2025 Senate Bill 297 Written Testimony Submitted to Joint Public Hearing Senate Finance Committee with Senate Election Law and Municipal Affairs

Submitted by: Scott DeRoche, Executive Director HealthTrust, Inc.

Date: March 4, 2025

Position: Opposes

HealthTrust opposes this bill in its current form for numerous reasons and believes that it is fatally flawed in substance. This bill unconstitutionally shifts the risk of losses from pooled risk management programs to the political subdivisions. Moreover, if passed, it would prevent HealthTrust from offering the medical coverage that the public sector has come to rely on.

Since 1987, New Hampshire's cities, towns, counties and school districts have participated in pooled risk management programs established pursuant to RSA 5-B. At that time pooled risk management programs were needed because political subdivisions needed reliable, cost-effective access to health, workers' comp, and property and liability coverage. *See* N.H. House Journal at 503 (1987). Access to pooled risk management is needed now as much as, or more than, it was needed in 1987.

Under RSA 5-B pooled risk management programs, the risk inherent in health, workers compensation, and property and liability claims is transferred from the individual political subdivisions to the risk pool. If enacted, Senate Bill 297 will shift the risk from the pooled risk management programs to the cities, towns, counties and school districts. This shift contradicts the very purpose underlying the enactment of RSA 5-B and the overarching intent of the law. *See* RSA 5-B:1 (purpose of RSA 5-B is to provide risk management, which can be achieved "by participation in pooled risk management programs established for the benefit of political subdivisions"). It also violates Part I, Article 28-a of the New Hampshire Constitution.

Three core provisions in the proposed legislation are particularly concerning: 1) the low maximum and narrow range allowed for contingency reserves held by the risk pools; 2) the new obligation for cities, towns, counties and school districts to pay assessments within 30 days if the program becomes financially impaired or insolvent; and 3) the narrow definition of expenses that may be retained and used for administration of the program.

To help you understand these issues, I'd like to provide some background information about HealthTrust and its experience over the past 10 years. HealthTrust provides a welfare and benefit program for New Hampshire's cities, towns, counties and school districts. We do not decline to quote any eligible political subdivision regardless of size, demographics or health status. We currently serve 191 municipalities, six counties, 85 school districts and 74 other governmental entities such as water districts, libraries, and fire districts. These entities represent employers with very few employees to nearly 1,000 employees.

HealthTrust provides a range of health plans so that New Hampshire's public sector employers can find one that best suits their needs.

Over the past 10 years, both nationally and locally, health care affordability for employers and employees has become a major issue. During and after COVID, claims volatility spiked due to individuals first postponing, and then later seeking, care. These spikes further complicated the complex process of establishing renewal rates, and highlighted the need for risk pools to maintain adequate capital.

<u>12% to 16% Contingency Reserve Is Too Low and Too Narrow:</u>

At the end of each fiscal year, HealthTrust engages Milliman, a highly-regarded actuarial firm, to perform an actuarial evaluation to assess the adequacy of contributions needed from participating groups and the reserves necessary to meet claims, expenses, and other projected needs of the plan. The amount needed for contingency reserves is included in this actuarial evaluation. In the materials that you have been provided, HealthTrust refers to this as its capital adequacy reserve. *See* Exhibit A, Recommended Capital Adequacy Reserve.

An adequate contingency reserve is needed because HealthTrust is a risk-bearing entity, very much like a health insurance company. A risk-bearing entity attempts to predict what will happen in the future, and its actuaries calculate the contributions (*see* Exhibit B, 2025 July Medical Rating and Exhibit C, 2025 January Medical Rating) and reserves needed to cover expected claims (*see* Exhibit D, Incurred but Not Paid Claim Reserves and Exhibit E, Premium Deficiency Reserves) and related expenses each year, but it also must plan for when things don't go as expected, such as when claims spiked after COVID. The purpose of the contingency reserve is to ensure that if things don't go as expected, all future obligations for claims and expenses can be fully paid. When things go better than expected, HealthTrust returns all surplus above the contingency reserve level to participating groups. *See* Exhibit F, Ten Year History of Net Position, Capital Reserve Target, and Return of Surplus.

The proposed legislation would limit the amount of contingency reserve to 16% of contributions for the then current fiscal year. This is much too low. Current contributions are expected to be $470 million. For FY2024, Milliman's actuaries recommended that HealthTrust set a target contingency reserve between $95 million and $150 million. The minimum level calculated by Milliman, $95 million, is 20% - that is 4% higher than the maximum allowed under the bill. In other words, the most HealthTrust could maintain under the bill is 4% lower than the minimum amount that HealthTrust's actuaries say is needed. At 16% HealthTrust would be undercapitalized by almost $20 million. *See* Exhibit G, SB297 Capital Limits Compared to Actuary Recommendation.

<u>Unconstitutional and Untenable Shift of Burden from Pooled Risk Management Programs to Political Subdivisions</u>

To account for the risks that this undercapitalization presents, the bill would require participating cities, towns, counties, and school districts to pay an assessment within 30 days, for any shortfalls, which may occur at any time during the year. In effect, the bill will prohibit HealthTrust from maintaining adequate

capital and then shift the burden of losses to the participating members. This shift not only contradicts the very purpose of RSA 5-B but it also assigns new responsibilities under RSA 5-B to political subdivisions. This shift of responsibility that necessitates additional local expenditures violates Part I, Article 28-a of the New Hampshire Constitution, which provides that

> *The state shall not* mandate or *assign any new, expanded or modified . . . responsibilities to any political subdivision in such a way as to necessitate additional local expenditures by the political subdivision unless such . . . responsibilities are fully funded by the state* or unless such programs or responsibilities are approved for funding by a vote of the local legislative body of the political subdivision.

(Emphasis added.)

There is no need for statutory requirements that require pooled risk management programs to levy assessments on political subdivisions. HealthTrust has a process for rebuilding capital in place that is consistent with industry standards. *See* Exhibit H, 2025 Ratings Risk Charge Scenarios and Exhibit I, HealthTrust, Inc. Statement of Net Position as of December 1, 2024. Further, the statutory mandate in this bill that such assessments for unexpected losses be collected within 30 days of an event is untenable as political subdivisions would not have funds available to pay for such assessments.

<u>New Definition of Administration Too Narrowly Limits Amounts That May Be Retained</u>

Finally, the narrow definition of “Administration” appears intended to significantly limit the type of expenses that may be retained by a program when determining how much surplus must be returned. HealthTrust consistently outperforms the commercial market in part due to robust risk management programs that, rather than simply paying for claims, actually reduce future claims exposure. For example, our well-being programs support healthy living, medical care access, expert medical support, disease management and mental health care. HealthTrust includes the costs of these programs in communications with Member Groups. *See, e.g.*, Exhibit J, How Your Rates Are Determined. The use of the word “reasonable” in the definition raises further concerns that the Secretary of State’s staff may dictate day-to-day operations in a way that would prevent HealthTrust’s Board of Directors and its executive team from carrying out their fiduciary duties.

In sum, HealthTrust follows actuarial standards that align with industry practice for like organizations. By forcing New Hampshire’s cities, towns, counties and school districts to bear the risk of required undercapitalization, Senate Bill 297 threatens the very existence of the pooled risk management program that HealthTrust offers and has served the vast majority of public sector employers well for nearly 40 years. If passed, this bill would limit coverage choices at a time when some political subdivisions, due to recent claims experience, are not able to even get a quote for medical coverage in the commercial market.

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Recommended Capital Adequacy Reserve for HealthTrust, Inc.

As of June 30, 2024

Prepared for:
HealthTrust, Inc.

Prepared by:
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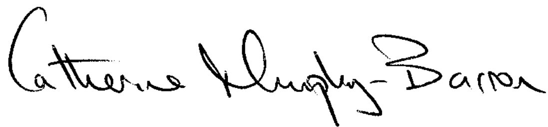
SUMMARY OF OPINION

It is my opinion that as of June 30, 2024 HealthTrust, Inc. should target a required capital adequacy reserve for the protection of its beneficiaries of between $95 million and $150 million. This amount is in addition to other required reserves. To reach this conclusion I relied on generally accepted actuarial methodologies.

My opinion is based on a sound actuarial methodology and assumptions as to future events. While I relied on financial data and information provided by HealthTrust to establish some of these assumptions, HealthTrust directed me to use the assumptions I believed were most appropriate and reasonable based on my actuarial training and experience in conducting actuarial analyses as applied to organizations similar to HealthTrust. As such, I chose the assumptions to use based on my professional judgment.

A change in assumptions will change the results and possibly the related conclusions. Actual experience will differ from the assumptions chosen and as such actual results will likely differ from estimates.

I, Catherine Murphy-Barron, am a member of the American Academy of Actuaries and meet its qualification standards to render the actuarial opinion contained in this report.



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Principal and Consulting Actuary

Milliman

BACKGROUND

HealthTrust, Inc. (HealthTrust) provides medical, prescription drug, long- and short-term disability, life and dental benefits to towns, cities, counties, schools, and quasi-municipal organizations in New Hampshire. Health benefits make up the bulk of HealthTrust's business, accounting for about 94% of HealthTrust's claim expenses for the fiscal year ended June 2024. HealthTrust's member groups purchase guaranteed cost health coverage similar to a fully insured arrangement in an insurance company. The health claims are administered through Anthem; however, HealthTrust retains the entire risk for the benefits.

HealthTrust is a pooled risk management program operating under Chapter 5-B of Revised Statutes Annotated (RSA) of the State of New Hampshire. RSA5-B:3 I states that "A political subdivision, by resolution of its governing body, may establish and enter into agreements for obtaining or implementing insurance by self-insurance; for obtaining insurance from any insurer authorized to transact business in this state as an admitted or surplus lines carrier; or for obtaining insurance secured in accordance with any method provided by law; or for obtaining insurance by any combination of the provisions of this paragraph."

HealthTrust retains the services of a consulting actuary to recommend premium rates and claim reserves for the benefits provided to its members. A pooled risk management program under this statute is not an insurance company[1], however, the services provided by HealthTrust to its members mirror the services provided by health insurance companies to policyholders. Like an insurance company, HealthTrust needs to hold funds on its balance sheet for the protection of its covered individuals. These funds can be referred to as capital, surplus, or risk reserve. For the purposes of this report we refer to them as a "capital adequacy reserve" in order to be consistent with the terminology used by the HealthTrust Board of Directors. For any risk bearing entity, an adequate capital adequacy reserve is crucial for continued viability and the protection of its beneficiaries. It is needed to:

- Cover variations between actual and expected experience that occur from year to year,
- Protect against unforeseen events,
- Maintain service capabilities, and
- Ensure that all commitments will be met.

The New Hampshire Supreme Court's interpretation of RSA5-B, upheld in its opinion[2] issued January 10, 2014 the requirement that a pooled risk management program "establish necessary reserves in accordance with an actuarially sound methodology and that it return amounts in excess of the amount needed for administration, claims, reserves, and reinsurance".

At its meeting on March 4, 2014, the HealthTrust Board of Directors voted to engage Milliman to "offer an opinion, based upon generally accepted actuarial methodologies, regarding the capital adequacy reserve that is needed for the HealthTrust pooled risk management program to maintain solvency, in addition to any other required reserves."

This report presents my opinion as to the capital adequacy reserve for the HealthTrust pooled risk management program as of June 30, 2024 and describes the methodology used to reach said opinion.

[1] RSA5-B:6,I

[2] Appeal of Local Government, Inc., No. 2012-729 (N.H. January 10, 2014)

RESULTS

It is my opinion that as of June 30, 2024, Health Trust should target a required capital adequacy reserve for the protection of its covered beneficiaries of between $95 million and $150 million. The amount should be held in addition to other reserves, such as incurred but not reported (IBNR) claim reserves, premium deficiency reserves, and any other required reserves. To reach this conclusion, I used a stochastic modeling approach which is a generally accepted actuarial methodology for determining capital adequacy reserve levels. The methodology used to reach this recommendation is consistent with that used in prior years.

