

**SUPPLEMENTAL REPORT
OF THE
2006
HEALTH INSURANCE MARKET
IN
NEW HAMPSHIRE**

March 6, 2008

Prepared by the New Hampshire Insurance Department
SUPPLEMENTAL REPORT
OF THE 2006 HEALTH INSURANCE MARKET
IN NEW HAMPSHIRE

By law, the Insurance Commissioner is authorized to prescribe the format and content of financial and other reports filed by insurers licensed in New Hampshire. The data submitted in the Supplemental Report is critical to understanding and evaluating the New Hampshire's health insurance market. The data are collected annually, and this report is based on activity during the calendar year 2006.

MAJOR FINDINGS

Presented below are summary statistics about the insurance data submitted to the NHID. These data include all members insured or covered by self funded policies. For more detailed discussion and analyses, please refer to the specific section of this report.

SUMMARY STATISTICS

- Total premiums and premium equivalents = \$2,326,507,565
- Total claims = \$1,952,661,349
- Average loss ratio = .839
- Average number of members insured = 597,676
- Average monthly member premium = \$324.38
- Total number of companies included in the data = 14 (determined by distinct NAIC numbers)

HIGH DEDUCTIBLE HEALTH PLANS

- Percent of members in an IRS defined High Deductible Health Plan (HDHP) = 1.5%

SELF FUNDED PLANS

- Percent of members covered under employer self insured plans = 45.8%

DEDUCTIBLES

Most common deductible amounts, based on percent of members:

- \$0 – 54%
- \$250 – 6%
- \$500 – 13%
- \$1,000 – 10%
- \$2,000 – 3%

CO-INSURANCE

Most common co-insurance amounts, based on percent of members:

- 0% co-insurance - 63%
- 10% co-insurance - 5%
- 20% co-insurance - 30%

CO-PAYS

Most common co-pay amounts, based on percent of members:

- \$5 - 12%
- \$10 - 19%
- \$15 - 21%
- \$20 - 18%
- \$30 - 14%

COVERAGE CATEGORY DISTRIBUTION

The coverage categories include self funded accounts. Self insured status is not shown separately from coverage type (e.g. HMO vs. PPO), although ASO and ASW are limited to self-funded accounts. A premium equivalent is calculated for self insured coverage. Percentages are based on total membership, (self-funded and insured) and loss ratios are calculated:

Coverage Category Code	Membership	Average Loss Ratio
ASO	26.9%	.88
ASW	18.9%	.81
Indemnity Type	1.6%	.78
HMO	33.8%	.83
POS	5.2%	.87
PPO	13.2%	.81
Short Term	0.4%	.56

ASO: self-funded plans that are administered by a third-party administrator, where the employer has not purchased stop-loss, or group excess insurance coverage.

ASW: self-funded plans that are administered by a third-party administrator, where the employer has purchased stop-loss, or group excess, insurance coverage.

Short Term: short-term non-renewable health insurance.

MARKET CATEGORY

Membership and loss ratios by market category:

Market Category	Membership	Loss Ratio
Individual (as a group conversion)	0.1%	.79
Individual Policy	5.5%	.58
Employers with 1 Employee	1.8%	1.02
Employers with 2-9 Employees	8.4%	.78
Employers with 10-25 Employees	7.4%	.85
Employers with 26-50 Employees	5.4%	.83
Employers with 51-99 Employees	6.0%	.85
Employers with >= 100 Employees	63.0%	.85
Employers Through a Qualified Trust	1.6%	.85
Single Carrier Student Insurance	0.8%	.82

SUPPLEMENTAL REPORT HISTORY

The first round of supplemental report filings occurred on May 1, 2002, and included data from calendar year 2001. The first data submission applied only to licensed non-profit health service corporations and licensed health maintenance organizations. All other licensed health carriers filed in 2003. In 2006, the department substantially revised the bulletin that describes how data need to be submitted to the NHID. For this reason, the 2006 report cannot be compared to prior submissions.

DATA COLLECTED

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

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

Data are submitted to the NHID by stop loss companies as a part of the Supplemental Report data collection process, but are not reported on here. The membership covered under these policies are tracked through the TPA, as is the overall health insurance premium equivalent and the corresponding medical claims.

