NEW HAMPSHIRE SECRETARY OF STATE
David M. Scanlan

March 19, 2025

RE: A note from Secretary of State David M. Scanlan:

Dear Senator,

Enclosed in this packet is a letter from the Secretary of State to New Hampshire's political subdivisions regarding SB 297, which pertains to the regulation of pooled risk management programs. In addition to the letter, we have included a fact sheet that refutes claims made by HealthTrust about the legislation and how it will impact political subdivisions.

We encourage you to review this information at your earliest convenience. If you have any questions, please reach out to our office.

Sincerely,

David M. Scanlan
Secretary of State

107 North Main St., Concord, NH 03301
(603) 271-3242 | elections@sos.nh.gov

NEW HAMPSHIRE SECRETARY OF STATE
David M. Scanlan

March 19, 2025

RE: An Important Message on Legislation SB 297

Dear Municipality, School District, and Governmental Entity,

As Secretary of State, the Legislature has delegated me as the exclusive authority with jurisdiction to regulate pooled risk management programs in the Granite State. The self-insurance programs, detailed in NH RSA 5-B, are owned by you, the political subdivisions. For this reason, I feel compelled to raise some concerns about inaccurate statements made by certain pools and groups about the nature of risk pools and recent legislation put forth by my office to fill crucial gaps in the regulation of these programs. These gaps have caused at least two of these pools to experience financial impairment and border on insolvency. My only concern is protecting the interests of the political subdivisions, their taxpayers, and active and retired employees.

SB 297, which was drafted after extensive consultation with certified actuarial experts, was introduced by Senate President Sharon Carson and worked on by Senator Gray, Finance Chair, and Deputy Democratic Leader Senator Rosenwald. This legislation would bolster transparency for member political subdivisions; set clear, uniform standards across all pooled risk management programs in New Hampshire; ensure stability in the pooled risk management arena as expenses relative to insurance are the second-largest cost driver for political subdivisions in the state; and protect the financial and insurance interests of political subdivisions, their employees, dependents, and retired employees from financial insolvency resulting from decisions made by risk pools that have not been in the best interest of members.

SB 297 is also supported by two of the four pools: SchoolCare and PRIMEX. We have attached a detailed analysis of the legislation and the minimal impact it will have on you.

Under RSA 5-B, pooled risk program members have always been liable for the ultimate financial gains or losses of the risk pool. This is the very nature of risk pool programs, and SB 297 does not change this. However, it does establish necessary guardrails to prevent the insolvency of these programs. Financial insolvency, which two risk pools are in danger of, would place a substantial burden on you as a member.

Our relationship with pooled risk management programs should be collaborative and in the best interests of participating members while also protecting the taxpaying public and their active and retired employees. Unfortunately, some programs have been adversarial to being regulated. These specific pools employ stalling tactics and resist regulation to the detriment of members like you. We have communicated our concerns repeatedly to no avail over the years, making this legislation necessary. The success of pooled risk management programs is in everyone's

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best interest. This is why we are still striving for a collaborative relationship through this carefully thought-out legislation.

We urge you as the leaders of your political subdivisions to read this legislation carefully and reach out to our office with any questions or concerns. The well-being and stability of political subdivisions like you are of great importance to me and my office.

Sincerely,

David M. Scanlan
Secretary of State

March 19, 2025

HealthTrust published a press release and accompanying fact sheet on March 13, 2025 regarding SB297. In response to this, other press releases including by NHIT, and testimony offered during the Senate Committee hearing on SB297, this package discusses:

- Explanation of Risk pooling
- How the ability to assess helps pools and their members
- The purpose of SB297
- The differences between the regulation of risk pools versus insurance companies
- The expected financial impact of SB297 on members

Detailed support for any of the information presented in this package can be presented upon request.

Risk Pooling

In New Hampshire, RSA 5-B allows two or more political subdivisions to form a pooled risk management program. To illustrate how risk pooling works, consider the following example:

- A pool has two members, City A and City B, and provides health coverage.
- The coverage is administered by a third party such as Anthem, Harvard Pilgrim, or Cigna.
- Each of the two members make contributions of $5M per year to the pool for the upcoming coverage year.
- At the start of the year, the contingency reserve is $600,000.
- City A's claim costs during the coverage year were at the level expected by the contribution calculation but City B's claim costs come in at $1M higher than expected by the contribution calculation.