The ability of an organization to adjust premium rates to account for variations in expected claims or an unforeseen event impacts an organization's appropriate capital adequacy reserve level. Sometimes, due to competitive pressures or government oversight, an organization will be unable to implement a premium increase in a timely manner after an unforeseen event. Such is the case for HealthTrust with its July renewals. Approximately, eighteen percent of HealthTrust's enrollees renew in January of each year with the remaining 82% renewing in July. Premium rates for both renewals are developed in June through August of the prior year, using claims experience for the 12 months ending April 30th for medical and prescription drug coverage. This is a little early but a reasonable timeline for premium rate development for groups with an effective date of January 1. Implicit in the premium rates for the January renewal is 20 months of trend.

This is not a typical timeline for groups with a July 1 effective date as claims will be trended 26 months as opposed to 20 months, adding to the uncertainty of the projection. In October of each year HealthTrust notifies July renewal groups of next year's expected premium rate, based on claims through April 30th. Ordinarily, rating for a July block of business would be based on more recent claims experience, thereby limiting the additional uncertainty from trending claims for additional months. In addition, the extended delay between the experience period and the rating period means it is not always possible to reflect current deterioration in experience into the renewal rating. The groups are not guaranteed the proposed rate but are given a guaranteed maximum rate (GMR), which is typically up to 1%-2% higher than the October estimated rate. The premium rates are revisited in February to March using claims paid through December of the prior year, creating the revisit rate. Each group will be charged its revisit rate unless that rate is higher than the group's GMR, quoted in October, in which case the group pays the GMR. Any shortfall in premium due to a group's revisit rate exceeding the GMR is pooled and allocated across the remaining groups up to each group's GMR or a cap on the premium increment as voted by the HealthTrust Board of Directors. HealthTrust bears the cost of any remaining shortfall after pooling.

As 82% of HealthTrust's enrollees are July renewals, prices are effectively set in October for approximately $560 million worth of claims as opposed to $380 million if these groups were to renew in January.

We recommend a target capital adequacy reserve for HealthTrust at an amount such that there is only a 5% chance of HealthTrust becoming insolvent within 5 years under a variety of conditions, including a limited set of moderate to extreme adverse conditions. We believe this level balances the two competing capital requirements. First, HealthTrust must hold enough capital adequacy reserve so that it can weather most unforeseen events. The objective here is for the organization to accumulate capital so that it can handle any event that may happen, i.e., a very small likelihood of insolvency.

The other requirement which has the opposite objective is the requirement, under New Hampshire law, RSA 5-B, that the organization return to groups all funds beyond those required for administration, claims, reserves, and purchase of excess insurance. The objective under this requirement is to return most, if not all, surplus, i.e., a much higher probability of insolvency. HealthTrust's premium rate equals expected claims plus expected expenses. There is no profit load built into the rates. The assumptions used are based on the actuaries' and staff's reasonable expectation as to experience during the projection period. There is no explicit conservatism built into these assumptions. Therefore, even if all the assumptions are correct, in some years costs will be higher than projected and in others, costs will be lower due simply to normal fluctuations, but on average premiums will equal costs. If surplus is returned to enrollees any year there is a gain, then HealthTrust may not have enough capital adequacy reserve in years with a loss.

We believe using a 5% chance of insolvency reasonably balances these two competing objectives.

We chose a 5-year threshold for insolvency for two main reasons:

- At the time of premium rate development HealthTrust knows with reasonable certainty the true level of historical claims used to develop the premium rates, although there is a possibility that claims will improve or worsen during the long period between the end of the experience period and the effective date of the new rates. July groups get the benefit of any improvements in claims between the time of the GMR rating and the revisit rating, but HealthTrust bears the cost of any deterioration in claims, in excess of the GMR and any pooling, during the same period. After a bad year, the

premiums can reflect any necessary premium increases due to the bad year. However, most organizations will hold enough capital adequacy reserve so that it does not have to make premium or benefit changes that are so draconian that the market will not accept them and therefore lose a large portion of enrollment. Ideally an organization will spread the premium realignment over multiple years.

- In addition, given that 82% of HealthTrust's business has a GMR, HealthTrust will be well into the 2nd year of the group's coverage before it can implement any needed rate adjustment.

Given the above considerations and HealthTrust's goal of protecting its covered individuals, it is my opinion that 5 years is a reasonable projection period for the purpose of estimating HealthTrust's capital adequacy reserve.

Since HealthTrust operates like an insurance company and is subject to many of the same risks as an insurance company, it is reasonable to consider the requirements imposed on insurance companies when thinking about risk management and capital adequacy reserve for HealthTrust. The National Association of Insurance Commissioners (NAIC) has established Risk-Based Capital (RBC) standards for setting minimum capital and surplus for licensed insurance companies. The NAIC asked the American Academy of Actuaries to develop the formulas and factors for health RBC. The Academy's recommended factors were set to cover a 5% probability of insolvency over a seven year period. For HealthTrust, we also used 5% probability but over five years, a slightly shorter time period. This is slightly less conservative than the health RBC. The American Academy of Actuaries in its RBC development was addressing all health-related risks including some products with long durations, such as long term disability and long term care insurance. HealthTrust's coverages – medical, dental, and short term disability – are all short duration products, so a somewhat shorter time period is appropriate.

A major driver of the level of capital adequacy reserve required is the organization's ability to increase or decrease premiums without having a detrimental impact on the long term viability of the pool. We therefore developed our capital adequacy reserve estimate under two premium development scenarios.

Under the first scenario, HealthTrust has the ability to recoup the full amount of any losses in the rate renewal, subject to a rate increase that is 5% above the expected long term trend. Conversely, if HealthTrust experiences excessive gains, the premium rate increase is adjusted downwards subject to 5% below the expected long term trend. Under this scenario we estimate the capital adequacy reserve required at June 30, 2024 to meet the 5% chance of insolvency over five years to be $95 million.

Under the second scenario, HealthTrust is unable to implement a rate increase above the expected long term trend. In this case losses will be recouped over several years. Conversely, if they experience excessive gains, the rate increase is held to the expected level without downward adjustment to recognize favorable claims experience. We estimate the required capital adequacy reserve as of June 30, 2024 under this scenario to be $150 million.

HealthTrust is not limited by regulation on the price it charges for its policies and so it appears to have the ability to recoup the full amount of any losses. In reality, due to market pressures and the risk of losing a large number of groups if premium increases are considered too high, there will be times when HealthTrust has less ability to increase premium rates than it would like to have. Therefore, I provide these two estimates, $95 through $150 million, as the range for a required capital adequacy reserve for HealthTrust as of June 30, 2024.

The result of any analysis involving estimation of future events is heavily dependent on the underlying assumptions. Our underlying assumptions are described in the methodology section below. Any changes to these assumptions will change the results and possibly the related conclusions. Actual experience will differ from the expected values.

METHODOLOGY

In order to determine the amount of capital adequacy reserve HealthTrust needs to remain solvent and therefore ensure its beneficiaries are protected over the next 5 years, with 95% confidence, we used a stochastic model. Stochastic models use probabilities to forecast a wide range of possible results, rather than a single outcome like deterministic projections that focus on expected values and not variances from expected. The purpose of the model is to determine needed levels of capital adequacy reserve by assessing the likelihood that specified target levels will be adequate under a wide range of possible scenarios.

Some variables in our modeling are quantifiable using statistics gathered from historical data, for example trend. Other variables are not easily quantifiable usually because they happen so infrequently that there is little data on the frequency or impact of these events. For example,

- Systems problems, such as provider payment errors, that cause rating problems due to lack of recognition of the actual underlying claim costs, or
- Errors in reserves due to poor technique or change in claim processing patterns.

In general, we used insurance industry assumptions and our actuarial judgment, tailored where appropriate for HealthTrust, to determine the impact and the probability of occurrence for most of the events described below. The target amount for the required capital adequacy reserve covers all coverages for which HealthTrust bears the risk and was developed assuming that the variability between actual and expected for all coverages is the same as it is for medical coverage. Medical coverage represents approximately 94% of total claim dollars.

Our analysis starts with a baseline, deterministic projection which represents our best estimate of premium, claims, and expenses projected annually for five years. Once we have set the baseline scenario, we develop a list of possible events that could change the financial position of HealthTrust relative to the best estimate values. We then use actuarial professional judgment and actual experience to choose which events are most appropriate to model. We define each event by determining its impact on key financial metrics, such as loss ratio, claim reserves, lapse rate, or new business rate. We discuss the possible events with HealthTrust and review our assumptions annually. The stochastic model then combines the baseline projection with the possibility of these events occurring at various magnitudes using Monte Carlo simulations.

A major driver of the level of capital adequacy reserves required is the organization's ability to increase or decrease premiums without having a detrimental impact on the long term viability of the pool. We therefore developed our estimate of HealthTrust's capital adequacy reserve under two pricing scenarios:

- Under the first scenario HealthTrust is able to adjust product prices beyond the expected long term trend to correct for mispricing, high claims, or any issues that cause a financial loss. Therefore, if premium rates in any one year exceed HealthTrust's obligations and HealthTrust experiences losses, they are able to implement a rate increase to a level high enough to recover losses, subject to 5% above the expected long term trend. Conversely, at the other end of the spectrum, if HealthTrust experiences gains, the rate increase is adjusted downward subject to 5% below the expected long term trend. This allows losses to be covered by future premium revenue rather than from the capital adequacy reserve, thereby reducing the required level of the capital adequacy reserve.
- In the second scenario HealthTrust is unable to adjust product prices beyond expected long term trend to correct for mispricing, high claims, or any issue that causes a financial loss. Therefore, if pricing in any one year is incorrect and HealthTrust experiences losses, they are unable to implement a rate increase above the expected long term trend in the following year high enough to recover the losses. Conversely, at the other end of the spectrum, if HealthTrust experiences gains, the rate increase is not adjusted downward but rather held to the expected level. Any realized loss will be funded from HealthTrust's capital adequacy reserve, thereby increasing the required level of the capital adequacy reserve that must be held.

ASSUMPTIONS UNDERLYING THE BASELINE PROJECTIONS

The baseline model projects the capital adequacy reserve on an annual basis from a June 30, 2024 starting point. The starting point for this analysis is based on the HealthTrust financial statements for the fiscal year ended June 30, 2024.

Please note that the other assumptions in our baseline projections represent a positive business environment, meaning the premium and claims trends will allow targets to be realized each year. The following describes the assumptions in the baseline, deterministic projection.

CLAIM AND PREMIUM TREND

For the purpose of the baseline projection we used the emerging and projected claim trend assumptions from the January 1, 2025 and July 1, 2025 rate development for the January and July renewals, respectively. The overall claim trend rate (medical, prescription drug, dental, and short-term disability combined) was assumed to be 13.0% in year one, 4.5% in year two, and 7.5% in subsequent years.

Every year some groups move to less expensive plans at renewal resulting in a reduction in claims simply due to a benefit reduction. For this projection we made a 1.0% annual reduction to claims to reflect this expected plan "buy-down".

Within our model, the premium is set at actual premium rates for the first two years and is based on HealthTrust's target loss ratio in future years. Therefore, by definition premium trend is the same as claim trend in years 3 and beyond.

LAPSE AND NEW BUSINESS RATE

Due to the expected transition of much of HealthTrust's Medicomp business effective January 1, 2025, we have assumed a net annual enrollment change of -4.0% in the next two fiscal years, and 0% in subsequent years.

STOP LOSS COVERAGE

Specific stop loss insurance protects against a high cost claim incurred by any one individual in a year. Aggregate stop loss insurance covers the situation where total claims are higher than expected. We assumed the following stop loss coverage throughout the projection period:

- Specific stop loss coverage with a $2.5 million dollar deductible
- Aggregate stop loss coverage with a 115% attachment point.

Given the size of HealthTrust's population, the expected value of recoveries from individuals with claims larger than the specific stop loss threshold amount is a small percent of HealthTrust's total expected claim level in a year. As such individual high cost claims do not have a material impact on the expected outcome and therefore does not have an impact on the resulting targeted claim level.

