New Hampshire Insurance Department

Final Report of the 2013 Medical Cost Drivers

November 2014

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1. Executive Summary

In May 2010, New Hampshire passed RSA 420-G:14-a, V-VII (Chapter 240 of the laws of 2010, an act requiring public hearings concerning health insurance cost increases). This law requires the New Hampshire Insurance Commissioner to "hold an annual public hearing concerning premium rates in the health insurance market and the factors, including health care costs and cost trends, that have contributed to rate increases during the prior year." This year's hearing was held on October 31, 2014. The law also requires the Commissioner to "prepare an annual report concerning premium rates in the health insurance market and the factors that have contributed to rate increases during the prior year." The Commissioner and the New Hampshire Insurance Department (NHID) have engaged Gorman Actuarial, Inc. (GA) to assist them in preparing this fourth Annual Report.

The key findings from this year's report are:

- **In 2013, average premiums in New Hampshire's fully-insured private markets increased 3%. The continued movement towards plans with increased member cost sharing prevented additional premium increases of approximately 2% to 4%.**
  The average 2013 premium increase was up from the 1.1% premium increase experienced in 2012.

- **Actual healthcare claims increased 1.3% from 2012 to 2013.**
  Overall claim trends decreased for the third straight year, from 3.3% in 2011 to 2.7% in 2012 to 1.3% in 2013. Utilization trends were negative for three straight years, although utilization trends increased from -3.5% in 2012 to -2.6% in 2013. Overall cost trends have decreased, from 6.4% in 2012 to 4.1% in 2013.

- **The overall combined inpatient and outpatient hospital rate change is 3.2% in 2013.**
  Inpatient and outpatient hospital spending represents 40% to 50% of total medical and pharmacy expenditures. While the overall hospital rate change has decreased from prior years, the majority of

hospital-specific rate changes continue to be higher than the 2013 Northeast Medical Consumer Price Index (CPI) of 1.6%.[1]

- **In addition to premium costs, members paid $966 on average in out-of-pocket cost sharing in 2013.**

The share of claims paid by members represents approximately 19% of total medical claims.

- **Pricing trends in 2014 and 2015 reflect the more favorable observed claim trends in recent years.**

2014 to 2015 pricing trends are approximately 8% and are generally lower than historic pricing trends and are consistent with national trend survey results. These trends differ from observed trends for several reasons. For example, there is a time lag between when premiums are set and emerging experience.[2]

- **Average deductible levels and member out-of-pocket maximums have increased in all market segments.**

The Individual and Small Group Markets saw the largest increases in deductibles and member out-of-pocket maximums, followed by the Large Group Market.

- **Carriers priced their 2013 plans such that 81.8% of premiums would go towards coverage of medical claims. Actual claims consumed only 78.6% of premiums.**

2013 pricing trends did not typically reflect negative utilization trends, which contributed to the variance between the target and actual medical loss ratio. Medical loss ratios for five carriers were below the minimum thresholds set by the ACA, resulting in those

[1] http://www.bls.gov/cpi/cpid1312.pdf The Northeast is defined as Connecticut, Maine, Massachusetts, New Hampshire, New York, New Jersey, Pennsylvania, Rhode Island and Vermont. The CPI for Medical Care is based on both medical care services (professional services, hospital and related services and health insurance) and medical care commodities (medicinal drugs, medical equipment and supplies.) For more information on how Medical CPI is calculated, see http://www.bls.gov/cpi/cpifact4.htm.

[2] For additional discussion regarding differences between pricing trend and observed trend, please see Section 7.5.

carriers paying nearly $5.5 million in premium rebates, or 0.4% of premium to New Hampshire policyholders for 2013.

- **Carrier-reported actual expenses, including taxes and assessments, increased 8.9% in 2013.**[3]

The percentage of premium going towards expenses has increased from 15.5% to 16.4% from 2012 to 2013. The increase in expenses is driven by a combination taxes and assessments along with other carrier administrative costs. While overall expenses are a much smaller percentage of total premium compared to claims, given this increase, it is recommended that future reports continue to further analyze the increase in expenses.

[3] Expenses reported by the carrier generally tie to information reported in the Supplemental Health Care Exhibits (SHCE) except in the case of Anthem where the information is adjusted to exclude the Federal Employees Program (FEP.)

2. Data Sources and Definitions

A number of data sources were utilized in preparing the report. GA utilized existing data and information collected by the NHID along with publicly available information. GA and the NHID also asked the major carriers in the New Hampshire fully-insured market to complete a questionnaire providing details not readily available from other data sources. This report uses only de-identified or aggregated responses to the questionnaires except where noted. Gorman Actuarial has not audited this information for accuracy. We have performed a limited review of the data for reasonableness and consistency. If the underlying data is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete. Additional details on key data sources and a glossary of key terms can be found in the Appendix at the end of this report. The report contains statements that attempt to provide some context to current or past trends. These statements are based on the understanding of the existing and proposed regulatory environment as of November 2014. If subsequent changes are made, these statements may not appropriately represent the expected future state.

3. Overview of New Hampshire Insurance Market

Many different types of health insurance plans are available in New Hampshire. To put the markets in some context, Figure 1 shows the estimated distribution by type of health insurance coverage for all New Hampshire residents during 2011 - 2012[4], the most recent years for which the data were available. It was estimated that 12% of New Hampshire residents were uninsured in 2012. This is below the national average of 15% and placed New Hampshire as the 14th lowest out of the 50 states that year.[5] In 2012, 23% of the population received health coverage through public sources including Medicare and Medicaid. The Medicaid rate of 8% was the lowest of any state, and significantly below the national average of 16%. Slightly less than two-thirds of the market received health coverage in the private market, either through individual insurance or employer-sponsored group insurance coverage. The 59% receiving employer-sponsored coverage was the highest of any state in the country and was well above the national average of 48%.

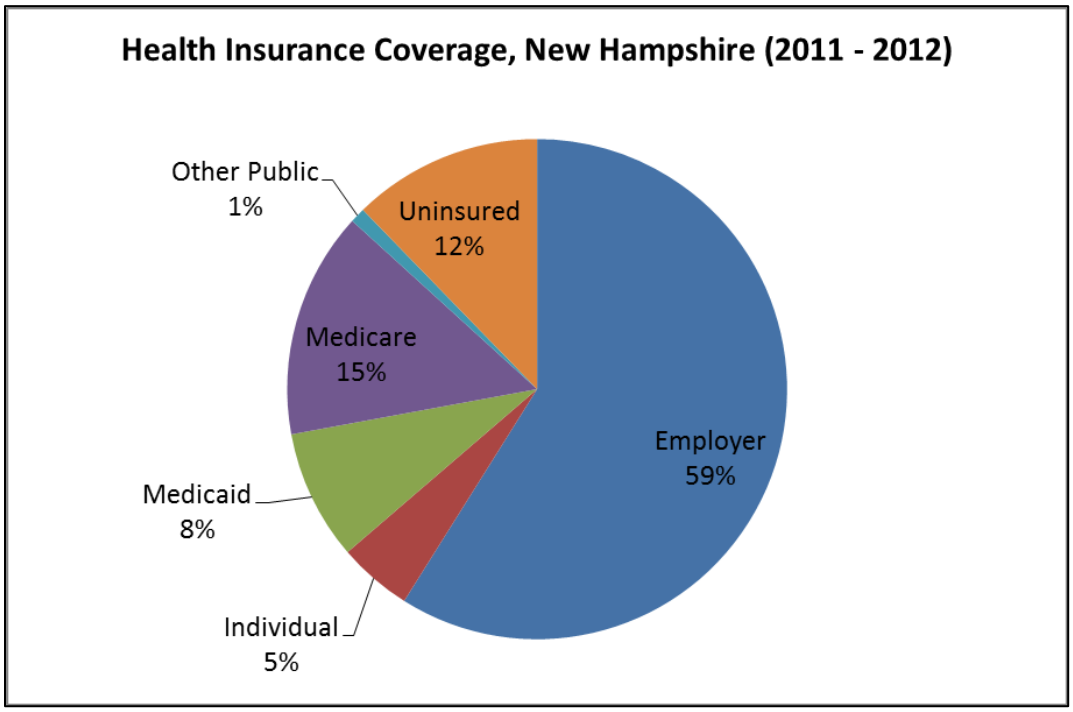

Figure 1 – Distribution of New Hampshire Health Insurance Coverage (2011 - 2012)

[4] Kaiser Family Foundation: http://www.statehealthfacts.org/profileind.jsp?cat=3&sub=39&rgn=31
The data is based on an analysis of the Census Bureau's March 2012 and 2013 Current Population Surveys (CPS; Annual Social and Economic Supplements) and are restricted to the civilian (not active duty military) population. The state data represent 2-year averages. In certain segments, the survey data may not be consistent with New Hampshire state reporting.

[5] For residents under age 65 (unlikely to be covered by Medicare), 14% of New Hampshire residents and 18% of residents nationally are estimated to be uninsured.

New Hampshire's private health insurance market membership can be further divided between self-insured coverage and fully-insured coverage. Self-insurance is a type of funding arrangement in which an employer does not actually pay insurance premiums to a carrier to accept the claims risk. The employer pays only a service fee to a carrier to administer the plan, and covers the cost of claims directly. These arrangements are common among larger employers. Approximately 55% of privately insured members in New Hampshire are covered under a self-insured arrangement. Because these employers pay claims directly, rather than paying premiums for their coverage, the primary focus of this report will be on the remaining 45% of privately insured members in the Individual, Small Group, and Large Group fully-insured segments.

Figure 2 shows each carrier's share of members in the combined fully-insured markets. Anthem, which includes Matthew Thornton, has 60% of the overall share of members and is the largest carrier in each market segment. Harvard Pilgrim is the second-largest carrier, with a 27% overall share. Cigna has just a 6% share of the fully-insured markets but maintains a substantial market presence in New Hampshire with approximately a third of the self-insured market. MVP's member share continued to decline and was only 3% of the fully-insured marketplace in 2013, as it had previously announced plans to withdraw from the New Hampshire market.[6] All other carriers combined have approximately 4% of the fully-insured market in New Hampshire.

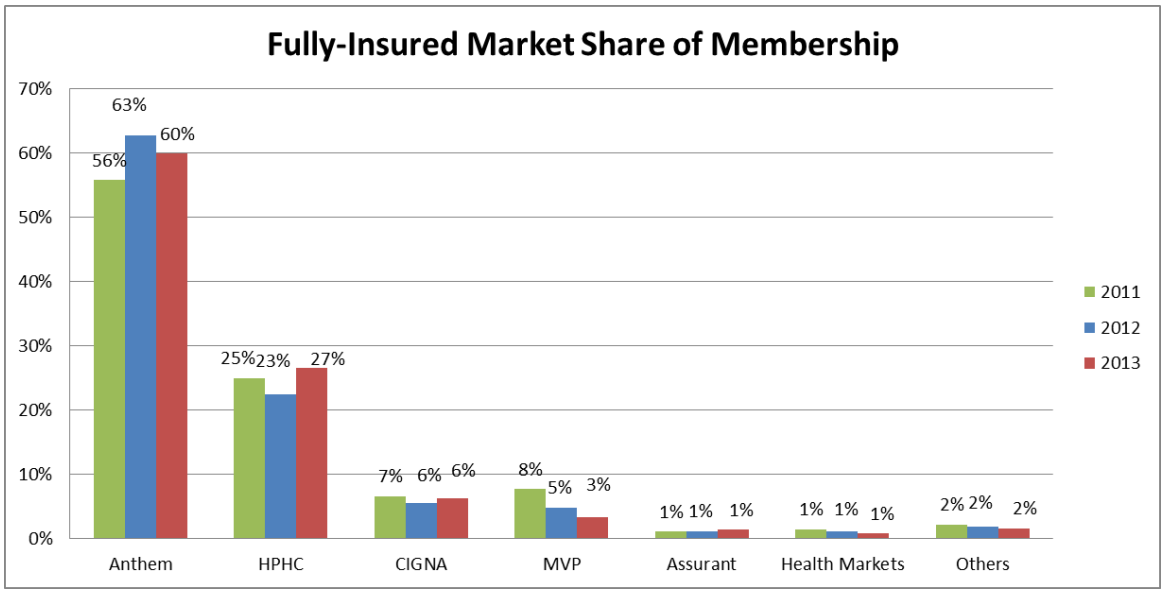

Figure 2 – Fully-Insured Market Share by Year[7]

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

[7] 2011 - 2013 Supplemental Health Care Exhibit filings, excluding Federal Employee Program members. This chart represents New Hampshire situs based members while Figure 1 represents New Hampshire residents.

4. Premium Trends - Unadjusted

Similar to previous reports, fully insured premium trends were analyzed on both an unadjusted and benefit-adjusted basis. The unadjusted basis examines earned premium[8] PMPM trends based on information provided by each carrier as shown in Table 1. In the case of the Group Markets, the premium PMPM includes both the employer and employee contribution. These premiums reflect actual average premium rates paid in each market and can be influenced by factors such as the demographic mix of the membership and the changing level of benefits covered under each plan. For example, if an employer group increases its deductible, its relative premium would decrease which would be reflected in the unadjusted premium. Therefore, the unadjusted premium trends do not fully reflect the increased cost of insurance borne by the average member, including changes in out-of-pocket cost sharing.

Unadjusted Earned Premium PMPM			
	2012	2013	% Change
Individual	$304.50	$309.74	1.7%
Small Group	$431.34	$447.13	3.7%
Large Group	$435.47	$449.89	3.3%
Total Fully-Insured	$417.10	$429.76	3.0%

Table 1 – Unadjusted Earned Premium by Market Segment and Year[9]

The Individual Market premium PMPM's remain well below the Group Market PMPM's. The Individual Market plans have higher average levels of member cost sharing, and the use of health underwriting (which is no longer permitted for ACA-compliant plans beginning in 2014) leads to a generally healthier risk pool. In 2013, the Small Group and Large Group Markets experienced the highest trends of 3.7% and 3.3%, respectively, while the Individual Market experienced the lowest trends, at 1.7%. In last year's report, the pattern of increases was opposite by market, with the highest premium trends in the Individual Market. The overall 2013 premium trend across all of the fully-insured markets is 3.0%, up from 1.1% in the prior year.

[8] Earned premium is defined per the instruction to the federal medical loss ratio annual reporting form: Earned premium means all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan and reported on a direct basis. Any amounts for ACA fees collected in advance of the MLR reporting year in which the fee is payable must not be reported as unearned premium.

[9] Source: 2013 and 2014 NHID Carrier Questionnaires

5. Member Cost Sharing and Benefit Buy-Down

5.1. Member Cost Sharing

Using data provided by carriers for the 2012 and 2013 New Hampshire Supplemental Reports data submissions, Gorman Actuarial was able to analyze the change in cost sharing between these two time periods. Health insurance plan designs can have many different member cost sharing attributes. The Supplemental Report captures data for several key cost sharing attributes, including deductibles, coinsurance, office visit copays, and member out-of-pocket maximums. Table 2 displays a distribution of membership by deductible level for each of the three fully-insured market segments in CY 2012 and CY 2013. Similar to last year's analysis, there continues to be movement in each of the market segments towards health plans with higher deductibles. The Small Group markets appear to have experienced the greatest amount of shift towards higher deductibles: 61% of the Small Group Market had deductibles of $3,000 or more in 2013, compared to 48% in 2012. The Individual Market has also experienced significant shift, with 50% of members with deductibles of $3,000 or more in 2013, compared to 37% in 2012.

	Individual		Small Group		Large Group	
Deductible	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**
$0	0%	0%	0%	0%	6%	5%
$1 - $499	0%	0%	0%	0%	1%	1%
$500 - $999	1%	2%	0%	0%	9%	7%
$1,000 - $1,499	26%	19%	15%	7%	14%	15%
$1,500 - $2,999	31%	29%	37%	32%	33%	30%
$3,000 - $4,999	5%	9%	40%	49%	30%	32%
greater than or equal to $5,000	36%	41%	8%	12%	7%	9%
Total	100%	100%	100%	100%	100%	100%

Table 2 – Member Distribution of Deductible by Market Segment and Year[10,11,12]

Figure 3 examines the membership distribution for the Individual and Small Group Markets combined from 2011 to 2013. In 2011, 37% of Individual and Small Group Market members were in plans with deductibles of $3,000 or higher. In 2013, the percentage of members in plans with deductibles of $3,000 or higher increased to 58%.

[10] Source: NH Supplemental Report Data. Excludes plans with no cost sharing.
[11] The data from the NH Supplemental Report was limited to a subset of carriers in 2012 and 2013 consistent with the subset of carriers surveyed in the 2014 NHID Carrier Questionnaires.
[12] One carrier restated their 2012 Large Group data submission and therefore this data will not match to the 2012 information reported in last year's annual hearing report.

