New Hampshire Insurance Department

Preliminary Report of the 2015 Medical Cost Drivers

Based on Annual Hearing and Supplemental Report Data

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Table of Contents

Section Title		Page Number
1.	Overview of New Hampshire Health Insurance Market in 2015	6
2.	Premium Levels and Trends	13
3.	Member Cost Sharing	19
4.	Benefit Buy-Down and Benefit Adjusted Premium Trends	27
5.	Claim Trends	29
6.	Provider Costs and Provider Payment Reform	36
7.	Medical Loss Ratios, Expenses and Profits	40
8.	Regional and National Comparisons	44
9.	Product Innovation	47
10.	Uncompensated Care Costs	50
11.	Future Considerations	52
12.	Appendix	53
A.	Data Sources	53
B.	Additional Data Tables	53
13.	Glossary	62
14.	Limitations and Data Reliance	63
15.	Qualifications	64

List of Tables

Table	Page Number
TABLE 1: NEW HAMPSHIRE RESIDENTS BY HEALTH INSURANCE STATUS IN 2015	7
TABLE 2: COST SHARING ATTRIBUTES FOR SMALL GROUP AND LARGE GROUP BY YEAR	21
TABLE 3: COMPARISON OF STATE AND MUNICIPAL COST SHARING TO SELF-INSURED POPULATION CY 2015	24
TABLE 4: BENEFIT BUY-DOWN BY MARKET SEGMENT	27
TABLE 5: NEW HAMPSHIRE PHARMACY SPENDING IN 2015	32
TABLE 6: FEDERAL REINSURANCE PAYMENTS IN THE INDIVIDUAL MARKET BY INSURER	42
TABLE 7: FEDERAL RISK ADJUSTMENT PAYMENTS IN THE INDIVIDUAL MARKET BY INSURER	42
TABLE 8: FEDERAL RISK ADJUSTMENT PAYMENTS IN THE SMALL GROUP MARKET BY INSURER	43
TABLE 9: CY 2017 HOSPITAL NETWORK PROFILE	48
TABLE 10: SINGLE POLICY, IN-NETWORK DEDUCTIBLE DISTRIBUTION SUMMARY FOR CY 2015	54
TABLE 11: SINGLE POLICY, IN-NETWORK DEDUCTIBLE DISTRIBUTION FOR CY 2015	55
TABLE 12: MEMBER COINSURANCE DISTRIBUTION FOR CY 2015	56
TABLE 13: PCP OFFICE VISIT COPAY DISTRIBUTION FOR CY 2015	56
TABLE 14: SINGLE POLICY OUT-OF-POCKET MAXIMUM DISTRIBUTION FOR CY 2015	57
TABLE 15: PHARMACY BENEFIT MEMBERSHIP DISTRIBUTION FOR CY 2015	57
TABLE 16: AVERAGE PHARMACY COPAY FOR CY 2015	57
TABLE 17: AVERAGE PREMIUM PMPM AND ACTUARIAL VALUE FOR CY 2015	58
TABLE 18: COVERAGE OF VARIOUS BENEFIT CATEGORIES FOR CY 2015	59
TABLE 19: PERCENT OF SELF-INSURED MEMBERS WITH STOP-LOSS COVERAGE FOR CY 2015	60
TABLE 20: DISTRIBUTION OF STOP-LOSS SPECIFIC ATTACHMENT POINT FOR CY 2015	60
TABLE 21: DISTRIBUTION OF STOP-LOSS AGGREGATE ATTACHMENT POINT FOR CY 2015	60

List of Figures

Figure	Page Number
FIGURE 1: NEW HAMPSHIRE RESIDENTS BY HEALTH INSURANCE STATUS IN 2015	7
FIGURE 2: DISTRIBUTION BY INSURER OF NEW HAMPSHIRE COMMERCIAL SITUS AND NON-SITUS AND FULLY-INSURED AND SELF-INSURED CY 2015	9
FIGURE 3: FULLY-INSURED COMMERCIAL MEMBERSHIP BY MARKET SEGMENT	11
FIGURE 4: FULLY-INSURED COMMERCIAL MEMBERSHIP BY PRODUCT	12
FIGURE 5: FULLY-INSURED COMMERCIAL UNADJUSTED EARNED PREMIUM BY MARKET SEGMENT	14
FIGURE 6: AVERAGE AGE BY MARKET SEGMENT	15
FIGURE 7: NON-EXCHANGE AND EXCHANGE PREMIUMS IN THE INDIVIDUAL MARKET CY 2015	16
FIGURE 8: AVERAGE AGES OF INDIVIDUAL MARKET POPULATIONS (NON-EXCHANGE AND EXCHANGE)	17
FIGURE 9: ILLUSTRATIVE EXAMPLE OF SUBSIDIZED MONTHLY PREMIUM	18
FIGURE 10: SMALL GROUP MARKET DISTRIBUTION OF DEDUCTIBLES CY 2012, CY 2014 AND CY 2015	19
FIGURE 11: LARGE GROUP MARKET DISTRIBUTION OF DEDUCTIBLES CY 2012, CY 2014 AND CY 2015	20
FIGURE 12: INDIVIDUAL MARKET DISTRIBUTION OF DEDUCTIBLES CY 2012, CY 2014 AND CY 2015	22
FIGURE 13: INDIVIDUAL MARKET DISTRIBUTION OF DEDUCTIBLES CY 2015 FOR NON-EXCHANGE, EXCHANGE AND CSR ONLY	23
FIGURE 14: INDIVIDUAL MARKET DISTRIBUTION OF CSR MEMBERSHIP, CY 2014 AND CY 2015	24
FIGURE 15: DISTRIBUTION OF MUNICIPAL AND OTHER SELF-INSURED BY DEDUCTIBLE LEVEL	25
FIGURE 16: MEMBER COST SHARING AS A PERCENTAGE OF TOTAL ALLOWED CLAIMS BY MARKET SEGMENT CY 2015	26
FIGURE 17: 2015 PREMIUM TRENDS ADJUSTED FOR BENEFIT BUY-DOWN	28
FIGURE 18: OBSERVED ALLOWED CLAIMS TREND BY FULLY-INSURED MARKET SEGMENT	29
FIGURE 19: OBSERVED ALLOWED CLAIMS TREND BY COMPONENT IN FULLY-INSURED SMALL AND LARGE GROUP MARKETS	30
FIGURE 20: OBSERVED ALLOWED CLAIMS PMPM TREND BY SERVICE CATEGORY	31
FIGURE 21: CY 2015 ALLOWED CLAIMS PERCENTAGE BY SERVICE CATEGORY	33
FIGURE 22: AVERAGE PRICING TRENDS IN THE FULLY INSURED MARKET	35
FIGURE 23: AVERAGE MEDICAL AND PHARMACY PRICING TRENDS IN THE FULLY INSURED MARKET	35
FIGURE 24: BLENDED INPATIENT AND OUTPATIENT AVERAGE HOSPITAL PAYMENT RATE CHANGES BY YEAR	37
FIGURE 25: BLENDED INPATIENT AND OUTPATIENT HOSPITAL RATE CHANGES BY FACILITY	37
FIGURE 26: PROFESSIONAL AVERAGE PAYMENT RATE CHANGES BY YEAR	38
FIGURE 27: MEMBERS IN RISK ARRANGEMENTS FOR FULLY-INSURED AND SELF-INSURED MARKETS	39
FIGURE 28: LOSS RATIO EXHIBITS BY MARKET FOR CY 2015	41
FIGURE 29: INDIVIDUAL MARKET PREMIUMS BY STATE- 2015 BENEFIT YEAR	45
FIGURE 30: SMALL GROUP MARKET PREMIUMS BY STATE- 2015 BENEFIT YEAR	46

FIGURE 31: UNCOMPENSATED CARE COSTS FOR NEW HAMPSHIRE NOT FOR PROFIT ACUTE CARE HOSPITALS IN FY 2014 51

FIGURE 32: MEMBERSHIP DISTRIBUTION BY SELF-INSURED VS. FULLY-INSURED FOR CY 2015 61

1. Overview of New Hampshire Health Insurance Market in 2015

The number of New Hampshire residents without health insurance dropped from 120,000 in 2014 to 83,000 in 2015.[1]

- The uninsured rate for all New Hampshire residents has decreased from 11% in 2013 to 9% in 2014 and down to 6% in 2015.
- Based on estimates as of October 2016, approximately 27% of the remaining uninsured are estimated to be eligible for Medicaid and 20% eligible for premium tax credits through the Exchange.[2]
- Private commercial insurance refers to health insurance obtained through one's employer or purchased on one's own. Of the 1.3 million New Hampshire residents in 2015, 831,000 (or approximately 64%) had private commercial insurance. This number increased from 2014, when approximately 820,000 New Hampshire residents had private commercial insurance. The commercial insurance market includes employers who may or may not be located in New Hampshire and do not all necessarily buy insurance from a New Hampshire licensed insurer.[3]
- The number of Medicaid recipients increased by approximately 21,000 members between 2014 and 2015 (including both Medicaid Coverage Only and Dual Medicare/Medicaid Coverage).[4]

[1] U.S. Census Bureau, American Community Survey 1-Year estimates for 2014 and 2015. Available at: http://factfinder.census.gov.
[2] R Garfield, A Damico, C Cox, G Claxton and L Levitt. Estimates of Eligibility for ACA Coverage among the Uninsured in 2016. Kaiser Family Foundation, October 2016. Available at: http://kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/.
[3] These totals include both New Hampshire situsted and non-New Hampshire situsted members. Situs is determined by the location from which the policy is issued. Employers with their headquarters located out of state typically buy policies situsted outside of New Hampshire, even when they have a branch location in New Hampshire.
[4] This is consistent with information from the New Hampshire Department of Health and Human Services (DHHS) and is primarily driven by the Medicaid expanded health care coverage program, also known as the New Hampshire Health Protection Program (NHHPP), which started August 15, 2014. Note that as of January 1, 2016, New Hampshire converted its Medicaid Expansion program to a Premium Assistance Program, which is discussed further below.

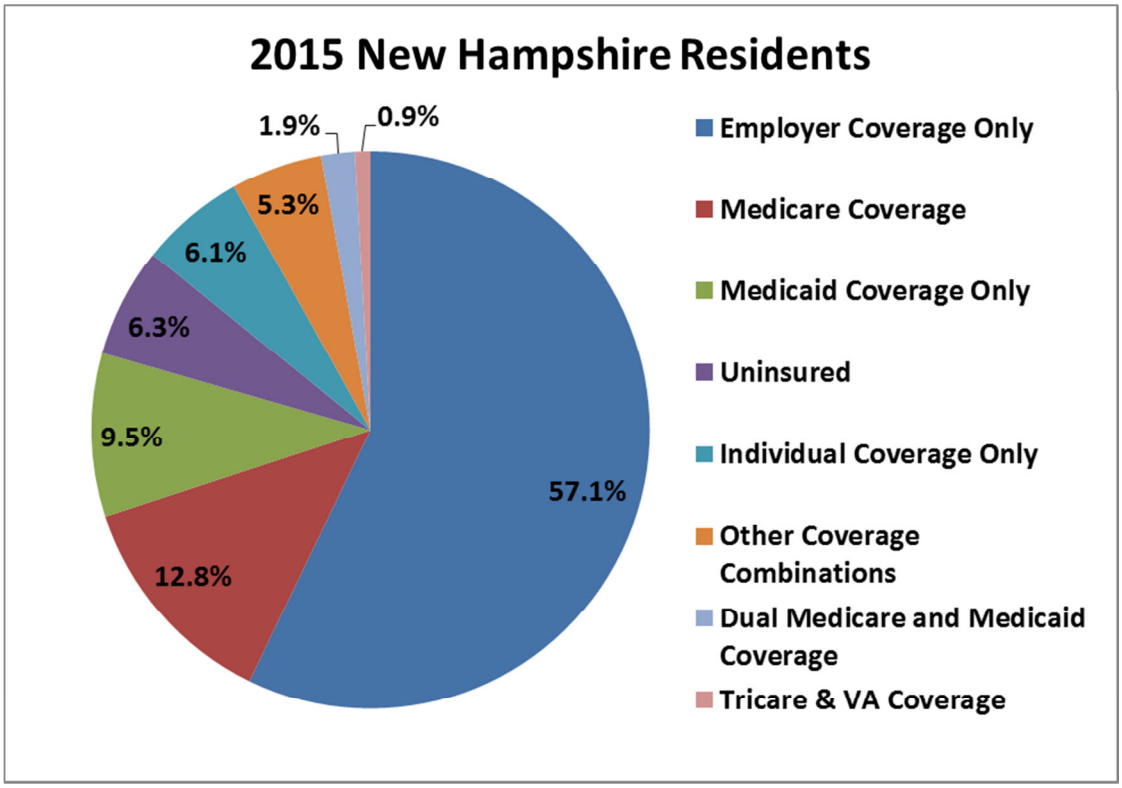


Table 1: New Hampshire Residents by Health Insurance Status in 2015[5]

	2014		2015	
	NH Number	NH %	NH Number	NH %
Employer Coverage Only	747,000	56.9%	751,000	57.1%
Medicare Coverage	160,000	12.2%	168,000	12.8%
Uninsured	120,000	9.2%	83,000	6.3%
Medicaid Coverage Only	107,000	8.1%	125,000	9.5%
Individual Coverage Only	76,000	5.8%	80,000	6.1%
Other Coverage	65,000	4.9%	70,000	5.3%
Dual Medicare and Medicaid	23,000	1.7%	26,000	1.9%
Tricare & VA Coverage	15,000	1.2%	12,000	0.9%
Total	**1,313,000**	**100%**	**1,315,000**	**100%**

Figure 1: New Hampshire Residents by Health Insurance Status in 2015[6]

[5] U.S. Census Bureau. 2015 American Community Survey 1-Year Estimates. Available at: http://factfinder.census.gov.
[6] U.S. Census Bureau. 2015 American Community Survey 1-Year Estimates. Available at: http://factfinder.census.gov.

In 2015, there are approximately 498,000 members who receive insurance through a New Hampshire licensed insurer (situs-based).[7, 8] Not all of these members are New Hampshire residents; however, most are employed with a New Hampshire employer.

- Approximately 398,000 (80%)[9] of the 498,000 New Hampshire situsd commercial members are New Hampshire residents.
- Among the 498,000 New Hampshire situsd commercial members, 266,000 (53%) are covered under self-insured policies.[10]
- There are approximately 220,000 non-New Hampshire situsd commercial members (that is, members who are insured through a policy sold outside of New Hampshire). Many of these non-New Hampshire situsd members are New Hampshire residents, and some may work for an employer based outside of New Hampshire with a branch location or satellite office located in New Hampshire.[11]

Consistent with prior years, three insurers – Anthem, CIGNA, and Harvard Pilgrim Health Care – dominate the New Hampshire commercial insurance market in CY 2015 (fully-insured and self-insured). There were also two new entrants to the Individual and Small Group Market in CY 2015: Minuteman Health and Community Health Options.

[7] "Situs" of a policy is defined as the jurisdiction in which the policy is issued or delivered as stated in the policy. Insurers are instructed to apply the same consideration when determining situs for this report as they do when preparing the NAIC Supplemental Health Care Exhibit. Third party administrators (TPAs) shall determine situs of their contracts in a similar manner. New Hampshire situsd members may not necessarily be residents of New Hampshire, and non-New Hampshire situsd members include New Hampshire residents whose employer is not situsd in New Hampshire. The Supplemental Data Request (SDR) collects more detailed data for New Hampshire situsd members than for non-New Hampshire situsd members.

[8] Data for this report primarily come from the NHID Supplemental Data Request (SDR) and Annual Hearing Carrier Questionnaire (AH). Data representing CY 2015 were collected in 2016 and are referred to throughout this report as data from the 2016 SDR and AH. Similarly, data representing CY 2014 were collected in 2015 and are referred to as data from the 2015 SDR and AH, and so on. See the Appendix for more information on these data sources.

[9] 2016 AH data. Excludes individuals covered under the Federal Employees Health Benefits Plan (FEHBP).

[10] The New Hampshire employers covering members on a self-insured basis are not subject to New Hampshire insurance laws and are regulated by the Department of Labor. As such, this report does not include detailed information on the self-insured population.

[11] The SDR collects data on these 220,000 non-New Hampshire situsd members, as these members are covered by an insurer or a TPA that is regulated by the NHID. These numbers do not include New Hampshire residents who work out of state and obtain their insurance from an insurer or TPA that is regulated by another state insurance department. The NHID does not have detailed information on the number of residents that fall into this category.

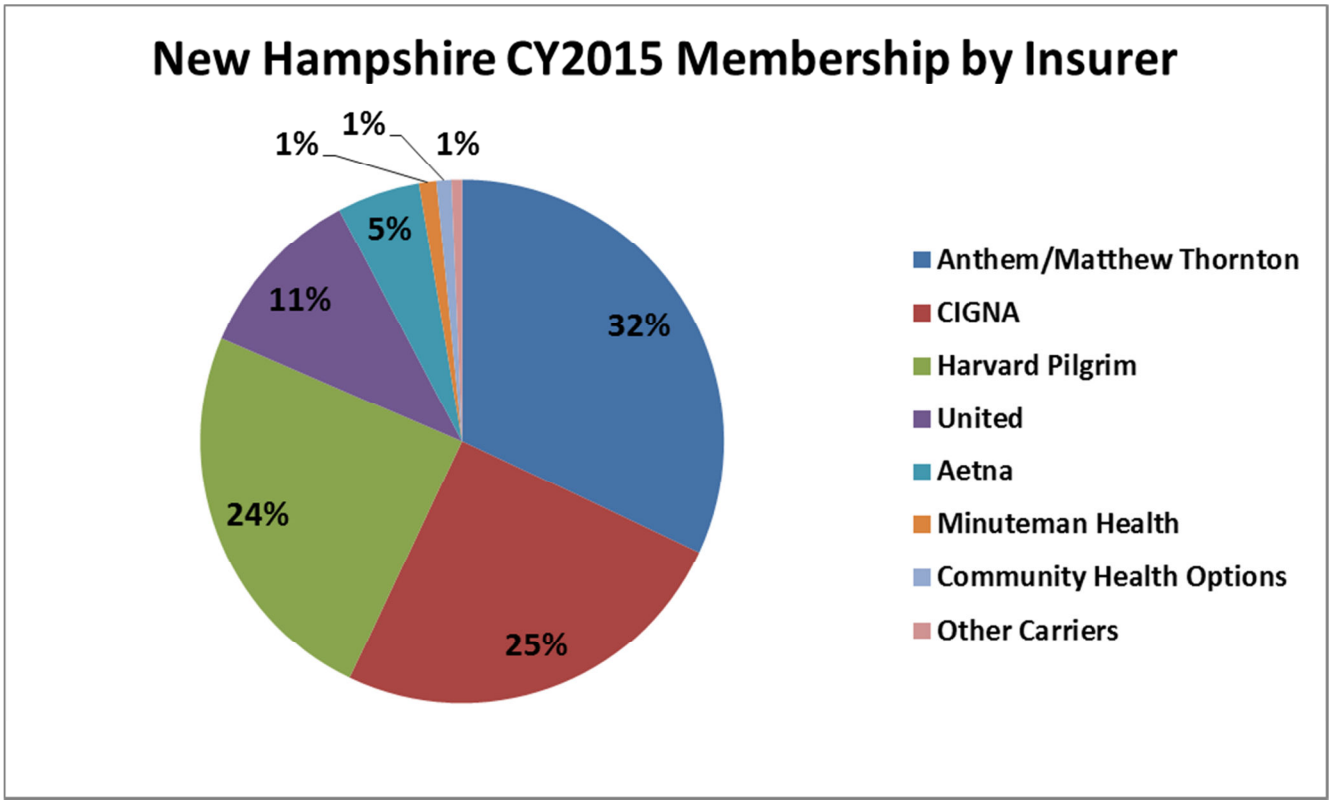


Figure 2: Distribution by Insurer of New Hampshire Commercial Situs and Non-Situs and Fully-Insured and Self-Insured CY 2015[12]

As of April 2016, approximately 275,000 of the New Hampshire situsued members in the commercial insurance market are fully-insured, representing an increase from prior years. The majority of the increase is due to a shift in enrollment from Medicaid Managed Care Plans to the New Hampshire Premium Assistance Program (NH PAP).[13]

- The overall fully-insured market in New Hampshire grew from approximately 228,000 members in December 2014 (representing 47% of the New Hampshire situs market) to 275,000 members as of April 2016 (52% of the New Hampshire situs market).[14]
- This increase in membership in the fully-insured market is largely attributable to New Hampshire converting its Medicaid Expansion program to the NH PAP, which went into effect on January 1, 2016. NH PAP members are part of the Commercial Individual Market Exchange, meaning they will be rated under the single risk pool requirements of the Individual Market under the Affordable Care Act (ACA).

[12] 2014 SDR data. Excludes individuals covered under FEHBP.
[13] 2013, 2014, 2015 and 2016 AH data. Excludes individuals covered under FEHBP; includes Community Health Options, Minuteman Health and Centene. Centene entered the New Hampshire insurance market in January 2016.
[14] The estimates are based on 2015 and 2016 AH data, with a slight increase to account for insurers not captured in the Annual Hearing Carrier Questionnaire.

Premiums for the NH PAP will be funded through Medicaid.[15, 16] Individuals eligible for the NH PAP generally include all adults aged 19-64 with incomes up to 138% of the Federal Poverty Level (FPL) who do not fall into other Medicaid eligibility categories and who do not qualify for Medicare.

- Continued growth in the Individual Exchange Market outside of the NH PAP has also partially contributed to the increase in the fully-insured market.

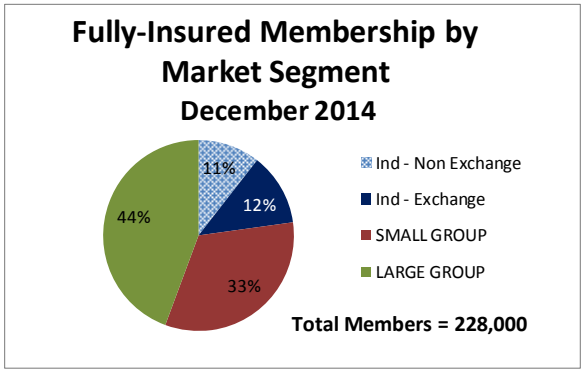
The Individual Market grew from 52,000 members in December 2014 to 107,000 members as of April 2016 due to growth from the NH PAP and the Individual Exchange Market.