Similarly for aggregate stop loss there is no material impact on the target claim level because the expected value of claims above the aggregate stop loss attachment point is a small percent of the total expected claims in a year.[3]

TARGET FINANCIAL MEASURES

In our modeling, premiums are set each year to target certain key financial metrics:

- Target medical loss ratio (claims divided by premium): 91% in year one and 94% in subsequent years
- Target administrative expense ratio (administrative expenses divided by premium): 9% in year one and 6% in subsequent years

[3] HealthTrust does not currently purchase stop loss insurance (specific or aggregate) as the expected return from such coverage, given their size, is much smaller than the amount HealthTrust could expect to pay for the insurance. However, since HealthTrust is prohibited from retaining excess reserves because it chooses not to purchase stop loss insurance, we developed our models as if stop loss coverage was in place.

- Target profit (profit divided by premium): 0%

Administrative expenses include any change in the capital adequacy reserve due to claims trend. We assume a 1.15% interest rate assumption in all years based on HealthTrust's historical experience.

ASSUMPTIONS UNDERLYING THE STOCHASTIC MODELING

The Monte Carlo method is a computational algorithm often employed to simulate financial systems. It relies on repeated random sampling of a deterministic model's results (in this case, our baseline projection) to provide a range or distribution of outcomes. In the stochastic portion of the model, we considered several potential events that could have an impact on HealthTrust's financial results. These events could impact claims or premium levels with varying degrees of likelihood. The stochastic model samples the results of many simulations of the deterministic model adjusted for these events and summarizes the results. We modeled the following events:

NORMAL CLAIM FLUCTUATIONS

While claims costs are generally assumed to follow a predictable trend, total claims costs possess an inherent volatility that may cause a variance between actual and expected claims. The amount of volatility generally decreases as the number of enrollees in the risk pool increases. We created a claims fluctuation probability distribution (CPD) using CPDs from Milliman's *Health Cost Guidelines* (*HCG*s)[4], adjusted to reflect HealthTrust's enrollment level at June 30, 2024.

SYSTEMS CHANGE

Health insurance carriers and risk pools pay claims in exchange for premiums. The speed at which claims are paid is a function of many variables, e.g., the rate at which providers submit their claims, the carrier's computer system, etc. When the rate of claim payment processing changes or there is some error that impacts claims payments, such as incorrect payment rates for certain providers, it can have a financial impact that is not immediately obvious. For example, when the rate of claims processing changes, it can cause reserves to be miscalculated, which causes the claim level for the current year to be misstated, which can lead to mispricing in the following year.

When modeling systems change we assume two things will happen. The primary impact is on claim reserve levels. When claims payments speed up or slow down the ability to estimate the outstanding claims is compromised. This can result in an under or over estimate of outstanding claims. The secondary impact from this event is that the actual loss ratio will not meet the target. If the claim reserve is over or under estimated, the resulting loss ratio will be lower or higher than expected.

CATASTROPHIC CLAIMS

Over the course of several years catastrophic events may occur. Catastrophic events, such as a pandemic, may cause an unexpected large increase in claims. These events are by definition rare. They seldom occur but when they do the results can be devastating to an organization if it is not prepared. Inclusion of this type of event in our modeling is appropriate from an actuarial perspective. We assume that this type of event will occur on average, once every 20 years, which is a reasonable assumption for these types of events. Our model assumes that HealthTrust has both specific and aggregate stop loss insurance to protect against catastrophic claim events. The impact of both the cost of this insurance and any recoveries are incorporated into our results.

MISESTIMATION OF TREND

Estimating trends in claim costs is a crucial component of premium development. It is difficult to get the trend rate exactly right and it will have an immediate impact on results. Misestimation of trend can happen for many reasons, including such things as the Third Party Administrator (TPA) failing to notify the organization of a fee change, high utilization of a new expensive specialty drug, inability to accurately forecast health care provider charges and reimbursement for services along with other drivers of inflation, or even relaxation of care management protocols which can cause an unexpected increase in utilization. When trend is misestimated

[4] The *HCG*s are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research, and judgment. An extensive amount of data is used in developing the *HCG*s and that data is updated annually. The HCGs are widely used by health insurers in setting expected medical costs.

the ultimate claim level is higher or lower than expected when the premiums were developed. Therefore, claims will be higher or lower than the targeted loss ratio relative to the premium that is collected. This impact can last for several years because of the rate guarantee, and it is not always possible to raise premiums high enough in one year to overcome the entire value of the misestimate. The secondary impact is that claim reserves will likely be misstated because generally trend miss is not immediately apparent and therefore claim reserves may be under or overstated.

REPUTATION RISK

Events related to reputation risk will impact the organization's ability to sign up new groups and retain existing members. These events can be anything that threatens the reputation of the organization and causes groups to move coverage to another organization, for example a scandal related to wrongdoing by the leadership or a data breach or cyber event resulting in the exposure of beneficiary protected information. There are three main impacts from this event:

- The primary impact is on the lapse rate. A negative event may cause some groups that are covered by HealthTrust to leave the plan. Even if their prior experience with the organization is positive, there may be political pressure within the group to distance themselves from the organization.
- The secondary impact is on the new business rate. Negative media exposure will make it very difficult to successfully enroll new groups. Groups that are considering a move to HealthTrust may be less likely to make the move after such an event.
- The final impact is on claim levels. The organization will likely see an increase in the loss ratio (claims divided by premium) because we expect the healthier groups to have an easier time leaving, as they can easily get insurance elsewhere, which results in HealthTrust's overall loss ratio increasing, above that projected at the time of rating.

CHANGE IN COMPETITIVE POSITION

HealthTrust's products are priced to cover expected medical expenses and administrative costs. If the resulting premium is higher than premium levels charged by competitor plans, then there will likely be a decrease in membership retention. Conversely, if premiums are lower than competitor premiums, HealthTrust may see an increase in membership. This event has the same three impacts as reputation risk described above; changes in the new business rate, the lapse rate and the loss ratio, but in this case the impact could be positive or negative depending on whether the premium rate is higher or lower than competitor rates.

MISPRICING OF PRODUCTS

If premiums are set too low or too high, the organization will see the same three impacts, change in new business rate, lapse rate, and loss ratio, as described in the change in competitive position above. The impact on each of these will vary depending on the order of magnitude of the mispricing. In the case where premiums are set too low, the plan will have to cover the excess of expenses over premium from its capital adequacy reserve. At the same time, new business could increase significantly due to the low price, resulting in a much larger volume of loss-making business, putting additional pressure on the organization's capital adequacy reserve. This event is independent from the other events described above.

The attached appendix shows the probability and impact we assumed for each of the events described above. Our assumptions are based on insurance industry experience and our own actuarial judgment.

CAVEATS AND LIMITATIONS

The opinion described in this report is based on assumptions as to future events. While I relied on financial data and information provided by HealthTrust to establish some of these assumptions, HealthTrust directed Milliman to utilize whatever assumptions it believed were most appropriate and reasonable based on its actuarial training and experience in conducting its actuarial analysis. As such, Milliman chose the assumptions to use based on its professional judgment.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate HealthTrust's capital adequacy reserve as of June 30, 2024. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information provided by HealthTrust for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete. If more relevant data becomes available, or if HealthTrust believes these parameters do not appropriately reflect its expectations, we should revise these assumptions. A change in assumptions will change the results and possibly the related conclusions. Actual experience will differ from the assumptions chosen and as such actual results will likely differ from our estimates.

This report is intended for the internal use of HealthTrust, Inc. We understand that this report may be provided to New Hampshire regulators for their internal use. We request that we be informed of any distribution to state regulators on this basis. This report may not be provided to any other third parties without Milliman's prior written consent. In the event such consent is given, the report should be provided in its entirety. Milliman does not intend to benefit any third party recipients of its work products, even if we consent to the release of the report.

Any reader of this report must possess a substantial level of expertise in areas relevant to this analysis to appreciate the significance of the assumptions used in the analysis, and the impact of the assumptions on the illustrated results. The report is intended to provide a sense of variability and risk of insolvency under the assumptions chosen and may not be appropriate for other purposes.

Catherine Murphy-Barron is a member of the American Academy of Actuaries and meet its qualification standards to render the actuarial opinion contained in this report.

APPENDIX

Recommended Capital Adequacy Reserve for HealthTrust
Assumptions for Events Modeled

Systems Change			
	Primary Effect	Secondary Effect	Tertiary Effect
Probability	Reserve Miss	Loss Ratio Increase	None
1%	25.0%	-2.8%	N/A
4%	12.5%	-1.4%	N/A
30%	0.0%	0.0%	N/A
30%	0.0%	0.0%	N/A
30%	0.0%	0.0%	N/A
4%	-12.5%	1.4%	N/A
1%	-25.0%	2.8%	N/A

Pandemic/Catastrophic Claims			
	Primary Effect	Secondary Effect	Tertiary Effect
Probability	Loss Ratio Increase	None	None
1%	-5%	N/A	N/A
4%	0%	N/A	N/A
30%	0%	N/A	N/A
30%	0%	N/A	N/A
25%	0%	N/A	N/A
5%	0%	N/A	N/A
5%	10%	N/A	N/A

Misestimation of Trend			
	Primary Effect	Secondary Effect	Tertiary Effect
Probability	Loss Ratio Increase	Reserve Miss	None
1%	-6%	-6%	N/A
4%	-4%	-4%	N/A
30%	-2%	-2%	N/A
30%	0%	0%	N/A
30%	2%	2%	N/A
4%	4%	4%	N/A
1%	6%	6%	N/A

Reputation Risk			
	Primary Effect	Secondary Effect	Tertiary Effect
Probability	Lapse Increase	Sales	Loss Ratio Increase
1%	0%	0%	0.0%
4%	0%	0%	0.0%
30%	0%	0%	0.0%
30%	0%	0%	0.0%
30%	0%	0%	0.0%
4%	10%	-30%	2.2%
1%	10%	-30%	2.2%

Change in Competitive Position			
	Primary Effect	Secondary Effect	Tertiary Effect
Probability	Lapse Increase	Sales	Loss Ratio Increase
0.5%	-20.0%	60%	-3.3%
2%	-13.3%	40%	-2.4%
15%	-6.7%	20%	-1.3%
65%	0.0%	0%	0.0%
15%	6.7%	-20%	1.4%
2%	13.3%	-40%	3.1%
0.5%	20.0%	-60%	5.0%

Mispricing of Products			
	Primary Effect	Secondary Effect	Tertiary Effect
Probability	Loss Ratio Increase	Sales	Lapse Increase
1%	-5.0%	-5.0%	2.0%
4%	-3.3%	-3.0%	1.0%
30%	-1.7%	-0.5%	0.5%
30%	0.0%	0.0%	0.0%
30%	1.7%	0.5%	-0.5%
4%	3.3%	3.0%	-1.0%
1%	5.0%	5.0%	-2.0%

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September 23, 2024

Mr. Scott DeRoche
Executive Director
HealthTrust, Inc.
25 Triangle Park Drive
Concord, NH 03302

Re: 2025 HealthTrust July Medical Rating

Dear Scott:

This letter documents the overall rating for groups in the July 2025 medical renewal as voted by the Finance & Personnel Committee.

The overall indicated rating outcome is an increase of 9.4%, with rate changes by group ranging from -2.3% to 19.4%.

The following table shows the factors contributing to the July medical overall rate increase of 9.4%.

Rating Item	Rating Impact	Resulting Rate
Re-rate July 2024 renewal • Use claims through April 30, 2024, excluding MC3 • Apply updated trend	 +0.0%	0.0% 0.0%
Trend claims to fiscal year 2025	+7.0%	7.0%
Update HealthTrust operating expenses, Anthem admin and NH vaccine fees, PCORI fees, and investment income	+0.1%	7.1%
Update pooling charge	+2.0%	9.1%
Update capital risk charge from 5.0% to 5.3%	+0.3%	9.4%
Additional risk load	+0.0%	9.4%

Exhibit I shows the derivation of the rating, including details of all rating assumptions. Exhibit II shows the components of the rating, in dollars, and as percentages of the total. Exhibit III shows recent historical excess claims experience.

