SUPPLEMENTAL REPORT
OF THE
2007
HEALTH INSURANCE MARKET
IN
NEW HAMPSHIRE

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Prepared by the New Hampshire Insurance Department
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By law, the Insurance Commissioner is authorized to prescribe the format and content of financial and other reports filed by insurers licensed in New Hampshire. The data submitted in the Supplemental Report 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 2007.

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

MAJOR FINDINGS

Presented below are summary statistics about insurance data submitted to the NHID. These data include members insured and members covered by self funded policies.

SUMMARY STATISTICS

- Total premiums and premium equivalents = $2,022,355,384
- Total claims = $1,788,661,300
- Average loss ratio = .884
- Average number of members insured = 501,872*
- Average monthly member premium per month:
    - Large Group $345
    - Small Group $341
    - Non-Group $215
- Total number of companies included in the data = 16 (determined by distinct NAIC numbers)

*Approximately 75,000 fewer lives from 2006 were included in Cigna's submission due to corporate restructuring of a major account that shifted the majority of members to out-of-state status. Another 21,000 (4%) fewer members overall were included in the 2007 submissions due to either account restructuring or health insurance erosion in New Hampshire.

HIGH DEDUCTIBLE HEALTH PLANS

- Percent of members in an IRS defined High Deductible Health Plan (HDHP) = 5.3%

SELF FUNDED PLANS

- Percent of members covered under employer self insured plans:
  No membership was reported as self insured for small group and non-group categories
  Large Group = 55.8%
  Overall = 39.6%

DEDUCTIBLES

Most common deductible amounts, based on percent of covered members:

- $0 – 46%
- $250 – 6%
- $500 – 15%
- $1,000 – 12%
- $2,000 – 6%

CO-INSURANCE

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

- 0% co-insurance - 64%
- 10% co-insurance - 6%
- 20% co-insurance - 28%

CO-PAYS

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

- $5 – 14%
- $10 – 19%
- $15 – 19%
- $20 – 20%
- $30 – 3%
- $40 – 5%

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 2007. In 2007 the IRS definition included policies with a minimum deductible of $1,100 for an individual, and $2,200 for a family.

The overall percentage of members in a HDHP is 5.3 percent. This is somewhat inconsistent with the 14 percent of members we see with a deductible of at least $1,100 in the data (see deductible section below). A possible explanation is the difference between tracking policies and deductibles on a family versus individual basis.

The 2007 percentage is substantially greater than what was observed in 2006 (1.5 percent). As with all tables shown in the report, the both self-insured and full-insured members are included in the large and small group columns. Self/Fully Insured columns are NOT mutually exclusive from the Large/Small/Non Group columns. Percentages are always determined for data within each column.

HDHP	All Members		Self Insured	Fully Insured		Large Group	Small Group	Non Group
No	94.7%		97.6%	92.7%		95.9%	94.7%	82.0%
Yes	5.3%		2.4%	7.3%		4.1%	5.3%	18.0%
Total Members	501,872		198,782	303,089		356,203	112,260	33,409

AVERAGE PREMIUMS

The average premiums by market category and plan type are shown below. The average premium is a calculated rate, based on the total premium amount received by the carrier/TPA, divided by covered members. Since carriers utilize different rating factors, average premium values are useful for comparisons, but may not represent the actual premium charged for a policy. The average premiums include packages that vary extensively with respect to coverage. The market category and insurance status are significant given that many of the New Hampshire insurance laws differ among the classifications shown.

Market Category	Plan Type	Self Insured* Members	Self Insured* Avg Premium	Fully Insured Members	Fully Insured Avg Premium
Large Group	Indemnity	4,698	$471	1,461	$159
	HMO	89,725	$351	113,019	$340
	POS	54,425	$378	5,589	$403
	PPO	49,935	$320	37,351	$319
Small Group	Indemnity	No Membership Reported		5,192	$239
	HMO			74,429	$344
	POS			6,157	$415
	PPO			26,483	$335
Non-Group	Indemnity			4,458	$157
	HMO			522	$310
	PPO			28,429	$223
Total Members		198,782	$353	303,089	$324

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

Within the categories shown, most people are covered by HMO plans. In general, the POS plans are most expensive, followed by the HMO and then PPO plans. The Indemnity rates suggest that the product design and account specific circumstances are more variable than with other plan types. Across all insurance types the highest premium rates are for Indemnity coverage provided to self insured members and the lowest premium rates are for Indemnity coverage provided to fully insured members. More evidence of the variability with Indemnity pricing is shown in the next section. The data provided to the NHID through the supplemental report filing are not detailed or extensive enough to fully understand the characteristics and trends within the Indemnity plan type.

