SUPPLEMENTAL REPORT
OF THE
2013
HEALTH INSURANCE MARKET
IN
NEW HAMPSHIRE

January 14, 2015

Prepared by the New Hampshire Insurance Department
SUPPLEMENTAL REPORT
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By law, the Insurance Commissioner is authorized to prescribe the format and content of financial and other reports filed by insurers licensed in New Hampshire. The data submitted in the Supplemental Report are critical to understanding and evaluating the New Hampshire health insurance market. The data are collected annually, and this report is based on activity during the calendar year 2013.

"Situs" of a policy is defined as the jurisdiction in which the policy is issued or delivered as stated in the policy. For employer business issued through a qualified association trust, the situs shall be based on the location of each member employer. Carriers are instructed to apply the same consideration when determining situs for this report as they do when preparing the NAIC Supplemental Health Care Exhibit. TPAs shall determine situs of their contracts in a similar manner. The Supplemental Report collects more detailed data for NH situs members than for non-NH situs members.

For this 2013 Supplemental Report, several changes have been made to the reporting requirements. Most notably, the definition and calculation of the Actuarial Value has changed (refer to the Data Notes section for more specific information on this change). As a result, 2012 data was resubmitted according to 2013 instructions, and tables from the 2012 Supplemental Report have been restated using this new data in Appendix C of this report. This will allow for a consistent comparison between 2012 and 2013 in this 2013 Supplemental Report.

Summary findings are presented first, followed by more detailed analyses. For those who are not familiar with the data collected in the Supplemental Report, you are encouraged to start with the Supplemental Report History, Data Collected, and Data Notes sections at the end of the report.

TRADITIONAL HEALTH INSURANCE POLICIES

Presented below are summary statistics about traditional health insurance data submitted to the NHID. These data include members insured and members covered by self funded policies but do not include members with limited coverage and/or limited eligibility products such as Stoploss, Student, and High Risk Pool. Due to the unique nature and features of these limited policies, data for these policies have been excluded from the report with the exception of a table at the end of the report that summarizes the 2013 premium and claim experience of members enrolled in these limited policy types.

<u>SUMMARY STATISTICS FOR TRADITIONAL HEALTH INSURANCE POLICIES</u>

NH SITUS STATISTICS

- Total premiums and premium equivalents = $2,503,087,497
- Total claims = $2,161,229,955
- Average loss ratio = 86.3%
- Average number of members insured = 470,266
- Average member premium per month:
  - Large Group $458
  - Small Group $449
  - Non-group $296

Table 1:
All Members, by Market Category and Policy Situs

	NH Situs	non-NH Situs	Total
Large Group	346,536	151,619	**498,156**
Small Group	86,740	9,276	**96,016**
Non-Group	36,991	45	**37,035**
Total	**470,266**	**160,940**	**631,206**

Table 2:
Small Group Members

	NH Situs	non-NH Situs	Total
Groups of 1 Employee	2,200	419	**2,619**
Groups of 2 to 50 Employees	84,540	8,857	**93,397**

Table 3:
Membership Distribution by Market Category

	NH Situs	non-NH Situs	Total
Large Group	55%	24%	**79%**
Small Group	14%	1%	**15%**
Non-Group	6%	0%	**6%**
Total	**75%**	**25%**	**100%**

Table 4:
Percentage of Members within each Market/Situs that are Fully Insured

	NH Situs	non-NH Situs	Total
Large Group	30%	20%	**27%**
Small Group	99%	97%	**99%**
Non-Group	100%	100%	**100%**
Total	**48%**	**24%**	**42%**

HIGH DEDUCTIBLE HEALTH PLANS

- Percent of members in an IRS defined High Deductible Health Plan (HDHP) for NH situs members is 16%, compared to 15% in 2012.

DEDUCTIBLES

Most common deductible amounts, based on percent of covered members (NH situs only):

- $0 – 28%
- $500 – 6%
- $1,000 – 7%
- $2,000 – 10%
- $3,000 – 16%
- $5,000 – 6%

CO-INSURANCE

Most common co-insurance amounts, based on percent of covered members (NH situs only):

- 0% co-insurance - 94%
- 10% co-insurance - 5%
- 20% co-insurance - 1%

COPAYS*

Most common copay amounts, based on percent of covered members (NH situs only):

- $0 – 10%
- $5 – 7%
- $10 – 10%
- $15 – 12%
- $20 – 21%
- $25 – 33%

* Note that for the 2013 Supplemental Report the instructions clarified that the copay reported was specified to be the primary care physician (PCP) copay.

DETAILED ANALYSES

HIGH DEDUCTIBLE HEALTH PLANS (HDHPs)

Data are identified for members enrolled in a high deductible health plan based on whether the policy qualified as an IRS defined high deductible health plan during the calendar year 2013. In 2013, the IRS definition included policies with a minimum deductible of $1,250 for an individual and $2,500 for a family.

The overall percentage of NH Situs members in a HDHP is 16 percent. This represents an increase from 2012, when the percentage of NH Situs members enrolled in an HDHP

was 15 percent. The highest penetration remains in the non-group market segment where 45% of members were enrolled in a HDHP in 2013. The large group market experienced an increase from 12% to 13% HDHP penetration in 2013, while the small group market remained at a level of 15%.

As with all tables shown in the report, both self-insured and fully-insured members are included in the large and small group columns. Self/Fully-insured columns are NOT mutually exclusive from the Large/Small/Non-Group columns. Percentages are always determined for data within each column. Tables from 2013 and 2012 are below.

Table 5:
2013 High Deductible Health Plan Coverage

Situs	HDHP	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
NH Situs	No	84%		89%	78%		87%	85%	55%
NH Situs	Yes	16%		11%	22%		13%	15%	45%
NH Situs Members		**470,266**		**242,305**	**227,961**		**346,536**	**86,740**	**36,991**

Table 6:
2012 High Deductible Health Plan Coverage

Situs	HDHP	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
NH Situs	No	85%		92%	79%		88%	85%	61%
NH Situs	Yes	15%		8%	21%		12%	15%	39%
NH Situs Members		**480,575**		**243,945**	**236,630**		**348,177**	**91,553**	**40,845**

Observations:

- The HDHP overall penetration rate grew slightly in 2013 from 2012.
- HDHP penetration rates for NH Situs increased in the Self-Insured, Fully-Insured, Large Group, and Non-Group market segments.
- HDHP penetration rates remained the same in the Small Group market segment. This may be due to movement towards HMO products in the Small Group market segment. Many HMO products do not meet the criteria for high deductible health plans. In 2012, 76% of the Small Group members were in HMO products compared to 78% in 2013.

AVERAGE PREMIUMS

The average premium is a calculated rate, based on the total amount paid by the policyholder to the carrier/TPA for health coverage, divided by covered member months. Categorizations by market segment (Non-Group, Small Group, Large Group), insurance status (self-insured, fully-insured), and plan type (HMO, POS, PPO, EPO, Indemnity) are important given that many of the New Hampshire insurance laws differ among the classifications shown. For example, for 2013 carriers are allowed to adjust individual rates for differences in age, health status, and tobacco use. For 2013, in Small Group, rates may be adjusted for differences in age, number of employees enrolled, and type of industry. In Large Group, the rates issued to an employer typically reflect historical claim experience of that employer group. Since the premiums are aggregated across carriers, average premium values will not represent the actual premium charged for a particular policy, but will reflect the aggregation of the benefit designs, product pricing strategies, and rating factors utilized by all carriers. Only NH Situs average premiums

per member per month by market category and plan type are shown below as this information is no longer collected for non-NH Situs.

Table 7:
Average Premium PMPM by Market Category and Plan Type

Market Category	Plan Type	Self-Insured* Members	Self-Insured* Avg Premium	Fully Insured Members	Fully Insured Avg Premium
Large Group	HMO	81,583	$449	64,016	$461
	POS	30,519	$497	3,203	$490
	PPO	124,667	$452	32,214	$445
	EPO	788	$648	4,273	$423
	Indemnity	3,800	$573	1,472	$460
Small Group	HMO	No Membership Reported		67,699	$445
	POS			1,211	$448
	PPO	948	$535	13,995	$450
	EPO	No Membership Reported		2,887	$503
	Indemnity	No Membership Reported		No Membership Reported	
Non-Group	HMO**	No Membership Reported		27	$1,156
	POS			0	-
	PPO			35,379	$301
	EPO**			4	$435
	Indemnity**			1,580	$172
Total		**242,305**	**$459**	**227,961**	**$427**

*A premium equivalent is provided for self-insured policyholders. Please see the Data Notes section for additional information regarding the calculation methodology.
** Due to limited membership, Non-Group Indemnity, EPO, and HMO values are disproportionately affected by outlier data. Please see Data Notes section for additional information on outlier data.

Observations:

- In the fully-insured market, most people are covered by HMO plans in the group market while most people are covered by PPO plans in the non-group market.
- The most popular self-insured plans are PPO plans, while the majority of fully-insured members are enrolled in HMO plans.
- HMO average premiums per member in the group market ranged from $445 to $461, compared to $1,156 in the non-group market.
- The high $1,156 premium pmpm in the non-group segment represents the average premium for a very small number of members and may reflect an older population and/or higher than average benefit richness.
- Significantly lower average premiums for PPO and Indemnity in the non-group market may be attributable to the ability of carriers to underwrite for health status and to lower overall benefit richness in that segment.
- Self Insured premiums are slightly higher than fully insured premiums overall. This is true despite lower tax and risk charge levels in self-insured plans. The higher self-insured premium pmpm is due to higher benefit richness with the self-

insured plans, where for example, a much greater portion of the membership has no deductible.

Average Premium and Benefit Richness

Benefit richness is measured using an actuarial value that can be used to compare benefit plans with different member cost sharing levels. Actuarial value is a percentage calculated as the ratio of the covered benefits after member cost sharing to the total allowed costs of standard covered benefits with no cost sharing. When comparing two health benefit plans, the plan with the higher actuarial value can be assumed to have richer benefits. For example, if Plan A has a $1,000 deductible with 100% coverage thereafter and Plan B has a $2,000 deductible with 100% coverage thereafter, with all other benefit provisions being the same, Plan A clearly has a higher actuarial value than Plan B. However, if Plan C has a $1,000 deductible but then the member has to pay 20% coinsurance until reaching an out-of-pocket maximum of $3,000 (including the deductible), Plan A clearly has a higher actuarial value and richer benefits than Plan C, but the comparison between Plans B and C is not as straightforward. The actuarial values of Plans B and C can be compared to determine which plan has richer benefits.

For the 2012 Supplemental Report and prior, actuarial value was defined as the health coverage plan rate for each coverage option to the health coverage plan rate for the corresponding standard health benefit plan designs (HMO, PPO, POS, Indemnity) as defined for the New Hampshire Small Employer Reinsurance Pool.

Beginning with this 2013 Supplemental Report, actuarial value in this report is defined as the Minimum Value measure as outlined in Section 1302 (d)(2)(C) of the Affordable Care Act. In accordance with the HHS regulations there are several options for determining the Minimum Value:

1) Determine the Minimum Value figure using the most recent version of the publically available Minimum Value Calculator Excel model tool which can be downloaded from the CMS website.
2) Determine the Minimum Value figure through any safe harbor established by HHS and IRS.
3) For plans incompatible with the Minimum Value Calculator or Safe Harbor Plan, the Minimum Value figure may be determined through an actuarial certification from a member of the American Academy of Actuaries.

For each set of reported coverage options, carriers and TPAs were required to report the Minimum Value in accordance with the three options mentioned above. In circumstances where benefits were incompatible with the calculator and certification was not readily available, a reasonable estimate based on comparison to similar plan designs was allowed to be reported.

In previous versions of the Supplemental Report, it was not possible to compare actuarial values across different product types. Comparisons could only be made within the same plan type category (e.g. only compare HMO benefit richness values to other HMO values). This new Actuarial Value methodology allows for comparisons across benefit

plan type. For example, it is now possible to have a valid benefit richness comparison between HMO products and PPO products.

It is important to note that the methodology used to calculate the actuarial values presented in this report are based on the Minimum Value calculator and are slightly different than actuarial values that are produced with the Actuarial Value calculator due to differences in the data and modeling underlying the two calculators.

Below is a NH Situs-only comparison table of average premiums and benefit richness (actuarial values) between the Small and Large Group markets and the Non-Group market.

Table 8:
Average Premium PMPM and Benefit Richness by Market Category and Plan Type

		Self-Insured*			Fully Insured		
Plan Type	**Market Category**	**Members**	**Avg Premium**	**Benefit Richness**	**Members**	**Avg Premium**	**Benefit Richness**
HMO	Large Group	81,583	$449	0.92	64,016	$461	0.81
	Small Group	No Membership Reported			67,699	$445	0.79
	Non-Group**	No Membership Reported			27	$1,156	0.90
POS	Large Group	30,519	$497	0.94	3,203	$490	0.78
	Small Group	No Membership Reported			1,211	$448	0.71
	Non-Group	No Membership Reported			No Membership Reported		
PPO	Large Group	124,667	$452	0.87	32,214	$445	0.79
	Small Group	948	$535	0.84	13,995	$450	0.77
	Non-Group	No Membership Reported			35,379	$301	0.72
EPO	Large Group	788	$648	0.91	4,273	$423	0.73
	Small Group	No Membership Reported			2,887	$503	0.76
	Non-Group**	No Membership Reported			4	$435	0.80
Indemnity	Large Group	3,800	$573	0.99	1,472	$460	0.92
	Small Group	No Membership Reported			No Membership Reported		
	Non-Group**	No Membership Reported			1,580	$172	0.69
Total Members		**242,305**	**$459.41**	**0.89**	**227,961**	**$426.71**	**0.78**

*A premium equivalent is provided for self-insured policyholders. Please see the Data Notes section for additional information regarding the calculation methodology.
** Due to limited membership, Non-Group Indemnity, EPO, and HMO values are disproportionately affected by outlier data. Please see Data Notes section for additional information on outlier data.

Observations:

- For the HMO products, the average premium for fully-insured Large Group is higher than for fully-insured Small Group, but some of the difference can be explained by the less rich benefits in the Small Group market.