The medical rating assumes:

- A combined annual trend rate of 7.5% (see notes to Exhibit I).
- $2.4 million of provider payments under Anthem's Enhanced Personal Health Care (EPHC) program.
- $1.4 million of mandated state and federal fees.
- A capital risk charge of 5.3% of claims. A capital risk charge of 15.1% of claims would be needed to achieve the capital target of $122.5 million[1] by June 30, 2026.
- Medicomp members with prescription drug coverage (MC3) transitioned to Medicare Advantage and are no longer enrolled in HealthTrust plans effective January 1, 2025.

This rating was derived from experience data and renewal information supplied by Anthem Blue Cross and Blue Shield of New Hampshire, CVS Caremark, and HealthTrust staff. We reviewed this information for reasonableness, for consistency with past submissions, and for consistency with financial statement results, but we did not independently verify the data. The overall rating methodology and selection of key assumptions were discussed with HealthTrust staff, and staff from Anthem and CVS Caremark.

This rating was derived from experience beginning 26 months earlier than the rating period. The underlying cost projections assume that the MC3 claims and contracts for each entity are excluded from the projection period and make no other allowance for changes in product mix that have occurred since the experience period or that may occur in the future. Therefore, the recommendations rely on the assumption that any product offered will be priced at the expected cost level for that product or, that when any product is not so priced, a compensating adjustment will be made to the prices of other products, with due regard for likely changes in product mix.

We are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Catherine Murphy-Barron, MBA, FSA, MAAA
Principal & Consulting Actuary

Eric A. Buzby, FSA, MAAA
Senior Consulting Actuary

[1] The capital target is in the range recommended in the capital adequacy report provided by Milliman on August 2, 2024.

Exhibit I
Rating Development for the July 2025 Medical Renewal

1. Experience period and rating period for 17,530 July Renewal enrollees (39,882 covered lives)

Experience Period [May 2023 - Apr 2024]		Rating Period [Jul 2025 - Jun 2026]	
2023	2024	2025	2026

2. Medical claims incurred in experience period and paid through May 2024, then completed and trended to the rating period.	Paid Claims	Completed Claims	Trended Claims
a) Non-excess medical claims	$ 229,265,388	$ 234,607,148	$ 272,163,657
b) Claims in excess of $175,000 per person	$ 27,022,814	$ 27,648,021	$ 32,105,096
c) Anthem EPHC provider payments			$ 2,432,781
d) Total medical claims [(a.) + (b.) + (c.)]	$ 256,288,202	$ 262,255,169	$ 306,701,535
e) Adjustment to excess claims			$ -
f) Adjusted medical claims [(d.) + (e.)]			$ 306,701,535
3. Prescription claims paid in the experience period, then completed and trended to the rating period.	**Paid Claims**	**Completed Claims**	**Trended Claims**
a) Claims	$ 63,363,107	$ 63,363,107	$ 76,370,777
b) Rebates and adjustments not reflected above			$ (3,990,160)
c) Total prescription drug claims [(a.) + (b.)]			$ 72,380,617
4. Medical and drug claims projected to rating period [(2.f.) + (3.c.)]			$ 379,082,152
5. Anthem administrative expense (contracted rates applied to enrollees in (1.))			$ 12,921,346
6. CareMark administrative expense			$ 921,082
7. HealthTrust administrative expense projected budget, allocated by number of enrollees			
a) Operations (July Renewal share of total budget)			$ 7,438,969
b) Wellness & 360 programs (July Renewal share of total budget)			$ 3,007,387
c) Total [(a.) + (b.)]			$ 10,446,357
8. Investment income credit (July Renewal share of total projected income)			($1,302,614)
9. New Hampshire Vaccine Fee ($12.50 per month per NH-resident child under age 19)			$ 1,317,900
10. Affordable Care Act PCORI fee ($3.22 per year per member)			$ 128,420
11. Projected costs before capital risk charge & additional risk load ((4.) through (10.))			$ 403,514,642
12. Capital risk charge [5.3% of (4.)]			$ 20,091,354
13. Projected cost [(11.)+(12.)]			$ 423,605,996
14. Aggregate premium at current rates (effective 7/1/2024) for 17,530 enrollees			$ 387,099,099
15. Indicated overall rate increase [(13.)/(14.) - 1]			9.4%
16. Additional risk load			0.0%
17. Indicated overall rate increase after additional risk load [(15.)+(16.)]			9.4%

Exhibit I
Rating Development for the July 2025 Medical Renewal
Notes

Large claims (line 2.b.): Excess claims, i.e., the portion of claims in excess of $175,000 per person, are 9.2% of non-excess claims, overall, for the July groups. When performing the rate calculation for an individual rating entity, the entity's excess claim costs are excluded from the rate calculation and replaced by a pooled claim amount of 9.2% of the entity's non-excess claims. This treatment recognizes the small size of most rating entities and reduces volatility in their rating outcomes. See Exhibit III for recent historical excess claims experience.

Claims Completion (item (2.) and (3.), middle column) and Trend (items (2.) and (3.), right column): Completion factors convert paid claims to fully incurred claims in items (2.) and (3.) and are based on analysis of Anthem and CVS Caremark claims runout patterns. They vary by product. Trended claims represent an annual overall trend rate of 7.1%, compounded for 26 months. This result is a composite of underlying trend assumptions that vary by coverage and time period within the 26-month projection period. For rating entities not enrolled for the entirety of the experience period, trend and completion factors appropriate for the time of enrollment are applied.

Coverage	Completion	Trend
HMO and SOS medical	2.6%	7.0%
POS and OA medical	1.4%	7.0%
CDHP medical and prescription drug	0.7%	8.5%
Medicomp medical	2.5%	6.5%
Combined medical (incl. CDHP prescription drug)	2.3%	7.1%
Prescription drug	0.0%	9.0%
Combined medical and prescription drug	1.9%	7.5%

The medical trend assumptions reflect HealthTrust's actual recent utilization experience and Anthem's expectations for contracted provider increases through June 2026. The prescription drug trend assumption is based on HealthTrust's actual recent experience and CVS Caremark's trend forecasts for HealthTrust's specific plans and enrollment. A group's overall assumed trend rate depends on the group's actual product mix.

Rebates and adjustments (line 3.b.): Prescription drug rebates are generally now credited at point of sale and are included in paid claims (line 3.a.). This value is for any rebates credited to claims incurred during the experience period but not paid at the point of sale.

Capital risk charge (line 12.): This charge is to increase the capital adequacy reserve toward its target level, should the actual net assets be below the target level, and to account for the additional risk should the target be at a level lower than that recommended by the actuary.

Exhibit II
Components of July Renewal's 2025 Projected Cost

	Component	Amount	% of Projected Cost
1.	Claims	$379,082,152	89.49%
2.	Claims administration	$13,842,428	3.27%
3.	HealthTrust: Operations	$7,438,969	1.76%
4.	HealthTrust: Wellness & 360 programs	$3,007,387	0.71%
5.	Investment income	($1,302,614)	-0.31%
6.	NH Vaccine fee	$1,317,900	0.31%
7.	Affordable Care Act fees	$128,420	0.03%
8.	Capital risk charge	$20,091,354	4.74%
9.	Additional risk load	$0	0.00%
10.	Total projected cost	$423,605,996	100.00%

Exhibit III
July 2025 Medical Renewal Historical Excess Claims
Based on 3/1/2019-2/29/2020 to 5/1/2023-4/30/20224 Experience

Rating	Total Claims	Excess Claims Over $175K	Non-Excess Claims	Excess Claims as % of Non-Excess Claims
721	$290,671,996	$15,146,382	$275,525,614	5.5%
722	$279,613,600	$15,975,469	$263,638,131	6.1%
723	$305,011,818	$17,432,885	$287,578,932	6.1%
724	$328,707,288	$25,052,374	$303,654,914	8.3%
725	$319,651,309	$27,022,814	$292,628,495	9.2%

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September 23, 2024

Mr. Scott DeRoche
Executive Director
HealthTrust, Inc.
25 Triangle Park Drive
Concord, NH 03302

Re: 2025 HealthTrust Dental, STD, and January Medical Ratings

Dear Scott:

This letter documents the overall ratings for medical coverage for groups in the January 2025 renewal and dental and STD coverage for all groups as voted by the Finance & Personnel Committee.

For dental coverage, the indicated rating outcome is an increase of 5.0%; see Exhibit IV.

For STD coverage, the indicated rating outcome is a decrease of 1.7%; see Exhibit V.

The overall indicated rating outcome for the January 2025 medical renewal is an increase of 9.8%, with rate changes by group ranging from 3.0% to 18.5%.

The following table shows the factors contributing to the January medical renewal overall rate increase of 9.8%.

Rating Item	Rating Impact	Resulting Rate
Re-rate January 2024 renewal		
• Use claims through April 30, 2024, excluding MC3		-1.4%
• Apply updated trend	-0.1%	-1.5%
Trend claims to calendar year 2025	+7.0%	5.5%
Update HealthTrust administrative expenses, Anthem administrative fees, NH vaccine fee, PCORI fee, and investment income	+0.3%	5.8%
Update pooling charge	+3.7%	9.5%
Update capital risk charge from 5.0% to 5.3%	+0.3%	9.8%
Additional risk load	+0.0%	9.8%

Exhibit I shows the derivation of the rating, including details of all rating assumptions. Exhibit II shows the components of the rating, in dollars, and as percentages of the total. Exhibit III shows recent historical excess claims experience.

The medical rating assumes:

- A combined annual trend rate of 7.5% (see notes to Exhibit I).
- $540,000 of provider payments under Anthem's Enhanced Personal Health Care (EPHC) program.
- $308,000 of mandated state and federal fees.
- A capital risk charge of 5.3% of claims. A capital risk charge of 15.1% of claims would be needed to achieve the capital target of $122.5 million[1] by June 30, 2026.
- Medicomp members with prescription drug coverage (MC3) transitioned to Medicare Advantage and are no longer enrolled in HealthTrust plans effective January 1, 2025.

The medical, dental, and STD ratings were derived from experience data and renewal information supplied by Anthem Blue Cross and Blue Shield of New Hampshire, CVS Caremark, Delta Dental, and HealthTrust staff. We reviewed this information for reasonableness, for consistency with past submissions, and for consistency with financial statement results, but we did not independently verify the data. The overall rating methodology and selection of key assumptions were discussed with HealthTrust staff, and staff from Anthem, CVS Caremark, and Delta Dental.

This rating was derived from experience beginning 20 months earlier than the rating period. The underlying cost projections assume that the MC3 claims and contracts for each entity are excluded from the projection period and make no other allowance for changes in product mix that have occurred since the experience period or that may occur in the future. Therefore, the recommendations rely on the assumption that any product offered will be priced at the expected cost level for that product or, that when any product is not so priced, a compensating adjustment will be made to the prices of other products, with due regard for likely changes in product mix.

We are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Catherine Murphy-Barron, MBA, FSA, MAAA
Principal & Consulting Actuary

Eric A. Buzby, FSA, MAAA
Senior Consulting Actuary

[1] The capital target is in the range recommended in the capital adequacy report provided by Milliman on August 2, 2024.