In this scenario, the entire $600,000 contingency reserve would be depleted and there would be a shortfall of $400,000. The administrator is only contracted to administer the coverage, not to bear the cost of claims should the pool be unable to pay. Therefore, the two members of the pool will be forced to pay for the $400,000 shortfall in one of two ways:

1. The pool can assess the two members for at least the amount of the shortfall to keep the pool operating. The assessment amount would usually be shared pro-rata with contributions, meaning that each city would have to contribute at least $200,000 to make up the $400,000 deficit.
2. If it is unwilling or unable to assess the members, the pool will have to liquidate. Both HealthTrust and NHIT have claimed that in this scenario, the remaining $400,000 deficit would simply disappear or that the administrator would volunteer to pay for the deficit. This is clearly false. The deficit is for healthcare services already provided, and **the amounts owed to healthcare providers for those services would not simply disappear along with the pool**. Additionally, the administrator would not pay for deficits that they are not contractually obliged to pay for. In reality, **the deficit would fall back on the members directly, meaning that each member would have to pay the amounts owed to the healthcare providers** for their own employees.

HealthTrust's factsheet and previous press releases state that SB297 "*shifts the ultimate liability to each Member Group*". As explained above, **the ultimate liability has always remained with each member group in the event of insolvency of a risk pool**. For this reason, risk pools are considered self-insurance performed as a group. This is confirmed by the following statement made by HealthTrust on December 14, 2016 to the IRS in order to retain its tax exempt status "*Health Trust is a voluntary nonprofit corporation formed under New Hampshire law to provide group health and other employee benefit programs on a self-insured basis to its members.*" **It is precisely because the ultimate liability has always remained with each member group in the event of insolvency that SB297 is being introduced to protect members by preventing insolvencies**.

While the ultimate liability has always remained with each member group if a pool runs out of money, participation in a risk pool does pool (i.e., spread) risk between the members as long as the pool does not run out of money. Using the above example, the ways in which this risk pooling works include:

- Any assessment would be spread pro-rata with contributions even though all of the adverse claims experience was related to City B.
- Any replenishment of the contingency reserves, such as the "capital risk charge" that HealthTrust adds to the member contributions, is generally pro-rata with contributions. This means that both cities replenish the contingency reserves even though only City B was responsible for depleting it.
- Had the pool experienced extremely favorable claim costs and returned surplus to members, that surplus would be returned pro-rata with contributions even if all the favorable experience was related to only one member.

A large pool with many members results in a much greater spread of risk between the members than a pool with two members if the pool does not run out of money. However, in the event the large pool does run out of money, the members are not shielded from any remaining unpaid liabilities, just like they would not be shielded for a pool with two members, and the ultimate liability always remains with each member in the event of insolvency.

Assessments

In their factsheet regarding SB297 and in previously released statements, HealthTrust has repeatedly stated that "*the current arrangement is that HealthTrust is responsible for losses*". However, this does not address **what happens if the pool runs out of the money needed to fulfil that responsibility to pay for losses**. HealthTrust has also stated that should they run out of money, the "current arrangement" is that they would refuse to assess members, thereby choosing instead to liquidate the pool. NHIT has also stated that they have a similar philosophy should they run out of money. The consequences for members of liquidating the pool rather than assessing include:

1. Unpaid liabilities would be the members' responsibility.
    - As explained in the previous section, any remaining unpaid liabilities upon the liquidation of a pool would have to be paid by the members.
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.
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.

These consequences of liquidation are worsened by the relatively fixed budgets of subdivisions such as school districts, which make it even harder to unexpectedly have to pay for remaining unpaid liabilities and for potentially more expensive coverage from other sources. In order to prevent these consequences, SB297 would give the pools explicit authority to self-assess members if they can provide actuarial justification. Many states have such laws explicitly allowing assessments by public risk pools, while no states prohibit public risk pools from assessing members. Additionally, section I-B 7 of the Association of Governmental Risk Pools' (AGRiP) standards for the governance of risk pools states that risk pools should have written policies in place for how assessments are to be performed even if the pool has not experienced and does not plan an assessment. Therefore, the explicit permission granted by SB297 for pools to self-asses simply codifies practices that AGRiP's governance standards already recommend.

To provide further protection for members against the consequences of liquidation, if pools choose not to self-assess, then the Secretary of State would have the authority under SB297, at his or her discretion, to require pools to charge an assessment if contingency reserves fall below 4% of annual payments (equivalent to about two weeks of cash reserves). HealthTrust's own actuarial analysis shows that once they are back above the 12% contingency reserve range minimum, the likelihood of their contingency reserves falling below this 4% threshold is **less than 5%** each year.