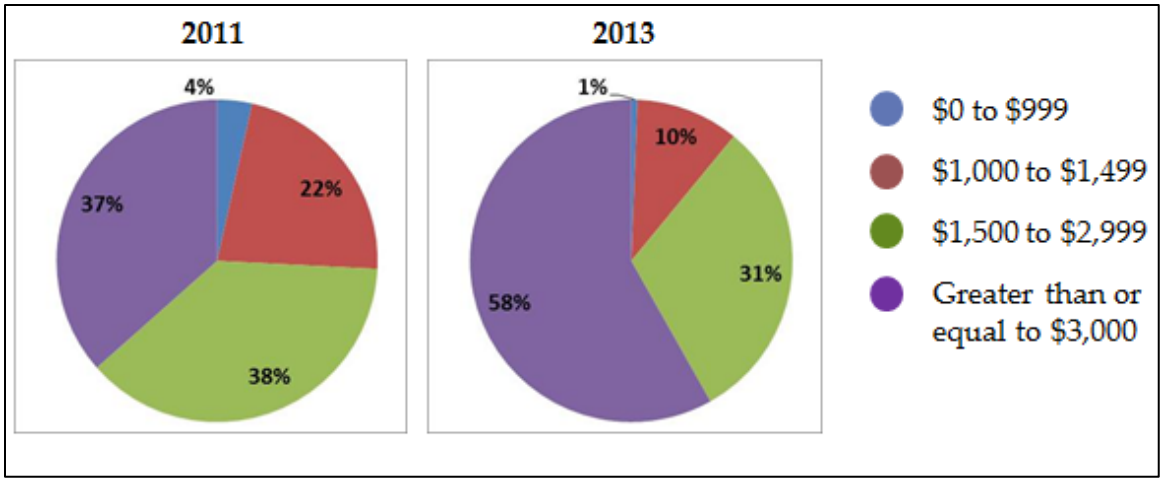

Figure 3 – Individual and Small Group Distribution by Deductible Level[13]

Table 3 shows the average deductible, member coinsurance percentage, and member out-of-pocket limit for 2012 and 2013. The average deductible in the Individual Market increased the most at $488, while the Small Group Market increased $308, followed by a smaller increase in the Large Group Market, of $154. The Individual Market continues to have the largest average deductible levels and average out-of-pocket maximums compared to the other market segments along with having a significantly higher percentage of members in high-deductible health plans, or HDHP's. The determination of HDHP is defined by the Internal Revenue Service (IRS) where, in 2013, a health policy had to have a deductible of at least $1,250 for individual coverage and an out-of-pocket maximum that did not exceed $6,250.[14]

	Individual		Small Group		Large Group	
	2012	2013	2012	2013	2012	2013
Average Deductible	$3,192	$3,679	$2,540	$2,847	$2,162	$2,315
Average Member Coinsurance	9%	8%	2%	2%	3%	3%
Average OOP Maximum	$4,159	$4,506	$3,130	$3,489	$3,252	$3,382
% of Members in High Deductible Health Plans (HDHP)	52%	53%	15%	15%	20%	19%

Table 3 – Cost Sharing Attributes by Market Segment and Year[15,16]

[13] Source: NH Supplemental Report Data, reporting years 2011 and 2013. Individual and Small Group Markets combined.
[14] http://www.irs.gov/pub/irs-drop/rp-12-26.pdf
[15] Source: NH Supplemental Report Data. Excludes plans with no cost sharing. Average out-of-pocket maximum also excludes plans with no out-of-pocket maximum.
[16] One carrier restated their 2012 Large Group data submission and therefore this data will not match to the 2012 information reported in last year's annual hearing report

Based on the information submitted in the 2014 NHID Annual Hearing Carrier Questionnaire, approximately 13% of the Individual Market members are in grandfathered plans as of April 2014, compared to 1% in the Small Group Market. An additional 31% of Individual Market members and 85% of Small Group Market members were in ACA transitional policies as of April 2014.[17] ACA transitional policies that renew on or before October 2016 are not considered out of compliance with certain provisions of the ACA.[18] It is assumed that members in the ACA transitional polices eventually will migrate to ACA-compliant policies. In 2014, the highest deductible levels in the New Hampshire Insurance Marketplace (the state healthcare Exchange) are $5,750.[19,20] Non-grandfathered Individual Market members who were in plans with deductibles greater than $5,750 in 2013, may need to choose plans with lower deductibles in 2014.

In addition to examining specific cost sharing attributes, we can also look at the overall average member out-of-pocket spending. The average member out-of-pocket spending on an annual basis was $966 in 2013. This is in addition to annual premium costs. On a percentage of total claims, this level of cost sharing equates to 19% of total allowed claims for the entire fully-insured market and 18% for Group Markets only. This percentage is higher when compared with a recent study by the Health Care Cost Institute (HCCI), which is based on employer group business only. HCCI reported the 2013 Northeast average annual cost sharing of $737 per member, which was 15% of their reported allowed claims.[21] The New Hampshire Individual Market has the highest cost sharing percentage at 28% of allowed claims which is the result of their lower overall allowed claims and higher cost sharing amounts.

[17] Note that the information in this report is based on April 2014 and therefore may differ from the information presented in the report "New Hampshire Health Insurance Market Analysis", August 18, 2014, Wakely Consulting Group which is based on data as of May 2014.
[18] http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf, http://www.nh.gov/insurance/media/bulletins/2014/documents/ins_14_009_ab.pdf
[19] http://www.nh.gov/insurance/consumers/documents/nh_mktplc_indvplns.pdf
[20] This is based on the Bronze metal level and does not include catastrophic plans.
[21] http://www.healthcostinstitute.org/issue-brief-out-pocket-spending-trends-2013 - HCCI 2013 Issue Brief: Out-of-Pocket Spending Trends 2013. Their report analyzed employer-sponsored insurance and members under age 65 only.

2013	
	Average Member Cost Sharing as % of Allowed
Individual	28%
Small Group	20%
Large Group	17%
Total Fully-Insured	19%
Total Group Only	*18%*

Table 4 – Member Cost Sharing as a Percentage of Total Allowed Claims by Market Segment in 2013[22, 23]

5.2. Benefit Buy Down

When analyzing premium changes and medical trends, it is helpful to understand what portion of the change is due to cost changes from the carrier and what portion of the change is due to a change in benefits purchased. For example, a policyholder could receive a premium increase of 10%. However, this 10% increase could reflect a 15% increase from the carrier and a 5% decrease because the policyholder purchased benefits that reflect higher cost sharing. "Benefit buy-down" is the process of selecting a plan with reduced benefits or higher member cost sharing as a way to mitigate premium increases.

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

Gorman Actuarial relied on several methodologies to review benefit buy-down in this year's report. Beginning with the March 2014 Supplemental Report data submissions, insurance carriers in New Hampshire were required to submit the Minimum Value with

[22] NH Supplemental Report Data. Analysis excludes records with no member months and negative member responsibility amounts.
[23] The source for last year's member cost sharing amounts was the 2013 Carrier Questionnaire, but since the NH Supplemental Report started capturing this information with the 2014 submissions, the data is now based on the NH Supplemental Report.

each plan design. Minimum Value is measured as stated in Section 1302 (d)(2)(C) of the ACA, and more details are provided in the 2014 NHID Supplemental Report Bulletin.[24] GA reviewed the change in the Minimum Value reported in the 2012 and 2013 Supplemental Report submissions. In addition, GA reviewed the reported cost sharing information from the Supplemental Report and estimated actuarial values using GA's internal actuarial value pricing model. The results of these analyses generated a range of benefit buy-down estimates for each market segment from 2012 to 2013.[25] Table 5 displays a range of estimated premium reductions due to benefit buy-down for each fully-insured market segment based on the results of these methodologies. Across the entire fully-insured market in 2013, the estimated range of premium reductions due to benefit buy-down is 2 to 4%. In 2013, the Individual Market and Small Group Markets experienced benefit buy-down in the range of 2% to 4%, while the Large Group Markets experienced less benefit buy-down, estimated at 1% to 3%.

	2013 Benefit Buy-Down Range
Individual	2% to 4%
Small Group	2% to 4%
Large Group	1% to 3%
Total	2% to 4%

Table 5 – Benefit Buy-Down by Market Segment

5.3. Product

While benefit buy-down has continued to impact premium trends in New Hampshire, the product selections in New Hampshire remained fairly stable through 2013, with some changes in 2014. Figure 4 displays the percentage of New Hampshire private market membership by product and insured status for years ending December 2011, 2012 and 2013 in addition to membership as of April 2014. This includes all market segments and both fully insured and self-insured membership, as reported by the carriers surveyed.[26] The overall proportion of self-insured membership has remained fairly stable, at around 52% to 53% when combined across all products. Within the self-insured membership, the product distribution has also remained fairly stable between HMO/POS/EPO products and PPO/Indemnity products. Some have suggested that there will be shifts to the self-insured market as a way for employers to avoid some of the requirements of the ACA.

[24] http://www.nh.gov/insurance/media/bulletins/documents/ins_14_005_ab.pdf

[25] There are limitations in each of the methodologies employed to calculate benefit buy-down, thus a range of benefit buy-down is shown for 2012 to 2013. Minimum Values were not reported in Supplemental Report data submissions prior to 2012 and therefore actuarial values reported in prior data submissions may not be comparable.

[26] Data in this section is based on information from the 2014 Carrier Questionnaire which only includes four carriers. This is different from the information in Section 3 which is based on the Supplemental Health Care Exhibits from all reporting carriers.

The data indicate that this expected trend has not yet impacted New Hampshire. It will be interesting to continue to track this information in the future, especially when the 51-to-100 Market is defined as the Small Group market in 2016 and beyond.

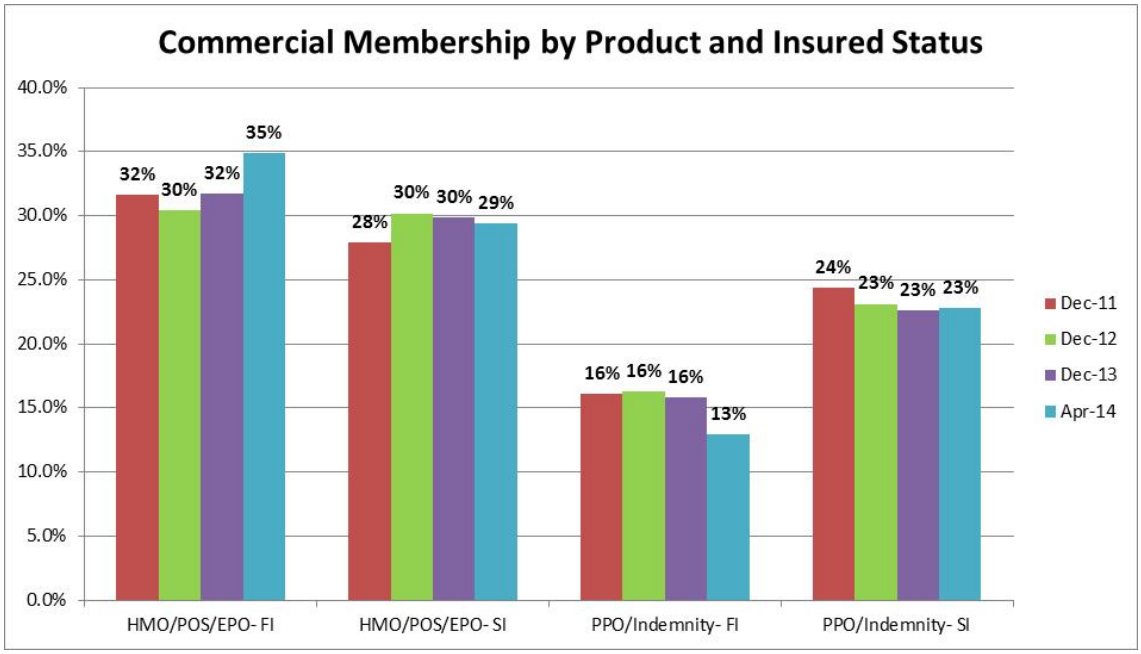

Figure 4 – Commercial Membership by Product, Insured Status and Year[27]

Figure 5 shows the membership distribution by product for only the fully insured market segments. The distribution of members by products remained fairly stable through December 2013, but in April 2014 there was a shift to HMO/POS/EPO products. This was primarily a result of an influx of members to the New Hampshire Health Insurance Marketplace and the introduction of an HMO product offering to these members.

[27] Source: 2014 Carrier Questionnaire

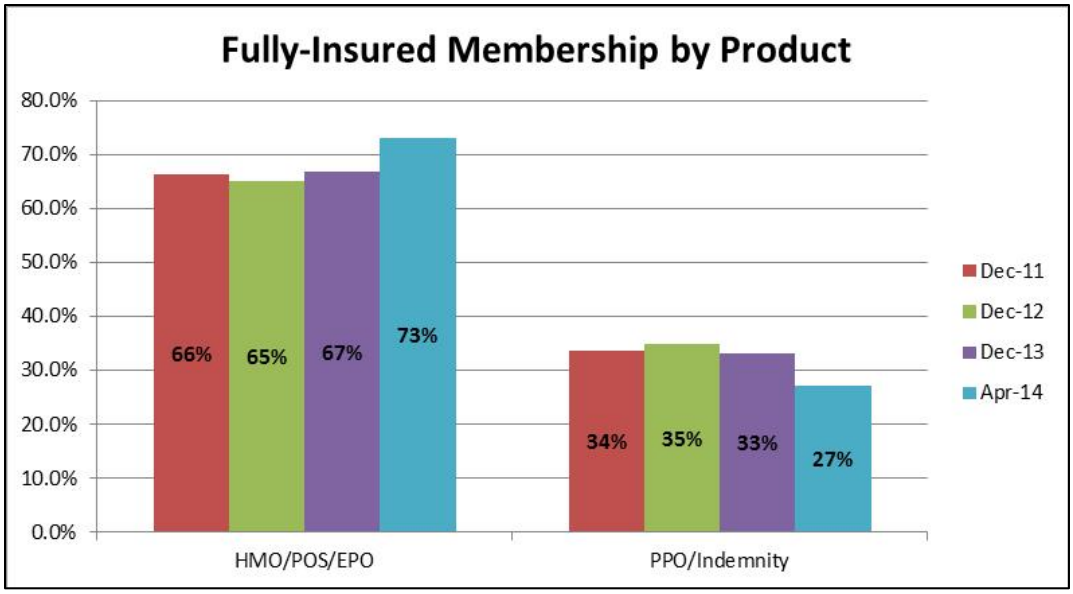

Figure 5 – Fully-Insured Membership by Product and Year[28]

6. Premium Trends - Adjusted

There are several key drivers of the unadjusted premium trend. One is the impact of benefit changes on premium trends. As consumers buy down to benefit plans with higher out-of-pocket cost sharing, the premiums do not increase as rapidly as they would have if the benefits had not been reduced. Using the benefit buy-down ranges calculated in Section 5, we can recalculate each market's estimated premium trends to demonstrate the trends after adjusting for benefit changes. This is referred to as benefit-adjusted premium trends. Table 6 shows the unadjusted and benefit-adjusted premium trends for each market segment in 2013. In each market, because of the impact of benefit buy-down, the adjusted trends are higher than the unadjusted trends. For example, if small employers did not change their current benefit levels, in 2013 the Small Group Market would have experienced average premium increases in the range of 6% to 8% (benefit-adjusted premium trend). However, since small employers did "buy-down" in 2013, the actual premium increase experienced in 2013 was 3.7% (unadjusted premium trend). On a benefit-adjusted basis, overall premiums in the fully-insured market increased 5% to 7% in 2013 compared to an unadjusted premium trend of 3.0%. In 2012, the unadjusted overall premium trend in the fully-insured market was 1.1% and the adjusted premium trend was 5% to 7%. Therefore, in both 2013 and 2012, the benefit-adjusted premium trend is estimated at 5% to 7%, but because there was less benefit buy-down in 2013 compared to 2012, the overall unadjusted premium trend was higher in 2013 compared to 2012 (3.0% compared to 1.1%.)