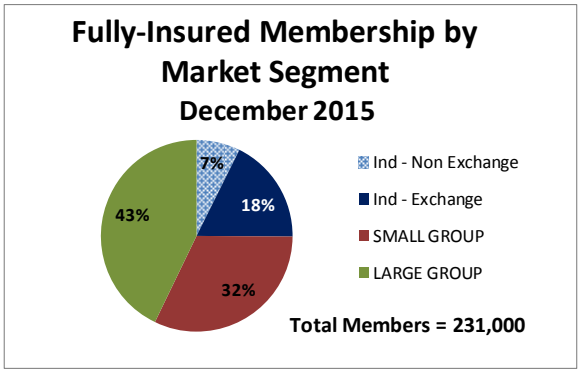
- The Individual Market has grown in its share of the fully-insured market from 23% as of December 2014, to 25% as of December 2015, and to 39% as of April 2016. This equates to 52,000 members as of December 2014, 58,000 members as of December 2015, and 107,000 members as of April 2016. This growth is driven by increases of approximately 22,000 members in the Individual Exchange Market and 40,000 members in the NH PAP. Meanwhile, the Individual Non-Exchange population decreased by 6,000 members during the same time period.
- Harvard Pilgrim, Minuteman Health, Community Health Options and Centene have all gained market share in the Individual Market during this time, while Anthem (including Matthew Thornton Health Plan) has lost some market share.[17]
- As of April 2016, 4% of members in the Individual Market are grandfathered[18] and 4% are in ACA transitional[19] products.[20] Within just the Individual Non-Exchange population, 51% are either grandfathered or in ACA transitional products.

The fully-insured Group Markets experienced a modest decline in membership between December 2014 and April 2016.

- The Small Group Market share has decreased from 33% as of December 2014, to 32% as of December 2015, to 25% as of April 2016. This equates to 75,000 members as of December 2014 and 69,000 members as of April 2016. Market share in the Small Group Market has shifted from Anthem (including Matthew Thornton Health Plan) to Harvard Pilgrim Health Care.
- The Large Group Market has also decreased in market share slightly from 44% as of December 2014, to 43% as of December 2015, to 36% as of April 2016. This equates to 101,000 members as of December 2014 and 99,000 members as of April 2016.

[15] Kaiser Family Foundation. Medicaid Expansion in New Hampshire. March 2015. Available at: http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-new-hampshire/.
[16] New Hampshire Department of Health and Human Services. Frequently Asked Questions for NHHPP Premium Assistance Program. September 2015. Available at: http://www.dhhs.nh.gov/ombp/pap/documents/faq.pdf.
[17] Matthew Thornton Health Plan entered the New Hampshire Exchange in 2014. Harvard Pilgrim, Minuteman Health and Community Health Options entered in 2015 along with Assurant/Time. Centene entered the New Hampshire Exchange in 2016.
[18] Grandfathered plans are plans that were purchased before March 23, 2010.
[19] New Hampshire Insurance Department. INS 14-009-AB: Extended Transition to ACA-Compliant Policies. March 2014. Available at: http://www.nh.gov/insurance/media/bulletins/documents/ins_14_009_ab.pdf.
[20] 2016 AH data. Includes Community Health Options, Minuteman Health and Centene.





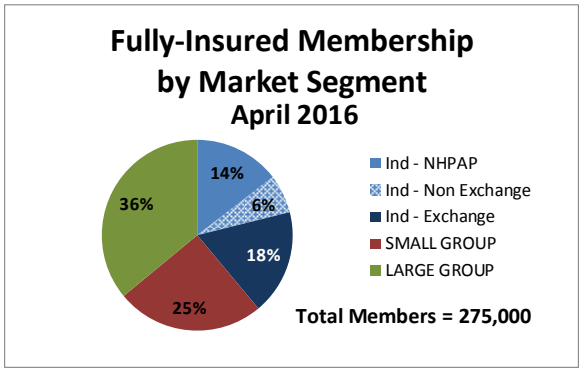


Figure 3: Fully-Insured Commercial Membership by Market Segment[21]

There has been a continued shift away from PPO products within the fully-insured market, driven by changes to the Individual Market.

- The increase in HMO/POS/EPO products is driven by the introduction of limited network HMO products in the Individual Market Exchange along with the introduction of the NH PAP in January 2016. Prior to 2014, almost 100% of the Individual Market was enrolled in PPO/Indemnity plan offerings. As of April 2016, only 13% of the Individual Market is enrolled in PPO/Indemnity plan offerings.[22]
- The fully-insured Group Market products have remained fairly stable and as of April 2016, 76% of this market is enrolled in HMO/POS/EPO plan offerings.
- Nearly 95% of the NH PAP members are enrolled in HMO/POS plans.
- Forty-eight percent (48%) of the self-insured market is enrolled in HMO/POS/EPO plan offerings as of April 2016, representing an increase from 44% in December 2014.

[21] 2014, 2015 and 2016 AH data. Excludes individuals covered under FEHBP; includes Community Health Options, Minuteman Health and Centene.

[22] Note that Anthem's Pathway HMO products do not require members to select a primary care physician and they do not require members to obtain referrals to see other in-network providers.

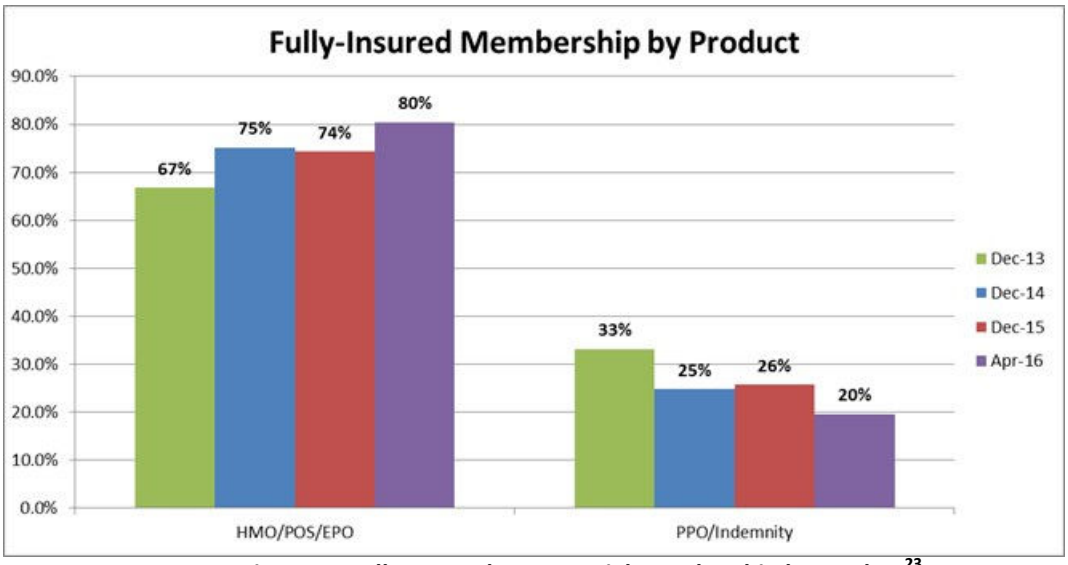


Figure 4: Fully-Insured Commercial Membership by Product[23]

There are an estimated 48,000 New Hampshire members in the Federal Employees Health Benefits Program (FEHBP).[24] The FEHBP population has coverage administered by a variety of insurers offering multiple plan options.

- Anthem, with 34,000 FEHBP members in New Hampshire, administers FEHBP coverage for the Large Group market. The plan design has a $350 deductible, 15% in-network coinsurance for certain services such as emergency department visits, and copays for services such as physician office visits.

[23] 2013, 2014, 2015 and 2016 AH data. Excludes individuals covered under FEHBP; includes Centene and NH PAP.

[24] This is Anthem's estimate of New Hampshire membership in all insurer plans combined for CY 2014, the last date for which an estimate is available.

2. Premium Levels and Trends

In the Group Market, the premiums insurers collect per member were slightly higher in 2015 as compared to 2014. Both Small Group and Large Group Market premium increases continue to be fairly low.

- The combined Small Group and Large Group unadjusted[25] premium trend was 1.4% in 2015 compared to 2.8% in 2014. These 2015 trends in New Hampshire are slightly lower than national information from the Kaiser Family Foundation's Employer Health Benefits Survey, which shows national trends of 3.7% and 4.2% for single and family coverage, respectively, in 2015.[26] The Kaiser report estimates a 3% national premium trend in 2016.[27]
- As shown in Figure 6, the average age of members in the Small Group and Large Group Markets has remained fairly steady, although there is a slight increase going into April 2016.

In the Individual Market, premium levels remained flat in 2015 compared to 2014.

- In 2014, the Individual Market experienced a large increase in average premium per member per months (PMPMs) as a result of the introduction of the ACA:
    - Insurers expected higher morbidity and higher average age as a result of the influx of members, many of whom came from the state's high risk pool resulting in significant increases to premiums.[28]
    - These increases were partially off-set by the introduction of new limited network HMO product offerings both on and off the Exchange. Previously, the Individual Market had been dominated by PPO products with broad or full networks.
    - The premiums shown in Figure 5 do not reflect premium subsidies for qualifying low income individuals.[29]
- In 2015, the Individual Market experienced relatively no change in the average premium PMPM due to the combination of several offsetting factors:
    - The Individual Exchange Market had three new entrants in 2015: Harvard Pilgrim, Minuteman, and Community Health Options. Each insurer offered different networks and different products at varying rate levels.
    - Rate changes for the existing Exchange products were very modest.

[25] Unadjusted means that premiums trends have not been adjusted to reflect the impact of changing benefits and cost sharing.
[26] Kaiser Family Foundation. 2015 Employer Health Benefits Survey. September 2015. Exhibit 1.11: 2015 single and family premiums of $6,251 and $17,545. 2014 single and family premiums of $6,025 and $16,843 respectively. Available at: http://kff.org/report-section/ehbs-2015-section-one-cost-of-health-insurance.
[27] Kaiser Family Foundation. Average annual workplace family health premiums rise modest 3% to $18,142 in 2016; More workers enroll in high-deductible plans with savings option over past two years. September 2016. Available at: http://kff.org/health-costs/press-release/average-annual-workplace-family-health-premiums-rise-modest-3-to-18142-in-2016-more-workers-enroll-in-high-deductible-plans-with-savings-option-over-past-two-years/.
[28] The federal high risk pool ceased coverage as of April 30, 2014 and the state high risk pool ceased coverage as of June 30, 2014.
[29] Premium subsidies are available on a sliding scale to individuals and families with incomes between 100-400 percent of the Federal Poverty Level (FPL).

- While the premiums for the Non-Exchange Market are increasing at a higher rate due to a large presence of grandfathered and ACA transitional members, the size of this market is shrinking compared to the Exchange Market.

- As shown in Figure 6, the average age in the Individual Market increased dramatically from December 2013 to December 2014 due to the influx of members coming from the state's high risk pool. There was only a slight increase in the average age from December 2014 to December 2015, followed by a decrease in April 2016 that was driven by the introduction of the NH PAP in January 2016.

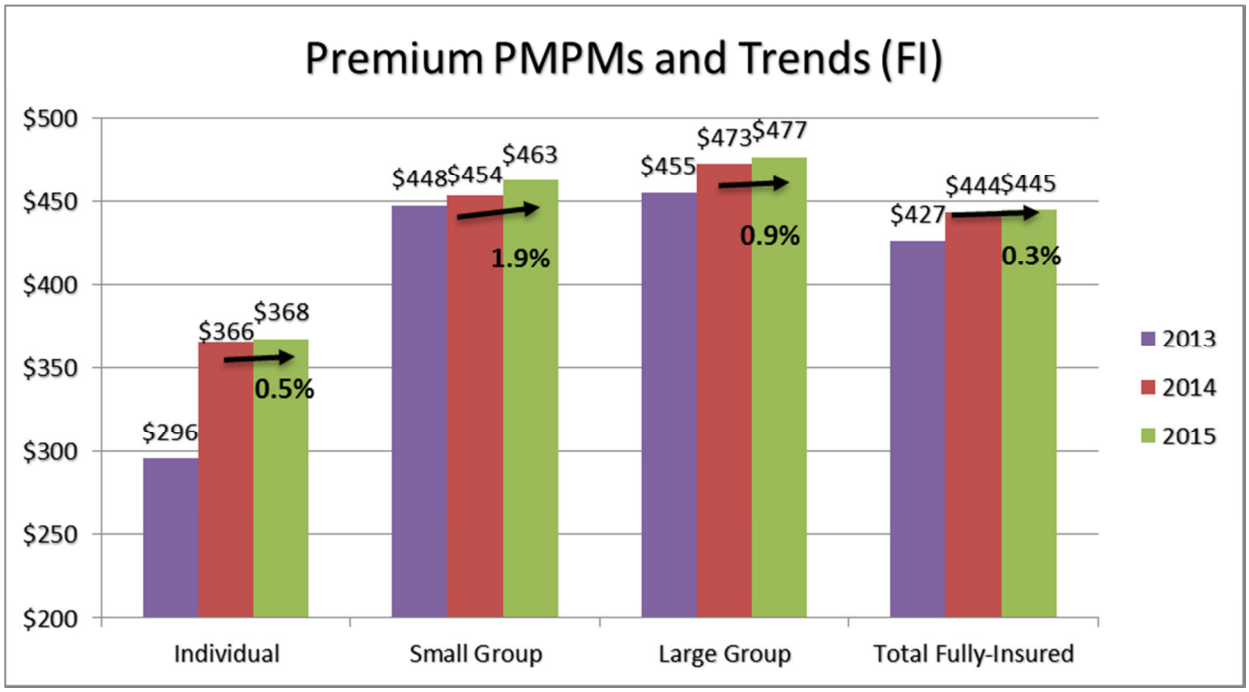


Figure 5: Fully-Insured Commercial Unadjusted Earned Premium by Market Segment[30]

[30] 2014, 2015 and 2016 SDR data. Excludes individuals covered under FEHBP.

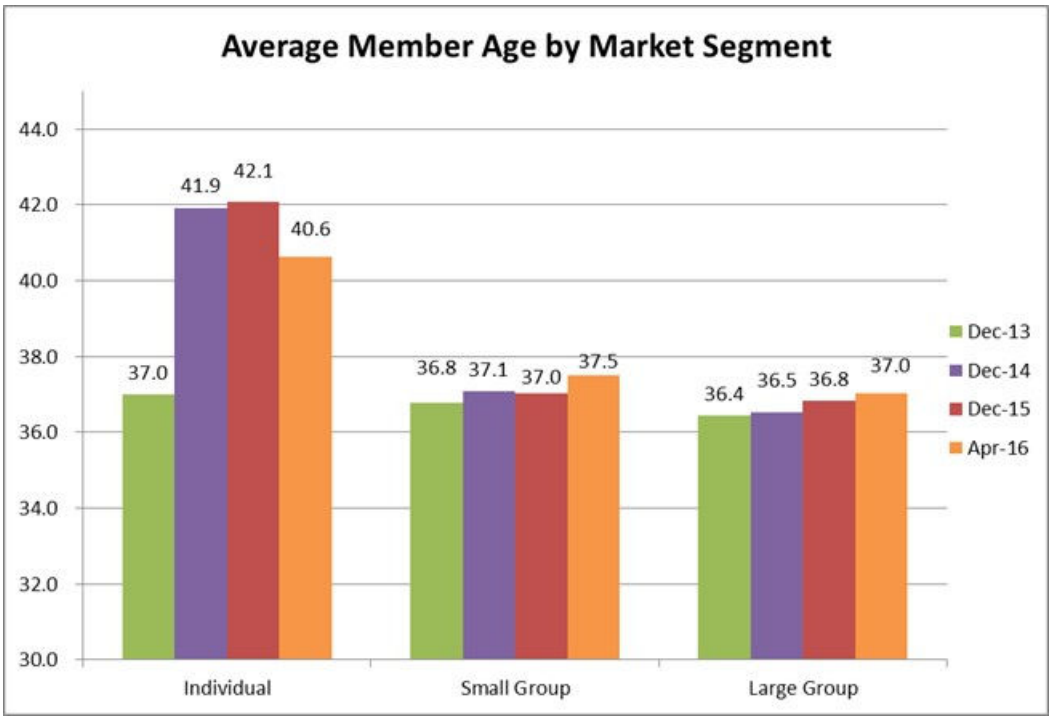


Figure 6: Average Age by Market Segment[31]

In the Individual Market, average premiums are nearly identical for Exchange and Non-Exchange markets, prior to the impact of premium subsidies for qualifying low income individuals. While more members on the Exchange are in lower-costing limited network products, they are also older than the Non-Exchange population.

- The premiums in the Non-Exchange market increased approximately 10%, while premiums in the Exchange Market decreased approximately 6% from 2015 to 2014, resulting in nearly identical average premiums in 2015.
- Forty-six percent (46%) of the Individual Market was Non-Exchange, with 54% on the Exchange as of December 2014. By December 2015, this shifted to 28% Non-Exchange and 72% Exchange. With the introduction of the NH PAP, this enrollment changed to 17% Non-Exchange and 83% Exchange as of April 2016.
- As of December 2015, 25% of Non-Exchange members are in limited network products, compared to 88% of the Exchange members in limited network products.[32]
- The average age of Individual Market populations (both Exchange and Non-Exchange) increased from December 2013 to December 2014 but remained fairly stable into December 2015 at 42.1 years. As of April 2016, the overall average age in the Individual Market has decreased to 40.6

[31] 2013, 2014, 2015 and 2016 AH data. Excludes individuals covered under FEHBP; includes Community Health Options, Minuteman Health and Centene and NH PAP.
[32] 2016 AH data.

years, driven by the inclusion of the NH PAP members, whose average age is slightly younger at 37.8 years.

- While more members are purchasing health care through the Exchange, the average age of the Exchange population has remained fairly consistent from 2014 to 2015.
- The average age of the Exchange population is 3.9 years older than the Non-Exchange population as of April 2016, slightly less than the difference from a year ago.
- As of December 2015, 61% of the Non-Exchange Market is either grandfathered or in transitional ACA products and therefore not subject to the same rating requirements as the non-grandfathered population. (The Exchange population is all non-grandfathered.)[33]

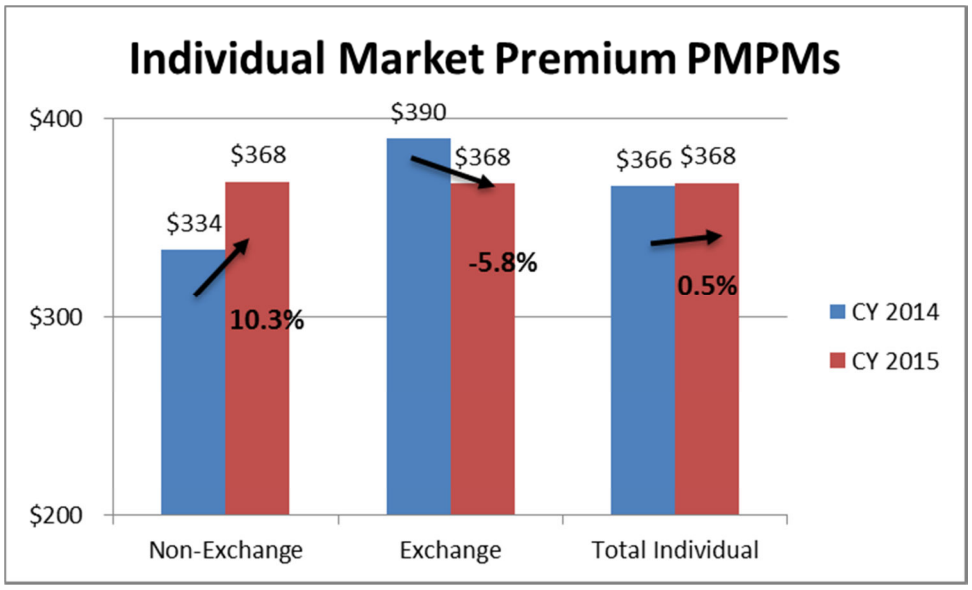


Figure 7: Non-Exchange and Exchange Premiums in the Individual Market CY 2015[34]

[33] 2016 AH data.
[34] 2015 and 2016 SDR data.

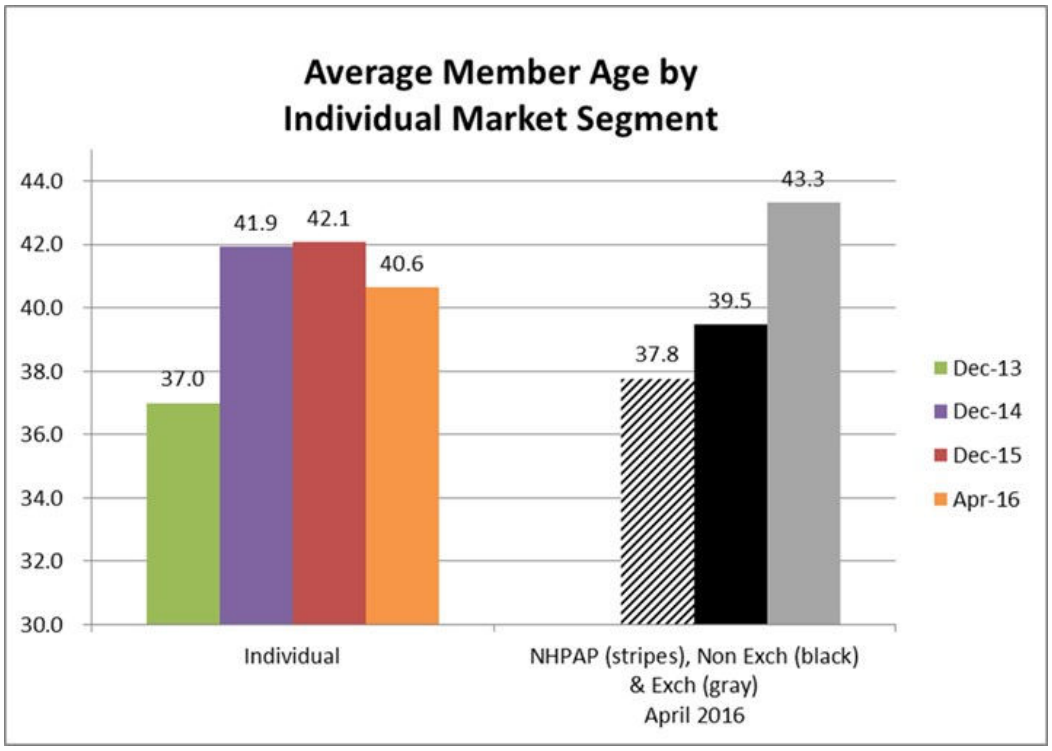


Figure 8: Average Ages of Individual Market Populations (Non-Exchange and Exchange)[35]

Premium subsidies are available on a sliding scale to qualifying individuals and families on the Exchange with incomes between 100% and 400% of the Federal Poverty Level. Figure 9 shows an illustrative example of what a single policyholder in New Hampshire would pay for the second lowest cost Silver plan at various income levels.