Exhibit I
Rating Development for the January 2025 Medical Renewal

1. Experience period and rating period for 3,925 January Renewal enrollees (8,623 covered lives)

	Experience Period [May 2023 - Apr 2024]		Rating Period [Jan 2025 - Dec 2025]
	2023	2024	2025

2. Medical claims incurred in experience period and paid through May 2024, then completed and trended to the rating period.	Paid Claims	Completed Claims	Trended Claims
a) Non-excess medical claims	$ 55,698,729	$ 57,015,882	$ 63,989,211
b) Claims in excess of $175,000 per person	$ 7,988,812	$ 8,167,999	$ 9,169,600
c) Anthem EPHC provider payments			$ 540,302
d) Total medical claims [(a.) + (b.) + (c.)]	$ 63,687,541	$ 65,183,881	$ 73,699,113
e) Adjustment to excess claims			$ -
f) Adjusted medical claims [(e.) + (f.)]			$ 73,699,113
3. Prescription claims paid in the experience period, then completed and trended to the rating period.	Paid Claims	Completed Claims	Trended Claims
a) Claims	$ 13,944,676	$ 13,944,676	$ 16,096,111
b) Rebates and adjustments not reflected above			$ (840,977)
c) Total prescription drug claims [(a.) + (b.)]			$ 15,255,134
4. Medical and drug claims projected to rating period [(2.f.) + (3.c.)]			$ 88,954,247
5. Anthem administrative expense (contracted rates applied to enrollees in (1.))			$ 2,993,385
6. CareMark administrative expense			$ 220,758
7. HealthTrust administrative expense projected budget, allocated by number of enrollees			
a) Operations (January Renewal share of total budget)			$ 1,661,291
b) Wellness & 360 programs (January Renewal share of total budget)			$ 686,473
c) Total [(a.) + (b.)]			$ 2,347,765
8. Investment income credit (January Renewal share of total projected income)			($291,672)
9. New Hampshire Vaccine Fee ($12.50 per month per NH-resident child under age 19)			$ 279,900
10. Affordable Care Act PCORI fee ($3.22 per year per member)			$ 27,766
11. Projected costs before capital risk charge & additional risk load ((4.) through (10.))			$ 94,532,149
12. Capital risk charge [5.3% of (4.)]			$ 4,714,575
13. Projected cost [(11.)+(12.)]			$ 99,246,724
14. Aggregate premium at current rates (effective 1/1/2024) for 3,925 enrollees			$ 90,371,536
15. Indicated overall rate increase [(13.)/(14.) - 1]			9.8%
16. Additional risk load			0.0%
17. Indicated overall rate increase after additional risk load [(15.)+(16.)]			9.8%

Exhibit I
Rating Development for the January 2025 Medical Renewal
Notes

Large claims (line 2.b.): Excess claims, i.e., the portion of claims in excess of $175,000 per person, are 11.6% of non-excess claims, overall, for the January groups during the experience period. When performing the rate calculation for an individual rating entity, the entity's excess claim costs are excluded from the rate calculation and replaced by a pooled claim amount of 11.6% of the entity's non-excess claims. This treatment recognizes the small size of most rating entities and reduces volatility in their rating outcomes. See Exhibit III for recent historical excess claims experience.

Claims Completion (item (2.) and (3.), middle column) and Trend (items (2.) and (3.), right column): Completion factors convert paid claims to fully incurred claims in items (2.) and (3.) and are based on analysis of Anthem and CVS Caremark claims runout patterns. They vary by product. Trended claims represent an annual overall trend rate of 7.5%, compounded for 20 months. This result is a composite of underlying trend assumptions that vary by coverage and time period within the 20-month projection period. For rating entities not enrolled for the entirety of the experience period, trend and completion factors appropriate for the time of enrollment are applied.

Coverage	Completion	Trend
HMO and SOS medical	2.6%	7.0%
POS and OA medical	1.4%	7.0%
CDHP medical and prescription drug	0.7%	8.5%
Medicomp medical	2.5%	6.5%
Combined medical (incl. CDHP prescription drug)	2.3%	7.2%
Prescription drug	0.0%	9.0%
Combined medical and prescription drug	1.9%	7.5%

The medical trend assumptions reflect HealthTrust's actual recent utilization experience and Anthem's expectations for contracted provider increases through December 2025. The prescription drug trend assumption is based on HealthTrust's actual recent experience and CVS Caremark's trend forecasts for HealthTrust's specific plans and enrollment. A group's overall assumed trend rate depends on the group's actual product mix.

Rebates and adjustments (line 3.b.): Prescription drug rebates are generally now credited at point of sale and are included in paid claims (line 3.a.). This value is for any rebates credited to claims incurred during the experience period but not paid at the point of sale.

Capital risk charge (line 12.): This charge is to increase the capital adequacy reserve toward its target level, should the actual net assets be below the target level, and to account for the additional risk should the target be at a level lower than that recommended by the actuary. We estimate that at June 30, 2025 net assets will be below the capital target, so a capital risk charge is required.

Exhibit II
Components of January Renewal's 2025 Projected Cost

	Component	Amount	% of Projected Cost
1.	Claims	$88,954,247	89.63%
2.	Claims administration	$3,214,143	3.24%
3.	HealthTrust: Operations	$1,661,291	1.67%
4.	HealthTrust: Wellness & 360 programs	$686,473	0.69%
5.	Investment income	($291,672)	-0.29%
6.	NH Vaccine fee	$279,900	0.28%
7.	Affordable Care Act fees	$27,766	0.03%
8.	Capital risk charge	$4,714,575	4.75%
9.	Additional risk load	$0	0.00%
10.	Total projected cost	$99,246,724	100.00%

Exhibit III
January 2025 Medical Renewal Historical Excess Claims
Based on 3/1/2019-2/29/2020 to 5/1/2023-4/30/2024 Experience

Rating	Total Claims	Excess Claims Over $175K	Non-Excess Claims	Excess Claims as % of Non-Excess Claims
121	$74,108,317	$4,604,099	$69,504,218	6.6%
122	$66,150,877	$3,865,775	$62,285,102	6.2%
123	$69,577,977	$4,232,582	$65,345,394	6.5%
124	$76,294,599	$6,671,218	$69,623,381	9.6%
125	$77,074,844	$7,988,812	$69,086,032	11.6%

Exhibit IV
Rating Development for the January 2025 Dental Renewal

1. Experience period and rating period for 26,843 dental enrollees

Experience Period [July 2023 - June 2024]		Rating Period [Jan 2025 - Dec 2025]
2023	2024	2025

2. Claims paid in the experience period, then completed and trended to the rating period.	Paid Claims	Completed Claims	Trended Claims
a) Total Claims	$ 27,863,643	$ 28,084,677	$ 29,786,498
b) Claims in excess of standard maximum	$ -	$ -	$ -
c) Claims for Rating [(a.) - (b.)]	$ 27,863,643	$ 28,084,677	$ 29,786,498
3. Delta Dental administrative fee (contracted rates applied to enrollees in (1.))			$ 1,932,696
4. HealthTrust administrative expense (dental share of total projected budget)			$ 639,513
5. Investment income credit (dental share of total projected income)			$ (91,987)
6. Projected costs before capital risk charge ((2.) through (5.))			$ 32,266,720
7. Capital risk charge [5.3% of (2.)]			$ 1,578,684
8. Total projected costs for rating period [(6.)+(7.)]			$ 33,845,405
9. Aggregate premium at current rates (effective 1/1/2024) for 26,843 enrollees			$ 32,227,864
10. Indicated overall rate increase [(8.)/(9.) - 1]			5.0%

Exhibit V
Rating Development for the 2025 Short-Term Disability Renewal

1. Experience period and rating period

	Experience Period [Jul 2023 - Jun 2024]		Rating Period [Jan 2025 - Dec 2025]
January Renewal Groups	**2023**	**2024**	**2025**

	Experience Period [Jul 2023 - Jun 2024]		Rating Period [Jul 2025 - Jun 2026]	
July Renewal Groups	**2023**	**2024**	**2025**	**2026**

2. Claims paid in experience period	$ 1,380,212
3. Credibility of one year's experience	50%
4. Credible claims	$ 1,482,168
5. Demographic adjustment	$ (8,271)
6. HealthTrust projected administrative expense	$ 116,275
7. Projected cost before capital risk charge [(4.)+(5.)+(6.)]	$ 1,590,172
8. Capital risk charge [5.3% of (4.)+(5.)]	$ 78,117
9. Projected cost [(7.)+(8.)]	$ 1,668,289
10. Aggregate premium at current rates	$ 1,697,296
11. Indicated overall rate increase [(9.)/(10.) – 1]	-1.7%

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August 1, 2024

Via Electronic Mail

Mr. George Tsiopras
Chief Financial Officer
HealthTrust, Inc.
25 Triangle Park Drive
Concord, NH 03302

Re: HealthTrust Incurred but Not Paid Claim Reserves as of June 30, 2024

Dear George:

As requested, we have developed the incurred but not paid (IBNP) claim reserves for HealthTrust as of June 30, 2024. These reserves are for claims incurred prior to June 30, 2024 that are not yet paid as of that date.

Results

Our estimates of the June 30, 2024 claim reserves for medical (excluding prescription drugs), dental, and short-term disability are summarized below. We believe that these amounts make a good and sufficient provision, in the aggregate, for all unpaid claims.

June 30, 2024 IBNP Claim Reserves

1.	**Reserve for claims**		
	a.	Medical (excl. prescription drugs)	$29,543,000
	b.	Dental	$990,000
	c.	Short-term disability	$283,969
	d.	Total reserve for claims	$30,816,969
2.	**Reserve for administration**		
	a.	Medical (excl. prescription drugs)	$2,512,914
	b.	Dental	$324,624
	c.	Total reserve for administration	$2,837,538
3.	**Total reserve**		
	a.	Medical (excl. prescription drugs)	$32,055,914
	b.	Dental	$1,314,624
	c.	Short-term disability	$283,969
	d.	Total reserve for claims/admin	$33,654,507

Details of the reserve development for medical and dental claim reserves are shown in the following attached exhibits:

- Exhibit I: Claim runout method for medical IBNP claims reserve
- Exhibit II: Claim runout method for dental IBNP claims reserve

The June 30, 2024 medical and dental IBNP claim reserves are based on analyses of paid claims through June 30, 2024 broken down by incurred date and paid date as furnished by HealthTrust. A 10% explicit margin is included in the medical claim reserve and a 5% explicit margin is included in the dental claim reserve.

Restated June 30, 2023 Medical Claim Reserve

The restated June 30, 2023 medical IBNP claim reserve is $24,559,000. The June 30, 2023 IBNP reserve (including margin) was $34,565,000. The restated estimate is 29.0% below the original reserve with margin and 25.4% below the original reserve without margin ($32,920,000). This decrease is driven by a change in run-out pattern from the prior period. When comparing the 12-month run-out period for the incurred claims of the year ending June 30, 2022 ($32.6M) and the year ending June 30, 2023 ($23.3M), there was a reduction of $9.3M, or 28.5%, resulting in the lower restated estimate.

Methodology

The IBNP reserves were calculated using the “claim runout” method which examines past claims payment patterns and determines the portion of claims incurred during a month that are paid within specific time periods. For recent months, when paid claims data is too sparse to develop estimated incurred claims, we use trend assumptions and average claims per member projections to develop incurred claims. The claim reserves were calculated as estimated incurred claims through June 30, 2024, minus claims paid through June 30, 2024.

We add an explicit margin to our reserve estimate to allow for volatility. We added a 10% explicit margin to the medical reserve and a 5% explicit margin to the dental reserve. The change in payment pattern noted above is reflected in the medical IBNP reserve estimate as of June 30, 2024. We increased the medical margin to 10% from our historical 5% margin due to the uncertainty related to the variability of the payment pattern for the most recent period versus the prior periods. We contacted Anthem regarding this change in payment pattern to gain a better understanding of the reason for the significant change and the likelihood that it will continue into future years. While no specific reasons were provided, Anthem does not anticipate a significant increase for the next year.

We estimate the reserve for STD to be the amount of premium received for May and June 2024, as reported by HealthTrust.

The reserve for administration covers the cost of administering unreported claims. The termination provisions in HealthTrust’s contracts with Anthem and Delta Dental require payment of two months of administrative fees upon contract termination. Therefore, the reserve is equal to two months of medical and dental administrative fees based on the respective June 2024 contracts.

Data Reliance

We relied upon the membership, claims data, and premiums provided in the following files:

- *Anthem Lag 6.30.2024.xlsx* - Medical claim triangles and monthly membership
- *Delta Lag 06.30.2024.xlsx* - Dental claim triangle and monthly membership
- *Healthtrust Capital Analysis as of 6.30.24 for Milliman.xlsx* - STD premiums
- *HT Reserve Balances 6.30.24 Prelim.xlsx* - medical and dental administrative fees

HealthTrust staff estimate the claim reserve for prescription drugs paid through Caremark.

