
New Hampshire Insurance Department

**Final Report of the 2016 Health Care Premium and Claim
Cost Drivers**

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Gorman Actuarial, Inc.

Jennifer Smagula, FSA, MAAA

Don Gorman

Linda Kiene, ASA

Bela Gorman, FSA, MAAA

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1. Overview of New Hampshire Health Insurance Market in 2016

The uninsured rate in New Hampshire has decreased from 10.7% in 2013 (pre-ACA) to 5.9% in 2016. The national uninsured rate in 2016 is 8.6%.¹

- The uninsured rate was impacted by the implementation of the ACA in 2014 and the expansion of Medicaid in New Hampshire effective August 2014.
- Effective January 1, 2016, New Hampshire converted its Medicaid Expansion program to the Premium Assistance Program (NH PAP).
- The number of Medicaid recipients has increased significantly over the past three years from 130,000 in 2014, to 151,000 in 2015, and to 158,000 in 2016. This includes both Medicaid Coverage Only and Dual Medicare/Medicaid Coverage.²
- Of the 1.3 million New Hampshire residents in 2016, 820,000 (or approximately 62%) had private commercial insurance.³

¹ U.S. Census Bureau. American Community Survey 1-Year Estimates for 2013 and 2016. Available at: <http://factfinder.census.gov> or <https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.2016.html>.

² New Hampshire expanded its Medicaid health care coverage program, also known as the New Hampshire Health Protection Program (NHHPP), effective August 15, 2014. Note that as of January 1, 2016, New Hampshire converted its Medicaid Expansion program to the Premium Assistance Program (NH PAP), which is discussed further below. The American Community Survey does not explicitly state that the NH PAP population is designated as Medicaid, but based on the size of the Medicaid and Individual membership, we assume that they are.

³ Private commercial insurance refers to health insurance obtained through one's employer or purchased on one's own. The commercial insurance market includes employers who may or may not be located in New Hampshire and do not all necessarily buy insurance from a New Hampshire licensed insurer. These totals include both New Hampshire situated and non-New Hampshire situated members. Situs is determined by the location from which the policy is issued. Employers with their headquarters located out of state typically buy policies situated outside of New Hampshire, even when they have a branch location in New Hampshire.

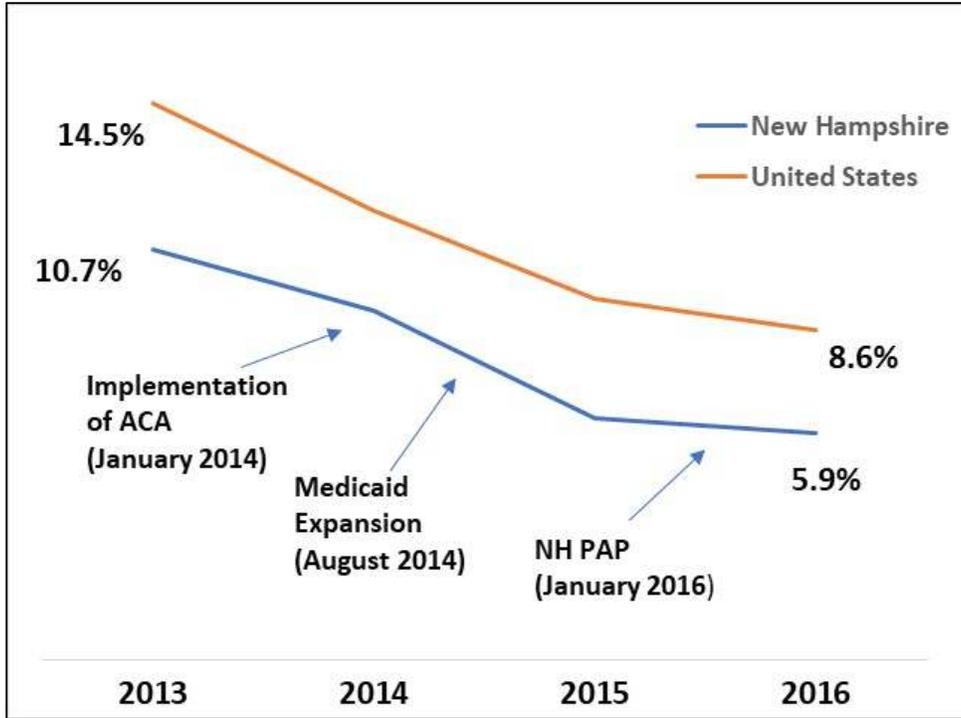


Figure 1: New Hampshire and United States Uninsured Rate 2013 - 2016⁴

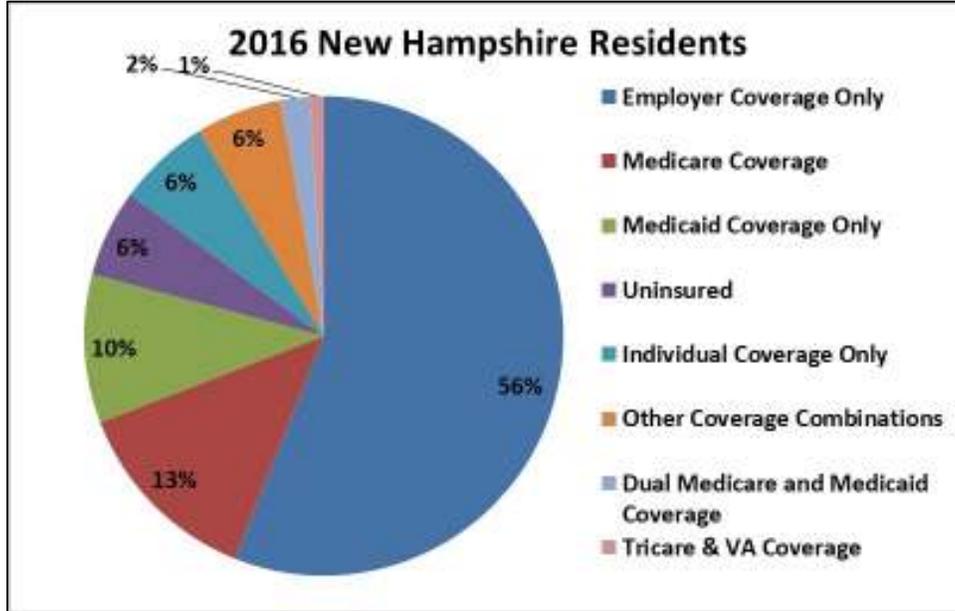


Figure 2: New Hampshire Residents by Health Insurance Status in 2016⁵

⁴ U.S. Census Bureau. American Community Survey 1-Year Estimates for 2013, 2014, 2015 and 2016. Available at: <http://factfinder.census.gov> or <https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.2016.html>.

⁵ U.S. Census Bureau. 2016 American Community Survey 1-Year Estimates. Available at: <http://factfinder.census.gov>.

	2014		2015		2016	
	NH Number	NH %	NH Number	NH %	NH Number	NH %
Employer Coverage Only	747,000	57%	751,000	57%	738,000	56%
Medicare Coverage	160,000	12%	168,000	13%	172,000	13%
Uninsured	120,000	9%	83,000	6%	78,000	6%
Medicaid Coverage Only	107,000	8%	125,000	9%	132,000	10%
Individual Coverage Only	76,000	6%	80,000	6%	82,000	6%
Other Coverage Combinations	65,000	5%	70,000	5%	76,000	6%
Dual Medicare and Medicaid Coverage	23,000	2%	26,000	2%	26,000	2%
Tricare & VA Coverage	15,000	1%	12,000	1%	12,000	1%
Total	1,313,000	100%	1,315,000	100%	1,316,000	100%

Table 1: New Hampshire Residents by Health Insurance Status in 2014, 2015 and 2016⁶

In 2016, there are approximately 539,000 members who receive insurance through a New Hampshire licensed insurer (situs-based).^{7, 8, 9} Not all of these members are New Hampshire residents; however, most are employed with a New Hampshire employer.

- Approximately 436,000 (81%) are New Hampshire residents.¹⁰
- 263,000 (49%) are covered under self-insured policies.¹¹

Consistent with prior years, three insurers – Anthem, CIGNA, and Harvard Pilgrim Health Care – dominate the New Hampshire commercial insurance market (fully-insured and self-insured.)

⁶ U.S. Census Bureau, American Community Survey (ACS) 1-Year estimates for 2014, 2015 and 2016. Available at: <http://factfinder.census.gov>.

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

⁸ Data for this report primarily come from the NHID Supplemental Data Request (SDR) and Annual Hearing Carrier Questionnaire (AH). Data representing CY 2016 were collected in 2017 and are referred to throughout this report as data from the 2017 SDR and AH. Similarly, data representing CY 2015 were collected in 2016 and are referred to as data from the 2016 SDR and AH, and so on. See the Appendix for more information on these data sources.

⁹ There are approximately 218,000 non-New Hampshire sitused commercial members (that is, members who are insured through a policy sold outside of New Hampshire). Many of these non-New Hampshire sitused members are New Hampshire residents, and some may work for an employer based outside of New Hampshire with a branch location or satellite office located in New Hampshire.

¹⁰ 2017 AH data. Excludes individuals covered under the Federal Employees Health Benefits Plan (FEHBP).

¹¹ The New Hampshire private employers covering members on a self-insured basis are not subject to New Hampshire insurance laws and are regulated by the Department of Labor. As such, this report does not include detailed information on the self-insured population.

- Ambetter¹² entered the Individual Health Insurance Marketplace, or the Exchange, in CY 2016, with virtually all of their members enrolled in the New Hampshire Premium Assistance Program (NH PAP) products.¹³
- Tufts Health Freedom Plan also entered the market in CY 2016 in the Small and Large Group markets.

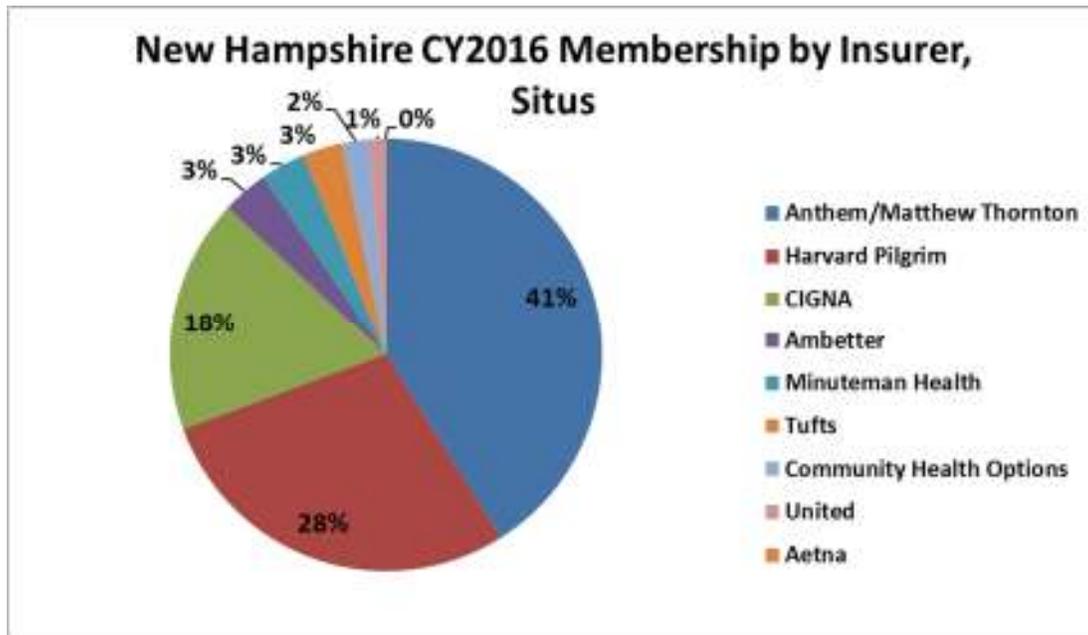


Figure 3: Distribution by Insurer of New Hampshire Situs and Fully-Insured and Self-Insured CY 2016¹⁴

Health Insurance Carrier/TPA	Fully Insured Members	Self-Insured Members	Average Members	Percentage of Total
Anthem/Matthew Thornton	114,500	106,700	221,300	41%
Harvard Pilgrim	102,500	49,800	152,300	28%
CIGNA	8,100	86,600	94,700	18%
Ambetter	18,600	0	18,600	3%
Minuteman Health	18,100	0	18,100	3%
Tufts	900	15,100	16,000	3%
Community Health Options	11,300	0	11,300	2%
United	1,800	4,500	6,300	1%
Aetna	100	0	100	0%
Total	276,000	263,000	539,000	100.0%

Table 2: Average Membership by Insurer of New Hampshire Situs and Fully-Insured and Self-Insured CY 2016¹⁵

¹² Ambetter from New Hampshire Healthy Families is Centene Corporation’s Health Insurance Marketplace product. The product entered the New Hampshire Exchange in January 2016. Ambetter from NH Healthy Families is underwritten by Celtic Insurance Company.

¹³ New Hampshire converted its Medicaid Expansion program to a Premium Assistance Program effective January 1, 2016. Further information can be found at: <http://www.dhhs.nh.gov/ombp/pap>

¹⁴ 2017 SDR data. Excludes individuals covered under FEHBP.

¹⁵ 2017 SDR data. Excludes individuals covered under FEHBP. Average membership is calculated using member months for CY 2016 divided by twelve. These may not match membership estimates in other sections of this report which are member estimates based on points in time.

Figure 4 and Figure 5 show the distribution of members in the Large Group fully-insured and self-insured markets, respectively. While Anthem and Harvard Pilgrim dominate the fully-insured market in New Hampshire, CIGNA has one-third of the market share in the self-insured segment.

- Membership in the self-insured market has increased 4% from CY 2014 to CY 2016.

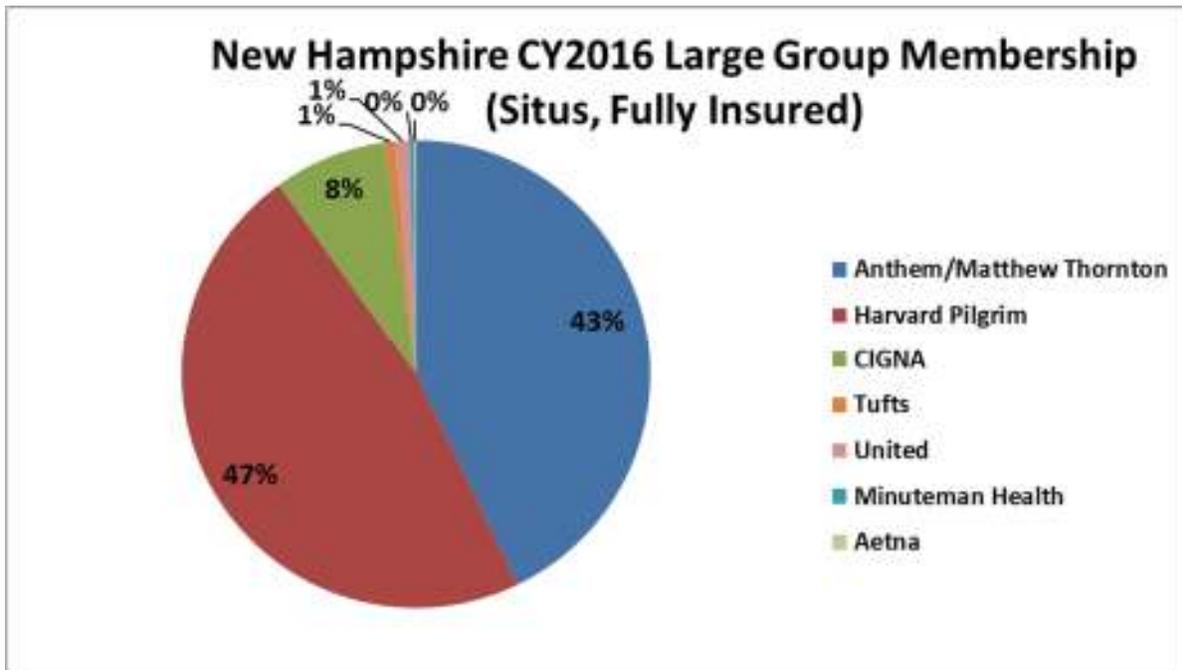


Figure 4: Distribution by Insurer of Large Group Situs and Fully-Insured CY 2016¹⁶

¹⁶ 2017 SDR data. Excludes individuals covered under FEHBP.

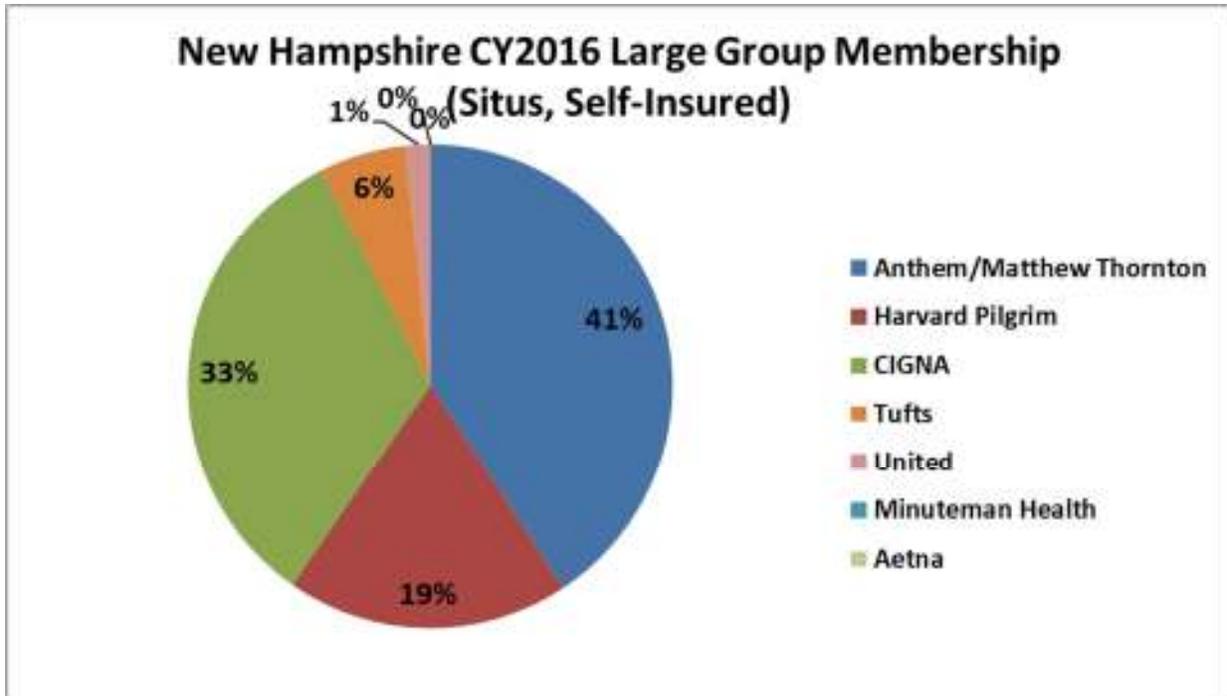


Figure 5: Distribution by Insurer of Large Group Situs and Self-Insured CY 2016¹⁷

Health Insurance Carrier/TPA	Fully Insured Members	Self-Insured Members	Average Members	Percentage of Total
Anthem/Matthew Thornton	43,200	106,700	149,900	41%
Harvard Pilgrim	47,500	49,500	97,000	27%
CIGNA	7,900	86,400	94,300	26%
Tufts	700	15,100	15,800	4%
United	1,000	4,300	5,300	1%
Minuteman Health	300	0	300	0%
Aetna	100	0	100	0%
Total	100,800	262,000	362,800	100%

Table 3: Average Large Group Membership by Insurer of Situs and Fully-Insured and Self-Insured CY 2016¹⁸

In the Small Group Market¹⁹, Harvard Pilgrim and Anthem are the dominant insurers, with 89% of membership, as shown in Figure 6.

¹⁷ 2017 SDR data. Excludes individuals covered under FEHBP.

¹⁸ 2017 SDR data. Average membership is calculated using member months for CY 2016 divided by twelve, and may not match membership estimates in other sections of this report.

¹⁹ Under New Hampshire law, the small group market is defined to include groups with between 1 and 50 eligible employees.

- The Small Group Market has not experienced as much fluctuation as the Individual Market, but there is still some impact with new insurers entering the market including Tufts Health Freedom Plan entering in 2016.

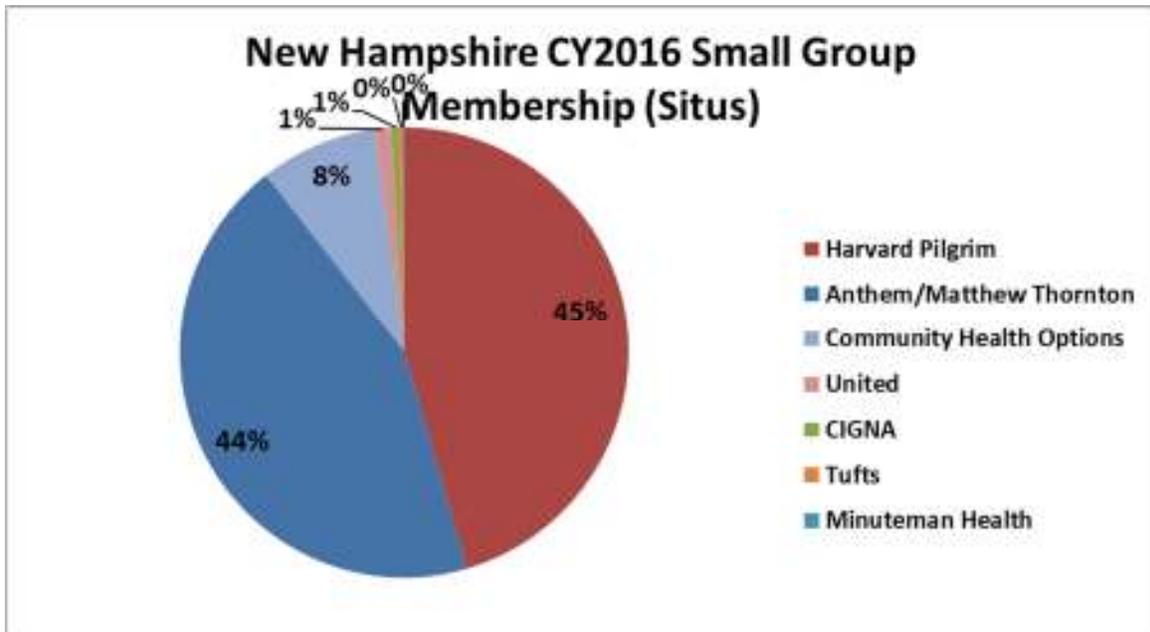


Figure 6: Distribution by Insurer of New Hampshire Small Group Market CY 2016²⁰

Health Insurance Carrier/TPA	Average Members	Percentage of Total
Harvard Pilgrim	33,100	45%
Anthem/Matthew Thornton	32,300	44%
Community Health Options	6,200	8%
United	800	1%
CIGNA	200	1%
Tufts	200	0%
Minuteman Health	100	0%
Total	72,900	100%

Table 4: Average Small Group Membership by Insurer of Situs and Fully-Insured and Self-Insured CY 2016²¹

²⁰ 2017 SDR data. Includes Situs, Fully-Insured and Self-insured members, however Self-insured members comprise only 1.5% of membership.

²¹ 2017 SDR data. Average membership is calculated using member months for CY 2016 divided by twelve and may not match membership estimates in other sections of this report.

There were five insurers participating in the Individual Market in CY 2016, as shown in Figure 7. Community Health Options exited the market on 12/31/16. Minuteman will exit the market on 12/31/17. That leaves three insurers (Anthem, HPHC and Ambetter) participating in the Individual Market in CY 2018.

- New Hampshire converted its Medicaid Expansion program to the Premium Assistance Program (NH PAP.) Figure 7 includes NH PAP members. Ambetter is almost entirely NH PAP members. Anthem/Matthew Thornton is 19% NH PAP, Harvard Pilgrim is 42% NH PAP, Minuteman is 15% NH PAP and Community Health Options is 36% PAP.

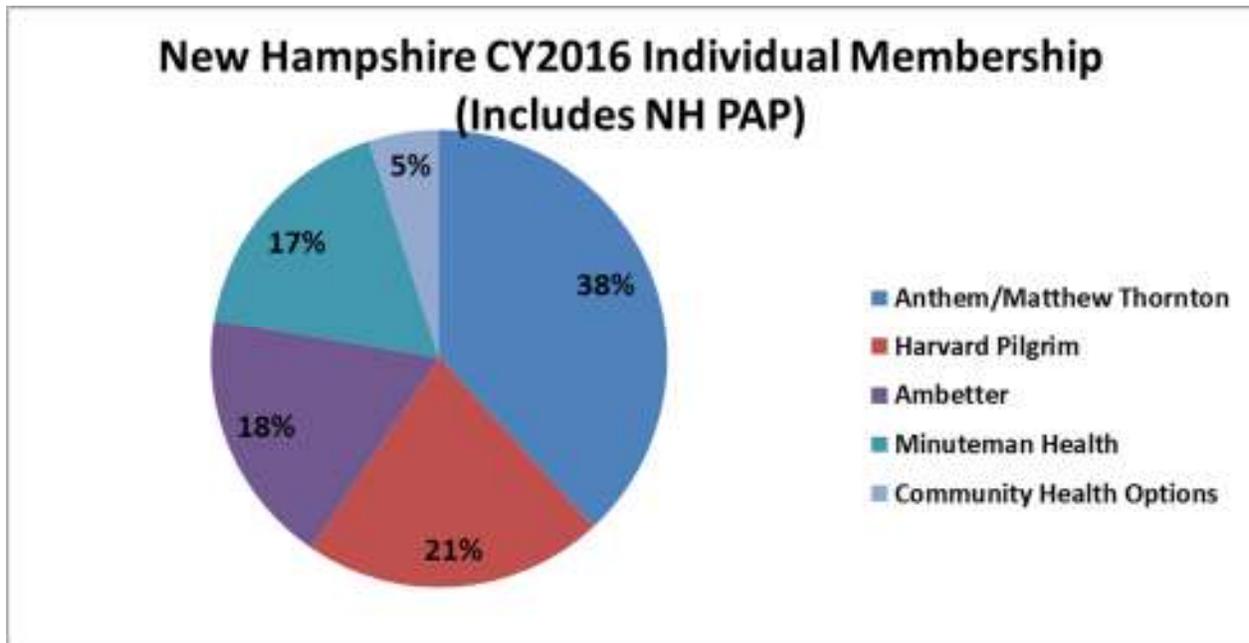


Figure 7: Distribution by Insurer of New Hampshire Individual Market CY 2016²²

Health Insurance Carrier/TPA	Average Members	Percentage of Total
Anthem/Matthew Thornton	39,000	38%
Harvard Pilgrim	21,800	21%
Ambetter	18,600	18%
Minuteman Health	17,800	17%
Community Health Options	5,100	5%
Total	102,300	100%

Table 5: Average Individual Market Membership by Insurer CY 2016²³

²² 2017 SDR data. Includes individuals covered under the Premium Assistance Program (NH PAP).

²³ 2017 SDR data. Includes individuals covered under the Premium Assistance Program (NH PAP). Average membership is calculated using member months for CY 2016 divided by twelve, and may not match membership estimates in other sections of this report.

The number of insurers in the Individual Market on the Exchange has fluctuated from year to year.

- Figure 8 shows the insurers entering and exiting the Individual Market and Individual Market Exchange, over the past several years.
- In 2014, Matthew Thornton Health plan was the only insurer on the Exchange (represented by the dark blue box.) This compares to 2015 and 2016 where there were five insurers on the Exchange.
- This fluctuation in the Individual Market continues into 2017 and 2018 with more changes and exiting of two insurers, Community Health Options and Minuteman.

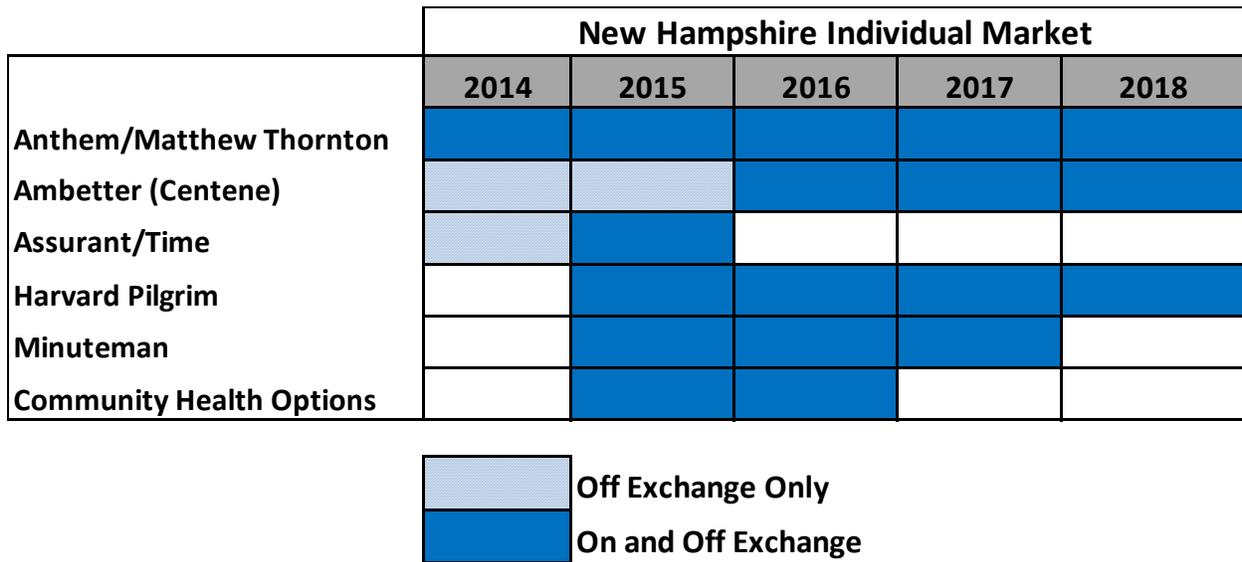


Figure 8: Insurers Participating in Individual Market 2014 to 2018

The overall fully-insured market in New Hampshire grew from approximately 231,000 members in 2015 to 279,000 members in 2017.²⁴

- This increase is primarily driven by the inclusion of the NH PAP program into the Individual Market.²⁵

²⁴ Estimates based on 2016 and 2017 AH data. Excludes individuals covered under FEHBP; New Hampshire Situs Only. Slight adjustment made for small group and large group to account for insurers not captured in the Annual Hearing Carrier Questionnaire. In addition, 2017 enrollment was estimated using the QHP Monthly Enrollment Reports, CMS’s 2017 Effectuated Enrollment Snapshot Report, and information received from the NH insurance carriers as of April 2017 through the 2017 AH data.

²⁵ NH PAP members are part of the Commercial Individual Market Exchange effective January 1, 2016, meaning they will be rated under the single risk pool requirements of the Individual Market under the Affordable Care Act (ACA). Premiums for the NH PAP will be funded through Medicaid. Individuals eligible for the NH PAP generally include all adults aged 19-64 with incomes up to 138% of the Federal Poverty Level (FPL) who do not fall into other Medicaid eligibility categories and who do not qualify for Medicare.

While the market share of both the Small Group and Large Group Markets within the fully-insured segment has decreased over time, there has been a slight increase in the absolute number of members between December 2015 and 2017.

- The Small Group Market share has decreased from 32% as of December 2015, to 25% in 2017. This equates to 74,000 members as of December 2015 and 69,000 members in 2017. Market share in the Small Group Market has shifted from Anthem (including Matthew Thornton Health Plan) to Harvard Pilgrim Health Care.
- The fully-insured Large Group Market has also decreased in market share slightly from 43% as of December 2015, to 39% as of December 2016, to 38% as of 2017. However, there was an increase in actual membership with 99,000 members as of December 2015 and 106,000 members as of 2017.
- Tufts Health Freedom Plan was a new market entrant in 2016 to both the Small Group and Large Group Markets.

The Individual Market grew from 58,000 members in December 2015 to 104,000 members in 2017 due to growth from the NH PAP and the Individual Exchange Market.

- The Individual Market has grown in its share of the fully-insured market from 25% as of December 2015, to 37% in 2017. This equates to 58,000 members as of December 2015 and 104,000 members in 2017. This growth is driven by increases of approximately 4,000 members in the Individual Exchange Market and 43,000 members in the NH PAP from 2015 to 2017. Meanwhile, the Individual Non-Exchange population decreased by 1,000 members during the same time period.
- Harvard Pilgrim, Minuteman Health and Ambetter have all gained market share in the Individual Market during this time, while Anthem (including Matthew Thornton Health Plan) has lost some market share.²⁶
- Community Health Options lost market share from 2015 to 2016 and has exited the market as of 12/31/2016.
- In 2017, 3% of members in the Individual Market are grandfathered²⁷ and 4% are in ACA transitional products.^{28, 29} Forty-four (44%) of the Individual Non-Exchange population are either grandfathered or in ACA transitional products.

²⁶ Matthew Thornton Health Plan entered the New Hampshire Exchange in 2014. Harvard Pilgrim, Minuteman Health and Community Health Options entered in 2015 along with Assurant/Time. Ambetter (Centene) entered the New Hampshire Exchange in 2016.

²⁷ Grandfathered plans are plans that were purchased before March 23, 2010 and not considered part of the single rating risk pool.

²⁸ New Hampshire Insurance Department. INS 14-009-AB: Extended Transition to ACA-Compliant Policies. March 2014. Available at: http://www.nh.gov/insurance/media/bulletins/documents/ins_14_009_ab.pdf.

²⁹ 2017 AH data. Includes Community Health Options, Minuteman Health and Ambetter (Centene).

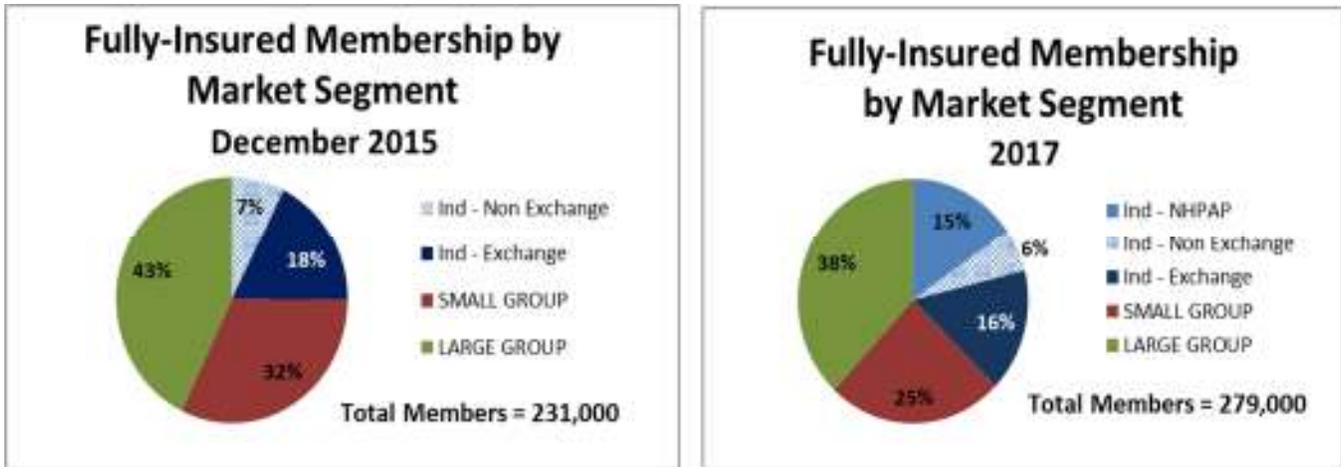


Figure 9: Fully-Insured Commercial Membership by Market Segment³⁰

Figure 10 shows a breakdown of the Individual Market into various sub-populations in 2017. Each of these sub-populations may have different plan offerings, different distribution channels and different risk characteristics.

