New Hampshire

Small Employer

Health

Reinsurance

Pool

Operation and Procedures Manual

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Section I

Final Order

STATE of NEW HAMPSHIRE INSURANCE DEPARTMENT

FINAL ORDER
Docket No.: Ins 05-039-AP
In Re: Small Employer Health Reinsurance Pool
2005 Chapter 225, RSA 420-K Plan of Operation

RSA 420-K established a nonprofit entity to be known as the "New Hampshire Small Employer Health Reinsurance Pool," ("the Pool"). The Pool was duly organized at a meeting that took place at the New Hampshire Insurance Department ("the Department") on July 14, 2005. Member insurers selected an initial board of directors ("the Board") at the organizational meeting.

RSA 420-K:4 I (c) states that "the standard health benefit plan, base reinsurance premium rates, and the rating methodology shall be submitted to the commissioner for approval within 45 days after the appointment of the board." The Department received the Board's proposed standard health benefit plan, base reinsurance premium rates, and the rating methodology on August 26, 2005. Since these items are integrally related to the Pool's plan of operation, the Department issued an Administrative Order on September 14, 2005 delaying approval of these items until it has had an opportunity to receive and hold a hearing on the Board's proposed plan of operation.

RSA 420-K:2 IV requires the Board to submit to the commissioner, within 60 days of the Board's appointment, a proposed plan of operation. The commissioner is required to provide notice and hearing prior to determining whether the plan of operation should be approved. A public hearing on the board's proposed plan of operation for the Pool was held at the offices of the New Hampshire Insurance Department, 21 South Fruit Street, Suite 14, Concord, New Hampshire on September 21, 2005 at 10:00 a.m. The hearing was continued to October 6, 2005 to enable the Board to complete its submission by amending the plan of operation with the filing of the Pool's articles and bylaws on or before September 23, 2005.

Having reviewed the proposed plan of operation together with the Pool's articles of incorporation and bylaws, the standard health benefit plan, the base reinsurance premium rates, and the rating methodology, and having considered the testimony offered on the September 21st and October 6th hearing dates, and finding that the plan of operation is suitable to assure the fair, reasonable and equitable administration of the pool and provides for the sharing of pool gains or losses on an equitable proportionate basis, the plan of operation dated September 12, 2005, articles of incorporation dated September 23, 2005, bylaws dated September 23, 2005, the standard health benefit plans, the base reinsurance premium rates, and the rating methodology of the Pool are hereby **APPROVED**.

So Ordered,

NEW HAMPSHIRE INSURANCE DEPARTMENT

Dated: 10-25-05

Roger A. Sevigny, Commissioner

Section II

Law

CHAPTER 225

SB 125-FN é FINAL VERSION

03/24/05 0840s

04/07/05 1049s

06/09/05 1921eba

2005 SESSION

05-1009

01/09

SENATE BILL 125-FN

AN ACT repealing health status and geographic location as small group rating factors, clarifying certain other issues relating to small group insurance, and establishing a reinsurance mechanism.

SPONSORS: Sen. Gatsas, Dist 16; Sen. Barnes, Dist 17; Sen. Gallus, Dist 1; Sen. Green, Dist 6; Sen. Roberge, Dist 9; Rep. Stone, Rock 1; Rep. R. Wheeler, Hills 7; Rep. Wendelboe, Belk 1

COMMITTEE: Banks and Insurance

AMENDED ANALYSIS

This bill makes certain changes in the small employer health insurance law, including:

I. Repealing health status and geographic location as rating factors for small group health insurance.

II. Adding a definition of case characteristics and certain other definitions.

III. Clarifying overall premium rate variability in the small group health insurance market.

IV. Clarifying the small group health insurance law regarding premium rates for small employer groups with similar case characteristics.

V. Establishing the New Hampshire small employer health reinsurance pool to offer pool coverage to eligible employees of small employers.

- -

Explanation: Matter added to current law appears in bold italics.

Matter removed from current law appears [~~in brackets and struckthrough.~~]

Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

03/24/05 0840s

04/07/05 1049s

06/09/05 1921eba

05-1009

01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Five

AN ACT repealing health status and geographic location as small group rating factors, clarifying certain other issues relating to small group insurance, and establishing a reinsurance mechanism.

Be it Enacted by the Senate and House of Representatives in General Court convened:

225:1 Small Group Health Insurance; Definitions Added. RSA 420-G:2, I is repealed and reenacted to read as follows:

I. "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer health carrier is in compliance with the provisions of and the rules adopted by the commissioner, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer health carrier in establishing premium rates for applicable health benefit plans.

I-a. "Case characteristics" means demographic or other relevant characteristics of a small employer group that may be considered by the health carrier in the determination of premium rates for that group.

225:2 New Paragraph; Definition Added. Amend RSA 420-G:2 by inserting after paragraph II the following new paragraph:

II-a. "Composite billing" means a method of calculating premium rates for small employer groups in which each enrolled employee's rate varies only by the enrolled employee's family composition.

225:3 New Paragraph; Definition Added. Amend RSA 420-G:2 by inserting after paragraph VII the following new paragraph:

VII-a. "Family composition" means health plan membership type, including: enrollee only; enrollee and spouse; enrollee and children; enrollee, spouse, and children; and other similar membership types.

225:4 Definition Changed. Amend RSA 420-G:2, IX-a to read as follows:

IX-a. "Health coverage plan rate" means a rate that is uniquely determined for each of the coverages or health benefit plans a health carrier writes and that is derived from the [~~base~~] market rate through the application of plan factors that reflect actuarially demonstrated differences in expected utilization [~~or cost~~] and health care costs attributable to differences in the coverage design and/or the provider contracts that support the coverage and by including provisions for administrative costs and loads. The health coverage plan rate is periodically adjusted to reflect expected changes in the market rate, utilization, health care costs, administrative costs, and loads.

225:5 Definition Added. Amend RSA 420-G:2, XII-a to read as follows:

XII-a. "List billing" means a method of calculating premium rates for small employer groups in which each enrolled employee's rate varies only by the enrolled employee's attained age and the enrolled employee's family composition.

XII-a a. "Loss information" means the aggregate claims experience and shall include, but not be limited to, the number of covered lives, the amount of premium received, the amount of total claims paid, and the claims loss ratio. "Loss information" shall not include any information or data pertaining to the medical diagnosis, treatment, or health status that identifies an individual covered under the group contract or policy. Catastrophic claim information shall be provided as long as the provision of this information would not compromise any covered individual's privacy.

225:6 New Paragraph; Definition Added. Amend RSA 420-G:2 by inserting after paragraph XII-b the following

new paragraph:

XII-c. "Market rate" means a single rate reflecting the carrier's average cost of actual or anticipated claims for all health coverages or health benefit plans the carrier writes and maintains in a market, including the nongroup individual health insurance market and, separately, the small employer group health insurance market, and which is periodically adjusted by the carrier to reflect changes in actual or anticipated claims.

225:7 New Paragraph; Definition Added. Amend RSA 420-G:2 by inserting after paragraph XIV-a the following new paragraph:

XIV-b. "Premium rate" means the rates used by a carrier to calculate the premium. For group coverage, premium rates shall be expressed as a rate per enrolled employee.

225:8 New Paragraph; Definition Added. Amend RSA 420-G:2 by inserting after paragraph XV the following new paragraph:

XV-a. "Rating period" means the time period for which the premium rate charged by a health carrier to an individual or a small employer for a health benefit plan is in effect.

225:9 Premium Rates. Amend RSA 420-G:4, I(a) to read as follows:

(a) All [~~premiums~~] premium rates charged shall be guaranteed for a rating period of at least 12 months, [~~unless otherwise allowed by the commissioner~~] and shall not be changed for any reason, including but not limited to a change in the group's case characteristics.

225:10 Small Group Insurance; Premium Rates. Amend RSA 420-G:4, I(e) and (f) to read as follows:

(e) In establishing the premium charged, health carriers [~~providing~~] offering coverage to small employers shall calculate [~~a rate~~] premium rates that [~~is~~] are derived from the health coverage plan rate [~~through the application of rating factors that the carrier chooses to utilize for age, group size, industry classification, geographic location, and health status~~] by making adjustments to reflect one or more case characteristics. Such [~~factors~~] adjustments from the health coverage plan rate may be [~~utilized~~] made only in accordance with the following limitations:

(1) [~~Carriers may use the attained age of covered persons as a rating factor. However, the maximum premium differential for age as determined by ratio shall be 4 to 1 beginning with age 19~~]. In establishing the premium rates, health carriers offering coverage to small employers may use only age, group size, and industry classification as case characteristics. No consideration shall be given to health status, claim experience, duration of coverage, geographic location, or any other characteristic of the group.

(2) Carriers [~~modifying such average premium~~] making adjustments from the health coverage plan rate for age may do so only by using the following age brackets:

0 - 18

19 - 24

25 - 29

30 - 34

35 - 39

40 - 44

45 - 49

50 - 54

55 - 59

60 - 64

65 +

(3) [~~Carriers may use group size as a rating factor. However, the highest factor based on group size shall not exceed the lowest factor based on group size by more than 20 percent; provided that for groups of one, an additional 10 percent rating factor shall be allowed from the highest factor.~~

~~(4) Carriers may use the small employer group's industry classification as a rating factor. However, the highest factor based on industry classification shall not exceed the lowest factor based on industry classification by more than 20 percent.~~

~~(5) Carriers may use the small employer group's geographic location as a rating factor. However, the highest factor based on geographic location shall not exceed the lowest factor based on geographic location by more than 15 percent.~~

~~(6) Carriers may use the health status of the small employer group as a rating factor. However, the application of a health status factor shall be subject to the following limitations:~~

~~(A) The health status factor may reflect health status of covered persons, the small employer's claim experience, or the duration of coverage since health statements were last provided.~~

~~(B) Variations from the arithmetic average of the highest rate charged to the lowest rate charged shall not exceed 25 percent.~~

~~(C) Upon the renewal of a small employer policy, any increase in the premium rate that is solely attributable to changes in the health status factor from the prior year shall be no more than 15 percent.~~

~~(7) Upon the renewal of a small employer policy, a carrier is prohibited from increasing the premium rate by more than 25 percent of the rate that was charged in the preceding year. Such rate increase limitation shall not include any premium rate increase that is based on a carrier's annual cost and utilization trends or changes in the rating factor for attained age of covered persons.~~] The maximum premium rate differential after adjusting for all case characteristics as determined by ratio shall be 3.5 to 1. This limitation shall not apply for determining premium rates for covered persons whose attained age is less than 19.