Average Premium and 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 the comparison of 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 proving ten with cost sharing.

The standard benefit plans carriers use to calculate the actuarial value are based on the NH small employer health reinsurance pool benefit plan. Given that the benefit plans differ by plan type, comparisons should only be made within the same plan type category (e.g. only compare HMO benefit richness values to other HMO values).

Below is a comparison table of average premiums and actuarial values among group sizes. Several key observations:

- The average premium for the large group HMO fully insured is 3.1 percent less than the self insured, but the average benefit value is 12.8 percent lower.
- The average premium and average benefit value between the HMO small group (fully insured) and the HMO large group are virtually the same. Among the POS and PPO plan types, small group premiums are on average higher than large group, but the value of benefits are similar.
- The average value of the benefits for self insured policies and fully insured policies are similar among the POS and PPO plan types. However, as shown in other sections (cost sharing, covered benefit categories), the actual benefit designs vary substantially.
- Policies under the Indemnity plan type vary extensively with respect to benefit richness and premiums.

		Self Insured*			Fully Insured		
Plan Type	**Market Category**	**Members**	**Avg Premium**	**Benefit Richness**	**Members**	**Avg Premium**	**Benefit Richness**
HMO	Large Group	89,725	$351	0.94	113,019	$340	0.82
HMO	Small Group	No Membership Reported			74,429	$344	0.83
HMO	Non-Group				522	$310	0.93
POS	Large Group	54,425	$378	0.92	5,589	$403	0.91
POS	Small Group	No Membership Reported			6,157	$415	0.90
PPO	Large Group	49,935	$320	0.80	37,351	$319	0.79
PPO	Small Group	No Membership Reported			26,483	$335	0.78
PPO	Non-Group				28,429	$223	0.36
Indemnity	Large Group	4,698	$471	0.95	1,461	$159	0.99
Indemnity	Small Group	No Membership Reported			5,192	$239	0.47
Indemnity	Non-Group				4,458	$157	0.41
Total Membership		198,782			303,089		

The table below provides comparative information between data reported for 2006 and 2007. Data are only reported for fully insured members as the plan type was not available for self insured data in 2006.

The “Change in Value” reflects the total overall change in both premiums and benefit richness. If premiums go up by five percent and benefit richness goes down by five percent, the total change in value is equal to negative ten percent. No adjustment for inflation is made. Key observations include:

- The HMO Large Group has the most members within the categories shown below, and on average, the value of the insurance for these members dropped by more than 16 percent.

- Substantial membership exists under PPO plan types. Despite experiencing average premium decreases, the decrease in benefit richness exceeded the decrease in premiums. These changes result in an overall erosion of insurance value by about six percent.
- The Indemnity plan type experienced extensive variability with respect to average premiums and benefit richness, but appears to have improved with respect to value. It should be noted that there are relatively few members insured under these products, and the high variability is likely due to major shifts in the covered populations' benefit packages and premium choices. Without further research, making determinations about the characteristics or trends within the Indemnity plan type is not possible.
- In general, large group members experienced a greater erosion of average benefit richness than small group members.
- In many cases, benefits decreased more than premiums increased.

Plan Type	Market Category	2007 Members	2006 Avg Premium	2007 Avg Premium	2006 Benefit Richness	2007 Benefit Richness	Change in Value
HMO	Large Group	113,019	$317	$340	0.90	0.82	-16.3%
HMO	Small Group	74,429	$325	$344	0.84	0.83	-7.5%
HMO	NG	522	$524	$310	1.21	0.93	17.2%
POS	Large Group	5,589	$384	$403	1.01	0.91	-14.8%
POS	Small Group	6,157	$406	$415	0.92	0.90	-4.8%
PPO	Large Group	37,351	$330	$319	0.88	0.79	-6.3%
PPO	Small Group	26,483	$341	$335	0.84	0.78	-5.7%
PPO	NG	28,429	$207	$223	0.35	0.36	-5.6%
Indemnity	Large Group	1,461	$228	$159	0.44	0.99	156.0%
Indemnity	Small Group	5,192	$402	$239	0.74	0.47	4.3%
Indemnity	NG	4,458	$245	$157	0.56	0.41	8.5%

Average Premium and Adjusted Premium

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 different policies would cost if the value of the covered benefits were the same. It is evident that the relatively inexpensive average premium in the PPO non-group market is actually the most expensive insurance once the weak benefits are adjusted for.

