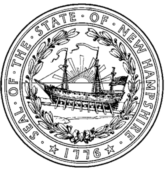

NEW HAMPSHIRE SECRETARY OF STATE
David M. Scanlan

April 25, 2025

RE: House Commerce and Consumer Affairs Committee Hearing on SB 297

Dear Municipality, School District, and Government Entity,

On April 23rd, the House Commerce and Consumer Affairs Committee held a hearing on Senate Bill 297, which would put necessary guardrails in place for the regulation of pooled risk management programs in New Hampshire. SB 297 is about the transparency, accountability, and solvency of the political subdivisions pooled risk management programs. We invite you to take a moment and read our attached analysis

During the hearing, several inaccurate and confusing statements were made about the intent and impact of SB 297 on political subdivisions by detractors of the bill. These statements have been made repeatedly since SB 297 was first introduced in the Senate, creating unnecessary panic and confusion among risk pool members. Unfortunately, this attempt at legislative paralysis through analysis is not at all helpful to the taxpayers of this state.

Simply put, this bill is about how much local taxpayer money will be required for this purpose and on whose balance sheet excess reserves will reside. Pooled risk management programs need prudent reserves to satisfy the claims costs of local employee benefit plans without excessive reserves. In 2014, the Supreme Court said: “Allowing such a program to amass extraordinary levels of reserves to self-insure against catastrophic losses is antithetical to that purpose.”[i]

It is vital that every political subdivision understands the purpose of RSA 5-B and how SB 297 will protect the best interests of political subdivisions by preventing the insolvency of pooled risk management programs. We invite you to read the attached summary of the provisions within SB 297 along with a detailed fact check sheet from Hua Li of Complete Actuarial Solutions Company (CASCO).

If you have any questions or concerns about SB 297, please do not hesitate to reach out to my office at (603) 271-3242.

Sincerely,

David M. Scanlan
Secretary of State

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[i] APPEAL OF THE LOCAL GOVERNMENT CENTER, INC. & a., No. 2012-72, page 14

April 24, 2025

On March 27, 2025, HealthTrust published a statement titled "*Why SB297 Precludes HealthTrust from Offering Coverage*". This letter responds to each of the claims made in HealthTrust's statement, with sections in blue representing statements made by HealthTrust and sections in red showing the responses. The claims can be categorized as:

1) **Clearly False**: For example, that SB297 precludes HealthTrust from offering coverage or that it shifts costs or risk onto members.
2) **Unexplained**: For example, how SB297 would restrict the benefits and services HealthTrust provides.
3) **Already in Practice**: Claiming that SB297 will force HealthTrust to do something that it already does.
4) **Irrelevant**: Assertions about HealthTrust operating like an insurance company rather than a risk pool that have no bearing the fact that insolvency would saddle members with unexpected losses to pay.

Why SB297 Precludes HealthTrust from Offering Coverage

SB297 fundamentally changes risk pool management in New Hampshire. If passed, SB297 will prevent HealthTrust from providing the high-quality, affordable, medical and related coverages that New Hampshire's cities, towns and school districts have come to rely on since 1985.

The claims that HealthTrust makes to support these assertions are discussed below.

HealthTrust Model Today

HealthTrust provides its participating Member Groups with fully-insured coverage through a pooled risk management program. HealthTrust operates like an insurance company and is subject to many of the same risks as an insurance company.

HealthTrust's application for tax exemption with the IRS stated that "*The Trust was organized pursuant to the State's Code on Voluntary Corporations to provide **group self-insurance***". Regardless of whether HealthTrust is allowed to operate like an insurance company, if HealthTrust does operate in such a way, then that would effectively make them an unlicensed insurance company operating in New Hampshire. Such an organization creates the worst possible insolvency risk to members since it has a higher insolvency risk than a normal risk pool because they cannot assess members but does not have the backing of the state guarantee fund that protects licensed insurers in the event of insolvency. This is explained in more detail on page 3.

Like an insurance company, HealthTrust determines the benefit plans, coverages, and rules for operating those coverages, and sets rates calculated to cover projected claims.

Pooled risk management programs also perform these functions, just like an insurance company would. None of the provisions of SB297 change this.

For times when things don't go as expected, HealthTrust maintains a contingency reserve. Because the coverage relationship is fully insured, participating Member Groups are protected at all times against the risks inherent in providing medical coverage.

The statement that member groups are protected "at all times" is clearly false. If contingency reserves are exhausted and the risk pool goes insolvent, member groups are no longer protected.

