Disclaimer

This presentation is provided for general informational purposes. These slides were used to supplement and illustrate the discussion with HealthTrust Member Groups at the 4/3/2025 Virtual Town Hall on SB297. Please reach out to your HealthTrust Benefits Advisor for more information on this important content.

HealthTrust Town Hall: SB297 and Impacts

April 3, 2025

Presenter: Scott DeRoche, Executive Director

Moderator: Dave Salois, Benefit Services Manager

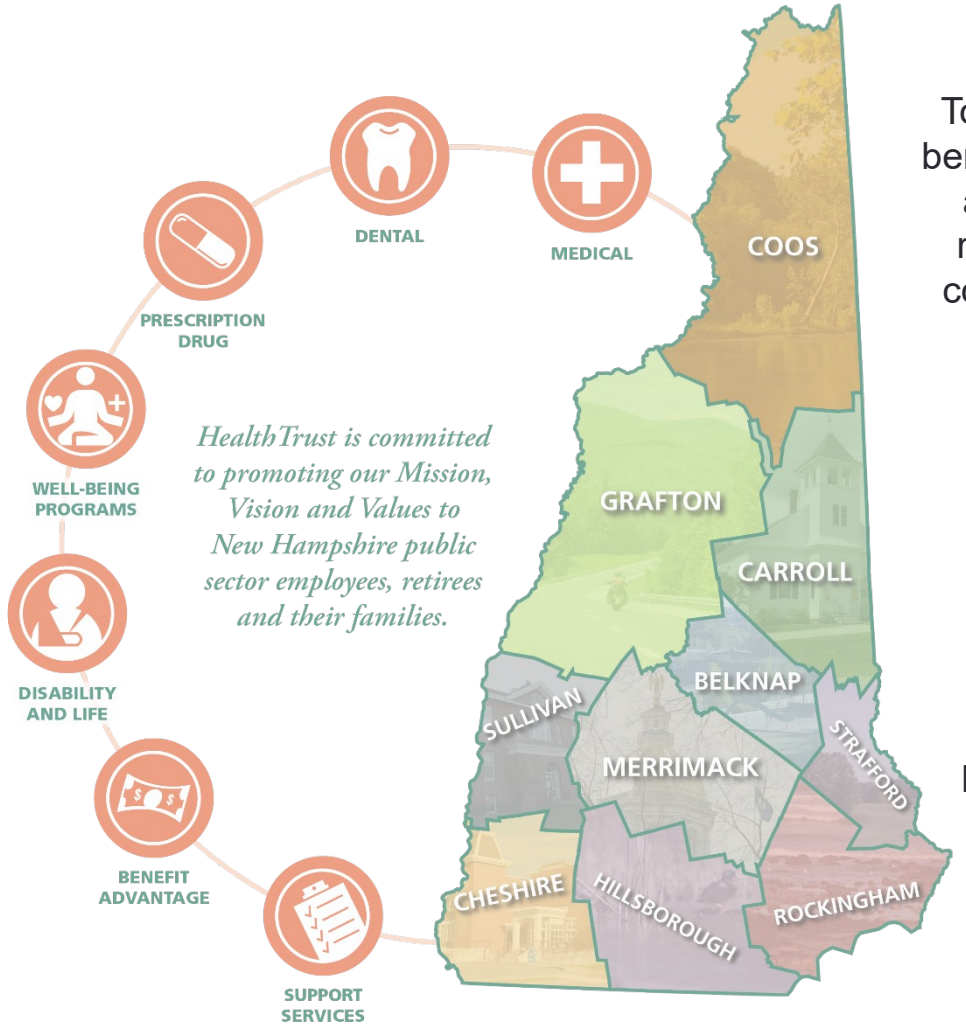
Agenda

- Introduction
- Understanding the Different Models of Risk Pools
- Contingency Reserves and Challenges Associated with SB297
- SB297 Would Not Have Prevented Recent Drop in Contingency Reserve
- Next Steps and HealthTrust's Focus
- Questions & Answers

The HealthTrust Advantage

HealthTrust's Mission, Vision and Values form the foundation of all we do. We are proud to be New Hampshire communities' most trusted partner in achieving optimum health through a culture of wellness.

By helping to keep our public sector employees and their families healthy, **HealthTrust** strives to make New Hampshire a better place to live and work – and that's a goal we share with all our Members.



Mission

To provide high quality, cost-effective, employee benefit products and services for public employers and employees in New Hampshire in order to reduce costs through pooling strategies with a commitment to education, health promotion and disease prevention.

Vision

New Hampshire communities' most trusted partner in achieving optimum health through a culture of wellness.

Values

Integrity • Service • Innovation • Collaboration

HealthTrust Board of Directors

Who is HealthTrust?

A nonprofit, public risk pool dedicated to serving our Members – New Hampshire's schools, towns, cities, counties and other quasi-municipal entities.

HealthTrust serves a total of **356** Member Groups.