Caveats, Limitations, and Qualifications

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate HealthTrust's IBNP claim reserve amount as of June 30, 2024. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness for their intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

The models rely on data and information as input to the models. We have relied upon certain data and information provided by HealthTrust for this purpose and accepted it without audit. HealthTrust staff estimates the claim reserve for prescription drugs paid through Caremark. To the extent that the underlying data or information is inaccurate or incomplete, our assessment may likewise be inaccurate or incomplete.

It should be emphasized that the claim reserve estimates shown in this letter are estimates based upon certain assumptions. Actual experience may differ from these assumptions. To the extent that actual experience differs, the resulting claim reserves would be different from what is presented in this letter. The exact liability can only be determined after a significant passage of time permits the filing and payment of outstanding claims.

This letter is prepared solely for the internal business use of HealthTrust, Inc. for the preparation of US GAAP financial statements. The reserve estimates stated in this letter may not be appropriate for other purposes. Our work may not be provided to third parties without our prior written consent. Milliman does not intend to benefit any third-party recipient of its work product, even if we consent to the release of the work product to such third party.

Catherine Murphy-Barron and Eric Buzby are Consulting Actuaries with Milliman. They are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Please let us know if you have any questions.

Sincerely,

Catherine Murphy-Barron, MBA, FSA, MAAA
Principal & Consulting Actuary

Eric A. Buzby, FSA, MAAA
Senior Consulting Actuary

CC: Scott DeRoche, HealthTrust
Kathleen Fox, HealthTrust
Alexander Hart, Milliman
Ananya Sridharan, Milliman

Exhibit I
HealthTrust
Reserve for Medical (excl. Rx) Claims as of June 30, 2024

	(A)	(B)	(C)	(D) = (B)/(C)	(E) = (C)/(A)	(F)	(G) = (C)-(B)
Incurred Month	Member Months	Cumulative Paid	Estimated Incurred	Completion Factor	Incurred Cost per Member Month	Rolling 3 Month Cost Per Member Month	Reserve (IBNP)
Jun-24	52,686	$12,467,954	$30,049,282	0.4149	$570.35	$564.32	$17,581,328
May-24	52,808	26,678,580	30,431,021	0.8767	576.26	559.51	3,752,441
Apr-24	52,834	27,471,076	28,867,657	0.9516	546.38	541.99	1,396,581
Mar-24	52,910	28,597,755	29,412,261	0.9723	555.89	553.71	814,506
Feb-24	52,891	27,158,293	27,698,598	0.9805	523.69	544.05	540,305
Jan-24	52,958	30,293,825	30,795,348	0.9837	581.51	553.55	501,523
Dec-23	52,907	27,457,309	27,876,477	0.9850	526.90	534.50	419,168
Nov-23	52,845	28,821,079	29,182,256	0.9876	552.22	509.34	361,177
Oct-23	52,713	27,384,280	27,641,051	0.9907	524.37	505.48	256,771
Sep-23	52,607	23,570,779	23,736,437	0.9930	451.20	492.59	165,658
Aug-23	52,403	28,177,516	28,348,655	0.9940	540.97	528.41	171,139
Jul-23	52,394	25,340,347	25,450,808	0.9957	485.76	542.93	110,461
Jun-23	53,038	29,492,738	29,602,220	0.9963	558.13	544.15	109,482
May-23	53,059	30,896,440	30,997,018	0.9968	584.20	545.28	100,578
Apr-23	53,096	25,951,005	26,025,254	0.9971	490.15	513.46	74,249
Mar-23	53,095	29,741,695	29,813,880	0.9976	561.52	530.92	72,185
Feb-23	53,180	25,940,288	25,991,802	0.9980	488.75	506.83	51,514
Jan-23	53,250	28,836,180	28,889,264	0.9982	542.52	512.28	53,084
Dec-22	53,305	26,035,945	26,077,902	0.9984	489.22	485.31	41,957
Nov-22	53,302	26,884,384	26,924,401	0.9985	505.13	478.69	40,017
Oct-22	53,296	24,567,541	24,600,336	0.9987	461.58	479.69	32,795
Sep-22	53,297	24,984,247	25,015,564	0.9987	469.36	469.60	31,317
Aug-22	52,979	26,898,103	26,929,541	0.9988	508.31	491.82	31,438
Jul-22	53,052	22,850,039	22,874,727	0.9989	431.18	479.56	24,688
Jun-22	52,879	28,325,137	28,351,440	0.9991	536.16	503.04	26,303
May-22	52,934	24,938,170	24,958,388	0.9992	471.50	503.16	20,218
Apr-22	53,029	26,574,976	26,593,730	0.9993	501.49	494.56	18,754
Mar-22	53,125	28,476,333	28,495,113	0.9993	536.38	481.95	18,780
Feb-22	53,194	23,713,077	23,719,065	0.9997	445.90	459.94	5,988
Jan-22	53,266	24,692,247	24,698,041	0.9998	463.67	468.42	5,794
Dec-21	53,540	25,168,223	25,172,828	0.9998	470.17	466.54	4,605
Nov-21	53,471	25,201,278	25,205,597	0.9998	471.39	462.01	4,319
Oct-21	53,477	24,492,408	24,496,207	0.9998	458.07	459.60	3,799
Sep-21	53,473	24,411,509	24,414,931	0.9999	456.58	464.92	3,422
Aug-21	53,136	24,660,526	24,663,872	0.9999	464.17	480.69	3,346
Jul-21	53,173	25,204,593	25,207,551	0.9999	474.07	470.44	2,958
Jun-21	53,503	26,945,407	26,948,241	0.9999	503.68	477.43	2,834
May-21	53,688	23,283,620	23,285,225	0.9999	433.71	473.07	1,605
Apr-21	53,719	26,588,948	26,589,102	1.0000	494.97	473.53	154
Mar-21	53,795	26,386,278	26,386,278	1.0000	490.50	458.29	0
Feb-21	53,845	23,432,726	23,432,726	1.0000	435.19	442.22	0
Jan-21	53,936	24,230,280	24,230,280	1.0000	449.24	449.24	0
Total		$1,093,223,134	$1,120,080,375				$26,857,241
					Provision for Adverse Deviation	10%	$2,685,724
					Rounded Final Reserve		$29,543,000
					CY 2021		$30,000
					CY 2022		$328,000
					CY 2023		$2,140,000
					CY 2024		$27,045,000

Exhibit II
HealthTrust
Reserve for Dental Claims as of June 30, 2024

	(A)	(B)	(C)	(D) = (B)/(C)	(E) = (C)/(A)	(F)	(G) = (C)-(B)
Incurred Month	Member Months	Cumulative Paid	Estimated Incurred	Completion Factor	Incurred Cost per Member Month	Rolling 3 Month Cost Per Member Month	Reserve (IBNP)
Jun-24	60,122	$1,565,506	$2,277,960	0.6872	$37.89	$36.88	$712,454
May-24	60,249	2,137,746	2,217,036	0.9642	36.80	36.41	79,290
Apr-24	60,253	2,125,106	2,166,123	0.9811	35.95	37.17	41,017
Mar-24	59,968	2,162,870	2,187,838	0.9886	36.48	38.81	24,968
Feb-24	60,034	2,327,856	2,346,891	0.9919	39.09	37.32	19,035
Jan-24	60,023	2,437,817	2,452,819	0.9939	40.86	36.80	15,002
Dec-23	60,000	1,911,165	1,920,260	0.9953	32.00	36.20	9,095
Nov-23	60,024	2,244,731	2,253,135	0.9963	37.54	37.18	8,404
Oct-23	59,852	2,330,367	2,337,530	0.9969	39.06	41.30	7,163
Sep-23	59,639	2,079,284	2,084,430	0.9975	34.95	43.95	5,146
Aug-23	59,134	2,950,296	2,955,745	0.9982	49.98	44.95	5,449
Jul-23	59,070	2,771,333	2,775,153	0.9986	46.98	40.33	3,820
Jun-23	59,407	2,249,886	2,252,494	0.9988	37.92	35.71	2,608
May-23	59,441	2,146,666	2,148,555	0.9991	36.15	35.93	1,889
Apr-23	59,490	1,966,421	1,967,692	0.9994	33.08	35.51	1,271
Mar-23	59,508	2,292,946	2,294,267	0.9994	38.55	37.25	1,321
Feb-23	59,534	2,076,847	2,077,905	0.9995	34.90	35.33	1,058
Jan-23	59,613	2,282,525	2,283,449	0.9996	38.30	35.98	924
Dec-22	59,450	1,948,343	1,949,044	0.9996	32.78	34.88	701
Nov-22	59,451	2,190,233	2,190,921	0.9997	36.85	35.35	688
Oct-22	59,362	2,077,659	2,078,190	0.9997	35.01	39.60	531
Sep-22	59,223	2,023,811	2,024,320	0.9997	34.18	42.45	509
Aug-22	58,524	2,911,239	2,911,750	0.9998	49.75	44.09	511
Jul-22	58,514	2,545,645	2,545,645	1.0000	43.50	38.04	0
Jun-22	57,541	2,238,929	2,238,929	1.0000	38.91	34.68	0
May-22	57,593	1,820,551	1,820,551	1.0000	31.61	35.08	0
Apr-22	57,651	1,933,475	1,933,475	1.0000	33.54	35.92	0
Mar-22	57,722	2,313,852	2,313,852	1.0000	40.09	35.67	0
Feb-22	57,783	1,973,011	1,973,011	1.0000	34.15	34.11	0
Jan-22	57,810	1,895,863	1,895,863	1.0000	32.79	34.49	0
Dec-21	57,974	2,052,088	2,052,088	1.0000	35.40	34.80	0
Nov-21	57,916	2,042,813	2,042,813	1.0000	35.27	34.46	0
Oct-21	57,942	1,953,956	1,953,956	1.0000	33.72	37.94	0
Sep-21	57,746	1,985,750	1,985,750	1.0000	34.39	40.95	0
Aug-21	57,137	2,617,635	2,617,635	1.0000	45.81	44.42	0
Jul-21	57,203	2,443,307	2,443,307	1.0000	42.71	41.07	0
Jun-21	56,749	2,538,513	2,538,513	1.0000	44.73	39.88	0
May-21	56,881	2,034,409	2,034,409	1.0000	35.77	39.11	0
Apr-21	56,957	2,229,947	2,229,947	1.0000	39.15	40.15	0
Mar-21	57,003	2,417,554	2,417,554	1.0000	42.41	39.72	0
Feb-21	57,145	2,222,711	2,222,711	1.0000	38.90	38.38	0
Jan-21	57,175	2,164,825	2,164,825	1.0000	37.86	37.86	0
Total		$92,635,487	$93,578,341				$942,854
					Provision for Adverse Deviation	5%	$47,143
					Rounded Final Reserve		$990,000
					CY 2021		$0
					CY 2022		$3,100
					CY 2023		$50,600
					CY 2024		$936,300

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milliman.com

July 31, 2024

Via Electronic Mail

Mr. George Tsiopras
Chief Financial Officer
HealthTrust, Inc.
25 Triangle Park Drive
Concord, NH 03302

Re: Premium Deficiency Reserve Estimate as of June 30, 2024

Dear George:

As requested, we have performed an analysis to determine the need for HealthTrust to hold a premium deficiency reserve as of June 30, 2024.

Results

Based on our projection of revenue and expenses for the period July 1, 2024 through June 30, 2025, HealthTrust does not require a premium deficiency reserve as of June 30, 2024.

The premium deficiency reserve is estimated based on the following information:

1. Historical membership information through June 2024 and current enrollment as of July 1, 2024.

2. Medical claims incurred May 1, 2023 through April 30, 2024, paid through May 31, 2024.

3. Prescription drug claims paid May 1, 2023 through April 30, 2024.

4. Dental and short-term disability claims paid July 1, 2023 through June 30, 2024.

5. Prescription drug rebates owed to HealthTrust for claims incurred January 1, 2020 through June 30, 2024.

6. Projected carrier, state and federal fees for July 1, 2024 through June 30, 2025.

7. Projected HealthTrust operating budget for July 1, 2024 through June 30, 2025.

8. Investment income projection for July 1, 2024 through June 30, 2025.

9. Current premium rates.

Methodology and Assumptions

We made the following assumptions in our calculations:

Deficiency Period: 6-month period ending December 31, 2024 for the January Renewal medical, dental, and short-term disability (STD) coverages.

