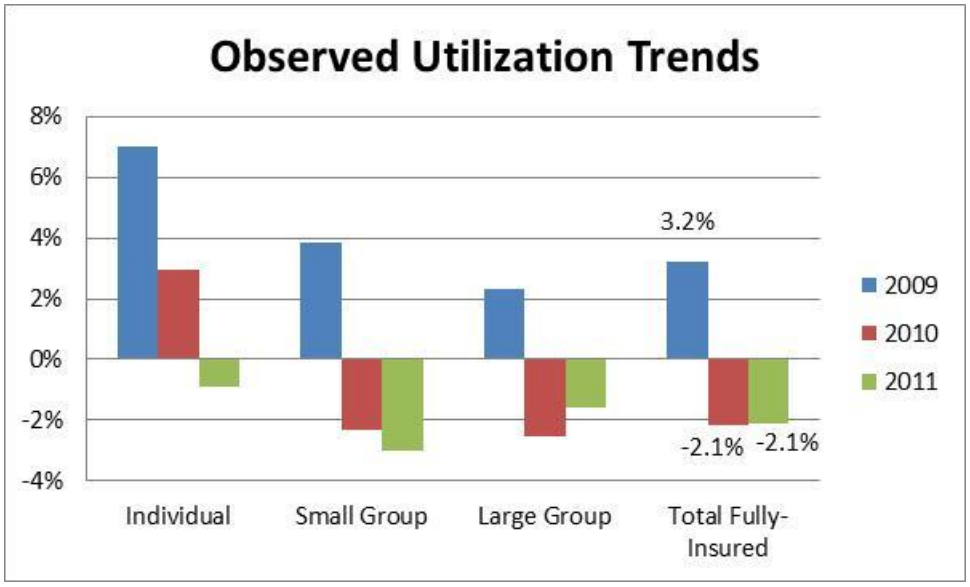

Figure 7– Observed Utilization Trends[24]

The cost trends represent both the changes in the negotiated rates with contracted providers as well as the changing severity mix. Across all fully-insured markets, the 2011 cost trends of 5.2% were down slightly from 2010 trends of 5.6%. This is consistent with average increases in provider reimbursement levels dropping slightly from 5.3% in 2010 to 5.0% in 2011.[25] The cost trends by market segment have shown more volatility in the last few years. The Individual Market trend increased more than four percentage points in 2011 after dropping three points the previous year. 2011 Small Group trends were also up after a drop of nearly four points in 2010. Conversely the Large Group Market did not have a significant drop in 2010 trends, but did have a decline of two points in 2011. Smoothing out the year to year

[24] 2012 Carrier Questionnaire – weighted average by paid claim amounts in the corresponding year.
[25] 2011 & 2012 Carrier Questionnaires – weighted by paid claim amounts in the corresponding year.

volatility, cost trends in each market segment have averaged in the range of 5.1% to 6.4% over the last two years.

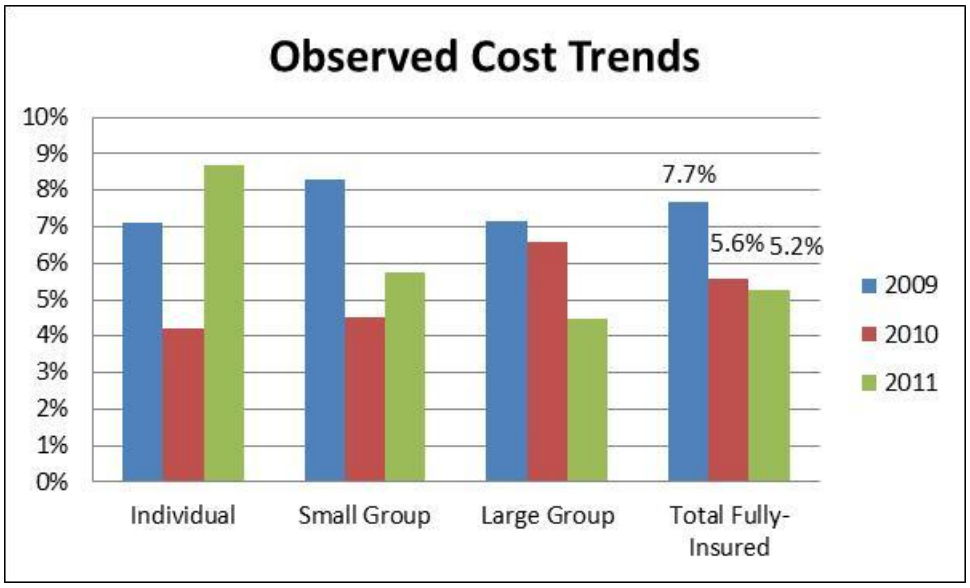

Figure 8– Observed Cost Trends[26]

Claim payments can also be segmented by the type of service that is being covered. Figure 9 shows the distribution of 2011 claim payments across all fully-insured markets by the various types of service. Slightly more than half of all claims were paid to a facility such as a hospital or ambulatory surgical center to cover inpatient or outpatient care. Professional care such as office visits to a physician or therapist accounted for 29% of total claims, while prescription drugs represented 15% 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.

[26] 2012 Carrier Questionnaire – weighted average by paid claim amounts in the corresponding year

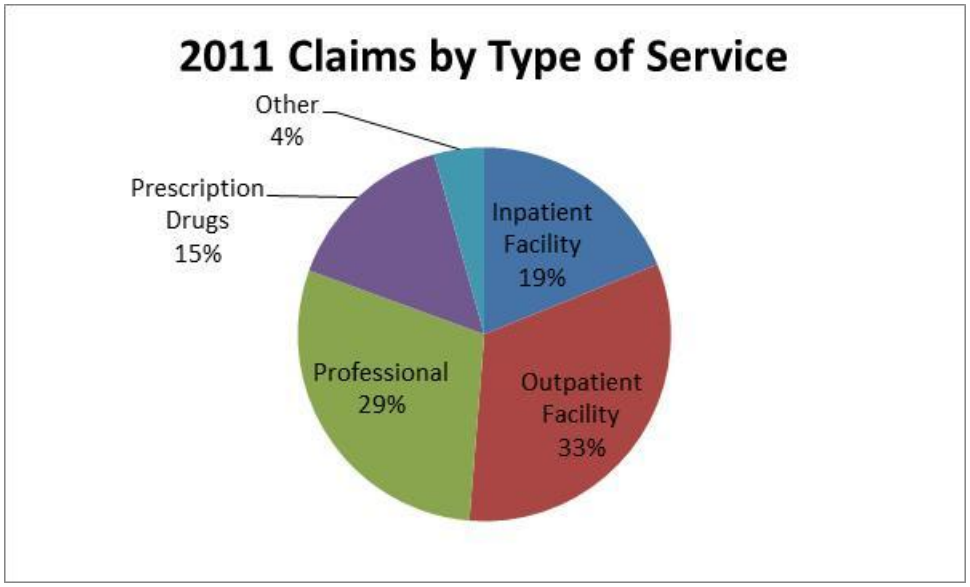

Figure 9 – 2011 Paid Claims by Type of Service, Fully-Insured Markets[27]