		Self Insured Members				Fully Insured Members		
Plan Type	**Market Category**	**Percent of Members**	**Average Premium**	**Adjusted Premium**		**Percent of Members**	**Average Premium**	**Adjusted Premium**
HMO	Large Group	45%	$351	$372		37%	$340	$415
HMO	Small Group	No Members Reported				25%	$344	$417
HMO	Non-Group					0%	$310	$335
POS	Large Group	27%	$378	$409		2%	$403	$443
POS	Small Group	No Members Reported				2%	$415	$463
PPO	Large Group	25%	$320	$400		12%	$319	$401
PPO	Small Group	No Members Reported				9%	$335	$431
PPO	Non-Group					9%	$223	$624
Indemnity	Large Group	2%	$471	$495		0%	$159	$160
Indemnity	Small Group	No Members Reported				2%	$239	$507
Indemnity	Non-Group					1%	$157	$386
Total Members		198,782				303,089		

MARKET CATEGORY

The market categories shown below with membership and loss ratios provide a more detailed breakdown of the summary market categories shown above. Separate tables exist for self insured and fully insured policies. On each table members are defined by market category and insurance status.

All Members, Self Insured, and Fully Insured

Market Category	All Members	Loss Ratio	Self Insured	Loss Ratio	Fully Insured	Loss Ratio
Individual policy	6.6%	0.62	No Members Reported		10.8%	0.62
Individual (as group conversion)	0.1%	2.29			0.2%	2.29
Employers with 1 Employee	2.3%	0.95			3.8%	0.95
Employers with 2-9 Employees	8.1%	0.81			13.3%	0.81
Employers with 10-25 Employees	7.5%	0.87			12.4%	0.87
Employers with 26-50 Employees	4.5%	0.90			7.5%	0.90
Employers with 51-99 Employees	6.6%	0.83	0.1%	0.94	10.9%	0.83
Employers with >=100 Employees	62.4%	0.91	98.6%	0.93	38.6%	0.89
Employers thru Qualified Trust	1.9%	0.88	1.3%	1.06	2.4%	0.81
Total Members	501,872	0.88	198,782	0.93	303,089	0.85

Large Group, Small Group, and Non-Group

Market Category	Large Group	Loss Ratio	Small Group	Loss Ratio	Non-Group	Loss Ratio
Individual policy	Not Applicable				98.4%	0.62
Individual (as group conversion)					1.6%	2.29
Employers with 1 Employee			10.2%	0.95	Not Applicable	
Employers with 2-9 Employees			36.0%	0.81		
Employers with 10-25 Employees			33.5%	0.87		
Employers with 26-50 Employees			20.3%	0.90		
Employers with 51-99 Employees	9.4%	0.83	Not Applicable			
Employers with >=100 Employees	87.9%	0.91				
Employers thru Qualified Trust	2.7%	0.88				
Total Members	356,203	0.91	112,260	0.86	33,409	0.64

Overall Comparison - 2006 and 2007

Market Category	2006 Percent of Members*	2007 Percent of Members	2006 Loss Ratio	2007 Loss Ratio
Individual policy	5.5%	6.6%	0.58	0.62
Individual (as group conversion)	0.1%	0.1%	0.79	2.29
Employers with 1 Employee	1.8%	2.3%	1.02	0.95
Employers with 2-9 Employees	8.4%	8.1%	0.78	0.81
Employers with 10-25 Employees	7.4%	7.5%	0.85	0.87
Employers with 26-50 Employees	5.4%	4.5%	0.83	0.90
Employers with 51-99 Employees	6.0%	6.6%	0.85	0.83
Employers with >=100 Employees	63.0%	62.4%	0.85	0.91
Employers thru Qualified Trust	1.6%	1.9%	0.85	0.88

*Totals will not equal 100% due to <1% of members who were classified as "other" in 2006. Total membership reported in 2006 was 597,676.