Carriers meeting the de minimis exemption do not submit data that are tabulated in this report, but instead file a registration report with the NHID. The de minimis exemption

applies to carriers that write less than \$250,000 in accident and health insurance premiums in New Hampshire and includes TPAs with fewer than 2,400 covered life months.

Data are only collected for New Hampshire policies. For example, assume a TPA administers a health benefit plan. This plan covers a New Hampshire employer and there are 250 lives associated with this employer's plan. 100 of the 250 lives are Massachusetts's residents, and the remaining 150 lives are New Hampshire residents. This TPA would to include, in its supplemental report, information for all lives, regardless of the state of residency, covered through this plan as they are all associated with a NH employer's health benefit plan.

In another example, assume a TPA administers a health benefit plan. This plan is for a Massachusetts employer and there are 500 lives associated with this employer's plan. Half of these lives are New Hampshire residents whose principal place of employment is in Massachusetts. This TPA would not include this plan in its supplemental report, as none of the 500 lives are associated with a NH employer's health benefit plan. The same principles apply to fully insured policies. Policies issued to NH employers should be reported in the New Hampshire Supplemental Report.

For an explanation of the data fields used in the supplemental report, please see the Supplemental Report bulletin on the NHID website that describes how the data must be submitted to the NHID: http://www.nh.gov/insurance/lifehealth/supp_report.htm.

DATA NOTES

Supplemental Report data are submitted to the NHID by June 1 of each year, for premium billed and claims with a date of service during the prior calendar year. The length of time after the incurred period is needed in order to adequately capture data on a claims paid basis, which may take several months for the provider to submit the claim, the carrier to process the claim, and the data to be loaded in reporting databases.

Upon receiving data from the carrier, the NHID analyzes the submission and provides a summary report back to the carrier. This quality assurance process takes place to confirm that what is submitted by the carrier is reasonable and without major errors that occasionally develop during a data submission process. No further auditing of the data takes place.

Many of the statistics contained herein are based on membership. Membership numbers are calculated averages based on member months. If a member was covered for twelve months that member is reported to the NHID with twelve member months and represent one complete member. If a member was only insured for half the year, six months are reported, and the membership value is 0.5. This method of averaging allows the NHID to provide comparable numbers of members, when in practice the actual number of members fluctuates throughout the year. Additionally, many individuals may be insured for only part of the year, due to moving in or out of state or changing employers. The

averaging mechanism avoids overestimating the number of persons insured by counting membership on a pro rated basis.

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

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

A loss ratio of .85 means that 85 cents of every premium dollar is used to cover the cost of medical claims. The difference between .85 and 1.0 in this example (equal to 15 cents of every premium dollar) is the amount that covers carrier administrative costs and profit.

Average premiums are provided in this report. These averages are calculated by the NHID on a per member basis. This allows comparability, but the average premiums may not reflect the actual premium paid by any particular enrollee. This is due to several factors related to the way premiums are calculated, including the employee/employer contributions and premium tiers, such as family, couple, and individual.

During the quality assurance process, data submitted by a carrier for a student health insurance plan was inconsistent with other submissions. The average member monthly premium was \$70 and the average claims cost was \$29. The explanation provided by the carrier was that the insurance was for a student health plan. Based on a comparison with another carrier that sells student insurance with a similar actuarial value, this fact did not explain the low costs. Therefore, this carrier's data was removed from all of the statistics and calculations in this report. The carrier's data include total premiums of approximately \$800,000.

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

DETAILED ANALYSES

HIGH DEDUCTIBLE HEALTH PLANS (HDHPs)

Data are identified for members enrolled in a high deductible health plan based on whether the policy qualifies as an IRS defined high deductible health plan during the calendar year 2006. In 2006 the IRS definition included policies with a minimum deductible of \$1,050 for an individual, and \$2,100 for a family.

The portion of members overall in a HDHP is 1.5 percent. This is somewhat inconsistent with the 9.4 percent of members we see with a deductible of at least \$1,050 in the data (see deductible section below). One possible explanation is the difference between tracking policies and deductibles on a family versus individual basis.

Members covered by self insured policyholders (generally large employers) are almost exclusively enrolled in insurance that does not meet the IRS definition of a HDHP. This is also the case for employers with greater than fifty employees.

Among members covered by small employers (number of employees equal to 1 – 50, but not including individual policies), 2.0 percent of employees are covered by HDHPs. Looking at all fully insured policies, 2.7 percent of employees are covered by HDHP plans.