Figure 10 presents the observed 2011 allowed trends by the four major types of service categories across all fully-insured markets. The pharmacy trends were the highest at 5.8% driven by the Individual Market. The trends in the non-pharmacy service categories showed some consistency across all markets in the 3.2% to 4.1% range.

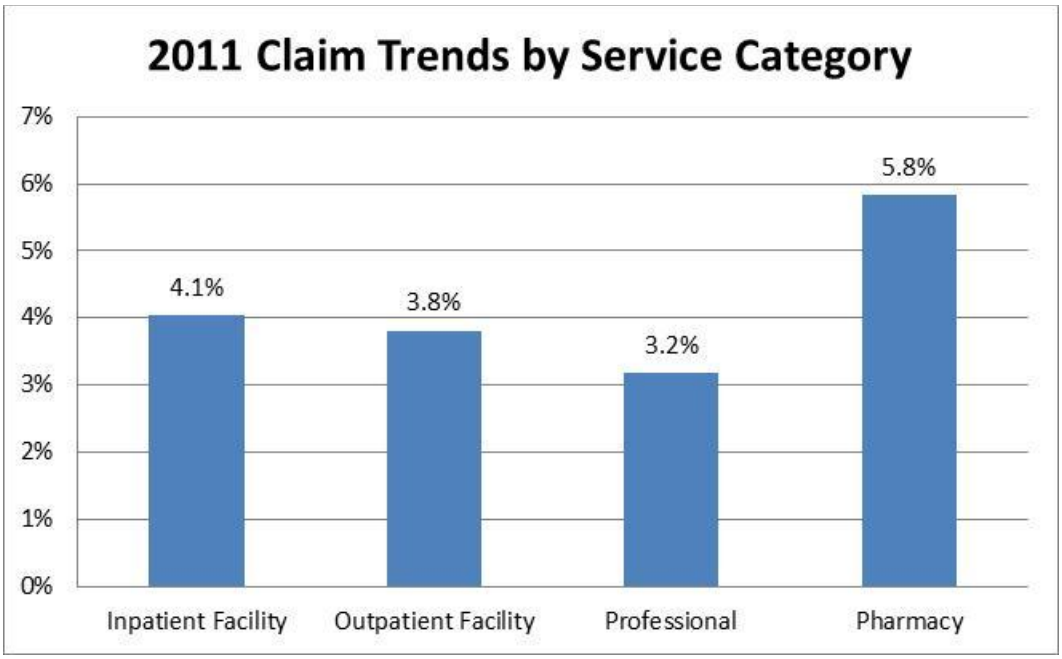

Figure 10 – Observed Trends by Service Category, Fully-Insured Markets[28]

[27] 2012 Carrier Questionnaire

One reason the Individual Market has been experiencing higher trends than the Group Markets is the aging of the membership within that block. Figure 11 shows average member age across each market segment as of December in 2009, 2010 and 2011. As of December 2011, all markets have the same average member age of 36.6. Yet just two years ago the average in the Individual Market was roughly one year younger than the group markets. The increase from 2010 to 2011 was 0.8 years in the Individual market compared to 0.2 and 0.3 years in the Small Group and Large Group markets, respectively. While these fractions may seem minor, the fact that the Individual Market has been aging at two to three times the rate seen in the Group Markets can have a significant impact on relative claim trends across markets.

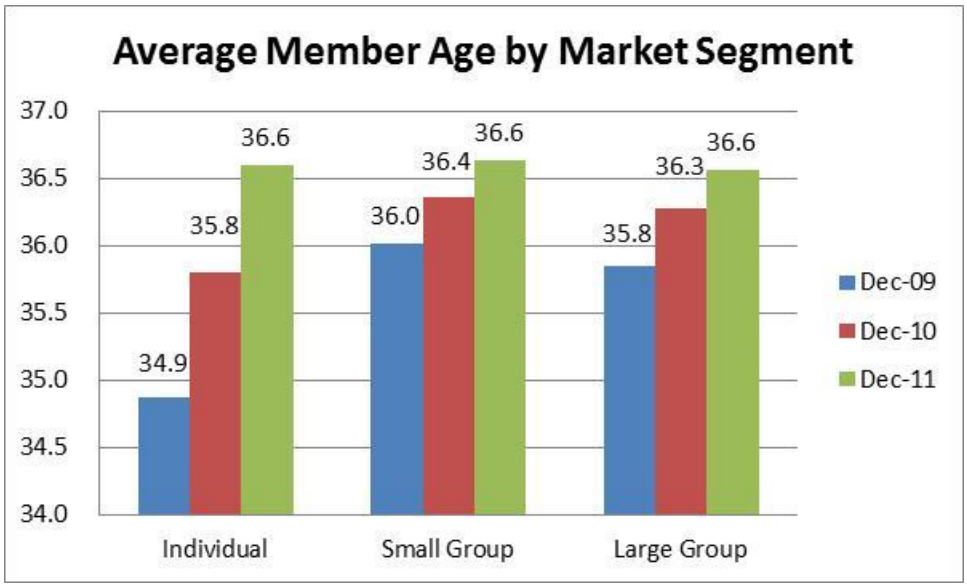

Figure 11– Average Member Age by Market Segment[29]

7.3. Pricing Trends

Our review thus far has focused on observed trends which are a retrospective view of the change in claim experience from one year compared to the prior year. These are calculated metrics from known outcomes. However, health insurance premiums are established well in advance of their effective period which requires insurance carriers to develop projected trend assumptions called pricing trends. Pricing trends are a prospective view, and represent a point estimate based on actuarial analysis of the expected increase in claim costs.