[28] Source: 2014 Carrier Questionnaire

2013 Impact of Benefit Buy Down on Premium Trends			
	Unadjusted Premium Trends	**Estimated Benefit Buy Down Range**	**Adjusted Premium Trends**
Individual	1.7%	2% to 4%	4% to 6%
Small Group	3.7%	2% to 4%	6% to 8%
Large Group	3.3%	1% to 3%	4% to 6%
Total Fully-Insured	3.0%	2% to 4%	5% to 7%

Table 6 – 2013 Impact of Benefit Buy Down on Premium Trends by Market Segment[29]

7. Components of Premium

7.1. Introduction

This section explores the trends and drivers of each component of premium – claims, expenses, and profits – in terms of how they impacted 2013 premium rate levels and actual 2013 results. It is important to remember that carriers must file premium rates several months in advance of the beginning of the period for which the rates are effective. This can lead to some lag between pricing assumptions, which are heavily influenced by past experience, and actual results seen in the projected period for which the premium rates are effective.

7.2. Medical Claims

Medical expenses, or claims, are the largest contributor to health insurance premiums, and the increase in claim costs has been the largest driver of the increase in premiums over time. Figure 6 shows the annual allowed claim trends by market segment. Allowed claims are the sum of the claim amounts paid by the carriers and the payments paid by the members through cost sharing, such as deductibles and copayments. Across all fully-insured markets the average allowed claim trends have been declining over the past three years, and was 1.3% in 2013. The Individual and Large Group Markets saw significant decreases, while the Small Group Market increased slightly, compared to 2012. Consistent with prior years, these overall New Hampshire trends are below trends seen nationally in the Segal Health Plan Cost Trend Survey.[30] However, the year-over-year pattern of the results in New Hampshire are consistent with those seen on a national basis, where 2013 national medical trends were down 0.6% to 1.7%, and are at the

[29] Unadjusted premium trends represent actual premium trends as reported by the carrier. Benefit-adjusted premium trends are estimated to reflect the premium trends assuming no benefit changes.

[30] http://www.segalco.com/publications/surveysandstudies/2015trendsurvey.pdf, Table 2: Selected Medical, Rx Carve Out and Dental Trends: 2003 – 2013 Actual and 2014-2015 Projected

lowest levels seen in the history of the survey, which dates back to 2002. Section 8 of this report has additional regional and national trend comparisons.

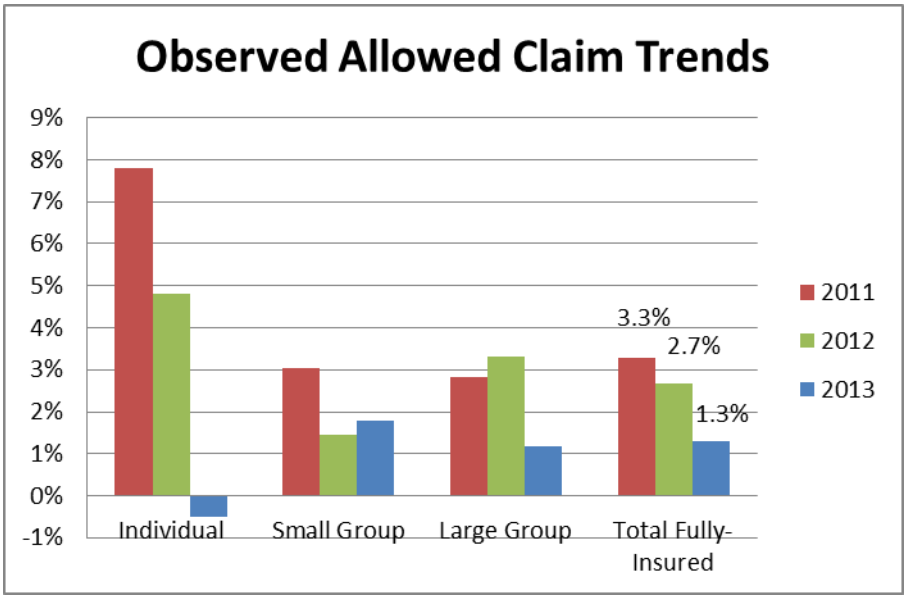

Figure 6 – Observed Allowed Claim Trends[31]

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

Figure 7 and Figure 8 isolate the utilization and the cost components of the allowed trends. Utilization trend has been the major driver of the overall deceleration in claim trends in recent years, with negative trends for the past three years. Across all markets, 2013 utilization trends were -2.6%. Leading the way is the Individual Market which experienced a claim trend of -4.5%. Within the Individual Market, the Inpatient and Outpatient Facility service categories experienced trends of -7% and -8% respectively. The Small Group Market utilization trend in 2013 increased compared to 2012 but was still negative at -2%. The Large Group Market utilization trend increased slightly from 2012 to 2013.

[31] 2014 Carrier Questionnaire – weighted average by allowed claim amounts in the corresponding year.

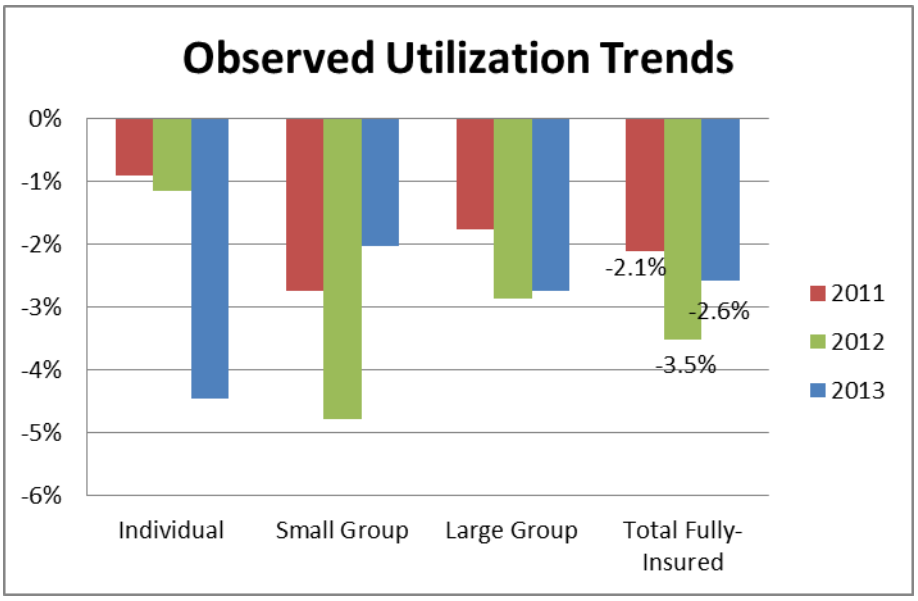

Figure 7 – Observed Utilization Trends[32]

While utilization trends remain favorable, the offsetting increase in provider reimbursement levels continued to drive allowed claim increases overall. Figure 8 shows the 2013 cost trends across all fully-insured markets at 4.1%. This is a decrease compared to 5.6% in 2011 and 6.4% in 2012. Each of the three market segments saw a decrease in cost trends, and the trend in 2013 was lower than in 2011 and 2012. Similar to 2012, the cost trends by market segment were fairly consistent and range from 4.0% to 4.3% in 2013. As stated above, these cost trends include the portion attributable to mix. As reported by the carriers surveyed, estimated mix trends for the past two years ranged from -1% to +1%.

[32] 2014 Carrier Questionnaire – weighted average by allowed claim amounts in the corresponding year.

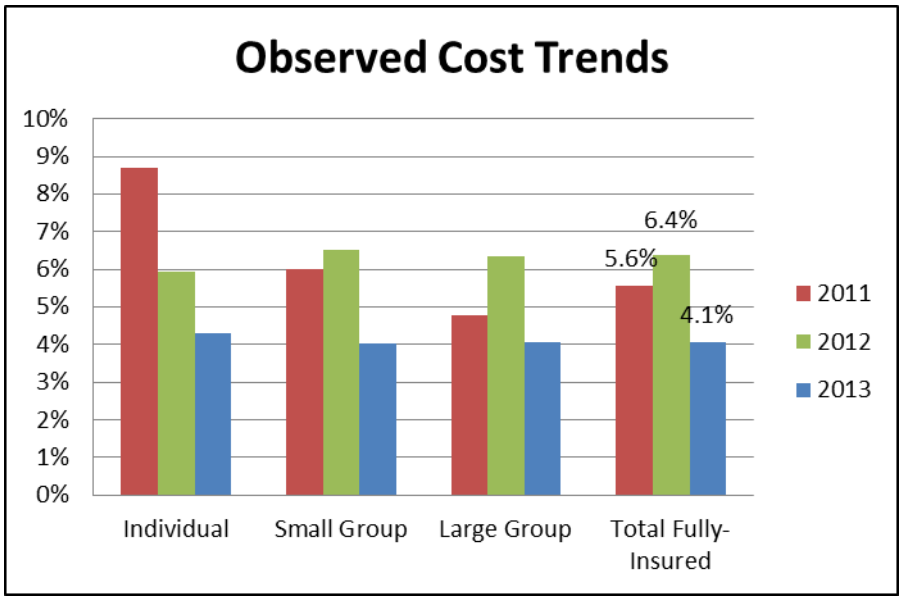

Figure 8 – Observed Cost Trends[33]

The finding that provider reimbursement, or price, is driving overall health care costs is not unique to New Hampshire. It is consistent with national experience. The 2013 Health Care Cost and Utilization Report from the Health Care Cost Institute (HCCI) found that "rising prices, rather than utilization, were the primary drivers of spending growth for all medical service categories and brand prescriptions."[34]

Claim payments can also be segmented by the type of service that is being covered. Figure 9 shows the distribution of 2013 allowed claim payments across all fully-insured markets by the various types of service. 43% of all claims were paid to a facility such as a hospital or ambulatory surgical center to cover inpatient or outpatient care. Professional care, such as office visits to a physician or therapist, accounted for 28% of total claims, while prescription drugs represented 18% of payments. The remaining 11% of claims consisted of other payments that don't easily fit into the four primary categories, such as durable medical equipment, such as wheelchairs and non-fee-for-service payments, such as capitation payments and quality incentives.

[33] 2014 Carrier Questionnaire – weighted average by allowed claim amounts in the corresponding year
[34] http://www.healthcostinstitute.org/2013-health-care-cost-and-utilization-report

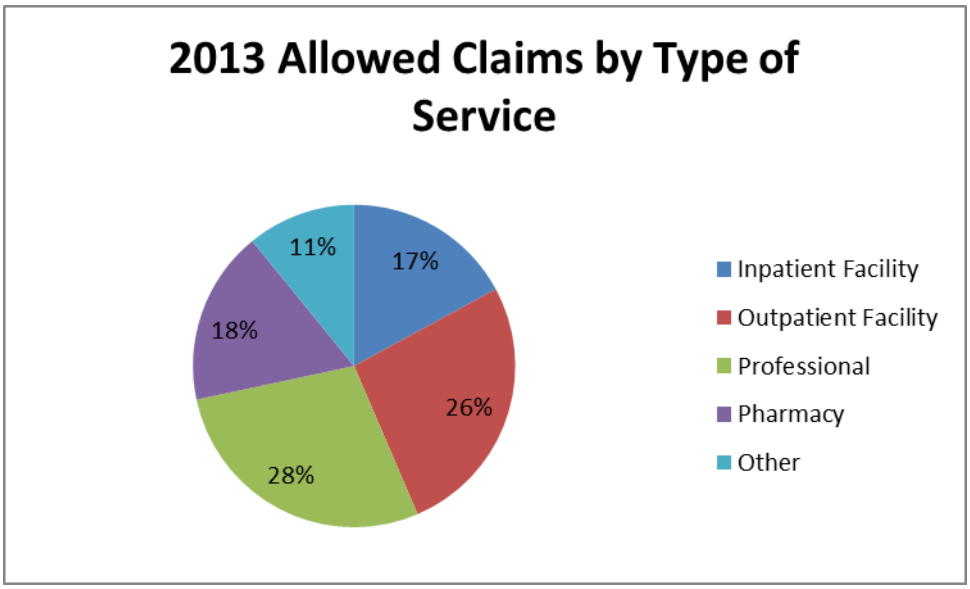

Figure 9 – 2013 Claims by Type of Service[35]

Figure 10 presents the observed allowed claim trends by the four major types of service categories across all fully-insured markets for the years 2011, 2012, and 2013. All service categories experienced a decrease in trends in 2013 compared to 2013 except Professional, which saw an increase from 2.3% in 2012 to 2.8% in 2013. Outpatient Facility, which is one of the largest segments of medical expenditures, saw a decrease in each of the market segments. The decrease in outpatient facility is driven by decreases in utilization, and the decrease in utilization for this segment is due in part to a shift of services (such as lab services) from outpatient facilities to independent labs, which is part of the professional service category.

[35] 2013 Carrier Questionnaire

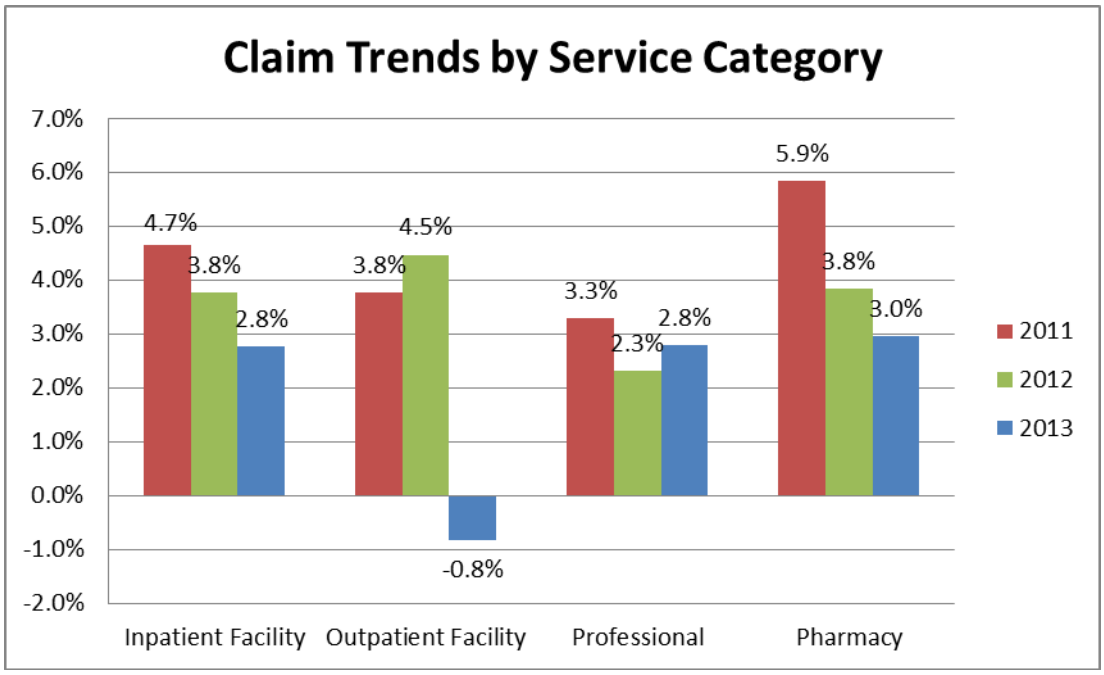

Figure 10 – Observed Trends by Service Category[36]

7.3. Provider Costs

As hospital spending generally comprises nearly half of total health care spending, and trends in hospital spending have been driven by increases in costs rather than utilization, carriers provided their 2013 and 2014 projected inpatient and outpatient hospital unit cost changes by facility so that we could further analyze these costs. Figure 11 displays the combined inpatient and outpatient unit cost changes by facility across all reporting carriers for both 2013 (in red) and 2014 (in blue). The single dark black line represents the 2013 Northeast Medical Consumer Price Index (CPI) of 1.6%.[37] Similar to what was observed last year, the vast majority of hospitals (22 out of 26) have unit price changes above the Northeast medical CPI. The hospitals are grouped into three geographic regions: Southeastern, Central/Western, and Northern.[38] The figure shows variation in the rate changes both across the state and also within each region. The Northern region continues to have lower rate changes than the rest of the state.

[36] 2014 Carrier Questionnaire – weighted average by allowed claim amounts. The total Fully-Insured trend for the "Other" service category was -0.9%.

[37] http://www.bls.gov/cpi/cpid1312.pdf
The Northeast is defined as Connecticut, Maine, Massachusetts, New Hampshire, New York, New Jersey, Pennsylvania, Rhode Island and Vermont. The CPI for Medical Care is based on both medical care services (professional services, hospital and related services and health insurance) and medical care commodities (medicinal drugs, medical equipment and supplies.) For more information on how Medical CPI is calculated, see http://www.bls.gov/cpi/cpifact4.htm.

[38] Regions defined based on definition from the report "Analysis of Price Variations in New Hampshire's Hospitals" by the University of Massachusetts Medical School (UMMS).