Key findings:

- The loss ratios show greater variability in 2007 across market categories.
- The individual market continues to have a comparatively low loss ratio.
- The small group category of "1 Employee" continues to have a comparatively high loss ratio, although to a lesser degree than in 2006. Overall this is a small percentage of the insurance marketplace, but represents greater than ten percent of members in the small group market.
- 2007 shows a higher loss ratio for large group policies. This may be due to several factors, including administrative costs accounting for a smaller percent of the total premiums paid, higher claims costs than expected, or fewer management services purchased from the carrier/TPA by self insured accounts (e.g. disease management).

DEDUCTIBLES

Information is collected on deductibles is 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.

<u>Comparison tables below</u>. Bold values represent the group with the highest percentage of members where the value is at least one percent.

Summary Table

Deductible	All Members		Self Insured	Fully Insured		Large Group	Small Group	Non-Group
$0	46%		**72%**	30%		59%	17%	4%
$1-250	9%		**10%**	8%		**10%**	7%	0%
$251-500	17%		9%	23%		15%	**30%**	2%
$501-750	1%		1%	1%		**2%**	0%	0%
$751-1,000	12%		5%	17%		7%	18%	**52%**
$1,001-1,500	2%		1%	2%		1%	2%	**3%**
$1,501-3,000	6%		0%	9%		3%	**13%**	9%
$3001-5,000	6%		2%	8%		3%	9%	**26%**
$5,001-7,500	0%		0%	0%		0%	0%	0%
$7,501-10,000	1%		0%	2%		0%	**4%**	**4%**
$10,001+	0%		0%	0%		0%	0%	0%
Total Members	501,872		198,782	303,089		356,203	112,260	33,409

The high percentage of members covered by a self insured account without any deductible is at least partly the result of the state of NH state employee plan.

The majority of large group members do not have a deductible. A strong majority of members with a deductible in the range of $7,501 – $10,000 have a deductible of $10,000.

In general, we see a greater percentage of members with higher deductibles than in 2006. The non-group market has the greatest proportion of members with high deductibles, but the small group market is experiencing substantial increases as well. Notable examples include 13 percent of small group members with a $2,000 deductible (up from 6.4 percent in 2006), and four percent at the $10,000 level (up from 0.6 percent).

A detailed comparison is set forth below:

Deductible	All Members		Self Insured	Fully Insured		Large Group	Small Group	Non-Group
$0	46%		72%	30%		**59%**	17%	4%
$100	1%		**2%**	1%		1%	1%	0%
$150	0%		0%	0%		0%	0%	0%
$200	1%		**3%**	0%		2%	0%	0%
$250	6%		5%	**7%**		**7%**	5%	0%
$300	2%		**4%**	0%		2%	0%	0%
$350	0%		0%	0%		0%	0%	0%
$400	0%		1%	0%		1%	0%	0%
$500	15%		4%	23%		12%	**30%**	2%
$600	0%		0%	0%		0%	0%	0%
$750	1%		1%	1%		1%	0%	0%
$900	0%		0%	0%		0%	0%	0%
$1,000	12%		5%	17%		7%	18%	**52%**
$1,100	0%		0%	0%		0%	0%	0%
$1,250	0%		0%	0%		0%	0%	**2%**
$1,350	0%		0%	0%		0%	0%	0%
$1,500	1%		0%	**2%**		1%	**2%**	1%
$1,600	0%		0%	0%		0%	0%	0%
$1,700	0%		0%	0%		0%	0%	0%
$1,750	0%		0%	0%		0%	0%	0%
$1,900	0%		0%	0%		0%	0%	0%
$2,000	6%		0%	9%		3%	**13%**	9%
$2,050	0%		0%	0%		0%	0%	0%
$2,100	0%		0%	0%		0%	0%	0%
$2,150	0%		0%	0%		0%	0%	0%
$2,200	0%		0%	0%		0%	0%	0%
$2,250	0%		0%	0%		0%	0%	0%
$2,400	0%		0%	0%		0%	0%	0%
$2,500	2%		0%	4%		1%	5%	**6%**
$2,550	0%		0%	0%		0%	0%	**2%**
$2,600	0%		0%	0%		0%	0%	**3%**
$2,700	0%		0%	0%		0%	0%	**2%**
$2,800	0%		0%	0%		0%	0%	0%
$2,850	0%		0%	0%		0%	0%	0%
$3,000	1%		1%	1%		1%	**3%**	0%
$3,500	0%		0%	0%		0%	0%	0%
$3,750	0%		0%	0%		0%	0%	0%
$4,000	0%		0%	0%		0%	0%	**1%**
$4,950	0%		0%	0%		0%	0%	**1%**
$5,000	1%		1%	1%		0%	0%	**10%**
$5,100	0%		0%	0%		0%	0%	0%
$5,400	0%		0%	0%		0%	0%	0%
$6,000	0%		0%	0%		0%	0%	0%
$7,000	0%		0%	0%		0%	0%	0%