Even though the likelihood of paying an assessment will be less than 5% each year, the creation of assessment funds was added to SB297 in response to concerns about the ability of members with relatively fixed budgets to pay for such assessments in the unlikely event that they are needed.

Finally, AGRiP addresses the benefits of risk pool assessments in their PR Tool Kit Q&A:

> *Q: I understand that pool members are at risk of facing assessments if the pool doesn't have enough money to pay the claims. Why would I want my town or school to take on this assessment risk?*
>
> *A: Pools adopt funding philosophies that reflect the laws and regulations under which they operate as well as the needs and preferences of their members. This sometimes includes the legal ability to use assessments should funds be inadequate.* ***Pools seldom assess their members, but having this ability ensures that the pool will never become insolvent, and that all claims will fairly and equitably be satisfied – no matter what****...In fact, there is more incidence of insolvency in the commercial insurance industry than among pools [due to the ability of pools to assess].*

Purpose of SB297

There are currently no safeguards in place in New Hampshire in terms of minimum contingency reserve requirements for risk pools. SB297 addresses this issue by allowing pools to self-assess and, if necessary, enabling the Secretary of State to impose assessments when reserves fall below 4% of annual payments. These measures aim to prevent insolvencies.

The purpose of the contingency reserve range in SB297 is to 1) encourage pools to charge actuarially recommended contributions and 2) require pools to replenish reserves within a reasonable timeframe.

Encouraging Pools to Charge Actuarially Recommended Contributions

The reserve range contained in SB297 will encourage pools to charge actuarially recommended contributions and to perform actuarial calculations of the impact of coverage and exposure changes. This is because failure to do this will likely result in the contingency reserve falling below the minimum, triggering an automatic contingency reserve replenishment charge during the second year after the shortfall occurs.

HealthTrust's meeting minutes show at least eight different instances in recent years where they intentionally charged less than the actuarially recommended contributions to compete for market share, including instances of intentionally not having their actuary price the impact of coverage changes or exposure changes. For example, in their meeting on September 22, 2020 their actuaries recommended increasing contributions to account for people returning to pre-pandemic levels of medical service utilization as the pandemic ended. HealthTrust ignored this recommendation and suffered significant losses as people did indeed return to pre-pandemic levels of medical service utilization. Another example is that a 2019 study showed the price for higher deductible plans to be too low compared to that of lower deductible plans. HealthTrust ignored this study and did not adjust the rates, causing financial losses for the pool as an increasing number of members migrating to the underpriced higher deductible plans. The impact on HealthTrust's members of these repeated decisions to charge below the actuarially recommended contribution levels include:

- Members are now facing an expected average rate increase of around 40% over 3 years starting in FY2025, **which is more than double the industrywide expected rate increase**, to make up for the prior intentional underfunding.
- The repeated intentional undercharging contributed to the precarious financial position they have been in for the last two years. In early 2023, HealthTrust self-reported to the regulator that they were in significant financial trouble and would end the year with only around 20 days of cash remaining. Since then, they have failed to rebuild their financial position and are on track to end 2025 with only about 15 days of cash remaining.[1]
- 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. If HealthTrust charged the contribution levels required to fund these coverages (and reflected the impact of deductible funding in contributions), and accepted any loss of market share that resulted from charging those required contribution levels, then those coverages would not have to be cut. Reducing their extremely high level of administrative expenses would also reduce the need to cut coverages.

NHIT has been relying on an underwriter to calculate contributions and has not been basing those contributions on actuarial analysis. When they have had an actuary evaluate the need to record a "premium deficiency reserve" on their financial statements, the actuary has consistently found their contributions to be materially less than needed. The net result of the years of such insufficient contributions is that NHIT had no contingency reserves remaining as of December 31, 2024 and their **liabilities were greater than their assets**. NHIT claimed in their most recent letter to senators that their current financial position is due to the COVID-19 pandemic. However, the failure to base contributions on actuarial analysis pre-dated the pandemic and the dangerously low contingency reserve level of about 4% they have had in the two full post-pandemic years is at the same level as prior to the pandemic in 2017 and 2018 as shown on page 7. Additionally, the recent drop to below zero contingency reserves cannot be attributed to the pandemic.