- The left side of Figure 10 shows the 16,000 individuals who are not on the Exchange; a population that represents about 15% of the total Individual Market. Within this Non-Exchange population, approximately 44% of the membership is in grandfathered or transitional products and not part of the Individual Market Single Risk Pool.³¹ These members are outlined in red to signify that they are excluded from the single risk pool. The grandfathered and transitional population has decreased from the prior year by approximately 2,000 members.
- The remaining 56% of the Non-exchange population is non-grandfathered and are included as part of the single risk pool. These members do not receive any kind of premium or cost sharing subsidy.
- The right side of Figure 10 shows the approximately 88,000 individuals who are members of the Exchange and who represent approximately 85% of the total Individual Market. Forty three thousand (43,000) of these Exchange members are part of the NH PAP. Premiums for NH PAP are fully subsidized and therefore the member pays no premium.
- The remaining 45,000 members on the Exchange do not belong to the NH PAP, although many are receiving assistance in the form of cost sharing reduction (CSR) subsidies³² and federal premium subsidies or Advance Premium Tax Credits (APTC's).³³ APTC's.

³⁰ 2015, 2016 and 2017 AH data. Excludes individuals covered under FEHBP.

³¹ Single risk pool is a provision of the ACA that requires issuers to include the claims experience of all enrollees in all health plans (other than grandfathered and transitional) to be considered when developing rates and premiums.

³² Cost sharing reduction (CSR) subsidies lower out-of-pocket costs, based on income, for Silver plans bought on the Exchange for low income individuals between 100% and 250% of the Federal Poverty Level. CSR plans lower the amount members have to pay out-of-pocket for deductibles, coinsurance, and copayments. In 2016, each of the Silver plans offered on the Exchange have three CSR variants, corresponding to the three levels of CSR subsidies: CSR 73, CSR 87, and CSR 94. The numbers refer to the actuarial value (AV). Members are eligible for CSR plans based on their income: 100-150% FPL = 94% Actuarial Value (CSR 94); 150-200% FPL = 87% Actuarial Value (CSR 87); 200-250% FPL = 73% Actuarial Value (CSR 73).

³³ Advance Premium Tax Credits (APTC) are a federal premium subsidy that can be applied to bronze, silver, gold or platinum plans on the Exchange. APTC's are generally available for members with incomes between 100% and 400% FPL and not already eligible for Medicaid or Medicare.

- In Figure 10, segments of the Individual Market population who are receiving some kind of subsidy are outlined in green while segments who are not receiving some kind of subsidy are outlined in blue.
- 16,000 non-NH PAP members are receiving both cost sharing reduction and federal premium subsidies, 13,000 are receiving federal premium subsidies but not cost sharing reduction subsidies, and the remaining 16,000 Exchange members receive no subsidies.
- These various sub-populations are explored further in subsequent sections of the report.

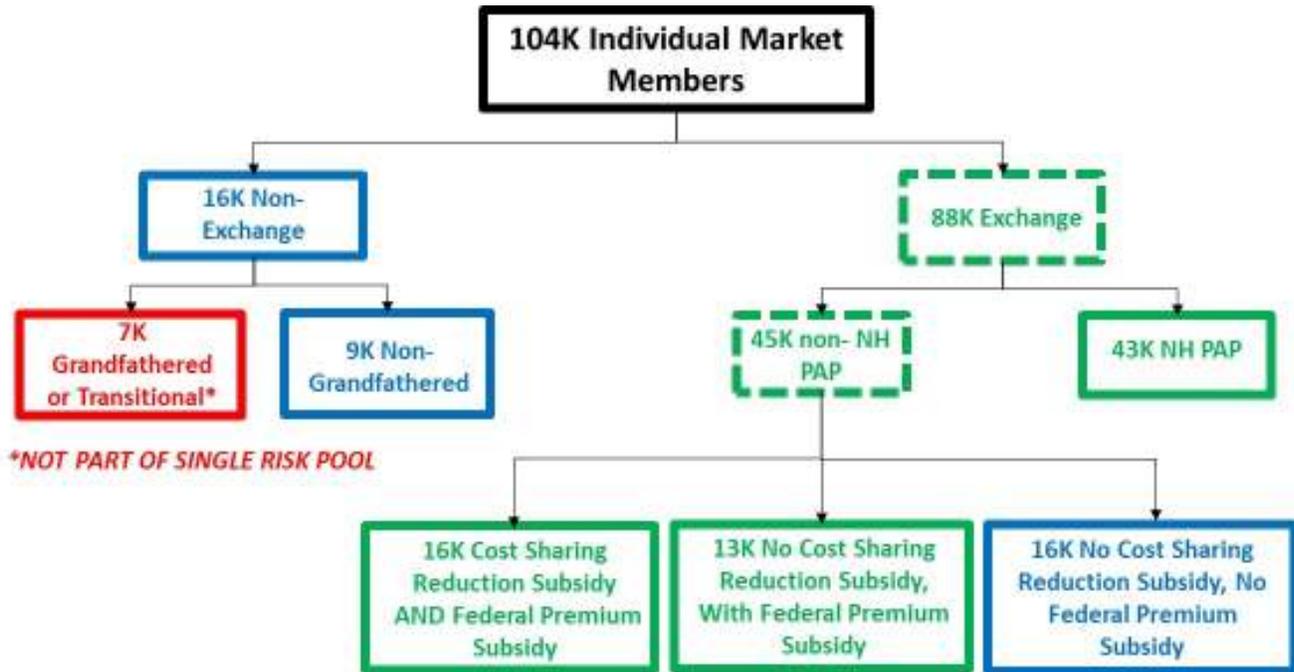


Figure 10: Individual Market Membership in 2017³⁴

Within the Individual Market Single Risk Pool, 74% of members receive some form of subsidies towards health insurance premiums in 2017.

- The Individual Market Single Risk Pool excludes the approximately 7,000 grandfathered and transitional members in 2017.
- As shown in Figure 11, 26% or 25,000 enrollees pay the full health insurance premium in New Hampshire’s Individual Market in 2017. This equates to the nine thousand Non-Exchange and non-grandfathered and transitional members plus the sixteen thousand Exchange members with no CSR or federal premium subsidy from Figure 10.
- The NH PAP population, estimated at 43,000, do not pay any premiums and this represents 44% of the Individual Market Single Risk Pool.

³⁴ Enrollment was estimated using the QHP Monthly Enrollment Reports, CMS’s 2017 Effectuated Enrollment Snapshot Report, and information received from the 2017 AH data.

- Approximately 29,000 enrollees receive federal premium subsidies or Advanced Premium Tax Credits (APTC) of which 55% (16,000) receive Cost Sharing Reduction (CSR) subsidies.³⁵

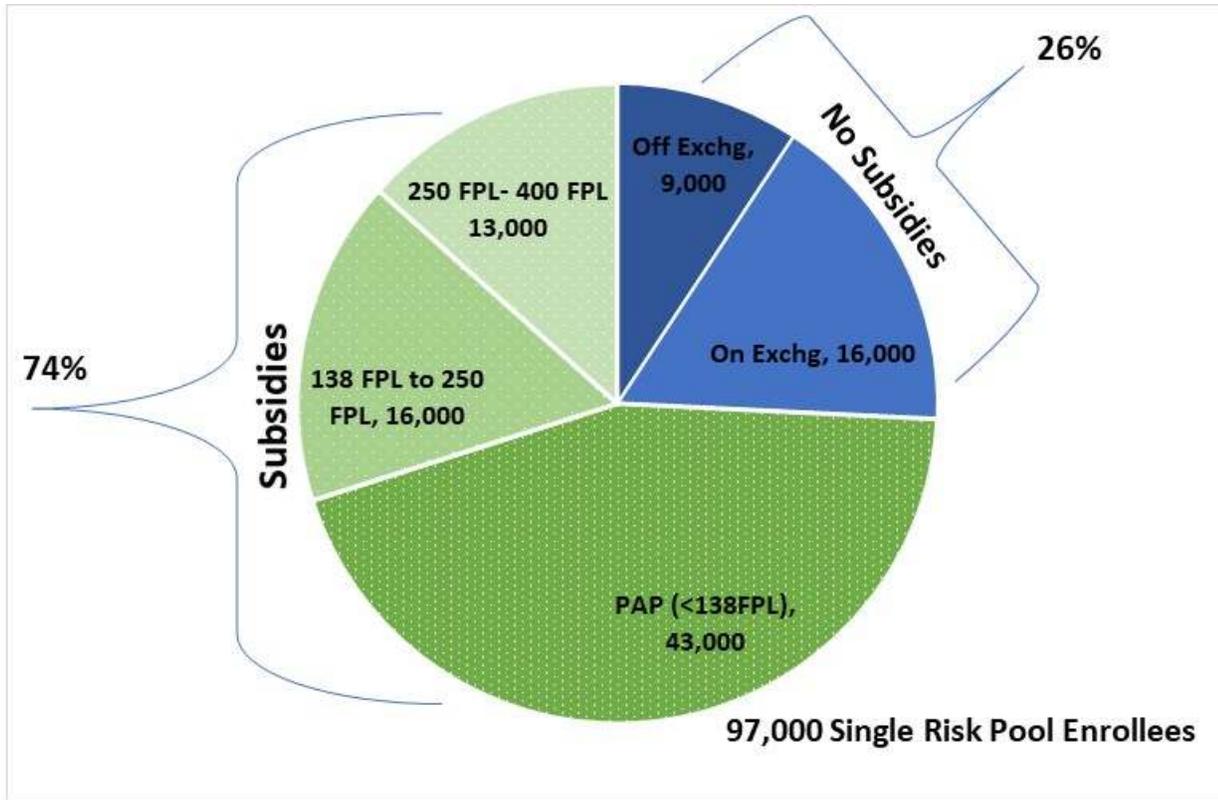


Figure 11: 2017 Individual Market Single Risk Pool Membership³⁶

There are an estimated 48,000 New Hampshire members in the Federal Employees Health Benefits Program (FEHBP).³⁷ The FEHBP population has coverage administered by a variety of insurers offering multiple plan options.

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

³⁵ Enrollees earning between 138% FPL and 250% FPL are eligible for CSR subsidies in addition to APTC.

³⁶ Enrollment was estimated using the QHP Monthly Enrollment Reports, CMS's 2017 Effectuated Enrollment Snapshot Report, and information received from the 2017 AH data.

³⁷ This is Anthem's estimate of New Hampshire membership in all insurer plans combined for CY 2014, the last date for which an estimate is available.

2. Premium Levels and Trends³⁸

Premiums in the Large Group Market have increased 4.4% in 2016 which contrasts with a flat change in 2015. Meanwhile, premiums in the Small Group Market the premiums were slightly lower on average in 2016 compared to 2015.

- The combined Small Group and Large Group unadjusted³⁹ premium trend was 2.2% in 2016 compared to 1.4% in 2015. These 2016 trends in New Hampshire are slightly lower than national information from the Kaiser Family Foundation's Employer Health Benefits Survey, which shows national trends of 2.9% and 3.4% for single and family coverage, respectively, in 2016.⁴⁰ The Kaiser report estimates a 3% national premium trend in 2017.⁴¹
- As shown in Figure 13, the average age of members in the Small Group and Large Group Markets has increased slightly over the past couple years.

In the Individual Market, 2016 premium levels increased 6.2% from 2015 levels as compared to relatively no change in 2015.

- In 2015, the Individual Market experienced relatively no change in the average premium PMPM compared to 2014 due to the combination of several offsetting factors:
 - The Individual Exchange Market had three new entrants in 2015: Harvard Pilgrim, Minuteman, and Community Health Options. Each insurer offered different networks and different products at varying rate levels.
 - Rate changes for the existing Exchange products were very modest.
 - While the premiums for the Non-Exchange Market are increasing at a higher rate due to a large presence of grandfathered and ACA transitional members, the size of this market is shrinking compared to the Exchange Market.
- In 2016, each of the segments within the Individual Market experienced premium increases. This is explored further below.
- As shown in Figure 13, the average age in the Individual Market decreased by approximately two years in December 2016 compared to December 2015 driven by the introduction of the NH PAP in January 2016.

³⁸ The average premiums presented throughout this section represents actual earned premium. This premium reflects the mix of demographics, plan designs, and a mix of applicable time periods for the reporting year. The average premium levels and trends presented in this section are different than rates and rate increases published by CMS, insurance departments and media outlets as that information typically reflects a static population and static plan design for a fixed time period.

³⁹ Unadjusted means that premiums trends have not been adjusted to reflect the impact of changing benefits and cost sharing.

⁴⁰ Kaiser Family Foundation. 2016 Employer Health Benefits Survey. September 2016. Exhibit 1.11: 2016 single and family premiums of \$6,435 and \$18,142, respectively. 2015 single and family premiums of \$6,251 and \$17,545, respectively. Available at: <http://kff.org/report-section/ehbs-2016-section-one-cost-of-health-insurance>.

⁴¹ Kaiser Family Foundation. Average annual workplace family health premiums rise 3% to \$18,764 in 2017; September 2017. Available at: <https://www.kff.org/health-costs/report/2017-employer-health-benefits-survey/>.

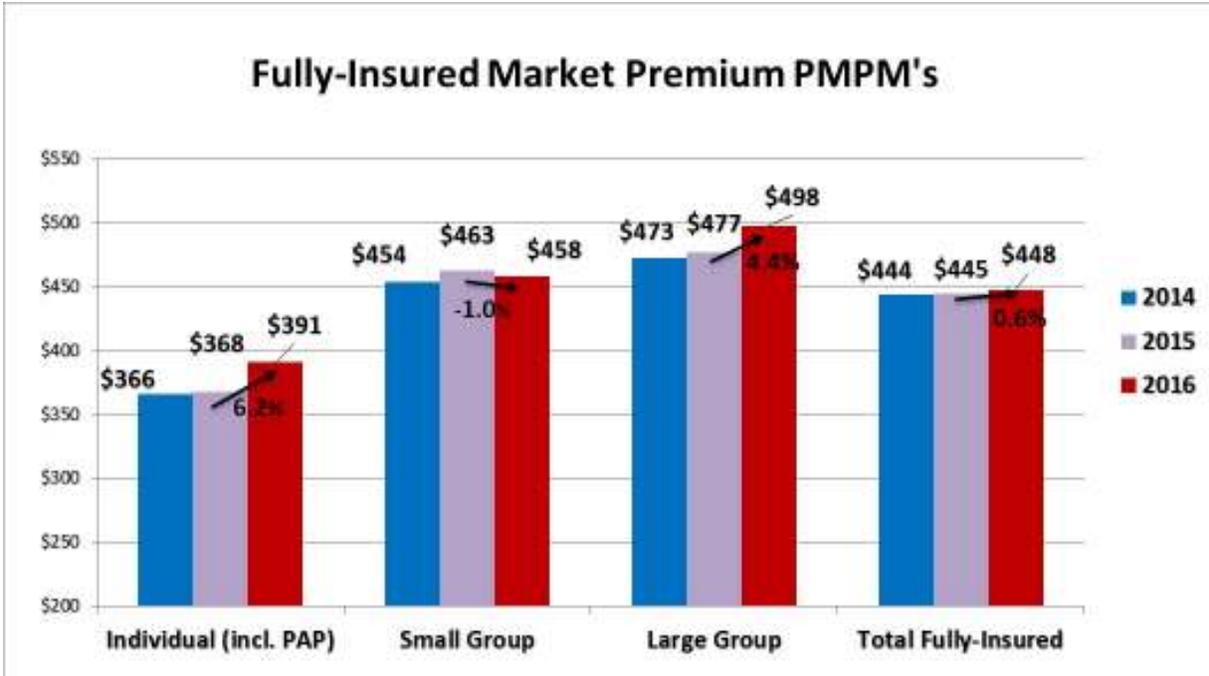


Figure 12: Fully-Insured Commercial Unadjusted Earned Premium by Market Segment⁴²

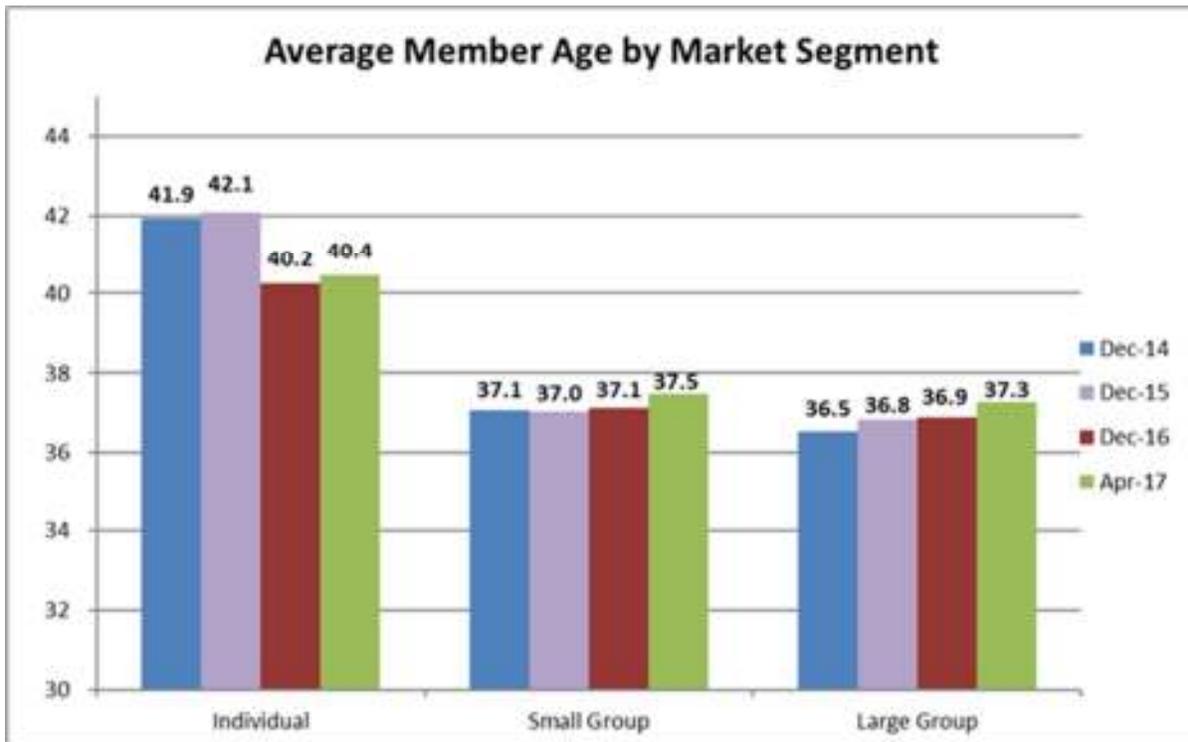


Figure 13: Average Age by Market Segment⁴³

⁴² 2015, 2016 and 2017 SDR data. Excludes individuals covered under FEHBP.

⁴³ 2015, 2016 and 2017 AH data. Excludes individuals covered under FEHBP.

In the Individual Market, 2016 Non-Exchange market premiums are 4% higher than Exchange market premiums.⁴⁴

- The Exchange population is older than the Non-Exchange population which might suggest higher premiums, but more Exchange members are enrolled in lower-costing limited network products driving the lower premiums.
- The premiums in the Exchange market increased 2.7%, while premiums in the Non-Exchange Market increased approximately 8.8% from 2015 to 2016. In 2015, the average premiums were fairly consistent between the two populations.
- 63% of Non-Exchange members are in limited network products compared to 88% of Exchange members (excluding NH PAP) in limited network products as of December 2015. Non-Exchange members in limited network products remained steady at 64% as of December 2016, while Exchange members (excluding NH PAP) in limited network products increased to 93%. By April 2017 Non-Exchange members in limited network products increased to 72% and the Exchange members (excluding NH PAP) in limited network products climbed up to 96%.⁴⁵
- The average age of NH PAP members is 37.7 which is lower than the other segments within the Individual Market.
- Thirty- six percent (36%) of NH PAP members are in limited network products as of December 2016. By April 2017 NH PAP members in limited network products increased to 40%.⁴⁶
- While more members are purchasing health care through the Exchange, the average age of the Exchange population (excluding NH PAP) has remained fairly consistent from 2014 through 2017.
- The average age of the Exchange population (excluding NH PAP) is 3.8 years older than the Non-Exchange population as of April 2017, consistent with prior years.
- In 2016, the average premium in the NH PAP is consistent with the average premium in the grandfathered/transitional market at \$403 PMPM. This is slightly higher than the average premiums in the Non-Exchange Market and 7% higher than the average premiums in the Exchange Market.

⁴⁴ Premiums are presented prior to the impact of premium subsidies for qualifying low income individuals.

⁴⁵ 2017 AH data. Excludes grandfathered and transitional Individual Market members and NH PAP members.

⁴⁶ 2016 and 2017 AH data.

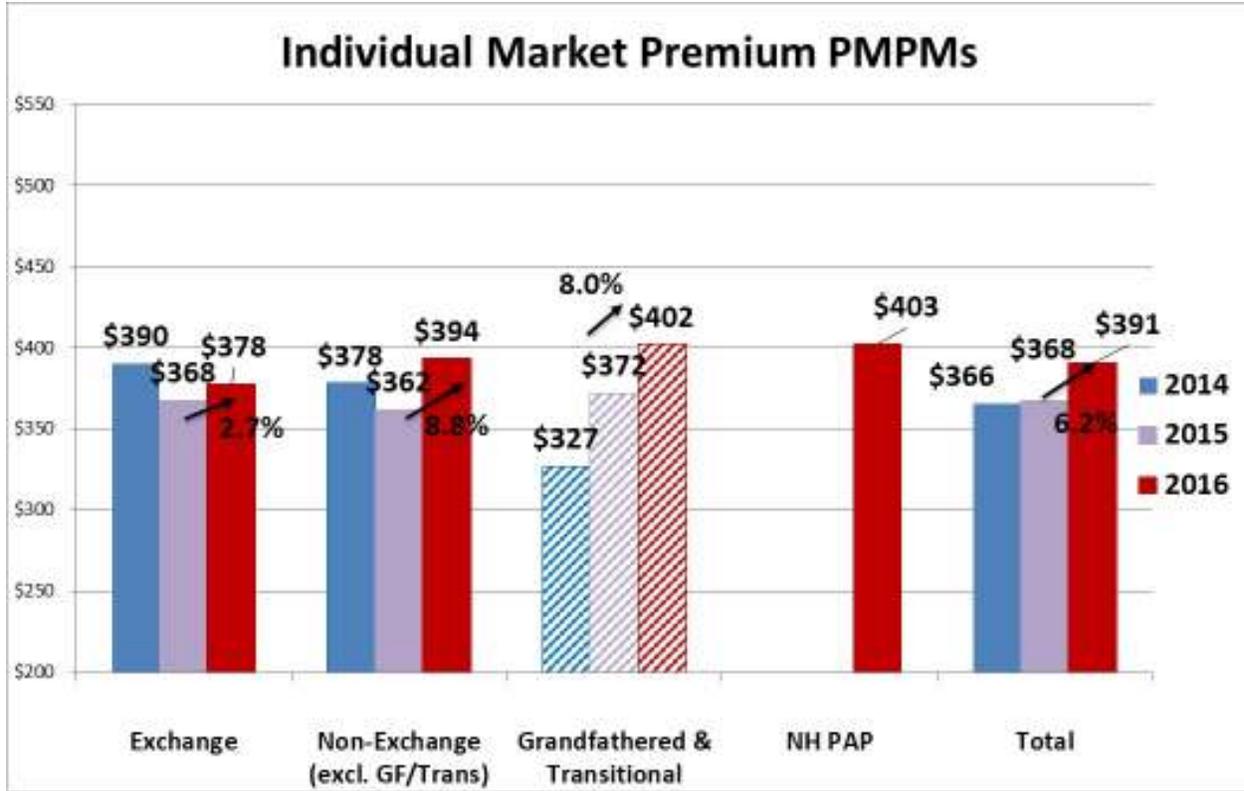


Figure 14: Premiums in the Individual Market CY 2014, CY 2015 and CY 2016 Prior to Subsidies⁴⁷

⁴⁷ 2016 and 2017 SDR data.

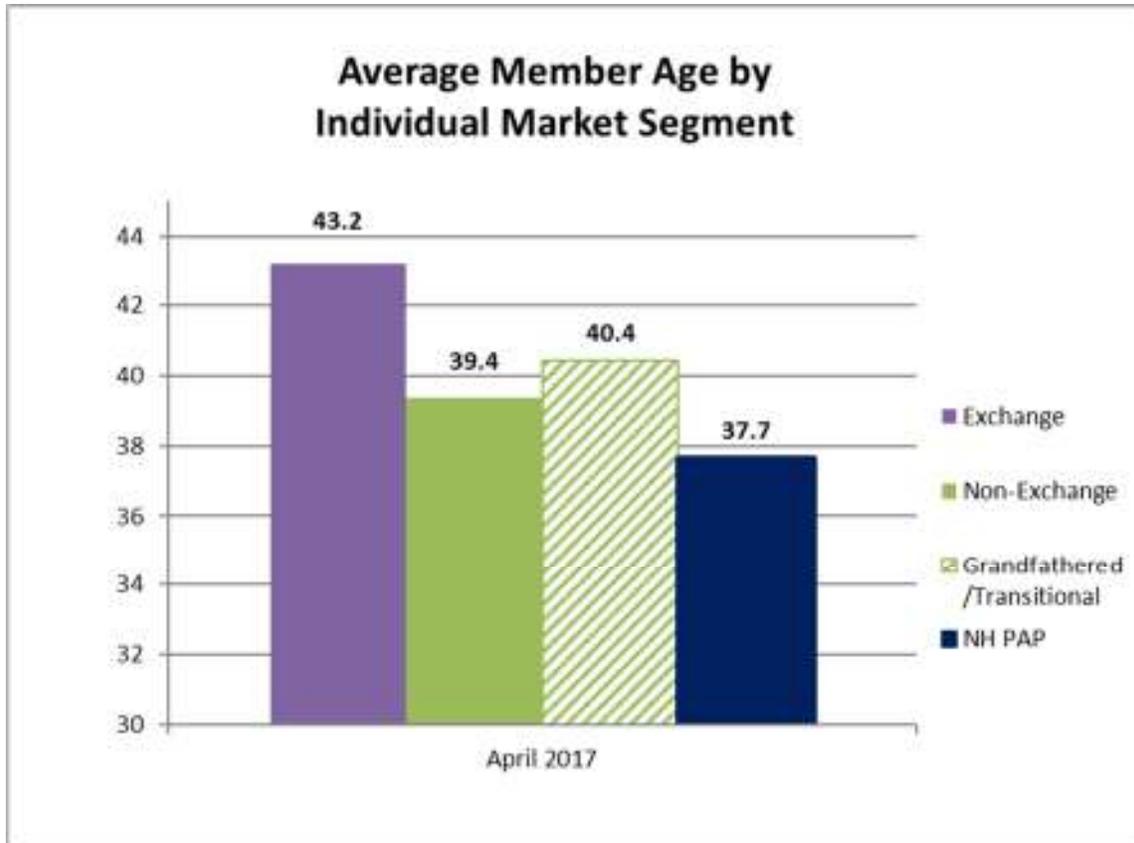


Figure 15: Average Ages of Individual Market Populations⁴⁸

When comparing the Non-PAP Exchange and Non-Exchange population to the PAP population, the PAP population is younger.

- The Non-PAP population in Figure 16 excludes grandfathered and transitional members as they are not part of the Individual Market Single Risk Pool.
- As shown in Figure 16, there are no children enrolled in the NH PAP. However, 59% of the PAP population is under the age of 40 contrasted with 39% of the Non-PAP population. 46% of the Non-PAP population is over the age of 50 compared to only 24% of the PAP population.
- The age differences in these two populations might suggest that observed medical costs for the PAP population should be lower than the Non-PAP population, not higher.

⁴⁸ 2014, 2015 and 2017 AH data. Excludes individuals covered under FEHBP.

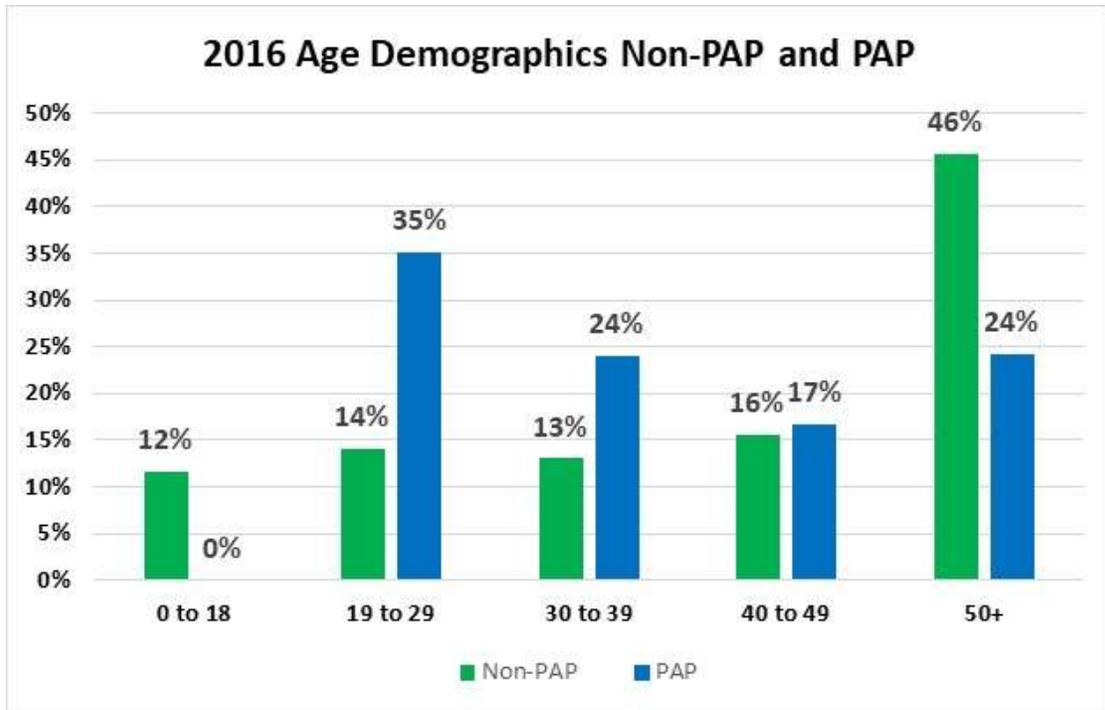


Figure 16: Age Demographics of Non-PAP and NH PAP CY 2016⁴⁹

Premium subsidies are available on a sliding scale to qualifying individuals and families on the Exchange with incomes less than 400% of the Federal Poverty Level. NH PAP members are in Platinum-equivalent plans and the premiums are fully subsidized. Figure 17 shows an illustrative example of what a single policyholder in New Hampshire would pay in 2018 at various income levels.

- The APTC population, which is highlighted in green, will pay between \$729 a year and \$4,612 a year in premium depending on their income. The non-subsidized individual pays \$8,527 a year, which is almost 12 times more than the enrollees earning 150% FPL.
- Note that members earning between 150% FPL and 200% FPL are eligible for CSR subsidies and are eligible to enroll in a Platinum or Gold equivalent plan.
- Based on the information in Figure 11, approximately 72,000, or 74%, of the members in the New Hampshire Individual Market Single Risk Pool receive a federal premium subsidy in the form of APTC or through the NH PAP.

⁴⁹ 2017 AH data. Excludes grandfathered and transitional Individual Market members.

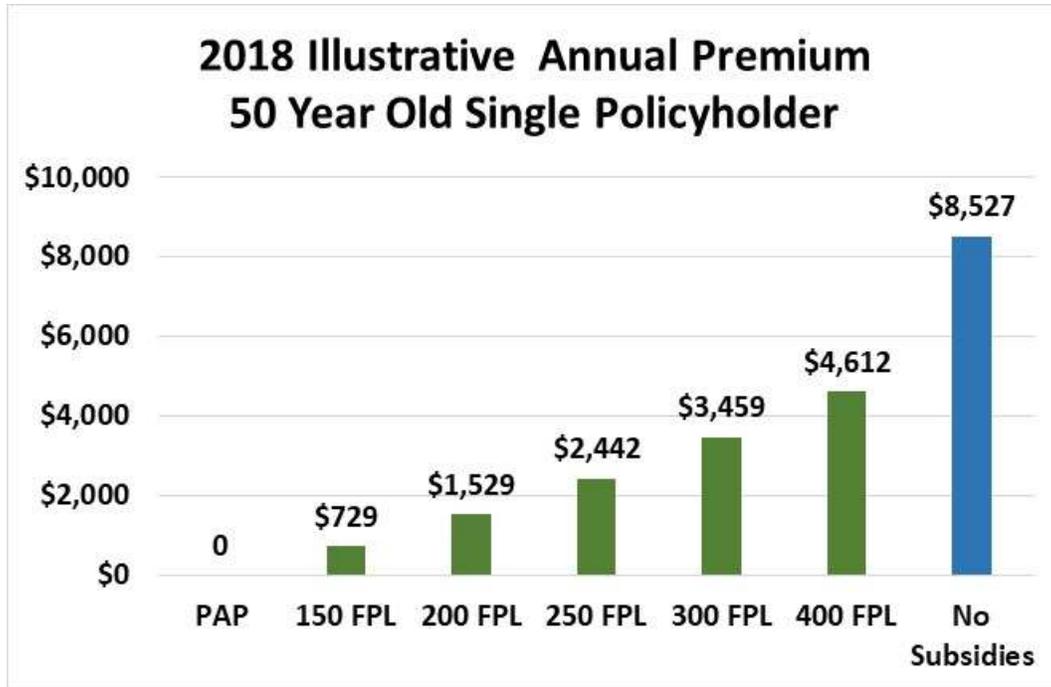


Figure 17: Illustrative Example of 2018 Subsidized Monthly Premium⁵⁰

3. Member Cost Sharing

In the Large Group Market groups are purchasing increasingly higher deductible levels from CY 2014 to CY 2016.