During their virtual town hall, Health Trust referenced Statement No. 10 of the Governmental Accounting Standards Board to support their argument that members are protected at all times by a "transfer of risk" to HealthTrust. However, the quotes that they provided from that accounting standard stopped immediately before the standard says there is no transfer of risk if the pool goes insolvent due to an inability to assess members. Specifically, the portion of the accounting standard that HealthTrust cut off states that "*However, also important is the concept that a transfer of risk is only as good as the amount of assets the insurer has available to pay claims on the entity's behalf. For example, if legislation establishing a multigovernment pool prohibits it from making supplemental assessments but that pool has no source of assets to pay the entity's claims,* ***the entity [i.e., political subdivision] remains liable for those unpaid claims and transfer of risk has not occurred for those claims***."

The consequences for members in the event of insolvency include:

1. Unpaid losses and other liabilities would be the members' responsibility. This fact will be demonstrated during NHIT's insolvency if they continue to have fewer assets than liabilities during their runoff. HealthTrust has erroneously tried to claim that such unpaid losses and liabilities would simply disappear with the risk pool. This is clearly false since those liabilities are amounts owed to healthcare providers for treatments that have already been provided. They have also tried to claim that it is not possible for there to be unpaid liabilities should they become insolvent because they record an "IBNR" liability. This is also false [1].
2. Coverage for any unexpired coverage periods would cease. For example, if a member has a contract with a pool to provide coverage from 7/1/2025 to 6/30/2026, and the pool becomes insolvent on 9/30/2025, there would be no coverage for the remaining period from 10/1/2025 to 6/30/2026. If HealthTrust gets more than 15 days behind in payments, Anthem can terminate the coverage that they administer.
3. New coverage will have to be secured.
   - Coverage terms may have already been agreed with unions and must be honored.
   - The liquidation of the pool would reduce the amount of negotiating leverage that each member has, which may result in higher rates.

SB297 does not allow HealthTrust's Model to Exist

There are various forms and models of risk pooling. For 40 years, HealthTrust's model has been for the organization to be a self-insured entity (meaning HealthTrust bears the risk of losses) and for our Member Groups to be fully insured against those losses. Groups are responsible to pay premiums, but bear no further responsibility for losses even if the costs of claims exceed expectations.

These two statements are clearly false. HealthTrust bears the risk of losses **only if the pool remains solvent**. If the pool becomes insolvent, losses fall back upon the members.

HealthTrust's coverage model would be explicitly prohibited if SB297 becomes law. SB297 fundamentally changes the pooled risk management program operated by HealthTrust by:

1. Removing HealthTrust's authority to provide fully-insured health coverages through a self-insured risk pool,

It is not possible to provide fully-insured coverage through a self-insured risk pool.

2. Requiring HealthTrust to shift the risk of losses from HealthTrust to the Member Groups (municipalities, school districts and counties),

It is extremely important to explain that even if HealthTrust is allowed to operate like an unlicensed insurance company as they claim they do, **they are incorrectly claiming that if an unlicensed insurance company goes insolvent then the risk for unpaid losses does not transfer to insureds**. **The consequences of insolvency listed above, including members assuming the risk of unpaid losses, also apply to unlicensed insurance companies**.

Insurers who are licensed to do business in New Hampshire participate in the state guarantee fund, the New Hampshire Life and Health Insurance Guaranty Association (NHLHGA). This protects members from assuming the risk for unpaid losses, up to the specified limits of the guarantee fund. However, HealthTrust does not participate in the guarantee fund since they are not a licensed insurance company. Therefore, **HealthTrust's members always have and always will bear the ultimate risk of loss should HealthTrust become insolvent, even if HealthTrust's claim that it is like an insurance company providing fully insured coverage were true**. SB297 does not change this fact but will vastly reduce the likelihood of insolvency. The Association of Governmental Risk Pools (AGRiP) says that "*Pools seldom assess their members, but having this ability ensures that the pool will never become insolvent, and that all claims will be fairly and equitably be satisfied – no matter what.*" Furthermore, the insolvency of a licensed insurance company that is supported by the state guarantee fund would still inflict the other consequences of insolvency from the previous page, namely loss of coverage for any unexpired coverage periods and the need to secure new, potentially more expensive, coverage. This is why the primary goal in the regulation of either commercial insurance or pooled risk management programs must be to protect members against insolvency and why SB297 needs to be passed to create such protection for the members of pooled risk management programs.

AGRiP also states that "*there is more incidence of insolvency in the commercial insurance industry than among pools [due to the ability of pools to assess].*" There have been health insurance companies operating in New Hampshire that have gone insolvent, as listed on the NHLHGA website. Therefore, even if HealthTrust is allowed to operate like an insurance company rather than a pooled risk management program, then their members would have the worst of both worlds in terms of insolvency risk:

- **HealthTrust's likelihood of insolvency is higher than a normal risk pool due to their supposed inability to assess members**
- **Members are not protected by the state guarantee fund in the event of insolvency because HealthTrust is not a licensed insurer**

3. Removing HealthTrust's ability to prudently manage benefit plans, coverages, and the rules for operating those coverages.