- For HMO Large Group, the average premium for self-insured is 3% percent lower than the average premium for fully-insured HMO, but the value of the self-insured benefits is about 14 percent greater than the value of the fully-insured benefits.
- The fully-insured large group POS premiums are about 1 percent less than the self-insured Large Group POS premiums, and the benefit richness for the fully-insured members is 17 percent less than the benefit richness for the self-insured members.
- For PPO Large Group, the self-insured premium is 2 percent higher than the fully-insured premium and the self-insured benefits are 10 percent richer.
- The average premium for PPO Large Group fully-insured is 1 percent lower than the average PPO premium for the Small Group segment; however the richness of the benefit value for Large Group is about 3% greater.
- The average premium for PPO Non-group is 48% lower than for PPO Large Group; however the benefits for PPO Non-group are 10% less rich than for PPO Large Group. The lower benefit richness in the Non-group segment is likely attributable to more members being enrolled in high deductible plans and enrolled in plan designs with higher coinsurance percentages.
- Policies under the Indemnity plan type vary extensively with respect to benefit richness and premiums.

The table below provides comparative information of NH Situs policies for 2012 and 2013. The "Change in Value" reflects the total overall change in both premiums and benefit richness. If premiums go up by five percent and benefit richness goes down by five percent, the total change in value is equal to negative ten percent. No adjustments are made for inflation, changes in taxes, fees and assessments, or for changes in the underlying risk of the members (due to factors such as age, health status, etc.), which may also be contributing factors to the change in average premium.

Table 9:
2013 to 2012 Change in Value

Plan Type	Market Category	Members 2012	Members 2013	Avg Premium* 2012	Avg Premium* 2013	Benefit Richness 2012	Benefit Richness 2013	Change in Value
HMO	Large Group	154,862	145,599	$463	$454	0.88	0.86	0%
	Small Group	69,702	67,699	$427	$445	0.80	0.79	-5%
	Non-Group**	4,762	27	$206	$1,156	0.89	0.90	-461%
POS	Large Group	44,472	33,722	$489	$496	0.93	0.92	-2%
	Small Group	1,322	1,211	$431	$448	0.72	0.71	-5%
	Non-Group	No Membership Reported						
PPO	Large Group	137,651	156,882	$430	$450	0.84	0.85	-4%
	Small Group	15,376	14,942	$443	$455	0.78	0.77	-4%
	Non-Group	34,606	35,379	$302	$301	0.72	0.72	0%
EPO	Large Group	5,817	5,061	$367	$458	0.76	0.76	-24%
	Small Group	5,091	2,887	$457	$503	0.76	0.76	-10%
	Non-Group**	4	4	$559	$435	0.70	0.80	36%
Indemnity	Large Group	5,375	5,272	$553	$541	0.97	0.97	2%
	Small Group	62	0	$508		0.90		
	Non-Group**	1,473	1,580	$191	$172	0.62	0.69	20%
Total Members		**480,575**	**470,266**	**$435**	**$444**	**0.85**	**0.84**	**-3%**

*A premium equivalent is provided for self-insured policyholders. Please see the Data Notes section for additional information regarding the calculation methodology.
** Due to limited membership, Non-Group Indemnity, EPO, and HMO values are disproportionately affected by outlier data. Please see Data Notes section for additional information on outlier data.

Observations include:

- HMO Large Group represents about 31 percent of the membership, and the value of the insurance for these members remained about the same from 2012 to 2013.
- Small Group HMO experienced an increase in average premium levels between 2012 and 2013, while the value of insurance for these members declined by 5 percent.
- Non-group HMO saw a significant decline in membership from 4,762 members in 2012 down to 27 members in 2013. Starting July 1, 2012, children covered by Healthy Kids Silver through Harvard Pilgrim Health Care and included in the Supplemental Report were moved to Medicaid which is not included in the Supplemental Report. Since children on average are healthier and less costly to insure than adults, the Non-group HMO premiums should not be compared across years, and the 2012 Non-group HMO premium should not be compared to the 2012 Large Group and 2012 Small Group premiums.

- The value for POS Small Group decreased by 5 percent, while the value for POS Large Group decreased by 2 percent between 2012 and 2013. Both segments experienced an increase in premium and a decrease in benefit richness.
- PPO Large Group, representing about 33% of the membership, experienced an increase in premium that was greater than the small increase in benefit richness, resulting in a 4% decline in value from 2012 to 2013. Small Group saw a similar decline in value caused by a small decrease in benefit richness coupled with an increase in premium.
- The majority of Non-Group members are enrolled in PPO products, and this segment held its value between 2012 and 2013, with no material premium or benefit richness change.
- The Indemnity plan type saw extensive variability with respect to average premiums and benefit richness. This type of variability is often observed when analyzing plans with small membership populations and shifting membership.
- In a number of cases, the value of benefits decreased while premiums increased, which will always result in a reduction in the value of the insurance coverage.
- In some cases the average premium decreased from 2012 to 2013, such as Large Group HMO, Non-Group EPO, Large-Group Indemnity and Non-Group Indemnity.

Average Premium and Adjusted Premium

With the actuarial value, average premiums can be adjusted based on the value of the benefits. This allows a more direct comparison, within each Plan Type, of what different policies would cost if the value of the covered benefits were the same; however, not all factors are adjusted for, such as changes due to age, health status, and other rating considerations. To the extent that those factors affect average premium levels, the adjusted premium values are not directly comparable. In some cases, membership is less than 0.5 percent and is shown as 0% due to rounding.

Table 10:
Average Premium and Adjusted Premium by Plan Type, Market Category, and Coverage Type

		Self-Insured*			Fully Insured		
Plan Type	**Market Category**	**Members**	**Avg Premium**	**Adjusted Premium**	**Members**	**Avg Premium**	**Adjusted Premium**
HMO	Large Group	34%	$449	$491	28%	$461	$569
	Small Group	No Membership Reported			30%	$445	$564
	Non-Group**	No Membership Reported			0%	$1,156	$1,285
POS	Large Group	13%	$497	$529	1%	$490	$628
	Small Group	No Membership Reported			1%	$448	$628
	Non-Group	No Membership Reported			No Membership Reported		
PPO	Large Group	51%	$452	$520	14%	$445	$561
	Small Group	0%	$535	$639	6%	$450	$586
	Non-Group	No Membership Reported			16%	$301	$417
EPO	Large Group	0%	$648	$713	2%	$423	$579
	Small Group	No Membership Reported			1%	$503	$658
	Non-Group**	No Membership Reported			0%	$435	$543
Indemnity	Large Group	2%	$573	$580	1%	$460	$500
	Small Group	No Membership Reported			No Membership Reported		
	Non-Group**	No Membership Reported			1%	$172	$250
Total Members		**242,305**			**227,961**		

*A premium equivalent is provided for self-insured policyholders. Please see the Data Notes section for additional information regarding the calculation methodology.
** Due to limited membership, Non-Group Indemnity, EPO, and HMO values are disproportionately affected by outlier data. Please see Data Notes section for additional information on outlier data.

Observations:

- For PPO and EPO fully-insured group plans, the premiums adjusted for benefit differences is inversely correlated with group size. Small groups have a higher adjusted premium than large groups. For HMO, large groups have slightly higher adjusted premium than small groups and for POS the adjusted premiums are the same between large groups and small groups.
- There are only 27 members in Non-group HMO for 2013, so the very high average premium shown above may be skewed by the age and health status of a few members.
- Adjusted Non-Group PPO premiums are 29 percent lower than adjusted Small Group premiums. This may be due to underlying population differences between the Non-group and Small Group markets.
- Large Group adjusted premiums are higher for fully-insured members as compared to self-insured members in the HMO, POS and PPO products.

Health insurance benefits and medical care utilization by state and municipal employees are frequently considered unique. The following table shows the same calculations for each of these account types.

Table 11:
Average Premium and Adjusted Premium by Account Type

Plan Type	Account Type	Percent of Members	Avg Premium*	Benefit Richness	Adjusted Premium*
HMO	State	5%	$465	0.90	$517
	Municipal	10%	$456	0.93	$492
	Healthy Kids	No Membership Reported			
	All Other Accounts	30%	$447	0.80	$557
POS	State	1%	$593	0.90	$659
	Municipal	4%	$494	0.97	$510
	All Other Accounts	2%	$431	0.80	$542
PPO	State	0%	$505	0.90	$561
	Municipal	0%	$606	0.90	$676
	All Other Accounts	44%	$423	0.83	$512
EPO	State	No Membership Reported			
	Municipal	No Membership Reported			
	All Other Accounts	2%	$474	0.76	$621
Indemnity	State	No Membership Reported			
	Municipal	0%	$776	1.00	$779
	All Other Accounts	1%	$318	0.88	$360
Total Members		**470,266**	**$444**	**0.84**	**$528**

*A premium equivalent is provided for self-insured policyholders. Please see the Data Notes section for additional information regarding the calculation methodology.

Observations include (please refer to Appendix C for 2012 figures):

- State plans held the same level of benefit richness between 2012 and 2013.
- Municipal HMO/POS plans and All Other Accounts HMO/POS plans experienced a decline in benefit richness between 2012 and 2013. Municipal HMO plan benefit richness decreased from 0.94 in 2012 to 0.93 in 2013 while All Other Accounts HMO plans benefit richness decreased from 0.82 in 2012 to 0.80 in 2013.
- Although fewer State covered members are enrolled in POS products, both the average premium and adjusted premium are substantially higher than for Municipal and All Other Accounts POS policies.
- The majority of the State and Municipal covered members are enrolled in HMO products, while the majority of All Other Accounts membership is enrolled in PPO and HMO products.

MARKET CATEGORY

The market categories shown below with membership and loss ratios provide a more detailed breakdown of the summary market categories shown above. Separate tables exist for 2013 self-insured and fully-insured policies (please refer to Appendix C for comparable 2012 tables). A comparison of 2013 to 2012 is made in total.

Table 12:
Loss Ratios by Market Category and Coverage Type

Market Category	All Members	Loss Ratio	Self-Insured Members	Loss Ratio	Fully-Insured Members	Loss Ratio
Total Large Group	**66%**	**0.89**	**85%**	**0.92**	**46%**	**0.82**
Employers with 51-99 Employees	7%	0.83	1%	0.80	13%	0.84
Employers with >=100 Employees	59%	0.89	84%	0.92	33%	0.81
Qualified Association Trust	**9%**	**0.96**	**15%**	**0.97**	**2%**	**0.86**
Total Small Group	**17%**	**0.79**	**0%**	**0.78**	**36%**	**0.79**
Employers with 1 Employee	0%	1.10	0%	0.00	1%	1.10
Employers with 2-9 Employees	7%	0.76	0%	0.89	14%	0.76
Employers with 10-25 Employees	6%	0.80	0%	0.69	13%	0.80
Employers with 26-50 Employees	4%	0.77	0%	0.79	7%	0.76
Total Non-Group	**8%**	**0.66**	**No Membership Reported**		**16%**	**0.66**
Non-Group Policy	8%	0.65			16%	0.65
Non-group as Group Conversion	0%	2.56			0%	2.56
Grand Total	**470,266**	**0.86**	**242,305**	**0.93**	**227,961**	**0.79**

The following table compares the membership distribution and loss ratios by market category for 2012 versus 2013.

Table 13:
Loss Ratio Comparison by Market Category – 2012 and 2013

	Percent of Members		Loss Ratio	
Market Category	**2012**	**2013**	**2012**	**2013**
Total Large Group	**66%**	**66%**	**0.89**	**0.89**
Employers with 51-99 Employees	7%	7%	0.83	0.83
Employers with >=100 Employees	59%	59%	0.90	0.89
Qualified Association Trust	**8%**	**9%**	**0.93**	**0.96**
Total Small Group	**18%**	**17%**	**0.81**	**0.79**
Employers with 1 Employee	0%	0%	1.07	1.10
Employers with 2-9 Employees	7%	7%	0.80	0.76
Employers with 10-25 Employees	7%	6%	0.81	0.80
Employers with 26-50 Employees	4%	4%	0.77	0.77
Total Individual	**8%**	**8%**	**0.68**	**0.66**
Individual Policy	8%	8%	0.67	0.65
Individual as Group Conversion	0%	0%	2.06	2.56
Grand Total	**480,575**	**470,266**	**0.87**	**0.86**

Observations:

- Overall, the loss ratio for the entire market decreased slightly from 2012 to 2013, dropping 1% from 87% to 86%**.** This may be attributable to the introduction of new ACA fees into pricing in 2013. The ACA fees were effective on January 1st of 2014, and were effective January 1st for all groups with all renewal dates. The two new fees were the annual health insurance industry fee and the transitional reinsurance fee. Since premium rates are issued for 12 months and rates starting with February 2013 renewals were effective for part of 2014, carriers were allowed to include tax fees in premiums on a pro-rata basis beginning with February 2013 renewals to adequately collect for these fees.
- The Large Group market's loss ratio remained stable between 2012 and 2013. Within the Large Group segment, employer groups with 51 -99 employees held steady with a loss ratio of 0.83, while employer groups with 100+ employees experienced a slight decline in loss ratio. Employers obtaining insurance through Qualified Association Trusts experienced an increase in loss ratio, from 93% in 2012 to 96% in 2013.
- The Small Group market experienced a 2% decline in the overall loss ratio between 2012 and 2013. Within the Small Group segment, the loss ratio for both employers with 10-25 employees and employers with 2-9 employees decreased in 2013. The loss ratio for employers with 26-50 employees remained stable at the 77% level. The loss ratio for groups with only one employee increased, and is still

running well over 100% at the 110% level. Groups of one experience a high loss ratio due to anti-selection issues. In 2013, rating rules allow the application of a group size factor; however rating bands limit the ability to fully rate for the higher risk that groups of one present. Sole proprietors who are able to obtain a favorable underwriting tier are likely to opt for an individual product where they could get a more attractive premium leaving a disproportionate number of higher risk members in the groups of one pool.

- The Non-group loss ratio was 66% in 2013, which is a decrease of 2% from the 2012 loss ratio of 68%.
- Group conversion policies show higher loss ratios for 2013 compared to 2012, and continue to run at a very high level of 256%. The conversion pool is small, and prone to high loss ratios due to the anti-selection caused by the inability to medically underwrite. Those members losing group coverage that are able to obtain a more favorable underwriting tier are likely to purchase less expensive individual insurance, leaving a disproportionate number of higher risk members in the group conversion pool.

DEDUCTIBLES

Information is collected on deductibles according to the dollar amount of the policy deductible. The deductible is the amount that the member pays before the health insurance carrier contributes to the cost of care. The deductible may or may not apply to all medical and pharmacy services. If the plan has more than one network tier, the deductible represents the most utilized tier. Dollar amounts refer to single person deductibles, not family deductibles.