[35] 2013, 2014, 2015 and 2016 AH data. Excludes individuals covered under FEHBP; includes Community Health Options, Minuteman Health and Centene.

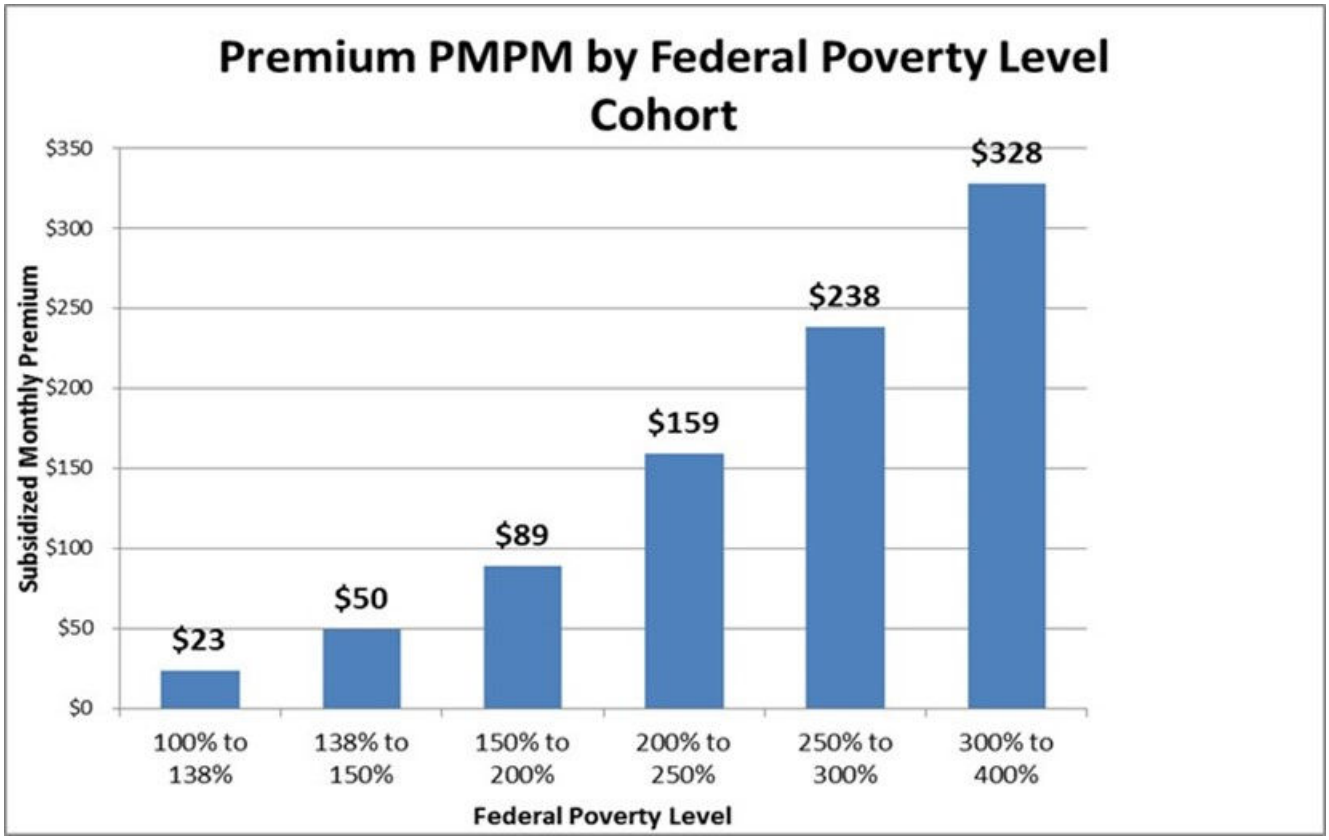


Figure 9: Illustrative Example of Subsidized Monthly Premium[36]

- The data from 2015 show that a single policyholder in the 100% to 138% Federal Poverty Level will pay approximately $23 per month, while a single policyholder in the 300% to 400% Federal Poverty Level will pay approximately $328 per month.
- As of March 2016, approximately 31,000, or 63%, of the members in the New Hampshire Exchange receive a federal premium subsidy.[37]

[36] Illustrative example of median premium for the second lowest cost Silver plan, for a single policy in February 2015. Data source: Health Insurance Marketplace 2015 Open Enrollment Period: March Enrollment Report, Office of the Assistant Secretary for Planning and Evaluation. Assumes Exchange members are in the middle of the income bracket.

[37] Centers for Medicare and Medicaid Services. March 31, 2016 Effectuated Enrollment Snapshot. March 2016. Available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html.

3. Member Cost Sharing

In CY 2015, the Small Group Market purchased plan offerings with similar deductible levels as the prior year.[38]

- Between CY 2012 and CY 2014, the percentage of members with a deductible of $3,000 or greater increased from 48% to 68% in the Small Group Market, but there was essentially no further change from CY 2014 to CY 2015. There was a slight increase in the percentage of members with deductibles $5,000 or greater from 2014 to 2015, increasing from 16% to 20%.
- The average deductible in the Small Group Market increased $67 (or 2%) from 2014 to 2015, which is lower than the increase from 2013 to 2014.
- In CY 2015, approximately 32% of the Small Group market are enrolled in High Deductible Health Plans (HDHPs).[39]

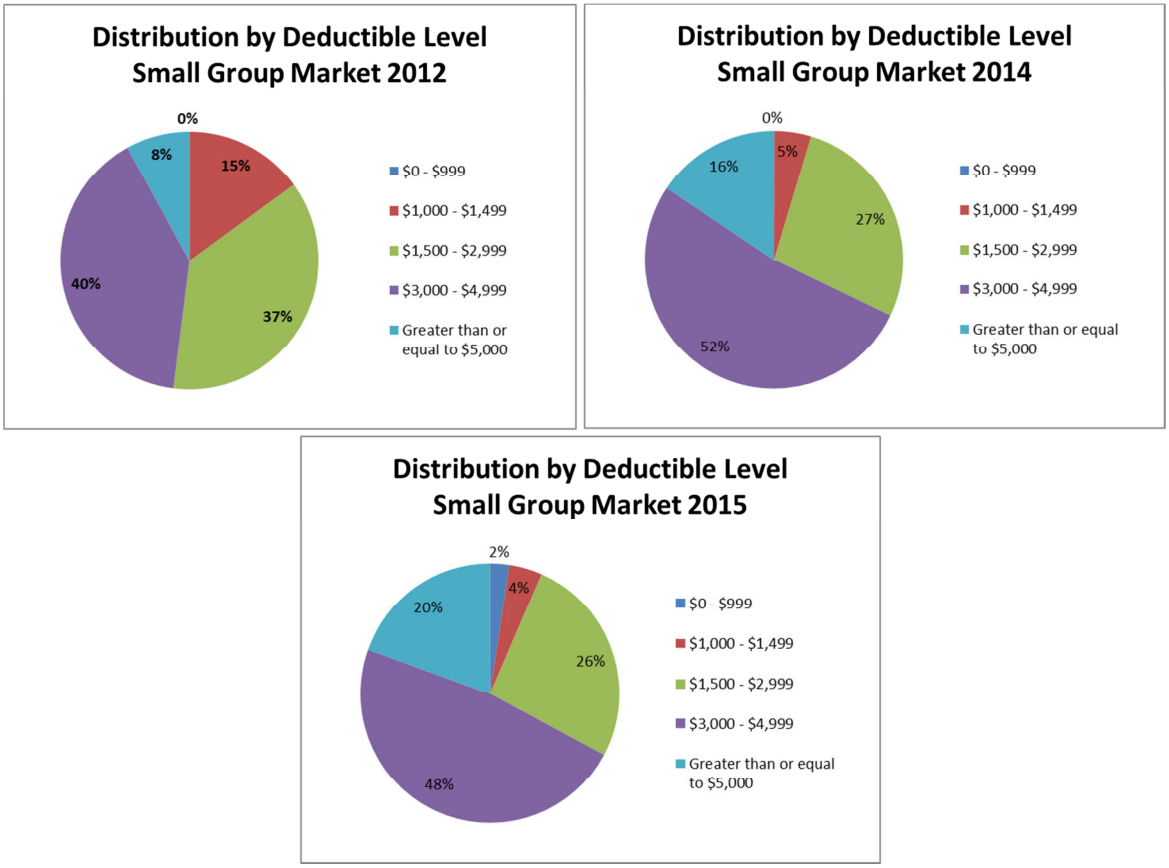


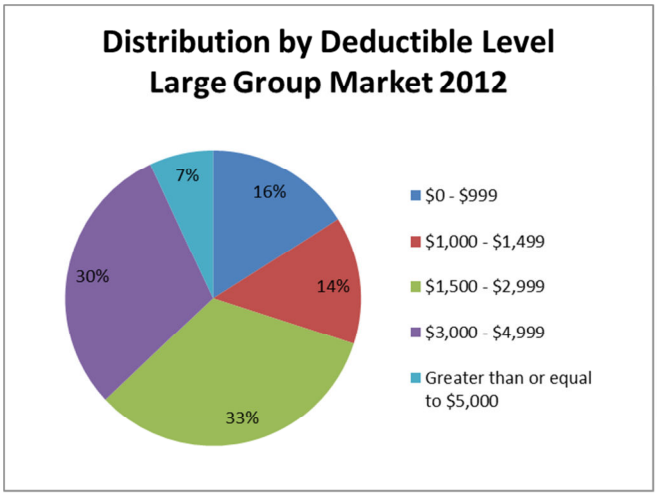
Figure 10: Small Group Market Distribution of Deductibles CY 2012, CY 2014 and CY 2015[40]

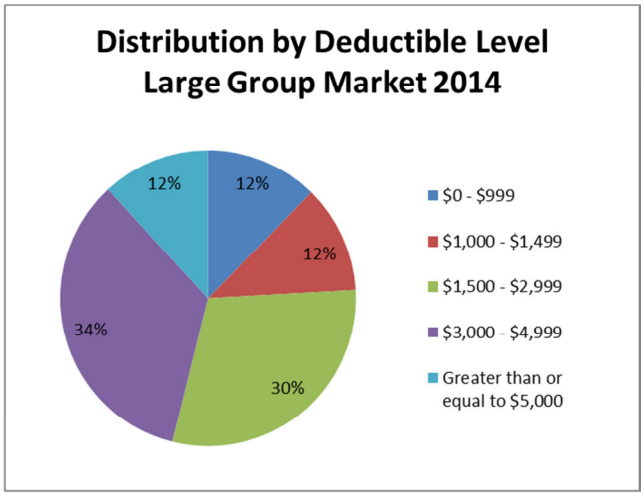
[38] These analyses do not account for the impact of tax advantaged programs such as Health Savings Accounts that are paired with a High Deductible Health Plan, Health Reimbursement Arrangements, Employer Payment Plans, and Health Flexible Spending Arrangements.

[39] For 2015, a HDHP is defined under § 223(c)(2)(A) as a health plan with an annual deductible that is not less than $1,300 for self-only coverage and $2,600 for family coverage, and with annual out-of-pocket expenses that do not exceed $6,450 for self-only coverage or $12,900 for family coverage.

The flat deductible levels in the Small Group Market contrast with the changes observed in the Large Group Market, where groups are purchasing higher deductible levels in CY 2015 compared to CY 2014.

- In the Large Group Market, the percentage of members with a deductible of $3,000 or greater increased from 37% in CY 2012 to 46% in CY 2014, and rose an additional nine percentage points to 55% in CY 2015.
- The average deductible in the Large Group Market increased $345 (or 14%) from 2014 to 2015, which is higher than the increase observed from 2013 to 2014.
- While the Small Group Market continues to show higher enrollment in High Deductible Health Plans compared to the Large Group Market, this difference is smaller in CY 2015 than in CY 2014. In CY 2015, approximately 27% of the Large Group Market are enrolled in High Deductible Health Plans.





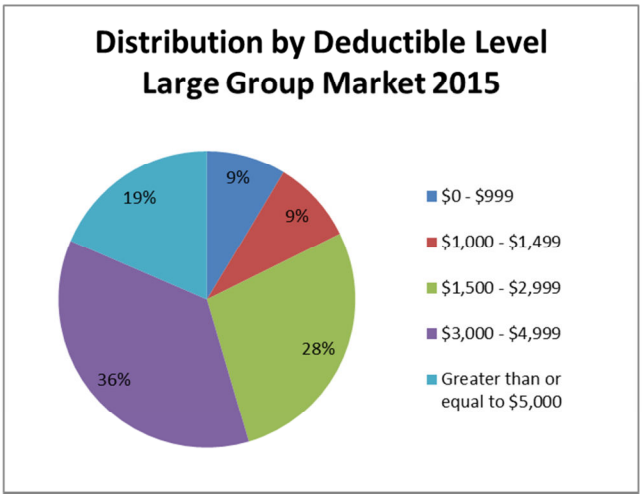


Figure 11: Large Group Market Distribution of Deductibles CY 2012, CY 2014 and CY 2015[41]

[40] 2013, 2015 and 2016 SDR data.
[41] 2013, 2015 and 2016 SDR data. Fully-insured market only. Excludes individuals covered under FEHBP.

	Small Group			Large Group		
	2013	2014	2015	2013	2014	2015
Average Deductible	$2,847	$3,082	$3,149	$2,315	$2,460	$2,814
Average OOP Maximum	$3,489	$3,824	$4,202	$3,382	$4,962	$5,508

Table 2: Cost Sharing Attributes for Small Group and Large Group by Year[42]

Deductible levels in the Individual Market have decreased 25%, from an average of $3,700 in CY 2013 to $2,800 in CY 2015.

- Overall deductible levels have generally decreased in the Individual Market in recent years. In CY 2015, 22% of the market have deductibles between $0-$999, compared to only 1% in CY 2012 and 2% in CY 2013.
- Average deductibles in the Individual Market in CY 2015 are very similar to CY 2014.

[42] 2014, 2015 and 2016 SDR data. Fully-insured market only. Excludes individuals covered under FEHBP. The out-of-pocket (OOP) maximum averages exclude members in plans with no reported OOP maximum (this represents 6% of Small Group members and 5% of Large Group members.)

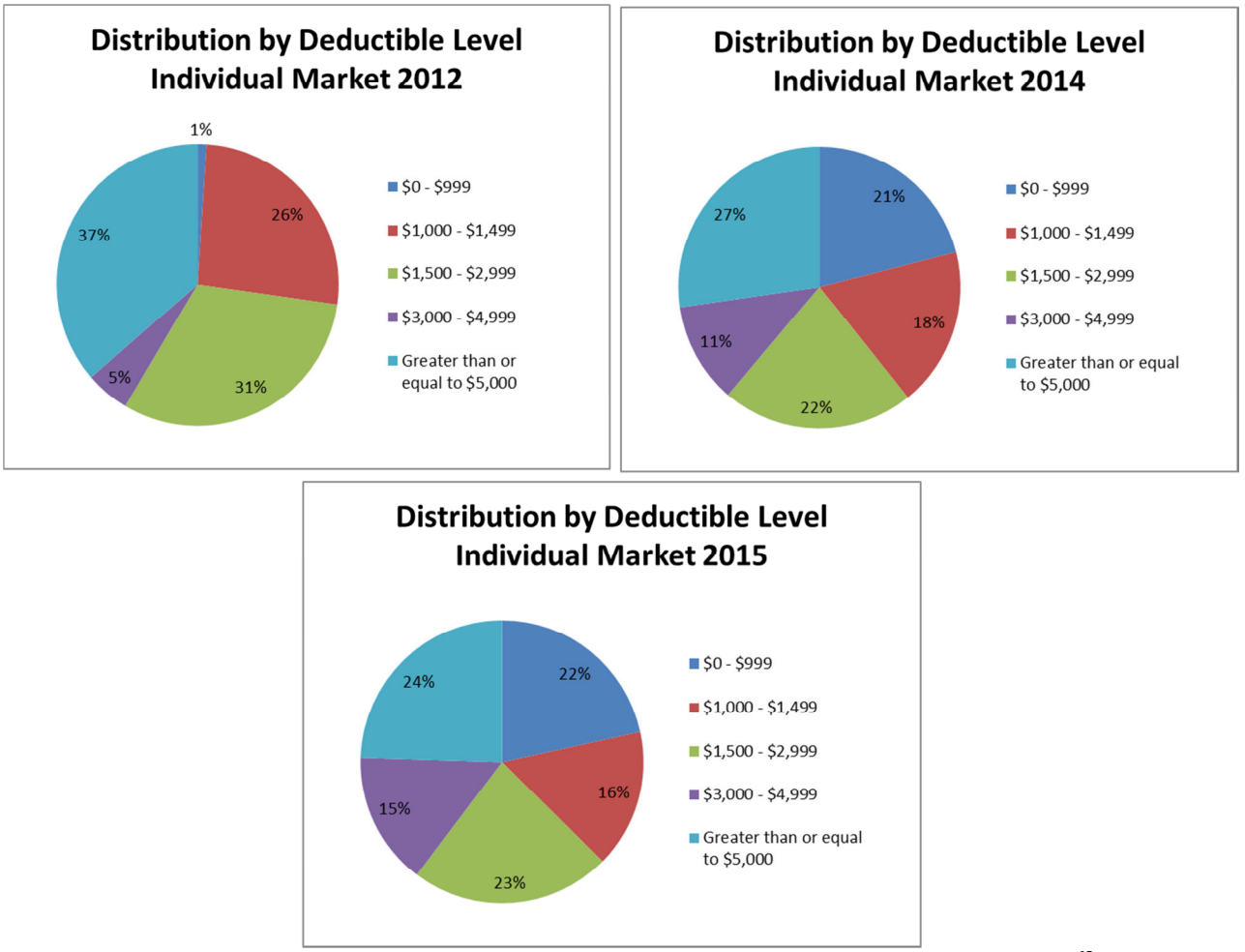


Figure 12: Individual Market Distribution of Deductibles CY 2012, CY 2014 and CY 2015[43]

The introduction of cost sharing reduction (CSR) subsidies for qualifying low income individuals in CY 2014 is the primary driver of decreasing deductible levels in the Individual Market compared to prior years.[44, 45]

- There are three kinds of CSR plans: CSR 94, CSR 87 and CSR 73. Members are eligible for different CSR plans based on their income. For example, an individual with income between 150% and 200% of the Federal Poverty Level (FPL) qualifies for the CSR 87 plan. This means that the individual is paying the premium for a Silver level plan (which has an actuarial value of .70) but the cost sharing for the plan

[43] 2013, 2015 and 2016 SDR data.

[44] Cost sharing reduction (CSR) subsidies lower out-of-pocket costs, based on income, for Silver plans bought on the Exchange for low income individuals between 100% and 250% of the Federal Poverty Level. CSR plans lower the amount members have to pay out-of-pocket for deductibles, coinsurance, and copayments. In 2015, each of the Silver plans offered on the Exchange have three CSR variants, corresponding to the three levels of CSR subsidies: CSR 73, CSR 87, and CSR 94. The numbers refer to the actuarial value (AV). Members are eligible for CSR plans based on their income: 100-150% FPL = 94% Actuarial Value (CSR 94); 150-200% FPL = 87% Actuarial Value (CSR 87); 200-250% FPL = 73% Actuarial Value (CSR 73).

[45] All deductibles and other cost sharing reflect the reduced amounts after the impact of the cost sharing reduction subsidies.

purchased reflects a .87 actuarial value, which is closer to a Platinum level plan – or, in other words, less cost sharing.

- CSR members in the Individual Exchange Market are driving the shift to overall lower deductibles in CY 2014 and CY 2015. The average number of CSR members increased from 13,000 in CY 2014 to 16,500 in CY 2015. In CY 2015, this represents 40% of the Exchange population and 29% of the total Individual Market. Sixty-nine percent (69%) of CSR members are in plans with deductibles between $0 and $999.[46]
- Of the members with a CSR plan, 37% are in the CSR 94 plan, 44% are in the CSR 87 plan and 19% are in the CSR 73 plan. Figure 14 below shows the change in CSR membership distribution from 2014 to 2015, and demonstrates that the primary shift has been from the CSR 94 plan into the CSR 87 plan.
- The overall average deductible for the CSR population increased from $717 in CY 2014 to $879 in CY 2015.

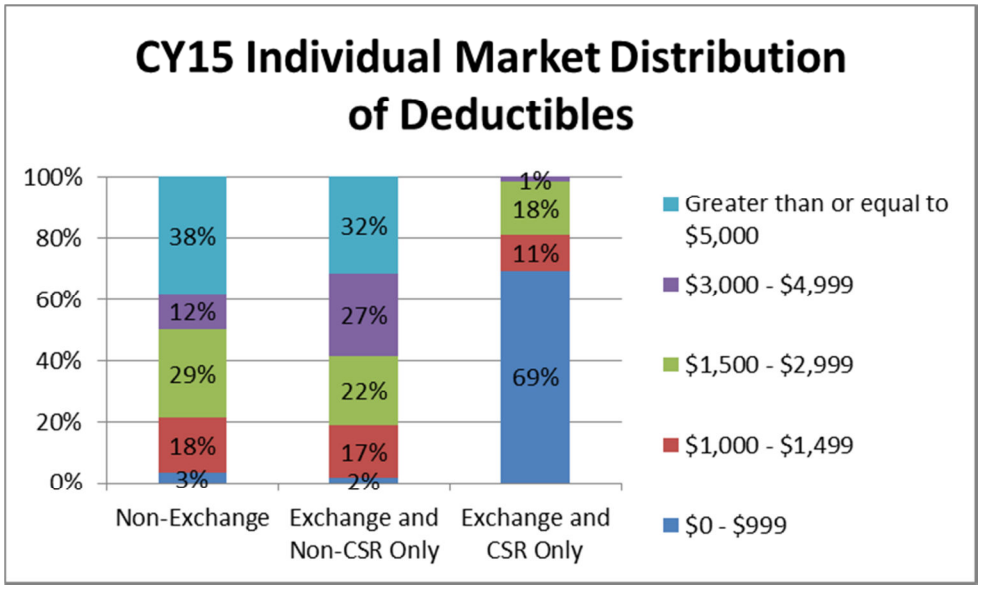


Figure 13: Individual Market Distribution of Deductibles CY 2015 for Non-Exchange, Exchange and CSR Only[47]

[46] In the SDR data, the premium reported for CSR members represents a Silver plan premium (actuarial value of 70%) while the cost sharing elements and actuarial values reported reflect those of the member's corresponding CSR plan (i.e. either 94%, 87% or 73% actuarial value).