No explanation is provided of how the provisions of SB297 restrict HealthTrust's ability to manage benefit plans, coverages, and the rules for operating those coverages. There are no provisions in SB297 that restrict these.

Rather than strengthening HealthTrust, SB297 self-asses HealthTrust to end its current risk pool model in which HealthTrust is the insurer and change into a new model where HealthTrust is the administrator. In short, SB297 harms the very entities and people risk pools are intended to help – municipalities, school districts, counties and their respective employees.

Please see the previous responses about how HealthTrust's supposed model of being an insurance company providing fully insured coverage creates the worst possible insolvency risk for members, as well as the responses on the next page about HealthTrust being an administrator.

HealthTrust's Model has Value

NH RSA 5-B was enacted in 1987 because the commercial market did not meet the needs of the public sector. We operate in a free market, competing with other risk pools and with the commercial market. Even with these choices, the vast majority of New Hampshire's political subdivisions still choose HealthTrust for their coverage. We remain the only organization (including commercial carriers and other risk pools) that **never** declines to quote an eligible Group. Our mission is to serve all who need us, and the need is as strong, or stronger, than it was in 1987.

Can HealthTrust Change Models?

As testified to and discussed in previous materials, HealthTrust does not operate under the model required by SB297.

This is inaccurate. HealthTrust already charges a mandatory "capital risk charge" to bring contingency reserves up to a target and already returns surplus once it is above a target, just like the contingency reserve replenishments required by SB297 and the maximum contingency reserve allowed by SB297. The primary differences are:

1. Timeframe
   At their September 19, 2024 board meeting, the Board pushed the rebuild plan to four years (which now may be stretched to five years as the net income has been much lower than projected by HealthTrust since that meeting) whereas their actuary "strongly recommended" a two-year rebuild plan during their August 10, 2023 Board meeting. The contingency reserve replenishments required by SB297 are delayed for a fiscal year after a shortfall below 12% is detected and collected over another full fiscal year. This two-year replenishment period is similar to the two-year period that HeathTrust's actuaries "strongly recommended" but that HealthTrust has chosen not to follow.
2. Target level
   The replenishments required by SB297 aim to bring contingency reserves held by the pools to within a range of 12% to 16% (or 18% if approved by the Secretary of State) of annual contributions. In contrast, HealthTrust's board selected a new target at their October 8, 2024 meeting of about 25% (increased from the previous target of about 20% that had been used for the prior ten years). This lower range is why HealthTrust's members are expected to pay lower contributions because of SB297 [2].

The biggest difference between SB297 and how HealthTrust operates currently is that SB297 requires risk pools to grant themselves self-assessment authority, as recommended by AGRiP, and if a pool chooses not to assess when they come close to insolvency, then the Secretary of State is granted the authority at his or her discretion to require assessments to bring contingency reserves back up to at least 4% of annual payments (about two weeks of claims). HealthTrust's own actuarial projections show that the likelihood of having to make an assessment is less than 5% per year once they are back in the contingency reserve range [3] and if HealthTrust funds the designated assessment fund of up to 4% to pay assessments on behalf of members then **the likelihood of members paying assessments is close to zero** once HealthTrust is back in the contingency reserve range.

While there are a number of other concerns with the SB297 model, three main questions must be answered:

1. **Does the SB297 model provide value to the public sector?** No. It increases costs for political subdivisions and lowers the coverage value for public sector employees.

SB297 is projected to lower contributions for HealthTrust members [2]. No explanation is provided of why the "*coverage value*" would be lowered by SB297. As explained on the next page, HealthTrust has been cutting coverage as one of the consequences of previously charging less than the actuarially recommended contributions, and SB297 will encourage pools to charge actuarially recommended contributions.

Public sector entities need protection from risk and SB297 removes that protection.

The previous pages explain why 1) HealthTrust's members always have and always will bear the ultimate risk of loss should HealthTrust become insolvent and 2) their supposed current model of operating like an unlicensed insurance company creates the worst possible insolvency risk. Assessments are the industry standard for how risk pools prevent insolvency and SB297 is making HealthTrust conform to this standard.

Further, the low and narrow band of required reserves along with strict assessment and one-year replenishment requirements will create significant volatility for Groups; for example, large rate increases one year, followed by returns of surplus the following year.