Summary comparison tables for deductibles are shown below. A more detailed table is contained in Appendix A. Bold values represent the group (within each comparison) with the highest percentage of members where the value is at least two percent.

Table 14:
Deductible by Coverage Type and Market Category

Deductible	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$0	28%		**52%**	3%		**38%**	0%	0%
$1-249	3%		**5%**	0%		**3%**	0%	0%
$250-499	5%		**9%**	0%		**7%**	0%	0%
$500-749	6%		**11%**	2%		**8%**	0%	1%
$750-999	2%		**3%**	2%		**3%**	0%	0%
$1,000-1,499	10%		8%	**12%**		10%	8%	**16%**
$1,500-2,999	18%		7%	**30%**		14%	**32%**	28%
$3,000-4,999	19%		4%	**35%**		13%	**49%**	8%
$5,000-7,499	8%		1%	**14%**		4%	11%	**36%**
$7,500-9,999	0%		0%	0%		0%	0%	**2%**
$10,000+	1%		0%	1%		0%	0%	**9%**
Grand Total	**470,266**		**242,305**	**227,961**		**346,536**	**86,740**	**36,991**

Table 15:
2013 to 2012 Comparison - Deductible

Deductible	All Members		Large Group		Small Group		Non-Group	
	2012	2013	2012	2013	2012	2013	2012	2013
$0	30%	28%	39%	38%	0%	0%	12%	0%
$1-249	2%	3%	3%	3%	0%	0%	0%	0%
$250-499	5%	5%	7%	7%	0%	0%	0%	0%
$500-749	7%	6%	9%	8%	1%	0%	1%	1%
$750-999	3%	2%	4%	3%	0%	0%	0%	0%
$1,000-1,499	11%	10%	9%	10%	15%	8%	19%	16%
$1,500-2,999	20%	18%	14%	14%	37%	32%	27%	28%
$3,000-4,999	17%	19%	12%	13%	40%	49%	4%	8%
$5,000-7,499	6%	8%	3%	4%	7%	11%	30%	36%
$7,500-9,999	0%	0%	0%	0%	0%	0%	1%	2%
$10,000+	1%	1%	0%	0%	0%	0%	7%	9%
Grand Total	**480,575**	**470,266**	**348,177**	**346,536**	**91,553**	**86,740**	**40,845**	**36,991**
Avg Deductible	**1,484**	**1,632**	**1,003**	**1,070**	**2,524**	**2,830**	**3,258**	**4,084**
Annual Deductible Change		**10%**		**7%**		**12%**		**25%**
Avg Non-$0 Deductible	**2,107**	**2,268**	**1,653**	**1,725**	**2,528**	**2,836**	**3,702**	**4,104**
Annual Deductible Change		**8%**		**4%**		**12%**		**11%**

Observations:

- The self-insured population benefits reflect lower deductibles than the fully-insured population.
- Generally, the Large Group market has lower deductibles, while the Non-group and Small Group markets have higher deductibles.
- Between 2012 and 2013, average deductibles grew $148 or by 10% overall. Over the same time period, the average for non-zero deductibles grew 8% overall.
- Non-group experienced the largest change and percentage change in deductible at 25% but this is skewed by a change in Healthy Kids between 2012 and 2013. Starting July 1, 2012, children covered by Healthy Kids Silver, a zero dollar deductible product, were moved to Medicaid, which is not included in the Supplemental Report data. The percentage change in the average non-zero deductible for Non-group was 11%.
- While the most common non-zero deductibles for Large Group and Small Groups fall in the $1,500-$4,999 range, the average non-zero Small Group deductible exceeds Large Group by more than $1,000, due to the prevalence of deductibles under $1,000 in the Large Group market.
- All Small Group members (100%) have deductibles in the $1,000-$7,499 range compared with approximately 88% of Non-Group members in the same range, with 12% of Non-Group members having deductibles of $7,500 or more.
- The high percentage of members covered by a self-insured account without any deductible is partly the result of the State of NH employee plan and the benefit plans covering municipal employees. See chart below.

Table 16:
Deductible by Account Type

Deductible	All Self-Insured Members		State	Municipal	Other
$0	52%		**89%**	75%	33%
$1-249	5%		0%	0%	**8%**
$250-499	9%		0%	9%	**11%**
$500-749	11%		11%	8%	**12%**
$750-999	3%		0%	0%	**5%**
$1,000-1,499	8%		0%	5%	**11%**
$1,500-2,999	7%		0%	3%	**11%**
$3,000-4,999	4%		0%	0%	**7%**
$5,000-7,499	1%		0%	0%	**2%**
$7,500-9,999	0%		0%	0%	0%
$10,000+	0%		0%	0%	0%
Grand Total	**242,305**		**29,022**	**69,969**	**143,313**

COINSURANCE
Coinsurance is the percentage of the total claim that the member is responsible for paying. Coinsurance is paid after the deductible has been met. If the plan has more than one coinsurance level, the highest coverage level for medical services (i.e. lowest member coinsurance %) within network is reported.

Table 17:
Coinsurance by Market Category and Coverage Type

Coinsurance	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
0%	93.8%		**98.6%**	89.2%		92.5%	**99.8%**	91.6%
5%	0.1%		0.0%	0.2%		0.2%	0.0%	0.0%
10%	4.5%		0.0%	**8.8%**		**6.1%**	0.1%	0.0%
20%	0.7%		0.2%	1.2%		0.8%	0.1%	1.5%
25%	0.0%		0.0%	0.0%		0.0%	0.0%	0.0%
30%	0.0%		0.0%	0.0%		0.0%	0.0%	0.0%
50%	0.1%		0.2%	0.0%		0.0%	0.0%	1.2%
100%	0.8%		0.9%	0.6%		0.4%	0.0%	**5.7%**
Grand Total	**470,266**		**227,961**	**242,305**		**346,536**	**86,740**	**36,991**

Table 18:
2013 to 2012 Comparison – Coinsurance

	All Members		Large Group		Small Group		Non-Group	
Coinsurance	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**
0%	99.3%	93.8%	99.9%	92.5%	100.0%	99.8%	93.3%	91.6%
5%	0.0%	0.1%	0.0%	0.2%	0.0%	0.0%	0.0%	0.0%
10%	0.1%	4.5%	0.1%	6.1%	0.0%	0.1%	0.0%	0.0%
20%	0.1%	0.7%	0.0%	0.8%	0.0%	0.1%	1.7%	1.5%
25%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%
50%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.3%	1.2%
100%	0.4%	0.8%	0.1%	0.4%	0.0%	0.0%	4.4%	5.7%
Average Coinsurance	**0.5%**	**1.4%**	**0.1%**	**1.2%**	**0.0%**	**0.0%**	**5.0%**	**6.6%**

Observations:

- The Non-group market tends to have higher coinsurance levels than the group market. In 2013, the average coinsurance level for a non-group plan was 6.6% compared to 0% in the small group market and 1.2% in the large group market. The coinsurance levels of the Small Group market are lower than the coinsurance levels in the Large Group market. It is important to note that coinsurance is only one measure of benefit richness. The Small Group market's members tend to have much higher deductibles than the Large Group market's members. The overall benefit richness of the Small Group market is much lower than the Large Group market since the higher deductibles more than offset the lower coinsurance levels that only apply after the deductible has been met.

PHYSICIAN COPAYS

Physician copays represent the dollar amount the member must contribute for primary care physician (PCP) office visits within network. For tiered network HMO products, the copayment for the most utilized tier is reported. Observations are focused on the non-zero PCP copay levels because of data quality concerns related to one large carrier not distinguishing between $0 copay and instances where the deductible and coinsurance apply to the PCP office visits. Generally, the distributions of members by copay amounts are similar in 2013 and 2012.

Table 19:
PCP Copay by Market Category and Coverage Type

PCP Copay	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$0	10%		5%	**14%**		6%	4%	**54%**
$1	0%		0%	0%		0%	0%	0%
$5	7%		**13%**	0%		**9%**	0%	0%
$10	10%		**20%**	1%		**14%**	0%	0%
$15	12%		**22%**	3%		**17%**	0%	0%
$20	21%		**28%**	13%		**26%**	2%	14%
$25	33%		5%	**61%**		21%	**92%**	0%
$30	2%		2%	**3%**		2%	1%	**13%**
$35	2%		**2%**	1%		2%	0%	**6%**
$40	2%		2%	**3%**		2%	1%	**8%**
$45	1%		1%	0%		1%	0%	0%
$50	0%		0%	0%		0%	0%	**2%**
$75	0%		0%	1%		0%	0%	**4%**
D/C	16%		**18%**	14%		**17%**	12%	14%
Total Members	**470,266**		**242,305**	**227,961**		**346,536**	**86,740**	**36,991**
Average PCP Copay	**$18**		**$15**	**$21**		**$17**	**$24**	**$16**
Average non-$0 PCP Copay	**$20**		**$16**	**$25**		**$18**	**$25**	**$34**

Table 20:
2013 to 2012 Comparison – PCP Copay

PCP Copay	2012	2013
$0	**13%**	10%
$1	0%	0%
$5	**7%**	7%
$10	**11%**	10%
$15	11%	**12%**
$20	19%	**21%**
$25	29%	**33%**
$30	2%	2%
$35	1%	2%
$40	**4%**	2%
$45	1%	1%
$50	0%	0%
$75	0%	0%
D/C	9%	**16%**
Total Members	**480,575**	**470,266**
Average PCP Copay	**$18**	**$18**
Average non-$0 PCP Copay	**$20**	**$20**

Observations:

- Overall the average non-zero copay rounded to $20 for both 2012 and 2013, but actually decreased by 0.7% which appears to be driven by a movement out of the $40 copay level and an increase in the $25 copay level.
- The self-insured market tends to have lower non-zero copays than the fully-insured market (averages of $16 and $25, respectively), and the Large Group market tends to have lower non-zero copays than the Small Group and Non-group markets (averages of $18, $25, and $34, respectively).
- The Non-group market experienced the biggest change in non-zero PCP copays, climbing from $29 in 2012 to $34 in 2013.

PHARMACY BENEFITS

There are many different benefit structures for pharmacy (Rx) benefits. In some benefit designs the medical deductible applies to pharmacy and then pharmacy copays apply after the medical deductible has been met. In other benefit designs there are pharmacy copays that are charged, which may or may not be coupled with a pharmacy specific deductible that applies before benefits are paid. Some larger groups carve out their pharmacy benefits from the health plan and contract directly with pharmacy benefit managers, resulting in some missing pharmacy information for this report. Below are summary tables comparing 2012 and 2013 pharmacy benefits as reported by the carriers/TPAs. Comments follow each table.

Types of Pharmacy (Rx) Coverage

Table 21:
Types of Rx Coverage

	All Members		Large Group		Small Group		Non-Group	
	2012	2013	2012	2013	2012	2013	2012	2013
No Rx Coverage	6%	13%	8%	15%	0%	10%	6%	5%
Medical Deductible Applies to Rx	14%	15%	9%	12%	11%	13%	64%	51%
Rx Specific Deductible	4%	2%	5%	3%	1%	0%	0%	5%
Copay with No Deductible	76%	69%	78%	71%	88%	77%	29%	40%

Observations:

- The percentage of members with no pharmacy coverage reported increased from 6% in 2012 to 13% in 2013, attributable to the large and small group market categories. This may mean that employer groups are carving out the pharmacy benefits and contracting directly with a pharmacy benefit manager.
- The percentage of members with Rx copays and no Rx deductible decreased from 76% to 69%.

Most Popular Pharmacy Copays for Members with Copay Structure and No Deductible

Table 22:
Most Popular Pharmacy Copays for Members with Copay Structure and No Deductible

	All Members		Large Group		Small Group		Non-Group	
	2012	2013	2012	2013	2012	2013	2012	2013
Generic	$10	$10	$10	$10	$10	$10	$10	$10
Brand Formulary	$35	$35	$30	$30	$35	$35	$20	$25
Brand Non-Formulary	$50	$50	$50	$50	$50	$50	$30	$40

Observations:

- The most popular pharmacy copays remained the same in the large and small employer group market categories.
- In the Non-group market, the most popular pharmacy copays increased for brand name drugs but stayed the same for generic drugs.

Most Popular Pharmacy Specific Deductible

Table 23:
Most Popular Pharmacy Specific Deductible

	All Members		Large Group		Small Group		Non-Group	
	2012	2013	2012	2013	2012	2013	2012	2013
Generic	$100	$100	$100	$100	$100	$0	$0	$0
Brand Formulary	$100	$100	$100	$100	$100	$100	$1,000	$500
Brand Non-Formulary	$100	$100	$100	$100	$100	$100	$1,000	$500

Observations:

- The most popular pharmacy specific deductible stayed the same for Large Group generic and brand name drugs and for Small Group brand name drugs, but changed from $100 in 2012 to zero in 2013 for Small Group generic drugs. This is likely due to carriers encouraging members to obtain less expensive generic alternatives of drugs instead of the more expensive brand versions.
- In the Non-group market, the most popular deductible for brand name drugs was $1,000 in 2012 and $500 in 2013.

OUT-OF-POCKET MAXIMUMS

Many 2013 health benefit plans include out-of-pocket maximums that limit amount of cost sharing that the contract holder or member has to pay in a coverage year, while other health benefit plans may have unlimited cost sharing (for 2014, non-grandfathered health benefit plans have limits on out-of-pocket maximums due to ACA provisions in section 1302(c)(1)). Out-of-pocket maximums can take on many forms relating to a single person or family and relating to network tiers. For the purposes of this report, the out-of pocket maximums represent the maximum single person out-of-pocket cost sharing expenses (including deductibles) for services within network for a single tier type product. For tiered network products, the maximums in this report relate to the most utilized tier. The table below compares 2012 and 2013 membership distributed by out-of-pocket maximum ranges.