[28] 2012 Carrier Questionnaire – weighted average by paid claim amounts. The total Fully-Insured trend for the "Other" service category was 0.1%.
[29] 2012 Carrier Questionnaire

Figure 12 shows a timeline of the typical pricing process that actuaries at each carrier will follow to develop premium rates. In this example, the rates will apply for someone purchasing coverage effective for calendar year 2013. Working backward on the timeline, rates typically must be filed with the state for review three months before the effective period, or in this case, October 1, 2012. Actuaries will do most of the pricing work for this effective period between July and September 2012. In order to get the most complete and accurate claims data to be used in the base for premium development, actuaries will allow for two or three months of lag in claim reporting. In this example, for premiums effective January 2013, the base experience used in pricing would be claims incurred April 2011 through March 2012. Pricing trend assumptions, particularly for utilization and severity, are typically based on analysis of historical experience up to four years prior to the effective period. Unit cost trend assumptions are based on the provider contracting changes between the base and the effective periods. Due to these timing issues, there is typically a significant lag between what is observed in experience and what gets reflected in premiums.

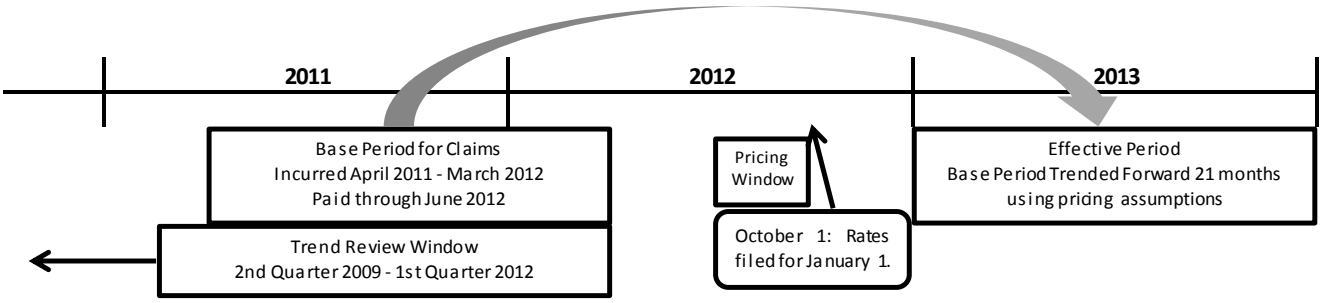

Figure 12– Typical Pricing Timeline

At the beginning of this section, in Figure 6, the observed trends showed significant favorable development in 2010 and 2011 relative to 2009. Figure 13 shows average pricing trends across all fully-insured markets from 2009 through 2013. As shown, the favorable observed trends that began in 2010 do not get reflected in pricing trend assumptions until 2011 and then more so in 2012 and 2013 as the favorable experience has continued. The 2013 Segal Health Plan Cost Trend Survey[30] reported average projected 2013 trends of 7.9% - 8.8%. The average 2013 pricing trend in New Hampshire of 8.6% is consistent with this national trend survey.

[30] http://www.sibson.com/publications/surveysandstudies/2013trendsurvey.pdf
2013 Medical (Actives and Retirees < age 65) with Pharmacy; excluding FFS / Indemnity plans

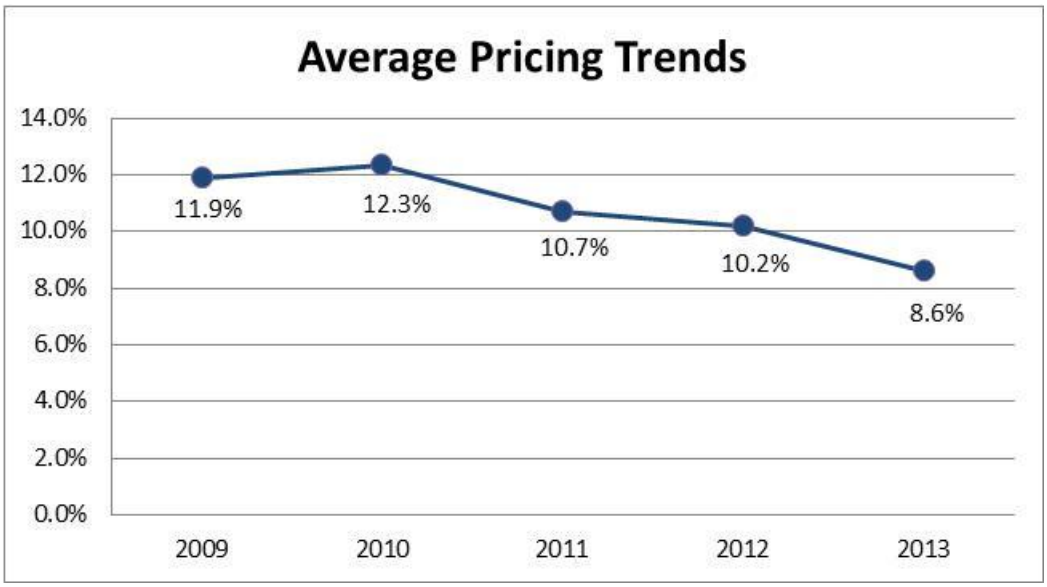

Figure 13– Average Pricing Trends[31]

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. Carriers establish target loss ratio assumptions during their pricing process. Given the rates filed, this is the percentage of premium that can fund projected claims. Table 7 shows the average target loss ratios by market segment in 2010 and 2011. As shown, the 2011 target medical loss ratio was 83.3%. Therefore, on average, carriers charged 16.7% of the premium rate to cover administrative expenses and to contribute to profits. The Large Group market shows the greatest change in target moving from 84.4% to 84.9%, but the other markets show minimal change from the prior year targets. The 2009 targets were consistent with 2010. Carrier pricing strategies, including loss ratio targets, tend not to shift dramatically from year to year so this is not unexpected. In subsequent sections, we will explore expenses and margin in more detail.