RSA 5-B requires surplus that is not needed for reserves to be returned annually. HealthTrust's attempts to smooth out contribution increases rather than charging actuarially recommended contributions (on at least eight occasions in recent years, including choosing not to add an actuarially recommended charge for COVID impacts) has contributed to the following consequences [4]:

- Members are now facing an expected average rate increase of around 40% over 3 years starting in FY2025 [5], which is more than double the industrywide expected rate increase, to make up for the prior "rate smoothing". Therefore, **the current rate volatility is already much higher than it should be because of the prior rate smoothing attempts**.
- Financial difficulty. In early 2023, HealthTrust self-reported to the regulator that they were in significant financial trouble and ended the year with only 10 days of cash on hand remaining. Since then, they have failed to rebuild their financial position at the rate that was strongly recommended by their actuaries or even at the rate they internally targeted [7], and if the last three months of 2025 play out like the last two years, then they would end 2025 with even less reserves than when they self-reported to the regulator that they were in significant financial trouble.
- HealthTrust is now cutting the health coverage it provides, including for Wegovy and other weight loss drugs, retiree medical, the Smart Shopper program, and limiting deductible funding by employers.

The size of the band (either 4% or 6% if approved by the Secretary of State) must be narrow enough to encourage risk pools to charge actuarially recommended rates. A band that is too wide will allow risk pools to continue to not charge actuarially recommended rates, with the consequences listed above. During the Senate Committee hearing, the Committee Chairman offered to widen the range to 8% for 4 years (i.e., 12% to 20% rather than 12% to 16%), with the chance to continue at that wider range if actuarial support can be provided for doing so. HealthTrust declined the offer.

In terms of the reserve band being too "low", HealthTrust's previous statement to this effect were mainly based upon Milliman's five-year Capital Adequacy Reserve (CAR) analysis as of June 30, 2024. On March 26, 2025, Milliman stated that they did not approve HealthTrust's use of their CAR analysis in the legislative process for SB297. They also stated that HealthTrust did not engage them to analyze any of the provisions of SB297 including how the bill affects the level of contingency reserve needed by HealthTrust. Therefore, HealthTrust has been using the CAR analysis inappropriately, the CAR analysis does not reflect the impact of the provisions of SB297 on the contingency reserves they need, and the central assumptions in the analysis have been clearly disproved [6]. If HealthTrust were to ask Milliman to update their analysis to reflect the key provisions of SB297 and to change the central assumption to one that has not been clearly disproved, **Milliman could provide updated results of their CAR analysis very quickly** [7] but HealthTrust has stated that they will not ask Milliman to update that analysis. That updated analysis would show that the maximum contingency reserve allowed by SB297 of 16% or 18% and the designated assessment fund up to 4% **are much higher than the amount needed to achieve HealthTrust's target of no more than a 5% likelihood of insolvency**.

Even if Milliman's current CAR analysis was appropriate or reasonable for use in determining the maximum contingency reserve, HealthTrust's factsheet released on March 11, 2025 stated that the analysis showed **$95M** is required in contingency reserves. If the restricted assessment fund of up to 4% of annual contributions that risk pools can hold are added to the 16% (or 18% if approved by the Secretary of State) maximum contingency reserve, the total cushion risk pools can hold under SB297 is up to 20% (or 22%) or **$97.4M (or $107.1M)** based on FY2024 contributions.

The worst loss HealthTrust has experienced over a period of any length of time during its 40 year history was **17%** of annual contributions in 1995-1997. In comparison, the total cushion allowed under SB297 is up to **22%** as explained above.

An additional claim that HealthTrust has repeatedly made to argue for a higher contingency reserve than allowed by SB297 centers on the surplus returns they have made. After returning $57M in surplus in 2020 and 2021, HealthTrust then saw adverse claims experience and needed to raise approximately $60M to reach their target contingency reserve level. HealthTrust claims that these two numbers can simply be added together to show the indicated amount of contingency reserve during this period. This claim is clearly incorrect [8].

Finally, HealthTrust is not expected to hit the top of the contingency reserve range that they can hold until **2028** if they continue to charge the 5.3% capital risk charge until they hit the top [2]. If they decide to stop charging the 5.3% capital risk charge once they are inside the contingency reserve range, they would be expected to hit the top of the range even later than that. In **2029**, they and the other risk pools will have the opportunity to ask for revaluation of the contingency reserve range.

> Compared to HealthTrust's current model, Groups would go from being protected from both risk and volatility to now being exposed to both. If SB297 passes into law, many Groups will be better served by going to the commercial market (at a higher cost and with less services) to obtain the protection they need from risk of losses and rate volatility.