- In the Large Group Market, the percentage of members with a deductible of \$3,000 or greater increased steadily from CY 2014 to CY 2016, from 46% in CY 2014, to 55% in CY 2015 and to 59% in CY 2016.
- The average deductible in the Large Group Market increased \$345 (or 14%) from 2014 to 2015 and an additional \$72 (2.6%) from CY 2015 to CY 2016.
- The Large Group Market has seen an increase in enrollment in High Deductible Health Plans. In CY 2014 35% of members were enrolled and in CY 2016 47% of members were enrolled in High Deductible Health Plans. This percentage is similar to the fully-insured Small Group Market (47%).

⁵⁰ Figure 17 assume the age of the adult enrollee is 50 and that the APTC enrollees are enrolled in the 2nd lowest cost silver plan. It also assumes the enrollees in the non-subsidized market are enrolled in the plan with the median rate among silver plan offerings.

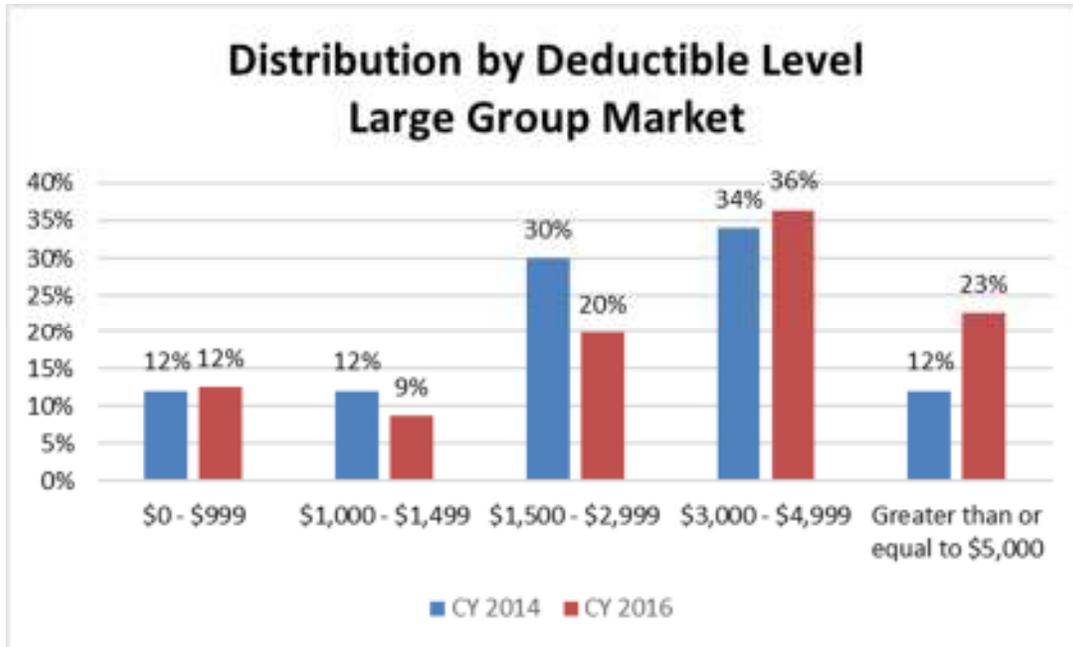


Figure 18: Large Group Market Distribution of Deductibles CY 2014 and CY 2016⁵¹

The average deductible for state and municipal plans are 50% to 70% lower than other self-insured plans and 80% to 90% lower than Large Group fully-insured plans.^{52, 53}

- Data reported show that virtually all state plans have a \$500 deductible, while municipal plans have an average deductible of \$316 in CY 2016. This is considerably lower than the average deductible of \$1,150 found in the remaining self-insured population and the average deductible in the Large Group fully-insured population.
- Two-thirds (67%) of the municipal population have no deductible, as compared to one-fifth (20%) of the other self-insured population, and just 8% of the Large Group fully-insured market.

Market Segment	Average Deductible	Average Coinsurance	Average OOPMAX	Number of Members
State	\$530 \$500 for 99.4% of members	No Coinsurance for 99.7% of members (10% Coinsurance for 0.3%)	\$1,023 \$1,000 for 99.4% of members	28,000
Municipal Self-Insured	\$316	2.6%	\$4,009	96,000
Other Self-Insured Market (excluding State, Muni)	\$1,150	9.4%	\$3,510	139,000

Table 6: Comparison of State and Municipal Cost Sharing to Self-Insured Population CY 2016⁵⁴

⁵¹ 2015 and 2017 SDR data. Single policy, in-network deductibles only. Fully-insured market only. Excludes individuals covered under FEHBP.

⁵² The New Hampshire Purchasers Group on Health is a collaboration of the state’s four largest public health care purchasers: the State of New Hampshire Employee Health Benefit Program (administered by Anthem and Matthew Thornton Health Plan), HealthTrust (administered by Anthem and Matthew Thornton Health Plan), the New Hampshire School Health Care Coalition (administered by CIGNA), and the University System of New Hampshire (administered by Harvard Pilgrim). The State of New Hampshire Employee Health Benefit Program is represented by the “State” designation and the other three entities are part of the “Municipal” population in the 2016 SDR data.

⁵³ The vast majority of state and municipal members identified by insurers are in self-insured plans.

⁵⁴ 2017 SDR data. Situs only.

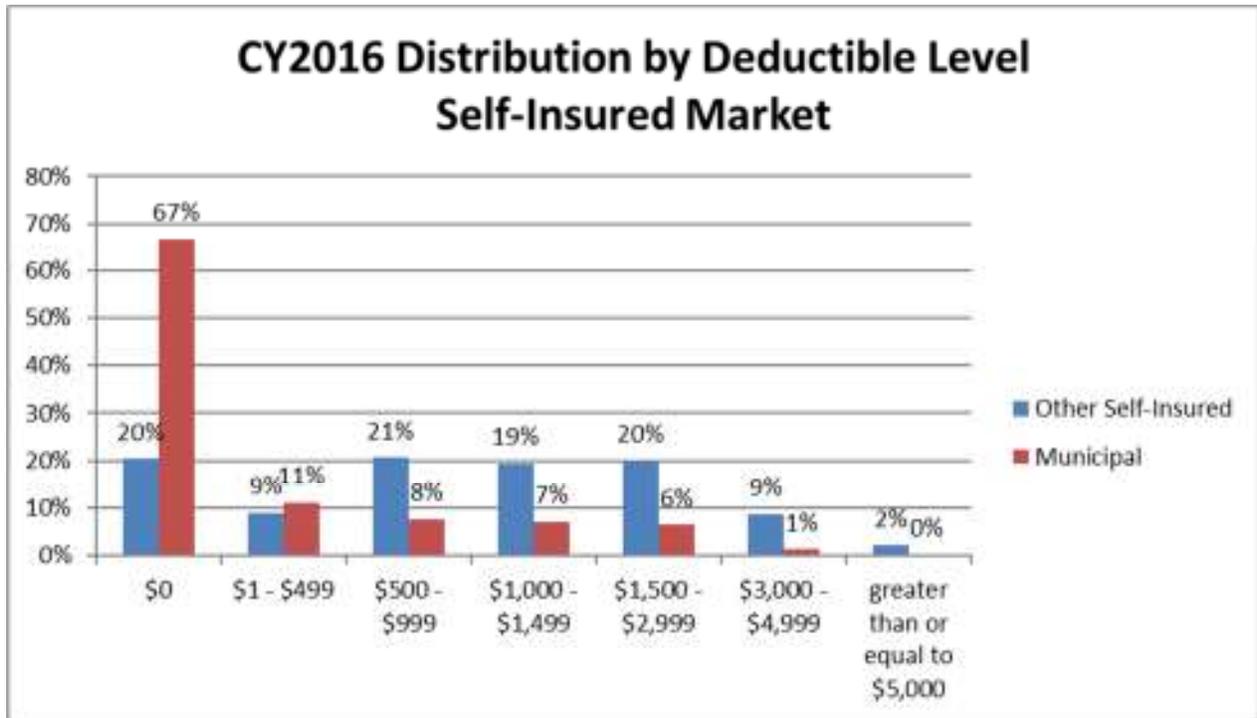


Figure 19: Distribution of Municipal and Other Self-Insured by Deductible Level⁵⁵

In the Small Group Market in CY 2016, the percentage of members in both the lowest deductibles and the highest deductibles increased leading to a slightly lower overall average deductible. ^{56, 57}

- Between CY 2014 and CY 2016, the percentage of members with a deductible less than \$1,000 increased from 0% to 5%. Similarly, between CY 2014 and CY 2016 there was an increase in the percentage of members with deductibles \$5,000 or greater from 16% to 22%.
- The average deductible in the Small Group Market increased \$67 (or 2%) from 2014 to 2015, and decreased \$36 (-1.1%) from 2015 to 2016.
- In CY 2016, approximately 46% of the Small Group market is enrolled in High Deductible Health Plans (HDHPs)⁵⁸, compared to 32% in CY 2015. While the percentage of members in enrolled in HDHP's has increased, the average deductible in the Small Group market decreased due to an increase in the prevalence of plans with a lower deductible.

⁵⁵ibid.

⁵⁶ One carrier saw an increase in membership and has average deductible levels that are much lower than the rest of the Small Group Market. Even though this carrier's average deductible in the Small Group Market has increased from 2015 to 2016, their growth causes the market-wide average deductible to decrease.

⁵⁷ These analyses do not account for the impact of tax advantaged programs such as Health Savings Accounts that are paired with a High Deductible Health Plan, Health Reimbursement Arrangements, Employer Payment Plans, and Health Flexible Spending Arrangements.

⁵⁸ For 2016, a HDHP is defined under § 223(c)(2)(A) as a health plan with an annual deductible that is not less than \$1,300 for self-only coverage and \$2,600 for family coverage, and with annual out-of-pocket expenses that do not exceed \$6,550 for self-only coverage or \$13,100 for family coverage.

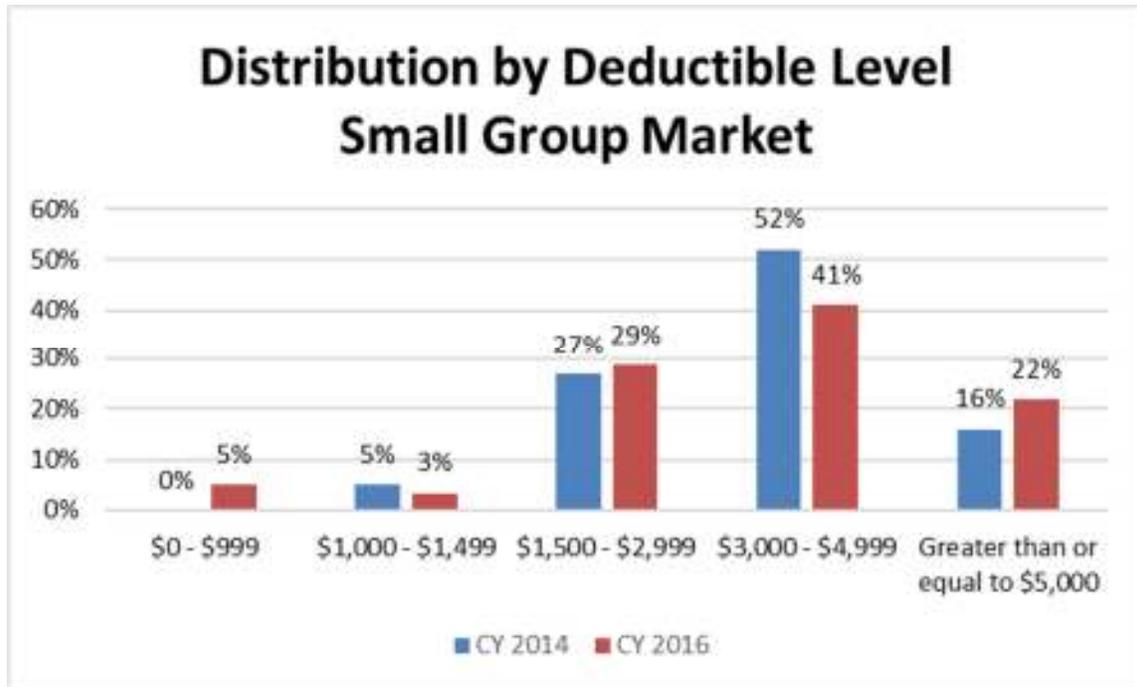


Figure 20: Small Group Market Distribution of Deductibles CY 2014 and CY 2016⁵⁹

	Small Group			Large Group		
	2014	2015	2016	2014	2015	2016
Average Deductible	\$3,082	\$3,149	\$3,113	\$2,460	\$2,814	\$2,886
Average OOP Maximum	\$3,824	\$4,202	\$4,577	\$4,962	\$5,508	\$5,727

Table 7: Cost Sharing Attributes for Small Group and Large Group by Year⁶⁰

Deductible levels in the Individual Market (excluding NH PAP) have increased 11.1%, from an average of \$2,781 in CY 2014 and CY 2015 to \$3,090 in CY 2016, driven by the change in the Exchange Non-CSR population.⁶¹

- As shown in Figure 21, deductibles in the \$3,000 to \$4,999 segment saw the largest increase from 11% to 20%.
- Figure 22 shows the distribution of deductible for segments within the Individual Market: Exchange and Non-CSR; Exchange and CSR; Non-Exchange excluding grandfathered and transitional members; and lastly grandfathered and transitional members.

⁵⁹ 2015 and 2017 SDR data.

⁶⁰ 2015, 2016 and 2017 SDR data. Fully-insured market only. Excludes individuals covered under FEHBP. The out-of-pocket (OOP) maximum averages exclude members in plans with no reported OOP maximum.

⁶¹ All deductibles and other cost sharing reflect the reduced amounts after the impact of the cost sharing reduction subsidies.

- Figure 23 shows the average deductible for each of these segments CY 2014 and CY 2016. The Exchange population with no CSR experienced the largest increase in average deductibles from \$3,279 to \$3,887.
- In CY 2016, the combined Exchange CSR members (94%, 87% and 73%) have the lowest average deductible at \$1,043. Grandfathered and transitional members have the next lowest average deductible at \$3,368. The average deductible for the remaining two segments is similar at \$3,887 for the Exchange Non-CSR population and \$3,831 for the Non-Exchange population excluding grandfathered and transitional members.
- The average deductibles for CSR members are significantly lower than non-CSR members.
- Figure 24 shows the distribution of membership for these four segments in the Individual Market. This distribution excludes NH PAP.⁶²

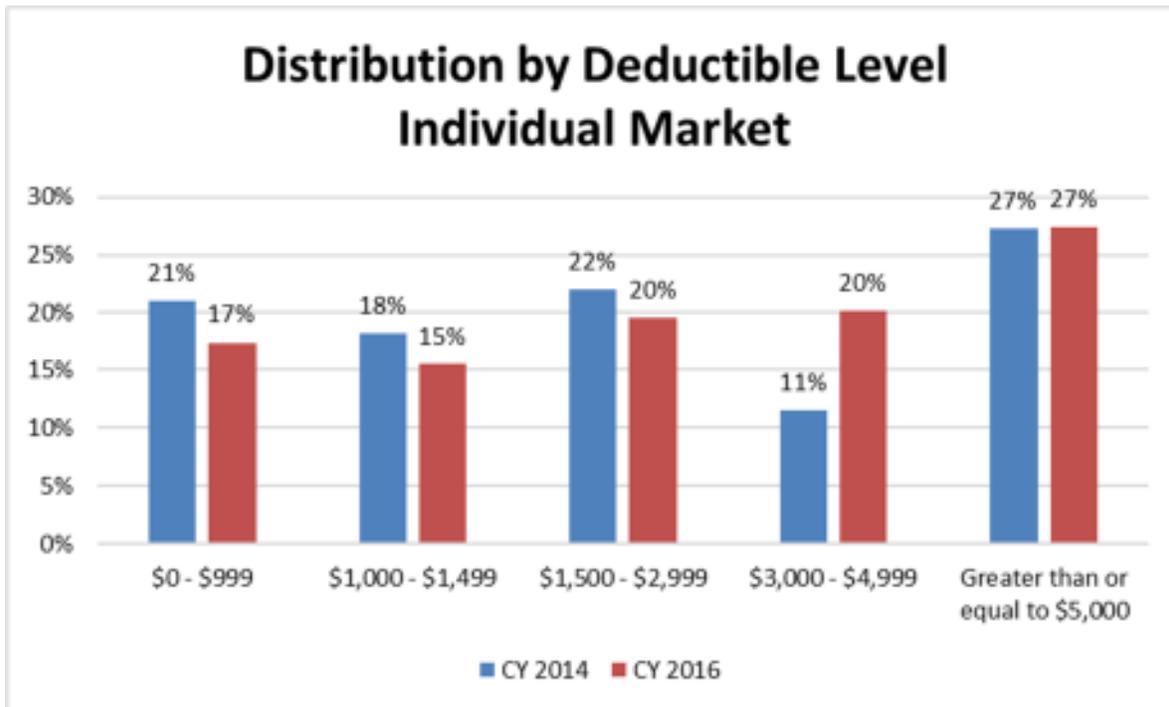


Figure 21: Individual Market Distribution of Deductibles CY 2014 and CY 2016⁶³

⁶² Nearly all of the NH PAP members have no deductible and very low-cost sharing. Because of this they have been excluded when analyzing cost sharing amounts.

⁶³ 2015 and 2017 SDR data.

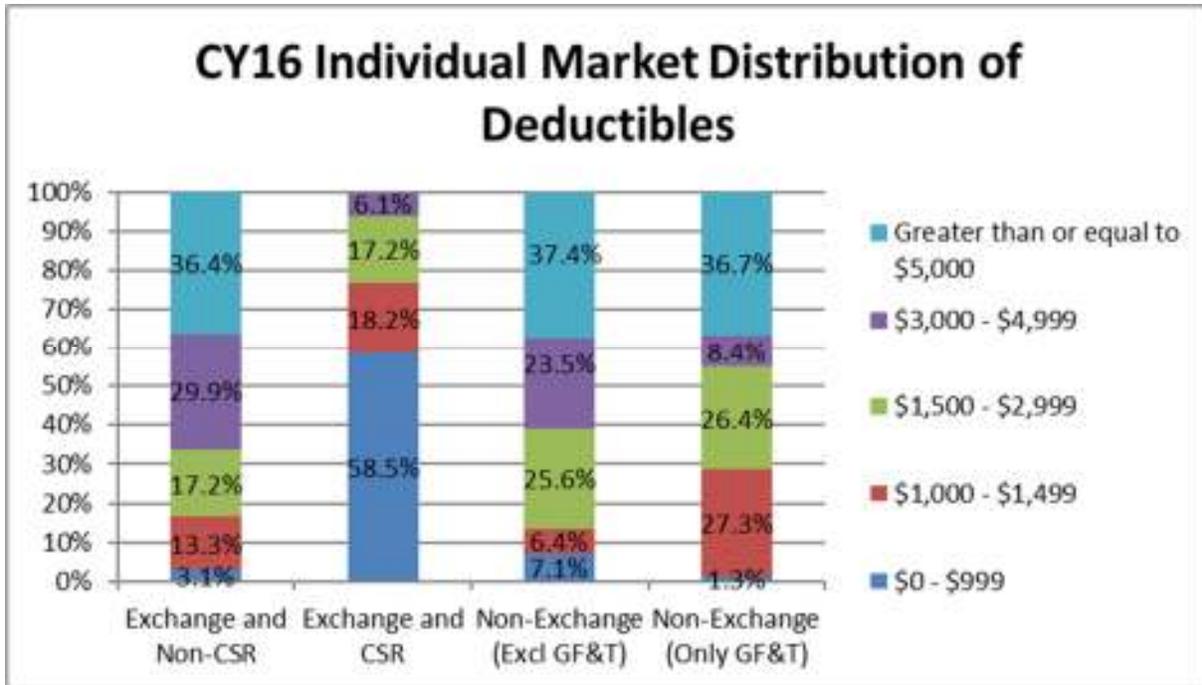


Figure 22: Individual Market CY 2016 Distribution of Deductibles⁶⁴

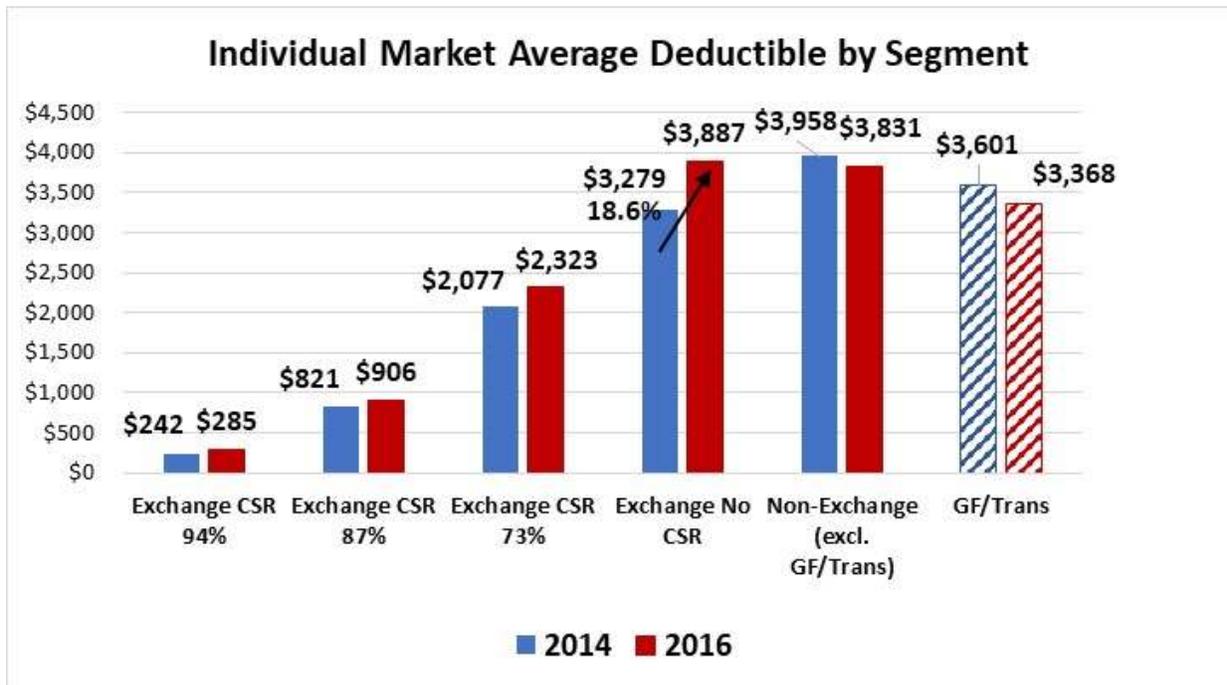


Figure 23: Individual Market CY 2014 and CY 2016 Average Deductible⁶⁵

⁶⁴ 2017 SDR data.

⁶⁵ 2015 and 2017 SDR data.

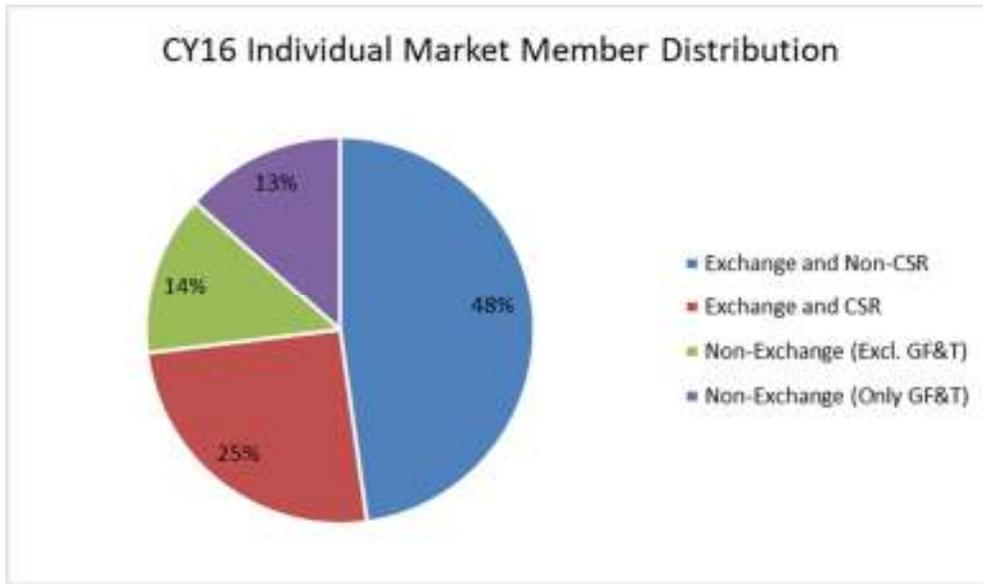


Figure 24: Individual Market CY 2016 Member Distribution⁶⁶

The introduction of cost sharing reduction (CSR) subsidies for qualifying low-income individuals in CY 2014 was the primary driver of decreasing deductible levels in the Individual Market compared to prior years.⁶⁷

- There are three kinds of CSR plans: CSR 94, CSR 87 and CSR 73. Members are eligible for different CSR plans based on their income. For example, an individual with income between 150% and 200% of the Federal Poverty Level (FPL) qualifies for the CSR 87 plan. This means that the individual is paying the premium for a Silver level plan (which has an actuarial value of .70) but the cost sharing for the plan purchased reflects a .87 actuarial value, which is closer to a Platinum level plan – or, in other words, less cost sharing.
- In CY 2016, there were approximately 16,000 CSR members, which comprises 35% of the Exchange population and 25% of the total Individual Market. Fifty-nine percent (59%) of CSR members are in plans with deductibles between \$0 and \$999.⁶⁸
- Of the members with a CSR plan, 31% are in the CSR 94 plan, 46% are in the CSR 87 plan and 23% are in the CSR 73 plan in CY 2016. Figure 25 shows the change in CSR membership distribution from 2014 to 2016, and shows a continued shift from the CSR 94 plan into the CSR 87 plan and to a lesser extent into the CSR 73 plan.
- The overall average deductible for the CSR population increased from \$717 in CY 2014 to \$879 in CY 2015 and to \$1,043 in CY 2016.

⁶⁶ 2017 SDR data. Excludes NH PAP.

⁶⁷ All deductibles and other cost sharing reflect the reduced amounts after the impact of the cost sharing reduction subsidies.

⁶⁸ In the SDR data, the premium reported for CSR members represents a Silver plan premium (actuarial value of 70%) while the cost sharing elements and actuarial values reported reflect those of the member’s corresponding CSR plan (i.e. either 94%, 87% or 73% actuarial value).

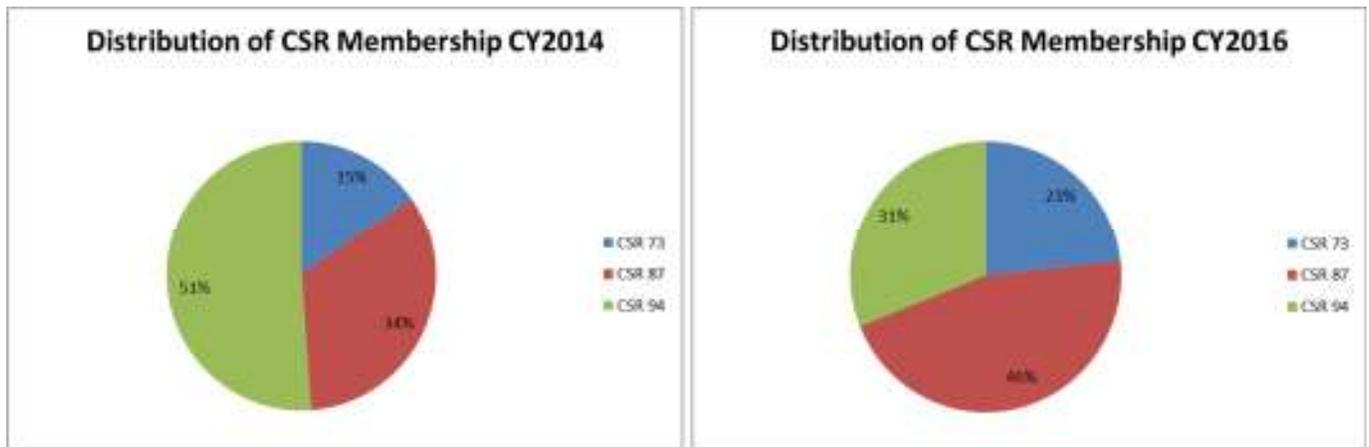


Figure 25: Individual Market Distribution of CSR Membership, CY 2014 and CY 2016⁶⁹

In CY 2016, the average commercial fully-insured member spent \$88 per month or \$1,054 per year in the form of deductibles, copays and coinsurance (collectively referred to as cost sharing.) This excludes NH PAP.

- In CY 2016, the average member cost sharing in the Individual Market was \$88 per month compared to \$83 in CY 2015. Member cost sharing also increased in the Large Group Market from \$81 per month in CY 2015 to \$84 per month in CY 2016. The Small Group Market saw a decrease from \$101 per month in CY 2015 to \$93 per month in CY 2016.
- These member cost sharing amounts represent 21% of total allowed claims in the Individual Market, 20% in the Small Group Market, and 17% in the fully-insured Large Group Market.

⁶⁹ 2015 and 2017 SDR data

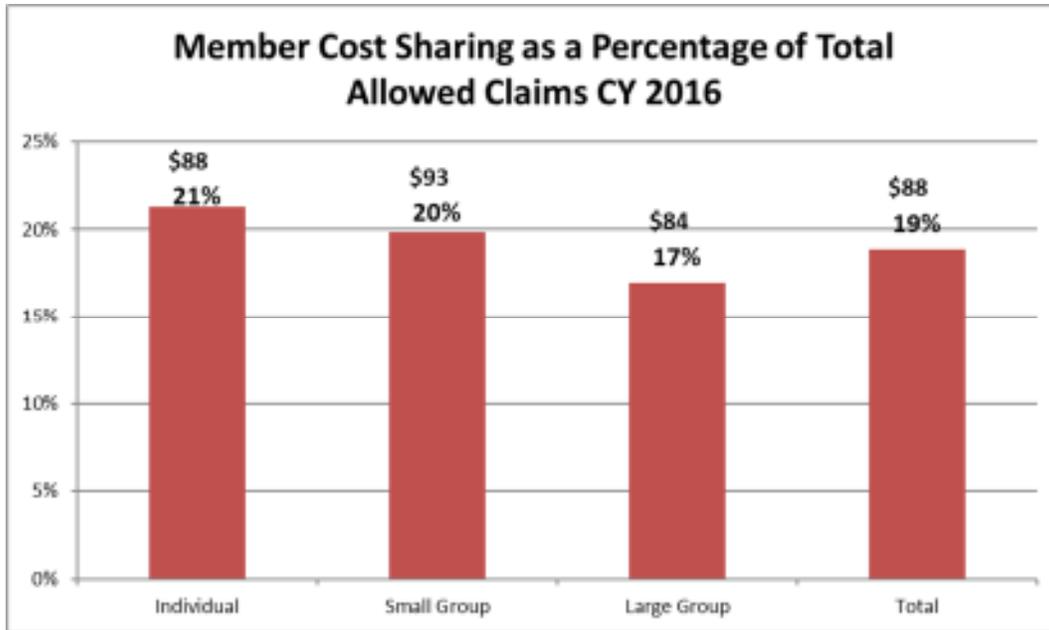


Figure 26: Member Cost Sharing as a Percentage of Total Allowed Claims by Market Segment CY 2016⁷⁰

⁷⁰ 2017 SDR data. Excludes NH PAP. Excludes individuals covered under FEHBP.

4. Benefit Buy-Down and Benefit Adjusted Premium Trends

The Group Markets made changes worth 1% to 3% to the cost sharing of their plan designs in CY 2016 compared to CY 2015 (“benefit buy-down”).⁷¹ The Individual Market made changes in cost sharing worth slightly more at 2% to 4%.

- The estimated benefit buy-down in the Group Markets reduced premium 0% to 2% for the Small Group Market and 1% to 3% for the Large Group Market in 2016. This is consistent with results from 2015.
- If employers had not changed their 2015 plan designs, in 2016 the Small Group Market would have experienced average premium increases in the range of -1% to 1% and the Large Group Market would have experienced average premium increases in the range of 5% to 7% (benefit-adjusted premium trends).
- In CY 2014, the Individual Market was enrolled in plan offerings with lower deductibles, copays and coinsurance amounts compared to CY 2013. This is due to the introduction of cost sharing reduction subsidies for qualifying low-income individuals. There was little change in cost sharing from CY 2014 to CY 2015. In CY 2016, there has been a shift to plan offerings with higher cost sharing. This analysis excludes the NH PAP population, which has very low cost sharing.
- If individuals had not changed their 2015 plan designs, in 2016 the Individual Market would have experienced average premium increases in the range of 6% to 8% (benefit-adjusted premium trends).

	2016 Benefit Buy-Down Range
Individual	2% to 4%
Small Group	0% to 2%
Large Group	1% to 3%
Total Fully Insured	1% to 3%
Total Group Only	0% to 2%

Table 8: Benefit Buy-Down by Market Segment⁷²

⁷¹ Benefit buy-down” is the process of selecting a plan with reduced benefits or higher member cost-sharing as a way to mitigate premium increases. Benefit buy-down is estimated by reviewing changes in cost sharing attributes along with insurer-reported actuarial values using the federal minimum value calculator. The percentage reflects the reduction in premium due to benefit buy-down.

⁷² Derived based on actuarial values and cost sharing attributes from the 2016 and 2017 SDR data. Fully-insured market only; excludes populations covered under FEHBP and NH PAP.