[47] 2016 SDR data.

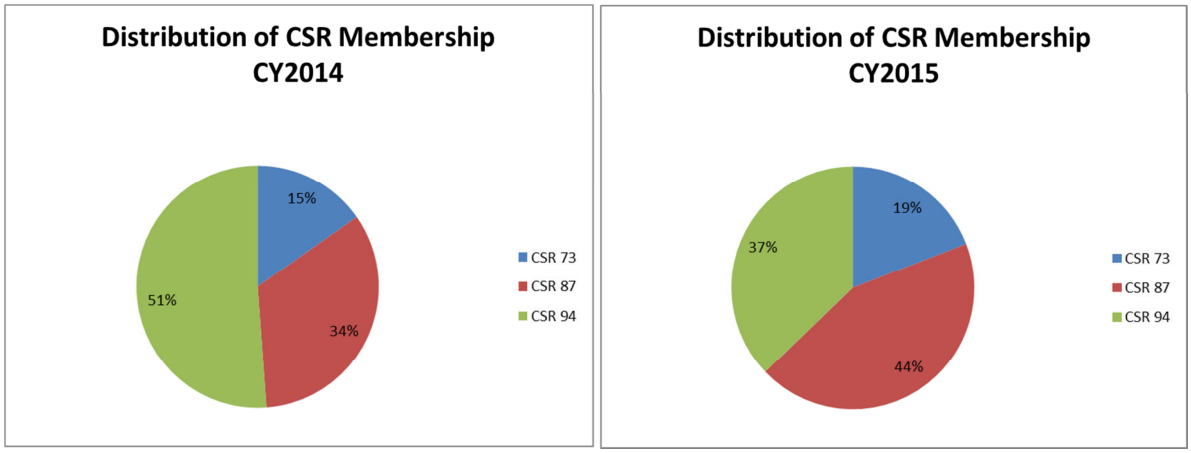


Figure 14: Individual Market Distribution of CSR Membership, CY 2014 and CY 2015

Members in state and municipal plans generally have lower cost sharing than other self-insured members.[48, 49]

- Data reported show that all state plans have a $500 deductible, while municipal plans have an average deductible of $430 in CY 2015. This is lower than the average deductible of $1,435 found in the remaining self-insured population.
- Two-thirds (67%) of the municipal population have no deductible, as compared to one-fourth (25%) of the other self-insured population.

Market Segment	Average Deductible	Average Coinsurance	Average OOPMAX	Number of Members
State	$500 for All	No Coinsurance for All	$1,000 for All	28,000
Municipal Self-Insured	$430	1.7%	$4,867	97,000
Other Self-Insured Market (excluding State, Muni)	$1,435	11.1%	$4,723	139,000

Table 3: Comparison of State and Municipal Cost Sharing to Self-Insured Population CY 2015[50]

[48] The New Hampshire Purchasers Group on Health is a collaboration of the state's four largest public health care purchasers: the State of New Hampshire Employee Health Benefit Program (administered by Anthem and Matthew Thornton Health Plan), HealthTrust (administered by Anthem and Matthew Thornton Health Plan), the New Hampshire School Health Care Coalition (administered by CIGNA), and the University System of New Hampshire (administered by Harvard Pilgrim). The State of New Hampshire Employee Health Benefit Program is represented by the "State" designation and the other three entities are part of the "Municipal" population in the 2016 SDR data.

[49] The vast majority of state and municipal members identified by insurers are in self-insured plans.

[50] 2016 SDR data.

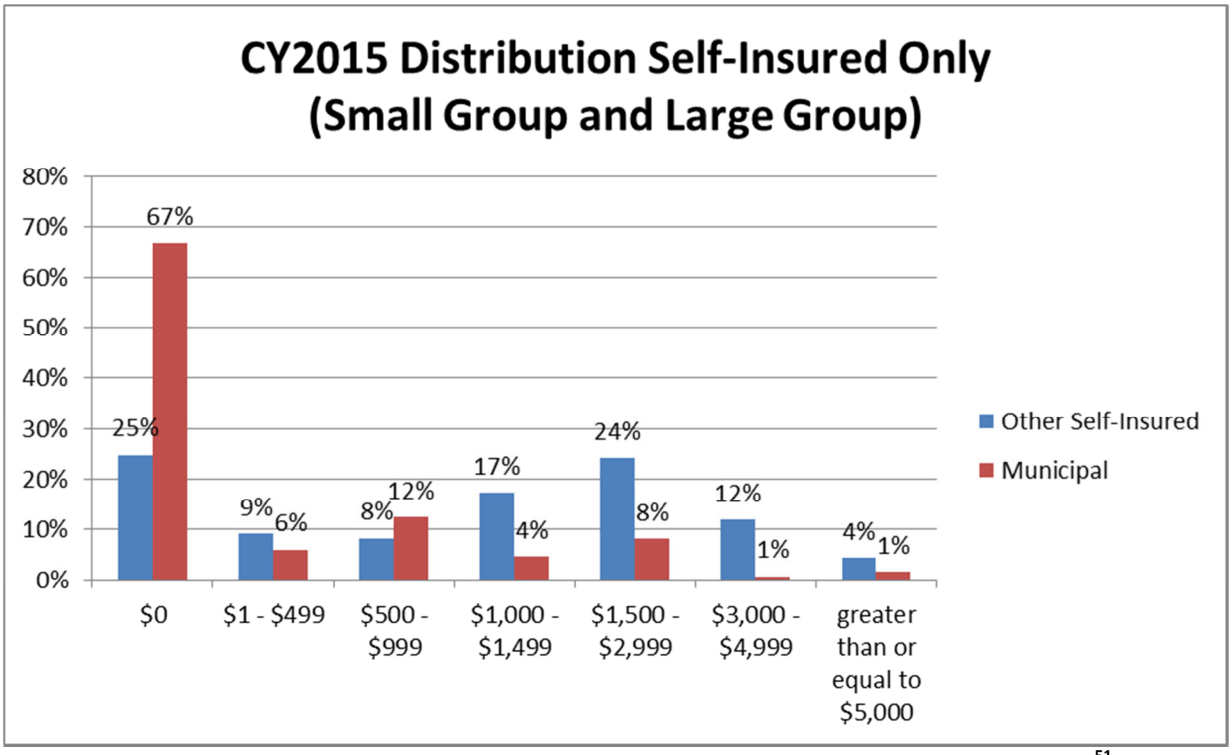


Figure 15: Distribution of Municipal and Other Self-Insured by Deductible Level[51]

In CY 2015, the average commercial fully-insured member spent $88 per month or $1,050 per year in the form of deductibles, copays and coinsurance (collectively referred to as cost sharing.)

- In CY 2015, the average member cost sharing has increased in each market segment. In the Individual Market it was $83 per month compared to $74 in CY 2014, $90 per month in the Small Group Market compared to $101 in CY 2014, and $81 per month in the Large Group Market compared to $77 in CY 2014.
- These member cost sharing amounts represent 22% of total allowed claims in the Individual Market, 22% in the Small Group Market, and 17% in the fully insured Large Group Market.

[51] Ibid.

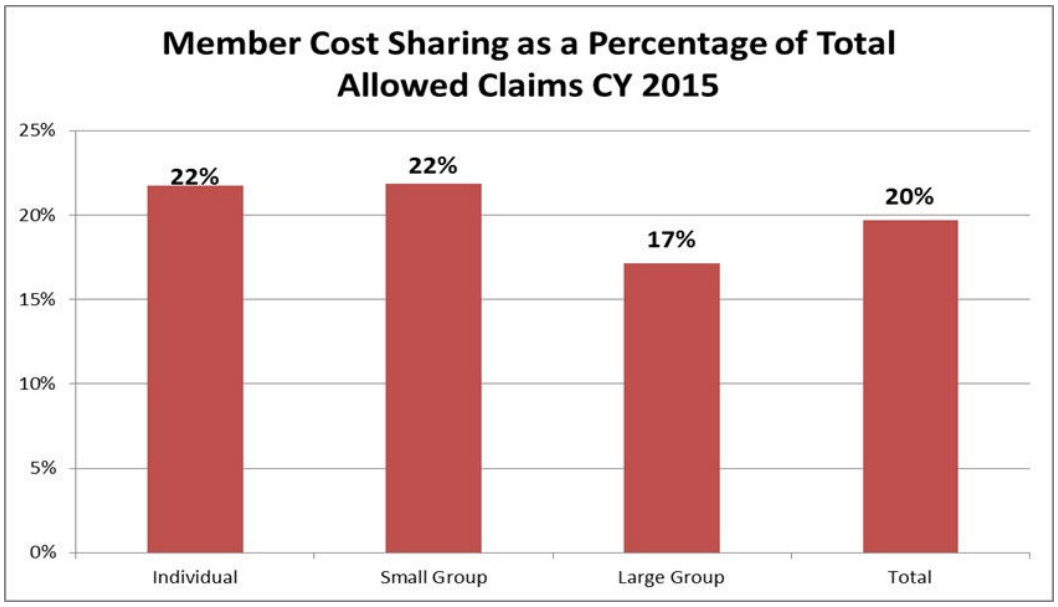


Figure 16: Member Cost Sharing as a Percentage of Total Allowed Claims by Market Segment CY 2015[52]

Absent premium subsidies, in CY 2015 the average Individual Market member pays a total of $454 per month, or $5,450 per year, for health care.

- In the Individual Market, a member is responsible for 100% of the premium, as there is no employer contribution.
- The average Individual Market member pays $368 in premiums per month and $83 in cost sharing per month, resulting in a total of $454 per month.
- A family of four in the Individual Market pays $1,816 per month and $21,800 per year, on average. (Again, this does not reflect premium subsidies for low-income enrollees in the exchange.)

[52] 2015 SDR data.

4. Benefit Buy-Down and Benefit Adjusted Premium Trends

The Group Markets made minimal changes to the cost sharing of their plan designs in CY 2015 compared to CY 2014 ("benefit buy-down").[53] There was little to no change in cost sharing from CY 2014 to CY 2015 for the Individual Market.

- In CY 2014, the Individual Market was enrolled in plan offerings with lower deductibles, copays and coinsurance amounts compared to CY 2013. This is due to the introduction of cost sharing reduction subsidies for qualifying low-income individuals. However, there was little change in cost sharing from CY 2014 to CY 2015.
- The estimated benefit buy-down in the Group Markets reduced premium 0% to 1% for the Small Group Market and 1% to 3% for the Large Group Market in 2015.
- If employers had not changed their 2014 plan designs, in 2015 the Small Group Market would have experienced average premium increases in the range of 2% to 3% and the Large Group Market would have experienced average premium increases in the range of 2% to 4% (benefit-adjusted premium trends).

	2015 Benefit Buy-Down Range
Individual	0%
Small Group	0% to 1%
Large Group	1% to 3%
Total Group Only	1% to 2%

Table 4: Benefit Buy-Down by Market Segment[54]

[53] 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. Benefit buy-down is estimated by reviewing changes in cost sharing attributes along with insurer-reported actuarial values using the federal minimum value calculator. The percentage reflects the reduction in premium due to benefit buy-down.

[54] Derived based on actuarial values and cost sharing attributes from the 2015 and 2016 SDR data. Fully-insured market only; excludes populations covered under FEHBP.

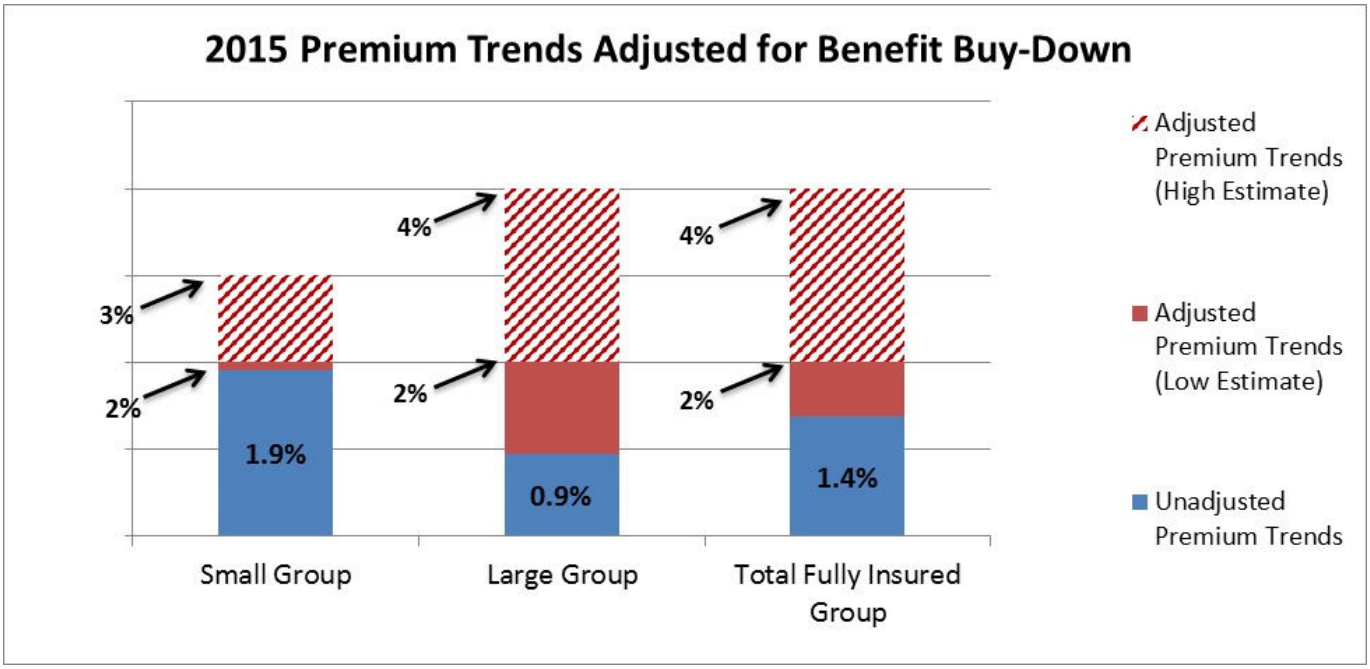


Figure 17: 2015 Premium Trends Adjusted for Benefit Buy-Down[55]

[55] Ibid.

5. Claim Trends

In CY 2015, medical and pharmacy claims per member per month ("allowed claims PMPM") have increased at a moderate rate of 3.7% overall.

- The combined Small Group and Large Group Market trend is 2.5% in 2015, which reflects an increase compared to the 2014 Group Market trend of 1.0%.
- Small Group Market trends in 2015 have increased compared to 2014, while Large Group Market trends in 2015 are very consistent with trends from 2014.
- In 2014, the 15.7% Individual Market trend was driven by the dramatic changes in the Individual Market as a result of the ACA, as described previously. In 2015, the Individual Market trend is lower at 9.4%, but is still higher than other market segments.
- Pharmacy unit cost and mix trends are now a key driver of trends for each of the market segments. Detail on pharmacy trends and overall costs are explored further below.

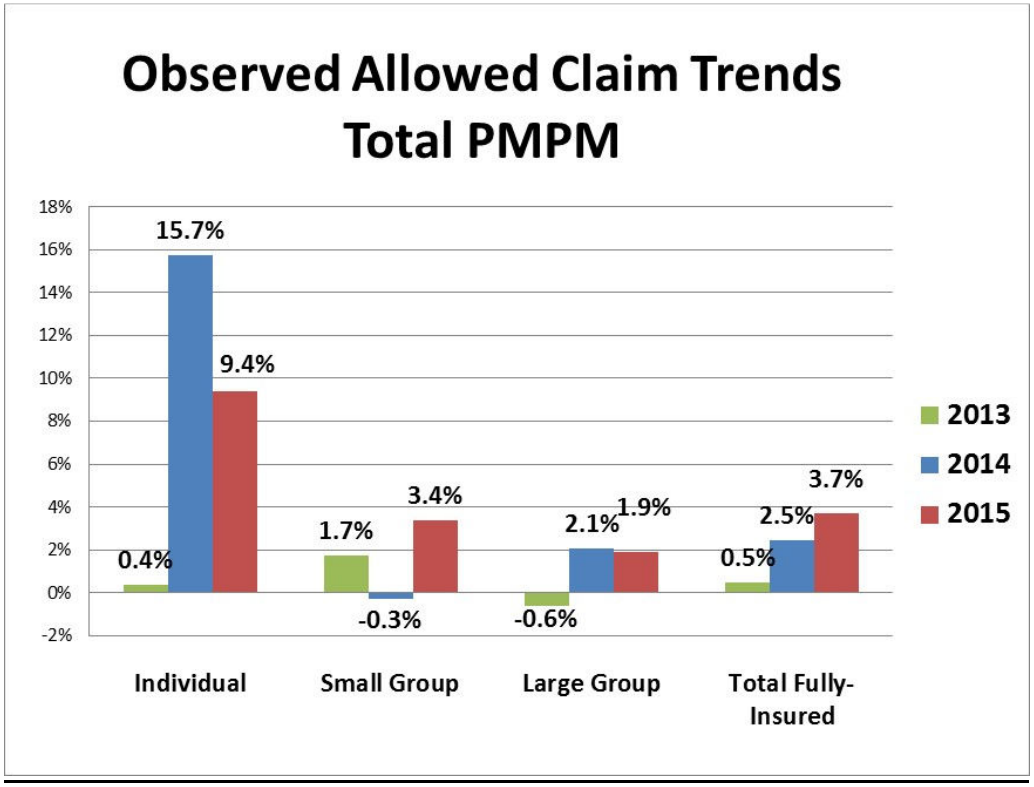


Figure 18: Observed Allowed Claims Trend by Fully-Insured Market Segment[56]

[56] 2015 and 2016 AH data. Trends weighted by allowed claims in corresponding years.

In the Group Markets, unit cost increases continue to be the main driver of overall medical increases, although to a slightly lesser extent as compared to prior years. Medical services utilization continues to decline each year; however, this decline is less in 2015 than in 2014. Mix trends are increasing but overall have remained fairly small.[57]

- While utilization trends remain negative, they have increased in each of the past three years, from -3.2% in 2013 to -1.1% in 2015.
- The "mix" portion of the cost and mix trends is estimated to be around 0% to 1% in 2015, slightly higher than past years where the estimate was in the range of -1% to +1%.
- Unit cost trends continue to be the main driver of overall claims trends. The unit cost and mix trend is 3.8% in 2015, which is fairly consistent with the unit cost and mix trends from 2014.

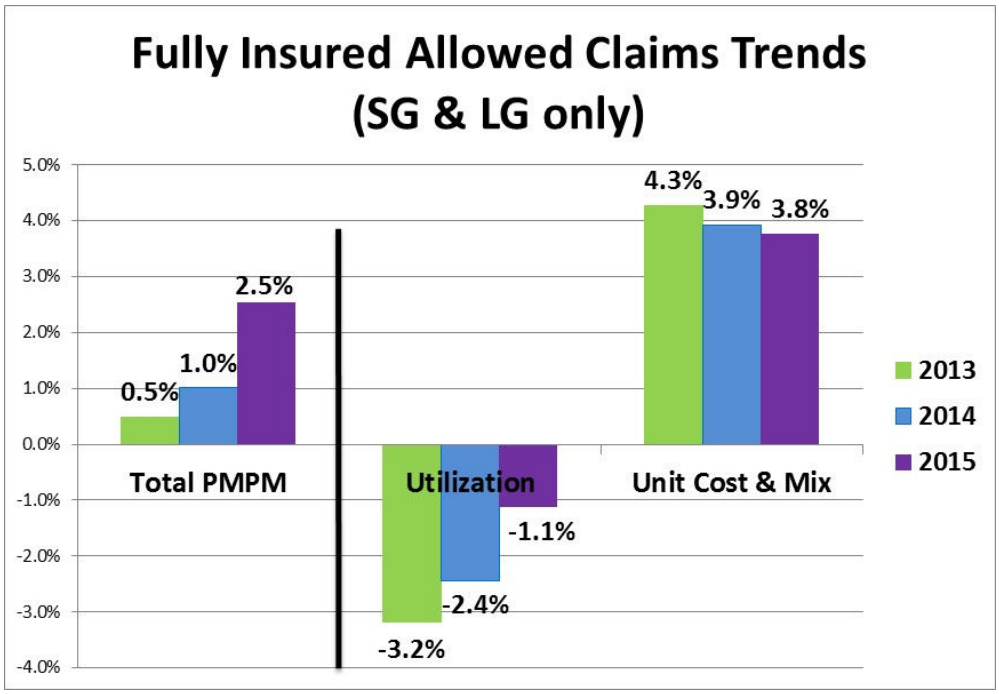


Figure 19: Observed Allowed Claims Trend by Component in Fully-Insured Small and Large Group Markets[58]

When examining allowed claims trend by service category, inpatient facility trends have decreased, while pharmacy and other medical service trends have increased.

[57] Claims PMPM trends generally consist of two components: utilization, and unit cost and mix. Utilization is the number of services provided (e.g. admissions to a hospital or number of prescriptions filled). Unit cost and mix trends are a combination of the change in unit price of specific services and changes in the mix of services, or changes in the mix of providers being used by patients.

[58] 2015 AH data. Utilization and unit cost trends reported by service categories and in total by categories. Total utilization and unit cost trends are generally weighted by service category allowed PMPMs. Utilization metrics generally reflect admits for inpatient, prescriptions for pharmacy, and visits for professional and outpatient categories.