Among non-group policies, 13.1 percent of members are enrolled in HDHPs.

DEDUCTIBLES

Information is collected on deductibles according to the dollar amount of the policy deductible. The deductible is the amount that the member pays before the health insurance carrier contributes to the cost of care. If the plan has more than one deductible, the highest level for medical services within the network is used. Dollar amounts refer to individual deductibles, not family deductibles.

All members:

Deductible Amount	Percent of Members	Total Members
\$0	54.1%	323,635
\$50	0.0%	7
\$100	1.2%	6,919
\$125	0.1%	633
\$150	0.4%	2,372
\$200	1.0%	5,696
\$250	6.4%	38,282
\$251	0.0%	6
\$300	1.9%	11,565
\$350	0.1%	572
\$400	1.0%	6,002

\$500	13.3%	79,435
\$600	0.0%	37
\$750	0.7%	4,229
\$1,000	10.4%	62,043
\$1,050	0.0%	17
\$1,100	0.0%	28
\$1,200	0.2%	1,066
\$1,250	0.1%	385
\$1,350	0.1%	320
\$1,500	1.3%	8,004
\$1,600	0.0%	32
\$1,650	0.0%	4
\$1,700	0.0%	92
\$1,750	0.0%	77
\$1,800	0.0%	23
\$2,000	3.0%	17,949
\$2,050	0.0%	55
\$2,100	0.0%	87
\$2,150	0.0%	33
\$2,200	0.0%	90
\$2,250	0.0%	21
\$2,400	0.0%	71
\$2,500	1.8%	10,876
\$2,550	0.1%	778
\$2,600	0.2%	1,262
\$2,700	0.1%	614
\$3,000	0.6%	3,401
\$3,750	0.0%	14
\$4,000	0.1%	823
\$4,950	0.0%	264
\$5,000	0.6%	3,590
\$5,100	0.0%	13
\$7,000	0.0%	263
\$7,500	0.0%	6
\$10,000	1.0%	5,942
\$12,000	0.0%	30
\$20,000	0.0%	2
\$24,000	0.0%	12

Comparison table below. Bold values represent the group with the highest percentage of members and the value is at least one percent. Please note, groups within the gray bars are mutually exclusive, but across gray bars are not.

There are a greater percentage of members covered by a self insured account without any deductible. This is partly the result of the state of NH plan in the data submission and the benefit design of state health insurance.

The majority of large group members do not have a deductible. By contrast, the highest percentage of small group members has a deductible of \$500, and the majority of non-group members are subject to a \$1,000 deductible. Also noteworthy, is the 9.1 percent of non-group members with a \$5,000 deductible.

Deductible	All Members	Self Insured Members	Fully Insured Members	Large Group Members	Small Group Members	Non-Group Members
\$0	54.1%	79.7%	32.6%	68.5%	22.3%	0.9%
\$50	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$100	1.2%	2.1%	0.4%	1.5%	0.4%	0.0%
\$125	0.1%	0.2%	0.0%	0.1%	0.0%	0.0%
\$150	0.4%	0.7%	0.1%	0.5%	0.3%	0.0%
\$200	1.0%	1.1%	0.8%	0.9%	1.3%	0.0%
\$250	6.4%	4.3%	8.2%	6.4%	7.9%	0.5%
\$251	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$300	1.9%	3.6%	0.5%	2.7%	0.1%	0.0%
\$350	0.1%	0.0%	0.2%	0.1%	0.0%	0.0%
\$400	1.0%	1.5%	0.6%	1.0%	1.2%	0.0%
\$500	13.3%	1.1%	23.6%	9.2%	28.9%	1.7%
\$600	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$750	0.7%	1.0%	0.5%	1.0%	0.1%	0.0%
\$1,000	10.4%	4.1%	15.7%	4.6%	17.5%	56.0%
\$1,050	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$1,100	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$1,200	0.2%	0.0%	0.3%	0.1%	0.6%	0.0%
\$1,250	0.1%	0.1%	0.0%	0.1%	0.0%	0.5%
\$1,350	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%
\$1,500	1.3%	0.2%	2.3%	0.2%	5.0%	1.2%
\$1,600	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
\$1,650	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$1,700	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%
\$1,750	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
\$1,800	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
\$2,000	3.0%	0.3%	5.3%	1.4%	6.4%	9.1%
\$2,050	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%
\$2,100	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%
\$2,150	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
\$2,200	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$2,250	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$2,400	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
\$2,500	1.8%	0.0%	3.4%	0.6%	4.6%	5.7%
\$2,550	0.1%	0.0%	0.2%	0.0%	0.0%	2.4%
\$2,600	0.2%	0.0%	0.4%	0.0%	0.0%	3.8%
\$2,700	0.1%	0.0%	0.2%	0.0%	0.0%	1.9%
\$3,000	0.6%	0.0%	1.0%	0.1%	2.0%	0.4%