$10,000	1%		0%	2%		0%	**4%**	**4%**
$12,000	0%		0%	0%		0%	0%	0%
Total Members	501,872		198,782	303,089		356,203	112,260	33,409

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.

Overall, the 2007 distribution of co-insurance amounts is similar to 2006, suggesting that this is not the dominate method of shifting costs to the member across all market segments. However, at the twenty percent level, there are decreases in the large group and non-group markets, but an increase within the small group market. In 2006, 37 percent of small group members had a twenty percent coinsurance benefit design, and in 2007 the percentage was up to 45 percent.

Comparison Table

Coinsurance	All Members		Self Insured	Fully Insured		Large Group	Small Group	Non-Group
0%	65%		77%	56%		71%	54%	28%
5%	0%		0%	0%		0%	0%	0%
10%	6%		11%	3%		8%	0%	0%
20%	28%		11%	39%		20%	45%	61%
25%	0%		0%	0%		0%	0%	0%
30%	1%		0%	2%		1%	1%	9%
35%	0%		0%	0%		0%	0%	0%
40%	0%		0%	0%		0%	0%	0%
50%	0%		0%	1%		0%	1%	2%
Total Members	501,872		198,782	303,089		356,203	112,260	33,409

CO-PAYS

Co-pays represent the dollar amount of the highest office visit member contribution for services within network. There appears to be a gradual shift from 2006 toward LOWER copay amounts, with the greatest decrease at the $30 level: 2006 = 14.1 percent, 2007 = 3 percent.

Copay	All Members		Self Insured	Fully Insured		Large Group	Small Group	Non-Group
0	11%		10%	12%		9%	11%	41%
5	14%		35%	0%		20%	0%	0%
10	19%		20%	19%		21%	18%	0%
15	19%		11%	24%		17%	30%	0%
20	20%		11%	26%		18%	19%	49%
25	4%		4%	3%		4%	3%	0%
30	3%		3%	4%		3%	5%	0%
35	2%		3%	2%		2%	4%	0%
40	5%		3%	6%		4%	7%	9%
50	2%		0%	4%		2%	5%	1%
All Members	501,871		198,782	303,088		356,203	112,259	33,409

Copay	2006 All Members	2007 All Members
0	7%	11%
5	12%	14%
10	19%	19%
15	21%	19%
20	18%	20%
25	4%	4%
30	14%	3%
35	7%	2%
40	3%	5%
50	8%	2%

COVERED BENEFITS

Coverage for benefits is based on whether the policy provides coverage at the level described in the Supplemental Report bulletin. Definitions are provided in Appendix A for all 26 benefit categories included in the Supplemental Report filing. A few of these categories had none or very few members without coverage. Listed below are the categories had at least one percent of one category of members without coverage.

Covered benefits are particularly subject to reporting variation. This variation is due to differences in how carriers interpret policy coverage and the definition of the benefits described in the bulletin. The NHID discussed the category definitions with several carriers, and the consistency is likely to improve from the 2006 reporting period. Comparing 2006 to 2007 could be misleading.

Members appearing to be without coverage for a particular benefit may obtain coverage for that benefit through a mechanism other than the primary insurance carrier. Examples of this include mental health benefits and prescription drug coverage.