- The Inpatient Facility category experienced a large decrease in trend driven by both decreasing utilization and unit cost and mix trends. Some drivers noted by insurers include lower utilization for both inpatient rehab services and maternity/newborn services in addition to shifting of some services to outpatient.
- The continued increase in Pharmacy trend is driven by increases in both utilization and unit cost and mix trends. While the utilization trend is increasing compared to 2014, it is still slightly negative in 2015. The unit cost and mix trend for Pharmacy is approximately 9%. Insurers cited that the increases are due to less savings from brand to generic conversions along with new and costly specialty drugs.
- The Other service category, although representing a small portion of total claims at 6% (see Figure 21), experienced a large increase in 2015 compared to prior years. One driver identified for this is an increase in pharmacy provided in an outpatient setting (i.e. prescription drugs that are covered under the medical benefit.)
- Each service category in each year continues to experience either flat or negative utilization trends.

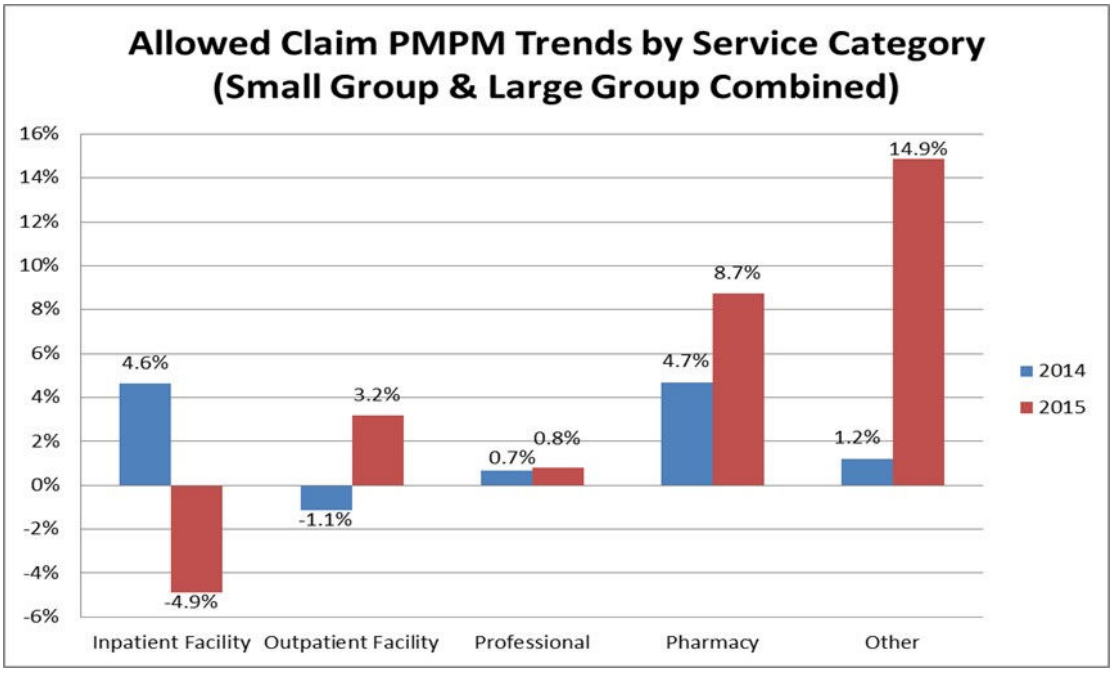


Figure 20: Observed Allowed Claims PMPM Trend by Service Category[59]

The top 50 high cost brand drugs by total spend comprise less than 1% of total prescriptions in the Group Markets but 9% of total costs.

- Some of the most common high cost drugs in New Hampshire are drugs used to treat Hepatitis C (e.g. Harvoni & Solvadi), chemotherapy drugs and drugs to treat cystic fibrosis. The average cost for these drugs is over $17,000 per prescription.

[59] 2016 AH data. Fee-for-service (FFS) claims only.

- Due to the cost sharing structure for high cost drugs in addition to the high unit cost of these drugs, 99% of the cost is paid by the insurer and only a small portion paid by the member in the form of deductibles, copays or coinsurance.
- Generic drugs which comprise a large portion of total prescriptions at 84%, cost $32 on average and comprise approximately 28% of total pharmacy spending. In the case of generics, the insurer is responsible for 71% of the costs while the member pays the remaining 29%, on average.

Small Group and Large Group- YTD November 2015					
	Scripts per 1000 members per year	**% Distribution by Scripts**	**Average Allowed per Script**	**% Distribution by Total Allowed**	**% Insurer Responsibility**
Generic	8,514	83.9%	$32	28.2%	71%
Brand	1,451	14.3%	$381	61.3%	88%
Over the Counter	172	1.7%	$81	1.5%	76%
High Cost Brands	5	0.1%	$17,544	9.0%	99%
Total	10,142	100.0%	$92	100.0%	84%

Table 5: New Hampshire Pharmacy Spending in 2015[60]

The percentage of total allowed claims for each service category has remained fairly consistent over the past two years, with the most significant increases seen in the pharmacy category as pharmacy trends are higher in recent years than overall medical trends.

- Pharmacy currently reflects 19% of total allowed spending in the fully-insured market in 2015. It represented 16% of total spending in 2013.[61]
- Inpatient Facility and Outpatient Facility spending comprise 41% of total medical spending, followed by professional spending at 34% of total medical spending.

[60] NHID provided NHCHIS pharmacy data.

[61] Note that one insurer needed to restate its reporting by service category in this year's data submission for 2015 and 2014. Pharmacy, inpatient and total claims were not impacted.

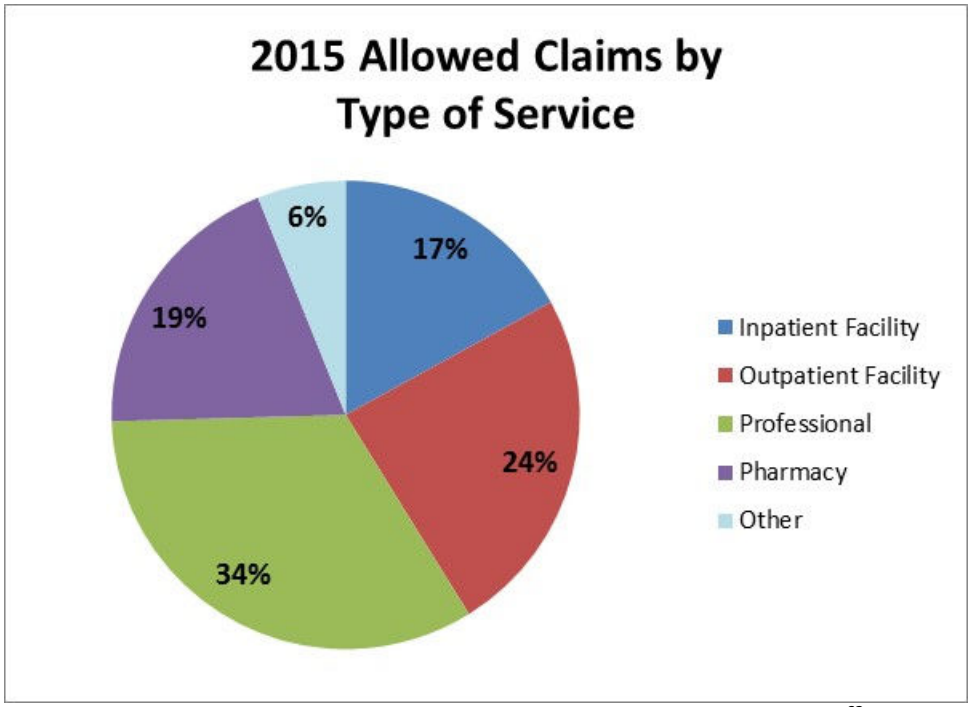


Figure 21: CY 2015 Allowed Claims Percentage by Service Category[62]

The Individual Market trend of 9.4% is lower than last year but higher than the trend in the Group Markets. There continues to be significantly more fluctuation in the allowed claims trend for the Individual Market since the introduction of the ACA.[63]

- In 2014, the 15.7% PMPM trend was a result of utilization trends over 30% (primarily driven by influx of newly insured and former high risk pool members). This was partially offset by cost and mix trends below -10% (primarily driven by the introduction of the limited network product for Exchange and Non-Exchange members.)
- In 2015, the utilization trends are generally lower while the unit cost and mix trends are higher compared to 2014.
- Pharmacy trends continue to be a key driver of the unit cost and mix trends in the Individual Market in 2014 and 2015, with the pharmacy trend over 30%.
- As stated previously, there were three new entrants to the Individual Exchange Market in 2015 (Community Health Options, Harvard Pilgrim and Minuteman) with Community Health Options and Minuteman being completely new to New Hampshire. This will cause fluctuation in claims levels and trends as new entrants come in with different provider contracts and networks, leading to different unit costs. There has also been movement of members between insurers from 2014 to 2015 as individuals "shop around."
- The allowed claims levels and trend in the Individual Market will continue to fluctuate into 2016 and beyond with continued changes in insurer and product offerings along with the introduction of the 40,000 NH PAP members in 2016.

[62] 2016 AH data. FFS claims only.
[63] Only insurers with three years of experience are included in this analysis.

Trend assumptions used by insurers to develop prices in the fully-insured market (known as "pricing trends") have decreased over the past several years, from a high of 10.5% in 2012 to 7.8% in 2017. This is driven by decreases in the pricing trend for medical services that are partially offest by increases in the pricing trends for pharmacy services.

- Health insurance premiums are established well in advance of their effective period, which requires insurers to develop projected trend assumptions called pricing trends. Pricing trends are based on a static level of benefits, while observed trends will reflect the impact of benefit changes to utilization levels. Furthermore, given the significant lag between observed historical data and the projection period for a pricing trend, it may take time to see the same deceleration in pricing trends compared to what is occurring in observed historical trends.
- Another factor that impacts pricing trends but not observed claims trends is the impact of leveraging due to fixed cost sharing elements such as the deductible. If health care costs increase while deductibles remain fixed, the insurer assumes a greater percentage of health care costs, and an upward adjustment to the pricing trends is required to reflect the increase in costs above the fixed dollar deductible. The larger the deductible, the greater the adjustment needed due to the impact of leverage.
- In 2017, the medical services pricing trend is around 7% while the pharmacy pricing trend is around 15%, resulting in an overall average of 7.8%. Figure 23 shows how the medical trends have generally decreased over time while the pharmacy trends have increased, although it does appear that pharmacy pricing trends are slightly lower in 2017 than they were at their peak in 2015.
- The 2017 Segal Health Plan Cost Trend Survey reported average projected 2017 trends of 6.7% to 7.7% for medical services and 11.6% for carve-out pharmacy services (including both specialty and non-specialty drugs). Projected trend rates for specialty drug/biotech in 2017 are 18.7%.[64]

[64] Double-Digit Rx Benefit Cost Trends Projected for 2017. 2017 Segal Health Plan Cost Trend Survey. Segal Consulting, Fall 2017. Available at: https://www.segalco.com/media/2716/me-trend-survey-2017.pdf. The 6.7% medical services trend represents HMOs and the 7.7% trend represents HDHPs.

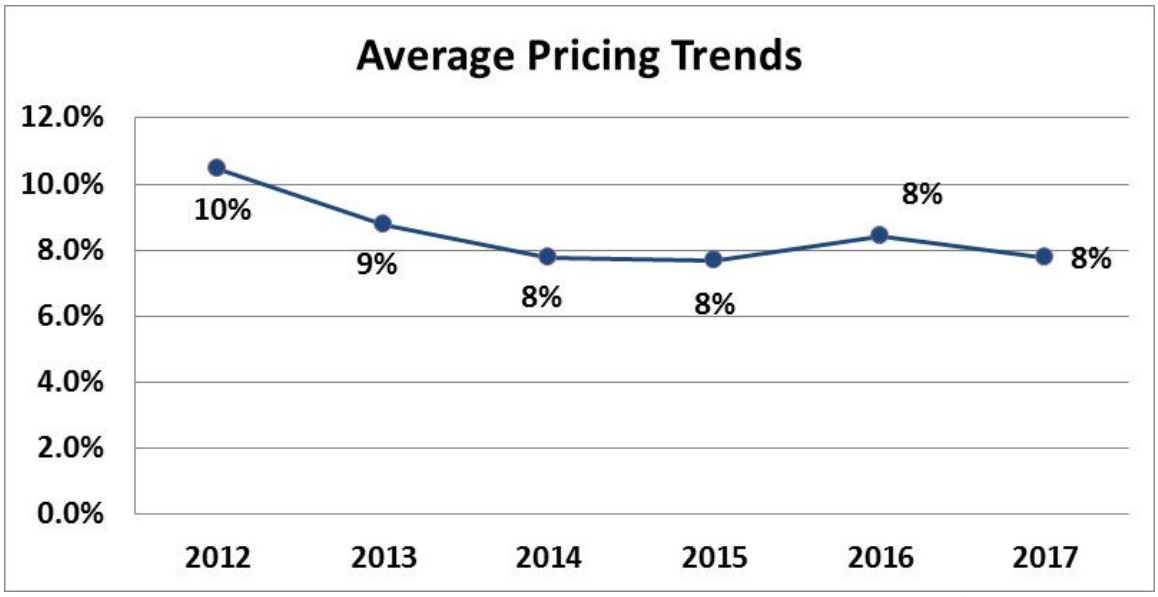


Figure 22: Average Pricing Trends in the Fully Insured Market[65]

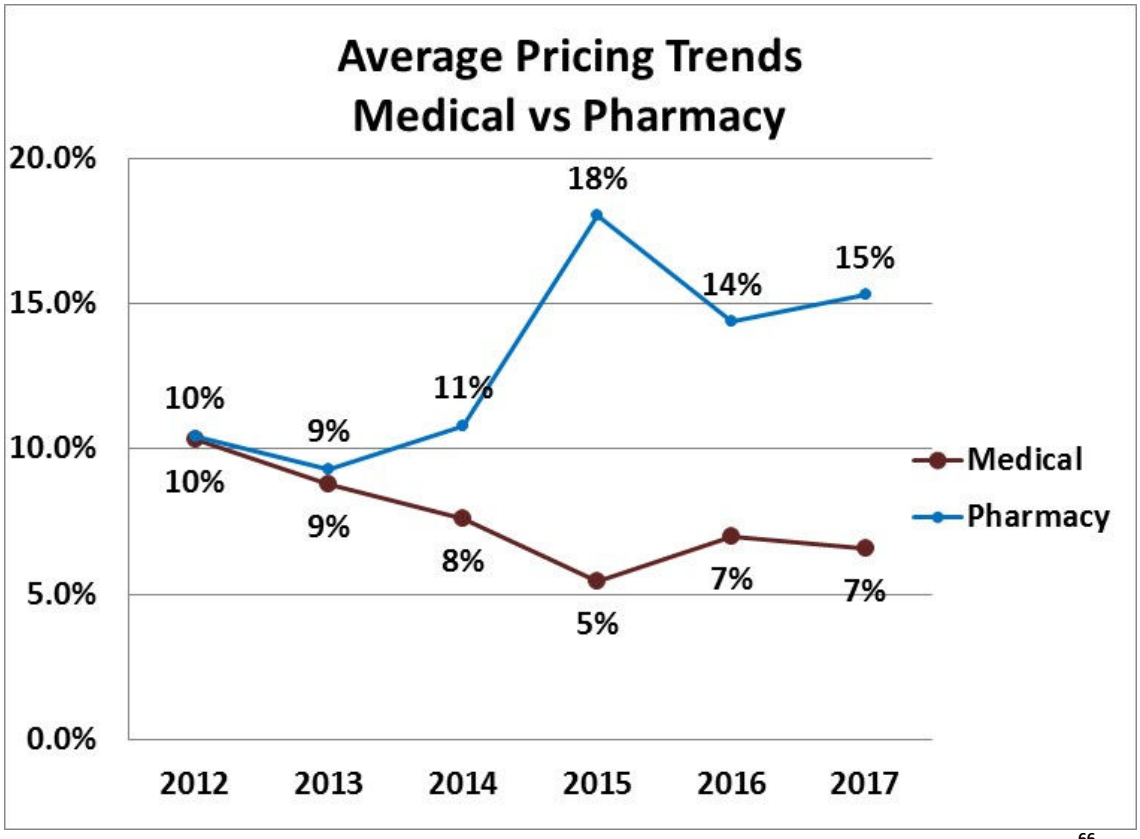


Figure 23: Average Medical and Pharmacy Pricing Trends in the Fully Insured Market[66]

[65] 2013, 2014, 2015 and 2016 AH data.
[66] 2013, 2014, 2015 and 2016 AH data.

6. Provider Costs and Provider Payment Reform

While the overall average blended inpatient and outpatient hospital payment rate changes have decreased slightly in the past year, there continues to be significant variation when examining rate changes across hospitals.

- The overall average hospital rate increase remained fairly stable at 2.9% in 2014 and 3.0% in 2015, and is expected to decrease to 2.3% in 2016.
- The payment rate changes by facility continue to vary considerably by hospital, with variation seen within each of the Southeastern, Central/Western, and Northern regions of New Hampshire.[67] This is consistent with prior years' findings.
- While historically, the Northern region had the lowest payment rate changes compared to the rest of the state, it appears that this region's payment rate changes in 2016 are higher than the other regions at an average of 3.7% compared to 3.0% and 2.4% in the Southeastern and Central/Western regions, respectively.
- The single dark black line in Figure 25 represents the December 2015 Northeast Medical Consumer Price Index (CPI) of 2.2%.[68] In 2015, 19 out of the 26 hospitals have unit price changes above the Northeast Medical CPI; this increases to 22 hospitals out of 26 in 2016.
- The dashed black line in Figure 25 represents the December 2015 Northeast Total Consumer Price Index (CPI) of 0.5%.[69] The unit price rate changes for all hospitals in 2015 are above the Northeast Total CPI, and all but two hospitals in 2016 are above the Northeast Total CPI.
- In addition to variation in hospital payment rate changes, there continues to be variation in the level of hospital prices across all insurers. Based on commercial relative prices as reported by insurers, the most expensive hospitals in New Hampshire continue to be more than twice as much as the least expensive hospital in both 2015 and 2016.[70]

[67] For the purposes of this analysis, New Hampshire was divided into the following three regions: Southeastern, Central/Western, and Northern, using the definitions provided in the following report: K London, MG Grenier, TN Friedman and PT Swoboda. Analysis of Price Variations in New Hampshire Hospitals. University of Massachusetts Medical School, April 2012. Available at: http://www.nh.gov/insurance/lah/documents/umms.pdf.

[68] Medical CPI for December 2014 is available at the following source: M Crawford, J Church and B Akin. CPI Detailed Report: Data for December 2014. Table 11. Available at: http://www.bls.gov/cpi/cpid1412.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 the following: US Department of Labor, Bureau of Labor Statistics. Consumer Price Index: Measuring Price Change for Medical Care in the CPI. Available at: http://www.bls.gov/cpi/cpifact4.htm.

[69] Medical CPI for December 2015 is available at the following source: M Crawford, J Church and B Akin. CPI Detailed Report: Data for December 2015. Table 11. Available at: http://www.bls.gov/cpi/cpid1512.pdf.

[70] 2016 AH data. Standard Network rate changes only.

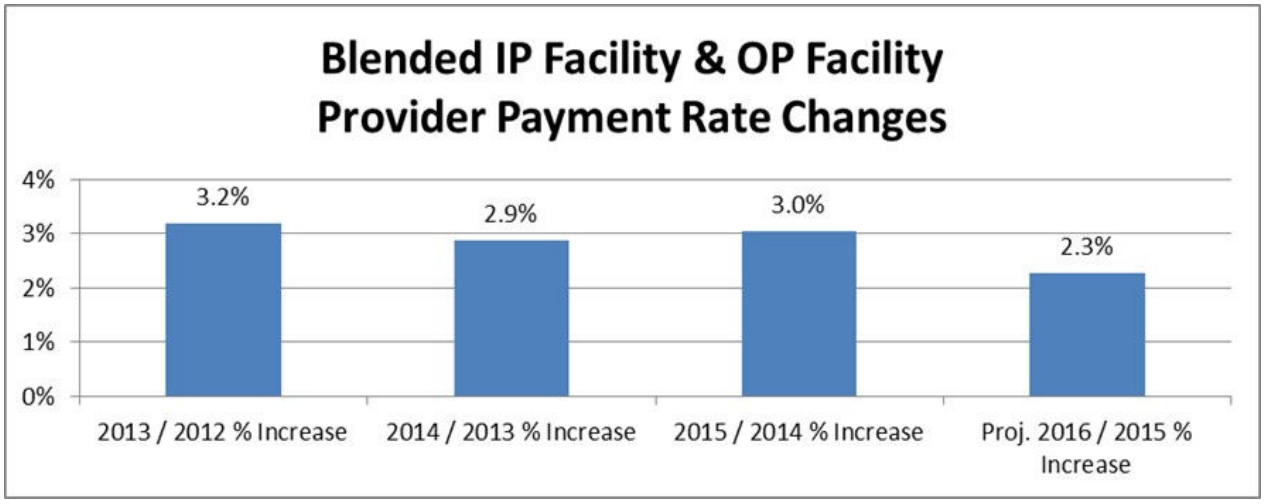


Figure 24: Blended Inpatient and Outpatient Average Hospital Payment Rate Changes by Year[71]

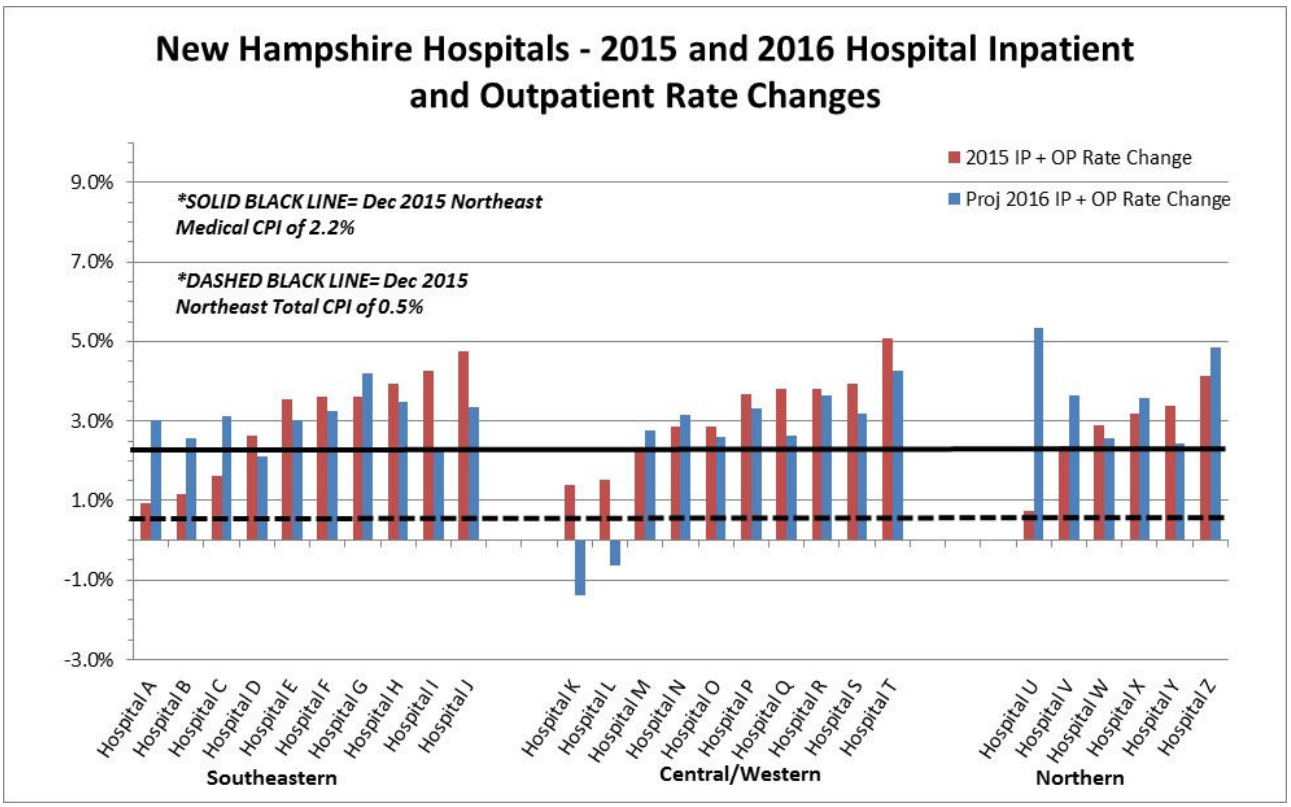


Figure 25: Blended Inpatient and Outpatient Hospital Rate Changes by Facility[72]

[71] 2014, 2015 and 2016 AH data. Standard Network rate changes only.
[72] 2015 AH data.