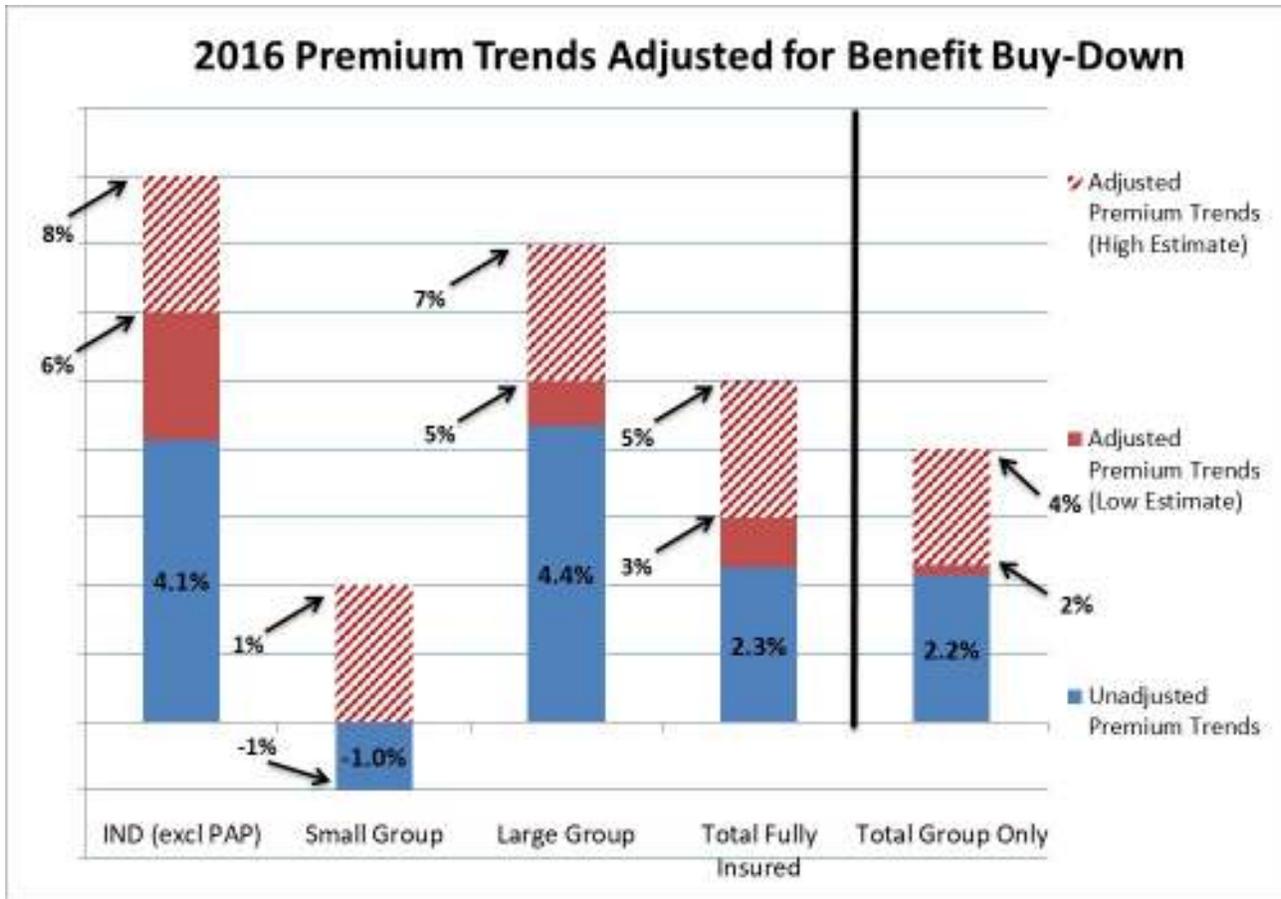


Figure 27: 2016 Premium Trends Adjusted for Benefit Buy-Down⁷³

⁷³ Ibid.

5. Claim Trends

Claims trends in all markets are experiencing an uptick in 2016, most notably in the Individual Market where claims trends are 23.2%.

- In CY 2016, fully-insured medical and pharmacy claims per member per month (“allowed claims PMPM”) have increased 8.6% compared to CY 2015.
- The increase in allowed claims PMPM is driven by a steep increase (23.2%) in the individual market driven by the inclusion of the NH PAP. While the individual market has experienced greater increases over the years due to many market changes, the highest increase was in 2016.
- Both Small Group Market and Large Group Market trends in 2016 have increased compared to 2015. The Small Group trend has increased 1.3 percentage points and the Large Group Market trend has increased 2.5 percentage points. The increase is primarily driven by increases in utilization.
- Pharmacy unit cost and mix trends continue to be a key driver of trends for each of the market segments. Detail on pharmacy trends and overall costs are explored further below.

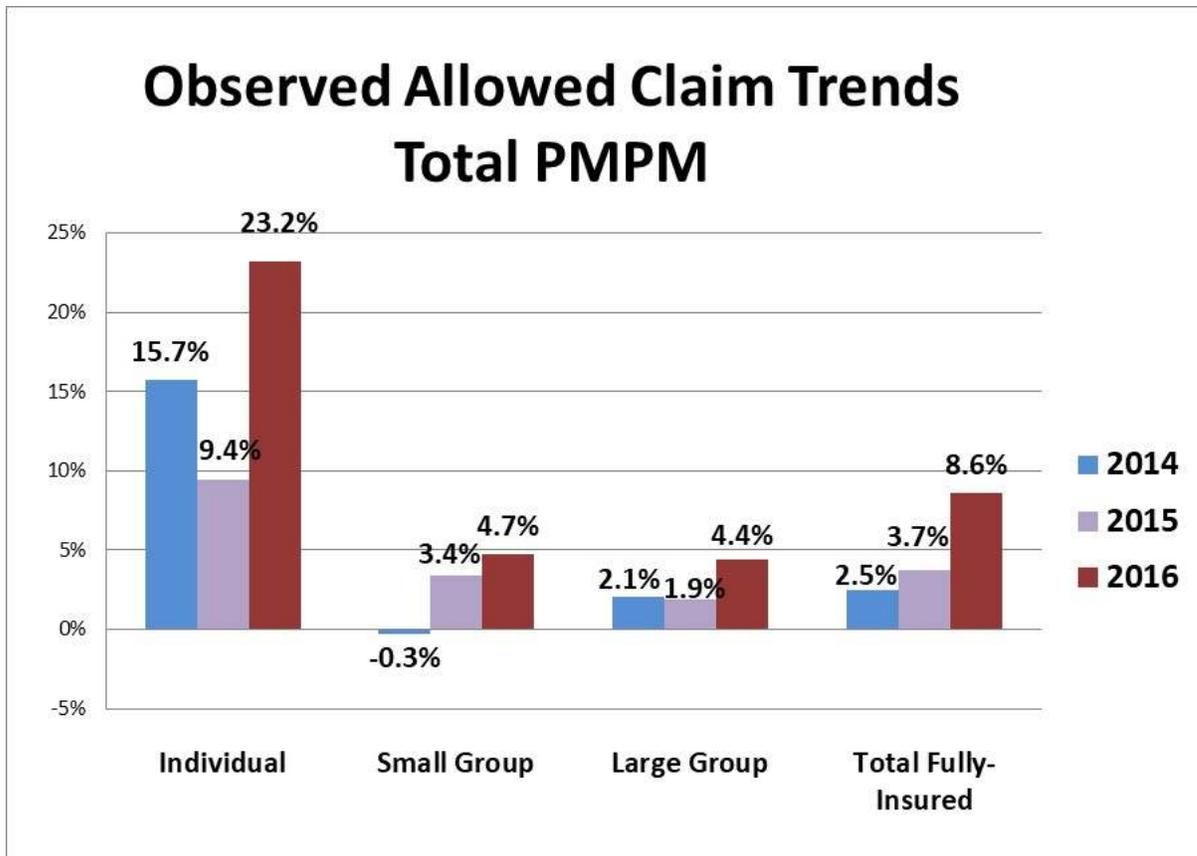


Figure 28: Observed Allowed Claims Trend by Fully-Insured Market Segment⁷⁴

⁷⁴ 2016 and 2017 AH data. Trends weighted by allowed claims in corresponding years.

In 2016 for the Group Markets, half of the allowed claims PMPM trend is due to utilization increases. This is a significant change from past years as utilization trends were negative and claims increases were all due to provider unit cost increases and mix.⁷⁵

- Utilization trends have increased in each of the past two years, from -2.4% in 2014 to +2.3% in 2016.
- The unit cost and mix trend has decreased from 3.8% in 2015 to 2.3% in 2016.
- The “mix” portion of the cost and mix trends is estimated to be around -1% to 0% in 2016, slightly lower than in 2015 where the estimate was in the range of 0% to +1%.

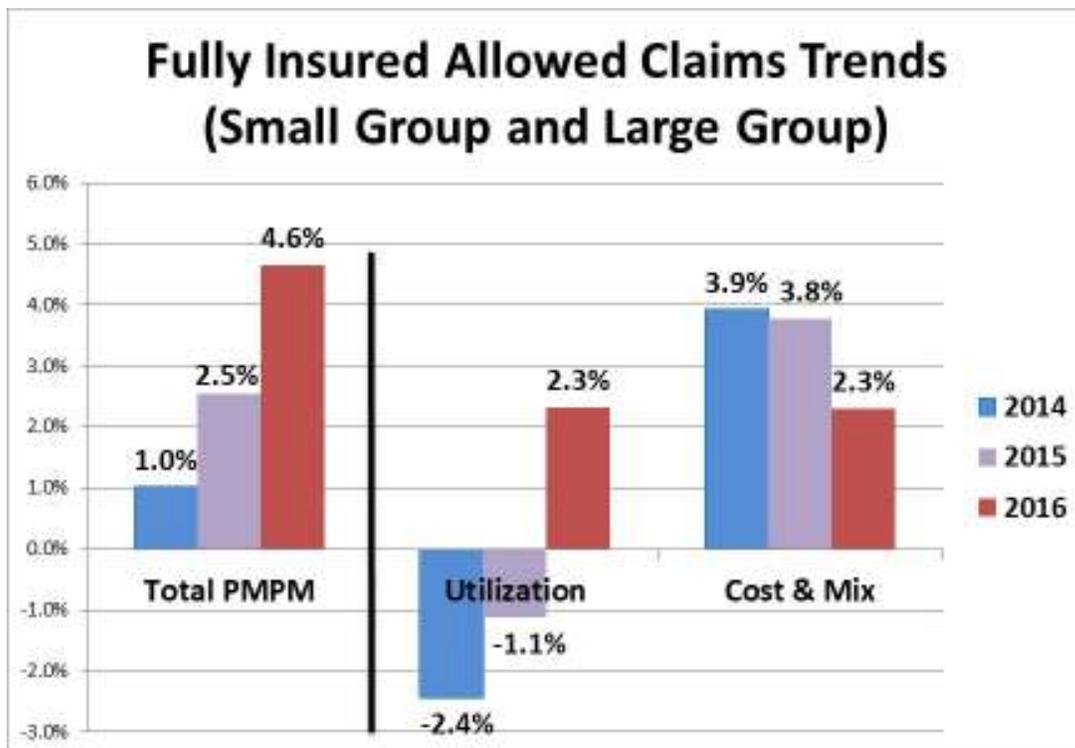


Figure 29: Observed Allowed Claims Trend by Component in Fully-Insured Small and Large Group Markets⁷⁶

⁷⁵ Claims PMPM trends generally consist of two components: utilization, and unit cost and mix. Utilization is the number of services provided (e.g. admissions to a hospital or number of prescriptions filled). Unit cost and mix trends are a combination of the change in unit price of specific services and changes in the mix of services, or changes in the mix of providers being used by patients.

⁷⁶ 2016 and 2015 AH data. Utilization and unit cost trends reported by service categories and in total by categories. Total utilization and unit cost trends are generally weighted by service category allowed PMPMs. Utilization metrics generally reflect admits for inpatient, prescriptions for pharmacy, and visits for professional and outpatient categories.

When examining allowed claims trend by service category in the Group Markets, Pharmacy and Other category have largest trends over period of 2014 to 2016, while Inpatient trends have experienced large fluctuations.

- While the Inpatient Facility category experienced a large decrease in trend in 2015, this has changed in 2016 where the Inpatient Facility trends have changed to be positive 6.0%. This is driven by both increasing utilization and unit cost and mix trends. The combined trend 2014 to 2016 is 5%.
- Insurers pointed to musculoskeletal, neoplasm and other high cost cases as drivers of the increase in inpatient trends. Some also noted that 2014 inpatient experience was particularly unfavorable, leading to high 2014 trends, but low 2015 trends as the experience returned to lower levels. It is useful to examine trends over multiple years in light of these fluctuations.
- Pharmacy trends continue to be positive, they are not as high in 2016 as they were in 2015. This appears to be driven by lower cost and mix trends and offset by higher utilization trends. The combined trend 2014 to 2016 is 15%. Some insurers pointed to Hepatitis C drugs as the driver of the increase in trends in 2014 and 2015 and then a leveling off in 2016.
- While not as high as in 2015, the Other service category continues to experience a large trend in 2016. This category does represent a small portion of total claims at 6% (see Figure 31.) One driver identified for this is an increase in pharmacy provided in an outpatient setting (i.e. prescription drugs that are covered under the medical benefit.) The combined trend 2014 to 2016 is 25%.
- In 2014 and 2015, each service category experienced either flat or negative utilization trends. In 2016, the opposite has occurred, where each service category has flat or positive utilization trends.

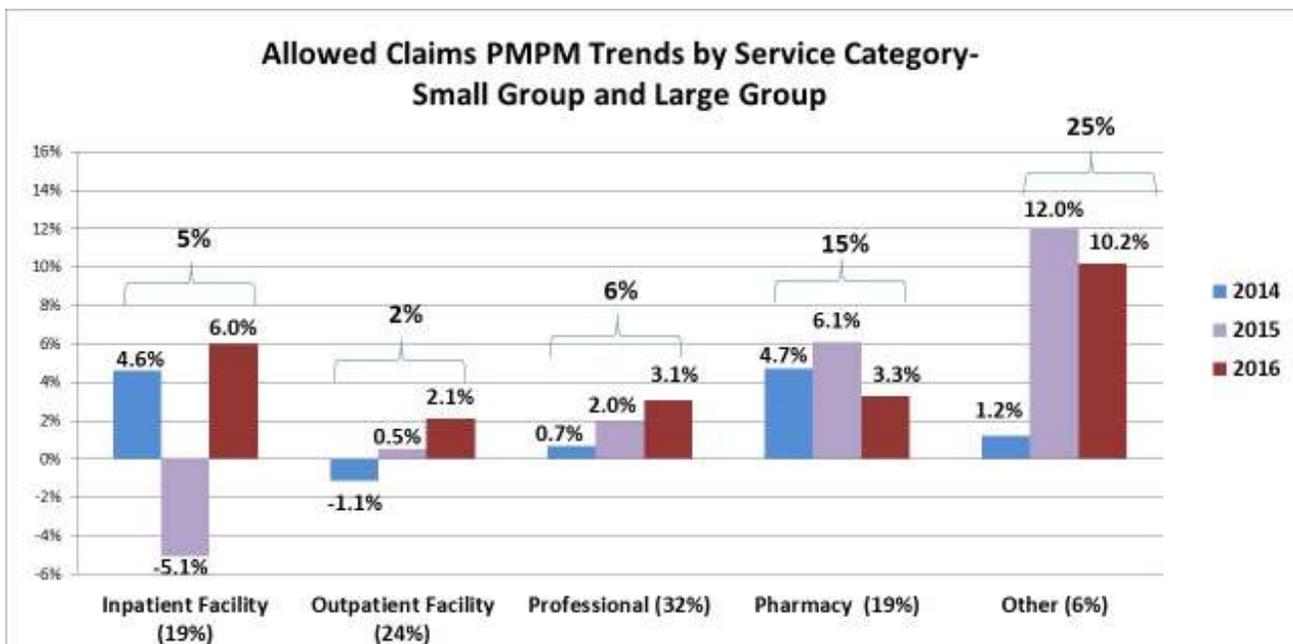


Figure 30: Observed Allowed Claims PMPM Trend by Service Category⁷⁷

⁷⁷ 2016 AH data. Fee-for-service (FFS) claims only.

The percentage of total allowed claims for each service category has remained fairly consistent over the past three years.

- Pharmacy currently reflects 19% of total allowed spending in the fully-insured market in 2016 which is consistent with 2015.
- Inpatient Facility and Outpatient Facility spending comprise 43% of total medical spending, followed by professional spending at 32% of total medical spending.

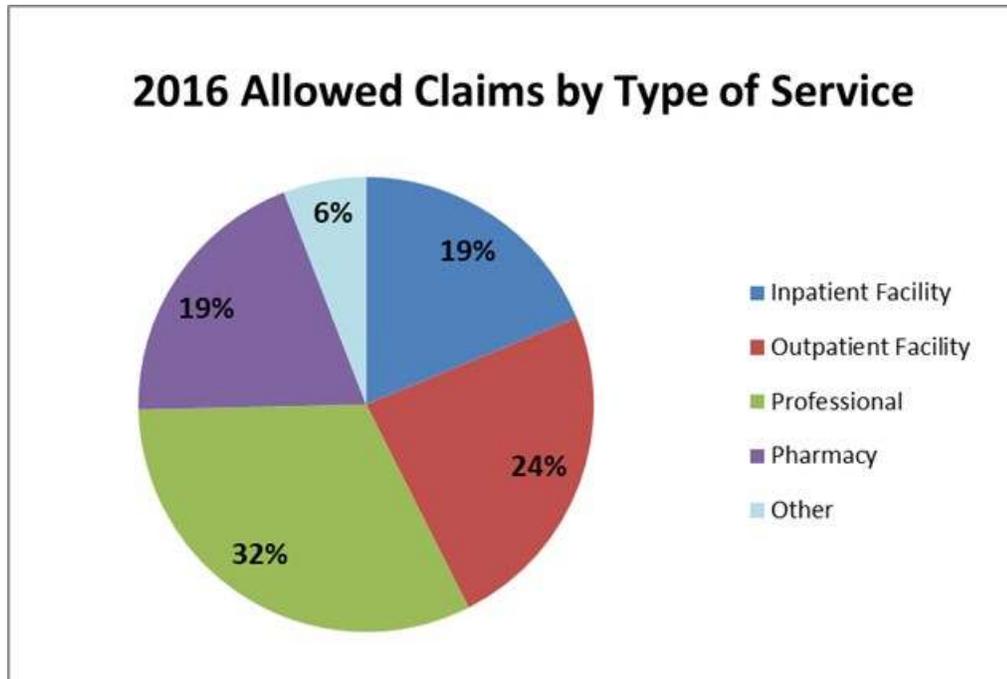


Figure 31: CY 2016 Allowed Claims Percentage by Service Category⁷⁸

While overall pharmacy trends in the Group Markets have decreased in 2016 compared to the prior year, pharmacy continues to be largest driver of overall medical trend over the past three years. Within pharmacy, specialty drugs are driving increases in pharmacy costs.⁷⁹

- In 2014, overall pharmacy trend was 4.7%, increasing to 6.1% in 2015 and decreasing to 3.3% in 2016. This is a combined trend of 15% from 2014 to 2016.
- Pharmacy represents 19% of total medical costs and contributed 37% to the Group Market trends from 2014 to 2016, the largest contributor of any service category.

⁷⁸ 2017 AH data. Includes Individual, Small Group and Large Group Markets. FFS claims only.

⁷⁹ Insurers with pharmacy data that appeared unreasonable or did not reconcile to other sources were excluded.

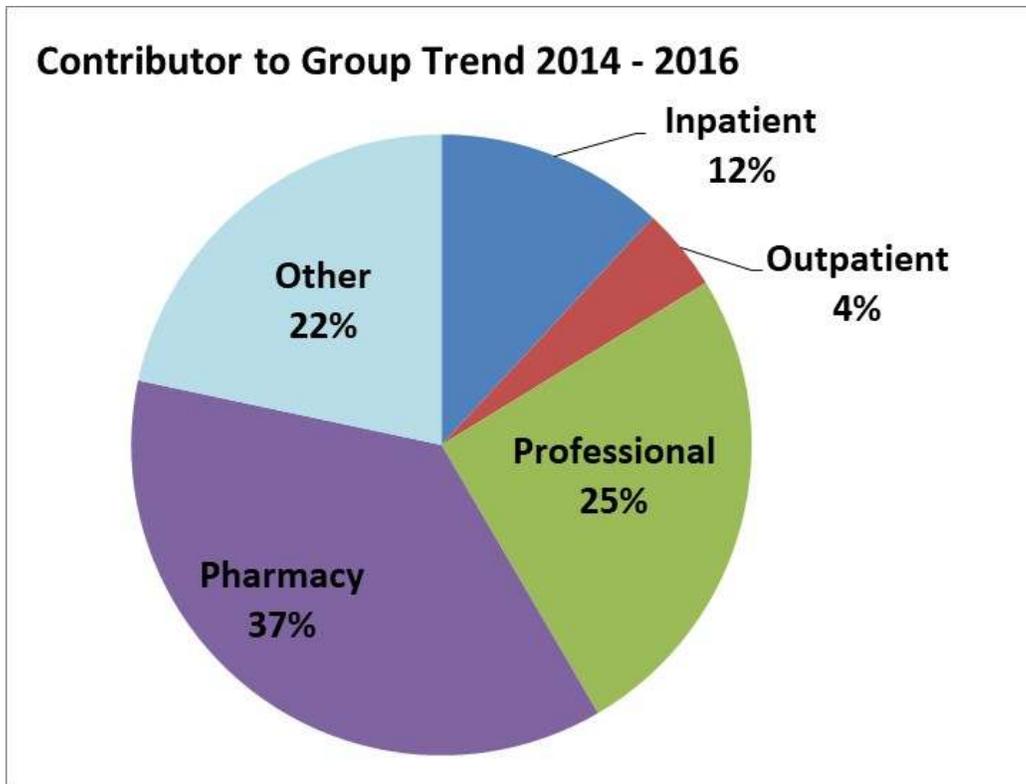


Figure 32: Contributors to Group Market Trends 2014 - 2016⁸⁰

Within pharmacy, specialty drugs are driving increases in pharmacy costs.

- In the Group Markets in 2016, specialty drugs have become a larger portion of pharmacy spending moving from 30% of total pharmacy spending to 37%.
- As shown in Figure 34, specialty pharmacy trends outpace the other pharmacy categories with trends ranging from 14% to 18% while other trends for generic non-specialty and brand non-specialty are flat or negative.
- The right side of Figure 34 shows pharmacy drug costs covered under the medical benefit which include prescriptions drugs that are administered at a physician's office or in a hospital setting. In many cases these are high costing injectables. Common drugs covered under the medical benefit include chemotherapy, drugs to treat side effects from chemotherapy, and drugs to treat Crohn's disease, multiple sclerosis, hemophilia and immune deficiencies.
- Pharmacy costs paid under the medical benefit represent an additional \$30 PMPM or 6.2% of total medical spending in 2016. This category trended at 20% in 2015 and 10% in 2016. Therefore, the trends and level of the pharmacy costs paid under the medical benefit is similar to the trend and levels of the specialty drug category within the pharmacy benefit shown on the left of Figure 34.
- Combining traditional pharmacy costs with pharmacy costs paid under the medical benefit, changes the overall pharmacy trend from 3.3% to 5.0% in 2016.

⁸⁰ 2016 and 2017 AH data. FFS claims only.

- When diving into the components of pharmacy trends, each segment is driven by different factors. Generic non-specialty PMPM trends were negative in 2016 driven by decreasing cost trends and offset by increasing utilization. Brand non-specialty PMPM trends have remained close to flat the past two years driven by negative utilization trends offset by positive cost trends. Lastly, specialty PMPM trends are driven by both positive utilization and cost trends, where cost trends are nearly three times as high as utilization trends.

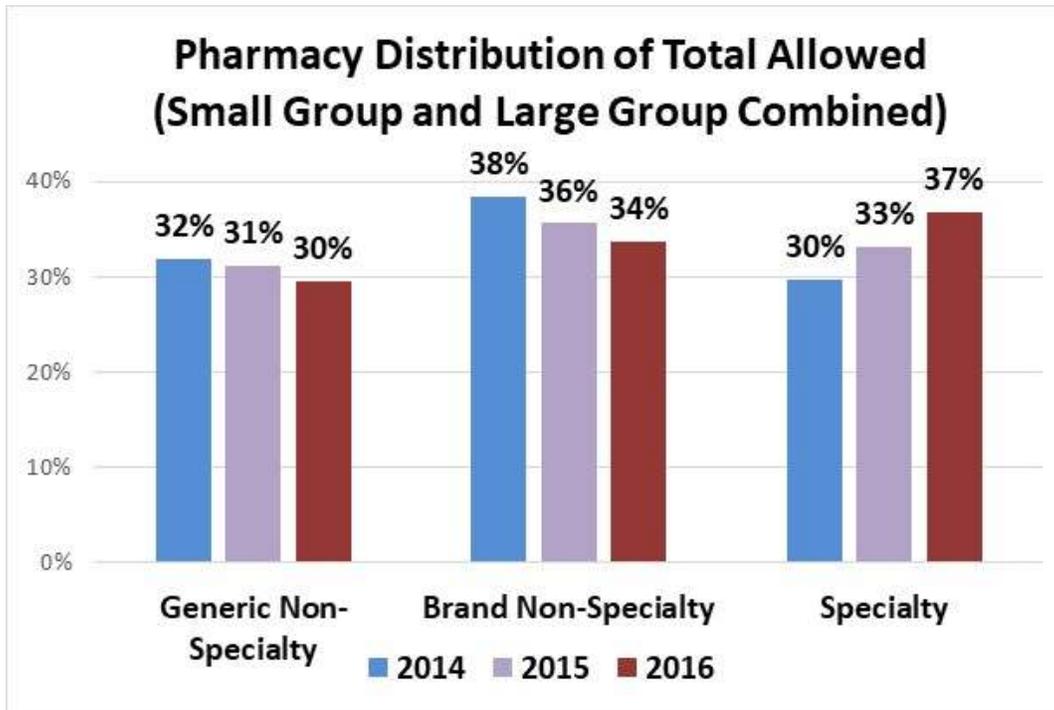


Figure 33: Small and Large Group Allowed Pharmacy Claims PMPM Distribution by Category⁸¹

⁸¹ 2017 AH data.

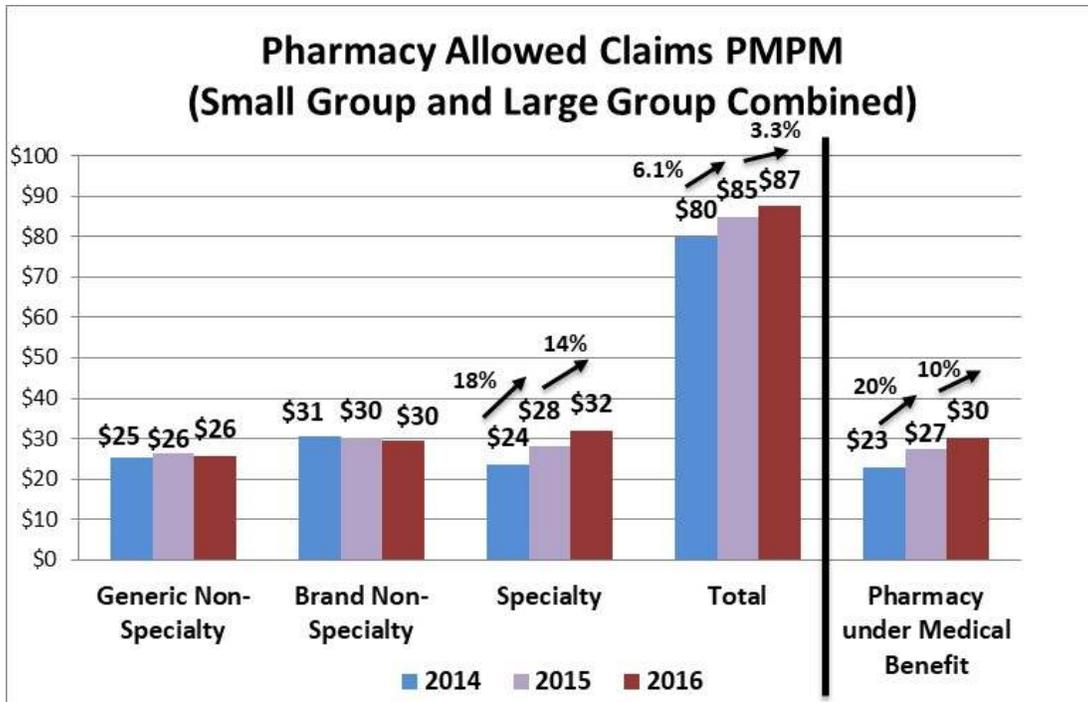


Figure 34: Small and Large Group Observed Allowed Pharmacy Claims PMPM by Category Including Pharmacy Paid Under the Medical Benefit⁸²

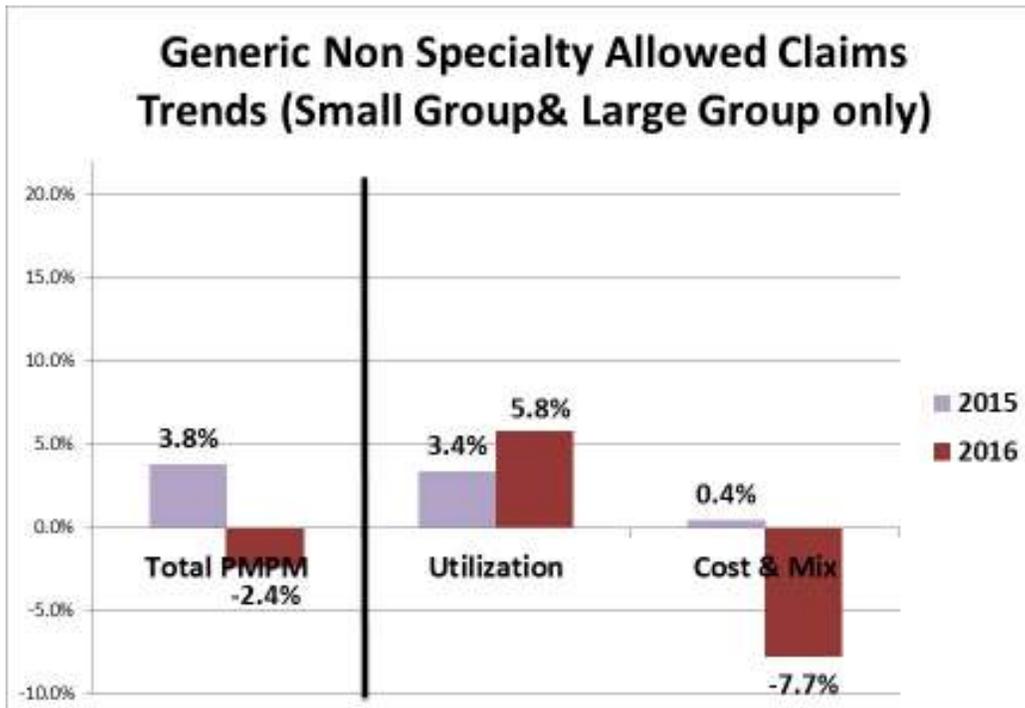


Figure 35: Small and Large Group Generic Non-Specialty Allowed Pharmacy Claims Trends⁸³

⁸² 2017 AH data.

⁸³ Ibid.

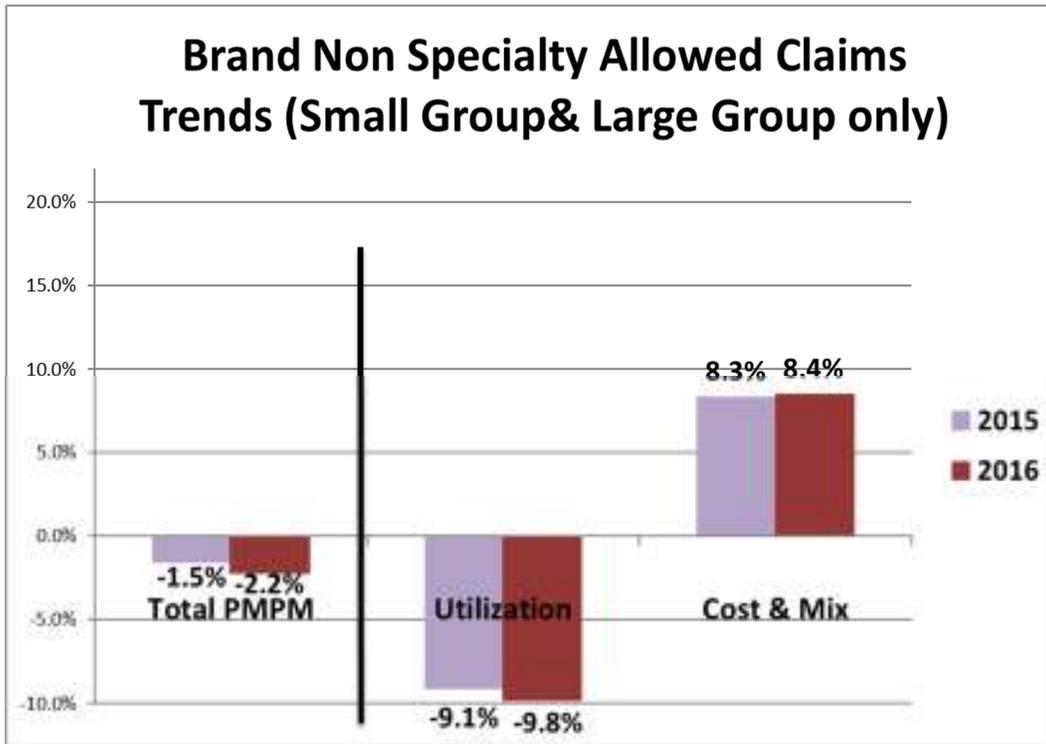


Figure 36: Small and Large Group Brand Non-Specialty Allowed Pharmacy Claims Trends⁸⁴

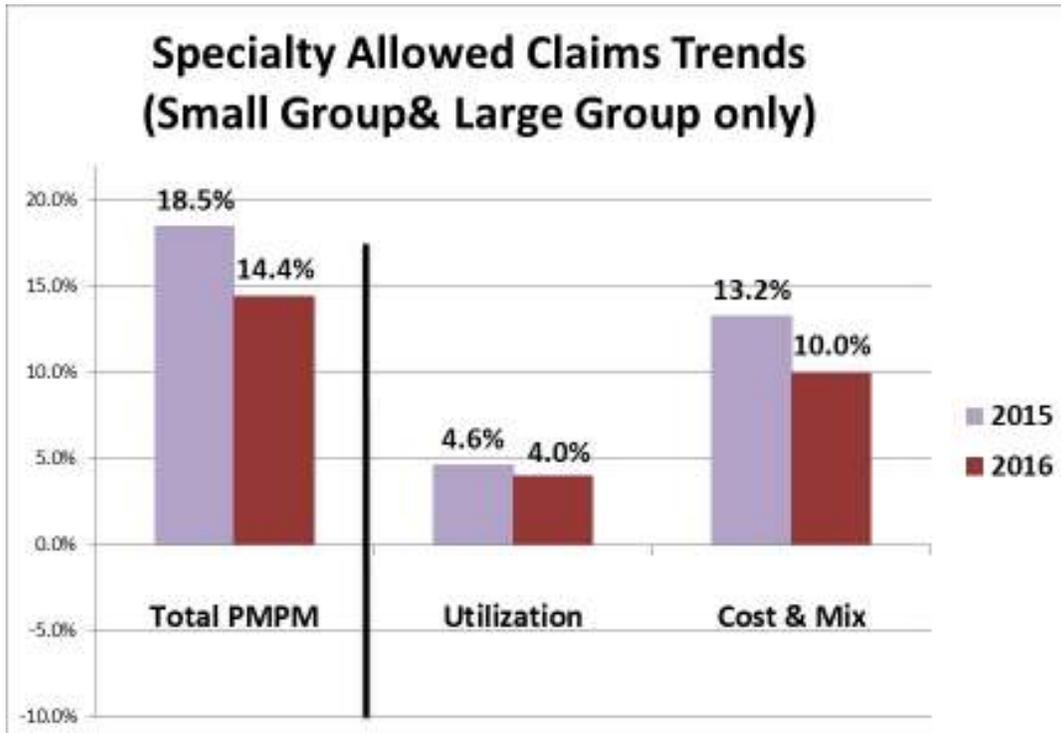


Figure 37: Small and Large Group Specialty Allowed Pharmacy Claims Trends⁸⁵

⁸⁴ Ibid.