Table 24:
Out-of-Pocket Maximum by Market Category

	All Members		Large Group		Small Group		Non-Group	
Out-of-Pocket Maximum	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**	**2012**	**2013**
$0-$499	2%	9%	2%	12%	0%	0%	0%	0%
$500-$999	8%	8%	11%	11%	0%	0%	0%	0%
$1,000 -$1,499	7%	6%	8%	7%	5%	2%	5%	4%
$1,500-$1,999	4%	3%	5%	4%	1%	1%	2%	2%
$2,000-$2,999	30%	31%	14%	16%	23%	21%	11%	14%
$3,000-$3,999	5%	5%	11%	12%	37%	37%	13%	13%
$4,000-$4,999	10%	10%	5%	4%	4%	6%	7%	9%
$5,000-$9,999	5%	7%	9%	9%	16%	21%	41%	46%
$10,000-$14,999	1%	1%	1%	1%	0%	1%	7%	9%
$15,000-$30,000	0%	0%	0%	0%	0%	0%	2%	3%
Unlimited	28%	20%	34%	25%	14%	12%	12%	0%
Total	**480,575**	**470,266**	**348,177**	**346,536**	**91,553**	**86,740**	**40,845**	**36,991**
Avg for Mbrs with OOP Max	**$2,892**	**$2,724**	**$2,560**	**$2,205**	**$3,123**	**$3,477**	**$5,100**	**$5,422**

Observations:

- For all markets shown, the percentage of members with unlimited out-of-pocket expenses decreased from 2012 to 2013 (from 28% to 20% in aggregate). This movement may reflect benefit designs being marketed in anticipation of the ACA provisions set to take effect in 2014.
- In the Large Group market the percentage of members with $0-$499 out-of-pocket maximums increased from 2% in 2012 to 12% in 2013.

COVERED BENEFITS

Coverage for benefits is based on whether the policy provides coverage at the level described in the Supplemental Report bulletin dated February 7, 2014. Definitions are provided in Appendix B of this report for all 28 benefit categories included in the Supplemental Report filing. There were two new benefit coverage categories (Pediatric Dental and Pediatric Vision), included as essential health benefits under the Affordable Care Act, which were added to this and subsequent Supplemental Reports. A few of these categories had none or very few members without coverage, but all categories are listed in the table below.

Covered benefits are subject to greater reporting variation. This variation is due to differences in how carriers interpret policy coverage and the definition of the benefits

which is described in the bulletin. An enhancement was made in the data collection for this report to capture situations where a carrier generally covers the benefit, but not to the exact specifications in the Supplemental Report bulletin definition. In previous Supplemental Reports, the carrier was instructed to not to report a benefit as being covered by the policy if coverage was not to the exact specifications in the definition. For this and subsequent Supplemental Reports, the carriers are instructed to distinguish between covering the benefit to the exact specifications, general coverage of the benefit but not meeting the exact specifications (identified as DM in the table below), and no coverage. It should be noted that members appearing to be without coverage for a particular benefit may obtain coverage for that benefit through a mechanism other than the primary insurance carrier. Examples of this include mental health benefits and prescription drug coverage provided by an organization external to the employer or insurance carrier.

Table 25:
Benefit Category by Market Category in Detail

Coverage Category	Covered*	All Members		Self-Insured	Fully Insured		Large Group	Small Group	Non-Group
Ambulance Services	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Audiology Screening of Newborns	Yes	99%		100%	98%		100%	100%	91%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	1%		0%	2%		0%	0%	9%
Blood and Blood Products	Yes	79%		66%	93%		72%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	21%		34%	7%		28%	0%	0%
Case Management Programs	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Chiropractic Services	Yes	92%		100%	85%		99%	99%	14%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	8%		0%	15%		1%	1%	86%
Durable Medical Equipment	Yes	100%		100%	100%		100%	100%	99%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	1%
Emergency Room Services	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Family Planning Services	Yes	88%		81%	97%		87%	99%	81%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	12%		19%	3%		13%	1%	19%
Habilitative Services	Yes	75%		78%	72%		78%	90%	14%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	25%		22%	28%		22%	10%	86%
Hearing Aids	Yes	76%		54%	99%		68%	99%	96%
	Yes, DM	1%		3%	0%		2%	0%	0%
	No	23%		43%	1%		30%	1%	4%
Home Health Care	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Hospice	Yes	79%		65%	93%		72%	99%	95%
	Yes, DM	1%		2%	0%		1%	0%	0%
	No	20%		33%	7%		27%	1%	5%
Hospitalization	Yes	100%		100%	99%		100%	100%	95%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	1%		0%	0%	5%
Infertility Services	Yes	39%		35%	43%		37%	61%	0%
	Yes, DM	3%		5%	2%		5%	0%	0%
	No	58%		60%	55%		58%	39%	100%
Medical Food	Yes	78%		66%	92%		72%	100%	91%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	22%		34%	8%		28%	0%	9%
Mental Health and Substance Abuse	Yes	79%		66%	93%		72%	100%	90%
	Yes, DM	20%		33%	6%		27%	0%	0%
	No	1%		1%	2%		0%	0%	10%
Nutritional Services	Yes	77%		63%	90%		70%	99%	84%
	Yes, DM	20%		34%	6%		27%	0%	0%
	No	3%		3%	4%		2%	1%	16%

Coverage Category	Covered*	All Members		Self-Insured	Fully Insured		Large Group	Small Group	Non-Group
Outpatient Hospital Services and Surgery	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Outpatient Laboratory and Diagnostic Services	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Outpatient Rehabilitation Services	Yes	99%		100%	99%		100%	100%	94%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	1%		0%	1%		0%	0%	6%
Pediatric Dental Services	Yes	62%		59%	64%		56%	74%	89%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	38%		41%	36%		44%	26%	11%
Pediatric Vision Services	Yes	68%		72%	64%		64%	75%	89%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	32%		28%	36%		36%	25%	11%
Pregnancy and Maternity Services	Yes	99%		100%	97%		100%	100%	83%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	1%		0%	3%		0%	0%	17%
Prescription Drugs	Yes	87%		83%	91%		85%	90%	95%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	13%		17%	9%		15%	10%	5%
Preventive Services	Yes	95%		93%	98%		94%	100%	96%
	Yes, DM	4%		7%	1%		6%	0%	0%
	No	0%		0%	1%		0%	0%	4%
Skilled Nursing Facility	Yes	84%		73%	96%		79%	100%	96%
	Yes, DM	15%		27%	3%		21%	0%	0%
	No	1%		0%	1%		0%	0%	4%
Transplants	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Well Child and Immunization Benefits	Yes	81%		67%	94%		74%	100%	96%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	19%		33%	6%		26%	0%	4%

***Yes** – indicates that the service is covered and meets the exact specifications of the service description characterized in the Supplement Report Bulletin
Yes, DM – indicates that the service is generally covered but does not meet the exact specifications of the service description characterized in the Supplemental Report Bulletin
No – indicates that the service is not covered

Typically fewer fully-insured or Small Group members are without coverage for a particular benefit. This is probably due to NH laws for mandated benefits. Larger employers are more likely to be self-insured and have more flexibility to negotiate which benefits will be covered under their policy.

There was a noticeable increase in the percentage of members with coverage for Pediatric Dental Services and Pediatric Vision Services in the self-insured market. In 2012, 55% of self-insured business covered Pediatric Dental Services while 58% covered Pediatric Vision Services. In 2013, 62% of self-insured members had Pediatric Dental coverage while 68% had Pediatric Vision Coverage. Pediatric Dental and Pediatric Vision services are considered Essential Health Benefits under the Affordable Care Act. Beginning in

2014, all non-grandfathered plans must cover Essential Health Benefits. The increase may be due to self insured plans adjusting their plan designs to be compatible with the Essential Health benefits requirements to prepare for 2014.

A category with a noticeable decrease in coverage was Prescription Drugs. In 2012, coverage for Presciption drugs was described by carriers as 94% of all New Hampshire situs members having coverage. In 2013, 87% of all New Hampshire situs members had coverage for this benefit. It is likely that this decline is due to more carriers, TPAs and self insured groups using a prescription drug vendor to administer the drug benefits for their members.

Another category with a noticeable increase in percentage of enrollees with coverage was Family Planning Services. In 2012, carriers reported that 94% of enrollees had Family Planning Services covered. In 2013, the percentage has decreased to 88%. This decline was due to a decline in the number of self-insured members with coverage for Family Planning services.

CARRIER MEMBERSHIP DISTRIBUTION

Data submitted for the Supplemental Report is based on policyholder and New Hampshire residents. The data include insured members who reside outside of NH if covered under a NH policy as well as insured members employed in a NH branch location but covered under an out-of-state health policy. These data include self-funded accounts.

The following companies have been grouped into one "family" company name for the tables below:

- Anthem includes: Anthem Health Plans of NH and Matthew Thornton
- Assurant includes: Time Life Insurance Company and John Alden Life Insurance Company
- CIGNA includes: CIGNA Health and Life Insurance Company and Connecticut General Life Insurance Company
- Harvard Pilgrim includes: Harvard Pilgrim HealthCare of NE, HPHC Insurance Company, Harvard Pilgrim Health Care, and Health Plans, Inc.

Based on the Supplemental Report submission, the distribution of members by carrier, coverage type, and market segment is shown in the charts below.

Table 26:
Distribution of Members by Carrier (NH Situs and Non-NH Situs)

Health Insurance Carrier/TPA	Self-Insured Members	Fully-Insured Members	Total Members	Percentage of Total
Anthem	106,970	136,671	243,641	38.6%
CIGNA	145,273	21,610	166,883	26.4%
Harvard	69,622	78,560	148,182	23.5%
Aetna	40,978	6,125	47,103	7.5%
MVP	8	9,336	9,344	1.5%
United Healthcare	-	7,734	7,734	1.2%
Assurant	-	4,514	4,514	0.7%
Chesapeake	-	1,831	1,831	0.3%
Celtic	-	707	707	0.1%
Usable Mutual	653	-	653	0.1%
Health Partners	441	-	441	0.1%
State Farm	-	175	175	0.0%
American Republic	-	-	-	0.0%
Total	**363,945**	**267,261**	**631,206**	**100.0%**