SB297 would lower the expected contributions for HealthTrust members [2], so from an expected cost perspective, the bill would not "cause groups to be better served by going to the commercial market". In terms of volatility, the response to the previous point explains that the current rate volatility is already much higher than it should be because of the repeated decisions to not charge actuarially recommended rates, and SB297 will encourage pools to charge actuarially recommended rates.

2. **Is the SB297 model financially viable?** No. It removes the financial stability that comes with fully insured coverage through a self-insured risk pool. Under SB297, solvency depends on replenishments and assessments being able to be paid by the towns, cities, schools, counties, and other public sector entities we serve, whenever needed. This is a flawed assumption and a fundamental flaw in SB297.

As stated previously, it is not possible to provide fully-insured coverage through a self-insured risk pool.

In terms of financial stability, contingency reserve replenishments are delayed for a fiscal year after a shortfall is detected and collected over another full fiscal year. This timeframe allows political subdivisions to budget for the replenishments and is similar to the two-year replenishment period that HeathTrust's actuaries "*strongly recommended*" and that HealthTrust did not implement. Any **assessments can be funded by the restricted assessment funds so that members' budgets are not affected**. This is significantly more financially stable than if the inability or unwillingness to assess causes HealthTrust to go insolvent, with the financial consequences to members described on page 2.

HealthTrust does not explain why solvency being dependent on replenishments or assessments is "*flawed*". **Assessments are the standard industry approach to preventing insolvency as recommended by AGRiP.** Currently, **HealthTrust's solvency is already dependent on their capital risk charge, which is the same as a replenishment**, and if HealthTrust's contingency reserves run out then they have no protection against insolvency since they have chosen a policy of not assessing members. As AGRiP states, **the alternative to assessments is a much higher likelihood of insolvency**.

> By nature, insurance is protection against potential future risk. In most years, those risks will likely be as predicted. However, if events occur such that losses are *significantly* worse than expected, only fully-insured coverage would protect Groups.

This is clearly false. Groups are only protected if the risk pool or insurer remains solvent. If a risk pool or unlicensed insurer goes insolvent, then the risk of losses falls back upon the groups.

> In those years, it is unlikely that political subdivisions and their taxpayers will be able to bear the burden of steep rate increases and required replenishments and assessments without extraordinary sacrifices.

As stated above, HealthTrust is already expected to raise rates by around 40% over 3 years starting in FY2025 [5], which is more than double the industrywide expected rate increase, while at the same time cutting benefits. This means that members are already being asked to make "extraordinary sacrifices" to make up for HealthTrust repeatedly choosing not to charge actuarially recommended contributions.

HealthTrust already requires contingency reserve replenishment of 5.3% per year through their capital risk charge. The likelihood of an assessment in a given year is less than 5% once HealthTrust is back above the minimum contingency reserve and assessments can be funded by the restricted assessment funds so that the likelihood of members' having to pay assessments is essentially zero.

3. **Will the SB297 model allow for prudent management?** No. The SB297 model creates conflicting rights and responsibilities for participating Groups that cannot be reconciled. In the SB297 model each Group is an owner, is ultimately responsible for the risk of losses, and is owed an individual fiduciary duty by the organization.

Who does HealthTrust believe it is owned by if not the members? As explained above, the members have always been ultimately responsible for the risk of loss if HealthTrust becomes insolvent and SB297 does not change this. Most alarmingly, **this statement claims that members are not currently owed a fiduciary duty by the organization**. HealthTrust makes this claim again in their virtual town hall when they claims that board members owe a fiduciary duty to the "organization" but not to the members.

HealthTrust claimed during their virtual town hall that it is not possible for them to owe a fiduciary duty to their members because there are so many members. This claim is clearly false and would be like a large corporation claiming that it and/or its directors do not owe a fiduciary duty to their shareholders because the corporation has thousands or even millions of shareholders. **The owners of pooled risk management programs have always been the members, and those members have always been owed a fiduciary duty by the programs and their directors. SB297 does not change this fact**.

> As such, conflicts will arise from the competing interests of individual Groups. For example, if the board did not retire a costly and ineffective benefit, it could face allegations of not fulfilling its fiduciary duty to provide cost-effective coverage to one subset of Groups.
> However, if it retired the benefit, it could face allegations of interfering in the collective bargaining agreements of another subset of Groups.

These inherent conflicts have clearly always existed for pooled risk management programs, and no explanation is provided by HealthTrust's statement as to how these conflicts are "created" by SB297. In fact, conflicts regarding fiduciary duty will always exist for any organization with more than one owner or shareholder. It will always be the responsibility of HealthTrust's board, management, and regulators to handle these unavoidable conflicts to the best of their abilities, regardless of the presence of SB297.