Overall average professional payment rate changes have remained stable from 2014 through 2016, although they are lower compared to 2013.

- Similar to hospital payment rate changes, there continues to be variation in the level of physician prices across all insurers. Based on commercial relative prices as reported by insurers, the most expensive physician groups in New Hampshire are 2.5 times the least expensive physician group in both 2015 and 2016.[73]

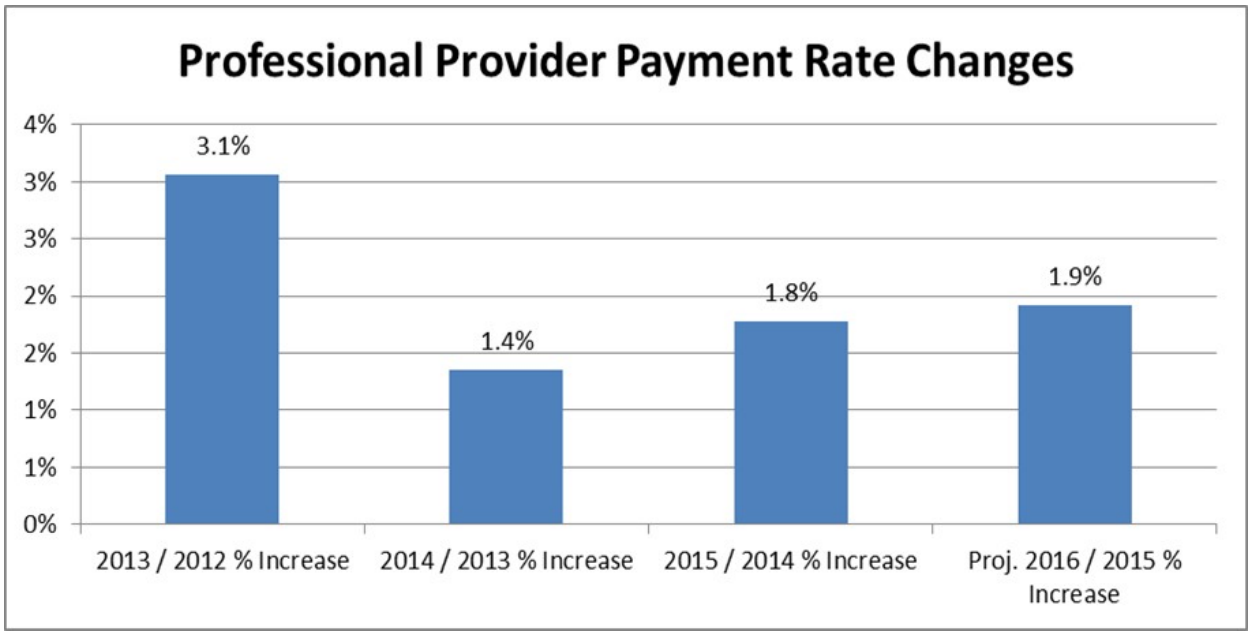


Figure 26: Professional Average Payment Rate Changes by Year[74]

The majority of members in New Hampshire have providers with no downside risk in their contracts with insurers.

- The percentage of members in upside only risk contracts[75] in 2015 increased to 39% in the fully-insured markets and 40% in the self-insured markets.
- Slight increases since 2011 were shown for members in full risk contracts with both upside and downside risk sharing. The percentage of members in upside only risk contracts remains significantly higher than members in full risk contracts.
- Insurers reported on several payment reform initiatives including the following:

[73] 2016 AH data. Standard Network rate changes only.

[74] 2014, 2015 and 2016 AH data. Standard Network rate changes only.

[75] An upside only agreement involves no downside risk to the provider for failing to achieve the metrics defined in the contract agreement between the insurer and the provider. In other words, an upside only agreement is an agreement where the provider can only benefit or receive a payment for achieving a certain metric. A full risk contract agreement has both upside and downside risk and involves providers agreeing to pay a specified amount back to the insurer if certain metrics are not achieved.

- Primary Care Payment Models: At least two insurers in New Hampshire are working with primary care physicians to improve care coordination and outcomes by providing data, tools, and financial incentives to the provider groups for meeting certain cost and quality metrics. These arrangements primarily represent upside only risk to the provider. One insurer reported that 88% of New Hampshire providers are currently participating in this program.
- Capitation: Provider groups are fully at risk for the majority of services incurred by members and reimbursed on a PMPM basis. While not widely prevalent in New Hampshire, at least one large provider group participates in this type of arrangement. Historically, these arrangements are for HMO/POS members who choose a primary care provider (PCP), but at least one insurer has initiated a pilot program attributing PPO members to a PCP in 2015.
- Accountable Care Organizations: At least two insurers have established accountable care type models with larger provider systems in New Hampshire. In one case, this arrangement is centered on sharing information with providers related to gaps in care and pharmacy compliance, and does not represent any financial risk sharing.
- Hospital Pay for Performance Programs: At least two insurers in New Hampshire participate in pay for performance type programs with hospitals, in which a portion of the hospital's payment is tied to performance on a defined set of quality metrics. These programs typically apply to all fully-insured and self-insured HMO, POS and PPO members. One insurer reported eight participating hospitals in 2015 and 2016.

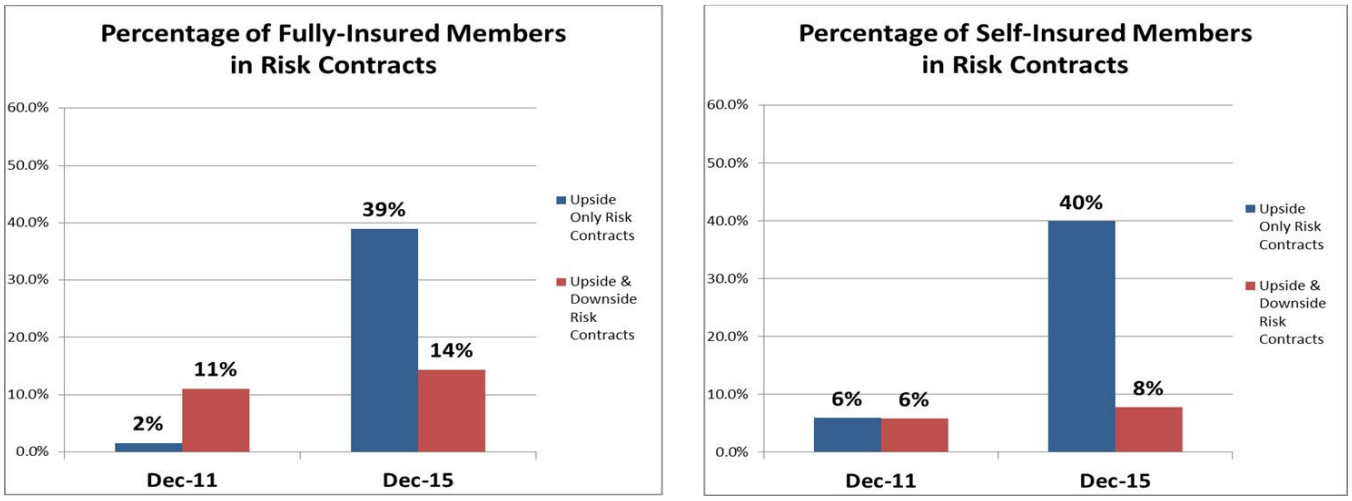


Figure 27: Members in Risk Arrangements for Fully-Insured and Self-Insured Markets[76]

[76] 2013, 2014, 2015 and 2016 AH data.

7. Medical Loss Ratios, Expenses and Profits

In CY 2015 in the New Hampshire fully-insured market, for every $1 of premium, 79 cents are used to pay for medical and pharmacy claims, 9 cents for taxes and fees, 8 cents for administrative expenses and 4 cents for profit. Note that this information is not on the same basis as what is used for the federal Medical Loss Ratio (MLR) formula for rebate purposes.

- In CY 2015, the profit margins for the Small Group and Large Group markets have increased compared to the prior year, from 6% to 8% in the Small Group Market and from 5% to 7% in the Large Group Market.
- The Individual Market continues to experience a significant decrease in the profit margin, decreasing from over 10% in 2013, to 4% in 2014, down to -9% in 2015. The dramatic change between 2014 and 2015 is driven by an increase in the percentage of medical and pharmacy claims (as a percent of premium) along with an increase in administrative expenses and fees for new market entrants (Minuteman and Community Health Options).[77] As is detailed further below, Minuteman in particular was a large payer in the Individual Market risk adjustment program, thus significantly impacting their financial results.
- In each market segment, 2% to 3% of premiums are used for ACA related fees including the ACA health insurance tax, Patient-Centered Outcomes Research Institute (PCORI), and the transitional reinsurance fees.
- The percentage of claims for medical and pharmacy services is very consistent with last year's results in the Group Markets.
- The medical loss ratios in the figures below reflect payments or receivables due to risk adjustment and federal reinsurance, but do not reflect the impact of federal MLR rebates. This is discussed further below.
- By comparison, in the Large Group Self-Insured Market, 93% of premiums is spent on claims.[78]

[77] Profit margins and administrative costs for new market entrants are impacted by risk adjustment payments and start-up costs.
[78] Based on premium equivalents reported in the 2016 SDR data.

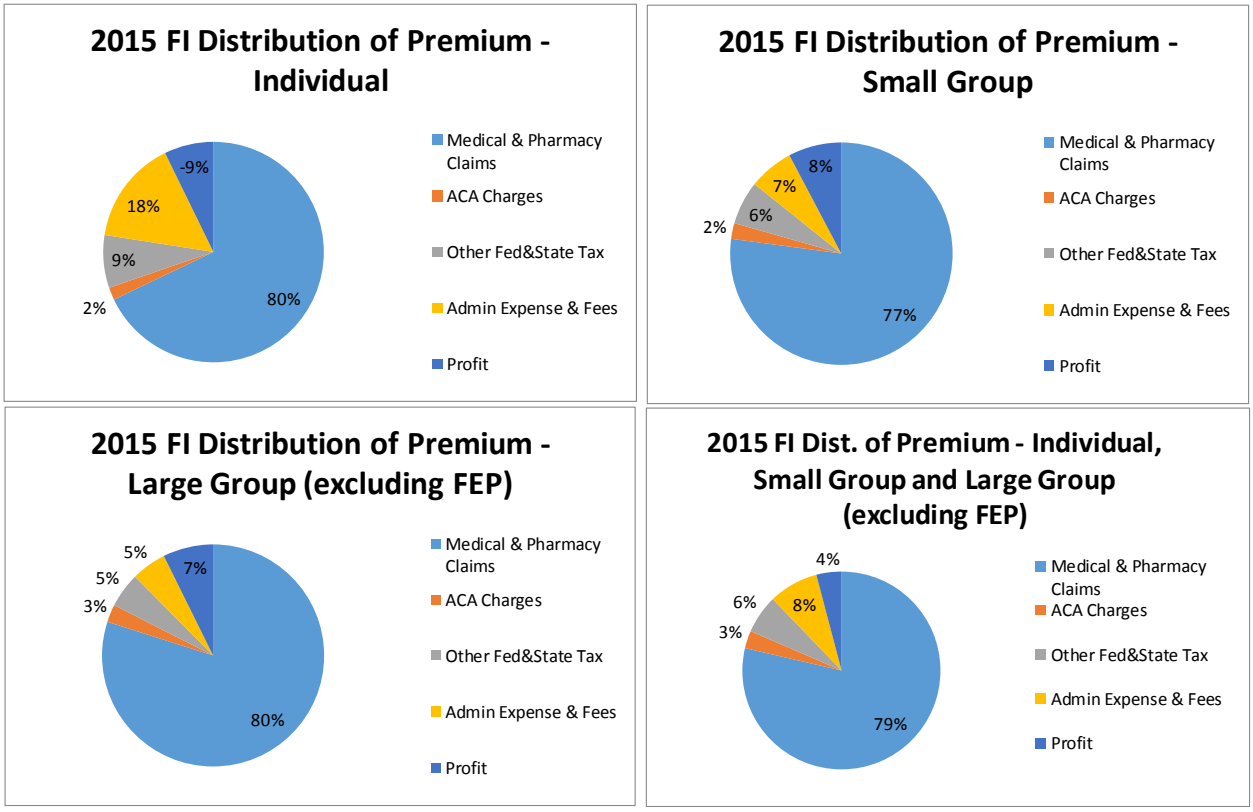


Figure 28: Loss Ratio Exhibits by Market for CY 2015[79]

$21.5 million in federal reinsurance payments were made to New Hampshire insurers in 2015, estimated to reduce Individual Market premiums by approximately 8%.

- The largest reinsurance payment was made to Matthew Thornton Health Plan for $8.3 million. This translates to 7% of their premium in CY 2015, meaning that premiums to consumers were approximately 7% lower than they would have been due to the expectation of payments from this program.
- Community Health Options and Minuteman received 12% and 11% of their premium, respectively, in federal reinsurance payments in CY 2015.

[79] 2015 federal MLR reports provided by insurers. Anthem provided additional information for FEHBP to make necessary adjustments to exclude this population from the Large Group.

Individual Market- Federal Reinsurance Program		
	2014 Reinsurance ($ millions)	2015 Reinsurance ($ millions)
Celtic Insurance Company	$0.1	$0.1
Harvard Pilgrim Health Care of NE	n/a	$2.6
Matthew Thornton Hlth Plan(Anthem BCBS)	$15.6	$8.3
Time Insurance Company	$6.1	$5.0
Community Health Options	n/a	$3.3
Minuteman Health, Inc.	n/a	$2.1
Total	**$21.8**	**$21.5**

Table 6: Federal Reinsurance Payments in the Individual Market by Insurer[80]

Additional monies were shared among insurers in New Hampshire for the risk adjustment program in CY 2014 and CY 2015.

- The Risk Adjustment program is revenue neutral within both the New Hampshire Individual Market and Small Group Market. In the Individual Market, Time Insurance Company and Community Health Options have a higher risk population and receive $6.2 million and $5.3 million respectively, primarily from Minuteman Health who has a lower risk population and pays $10.5 million. The risk adjustment payers and recipients in 2015 are very different than those in 2014, when Time Insurance Company was the primary receiver and Matthew Thornton Health Plan was the primary payer.
- In the Small Group Market, Harvard Pilgrim and Anthem receive risk adjustment payments due to their higher average risk, while primarily Community Health Options makes risk adjustment payments due to its lower average risk.

Individual Market- Federal Risk Adjustment Program		
	2014 Risk Adjustment ($ millions)	2015 Risk Adjustment ($ millions)
Celtic Insurance Company	$0.1	$0.1
Harvard Pilgrim Health Care of NE	n/a	($1.2)
Matthew Thornton Hlth Plan(Anthem BCBS)	($5.3)	$0.2
Time Insurance Company	$5.2	$6.2
Maine Community Health Options	n/a	$5.3
Minuteman Health, Inc.	n/a	($10.5)
Total	**$0.0**	**$0.0**

***Negative = Company was a PAYER; Positive = Company was a RECEIVER**

Table 7: Federal Risk Adjustment Payments in the Individual Market by Insurer [81]

[80] Centers for Medicare and Medicaid Services. Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year. June 2016. Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf.

Small Group Market- Federal Risk Adjustment Program		
	2014 Risk Adjustment ($ millions)	2015 Risk Adjustment ($ millions)
Anthem Health Plans of NH(Anthem BCBS)	$1.2	$1.3
Harvard Pilgrim Health Care of NE	($3.0)	($0.8)
HPHC Insurance Company, Inc	$1.5	$1.9
Matthew Thornton Hlth Plan(Anthem BCBS)	$0.2	$1.5
UnitedHealthcare Insurance Company	$0.0	($0.2)
Community Health Options	n/a	($3.6)
Minuteman Health, Inc.	n/a	($0.0)
Total	**$0.0**	**$0.0**

***Negative = Company was a PAYER; Positive = Company was a RECEIVER**

Table 8: Federal Risk Adjustment Payments in the Small Group Market by Insurer[82]

[81] Ibid.
[82] Ibid.

8. Regional and National Comparisons

New Hampshire continues to have higher than average premiums in all markets, but in the Individual and Small Group Markets the rank of premium levels compared to other states has decreased in 2015 compared to 2014.

- Based on data from the Centers for Medicare and Medicaid Services' (CMS) risk adjustment report, New Hampshire's 2015 premiums rank 18th highest in the Individual Market and tenth highest in the Small Group Market for ACA compliant plans,[83] as shown in Figure 29 and Figure 30. This is lower than New Hampshire's 2014 rankings, in which the state was ranked tenth highest in the Individual Market and fourth highest in the Small Group Market.[84]
- Using information from CMS' risk adjustment report, New Hampshire's actuarial value in 2015 compared to the average across all states is lower in both the Individual and Small Group Markets. New Hampshire's plan liability risk score (PLRS) in 2015 is also lower compared to the average across all states for both the Individual and Small Group Markets. Therefore, New Hampshire's higher than average premiums cannot be attributed to richer benefits (as seen by the actuarial values) or higher morbidity (as seen by the PLRS values).
- When comparing the second lowest costing Silver plans (before federal premium subsidies) across the country, New Hampshire ranked as the 17th highest in 2014, dropping to the 30th highest in 2015 and dropping further to the 33rd highest in 2016.[85, 86]
- New Hampshire ranks third in the nation in terms of highest average single premium in the employer health insurance market.[87]
- New Hampshire has the highest median annual household income based on 2015 dollars.[88]
- New Hampshire's premium as a percentage of household income is one of the lowest in the country; according to 2013 data, New Hampshire ranked eighth lowest in the country with its premiums at 18% of household income, compared to the national average of 22%.[89]

[83] Centers for Medicare and Medicaid Services. Appendix A to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year. June 2016. Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-to-June-30-2016-RA-and-RI-Report-5CR-063016.xlsx.

[84] These data have not been adjusted for demographic or benefit differences by state. Massachusetts is not included in this chart since they are the only state to have a state operated risk adjustment program.

[85] C Cox, L Levitt, G Claxton, R Ma and R Duddy-Tenbrunsel. Analysis of 2015 Premium Changes in the Affordable Care Act's Health Insurance Marketplace. Kaiser Family Foundation, January 2015. Available at: http://kff.org/health-reform/issue-brief/analysis-of-2015-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/.

[86] C Cox, S Gonzales, R Kamal, G Claxton and L Levitt. Analysis of 2016 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces. Kaiser Family Foundation, October 2015. Available at: http://kff.org/health-reform/fact-sheet/analysis-of-2016-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/.

[87] The Kaiser Family Foundation State Health Facts. Data sources: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey (MEPS)- Insurance Component, 2013-2015; Tables II.C.1, II.C.2, II.C.3 available at: Medical Expenditure Panel Survey (MEPS).

[88] The Kaiser Family Foundation State Health Facts. Data source: U.S. Census Bureau, 2016 Current Population Survey, Annual Social and Economic Supplements Data Tables. Historical Household Income.

[89] C Schoen, D Radley and SR Collins. State Trends in the Cost of Employer Health Insurance Coverage, 2003-2013. The Commonwealth Fund, January 2015. Available at: http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/jan/1798_schoen_state_trends_2003_2013.pdf.

