ACTUARIAL MEMORANDUM

1. General Information

- Company Identifying Information

Company Legal Name:	Anthem Health Plans of New Hampshire, Inc.
State:	New Hampshire
HIOS Issuer ID:	57601
NAIC Company Code:	53759
Market:	Individual
Effective Date:	January 1, 2026

- Company Contact Information

Primary Contact Name:	[redacted]
Primary Contact Email Address:	[redacted]

2. Scope and Purpose of the Filing

This is a rate filing for the Individual market ACA-compliant plans offered by Anthem Health Plans of New Hampshire, Inc., also referred to as Anthem. The policy forms associated with these plans are listed below. The proposed rates in this filing are for a new HMO product that will be effective for the 2026 plan year beginning January 1, 2026, and apply exclusively to off-exchange plans.

Per the filing requirements from New Hampshire Bulletin #INS 25-023-AB, two rate scenarios will be submitted for on-exchange business. The first reflects the continuation of enhanced ACA premium tax credits into the 2026 plan year, which requires an act of congress. The second reflects the expiration of enhanced ACA premium tax credits on December 31, 2025, which is in accordance with current regulation as of July 25, 2025. Since all plans issued in this filing are off-exchange only, the status of the enhanced ACA premium tax credits extension is not applicable. Therefore, only one rate scenario is provided.

In addition, New Hampshire has a Section 1332 State Innovation Waiver for a reinsurance program in the individual ACA market. The reinsurance program is expected to reimburse 41% of paid claims between $60,000 and $400,000 in 2026. The rates included in this filing reflect these reinsurance parameters. A separate rate template without the impact of the reinsurance program is included in the Supporting Documentation tab in SERFF. If the reinsurance parameters change, the rates contained in this filing may require revision.

The Memorandum provides support to the rate development and demonstrates that rates are established in compliance with state laws and provisions of the Affordable Care Act. The rates proposed in this submission reflect the regulatory framework and insurer participation in the market as of July 25, 2025. If the regulatory framework or insurer participation in the market changes after this date, proposed rates may no longer be appropriate and should be reevaluated for revision and resubmission. This rate filing is not intended to be used for other purposes.

Policy Form Number(s):

NH_OFFHIX_HMO_01-26

3. Proposed Rate Increase(s)

Anthem offers ACA plans in the Individual market through two different legal entities in New Hampshire: Anthem Health Plans of New Hampshire, Inc. and Matthew Thornton Health Plan, Inc. This rate filing pertains to the Individual market ACA-compliant plans offered by Anthem Health Plans of New Hampshire, Inc. The Individual off-exchange EPO product offered in plan year 2025 is being terminated, and a new off-exchange HMO product will be introduced for plan year 2026 under this legal entity. The 2024 Individual ACA experience from Anthem Health Plans, also known as the experience rate, has been assigned 0.00% credibility in the rate development since it is not fully credible nor representative of the new Individual HMO off-exchange product being offered in 2026. The proposed rates for the new HMO product have been developed from a manual rate based on Anthem's 2024 ACA Individual off-exchange HMO experience with Matthew Thornton Health Plan. The development of the experience rate and manual rate are described in sections 6 and 7.

The proposed annual rate change for the product in this filing is [redacted]. This methodology aligns with the Unified Rate Review Template. The annual rate change was derived, per guidance, by mapping the terminated EPO plans offered in 2025 plan year to the new HMO plans offered by this legal entity in 2026 plan year. Consequently, the HMO plans incorporating EPO membership and experience are categorized as Renewing in the URRT despite being new plans. Exhibit A shows the rate change for each plan.

Factors that affect the rate changes for all plans include:

- Emerging experience different than projected.
- Trend: This includes the impact of inflation, provider contracting changes, and changes in utilization of services.
- Reinsurance recoveries under a Section 1332 waiver program.
- Benefit modifications, including changes made to comply with updated AV requirements.
- Changes in taxes, fees, and some non-benefit expenses.
- Updated tobacco factors that impact smoker rates.