12-month period ending June 30, 2025 for the July Renewal medical, dental, and short-term disability (STD) coverages.

Membership: Enrollment for July 1 through December 31, 2024 will remain the same as on July 1, 2024. Enrollment for January 1 through June 30, 2025 accounts for the transition of Medicomp (MC3) members to Medicare Advantage effective January 1, 2025.

Claims Trend: Annual claims trends:

- HMO & POS 7.0%
- Medicomp 6.5%
- CDHP 8.5%
- Prescription Drug 9.0%
- Dental 3.0%

Our analysis and results are shown in the attached exhibit.

Data Reliance

We relied upon the membership, claims, expenses, investment income and premium information provided in the following files:

- *Global Data-725 GMR.xlsx* - July renewal membership, paid claims and income at current rates
- *Global Data-125.xlsx* - January renewal membership, paid claims and income at current rates
- *2025 Dental RateCalc D1.xlsx* - dental paid claims and income at current rates
- *STD Ratecalc 2025 Draft1.xlsx* - STD paid claims and contributions
- *HEALTH TRUST Interim Settlement 2024 as of 20240630.xlsx* - prescription drug rebates owed to HealthTrust
- *RateCalc725 Fixed Fees to Milliman 5.31.2024.xlsx* - HealthTrust administrative expenses and investment income

- *725 GMR RateCalc D1.xlsx* - July renewal number of children under age 19 and ratio of members to contracts for non-Medicomp enrollees

- *125 RateCalc D1.xlsx* - January renewal number of children under age 19 and ratio of members to contracts for non-Medicomp enrollees

- The following files were used in determining current vs. average membership for July and January renewals:

    - *125 Ratesfile Counts 7.1.24.xlsx*

    - *725 GMR Ratefile Counts 7.1.2024-Milliman.xlsx*

- *Anthem Lag 6.30.2024.xlsx* - medical completion factors

- *Delta Lag 06.30.2024.xlsx* - current vs. average membership for dental and dental completion factors

- *Dental Covered Lives Count by Renewal as of 7.1.2024.xlsx* - split of covered dental membership between January and July renewal groups

- *Historical Enrollment by Fiscal Year 2024.xlsx* - current vs. average membership for STD

- *725 GMR Enrollee Counts 624-724.xlsx* - current vs. average membership and income used for buy-down revenue calculation

- The following files were used in determining the additional costs, revenues, and enrollment for the Medicomp (MC3) members that will transition to Medicare Advantage on January 1, 2025

    - *725 GMR Rating Income W_MC3.xlsx*

    - *125 Rating Income W_MC3.xlsx*

    - *725 Renewal Enrollee Count_7.1.24 w_MC3.xlsx*

    - *125 Renewal Enrollee Count _7.1.2024 w_MC3.xlsx*

    - *725 GMR Claims All w_MC.xlsx*

    - *125 Claims All w_MC3.xlsx*

    - *725 GMR RX All w_MC3.xlsx*

    - *125 RX All w_MC3.xlsx*

We evaluated this information for reasonableness and consistency to the extent practicable. As is our practice, we did not audit or verify the underlying data and information but relied on it as provided to us. If

the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Caveats, Limitations, and Qualifications

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate HealthTrust's premium deficiency reserve amount as of June 30, 2024. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness for their intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

The models rely on data and information as input to the models. We have relied upon certain data and information provided by HealthTrust for this purpose and accepted it without audit. To the extent that the underlying data or information is inaccurate or incomplete, our assessment may likewise be inaccurate or incomplete.

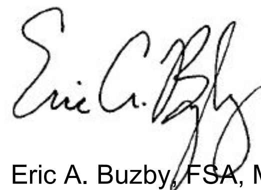
It should be emphasized that the estimates shown in this letter are estimates based upon certain assumptions. Actual experience may differ from these assumptions. To the extent that actual experience differs, the resulting reserve would be different from what is presented in this letter.

This letter is prepared solely for the internal business use of HealthTrust, Inc. for the preparation of US GAAP financial statements. The reserve amount stated in this letter may not be appropriate for other purposes. Our work may not be provided to third parties without our prior written consent. Milliman does not intend to benefit any third-party recipient of its work product, even if we consent to the release of the work product to such third party.

Catherine Murphy-Barron and Eric Buzby are Consulting Actuaries with Milliman. They are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Please let us know if you have any questions.

Sincerely,



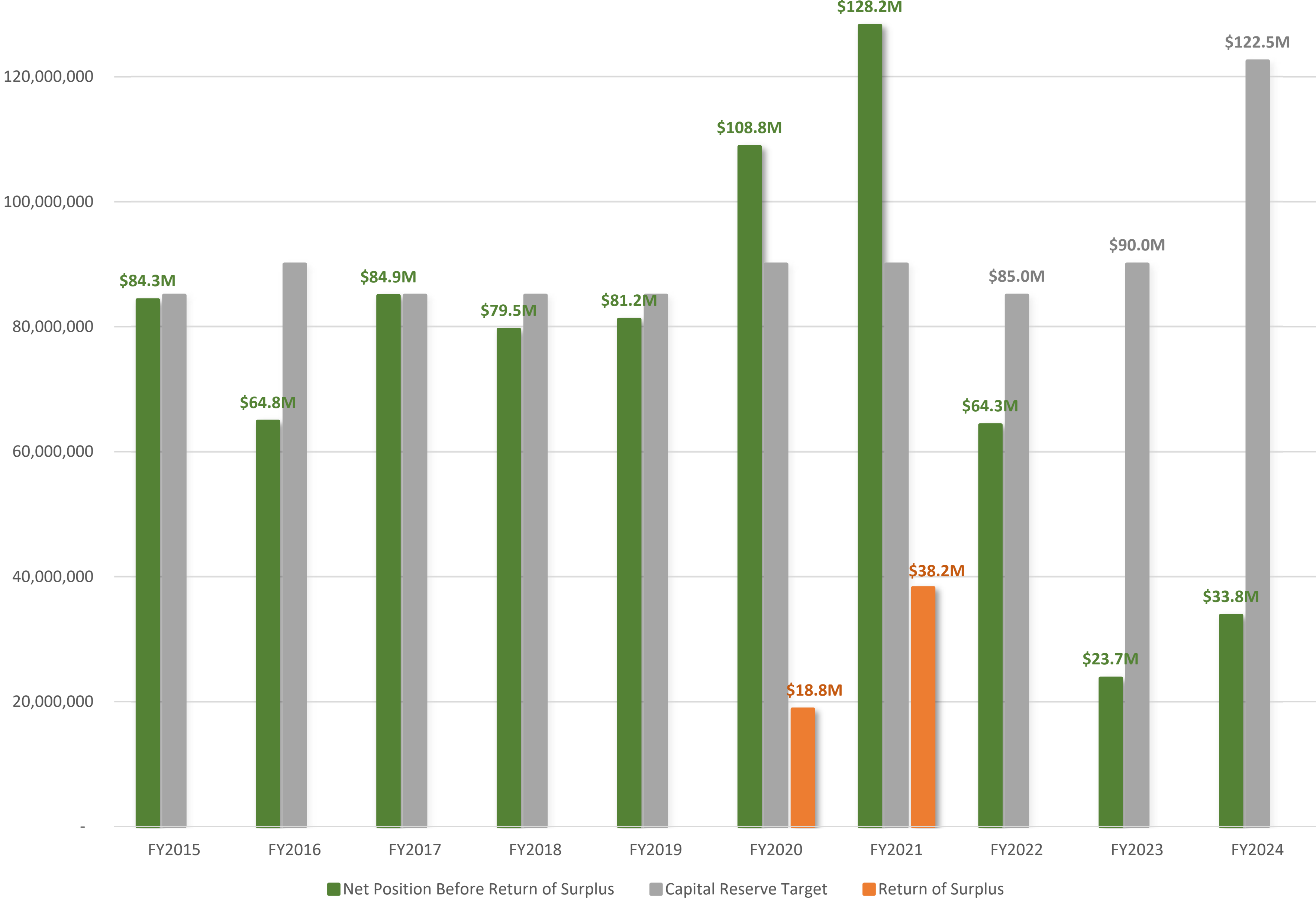
Catherine Murphy-Barron, MBA, FSA, MAAA
Principal & Consulting Actuary

Eric A. Buzby, FSA, MAAA
Senior Consulting Actuary

CC: Scott DeRoche, HealthTrust
Kathleen Fox, HealthTrust
Alexander Hart, Milliman
Ananya Sridharan, Milliman

HealthTrust, Inc.
Premium Deficiency Reserve (PDR) as of June 30, 2024

			July Renewal Medical/Rx	January Renewal Medical/Rx	Medicomp Medical/Rx	Dental	STD	Total
1.	Experience Period (EP)		5/1/23 - 4/30/24	5/1/23 - 4/30/24	5/1/23 - 4/30/24	7/1/23 - 6/30/24	7/1/23 - 6/30/24	
2.	Average number of enrollees		17,530	3,889	4,177	26,843	4,497	
3.	a.	Average number of members	39,882	8,543	4,177			
	b.	Average number of non-Medicomp members	37,505	8,250	0			
4.	Claims							
	a.	Paid claims	$319,651,308	$77,074,845	$37,307,949	$27,863,643	$1,356,456	
	b.	Completion	$5,966,967	$1,409,410	$275,610	$221,034	$0	
	c.	Plan changes	$0	$0	$0	$0	$0	
	d.	Prescription drug rebates	($3,312,102)	($727,014)	($1,372,904)	$0	$0	
	e.	Adjusted completed claims	$322,306,173	$77,757,240	$36,210,656	$28,084,677	$1,356,456	
5.	Guarantee period claims		*7/1/24 - 6/30/25*	*7/1/24- 12/31/24*	*7/1/24- 12/31/24*	*July: 7/1/24 - 6/30/25* *Jan: 7/1/24 - 12/31/24*	*July: 7/1/24 - 6/30/25* *Jan: 7/1/24 - 12/31/24*	
	a.	Claims trended to guarantee period	$350,501,282	$83,086,693	$38,929,398	$29,168,896	$1,356,456	
	b.	Total claims, adjusted for length of guarantee period	$350,501,282	$41,543,346	$19,464,699	$27,181,352	$1,035,976	
6.	Carrier fees (contract rates applied to enrollees or members)							
	a.	Administrative fee	$11,242,644	$1,297,136	$568,736	$1,799,884	$0	
	b.	Anthem EPHC provider payments	$2,432,781	$267,556	$0	$0	$0	
	c.	Total	$13,675,426	$1,564,693	$568,736	$1,799,884	$0	
7.	HealthTrust administrative expense (projected budget, allocated by number of contracts)		$12,425,608	$1,336,029	$1,341,156	$586,766	$87,536	
8.	Investment income credit		($1,187,963)	($120,077)	($128,968)	($85,666)	$0	
9.	State & federal fees							
	a.	New Hampshire Vaccine Fee	$1,317,900	$135,900	$0			
	b.	ACA PCORI fee	$128,420	$13,754	$13,451			
	c.	Total	$1,446,320	$149,654	$13,451			
10.	Total projected cost on average enrollment in experience period [(5.b.)+(6.c.)+(7.)+(8.)+(9.c.)]		$376,860,673	$44,473,646	$21,259,074	$29,482,337	$1,123,513	
11.	Income at current rates on average enrollment in experience period		$387,099,098	$44,671,215	$19,488,276	$30,638,689	$1,298,276	
12.	Cost and income scaled to current enrollment and adjusted for July medical buy-downs							
	a.	Cost	$372,153,699	$44,616,639	$20,825,551	$29,734,012	$1,171,700	$468,501,601
	b.	Income at current rates on current enrollment	$378,177,499	$44,818,881	$19,071,267	$30,904,758	$1,358,664	$474,331,069
13.	Premium Deficiency Reserve [(12.a) - (12.b), "Total" column, but not less than zero]							**$0**