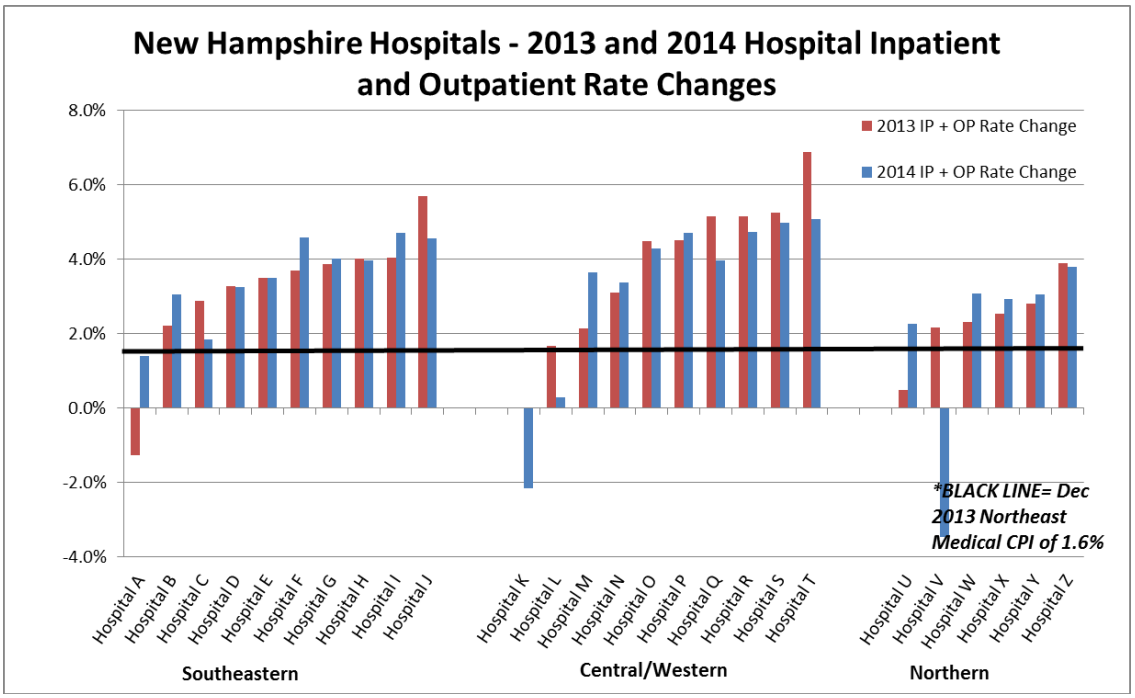

Figure 11 – Hospital Inpatient and Outpatient Combined Average Rate Changes 2013 and 2014[39]

While the rate changes for many hospitals are above the Northeast medical CPI, there is a general decrease in the rate changes when we look at the trends for the past several years. Figure 12 shows that the blended Inpatient and Outpatient unit cost rate change decreased from 2011 through 2013, with a slight increase projected for 2014.

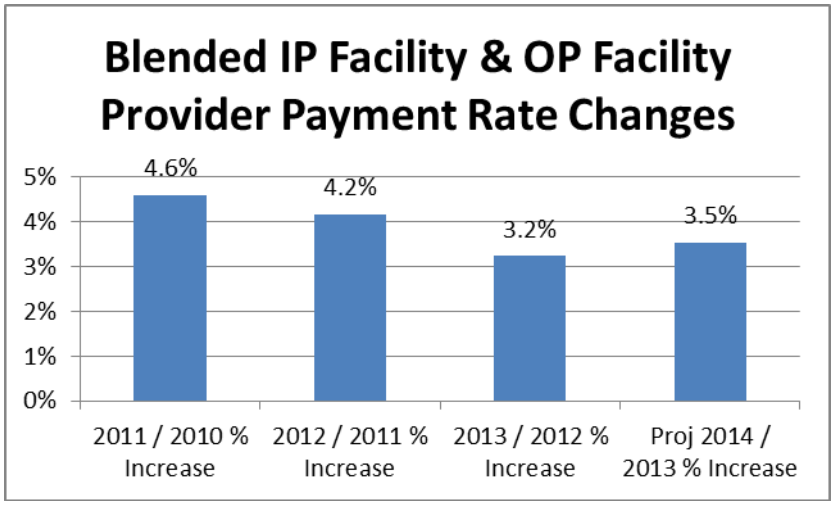

Figure 12 – Inpatient and Outpatient Facility Combined Average Rate Changes[40]

[39] 2014 Carrier Questionnaire – weighted average across all reporting carriers.
[40] Ibid.

In addition to variation in rate changes to hospitals in New Hampshire, there continued to be significant variation in the level of payments across carriers. As cited in the reports for the previous two years, several studies were commissioned by the NHID related to understanding the variation in prices paid to hospitals, including "Analysis of Price Variations in New Hampshire's Hospitals," by the University of Massachusetts Medical School (UMMS)[41], and "The Costs of NH's Health Care System: Hospital Prices, Market Structure, and Cost Shifting," by the New Hampshire Center for Public Policy Studies (NHCPPS)[42]. The study by UMMS concluded that there was wide variation in commercial prices paid to New Hampshire hospitals even after adjusting for case mix, while the NHCPPS report stated that New Hampshire's hospital prices demonstrate significant variation that is not necessarily explained by patient morbidity, quality of care, or payer mix. In addition, the analysis generated by the UMMS report demonstrated that on a case-mix adjusted basis, the most expensive hospital was paid more than twice as much for inpatient services and outpatient services than the least expensive hospital, based on data from 2009. The NHCPPS report also demonstrated that based on hospital price data from 2005 to 2009, high-cost hospitals generally tend to hold their position as high-cost hospitals over time, while low-cost hospitals tended to remain low-cost hospitals over time.

In order to understand whether the variation in price observed in these previous studies was still in existence, we asked each carrier surveyed to provide 2012, 2013, and 2014 price index data for inpatient and outpatient hospitals based on their contracted rates with each facility. Recognizing that each carrier had different methodologies for calculating a hospital's price index, our goal was not to duplicate the analyses from the UMMS and NHCPPS but rather to understand at a high level if price disparity continued in the New Hampshire market. Figure 13 provides an example of the results of one carrier's price indices, or relative price, by hospital. In this case, the most expensive hospital was paid more than twice as much as the least expensive hospital. While the rank or order of hospitals varied by carrier, the variation across hospitals and the difference between the most expensive and least expensive hospital was consistent among carriers. The fact that the most expensive hospital was more than twice as much as the least expensive hospital was also consistent with the earlier UMMS study.

[41] http://www.nh.gov/insurance/lah/documents/umms.pdf
[42] http://www.nh.gov/insurance/reports/documents/nhcpps.pdf

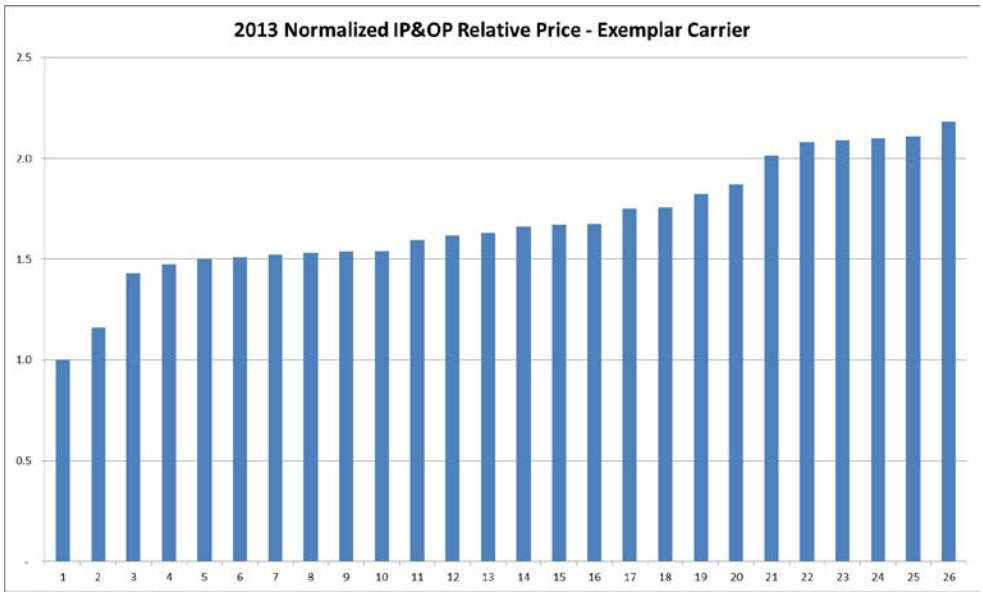

Figure 13 – Example of Relative Price by Acute Care Hospitals[43,44]

Professional services spending is generally the next largest service category after hospital spending. Analyzing physician prices is typically more difficult than analyzing hospital prices because of the way a physician group is structured as a contracting entity, which can vary significantly by carrier. The carriers surveyed were asked to provide the payment rate changes for their 10 largest provider groups for 2012, 2013, and projected 2014. The percent rate change for each of the carrier's top provider groups varied by provider group and by year. As shown in Figure 14, annual rate changes ranged from 0% up to 9%. This variation by provider group was on par with the variation seen in rate changes by hospital, shown in Figure 11.

[43] 2014 Carrier Questionnaire

[44] When carriers did not provide a combined Inpatient and Outpatient relative price, they were blended using the Inpatient and Outpatient dollar amounts for the time period.

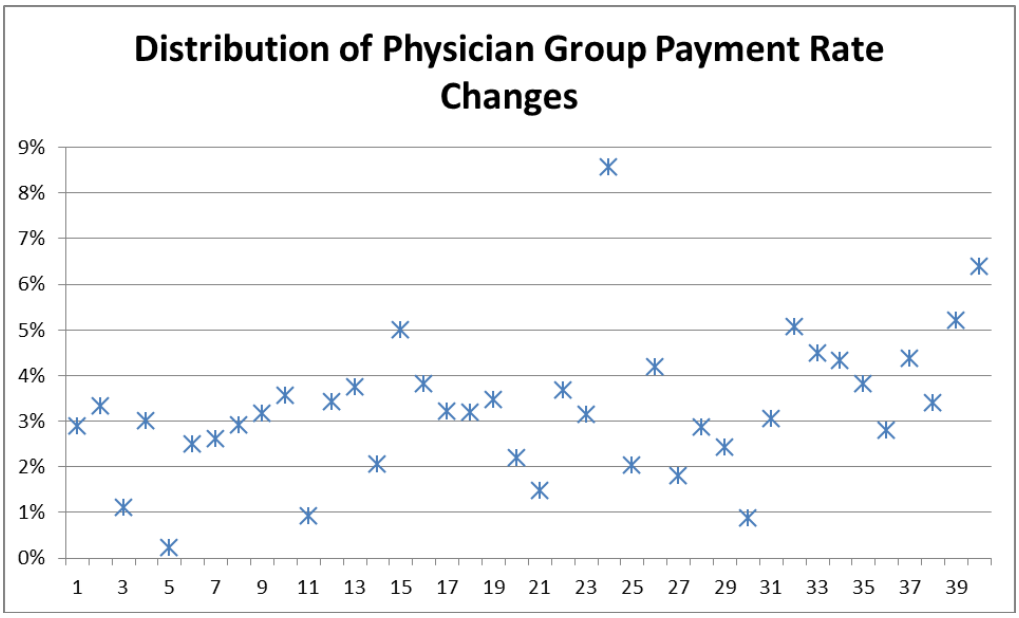

Figure 14 – Three Year Average Physician Group Payment Rate Changes

When analyzing the weighted average percent rate change for provider groups for each of the three years, Table 7 shows that the combined rate change varied slightly from year to year, from a low of 2.1% to a high of 3.1%. This was generally lower than the weighted average payment rate changes for hospitals shown in Figure 12.

	Percentage Change 2012 over 2011	Percentage Change 2013 over 2012	Percentage Change 2014 over 2013
Total Weighted Average	3.1%	2.1%	2.4%

Table 7 – Weighted Average Percent Change for Top 10 Physician Groups

7.4. Market Demographics

Age is an important factor used in the rating process, so isolating age demographics can be insightful in understanding claim trends over time. Figure 16 shows average member age across each market segment as of December 2011, 2012, and 2013 and April 2014. Through December 2013, the average age of each of the market segments was in a rather tight range of 36.8 to 37.0. The average age of the Small and Large Group Markets remained stable over the previous several years. It is interesting to see that the average age in the Individual Market increased significantly after the January 1, 2014 effective date of the Affordable Care Act and the subsequent enrollment of members through the Exchange[45]. The average age in the Individual Market rose from 37.0 in December 2013 to 41.3 in April 2014. Given the large increase in the average age of the Individual Market segment, we anticipate that average claim costs would also increase in 2014.

[45] The health insurance Exchange is implemented by the federal government in New Hampshire

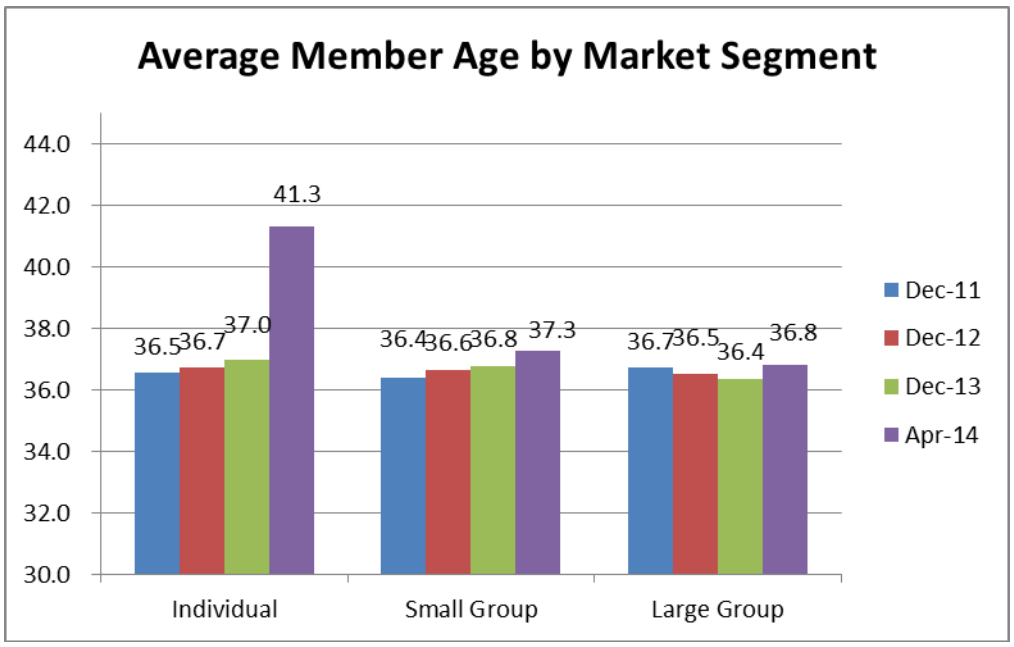

Figure 15 – Average Member Age by Market Segment[46]

Figure 14 further breaks out the Individual Market into those members who obtain their policy outside of the Exchange (black bar) and those who obtain their policy through the Exchange (grey bar). The Exchange population is much older on average (44.9) compared to the non-Exchange population (38.7). This may be attributed to the changes from the ACA that have made insurance coverage more attractive to an older demographic that was previously uninsured[47], higher subsidies for the older demographic, and a relatively smaller percentage of children enrolled in policies through the Exchange.[48]

[46] 2014 Carrier Questionnaire. Note that the information for 2014 is based on April 2014 which differs from the information from the report "New Hampshire Health Insurance Market Analysis", August 18, 2014, Wakely Consulting Group which is based on data as of May 2014.

[47] ACA restricts the age factor to 3:1. That is, rates charged to older adults can be no more than three times those charged to younger adults,

[48] A recently published analysis speculates this may be a result of the fact that New Hampshire's Children's Health Insurance Plan (CHIP) covers children up to 323% of the federal poverty level (FPL), and children eligible for CHIP are not eligible for subsidized coverage through the Exchange. "New Hampshire Health Insurance Market Analysis", August 18, 2014, Wakely Consulting Group.