Although rates are based on the same claims experience, the rate changes vary by plan due to the following factors:

- Changes in benefit design that vary by plan.
- Updates in benefit relativity factors among plans.
- Updated adjustment factors for catastrophic plans.
- Changes in some non-benefit expenses that are applied on a PMPM basis.
- Changes in the claim cost relativity by network.

4. Experience and Current Period Premium, Claims, and Enrollment

The experience period premium and claims reported in Worksheet 1, Section I of the Unified Rate Review Template (URRT) are for the non-grandfathered, single risk pool compliant policies of Anthem Health Plans of New Hampshire legal entity in the Individual market.

• Paid Through Date

The experience reported in Worksheet 1, Section I of the URRT reflects the incurred claims from January 1, 2024 through December 31, 2024 based on claims paid through May 31, 2025.

• Current Date

The Current Date for Current Enrollment and Current Premium PMPM in Worksheet 2, Section II of the URRT is May 31, 2025.

• Experience Period Premium

The earned premium prior to MLR rebate is [redacted] The earned premium reflects the pro-rata share of premium based on policy coverage dates.

[redacted]

• Allowed and Incurred Claims Incurred During the Experience Period

The allowed claims are determined by subtracting non-covered benefits, provider discounts, and coordination of benefits amounts from the billed amount.

Allowed and incurred claims are completed using the chain ladder method, an industry standard, by using historic paid vs. incurred claims patterns. The method calculates historic completion percentages, representing the percent of cumulative claims paid of the ultimate incurred amounts for each lag month. Claim backlog files are reviewed on a monthly basis and are accounted for in the historical completion factor estimates.

[redacted]

5. Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the URRT is as follows:

- Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital-based professionals whose payments are included in facility fees.
- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, and dental services.
- Capitation: Includes all services provided under one or more capitated arrangements.
- Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

6. Experience Rate Projection Factors

The experience period claims in Worksheet 1, Section I of the URRT represent the single risk pool compliant policies of Anthem Health Plans of New Hampshire legal entity in the Individual market as prescribed by URRT methodology. These claims were not relied upon to develop the projected rates. They are projected to the rating period using the factors described below. Exhibit C provides a summary of the experience rate factors.

The factors used to develop the manual rate, which was relied on to develop projected rates, are fully detailed in Section 7 below.

- Trend Factors (cost/utilization)

  - The annual pricing trend used in the development of proposed rates is [redacted]. The trend is developed by normalizing historical benefit expense for changes in the underlying population and known cost drivers, which are then projected forward to develop the pricing trend. Examples of such changes or cost drivers include contracting, cost of care initiatives, workdays, average wholesale price, expected introduction of new brand or generic drugs, changes in medical and pharmacy utilization and other changes in practice patterns. [redacted]

- Changes in Demographics (Normalization)

  The experience period claims are normalized to reflect anticipated changes in age/gender, network, and benefit plan in the projection period. Exhibit D provides detail of each normalization factor below:

  - Age/Gender: The assumed claims cost is applied by age and gender to the experience period membership distribution and the projection period membership distribution.
  - Network: The network claims factors are developed based on an analysis of allowed claims by network.
  - Benefit Plan: The experience period claims are normalized to reflect the average benefit level in the projection period using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements.

- Plan Design Changes

  Changes in benefits include the following items. Exhibit E shows each adjustment factor.

  - Rx Adjustments: Adjustments are made to reflect differences in the Rx formulary, Rx networks and discounts, and mail order programs between the experience period and the projection period.

- Other Adjustments

  Other adjustments to the experience claims data include the following items. Exhibit E and Exhibit F show the factors used for each adjustment.

  - Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections take into account the most up-to-date information regarding anticipated rebate contracts, drug prices, anticipated price inflation, and upcoming patent expirations.
  - Projected costs of pediatric vision benefits are included.