Replenishing Reserves Within a Reasonable Timeframe

In their August 10, 2023 meeting, HealthTrust's actuary "*strongly recommended*" rebuilding their contingency reserves over **two years**. However, HealthTrust ignored this strong recommendation and chose a **three-year** rebuild period instead, which they subsequently reset at their meeting on September 19, 2024, to push the total rebuild period to **four years**. Should they continue their policy of limiting the capital risk charge to not more than about 5%, the rebuild period will be extended even further to at least **five years**, as their net income since the September 19, 2024 meeting has been significantly lower than expected. The choice to not implement the two-year rebuilding period that was strongly recommended by their actuary has contributed to their current precarious financial position.

In 2023, NHIT performed actuarial analyses of the amount of contingency reserve needed. The analysis showed a contingency reserve of at least 13% is needed to keep the likelihood of insolvency below 5%, and a contingency reserve of at least 18.6% is needed to keep the likelihood of insolvency below 1%. However, NHIT's actual contingency reserve has remained below 5% and has been falling for the last three years. It is now below zero. Therefore, they have not taken any effective steps in the last two to three years to replenish contingency reserves to the amount recommended by their actuarial analysis.

SB297 will require risk pools to add a replenishment charge to attempt to build contingency reserves back up to 12% of contributions should they fall below that threshold at the end of a fiscal year. The collection period for this charge ends two fiscal years after a pool falls below the threshold, which is similar to the two-year replenishment period that was strongly recommended by HealthTrust's actuaries.

Regulation of Risk Pools vs Insurance Companies

HealthTrust's press release on March 13, 2025 claims that the provisions of SB297 "*are not based on commonly accepted, actuarially sound standards (such as those used by the NH Department of Insurance)*". However, the actuarial standards used by the NH Department of Insurance are for the regulation of commercial insurers; the department has not developed standards for the regulation of public risk pools. **AGRiP 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.***"

Two actuarial consulting firms and five accredited actuaries were engaged to consult on the provisions of the bill. The provisions of the bill also draw extensively on actuarial analyses performed by HealthTrust and NHIT as shown by, but not limited to, the references to those analyses made throughout this document.[2] Other than their incorrect reference to the NH Department of Insurance which has not created standards for regulating RSA 5-B risk pools, HealthTrust has not explained what "*commonly accepted, actuarially sound standards*" SB297 allegedly fails to adhere to. As explained in the previous section, both HealthTrust and NHIT have consistently chosen not to charge actuarially recommended contributions and contingency reserve replenishments, which has driven the need for SB297.

Financial Impact of SB297 on Risk Pool Members

SB297 includes provisions for the creation of healthcare stabilization funds that are held and managed separately by each member of a pooled risk management program. The funds can be used to pay for assessments and other costs related to healthcare or health benefits. As stated above, once a pool is back in the contingency reserve range, the likelihood of an assessment is less than 5% per year. Surplus distributions can be put into the funds and there is no limit to the maximum amount that can be held in the funds.

These funds can cushion members against the impact of large rate increases, and can help pay for better coverage. For example, if HealthTrust members had kept the surplus distributions they received after 2020 and 2021 (equaling a total of $57M) in health care stabilization funds, then those amounts could then have been used to help offset the impact of the 15.3% average rate increase in 2025. Similarly, if NHIT members had kept the $6.8M in total distributions they received after 2019, 2020, and 2021 in health care stabilization funds, those amounts would then be available to help pay for any contingency reserves replenishments later required by the pool. Surplus distribution amounts held in assessment funds could also have been used by HealthTrust's members to help support HealthTrust charging the higher contribution amounts needed to keep providing the benefits that have been cut as listed on page 4.

The health care stabilization funds increase the amount of control political subdivisions have of their own money. The funds act as additional contingency reserves for the pools that can be drawn upon in the unlikely event that assessments are needed but are controlled and held by the members rather than by the pools. This is significantly better for the members since members keep the health care stabilization funds if they leave the pool. Currently, members cannot take any of the pool's contingency reserve when they leave, even though they contributed for years to those contingency reserves. Therefore, having a portion of the pool's contingency reserves held by members in healthcare stabilization funds is significantly fairer on members who leave.