MUNICIPALITY	SCHOOL	COUNTY	GROUP OTHER
191	85	6	74

- Exceptional service with a personal touch
- More than 72,000 unique NH public sector employees, retirees and covered dependents in one or more coverage lines

DANIEL ROSSNER
Chair
Business Administrator,
SAU #48 - Plymouth Schools

SUSAN HILCHEY
Vice Chair
Director of Human Resources,
SAU #25 - Bedford Schools

TROY BROWN
Town Manager,
Town of Littleton

MICHELLE CLARK
Business Administrator,
SAU #66 - Hopkinton Schools

RUSSELL DEAN
Town Manager,
Town of Exeter

ALISON KIVIKOSKI
Sr. Director of Human Resources,
Rockingham County

BRIAN RAPP
Deputy Chief,
Claremont Fire Department

TIMOTHY RUEHR
Chief Financial Officer,
SAU #29 - Keene

JILL SHEING
HR Payroll Coordinator,
Strafford County

SARAH TRAHAN
Social Studies Teacher,
Winnacunnet High School

KATIE WILLIAMS
Director of Human Resources,
Town of Hanover

Introduction to SB297

- Late Bill. Incredibly fast process. Introduced 2/13/2025, bill text became available 2/25/2025, Senate Hearing 3/4/2025, Committee Amended and Advanced 3/13/2025, Approved by Senate 3/20/25, Introduced to House 3/28/2025

- We welcome standards being added to NH RSA 5-B, however the limited opportunity to review and discuss is very concerning given the magnitude of the changes proposed.
  - In 38 years, no actuarial standards have been added to the law nor has regulatory rulemaking been conducted
  - If passed by the House in current form, could go into law in the next several weeks

- No opportunity for stakeholders to review or comment prior to the bill's introduction

- Sweeping changes to NH RSA 5-B risk pools lowering maximum reserve levels and shifting risk to member groups

- Complex and varied industry - changes can have significant intended and unintended consequences

Major Provisions of SB297

- Groups are ultimately responsible for losses of risk pools (i.e. risk is transferred to Group)
  - Effective upon passage
- HealthTrust reserves required to be 12-16% of contributions (18%, if exception is granted)
- Groups must establish their own reserves to participate in RSA 5-B risk pools
- Groups must pay assessments when issued (if contingency reserve falls below 4% of claims)
- Groups must pay capital replenishments when required (if contingency reserve is below 12% of contributions; payable even if Group leaves)
- Risk pools must be member-owned and Board owes fiduciary duty to each *individual* member
  - Raises significant questions about how to navigate conflicts regarding ability to prudently manage program, risk pool being bound by Collective Bargaining Agreements of Member Groups, etc.
- Narrow definition of Administration
  - Unclear if services such as contact center, retiree individual billing (vending NHRS), COBRA, FSA/HRA, well-being programs, etc. will be allowed

Clarification and Collaboration Needed

- HealthTrust was not involved in modeling/preparation/study
- The bill's language and systems have significantly changed twice since introduction
- Backup reports and information behind model have not yet been released by the Secretary of State's Office including:
  - Actuarial reports gauging frequency and size of returns, assessments, and replenishments, including the underlying actuarial assumptions
  - Modeling on the ability of public sector entities to pay assessments and replenishments, particularly in years when the replenishment and assessments are above the 4% or required following back-to-back bad years
  - Sources utilized to land on the 12-16% contingency reserve range

Additional Questions Raised

- Throughout this process, questions have been raised about:
  - HealthTrust's ability to continue to operate as a nonprofit corporation
    - Would it be required to re-form as an association, trust, partnership, etc.?
    - Can assets move from corporation to new entity or need to be liquidated?
  - HealthTrust Board's ability to prudently manage costs
    - Alleged Board is not allowed to retire inefficient plans
    - Alleged Board is not allowed to adjust benefits
    - Alleged Board is not allowed to revise plan rules such as deductible funding limitations
  - Conflicting duties in SB297
    - Fiduciary duty to the whole vs. conflicting duties to each individual political subdivision
    - "Member-owned" governance structure - Membership council that manages plans, etc.?
  - Administrative Services
    - What is allowed? Retiree individual billing (vending NHRS), COBRA individual billing, FSA/HRA services, contact center, well-being programs, etc.

Our Goal

- Our mission is to serve the public sector of New Hampshire.
- That has been our focus for 40 years and it still is today.
- Need to make sure that any service we offer is viable and in the interests of New Hampshire's public sector.
- As an organization we care deeply and we want to hear from you.
- Our Goal is to ensure that legislation intended to promote financial stability of risk pools does not adversely impact our ability to provide the benefits, services, and protection our member groups rely upon.

Seeking Collaboration and Reasonable Solutions

- HealthTrust is open to reasonable regulation and standards
- Recent volatility in the health industry, on the heels of the post-COVID rebound, have tried and tested current models
- However, this is a complex system and collaboration and study by all stakeholders is critical to ensure that changes to the system are sustainable and balance the interests of all
- No need to rush - Changes of this magnitude should be thoroughly reviewed and vetted.