Detailed Benefit Category Table:

Coverage Category	Covered	All Members	Self Insured	Fully Insured	Large Group	Small Group	Non-Group
Ambulance Services	Yes	100%	100%	100%	100%	100%	99%
	No	0%	0%	0%	0%	0%	1%
Prescription Drug Coverage	Yes	98%	98%	98%	99%	96%	95%
	No	2%	2%	2%	1%	4%	5%
Audiology Screening for Newborns	Yes	97%	100%	96%	100%	96%	75%
	No	3%	0%	4%	0%	4%	25%
Blood and Blood Products	Yes	77%	61%	88%	72%	88%	99%
	No	23%	39%	12%	28%	12%	1%
Case Management Program	Yes	99%	100%	98%	100%	96%	95%
	No	1%	0%	2%	0%	4%	5%
Chiropractic Services	Yes	93%	100%	89%	100%	93%	22%
	No	7%	0%	11%	0%	7%	78%
DME	Yes	100%	100%	100%	100%	100%	96%
	No	0%	0%	0%	0%	0%	4%
Emergency Room	Yes	99%	100%	99%	100%	96%	100%
	No	1%	0%	1%	0%	4%	0%
Family Planning Services	Yes	81%	71%	87%	78%	90%	73%
	No	19%	29%	13%	22%	10%	27%
Habilitative Services	Yes	42%	41%	42%	42%	46%	21%
	No	58%	59%	58%	58%	54%	79%
Hearing Aids	Yes	60%	58%	62%	62%	50%	73%
	No	40%	42%	38%	38%	50%	27%
Home Health Care	Yes	99%	100%	98%	100%	96%	95%
	No	1%	0%	2%	0%	4%	5%
Hospice	Yes	77%	61%	88%	72%	88%	95%
	No	23%	39%	12%	28%	12%	5%
Infertility Services	Yes	62%	66%	59%	63%	53%	75%
	No	38%	34%	41%	37%	47%	25%
Medical Food	Yes	98%	100%	96%	98%	100%	94%

	No	2%	0%	4%	2%	0%	6%
Mental Health and SA Treatment	Yes	77%	61%	88%	72%	88%	93%
	No	23%	39%	12%	28%	12%	7%
Nutritional Services	Yes	72%	59%	81%	69%	83%	73%
	No	28%	41%	19%	31%	17%	27%
OP Short Term Rehabilitation	Yes	99%	100%	99%	100%	100%	93%
	No	1%	0%	1%	0%	0%	7%
Pregnancy & Maternity	Yes	98%	100%	97%	100%	96%	88%
	No	2%	0%	3%	0%	4%	12%
Preventive Services	Yes	78%	65%	86%	75%	84%	88%
	No	22%	35%	14%	25%	16%	12%
Skilled Nursing Facility	Yes	83%	72%	91%	81%	88%	94%
	No	17%	28%	9%	19%	12%	6%
Transplants	Yes	100%	100%	100%	100%	100%	97%
	No	0%	0%	0%	0%	0%	3%
Well Child and Immunization Benefits	Yes	81%	64%	93%	77%	93%	92%
	No	19%	36%	7%	23%	7%	8%

Sometimes fewer fully insured or small group members are without coverage for a particular benefit. This is could be due to the requirements of NH laws for mandated benefits. Larger employers are more likely to be self insured and have more flexibility to determine which benefits will be covered under their policy.

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.

Based on the Supplemental Report submission, the distribution of members by carrier is shown in the chart below:

Health Insurance Carrier/TPA	Members	Percent of Total
Aetna	713	0.1%
Anthem-NH	285,948	57.0%
Cigna	112,722	22.5%
Golden Rule	424	0.1%
Guardian Life	282	0.1%
Harvard Pilgrim Health Care	85,872	17.1%
John Alden	2,187	0.4%
MVP	1,615	0.3%
Mega Life & Health	5,858	1.2%
Security Mutual Life	1,013	0.2%
Time Insurance Company	4,420	0.9%
Trustmark	24	0.0%
United	795	0.2%

SUPPLEMENTAL REPORT HISTORY

The first round of supplemental report filings occurred on May 1, 2002, and included data from calendar year 2001. The first data submission applied only to licensed non-profit health service corporations and licensed health maintenance organizations. All other licensed health carriers filed in 2003. In 2006, the department substantially revised the bulletin that describes how data need to be submitted to the NHID. For this reason, the 2006 report cannot be compared to prior submissions. The 2007 bulletin had minor changes, but included a separate variable for self insured vs. fully insured data. This separation allows greater insight into the market dynamics of the differing policy types.

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 here. The membership covered under these polices are tracked through the TPA, as is the overall health insurance premium equivalent and the corresponding medical claims.

Carriers meeting the de minimis exemption do not submit data that are tabulated in this report, 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/media/bulletins/2008/documents/ins_08_001ab.pdf.