7. Manual Rate Adjustments

The Anthem Health Plans of New Hampshire off-exchange EPO experience period claims are not 100% credible based on the credibility method used. In addition, they are not representative of the new HMO off-exchange product to be offered in the projection period. Therefore, a manual rate was used in the rate development and assigned 100% credibility weight. The section below provides details of how the manual rate was developed.

Experience used and projected herein is the January 2024 through December 2024 Individual ACA experience of Anthem's off-exchange HMO experience under the Matthew Thornton Health Plan legal entity. The experience has been adjusted by the factors below in developing the projected claims. Exhibit C provides a summary of the of the manual rate factors.

- Source and Appropriateness of Experience Data Used

The source data used for the manual rate is Anthem's Individual ACA off-exchange HMO experience under the Matthew Thornton Health Plan legal entity with incurred date from January 1, 2024 through December 31, 2024 and paid through May 31, 2025. The Matthew Thronton Health Plan off-exchange HMO product will be terminated at the end of plan year 2025, and members currently enrolled in this product are anticipated to enroll in the new Anthem Health Plans of New Hampshire off-exchange HMO product. Therefore, the manual rate claims will most likely reflect the anticipated experience in the projection period. Exhibit B provides manual claims detail.

- Adjustments Made to the Data

The source data underlying the manual rate has been adjusted by the factors below in developing the projected claims. The manual rate column in Exhibit C has details.

Trend Factors (cost/utilization)

- The annual pricing trend used in the development of proposed rates is [redacted]. The trend is developed by normalizing historical benefit expense for changes in the underlying population and known cost drivers, which are then projected forward to develop the pricing trend. Examples of such changes or cost drivers include contracting, cost of care initiatives, workdays, average wholesale price, expected introduction of new brand or generic drugs, changes in medical and pharmacy utilization and other changes in practice patterns. [redacted]

Changes in Demographics (Normalization)

The data underlying the manual rate is normalized to reflect anticipated changes in age/gender, area, network, and benefit plan in the projection period. Exhibit D provides detail of each normalization factor below:

- Age/Gender: The assumed claims cost is applied by age and gender to the source data membership distribution and the projection period membership distribution.
- Network: The area claims factors are developed based on an analysis of allowed claims by network.
- Benefit Plan: The source data is normalized to reflect the average benefit level in the projection period using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements.

Plan Design Changes

Changes in benefits include the following items. Exhibit E shows each adjustment factor.

- Rx Adjustments: Adjustments are made to reflect differences in the Rx formulary, Rx networks and discounts, and mail order programs between the experience period and the projection period.

Other Adjustments

Other adjustments to the manual rate data include the following items. Exhibit E and Exhibit F show the factors used for each adjustment.

- Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections take into account the most up-to-date information regarding anticipated rebate contracts, drug prices, anticipated price inflation, and upcoming patent expirations.
- Projected costs of pediatric vision benefits are included.

8. Credibility of Experience

- Credibility Method Used

Based on an analysis of historical data, the standard for fully credible experience is [redacted] members.

To determine credibility, the following formula was used: square root(experience period members / [redacted])

- Resulting Credibility Level Assigned to Base Period Experience

With [redacted] members, the single risk pool experience period data is not fully credible. In addition, the experience is not representative of the new HMO off-exchange product to be offered in the projection period, so the credibility level assigned is 0.00%. With [redacted] members, the manual rate data is fully credible. It has been assigned 100% credibility to develop rates as shown in Exhibit C.

9. Establishing the Index Rate

- Experience Period Index Rate

The experience period Index Rate is equal to the allowed claims PMPM for the essential health benefits of Anthem's non-grandfathered business in the Individual market. The experience period Index Rate is [redacted] A comparison to the benchmark was performed, and only essential health benefits were covered during the experience period.

- Projection Period Index Rate

The projection period Index Rate is equal to projected allowed claims PMPM for the essential health benefits of Anthem's non-grandfathered business in the Individual market. It reflects the anticipated claim level of the projection period including impact from trend, benefit and demographics as described in Section 7 of this memo.