- In 2016, New Hampshire was ranked as the second highest-earning state for physicians overall, with $322,000 per year.[90]
- According to 2014 data, New Hampshire hospital admissions per 1000 population rank tenth lowest compared to other states. New Hampshire has 88 admissions per 1000 population compared to the national average of 104 admissions per 1000.[91] Conversely, New Hampshire has higher than average emergency room visits (485 visits per 1000 population compared to the national average of 428), ranking them the 15th highest in the nation.[92]
- New Hampshire has a high median age compared to other states, ranking as the third highest in 2014.[93]

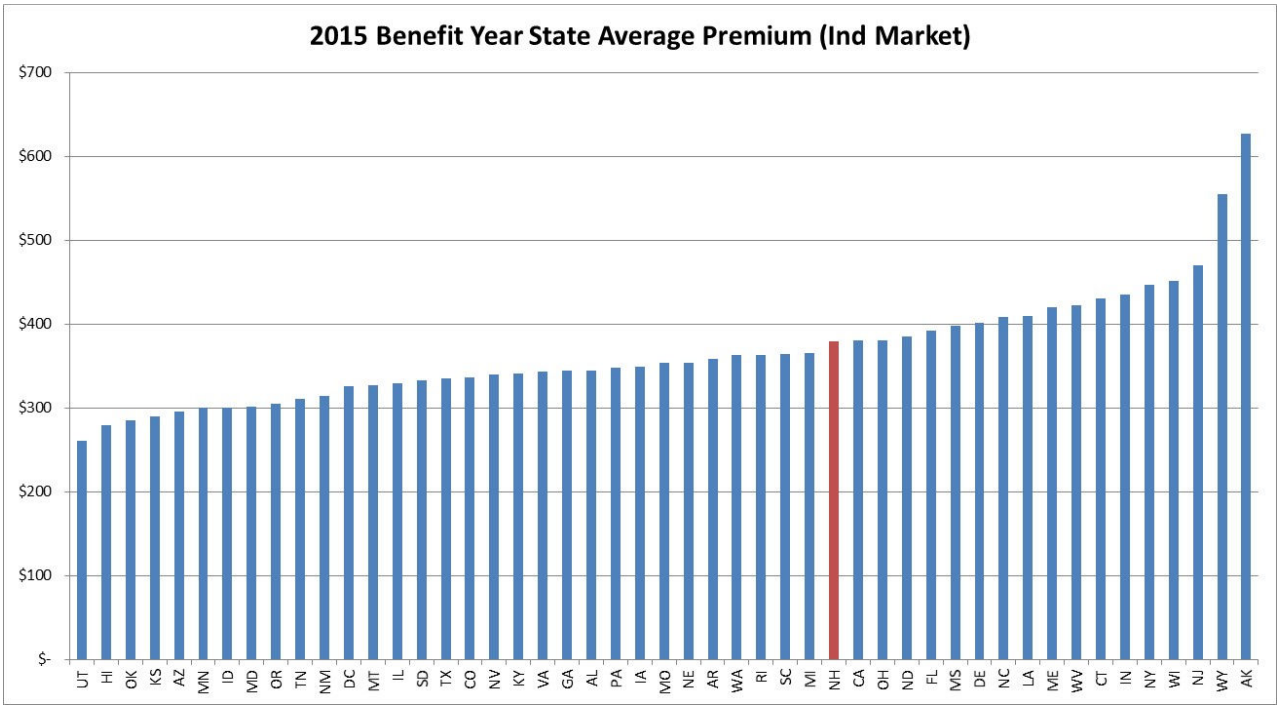


Figure 29: Individual Market Premiums by State- 2015 Benefit Year[94]

[90] C Peckham. Medscape Physician Compensation Report 2016. Medscape, April 2016. Available at: http://www.medscape.com/features/slideshow/compensation/2016/public/overview#page=1.

[91] The Kaiser Family Foundation State Health Facts. Data sources: 1999 - 2014 AHA Annual Survey, Copyright 2015 by Health Forum, LLC, an affiliate of the American Hospital Association. Special data request, 2015. Available at: http://www.ahaonlinestore.com. Population data from Annual Population Estimates by State, U.S. Census Bureau; available at http://www.census.gov/popest/.

[92] The Kaiser Family Foundation State Health Facts. Data sources: 1999 - 2014 AHA Annual Survey, Copyright 2015 by Health Forum, LLC, an affiliate of the American Hospital Association. Special data request, 2015. Available at: http://www.ahaonlinestore.com. Population data from Annual Population Estimates by State, U.S. Census Bureau; available at: http://www.census.gov/popest/.

[93] *The Denver Post.* Census: Median age, by state, 2005-2014. Data Source: U.S. Census Bureau's American Community Survey. Available at: http://extras.denverpost.com/census/2015/median-age-in-the-us.html.

[94] Centers for Medicare and Medicaid Services. Appendix A to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year. June 2016. Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-to-June-30-2016-RA-and-RI-Report-5CR-063016.xlsx.

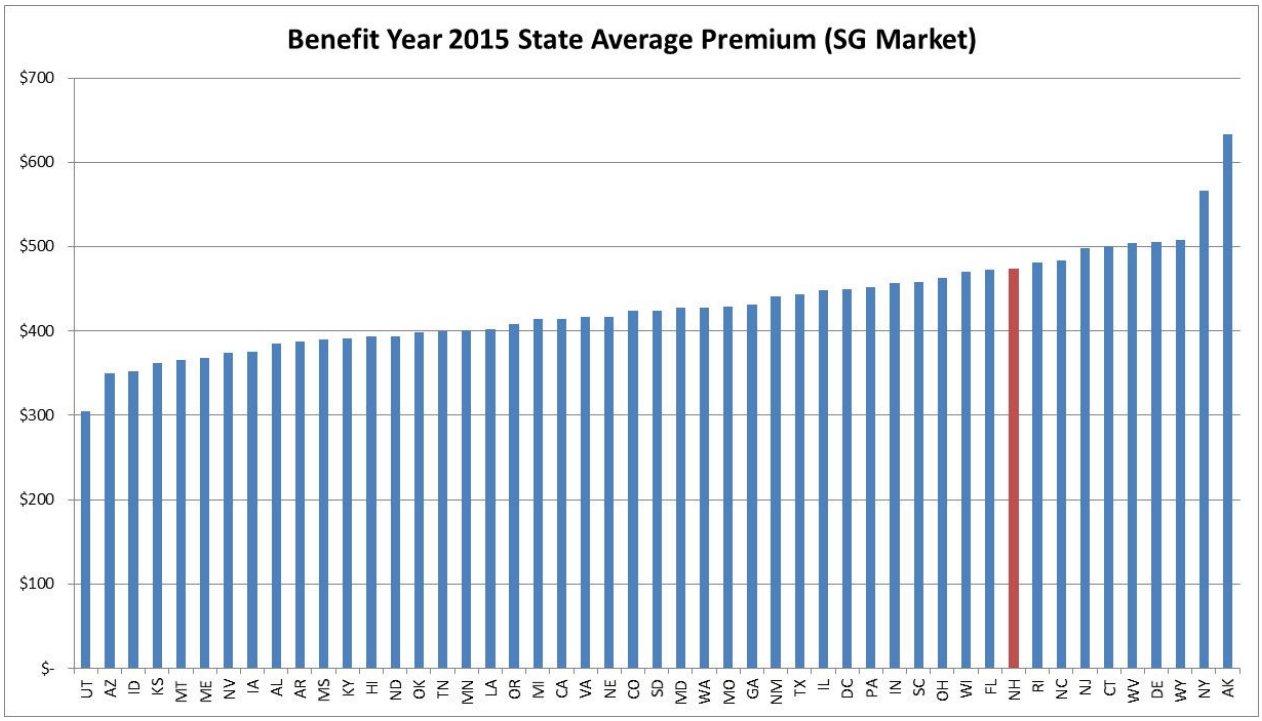


Figure 30: Small Group Market Premiums by State- 2015 Benefit Year[95]

[95] Ibid.

9. Product Innovation

Limited network products continue to gain market share, primarily in the Individual Market Exchange. Of the insurers with both a standard and limited network, the data show that the hospital unit prices in the limited network are 20% - 40% lower on average.[96]

- Anthem (Matthew Thornton Health Plan) has offered a limited network product (referred to as the Pathway Network) on the Exchange since 2014. Harvard Pilgrim began offering a limited network HMO product (referred to as the Elevate Health Network) to Small Groups and Large Groups in 2014, and joined the Exchange in 2015 where this product is also being sold in the Individual Market. Minuteman Health also began offering a product on the Exchange in 2015 with a more limited network.
- Table 9 summarizes the number of hospitals included by insurer network in 2017. Some insurers have stated that their original limited network products have continued to expand their networks since their introduction. There is generally a trade-off between the size of the network and the premium savings generated for customers, where the larger the network the lower the premium savings compared to a broad network product. For purposes of this year's analysis, Anthem's Pathway Network, HPHC's Elevate, and Minuteman Health's product are considered "Limited Network," but this designation may change over time as these networks continue to evolve.
- As of December 2015, 19% of the overall fully-insured market members are in limited network products driven by 88% participation in the Individual Exchange Market and 25% participation in the Individual Non-Exchange Market. In the Non-Exchange Market, the average age of members choosing limited network products is 37.9 years, while the average age of members choosing standard network products is 39.1.
- With the introduction of the NH PAP and continued growth on the Exchange, the percentage of overall fully-insured market members in limited network products rose to 25% as of April 2016, with 93% participation in the Individual Exchange Market, 33% in the Individual Non-Exchange Market, and 31% in the Individual NH PAP market.
- Limited network presence in the self-insured market remains small, with 5% market share as of April 2016.
- Anthem stated that premiums for limited network products are approximately 30% lower than those for comparable plans with a broad network in 2015.[97] Harvard Pilgrim stated that limited network products are generally lower by double-digits compared to comparable broad network plans.[98]

[96] This range is an average and actual differences will vary by hospital and insurer.

[97] Anthem Blue Cross Blue Shield. Anthem Blue Cross and Blue Shield, Elliot Health System Reach Agreement on Pathway Network. No date. Available at: https://www.anthem.com/health-insurance/about-us/pressreleasedetails/NH/2015/1876/anthem-blue-cross-and-blue-shield-elliot-health-system-reach-agreement-on-pathway-network.

[98] Elevate Health plan information available at: https://www.harvardpilgrim.org/portal/page?_pageid=849,2919992&_dad=portal.

2017 Hospital Network Profile for Exchange Products	
	Number of Hospitals included in 2017
Anthem (Pathway X and Pathway X Enhanced)	20
Centene (Ambetter)	23
Harvard Pilgrim Health Care of New England (Full Network)	26
Harvard Pilgrim Health Care of New England (Elevate Health)	16
Minuteman Health	15

Table 9: CY 2017 Hospital Network Profile[99]

Low-cost provider benefit designs, or site of service benefit designs,[100] continue to be a popular option for many employers. Although their market penetration may have peaked at this point, opportunities for future cost savings may exist by expanding cost sharing incentives to other types of services.

- As of December 2015, approximately 72% of Small Group and 42% of Large Group fully-insured members are in low-cost provider options. The percentage in the Small Group Market has slightly decreased compared to the past two years, while the percentage in the Large Group is fairly consistent with results from these prior years.
- Market penetration of the low-cost provider options has increased in the self-insured market but also appears to have achieved a peak with approximately 11% of members as of December 2015.
- Current low-cost provider options have mainly focused on creating cost sharing incentives for ambulatory surgery and outpatient lab services, but insurers are exploring expanding these options to other services such as outpatient ultrasound, x-ray imaging, physical therapy, occupational therapy and speech therapy.
- Results will vary for specific surgeries and labs, but generally there are significant cost differences, both for total allowed costs and member costs for utilization at ambulatory surgical centers and zero cost labs versus outpatient hospital settings.[101, 102]
- Members in the low-cost provider options have generally had a higher usage of ambulatory surgical centers and other designated low-cost settings compared to members *not* in the low-cost provider

[99] New Hampshire Insurance Department. Network Adequacy: Public Information Release, Marketplace Issuer Networks for the 2017 Plan Year. July 2016. Available at: https://www.nh.gov/insurance/consumers/documents/2017_na_pres_issuer_ntw.pdf.

[100] The benefit designs provide financial incentives for members to choose insurer-designated lower-cost facilities, specifically for outpatient surgery or laboratory services. An example of how this benefit design works is as follows: If a member has an outpatient surgery at a certain hospital, the deductible will first apply, and that deductible may be anywhere from $1,000 to $5,000. If the member has the same outpatient surgery at an ambulatory surgical center (ASC) or other designated low-cost provider, the cost sharing is a fixed copayment amount of $100, for example. In the case of a laboratory service, if the laboratory service takes place at a certain outpatient hospital, the deductible will first apply. If the member has the same laboratory service at an independent lab or other designated low-cost provider, the member pays no cost sharing.

[101] The analysis does not adjust for risk differences between the populations using lower-cost settings versus those who do not.

[102] See the NHID's report on 2014 Medical Cost Drivers for details on the analysis on low-cost provider benefit designs. Available at: https://www.nh.gov/insurance/reports/documents/2015_annual_report_cost_drivers.pdf.

options, although it appears that members not in the low-cost provider options are catching up to their usage levels in the most recent years.[103]

- Low-cost provider options are not currently offered in the Individual Markets in New Hampshire.

Membership in tiered network hospital products[104] appeared to have been gaining some increasing membership back in 2010, but has since declined. As of April 2016, only 2% of members are in these products in the fully-insured market. These are slightly more popular in the self-insured market with approximately 8% of members as of April 2016.

[103] Ibid.

[104] Tiered network plans typically separate a broad network of providers into one, two, or three "tiers," or groupings, of providers. The first tier, or Tier 1, is generally the smallest group of providers and is considered the most efficient, based on cost and quality metrics. The next level, or Tier 2, would generally include a larger grouping of providers and would be considered not as efficient as Tier 1. These products offer member cost sharing incentives when members choose services from the Tier 1 group of providers. These products are designed to encourage members to utilize services of more efficient providers, which results in lower costs and improved quality of care.

10. Uncompensated Care Costs

Uncompensated Care Costs, such as charity care and bad debt, for New Hampshire hospitals are important to track into 2014 and beyond to understand the potential impact of the Medicaid expansion, the decrease of the uninsured population in New Hampshire, and other ACA and market dynamics.

- Uncompensated Care Costs (UCC) are generally defined as health care services provided by hospitals or providers that do not get reimbursed for a variety of reasons. This can be because patients do not have health insurance or do not have enough health insurance to cover the costs of their medical bills. Uncompensated care costs can also include underpayment from either Medicare or Medicaid reimbursement.
- Data were collected from both the New Hampshire Hospital Association (NHHA) and the New Hampshire Department of Health and Human Services (DHHS) to understand current levels of uncompensated care for New Hampshire acute care hospitals.
- NHHA compiles UCC information from the Internal Revenue Service 990 Schedule H Form for hospitals. These IRS forms are publically available and are considered an industry standard source for UCC. As compiled by NHHA in fiscal year 2014, the two largest categories of UCC are for unreimbursed Medicaid at $255 million and unreimbursed Medicare at $216 million.[105] Community Benefits, which includes items such as grants to heath care centers and community health initiatives, represent $172 million. Bad debt and expenses represents $166 million and financial assistance or charity care provided by hospitals represents $99 million. Combined across these UCC categories, this totals to approximately $908 million in FY 2014. This total is similar to the FY 2013 total of $855 million.
- DHHS determines UCC for purposes of calculating disproportionate share hospital (DSH) payments. DSH payments are made to qualifying hospitals that serve a large number of Medicaid and uninsured patients. DHHS follows federal guidelines to determine UCC for this purpose and generally includes unreimbursed Medicaid costs and costs for treating the uninsured. UCC, as reported by DHHS for the state fiscal year 2016 DSH payment, is based on the hospitals' fiscal year 2014 financial data and totals to $439 million. The information received from DHHS is not comparable to the UCC information from NHHA given the differences in methodology and the purpose of the DHHS data being used exclusively for DSH payment calculations.

[105] Unreimbursed Medicaid and Medicare is based on the difference between Medicaid/Medicare reimbursement and hospital costs (not charges.) The Medicaid/Medicare costs are determined based on federal definitions and are audited.

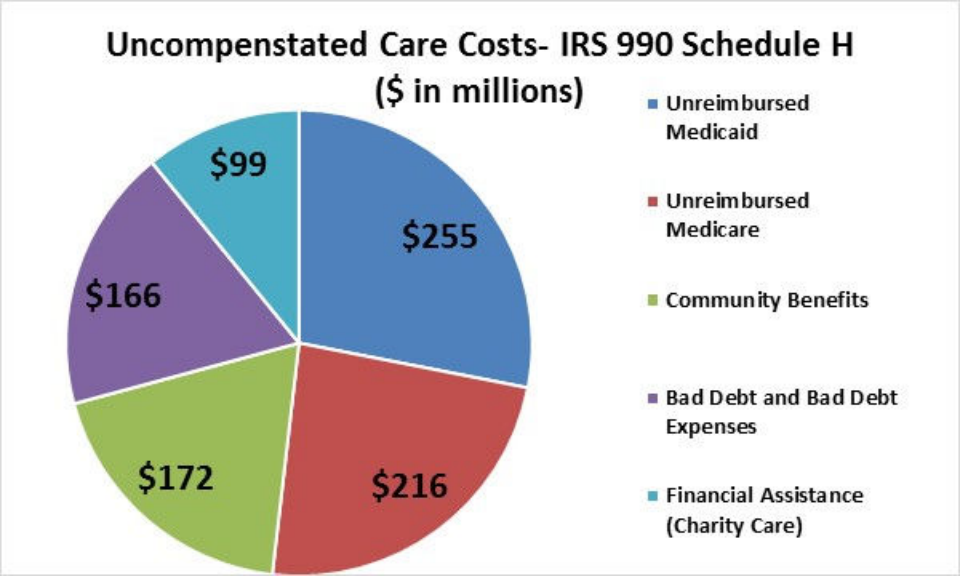


Figure 31: Uncompensated Care Costs for New Hampshire Not for Profit Acute Care Hospitals in FY 2014[106]

- The Kaiser Family Foundation released a report in 2016 titled "Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes." The analysis within the report states that "Medicare Cost Report data for 2013 and 2014 shows overall declines in uncompensated care from $34.9 billion to $28.9 billion in 2014 nationwide. Nearly all of this decline occurred in expansion states, where uncompensated care costs were $10.8 billion in 2014, $5.7 billion or 35% less than in 2013."[107] Because New Hampshire implemented its Medicaid Expansion program on August 15, 2014, an impact would not yet be expected in FY 2014 Uncompensated Care Costs due to Medicaid Expansion.

[106] Information shared by the New Hampshire Hospital Association & Foundation for Healthy Communities. Source: FY 2014 990 Report, Schedule H.

[107] P Cunningham, R Rudowitz, K Young, R Garfield and J Foutz. Understanding Medicaid Hospital Payments and the Impact of Recent Policy Changes. Kaiser Family Foundation: The Kaiser Commission on Medicaid and the Uninsured, June 2016. Available at: http://files.kff.org/attachment/issue-brief-understanding-medicaid-hospital-payments-and-the-impact-of-recent-policy-changes.

11. Future Considerations

As we look into 2016 and beyond, the health care insurance landscape will continue to change. New Hampshire will be impacted by the addition of new insurers and products on the Exchange along with the transition of the Medicaid population to a Premium Assistance Program. This is in addition to New Hampshire stakeholders continuing to pursue health care cost transparency, provider payment reform and product innovation such as limited networks as ways to further manage health care costs.

- In 2014, there was only one insurer on the Individual Market exchange (Anthem/Matthew Thornton). In 2015, there are five insurers on the exchange (Anthem/Matthew Thornton, Harvard Pilgrim Health Care, Minuteman Health, Community Health Options and Assurant/Time). In 2016, there will continue to be five insurers on the exchange, although one insurer has exited the market (Assurant/Time) and been replaced by one new insurer (Ambetter/Celtic). In 2017, Community Health Options will exit the Individual Market Exchange.

12. Appendix

A. Data Sources

- Data are collected from two data requests: The Supplemental Data Request (SDR) and Annual Hearing Carrier Questionnaire (AH). Each serves a different purpose and captures a slightly different population.
    - For the SDR, we collect data from all insurers in the market, except those that request an exemption due to meeting the *de minimis* requirements.[108] For the New Hampshire situs population in CY 2015, we estimate that the data collected represent approximately 97% of the covered lives in the Individual Market.[109] For the Small Group, Large Group and Self-Insured Markets, we estimate that the data collected represent approximately 99% of the market. Data are also collected for the Federal Employees Health Benefits Program (FEHBP) and non-New Hampshire situs membership. The focus of the SDR is detailed benefit information along with membership, cost sharing, claims and premium.
    - For the AH, we collect data from the five largest insurers for CY 2015: Anthem/Matthew Thornton Health Plan, Harvard Pilgrim Health Care, CIGNA, Community Health Options,[110] and Minuteman Health. In addition, we obtained a limited set of data from Centene[111] for early 2016. For CY 2015, data for these largest insurers cover percentages of the market very similar to those for the SDR. The focus of the AH is more detailed claims trend, rating assumptions and demographic information.
    - The information from these two separate data requests are integrated into one set of findings in this report.
- The NHID reviews premium rates and ensures compliance with all New Hampshire insurance laws for fully-insured products sitused in New Hampshire. Fully-insured members covered under policies outside of New Hampshire receive the benefit of New Hampshire insurance mandates and other coverage requirements when they work at a New Hampshire branch location, but the NHID does not review premium rates for non-New Hampshire sitused policies.

B. Additional Data Tables[112]

[108] New Hampshire Insurance Department. Bulletin: INS No. 16-010-AB: Supplemental Data Request. March 2016. Available at: https://www.nh.gov/insurance/media/bulletins/2016/documents/sdr_bulletin_2016.pdf.
[109] The remaining 6% represents data primarily from Assurant (Time) and MVP, which both met the *de minimis* requirements.
[110] Formerly Maine Community Health Options.
[111] Centene entered the New Hampshire Exchange in January 2016. The company is also known as Ambetter from New Hampshire Healthy Families.
[112] New Hampshire situs only, unless otherwise noted.