[31] Average pricing trends are based on Carrier Questionnaire responses in 2011 and 2012. Carrier responses by market segment were weighted by paid claim amounts for the corresponding year. 2012 and 2013 averages are weighted based on 2011 claims. The 2012 Carrier Questionnaire requested detail on pricing trends separating utilization versus cost, and pricing trends by medical type of service categories. Not all carriers were able to comply with this request.

Medical Loss Ratios in Rating Assumptions by Market Segment			
	2010	2011	Change
Individual	72.5%	72.6%	0.1%
Small Group	83.0%	82.9%	-0.1%
Large Group	84.4%	84.9%	0.5%
Total Fully-Insured	83.0%	83.3%	0.3%

Table 7 – Average Target Medical Loss Ratios, Carrier Rate Filings[32]

The Affordable Care Act (ACA) established Minimum Medical Loss Ratio 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. 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. subtracting administrative expenses used to improve health care quality) and also for credibility where carriers have relatively small market penetration.

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 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.[33]

Based on 2011 experience, New Hampshire carriers generally were compliant with the minimum loss ratio standards. Of the $1.1 billion in rebates paid nationwide, there was only one small rebate paid in New Hampshire.[34] In the Large Group Market, Cigna had a medical loss ratio of 84.9% based on the NAIC definition compared to the 85.0% minimum standard. As a result, Cigna paid rebates of $77,507 shared by approximately 16,000 covered lives. There were no rebates required in the New Hampshire Individual and Small Group markets.

Table 8 shows the average actual medical loss ratios by market segment. Note that these are not the medical loss ratio metrics as defined by the ACA, but the more simple calculation of claims divided by premium. There are much more substantial shifts in experienced loss ratios from 2010 to 2011 as compared to the target loss ratios. The average experienced loss ratio across all fully-insured markets declined from 85.4% to 82.2%. The average medical loss ratios in the Small Group and

[32] 2011 & 2012 Carrier Questionnaire: weighted average by market membership
[33] http://cciio.cms.gov/programs/marketreforms/mlr/nh_mlr_adj_decletter.pdf
[34] http://www.healthcare.gov/law/resources/reports/mlr-rebates06212012a.html

Large Group Markets declined by 5.4 and 2.0 percentage points, respectively. This was driven by the lower than expected observed claim trends in 2011 compared to pricing trend assumptions. However the Individual Market loss ratio increased by 3.5 percentage points from 62.5% to 66.0%. Although 2011 paid claim trends in this market were relatively modest at 3.7%, 2011 premium PMPM declined by 1.8% as it is assumed that carriers adjusted their pricing levels in this market to manage to the minimum loss ratio standards established under the ACA.

Actual Medical Loss Ratios by Market Segment			
	2010	2011	Change
Individual	62.5%	66.0%	3.5%
Small Group	87.4%	82.0%	-5.4%
Large Group	86.8%	84.8%	-2.0%
Total Fully-Insured	85.4%	82.2%	-3.2%

Table 8 – Average Medical Loss Ratios, Actual Experience[35]

7.5. Administrative Expenses

As indicated above, carriers filed premium rates in 2011 expecting 16.7% 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. After remaining consistent from 2009 to 2010, the overall expense ratio across the fully-insured markets increased from 13.0% in 2010 to 14.0% in 2011. Therefore, on average, carriers charged 14% of the premium rate for administrative expenses in 2011. The Individual Market expense assumptions declined by 1.2 percentage points, but this drop was more than offset by increases of 1.7 and 0.7 percentage points in the Small Group and Large Group Markets. Some administrative functions tend to be more cost efficient in the Group Markets than in the Individual Market. One example of this would be carrier billing. Typically each group receives one consolidated bill for all subscribers whereas every subscriber in the Individual Market receives their own bill. Due to these efficiencies, it is not unusual to see higher expense ratios in the Individual Market.

[35] 2012 Carrier Questionnaire

Expense Ratios in Rating Assumptions by Market Segment			
	2010	2011	Change
Individual	19.0%	17.8%	-1.2%
Small Group	13.2%	14.9%	1.7%
Large Group	12.1%	12.7%	0.7%
Total Fully-Insured	13.0%	14.0%	1.0%

Table 9 – Average Expense Ratios, Carrier Rate Filings[36]

Table 10 shows the actual expense ratios and expense PMPM costs experienced by market segment in 2010 and 2011. In both years, the actual expense ratios are above the ratios assumed in the premium rates, in total and in each market segment. This is likely due to a growth in higher deductible benefit plans with reduced premiums. Since a portion of administrative expenses are fixed costs, plans with lower premiums will typically have higher expense ratios.

Across all fully-insured markets, the actual total administrative expense PMPM as reported by carriers increased 5.6%. Since this was above the overall premium trend of 3.8%, the actual expense ratios increased 0.2 percentage points from 14.6% in 2010 to 14.9% in 2011. The directional change in expense ratios was fairly consistent with the change in the assumed expense ratios in the rate filings by market segment. The exception was the Large Group Market, in which the expense ratio declined by 0.3 percentage points. The expense PMPM in the Large Group Market did increase by 3.0%, but because that was below the Large Group Premium PMPM increase of 5.4%, the expense ratio in that market declined.

Actual Expense Ratios and PMPM's by Market Segment			
Expense Ratio	2010	2011	Change
Individual	23.0%	21.9%	-1.1%
Small Group	14.3%	15.3%	1.1%
Large Group	13.8%	13.5%	-0.3%
Total Fully-Insured	14.6%	14.9%	0.2%
Expense PMPM	2010	2011	% Change
Individual	$67.84	$63.53	-6.4%
Small Group	$57.63	$64.49	11.9%
Large Group	$56.78	$58.50	3.0%
Total Fully-Insured	$58.17	$61.41	5.6%

Table 10 – Average Expense Ratios and PMPM's, Actual Experience[37]

[36] 2011 & 2012 Carrier Questionnaire: weighted average by market membership
[37] 2012 Carrier Questionnaire

7.6. Profit Margins

Insurance carriers set target margins in their pricing with two distinct goals in mind: profit and risk management. The profit motive is easily understood. The risk management goal is less obvious, and certainly less discussed. Pricing assumptions for claims and expenses represent actuarial best estimates based on a thorough analysis. The degree to which the actuaries feel the best estimates are based on a large enough sample of credible data will impact their margin assumptions as well. In markets where a carrier has lower membership, the available data is generally less credible. This leads to a higher degree of volatility and higher likelihood that a small number of adverse events can drive the overall financial results of the block. Therefore these smaller blocks tend to have a higher risk margin added on to the profit margin targets when products are priced.