Understanding the Different Models of Risk Pools

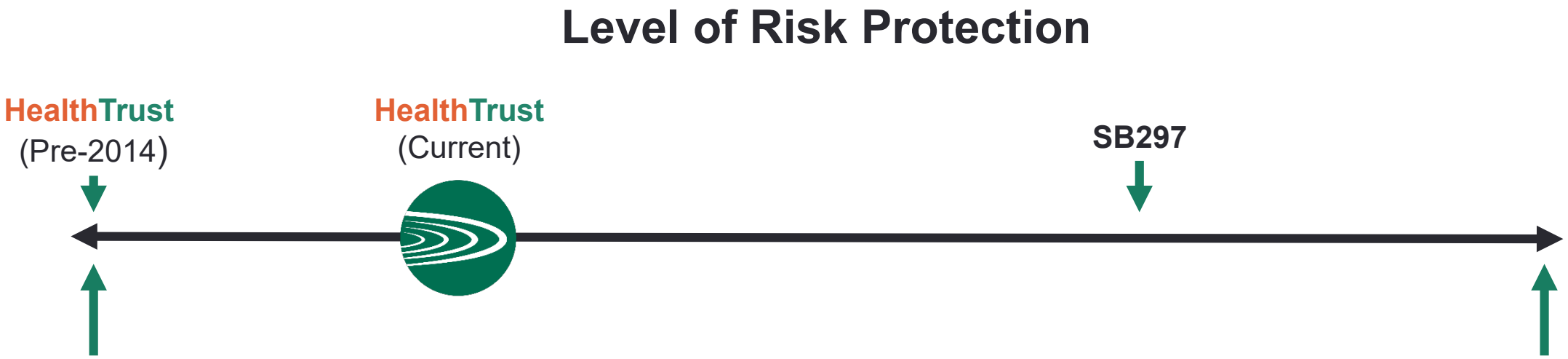
Different Types of Risk Pools

- There are different types of risk pools in New Hampshire and nationally
- A full spectrum of risk pool models exist, balancing level of risk, individual vs. aggregate experience, level of autonomy/decision-making, etc.
- SB297 would allow only one type of risk pool in New Hampshire

This bill does not strengthen HealthTrust

Rather, it does not allow HealthTrust's current model to exist

Different Models of Risk Pools



High Protection

Pool Holds Risk – Members are Insured

Higher Reserves Held by Pool

Surplus Retained by Pool

Replenishments Gradual via Multi-Year Rebuild

No Assessments

Prioritizes Long-Term Stability of Pool and Protection of Member Against Volatility

Low Protection

Member Holds Risk – Pool is Administrator

Lower Reserves Held by Pool

“Pass Through” Costs and Surplus

Replenishments are Rapid

Assessments Occur

Prioritizes Member Choice in Managing Plan Design and Requires High Risk Tolerance

Multiple Models Recognized

- Organizations such as the Association of Governmental Risk Pools (AGRiP) and the Governmental Accounting Standards Board (GASB) acknowledge that various types of risk pools exist all throughout the spectrum, including high protection and high reserves and low protection and low reserves.

- Level of reserves depends on the objectives of the pool and the level of risk transferred from the group to the pool.

AGRiP on Contingency Reserves

A national association of pooled risk management groups, AGRiP (Association of Government Risk Pools), with members in forty-six states, noted that there was not a consensus on the issue as to the proper amount of reserves versus surplus. Such determinations, AGRiP noted, are dependent upon the broader objectives of the pool, such as "rate stability", "rate certainty", "rate security", "long term solvency", "appropriate use of assessments", etc, etc. Each pool was noted as likely to have very different objectives in regard to any of these issues, depending upon what their members expect from the pool.

For example, members of one pool might deem it more appropriate to rely upon assessments rather than any surplus to achieve their long-term objectives; while others may deem it more appropriate to develop a significant surplus to avoid the need for assessments; or to fund additional services or programs that could not be provided through normal income streams. Some pools set surplus targets or objectives on criteria other than "reserves". One policy may

SOURCE: Secretary of State - 2010 Recommendations Concerning Limitations of Reserves for Risk Pools https://www.sos.nh.gov/sites/g/files/ehbemt561/files/inline-documents/sonh/26-3-12-12-supporting-material-bsr-recommendations-on-reserves-12-30-10.pdf

AGRiP on Contingency Reserves, Cont.

Capital Adequacy

Perhaps the most complex and important question any pool can ask is: Are we funded adequately to meet promises we've made to our members?

Capital adequacy is not a singular definition and the question doesn't go away just because a pool has answered it once. Measuring adequacy of a pool's capital is dynamic and ongoing.

Capital adequacy means a pool has enough funding to pay all claim and operational liabilities. Because ultimate claim liabilities are hard to project long into the future, pools hold significant reserve funding and may also hold significant amounts of member equity or surplus as additional assurance that all financial obligations can be adequately met in any circumstance.

Member equity also helps a pool navigate unexpected changes or challenges – new coverage mandates, changes in reinsurance availability or costs, membership changes, and other factors.

There is no singular measure or metric to determine the adequacy of a pool's overall funding. Although baseline financial ratios exist for the insurance industry, they're only a starting point for most pools. Other factors, like confidence level funding and discounting practices, can also significantly impact a pool's overall financial picture.