Chart 1:
Distribution of Members by Carrier

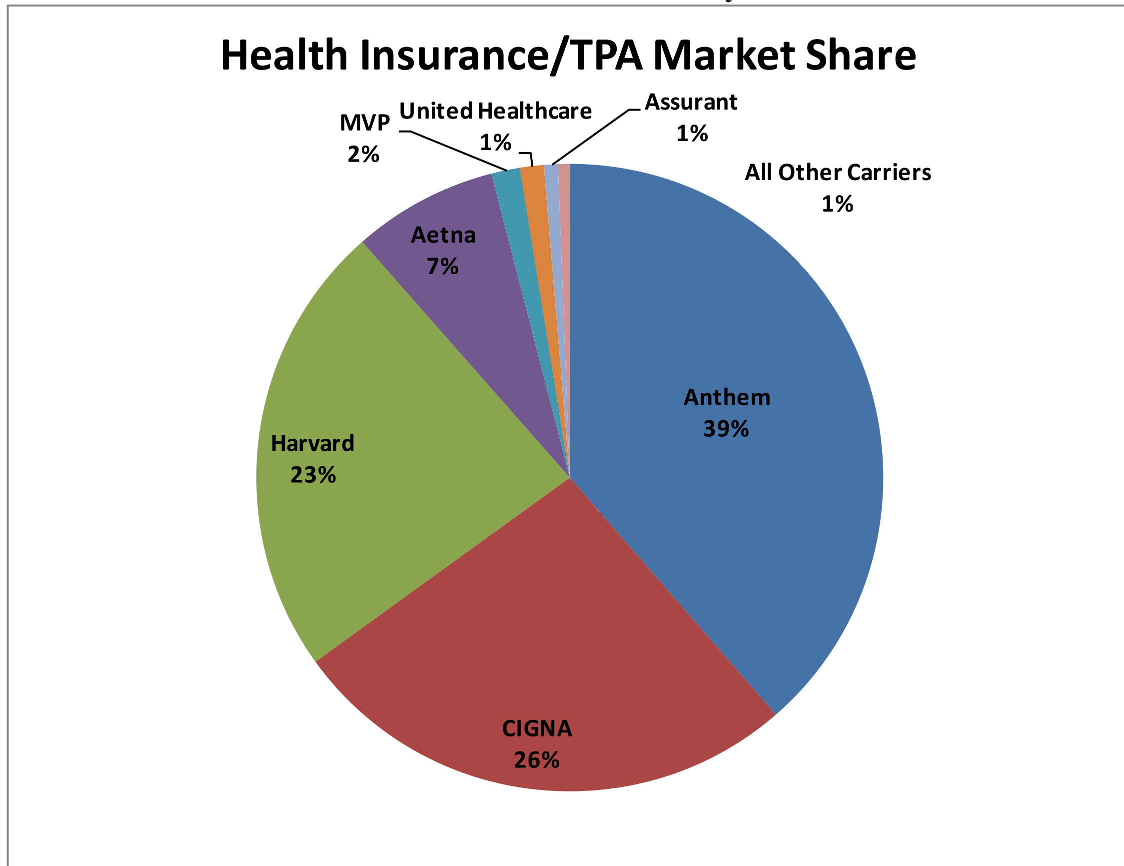


Chart 2:
Health Insurance Carrier/TPA Member Distribution by Coverage Type

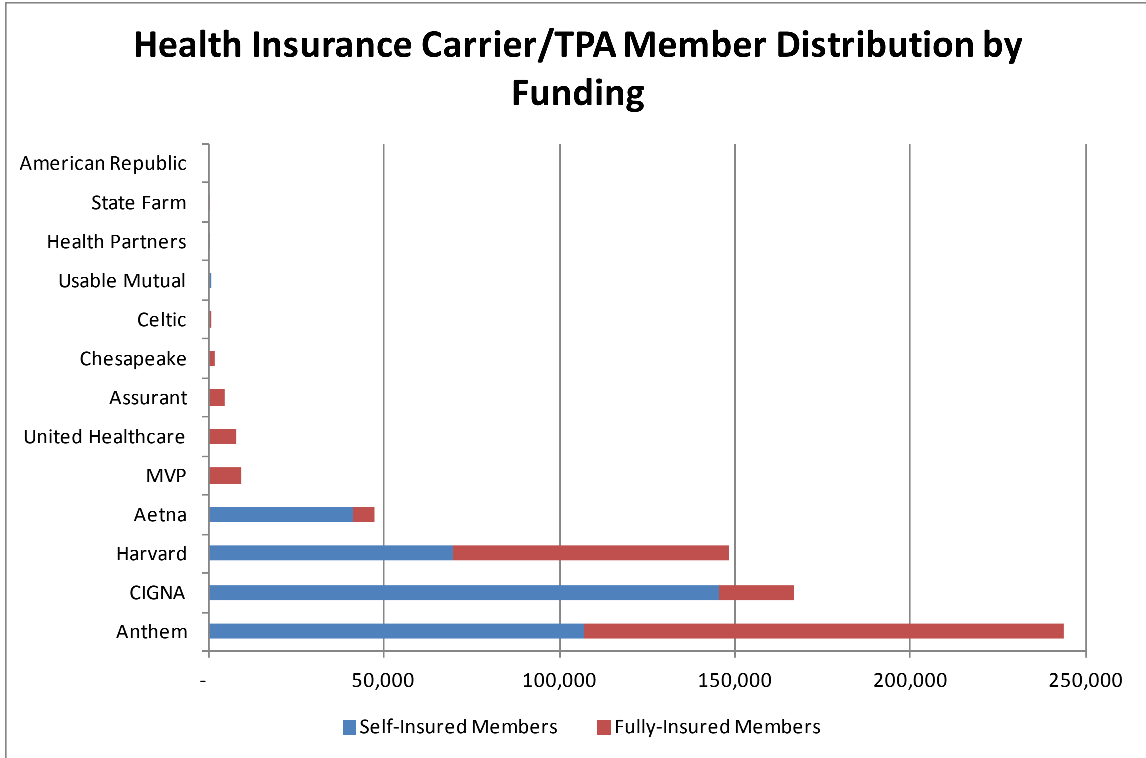
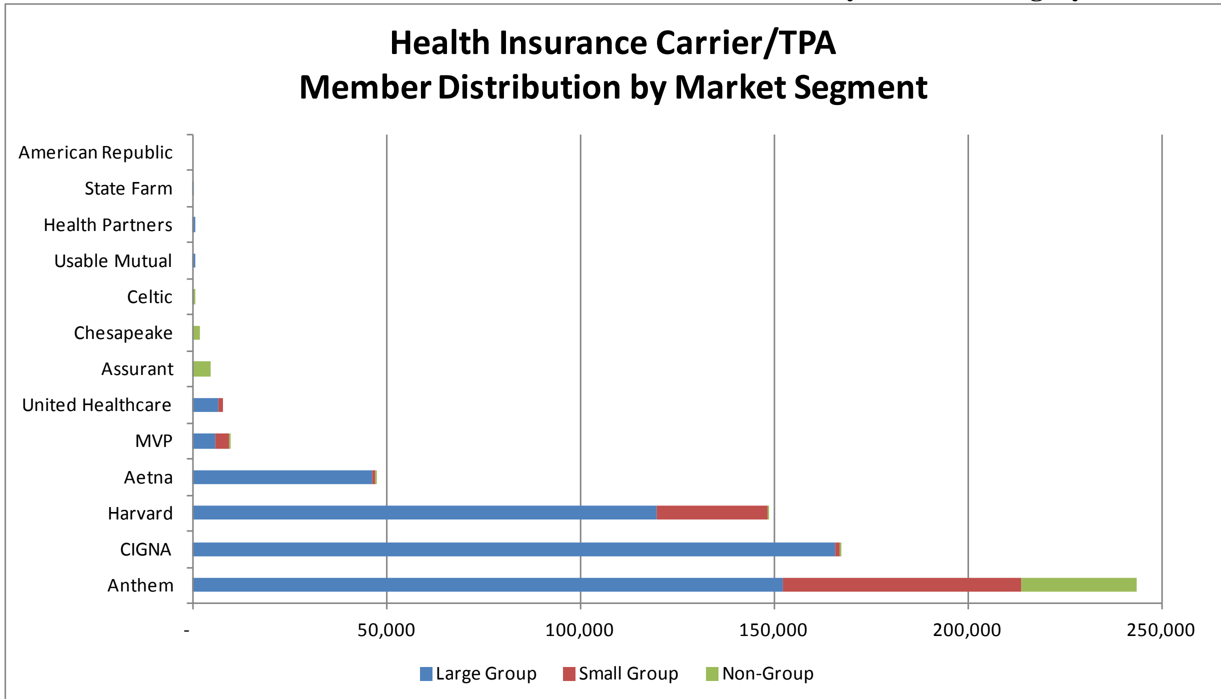


Chart 3:
Health Insurance Carrier/TPA Member Distribution by Market Category



LIMITED COVERAGE AND LIMITED ELIGIBILITY POLICIES

Some heath insurance policies offered in the NH insurance market have limited coverage and/or limited eligibility. Policies of this type include stoploss, student, and high risk pool. Descriptions and comments related to each are below the summary table.

The following table shows Summary Statistics for members enrolled in Limited Coverage and Limited Eligibility Policies.

Table 27:
Limited Coverage Summary Statistics

Limited Coverage	Situs	Members	Premium PMPM	Claims PMPM	Loss Ratio
Stoploss	NH	100,247	$ 28	$ 31	111%
Stoploss	non-NH	71,919	$ 98	$ 70	72%
Stoploss Total	**NH & non-NH**	**172,165**	**$ 57**	**$ 47**	**83%**
Student	NH	250	$ 91	$ 51	56%
Student	non-NH	914		$ 38	
Student Total	**NH & non-NH**	**1,164**		**$ 41**	
High Risk Pool (NHHP)	NH	2,785	$ 569	$ 884	155%
High Risk Pool (NHHP-FED)	NH	337	$ 480	$ 3,683	767%
High Risk Pool Total	**NH**	**3,122**	**$ 560**	**$ 1,186**	**212%**

Stoploss insurance is an example of an insurance policy with limited coverage. It protects against catastrophic or unpredictable losses. Groups with stoploss insurance are liable for all claims up to a specific or aggregate prescribed threshold. The insurance company offering stoploss coverage only becomes liable for claims after the prescribed threshold has been exceeded. Specific stoploss caps a member's claims at a dollar threshold for that member, such as $100,000, and the stop loss carrier becomes liable for that individual's claims once they exceed that threshold in the policy year. A stoploss carrier offering aggregate stoploss projects claims in total for the group, and the carrier becomes liable when claims exceed the expected claims plus a prescribed corridor or margin such as 125% of projected claims. Stop loss carriers can offer either type of stoploss independently, or offer them together. If offered together, the specific stoploss is typically accounted for first. Please note that stoploss coverage data above is for employer groups only and excludes any reinsurance coverage that an insurance or stop loss carrier may purchase for an additional layer of reinsurance.

Approximately 47% of the total self-insured membership has some type of stoploss coverage. Some very large employers with more credible claims experience and the ability to absorb a greater amount of risk are more likely to forgo purchasing stoploss protection.

The loss ratio for stoploss increased significantly in 2013 and is 83%, which is up from 69% in 2012. The increase in 2013 is driven by one large stoploss carrier realizing a large increase in their loss ratio.

Stoploss data was collected at a more detailed level of coverage for the 2013 Supplemental Report as compared to the data collected for the 2012 Supplemental Report. Data was collected for each threshold level of stoploss that was underwritten. For example, specific stoploss policies could cover individuals at thresholds of $100,000, $150,000, $200,000, etc. depending upon a group's tolerance for risk. While in total the stoploss data that was collected is reasonable, data reported at the more detailed coverage level may not be accurate and so is not included in this report.

Student health insurance is an example of a health insurance product where eligibility is limited. Coverage for student health insurance is offered through participating colleges and universities and specific eligibility rules apply. In 2013 the average membership for NH Sitused student insurance is 250, a substantial decrease from the 2012 membership of 1,566. The loss ratio also decreased, from 88% to 56%, but given the dramatic change in the student insurance population and the minimal enrollment, volatility is not unexpected.

Insurance offered in a High Risk Pool is another example of insurance coverage where the eligibility is limited, specifically to high risk members. For 2013 there are two options for high risk members seeking coverage in a High Risk Pool in NH. The New Hampshire Health Plan (NHHP) was established as a high risk pool under state statute to provide health insurance to NH residents who are declined coverage through the private market, and members who have a pre-qualifying condition or are otherwise not eligible for health insurance. The NHHP-FED is a federal high risk pool established by the United States Department of Health and Human Services (HHS) to provide access to affordable health insurance coverage for the uninsured regardless of health condition. The NHHP administers the federal plan on behalf of HHS. Both of the high risk pools in existence for 2013 are impacted by the implementation of the Affordable Care Act (ACA). Starting in January of 2014, the ACA provides "guaranteed issue" coverage, meaning carriers can no longer deny high risk individuals seeking coverage. Individuals can purchase coverage on or off the insurance exchange (the Marketplace) regardless of their health status. As a result, the federal high risk pool ceased operations on June 30, 2013. The members were given the opportunity to transition to coverage provided through the federally run preexisting coverage insurance plan (PCIP) beginning July 1, 2013. The New Hampshire high risk pool was scheduled to cease operations on December 31, 2013. However due to delays in ACA Marketplace enrollment capabilities the New Hampshire High Risk pool remained open until June 30, 2014. At that time the New Hampshire high risk pool ceased operations. All pool members were eligible to purchase guarantee issue plans through the insurance Marketplace. As a result of these changes, membership data in the federal high risk pool ended in June of 2013, which explains the membership decrease from 2012 to 2013. New Hampshire high risk pool data will only reflect membership through June 2014 in the 2014 Supplemental Report, and this data will no longer be included in Supplemental Reports after 2014. Please note that the premiums shown in the table above for the High Risk Pool reflect what the insured member pays and do not include assessments or government subsidies.

SUPPLEMENTAL REPORT HISTORY

The first round of Supplemental Report filings occurred on May 1, 2002, and included data from calendar year 2001. The first data submission applied only to licensed non-profit health service corporations and licensed health maintenance organizations. All other licensed health carriers filed in 2003. In 2006, the department substantially revised the bulletin that describes how data need to be submitted to the NHID. For this reason, the 2006 report cannot be compared to prior submissions. The 2007 bulletin had minor changes, but included a separate variable for self-insured vs. fully-insured data. This separation allows greater insight into the market dynamics of the differing policy types. The 2009 bulletin clarified that out-of-state employer's branch location in NH shall be considered a New Hampshire employer, and the carrier/TPA shall submit data for all members who are employed at that branch location. Beginning in 2012, to ease the burden on carriers submitting data for the Supplemental Report, the New Hampshire Insurance Department no longer requires carriers to submit benefit option details and premium for non-NH situs membership. Carriers continue to submit membership and claims information for non-NH situs enrollment. For the 2013 Supplemental Report, the New Hampshire Insurance Department changed the reporting requirements to better align with recent federal reporting requirements related to the implementation of the Affordable Care Act. The most significant change was to modify the definition of Actuarial Value (AV) from a New Hampshire specific definition to the Minimum Value (MV) measure as outlined in Section 1302 of the Affordable Care Act. Using the MV will result in more consistent comparisons of benefit design richness across product lines and market segments. In 2012 and prior versions of this report, the standard benefit designs (denominator) used in the calculation of AV represented small group and differed by product (HMO, PPO, POS, Indemnity). This resulted in AVs that not only reflected market segment pricing differences but the AVs also could not be used to compare benefit richness across product lines. Other significant changes for the 2013 Supplemental Report were to expand the detail collected on both first dollar health coverage benefit designs and Stoploss coverage attachment points. Due to these and other changes, the New Hampshire Insurance Department required that carriers re-submit 2012 data in the new format to use as a baseline for the 2013 report so that the measures would be consistent and accurately reflect the year over year change (2013 versus 2012). Tables from the 2012 Supplemental Report have been restated in Appendix C of this report and will allow for a consistent comparison to the 2013 Supplemental Report.

DATA COLLECTED

The Supplemental Report data collection applies to all health insurance companies and health maintenance organizations licensed in New Hampshire. All third party administrators (TPAs) licensed or registered in New Hampshire must submit data.

Data submitted by TPAs must comply with instructions in order to compare self-insured costs to what is experienced with underwritten insurance. To compare self-insured to fully-insured, a premium equivalent is calculated, based on the total cost to the employer including special programs such as disease management.

Data are submitted to the NHID by stop loss companies as a part of the Supplemental Report data collection process, but are reported separately to avoid double counting. The membership covered under these polices are tracked through the TPA, as is the overall health insurance premium equivalent and the corresponding medical claims.

Carriers meeting the de minimis exemption do not submit data that are tabulated in this report. Carriers that write less than $250,000 in accident and health insurance premiums in New Hampshire are no longer required to submit a null report. TPAs with fewer than 2,400 covered life months are not required to file a report with the NHID.

Data are collected for New Hampshire policies, including when an organization has "bricks and mortar" in New Hampshire. For example, assume a TPA administers a health benefit plan. This plan covers a New Hampshire employer and there are 250 lives associated with this employer's plan of which 100 of the 250 lives are Massachusetts residents, and the remaining 150 lives are New Hampshire residents. This TPA is required to report all lives, regardless of the state of residency, covered through this plan as they are all associated with a NH employer's health benefit plan.

In another example, assume a TPA administers a health benefit plan. This plan is for a Massachusetts employer and there are 500 lives associated with this employer's plan and the employer has no facilities in NH. Half of these lives are New Hampshire residents whose principal place of employment is in Massachusetts. This TPA would be required to report limited data for the NH residents but would not report on the non-NH residents since the coverage is not associated with a NH employer's health benefit plan. The same principles apply to fully-insured policies. Policies issued to NH employers or that cover members who have a work location in New Hampshire should be reported in the New Hampshire Supplemental Report.

For an explanation of the data fields used in the Supplemental Report, please see the Supplemental Report bulletin on the NHID website that describes how the data must be submitted to the NHID:
http://www.nh.gov/insurance/media/bulletins/documents/ins_14_005_ab.pdf

DATA NOTES

Supplemental Report data are submitted to the NHID by July 15 of each year for premium billed and claims with a date of service during the prior calendar year. The length of time after the incurred period is needed in order to adequately capture data on a "claims paid" basis, which may take several months for the provider to submit the claim, the carrier to process the claim, and the data to be loaded in reporting databases.

Due to the methodology of the Actuarial Value statistic changing in the 2013 Supplemental Report, it was necessary to have carriers resubmit the 2012 data in the new format. This allowed for consistent comparison between 2012 and 2013. This special re-submission of the 2012 data was due on March 15, 2014.

Upon receiving data from the carrier, the NHID analyzes the submission and provides a summary report back to the carrier. This quality assurance process takes place to confirm that what is submitted by the carrier is reasonable and without major errors that occasionally develop during a data submission process. Additionally, questions are presented to the carriers when apparent anomalies are discovered upon examination of the submitted data. As a result, some carriers resubmit data to correct errors, however not all anomalies and data errors are eliminated with this process. No further auditing of the data takes place.