For HealthTrust, the table on page shows that even with the creation of the health care stabilization funds which members must build at a rate of at least 1% of contributions per year until 4% is reached, members are still expected to pay lower contributions because of SB297. This is because the maximum contingency reserve level in SB297 is lower than the new target contingency reserve level that HealthTrust's board selected at their October 8, 2024 meeting. If the contingency reserve range maximum is 16% then the expected net impact is to reduce

contributions by 1.1% per year from FY2027 to FY2030; if HealthTrust applies for and is granted a higher maximum of 18% then the expected net impact is to reduce contributions by 0.6% per year. These projections assume claims experience over the next several is close to the level projected by HealthTrust. Given that HealthTrust is expected to only have around 15 days of cash remaining at the end of the year, if claims experience is significantly worse than the projected level, then the assessment provisions of SB297 will help to prevent insolvency and protect members from the consequences discussed on page 2.

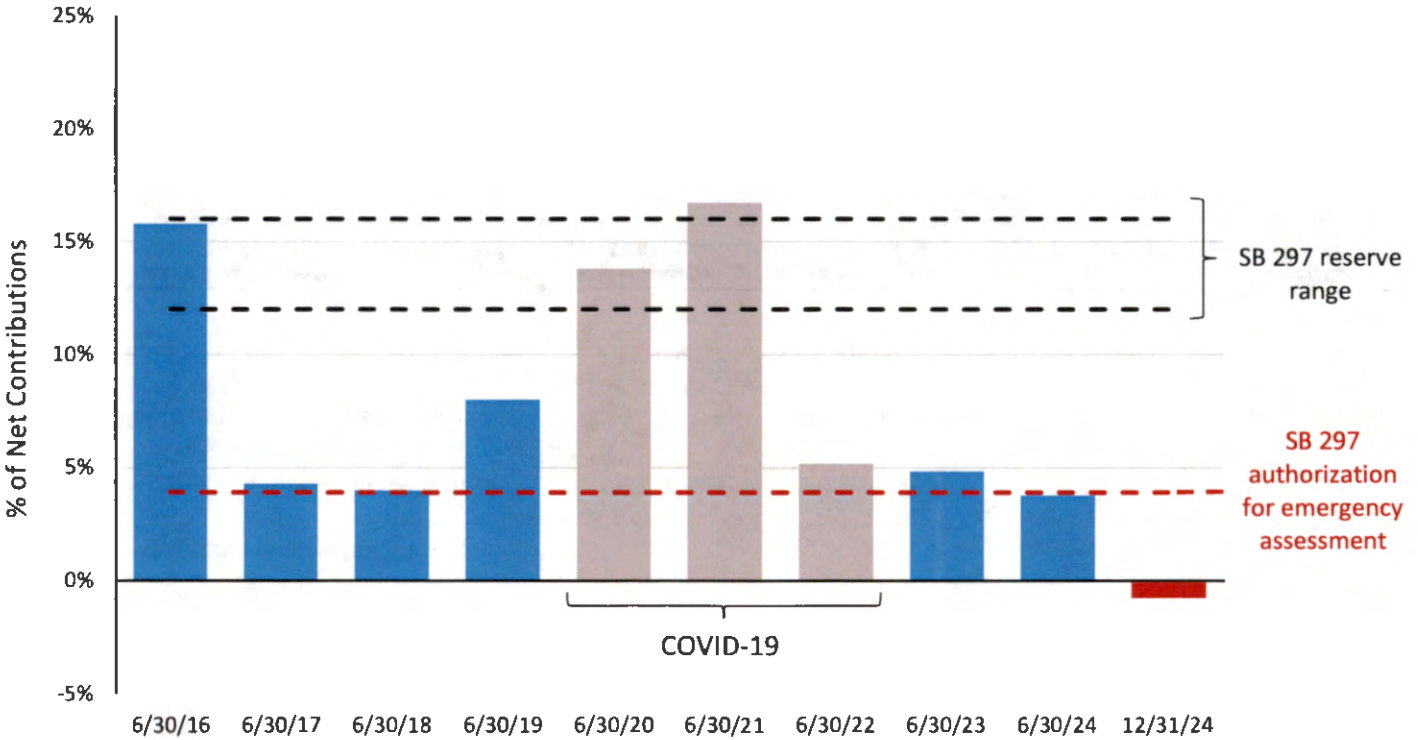
Sincerely,

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

1. For each of the last two years, HealthTrust's average monthly claim costs during the last four months of the year were 9%-14% higher than for the first eight months of the year. If a 9% difference is assumed for FY2025, then they would end the year with approximately $21.2M in contingency reserves, which would correspond to around 15 days of operating cash.