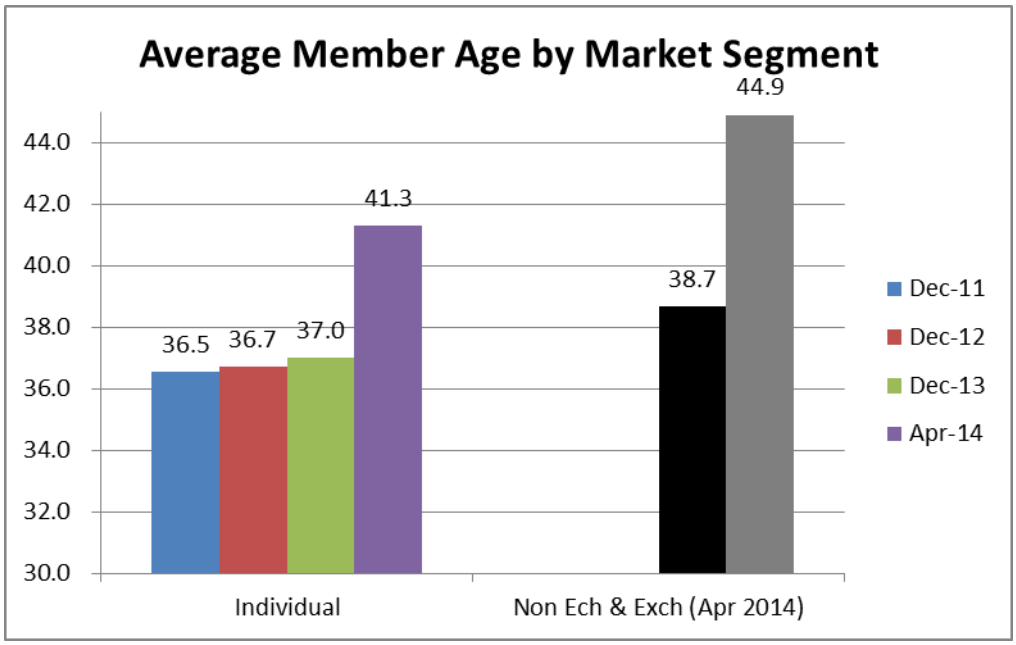

Figure 16 – Average Member Age by Individual Market Segment[49]

7.5. Pricing Trends

Section 7 has thus far focused on observed historical trends. Section 7.5 focuses on pricing trends. Observed trends represent a retrospective view of the change in claim experience from one year compared to the prior year. These are calculated metrics from known outcomes. However, health insurance premiums are established well in advance of their effective period which requires insurance carriers to develop projected trend assumptions called pricing trends. Pricing trends are a prospective view, and represent a point estimate based on actuarial analysis of the expected increase in claim costs. Pricing trends are generally developed from a combination of historical experience adjusted for expected future differences, such as a new medical technology which may increase future costs or a new utilization management policy with may decrease future utilization. In addition to the timing differences between observed trends and pricing trends, there are several other differences. Pricing trends are based on a static level of benefits while observed trends will reflect the impact of benefit changes to utilization levels. Also, 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 as what is occurring in observed historical trends. Section 7.3 of the "2011 Medical Cost Drivers"[50] report provides further context around the differences between observed and pricing trends.

[49] 2014 Carrier Questionnaire
[50] 2011 Medical Cost Drivers, Gorman Actuarial, LLC, March 7, 2013
http://www.nh.gov/insurance/consumers/documents/nhid_ann_rrhrng_2012rpt.pdf

Figure 17 shows average pricing trends in New Hampshire across all fully-insured markets from 2011 through 2015. Figure 6 showed that observed claims trend decreased from 3.3% in 2011 to 2.7% in 2012 and 1.3% for 2013. As this experience emerged, pricing trends declined in each of the most recent pricing periods, although there was a slight increase from 2014 to 2015. When analyzing the pricing trends by service type, we noted that in each of the market segments, prescription drugs had the highest trend and had been increasing over previous years. Reasons cited by the carriers for this included the declining volume of brand drugs with patent expirations and the availability of drugs like Sovaldi to treat Hepatitis C. Medical trends were generally lower than prescription drug trends and had mostly been decreasing over the same time period.

Observed utilization trends emerged at negative levels over the past few years. While carriers in New Hampshire have not assumed negative utilization trends in their pricing, they have continued to lower the utilization trend assumed in their overall pricing trend. The 2015 Segal Health Plan Cost Trend Survey[51] reported average projected 2014 trends of 6.2% to 7.9% in total. Overall, the average 2015 pricing trend in New Hampshire of 8.1% is slightly outside the upper end of this national trend survey.

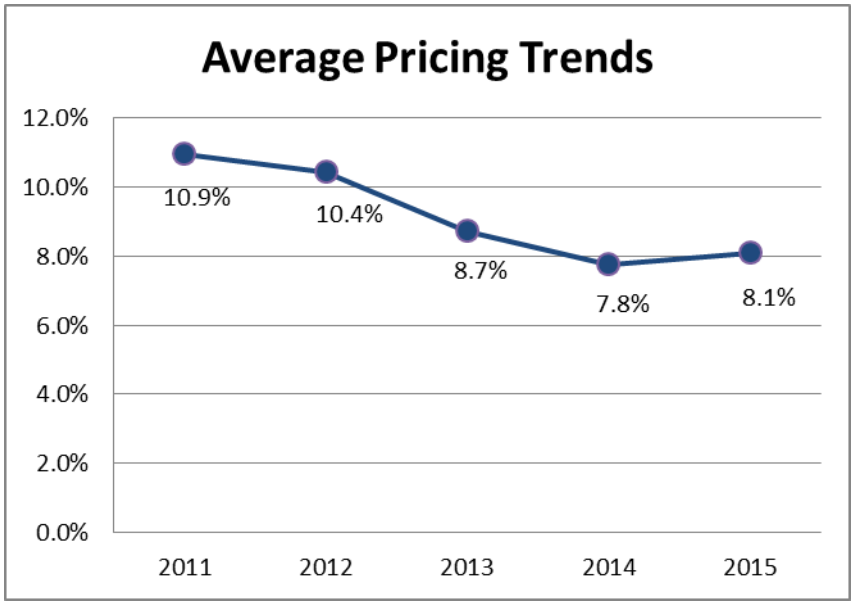

Figure 17 – Average Pricing Trends[52]

[51] http://www.segalco.com/publications/surveysandstudies/2015trendsurvey.pdf, Graph 1 - 2014 Projected Medical (Actives and Retirees < age 65) with Pharmacy excluding FFS / Indemnity plan

[52] Average pricing trends are based on Carrier Questionnaire responses in 2012, 2013 and 2014. Carrier responses by market segment were weighted by paid claim amounts in 2013. 2014 trend assumptions were restated in the latest questionnaire (now 7.8% compared to 8.1% in last year's report).

7.6. Medical Loss Ratios

In health insurance, the medical loss ratio is a measure of the percentage of each premium dollar used to pay for medical expenses. The remainder of each premium dollar is available to cover administrative expenses, taxes and fees and contribute to profit margins or surplus. Carriers establish target loss ratio assumptions during their pricing process. Given the rates filed, this is the expected portion of premium dollars needed to pay projected claims. Table 8 shows the average target loss ratios by market segment for the three year period of 2011 through 2013. The 2013 target medical loss ratio was 81.8%. Therefore, on average, carriers expected 18.2% of the premium rate to cover expenses and to contribute to profits. The Large Group segment showed relatively minor decreases in its target loss ratios. The Individual Market target loss ratio increased to about the level it was in 2011. The Small Group Market target loss ratio dropped from 82.8% to 80.8%, driving the overall average fully-insured target down by 0.8 percentage points compared to 2012. In subsequent sections, we will explore expenses and margin in more detail.

Medical Loss Ratios in Rating Assumptions by Market Segment			
	2011	2012	2013
Individual	70.0%	68.0%	69.8%
Small Group	82.9%	82.8%	80.8%
Large Group	84.9%	84.5%	84.6%
Total Fully-Insured	83.1%	82.6%	81.8%

Table 8 – Average Target Medical Loss Ratios, Carrier Rate Filings[53]

Table 9 shows the average actual medical loss ratios by market segment. These ratios represent a simple calculation of claims divided by premium, consistent with the targets shown in Table 8. The average experienced loss ratio across all fully-insured markets declined from 79.5% to 78.6% and represented the third straight year with a decrease. From 2011 to 2013, the average loss ratio across all fully-insured markets decreased by 3.6 percentage points. The average medical loss ratios in the Individual Market increased slightly to about the 2011 level. The average medical loss ratio in the Group markets continued to decrease, with each of the markets very close to 80%. 2013 pricing trends did not typically reflect negative utilization trends, which contributed to the variance between the target and actual medical loss ratio.

[53] 2012 & 2013 Carrier Questionnaire: weighted average by market membership

Actual Medical Loss Ratios by Market Segment			
	2011	2012	2013
Individual	66.0%	65.0%	65.8%
Small Group	82.0%	80.3%	79.8%
Large Group	84.8%	81.5%	80.1%
Total Fully-Insured	82.2%	79.5%	78.6%

Table 9 – Average Medical Loss Ratios, Actual Experience[54]

The Affordable Care Act (ACA) established Minimum Medical Loss Ratio (MLR) standards on a nationwide basis, starting in 2011. The national minimum medical loss ratios are 80% in the Individual and Small Group (2 – 50 eligible lives) markets, and 85% in the Large Group (greater than 50 eligible lives) market. The medical loss ratio formula used in determining whether a carrier satisfied the minimum requirements is a more complex calculation process than those shown above in Table 8 and Table 9. The ACA allows for a number of technical adjustments to both the premium revenue (i.e. subtracting state and federal taxes, assessments and fees) and claim costs (i.e. adding administrative expenses used to improve health care quality) and also for credibility where carriers have low market membership.

Carriers that experience medical loss ratios below the standards are required to provide premium rebates to policyholders for the amounts below the minimum threshold. To prevent significant disruptions in the Individual Market, at the request of the New Hampshire Insurance Department, the Department of Health and Human Services (HHS) granted a waiver for the New Hampshire Individual Market allowing the loss ratio standard to grade up from 72% in 2011 to 75% in 2012 to 80% for 2013 and beyond.[55]

Based on 2013 experience, five New Hampshire carriers were required to pay refunds due to the minimum loss ratio standards, as shown in Table 10.

[54] 2013 Carrier Questionnaire
[55] http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/nh_mlr_adj_decletter.pdf

2013	Refunds in the Individual Market	Refunds in the Small Group Market	Refunds in the Large Group Market
Anthem Health Plans of New Hampshire, Inc.	$ 3,006,863	$ -	$ -
Celtic Insurance Company	$ 53,510	$ -	$ -
Connecticut General Life Insurance Company	$ -	$ -	$ 1,422,766
Time Insurance Company	$ 950,354	$ -	$ -
UnitedHealthcare Insurance Company	$ -	$ -	$ 35,218
Total	**$ 4,010,727**	**$ -**	**$ 1,457,984**

Table 10 – Summary of 2013 MLR Refunds in New Hampshire[56]

Of the $332 million in rebates payable nationwide, $5.5 million or 0.4% of premium was payable based on carrier experience in New Hampshire.[57] This represented 1.6% of national rebates and an increase from the $1.2 million in rebates paid based on 2012 experience. New Hampshire represented 0.54% of national premium in 2013.[58] In the Large Group Market, Cigna paid total premium rebates of $1,422,766 or 0.2% of premium, which represents an average annual refund per family of approximately $279. In the Individual Market, Anthem and Time Insurance Company (a subsidiary of Assurant) paid premium rebates of $3,006,863 and $950,354 or 3.1% of premium, respectively. This represented an average annual refund per family of $140.[59]

7.7. Expenses

As indicated above, carriers filed premium rates in 2013 expecting 18.2% of the premium to pay for expenses and to contribute to profit margins. The expense premium charge is generally developed by analyzing actual carrier administrative expenses in additional to any known future changes to taxes or assessments. Carriers incur administrative costs from a variety of sources such as employee compensation, vendor costs for health management programs, broker commissions and other marketing costs, maintenance of real estate and technology assets, and federal and state assessments and taxes. Just as claims are viewed relative to premium in the medical loss ratio, the expense ratio is defined as expenses divided by premium. While the expenses reported do include assessments and taxes which are generally outside of a carrier's control, expense ratios are generally viewed as one measure of how efficient a carrier is at providing their services.

[56] "Issuers Owing Refunds for 2013", as of June 30, 2014.
http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Issuers_Owing_Refunds_for_2013.pdf
[57] "MLR Refunds by State and Market for 2013", as of June 30, 2014.
http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2013_MLR_Refunds_by_State.pdf
[58] NAIC Statistical Compilation of Annual Statement Information for Health Insurance Companies in 2013
[59] "Issuers Owing Refunds for 2013", as of June 30, 2014.
http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Issuers_Owing_Refunds_for_2013.pdf

Table 11 shows the average expense ratios assumed in rate filings by market segment. These expense ratios reflect the assumed charge that is included in premium rates for expenses including taxes and assessments. The overall expense ratio across the fully-insured markets continued to increase modestly, from 14.1% in 2011 to 14.4% in 2012 to 14.6% in 2013. Therefore, on average, carriers charged 14.6% of the premium rate for expenses in 2013. The modest overall increase was driven by the Small Group Market, which increased a percentage point from 2011 to 2013. The Individual Market expense target declined by about a percentage point, and the Large Group expense target remained flat over the same period.

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

Expense Ratios in Rating Assumptions by Market Segment			
	2011	2012	2013
Individual	20.4%	19.8%	19.4%
Small Group	14.9%	15.1%	15.9%
Large Group	12.7%	13.1%	12.7%
Total Fully-Insured	14.1%	14.4%	14.6%

Table 11 – Average Target Expense Ratios, Carrier Rate Filings[60]

Table 12 shows the actual expense ratios and expense PMPM costs experienced by market segment in 2012 and 2013. The actual expense ratios reflect the carrier's true expenses including taxes and assessments and will not always line up with the expense charge that is reflected in premiums. Across all fully-insured markets, the actual total expense PMPM as reported by carriers increased by 8.9% to $70.46. Approximately 50% to 60% of this increase is attributable to increases in state and federal taxes and assessments, while the remaining 40% to 50% of the increase is attributable to carrier administrative expenses. Even after accounting for the portion of the increase attributable to taxes and assessments, the carrier administrative portion of the expense trend is higher than the 2013 Northeast Medical Consumer Price Index (CPI) of 1.6%.[61,62] It is recommended that future reports continue to analyze the increase in

[60] 2011, 2012 & 2013 Carrier Questionnaire: weighted average by market membership

[61] http://www.bls.gov/cpi/cpid1312.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

expenses to better understand the drivers of the expenses and to provide additional transparency.

Actual Expense Ratios and PMPM's by Market Segment			
Expense Ratio	**2012**	**2013**	**Change**
Individual	22.3%	23.7%	1.4%
Small Group	15.5%	15.9%	0.5%
Large Group	14.3%	15.4%	1.0%
Total Fully-Insured	15.5%	16.4%	0.9%
Expense PMPM	**2012**	**2013**	**% Change**
Individual	$67.84	$73.41	8.2%
Small Group	$66.67	$71.17	6.8%
Large Group	$62.34	$69.08	10.8%
Total Fully-Insured	$64.73	$70.46	8.9%

Table 12 – Average Expense Ratios and PMPM's, Actual Experience[63]

In 2014, there were several ACA-driven fees and assessments that were expected to continue to increase expenses in all markets. Two of the more impactful assessments include the Health Insurance Providers Fee[64] and the Transitional Reinsurance Assessment.[65] The Health Insurance Providers (HIP) Fee is an excise tax starting in 2014 that will assess $8 billion industry-wide and will increase each year after that. The cost to each carrier will vary based on their size and tax status. Based on studies from Oliver Wyman and Milliman, estimates of the HIP Fee range from 1.7% to 2.3% of premium in 2014 increasing to 2.0% to 3.7% in later years.[66, 67] Using the 2013 average premium PMPM from Table 1, 1.7% of premium represents $7.30 PMPM and 3.7% of premium represents $15.90 PMPM. The Transitional Reinsurance program will help offset the expected increase in costs due to higher morbidity of new entrants moving into the Individual Market from 2014 to 2016. The program will be funded with an industry-wide assessment starting at $5.25 PMPM in 2014, changing to $3.67 PMPM in 2015[68] and it is expected to decline further in 2016 before being eliminated in 2017.

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commodities (medicinal drugs, medical equipment and supplies.) For more information on how Medical CPI is calculated, see http://www.bls.gov/cpi/cpifact4.htm.

[62] The rate review process in some states examines the carrier administrative expense. For example, in Massachusetts the merged market premium rates will be presumptively disapproved if the filing's projected administrative expense load, not including taxes and assessments, increases by more than the most recent calendar year's increase in the New England medical CPI, per 211 CMR 66.09 (4)(c)(1).