It's important that pool management and the governing body have regular, informed discussions about capital adequacy. Some questions to consider:

- How does our pool measure its capital adequacy?
- What is the purpose for which we hold member equity or surplus?
- What is the minimum member equity we want to hold for financial solvency purposes and to make good on our member promises?
- What is the maximum member equity we want to hold?

SOURCE: AGRiP Pooling Basics Textbook https://higherlogicdownload.s3.amazonaws.com/AGRIP/613d38fc-c2ec-4e1a-b31f-03fa706321aa/UploadedImages/documents/PoolingBasicsTextbook1120.pdf

AGRiP on Contingency Reserves, Cont.

Cost Savings and Stability

Cost savings for pool members are largely achieved through reducing the number and cost of claims. Pools also function for a public purpose, not a profit margin, and employ economies of scale. So, there is generally lower overhead and no profit target being generated by a pool.

Most pools focus on long-term, stable pricing to match public entity budget needs. Members of pools value predictable, sustainable contributions for coverage year-over-year, rather than the sometimes dramatic premium increases and decreases more common in the profit-driven commercial insurance market. Because public entity pools are not concerned with making a profit, they are able to price coverage more effectively for public sector budgets.

SOURCE: AGRiP Pooling Basics Textbook https://higherlogicdownload.s3.amazonaws.com/AGRIP/613d38fc-c2ec-4e1a-b31f-03fa706321aa/UploadedImages/documents/PoolingBasicsTextbook1120.pdf

GASB

Po20—Public Entity Risk Pools

Transfer of Risk

.106 One question that surfaces repeatedly in any discussion of insurance and risk management activities is whether risk has, in fact, been transferred or whether it has been retained by the governmental entity, even if a third party (such as a commercial insurer) is involved. The important concept here is that risk retention and risk transfer generally are not mutually exclusive or absolute. For example, assume an entity other than a pool pays a **premium** or **required contribution** of some sort to an insurer or pool, with the ultimate charge to the entity being determined based on the individual entity's **claims**/loss experience. If that entity's losses exceed the initial charge, it will be assessed an additional amount to fully reimburse the insurer for those losses. On the other hand, if the premium exceeds the losses, the entity will receive a refund. In this situation, risk has been retained by the entity, the annual premium is more in the nature of a **deposit** and the insurer or pool is functioning more as a claims servicer. [GASBS 10, ¶7]

.107 As another example, assume an insurer collects premiums that it estimates will cover the costs of *all* claims for which the insurer is obligated. If the covered entity's losses exceed its premiums, there is no individual supplemental assessment; on the other hand, if the entity's losses are low, it will not receive a refund. The insurer or pool views its activities in the aggregate, rather than on an individual insured entity basis (as in paragraph .106). It may make an *overall* supplemental assessment or declare a refund depending on the loss experience of all the entities it insures. Or it may increase or decrease premiums for the same type of coverage in the following years. The insurer or pool, in effect, pools risks among insured entities. Except for deductible amounts, in this example, risk appears to have been transferred to the insurer or pool. [GASBS 10, ¶8]

SOURCE: GASB
https://gars.gasb.org/3154072/2147483045/gars/standards#po20_standards

HealthTrust Current Reserve Priorities

- Prioritizes:
  - Risk transferred to the pool to protect Groups
  - High rate stability
  - High rate security
  - Long-term solvency
  - Sufficient reserves so as to have a 95% chance of solvency over a 5-year time period *without* the use of assessments
  - Reserves will allow stability for Groups, even in periods of claims spikes
  - **Seen in Action with Post-COVID Claims Spike**
    - All claims paid
    - No assessments
    - No mid-year rate increases or increases above quoted rates
    - Multi-year replenishment plan