Many of the statistics in this report are based on membership. Membership numbers are calculated averages based on member months. If a member was covered for twelve months, that member is reported to the NHID with twelve member months and represents one complete member. If a member was only insured for half the year, six months are reported and the membership value is 0.5. This method of averaging allows the NHID to provide comparable numbers of members, when in practice the actual number of members fluctuates throughout the year. Additionally, many individuals may be insured for only part of the year due to moving in or out of state, changing employers, or becoming uninsured. The averaging mechanism avoids overestimating the number of persons insured by counting membership on a pro-rated basis. As members can be counted on a partial basis, summary totals may differ due to rounding errors.

“Loss ratio” is the term that is used to assess what percentage of the premium is paid out for medical claims. Loss ratio is calculated using the data submitted in the Supplemental Report by dividing the total medical and pharmacy claims dollars by the total premium dollars. This calculation also takes place for self-funded insurance using a premium equivalent.

Third party administrators (TPAs) calculate an earned premium equivalent based on the contribution rates established for the coverage being reported. These premium equivalents include all funds collected by the TPA from the account in relation to the TPA's administration of the group's health plan. The funds include provisions for claims, administration, stop-loss insurance, TPA's profit margins, commissions, wellness programs, network fees, and disease management programs.

A loss ratio of 0.85 indicates that 85 cents of every premium dollar is used to cover the cost of medical claims. The difference between 0.85 and 1.0 in this example (equal to 15 cents of every premium dollar) is the amount that covers carrier administrative costs and profit, but does not include all factors that affect carrier profitability.

Average premiums are provided in this report. These averages are calculated by the NHID on a per member per month basis. This allows comparability, but the average premiums will not reflect the actual premium paid by any particular enrollee. This is due to several factors related to the way premiums are calculated, including the application of rating factors, the employee/employer contributions, and premium tiering for coverage types including family, couple, and individual.

Actuarial Values (AVs) were calculated in accordance with the reporting requirements by using the Minimum Value (MV) calculator tool which was made available by HHS. In some instances, plan designs were not compatible with the MV calculator so other methods of estimation were allowed. As with any model or tool, the MV calculator has limitations but should produce an accurate measure most of the time. With respect to health plan designs that are compatible with Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs), employer contributions may be used to meet deductibles, to meet out of pocket maximums and to pay for benefits that are medically necessary but not covered by the health plan. For the purposes of this report, most carriers did not include employer contributions to HSAs or HRAs when calculating the Actuarial Value for the plan designs. Employer contribution totals are not always available to carriers and TPAs, especially when an outside vendor is being used to administer the HSAs or HRAs. However, one large carrier assumed a standard employer contribution for all HSA and HRA compatible plan designs.

Benefit richness is a ratio of the unadjusted premium to the adjusted premium (premium divided by the actuarial values submitted by the carriers). When aggregating data, the benefit richness is the ratio of the sum of the unadjusted premiums divided by the sum of the adjusted premiums.

Starting July 1, 2012, children using Healthy Kids Silver through Harvard Pilgrim Health Care were moved to Medicaid. The Supplemental Report does not include data for members enrolled in plans administered by Medicaid. Caution must be used when comparing the results from the 2012 Supplemental Report to the 2013 Supplemental Report since the 2012 measures include half a year's worth of Healthy Kids data while the 2013 measures do not contain Healthy Kids data. In the 2012 Supplemental Reporting data, Harvard is reporting the Healthy Kids population in the Non-group market category.

Typically when insured members visit a primary care provider or a specialist, they are responsible for paying a copay amount. In some plan designs, these visits are subject to the medical deductible and coinsurance and there is no copay. One large carrier did not distinguish between plan designs with a $0 copay and plan designs where the medical deductible and coinsurance applied. Caution must be used when reviewing the copay data.

Carriers are beginning to become accustomed to the new Stop Loss reporting requirements. In the 2013 Supplemental Reporting process, more detailed stop loss information was collected (aggregate versus specific thresholds, etc). This report does not show detailed information because one large carrier was unable to accurately report data by threshold level.

The New Hampshire Insurance Department is striving for data consistency across all reporting requirements. The Supplemental Reporting process requires that carriers and TPAs compare, at a high level for data elements that are comparable, the Supplemental

Report data submitted to data reported in the NAIC Supplemental Health Care Exhibit (SHCE) and the data submitted to New Hampshire Comprehensive Health Care Information System (NHCHIS). In most instances, carriers/TPAs were able to reconcile within a reasonable tolerance against the SHCE after conducting research. There were some carriers that were unable to line up with the data that they submitted to the (NHCHIS). Ongoing research is being conducted and carriers are expected to improve data submissions and reconciliations in next year's Supplemental Report submission.

Carriers not submitting accurate and compliant data to the NHID are subject to enforcement actions.

Due to the unique nature of these products and to avoid double counting stop-loss, data related to policies for stop-loss, student coverage, blanket insurance, and the high risk pool were included only in the table titled 'LIMITED COVERAGE AND LIMITED ELIGIBILITY POLICIES', and were excluded from the remainder of the report. The stop loss data in the 2013 Supplemental Report is based on only a portion of the stop loss market in New Hampshire.

Like any data collection tool, the Supplemental Reporting tool has limitations. These limitations are not unlike any that are to be expected with survey data. Therefore, while the NHID believes this report accurately represents the health insurance marketplace in New Hampshire, we believe that the data include a degree of error that cannot be eliminated with this type of reporting process.

Comments or questions should be directed to tyler.brannen@ins.nh.gov.

Appendix A – Detailed Distribution of Members by Deductible

Deductible	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$0	28%		**52%**	3%		**38%**	0%	0%
$100	0%		1%	0%		1%	0%	0%
$125	0%		0%	0%		0%	0%	0%
$135	0%		0%	0%		0%	0%	0%
$147	0%		0%	0%		0%	0%	0%
$150	0%		0%	0%		0%	0%	0%
$200	2%		**4%**	0%		**3%**	0%	0%
$250	4%		**7%**	0%		**5%**	0%	0%
$300	1%		1%	0%		1%	0%	0%
$400	0%		0%	0%		0%	0%	0%
$500	6%		**10%**	2%		**8%**	0%	1%
$600	0%		0%	0%		0%	0%	0%
$750	2%		**3%**	1%		**3%**	0%	0%
$900	0%		0%	1%		0%	0%	0%
$1,000	7%		3%	**11%**		6%	8%	**12%**
$1,100	0%		0%	0%		0%	0%	0%
$1,200	0%		0%	0%		0%	0%	0%
$1,250	1%		1%	1%		1%	0%	**4%**
$1,300	2%		**4%**	0%		**3%**	0%	0%
$1,350	0%		0%	0%		0%	0%	0%
$1,500	4%		3%	**4%**		**4%**	2%	3%
$1,600	0%		0%	0%		0%	0%	0%
$1,700	0%		0%	0%		0%	0%	0%
$1,750	0%		0%	0%		0%	0%	1%
$2,000	10%		1%	**19%**		6%	**27%**	5%
$2,100	0%		0%	0%		0%	0%	0%
$2,150	0%		0%	0%		0%	0%	0%
$2,250	0%		0%	0%		0%	0%	0%
$2,400	0%		0%	0%		0%	0%	0%
$2,500	4%		3%	**6%**		3%	3%	**18%**
$2,550	0%		0%	0%		0%	0%	0%
$2,600	0%		0%	0%		0%	0%	0%
$2,700	0%		0%	0%		0%	0%	0%
$2,800	0%		0%	0%		0%	0%	0%
$2,850	0%		0%	0%		0%	0%	0%
$3,000	16%		4%	**29%**		11%	**42%**	1%
$3,050	0%		0%	0%		0%	0%	0%
$3,500	0%		0%	1%		0%	0%	**3%**
$3,750	0%		0%	0%		0%	0%	0%
$4,000	3%		1%	**5%**		2%	**6%**	4%
$4,500	0%		0%	0%		0%	0%	0%
$4,950	0%		0%	0%		0%	0%	0%

Deductible	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$5,000	6%		1%	**11%**		3%	11%	**23%**
$5,100	0%		0%	0%		0%	0%	0%
$5,150	0%		0%	0%		0%	0%	0%
$5,500	0%		0%	0%		0%	0%	0%
$5,950	1%		0%	**2%**		0%	0%	**13%**
$6,000	0%		0%	1%		1%	0%	0%
$6,500	0%		0%	0%		0%	0%	0%
$7,000	0%		0%	0%		0%	0%	0%
$7,500	0%		0%	0%		0%	0%	**2%**
$9,500	0%		0%	0%		0%	0%	0%
$10,000	1%		0%	1%		0%	0%	**8%**
$12,000	0%		0%	0%		0%	0%	1%
$15,000	0%		0%	0%		0%	0%	0%
$25,000	0%		0%	0%		0%	0%	0%

Appendix B- Benefit Category Descriptions

Ambulance Service	Includes: ambulance transportation.
Audiology Screening for Newborns	Includes: covered for one screening and one confirming screening.
Blood and Blood Products	Includes: fees associated with the collection or donation of blood or blood products, all cost recovery expenses for blood, blood derivatives, components, biologics, and serums to include autologous services and albumin.
Case Management Program	Includes: available for medically complex and costly services.
Chiropractic Services	Includes chiropractic services.
Durable Medical Equipment (DME)	Includes: nebulizers, peak flow meters, and diabetes glucose monitoring equipment.
Emergency Room	Includes: emergency room treatment.
Family Planning Services	Full range of services including: Counseling services and patient education; examination and treatment by medical professionals; laboratory examinations and tests; medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception. *This category does not include infertility services; these services are covered under a separate benefit category.*
Habilitative Services	Includes: coverage for children 0-19 years of age for treatment of congenital and genetic birth defects.
Hearing Aids	Includes: coverage and services as defined by NH State Law; including hearing aid for each hearing-impaired ear, every 60 months.
Home Health Care	Includes: coverage as an alternative to otherwise covered services in a hospital or other related institution.
Hospice	Includes: coverage same as Medicare, including nursing care, medical social services, physicians' services, counseling services, short-term inpatient care, medical appliances and supplies, home health aide services, physical therapy, occupational therapy, speech-language pathology, and other items and services.
Hospitalization	Includes: unlimited (includes detoxification)
Infertility Services	Includes: coverage for services obtained after diagnosis of infertility including all non-experimental infertility procedures including, but not limited to, artificial insemination and intrauterine insemination, in vitro fertilization and embryo transfer, gamete intrafallopian transfer, sperm and/or egg procurement and processing, intracytoplasmic sperm injection, zygote intrafallopian transfer, assisted hatching, cryopreservation of eggs, and

	infertility-related drugs. Does not include any experimental infertility procedure, surrogacy, or reversal of voluntary sterilization.
Medical Food	Includes: for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis or treatment in the field of metabolic disorders
Mental Health and Substance Abuse	Includes: when delivered through a managed care system for 60 inpatient days with partial hospitalization traded on a 2 to 1 basis and unlimited outpatient visits
Nutritional Services	Includes: six visits per year for cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease.
Outpatient Hospital Services & Surgery	Includes: outpatient hospital services and surgery.
Outpatient Laboratory & Diagnostic Services	Includes: outpatient laboratory and diagnostic services.
Outpatient Short-Term Rehabilitative Services	Includes: physical therapy, speech therapy, and occupational therapy.
Pediatric Dental Services	Includes: coverage for diagnostic, preventative services, minor and major restorative services, implants, and orthodontia. Minor restorative services include but are not limited to filings, crowns, and oral surgery for impacted teeth. Major restorative services include inlays, root canals and fixed prosthesis.
Pediatric Vision Services	Includes: but is not limited to, diagnostic services, frames & prescription lenses, or contact lenses.
Pregnancy and Maternity	Includes: services related to pregnancy and maternity.
Prescription Drugs (Rx)	Includes: prescriptions available on an open formulary with coverage at least the generic drug equivalent amount when the brand name drug is prescribed.
Preventive Services	Includes: preventive services as defined and required in the Affordable Care Act as of the reporting year.
Skilled Nursing Facility	Includes: 100 days as an alternative to otherwise covered care in a hospital or other related institution.
Transplants	Includes: for bone marrow, cornea, kidney, liver, lung, heart, pancreas, and pancreas/kidney transplants.
Well Child & Immunization Benefits	Includes: for children 0 – 13 years of age.

Appendix C – 2012 Supplemental Report Restated Tables

Appendix C shows tables from the 2012 Supplemental Report that have been restated and will allow for a consistent comparison to the tables in the 2013 Supplemental Report. Table numbers in the appendix correspond to the table numbers used in the main portion of the report.

SUMMARY STATISTICS

NH SITUS ONLY STATISTICS

- Total premiums and premium equivalents = $2,506,524,086
- Total claims = $2,178,430,366
- Average loss ratio = 86.9%
- Average number of members insured = 480,575
- Average member premium per month:
    - Large Group $453
    - Small Group $432
    - Non-group $286

Table 1 (2012):
All Members, by Market Category and Policy Situs

	NH Situs	non-NH Situs	Total
Large Group	348,177	149,456	**497,633**
Small Group	91,553	9,890	**101,443**
Non-Group	40,845	44	**40,890**
Total	**480,575**	**159,391**	**639,966**

Table 2 (2012):
Small Group Members

	NH Situs	non-NH Situs	Total
Groups of 1 Employee	2,407	691	**3,098**
Groups of 2 to 50 Employees	89,146	9,199	**98,345**

Table 3 (2012):
Membership Distribution by Market Category

	NH Situs	non-NH Situs	Total
Large Group	54%	23%	**78%**
Small Group	14%	2%	**16%**
Non-Group	6%	0%	**6%**
Total	**75%**	**25%**	**100%**

Table 4 (2012):
Percentage of Members within each Market/Situs that are Fully Insured

	NH Situs	non-NH Situs	Total
Large Group	30%	16%	**26%**
Small Group	99%	97%	**99%**
Non-Group	100%	100%	**100%**
Total	**49%**	**21%**	**42%**

HIGH DEDUCTIBLE HEALTH PLANS

- For 2012, the percent of members in an IRS defined High Deductible Health Plan (HDHP) for NH situs members is 15%, compared to 18% for non-NH situs members.

DEDUCTIBLES

Most common deductible amounts, based on percent of covered members (NH Situs only):

- $0 – 30%
- $500 – 7%
- $1,000 – 8%
- $2,000 – 10%
- $3,000 – 14%
- $5,000 – 5%

CO-INSURANCE

Most common co-insurance amounts, based on percent of covered members (NH Situs only):

- 0% co-insurance – 99.3%
- 10% co-insurance – 0.1%
- 20% co-insurance – 0.1%

COPAYS

Most common copay amounts, based on percent of covered members (NH Situs only):

- $0 – 13%
- $5 – 7%
- $10 – 11%
- $15 – 11%
- $20 – 19%
- $25 – 29%

DETAILED ANALYSES

AVERAGE PREMIUMS

Table from 2012 Supplemental Report restated using 2012 data that was resubmitted according to the 2013 Supplemental Reporting requirements.