[63] 2012, 2013 and 2014 Carrier Questionnaires

[64] https://www.federalregister.gov/articles/2013/03/04/2013-04836/health-insurance-providers-fee

[65] http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf

[66] http://www.ahipcoverage.com/wp-content/uploads/2011/11/Insurer-Fees-report-final.pdf

[67] http://us.milliman.com/uploadedFiles/insight/healthreform/pdfs/ACA-health-insurer-fee.pdf

[68] http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/proposed-2015-payment-notice.html

7.8. Profit Margins

In the 2011 Medical Cost Drivers report[69], we briefly discussed that carriers put margin into their pricing to cover explicit profit expectations but also as a margin against adverse risk. The risk margin tends to increase in smaller blocks of business due to higher volatility of results and lower credibility of the experience on which pricing assumptions are based.

Table 13 shows the average pricing margins by market segment in rate filings for 2011, 2012, and 2013. Consistent with the smaller market size, the Individual Market in New Hampshire has much higher pricing margins than the Group Markets. Pricing margins decreased to 10.8% in the Individual Market and increased to 3.3% and 2.7% in the Small and Large Group markets, respectively. On average, across all fully-insured markets, carriers charged 3.7% of premiums for profit and risk margin in 2012.

Pricing Margin in Rating Assumptions by Market Segment			
	2011	2012	2013
Individual	9.6%	12.2%	10.8%
Small Group	2.2%	2.1%	3.3%
Large Group	2.4%	2.4%	2.7%
Total Fully-Insured	2.8%	3.1%	3.7%

Table 13 – Average Target Pricing Margins, Carrier Rate Filings[70]

Table 14 shows the actual profit margins by market segment experienced in 2011, 2012, and 2013. Profit margin, in this exhibit, is defined as the percentage of premium remaining when you subtract out claims and expenses (100% minus Medical Loss Ratio minus Expense Ratio). Overall profit margins in the fully-insured market remained the same from 2012 to 2013, at 5.0%, which is 1.3% above the assumed charge. The actual profit margins reported in Table 14 for 2013 do not reflect rebate payments for 2013.

[69] 2011 Medical Cost Drivers, Gorman Actuarial, LLC, March 7, 2013
http://www.nh.gov/insurance/consumers/documents/nhid_ann_rrhrng_2012rpt.pdf
[70] 2011, 2012 and 2013 Carrier Questionnaire – weighted average by market membership

Actual Profit Margins by Market Segment			
Profit Margin %	**2011**	**2012**	**2013**
Individual	12.2%	12.7%	10.5%
Small Group	2.6%	4.2%	4.2%
Large Group	1.7%	4.2%	4.5%
Total Fully-Insured	2.9%	5.0%	5.0%
Profit PMPM	**2011**	**2012**	**2013**
Individual	$35.29	$38.73	$32.39
Small Group	$11.12	$18.11	$18.99
Large Group	$7.39	$18.38	$20.41
Total Fully-Insured	$11.96	$20.88	$21.51

Table 14 – Average Profit Margin and PMPM, Actual Experience[71]

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

Figure 18 shows the underwriting gain percentage (the operating profit margin) by carrier and in aggregate for the combined Individual, Small Group and Large Group Markets from the 2012 and 2013 Supplemental Health Care Exhibits. The total underwriting gain percentage decreased modestly, from 3.4% in 2012 to 3.1% in 2013 (which is the same percentage as 2011). In total dollars, the 2013 underwriting gain was $44 million on premiums of $1.4 billion. Anthem's gain percentage decreased slightly, and Harvard Pilgrim's increased slightly from 2012 to 2013. Cigna's underwriting gain percentage decreased from 7.3% to 5.4%, and for the third year in a row, MVP experienced an underwriting loss.

[71] 2011, 2012 and 2013 Carrier Questionnaire

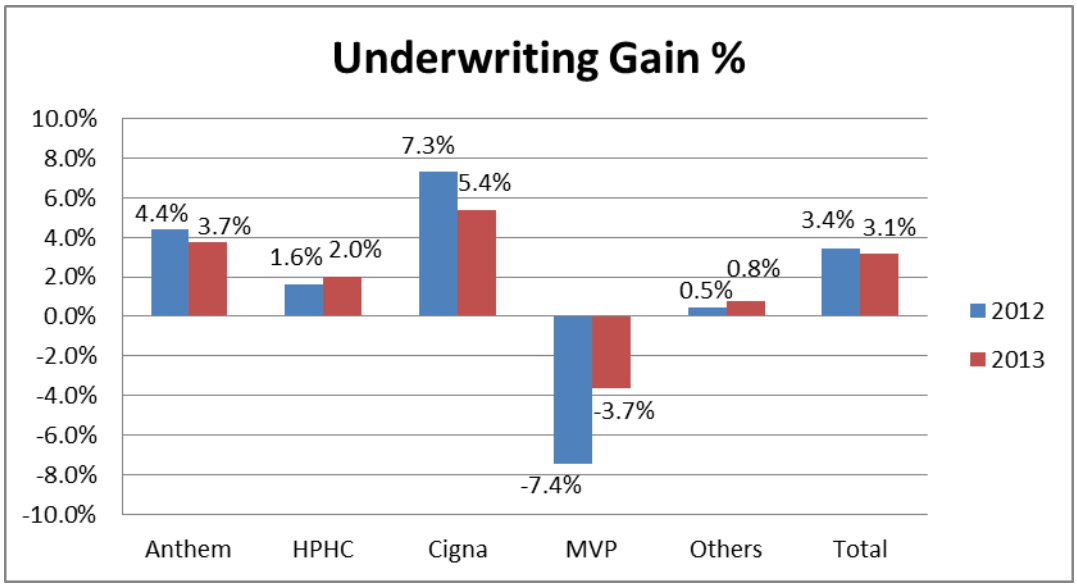

Figure 18 – Underwriting Gain Percentage by Carrier[72,73,74]

[72] 2012 & 2013 Supplemental Health Care Exhibits. Underwriting Gain/Loss (Part 1, Line 11) divided by Health Premiums Earned (Part 1, Line 1.1).

[73] 2013 Underwriting Gain and Premium by Carrier:

Anthem: $34.2M gain on $913M premium
Harvard Pilgrim: $6.6M gain on $328M premium
Cigna: $4.5M gain on $83M premium
MVP: $1.5M loss on $41M premium
Others: $0.3M gain on $35M premium. Others include Assurant, Aetna, HealthMarkets, United, Celtic and several other carriers with less than $1 million of health premiums in New Hampshire.

[74] The data requirements in the carrier questionnaires and the Supplemental Health Care Exhibits were not identical and therefore the total underwriting gain percentage in Figure 17 shows a lower gain in 2013 than the aggregated carrier questionnaire results shown in Table 14. The largest variance is the inclusion of the experience of the Federal Employees Program (FEP) in the Supplemental Health Care Exhibits. FEP business was specifically excluded from the carrier questionnaire because it functions quite differently than a typical fully-insured account. In an effort to reconcile this difference, GA has calculated an estimated total underwriting gain percentage excluding the impact of FEP. With this adjustment, the total underwriting gain percentage for 2013 increased to 4.6% compared to 3.1% without the adjustment. The 4.6% UW gain is more in line with the 5% profit margin shown in Table 14.

8. Regional and National Comparisons

Along with the deeper dive into New Hampshire trends, it is useful to examine how insurance costs and trends in the state compare to regional and national levels. The NAIC requires detailed financial statements to be filed annually by all insurance carriers.[75] From these filings, the NAIC produces a summary of all health insurance carrier filings aggregated at the state and national level. Table 15 shows a comparison of New Hampshire results to the New England region and national results.

	National	New England	New Hampshire
2012 Premium PMPM	$318.19	$423.42	$408.16
2012 Claims PMPM	$271.60	$364.13	$331.18
2012 Medical Loss Ratio	85.4%	86.0%	81.1%
2013 Premium PMPM	$325.46	$430.70	$425.57
2013 Claims PMPM	$276.23	$374.12	$342.85
2013 Medical Loss Ratio	84.9%	86.9%	80.6%
% Change in Premium PMPM	2.3%	1.7%	4.3%
% Change in Claims PMPM	1.7%	2.7%	3.5%

Table 15 – Comparison of National, Regional and State Costs and Trends[76]

New Hampshire premium PMPM in 2013 was 30.8% higher than the national level yet 1.2% below the regional PMPM. The New Hampshire claims PMPM was 24.1% above the national level but 8.4% below the regional mark. Although the variances are worth noting, it is difficult to assess relative affordability without understanding more about contributing factors, such as the relative differences in the demographic profile or health status of the insured populations and the relative actuarial value of medical benefits provided.

Table 16 presents the 2013 NAIC data in a more detailed form. In this table, the premium PMPM and medical loss ratio are shown for the Individual and Group Markets separately for each state in New England along with the total regional and national averages. New Hampshire average premium PMPM was 38% and 28% above the national averages in the Individual and Group Markets, respectively. However, in the Individual Market, the average New Hampshire premium PMPM of $302.89 was below

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

[76] The loss ratio calculation is claims divided by premium. They do not include any of the adjustments allowed in the ACA loss ratio formula used for rebate purposes, which can increase the result by several percentage points. See Section 7.6 for more discussion of loss ratios.

all the other New England states and 22% below the regional average. Figure 19 shows New Hampshire premium PMPM compared to the National and New England averages, for the Individual and Group Markets.

	Individual Market		Group Markets	
	Premium PMPM	Loss Ratio	Premium PMPM	Loss Ratio
NH	$302.89	66.2%	$446.33	82.2%
CT	$330.23	88.0%	$489.82	80.0%
ME	$382.80	96.9%	$425.21	84.9%
MA	$407.74	97.1%	$430.03	87.7%
RI	$343.07	93.8%	$418.78	84.6%
VT	$401.47	94.7%	$392.46	91.7%
New England	$387.22	94.3%	$437.81	85.8%
National	$220.09	86.4%	$349.46	84.7%

Table 16 – 2013 Premium PMPM's and Loss Ratios by Market Segment – New England States and National[77]

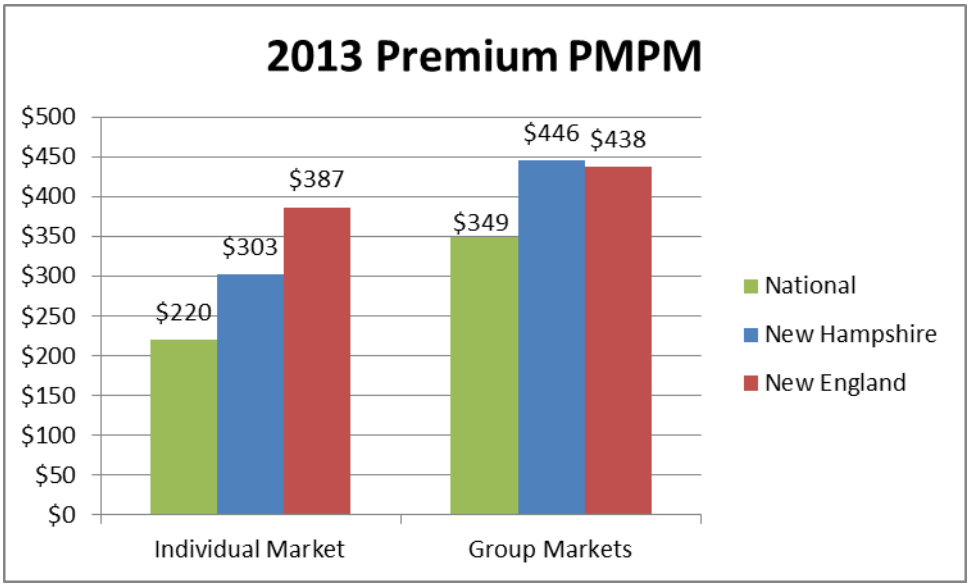

Figure 19 – Comparison of New Hampshire to National and Regional Premium

These results are similar to the patterns seen in prior years. New Hampshire is the only New England state that allowed health underwriting in the Individual Market in 2013, so this lower premium is likely reflective of a relatively healthier risk pool. However, the New Hampshire loss ratio, the best indicator of relative value for each premium dollar, was only 66.2%, roughly 28 percentage points below the average Individual Market loss ratio in New England (94.3%) and 22 percentage points below the next lowest state loss

[77] The loss ratio calculation is claims divided by premium. They do not include any of the adjustments allowed in the ACA loss ratio formula used for rebate purposes, which can increase the result by several percentage points. See Section 7.6 for more discussion of loss ratios.

ratio (88.0% in Connecticut). It is reasonable to conclude that at least a portion of the loss ratio differential between the Individual Market in New Hampshire and the other New England states is due to more aggressive regulation in states outside of New Hampshire as well as market differences such as the merged Individual and Small Group Market for rating in Massachusetts. As was discussed in Section 7.6, the ACA Minimum Loss Ratio requirements require carriers in the New Hampshire Individual Market to achieve the specified loss ratio or pay additional premium rebates back to policyholders. In 2013, three carriers in the Individual Market paid rebates totaling approximately $4 million as a result of the ACA MLR requirements. By comparison, there was much more consistency in the premiums and loss ratios in the Group Markets across the New England states. The average New Hampshire premium PMPM of $446.33 for the Group Markets was just 2% above the regional average of $437.81, and the New Hampshire loss ratio for the Group Markets of 82.2% was much more in line with the regional average of 85.8%.

9. Product Innovation: Provider Differentiation & Network Design

Although there had been a deceleration in the increase of health insurance premiums in New Hampshire and across the country, affordability of health insurance was still a major concern in 2013. As discussed in previous sections, there are several factors that drive the cost of insurance, including administrative costs and margins. However, the main cost component of health insurance in all markets is the cost of claims or medical expenditures. With ACA MLR regulations limiting the level of administrative costs and margins, it is clear that managing the cost of claims is tantamount to controlling premiums. As the trend analysis in Section 7 shows, the claims cost is driven by two primary factors: utilization and cost of services. Utilization is driven primarily by a member's health and treatment decisions made with his or her health care providers. The cost component is primarily controlled by the negotiation that occurs between insurance carriers and providers.

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

(1) **Benefits:** Medical expenditures increase as new benefits are included within the insurance product. For example, the ACA generally requires Individual and Small Group members to have a pediatric dental benefit. Many carriers have included this benefit in health insurance products. This added benefit increases the cost of health insurance.

(2) **Network:** The cost of which providers are included in a carrier's network impacts medical expenditures. The more expensive the hospital or physician, the higher the medical expenditures and resulting health insurance premiums.

(3) **Provider Payment Models:** The way providers are reimbursed by carriers can impact medical expenditures. A fee-for-service reimbursement methodology may encourage volume and increase medical expenditures and resulting health insurance premiums.

(4) **Cost Sharing:** The amount a member is required to pay through member cost sharing (e.g., copayments, deductibles, and coinsurance) impacts a health carrier's medical expenditures. The more the member pays as a percent of total medical expenditures, the lower the health insurance premiums.

Given constraints in place due to the ACA and other market dynamics, it is evident that carriers in New Hampshire and many other states across the country are continuing to

explore multiple options to impact premiums through provider differentiation and network design.

9.1. Description of Tiered Network and Site of Service Plan Offerings

In the last two years' reports, both Tiered Network options and Site of Service[78] benefit designs were discussed. 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.

In a tiered network product, hospital A is considered Tier 1 and hospital B is Tier 2. If a member chooses to use hospital A for a certain service, the deductible is $1,250 and the coinsurance is 10% up to the member's out-of-pocket limit. If the member chooses to use hospital B for that same service, the deductible is $2,500 and the coinsurance is 25% up to the member's out-of-pocket limit. Therefore, when a member chooses hospital A over hospital B, his or her out-of-pocket costs will be significantly less.

Site of service benefit designs, or low-cost provider benefit designs, offered in New Hampshire provide financial incentives to members to choose 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 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), the cost sharing is a fixed copayment amount of $100 to $125. In the case of a laboratory service, if the laboratory service takes place at an outpatient hospital, the deductible will first apply. If the member has the same laboratory service at an independent lab, the member pays no cost sharing.

9.2. New Hampshire Tiered Network and Site of Service Market Share

While neither tiered network plans nor site of service benefit designs prohibit a member from choosing his or her preferred provider, they introduce some cost transparency by exposing the member to a financial decision. Insurance carriers expect collective

[78] In the New Hampshire Market "Site of Service" benefit options are also referred to as "Low-Cost Provider" options.

member behavior to change, which ultimately will reduce claims costs, therefore allowing carriers to reduce premiums. These types of plans continue to gain popularity in New Hampshire. As shown in Figure 20, as of December 2013, 52% of the fully-insured market was in either site of service benefit designs or tiered network products. As of April 2014, this percentage decreased to 46%. This was due in part to a decrease in percentage uptake in the Small Group Market but also due to an increase in the overall Individual Market where these types of products are not offered. The growth has been in the site of service benefit options, while membership in tiered network products has been decreasing.