\$3,750	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$4,000	0.1%	0.0%	0.3%	0.0%	0.2%	1.1%	
\$4,950	0.0%	0.0%	0.1%	0.0%	0.0%	0.8%	
\$5,000	0.6%	0.0%	1.1%	0.0%	0.4%	9.1%	
\$5,100	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
\$7,000	0.0%	0.0%	0.1%	0.0%	0.2%	0.0%	
\$7,500	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
\$10,000	1.0%	0.0%	1.8%	0.9%	0.6%	3.6%	
\$12,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
\$20,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	

CO-INSURANCE

Co-insurance is the percentage of the total claim that the member is responsible for paying. Co-insurance is paid after the deductible has been met. If the plan has more than one co-insurance level, the highest level for medical services within network is reported.

Co-Insurance Amount	Percent of Members	Members
0%	63.2%	377,981
5%	0.0%	272
10%	4.6%	27,305
20%	30.2%	180,415
25%	0.0%	15
30%	0.9%	5,101
35%	0.0%	155
40%	0.1%	483
50%	0.2%	1,111
70%	0.0%	6
80%	0.8%	4,833
100%	0.0%	0

Comparison table below

Patterns related to co-insurance are somewhat similar to what is seen with deductibles. The majority of large and small group members do not have co-insurance, while most non-group policies have co-insurance.

Co-Insurance	All Members	Self Insured Members	Fully Insured Members	Large Group Members	Small Group Members	Non-Group Members
0%	63.2%	60.7%	65.4%	67.0%	61.4%	23.0%
5%	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%
10%	4.6%	6.6%	2.8%	6.3%	0.4%	0.0%
20%	30.2%	32.6%	28.2%	25.3%	37.0%	65.6%
25%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
30%	0.9%	0.1%	1.5%	0.4%	0.4%	8.7%
35%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
40%	0.1%	0.0%	0.1%	0.0%	0.3%	0.0%
50%	0.2%	0.0%	0.3%	0.0%	0.1%	2.7%
70%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
80%	0.8%	0.0%	1.5%	1.0%	0.4%	0.0%

CO-PAYS

Co-pays represent the dollar amount of the highest office visit member contribution for services within network.

Only one carrier sells a product with a co-pay greater than \$100. This is on an individual short-term policy. Most of this carrier's members are subject to a \$2,000 co-pay, and there is a relatively even distribution of \$250, \$1,000 and \$2,000 deductibles for members with a \$2,000 co-pay. Other insurance products or plans generally have a co-pay of \$30.00 or less as shown on the chart below.

Co-pay Amount	Percent of Members	Members
\$0	7.4%	44,379
\$5	11.9%	70,984
\$10	19.2%	114,987
\$12	0.3%	1,622
\$15	20.7%	123,716
\$20	17.5%	104,866
\$25	3.7%	22,333
\$30	14.1%	84,446
\$35	0.7%	4,365
\$40	3.4%	20,507
\$45	0.0%	1
\$50	0.8%	4,562
\$60	0.0%	207
\$75	0.0%	190
\$2,000	0.1%	494
\$5,000	0.0%	20

Below is a comparison table sharing co-pays by market segment.

Co-pay	All Members	Self Insured Members	Fully Insured Members	Large Group Members	Small Group Members	Non-Group Members
\$0	7.4%	7.0%	7.8%	6.3%	4.1%	35.3%
\$5	11.9%	25.8%	0.1%	16.5%	0.3%	0.0%
\$10	19.2%	15.3%	22.6%	18.5%	26.1%	0.0%
\$12	0.3%	0.6%	0.0%	0.4%	0.0%	0.0%
\$15	20.7%	9.9%	29.8%	15.8%	40.8%	0.7%
\$20	17.5%	7.7%	25.9%	14.9%	17.3%	53.6%
\$25	3.7%	3.6%	3.8%	4.5%	2.4%	0.1%
\$30	14.1%	27.9%	2.5%	19.7%	0.2%	0.0%
\$35	0.7%	1.1%	0.5%	0.9%	0.5%	0.0%
\$40	3.4%	1.1%	5.4%	2.2%	5.9%	8.7%
\$45	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
\$50	0.8%	0.0%	1.4%	0.3%	2.4%	0.0%
\$60	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%
\$75	0.0%	0.0%	0.1%	0.0%	0.1%	0.0%
\$2,000	0.1%	0.0%	0.2%	0.0%	0.0%	1.5%
\$5,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%