The projected Index Rate is reported in Worksheet 1, Section II, cell F42 of the URRT and is also shown in Exhibit C. No benefits in excess of the essential health benefits have been included in this amount.

10. Development of the Market-wide Adjusted Index Rate

The Market-wide Adjusted Index Rate is calculated as the Index Rate adjusted for all allowable market-wide modifiers defined in the market rating rules. The three market-wide adjustments - Risk Adjustment, Reinsurance, and Exchange User Fee adjustment - are described below. In compliance with URR Instructions, these adjustments were applied on an allowed basis in the development of the Market-wide Adjusted Index Rate. Exhibit C illustrates the development of the Market-wide Adjusted Index Rate.

- Projected Risk Adjustments PMPM

Projection period risk adjustments are estimated based on the HHS payment transfer formula. The final CMS 2024 risk adjustment transfer is used to develop the assumptions for the company's relative risk to the market. Projected changes in population movements and demographics that may affect risk adjustments are also considered, as well as the impact of high-cost risk pooling.

The projected risk adjustment PMPMs reported in Worksheet 2 of the URRT are on a paid claim basis, while the projected amount applied to the development of Market-wide Adjusted Index Rate is on an allowed claim basis. Exhibit C and Exhibit G provide details.

- Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

Beginning in 2017, the Federal reinsurance program is no longer in effect. The projected reinsurance amount is $0.

The impact of the reinsurance program established by State Relief and Empowerment Waivers under section 1332 of the ACA is displayed in Exhibit C and Exhibit G. The impact of reinsurance in Worksheet 1 of the URRT is on an allowed basis.

The reinsurance amount consists of the contribution fee on an allowed claims basis for the expected 1332 waiver reinsurance program for the individual ACA market. Exhibit G provides details.

- Exchange User Fees

Exchange User Fee: The Exchange User Fee is set to zero for this legal entity since Anthem will not be participating in the Exchange at this time.

11. Plan Adjusted Index Rate

The Plan Adjusted Index Rate is calculated as the Market-wide Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules. Exhibit J shows the development. The plan level modifiers are described below:

- AV and Cost Sharing Adjustments: This is a multiplicative factor that adjusts for the projected paid/allowed ratio of each plan, based on the AV metal value with an adjustment for utilization differences due to differences in cost sharing.
- Provider Network Adjustments: This is a multiplicative factor that adjusts for differences in projected claims cost due to different network discounts.
- Adjustments for Benefits in Addition to the Essential Health Benefits: A factor of 1.00 indicates that the plan does not provide benefits beyond the essential health benefits.
- Catastrophic Plan Adjustment: This adjustment reflects the projected costs of the population eligible for catastrophic plans. The catastrophic adjustment factor is applied to catastrophic plans only; all other plans have an adjustment factor of 1.0.
- Adjustments for Distribution and Administrative Cost: This is an additive adjustment that includes all the selling expense, administration and retention Items shown in Exhibit H.

12. Calibration

The Plan Adjusted Index Rate is calibrated by the Age and Tobacco factors so that the schedule of premium rates for each plan can be further developed. Exhibit K shows the calibration factors.

- Age Curve Calibration

  The age factors are based on the Default Federal Standard Age Curve. The age calibration adjustment is calculated as the member weighted average of the age factors, using the projected membership distribution by age, with an adjustment for the maximum of 3 child dependents under age 21. Under this methodology, the approximate average age rounded to the nearest whole number for the risk pool is [redacted].

- Tobacco Factor Calibration

  The tobacco calibration adjustment is calculated as the member weighted average of the tobacco factors, using the projected membership distribution by age, with an adjustment for the maximum of 3 child dependents under age 21.