In the Small Group Market, the percentage of members in the site of service benefit designs and tiered network products increased from 21% as of December 2010 to 77% as of April 2014. Site of service benefit designs had become the standard option in the Small Group Market for some carriers. Their prevalence has also increased in the Large Group Market, where the percentage of members in site of service benefit designs and tiered network products increased from 11% as of December 2010 to 42% in April 2014. As referenced in the hearing from 2012, the premium for the site of service benefit option was 6% to 9% lower than a plan offering without the site of service benefit option for at least one carrier.[79] While not shown, it is also of interest that the portion of self-insured membership in both site of service benefit options and tiered network products increased, from around 5% as of December 2010 to more than 20% as of April 2014.

[79] http://www.nh.gov/insurance/consumers/documents/2012_rate_hearing.pdf

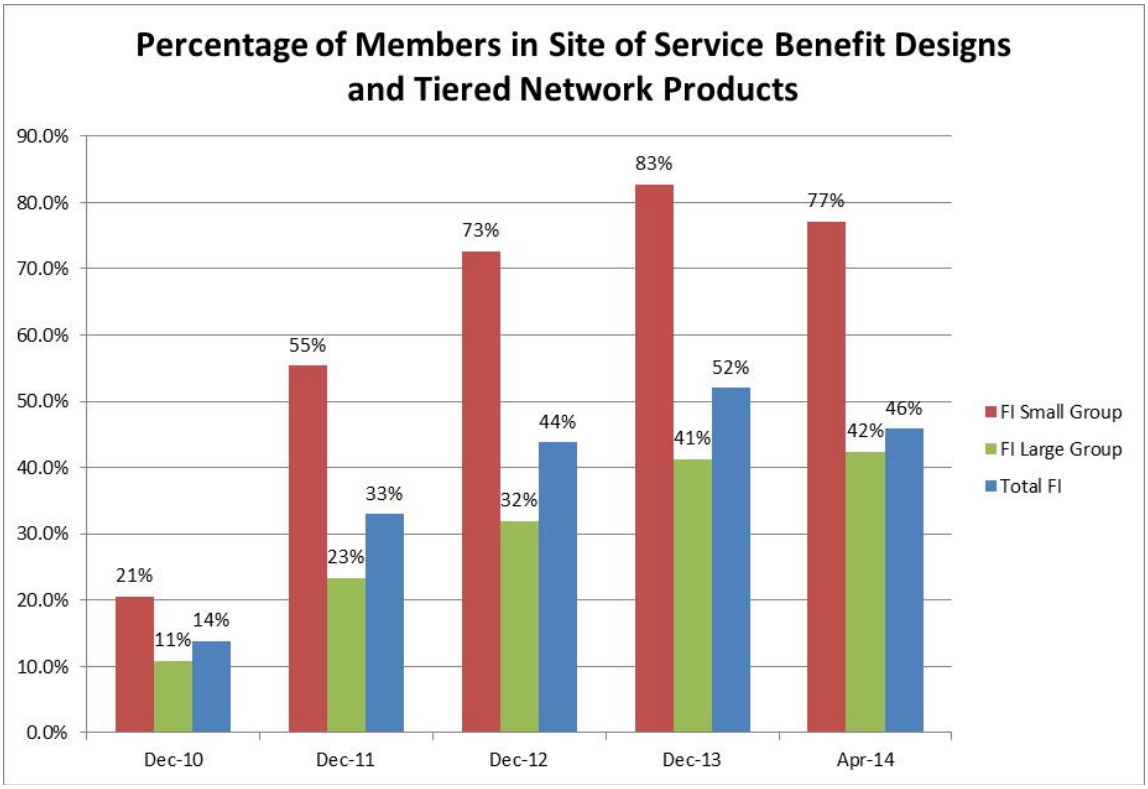

Figure 20 – Percentage of Members in Site of Service Benefit Designs and Tiered Network Products by Market Segment and Year[80]

9.3. New Hampshire Site of Service Analysis

To continue to understand the value proposition of the site of service benefit designs, data were collected for the top outpatient surgeries and laboratory services by total spend over a two- or three-year time period. These data were separated into two categories: members in plans with the site of service benefit option and members in plans without the site of service benefit option.[81] We looked at both the utilization differences between members with a site of service benefit option versus members not in a site of service benefit option and the average cost differences by site of care for these specific surgeries and labs. We focused our analysis on three outpatient surgeries (GI endoscopies,

[80] Source: 2014 NHID Carrier Questionnaire

[81] The information in this section is based on data provided by one carrier with the most experience with this type of benefit option. Data based on members in group markets only. Data excludes experience for members in the public sector and non-HMO and non-PPO, as site of service benefit options are not offered to these members.

colonoscopies, and knee arthroscopies) that represented approximately 23% of total outpatient surgery spending in 2013.[82]

Table 17 shows the average allowed costs for GI endoscopies at a hospital outpatient setting and at an ambulatory surgical center (ASC). In addition, the table includes member cost sharing and the net costs for these surgeries. Allowed costs include member cost sharing, while net costs are the true costs to the insurance carrier. As shown, the average allowed cost for this specific surgery was significantly lower at ASCs compared to hospital outpatient settings. The average allowed cost in 2013 was $2,746 at a hospital outpatient site compared to $1,395 at an ambulatory surgical center. For this surgery, costs at an ASC were $1,350 or 49% lower than costs at a hospital outpatient setting. The average net costs were also significantly lower at an ASC compared to a hospital outpatient site; $1,305 versus $1,862 in 2013.

CY 2013 GI Endoscopy Costs- Members in Site of Service Option				
	Outpatient Hospital	**Ambulatory Surgical Centers**	**$ Difference**	**% Reduction**
Allowed Cost per Surgery	$2,746	$1,395	-$1,350	49%
Member Cost Sharing per Surgery	$883	$91	-$793	90%
Net Cost per Surgery	$1,862	$1,305	-$558	30%

Table 17 – 2013 Costs for GI Endoscopy by Site of Procedure[83]

Figure 21 shows the difference in percentage of services at ASCs for three years and for members in a site of service benefit option versus those who were not in a site of service benefit option for GI endoscopies. Members in site of service benefit options continued to use ambulatory surgical centers at a higher rate for these types of surgeries, 45% compared to 38% in 2013. Over the three years studied, both members with and without a site of service benefit option continued to shift their usage towards the lower cost ASCs, and members without a site of service benefit option were actually shifting their usage to ASCs at a higher rate than members with a site of service option. Members with a site of service benefit option increased their usage from 41% to 45%, a 4 percentage point increase over the three years studied, while members without a site of service benefit option increased their usage from 25% to 38%, a 13 percentage point increase.

[82] GI Endoscopy is CPT 43239. Colonoscopy is CPT codes 45380, 45385 and 45378. Knee Arthroscopy is CPT code 29881.
[83] Source: 2014 NHID Carrier Questionnaire

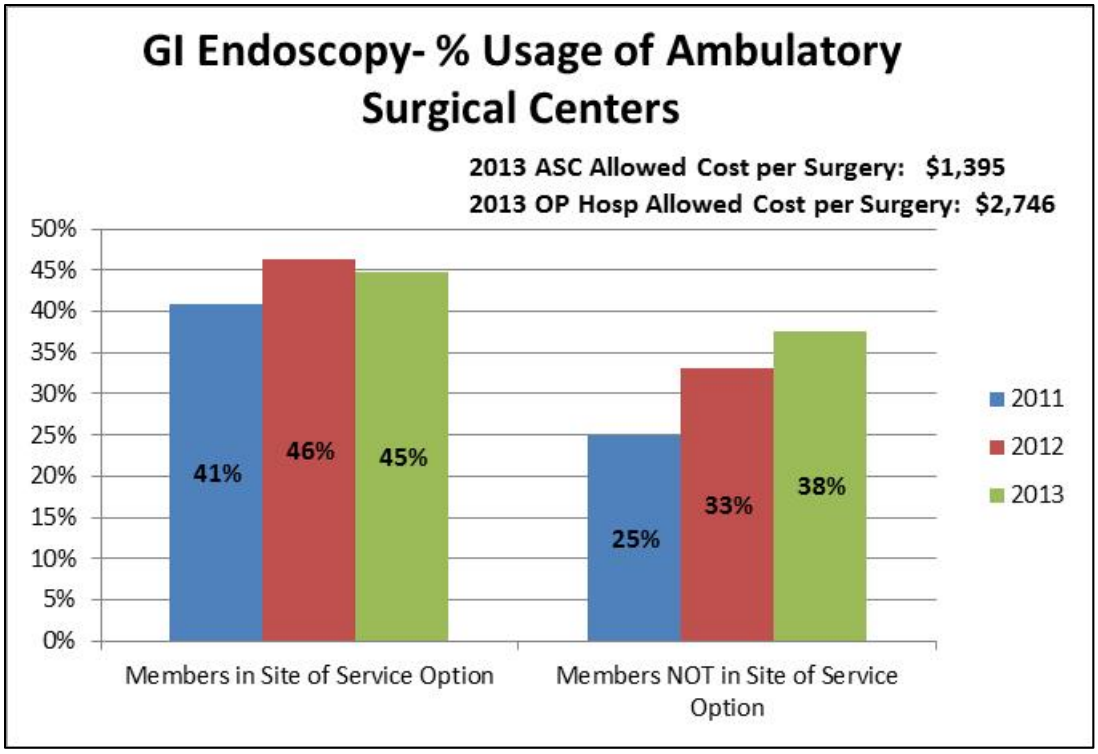

Figure 21 – GI Endoscopy Percentage Usage of Ambulatory Surgical Centers[84]

Results are similar when examining colonoscopies. As shown in Figure 22, members with a site of service benefit option continued to use ASCs at a higher rate than members without a site of service benefit option (48% versus 42% in 2013) and like GI endoscopies, there was a significant allowed cost differential between ASCs and outpatient hospital settings ($1,881 versus $2,779 in 2013.) Also very similar to GI endoscopies, both members with and without a site of service benefit option continued to shift their colonoscopy usage towards the lower cost ASCs, and members without a site of service benefit option actually shifted their usage to ASCs at a higher rate than members with a site of service option. Members with a site of service benefit option increased their usage slightly from 47% to 48%, a 1 percentage point increase over the three years studied, while members without a site of service benefit option increased their usage from 33% to 42%, a 9 percentage point increase. Similar results were also found when examining results for knee arthroscopies.

[84] Source: 2014 NHID Carrier Questionnaire

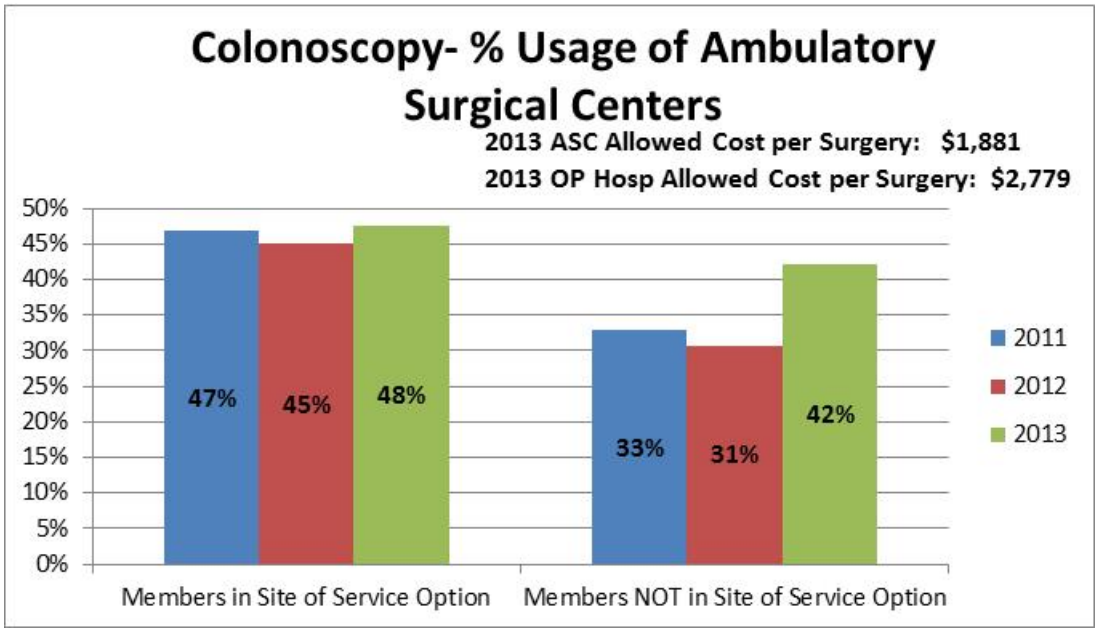

Figure 22 – Colonoscopy Percentage Usage of Ambulatory Surgical Centers[85]

In this year's report, we also examined data for the top laboratory services by spend. Laboratory services are generally much less expensive than outpatient surgeries but are more prevalent. Figure 23 shows the results for a common laboratory service, a lipid profile and cholesterol test. In the case of the lipid profile and cholesterol tests, the allowed cost was $16 per test at an independent lab versus $64 at an outpatient facility. Members in site of service benefit options used independent labs at a higher rate than members not in a site of service benefit option for this laboratory service, 70% compared to 53% in 2013. Also similar to the outpatient surgeries studied, both members with and without a site of service benefit option continued to shift their lipid profile and cholesterol test usage towards the lower-costing independent labs. Members with a site of service benefit option increased their usage from 65% to 70%, a 5 percentage point increase over the two years studied, while members without a site of service benefit option increased their usage from 41% to 53%, a 12 percentage point increase.

[85] Source: 2014 NHID Carrier Questionnaire

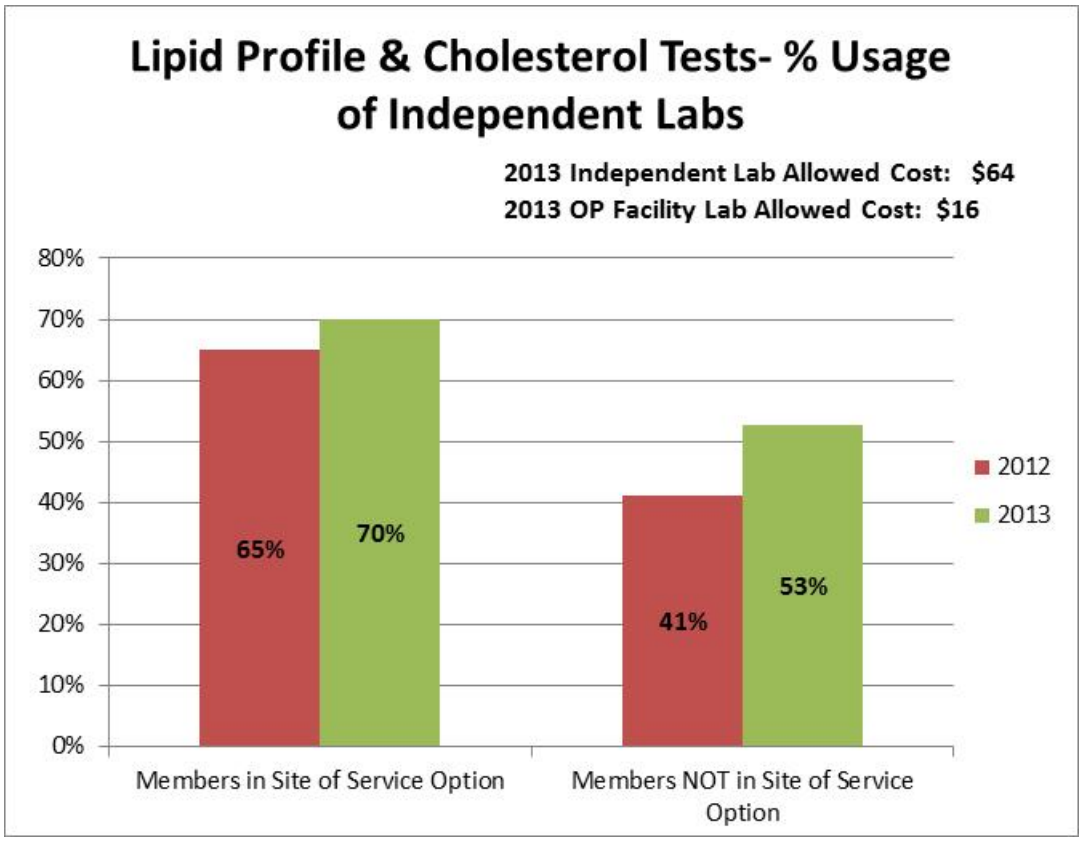

Figure 23 – Lipid Profile and Cholesterol Test Usage of Independent Labs[86,87]

Members with a site of service benefit design are specifically incented to use ASCs and independent labs, as the cost sharing at these locations is significantly lower than the cost sharing at an outpatient hospital facility for the same service. The shift for members not in a site of service option could be due to several factors, including increasing deductibles, so that even members not in site of service options also benefit from use of lower costing facilities, in addition to the increased availability and ease of use of lower cost facilities.