Ten Year History of Net Position, Capital Reserve Target, and Return of Surplus
120,000,000
100,000,000
80,000,000
60,000,000
40,000,000
20,000,000
-
$84.3M
$64.8M
$84.9M
$79.5M
$81.2M
$108.8M
$18.8M
$128.2M
$38.2M
$64.3M
$85.0M
$23.7M
$90.0M
$33.8M
$122.5M
FY2015
FY2016
FY2017
FY2018
FY2019
FY2020
FY2021
FY2022
FY2023
FY2024
Net Position Before Return of Surplus
Capital Reserve Target
Return of Surplus

SB297 CAPITAL LIMITS COMPARED TO ACTUARY RECOMMENDATION

Year	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Actuarial Maximum Capital Adequacy Target	$130,000,000	$140,000,000	$130,000,000	$130,000,000	$130,000,000	$140,000,000	$145,000,000	$135,000,000	$150,000,000	$150,000,000
Actuarial Minimum Capital Adequacy Target	$85,000,000	$90,000,000	$85,000,000	$85,000,000	$85,000,000	$90,000,000	$90,000,000	$85,000,000	$90,000,000	$95,000,000
Capital Adequacy Minimum as % of Contributions	**21%**	**22%**	**21%**	**21%**	**22%**	**22%**	**21%**	**20%**	**20%**	**20%**
Statutory Maximum 16% of Contributions	$65,045,361	$64,266,153	$64,315,832	$64,351,385	$60,988,893	$65,361,335	$67,877,221	$68,522,978	$71,460,865	$75,229,209
Statutory Minimum 12% of Contributions	$48,784,021	$48,199,614	$48,236,874	$48,263,539	$45,741,670	$49,021,001	$50,907,915	$51,392,233	$53,595,649	$56,421,907
Narrow Window Between Statutory Min and Max	$16,261,340	$16,066,538	$16,078,958	$16,087,846	$15,247,223	$16,340,334	$16,969,305	$17,130,744	$17,865,216	$18,807,302
Amount Under Capitalized at 16%	**$19,954,639**	**$25,733,847**	**$20,684,168**	**$20,648,615**	**$24,011,107**	**$24,638,665**	**$22,122,779**	**$16,477,022**	**$18,539,135**	**$19,770,791**
Current Fiscal Year Contributions										
Jul-Dec (January Renewal)	$45,756,695	$39,315,191	$39,860,486	$40,009,242	$33,274,523	$38,337,173	$42,215,023	$43,433,327	$42,152,015	$42,404,086
Jan-Jun (January Renewal)	$39,315,191	$39,860,486	$40,009,242	$33,274,523	$38,337,173	$42,215,023	$43,433,327	$42,152,015	$42,404,086	$47,910,792
July Renewal	$321,461,623	$322,487,778	$322,104,225	$328,912,392	$309,568,887	$327,956,148	$338,584,279	$342,683,270	$362,074,307	$379,867,678
Total Rated Contributions	$406,533,508	$401,663,454	$401,973,953	$402,196,157	$381,180,583	$408,508,344	$424,232,629	$428,268,611	$446,630,408	$470,182,556

Exhibit VI
2025 Ratings: January Medical, July Medical, Dental, STD
Risk Charge Scenarios[1]

	Net Assets				Net Assets, Less Target Capital			
Year Ending June 30	1-Year (15.1%)[2]	2-Year (7.9%)[2]	3-Year (5.3%)[2]	>3-Year (5.0%)[3]	1-Year (15.1%)[2]	2-Year (7.9%)[2]	3-Year (5.3%)[2]	>3-Year (5.0%)[3]
2024	$33,724,222	$33,724,222	$33,724,222	$33,724,222	($88,775,778)	($88,775,778)	($88,775,778)	($88,775,778)
2025	$46,631,396	$43,256,596	$42,037,918	$41,897,301	($75,868,604)	($79,243,404)	($80,462,082)	($80,602,699)
2026	$122,500,000	$82,878,298	$68,858,612	$64,960,955	$0	($39,621,702)	($53,641,388)	($57,539,045)
2027	$122,500,000	$122,500,000	$95,679,306	$88,024,608	$0	$0	($26,820,694)	($34,475,392)
2028	$122,500,000	$122,500,000	$122,500,000	$111,088,262	$0	$0	$0	($11,411,738)
2029	$122,500,000	$122,500,000	$122,500,000	$122,500,000	$0	$0	$0	$0

	2025 Indicated Rate Increase				
	1-Year (15.1%)[2]	2-Year (7.9%)[2]	3-Year (5.3%)[2]	>3-Year (5.0%)[3]	No risk charge
January medical	19.5%	12.4%	9.8%	9.5%	4.6%
July medical	19.0%	12.0%	9.4%	9.1%	4.2%
Dental	14.1%	7.4%	5.0%	4.7%	0.1%
Short-term disability	6.8%	0.5%	-1.7%	-2.0%	-6.3%

1 Projections are based on a capital target of $122.5M through June 30, 2029.

2 Risk charge dollar amounts are assumed to be consistent for all years, based on the risk charge percentage assessed in the first year.

3 Risk charge dollar amounts are assumed to be consistent through June 30, 2028. A lower amount would be applicable after June 30, 2028 to avoid exceeding the capital target.

Caveats, Limitations, and Qualifications

Milliman has developed certain models to estimate the values included in this exhibit. The intent of the models is to project future claim costs. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness for their intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

The models rely on data and information as input to the models. Milliman relied upon certain data and information provided by Anthem Blue Cross and Blue Shield of New Hampshire, CVS Caremark, and HealthTrust staff for this purpose and accepted it without audit. To the extent that the underlying data or information is inaccurate or incomplete, our assessment may likewise be inaccurate or incomplete.

The overall rating methodology and selection of key assumptions were discussed with HealthTrust staff, and staff from Anthem and CVS Caremark.

This exhibit is based on a rating derived from experience beginning 26 months earlier than the rating period. The underlying cost projections assume that the MC3 claims and contracts for each entity are excluded from the projection period and make no other allowance for changes in product mix that have occurred since the experience period or that may occur in the future. Therefore, the projection relies on the assumption that any product offered will be priced at the expected cost level for that product or, that when any product is not so priced, a compensating adjustment will be made to the prices of other products, with due regard for likely changes in product mix.

This exhibit is prepared solely for the internal business use of HealthTrust, Inc. The values included in this exhibit may not be appropriate for other purposes. Our work may not be provided to third parties without our prior written consent. Milliman does not intend to benefit any third-party recipient of its work product, even if we consent to the release of the work product to such third party.

Catherine Murphy-Barron and Eric Buzby are Consulting Actuaries with Milliman. They are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to perform the analysis underlying this exhibit.

HEALTHTRUST, INC
STATEMENT OF NET POSITION
As of December 31, 2024*

	December 2024
ASSETS	
Cash and Cash Equivalents	$44,819,500
Fixed Maturity Securities	23,985,579
Contributions receivable from members	6,186,751
Accounts receivable	3,330,646
Accrued interest receivable	105,877
Deposits - Vendor & Contractual	2,011,724
Prepaid expenses	350,311
Property & equipment, net	419,014
Right-of-Use Asset OneSource, net	2,745,868
Right-of-Use Asset Rent, net	519,847
Right-of-Use Asset IT Leases, net	17,400
Majority interest in CTP	4,795,744
	$89,288,261
DEFERRED PENSION OUTFLOWS	$2,602,782
Total Assets	**$91,891,042**
LIABILITIES	
Claims Payable	$12,816,034
Claims Reserves	30,725,580
Claims Administration Reserve	2,833,906
Accounts Payables and Accrued Expenses	2,972,057
Net Pension Liability	2,647,970
Capitalized Lease Liability	18,908
Subscription Liability - OneSource	1,803,053
Lease Liability - Rent	519,847
Total Liabilities	**$54,337,354**
DEFERRED PENSION INFLOWS	$1,806,739
NET ASSETS	
Net Assets-Unrestricted	$32,625,498
Net Assets-Unrealized gain on investment securities	(3,034,613)
Majority interest in CTP	4,795,744
Invested in Capital Assets	1,360,321
Total Net Assets	**$35,746,949**
Total Liabilities and Net Position	**$91,891,042**

***unaudited**

How Your Rates are Determined

Rating Process

The annual rating process begins with an actuarial determination of the overall amount needed in order to cover all claims and other expenses expected to be incurred during the upcoming rating period. In developing the projected estimate of the overall contributions needed, HealthTrust uses the actual claims incurred during the experience period. The projected estimate also includes the application of completion, trend and other applicable factors developed using experience data and information supplied by HealthTrust and its service providers, which is reviewed by the actuary. In addition, the projected estimate includes projected costs of fees, taxes, administration, and amount necessary to replenish the capital adequacy reserve.

In September, the Board's Finance and Personnel Committee reviews the proposed rating information and determines the recommended renewal rates, which are then presented at two public hearings for Member Groups. In early October, the HealthTrust Board sets the final renewal rates, taking into consideration the recommendation by the Finance and Personnel Committee and feedback received at the public hearings.

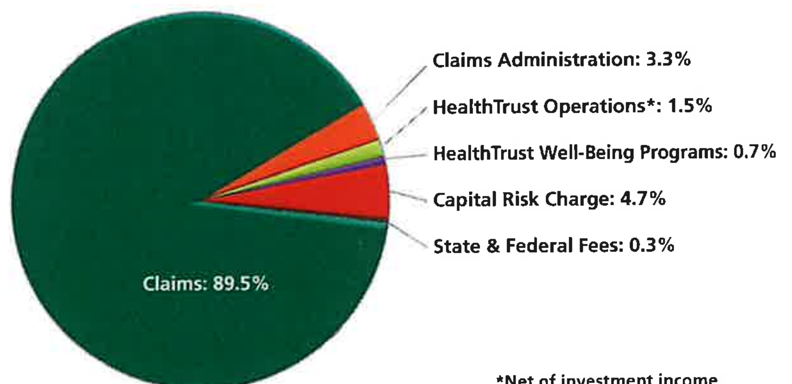
Capital Risk Charge

In years when the fiscal end of year net position is below the capital adequacy target, a capital risk charge may be added to each participating Member Group's rate to replenish the capital adequacy reserve. For each participating Member Group, the capital risk charge is calculated as a percentage of its proportionate projected claims expenses and added to its rate. In this year's renewal, the capital risk charge of 5.3% was added to each self-insured coverage as part of the multi-year capital adequacy rebuild plan. The HealthTrust Board established a target capital adequacy reserve level of $122.5 million as of June 30, 2024.

Medical Contribution Components

The overall medical rates are comprised of several components. Claims are the largest component at approximately 89.5% of the rate. Additionally, 4.7% of the rate is the capital risk charge, which goes towards rebuilding the capital adequacy reserve. Other components include 3.3% for claims administration, 1.5% for HealthTrust's operations (net of investment income), and 0.7% for HealthTrust well-being programs. The remainder of the rate is for required state and federal fees (0.3%).

July Renewal (FY2026)



Medical Rating Summary

The Medical Rating Summary provides each Member Group with specific information on how the medical rates are calculated along with the dollar amounts associated with each component of the rating calculation used to determine each Member Group's rate adjustment. This information is available in the Secure Member Portal (SMP).

Plan Specific Pricing

After the overall rate change is established for each rating entity, product specific pricing is determined. This fiscal year, the HealthTrust Board of Directors commissioned an actuarial review of medical and prescription plan pricing. The results of this study indicated changes to the relative value of products, also known as relativities, may be needed in order to more accurately price certain products. After careful review, the HealthTrust Board of Directors has adopted a three year plan to implement these indicated relativity changes, beginning with this rating cycle.

These relativity changes mean that the medical and prescription products you offer each have their own rate change, rather than each product having the same rate change. Within a rating entity, both the 1) dollar value of contributions required to be raised and 2) the overall rate change for the rating entity remains the same as it would if relativities were not adjusted, presuming no movement in enrollment. If you are part of a combined rating entity or the 50 and Under rating entity, your own Member Group rate change will vary depending on the relative value of the products selected by your Member Group. Please see your Member Group's Medical Rate Exhibit for your specific rate adjustments.

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