(4) In establishing the premium rates, health carriers offering coverage to small employers may make further adjustments based on family composition.

(5) The small employer health carrier shall set premium rates for small employers after consideration of case characteristics of the small employer group as well as family composition. No small employer health carrier shall inquire regarding health status or claims experience of the small employer or its employees or dependents until after the premium rates have been agreed upon by the carrier and the employer.

(6) Carriers may calculate premium rates using either list billing or composite billing. Carriers shall use the same billing method in all succeeding rating periods unless the small employer agrees to allow the carrier to change the methodology.

(7) The percentage increase in the premium rates used by a health carrier for a new rating period shall not exceed 20 percent of the premium rates used by that carrier in the preceding rating period. Such rate increase limitation shall not include any premium rate increase that is based on changes in the health coverage plan rate.

(f) Each rating factor that a carrier chooses to utilize in the individual market shall be reflective of claim cost variations that correlate with that factor independently of claim cost variations that correlate with any of the other allowable factors.

225:11 Medical Underwriting. Amend RSA 420-G:5, I to read as follows:

I. Health carriers providing health coverage for individuals [~~or small employer groups~~] may perform medical

underwriting, including the use of health statements or screenings or the use of prior claims history, to the extent necessary to establish or modify premium rates as provided in RSA 420-G:4. The commissioner may allow group carriers to use standardized health statements. Small group carriers may use the standard reinsurance underwriting form for their reinsurance ceding decisions to the New Hampshire small employer health reinsurance pool, established in RSA 420-K:2, after premium prices have been agreed upon by the carrier and the small employer.

225:12 New Chapter; Small Employer Health Reinsurance Pool. Amend RSA by inserting after chapter 420-J the following new chapter:

CHAPTER 420-K

SMALL EMPLOYER HEALTH REINSURANCE POOL

420-K:1 Definitions. In this chapter:

I. "Assessment" means the liability of the member insurer to the reinsurance pool.

II. "Board" means the board of directors of the small employer health reinsurance pool.

III. "Commissioner" means the insurance commissioner.

IV. "Covered lives" means "covered lives" as defined in RSA 404-G:2, V.

V. "Health carrier" means any entity licensed pursuant to RSA 402, RSA 420-A, or RSA 420-B that delivers, issues for delivery or maintains in force policies of health insurance in New Hampshire.

VI. "Health insurance" means "health insurance" as defined in RSA 404-G:2, VII.

VII. "Plan of operation" means the plan of operation of the small employer health reinsurance pool, including articles, bylaws and operating rules, procedures and policies approved by the commissioner and adopted by the pool.

VIII. "Pool" means the small employer health reinsurance pool.

IX. "Small employer" means "small employer" as defined in RSA 420-G:2, XVI.

X. "Standard health benefit plan" means a health benefit plan developed pursuant to RSA 420-K:4, I.

420-K:2 Establishment of the Pool.

I. There is established a nonprofit entity to be known as the "New Hampshire small employer health reinsurance pool." All health carriers, writers of health insurance, and other insurers issuing or maintaining health insurance in this state shall be members of the pool.

II. On or before July 1, 2005, the commissioner shall give notice to all members of the pool of the time and place for the initial organizational meeting, which shall take place by July 15, 2005. The members shall select the initial board, subject to approval by the commissioner. The board shall consist of at least 5 and not more than 9 representatives of members. There shall be no more than one board member representing any one member company. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The vote shall be proportional to the member's covered lives. To the extent possible, at least 2/3 of the members of the board shall be small employer health carriers. At least one member shall be a small employer health carrier with less than $100,000,000 in net small employer health insurance premium in this state. The commissioner, or designee, shall be an ex-officio member of the board. In approving selection of the board, the commissioner shall assure that all members are fairly represented. The membership of all boards subsequent to the initial board shall be approved by the commissioner and shall, to the extent possible, reflect the same distribution of representation as is described in this paragraph.

III. If the initial board is not elected at the organizational meeting, the commissioner shall appoint the initial board within 15 days of the organizational meeting.

IV. Within 60 days after the appointment of such initial board, the board shall submit to the commissioner a plan of operation and thereafter any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the pool. The commissioner shall, after notice and hearing, approve the plan of operation provided he or she determines it to be suitable to assure the fair, reasonable, and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis in accordance with the provisions of paragraph VI of this section. The plan of operation shall become effective upon approval in writing by the commissioner consistent with the date on which the coverage under this section shall be made available. If the board fails to submit a suitable plan of operation within 60 days after its appointment, or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner shall, after notice and hearing, adopt and promulgate a plan of operation or amendments no later than October 1, 2005. The commissioner shall amend any plan adopted by him or her, as necessary at the time a plan of operation is submitted by the board and approved by the commissioner.

V. The board shall select reinsurance pool administrators through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board. Each month, total payments to administrators shall not exceed the larger of $2,500 or an amount equal to $10 per life for which the reinsurance pool has any potential claims liability.

VI. The plan of operation shall establish procedures for:

(a) Handling and accounting of assets and moneys of the pool, and for annual fiscal reporting to the commissioner.

(b) Filling vacancies on the board, subject to the approval of the commissioner.

(c) Selecting an administrator and setting forth the powers and duties of the administrator.

(d) Reinsuring risks in accordance with the provisions of this chapter.

(e) Collecting assessments from all members to provide for claims reinsured by the pool and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made.

(f) Any additional matters at the discretion of the board.

420-K:3 Powers of the Pool.

I. The pool shall have the general powers and authority granted under the laws of New Hampshire to insurance companies licensed to transact health insurance.

II. In addition, the pool shall have the specific authority to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this chapter, including the authority, with the approval of the commissioner, to enter into contracts with programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions.

(b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against members.

(c) Take such legal action as necessary to avoid the payment of improper claims against the pool.

(d) Define the array of health coverage products for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this chapter.

(e) Establish rules, conditions, and procedures pertaining to the reinsurance of members îrisks by the pool.

(f) Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and any other actuarial functions appropriate to the operation of the pool.

(g) Assess members in accordance with the provisions of this chapter, and to make advance interim assessments

as may be reasonable and necessary for organizational and interim operating expenses. Any such interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year.

(h) Appoint from among the members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the pool, policy, and other contract design, and any other function within the authority of the pool.

(i) Borrow money to effectuate the purposes of the pool. Any notes or other evidence of indebtedness of the pool not in default shall be legal investments for insurers and may be carried as admitted assets.

(j) Develop a standard health benefit plan.

420-K:4 Standard Health Benefit Plan.

I. The board shall:

(a) Develop a standard health benefit plan which shall contain benefit and cost sharing levels that reflect the health coverages most commonly sold by small employer carriers in the state.

(b) Develop base reinsurance premium rates for the standard health benefit plan. The base reinsurance premium rates shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard health benefit plan. The base premium rates shall be subject to approval of the commissioner.

(c) Establish a methodology for determining premium rates to be charged by the pool to reinsure small employer groups and individuals. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in establishing premium rates.

II. The standard health benefit plan, base reinsurance premium rates, and the rating methodology shall be submitted to the commissioner for approval within 45 days after the appointment of the board and shall subsequently be revised as necessary and appropriate.

420-K:5 Eligibility, Coverage, and Rates. Beginning January 1, 2006, members may reinsure with the pool health coverage provided to small employers as follows:

I. The pool shall reinsure the level of coverage provided up to, but not exceeding, the level of coverage provided in the standard health benefit plan or the actuarial equivalent thereof as defined and authorized by the board.

II. The pool shall not reimburse a ceding carrier with respect to claims of a reinsured employee or dependent until the carrier has incurred an initial level of claims for such employee or dependent of at least $5,000 in a calendar year for benefits covered by the standard health benefit plan. The amount of the deductible shall be periodically reviewed by the board and may be adjusted upward as determined by the board.

III. A member may reinsure an entire small employer group within a period of 60 days following the small employer's health insurance policy issue or renewal date.

IV. A member may reinsure an eligible employee or dependent of a small employer group within a period of 60 days following the small employer's health insurance policy issue or renewal date.

V. A member may reinsure a newly eligible employee or dependent of a small employer group within a period of 60 days following the commencement of his or her coverage.

VI. Reinsurance coverage may be terminated for each reinsured employee or dependent on any plan anniversary.

VII. Reinsurance of newborn dependents shall be allowed only if the mother of any such dependent is reinsured as of the date of birth of such child, and all newborn dependents of reinsured persons shall be automatically reinsured as of their date of birth.

VIII. Notwithstanding the provisions of paragraphs III and IV:

(a) Coverage for eligible employees and their dependents provided under a group policy covering 2 or more small employers shall not be eligible for reinsurance when such coverage is discontinued and replaced by a group policy of another carrier covering 2 or more small employers, unless coverage for such eligible employees or dependents was reinsured by the prior carrier; and

(b) At the time coverage is assumed for such group by a succeeding carrier, such carrier shall notify the pool of its intention to provide coverage for such group and shall identify the employees and dependents whose coverage will continue to be reinsured. The time limitations for providing such notice shall be established by the pool.

IX. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged for reinsuring small employers and individuals. The methodology shall include a system for classification of small employers that reflects the way case characteristics are commonly used by small employer carriers in the state. Pool reinsurance premiums shall be established at the following percentages of the base reinsurance premium rate established by the pool for that classification of small employers with similar case characteristics:

(a) An entire small employer group consisting of 2 or more employees may be reinsured for a rate that is 150 percent of the applicable base reinsurance premium rate for the group established pursuant to RSA 420-K:4, II; and

(b) An eligible employee or dependent may be reinsured for a rate that is 500 percent of the applicable base reinsurance premium rate for the individual established pursuant to RSA 420-K:4, II.

X. On or before December 1, 2005, the board shall establish, subject to the approval of the commissioner, a standard reinsurance underwriting form for use by small employer carriers in ceding risks to the pool. The form may be amended from time to time as the board deems necessary, subject to the approval of the commissioner.

420-K:6 Assessments.

I. Following the close of each fiscal year, the administrator shall determine the net premiums, the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

(a) Each member's assessment for the reinsurance pool shall be based on its number of covered lives times a specified assessment rate. The board of directors shall specify the basis used to set the assessment rate. The board of directors shall establish a regular assessment rate, which shall be:

(1) Calculated on a calendar year basis based on the net losses from the audited financial statements of the prior fiscal year;

(2) Established no later than November 1 in the current fiscal year; and

(3) Anticipated to be sufficient to meet the pool's funding needs.