Single Policy In-Network Deductible	Fully Insured - Individual Market	Fully Insured - Small Group Market	Fully Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
$0	0.1%	0.3%	5.4%	2.4%	37.6%	21.3%
$1 - $249	7.5%	0.0%	0.0%	1.9%	3.5%	2.8%
$250 - $499	0.4%	1.0%	0.6%	0.7%	3.5%	2.2%
$500 - $749	5.9%	1.1%	2.4%	2.9%	14.7%	9.2%
$750 - $999	7.7%	0.0%	0.3%	2.0%	4.8%	3.5%
$1,000 - $1,499	15.9%	4.1%	9.0%	9.2%	10.8%	10.0%
$1,500 - $2,999	22.9%	26.3%	27.7%	26.1%	15.7%	20.5%
$3,000 - $4,999	15.2%	47.7%	36.0%	34.5%	6.5%	19.5%
$5,000 - $7,499	23.9%	19.5%	18.2%	20.1%	2.2%	10.5%
$7,500 - $9,999	0.1%	0.0%	0.0%	0.0%	0.2%	0.1%
$10,000 +	0.5%	0.0%	0.3%	0.3%	0.4%	0.4%
Grand Total	100%	100%	100%	100%	100%	100%
Average Deductible	$ 2,769	$ 3,149	$ 2,814	$ 2,909	$ 966	$ 1,868

Table 10: Single Policy, In-Network Deductible Distribution Summary for CY 2015

Single Policy In-Network Deductible	Fully Insured - Individual Market	Fully Insured - Small Group Market	Fully Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
$ -	0.15%	0.26%	5.39%	2.45%	37.64%	21.29%
$ 100	0.00%	0.00%	0.00%	0.00%	0.41%	0.22%
$ 150	0.00%	0.00%	0.00%	0.00%	0.05%	0.03%
$ 175	2.60%	0.00%	0.00%	0.65%	0.00%	0.30%
$ 200	4.85%	0.00%	0.00%	1.22%	3.08%	2.22%
$ 250	0.40%	1.03%	0.58%	0.67%	2.48%	1.64%
$ 300	0.00%	0.00%	0.00%	0.00%	1.02%	0.54%
$ 500	3.95%	0.05%	2.42%	2.06%	14.28%	8.60%
$ 600	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
$ 650	1.40%	1.08%	0.00%	0.70%	0.00%	0.32%
$ 675	0.53%	0.00%	0.00%	0.13%	0.00%	0.06%
$ 700	0.00%	0.00%	0.00%	0.00%	0.45%	0.24%
$ 750	5.97%	0.00%	0.26%	1.61%	2.83%	2.27%
$ 800	1.70%	0.00%	0.00%	0.43%	0.00%	0.20%
$ 900	0.00%	0.00%	0.00%	0.00%	1.99%	1.06%
$ 1,000	11.58%	4.13%	8.63%	7.95%	5.32%	6.54%
$ 1,150	2.46%	0.00%	0.00%	0.62%	0.00%	0.29%
$ 1,250	1.83%	0.00%	0.39%	0.63%	1.27%	0.97%
$ 1,300	0.00%	0.00%	0.01%	0.01%	0.10%	0.06%
$ 1,400	0.00%	0.00%	0.00%	0.00%	4.06%	2.17%
$ 1,500	6.24%	0.71%	3.05%	3.11%	4.79%	4.01%
$ 1,600	0.00%	0.00%	0.00%	0.00%	0.14%	0.08%
$ 1,750	0.82%	0.00%	0.22%	0.30%	0.00%	0.14%
$ 2,000	4.30%	23.14%	17.65%	16.02%	4.67%	9.95%
$ 2,050	0.17%	0.00%	0.00%	0.04%	0.00%	0.02%
$ 2,250	0.92%	0.00%	0.00%	0.23%	2.11%	1.24%
$ 2,300	0.34%	0.64%	0.00%	0.29%	0.00%	0.13%
$ 2,350	1.34%	0.00%	0.00%	0.34%	0.00%	0.16%
$ 2,400	0.00%	0.00%	0.00%	0.00%	0.63%	0.34%
$ 2,500	6.79%	1.74%	6.80%	5.20%	3.17%	4.11%
$ 2,600	0.00%	0.00%	0.00%	0.00%	0.18%	0.10%
$ 2,700	0.00%	0.00%	0.02%	0.01%	0.00%	0.00%
$ 2,850	0.83%	0.05%	0.00%	0.23%	0.00%	0.10%
$ 2,900	1.13%	0.00%	0.00%	0.28%	0.00%	0.13%
$ 3,000	1.93%	33.08%	26.64%	22.45%	4.22%	12.69%
$ 3,250	1.76%	0.00%	0.00%	0.44%	0.00%	0.21%
$ 3,500	0.36%	0.73%	0.04%	0.34%	0.20%	0.26%
$ 3,600	2.37%	0.00%	0.00%	0.60%	0.15%	0.36%
$ 3,750	0.98%	0.00%	0.00%	0.25%	0.02%	0.12%
$ 4,000	3.45%	13.85%	9.37%	9.30%	1.74%	5.25%
$ 4,300	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
$ 4,400	2.68%	0.00%	0.00%	0.67%	0.00%	0.31%
$ 4,500	1.68%	0.00%	0.00%	0.42%	0.05%	0.23%
$ 4,800	0.00%	0.00%	0.00%	0.00%	0.15%	0.08%
$ 5,000	4.97%	18.01%	16.55%	14.10%	1.45%	7.33%
$ 5,080	0.00%	0.00%	0.12%	0.05%	0.01%	0.03%
$ 5,200	0.00%	0.00%	0.06%	0.02%	0.04%	0.03%
$ 5,250	0.00%	0.23%	0.00%	0.07%	0.00%	0.03%
$ 5,500	3.48%	0.29%	0.01%	0.97%	0.00%	0.45%
$ 5,750	0.28%	0.01%	0.00%	0.07%	0.00%	0.03%
$ 5,800	2.90%	0.12%	0.00%	0.77%	0.00%	0.36%
$ 5,900	0.00%	0.19%	0.42%	0.24%	0.02%	0.12%
$ 5,950	4.02%	0.00%	0.00%	1.01%	0.00%	0.47%
$ 6,000	5.95%	0.02%	0.81%	1.86%	0.65%	1.21%
$ 6,100	0.00%	0.10%	0.00%	0.03%	0.00%	0.01%
$ 6,300	0.63%	0.00%	0.00%	0.16%	0.00%	0.07%
$ 6,350	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
$ 6,450	0.00%	0.00%	0.02%	0.01%	0.00%	0.00%
$ 6,600	1.69%	0.00%	0.21%	0.52%	0.00%	0.24%
$ 7,000	0.00%	0.55%	0.00%	0.17%	0.00%	0.08%
$ 7,500	0.11%	0.00%	0.00%	0.03%	0.00%	0.01%
$ 8,000	0.00%	0.00%	0.00%	0.00%	0.07%	0.04%
$ 9,000	0.00%	0.00%	0.00%	0.00%	0.12%	0.07%
$ 10,000	0.32%	0.00%	0.29%	0.21%	0.41%	0.32%
$ 12,000	0.16%	0.00%	0.00%	0.04%	0.00%	0.02%
$ 12,700	0.00%	0.00%	0.02%	0.01%	0.03%	0.02%
Grand Total	100%	100%	100%	100%	100%	100%
Average Deductible	$ 2,769	$ 3,149	$ 2,814	$ 2,909	$ 966	$ 1,868

Table 11: Single Policy, In-Network Deductible Distribution for CY 2015

Member Coinsurance	Fully Insured - Individual Market	Fully Insured - Small Group Market	Fully Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
0%	35.3%	72.3%	82.1%	67.2%	64.7%	65.9%
5%	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%
10%	18.4%	12.6%	3.7%	10.2%	13.8%	12.1%
15%	1.8%	0.0%	0.2%	0.5%	2.8%	1.8%
20%	20.0%	10.3%	11.9%	13.4%	12.1%	12.7%
25%	4.0%	3.1%	0.0%	2.0%	0.1%	1.0%
30%	17.9%	1.2%	2.2%	5.8%	3.8%	4.7%
40%	0.0%	0.2%	0.0%	0.1%	1.3%	0.7%
50%	2.7%	0.2%	0.0%	0.7%	1.0%	0.9%
Grand Total	100%	100%	100%	100%	100%	100%

Table 12: Member Coinsurance Distribution for CY 2015

PCP Office Visit Copay	Fully Insured - Individual Market	Fully Insured - Small Group Market	Fully Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
$ -	10.9%	1.3%	3.8%	4.8%	3.0%	3.8%
$ 5	3.4%	0.0%	0.0%	0.9%	6.6%	3.9%
$ 10	7.6%	0.2%	0.8%	2.3%	7.7%	5.2%
$ 15	2.0%	0.8%	1.2%	1.3%	14.8%	8.5%
$ 20	12.2%	14.4%	7.8%	11.0%	18.8%	15.2%
$ 25	0.9%	51.8%	60.5%	42.8%	3.5%	21.8%
$ 30	16.8%	4.8%	1.3%	6.3%	0.7%	3.3%
$ 35	6.9%	1.1%	1.7%	2.8%	0.0%	1.3%
$ 40	10.6%	12.4%	0.6%	6.9%	0.0%	3.2%
$ 45	1.1%	0.2%	0.0%	0.3%	0.0%	0.1%
$ 50	1.7%	0.3%	0.6%	0.8%	0.0%	0.4%
$ 200	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%
$ 500	0.0%	0.0%	0.0%	0.0%	0.1%	0.1%
D/C	26.0%	12.9%	21.7%	20.0%	44.6%	33.2%
Grand Total	100%	100%	100%	100%	100%	100%

Table 13: PCP Office Visit Copay[113] Distribution for CY 2015

[113] D/C means that the member cost sharing is subject to the deductible and/or coinsurance.

Single Policy Out-of-Pocket Maximum	Fully Insured - Individual Market	Fully Insured - Small Group Market	Fully Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
$0 - $499	0.02%	0.00%	0.02%	0.02%	0.00%	0.01%
$500 - $999	10.6%	0.0%	0.0%	2.8%	0.2%	1.7%
$1,000 - $1,499	8.8%	1.0%	0.7%	2.9%	22.4%	11.3%
$1,500 - $1,999	4.5%	0.0%	0.6%	1.4%	5.9%	3.3%
$2,000 - $2,999	4.3%	9.3%	4.4%	6.0%	18.1%	11.2%
$3,000 - $3,999	12.8%	33.9%	6.7%	17.2%	6.0%	12.4%
$4,000 - $4,999	10.4%	11.6%	5.4%	8.7%	1.8%	5.7%
$5,000 - $5,999	10.7%	19.7%	7.9%	12.5%	18.5%	15.1%
$6,000 - $6,999	37.1%	16.2%	69.7%	43.6%	25.4%	35.7%
$7,000 - $9,999	0.3%	1.9%	0.0%	0.7%	0.0%	0.4%
$10,000 - $15,000	0.5%	0.4%	0.0%	0.3%	0.0%	0.2%
Unlimited	0.1%	5.8%	4.4%	3.7%	1.7%	2.8%
Grand Total	100%	100%	100%	100%	100%	100%

Table 14: Single Policy Out-of-Pocket Maximum Distribution for CY 2015

	Fully Insured - Individual Market	Insured - Small Group Market	Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
RX not covered	0.0%	7.9%	9.6%	6.7%	39.9%	24.5%
Integrated Medical and Rx Deductible	52.0%	12.6%	13.8%	23.0%	10.2%	16.1%
Rx Specific Deductible	0.0%	0.0%	2.0%	0.9%	0.9%	0.9%
Copay or Coinsurance with No Deductible	47.9%	79.5%	74.6%	69.5%	49.0%	58.5%
Grand Total	100%	100%	100%	100%	100%	100%

Table 15: Pharmacy Benefit Membership Distribution for CY 2015

	Fully Insured - Individual Market	Insured - Small Group Market	Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
Average Generic Copay	$ 16	$ 12	$ 10	$ 12	$ 10	$ 11
Average Brand Formulary Copay	$ 32	$ 39	$ 30	$ 33	$ 28	$ 32
Average Brand Non-Formulary Copay	$ 34	$ 63	$ 47	$ 48	$ 47	$ 47

Table 16: Average Pharmacy Copay[114] for CY 2015

[114] For those members with a pharmacy benefit that has a copay. Excludes zero dollar copays.

Market Category	Plan Type	Fully Insured Membership Percentage	Fully Insured Average Premium PMPM	Fully Insured Actuarial value	Self-Insured Membership Percentage	Self-Insured Average Premium PMPM	Self-Insured Actuarial Value
Large Group	HMO	27.8%	$ 482	0.80	31.15%	$ 449	0.90
	POS	1.2%	$ 446	0.78	11.27%	$ 545	0.91
	EPO		N/A		6.57%	$ 486	0.81
	PPO	12.8%	$ 458	0.79	48.75%	$ 504	0.85
	FFS	1.3%	$ 592	0.86	1.93%	$ 232	0.96
Small Group	HMO	25.6%	$ 459	0.78			
	POS						
	EPO		N/A			N/A	
	PPO	5.4%	$ 477	0.76			
	FFS		N/A				
Individual	HMO	18.8%	$ 363	0.80			
	POS						
	EPO		N/A			N/A	
	PPO	6.3%	$ 377	0.77			
	FFS		N/A				

Table 17: Average Premium[115] PMPM and Actuarial Value[116] for CY 2015[117]

[115] For self-insured business, premium is calculated by the insurer as described in the Supplemental Reporting bulletin. Available at: https://www.nh.gov/insurance/media/bulletins/2016/documents/sdr_bulletin_2016.pdf.

[116] Actuarial Value is the federal Minimum Value measure, as described in the Supplemental Reporting bulletin. Available at: https://www.nh.gov/insurance/media/bulletins/2016/documents/sdr_bulletin_2016.pdf.

[117] Data are reported as N/A when there is low (less than 1%) or no membership.

Coverage Category	Covered?	Fully Insured - Individual Market	Fully Insured - Small Group Market	Fully Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
Ambulance Service	All policies in the market cover this benefit						
Audiology Screening for Newborns	All policies in the market cover this benefit						
Blood and Blood Products	Covered	100%	100%	92%	96%	65%	79%
	Not Covered	0%	0%	8%	4%	35%	21%
Case Management Program	All policies in the market cover this benefit						
Chiropractic Services	Covered	82%	100%	99%	95%	92%	93%
	Not Covered	18%	0%	1%	5%	8%	7%
DME	All policies in the market cover this benefit						
Emergency Room	All policies in the market cover this benefit						
Family Planning Services	Covered	100%	100%	100%	100%	98%	99%
	Not Covered	0%	0%	0%	0%	2%	1%
Habilitative Services	Covered	82%	92%	90%	89%	57%	72%
	Generally Covered	0%	0%	1%	0%	5%	3%
	Not Covered	18%	8%	9%	11%	38%	25%
Hearing Aids	Covered	100%	100%	96%	98%	83%	90%
	Generally Covered	0%	0%	0%	0%	3%	2%
	Not Covered	0%	0%	4%	2%	14%	8%
Home Health Care	All policies in the market cover this benefit						
Hospice	Covered	100%	100%	99%	100%	96%	98%
	Not Covered	0%	0%	1%	0%	4%	2%
Hospitalization	All policies in the market cover this benefit						
Infertility Services	Covered	47%	42%	43%	43%	53%	48%
	Generally Covered	0%	0%	0%	0%	2%	1%
	Not Covered	53%	58%	57%	56%	46%	51%
Medical Food	Covered	100%	99%	91%	96%	61%	77%
	Generally Covered	0%	0%	0%	0%	1%	0%
	Not Covered	0%	1%	9%	4%	39%	23%
Mental Health and Substance Abuse	Covered	93%	100%	100%	98%	99%	98%
	Not Covered	7%	0%	0%	2%	1%	2%
Nutritional Services	Covered	100%	99%	91%	96%	82%	89%
	Generally Covered	0%	0%	0%	0%	0.4%	0.2%
	Not Covered	0%	1%	9%	4%	17%	11%
Outpatient Hospital Services and Surgery	All policies in the market cover this benefit						
Outpatient Laboratory and Diagnostic Services	All policies in the market cover this benefit						
Outpatient Short-Term Rehabilitative Services	All policies in the market cover this benefit						
Pediatric Dental Services	Covered	81%	55%	44%	57%	40%	48%
	Not Covered	19%	45%	56%	43%	60%	52%
Pediatric Vision Services	Covered	86%	58%	44%	59%	51%	55%
	Generally Covered	14%	32%	45%	33%	7%	19%
	Not Covered	0%	9%	11%	8%	42%	26%
Pregnancy and Maternity	All policies in the market cover this benefit						
Rx	Covered	100%	92%	90%	93%	60%	76%
	Not Covered	0%	8%	10%	7%	40%	24%
Preventive Services	Covered	100%	100%	97%	99%	91%	95%
	Generally Covered	0%	0%	0%	0%	0.5%	0.3%
	Not Covered	0%	0%	3%	1%	9%	5%
Skilled Nursing Facility	Covered	100%	100%	97%	99%	91%	94%
	Generally Covered	0%	0%	0%	0%	1%	0%
	Not Covered	0%	0%	3%	1%	9%	5%
Transplants	All policies in the market cover this benefit						
Well Child and Immunization Benefits	Covered	100%	100%	97%	99%	91%	95%
	Not Covered	0%	0%	3%	1%	9%	5%

Table 18: Coverage of Various Benefit Categories[118] for CY 2015

[118] Coverage for benefits is based on whether the policy provides coverage at the level described in the Supplemental Reporting bulletin. Insurers are instructed to distinguish between covering the benefit to the exact specifications, general coverage of the benefit but not

Situs	Percent Self-Insured Members with Stop-Loss Coverage
NH Situs	34.0%
Non-NH Situs	13.2%
Total	25.4%

Table 19: Percent of Self-Insured Members with Stop-Loss Coverage for CY 2015

Stop-Loss Specific Attachment Point	Membership
< $100,000	9%
$100,000 - $499,999	52%
$500,000 -$999,999	29%
$1,000,000	10%

Table 20: Distribution of Stop-Loss Specific Attachment Point for CY 2015

Stop-Loss Aggregate Attachment Point	Membership
1.00	64%
1.10	3%
1.20	4%
1.25	29%

Table 21: Distribution of Stop-Loss Aggregate Attachment Point for CY 2015

meeting the exact specifications (identified as "Generally Covered"), and no coverage. Available at: https://www.nh.gov/insurance/media/bulletins/2016/documents/sdr_bulletin_2016.pdf.

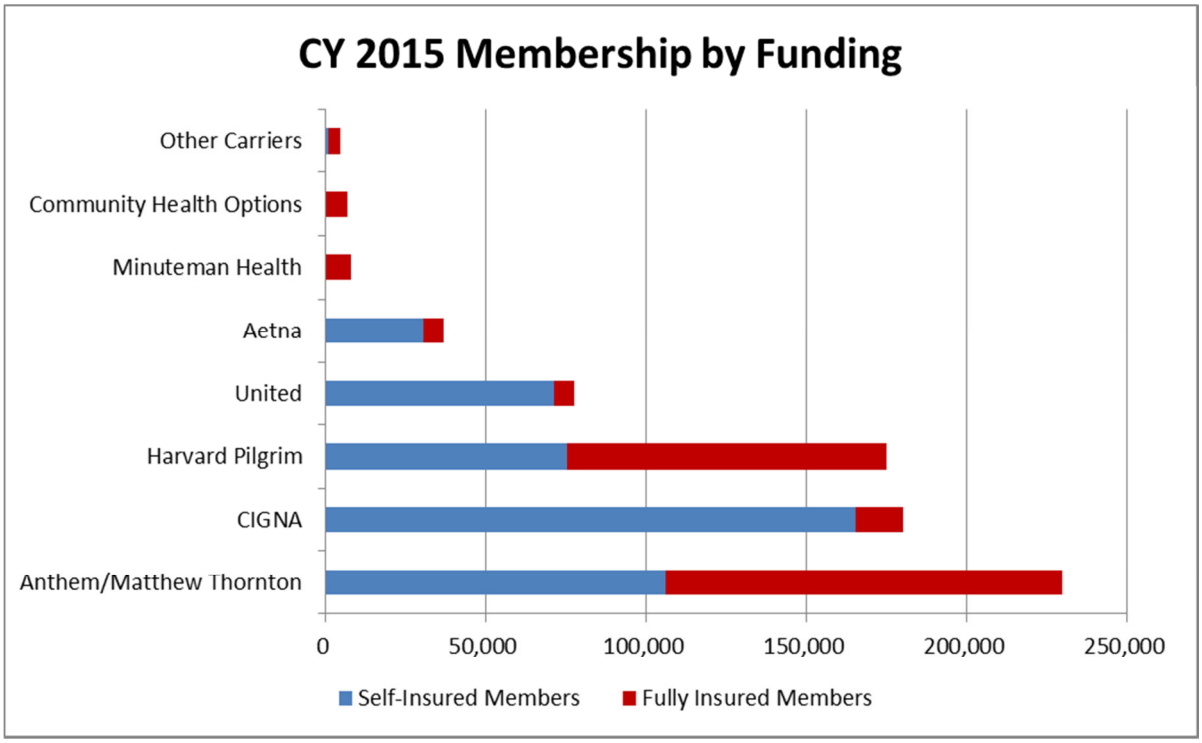


Figure 32: Membership Distribution by Self-Insured vs. Fully-Insured for CY 2015

13. Glossary

- ***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, and is the federal Minimum Value measure as outlined in Section 1302 (d)(2)(C) of the Affordable Care Act.
- ***Allowed Costs:*** These costs include both the amount paid by the insurer and the amount paid by the member through cost sharing such as deductibles, copayments and coinsurance.
- ***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. 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 insurer 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.

- ***Situs:*** "Situs" of a policy is defined as the jurisdiction in which the policy is issued or delivered as stated in the policy.
- ***Self-Insured Plan:*** A health plan in which an employer does not actually pay insurance premiums to an insurer to accept the claims risk. The employer pays only a service fee to an insurer to administer the plan, but then the employer covers the cost of claims for their enrollees directly.
- ***Stop-Loss Coverage:*** Self-insured groups with stop-loss insurance are liable for claims up to a specific or aggregate prescribed threshold. The stop loss insurer only becomes liable for claims after the prescribed threshold has been exceeded. Specific stop-loss caps a member's claims at a dollar threshold for that member, such as $100,000, and the stop-loss insurer becomes liable for that individual's claims once they exceed that threshold in the policy year. A stop-loss insurer offering aggregate stop-loss projects claims in total for the group, and the insurer becomes liable when claims exceed the expected claims plus a prescribed corridor or margin such as 125% of projected claims. Stop loss insurers can offer either type of stop-loss independently, or offer them together.
- ***Unadjusted Premium Trend:*** The actual percentage increase in premium PMPMs as reported by insurers.
- ***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.

14. Limitations and Data Reliance

Gorman Actuarial prepared this report for use by the New Hampshire Insurance Department. While we understand that this report may be distributed to third parties, Gorman Actuarial assumes no duty or liability to any third parties who receive the information herein. This report should only be distributed in its entirety.

Users of this report must possess a reasonable level of expertise and understanding of health care, health insurance markets and financial modeling so as not to misinterpret the information presented. 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, insurers in the New Hampshire health insurance markets, and other public sources. Gorman Actuarial has not audited this information for accuracy. We have performed a limited review of the data for reasonableness and consistency. If the underlying data are inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

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 October 2016. If subsequent changes are made, these statements may not appropriately represent the expected future state.

15. Qualifications

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