Table 7 (2012):
Average Premium PMPM by Market Category and Plan Type

		Self-Insured*		Fully Insured	
Market Category	**Plan Type**	**Members**	**Avg Premium**	**Members**	**Avg Premium**
Large Group	HMO	92,613	$471	62,249	$450
	POS	40,982	$489	3,489	$483
	PPO	105,146	$430	32,506	$429
	EPO	No Membership Reported		5,817	$367
	Indemnity	4,607	$549	768	$576
Small Group	HMO	169	$521	69,533	$427
	POS	4	$556	1,318	$431
	PPO	363	$484	15,013	$442
	EPO	No Membership Reported		5,091	$457
	Indemnity	62	$508	No Membership Reported	
Non-Group	HMO**	No Membership Reported		4,762	$206
	POS			No Membership Reported	
	PPO			34,606	$302
	EPO**			4	$559
	Indemnity**			1,473	$191
Total		**243,945**	**$458**	**236,630**	**$411**

Average Premiums with Benefit Richness

Table from 2012 Supplemental Report restated using 2012 data that was resubmitted according to the 2013 Supplemental Reporting requirements.

Table 8 (2012):
Average Premium PMPM and Benefit Richness by Market Category and Plan Type

		Self-Insured*			Fully Insured		
Plan Type	**Market Category**	**Members**	**Avg Premium**	**Benefit Richness**	**Members**	**Avg Premium**	**Benefit Richness**
HMO	Large Group	92,613	$471	0.92	62,249	$450	0.82
	Small Group	169	$521	0.90	69,533	$427	0.80
	Non-Group**	No Membership Reported			4,762	$206	0.89
POS	Large Group	40,982	$489	0.94	3,489	$483	0.81
	Small Group	4	$556	0.92	1,318	$431	0.72
	Non-Group	No Membership Reported			No Membership Reported		
PPO	Large Group	105,146	$430	0.85	32,506	$429	0.81
	Small Group	363	$484	0.86	15,013	$442	0.78
	Non-Group	No Membership Reported			34,606	$302	0.72
EPO	Large Group	No Membership Reported			5,817	$367	0.76
	Small Group				5,091	$457	0.76
	Non-Group**				4	$559	0.70
Indemnity	Large Group	4,607	$549	1.01	768	$576	0.83
	Small Group	62	$508	0.90	No Membership Reported		
	Non-Group**	No Membership Reported			1,473	$191	0.62
Total Members		**243,945**	**$458.05**	**0.90**	**236,630**	**$410.51**	**0.79**

Average Premium and Adjusted Premium

Table from 2012 Supplemental Report restated using 2012 data that was resubmitted according to the 2013 Supplemental Reporting requirements.

Table 10 (2012): Average Premium and Adjusted Premium by Plan Type, Market Category, and Coverage Type

		Self-Insured*			Fully Insured		
Plan Type	Market Category	Members	Avg Premium	Adjusted Premium	Members	Avg Premium	Adjusted Premium
HMO	Large Group	38%	$471	$510	26%	$450	$551
	Small Group	0%	$521	$579	29%	$427	$534
	Non-Group**	No Membership Reported			2%	$206	$231
POS	Large Group	17%	$489	$522	1%	$483	$595
	Small Group	0%	$556	$605	1%	$431	$599
	Non-Group	No Membership Reported			No Membership Reported		
PPO	Large Group	43%	$430	$503	14%	$429	$531
	Small Group	0%	$484	$562	6%	$442	$568
	Non-Group	No Membership Reported			15%	$302	$419
EPO	Large Group	No Membership Reported			2%	$367	$484
	Small Group				2%	$457	$599
	Non-Group**				0%	$559	$798
Indemnity	Large Group	2%	$549	$547	0%	$576	$696
	Small Group	0%	$508	$565	No Membership Reported		
	Non-Group**	No Membership Reported			1%	$191	$306
Total Members		**243,945**			**236,630**		

State and Municipal Account Comparison

Table 11 (2012):
Average Premium and Adjusted Premium by Account Type

Plan Type	Account Type	Percent of Members	Avg Premium*	Benefit Richness	Adjusted Premium*
HMO	State	5%	$440	0.90	$489
	Municipal	10%	$459	0.94	$490
	Healthy Kids	1%	$198	0.89	$222
	All Other Accounts	32%	$451	0.82	$547
POS	State	1%	$627	0.90	$696
	Municipal	5%	$508	0.98	$520
	All Other Accounts	3%	$406	0.84	$484
PPO	State	0%	$550	0.90	$611
	Municipal	0%	$543	0.90	$605
	All Other Accounts	39%	$406	0.82	$497
EPO	State	No Membership Reported			
	Municipal	0%	$486	0.80	$607
	All Other Accounts	2%	$409	0.76	$538
Indemnity	State	No Membership Reported			
	Municipal	1%	$738	1.00	$741
	All Other Accounts	1%	$291	0.83	$351
Total Members		**480,575**	**$435**	**0.85**	**$514**

MARKET CATEGORY

Table from 2012 Supplemental Report restated using 2012 data that was resubmitted according to the 2013 Supplemental Reporting requirements.

Table 12 (2012):
Loss Ratios by Market Category and Coverage Type

Market Category	All Members	Loss Ratio	Self-Insured Members	Loss Ratio	Fully-Insured Members	Loss Ratio
Total Large Group	**66%**	**0.89**	**87%**	**0.92**	**44%**	**0.83**
Employers with 51-99 Employees	7%	0.83	1%	0.95	14%	0.82
Employers with >=100 Employees	59%	0.90	86%	0.92	30%	0.84
Qualified Association Trust	**8%**	**0.93**	**13%**	**0.95**	**2%**	**0.85**
Total Small Group	**18%**	**0.81**	**0%**	**0.84**	**36%**	**0.81**
Employers with 1 Employee	0%	1.07	No Membership Reported		1%	1.07
Employers with 2-9 Employees	7%	0.80	0%	0.94	15%	0.79
Employers with 10-25 Employees	7%	0.81	0%	0.95	13%	0.81
Employers with 26-50 Employees	4%	0.77	0%	0.82	7%	0.77
Total Non-Group	**8%**	**0.68**	**No Membership Reported**		**17%**	**0.68**
Non-Group Policy	8%	0.67			17%	0.67
Non-group as Group Conversion	0%	2.06			0%	2.06
Grand Total	**480,575**	**0.87**	**243,945**	**0.92**	**236,630**	**0.81**

DEDUCTIBLES

Table from 2012 Supplemental Report restated using 2012 data that was resubmitted according to the 2013 Supplemental Reporting requirements.

Table 14 (2012):
Deductible by Coverage Type and Market Category

Deductible	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$0	30%		**53%**	5%		**39%**	0%	12%
$1-249	2%		**4%**	0%		**3%**	0%	0%
$250-499	5%		**10%**	1%		**7%**	0%	0%
$500-749	7%		**11%**	2%		**9%**	1%	1%
$750-999	3%		**3%**	2%		**4%**	0%	0%
$1,000-1,499	11%		6%	**15%**		9%	15%	**19%**
$1,500-2,999	20%		7%	**33%**		14%	**37%**	27%
$3,000-4,999	17%		5%	**29%**		12%	**40%**	4%
$5,000-7,499	6%		1%	**11%**		3%	7%	**30%**
$7,500-9,999	0%		0%	0%		0%	0%	1%
$10,000+	1%		0%	1%		0%	0%	**7%**
Grand Total	**480,575**		**243,945**	**236,630**		**348,177**	**91,553**	**40,845**

Table 16 (2012):
Deductible by Account Type

Deductible	All Self_Insured Members		State	Municipal	Other
$0	53%		**88%**	80%	33%
$1-249	4%		0%	1%	**7%**
$250-499	10%		0%	8%	**13%**
$500-749	11%		**12%**	7%	**12%**
$750-999	3%		0%	0%	**5%**
$1,000-1,499	6%		0%	4%	**9%**
$1,500-2,999	7%		0%	2%	**10%**
$3,000-4,999	5%		0%	0%	**8%**
$5,000-7,499	1%		0%	0%	**2%**
$7,500-9,999	0%		0%	0%	0%
$10,000+	0%		0%	0%	0%
Grand Total	**243,945**		**29,462**	**71,261**	**143,222**

CO-INSURANCE

Table from 2012 Supplemental Report restated using 2012 data that was resubmitted according to the 2013 Supplemental Reporting requirements.

Table 17 (2012):
Coinsurance by Market Category and Coverage Type

Coinsurance	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
0%	99.3%		98.7%	**100.0%**		**99.9%**	**100.0%**	93.3%
5%	0.0%		0.0%	0.0%		0.0%	0.0%	0.0%
10%	0.1%		0.1%	0.0%		0.1%	0.0%	0.0%
20%	0.1%		0.3%	0.0%		0.0%	0.0%	**1.7%**
25%	0.0%		0.0%	0.0%		0.0%	0.0%	0.0%
30%	0.0%		0.0%	0.0%		0.0%	0.0%	0.3%
50%	0.0%		0.1%	0.0%		0.0%	0.0%	0.3%
100%	0.4%		0.8%	0.0%		0.1%	0.0%	**4.4%**
Grand Total	**480,575**		**236,630**	**243,945**		**348,177**	**91,553**	**40,845**

COPAYS

Table from 2012 Supplemental Report restated using 2012 data that was resubmitted according to the 2013 Supplemental Reporting requirements.

Table 19 (2012):
Physician Copay by Market Category and Coverage Type

PCP Copay	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$0	13%		12%	**14%**		11%	5%	**46%**
$1	0%		0%	0%		0%	0%	0%
$5	7%		**14%**	0%		**10%**	0%	0%
$10	11%		**19%**	3%		**14%**	0%	12%
$15	11%		**18%**	4%		**15%**	1%	0%
$20	19%		**23%**	16%		**23%**	6%	17%
$25	29%		4%	**56%**		18%	**86%**	0%
$30	2%		**2%**	**2%**		2%	1%	**6%**
$35	1%		**2%**	1%		1%	0%	**3%**
$40	4%		**4%**	3%		4%	1%	**9%**
$45	1%		1%	0%		1%	0%	0%
$50	0%		0%	0%		0%	0%	**2%**
$75	0%		0%	1%		0%	0%	**5%**
D/C	9%		6%	**12%**		9%	10%	**11%**
Total Members	**480,575**		**243,945**	**236,630**		**348,177**	**91,553**	**40,845**
Average PCP Copay	**$18**		**$15**	**$21**		**$17**	**$24**	**$16**
Average non-$0 PCP Copay	**$20**		**$17**	**$24**		**$19**	**$25**	**$29**

2012 Restated- Detailed Benefit Category Table

Table from 2012 Supplemental Report restated using 2012 data that was resubmitted according to the 2013 Supplemental Reporting requirements.

Table 25 (2012):
Benefit Category by Market Category in Detail

Coverage Category	Covered*	All Members		Self-Insured	Fully Insured		Large Group	Small Group	Non-Group
Ambulance Services	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Audiology Screening of Newborns	Yes	98%		100%	97%		100%	100%	85%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	2%		0%	3%		0%	0%	15%
Blood and Blood Products	Yes	82%		70%	94%		75%	99%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	18%		30%	6%		25%	1%	0%
Case Management Programs	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Chiropractic Services	Yes	93%		100%	85%		99%	99%	24%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	7%		0%	15%		1%	1%	76%
Durable Medical Equipment	Yes	100%		100%	100%		100%	100%	99%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	1%
Emergency Room Services	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Family Planning Services	Yes	94%		91%	97%		94%	100%	82%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	6%		9%	3%		6%	0%	18%
Habilitative Services	Yes	76%		70%	82%		75%	100%	26%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	24%		30%	18%		25%	0%	74%
Hearing Aids	Yes	77%		56%	99%		69%	99%	97%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	23%		44%	1%		31%	1%	3%
Home Health Care	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Hospice	Yes	82%		71%	94%		76%	100%	96%
	Yes, DM	1%		2%	0%		1%	0%	0%
	No	17%		28%	6%		23%	0%	4%
Hospitalization	Yes	99%		100%	99%		100%	100%	94%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	1%		0%	1%		0%	0%	6%

Coverage Category	Covered*	All Members		Self-Insured	Fully Insured		Large Group	Small Group	Non-Group
Infertility Services	Yes	39%		31%	46%		36%	66%	0%
	Yes, DM	3%		5%	1%		4%	0%	0%
	No	58%		64%	52%		60%	34%	100%
Medical Food	Yes	81%		70%	92%		75%	100%	91%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	19%		30%	8%		25%	0%	9%
Mental Health and Substance Abuse	Yes	80%		71%	90%		76%	100%	74%
	Yes, DM	17%		29%	6%		24%	0%	0%
	No	2%		0%	5%		0%	0%	26%
Nutritional Services	Yes	79%		67%	91%		73%	99%	85%
	Yes, DM	17%		29%	6%		24%	0%	0%
	No	4%		5%	3%		3%	0%	15%
Outpatient Hospital Services and Surgery	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Outpatient Laboratory and Diagnostic Services	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Outpatient Rehabilitation Services	Yes	99%		100%	99%		100%	100%	92%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	1%		0%	1%		0%	0%	8%
Pediatric Dental Services	Yes	61%		55%	68%		54%	80%	77%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	39%		45%	32%		46%	20%	23%
Pediatric Vision Services	Yes	63%		58%	68%		57%	80%	77%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	37%		42%	32%		43%	20%	23%
Pregnancy and Maternity Services	Yes	99%		100%	97%		100%	100%	84%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	1%		0%	3%		0%	0%	16%
Prescription Drugs	Yes	94%		88%	99%		92%	100%	94%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	6%		12%	1%		8%	0%	6%
Preventive Services	Yes	97%		95%	98%		96%	100%	97%
	Yes, DM	3%		5%	1%		4%	0%	0%
	No	0%		0%	1%		0%	0%	3%
Skilled Nursing Facility	Yes	87%		77%	97%		82%	100%	97%
	Yes, DM	11%		19%	3%		15%	0%	0%
	No	2%		4%	1%		3%	0%	3%
Transplants	Yes	100%		100%	100%		100%	100%	100%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	0%		0%	0%		0%	0%	0%
Well Child and Immunization Benefits	Yes	85%		76%	95%		80%	100%	97%
	Yes, DM	0%		0%	0%		0%	0%	0%
	No	15%		24%	5%		20%	0%	3%