Table 11 shows the average pricing margins by market segment in rate filings for 2010 and 2011. Consistent with the smaller market size, the Individual Market in New Hampshire has much higher pricing margins than the group markets. Overall, pricing margins declined to 2.8% in 2011 led by the Group Market segments. Therefore, on average, in 2011 carriers charged 2.8% of premiums for profit and risk margin, down from 4.0% in 2010.

Pricing Margin in Rating Assumptions by Market Segment			
	2010	2011	Change
Individual	8.5%	9.6%	1.1%
Small Group	3.9%	2.2%	-1.7%
Large Group	3.5%	2.4%	-1.1%
Total Fully-Insured	4.0%	2.8%	-1.2%

Table 11 – Average Pricing Margins, Carrier Rate Filings[38]

Table 12 shows the actual profit margins by market segment experienced in 2010 and 2011. 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 0.0% to 2.9%. The increased profit margins in 2011 are consistent with the reduced loss ratio, and the recent favorable claim trends, particularly utilization, at a level below pricing assumptions.

[38] 2011 and 2012 Carrier Questionnaires – weighted average by market membership

Actual Profit Margins by Market Segment			
Profit Margin %	**2010**	**2011**	**Change**
Individual	14.6%	12.2%	-2.4%
Small Group	-1.7%	2.6%	4.3%
Large Group	-0.6%	1.7%	2.3%
Total Fully-Insured	0.0%	2.9%	2.9%
Profit PMPM	**2010**	**2011**	**$ Change**
Individual	$43.09	$35.29	-$7.80
Small Group	-$6.85	$11.12	$17.97
Large Group	-$2.50	$7.47	$9.97
Total Fully-Insured	-$0.07	$12.00	$12.07

Table 12 – Average Profit Margin and PMPM, Actual Experience[39]

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 14 shows the underwriting gain percentage (the operating profit margin) for the combined Individual, Small Group and Large Group Markets from the 2010 and 2011 Supplemental Health Care Exhibits. The total underwriting gain percentage increased from -0.1% in 2010 to 3.1% in 2011, relatively consistent with the total values shown in Table 12. In total dollars, this was an increase from an underwriting loss of $2.1 million on premiums of $1.45 billion in 2010 to a gain of $44.8 million on a similar amount of premium in 2011. Each of the four largest carriers showed improvement from 2010 to 2011. Although MVP still showed an underwriting loss of 1.7% in 2011, they showed the largest improvement from 2010 in both percentage and actual dollars of underwriting margin. Harvard Pilgrim showed the second largest improvement in both percentage and dollar terms. Anthem continued to lead the market with a 4.5% underwriting gain in 2011.

[39] 2012 Carrier Questionnaire

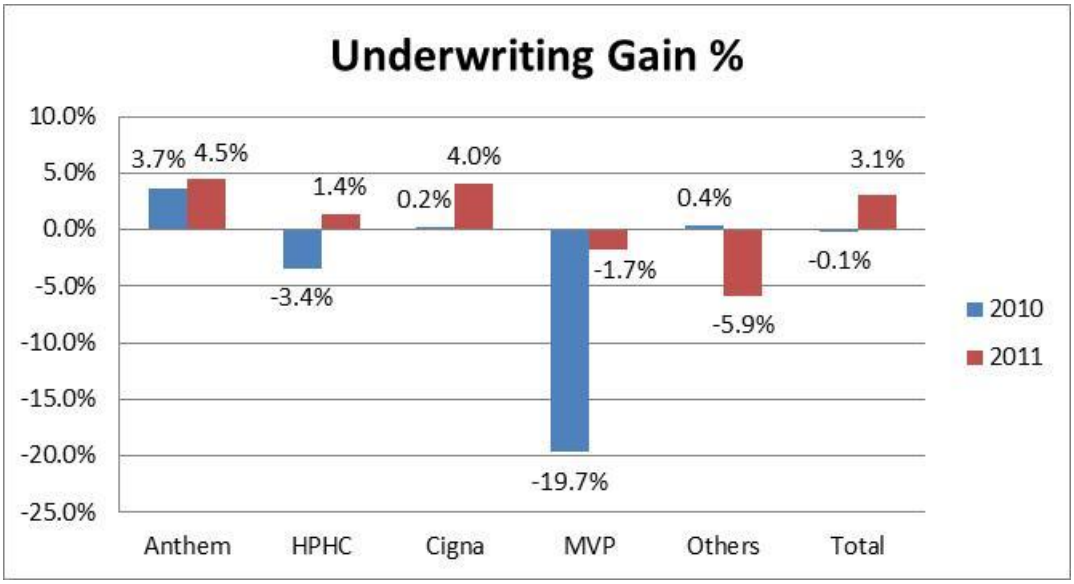

Figure 14– Underwriting Gain Percentage by Carrier[40,41]

[40] 2010 & 2011 Supplemental Health Care Exhibits. Underwriting Gain/Loss (Part 1, Line 11) divided by Health Premiums Earned (Part 1, Line 1.1).
[41] "Others" represent 2.6% of the fully-insured premium.

8. Cost Control Strategies

8.1. Plan Design

In the public hearing both this year and last, the carriers discussed benefit designs as a key lever in managing health care costs. Site of service benefit designs offer differential member cost sharing depending on where the member receives specific services, such as labs and ambulatory surgery. These plan designs provide an incentive, through reduced cost sharing, for members to choose lower cost providers.

Tiered network products are another type of plan design that provides incentives through reduced cost sharing for members to choose lower cost providers. These products offer different deductibles and copayments depending on the provider tier chosen by the member. There are several different types of tiered network products. For example, some tiered network products tier hospital services only, while other tiered network products tier both physician and hospital services. The tiering methodology is typically based on some combination of cost and quality metrics and the specific methodology may vary by carrier. Lower costing and higher quality providers are generally placed in tiers with lower member cost sharing, while higher costing or lower quality providers are placed in tiers with higher member cost sharing. The general goals of these types of benefit designs and products are to use increased transparency to engage consumers in the cost of their healthcare decisions while influencing providers to maintain cost competitiveness in contract negotiations.