⁸⁵ Ibid.

The average cost per script for a specialty drug is \$3,500 which is almost 16 times the cost of a brand non-specialty drug.

- Due to the cost sharing structure for specialty drugs in addition to the high unit cost of these drugs, 91% of the cost is paid by the insurer and only 9% is paid by the member in the form of deductibles, copays or coinsurance.
- Generic drugs, which comprise 86% of all prescriptions, cost \$29 on average and represent approximately 30% of total pharmacy spending. In the case of generic drugs, the insurer is responsible for 71% of the costs while the member pays the remaining 29%, on average.

Small Group and Large Group Combined CY 2016					
	Scripts per 1000 members per year	% Distribution by Scripts	Average Allowed per Script	% Distribution by Total Allowed	% Insurer Responsibility
Generic Non-Specialty	10,770	86%	\$29	30%	71%
Brand Non-Specialty	1,587	13%	\$223	34%	71%
Specialty	<u>110</u>	<u>1%</u>	<u>\$3,509</u>	<u>37%</u>	<u>91%</u>
Total	12,467	100%	\$84	100%	78%

Table 9: Small Group and Large Pharmacy Metrics CY 2016^{86, 87}

More than half of the 2016 Individual Market allowed claims PMPM trend of 23.2% is due to the introduction of the NH PAP.

- The Individual Market trend excluding the impact of NH PAP is 10.6%, or 12.6 percentage points less than the trend including the NH PAP enrollees.
- Within the Individual Market non-PAP population, there are three sub-segments: Individual Exchange, Individual Non-Exchange and the Grandfathered/Transitional. In each of these populations, one of the key driver of trend is pharmacy services.
- The Grandfathered/Transitional population is not part of the Individual Market Single Risk Pool. If this population were excluded, the total trend would be 24.7%.
- Trends in the Individual Market have been volatile and are expected to continue to be more volatile compared to the Group Markets. In 2015, there were three new entrants to the Individual Exchange Market (Community Health Options, Harvard Pilgrim and Minuteman.) In 2017 and 2018, there are two insurers exiting the market (Community Health Options and Minuteman.) The

⁸⁶ Ibid.

⁸⁷ The source of the detailed pharmacy information in this year's report is the 2017 AH data. The source of the detailed pharmacy information in last year's report was the NHCHIS provided by the NHID. Specialty pharmacy in this year's report is as defined by the insurers.

Grandfathered/Transitional Market is shrinking over time. There has also been movement of members among insurers from 2014 to 2015 and 2016 as individuals “shop around.”

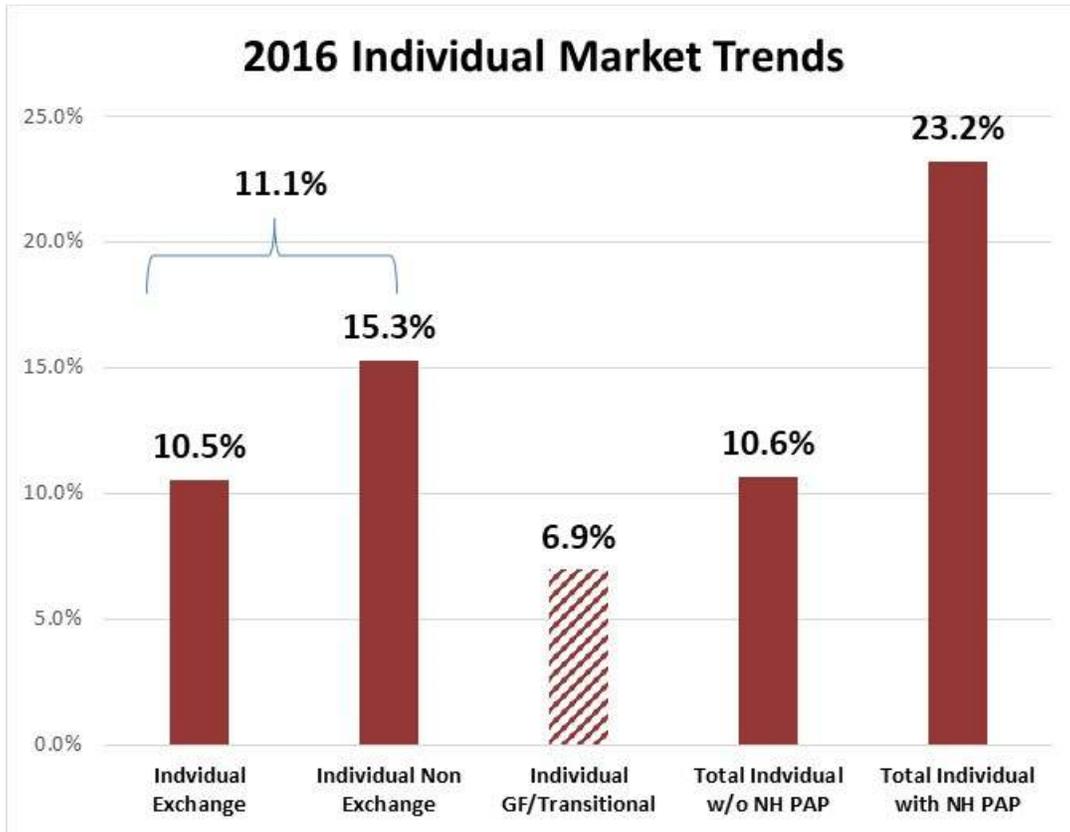


Figure 38: Individual Market Allowed Claims Trends by Segment⁸⁸

Within the Individual Market excluding PAP, the pharmacy allowed claims PMPM is 23.6%, significantly higher than the Group Market Pharmacy trend of 3.3%. Pharmacy trends contribute 37% to the overall trend in 2016. This trend is driven by both utilization and cost.⁸⁹

- The Individual Market has higher trends across each of the three categories of pharmacy (generic non-specialty, brand non-specialty and specialty.)
- The Individual Market specialty trend is 37.0% in 2016, compared to 14.4% in the Group Markets. This is driven by a significantly higher utilization trend in the Individual Market compared to the Group Markets.

⁸⁸ 2017 AH data.

⁸⁹ Insurers with pharmacy data that appeared unreasonable or did not reconcile to other sources were excluded.

- Specialty drugs has become a larger portion of pharmacy spending moving from 40% of total pharmacy spending to 44% in 2016. This is higher than the Group Markets where specialty pharmacy spend comprises 37% of total pharmacy in 2016.

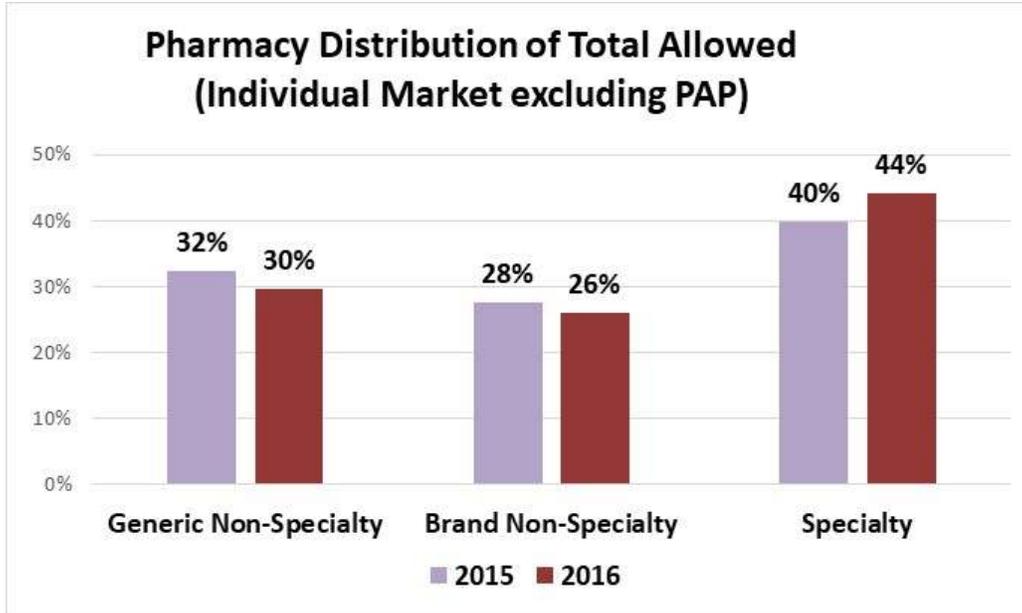


Figure 39: Individual Market Allowed Pharmacy Claims PMPM Distribution by Category⁹⁰

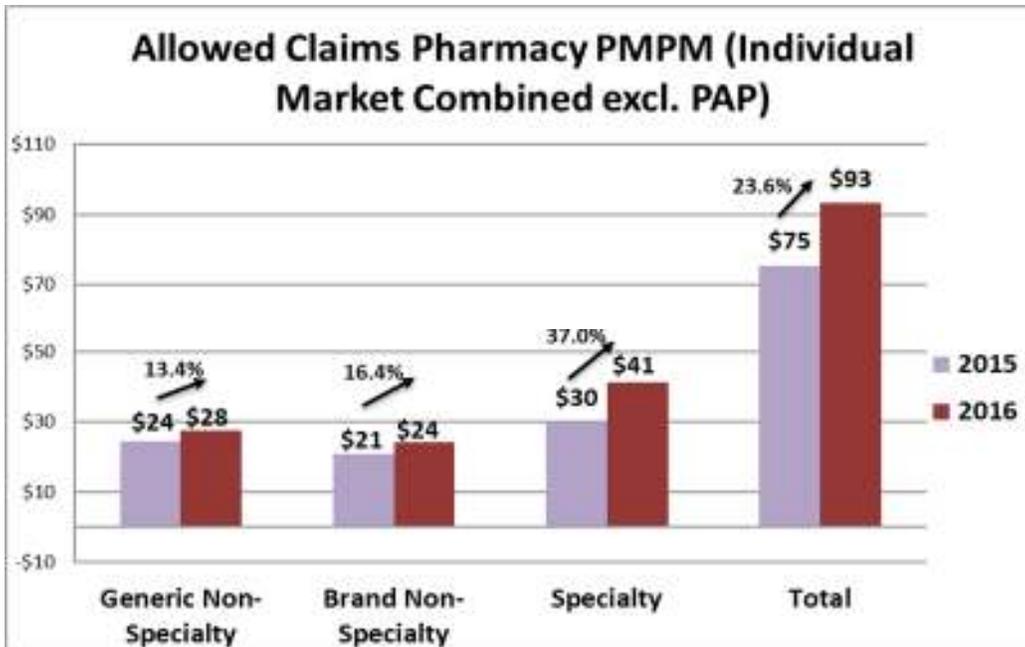


Figure 40: Individual Market Excluding NH PAP Observed Allowed Pharmacy Claims PMPM by Category⁹¹

⁹⁰ 2017 AH data.

⁹¹ 2017 AH data. Exclude NH PAP.

When comparing the average allowed claims PMPM for the Individual Market excluding NH PAP with the PAP population, the PAP population’s medical costs are 24% higher than the average Non-PAP population.

- Allowed PMPM costs for the PAP population is \$539 PMPM and for the Individual Market Single Risk Pool Non-PAP population it is \$433, a difference of \$106 PMPM or 24%.
- By service category, NH PAP inpatient PMPM’s are significantly higher than the Individual Market Single Risk Pool Non-PAP population while pharmacy PMPM’s are fairly close.
- Inpatient allowed PMPM costs for the PAP population is \$122 PMPM and for the Non-PAP population it is \$80, a difference of \$42 PMPM or 53%.

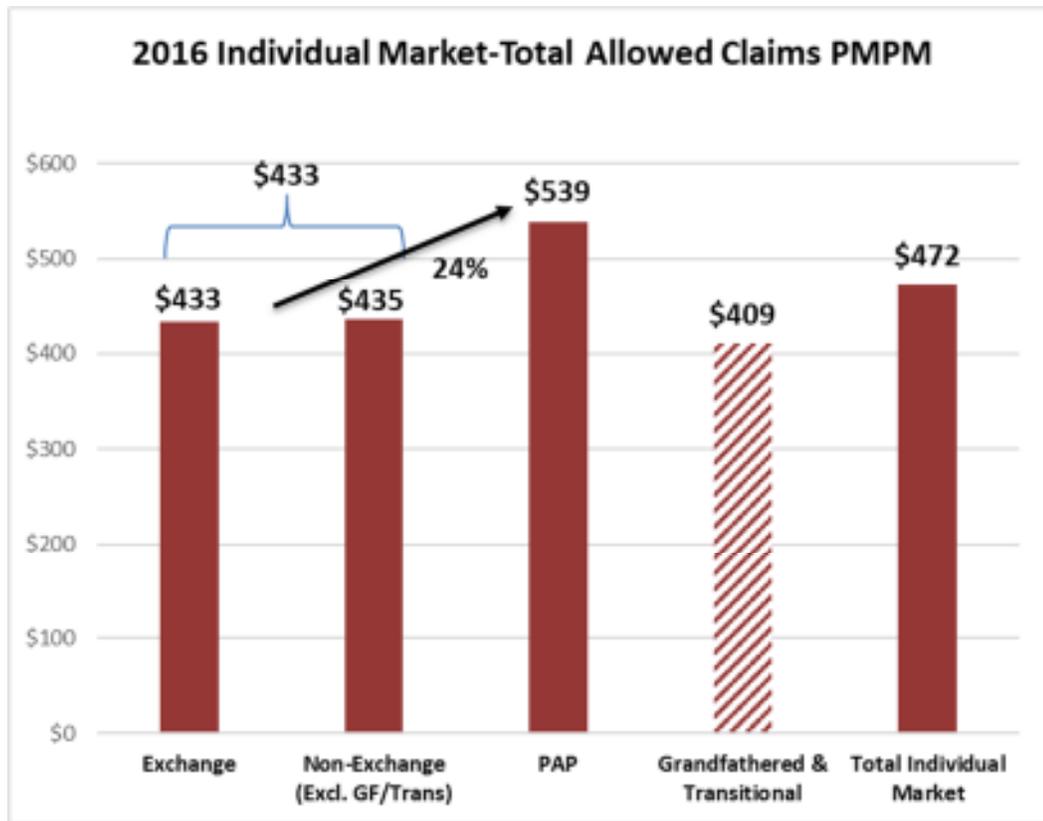


Figure 41: Individual Market Observed Allowed Total Claims PMPM by Segment⁹²

⁹² 2017 AH data.

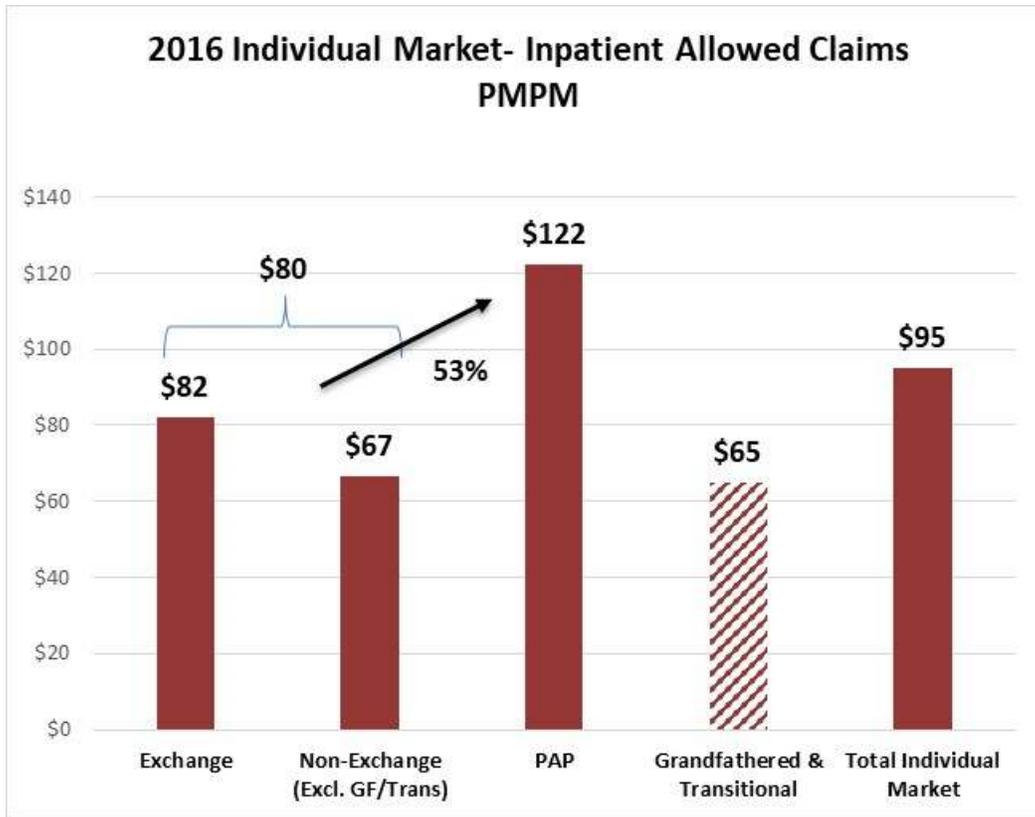


Figure 42: Individual Market Inpatient Allowed Total Claims PMPM by Segment⁹³

The medical expenditures of the Individual Market Single Risk Pool, excluding NH PAP enrollees, earning below 250% of the Federal Poverty Level (FPL) are similar to the medical expenditures of the NH PAP enrollees.

- As shown in Figure 2, the NH PAP population’s medical expenditures per enrollee are approximately 1.44 times greater (green bar) than that of the population that earns above 250% FPL (red bar). The red bar reflects the population that receives APTC (those earning between 250% and 400% FPL) and enrollees that do not receive any subsidies.
- In addition, enrollees earning between 138% and 250% FPL (blue bars) have medical expenditures that on average look very similar to the NH PAP population as their medical expenditure relativities range from 1.32 to 1.40. Note that some of these differences could be due to utilization differences due to induced demand resulting from lower cost sharing. Generally, individuals enrolled in plans with lower cost sharing may utilize more services.
- NH PAP enrollees and those earning between 138% and 150% FPL are enrolled in Platinum equivalent plans, and those earning between 150% and 200% FPL are enrolled in Gold equivalent plans. Those earning above 200% FPL are mostly enrolled in Silver and Bronze plans.

⁹³ 2017 AH data.

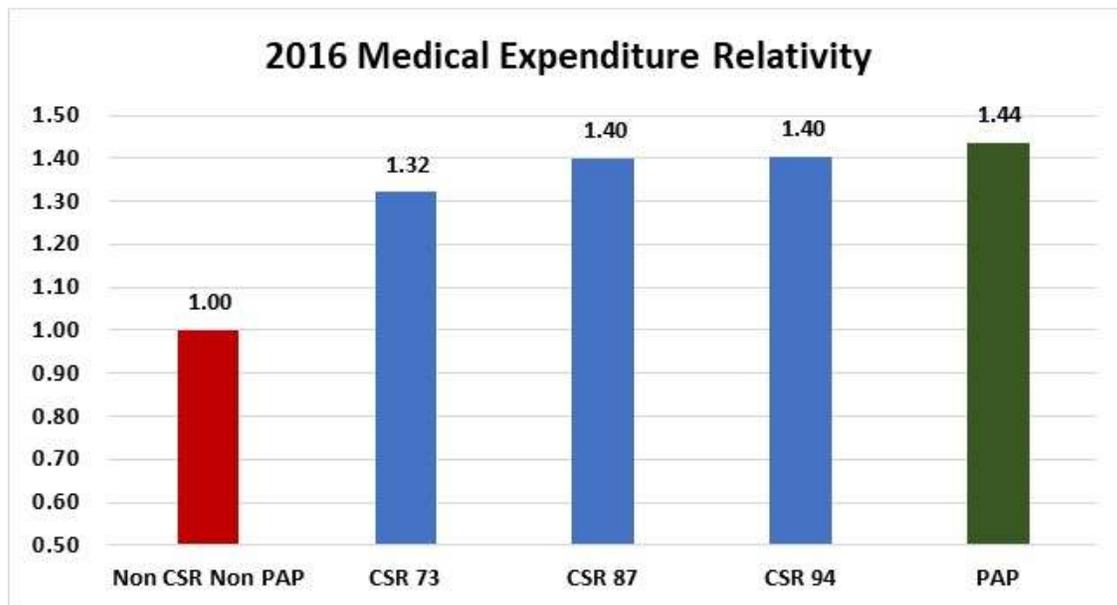


Figure 43: 2016 Individual Market Allowed Medical Expenditure Relativity^{94, 95}

Trend assumptions used by insurers to develop prices in the fully-insured market (known as “pricing trends”) have decreased over the past several years, from a high of 10% in 2012 to 8% in 2018, although there has been a slight increase in 2018 compared to 2017.

- Health insurance premiums are established well in advance of their effective period, which requires insurers to develop projected trend assumptions called pricing trends. Pricing trends are based on a static level of benefits and a static population, while observed trends will reflect the impact of benefit changes to utilization levels and the impact of population changes. Furthermore, given the significant lag between observed historical data and the projection period for a pricing trend, it may take time to see the same deceleration in pricing trends compared to what is occurring in observed historical trends.
- Another factor that may impacts pricing trends but not observed claims trends is the impact of leveraging due to fixed cost sharing elements such as the deductible. If health care costs increase while deductibles remain fixed, the insurer assumes a greater percentage of health care costs, and an upward adjustment to the pricing trends is required to reflect the increase in costs above the fixed dollar deductible. The larger the deductible, the greater the adjustment needed due to the impact of leverage.
- In 2018, the medical services pricing trend is around 7% while the pharmacy pricing trend is around 13%, resulting in an overall average of approximately 8.5%. Figure 45 shows how the medical trends have generally decreased over time while the pharmacy trends have increased, although it does appear that

⁹⁴ 2017 SDR data.

⁹⁵ Individuals earning below 250% FPL are eligible for CSR subsidies. Those that earn between 200% and 250% FPL are eligible to enroll in a plan that has an actuarial value of 73%. Those that earn between 150% and 200% FPL are eligible to enroll in a plan that has an actuarial value of 87%. Those that earn between 138% and 150% FPL are eligible to enroll in a plan that has an actuarial value of 94%.

pharmacy pricing trends are slightly lower in 2017 and 2018 compared to where than were at their peak in 2015.

- The 2017 Segal Health Plan Cost Trend Survey reported average projected 2018 trends of 6.9% to 7.8% for medical services and 10.3% for outpatient pharmacy coverage (including both specialty and non-specialty drugs). Projected trend rates for specialty drug/biotech in 2018 are 17.7%.⁹⁶



Figure 44: Average Pricing Trends in the Fully-Insured Market⁹⁷

⁹⁶ High Rx Cost Trends Projected to be Lower for 2018. 2018 Segal Health Plan Cost Trend Survey. Segal Consulting, Fall 2017. Available to download at <https://www.segalco.com/publications-videos/data/#PublicSector>. The 6.9% medical services trend represents HMOs and the 7.8% trend represents HDHPs as well as PPO/POS Plans.

⁹⁷ 2013, 2014, 2015, 2016 and 2017 AH data.

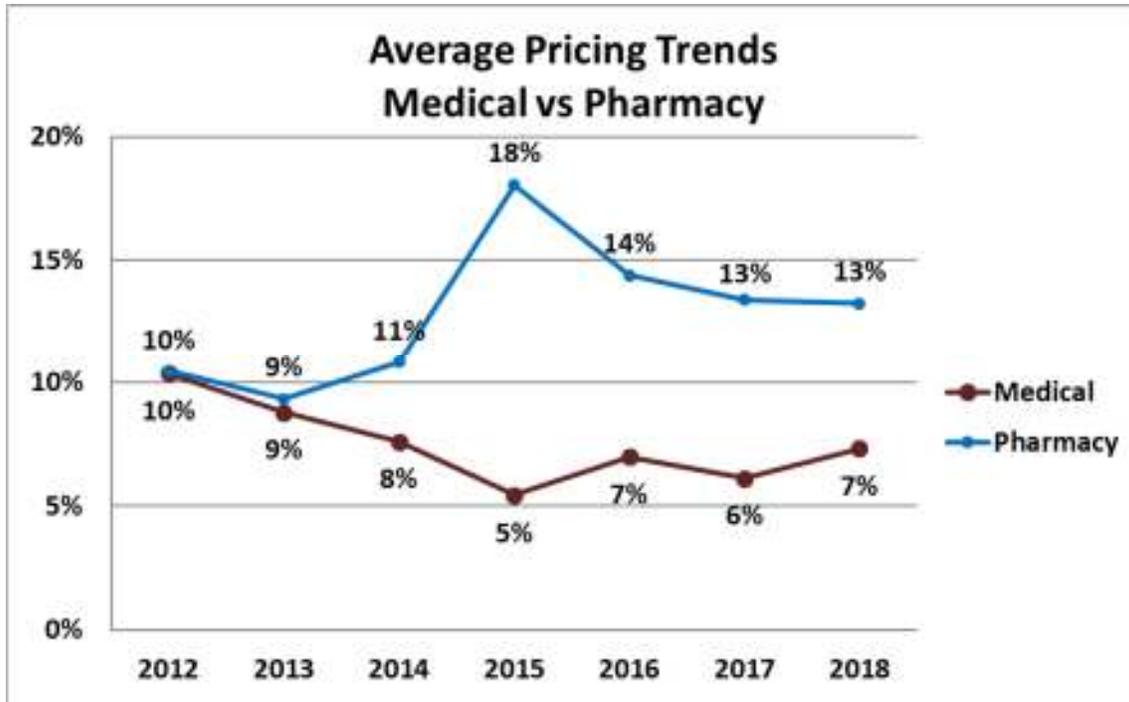


Figure 45: Average Medical and Pharmacy Pricing Trends in the Fully-Insured Market⁹⁸

6. Utilization Levels

For the first time in this year’s Annual Hearing Report, data were collected to analyze utilization levels across markets segments. Utilization is generally much higher in the Individual Market compared to the Group Markets. The Group Markets utilization is consistent with national benchmarks.

- The Group Market utilization is consistent with national benchmarks.⁹⁹
- CY 2016 inpatient admissions per 1000 were 45.0 for Small Group and 55.3 for Large Group, with an average of 50.9. This is consistent with the HCCI 2015 admissions per 1000 of 51. Individual Market admissions per 1000 are 65.9 or 29% higher than the combined Group Market admission rate per 1000.
- A larger difference between Individual Market and Group Markets is seen with emergency department (ED) Visits per 1000. CY 2016 ED visits per 1000 were 169.1 for Small Group and 183.8 for Large Group, for a combined total of 177.6. This is slightly higher than the HCCI 2015 ED visits per 1000 of 173.

⁹⁸ 2013, 2014, 2015, 2016 and 2017 AH data.

⁹⁹ Comparisons were made where available to national benchmark data. In the case of inpatient admissions and emergency department visits, comparisons were made to the Health Care Cost Institute 2015 data. Note that this data only reflects employer sponsored insurance.

Individual Market ED visits per 1000 are 381.4 or 115% higher than the combined Group Market ED visits per 1000.

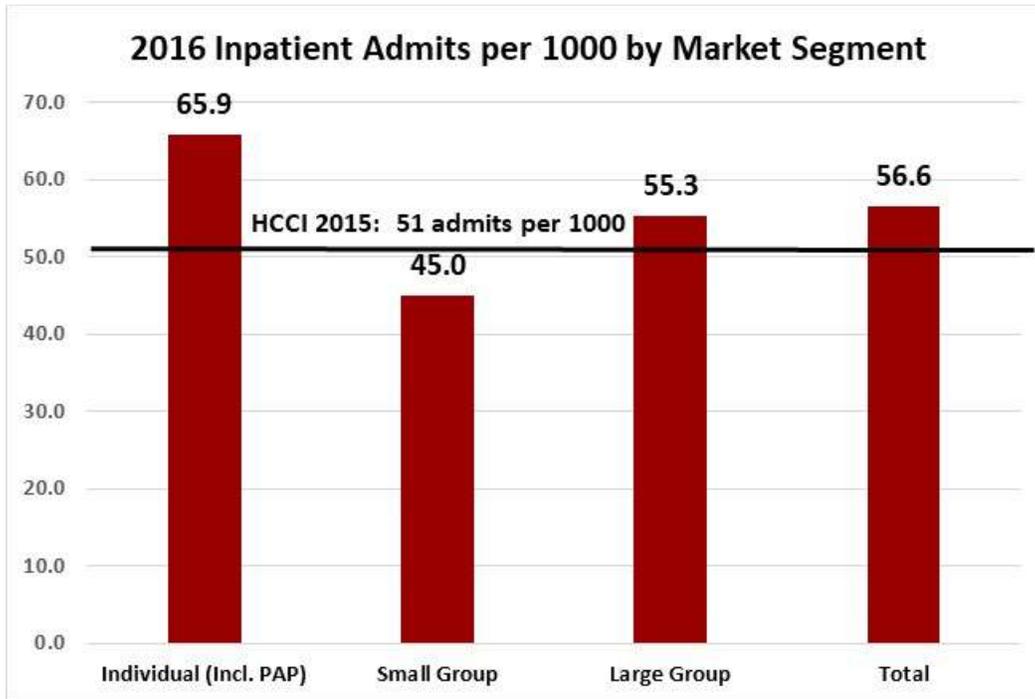


Figure 46: 2016 Inpatient Admits per 1000 New Hampshire Fully-Insured Market¹⁰⁰

¹⁰⁰2017 AH data.

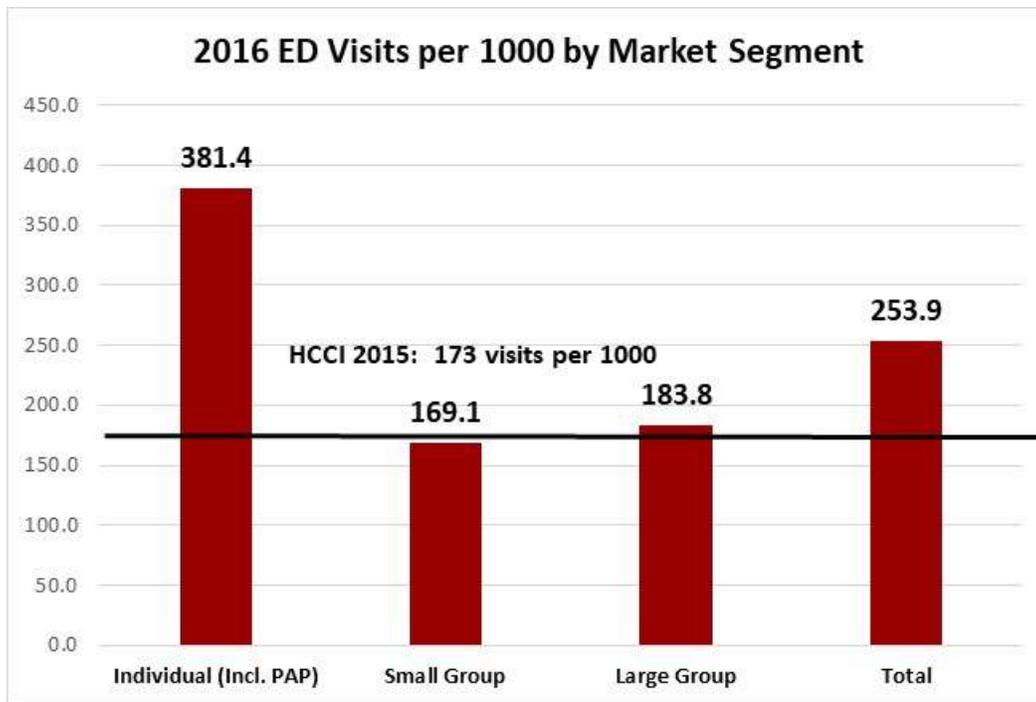


Figure 47: 2016 Emergency Department Visits per 1000 New Hampshire Fully-Insured Market¹⁰¹

The higher utilization in the Individual Market compared to the Group Markets is driven by the NH PAP population.

- The Individual Market was segmented into the following populations: Exchange business, Non-Exchange (excluding grandfathered and transitional), Grandfathered and Transitional and NH PAP. In general, NH PAP has the highest utilization levels within the Individual Market and the Grandfathered/Transitional members have the lowest.
- The PAP ED Visits per 1000 is 712.2 compared to 181.0 for the Individual Market Single Risk Pool Non-PAP, or 294% higher.
- For Inpatient Admits per 1000 and ED visits per 1000, the Individual Market Single Risk Pool Non-PAP population has similar utilization levels to the Group Markets. For example, inpatient admissions per 1000 for the Non-PAP population is 53.6 compared to 50.9 in the Group Markets. ED visits per 1000 for the Non-PAP population is 181.0 compared to 177.6 in the Group Markets.

¹⁰¹2017 AH data.

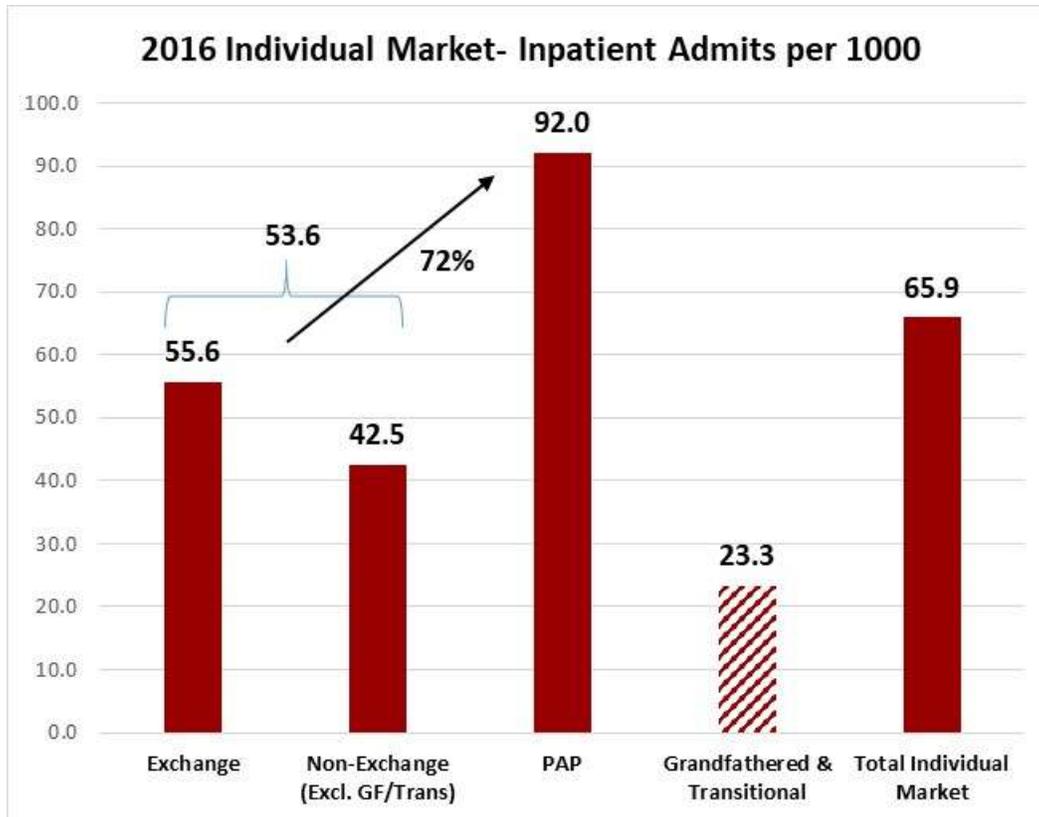


Figure 48: 2016 Individual Market Inpatient Admits per 1000 by Segment¹⁰²

¹⁰²2017 AH data.