COVERED BENEFITS

Coverage for benefits is determined based on whether the policy provides coverage at the level described in the Supplemental Report bulletin. A total of 26 benefit categories are included in the Supplemental Report filing. Several of these categories had very few members without coverage. Listed below are the 15 benefit categories had at least two percent of all members without coverage.

This section of the supplemental report is subject to reporting variation. This is due to differences in the interpretation of policy coverage and the definition of the benefit described in the bulletin. During the quality assurance process and in response to the summary report provided by the NHID, a few carriers identified issues with their submission and resubmitted data to correct their earliest submission.

Additionally, members appearing to be without coverage for a particular benefit may obtain coverage for that benefit through a mechanism other than the primary insurance carrier; examples of this are mental health benefits and prescription drug coverage.

Percentages report members without coverage for the benefit category:

Benefit Coverage Category	All Members	Self Insured Members	Fully Insured Members	Large Group Members	Small Group Members	Non-Group Members
Audiology Screening for Newborns	2.6%	0.0%	4.8%	1.4%	0.9%	26.1%
Blood and Blood Products	34.5%	53.9%	18.0%	43.3%	14.7%	2.0%
Chiropractic Services	5.9%	0.0%	11.0%	1.2%	3.6%	77.0%
Family Planning Services	15.8%	26.2%	7.1%	19.7%	1.0%	27.6%
Habilitative Services	3.7%	3.4%	3.9%	3.9%	2.4%	7.0%
Hearing Aids	47.3%	58.0%	38.2%	55.6%	25.9%	28.3%
Hospice	34.6%	53.9%	18.2%	43.4%	14.7%	3.5%
Infertility Services	38.7%	48.5%	30.5%	45.4%	20.9%	26.1%
Medical Food	2.2%	0.0%	4.1%	2.5%	0.6%	5.3%
Mental Health and Substance Abuse	34.7%	53.9%	18.4%	43.2%	14.8%	6.9%
Nutritional Services	36.7%	57.4%	19.4%	48.6%	2.1%	27.6%
Preventive Services	32.4%	53.9%	14.2%	44.1%	0.7%	11.9%
Prescription Drugs	19.0%	39.0%	2.1%	26.1%	0.4%	4.5%
Skilled Nursing Facility	28.7%	47.6%	12.7%	35.0%	14.7%	5.2%
Well Child and Immunization Benefits	20.0%	38.7%	4.4%	27.3%	0.4%	8.3%

Generally fewer fully insured or small group members are without coverage for a particular benefit. This is largely due to the requirements of NH law for mandated benefits. Larger employers are more likely to be self insured and have more flexibility when determining what benefits will be covered under their policy.

POLICYHOLDER LOCATION AND LOSS RATIOS

Policyholder location is determined by the zip code that is mapped to a county. As zip codes do not consistently map to county locations there is a level of imperfection with the mapping. Additionally, policyholder location does not reflect where the members reside. Policyholder is typically either the employer or the individual member (for non-group policies).

Loss ratio comparison table:

Policyholder Location	All Policies	Self Insured Policies	Fully Insured Policies	Large Group Policies	Small Group Policies	Non Group Policies
Belknap	0.84	0.91	0.82	0.89	0.80	0.61
Carroll	0.86	0.82	0.87	0.95	0.84	0.54
Cheshire	0.83	0.85	0.83	0.91	0.76	0.32
Coos	0.88	NA	0.88	1.01	0.75	0.49
Grafton	0.78	0.77	0.79	0.78	0.76	0.50
Hillsborough	0.82	0.83	0.81	0.85	0.83	0.60
Merrimack	0.88	0.89	0.86	0.89	0.85	0.58
Rockingham	0.85	0.89	0.84	0.84	0.87	0.44
Strafford	0.84	0.81	0.84	0.83	0.87	0.27
Sullivan	0.85	0.81	0.85	0.87	0.84	0.34

BENEFIT RICHNESS

Benefit richness is measured using an actuarial value that represents the cost of providing benefits when compared to a hypothetical standard benefit package. For example, if the standard benefit package covers a range of medical services including ten physical therapy (PT) visits, and is compared to a policy that has the same benefits except coverage for only five PT visits, then the difference in the actuarial value would reflect the difference in the cost of providing coverage for an additional five PT visits.