Site of service benefit designs and tiered network products have experienced significant membership growth over the past several years in certain market segments as demonstrated in Figure 15. In the Small Group Market, the percentage of members in site of service benefit designs and tiered network products has increased from 10% as of December 2009 to over 56% as of December 2011. As noted in the carriers' public testimony, in the Small Group Market these types of benefit designs and products have become the standard benefit design thus driving the large increase. There have also been moderate increases in the fully-insured 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 25% in December 2011. The largest carriers surveyed indicated that site of service benefit designs and tiered network products are not currently offered in the Individual Market. As of December 2011, 34% of the members in the total fully-insured market are in either site of service benefit designs or tiered network products and over 80% of these members are in site of service benefit designs as opposed to tiered network products.

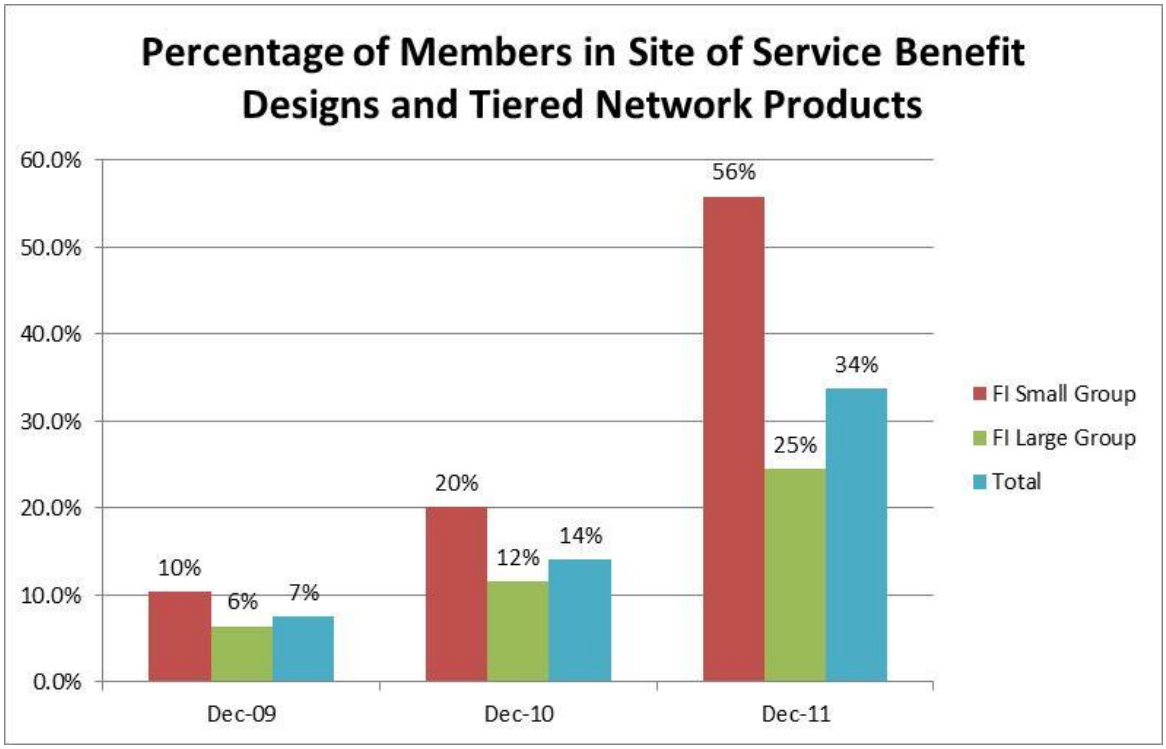

Figure 15– Percentage of Members in Site of Service Benefit Designs and Tiered Network Products by Market Segment and Year[42]

Some in the industry, particularly providers, have questioned how much the site of service benefit designs and tiered network products lower health care costs to the overall system. As the shifts to these benefit designs and products are fairly recent, analyzing their impact on overall health costs may be premature. As experience for this population grows, we recommend conducting further analysis in future reports on this subject.

8.2. Provider Reimbursement

As shown above, a primary contributor of medical costs and medical trends is provider reimbursement. Many health care industry experts believe that fee-for-service provider payment models, widely in use across the country, lead to excess utilization of services and higher costs overall than are necessary to provide quality care to patients. These experts commonly state that risk-sharing arrangements better align incentives between the carrier and the providers as compared to traditional fee-for-service type payment arrangements and will ultimately lower costs to the health care system.

In response to the carrier questionnaire, all carriers indicated that they are either exploring opportunities to move towards more risk-sharing arrangements, or they

[42] Source: 2012 NHID Carrier Questionnaire

already have risk-sharing arrangements in place with certain providers. In a risk-sharing arrangement, the providers have more responsibility for managing the utilization and cost of care for their patients. In order for risk-sharing arrangements to be successful, providers need the infrastructure and data tools necessary to manage the risk.

Risk-sharing arrangements with providers can take on different forms. In a typical risk-sharing arrangement, there is a total claims PMPM "global budget" target that is negotiated between the carrier and the provider in advance and then the provider is financially responsible for all the care their patients receive regardless of where the patient receives the care. Providers in these types of arrangements can keep the surplus if care is provided at a cost below the global budget, but they receive no additional payments if care is more costly than the negotiated rate. Some risk-sharing arrangements also include a quality incentive component, so that the provider is incented to not only control use and costs, but to also improve the quality of care. In some arrangements, a surplus payment may only be made if certain quality targets are met. In addition, instead of measuring a provider against a global budget PMPM target, the provider may be measured against a trend target, where a surplus payment is made only if a provider's trend is below a certain target. Certain services or members may be carved-out of the global budget, such as high cost claimants. Each component of the contract is negotiated between the provider and carrier and each carrier's contract may differ greatly from provider to provider.

Given the potential to decrease overall health care costs and to improve quality of care, provider risk-sharing arrangements are a topic of great interest in New Hampshire and throughout the country. As shown in Figure 16, while New Hampshire has experienced growth in its percentage of membership represented in risk sharing arrangements with both upside and downside risk, it is still a relatively small percentage of total fully-insured membership at 11% as of December 2011.