SB297 Reserve Priorities

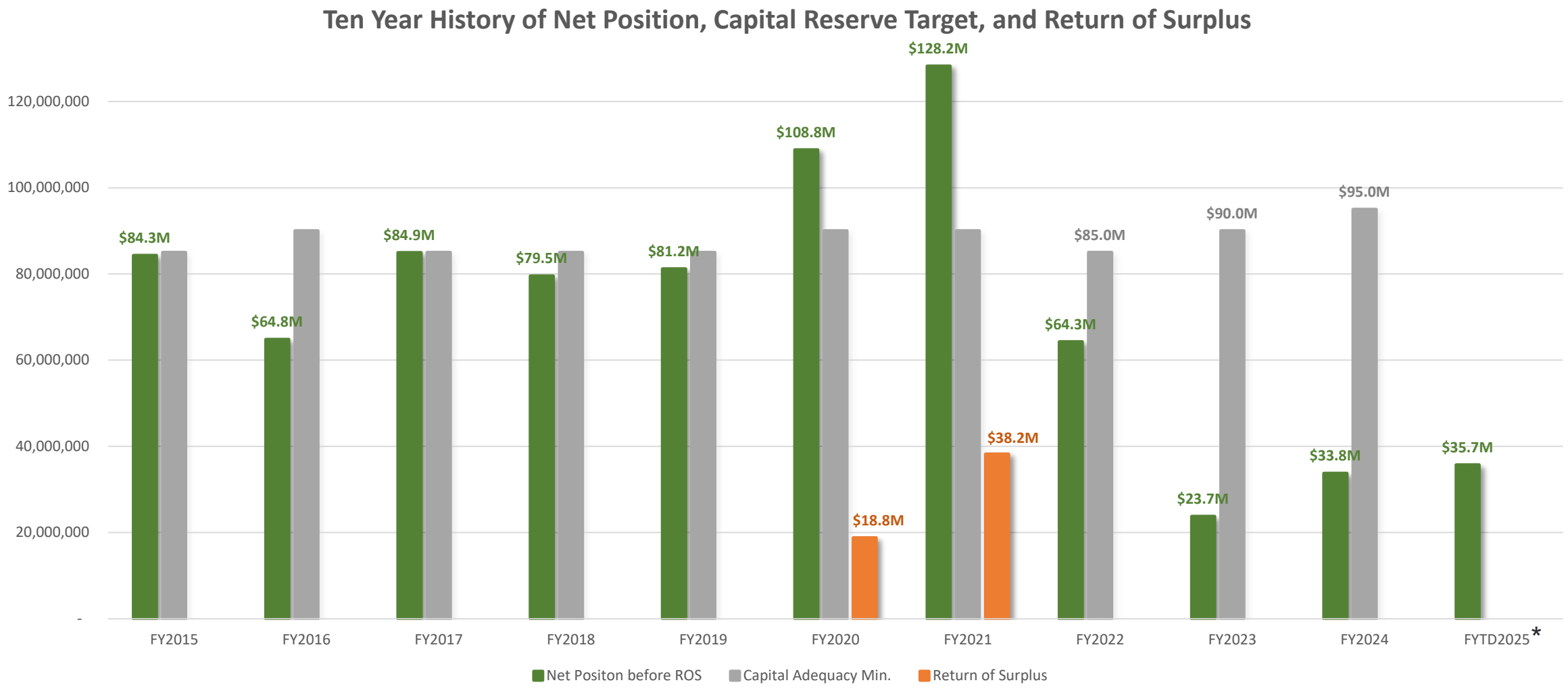
- Priorities
  - Implement minimum reserve level held by health risk pools
  - Reduce maximum reserves held by health risk pools (maximize future return of surplus to Member Groups)
  - Set forth in law that risk is retained by Member Groups if reserves are insufficient
- Effects
  - Lower protection from risk (risk transferred to Member groups)
  - Increased rate volatility
  - Pool solvency relies upon Member Groups' ability to pay assessments/replenishments promptly when needed, even when assessments exceed Member Group reserves and approved budgetary amounts

SB297 Removes Choice

- SB297 has been presented as if there is just one way to be a risk pool.
- As shown, there are many ways to be a risk pool.
- HealthTrust's current model prioritizes protection from risk.
- SB297 lessens protection in favor of increased Member Group exposure to risk and accountability.
- SB297 memorializes in law that only this one form can exist in New Hampshire.
- It may not meet the needs to most public sector organizations in New Hampshire, particularly in a bad year or a series of bad years.

Contingency Reserves and Challenges Associated with SB297

Reserves in Action



*2025 Fiscal Year to Date through February (8 months); unaudited

Models in Action

- Surplus returned and remaining reserves utilized during Post-COVID spike:

$57M in Return of Surplus during COVID

Currently need to raise $59M to get to minimum of current Contingency Reserve Range

- **How to Rebuild Reserves?**
  - **Pre-2014 HealthTrust Model:** Would have retained surplus and used to cover post-COVID rebound claims, smoothing the member group experience and ensuring solvency.
  - **HealthTrust Current Model:** Returned surplus as required. Rebuilding contingency reserve to level recommended by external actuaries over a period of several years
  - **SB297 Model:** Rebuild to a lower statutory contingency reserve level in one rating cycle
- **How to Prevent in Future?**
  - **HealthTrust Current Model:** Retain more in reserves in the future so that Groups are protected if spike happens again – Board adopted higher Capital Adequacy Target of $122.5M (24% of contributions)
  - **SB297 Model:** Retain less in reserves but charge Groups (Replenishments and/or Assessments) to maintain solvency if a spike happens in the future.

Key Questions

- Will Groups be able to pay assessments and replenishments? If they don't and can't pay – future solvency?
- What about in a bad year? (Stochastic modeling models 10,000 years every rating cycle; in how many years would an assessment or replenishment of more than 4% occur?)
- What about in back-to-back bad years?
- Will Groups be able to withstand volatility? (rate fluctuations, returns of surplus, assessments, etc.)
- In a bad year with a significant rate increase, will Groups pay Capital Replenishment "exit charge"?
- How would this model compare to commercial, fully-insured plans? (higher rates and fewer benefits/services *but* full protection from assessments/replenishments)

Example

Year 1 – Claims spike occurs during the year (i.e., HealthTrust FY2023)

- Begin (July 1) at 14% contingency reserve
- End (June 30) at 5% contingency reserve
- Group Experience:
  - **Current Year (6 mos. Jan group; 12 mos. July group):** Assessment if reserve drops below 4% of claims
  - **October Rating for Next Year (Jan/July):**
  - Rate increase of 11.5% average based on increased claims
  - Capital replenishment of 7% to get back to 12% minimum; 9% to get back to starting point; 11% to get to maximum
  - Overall rate increase of 18.5%; 20.5%; 22.5%
  - Higher end of range would likely be north of 30% for certain groups
- Group Choice:
  - Renew with large increase
  - Terminate but pay 7%-11% replenishment “exit charge”
- Group Funding Issue:
  - What if, during the current year before new rates, an assessment is issued for part or all of the 4% Group reserve?
  - How to pay 7% exit charge if only 4% is in Group reserve? Fund through taxpayers? What if voted down?