(b) In addition to the regular assessment rate, the board may establish a special assessment rate for organizational expenses. Notwithstanding RSA 420-G:4, a writer of health insurance may increase the premiums charged by the amount of the special assessment. Any assessment may appear as a separate line item on a policyholder's bill.

(1) The board shall only establish an interim assessment if the board determines that its funds are or will become insufficient to pay the reinsurance pool's expense in a timely manner.

(2) The regular assessment rate, and any special assessment rate, shall be subject to the approval of the commissioner. The commissioner shall approve the rate if he or she finds that the amount is required to fulfill the purpose of the reinsurance pool. For the purpose of making this determination, the commissioner may, at the expense of the pool, seek independent actuarial certification of the need for the proposed rate.

(c) The board shall impose and collect assessments on members of the pool.

(d) If the assessment exceeds the amount actually needed, the excess shall be held and invested and, with the earnings and interest thereon, be used to offset future net losses. Each covered life shall be included in the

assessment on an aggregate basis and procedures shall be maintained to ensure that no covered life is counted more than once.

II. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments.

III. The board may defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is deferred in whole or in part, the amount by which such assessment is deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in this chapter. The member insurer receiving such deferral shall remain liable to the pool for the amount deferred. The board may attach appropriate conditions to any such deferral.

420-K:7 Immunity and Indemnification.

I. Neither the participation in the pool as members, the establishment of rates, forms, or procedures, nor any other joint or collective action required by this chapter shall be the basis of any legal action against the pool or any of its members.

II. Any person or member made a party to any action, suit, or proceeding because the person or member served on the board or on a committee or was an officer or employee of the pool shall be held harmless and be indemnified by the pool against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit, or proceeding. The indemnification shall not be provided on any matter in which the person or member is finally adjudged in the action, suit, or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance, or reckless disregard of the responsibilities of office. Costs and expenses of the indemnification shall be prorated and paid for by all members. The commissioner may retain actuarial consultants necessary to carry out his or her responsibilities pursuant to this chapter and such expenses shall be paid by the pool established in this chapter.

225:13 Repeal. RSA 420-G:4, I(e)(7), relative to increasing the premium rate for small employers at successive rating periods, is repealed.

225:14 New Hampshire Small Employer Health Reinsurance Pool; Ceding at Renewal Restricted. Amend RSA 420-K:5, III and IV to read as follows:

III. A member may reinsure an entire small employer group within a period of 60 days following the small employer's health insurance policy issue [~~or renewal~~] date.

IV. A member may reinsure an eligible employee or dependent of a small employer group:

(a) Within a period of 60 days following the small employer's health insurance policy issue [~~or renewal~~] date; or

(b) On the first plan anniversary after the coverage has been in effect for a period of 3 years, and every third plan anniversary thereafter; provided, that reinsurance pursuant to this subparagraph shall only be permitted with respect to eligible employees and their dependents of a small employer which has no more than 5 eligible employees as of the applicable anniversary.

225:15 Reference Change. Amend RSA 420-G:4, I(b) to read as follows:

(b) [~~Base rate~~] Market rate shall be established by each health carrier for all of its health coverages offered to individuals and, separately, for all of its health coverages offered to small employers.

225:16 Effective Date.

I. Section 12 of this act shall take effect July 1, 2005.

II. Sections 13 and 14 of this act shall take effect January 1, 2007.

III. The remainder of this act shall take effect January 1, 2006.

(Approved: July 5, 2005)

(Effective Date: I. Section 12 shall take effect July 1, 2005

II. Sections 13 and 14 shall take effect January 1, 2007

III.Remainder shall take effect January 1, 2006)

Section III

Plan of Operation

New Hampshire Small Employer Health Reinsurance Pool
Plan of Operation

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NEW HAMPSHIRE SMALL EMPLOYER HEALTH REINSURANCE POOL

PLAN OF OPERATION

Article I - Name

The Pool shall be known as the New Hampshire Small Employer Health Reinsurance Pool, hereinafter referred to as the Pool, a nonprofit entity created pursuant to RSA Chapter 420-K of Title XXXVII (the Statute).

Article II - Members of Pool

All Health Carriers, writers of Health Insurance, and other insurers issuing or maintaining Health Insurance in this state shall be members of the Pool.

Article III - Purpose

The purposes of the Pool are to support the goals of RSA 420-G which is to:

A. Facilitate the portability, availability, and renewability of Health Coverage for all persons principally employed in New Hampshire who wish to obtain Health Coverage as Employees of Small Employers.

B. To promote competition among Health Carriers on the basis of efficient claims handling, ability to manage health care services, consumer satisfaction, and low administrative costs.

C. To regulate underwriting and rating practices in the Small Employer market so as to promote access to affordable coverage for higher risk groups.

Article IV - Definitions

As used in this Plan:

A. Administrator means the organization selected by the Board for the fair equitable and reasonable administration of the Pool.

B. Assessment means the liability of a Member to the Pool.

C. Base Reinsurance Premium Rate means the single base rate for each of the Standard Health Benefit Plans that reasonably approximates gross premiums charged to Small Employers by Small Employer Health Carriers.

D. Board means the Board of Directors of the Pool.

E. Case Characteristics means demographic or other relevant characteristics of a Small Employer group that may be considered by the Health Carrier in the determination of Premium Rates for that group.

F. Commissioner means the Insurance Commissioner of the State of New Hampshire.

G. Covered Lives shall include all persons who are:

   a. Covered under an individual Health Insurance policy issued or delivered in New Hampshire;

   b. Covered under a group Health Insurance policy that is issued or delivered in New Hampshire;

   c. Covered under a group Health Insurance policy evidenced by a certificate of insurance that is issued or delivered in New Hampshire;

   d. Protected, in part, by a group excess loss insurance policy where the policy or certificate of coverage has been issued or delivered in New Hampshire, and where coverage has been purchased by a group Health Insurance plan subject to the Employee Retirement Income Security Act of 1974, Public Law No. 93-406 (ERISA).

H. Department means the Department of Insurance.

I. Director(s) of the Board (hereinafter also referred to as the Director) means a representative of a Member elected to the Board.

J. Eligible Dependents means a dependent person of an Eligible Employee who meet the requirements for eligibility set forth by the employer, the Health Coverage plan and state law that may be ceded to the Pool.

K. Eligible Employee means an employee who meets the requirements for eligibility set forth by the employer, the Health Coverage plan and state law that may be ceded to the Pool.

L. Exclusion Period means the length of time that must expire before a Health Carrier will cover medical treatment expense relating to a Preexisting Condition.

M. Extra Eligible means an employee that is covered by a benefit plan who shall not be ceded to the Pool. Extra Eligibles include late enrollees and newborn dependents whose mothers are not in the Pool at the date of birth.

N. Health Carrier means any entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to provide, deliver, arrange for, pay for or reimburse any of the costs of health services; including an insurance company, a health maintenance organization, a nonprofit health services corporation, or any other entity providing Health Coverage.

O. Health Coverage means any hospital or medical expense incurred policy or certificate, nonprofit health services corporation subscriber contract, or health maintenance organization subscriber contract and any other Health Insurance plan or health benefit plan. For the purposes of this Plan, Health Coverage does not include:

a. Accident-only or disability income insurance.

b. Coverage issued as a supplement to liability insurance.

c. Liability insurance, including general liability insurance and automobile liability insurance.

d. Workers' compensation or similar insurance.

e. Automobile medical-payment insurance.

f. Credit only insurance.

g. Coverage for on-site medical clinics.

h. Short-term, individual, nonrenewable medical, hospital, or major medical policies.

i. Other similar insurance coverage, specified in rules, under which benefits for medical care are secondary or incidental to other insurance benefits.

j. If offered separately:

(1) Limited scope dental or vision benefits.

(2) Long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(3) Prescription drug benefits.

(4) Other similar, limited benefits as are specified in rules.

k. If offered as independent, noncoordinated benefits:

(1) Specified disease or illness benefits.

(2) Hospital or surgical indemnity benefits.

l. If offered as a separate insurance policy, medicare supplemental Health Insurance, coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code, and similar supplemental coverage as specified in regulations.

P. Health Insurance means Health Insurance coverage issued in accordance with RSA 415, 420-A, or 420-B. Health Insurance shall not include accident only, credit, dental, vision, Medicare supplement, Medicare Risk, Medicare+Choice, Managed Medicaid, long-term care, disability income, coverage issued as a supplement to a liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, policies or certificates of specified disease, hospital confinement indemnity, limited benefit Health Insurance or short-term, nonrenewable individual Health Insurance, coverage provided through the New Hampshire healthy kids association, and coverage provided through the

Federal Employees' Program. Nonprofit health service corporations shall exclude coverage provided through national account policies originating outside of New Hampshire to the extent the nonprofit health service corporation assumes no risk for the provision of such insurance. Health Insurance does include group excess loss insurance.

Q. Late Enrollee means a Small Employer employee who has met any employer imposed waiting period and is otherwise eligible for health coverage, who declines a small employer's health coverage plan during the initial offering or subsequent open enrollment period, and shall not be allowed on the plan until the next open enrollment period. An Eligible Employee or Eligible Dependent shall not be considered a Late Enrollee if:

1. The person was covered under public or private health coverage at the time the person was able to enroll; and

    a. Has lost public or private health coverage as a result of termination of employment or eligibility, the termination of the other plan's coverage, death of a spouse, or divorce; and

    b. Requests enrollment within 30 days after termination of such health coverage; or

2. Is employed by an employer that offers multiple health coverages and the person elects a different plan during an open enrollment period; or

3. Was ordered by a court to provide health coverage for an ex-spouse or a minor child under a covered employee's plan and request for enrollment is made within 30 days after issuance of such court order.

R. Member means all Health Carriers, writers of Health Insurance, and other insurers issuing or maintaining Health Insurance in New Hampshire.

S. Notification of Intent to Cede means notification sent by a Small Employer Health Carrier expressing its intention to cede an entire small group, individual or dependent for whom all information necessary to cede has not yet been compiled.

T. Plan of Operation also referred to as Plan means the Plan of the Pool, including articles, bylaws and operating rules, procedures and policies approved by the Commissioner and adopted by the Pool.

U. Pool means the New Hampshire Small Employer Health Reinsurance Pool, established pursuant to RSA 420-K.

V. Preexisting Condition means a condition, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received during the 3 months immediately preceding the effective date of Health Coverage.

W. Premium Rate means the rates used by a carrier to calculate the premium.

X. Rating Methodology shall be the method used to establish ceding premium rates from the Base Reinsurance Premium Rates.