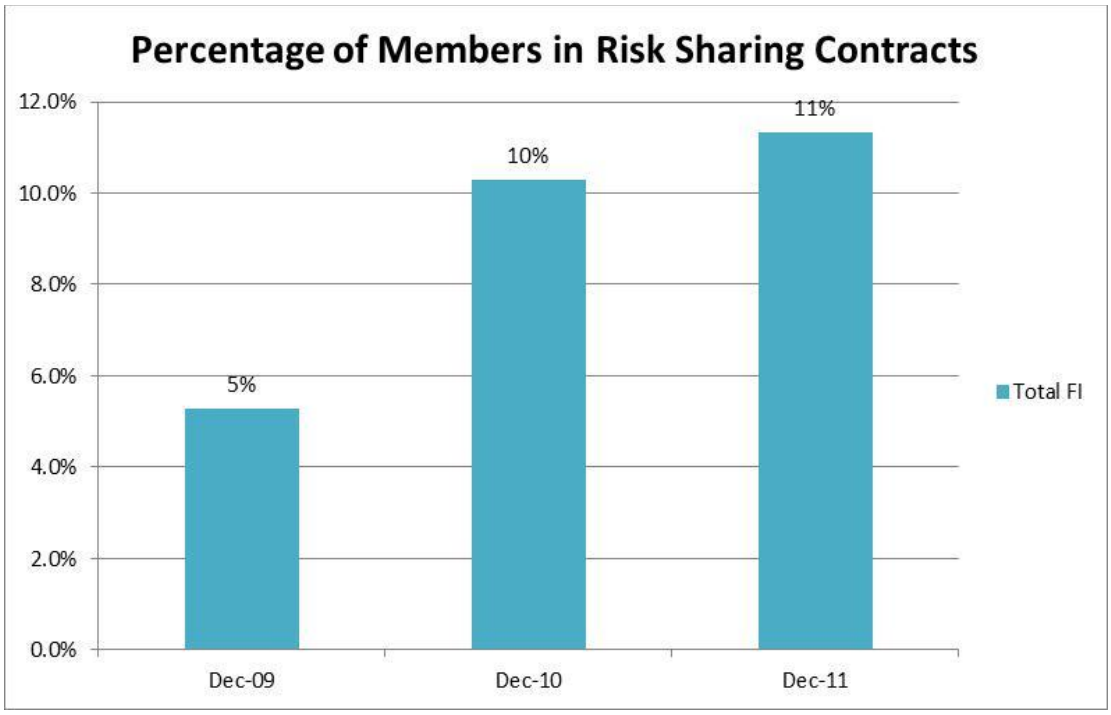

Figure 16– Percentage of Members in Risk Sharing Contracts by Market Segment and Year[43]

In both the carrier questionnaire and the testimony presented at the public hearing, several common themes emerged from the carriers regarding challenges to their provider contracting strategy over the next several years. These challenges include:

- The ability to appropriately assess a provider's readiness and ability to accept financial risk and providing tools and information to help providers manage that risk;
- In addition to aligning carrier and provider financial incentives, the ability to also align consumer incentives with benefit plan designs that promote the highest quality of care at the most cost efficient and appropriate place of service;
- The continued concerns regarding provider cost-shifting from public payers (Medicare and Medicaid) to private commercial payers;
- The ability to evolve provider payment models to include PPO products;
- The continued focus on controlling medical costs while simultaneously maintaining or increasing quality of care;
- The concerns of carriers with smaller market share in their ability to effectively negotiate and drive provider payment reform without some level of

[43]Source: 2012 NHID Carrier Questionnaire

statewide support and coordination given their lack of leverage with providers;
- The uncertainty resulting from changes related to the ACA;
- The consolidation of providers in New Hampshire.

The only provider representative at the public hearing, Dr. John Butterly of Dartmouth Hitchcock Medical Center, further emphasized several points from a provider perspective in regards to provider payment reform:

- There are vast differences in the requirements needed to manage a fee-for-service payment system compared to a "population health management" payment system.
- Providers need to be able to share in the "cost-savings" resulting from efficiencies in provider payment reform in order to cover the costs of transitioning to a population health management payment system.
- When analyzing provider efficiency in a population health management system, there needs to be less focus on the average costs of individual types of services, and greater focus on total medical expenditures to the system.
- Physicians are typically unaware of each specific patient's insurance carrier and benefit plan, and because of that, they believe that their patients are best served when the physician, rather than the carrier, is controlling each patient's care coordination.

In future reports, it would be beneficial to further analyze the provider perspective on health care costs in New Hampshire and to encourage increased participation from providers in the annual hearing process.

There were several studies commissioned by the New Hampshire Insurance Department and published in 2012 related to understanding the variation in prices paid to hospitals and the impact of cost-shifting:

- "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)
- "Understanding Hospital Costs in New Hampshire" by Susan Palmer Terry
- "Analysis of Price Variations in New Hampshire's Hospitals" by the University of Massachusetts Medical School (UMMS)

These reports each study slightly different aspects of hospitals costs. One of the key findings from the study by the NHCPPS is that "variation in prices paid by health insurance companies to hospitals are not explained by differences in the quality of

care, the complexity of the population served, payer mix, levels of market competition or the penetration of managed care."[44]

The study by the UMMS concluded that the "commercial prices paid to New Hampshire hospitals varied widely, before and after adjusting for case mix."[45] These findings are consistent with findings from studies conducted in Massachusetts where a 2011 report from the Massachusetts Attorney General's Office found that "there is wide variation in payments made by health insurers to providers that is not adequately explained by differences in quality of care."[46] With regards to cost-shifting, the UMMS study suggests "a complex relationship between public payer mix and commercial prices" and that "no significant relationships were found between the proportion of uninsured charges and commercial prices for either inpatient or outpatient services."[47]

The report by Susan Palmer Terry is an in-depth analysis of hospital costs and the financial pressures faced by hospitals. The report states that hospitals "face a number of cost pressures that are not faced by entities in other industries" and that "this is due in part to the fact that hospitals do not have a typical economic relationship with its customers or patients." [48] The report goes on to conclude that both hospitals and commercial payers must work together and share joint responsibility for lowering costs in the healthcare system. In conjunction with the information collected through the annual public hearings and this report, these studies can be an important piece of groundwork for provider payment reform opportunities in New Hampshire. They highlight the importance of considering all key stakeholder perspectives when developing a payment reform strategy that will meaningfully address healthcare costs in New Hampshire.