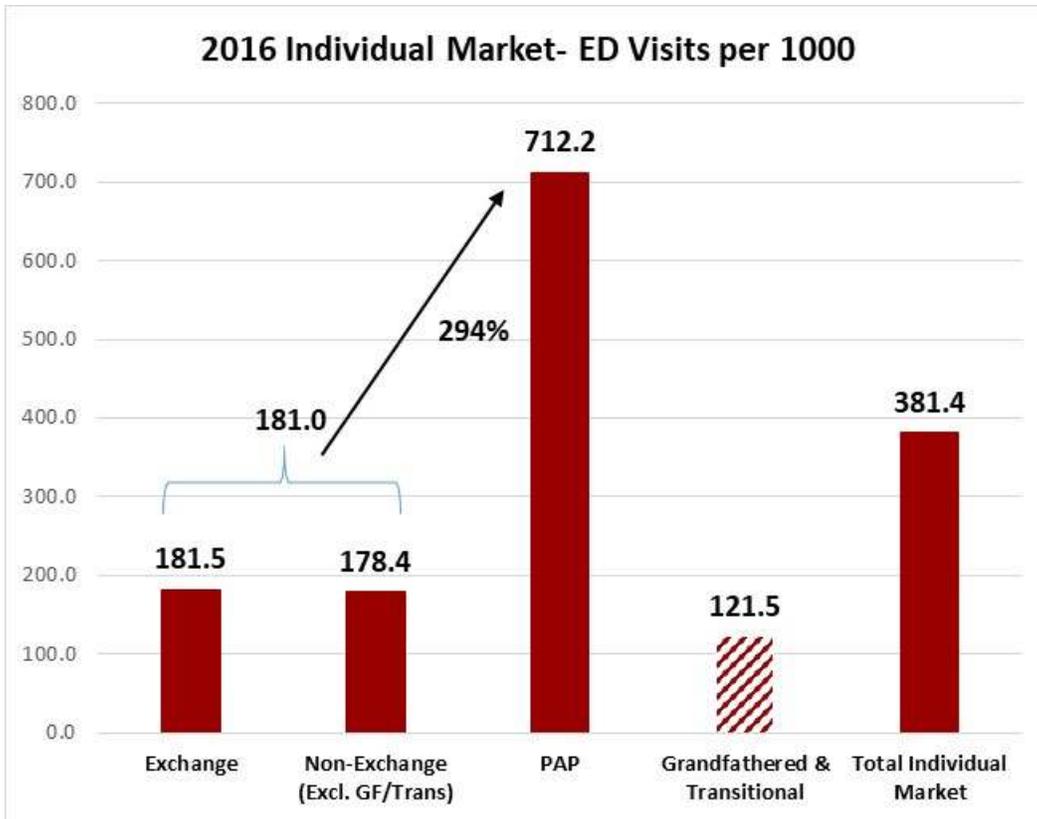


Figure 49: 2016 Individual Market Emergency Department Visits per 1000 by Segment¹⁰³

7. Provider Costs and Provider Payment Reform

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

- The overall average hospital rate increase remained fairly stable at 2.9% in 2014 and 3.0% in 2015 but has decreased to 2.4% in 2016 and is projected to be 2.5% in 2017.
- The payment rate changes by facility continue to vary considerably by hospital with inpatient hospital rate changes ranging from -1.3% to 6.8% and outpatient hospital rate changes varying from -0.3% to 3.9% in 2016.¹⁰⁴
- In addition to variation in hospital payment rate changes, there continues to be variation in the level of hospital prices across all insurers. Based on commercial relative prices as reported by insurers, the most

¹⁰³2017 AH data.

¹⁰⁴ 2017 AH data. Weighted averages across insurers. Standard networks only.

expensive hospitals in New Hampshire are 2.5 times as much as the least expensive hospital in both 2016 and 2017.¹⁰⁵

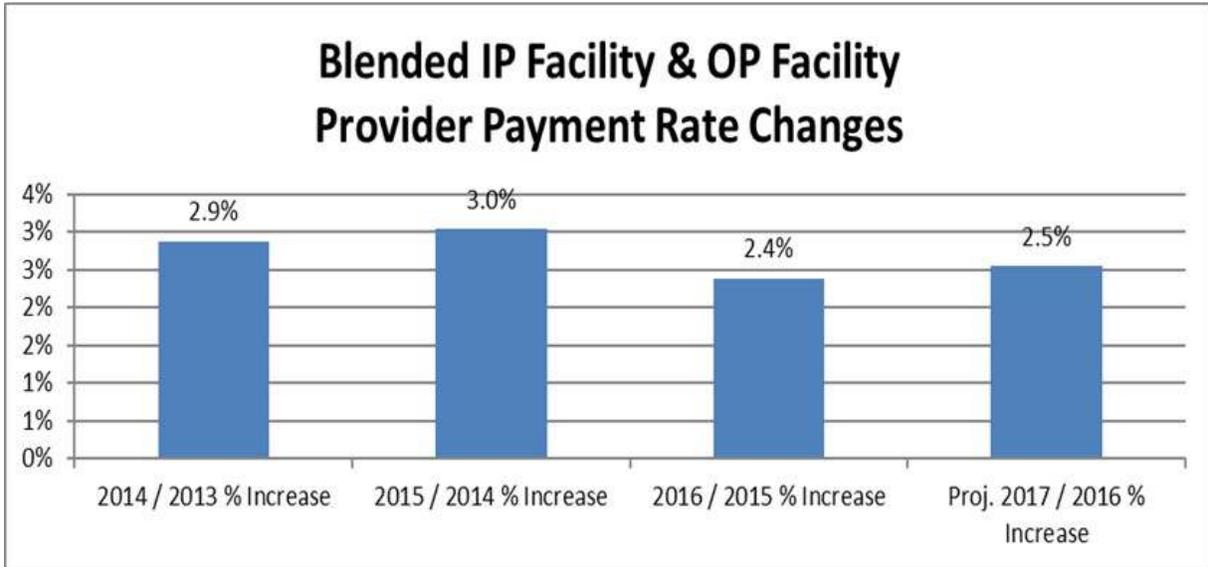


Figure 50: Blended Inpatient and Outpatient Average Hospital Payment Rate Changes by Year¹⁰⁶

Overall average professional payment rate changes have increased from 2014 to 2016, and is projected to increase further in 2017.

- Similar to hospital payment rate changes, there continues to be variation in the level of physician prices across all insurers. Based on commercial relative prices as reported by insurers, the most expensive physician groups in New Hampshire are more than two times the least expensive physician group in both 2016 and 2017.¹⁰⁷

¹⁰⁵ 2017 AH data. Standard Network rate changes only. Approximate average across insurers.

¹⁰⁶ 2015, 2016 and 2017 AH data. Standard Network rate changes only.

¹⁰⁷ 2017 AH data. Standard Network rate changes only. Approximate average across insurers.

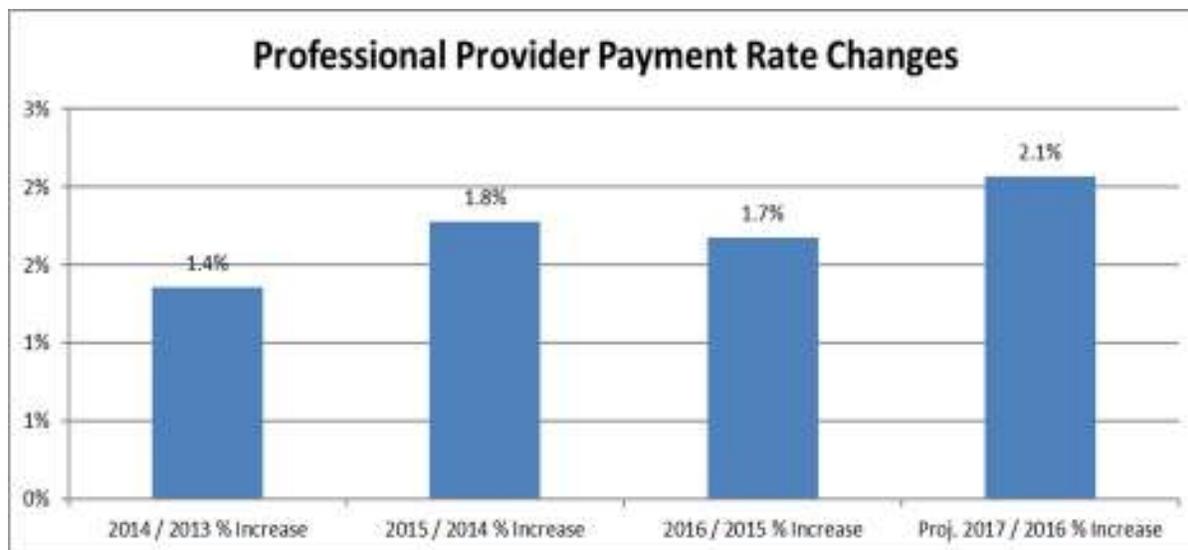


Figure 51: Professional Average Payment Rate Changes by Year¹⁰⁸

While the total percentage of people in risk contracts has remained fairly stable from 2014 to 2016, there is a shift happening from upside only risk to full risk sharing.

- The percentage of members in upside only risk contracts¹⁰⁹ decreased 31% in 2014 to 26% in 2016 in the fully-insured markets.
- The fully-insured market has seen increases in members in full risk contracts with both upside and downside risk sharing. The percentage of members in full risk contracts is now closer to the percent of members upside only risk contracts.
- The self-insured market saw a slight increase to 37% of members in upside only risk contracts. The percentage of members in upside only risk contracts remains significantly higher than members in full risk contracts in the self-insured market.
- Insurers reported on several payment reform initiatives including the following:
 - Primary Care Payment Models: At least two insurers in New Hampshire are working with primary care physicians to improve care coordination and outcomes by providing data, tools, and financial incentives to the provider groups for meeting certain cost and quality metrics. These arrangements primarily represent upside only risk to the provider.
 - Capitation: Provider groups are fully at risk for the majority of services incurred by members and reimbursed on a PMPM basis. While not widely prevalent in New Hampshire, at least one large provider group participates in this type of arrangement. Historically, these arrangements are for HMO/POS members who choose a primary care

¹⁰⁸ 2014, 2015 and 2016 AH data. Standard Network rate changes only.

¹⁰⁹ An upside only agreement involves no downside risk to the provider for failing to achieve the metrics defined in the contract agreement between the insurer and the provider. In other words, an upside only agreement is an agreement where the provider can only benefit or receive a payment for achieving a certain metric. A full risk contract agreement has both upside and downside risk and involves providers agreeing to pay a specified amount back to the insurer if certain metrics are not achieved.

provider (PCP), but at least one insurer has initiated a pilot program attributing PPO members to a PCP in 2015.

- Accountable Care Organizations: At least two insurers have established accountable care type models with larger provider systems in New Hampshire. In one case, this arrangement is centered on sharing information with providers related to gaps in care and pharmacy compliance, and does not represent any financial risk sharing.
- Shared Savings with Hospital Systems: At least two insurers in New Hampshire participate in pay for performance type programs with hospitals, in which a portion of the hospital’s payment is tied to performance on a defined set of quality metrics. These programs typically apply to all fully-insured and self-insured HMO, POS and PPO members.

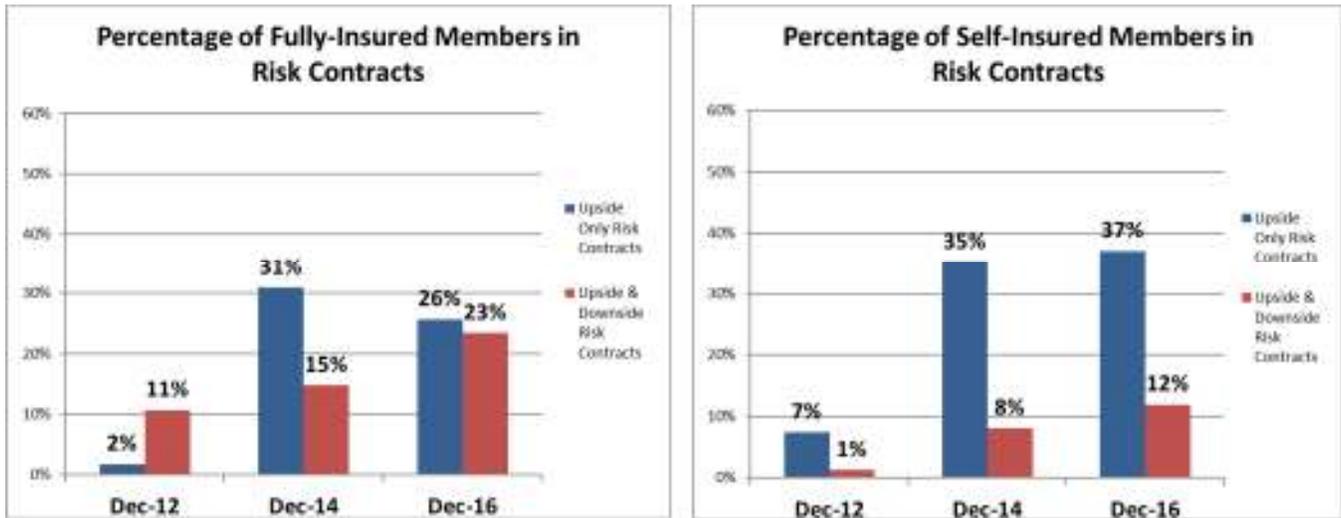


Figure 52: Members in Risk Arrangements for Fully-Insured and Self-Insured Markets¹¹⁰

¹¹⁰ 2013, 2014, 2015, 2016 and 2017 AH data.

8. Medical Loss Ratios, Expenses and Profits

In CY 2016, New Hampshire insurers made 2% profit.¹¹¹ However, the profit varies by market segment where the Individual Market continues to contribute losses while the Group Market experiences gains.¹¹²

- In CY 2016, the profit margins for the Small Group and Large Group markets have decreased compared to the prior year, from 8% to 3% in the Small Group Market and from 7% to 6% in the Large Group Market.
- The Large Group Market has the highest profit margin across all segments at 6%.
- The Individual Market continues to experience a decrease in the profit margin, decreasing from over +9% in 2014 down to -5% in 2016.¹¹³ The dramatic change between is driven by an increase in the percentage of medical and pharmacy claims (as a percent of premium) along with an increase in administrative expenses and fees for new market entrants (Minuteman and Community Health Options).¹¹⁴ As is detailed further below, Minuteman in particular was a large payer in the Individual Market risk adjustment program, thus significantly impacting their financial results.
- In each market segment, 1% to 2% of premiums are used for ACA related fees including the ACA health insurance tax, Patient-Centered Outcomes Research Institute (PCORI), and the transitional reinsurance fees.
- The percentage of premium for medical and pharmacy services is very consistent with last year's results in the Large Group Market. In the Small Group Market, the percentage of premium for medical and pharmacy services has increased from 77% in 2015 to 82% in 2016.
- The medical loss ratios in the figures below reflect payments or receivables due to risk adjustment and federal reinsurance along with CSR payments, but do not reflect the impact of federal MLR rebates. This is discussed further below.¹¹⁵
- By comparison, in the Large Group Self-Insured Market, 93% of premiums is spent on claims.¹¹⁶

¹¹¹ Subsequent to the Annual Hearing and the Preliminary Annual Hearing Report, Minuteman provided a revised MLR report on 11/22/17 where the incurred claims increased from approximately \$49 million to \$60 million. This decreased the profit margin from 3% to 2% for the total insured market and from -3% to -5% for the Individual Market.

¹¹² This information is not on the same basis as what is used for the federal medical loss ratio (MLR) formula for rebate purposes.

¹¹³ See footnote 111.

¹¹⁴ Profit margins and administrative costs for new market entrants are impacted by risk adjustment payments and start-up costs.

¹¹⁵ Federal reinsurance and risk adjustment payments/receivables are included in the Earned Premium as reported in Part I of the federal MLR reports. CSR payments are subtracted from the Incurred Claims report in Part I of the federal MLR reports.

¹¹⁶ Based on premium equivalents reported in the 2017 SDR data.

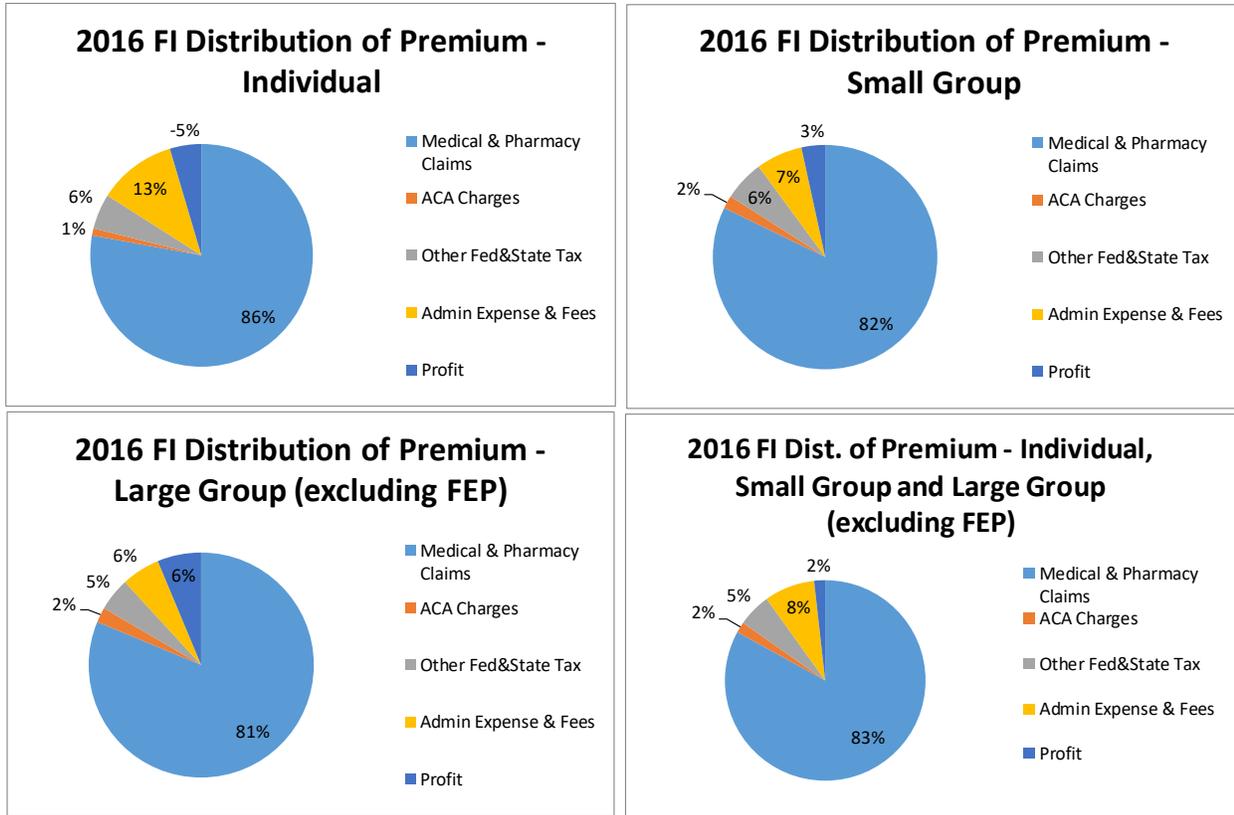


Figure 53: Loss Ratio Exhibits by Market for CY 2016^{117, 118}

\$19.1 million in federal reinsurance payments were made to New Hampshire Individual Market insurers in 2016, estimated to reduce Individual Market premiums by approximately 4%.

- The largest reinsurance payment was made to Matthew Thornton Health Plan for \$6.4 million. This translates to 4% of their premium in CY 2016, meaning that premiums to consumers were approximately 4% lower than they would have been due to the expectation of payments from this program.
- Community Health Options and Minuteman received 9% and 6% of their premium, respectively, in federal reinsurance payments in CY 2016. While Harvard Pilgrim and Celtic Insurance Company (Ambetter) received 4% and 2% of their premium, respectively, in federal reinsurance payments in CY 2016.
- 2016 is the last year of the transitional federal reinsurance program and beginning in 2017, premiums will be higher due to the elimination of this program.

¹¹⁷ 2016 federal MLR reports provided by insurers. Anthem provided additional information for FEHBP to make necessary adjustments to exclude this population from the Large Group.

¹¹⁸ See footnote 111.

Individual Market- Federal Reinsurance Program			
	2014 Reinsurance (\$ millions)	2015 Reinsurance (\$ millions)	2016 Reinsurance (\$ millions)
Celtic Insurance Company	\$0.1	\$0.1	\$2.0
Harvard Pilgrim Health Care of NE	n/a	\$2.6	\$4.3
Maine Community Health Options	n/a	\$3.3	\$3.7
Matthew Thornton Hlth Plan(Anthem BCBS)	\$15.6	\$8.3	\$6.4
Minuteman Health, Inc.	n/a	\$2.1	\$2.7
Time Insurance Company	\$6.1	\$5.0	n/a
Total	\$21.8	\$21.5	\$19.1

Table 10: Federal Reinsurance Payments in the Individual Market by Insurer¹¹⁹

The Individual Market experienced a dramatic increase in total monies distributed through the risk adjustment program in 2016 compared to prior years, due in large part to the introduction of the NH PAP.

- The Risk Adjustment program is revenue neutral within both the New Hampshire Individual Market and Small Group Market.
- In 2016, Ambetter, who is nearly all NH PAP enrollees, had a higher-risk population and received \$17.3 million, whereas Minuteman Health paid \$25.4 million. This compares to 2015, where Time Insurance Company and Community Health Options had a higher risk population and received \$6.2 million and \$5.3 million respectively, where Minuteman Health who has a lower risk population paid \$10.5 million.
- The total amount distributed through the federal risk adjustment program in the Individual Market has changed dramatically from 2014 to 2016. In 2014, the total amount distributed was \$5.3 million. In 2016, the amount increased almost 5 times to \$25.9 million. This again is driven by dramatic changes to the Individual Market during this time including new market entrants and introduction of NH PAP.

¹¹⁹ Centers for Medicare and Medicaid Services. Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year. June 2017. Available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf>.

Individual Market- Federal Risk Adjustment Program			
	2014 Risk Adjustment (\$ millions)	2015 Risk Adjustment (\$ millions)	2016 Risk Adjustment (\$ millions)
Celtic Insurance Company	\$0.1	\$0.1	\$17.3
Harvard Pilgrim Health Care of NE	n/a	(\$1.2)	\$0.4
Maine Community Health Options	n/a	\$5.3	\$8.2
Matthew Thornton Hlth Plan(Anthem BCBS)	(\$5.3)	\$0.2	(\$0.5)
Minuteman Health, Inc.	n/a	(\$10.5)	(\$25.4)
Time Insurance Company	\$5.2	\$6.2	n/a
Total	\$0.0	\$0.0	\$0.0
Total Amount Distributed	\$5.3	\$11.7	\$25.9

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

Table 11: Federal Risk Adjustment Payments in the Individual Market by Insurer¹²⁰

Within the Individual Market, \$41 million was transferred from Non-PAP plans to PAP plans in 2016 through the federal risk adjustment program.¹²¹

- When comparing risk scores by plan within the Individual Market, the risk score for PAP plans is 27% higher than the risk score for Non-PAP plans.
- The federal risk adjustment program transfers payments from plan offerings with members that are less healthy than average (i.e., higher risk) to plan offerings whose members are healthier than average (i.e., lower risk). GA analyzed the risk transfers from Non-PAP plans to PAP plans. There was \$41 million dollars transferred from Non-PAP HIOS plan ID's to PAP HIOS plan ID's based on the federal risk adjustment reports.

In contrast, the total amount of monies distributed through the risk adjustment program in the Small Group Market has remained fairly stable from 2015 to 2016.

- In 2016, Anthem and Matthew Thornton continue to receive money due to their generally higher risk population. Community Health Options was a payer due to their generally lower risk population.

¹²⁰ Ibid.

¹²¹ GA received the federal risk adjustment reports from each insurance carrier. Each report provides a plan liability risk score by HIOS ID, which allowed GA to aggregate these scores across insurance carriers. Each insurer's product portfolio offers a plan that is designed for the PAP population. However, this plan offering is offered to the entire individual market, including PAP and Non-PAP enrollees. GA has estimated that 82% of enrollees within the PAP plan offerings are actual PAP enrollees. Using this information, GA determined that the average risk score for enrollees in Non-PAP plans is 1.42 while the average risk score for enrollees in PAP plans is 1.81, representing a 27% difference.

Harvard Pilgrim pays a small amount when combining experience from both companies (Harvard Pilgrim Health Care of NE and HPHC Insurance Company, Inc.)

Small Group Market- Federal Risk Adjustment Program			
	2014 Risk Adjustment (\$ millions)	2015 Risk Adjustment (\$ millions)	2016 Risk Adjustment (\$ millions)
Anthem Health Plans of NH(Anthem BCBS)	\$1.2	\$1.3	\$1.9
Harvard Pilgrim Health Care of NE	(\$3.0)	(\$0.8)	(\$2.6)
HPHC Insurance Company, Inc	\$1.5	\$1.9	\$1.9
Maine Community Health Options	n/a	(\$3.6)	(\$2.8)
Matthew Thornton Hlth Plan(Anthem BCBS)	\$0.2	\$1.5	\$2.4
Minuteman Health, Inc.	n/a	(\$0.0)	(\$0.0)
Tufts Health Freedom Insurance Company	n/a	n/a	(\$0.5)
UnitedHealthcare Insurance Company	\$0.0	(\$0.2)	(\$0.2)
Total	\$0.0	\$0.0	\$0.0
Total Amount Distributed	\$3.0	\$4.7	\$6.2

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

Table 12: Federal Risk Adjustment Payments in the Small Group Market by Insurer¹²²

Insurers that experience medical loss ratios below the federal standards are required to provide premium rebates to policyholders for the amounts below the minimum threshold. This information is not yet publicly available.

¹²² Ibid.

9. Regional and National Comparisons

In 2014, New Hampshire was ranked 9th highest in the nation for per capita health care expenditures, which represents no change from 2009.

- New Hampshire’s 2014 per capita personal health care spending was 19% higher than the national average. The national average was \$8,045 which compares to New Hampshire’s spending of \$9,589.
- New Hampshire’s per capita spending is consistent with the other New England states.
- New Hampshire’s average annual growth rate in personal health care spending was slightly higher than the national average at 3.3%, as shown in Figure 56.
- New Hampshire was ranked 9th highest among the private insurance market as well in 2014. However, the 2014 per capita personal health care spending was only 7% higher than the national average (\$4,880 vs. \$4,551).

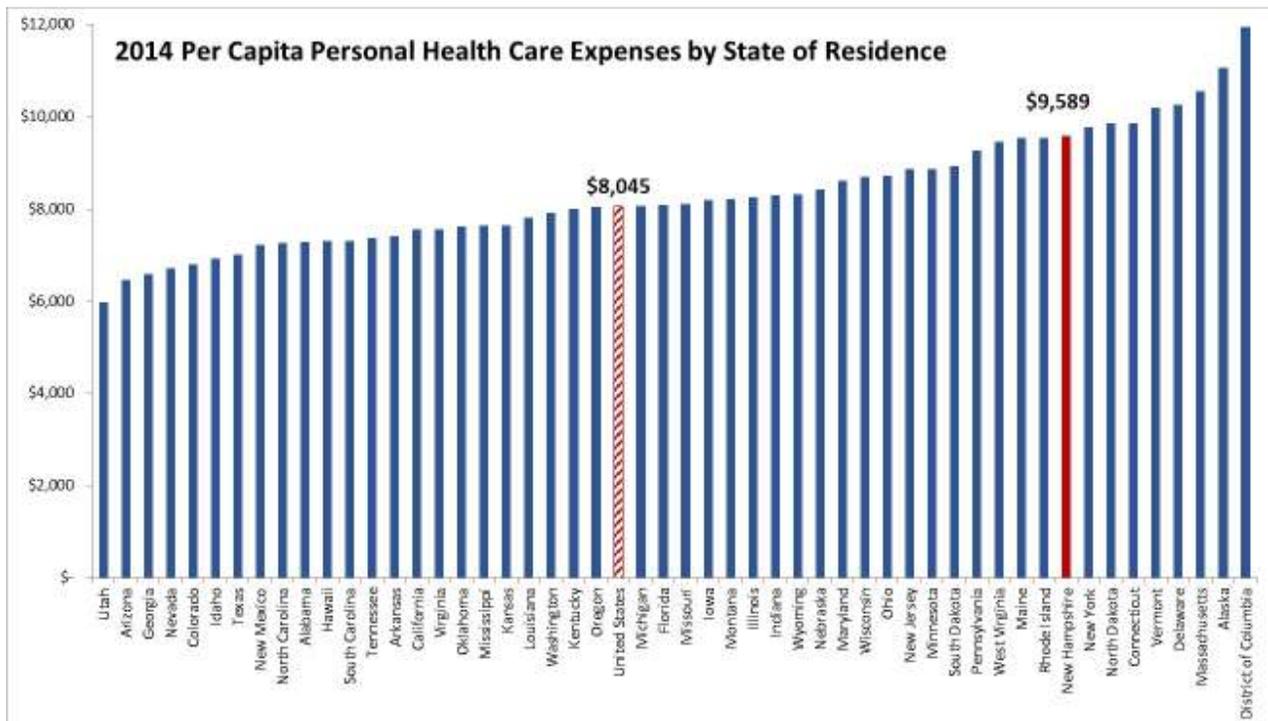


Figure 54: Per Capita 2014 Personal Health Care Spending by State¹²³

¹²³ Centers for Medicare & Medicaid Services (2017). *Health Expenditures by State of Residence*. Retrieved (date accessed) at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/resident-state-estimates.zip>. State health expenditures are measured at the personal health care level, which reflects all health care goods and services consumed but excludes items such as government administrative costs, government public activity, the net cost of private health insurance, and investment. These personal health care spending reflects all payers, Medicare, Medicaid, private health insurance, other payers and programs including out of pocket expenses.

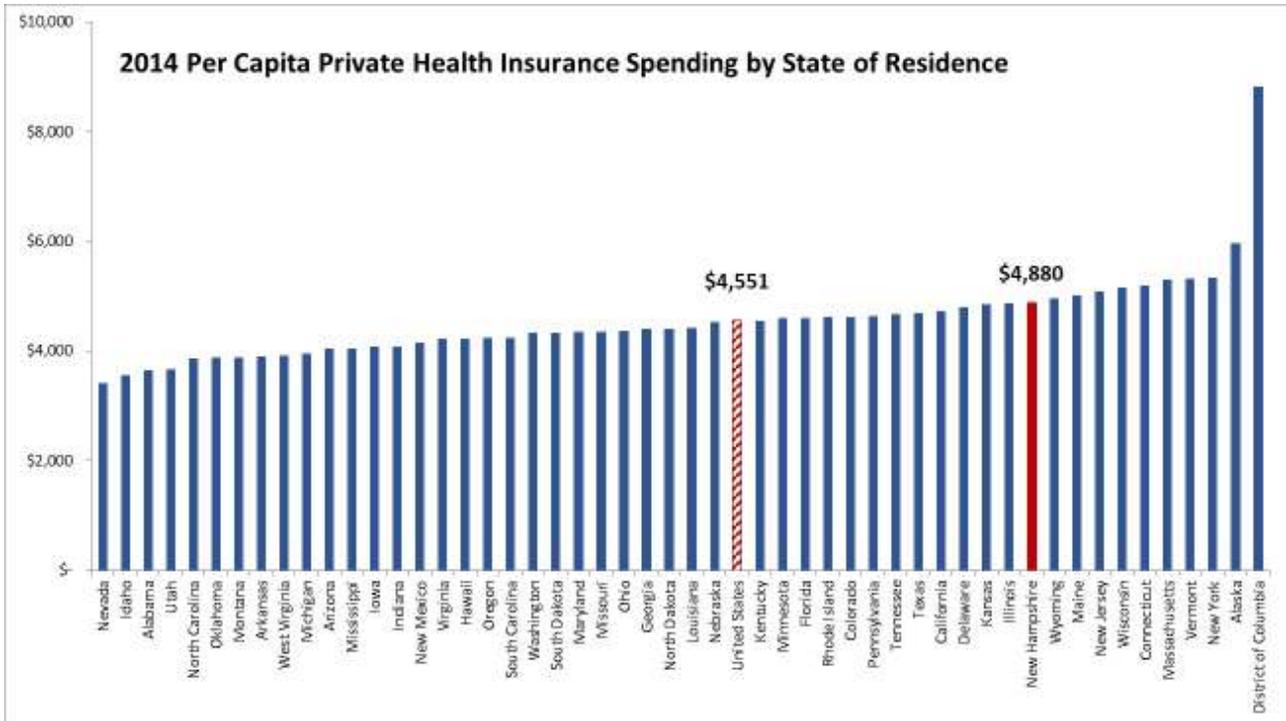


Figure 55: Per Capita 2014 Private Health Insurance Personal Health Care Spending by State¹²⁴

¹²⁴ Centers for Medicare & Medicaid Services (2017). *Health Expenditures by State of Residence*. Retrieved (date accessed) at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/resident-state-estimates.zip>.