Y. Small Employer Health Carrier (hereinafter also referred to as Carrier) means any Health Carrier which offers or maintains group Health Coverage Plans covering Eligible Employees of one or more Small Employers who may reinsure with the Pool.

Z. Small Employer means a business or organization which employed on average, one and up to 50 employees, including owners and self-employed persons, on business days during the previous calendar year. An employer's designation as a Small Employer, including its group size, is not dependent on whether it becomes part of an association, multi-employer plan, trust or any other entity cited in RSA 420-G:3 and shall not change for any reason during the policy year.

In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

AA. Standard Health Benefit Plan shall mean the Health Coverage used by the Pool to adjudicate reinsurance claims.

BB. Standard Reinsurance Underwriting Form means the standardized health statement that Small Employer Health Carriers may use to make reinsurance ceding decisions.

Article V - Powers of Pool

A. The Pool shall have the general powers and authority granted under the laws of New Hampshire to insurance companies licensed to transact Health Insurance.

B. In addition, the Pool shall have the specific authority to:

1. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Plan, including the authority, with the approval of the Commissioner, to enter into contracts with programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions.

2. Sue or be sued, including taking any legal actions necessary or proper for recovery of any Assessments for, on behalf of, or against Members.

3. Take such legal action as necessary to avoid the payment of improper claims against the Pool.

4. Define the array of Health Coverage products for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this Plan.

5. Establish rules, conditions, and procedures pertaining to the reinsurance of Small Employer Health Carrier's risks by the Pool.

6. Establish appropriate rates, rate schedules, rate adjustments, rate classifications, and any other actuarial functions appropriate to the operation of the Pool.

7. Assess Members in accordance with the provisions of this Plan.

8. Appoint from among the Members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the Pool, policy, and other contract design, and any other function within the authority of the Pool.

9. Borrow money to effectuate the purposes of the Pool. Any notes or other evidence of indebtedness of the Pool not in default shall be legal investments for insurers and may be carried as admitted assets.

10. Develop a Standard Health Benefit Plan.

Article VI - Plan of Operation

The Pool shall perform its functions under this Plan of Operation, and in accordance with the Statute. The Plan shall assure the fair, reasonable and equitable administration of the Pool, and provide for the sharing of Pool gains or losses on an equitable proportionate basis in accordance with the provisions of RSA 420-K:2 VI. The Plan shall become effective upon approval in writing by the Commissioner.

Article VII - Board of Directors and Annual Meeting of Members

A. The Pool shall exercise its powers through the Board.

1. The Board shall be made up of at least five and not more than nine representatives of Members (such representatives referred to hereinafter as Directors or Director). To the extent possible, the composition of the Board shall be as follows:

   a. At least one Director shall represent a Small Employer Health Carrier with less than one hundred million dollars ($100,000,000) in net Small Employer Health Carrier Insurance premium in this state.

   b. There shall be no more than one Director representing any one Member company.

   c. The Commissioner, or designee, shall be a non-voting ex-officio member of the Board.

2. There shall be a designated alternate, to represent each Director in the event of the Director's unavailability.

3. Directors shall serve for a term of three (3) years expiring on the date of the third subsequent annual meeting following their election.

4. Upon election of the Board, the Board shall notify the Commissioner and request written approval of the Board as elected.

5. The Directors shall elect a Chairman and a Vice Chairman/Secretary from among its Board membership and such other officers as it deems appropriate, for such terms as it deems appropriate.

6. The previously elected Directors shall serve until their successors have been duly elected and approved by the Commissioner.

7. Vacancies occurring on the Board between annual meetings shall be filled for the remaining period of the term by the Board with the approval of the Commissioner. Insofar as practicable, each such vacancy shall be filled with a representative of the same Member represented by the previous Director.

8. Directors serve at the pleasure of the Members they represent. A Member may, upon written notice to the Commissioner, replace a Director representing said Member with a different representative acceptable to the Commissioner.

B. The votes of the Board shall be on a one Director, one vote basis.

C. A majority of the Directors shall constitute a quorum for the transaction of business. The acts of the majority of the Directors present at a meeting at which a quorum is present shall be the acts of the Board, except as provided in Section I below.

D. An annual meeting of Members and the Board shall be held not later than August, and not later than August in each subsequent year, unless the Board, upon at least a thirty (30) calendar day notice, designates some other date or place.

E. At each annual meeting the Board shall:

1. Review this Plan and submit proposed amendments, if any, to the Commissioner for approval.

2. Review reports of the Administrator, including audited financial reports, reports on outstanding contracts and obligations, and all other material matters.

3. Review reports of the committees established by the Board.

4. Determine whether any technical corrections or amendments to the provisions of the statute applicable to the Pool shall be recommended to the Commissioner.

5. Review and give consideration to the performance of the Pool in support of the Pool's purpose.

6. Review the Standard Health Benefit Plans, Rating Methodology and Base Reinsurance Premium Rates.

7. Determine if an Assessment is necessary for the proper administration of the Pool.

8. Review, consider and act on any matters deemed by the Board to be necessary and proper for the administration of the Pool.

F. The Board shall hold other meetings upon the request of two (2) or more Directors, at such times and with such frequency as it deems appropriate. These meetings may be held either in person or telephonically.

G. A written record of the proceedings of each Board meeting shall be made. The original of the record shall be retained by the Administrator.

H. Directors may be reimbursed from the monies of the Pool for expenses incurred by them as Directors upon approval of such expenses by the Board, but shall not otherwise be compensated by the Pool for their services.

I. Amendments to the Plan or suggestions of technical corrections to the Statute shall require the concurrence of a majority of the entire Board.

Article VIII - Committees

Each Director shall be entitled to participate personally or to appoint a person from within their company to any committee set forth in the Plan or otherwise established by the Board. A written record of the proceedings of each committee shall be maintained by a Secretary appointed from the membership of the committee.

A. Actuarial Committee

The duties of the Actuarial Committee are to:

1. Recommend to the Board the appropriate Rating Methodology and Base Reinsurance Premium Rates.

2. Recommend changes to the Standard Health Benefit Plan.

3. Review the reinsurance deductible and recommend any upward adjustments.

4. Recommend to the Board reports to be made by Members.

5. Provide reports and other recommendations as directed by the Board.

6. Determine the incurred claim losses of the Pool including amounts for incurred but not reported claims.

7. Recommend Assessments to the Board.

B. Operations Committee

The duties of the Operations Committee are to:

1. Periodically review the Plan and/or make recommendations to the Board.

2. Provide administrative interpretation as to the intent of the Plan and to provide administrative direction on issues referred to it by the Board or the Administrator or Members.

3. Identify items for which operating rules are needed and to propose them for adoption by the Board.

4. Receive operating reports from the Administrator.

5. Provide oversight of Administrator functions.

6. Recommend Administrator selection to the Board.

C. Legal Committee

The duties of the Legal Committee are to handle the following legal matters at the request of the Board:

1. Interpret the provisions of the statute applicable to the Pool.

2. Review the Plan, amendments to the Plan, and the various Standard Health Benefit Plans proposed by the Board for compliance with the provisions of the statute applicable to the Pool.

3. Prepare proposed amendments to the statute for Board approval.

4. Coordinate with the Administrator, as needed, on routine legal matters relating to the Pool operations, including proposed contracts and operational practices.

5. Prepare contracts and legal documents for the Pool as requested by the Board.

6. Be familiar with and provide assistance to the Board concerning all litigation and other disputes involving the Pool and its operations.

7. Maintain a written record of all questions to the legal committee or legal counsel received and responses provided, and shall provide copies of all such responses to the Board.

D. Audit Committee

The duties of the Audit Committee shall include the following items, as well as any other appropriate tasks assigned to it by the Board:

1. Develop a uniform audit program to be utilized to conduct a review of agreed upon procedures between the ceding Carriers and the Pool that indicate compliance with the provisions of this Plan of Operation.

2. Establish standards of acceptability for the selection of independent auditors or consultants

3. Assist the Board in the selection of an independent auditor for the annual audit of the Pool financial statements.

4. Assist the Board in the review of the reports prepared by the independent auditors in conjunction with 1. and 3. above and any other audit-related matters the Board deems necessary.

E. Other Committees:

The Board may establish other committees as needed from time to time.

Article IX - Administrator

The Administrator is jointly responsible, along with the Board and the Members, for the fair, equitable and reasonable administration of the Pool.

A. The Board shall select the Administrator through a competitive bidding process to administer the Pool. The Board shall evaluate bids submitted based on criteria established by the Board.

B. The Administrator shall perform the following functions, on behalf of, and as directed by the Board:

1. Establish procedures and install and maintain the systems needed to properly administer the operations of the Pool in accordance with the statute and this Plan.

2. Establish on behalf of the Pool one or more bank accounts for the transaction of Pool business. These bank accounts will be approved by the Board.

3. Accept, on behalf of the Pool, eligible risks that are ceded to the Pool by Small Employer Health Carriers.

4. Collect monthly reinsurance data from the ceding carriers.

5. Accept automated or semi-automated feeds of information from the ceding carriers.

6. Collect reinsurance premium for ceded risks and collect all other amounts due to the Pool in a timely basis.

7. Deposit all cash collected on behalf of the Pool in the established bank account(s) on a timely basis.

8. Perform reinsurance reimbursement for claims paid on ceded risks consistent with the timeliness established by the Board.

9. Issue checks or drafts on and/or approve charges against bank accounts of the Pool.

10. Keep all accounting, administrative and financial records of the Pool in accordance with this Plan.

11. Act as a communications resource for Small Employer Health Carriers in reviewing their administrative operations under this Plan.

12. Provide the information to calculate the Assessments in accordance with the methodology specified in this Plan, and collect appropriate amounts due.

13. Invest available cash in marketable securities as specified in this Plan and as approved by the Board.

14. Perform other necessary functions as directed by the Board.

15. Arrange for a line of credit on behalf of the Pool for an amount specified and authorized by the Board.

C. The Administrator, unless otherwise approved by the Board, shall maintain all records pertaining to Pool operation for a period of seven (7) years. The Administrator shall maintain all other records maintained by Pool for a period of seven (7) years following the date such records were created.

D. The Administrator shall serve under the terms of the contract with the Pool.

Article X – Standard Health Benefit Plan

The Board shall develop Standard Health Benefit Plans which shall contain benefit and cost sharing levels that reflect the Health Coverages most commonly sold by Small Employer Health Carriers in the state.