Example Cont.

Solvency Concerns:

- Pool is at 5% contingency reserve; Just lost 9% last year
- What if claims continue to exceed actuarial projections:
  - Lose 3%
    - Issue assessments to Groups
  - Lose 6%
    - Issue assessments to Groups; Assessments are greater than 4% Group reserves
  - Lose 9%
    - Issue assessments to Groups; Assessments are far greater than 4% Group reserves
- Concurrent – Group is actively paying assessments while also trying to fund exit charge to get out of pool
- **Pool Solvency:** Cash flow depends on *all* Groups paying the assessments and replenishments as needed. If they don't pay them, or don't pay them in a timely manner, pool may become insolvent.

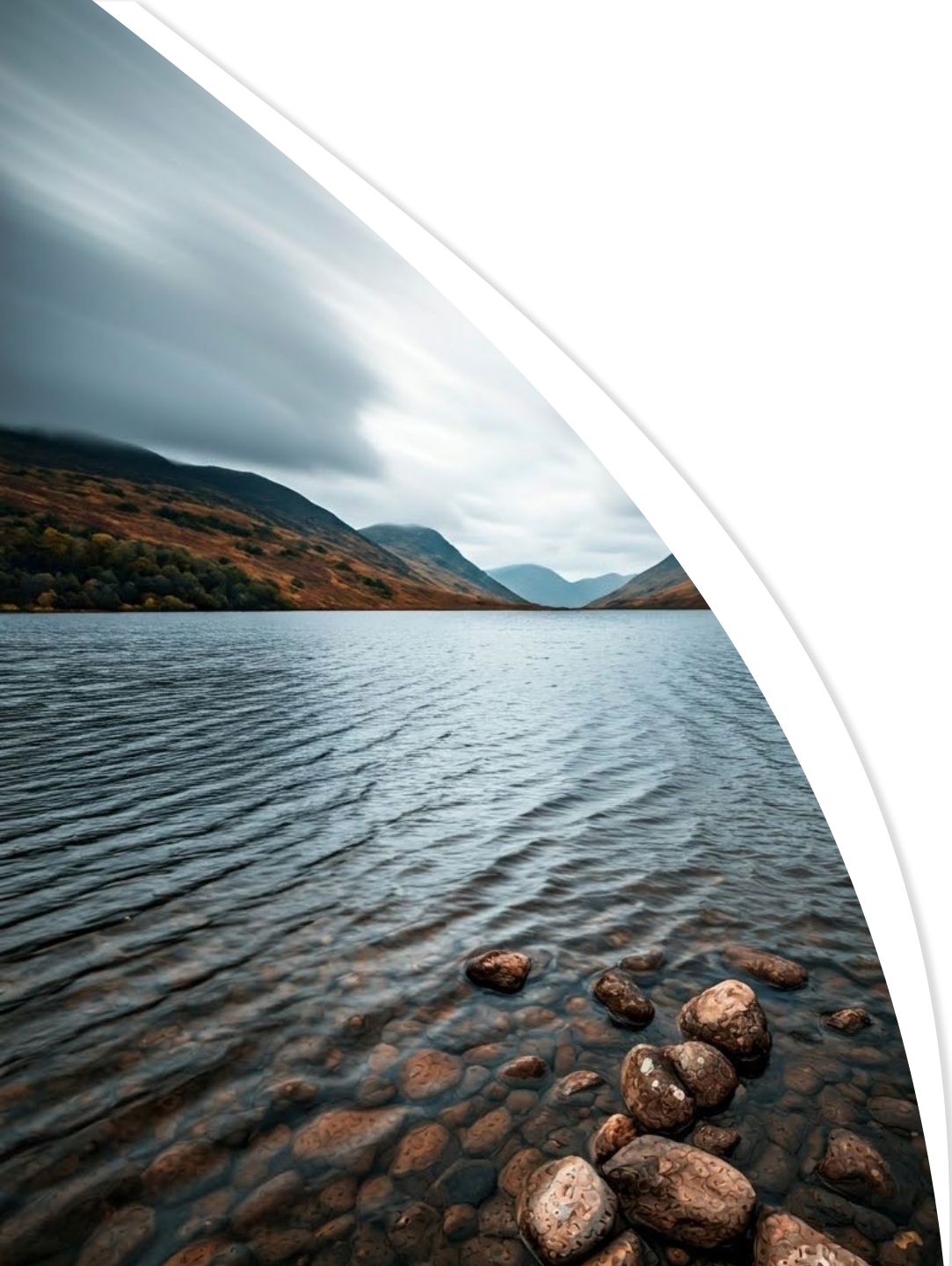
Example Cont.