2012 Restated – Carrier Membership Distribution

Table 26 (2012): Distribution of Members by Carrier

Health Insurance Carrier/TPA	Self-Insured Members	Fully-Insured Members	Total Members	Percentage of Total
Anthem	130,400	144,760	275,160	43.0%
CIGNA	133,833	20,434	154,267	24.1%
Harvard	58,007	74,489	132,496	20.7%
Aetna	41,903	5,923	47,826	7.5%
MVP	358	13,260	13,618	2.1%
Usable Mutual	5,054	-	5,054	0.8%
Assurant	-	3,972	3,972	0.6%
United Healthcare	-	3,663	3,663	0.6%
Chesapeake	-	2,520	2,520	0.4%
Celtic	-	886	886	0.1%
Health Partners	265	-	265	0.0%
State Farm	-	184	184	0.0%
American Republic	-	55	55	0.0%
Total	**369,821**	**270,145**	**639,966**	**100.0%**

Chart 1 (2012): Distribution of Members by Carrier

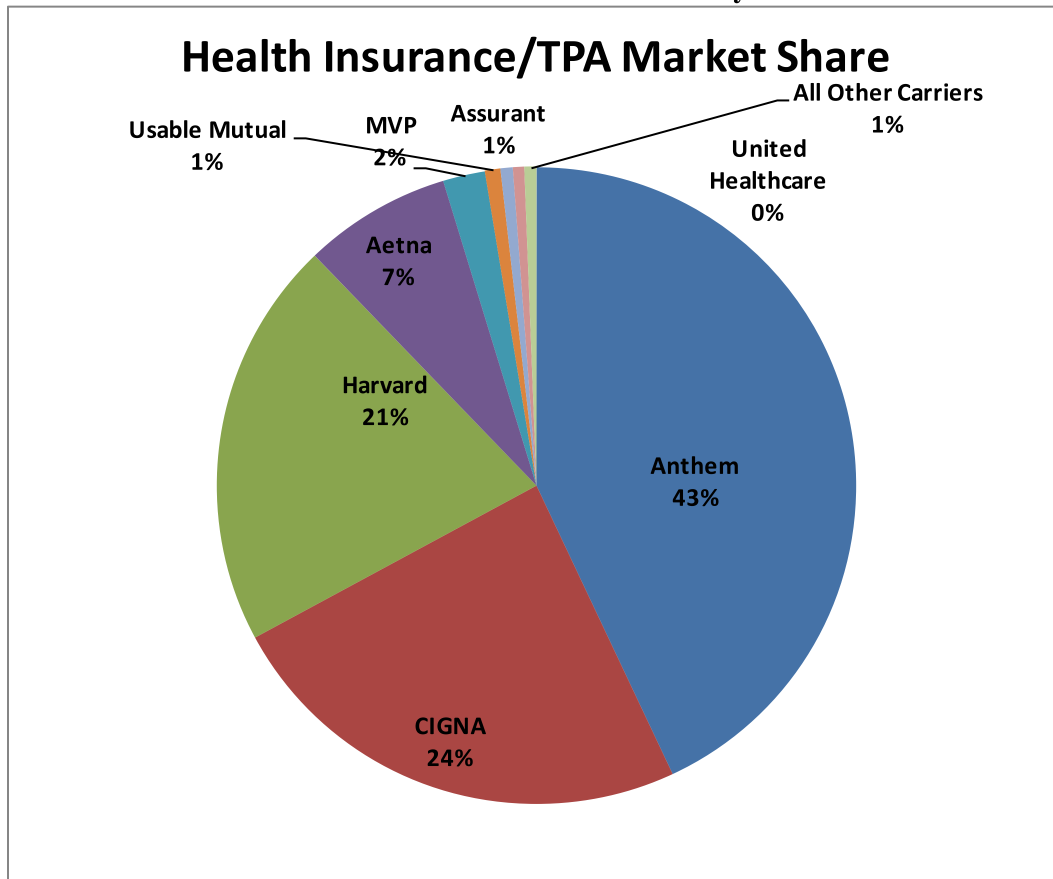


Chart 2 (2012):
Health Insurance Carrier/TPA Member Distribution by Coverage Type

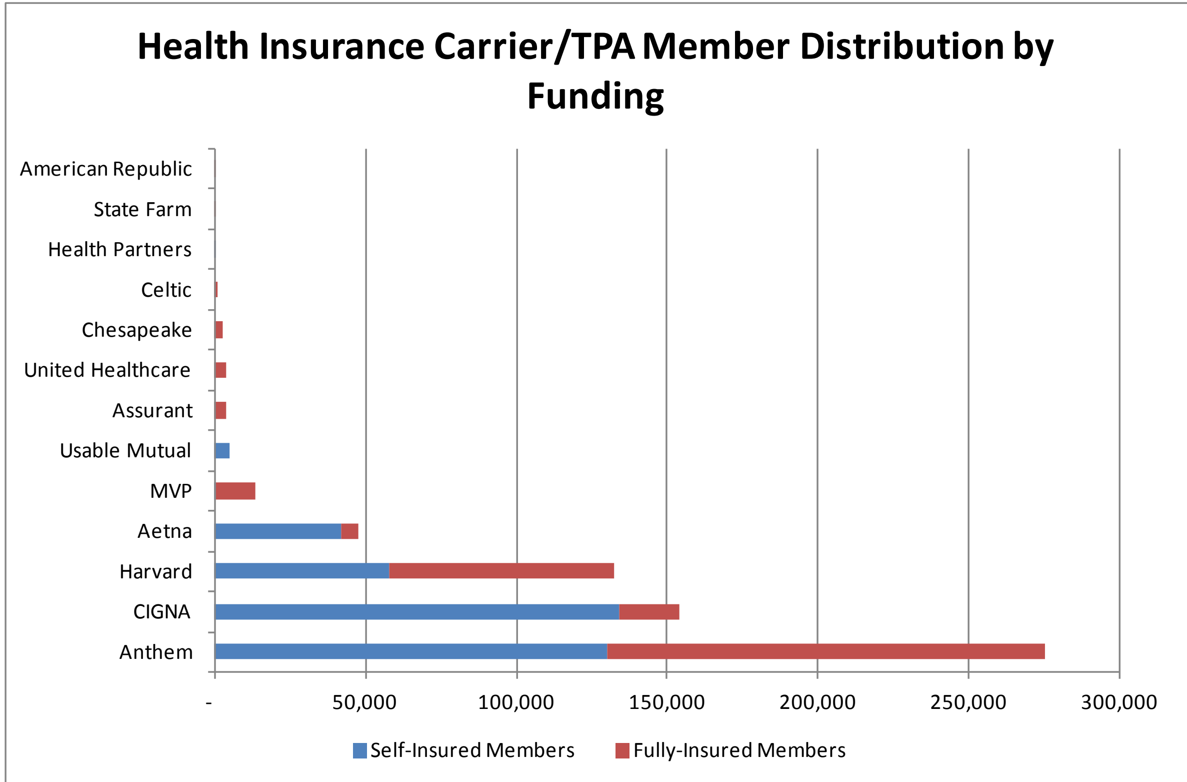


Chart 3 (2012):
Health Insurance Carrier/TPA Member Distribution by Market Category

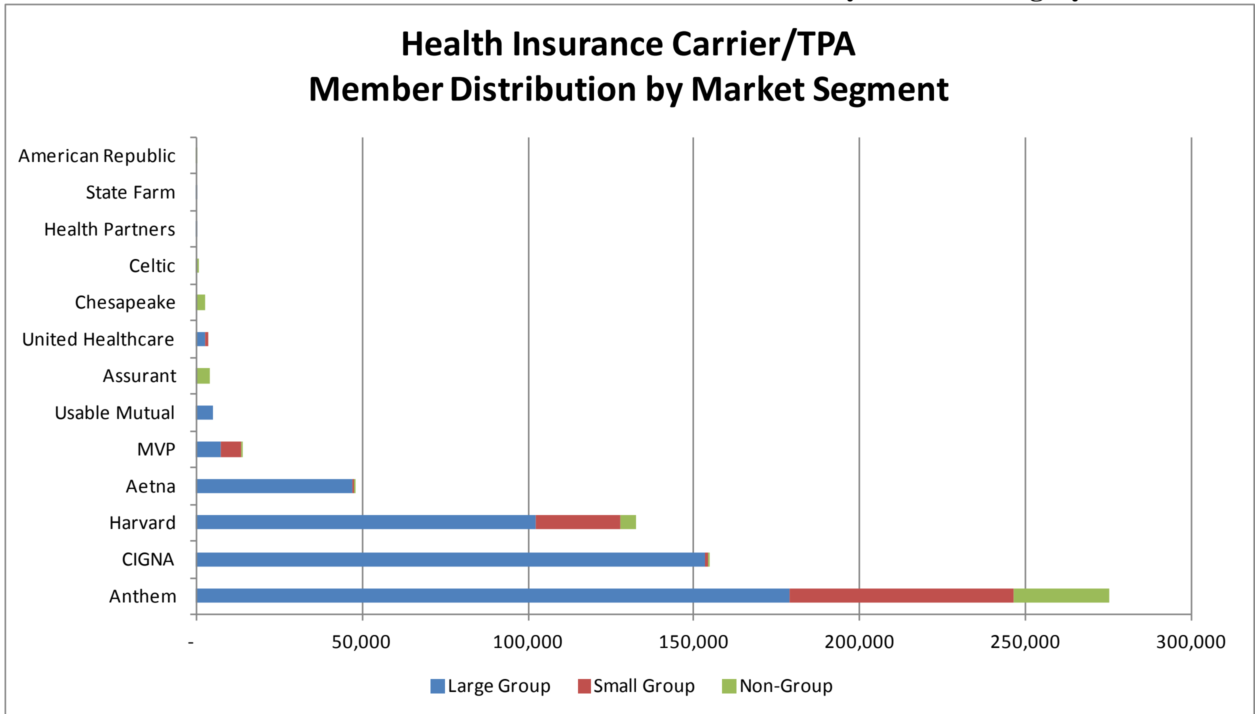


Table 27 (2012):
Limited Coverage Summary Statistics

Limited Coverage	Situs	Members	Premium PMPM	Claims PMPM	Loss Ratio
Stoploss	NH	94,336	$ 26	$ 17	67%
Stoploss	non-NH	46,191	$ 33	$ 24	71%
Stoploss Total	**NH & non-NH**	**140,526**	**$ 28**	**$ 20**	**69%**
Student	NH	1,566	$ 115	$ 101	88%
Student	non-NH	1,414		$ 67	
Student Total	**NH & non-NH**	**2,979**		**$ 85**	
High Risk Pool (NHHP)	NH	2,799	$ 491	$ 834	170%
High Risk Pool (NHHP-FED)	NH	506	$ 473	$ 4,874	1031%
High Risk Pool Total	**NH**	**3,305**	**$ 488**	**$ 1,453**	**297%**

2012 Restated – Detailed Distribution of Members by Deductible

Deductible	All Members	Self-Insured	Fully-Insured	Large Group	Small Group	Non-Group
$0	30%	**53%**	5%	**39%**	0%	12%
$100	1%	1%	0%	1%	0%	0%
$125	0%	0%	0%	0%	0%	0%
$135	0%	0%	0%	0%	0%	0%
$147	0%	0%	0%	0%	0%	0%
$150	0%	0%	0%	0%	0%	0%
$200	2%	**3%**	0%	**2%**	0%	0%
$250	5%	**9%**	0%	**7%**	0%	0%
$300	0%	1%	0%	1%	0%	0%
$400	0%	0%	0%	0%	0%	0%
$500	7%	**11%**	2%	**9%**	1%	1%
$600	0%	0%	0%	0%	0%	0%
$750	2%	**3%**	2%	**3%**	0%	0%
$900	0%	0%	1%	0%	0%	0%
$1,000	8%	2%	**14%**	6%	**15%**	14%
$1,100	0%	0%	0%	0%	0%	0%
$1,200	2%	**3%**	0%	**2%**	0%	0%
$1,250	1%	0%	1%	0%	0%	**5%**
$1,300	0%	0%	0%	0%	0%	0%
$1,350	0%	0%	0%	0%	0%	0%
$1,500	4%	2%	**6%**	**4%**	4%	3%
$1,600	0%	0%	0%	0%	0%	0%
$1,700	0%	0%	0%	0%	0%	0%
$1,750	0%	0%	0%	0%	0%	0%
$2,000	10%	2%	**19%**	6%	**27%**	6%
$2,100	0%	0%	0%	0%	0%	0%
$2,150	0%	0%	0%	0%	0%	0%
$2,250	0%	0%	0%	0%	0%	0%
$2,400	1%	1%	0%	1%	0%	0%
$2,500	5%	2%	**7%**	3%	6%	**17%**
$2,550	0%	0%	0%	0%	0%	0%
$2,600	0%	0%	0%	0%	0%	0%
$2,700	0%	0%	0%	0%	0%	0%
$2,800	0%	0%	0%	0%	0%	0%
$2,850	0%	0%	0%	0%	0%	0%
$3,000	14%	3%	**25%**	9%	**36%**	1%
$3,050	0%	0%	0%	0%	0%	0%
$3,500	1%	1%	0%	1%	0%	1%
$3,750	0%	0%	0%	0%	0%	0%
$4,000	2%	1%	**3%**	2%	**4%**	2%
$4,500	0%	0%	0%	0%	0%	0%
$4,950	0%	0%	0%	0%	0%	0%

Deductible	All Members	Self-Insured	Fully-Insured	Large Group	Small Group	Non-Group
$5,000	5%	1%	**10%**	3%	7%	**23%**
$5,100	0%	0%	0%	0%	0%	0%
$5,150	0%	0%	0%	0%	0%	0%
$5,500	0%	0%	0%	0%	0%	0%
$5,950	1%	0%	1%	0%	0%	**6%**
$6,000	0%	0%	0%	0%	0%	0%
$6,500	0%	0%	0%	0%	0%	0%
$7,000	0%	0%	0%	0%	0%	0%
$7,500	0%	0%	0%	0%	0%	1%
$9,500	0%	0%	0%	0%	0%	0%
$10,000	1%	0%	1%	0%	0%	**6%**
$12,000	0%	0%	0%	0%	0%	1%
$15,000	0%	0%	0%	0%	0%	0%
$25,000	0%	0%	0%	0%	0%	0%