Article XI – Methodology for Determining Reinsurance Rates.

A. The Board shall approve Base Reinsurance Premium Rates as recommended by the Actuarial Committee for the Standard Health Benefit Plans.

B. The Base Reinsurance Premium Rates shall be set at levels which reasonably approximate gross premiums charged to Small Employers by Small Employer Health Carriers for Health Coverages with benefits similar to the Standard Health Benefit Plan. The Base Reinsurance Premium Rates shall be subject to the approval of the Commissioner.

C. The Board shall approve a Rating Methodology as recommended by the Actuarial Committee for determining Base Reinsurance Premium Rate to be charged by the Pool to reinsure Small Employer groups and individuals.

1. The Rating Methodology shall include a system for classification of Small Employers that reflects the types of Case Characteristics that are commonly used by Small Employer Health Carriers in the state in establishing Premium Rates.

2. The Rating Methodology shall consider the following provisions:

a. An entire Small Employer group consisting of two or more employees may be reinsured for a rate that is 150 percent of the applicable Base Reinsurance Premium Rate for the group.

b. An Eligible Employee or Dependent may be reinsured for a rate that is 500 percent of the applicable Base Reinsurance Premium Rate for the individual.

3. The Rating Methodology shall include an adjustment for the reinsurance deductible.

4. The Rating Methodology may include an adjustment to account for the varying load requirements between direct insurance and reinsurance.

5. The Rating Methodology may include provisions for trend which shall adjust ceding premium rates for reinsurance periods with varying effective dates.

6. Ceding premium rates shall be guaranteed to the ceding carrier for a period coterminous with the Small Employer's policy year.

Article XII - Reinsurance

A. Small Employer Health Carriers may reinsure with the Pool the coverage of an Eligible Small Employer Group, an Eligible Employee of an Eligible Small Employer and/or the coverage of any Eligible Dependents.

B. Eligibility of groups and individuals must be determined and then certified by the Small Employer Health Carrier that such groups and/or individuals meet the minimum eligibility requirements in the statutes and the Carrier's customary marketing and underwriting practices and protocols as applicable.

C. Reinsurance Ceding Rules and Premium Levels

1. Each Carrier proposing to cede reinsurance of the coverage provided under a Small Employer's plan for any group or individual is responsible for ascertaining and certifying:

a. That the group is an eligible Small Employer, and

b. That each ceded individual is an Eligible Employee or an Eligible Dependent.

c. That the reinsurance rate level payable to the Pool for that group or individual has been correctly determined in accordance with this Plan.

d. That the Standard Health Benefit Plan chosen for reinsurance is consistent with the Health Coverage of the Small Employer Health Coverage.

e. Such certification must be made to the Administrator within a period of 60 days following the insurance policy issue or renewal date for an entire small group. Certification for an Eligible Employee or Eligible Dependent of a Small Employer

must be made within a period of 60 days following the commencement of his or her Health Coverage.

f. Certification may be made either with the Notification of Intent to Cede or with the ceding Carrier's next monthly report that is required by the 20th of the month. The monthly report must contain the information specified in Article XV.

2. The Pool's liability for reinsurance of a Small Employer groups commences subject to proper notification and certification at one of the following dates:

   a. The issue date of a Small Employer's plan or the first anniversary date that the group is determined to be a Small Employer.

   b. The effective date of transfer of the group from a prior Carrier, except that replacement is not available for employees and dependents under replacement plans covering two (2) or more Small Employers, unless the coverage was reinsured by the prior Carrier and the new Carrier informs the Pool of its intention to provide coverage for the group and identified the employees that will continue to be reinsured.

   c. The renewal date of the Small employer Health Care plan that occurs in 2006.

3. The Pool's liability for reinsurance of Eligible Employees and/or Eligible Dependents commences subject to proper notification and certification at one of the following dates:

   a. The issue date of a Small Employer's plan or the first anniversary date that the group is determined to be a Small Employer.

   b. The effective date of transfer of the group from a prior Carrier, except that replacement is not available for employees and dependents under replacement plans covering two (2) or more Small Employers, unless the coverage was reinsured by the prior Carrier and the new Carrier informs the reinsurance Pool of its intention to provide coverage for the group and identifies the employees that will continue to be reinsured.

   c. The renewal date of the Small Employer's Health Care plan that occurs in 2006.

   d. On and after January 1, 2007, at the first plan anniversary after the coverage has been in effect for a period of 3 years, and every third plan anniversary thereafter; provided, that reinsurance shall only be permitted with respect to Eligible Employees and their Eligible Dependents of a Small Employer which has no more than 5 (five) Eligible Employees as of the applicable anniversary.

   e. Within 60 days of commencement of insurance, if the Eligible Employee's or Eligible Dependent's effective date does not coincide with the Small Employer group's effective date or renewal date.

4. Availability of reinsurance is subject to the following rules:

a. All new entrants reinsured as entire groups, shall also be reinsured automatically upon proper notification to the Administrator and payment of premium at the effective dates of their insurance coverage. Such reinsurance is called whole group reinsurance.

   If a Carrier discovers that an insured Eligible Employee or Dependent has been omitted from whole group reinsurance of the entire group then the Administrator must be notified within 60 days of discovery but, in any event, not later than one year from the date the reinsurance for the group took effect.

b. The Carrier may reinsure coverage of an employee without reinsuring coverage of any specific dependent of that employee, or may reinsure coverage of a specific dependent without reinsuring coverage of the employee or his/her dependent. Such reinsurance is called individual reinsurance. Reinsurance of newborn dependents shall be allowed only if the mother of any such dependent is reinsured as of the date of birth of such child, and all newborn dependents of reinsured persons shall be automatically reinsured as of their date of birth.

5. The Pool's liability for reinsurance ceases at the earlier of the following dates:

   a. The anniversary date on which the ceding carrier has notified the Pool of its intent to terminate reinsurance provided that such notice was received by the Administrator at least 30 days prior to such anniversary date.

   b. The first anniversary date that the Small Employer is determined to no longer be an eligible Small Employer.

   c. The first date on which any ceded individual no longer has coverage through the ceding carrier.

6. Standard Reinsurance Underwriting Form:

   a. The Board shall establish, subject to the approval of the Insurance Commissioner, the Standard Reinsurance Underwriting Form.

   b. Small group carriers may use the Standard Reinsurance Underwriting Form for their reinsurance ceding decisions to the Pool.

   c. The form may be amended from time to time as the Board deems necessary, subject to the approval of the Insurance Commissioner.

   d. No Carrier, Agent or Broker shall disclose to a Small Employer the fact that any or all of the Eligible Employees of such Small Employer have been or will be reinsured with the Pool.

D. Level of Coverage

The Pool will reinsure the lesser of the Standard Health Benefit Plan level of coverage or the level of Health Coverage sold by the Carrier. Both levels of coverage are subject to the reinsurance deductible amount.

E. Reinstatements

Reinsurance may continue as long as coverage for the Eligible Employee and Dependents remains in effect, but reinsurance will end on the first plan anniversary after a Small Employer ceases to be a Small Employer.

If Carrier reinstates insurance for a group that has previously been reinsured then reinsurance can be reinstated without a new effective date provided that the Administrator is notified in writing of the reinstatement within thirty (30) days of the insurance reinstatement date.

F. Determination of Reinsurance Premium

1. Tables of reinsurance rates for ceding Carriers, as determined by the Actuarial Committee, and approved by the Board, will be communicated to Small Employer Health Carriers.

2. The ceding company will determine the reinsurance premium for each individual reinsured.

3. The ceding company will determine the reinsurance premium for each group reinsured. Ceding carriers shall only use the individual reinsurance premium rates when ceding whole groups consisting of only one Eligible Employee, as well as any additions to the group of one during the plan year.

4. Rates are computed for each group or individual being ceded as follows:

   a. Determine the type of benefit plan (HMO, POS, PPO, Indemnity). Determine which Standard Health Benefit Plan comes closest to matching the benefit plan that has been sold to the group and select the Standard Health Benefit Plan which will be used for reinsurance.

   b. Determine whether to cede the entire group or one or more individuals. Determine whether to use entire group or individual reinsurance rate tables.

      (1) If the entire group is to be ceded then it shall include every Eligible Employee and every Eligible Dependent of each Eligible Employee in calculating the Whole Group Reinsurance premium required.

      (2) If individual reinsurance is used then any Eligible Employee and any Eligible Dependent of an Eligible Employee may be ceded using the individual reinsurance rate tables.

   c. Determine the age of the life/lives to be ceded.

d. Look up the appropriate rate in the rate table for each person being ceded

e. Adjust the rates for effective date of the reinsurance. Based on the reinsurance effective date for the group, apply the effective date adjustment factor for the applicable quarter.

f. Sum the rates across all the lives.

g. Apply other applicable Case Characteristics.

G. Billing and Payment

1. Monthly, the ceding Carrier will provide the Administrator with a listing of the individuals and/or whole groups reinsured and the premium for each individual and such other information as may be required by the Pool. It is the ceding Carriers responsibility to notify the Administrator of any corrections to previous transactions. When notified, the Administrator will then make any necessary corrections and send the corrected statement to the ceding company.

   Payment of reinsurance premium must be received by the Administrator before the related reinsurance transactions will be processed.

2. The reinsurance premiums charged by the Pool for each individual will be determined by the table of rates in effect on the Small Employer's most recent coincident anniversary date.

3. Premiums are determined as of the 1st of the month and are due by the twentieth (20th) of the month.

4. Reinsurance premium amounts are to be paid based on whole month increments only. If a Carrier's reinsured coverage is effective between the 1st and the 15th of the month, the entire month is paid in full. When coverage becomes effective between the 16th and the last day of the month, no premiums will be payable until the 1st month following the effective date. Notwithstanding the requirements of this paragraph the Pools liability will follow the ceding Carriers liability.

5. Conversely, terminations effective between the 1st and the 15th of the month will be allowed refunds for the entire month, and terminations effective between the 16th and the last day of the month will not be allowed a premium refund.

6. Reinsurance premium is due monthly to the Pool regardless of the ceding company's inability to charge back or collect the Small Employer's premium. The Pool has no responsibility for the collection of Small Employer's premiums.

7. Reinsurance claims shall not be netted against reinsurance premium due.

H. Reinsurance Claim

1. Statement of Reinsurance

The Pool shall indemnify Carriers for the covered claims incurred with respect to Eligible Employees and Eligible Dependents whose coverage with the Carrier is reinsured with the Pool subject to the following:

No reinsurance shall be provided until five thousand dollars ($5,000) in benefit payments, as specified by the Board, have been paid by the Carrier for services provided during a calendar year for a reinsured employee or dependent which payments would have been reimbursed through said reinsurance in the absence of said deductible. These deductible amounts shall be periodically reviewed by the Board and may be adjusted for appropriate factors as determined by the Board.