> Political subdivisions cannot operate independently when making decisions while at the same time operating collectively when sharing the cost of those decisions.

What this sentence says "cannot" be done is exactly what all pooled risk management programs, including HealthTrust, already do. In fact, the most basic function of a pooled risk management program can be boiled down **sharing costs while collectively making decisions about coverage**.

> These concerns are not hypothetical; HealthTrust faces misguided claims from our regulator with respect to these very concerns today. If SB297 passes, these claims will be even more difficult to defend.

The alleged "misguided claims" from the regulator are not listed or explained.

In total, when reviewing the challenges and ramifications of the model required by SB297, HealthTrust has identified that such a change is untenable.

The responses in this document show that HealthTrust has not identified any change required by SB297 that is "untenable". In fact, many of the supposed changes that HealthTrust has identified are practices they already perform. The most significant change is the provisions related to assessments that are standard industry practice and are recommended by AGRiP.

Can the Stated Objectives be Accomplished?

If the motivating goal behind SB297 is to improve the financial stability of risk pools, there are many ways to accomplish that. HealthTrust welcomes reasonable regulation and standards that can help ensure future stability.

There are many available models in use throughout the country and in New Hampshire that can be adapted to apply to New Hampshire risk pools. Chief among them is the Risk Based Capital (RBC) model developed by the National Association of Insurance Commissioners (NAIC) and in use by the New Hampshire Insurance Department to ensure financial stability of insurers providing fully-insured medical coverage like HealthTrust does.

The RBC model's entire focus is to ensure that appropriate levels of reserves are retained in order to ensure the solvency and viability of an insurer. It is a tried-and-true, proven methodology supported by a full set of well-developed systems and standards. Rather than a fixed percentage of reserves, the system adapts to changes in the wider ecosystem, which is critical in a period of volatility.

HealthTrust's current model would remain viable and would be strengthened by the application of such reasonable standards.

RBC is used for the regulation of insurance companies, not public risk pools, NAIC provides guidance on the regulation of insurance companies, not public risk pools, and the New Hampshire Insurance Department regulates insurance companies, not public risk pools. Section 6 of RSA 5-B specifies that "*Any pooled risk management program meeting the standards required under this chapter is not an insurance company, reciprocal insurer, or insurer under the laws of this state, and administration of any activities of the plan* ***shall not constitute doing an insurance business for purposes of regulation***". AGRiP also states that "***Any approach to regulation must understand that pools are fundamentally different from commercial insurers in purpose, core values and operations***." and that "*Pools [should] strive to ensure that regulators understand basic differences between pools and insurers –* ***so each is regulated appropriately***."

Conclusion

Risk pooling is an important and essential option for New Hampshire's public sector. HealthTrust has had the privilege of serving the vast majority of the towns, cities, schools, counties, and other eligible organizations during those years.

Our operating model as a self-insured entity while individual Member Groups are fully-insured has met the unique needs of the public sector.

A "*self-insured entity [whose] individual member groups are fully insured*" describes a commercial insurance company, not a risk pool. As explained above, even if this were an accurate description of how risk pools function (which it clearly is not), such "fully insured" coverage would only exist while the risk pool is solvent, and the likelihood of insolvency is higher because of the supposed inability to assess members.

This includes keeping rates low for taxpayers, protecting the political subdivisions from risk, and providing coverages to all eligible Groups, **never** declining to quote even those who are unable to obtain coverage elsewhere.

- SB297 is expected to reduce contributions for HealthTrust's members [4].
- The risk of the significant consequences of insolvency is much more consequential than the risk of paying assessments, which are expected to be funded through restricted assessment funds.
- SB297 encourages risk pools to charge actuarially recommended contributions which further increases their ability to quote political subdivisions who are unable to obtain coverage elsewhere.

HealthTrust exists to serve New Hampshire's public sector. As we have said from the beginning, we welcome the opportunity to work collaboratively with the legislature, Members, Covered Individuals, unions and all other stakeholders to craft a law that protects sustainable access to health coverage through RSA 5-B pooled risk management programs.

The concerns that HealthTrust and the other risk pools have raised regarding the provisions of SB297 have either been addressed in responses such as this letter, the Secretary of State's informational packet released on March 19, 2025, and the response dated March 22, 2025 in response to the statement by HealthTrust's Board, or have been incorporated into the amendment to SB297 which:

- allows the maximum contingency reserve to be increased to 18% if sufficient justification can be provided,
- allows risk pools to ask for revaluation of the contingency reserve range every four years, and
- allows risk pools to create restricted assessment funds of up to 4% to help members pay for potential assessments, however unlikely they are.