Timing Concerns (January Group Example):

- July: Town has 4% town reserve funded
- September: Pool issues assessment that depletes town reserve
- October: Pool issues Town 20% increase which includes 9% replenishment
- December: Town has decided to renew for January 1
- March Town Meeting: Taxpayers asked to approve budget that includes replenishing the town's health care stabilization fund reserve ***and*** 20% premium increase
- Taxpayers say no:
  - Town still needs to find a way to rebuild town reserve or SB297 states they can't participate in the pool
  - They can't leave the pool without paying the 9% capital replenishment amount
  - Their reserve is depleted so they can't pay the 9% capital replenishment amount
  - Can't stay in; Can't get out
- **Pool Solvency:** Cash flow depends on *all* Groups paying the assessments and replenishments as needed. If the don't pay them, or don't pay them in a timely manner, pool may become insolvent.

Answer – Rate Correctly?

- Claims are extremely volatile – particularly in recent years.
- Claims trend – driven by increased utilization and new technologies – are extremely large.
- Actuaries make projections based on available data but they do not have crystal balls.
- Appropriate and sufficient reserves are the best protection.



SB297 Would Not Have Prevented Recent Drop in Contingency Reserve

Not Hypothetical - FY2023

- FY2023 started at $64.3M net position (13.5% of upcoming contributions) and ended at $23.7M net position (4.7% of upcoming contributions) – a reduction of $40.6M (8.8% of upcoming contributions)

- Actuarial Gain/Loss Report conducted - shows vast majority of loss due to claims spike

- SB297 would have had no impact
  - Started year at contingency reserve of 13.5% of expected contributions (middle of 12-16% range).
  - No assessments required, no replenishments required

FY2023 – Rated Correctly?

- Rates were adopted as recommended by actuaries with only exception of Cost to Honor GMR listed below.
- Trends spiked during the year, differently than rated.

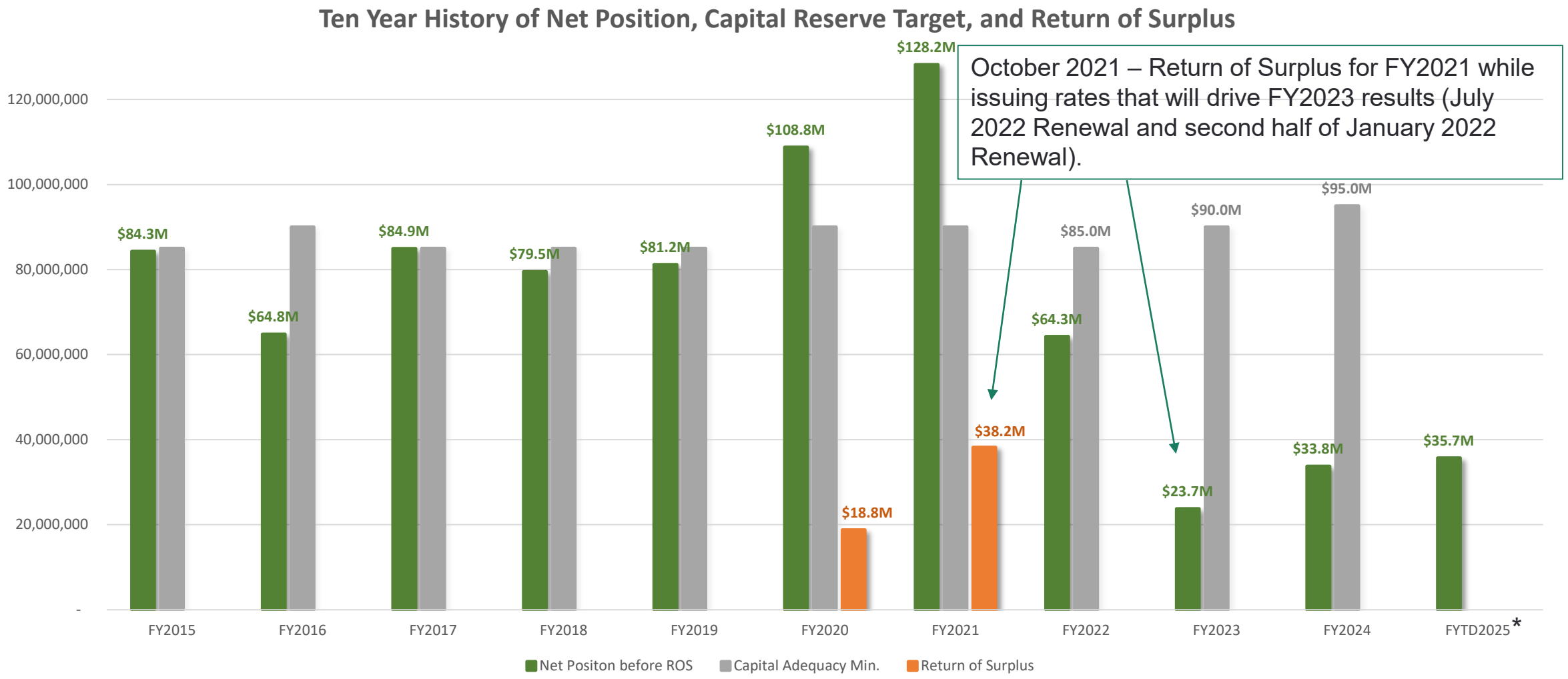
Renewal Period	Actuary Recommended	Board Adopted
July 2022 Renewal Rates (GMR); Adopted October 2021	6.20%	6.20%
July 2022 Renewal Rates (Revisit); Adopted March 2023	6.70%	Adopted Except for Cost to Honor GMR above 1% Assessment
January 2022 Renewal	-0.30%	-0.30%
January 2023 Renewal	5.20%	5.20%