2. Amongst the actuarial analyses presented by all the risk pools, the one calculation that was clearly not relevant when determining the provisions for SB297 was the calculation by Milliman that HealthTrust needs $95M in contingency reserves to have no more than a 5% likelihood of insolvency over 5 years. The primary reason why this calculation is **cannot be compared to the contingency reserve range specified by SB297** is that the calculation does not take into account the impact of the key provisions of the bill such as the mandatory contingency reserve replenishment charge that is added when contingency reserves fall below 12%, the ability for pools to self-assess when actuarially justified, and the authority for the regulator to require assessments if contingency reserves fall below 4% of annual payments. Those provisions significantly reduce the likelihood of insolvency over a 5-year period meaning that if such provisions were considered in the calculation then the indicated amount of needed contingency reserve would be much lower. Additionally, the calculation assumes that HealthTrust cannot raise rates by more than 5% above the long-term average trend. This assumption was clearly disproved when HealthTrust raised rates by an average of 15.3% last year, which is much more than 5% above the long-term average trend. Without this assumption, the indicated amount of contingency reserve needed would again be much lower.

NHIT Contingency Reserve
(Health Coverage)



Note: Years highlighted in gray were impacted by COVID-19. Health programs saw reduced utilization early during the pandemic, which contributed to lower claim costs, followed by a recovery in utilization toward the end of the pandemic, contributing to higher claim costs.

Projected Impact of SB297 on Funding for HealthTrust Members

	Projected impact of SB297 [1]				Average annual net impact FY2027-FY2023
	FY2027	FY2028	FY2029	FY2030	
Assuming contingency reserve range of 12% to 16%					
Projected impact on contributions to HealthTrust	No impact	2.9% lower [2]	5.3% lower [3]	No impact	
Expected contributions to health care stabilization fund [4]	1%	1%	1%	1%	
Net impact on funding	**1% higher**	**1.9% lower**	**4.3% lower**	**1% higher**	**1.1% lower**
Assuming contingency reserve range of 12% to 18%					
Projected impact on contributions to HealthTrust	No impact	0.9% lower [2]	5.3% lower [3]	No impact	
Expected contributions to health care stabilization fund [4]	1%	1%	1%	1%	
Net impact on funding	**1% higher**	**0.1% higher**	**4.3% lower**	**1% higher**	**0.6% lower**

1. FY2027 is the first year shown because it is the first year where contributions to the Expected contributions to health care stabilization fund are required. Contingency reserves at 6/30/2025 are assumed to be $21.2M as explained in the footnote on the previous page. 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 and FY2028 (before surplus returns) is assumed to equal the 5.3% capital risk 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 8.3% and the projected replenishment charge required in FY2028 due to the proposed 12% minimum is 3.7% (=12%-8.3%). 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 18.9% of contributions. If the maximum contingency reserve is 16% then that would result in a 2.9% surplus return; if the maximum contingency reserve is 18% then that would result in a 0.9% surplus return.

3. HealthTrust's new contingency reserve target that was selected by their board on October 8, 2024 is about 25% of contributions. Their projected contingency reserve at the end of FY2026 is 8.3% of contributions, meaning that the capital risk charge of 5.3% is expected to be charged through at least FY2029 . In comparison, the maximum contingency reserve under SB297 is lower 16% or 18%, and the contingency reserve is projected to reach 18.9% by the end of FY2028, so the 5.3% capital risk charge would no longer be needed in FY2029.

4. For illustrative purposes, this assumed surplus returns are not into the Expected contributions to health care stabilization funds. If surplus returns are not into the Expected contributions to health care stabilization funds then the amounts in this row would be lower. Once the Expected contributions to health care stabilization fund in built up above 4%, further contributions are not required but can still be made.

SB297 (as Amended by 2025-0894s) Fact Sheet

Comments from the Secretary of State in Red (SB297_Fact_Sheet.pdf)

Member Group Impacts:

1. You are ultimately responsible for losses.
    a. **Effective upon passage:**
    b. You **must** agree in writing that you (as a Member Group) are ultimately responsible for any potential losses incurred while participating in an NH RSA 5-B risk pool, such as HealthTrust.
    Member Groups have always borne the ultimate responsibility for losses in the event of the insolvency of a risk pool. This very fact is why SB297 is being introduced to prevent insolvencies. This is explained in the attached letter dated March 19, 2025.
    c. You **must** acknowledge that HealthTrust coverage is not insurance, does not function like an insurance company, and is not an insurer.
    This is acknowledging a true statement as explained in the attached letter.
    d. HealthTrust **must** collect funds from Members (through assessments or replenishments) in the event of losses that cause HealthTrust reserves to fall below the minimum reserve requirements or insolvency.
    This is true regarding replenishments. HealthTrust already collects a 5.3% replenishment (called the "capital risk charge"). Because of this, the last page of the attached letter shows that SB297 is expected to result in lower overall contributions for HealthTrust members from FY2027 to FY2030, if claims experience is close to the amount expected by HealthTrust. For assessments, this collection is at the discretion of the Secretary of State.
    e. If you terminate coverage, you remain responsible for losses that occurred during the prior year.
    Currently, HealthTrust members have an incentive to exit the pool after the pool has adverse claims experience since they would then not have to pay for the replenishment for that adverse experience (such as the 5.3% capital risk charge than HealthTrust already charges). The new provision described in 3.a.iii targets fairness by ensuring that Member Groups who pay assessments or replenishments are only those who participated in the fiscal years for which assessments or replenishments are based on. It also reduces the incentive for members to leave in order to avoid paying replenishments.

f. This policy change stands in stark contrast to the current arrangement. Today, HealthTrust (a non-profit New Hampshire corporation) would be the responsible entity. This shifts the ultimate liability to each Member Group.
This is untrue as explained in the attached letter.

2. You will need to create a reserve.
   a. **Effective upon the next setting of fiscal year budgets following passage.**
   b. In order to participate in an RSA 5-B health risk pool, you **must** create a non-lapsing reserve account held by you as a Member Group.
   The amendment enhances local control of their own money by including a "health care stabilization fund" in response to concerns that Member Groups are not prepared for unpredictable expenditures such as assessments, as described by the NHMA in the copy of SB297 published by HealthTrust. The likelihood of an assessment is less than 5% per year once pools are back within the contingency reserve range. ***These funds increase the amount of control political subdivisions have of their own money, can cushion members against the impact of large rate increases, and can help pay for better coverage*** *as explained in the attached letter.*
   c. This reserve will be utilized to fund assessments for which you may be responsible.
   See comment above regarding the uses of the funds.
   d. You **must** fund an amount equivalent to at least 1% of your health coverage contributions each year, until the reserve account is funded to a total of 4% of contributions.
   This begins in FY2027 to allow time to adjust budgets. The last page of the attached letter shows that SB297 is expected to result in lower overall contributions for HealthTrust members even after factoring in the building of health care stabilization funds, if claims experience is close to the amount expected by HealthTrust.
   e. If you utilize these reserves, you **must** rebuild the fund at a rate of at least 1% the following year, until the 4% funding has been achieved.
   f. You may **not** participate in a RSA 5-B risk pool for health coverage without having this reserve account in place.
   g. In the years where there are returns of surplus from HealthTrust, they may be deposited into this reserve account.
3. You **must** pay replenishments and/or assessments when needed. You, as the Member Groups, would utilize the funds created in Section 2 above to pay these costs.

a. **Replenishments:**
    i. **Effective as of closure of HealthTrust Fiscal Year 2026 (for renewals starting January 1, 2027 and July 1, 2027)**
    ii. If HealthTrust reserves fall below 12% of member group contributions in a fiscal year, HealthTrust **must** include a contingency reserve replenishment amount in the next rating cycle (i.e., FY2028 in the first year) that mandates a recovery to at least that 12% level.
    HealthTrust is currently including a "Capital Adequacy Charge" of 5.3% of contributions, which serves the same purpose as the proposed contingency reserve replenishment.
    iii. This replenishment amount will be due from Groups who participated in the fiscal year for which the replenishment is calculated, even if they have terminated membership.
    Please see point 1.e above for the explanation of why this is necessary.

b. Assessments:
    i. **Effective upon passage.**
    ii. If HealthTrust reserves fall below 8% of annual paid claims, HealthTrust **must** notify you of a potential required assessment if reserves fall below 4% of annual paid claims.
    iii. If HealthTrust reserves fall below 4% of annual paid claims, you **must** pay an assessment **within 30 days** to satisfy the amount of the deficiency.
    This is inaccurate. This assessment would be at the discretion of the Secretary of State.
    iv. Evaluation occurs at the end of each fiscal month.
    v. Calculated on a pro-rata basis based on contribution amounts.