Reinsurance claims will be handled on a "self adjudicated" basis. Coverage provided by Small Employer Health Carriers under plans other than the Standard Health Benefit Plan shall be adjudicated by the reinsuring carrier.

2. "Covered Claims" - For the purposes of this section, "Covered Claims" shall mean only such amounts as are actually paid by the Carriers for benefits provided for individuals reinsured by the Pool, but Covered Claims shall not include:

    a. Claim expenses or salaries paid to employees of the Carriers who are not providers of health care services;

    b. Court costs, attorney's fees or other legal expenses;

    c. Any amount paid by the Carrier for:

        (1) Punitive or exemplary damages; or

        (2) Compensatory or other damages awarded to the insured, arising out of the conduct of the Carriers in the investigation, trial, or settlement of any claim or failure to pay or delay in payment of any benefits under any policy; or the operation of any managed care, cost containment, or related programs;

    d. Any statutory penalty imposed upon a Carrier.

3. General Requirements

    a. The Carriers agree that they will promptly investigate, settle or defend all claims arising under the risks reinsured and that they will forward promptly to the Pool copies of such reports of investigation as may be requested by the Pool.

    b. Carriers will adjudicate all claims on ceded risks.

    c. The Carriers agree to use their normal large case management and psychiatric/alcoholism/substance abuse case management programs to control costs on reinsured basis to the same extent that they would use such programs on their

direct business. The failure to follow such procedures will result in the denial or reduction of reinsurance claim payments, as determined by the Board.

d. The Pool shall have the right, at its own expense, to participate jointly with a Carrier in the investigation, adjustment or defense of any claim.

e. Carriers will be required to assure that their claim management practices are consistent for reinsured and non-reinsured risks. The failure to follow such procedures will result in the denial or reduction of reinsurance claim payments, as determined by the Board.

f. The Pool shall have the right to inspect the records of the Carrier in connection with the risks reinsured with the Pool and the Carrier shall submit to the Pool any additional information the Pool may require in connection with claims submitted to it for reimbursement. Carriers shall secure necessary authorizations from insured employees or dependents for this purpose.

g. All information disclosed to the Pool by the Carrier or to the Carrier by the Pool, in connection with this plan, shall be considered to be privileged and confidential information by both the Carrier and the Pool.

h. If any payment made by the Pool and the Carrier is reimbursed by another party for the same expenses due to subrogation, coordination of benefits or other reimbursement, the Pool shall be reimbursed to the extent that the Carrier is reimbursed for expenses actually paid by the Pool. The Carrier shall execute and deliver instruments and do whatever is necessary to preserve and secure such reimbursement rights.

i. Carriers which pay for certain provider services on a basis other than fee-for-service will be allowed reimbursement for those costs on reinsured persons from the Pool through a methodology approved by the Board.

j. Except as approved by the Board, reinsurance will be provided only for covered claims submitted within two (2) years from the date the expenses on which the claim is based were incurred.

4. Claims Reporting

a. Within twenty (20) days after the close of each quarter or month, as chosen by the Carrier, the Carrier shall furnish to the Pool the information specified in article XV with respect to reinsured losses submitted to the Pool by the Carrier.

b. Carriers shall notify the Pool as soon as reasonably possible of all claims or potential claims for a reinsured employee or dependent where the losses expected to be paid by the Carriers will exceed one hundred thousand dollars ($100,000) in the aggregate.

c. Claims denied based on incomplete or missing information must be resubmitted within sixty (60) days of the date that such claims were denied.

5. Appeals of Claim Decisions

    a. All appeals of claim related decisions must be submitted within sixty (60) days of the date of such claim decision.

6. Reinsurance Reimbursements

    a. The reinsurance claims will be reimbursed when the accumulated amount due as of the end of any month exceeds fifty thousand dollars (50,000). Regardless of this limitation, all balances due will be paid by the Pool to ceding Carriers no less often than every six (6) months.

Article XIII - Audit Functions

A. Each Member of the Pool shall hire a Certified Public Accountant (CPA) or other party approved by the Board to conduct agreed upon procedures of various items related to Pool reinsurance and assessments. To be acceptable, the auditor must be independent, in accordance with standards established by the Audit Committee. The agreed upon procedures must be performed in accordance with generally accepted auditing standards as adopted by the membership of the American Institute of Certified Public Accountants.

B. The agreed upon procedures shall be conducted in accordance with a uniform agreed upon procedure program (herein after called "Program") for Members, as developed by the Board. This Program shall clearly specify all items to be examined. It shall include a certification statement form, to be completed by the auditor, to verify the completion of all prescribed agreed upon procedures as dictated by the Program. Also, details regarding the number and types of records reviewed and any errors found shall be submitted in a written report which accompanies the certification statement. A copy of this report and the certification statement shall be submitted to the Board by the auditor.

C. The Program shall include, but not be limited to, detail testing of representative samples of the following items:

    1. Reinsurance claims submitted to the Pool, in particular:

        a. Eligibility of ceded individuals and their Small Employers for reinsurance by the Pool;

        b. Proper determination of reinsurance claim amounts requested by the Carrier including:

            (1) Verification that the related claim was paid.

            (2) Appropriate adjudication against the proper Standard Health Benefit Plan.

            (3) Proper use of the approved methodology to convert capitated claims to fee for service basis.

(4) Properly applied reinsurance deductible.

(5) Proper application of any recoveries mad by the Carrier.

2. Reimbursements to the Pool have been properly determined considering reimbursement by other parties for the same expenses due to subrogation, coordination of benefits, outside reinsurance or other reimbursement.

3. Reinsurance premiums submitted to the Pool, including:

   a. Eligibility of those lives for whom premium is paid for reinsurance by the Pool;

   b. Proper determination of reinsurance premium amounts paid.

   c. Appropriate selection of the Standard Health Benefit Plan.

4. Data submitted to the Pool for use in the calculation of Member Assessments. Tie-out covered lives to source data, including any adjustment amounts if applicable.

5. The frequency of these agreed upon procedures, but shall be no more frequent than annually, shall be determined by the Audit Committee. The cost of the performance of the agreed upon procedures of a Member shall be borne by that Member.

D. Random reviews of provider bills or other records shall be conducted as deemed necessary by the Audit Committee to verify the accuracy and appropriateness of reinsurance claim submissions.

E. The Board shall have the right to conduct such additional reviews and or agreed upon procedures audits of Members as it deems appropriate.

F. All information disclosed in the course of the performance of the agreed upon procedures of a Member shall be considered privileged and confidential information by the Member, the auditing firm and the Pool.

G. The Pool shall have an annual audit of its operations conducted by an independent Certified Public Accountant, as approved by the Board. The Board shall file this annual audit with the Commissioner. This audit shall encompass at least the following items:

   1. The handling and accounting of assets and money for the Pool;

   2. The annual fiscal report of the Pool;

   3. The calculation and the collection of any Assessments of Members.

   4. The reinsurance premiums due to the Pool and the claim reimbursements made to the Carriers.

Article XIV - Assessments

All Assessments shall be imposed on and collected from all Members of the Pool. Each covered life shall be included in the calculation of Assessments on an aggregate basis.

A. Regular Assessments

Following the close of each fiscal year, the Administrator shall determine the net premiums, the Pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

Each Member's Assessment for the Pool shall be based on its number of Covered Lives multiplied by the regular Assessment rate. The regular Assessment rate will be established on an annual basis, and will be established no later than November 1 of the current fiscal year and subject to the approval of the Commissioner. The regular Assessment rate shall be based on the audited net loss of the Pool for the prior fiscal year and shall be anticipate to be sufficient to meet the Pool's funding needs incurred, or

B. Special Assessments

1. In addition to the regular Assessment rate the Board may establish a special Assessment rate for organizational expenses. A writer of Health Insurance may increase the premiums charged by the amount of the special Assessment. Any special Assessment may appear as a separate line item on a policyholder's bill and is subject to the approval of the Commissioner.

C. Interim Assessments

The Board shall only establish an interim Assessment if the Board determines that the Pool's funds are or will become insufficient to pay the Pool's liabilities in a timely manner.

D. Excess Assessments

1. If the Assessment exceeds the amount actually needed, the excess shall be held and invested and, with the earnings and interest thereon, be used to offset future net losses

E. Assessment Deferral

On application to the Board, the Board may defer, in whole or in part, the Assessment of a Member insurer if, in the opinion of the Board, payment of the Assessment would endanger the ability of the insurer to fulfill its contractual obligations. In the event an Assessment against a Member insurer is deferred in whole or in part, the amount by which such Assessment is deferred may be assessed against the other Members in a manner consistent with the basis for Assessments set forth in this Plan. The Member insurer receiving such deferral shall remain liable to the Pool for the amount deferred. The Board may attach appropriate conditions to any such deferral.

F. Late Payments

Assessments shall be paid when billed. If the Assessment is not received by the Administrator within thirty (30) days of the billing date, the Member shall pay interest on the Assessment from the billing date at the annual rate of prime plus 3%. The Board may suspend reinsurance rights if payments are not made in accordance with this article.

Article XV - Reports of Carriers and Administrator

A. Information Required by Pool

1. Unless otherwise specified by the Board, the following information shall be required by the Pool for reinsured risks:

   a. Identification of the Carrier;

   b. Name, date of birth, sex and the Carrier identification number of the person being reinsured;

   c. Identification of the reinsured as an employee, spouse or child;

   d. Employee name (if different) and unique identification number;

   e. Plan anniversary date;

   f. Employer's name, address, zip code and SIC/NAICS code;

   g. Reinsurance plan indicator;

   h. Effective date of Small Employer coverage;

   i. Effective date of reinsurance;

   j. Date of applicable employee's employment;

   k. Group Size;

   l. Other information required by the Board.

2. Changes in Reinsurance Coverage require the following information:

   a. The reinsured's name and identification number;

   b. The employee's name (if different) and unique identification number;

   c. Effective date of status change;

   d. Status code for change as required by the Board;

   e. Other information required by the Board.

3. Claims Reporting

    a. the claimant's name and date of birth;

    b. the claim incurred date and paid date;

    c. the reinsurance claim amount;

    d. the claim coding as required by the Board (e.g., CPT and ICD);

    e. Service type, place of service;

    f. Submitted charges, covered charges;

    g. Other information deemed necessary by the Board.