The computed actuarial value of the standard benefit package allows the NHID to compare the value of different benefit packages that do not cover the same services at the same level. The actuarial value allows us to compare the value of benefits that are different in ways beyond the number of PT visits. Continuing to use the example above with five PT visits that are fully covered, the value of that plan can be compared against another plan that covers ten PT visits with a fifty percent co-insurance for each visit. If both benefit packages have the same premium, which is the better value? The actuarial value is a calculation that identifies the difference in the actual cost of providing one insurance policy versus another. For example, if the insurer pays fifty percent of ten visits, it might be assumed that the value of a plan is equal to a plan on which the insurer pays the full amount of five visits. In fact, the actuarial value may be different because a member may utilize more than five visits infrequently, so that the cost to the carrier of providing five visits with no co-insurance is greater than providing ten with cost sharing.

The standard benefit plans carriers used to calculate the actuarial value are based on the plans developed for the NH small employer health reinsurance pool.

Below is a comparison table of average premiums and actuarial values among group sizes. Direct comparisons of the actuarial values are only possible within coverage type, as the standard benefit plan is different between coverage types. Self funded accounts are not included, as there is a mix of coverage types within ASO and ASW designations. Although short term and “other” designations also include a mix of coverage types, the relative actuarial values and cost are reported.

Coverage Type	All Members		Large Group		Small Group		Non Group	
	Average Premium	Benefit Richness						
HMO	\$321	0.87	\$317	0.90	\$325	0.84	\$524	1.21
POS	\$390	0.98	\$384	1.01	\$406	0.92	NA	NA
PPO	\$289	0.68	\$330	0.88	\$341	0.84	\$207	0.35
Indemnity Type Plans	\$271	0.54	\$228	0.44	\$402	0.74	\$245	0.56
Short Term, Non Renewable	\$86	0.46	NA	NA	NA	NA	\$86	0.46
Other	\$145	0.16	\$145	0.16	NA	NA	NA	NA

The actuarial value also allows adjustment of average premiums based on the value of the covered benefits. This allows a more direct comparison of what the policies would cost if the value of the covered benefits were the same. In doing so, it is evident that a relatively inexpensive average premium in the PPO non-group market is actually quite expensive once adjusted for the value of the benefits provided.

Coverage Type	All Members		Large Group		Small Group		Non Group	
	Crude Average Premium	Adjusted Average Premium						
HMO	\$321	\$370	\$317	\$353	\$325	\$386	\$524	\$433
POS	\$390	\$396	\$384	\$381	\$406	\$442	NA	NA
PPO	\$289	\$425	\$330	\$372	\$341	\$404	\$207	\$586
Indemnity Type Plans	\$271	\$506	\$228	\$521	\$402	\$546	\$245	\$434
Short Term, Non Renewable	\$86	\$185	NA	NA	NA	NA	\$86	\$185
Other	\$145	\$916	\$145	\$916	NA	NA	NA	NA

CARRIER MEMBERSHIP DISTRIBUTION

Data submitted for the Supplemental Report is based on policyholder. The data include insured members who reside outside of NH. "Anthem-NH" includes both Anthem-NH products and Matthew Thornton Health Care products. "Cigna" includes Cigna and Connecticut General Life Insurance products. The data include self funded accounts, not just fully insured members. Based on the Supplemental Report submission, the distribution of members by carrier is shown in the chart below:

Calendar Year 2006 Membership Distribution

Health Insurance Carrier	Membership	Percent
Anthem-NH	306,617	51.3%
Cigna	204,600	34.2%
Harvard Pilgrim Health Care	66,415	11.1%
Mega Life & Health	6,730	1.1%
Patriot Health Care	2,678	0.4%
Time Insurance Company	4,653	0.8%
Other Health Plans	5,982	1.0%
Total Membership	597,676	100.0%