	July 2022 Renewal		Jan 2022 Renewal (6 months)		Jan 2023 Renewal (6 months)	
	Medical	Rx	Medical	Rx	Medical	Rx
Expected Claims	$ 256,807,766	$ 69,385,421	$ 30,745,502	$ 6,884,979	$ 31,825,512	$ 6,694,130
Actual Claims	$ 271,614,017	$ 87,051,130	$ 30,789,400	$ 7,970,612	$ 34,696,536	$ 8,377,683
Gain/(Loss)	$ (14,806,251)	$ (17,665,709)	$ (43,898)	$ (1,085,634)	$ (2,871,024)	$ (1,683,552)
Expected Trend	6.7%	1.7%	10.6%	4.0%	6.2%	2.4%
Actual Trend	10.5%	17.3%	10.6%	12.3%	12.9%	19.9%

- Claims Timing
  - Rating for FY2023 (July 1 2022-June 30, 2023) started in October 2021, looking back at low claims from COVID (Experience period of May 1, 2020 through April 30, 2021) – During this fall rating process, we were returning surplus from FY2021.
  - Claims can change completely over the course of 2 years – that is why sufficient reserves are needed to handle volatility
- Cost to Honor GMR from the July 2022 renewal
  - If full cost were assessed, would have increased year end contingency reserve by 1% of contributions (i.e., approx. 6% year end)
  - Does not avoid the overall reduction in net position that occurred during FY2023 due to claims spike
- Capital Risk Charge/Capital Replenishment
  - By start of FY2023 (July 1, 2022), we were at a contingency reserve of 13.5% of contributions and therefore, under the SB297 model, no capital replenishment would be required.

Reality is that claims are volatile and sufficient reserves are needed to handle volatility.

Reserves in Action



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Impact on Rebuild + Future

SB297 would not have prevented FY2023.

SB297 impact is in how the rebuild occurs and how future bad years are handled.

- This is question of models:

- **HealthTrust's Model**: Starting at 13.5% was too low. Determined to increase reserve target (Board raised target to $122.5M, which is equal to 24% of FY2024 contributions) so as to avoid future similar reduction. Build to that level over several years.

- **SB297 Model**: Starting at 13.5% was fine. Rebuild from 5% to at least 12% in one year. If drop below 4% occurs, assess Groups. If Groups leave, the 7-11% capital replenishment is still due to be paid.

Next Steps and HealthTrust's Focus

Reserves and Volatility

The healthcare industry in America is going through a rapid and volatile evolution with incredible increases in utilization and costs.

The answer to concerns about low reserves and increased volatility *is not to enact a law that lowers reserves and increases volatility* even further.

Real solutions require hard work, collaboration, and agreed-upon objectives with representation from all stakeholders.

HealthTrust is, and remains, available for such collaboration.

HealthTrust's Model under SB297

- Is there a way for HealthTrust's model to continue if SB297 becomes law?
  - As currently drafted, no.
  - HealthTrust's model of rebuilding back to larger reserves and groups being fully protected (fully insured) is explicitly not allowed by the current bill.
  - SB297 requires a new model, further down the spectrum of lower target reserves and increased group responsibility.
- Can HealthTrust transition models to the SB297 model as written?
  - Current belief is no
  - Significant concerns with value to groups and solvency of model
  - Need much more information (actuarial reports, etc.) and time to study and collaborate with all stakeholders on value and viability
  - Need to understand if we would be required (and allowed) to transition to new model (potential change in type of entity, potential transfer of assets, new bylaws, new membership agreements, etc.)
  - Need to understand other changes such as governance structure, ability to prudently manage, ways to navigate through the conflicts inherent in SB297 and alleged against HealthTrust today
  - Value and viability aside, still may not be feasible for HealthTrust to transition to SB297 model (evaluation, corporate structure, governance, bylaws, agreements, rating process, etc.) by next rating cycle (October)

Alternatives?

- We understand, and share, the desire for standards to ensure risk pools are stable and solvent and remain so over the long term.
- Our contingency reserve is reduced today and we agree with the need to rebuild and to protect against future adverse years.
- Existing standards (such as RBC) can be easily transitioned to and provide protection now, while allowing all models of risk pools to exist.
- If the desire is to overhaul the system and only allow certain types of risk pools, much more time and more collaboration is needed with all stakeholders in order to ensure that the resulting model is valuable and viable.

Questions?

THANK YOU!