Article XVI - Financial Administration

A. Books and Records

The Administrator shall maintain the books and records of the Pool so that financial statements can be prepared to satisfy the Board. Further, these books shall satisfy any additional requirements as may be deemed necessary to meet the needs of the Board and the outside auditors. Records will be kept for the following:

1. The receipt and disbursement of cash by the Pool shall be recorded as it occurs.

2. Non-cash transactions shall be recorded when the asset or the liability should be realized by the Pool in accordance with generally accepted accounting principles.

3. Assets and liabilities of the Pool, other than cash, shall be accounted for and described in itemized records.

4. The net balance due to/from the Pool shall be calculated for each Member and confirmed with Members as deemed appropriate by the Board or when requested by the respective Member. These balances should be supported by a record of each individual Member's financial transactions with the Pool. These records include:

    a. Assessment, if applicable to the particular Member.

    b. The amount of reinsurance premium due to the Pool for risks ceded and accepted by the Pool.

    c. The amount of reimbursement due from the Pool for claims paid by the Carrier.

    d. Adjustment to the amount due to/from the Pool based upon corrections to the Member submissions.

    e. Interest charges due from the Member for late payment of amounts due to the Pool.

f. Such other records as may be required by the Board.

5. The Pool shall maintain a general ledger whose balances are used to produce the Pool's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger shall agree with the corresponding balances in subsidiary ledgers or journals.

B. Handling and Accounting of Assets and Money

Money and marketable securities shall be kept in bank accounts and investment accounts as approved by the Board. The Administrator shall deposit receipts and make disbursements from these accounts.

C. Bank Accounts

All bank accounts/checking accounts shall be established in the name of the New Hampshire Small Employer Health Reinsurance Pool, and shall be approved by the Board of Directors. Authorized check signers shall be approved by the Board.

D. Lines of Credit

All lines of credit shall be established in the name of the New Hampshire Small Employer Health Reinsurance Pool, and shall be approved by the Board of Directors. Lines of credit shall be used to meet cash shortfalls.

E. Investment Policy

All cash shall be invested in available investment vehicles deemed appropriate by the Board.

Article XVII - Penalties/Adjustments and Dispute Resolution

A. Penalties/Adjustments

1. Given numerous factual determinations and tasks to be performed by Members relative to their participation in the Pool, it is expected that all Members will exercise the highest degree of good faith and due diligence in all aspects of their relationship with the Pool. Errors will occur, however, and it is appropriate that the sanctions applicable to such errors be detailed.

2. Errors related to reinsurance:

a. Ineligible Small Employers/employees/dependents (initial placement of ineligible persons or failure to remove persons becoming ineligible). Reinsurance coverage for the individuals involved shall be terminated as of the first date of ineligibility. Claims paid by the Pool in excess of premiums received are to be returned to the Pool with interest. Premiums paid in excess of claims will be refunded without interest. An administrative charge established by the Board will be assessed in such situations.

b. Reinsuring employees/dependents at the incorrect reinsurance premium (failure to use the Rating Methodology proscribed correctly correct Pool rates and/or to apply correct rates to persons reinsured). Reinsurance premiums for the persons involved should be recalculated and immediate payment of additional premiums must be made, plus interest and an administrative charge. Excess payments will be refunded without interest, subject to the limitation on premium refund provision. See Article XVII, A 7.

c. Reinsuring incorrect Standard Health Benefit Plan. Premiums will be recalculated on the basis of the correct Standard Health Benefit Plan and all additional premiums due will be paid immediately, with interest and the administrative charge. Excess premiums will be refunded without interest and subject to the limitation on premium refunds provision.

d. Incorrect claim payments/submissions. The claim will be recalculated and any amount due to the Pool will be repaid immediately, with interest. Adjustments of claim payments for amounts recovered by the Small Employer Health Carrier under coordination of benefit, subrogation or similar provisions shall not be considered errors for which interest or any administrative charge shall be due.

3. Errors related to Assessments: All Member errors related to the Assessment shall require the immediate payment of additional amounts due plus interest calculated from the date such sum should have been paid, plus an administrative charge as established by the Board.

4. Errors not listed: All additional sums due to the Pool as a result of errors made by Members other than those listed above shall be paid immediately, with interest, on the applicable administrative charge.

5. Gross negligence and intentional misconduct: If the Board determines that the nature or extent of the errors related to the use of the reinsurance mechanism or otherwise by a particular Carrier evidences gross negligence or intentional misconduct, the Board may, after notice and a hearing, terminate some or all current reinsurance for the Carrier and/or suspend the right of the Carrier to use the reinsurance mechanism for an appropriate period of time. The Board will ensure, to the extent possible, that the suspension or termination of reinsurance for the Carrier shall not adversely affect individuals or groups already insured by the Carrier.

6. Interest and Administrative Charges: All interest payments required under this Article shall be calculated from the date the incorrect payment occurred or correct payment should have been made through the date of payment. The rate of interest shall be the prime rate plus 3%. The administrative charge(s) shall be established by the Board annually prior to December 31.Not withstanding the above, errors reported by Members within ninety (90) days of their occurrence shall not be subject to interest or any administrative charges.

7. Limitation on Premium Refunds: All premium refunds due under this Article shall be limited to a period of twelve (12) months from the date the error was corrected.

B. Member Appeal of Disputes to Board

The Administrator will act on behalf of the Board in the attempt to resolve disputes between a Member and the Pool; however, Members may request permission to appear before the Board at any time in connection with any dispute with the Pool.

Article XVIII - Indemnification

A. Neither participation in the Pool as Members, the establishment of rates, forms or procedures nor any other joint or collective action required by the Statute shall be the basis of any legal action, criminal or civil liability or penalty against the Pool or any of its Members.

B. Persons or Members made a party to any action, suit, or proceeding because the person or Member serves on the Board or on a committee or was an officer or employee of the Pool shall be held harmless and be indemnified by the Pool against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit or proceeding. This indemnification shall not be provided on any matter in which the person or Member is finally adjudged in the action, suit or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance or reckless disregard of the responsibilities of office. Costs and expenses of the indemnification shall be prorated and paid for by all Members. The Commissioner may retain actuarial consultants necessary to carry out his or her responsibilities pursuant to this Plan and such expenses shall be paid by the Pool established in this Plan.

Article XIX – General Provisions

A. Amendment and Compliance with Applicable Laws

1. Amendments to this Plan may be suggested by any Member and may be made as approved by a majority of the Board at any time. Amendments to this Plan shall be subject to the approval of the Commissioner.

2. Unless otherwise specified by the Board, any provision of the Plan that conflicts with any applicable requirement of federal or state law or regulation shall be deemed amended to comply with such requirement

B. Amounts due to Pool under the Plan

The Pool shall be entitled to recover all costs and expenses including, attorneys' fees that are incurred either directly, or through a third party, to collect any amounts due to the Pool under the Plan.

Article XX – Termination

The Pool shall continue in existence subject to termination in accordance with the requirements of a law or laws of the State of New Hampshire or the United States of America. In case of enactment of a law or laws which in the determination of the Board and the Commissioner shall

result in the termination of the Pool, the Pool shall terminate and conclude its affairs in a manner to be determined by the Board with the approval of the Commissioner. Any funds or assets of any nature held by the Pool following termination and the payment of all claims and expenses of the Pool shall be distributed to the Members existing at that time in accordance with the then-existing Assessment formula.

Section IV

Benefit Plans

Board Approved Standard Health Benefit Plan Designs
HMO Version

HMO	
Plan Benefits	**Proposed by the NH Reinsurance Board**
Deductible	
Individual	None
Family	None
Out of Pocket Maximums	
Individual	None
Family	None
Coinsurance	None
Lifetime Maximum	None
Emergency Room	$50 co-pay per visit
Hospital Services	
Inpatient	Covered in full
Outpatient, other than emergency room	Covered in full
Physician Office Services	
PCP Office Visit	$10 co-pay per visit
Specialist Office Visit	$10 co-pay per visit
Preventative Care	Covered in full
Physician Hospital Visits	Covered in full
Surgery and Asst. Surgeon Fees	Covered in full
Laboratory and X-Ray	Covered in full
Clinical Trials	Not Covered
Diabetes	Covered in full
Diabetic Supplies	Under RX
Nonprescription Enteral Formulas	Not Covered
Mammography	Covered in Full
Pap Smear	Covered in Full

Routine Preventive Test	Covered in Full
Prescription Drug - Retail	
Generic	$5 co-pay
Preferred Brand	$10 co-pay
Non- Preferred Brand	$25 co-pay
Prescription Drug - Mail Order - per month	
Generic	$5 co-pay
Preferred Brand	$10 co-pay
Non- Preferred Brand	$25 co-pay
Maternity Expenses	
Pre/Post Natal Office Visits	Covered in full
Delivery Charges	Covered in full
Newborn Hospital Bill	Covered in full
Newborn Pediatrician	$10 co-pay per visit
Rehabilitation Therapies	
Physical Therapy	$10 co-pay per visit
Occupational Therapy	$10 co-pay per visit
Cardiac Therapy	Covered in full
Speech Therapy	$10 co-pay per visit
Home Health Care	Covered in full
Mental Health	
Inpatient	Mirror NH state mandate
Outpatient	Mirror NH state mandate
Substance Abuse	
Inpatient	Mirror NH state mandate
Outpatient	Mirror NH state mandate
Ambulance	Covered in full
Chiropractic Treatment	$10 co-pay per visit
Allergy Care	$10 co-pay per visit
Allergy Injections	$10 co-pay per visit

Durable Medical Equipment (DME)	$100 deductible with max annual benefit of $3,500
Prosthetics Appliances and Orthotics	Included in $100 DME deductible
Date: 8/19/2005	

Board Approved Standard Health Benefit Plan Designs
POS Version

POS	Proposed by the NH Reinsurance Board	
Plan Benefits	**IN Network (matches HMO)**	**Out of Network POS Benefits**
Deductible		
Individual	None	$150
Family	None	$450
Out of Pocket Maximums		
Individual	None	$900 Non-Network (includes deductible and coinsurance)
Family	None	$2700 Non-Network (includes deductible and coinsurance
Coinsurance	None	80%
Annual Maximum Benefit	None	$1,000,000
Lifetime Maximum	None	$2,000,000
Emergency Room	$50 co-pay per visit	Subject to deductible and co-insurance
Hospital Services		Subject to deductible and co-insurance
Inpatient	Covered in full	Subject to deductible and co-insurance
Outpatient, other than emergency room	Covered in full	Subject to deductible and co-insurance
Physician Office Services		
PCP Office Visit	$ 10 copay per visit	Subject to deductible and co-insurance
Specialist Office Visit	$10 copay per visit	Subject to deductible and co-insurance
Preventative Care	Covered in full	Subject to deductible and co-insurance