Sincerely,

Hua Li, ASA, FCAS, MAAA
Complete Actuarial Solutions Company (CASCO)

1. During the Senate Committee hearing on March 4, 2025, HealthTrust claimed that it was not possible for there to be an unpaid liability remaining if they went insolvent because they record an IBNR liability. The claim is untrue because insolvency generally results from having insufficient assets to satisfy all obligations and liabilities, including the IBNR liability. The recording of an IBNR liability in the financial statements in no way ensures that there will be assets available to pay for those liabilities.

2. As shown in the table on the last page.

3. Minutes of August 7, 2024 Board meeting show that HealthTrust's actuary modelled that there is less than a 5% chance that contingency reserves will fall by 6.2% of contributions or more. Therefore, the likelihood of falling contingency reserves falling from 12% of contributions to below the 4% assessment threshold is less than 5%.

4. HealthTrust has claimed that the roughly $60M in losses they experienced in 2022 and 2023 were due to pandemic related utilization recovery. This is inaccurate. Their losses in 2023 were not primarily driven by pandemic utilization recovery since no other NH risk pools, commercial insurers, or the State health plan experienced significant operating losses that year and all of their operating loss was towards the end of the year which is the same seasonality pattern seen in 2024. Additionally, the cumulative effect of repeatedly choosing not to charge actuarially recommended contributions would have contributed significantly to the losses in 2022 and 2023 and to the net income in 2024 and 2025 YTD being significantly less than expected by HealthTrust.

5. The last two July renewals had average rate increases of about 15% and 10%. Net income and claims experience in FY2025 has so far been significantly worse than projected by HealthTrust, with net income of $2M to date and likely to fall into the negative if the last four months follow the seasonality patterns of the last two year, compared to $19M expected as shown in the package presented on the third day of the 2024 corporate retreat. Therefore, the next renewal will likely again have a larger than normal rate increase, such as above 10%. The cumulative increase over three years would therefore be above 39%.

6. The contingency reserve replenishment and assessment authority provisions in SB297 reduce the level of contingency reserves that HealthTrust need to hold to achieve a given likelihood of remaining solvent over any period. Additionally, the key assumption in Milliman's calculation of the $95M target amount is that HealthTrust cannot raise rates by more than 5% above the average long-term trend due to the need to compete for market share. The key assumption in the calculation of the $150M target amount is that HealthTrust cannot raise rates above the average long-term trend at all due to the need to compete for market share. In a meeting on June 12, 2023, Milliman stated that these key assumptions were provided to them by HealthTrust's management and were based upon management's judgement. However, these assumptions have been clearly disproved by HealthTrust's average rate change of 15.3% for the 7/1/2024 renewal which is much more than 5% above the average long-term trend. Their average rate change of nearly 10% for the 1/1/25 and 7/1/2025 renewals is also well above the average long-term trend, which further disproves the key assumption for the $150M target.

7. The 15.3% rate increase that HealthTrust intuited is roughly 10% above the long-term average. Milliman already has a parameter in their model to assume HealthTrust cannot raise rates by either 5% or 0% more than the long-term average. Setting that parameter to 10% could be done extremely quickly. To reflect contingency reserve replenishments, the only change that would need to be made to the Milliman analysis would be to add an assumption that if the contingency reserve at the end of a coverage year is below 12% of annual contributions, then contributions in the coverage year beginning twelve months after that point would include a replenishment charge equal to the shortfall. This change is relatively straightforward to make. An extremely simple and conservative method of incorporating the impact of HealthTrust having assessment authority would be to not adjust the Milliman analysis for this but rather to make sure the portion of contingency reserve held in restricted assessment funds is included when comparing to the results of the analysis. For example, if the updated Milliman analysis indicated that a contingency reserve of 17% is needed to achieve a 95% confidence level over five years, then that amount would be compared to the sum of the 16% (or 18%) maximum contingency reserve and the restricted assessment fund of up to 4%. This is extremely conservative because it assumes HealthTrust would not be able to assess for more than the restricted assessment fund, when in fact they could.

8. Contingency reserves are needed to cover losses, while the $57M surplus return represents profits above the target that had to be returned. For example:

- If a risk pool was already at their maximum contingency reserve target at the start of 2021 and then made a $100M net profit during 2021, they would return $100M in surplus at the end of 2021.
- If that risk pool then made a $10M net loss in 2022, that would not indicate that $110M in contingency reserves were needed to cover the 2021-2022 period.
- Only net losses over any given period indicate the contingency reserve required to cover that period, so in this example $10M was the contingency reserve needed to cover the 2021-2022 period.

In HealthTrust's case, the contingency reserve that was needed to cover the period in question was the roughly $60M loss.