[44] http://www.nh.gov/insurance/reports/documents/nhcpps.pdf
[45] http://www.nh.gov/insurance/lah/documents/umms.pdf
[46] http://www.mass.gov/ago/docs/healthcare/2011-hcctd.pdf
[47] http://www.nh.gov/insurance/lah/documents/umms.pdf
[48] http://www.nh.gov/insurance/reports/documents/spt.pdf

9. Regional and National Comparisons

While this analysis of New Hampshire specific trends is certainly insightful by itself, insight can be gained by considering additional effects. Healthcare and the health insurance marketplace are also influenced by many macroeconomic and industry-wide developments such as population aging, national healthcare reform and the introduction of new technology. Because of this, it is valuable to also consider New Hampshire trends in the context of national and regional trends.

The NAIC requires detailed financial statements to be filed annually by all insurance carriers.[49] 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
2010 Premium PMPM	$299.32	$395.54	$389.21
2010 Claims PMPM	$252.50	$344.41	$333.42
2010 Medical Loss Ratio	84.4%	87.1%	85.7%
2011 Premium PMPM	$311.35	$413.26	$401.50
2011 Claims PMPM	$261.80	$352.14	$329.70
2011 Medical Loss Ratio	84.1%	85.2%	82.1%
% Change in Premium PMPM	4.0%	4.5%	3.2%
% Change in Claims PMPM	3.7%	2.2%	-1.1%

Table 13 –Comparison of National, Regional and State Costs and Trends

New Hampshire premium PMPM in 2011 is 29% higher than the national level, yet 2.9% below the regional PMPM. The New Hampshire claims PMPM is 26% above the national level, but 6.5% below the regional mark. Although the variances are worth noting, it is not possible to draw conclusions regarding relative affordability without understanding more about contributing factors, such as the relative differences in the demographic profile of the insured populations and the relative actuarial value of medical benefits provided.

The trends from 2010 to 2011 show a somewhat more consistent picture across the state, region and country. New Hampshire premium PMPM increased 3.2% in 2011, slightly below the 4.5% regional and 4.0% national level. New Hampshire claims PMPM

[49] 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 2012 Carrier Questionnaire. In addition, there may be minor difference in certain definitions or exclusions of certain types of business between the NAIC filing and the Carrier Questionnaire.

decreased by 1.1%, a sharper variance to the regional and national increases of 2.2% and 3.7%, respectively. Similar patterns, with New Hampshire trends below regional and national levels, were seen in 2010 relative to 2009 as well. The lower New Hampshire trends are consistent with a higher level of benefit buy-down than seen regionally or nationally.[50]

Table 14 presents the 2011 NAIC data in a more detailed form. In this representation, 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. In the Individual Market, while still above the national average, the average New Hampshire premium PMPM of $289.76 is below all the other New England states and 28% below the regional average. New Hampshire is the only New England state that allows health underwriting in the Individual Market, so this lower premium is 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 65.9%,[51] nearly 25 percentage points below the average Individual Market loss ratio in New England (90.6%) and 14 points below the next lowest state loss ratio (79.9% in Connecticut). 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 or pay rebates 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 $415.99 is in line with the regional average of $414.52, and the New Hampshire loss ratio for the group markets of 83.6% is just below the regional average of 84.6%.

	Individual Market		Group Markets	
	Premium PMPM	Loss Ratio	Premium PMPM	Loss Ratio
NH	$289.76	65.9%	$415.99	83.6%
CT	$305.50	79.9%	$439.63	79.5%
ME	$383.09	92.6%	$419.63	85.6%
MA	$456.65	95.7%	$410.15	86.4%
RI	$371.86	83.5%	$400.40	83.6%
VT	$370.49	87.2%	$369.94	85.9%
New England	$401.86	90.6%	$414.52	84.6%
National	$211.79	83.8%	$331.39	84.1%

Table 14 – New England State and National Premium 2011 PMPM's and Loss Ratios by Market Segment

[50] In the September 24, 2012 hearing both Anthem and Harvard Pilgrim stated that the level of benefit buy-downs were greater in New Hampshire than seen in their other markets.

[51] The loss ratio calculations in Table 13 and Table 14 represent claims divided by premium. They do not include any of the adjustments allowed in the ACA loss ratio formula for rebate purposes, which can increase the result by several percentage points. See Section 7.4 for more discussion of loss ratios.

10. Conclusion

The overarching goal of this report and other initiatives underway by the New Hampshire Insurance Department is to increase transparency and understanding of the drivers of health insurance premium increases in the state. This report represents a step forward in achieving this important goal.

Overall, 2011 was a relatively favorable year in terms of decelerating premium trends driven primarily by favorable utilization experience beginning in 2010. Given the time lag between actual experience and premium rate setting, consumers may continue to benefit from more modest premium increases in the future. The favorable utilization trends are due in part to macroeconomic factors experienced throughout the country, but are also driven by increased cost sharing as members buy down to lower premium plan designs and become more economically sensitive in their own healthcare decision making. While utilization trends have been decreasing, health care costs driven by provider rates have continued to increase at a fairly steady rate, both in what has been assumed in the premium rate setting process and in actual experience.

Addressing the cost of health care services through systemic solutions is critical to managing the increase in future health care premiums. In recent years there has been increased movement in New Hampshire towards site of service benefit designs and tiered network products that increase consumer awareness of the relative cost and quality differences among providers. In addition, there has been some collaboration between carriers and providers on payment reforms that increase overall engagement in managing health costs in a more efficient manner. Future reports should evaluate the success of these efforts in controlling costs. However given the overall market dynamics and the often competing priorities of the various stakeholders, it may be necessary for the state to play a more central role in facilitating and promoting a comprehensive approach to managing the growth of health care costs statewide.

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 written responses to questions regarding provider contracting and network strategies, member engagement initiatives, and cost containment programs. Only aggregated or de-identified information from the carrier questionnaires was used within this report.

- **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"[52]. Carriers and Third-Party Administrators must submit this data to NHID by July 15 for the previous calendar year. While the 2011 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 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

[52] The most recent 2010 report (http://www.nh.gov/insurance/lah/documents/sup-rep_10.pdf) includes a more detailed description of the data in its Appendix.

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.
- ***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.
- ***Pricing Trend:*** An assumption used in setting premium rates that represents the expected increase in future claims costs.
- ***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 of 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.

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.