HealthTrust Reserves:

1. HealthTrust contingency reserves (Capital Adequacy Reserves) **must** be between 12% and 16% of Member Group contributions for the current fiscal year.
    a. The upper limit may be temporarily increased to 18% if we apply for, and are granted, an exception.
    This is inaccurate. Risk pools can apply for this exception each year, meaning the 16% limit can be increased to 18% repeatedly if a risk pool can provide adequate justification each year for renewing the exception.

b. The bill states that the contingency reserve rate ranges will be reviewed by July 1, 2027 and every 4 years thereafter. No actuarially sound standards have been identified as the basis for this review such as those used by the New Hampshire Insurance Department.

The 4-year review entails holding a hearing with all pooled risk management programs and any affected party to "receive input and data regarding the contingency reserve rate ranges." The purpose of this review is for ***the risk pools*** *and their actuaries to provide the information to support any proposals they have regarding the ranges. Regarding the New Hampshire Insurance Department, the attached letter explains that they have standards for the regulation of commercial insurers but have not created any standards for the regulation of public risk pools.* ***AGRiP states that: "Any approach to regulation must understand that pools are fundamentally different from commercial insurers in purpose, core values and operations."***

c. As written, the upper limit is less than the minimum reserve level ($95 million, which is 20% of contributions for the current fiscal year) that our actuaries have determined is necessary in order to have only a 5% chance of reserves being depleted within 5 years.

This calculation of $95M in needed contingency reserves ***cannot be compared to, and is not relevant to, the upper limit of the range specified by SB297****. This is because the calculation does not take into account the impact of the key provisions of the bill such as the mandatory contingency reserve replenishment charge that is added when contingency reserves fall below 12%, the ability for pools to self-assess when actuarially justified, and the authority for the regulator to require assessments if contingency reserves fall below 4% of annual payments. Those provisions significantly reduce the likelihood of insolvency over a 5-year period meaning that if such provisions were considered in the calculation then the indicated amount of needed contingency reserve would be much lower. Other reasons why the $95M calculation is not relevant or reasonable are discussed in the attached letter. Finally, the attached letter explains how the healthcare stabilization fund of at least 4% is an additional contingency reserve that is held by the members. When this is added to the 16% (or 18%) maximum amount held by the pool, that equates to a total of* ***20% (or 22%)*** *in total contingency reserves. This exceeds the $95M amount (which equals 19.5% of FY2024 contributions) even if that amount was relevant or reasonable.*

d. As of the end of FY2024, HealthTrust is at a contingency reserve level equivalent to 7% of contributions and is in the midst of a Board-approved, actuarially-modeled plan to rebuild reserves over a period of three rating cycles. This would halt that rebuild effort at the 16% allowable limit and thereby prevent HealthTrust from accumulating the level of reserves that has been actuarially determined appropriate.
See previous point and the attached letter for why the $95M is has not been actuarially determined to be appropriate for the upper limit used in SB297.

e. **If HealthTrust becomes financially impaired, Groups will be responsible to replenish HealthTrust reserves through prescribed replenishments and/or assessments detailed above.**

Upon releasing this fact sheet, HealthTrust summarized the impacts by saying the following:

In short, these regulatory changes by the State of New Hampshire will negatively impact your city, town, county, or school district by:

- Shifting the ultimate financial liability for losses to you, the Member Groups of HealthTrust;

  As discussed above and in the attached letter, it is precisely because the ultimate liability has always remained with each Member Group in the event of insolvency that SB297 is being introduced to protect members by preventing insolvencies.

- Requiring Member Groups to establish reserve accounts used to pay for assessments and replenishments, and;

- Requiring Member Groups to accept changes for a new process and structure that are not based on commonly accepted, actuarially sound standards (such as those used by the NH Department of Insurance).

  See previous points and the attached letter explaining that the NH Department of Insurance has not created any standards for the regulation of public risk pools. Two actuarial consulting firms and five accredited actuaries were engaged to consult on the provisions of the bill. The provisions of the bill also draw extensively on actuarial analyses performed by HealthTrust and NHIT as shown by, but not limited to, the references to those analyses made throughout the attached letter. Other than their incorrect reference to the NH Department of Insurance which has not created standards for regulating RSA 5-B risk pools, HealthTrust has not explained what "commonly accepted, actuarially sound standards" SB297 allegedly fails to adhere

to. As explained in the attached letter, both HealthTrust and NHIT have consistently chosen not to charge actuarially recommended contributions and contingency reserve replenishments, which has driven the need for SB297.