Projected Impact of SB297 on HealthTrust Member Contributions

	Projected impact of SB297 on member contributions [1]		
	FY2028	FY2029	FY2030
Assuming contingency reserve range of 12% to 16%	No impact [2]	5.3% lower [2]	No impact [2]
Assuming contingency reserve range of 12% to 18%	No impact [2]	3.4% lower [2]	No impact [2]

1. Contingency reserves at 6/30/2025 are assumed to be $34.2M based on claims experience and net losses for the last three months of 2025 being similar to last year. If the claims experience over the last three months of FY2025 is better than last year, then the overall impact of SB297 on contributions would not materially change from this illustration. Net income in FY2026 is assumed to equal the 5.3% capital risk charge less the $4M per year depletion in contingency reserves that HealthTrust expect to realize as a result of adding reinsurance without letting their actuaries reflect the reinsurance cost in the contributions. Net income in FY2027 is assumed to equal the 5.3% capital risk charge. Net income in FY2028 is assumed to equal the amount of replenishment charge .

2. HealthTrust already charges a 5.3% annual replenishment charge referred to as the "Capital Risk Charge". The projected contingency reserve at the end of FY2026 is 10.8% and the projected replenishment charge required in FY2028 due to the proposed 12% minimum is 1.2% (=12%-10.8%). Since this amount is less than the 5.3% annual replenishment charge that HealthTrust has already planned, the proposed minimum contingency reserve is projected to have no impact on their contributions during FY2028. At the end of FY2028 the projected contingency reserve would be 16.1% of contributions. If the maximum contingency reserve is 16% then that would result in the 5.3% capital risk charge being removed; if the maximum contingency reserve is 18% then the capital risk charge would be 3.4% lower (=5.3%-1.9%).

April 24, 2025

On March 27, 2025, HealthTrust published a statement titled "*Why SB297 Precludes HealthTrust from Offering Coverage*". Several of the parties who testified to the House committee on April 23, 2025 repeated claims made in that statement including The New Hampshire Municipal Association (NHMA). This letter, as well as the accompanying detailed response, explain why those claims are untrue.

HealthTrust's statement claims that SB297 will increase costs when it will in fact lower member contributions if claims experience is close to the level expected by HealthTrust while protecting members if claims experience is adverse enough to cause insolvency. The likelihood of contingency reserves falling below the assessment threshold is less than 5% per year once HealthTrust is back in the contingency reserve range, and if HealthTrust funds their designated assessment fund of up to 4% to help pay assessments on the behalf of members, then **the likelihood of members paying assessments is close to zero** once HealthTrust is back in the contingency reserve range.

HealthTrust has also claimed that SB297 will increase rate volatility. In reality, HealthTrust's members are facing an average rate increases of around 40% over three years which is more than double the industrywide level. At the same time, HealthTrust has cut benefits and limited deductible funding. These rate hikes and benefit cuts are partly due to the need to make up for HealthTrust charging less than the actuarially recommended contributions in previous years. The contingency reserve range in SB297 will encourage risk pools to charge actuarially recommended contributions, thereby reducing the likelihood of members having to endure such painful measures in the future. HealthTrust also repeatedly claimed that the maximum amount of contingency reserves allowed by SB297 is too low. This claim is not supported by any evidence as explained in the attached detailed response. Additionally, HealthTrust is not projected to hit the maximum until 2028 or later, and in 2029 they are able to request changes to the maximum if they can provide justification.

HealthTrust's statement does not discuss the impact of insolvency on members even though the main purpose of SB297 is to prevent insolvencies. The statement incorrectly asserts that currently members do not bear the risk of losses, which is clearly false since **the risk of unpaid losses falls back upon the members** in the event of insolvency. This fact will be demonstrated during NHIT's insolvency if they continue to have fewer assets than liabilities during their runoff. In addition to potentially saddling members with unexpected losses, insolvency would also force members to quickly secure new, likely more expensive, coverage. Two of the five risk pools that existed in New Hampshire have now gone insolvent as a result of charging less than actuarially recommended contributions and because of the lack of minimum contingency reserve requirements. SB297 would have prevented these insolvencies.

There are currently no regulatory safeguards in place to prevent risk pool insolvency, maintain minimum contingency reserve levels, or encourage risk pools to charge actuarially recommended contributions. SB297 addresses these regulatory needs. Finally, HealthTrust's statement does not explain the assertion referenced in its title, since SB297 in fact does not preclude HealthTrust from offering coverage and does not reduce the coverages and services risk pools can provide.

Sincerely,

Hua Li, ASA, FCAS, MAAA
Complete Actuarial Solutions Company (CASCO)