13. Consumer Adjusted Premium Rate Development

The Consumer Adjusted Premium Rate is calculated by calibrating the Plan Adjusted Index Rate by the Age and Tobacco calibration factors described above, and applying consumer specific age and tobacco status rating factors. Exhibit N has the sample rate calculations.

14. Projected Loss Ratio

- Projected Federal MLR

  Exhibit I shows the projected Federal MLR for the products in this filing. The calculation is an estimate and is not meant to be a true measure for Federal or State MLR rebate purposes. Note that the projected Federal MLR presented here does not capture all adjustments, including but not limited to: three-year averaging, credibility, dual option, and deductible. Anthem's projected MLR is expected to meet or exceed the minimum MLR standards at the market level after including all adjustments.

15. Actuarial Value Metal Values

The Actuarial Value (AV) Metal Values reported in Worksheet 2, Section I of the URRT are based on the AV Calculator. To the extent a component of the benefit design was not accommodated by an available input within the AV Calculator, the benefit characteristic was adjusted to be actuarially equivalent to an available input within the AV Calculator for purposes of utilizing the AV Calculator as the basis for the AV Metal Values. When applicable, benefits for plans that are not compatible with the parameters of the AV Calculator have been separately identified and documented in the Unique Plan Design Supporting Documentation and Justification that supports the Plan & Benefits Template.

16. Membership Projections

Membership projections are reported in Worksheet 2, Section IV of the URRT. They are based on historical and current enrollment as well as expected new sales and lapses. The termination of the off-exchange EPO product under Anthem Health Plans of New Hampshire legal entity and the off-exchange HMO product under the Matthew Thronton legal entity also impact the projected enrollment. Members currently enrolled in these products are anticipated to enroll in the new Anthem Health Plans of New Hampshire off-exchange HMO product as developed from the methodology described in this memorandum.

17. Terminated Plans and Products

Exhibit O provides a listing of products from 2024 and 2025 that will be terminated prior to January 1, 2026.

Exhibit P provides a listing of 2024 and 2025 plans that will be terminated prior to January 1, 2026. The mapping of terminated EPO plans to the new plans is also included. The members currently enrolled in the 2025 EPO plans have been mapped to off-exchange 2026 HMO plans in the URRT. Therefore, the applicable 2025 EPO plans are not included as terminated plans in Worksheet 2 of the URRT.

18. Plan Type

The plan type for each plan reported in Worksheet 2, Section I of the URRT is consistent with the option chosen from the drop-down box.

19. Reliance

In support of this rate development, various data and analyses were provided by other members of Anthem's actuarial staff, including data and analysis related to cost of care, valuation, and pricing. I have reviewed the data and analyses for reasonableness and consistency. I have also relied on [redacted] to provide the actuarial certification for the Unique Plan Design Supporting Documentation and Justification for plans included in this filing.

20. Actuarial Certification

I, [redacted], am an actuary for Elevance Health, the holding company of Anthem. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. I hereby certify that the following statements are true to the best of my knowledge with regards to this filing:

(1) The projected Index Rate is:

- In compliance with all applicable state and Federal statutes and regulations (45 CFR 156.80 and 147.102)
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Not excessive nor deficient

(2) The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 156.80(d)(2) were used to generate plan level rates.

(3) The geographic rating factors reflect differences in the costs of delivery (which can include unit cost and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

(4) The most recent approved AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate changes, for certification of Qualified Health Plans for Federally-Facilitated Exchanges, and for certification that the Index Rate is developed in accordance with Federal regulation, used consistently, and only adjusted by the allowable modifiers. However, this Actuarial Memorandum does accurately describe the process used by the issuer to develop the rates.

The rates proposed in this submission reflect the regulatory framework and insurer participation in the market as of July 25, 2025. If the regulatory framework or insurer participation in the market change after this date, proposed rates may no longer be appropriate and should be reevaluated for revision and resubmission. Issuer market entry and exit can have a significant impact on rates through the risk adjuster mechanisms in the ACA and create a need for reconsideration and revision of proposed premium rates.