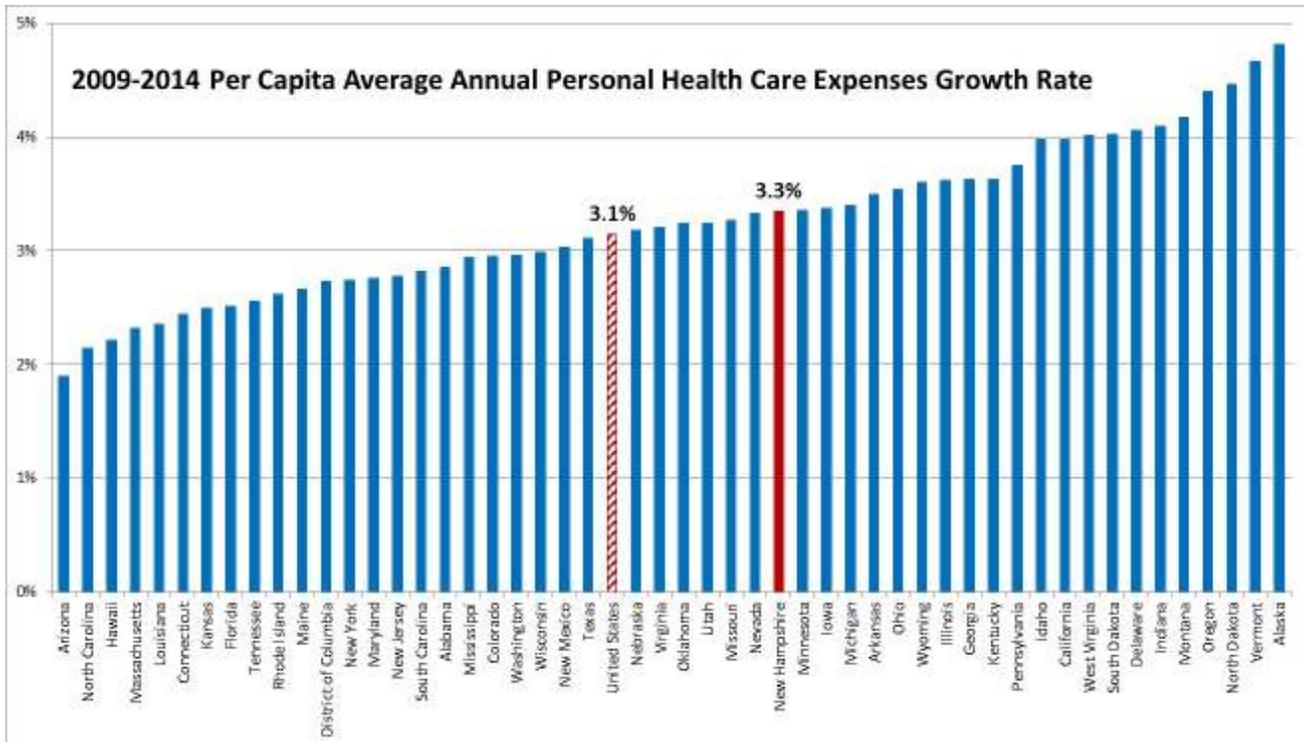


Figure 56: Per Capita, Personal Health Care Spending Annual Growth Rate 2009 - 2014¹²⁵

In 2014, New Hampshire had the second highest median income of all states, and higher than average per capita personal health care spending.

- New Hampshire has the 2nd highest median income in the country.
- There is a correlation between median income and per capita personal health care spending when comparing data by state. New Hampshire’s higher than average per capita personal health care spending appears to be correlated with their higher than average median income.

¹²⁵ Centers for Medicare & Medicaid Services (2017). *Health Expenditures by State of Residence*. Retrieved (date accessed) at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/resident-state-estimates.zip>.



Figure 57: 2014 Per Capita Personal Health Care Spending and Median Income by State^{126, 127}

In 2016, New Hampshire premiums in the Individual and Small Group Markets are near the median or close to the median across all states.¹²⁸

- New Hampshire’s 2016 premiums rank 25th highest in the Individual Market and 19th highest in the Small Group Market for ACA compliant plans as shown in Figure 58 and Figure 59.
- This represents a decrease in rank from 2015 and 2014 for both the Individual and Small Group Markets. In 2015, New Hampshire’s premium ranked 18th highest in the Individual Market and tenth highest in

¹²⁶ Centers for Medicare & Medicaid Services (2017). *Health Expenditures by State of Residence*. Retrieved (date accessed) at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/resident-state-estimates.zip>.

¹²⁷ Table H-8. Median Household Income by State: 1984 to 2016. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements Data Tables.

¹²⁸ Centers for Medicare and Medicaid Services. Appendix A to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year. June 2017. Available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-2017-Summary-Report-Data.xlsx>.

the Small Group Market for ACA compliant plans.¹²⁹ In 2014, New Hampshire ranked tenth highest in the Individual Market and fourth highest in the Small Group Market.¹³⁰

- Using information from CMS’ risk adjustment report, New Hampshire’s actuarial value and plan liability risk score (PLRS) in 2016 is very consistent with the average across all states for the Individual Market.
- In the Small Group Market, New Hampshire’s actuarial value and PLRS in 2016 is also lower than the average across all states. Therefore, New Hampshire’s slightly higher than average premiums in the Small Group Market are not attributed to richer benefits (as seen by the actuarial values) or higher morbidity (as seen by the PLRS values).
- When comparing the second lowest costing Silver plans (before federal premium subsidies) across the country, New Hampshire ranked as the 20th lowest in 2015, changing to the 18th lowest in 2016 and changing further to the 8th lowest in 2017.^{131, 132}
- New Hampshire has a high median age compared to other states, ranking as the second highest in 2016.¹³³

¹²⁹ Centers for Medicare and Medicaid Services. Appendix A to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year. June 2016. Available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-to-June-30-2016-RA-and-RI-Report-5CR-063016.xlsx>.

¹³⁰ These data have not been adjusted for demographic or benefit differences by state. Massachusetts is not included in this chart since they are the only state to have a state operated risk adjustment program.

¹³¹ C Cox, S Gonzales, R Kamal, G Claxton and L Levitt. Analysis of 2016 Premium Changes in the Affordable Care Act’s Health Insurance Marketplaces. Kaiser Family Foundation, October 2015. Available at: <http://kff.org/health-reform/fact-sheet/analysis-of-2016-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/>.

¹³² C Cox, M Long, A Semanskee, R Kamal, G Claxton and L Levitt. 2017 Premium Changes and Insurer Participation in the Affordable Care Act’s Health Insurance Marketplaces. Kaiser Family Foundation, October 2016. Available at: <https://www.kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/>.

¹³³ U.S. Census Bureau population estimates. Data Source: U.S. Census Bureau. Available at: <https://census.gov/newsroom/press-releases/2017/cb17-100.html#table1>.

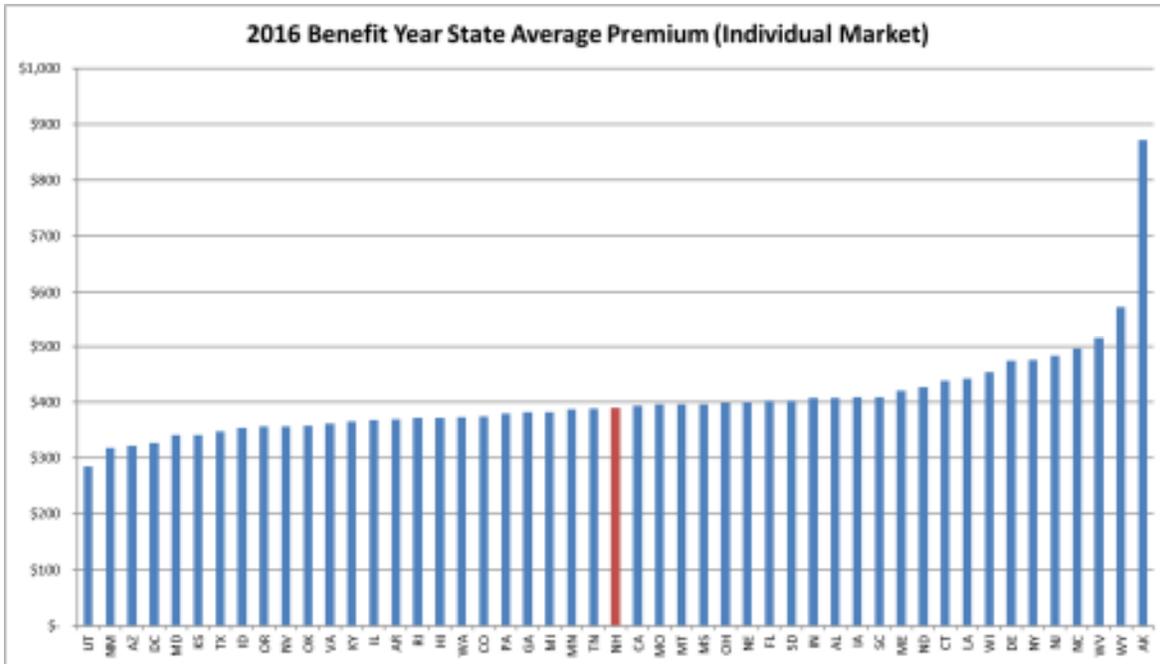


Figure 58: Individual Market Premiums by State - 2016 Benefit Year¹³⁴

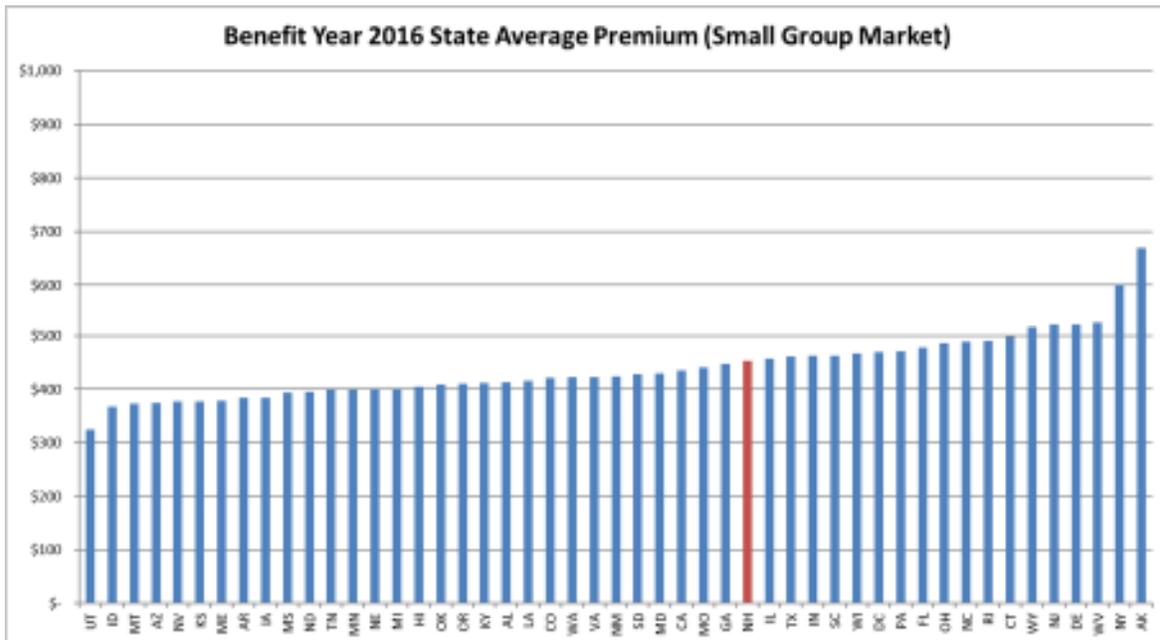


Figure 59: Small Group Market Premiums by State - 2016 Benefit Year¹³⁵

¹³⁴ Centers for Medicare and Medicaid Services. Appendix A to the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year. June 2017. Available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Appendix-A-2017-Summary-Report-Data.xlsx>.

¹³⁵ Ibid.

10. Product Innovation

Limited network products continue to gain market share, primarily in the Individual Market Exchange. Of the insurers with both a standard and limited network, the data continue to show that the hospital unit prices in the limited network are 20% to 40% lower on average.^{136, 137, 138}

- Table 13 summarizes the number of hospitals included by insurer network in 2017 and 2018. There are a total of 26 acute care hospitals in New Hampshire.
- Some insurers have stated that their original limited network products have continued to expand their networks since their introduction. There is generally a trade-off between the size of the network and the premium savings generated for customers, where the larger the network the lower the premium savings compared to a broad network product.
- The number of limited network offerings on the exchange has decreased from 2017 to 2018 with the exit of Minuteman and the discontinuation of HPHC’s Full Network product.
- As of December 2016, 24% of the overall fully-insured market members are in limited network products driven by 93% participation in the Individual Exchange Market (excluding PAP), 33% participation in the Individual Non-Exchange Market, and 36% in the Individual NH PAP market.
- The percentage of overall fully-insured market members in limited network products rose to 28% as of April 2017, with 96% participation in the Individual Exchange Market (excluding PAP), and 40% in both the Individual Non-Exchange Market and the Individual NH PAP market.
- Limited network presence in the self-insured market remains small, with 6% market share as of April 2017.
- Anthem stated that premiums for limited network products are approximately 30% lower than those for comparable plans with a broad network in 2015.¹³⁹ Harvard Pilgrim stated that limited network products are generally lower by double-digits compared to comparable broad network plans.¹⁴⁰

¹³⁶ This range is an average and actual differences will vary by hospital and insurer.

¹³⁷ Anthem (Matthew Thornton Health Plan) has offered a limited network product (referred to as the Pathway Network) on the Exchange since 2014. Harvard Pilgrim began offering a limited network HMO product (referred to as the Elevate Health Network) to Small Groups and Large Groups in 2014, and joined the Exchange in 2015 where this product is also being sold in the Individual Market. Minuteman Health also began offering a product on the Exchange in 2015 with a more limited network although they have exited the market for 2018.

¹³⁸ For purposes of analyzing 2015 through 2017 data, Anthem’s Pathway Network, HPHC’s Elevate, and Minuteman Health’s product are considered “Limited Network,” but this designation may change over time as these networks continue to evolve.

¹³⁹ Anthem Blue Cross Blue Shield. Anthem Blue Cross and Blue Shield, Elliot Health System Reach Agreement on Pathway Network. No date. Available at: <https://www.anthem.com/health-insurance/about-us/pressreleasedetails/NH/2015/1876/anthem-blue-cross-and-blue-shield-elliott-health-system-reach-agreement-on-pathway-network>.

¹⁴⁰ Elevate Health plan information available at: https://www.harvardpilgrim.org/portal/page?_pageid=849,2919992&_dad=portal.

Hospital Network Profile for Exchange Products 2017 and 2018		
	Number of Hospitals included in 2017	Number of Hospitals included in 2018
Anthem (Pathway X and Pathway X Enhanced)	20	21
Centene (Ambetter)	23	25
Harvard Pilgrim Health Care of New England (Full Network)	26	n/a
Harvard Pilgrim Health Care of New England (Elevate Health)	16	18
Minuteman Health	15	n/a

Table 13: 2017 and 2018 Hospital Network Profile^{141, 142}

Low-cost provider benefit designs, or site of service benefit designs,¹⁴³ continue to be a popular option for many employers. Although their market penetration may have peaked at this point, opportunities for future cost savings may exist by expanding cost sharing incentives to other types of services.

- As of December 2016, approximately 73% of Small Group and 48% of Large Group fully-insured members are in low-cost provider options. These percentages are fairly consistent with results from the prior year.
- Market penetration of the low-cost provider options has increased slightly to 13% in the self-insured market as of December 2016.
- Current low-cost provider options have mainly focused on creating cost sharing incentives for ambulatory surgery and outpatient lab services, but insurers are exploring expanding these options to other services such as outpatient ultrasound, x-ray imaging, physical therapy, occupational therapy and speech therapy.
- Results will vary for specific surgeries and labs, but generally there are significant cost differences, both for total allowed costs and member costs for utilization at ambulatory surgical centers and zero cost labs versus outpatient hospital settings.^{144, 145}

¹⁴¹ New Hampshire Insurance Department. Network Adequacy: Public Information Release, Marketplace Issuer Networks for the 2017 Plan Year. July 2016. Available at: https://www.nh.gov/insurance/consumers/documents/2017_na_pres_issuer_ntw.pdf.

¹⁴² New Hampshire Insurance Department. Network Adequacy: Public Information Release, Marketplace Issuer Networks for the 2018 Plan Year. September 2017. Available at: https://www.nh.gov/insurance/lah/documents/2017_na_pres_issuer_ntw.pdf.

¹⁴³ The benefit designs provide financial incentives for members to choose insurer-designated lower-cost facilities, specifically for outpatient surgery or laboratory services. An example of how this benefit design works is as follows: If a member has an outpatient surgery at a certain hospital, the deductible will first apply, and that deductible may be anywhere from \$1,000 to \$5,000. If the member has the same outpatient surgery at an ambulatory surgical center (ASC) or other designated low-cost provider, the cost sharing is a fixed copayment amount of \$100, for example. In the case of a laboratory service, if the laboratory service takes place at a certain outpatient hospital, the deductible will first apply. If the member has the same laboratory service at an independent lab or other designated low-cost provider, the member pays no cost sharing.

¹⁴⁴ The analysis does not adjust for risk differences between the populations using lower-cost settings versus those who do not.

¹⁴⁵ See the NHID's report on 2014 Medical Cost Drivers for details on the analysis on low-cost provider benefit designs. Available at: https://www.nh.gov/insurance/reports/documents/2015_annual_report_cost_drivers.pdf.

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

Membership in tiered network hospital products continues to remain minimal in the fully-insured market with 2.5% of members in these products as of April 2017. The self-insured market increased slightly to approximately 12% of members as of April 2017.

11. Uncompensated Care Costs

Total Uncompensated Care Costs for New Hampshire hospitals have remained consistent in total from FY 2014 to FY 2015.

- Uncompensated Care Costs (UCC) are generally defined as health care services provided by hospitals or providers that do not get reimbursed for a variety of reasons. This can be because patients do not have health insurance or do not have enough health insurance to cover the costs of their medical bills. Uncompensated care costs can also include underpayment from either Medicare or Medicaid reimbursement.
- Data were collected from both the New Hampshire Hospital Association (NHHA) and the New Hampshire Department of Health and Human Services (DHHS) to understand current levels of uncompensated care for New Hampshire acute care hospitals.
- NHHA compiles UCC information from the Internal Revenue Service 990 Schedule H Form for hospitals. These IRS forms are publicly available and are considered an industry standard source for UCC. As compiled by NHHA in fiscal year 2015, the two largest categories of UCC are for unreimbursed Medicaid at \$319 million and unreimbursed Medicare at \$255 million.¹⁴⁶ Community Benefits, which includes items such as grants to health care centers and community health initiatives, represent \$164 million. Bad debt and expenses represents \$113 million and financial assistance or charity care provided by hospitals represents \$58 million. Combined across these UCC categories, this totals to approximately \$909 million in FY 2015.
- The total UCC in FY 2015 is very similar to the FY 2014 total of \$908 million. While the totals are similar between the two time periods, the amount of UCC by category has shifted. In FY 2015, Unreimbursed Medicaid and Medicare comprised 63% of the total compared to 52% in FY 2014. Alternatively, Community Benefits, Bad Debt and Financial Assistance comprised 37% of the total UCC in FY 2015 compared to 48% in FY 2014.
- DHHS determines UCC for purposes of calculating disproportionate share hospital (DSH) payments. DSH payments are made to qualifying hospitals that serve a large number of Medicaid and uninsured patients. DHHS follows federal guidelines to determine UCC for this purpose and generally includes unreimbursed Medicaid costs and costs for treating the uninsured. UCC, as reported by DHHS for the state fiscal year 2017 DSH payment, is based on the hospitals' fiscal year 2015 financial data and totals to \$457 million. The information received from DHHS is not comparable to the UCC information from NHHA given the differences in methodology and the purpose of the DHHS data being used exclusively for DSH payment calculations.
- Compared to FY 2014, UCC determined by DHHS for DSH payments was \$440 million. This represents a 3.8% increase in FY 2015 compared to FY 2014.
- A 2017 report released by The Commonwealth Fund found the following: "Uncompensated care burdens fell sharply in expansion states between 2013 and 2015, from 3.9 percent to 2.3 percent of operating costs. Estimated savings across all hospitals in Medicaid expansion states totaled \$6.2 billion.

¹⁴⁶ Unreimbursed Medicaid and Medicare is based on the difference between Medicaid/Medicare reimbursement and hospital costs (not charges.) The Medicaid/Medicare costs are determined based on federal definitions and are audited.

The largest reductions in uncompensated care were found for hospitals in expansion states that care for the highest proportion of low-income and uninsured patients.”¹⁴⁷

- In New Hampshire, it appears that UCC has not decreased in FY 2015 due to Medicaid Expansion in 2014.¹⁴⁸

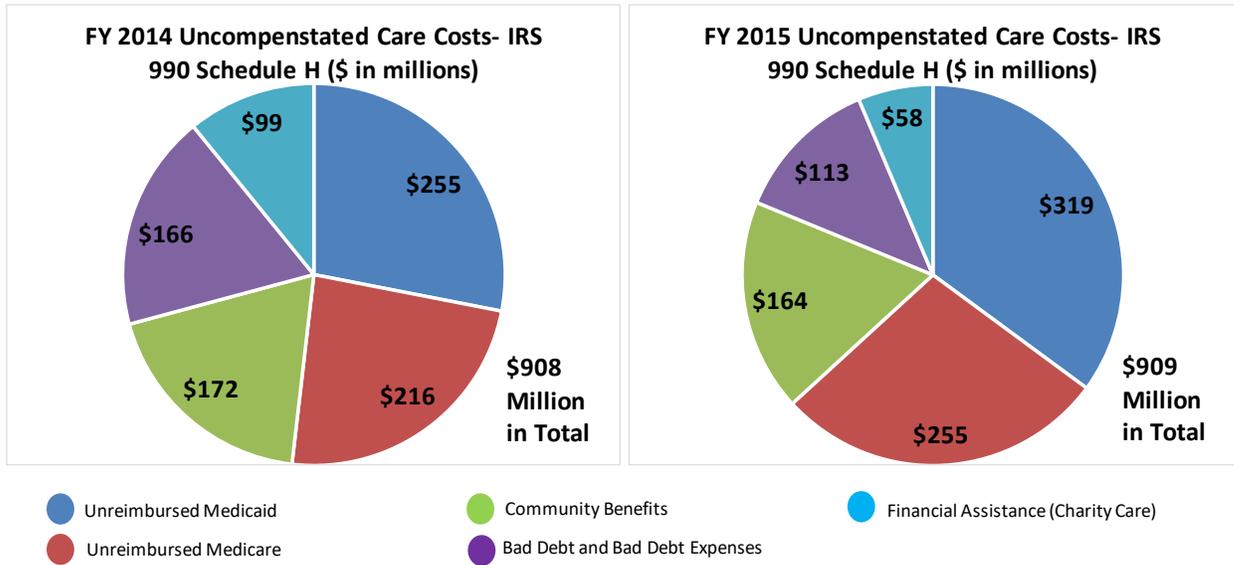


Figure 60: Uncompensated Care Costs for New Hampshire Not for Profit Acute Care Hospitals in FY 2015 and FY 2014¹⁴⁹

¹⁴⁷ The Commonwealth Fund. The Impact of the ACA’s Medicaid Expansion on Hospitals’ Uncompensated Care Burden and the Potential Effects of Repeal. Available at: <http://www.commonwealthfund.org/publications/issue-briefs/2017/may/aca-medicaid-expansion-hospital-uncompensated-care>.

¹⁴⁸ New Hampshire expanded its Medicaid program on August 15, 2014. UCC for FY 2015 in Figure 60 represents data for each hospital’s fiscal year ending in 2015. In New Hampshire, hospitals have fiscal years ending June 30th, September 30th, or December 31st. Therefore, the majority of the data for FY 2015 represents a full year of experience with the Medicaid Expansion.

¹⁴⁹ Information shared by the New Hampshire Hospital Association & Foundation for Healthy Communities. Source: FY 2014 990 Report, Schedule H.

12. Self-Insured Analysis

72% of the 2016 Large Group Market are self-insured members.

- This percentage distribution has been consistent since 2010 where 70% of the Large Group Market membership was self-insured.

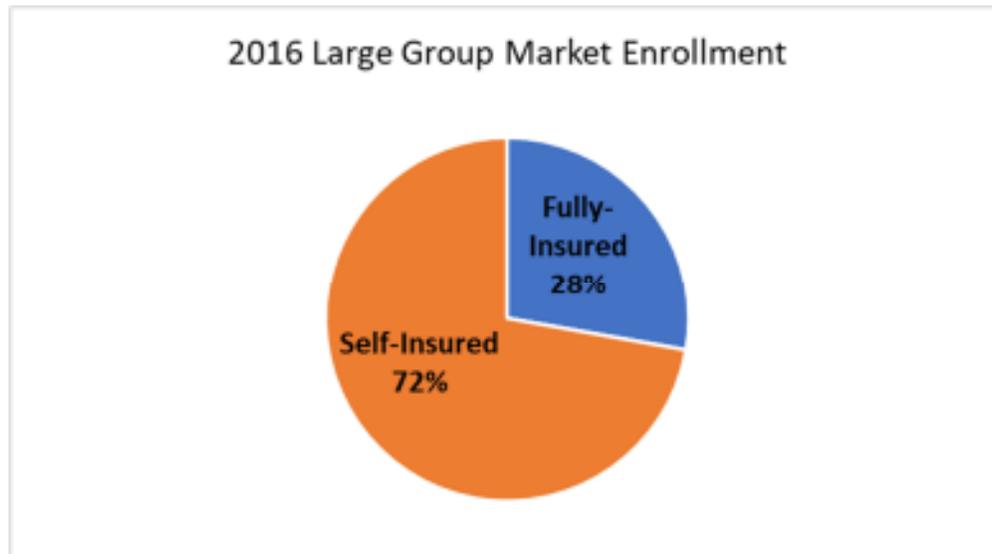


Figure 61: Large Group Membership Distribution¹⁵⁰

The top three insurers in the Large Group Self-Insured Market are Anthem, CIGNA, and HPHC.

- As was shown in Figure 4 and Figure 5, Anthem is the market leader in the self-insured market with 41% of the membership followed by CIGNA at 33% of the market. This contrasts with the fully-insured market where HPHC is the market leader representing 47% of the market followed by Anthem at 43% of the market.
- CIGNA has a much larger presence in the self-insured market compared to the fully-insured market.

¹⁵⁰ 2017 SDR. Situs based membership only.

The Large Group Fully-Insured and Self-Insured markets are similar in age.

- The average age and age factor for both markets are almost the same.¹⁵¹ The self-insured market appears to have more children (24% vs. 20%) and has fewer 30 to 39 year-olds (13% vs. 16%). This suggests that the self-insured market has more families.

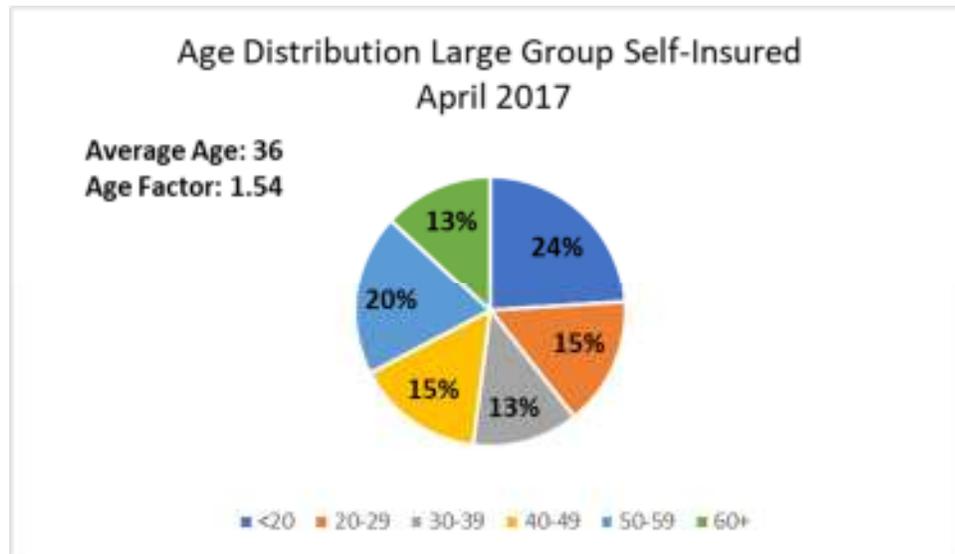


Figure 62: Large Group Market Membership Age Distribution, Self-Insured¹⁵²

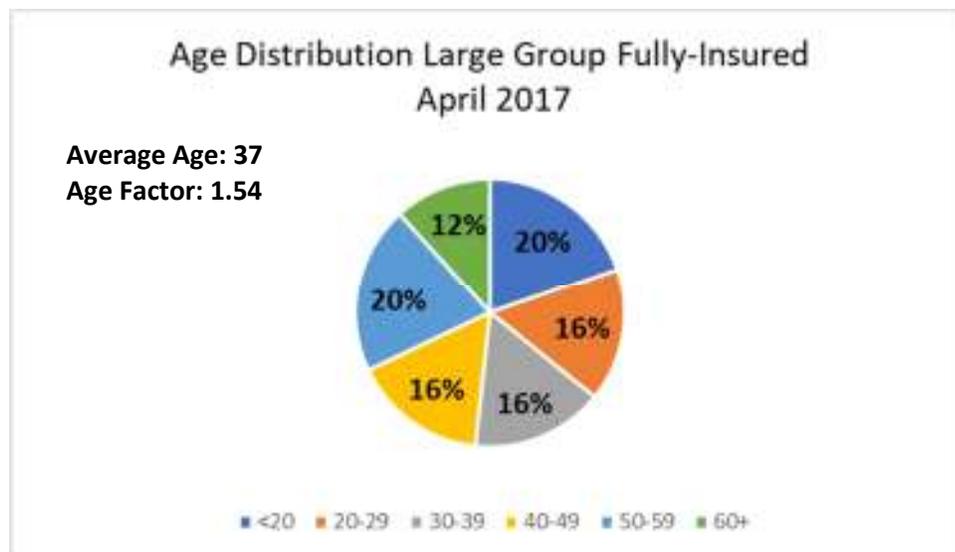


Figure 63: Large Group Market Membership Age Distribution, Fully-Insured¹⁵³

¹⁵¹ Age factors are used to adjust premiums to cover the higher expected medical costs of an older population. The higher the age factor, the older the population and the greater the expected medical costs.

¹⁵² 2017 SDR. Situs based membership only.

¹⁵³ Ibid.

A Large Group Market fully-insured member pays almost 80% more out of pocket as compared to a self-insured member.

- In 2016, a fully-insured Large Group Market member paid on average \$84 PMPM in member cost sharing. This translates to 17% of total medical costs. In other words, 17 cents out every \$1 of health care claims costs is paid for by the member through member cost sharing (copays, deductibles, coinsurance).
- This contrasts with \$47 PMPM for a self-insured Large Group Market members or 9% of total health care claims costs. This suggests that members enrolled through self-insured accounts have lower copays, deductibles and coinsurance as compared to their counterparts.
- As was shown in Figure 19, municipalities and state employees have “richer” benefits. This population makes up 47% of the self-insured market.

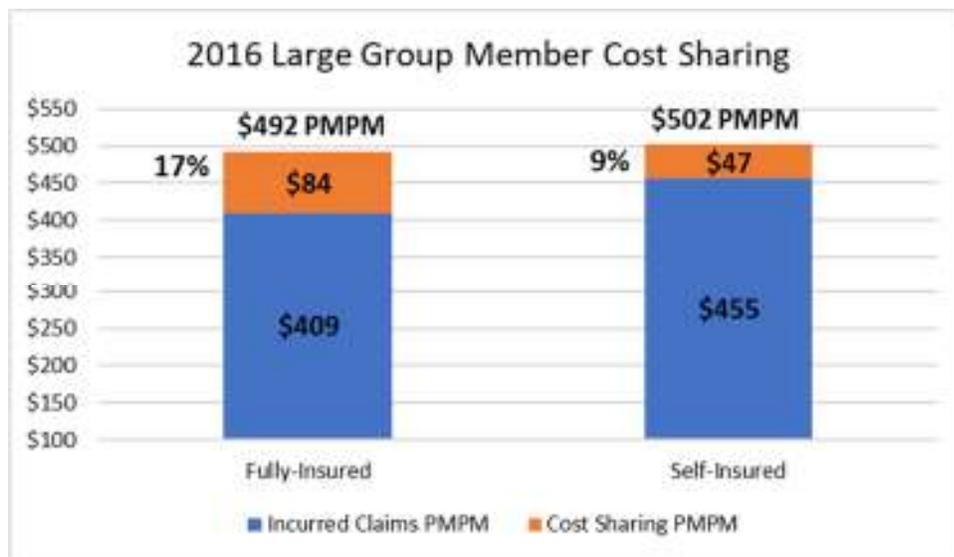


Figure 64: CY 2016 Large Group Market Cost Sharing and Total Allowed Claims PMPM¹⁵⁴

The average health care claims costs for the Large Group Self-Insured and Fully-Insured Markets are nearly the same.

- As shown in Figure 64, the allowed claims PMPM for the fully-insured market is \$492 which compares to \$502 for the self-insured market. This is a 2% difference.
- While the age demographics are nearly the same, the plan designs are not. We would expect to see higher medical claims on average for the self-insured market as they are enrolled in plan designs that have lower cost sharing as compared to the fully-insured market. Lower cost sharing can lead to

¹⁵⁴ Ibid.

induced demand or a higher utilization of services. Since we are not observing a significant difference in total allowed claims between these two populations, other factors may be influencing the medical costs. For example, the distribution of where members are receiving their care can influence the overall medical costs.

- In almost all cases, insurers have responded that provider reimbursement is the same between the two markets. Some insurers have responded that some medical management programs are different between the two markets¹⁵⁵.

The administrative fee charged by insurers to self-insured employers varies considerably by insurer, ranging from \$14 PMPM to \$64 PMPM.

- As shown, the administrative fee ranges from 3% to 16% of total health insurance costs. This suggests that insurers actual administrative expenses can be highly variable from one insurer to the next. In addition, this variability suggests that some insurers administrative fees only cover fixed costs and others cover fixed and variable expenses.

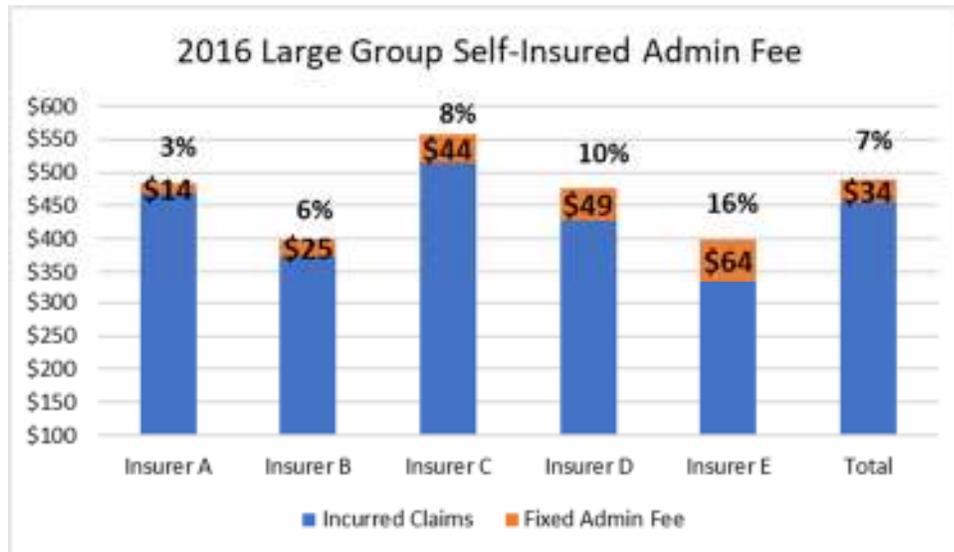


Figure 65: CY 2016 Large Group Market Self-Insured Administrative PMPM Fee by Insurer¹⁵⁶

For every \$1 spent on total health insurance costs, 19 cents was collected by the insurer for administrative expenses, profit, and risk margin in the Large Group Fully-Insured Market. In the Large Group Self-Insured Market, only 7 cents was collected by the insurer for administrative expenses and profit.