Physician Hospital Visits	Covered in full	Subject to deductible and co-insurance
Surgery and Asst. Surgeon Fees	Covered in full	Subject to deductible and co-insurance
Laboratory and X-Ray	Covered in full	Subject to deductible and co-insurance
Mammography	Covered in full	Subject to deductible and co-insurance
Pap Smear	Covered in full	Subject to deductible and co-insurance
Routine Preventive Test	Covered in full	subject to deductible and co-insurance
Prescription Drug - Retail		
Generic	$5 co-pay	$5 co-pay
Preferred Brand	$10 co-pay	$10 co-pay
Non- Preferred Brand	$25 co-pay	$25 co-pay
Prescription Drug - Mail Order - monthly		
Generic	$5 co-pay	$5 co-pay
Preferred Brand	$10 co-pay	$10 co-pay
Non- Preferred Brand	$25 co-pay	$25 co-pay
Maternity Expenses		
Pre/Post Natal Office Visits	Covered in full	Subject to deductible and co-insurance
Delivery Charges	Covered in full	Subject to deductible and co-insurance
Newborn Hospital Bill	Covered in full	Subject to deductible and co-insurance
Newborn Pediatrician	$10 co-pay	Subject to deductible and co-insurance
Rehabilitation Therapies		
Physical Therapy	$10 co-pay	Subject to deductible and co-insurance
Occupational Therapy	$10 co-pay	Deductible and co-insurance

Cardiac Therapy	No charge	Subject to deductible and co-insurance
Speech Therapy	$10 co-pay	
Home Health Care	Covered in full	Subject to deductible and co-insurance
Mental Health		
Inpatient	Mirror NH State Mandate	Mirror NH State Mandate subject to deductible and coinsurance
Outpatient	Mirror NH State Mandate	Mirror NH State Mandate subject to deductible and coinsurance
Substance Abuse		
Inpatient	Mirror NH State Mandate	Mirror NH State Mandate subject to deductible and coinsurance
Outpatient	Mirror NH State Mandate	Mirror NH State Mandate subject to deductible and coinsurance
Ambulance	Covered in full	Subject to deductible and co-insurance

Date: 8/19/2005

Board Approved Standard Health Benefit Plan Designs
PPO Version

PPO	Proposed by the NH Reinsurance Board	
Plan Benefits	**IN Network (matches HMO)**	**Out of Network PPO Benefits**
Deductible		
Individual	None	$200
Family	None	$600
Out of Pocket Maximums		
Individual	None	$800 Non-Network (includes deductible and coinsurance)
Family	None	$2400 Non-Network (includes deductible and coinsurance
Coinsurance	None	80%
Annual Maximum Benefit	None	$1,000,000
Lifetime Maximum	None	$2,000,000
Emergency Room	$50 co-pay per visit	Subject to deductible and co-insurance
Hospital Services		Subject to deductible and co-insurance
Inpatient	Covered in full	Subject to deductible and co-insurance
Outpatient, other than emergency room	Covered in full	Subject to deductible and co-insurance
Physician Office Services		
PCP Office Visit	$ 10 copay per visit	Subject to deductible and co-insurance
Specialist Office Visit	$10 copay per visit	Subject to deductible and co-insurance

Preventative Care	Covered in full	Subject to deductible and co-insurance
Physician Hospital Visits	Covered in full	Subject to deductible and co-insurance
Surgery and Asst. Surgeon Fees	Covered in full	Subject to deductible and co-insurance
Laboratory and X-Ray	Covered in full	Subject to deductible and co-insurance
Mammography	Covered in full	Subject to deductible and co-insurance
Pap Smear	Covered in full	Subject to deductible and co-insurance
Routine Preventive Test	Covered in full	subject to deductible and co-insurance
Prescription Drug - Retail		
Generic	$5 co-pay	$5 co-pay
Preferred Brand	$10 co-pay	$10 co-pay
Non- Preferred Brand	$25 co-pay	$25 co-pay
Prescription Drug - Mail Order - monthly		
Generic	$5 co-pay	$5 co-pay
Preferred Brand	$10 co-pay	$10 co-pay
Non- Preferred Brand	$25 co-pay	$25 co-pay
Maternity Expenses		
Pre/Post Natal Office Visits	Covered in full	Subject to deductible and co-insurance
Delivery Charges	Covered in full	Subject to deductible and co-insurance
Newborn Hospital Bill	Covered in full	Subject to deductible and co-insurance
Newborn Pediatrician	$10 co-pay	Subject to deductible and co-insurance
Rehabilitation Therapies		
Physical Therapy	$10 co-pay	Subject to deductible and co-insurance

Occupational Therapy	$10 co-pay	Deductible and co-insurance
Cardiac Therapy	No charge	
Speech Therapy	$10 co-pay	Subject to deductible and co-insurance
Home Health Care	Covered in full	Subject to deductible and co-insurance
Mental Health		
Inpatient	Mirror NH State Mandate	Mirror NH State Mandate subject to deductible and coinsurance
Outpatient	Mirror NH State Mandate	Mirror NH State Mandate subject to deductible and coinsurance
Substance Abuse		
Inpatient	Mirror NH State Mandate	Mirror NH State Mandate subject to deductible and coinsurance
Outpatient	Mirror NH State Mandate	Mirror NH State Mandate subject to deductible and coinsurance
Ambulance	Covered in full	Subject to deductible and co-insurance

Board Approved Standard Health Benefit Plan Designs
Indemnity Version

Indemnity

Plan Benefits	Indemnity
Deductible	
Individual	$250
Family	$500
Out of Pocket Maximums	
Individual	$650 Non-Network (includes deductible and coinsurance)
Family	$1700 Non-Network (includes deductible and coinsurance)
Coinsurance	80%
Annual Maximum Benefit	$1,000,000
Lifetime Maximum	$2,000,000
Emergency Room	Subject to deductible and co-insurance
Hospital Services	Subject to deductible and co-insurance
Inpatient	Subject to deductible and co-insurance
Outpatient, other than emergency room	Subject to deductible and co-insurance
Physician Office Services	
PCP Office Visit	Subject to deductible and co-insurance
Specialist Office Visit	Subject to deductible and co-insurance

Preventative Care	Subject to deductible and co-insurance
Physician Hospital Visits	Subject to deductible and co-insurance
Surgery and Asst. Surgeon Fees	Subject to deductible and co-insurance
Laboratory and X-Ray	Subject to deductible and co-insurance
Mammography	Subject to deductible and co-insurance
Pap Smear	Subject to deductible and co-insurance
Routine Preventive Test	subject to deductible and co-insurance
Prescription Drug - Retail	
Generic	$5 co-pay
Preferred Brand	$10 co-pay
Non- Preferred Brand	$25 co-pay
Prescription Drug - Mail Order - monthly	
Generic	$5 co-pay
Preferred Brand	$10 co-pay
Non- Preferred Brand	$25 co-pay
Maternity Expenses	
Pre/Post Natal Office Visits	Subject to deductible and co-insurance
Delivery Charges	Subject to deductible and co-insurance
Newborn Hospital Bill	Subject to deductible and co-insurance
Newborn Pediatrician	Subject to deductible and co-insurance
Rehabilitation Therapies	

Physical Therapy	Subject to deductible and co-insurance
Occupational Therapy	Deductible and co-insurance
Cardiac Therapy	
Speech Therapy	Subject to deductible and co-insurance
Home Health Care	Subject to deductible and co-insurance
Mental Health	
Inpatient	Mirror NH State Mandate subject to deductible and coinsurance
Outpatient	Mirror NH State Mandate subject to deductible and coinsurance
Substance Abuse	
Inpatient	Mirror NH State Mandate subject to deductible and coinsurance
Outpatient	Mirror NH State Mandate subject to deductible and coinsurance
Ambulance	Subject to deductible and co-insurance

Date: 8/19/2005

Section V

Rates

New Hampshire Small Employer Reinsurance Pool
2006 Monthly Reinsurance Rates

Group Reinsurance

	HMO	POS	PPO	Indemnity
<25	$ 177.96	$ 207.14	$ 221.96	$ 261.12
25-29	$ 217.96	$ 253.70	$ 271.84	$ 319.81
30-34	$ 223.77	$ 260.46	$ 279.09	$ 328.33
35-39	$ 235.36	$ 273.94	$ 293.54	$ 345.34
40-44	$ 267.67	$ 311.55	$ 333.84	$ 392.74
45-49	$ 338.28	$ 393.74	$ 421.90	$ 496.35
50-54	$ 450.98	$ 524.91	$ 562.46	$ 661.71
55-59	$ 595.74	$ 693.42	$ 743.01	$ 874.12
60-64	$ 753.96	$ 877.57	$ 940.34	$ 1,106.27
65+	$ 907.07	$ 1,055.78	$ 1,131.29	$ 1,330.92
65+ Med.	$ 317.47	$ 369.52	$ 395.95	$ 465.82
Child	$ 101.13	$ 117.70	$ 126.12	$ 148.38

Individual Reinsurance

	HMO	POS	PPO	Indemnity
<25	$ 593.21	$ 690.47	$ 739.86	$ 870.41
25-29	$ 726.54	$ 845.65	$ 906.14	$ 1,066.04
30-34	$ 745.90	$ 868.19	$ 930.29	$ 1,094.45
35-39	$ 784.53	$ 913.15	$ 978.46	$ 1,151.12
40-44	$ 892.23	$ 1,038.51	$ 1,112.79	$ 1,309.15
45-49	$ 1,127.59	$ 1,312.45	$ 1,406.33	$ 1,654.49
50-54	$ 1,503.26	$ 1,749.71	$ 1,874.86	$ 2,205.69
55-59	$ 1,985.82	$ 2,311.38	$ 2,476.71	$ 2,913.74
60-64	$ 2,513.21	$ 2,925.24	$ 3,134.47	$ 3,687.58
65+	$ 3,023.56	$ 3,519.26	$ 3,770.98	$ 4,436.40
65+ Med.	$ 1,058.25	$ 1,231.74	$ 1,319.84	$ 1,552.74
Child	$ 337.08	$ 392.35	$ 420.41	$ 494.60