Outpatient surgery and laboratory services comprise approximately 15% of a carrier's total allowed spending. Therefore, the site of service benefit designs alone are not enough to address the entire affordability issue, but they have proven to gain traction in the market and they are impacting member behavior by shifting care to lower cost providers. Carriers stated at the 2013 hearing that site of service benefit designs are having a favorable impact when it comes to contract negotiations with hospitals, as hospitals are concerned about losing volume to ambulatory surgical centers and therefore are willing to renegotiate outpatient hospital rates. At this most recent hearing, employer representatives stated that, from their perspective, site of service benefit options are generally perceived as positive.

[86] Source: 2014 NHID Carrier Questionnaire
[87] Lipid Profile and Cholesterol Test is CPT Code 80061.

While the site of service products have increased in market popularity, hospitals have cited the fact that shifting care outside of hospitals leads to less coordinated care and fragmentation of the health care system. It is difficult to find data to quantify this concern. In addition, hospitals have expressed concern that the site of service benefit designs specifically target certain higher-margin services such as certain outpatient surgeries, and if the volume of these higher-margin services decreases, then hospitals will need to make up that margin on other services.

9.4. New Hampshire Limited Network Products

Another type of product innovation is the idea of contracting with a more limited network of providers. By not contracting with all of the providers in a region, the carrier is typically able to negotiate more favorable terms in return for offering greater volume of its members to the provider. In late 2013 into early 2014, both Anthem and Harvard Pilgrim launched products with less than their full commercial network. In the Individual Market Health Exchange in 2014, Anthem is only offering plans with a limited network (referred to as Pathway X Enhanced.) Anthem stated that its 2015 Individual Exchange network product will include 17 hospitals, including one in Massachusetts and one in Maine, and 73% of the state's primary care providers. By contracting with a more limited group of providers, Anthem stated that 2015 premiums in the Individual Exchange would be approximately 30% lower, compared to plans with a broad network.[88] Harvard Pilgrim was offering plans with a limited network in the Small and Large Group Markets on its Elevate Health network. As of October 2014, there were 13 New Hampshire hospitals in the Elevate Health network and more than 575 primary care providers. Harvard Pilgrim stated that the Elevate Health plans reflect double-digit premium savings relative to comparable full network plans.[89] 56% of the Individual Market, 7% of the Small Group Market, and less than 1% of the Large Group Market were enrolled in a limited network product in April 2014. This equated to approximately 7% of the total fully-insured New Hampshire Market. There was general concern expressed at the hearing that consumers may not fully be aware of the limitations associated with these types of products and that more education and outreach needs to be provided. In the Individual Market Health Exchange, where limited network products are the only offering, Anthem representatives at the hearing stated that they have generally received positive feedback on these products. In addition, these representatives indicated that in-network usage is very high, once members have been in the product for a few months.

Limited, or narrow, networks are very prevalent in Exchanges across the country. A national study released in December 2013 showed 70% of hospitals networks on Exchanges had narrow or "ultra-narrow" networks. The study also found that for similar

[88] https://www.anthem.com/health-insurance/about-us/pressreleasedetails/NH/2014/1644/anthem-releases-hospital-list-for-aca-in-2015

[89] https://www.harvardpilgrim.org/portal/page?_pageid=849,2919992&_dad=portal&_schema=PORTAL&p_print=PRINT

product offerings, products with broad networks had a median premium increase of 26% compared to narrow network products.[90]

9.5. Provider Payment Methodologies

Provider payment reform continues to be an area of great discussion in New Hampshire and across the country. Both insurance carriers and providers are engaged in evaluating opportunities to migrate away from typical fee-for-service models to pay-for-performance or risk sharing models. The aim of these payment reform efforts is to better align financial incentives between the insurance carriers and the providers, to reduce unnecessary utilization, improve overall quality of care to patients, and to ultimately reduce costs to the overall health care system.

The variations of alternative payment strategies continue to grow in New Hampshire. Some models include only upside risk, which involves potential incentive rewards but no potential financial penalties. Other models include both upside and downside financial risk, in which the provider shares in both potential gains and losses depending on its performance, often relative to a benchmark or a network of peers. Examples of these arrangements currently employed in New Hampshire include:

- Pay for Performance Programs: At least one carrier in New Hampshire participates 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.
- Patient Centered Primary Care Homes: At least two carriers in New Hampshire are working with primary care physicians to improve care coordination and outcomes by providing data, tools, and financial incentives to the provider groups for meeting certain cost and quality metrics. These arrangements generally represent upside risk only to the provider.
- Capitation: Provider groups are fully at risk for the majority of services incurred by members. Historically, these arrangements are for HMO/POS members who choose a PCP, but at least one carrier has initiated a pilot program attributing PPO members to a primary care doctor.
- Accountable Care Organizations: At least two carriers have established accountable care type models with larger provider systems in New Hampshire. In one case, this arrangement was centered around sharing information with providers related to gaps in care and pharmacy compliance and does not represent any financial risk sharing. In another case, the arrangement represented more of a true risk-sharing arrangement in which the provider shares in both upside and downside risk.

[90] "Hospital Networks: Configuration on the Exchanges and their Impact on Premiums," McKinsey Center for U.S. Health Care Reform.
http://www.mckinsey.com/~/media/mckinsey/dotcom/client_service/healthcare%20systems%20and%20services/pdfs/hospital_networks_configurations_on_the_exchanges_and_their_impact_on_premiums.ashx

Figure 24 shows the percentage of members in New Hampshire associated with providers in risk-sharing arrangements from December 2010 to December 2013 for both members in upside-only risk contracts and members in upside and downside risk, or full risk, contracts. Through December 2012, the penetration of these arrangements was level, at around 11%. As of December 2013, New Hampshire experienced a significant increase in both for members in full risk arrangements (from 11% to 19%) and for members in upside-only risk contracts (from 1% to 13%.) While upside-only payment models represent progress towards greater provider-carrier alignment and can be a starting point for full risk sharing, upside-only arrangements may not create enough financial incentive to drive lasting behavior change and provider engagement. The relatively small size of some of the providers in New Hampshire may prohibit their ability to accept significant risk on their contracts and their ability to negotiate these arrangements on their own.

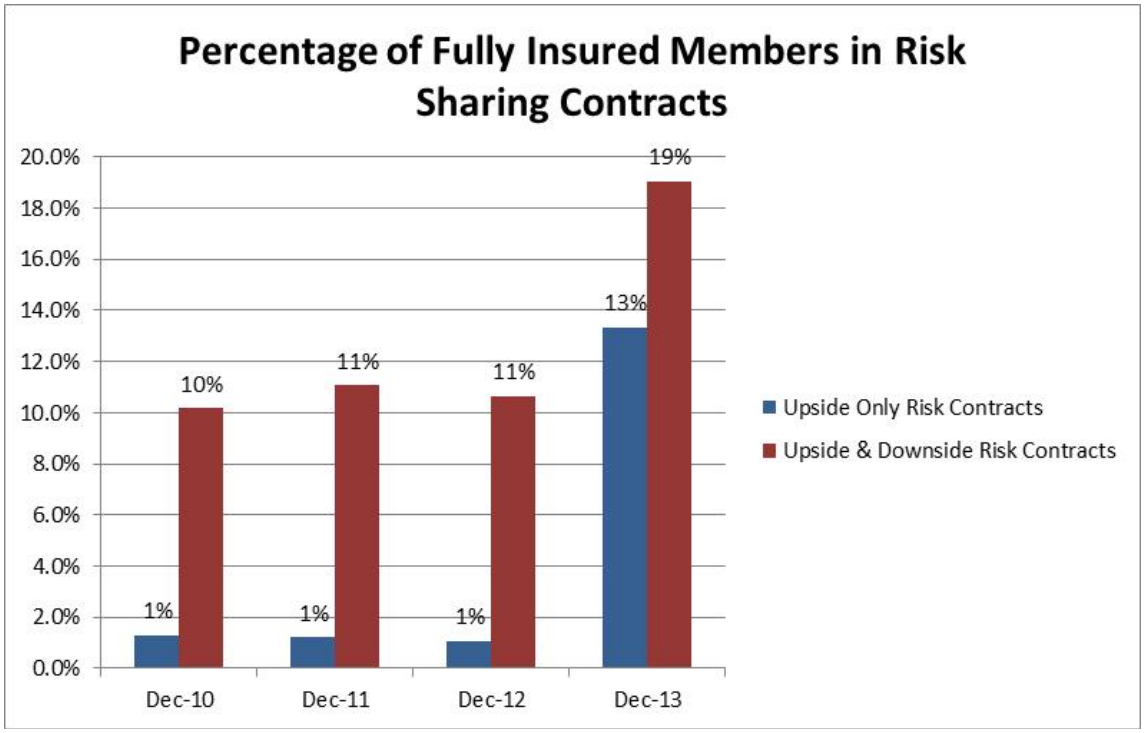

Figure 24 – New Hampshire Insured Membership in Risk Arrangements[91]

It is also worth noting that, of the carriers surveyed, the percentage of self-insured members in both upside only and full risk sharing arrangements also increased significantly from December 2012 to December 2013. In 2012, less than 2% of the self-insured members were in either upside-only or full risk sharing arrangements. As of December 2013, approximately 10% of members were in upside-only risk arrangements, and approximately 20% of members were in full risk sharing arrangements.

[91] Source: 2014 NHID Carrier Questionnaire

10. Conclusion

The primary directive for this report is to discuss and analyze the health insurance premium rate increases and the factors driving the increases in the previous year. New Hampshire premium trends averaged 3.0% in 2013, an increase compared to the prior year but still low compared to recent history. Over the past few years, New Hampshire has experienced lower premium trends mostly driven by reductions in utilization. However, there continue to be areas that call for additional focus in order to keep the cost of insurance from increasing if favorable utilization does not continue. In particular, provider unit cost trends continue to outpace inflation, as they have for several years. In addition to a focus on total premium costs, there continues to be a focus on increasing member out- of-pocket costs in the form of cost sharing and employee contributions. This was highlighted at the most recent public hearing on health care costs, where several constituents pointed out that while premium trends have stayed relatively low, each year employees and members bear an increasing portion of healthcare costs through higher employee contributions and higher cost sharing. Another area of focus includes member transparency. To ensure the success of new and innovative products in ultimately bending the cost trend curve, members will need to first understand these products. At the hearing, concerns were raised that even consumers that try to be well informed are oftentimes unable to understand what they will have to pay for a medical service. This is due many reasons, such as the wide variability in how prices are set, the lack of consumer price information and how the cost is affected by the member's benefit design attributes (copay, coinsurance, deductible, out-of-pocket maximum, and network design, to name a few). The New Hampshire Insurance Department has made great strides in recent years in the promotion of health care cost transparency, including creating tools like the NHHealthCost.org, conducting the annual hearing on health care costs, and issuing annual reports on the state of the market. However, as confirmed at the hearing, more collaboration is needed from key stakeholders to further engage and educate consumers.

11. Appendix

11.1. Data Sources

A brief summary of the key data sources used in the development of this report is included below. While GA reviewed the data for reasonableness and used care in evaluating and analyzing the data from each source, GA does not provide any warranties as to the accuracy of the data as reported by the carriers or as aggregated by the NHID or the NAIC.[92]

[92] Note that different data sources, such as the NAIC Supplemental Health Care Exhibits and the Carrier Questionnaire, may define Small Group differently. The federal definition of small group is based on number of employees while the New Hampshire Small Group rating definition is based on number of eligible employees. GA considered these differences for the analyses in this report.

- **Carrier Questionnaire:** The NHID and Gorman Actuarial developed a survey that required quantitative and other explanatory details on carrier experience in New Hampshire. The questionnaire asked carriers to provide details on historical financial results, trends, pricing assumptions, membership, benefit plans, and strategic initiatives to address premium cost drivers. Only aggregated or de-identified information from the carrier questionnaires was used within this report except where noted and the carrier has approved. Some results shown in prior year reports may have been revised based on updated results from this year's responses to the carrier questionnaire.

- **Supplemental Report Data:** This data submitted by carriers to the NHID to support the development of the annual "Supplemental Report of the Health Insurance Market in New Hampshire"[93]. Carriers and Third-Party Administrators must submit this data to NHID by July 15 for the previous calendar year (2013.) In addition, carriers were also required to resubmit CY 2012 data on March 15 given revised and additional new reporting requirements. While the 2013 Supplemental Report has not yet been released, a subset of the preliminary data that has been collected was used in the development of this report. Some results shown in prior year reports may have been revised based on updated results from this year's responses to Supplement Report Data request.

- **NAIC Supplemental Health Care Exhibits (SHCE):** Beginning in 2010, this was a new annual filing requirement used to assist state and federal regulators in tracking and comparing financial results, particularly elements that make up the medical loss ratio, of healthcare businesses as reported in the annual financial statements. A separate exhibit is required annually in each state in which a carrier has written any premium or has any claims or reserves in the Individual, Small Group or Large Group fully-insured Comprehensive Major Medical Markets.

- **NAIC Statistical Compilation of Annual Statement Information for Health Insurance Companies:** This report includes aggregated data from annual statements of the individual companies filing the health annual statement blank. Certain data is provided only at the total national level. Other data is also presented by state. New England regional calculations

[93] The 2012 Supplemental Report (http://www.nh.gov/insurance/lah/documents/supp_rpt_2012.pdf) includes a more detailed description of the data in its Appendix.

were based on the aggregated results reported for Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

11.2. Glossary of Terms

- ***ACA:*** Affordable Care Act of 2010
- ***Actuarial Value:*** For purposes of this report, "actuarial value" is defined as the share of medical costs covered by the health plan for a standard population.
- ***Allowed Costs:*** These costs include both the amount paid by the insurance carrier 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, but unlike an HMO, the member may not be required to select a Primary Care Physician or receive referrals to Specialists within the network.
- ***Fully Insured Plan:*** A health plan in which an insurance carrier receives a premium payment in return for covering all claims risk associated with the enrollees.
- ***HMO:*** Health Maintenance Organization; a type of health plan that employs medical management techniques such as a defined provider network, Primary Care Physician selection and Specialist referral requirements.
- ***NAIC:*** National Association of Insurance Commissioners
- ***NHID:*** New Hampshire Insurance Department
- ***Per Member Per Month (PMPM):*** A common method of expressing healthcare financial data that normalizes for the size of the membership pool. Dollars are divided by member months to calculate the PMPM value.
- ***POS:*** Point-of-Service plan; a type of health plan similar to an HMO, but with the option to self-refer to providers outside of the HMO network, typically with increased levels of member cost sharing

- ***PPO:*** Preferred Provider Organization; a type of health plan that employs a network of preferred providers, but does not limit a member from seeking care at any provider. Typically the member cost sharing will be lower when care is provided within the preferred network.
- ***Pricing Trend:*** An assumption used in setting premium rates that represents the expected increase in future claims costs.
- ***Self-Insured Plan:*** A health plan in which an employer does not actually pay insurance premiums to a carrier to accept the claims risk. The employer pays only a service fee to a carrier to administer the plan, but then the employer covers the cost of claims for their enrollees directly.
- ***Unadjusted Premium Trend:*** The actual percentage increase in premium PMPM's as reported by carriers.
- ***Utilization Trend:*** The change in the number of services provided. Examples of the types of metrics used to calculate utilization includes the number of admissions to a hospital, the number of visits to a specialist physician of the number of pharmacy prescriptions filled.

11.3. Limitations and Data Reliance

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

Users of this report must possess a reasonable level of expertise and understanding of healthcare, health insurance markets and financial modeling so as not to misinterpret the information presented. The report addresses certain provisions of the Affordable Care Act, but is not intended to act as an official or comprehensive interpretation of the legislation itself.

Analysis in this report was based on data provided by the New Hampshire Insurance Department, carriers in the New Hampshire health insurance markets, the NAIC and other public sources. Gorman Actuarial has not audited this information for accuracy. We have performed a limited review of the data for reasonableness and consistency. If the underlying data is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

The report contains statements that attempt to provide some prospective context to current or past trends. These statements are based on the understanding of the existing and proposed regulatory environment as of November 2014. If subsequent changes are made, these statements may not appropriately represent the expected future state.

11.4. Qualifications

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