¹⁵⁵ Responses are from the 2017 Annual Hearing Questionnaire.

¹⁵⁶ 2017 SDR. Situs based membership only.

- Generally, insurers need to retain more of the health insurance premium in the fully-insured market because in addition to administering the benefit, they are also assuming the risk on medical claims expenses. In addition, self-insured accounts are generally larger than fully-insured accounts, and an economy of scale is recognized which allows insurers to charge a lower administrative charge to this market.

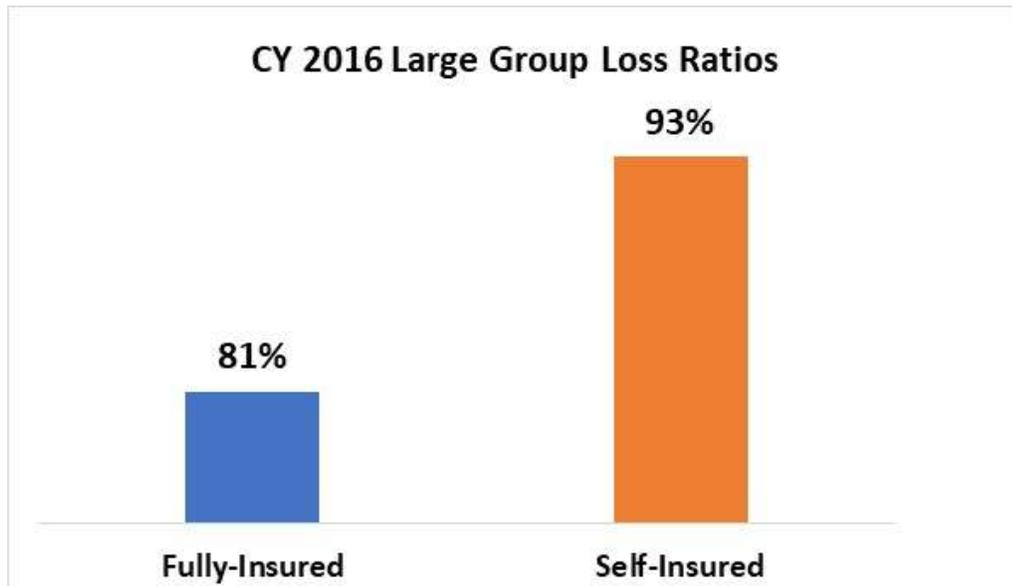


Figure 66: CY 2016 Large Group Market Loss Ratios¹⁵⁷

¹⁵⁷ Fully-insured based on federal MLR reports. Self-insured based on 2017 SDR data. Situs based membership only. Excludes individuals covered under FEHBP.

13. Conclusion

The New Hampshire health insurance market has experienced many changes from 2014 to 2016 due to Medicaid Expansion, the introduction of the New Hampshire Premium Assistance Program and the entering and exiting of various insurers. The impact of these changes is seen in the membership, premiums and claims for each impacted market segment. As we look to 2017 and 2018, we will continue to see impacts to the Individual Market in particular as the NH PAP population enters its second and third year as part of the Individual Market Single Risk Pool, along with the exit of Community Health Options in 2017 and Minuteman in 2018. In addition, changes to health care reform at the federal level may also impact New Hampshire markets.

14. Limitations and Data Reliance

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

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

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

The report contains statements that attempt to provide some prospective context to current or past trends. These statements are based on the understanding of the existing and proposed regulatory environment as of November 2017. If subsequent changes are made, these statements may not appropriately represent the expected future state.

15. Qualifications

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

16. Glossary

- **ACA:** Affordable Care Act of 2010
- **Actuarial Value:** For purposes of this report, “actuarial value” is defined as the share of medical costs covered by the health plan for a standard population, and is the federal Minimum Value measure as outlined in Section 1302 (d)(2)(C) of the Affordable Care Act.
- **Allowed Costs:** These costs include both the amount paid by the insurer and the amount paid by the member through cost sharing such as deductibles, copayments and coinsurance.
- **Benefit-Adjusted Premium Trend:** The premium trend recalculated to assume no changes in benefits from year to year.

- **Benefit Buy-Down:** The process of selecting a plan with reduced benefits or higher member cost sharing as a way to mitigate premium increases.
- **Cost Trend:** For purposes of this report, “cost trend” represents the combination of the change in the unit price of specific services, the change in the claim severity of the total basket of services provided, and the change in mix of providers being used.
- **EPO:** Exclusive Provider Organization; a type of health plan with a defined network of providers. Unlike an HMO, the member may not be required to select a Primary Care Physician or receive referrals to Specialists within the network.
- **Fully-Insured Plan:** A health plan in which an insurer receives a premium payment in return for covering all claims risk associated with the enrollees.
- **HMO:** Health Maintenance Organization; a type of health plan that employs medical management techniques such as a defined provider network, Primary Care Physician selection and Specialist referral requirements.
- **NAIC:** National Association of Insurance Commissioners
- **NHID:** New Hampshire Insurance Department
- **Per Member Per Month (PMPM):** A common method of expressing healthcare financial data that normalizes for the size of the membership pool. Dollars are divided by member months to calculate the PMPM value.
- **POS:** Point-of-Service plan; a type of health plan similar to an HMO, but with the option to self-refer to providers outside of the HMO network, typically with increased levels of member cost sharing.
- **PPO:** Preferred Provider Organization; a type of health plan that employs a network of preferred providers, but does not limit a member from seeking care at any provider. Typically, the member cost sharing will be lower when care is provided within the preferred network.
- **Pricing Trend:** An assumption used in setting premium rates that represents the expected increase in future claims costs.
- **Situs:** “Situs” of a policy is defined as the jurisdiction in which the policy is issued or delivered as stated in the policy.
- **Self-Insured Plan:** A health plan in which an employer does not actually pay insurance premiums to an insurer to accept the claims risk. The employer pays only a service fee to an insurer to administer the plan, but then the employer covers the cost of claims for their enrollees directly.
- **Stop-Loss Coverage:** Self-insured groups with stop-loss insurance are liable for claims up to a specific or aggregate prescribed threshold. The stop loss insurer only becomes liable for claims after the prescribed threshold has been exceeded. Specific stop-loss caps a member’s claims at a dollar threshold for that member, such as \$100,000, and the stop-loss insurer becomes liable for that individual’s claims once they exceed that threshold in the policy year. A stop-loss insurer offering aggregate stop-loss projects claims in total for the group, and the insurer becomes liable when claims

exceed the expected claims plus a prescribed corridor or margin such as 125% of projected claims. Stop loss insurers can offer either type of stop-loss independently, or offer them together.

- **Unadjusted Premium Trend:** The actual percentage increase in premium PMPMs as reported by insurers.
- **Utilization Trend:** The change in the number of services provided. Examples of the types of metrics used to calculate utilization includes the number of admissions to a hospital, the number of visits to a specialist physician, or the number of pharmacy prescriptions filled.

17. Appendix

A. Data Sources

- Data are collected from two data requests: The Supplemental Data Request (SDR) and Annual Hearing Carrier Questionnaire (AH). Each serves a different purpose and captures a slightly different population.
 - For the SDR, we collect data from all insurers in the market, except those that request an exemption due to meeting the *de minimis* requirements.¹⁵⁸ For the New Hampshire situs population in CY 2016, we estimate that the data collected represent virtually all of the covered lives in the Individual Market.¹⁵⁹ Data are also collected for the Federal Employees Health Benefits Program (FEHBP) and non-New Hampshire situs membership. The focus of the SDR is detailed benefit information along with membership, cost sharing, claims and premium.
 - For the AH, we collect data from the seven largest insurers: Anthem/Matthew Thornton Health Plan, Harvard Pilgrim Health Care, CIGNA, Community Health Options,¹⁶⁰ Minuteman Health, Ambetter (Centene)¹⁶¹ and Tufts Health Freedom Plan. The focus of the AH is more detailed claims trend, rating assumptions and demographic information.
 - The information from these two data requests are integrated into one set of findings in this report.
- The NHID reviews premium rates and ensures compliance with all New Hampshire insurance laws for fully-insured products situated in New Hampshire. Fully-insured members covered under policies outside of New Hampshire receive the benefit of New Hampshire insurance mandates and other coverage requirements when they work at a New Hampshire branch location, but the NHID does not review premium rates for non-New Hampshire situated policies.

¹⁵⁸ New Hampshire Insurance Department. Bulletin: INS No. 16-010-AB: Supplemental Data Request. March 2016. Available at: https://www.nh.gov/insurance/media/bulletins/2016/documents/sdr_bulletin_2016.pdf.

¹⁵⁹ No carriers in the Individual Market met the *de minimis* requirements.

¹⁶⁰ Formerly Maine Community Health Options.

¹⁶¹ Ambetter from New Hampshire Healthy Families is Centene Corporation's Health Insurance Marketplace product. The product entered the New Hampshire Exchange in January 2016. Ambetter from NH Healthy Families is underwritten by Celtic Insurance Company.

B. Additional Data Tables¹⁶²

Single Policy In-Network Deductible	Fully Insured - Individual Market	Fully Insured - Small Group Market	Fully Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
\$0	1.3%	0.4%	8.3%	4.0%	35.2%	20.4%
\$1 - \$249	4.1%	0.0%	0.0%	1.1%	4.1%	2.7%
\$250 - \$499	2.6%	1.2%	0.5%	1.3%	4.7%	3.1%
\$500 - \$749	2.4%	2.5%	3.4%	2.8%	22.3%	13.1%
\$750 - \$999	7.1%	1.0%	0.2%	2.3%	2.0%	2.1%
\$1,000 - \$1,499	15.5%	3.4%	8.6%	8.8%	12.8%	10.9%
\$1,500 - \$2,999	19.6%	28.9%	19.9%	22.6%	12.8%	17.4%
\$3,000 - \$4,999	20.1%	41.0%	36.4%	33.5%	5.1%	18.5%
\$5,000 - \$7,499	27.0%	21.8%	22.2%	23.4%	1.1%	11.6%
\$7,500 - \$9,999	0.1%	0.0%	0.3%	0.1%	0.0%	0.1%
\$10,000 +	0.3%	0.0%	0.3%	0.2%	0.0%	0.1%
Grand Total	100%	100%	100%	100%	100%	100%
Average Deductible	\$ 3,090	\$ 3,115	\$ 2,887	\$ 3,012	\$ 779	\$ 1,836

Table 14: Single Policy, In-Network Deductible Distribution Summary for CY 2016

¹⁶² 2016 SDR data. New Hampshire situs only, unless otherwise noted.

2016 Health Care Premium and Claim Cost Drivers – New Hampshire Insurance Department

Single Policy In-Network Deductible	Fully Insured - Individual Market	Fully Insured - Small Group Market	Fully Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
\$ -	1.28%	0.36%	8.27%	3.98%	35.16%	20.39%
\$ 100	0.00%	0.00%	0.00%	0.00%	0.41%	0.21%
\$ 125	0.00%	0.00%	0.00%	0.00%	0.03%	0.02%
\$ 150	0.00%	0.00%	0.00%	0.00%	0.57%	0.30%
\$ 175	1.98%	0.00%	0.00%	0.53%	0.00%	0.25%
\$ 200	2.10%	0.00%	0.00%	0.56%	3.08%	1.88%
\$ 250	0.26%	1.16%	0.54%	0.66%	4.01%	2.42%
\$ 300	0.00%	0.00%	0.00%	0.00%	0.47%	0.25%
\$ 350	2.31%	0.00%	0.00%	0.61%	0.00%	0.29%
\$ 400	0.00%	0.00%	0.00%	0.00%	0.22%	0.11%
\$ 500	1.87%	1.55%	3.40%	2.42%	22.12%	12.79%
\$ 650	0.00%	0.95%	0.00%	0.29%	0.00%	0.14%
\$ 675	0.51%	0.00%	0.00%	0.14%	0.00%	0.06%
\$ 700	0.00%	0.00%	0.00%	0.00%	0.14%	0.08%
\$ 750	6.02%	1.01%	0.20%	2.00%	1.96%	1.98%
\$ 800	1.09%	0.00%	0.00%	0.29%	0.00%	0.14%
\$ 900	0.00%	0.00%	0.01%	0.00%	0.00%	0.00%
\$ 1,000	10.15%	2.42%	7.87%	6.79%	6.78%	6.78%
\$ 1,150	1.52%	0.00%	0.00%	0.40%	0.00%	0.19%
\$ 1,200	2.10%	0.00%	0.00%	0.56%	0.00%	0.26%
\$ 1,250	1.41%	0.94%	0.68%	0.96%	0.06%	0.49%
\$ 1,300	0.32%	0.00%	0.02%	0.09%	1.29%	0.73%
\$ 1,400	0.00%	0.00%	0.00%	0.00%	4.70%	2.48%
\$ 1,500	6.41%	1.05%	3.43%	3.49%	3.18%	3.32%
\$ 1,750	0.73%	0.00%	0.08%	0.23%	0.34%	0.29%
\$ 1,800	0.57%	0.00%	0.00%	0.15%	0.13%	0.14%
\$ 2,000	1.84%	24.00%	13.59%	13.68%	5.18%	9.21%
\$ 2,100	0.04%	0.00%	0.00%	0.01%	0.00%	0.00%
\$ 2,200	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%
\$ 2,250	0.67%	0.00%	0.00%	0.18%	0.00%	0.08%
\$ 2,300	0.24%	0.66%	0.00%	0.27%	0.00%	0.13%
\$ 2,400	1.50%	0.00%	0.00%	0.40%	0.00%	0.19%
\$ 2,450	0.38%	0.62%	0.00%	0.29%	0.00%	0.14%
\$ 2,500	5.95%	1.56%	2.31%	3.05%	3.34%	3.20%
\$ 2,600	0.00%	0.92%	0.46%	0.48%	0.69%	0.59%
\$ 2,800	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%
\$ 2,850	0.56%	0.06%	0.00%	0.17%	0.00%	0.08%
\$ 2,900	0.66%	0.00%	0.00%	0.18%	0.00%	0.08%
\$ 3,000	3.46%	27.67%	25.01%	20.11%	3.76%	11.51%
\$ 3,250	1.23%	0.00%	0.00%	0.33%	0.00%	0.16%
\$ 3,275	0.00%	0.00%	0.00%	0.00%	0.01%	0.01%
\$ 3,300	0.18%	0.00%	0.00%	0.05%	0.00%	0.02%
\$ 3,400	1.41%	0.00%	0.00%	0.38%	0.00%	0.18%
\$ 3,425	0.00%	0.00%	0.00%	0.00%	0.07%	0.03%
\$ 3,500	2.27%	0.91%	0.11%	0.93%	0.25%	0.57%
\$ 3,600	1.52%	0.00%	0.00%	0.40%	0.00%	0.19%
\$ 3,750	1.32%	0.00%	0.00%	0.35%	0.00%	0.17%
\$ 4,000	0.86%	12.24%	11.29%	8.81%	0.94%	4.67%
\$ 4,200	0.86%	0.00%	0.00%	0.23%	0.00%	0.11%
\$ 4,250	0.00%	0.04%	0.00%	0.01%	0.00%	0.01%
\$ 4,300	0.00%	0.02%	0.00%	0.01%	0.00%	0.00%
\$ 4,400	3.15%	0.00%	0.00%	0.84%	0.00%	0.40%
\$ 4,500	3.86%	0.09%	0.00%	1.05%	0.02%	0.51%
\$ 5,000	2.98%	20.29%	20.03%	15.58%	1.01%	7.91%
\$ 5,250	0.00%	0.15%	0.00%	0.05%	0.00%	0.02%
\$ 5,500	2.10%	0.38%	0.00%	0.67%	0.00%	0.32%
\$ 5,750	2.32%	0.00%	0.00%	0.61%	0.00%	0.29%
\$ 5,800	3.40%	0.07%	0.00%	0.92%	0.00%	0.44%
\$ 5,900	0.00%	0.00%	1.21%	0.52%	0.00%	0.24%
\$ 5,950	2.84%	0.00%	0.00%	0.75%	0.00%	0.36%
\$ 6,000	0.42%	0.11%	0.87%	0.52%	0.00%	0.24%
\$ 6,100	0.00%	0.05%	0.00%	0.01%	0.00%	0.01%
\$ 6,250	0.00%	0.14%	0.00%	0.04%	0.00%	0.02%
\$ 6,300	4.48%	0.05%	0.00%	1.21%	0.00%	0.57%
\$ 6,350	0.00%	0.00%	0.02%	0.01%	0.00%	0.01%
\$ 6,500	0.06%	0.00%	0.00%	0.02%	0.00%	0.01%
\$ 6,550	0.00%	0.01%	0.00%	0.00%	0.00%	0.00%
\$ 6,600	7.68%	0.00%	0.00%	2.04%	0.00%	0.97%
\$ 6,850	0.75%	0.01%	0.10%	0.24%	0.06%	0.14%
\$ 7,000	0.00%	0.52%	0.00%	0.16%	0.01%	0.08%
\$ 7,500	0.05%	0.00%	0.00%	0.01%	0.00%	0.01%
\$ 8,000	0.00%	0.00%	0.25%	0.11%	0.03%	0.06%
\$ 10,000	0.23%	0.00%	0.27%	0.18%	0.00%	0.08%
\$ 12,000	0.09%	0.00%	0.00%	0.02%	0.00%	0.01%
Grand Total	100%	100%	100%	100%	100%	100%
Average Deductible	\$ 3,090	\$ 3,115	\$ 2,887	\$ 3,012	\$ 779	\$ 1,836

Table 15: Single Policy, In-Network Deductible Distribution for CY 2016

2016 Health Care Premium and Claim Cost Drivers – New Hampshire Insurance Department

Member Coinsurance	Fully Insured - Individual Market	Fully Insured - Small Group Market	Fully Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
0%	38.6%	63.0%	83.1%	65.1%	68.4%	66.8%
5%	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%
10%	16.7%	21.3%	2.2%	11.9%	10.9%	11.4%
15%	2.0%	0.1%	0.1%	0.6%	1.0%	0.8%
20%	14.8%	8.0%	12.8%	11.9%	15.1%	13.6%
25%	1.5%	3.1%	0.0%	1.4%	0.0%	0.6%
30%	17.2%	2.9%	1.8%	6.2%	2.7%	4.3%
35%	0.0%	0.9%	0.0%	0.3%	0.0%	0.1%
40%	0.0%	0.2%	0.0%	0.1%	1.3%	0.7%
50%	9.1%	0.6%	0.0%	2.6%	0.5%	1.5%
Grand Total	100%	100%	100%	100%	100%	100%

Table 16: Member Coinsurance Distribution for CY 2016

PCP Office Visit Copay	Fully Insured - Individual Market	Fully Insured - Small Group Market	Fully Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
\$ -	16.3%	0.6%	7.5%	7.7%	4.5%	6.0%
30%	0.0%	0.0%	2.2%	0.9%	0.0%	0.5%
\$ 3	2.3%	0.0%	0.0%	0.6%	0.0%	0.3%
\$ 5	1.3%	0.0%	0.0%	0.3%	5.2%	2.9%
\$ 10	5.6%	0.0%	0.8%	1.8%	12.0%	7.2%
\$ 15	2.5%	0.3%	1.2%	1.3%	16.8%	9.4%
\$ 20	11.5%	19.4%	8.5%	12.7%	23.8%	18.5%
\$ 25	3.8%	42.1%	59.8%	39.5%	6.7%	22.2%
\$ 30	22.1%	6.5%	2.5%	8.9%	1.0%	4.8%
\$ 35	8.2%	0.6%	1.4%	3.0%	1.1%	2.0%
\$ 40	6.6%	16.6%	1.5%	7.5%	0.6%	3.9%
\$ 45	0.8%	0.4%	0.0%	0.3%	1.5%	0.9%
\$ 50	1.8%	0.1%	0.0%	0.5%	0.0%	0.2%
\$ 200	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$ 500	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
D/C	17.2%	13.5%	14.6%	15.0%	26.7%	21.1%
Grand Total	100%	100%	100%	100%	100%	100%

Table 17: PCP Office Visit Copay¹⁶³ Distribution for CY 2016

¹⁶³ D/C means that the member cost sharing is subject to the deductible and/or coinsurance.

2016 Health Care Premium and Claim Cost Drivers – New Hampshire Insurance Department

CY 2016 Single Policy Out-of-Pocket Maximum	Fully Insured - Individual Market	Fully Insured - Small Group Market	Fully Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
\$0 - \$499	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%
\$500 - \$999	7.9%	0.0%	0.0%	2.2%	0.1%	1.3%
\$1,000 - \$1,499	5.8%	2.7%	0.7%	2.7%	19.4%	9.7%
\$1,500 - \$1,999	3.8%	0.0%	0.7%	1.3%	6.2%	3.3%
\$2,000 - \$2,999	5.2%	4.6%	4.7%	4.8%	15.8%	9.4%
\$3,000 - \$3,999	11.2%	32.5%	6.3%	16.0%	12.6%	14.6%
\$4,000 - \$4,999	7.5%	9.2%	4.4%	6.8%	1.7%	4.7%
\$5,000 - \$5,999	13.7%	19.2%	5.6%	12.2%	28.9%	19.1%
\$6,000 - \$6,999	44.4%	25.8%	72.4%	49.8%	13.8%	34.9%
\$7,000 - \$9,999	0.2%	1.3%	0.2%	0.6%	0.0%	0.3%
\$10,000 - \$15,000	0.3%	0.3%	0.0%	0.2%	0.0%	0.1%
Unlimited	0.1%	4.3%	5.0%	3.4%	1.4%	2.6%
Grand Total	100%	100%	100%	100%	100%	100%
Average OOP Max	\$ 4,717	\$ 4,567	\$ 5,811	\$ 5,106	\$ 3,516	\$ 4,439

Table 18: Single Policy Out-of-Pocket Maximum Distribution for CY 2016

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

Table 19: Pharmacy Benefit Membership Distribution for CY 2016

CY 2016	Fully Insured - Individual Market	Fully Insured - Small Group Market	Fully Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
Average Generic Copay	\$ 16	\$ 15	\$ 11	\$ 13	\$ 11	\$ 13
Average Brand Formulary Copay	\$ 38	\$ 38	\$ 31	\$ 35	\$ 30	\$ 33
Average Brand Non-Formulary Copay	\$ 64	\$ 71	\$ 47	\$ 53	\$ 48	\$ 51

Table 20: Average Pharmacy Copay¹⁶⁴ for CY 2016

¹⁶⁴ For those members with a pharmacy benefit that has a copay. Excludes zero dollar copays.

2016 Health Care Premium and Claim Cost Drivers – New Hampshire Insurance Department

Market Category	Plan Type	Fully Insured Membership Percentage	Fully Insured Average Premium PMPM	Fully Insured Actuarial value	Self-Insured Membership Percentage	Self-Insured Average Premium PMPM	Self-Insured Actuarial Value		
Large Group	HMO	29.8%	\$	493	0.79	32.0%	\$	473	0.90
	POS	0.6%	\$	525	0.75	9.3%	\$	548	0.92
	EPO	0.5%	\$	520	0.78	6.5%	\$	527	0.81
	PPO	11.5%	\$	504	0.79	51.1%	\$	467	0.84
	FFS	0.3%	\$	643	0.93	0.8%	\$	315	0.95
Small Group	HMO	23.5%	\$	454	0.77			N/A	
	POS	0.4%	\$	505	0.78	0%	\$	257	0.73
	EPO	0.1%	\$	469	0.69			N/A	
	PPO	6.8%	\$	467	0.76	0%	\$	705	0.81
	FFS			N/A				N/A	
Individual	HMO	21.6%	\$	373	0.77				
	POS			N/A					
	EPO			N/A					
	PPO	4.9%	\$	427	0.76				
	FFS			N/A					

Table 21: Average Premium¹⁶⁵ PMPM and Actuarial Value¹⁶⁶ for CY 2016¹⁶⁷

¹⁶⁵ For self-insured business, premium is calculated by the insurer as described in the Supplemental Data Request bulletin. Available at: https://www.nh.gov/insurance/media/bulletins/2016/documents/sdr_bulletin_2016.pdf.

¹⁶⁶ Actuarial Value is the federal Minimum Value measure, as described in the Supplemental Data Request bulletin. Available at: https://www.nh.gov/insurance/media/bulletins/2016/documents/sdr_bulletin_2016.pdf.

¹⁶⁷ Data are reported as N/A when there is low (less than 1%) or no membership.

2016 Health Care Premium and Claim Cost Drivers – New Hampshire Insurance Department

Coverage Category	Covered?	Fully Insured - Individual Market	Fully Insured - Small Group Market	Fully Insured - Large Group Market	Fully Insured - Total	Self-Insured - Total	Fully Insured and Self-Insured Total
Ambulance Service	All policies in the market cover this benefit						
Audiology Screening for Newborns	All policies in the market cover this benefit						
Blood and Blood Products	Covered Generally Covered Not Covered	100% 0% 0%	99% 0% 0%	91% 1% 8%	96% 0% 3%	61% 6% 33%	78% 3% 19%
Case Management Program	All policies in the market cover this benefit						
Chiropractic Services	Covered Not Covered	87% 13%	100% 0%	99% 1%	96% 4%	93% 7%	94% 6%
DME	All policies in the market cover this benefit						
Emergency Room	All policies in the market cover this benefit						
Family Planning Services	Covered Not Covered	100% 0%	100% 0%	100% 0%	100% 0%	100% 0%	100% 0%
Habilitative Services	Covered Generally Covered Not Covered	87% 0% 13%	100% 0% 0%	92% 1% 7%	93% 0% 7%	60% 7% 33%	76% 4% 21%
Hearing Aids	Covered Generally Covered Not Covered	100% 0% 0%	100% 0% 0%	96% 0% 4%	98% 0% 2%	86% 1% 13%	92% 1% 7%
Home Health Care	All policies in the market cover this benefit						
Hospice	Covered Not Covered	100% 0%	100% 0%	99% 1%	100% 0%	98% 2%	99% 1%
Hospitalization	All policies in the market cover this benefit						
Infertility Services	Covered Generally Covered Not Covered	61% 0% 39%	36% 0% 64%	35% 0% 65%	42% 0% 58%	44% 1% 54%	43% 1% 56%
Medical Food	Covered Generally Covered Not Covered	100% 0% 0%	99% 0% 1%	91% 0% 9%	96% 0% 4%	66% 0% 33%	80% 0% 20%
Mental Health and Substance Abuse	Covered Not Covered	95% 5%	100% 0%	100% 0%	99% 1%	99% 1%	99% 1%
Nutritional Services	Covered Generally Covered Not Covered	100% 0% 0%	99% 0% 1%	91% 8% 1%	96% 3% 1%	86% 13% 0%	91% 9% 1%
Outpatient Hospital Services and Surgery	All policies in the market cover this benefit						
Outpatient Laboratory and Diagnostic Services	All policies in the market cover this benefit						
Outpatient Short-Term Rehabilitative Services	All policies in the market cover this benefit						
Pediatric Dental Services	Covered Not Covered	75% 25%	49% 51%	43% 57%	53% 47%	42% 58%	48% 52%
Pediatric Vision Services	Covered Generally Covered Not Covered	80% 0% 20%	76% 0% 24%	78% 0% 22%	78% 0% 22%	96% 0% 4%	87% 0% 13%
Pregnancy and Maternity	All policies in the market cover this benefit						
Rx	Covered Not Covered	100% 0%	100% 0%	92% 8%	97% 3%	58% 42%	76% 24%
Preventive Services	Covered Generally Covered Not Covered	100% 0% 0%	100% 0% 0%	100% 0% 0%	100% 0% 0%	99% 1% 0%	100% 0% 0%
Skilled Nursing Facility	Covered Generally Covered Not Covered	100% 0% 0%	100% 0% 0%	100% 0% 0%	100% 0% 0%	99% 1% 0%	99% 1% 0%
Transplants	All policies in the market cover this benefit						
Well Child and Immunization Benefits	All policies in the market cover this benefit						

Table 22: Coverage of Various Benefit Categories¹⁶⁸ for CY 2016

¹⁶⁸ Coverage for benefits is based on whether the policy provides coverage at the level described in the Supplemental Reporting bulletin. Insurers are instructed to distinguish between covering the benefit to the exact specifications, general coverage of the benefit but not meeting the exact specifications (identified as “Generally Covered”), and no coverage. Available at: https://www.nh.gov/insurance/media/bulletins/2016/documents/sdr_bulletin_2016.pdf.

Situs	Percent Self-Insured Members with Stop-Loss Coverage
NH Situs	27.2%
Non-NH Situs	23.5%
Total	26.1%

Table 23: Percent of Self-Insured Members with Stop-Loss Coverage for CY 2016

Stop-Loss Specific Attachment Point	Membership
< \$100,000	10%
\$100,000 - \$499,999	53%
\$500,000 - \$999,999	26%
\$1,000,000	12%

Table 24: Distribution of Stop-Loss Specific Attachment Point for CY 2016

Stop-Loss Aggregate Attachment Point	Membership
1.00	63%
1.10	5%
1.20	5%
1.25	27%

Table 25: Distribution of Stop-Loss Aggregate Attachment Point for CY 2016

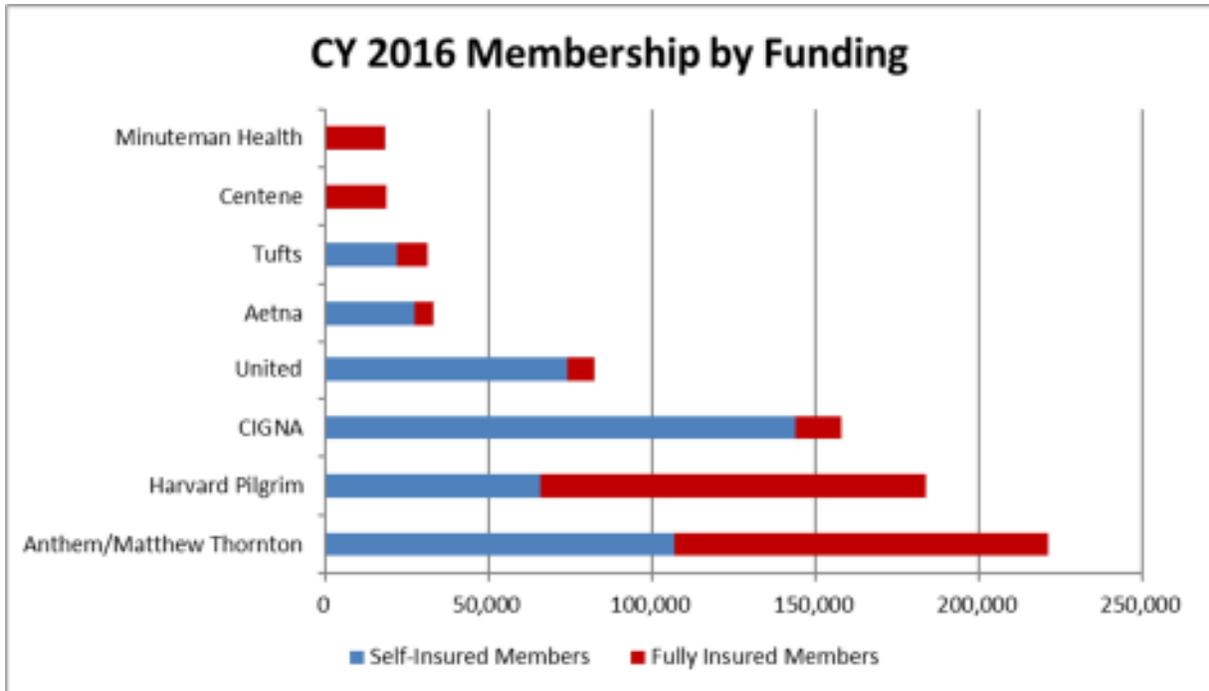


Figure 67: Membership Distribution by Self-Insured vs. Fully-Insured for CY 2016

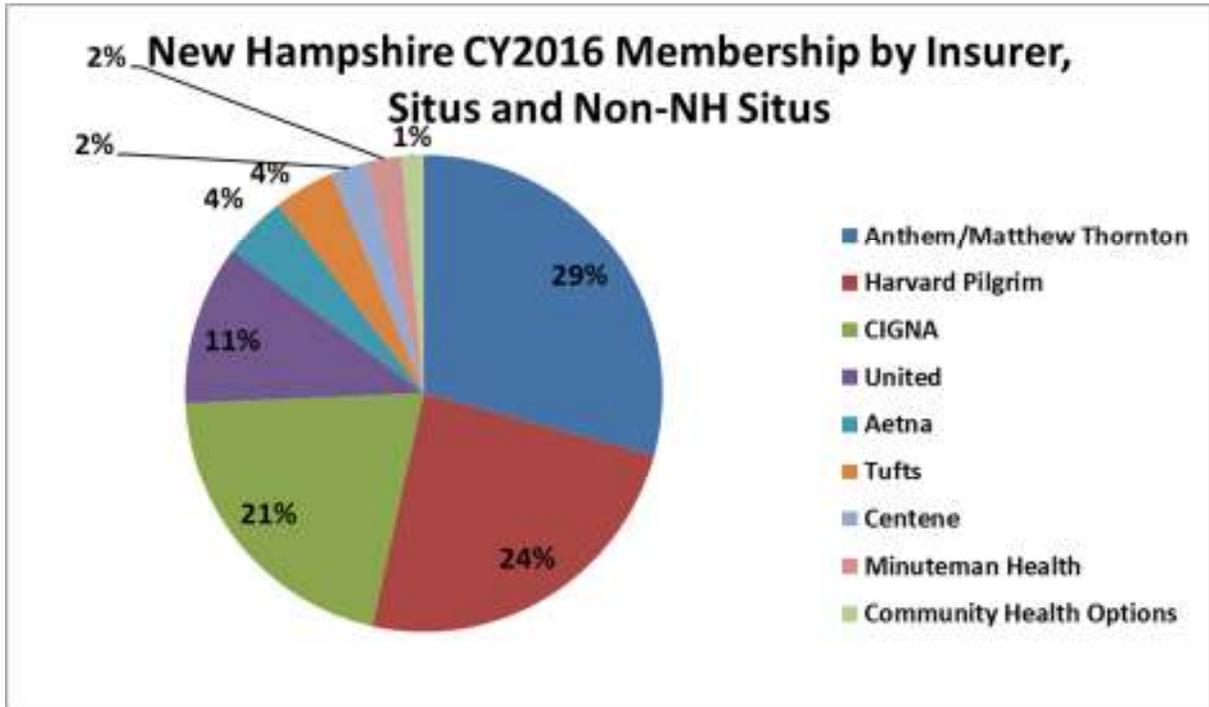


Figure 68: Distribution by Insurer of New Hampshire Commercial Situs and Non-Situs and Fully-Insured and Self-Insured CY 2016¹⁶⁹

¹⁶⁹ 2017 SDR data. Excludes individuals covered under FEHBP.