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 represents one complete member. If a member was only insured for half the year, six months are reported, and the membership value is 0.5. This method of averaging allows the NHID to

provide comparable numbers of members, when in practice the actual number of members fluctuates throughout the year. Additionally, many individuals may be insured for only part of the year, due to moving in or out of state, changing employers, or becoming uninsured. The averaging mechanism avoids overestimating the number of persons insured by counting membership on a pro rated basis. Since members can be counted on a partial basis, summary totals may differ slightly due to rounding errors.

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

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

A loss ratio of .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, but does not include all factors that affect carrier profitability.

Average premiums are provided in this report. These averages are calculated by the NHID on a per member 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 health insurance plan was inconsistent with other submissions. 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, the carrier's data was removed from all of the statistics and calculations in this report.

A second anomaly was discovered during the quality assurance process. There are separate submissions for Cigna HealthCare of New Hampshire and Connecticut General Life Insurance Company (CGLI), but these organizations are part of the same entity. The combined membership of the submissions was substantially less in 2007 than in 2006, and the explanation provided was that a restructuring of a major account moved the policyholder location out of NH. This account included about 75,000 members.

The loss of the Cigna/CGLI membership in the data means the sample of members we use to characterize the insurance marketplace in NH may be different. The differences may impact how the data compare between 2006 and 2007. Since this is a large account, comparisons are most meaningful when other policy types (non-group, small group) are compared between years, rather than the aggregated totals. The differences between the 2006 large group statistics and the 2007 large group statistics may, or may not be influenced by this change in membership. If the account had similar characteristics to other large accounts in NH, than there is minimal impact to our comparisons. If not, there will be differences in our comparisons simply due to the population bias of the samples.

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.

Appendix A- Benefit Category Descriptions

Ambulance Service	Includes: ambulance transportation.
Audiology Screening for Newborns	Includes: covered for one screening and one confirming screening.
Blood and Blood Products	Includes: fees associated with the collection or donation of blood or blood products, all cost recovery expenses for blood, blood derivatives, components, biologics, and serums to include autologous services and albumin.
Case Management Program	Includes: available for medically complex and costly services.
Chiropractic Services	Includes chiropractic services.
Durable Medical Equipment (DME)	Includes: nebulizers, peak flow meters, and diabetes glucose monitoring equipment.
Emergency Room	Includes: emergency room treatment.
Family Planning Services	Full range of services including: Counseling services and patient education; examination and treatment by medical professionals; laboratory examinations and tests; medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception; and infertility services, including sterilization reversals.
Habilitative Services	Includes: coverage for children 0-19 years of age for treatment of congenital and genetic birth defects.
Hearing Aids	Includes: coverage for persons 0-18 years of age, including hearing aid for each hearing-impaired ear, every 36 months.
Home Health Care	Includes: coverage as an alternative to otherwise covered services in a hospital or other related institution.
Hospice	Includes: coverage same as Medicare, including nursing care, medical social services, physicians' services, counseling services, short-term inpatient care, medical appliances and supplies, home health aide services, physical therapy, occupational therapy, speech-language pathology, and other items and services.
Hospitalization	Includes: unlimited (includes detoxification)
Infertility Services	Includes: coverage for services obtained after diagnosis of infertility (excludes in vitro fertilization)
Medical Food	Includes: for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis or treatment in the field of metabolic disorders
Mental Health and Substance Abuse	Includes: when delivered through a managed care system for 60 inpatient days with partial hospitalization traded on a 2 to 1 basis and unlimited outpatient visits

Nutritional Services	Includes: six visits per year for cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease.
Outpatient Hospital Services & Surgery	Includes: outpatient hospital services and surgery.
Outpatient Laboratory & Diagnostic Services	Includes: outpatient laboratory and diagnostic services.
Outpatient Short-Term Rehabilitative Services	Includes: physical therapy, speech therapy, and occupational therapy.
Pregnancy and Maternity	Includes: pregnancy and maternity.
Prescription Drugs (Rx)	Includes: prescriptions available on an open formulary with coverage at least the generic drug equivalent amount when the brand name drug is prescribed.
Preventive Services	Includes: services recommended by the U.S. Preventive Services Task Force and other services required to be a Federally Qualified HMO, including: a broad range of voluntary family planning services; services for infertility; well-child care from birth; periodic health evaluations for adults; eye and ear examinations for children through age 17, to determine the need for vision and hearing correction; pediatric and adult immunizations in accord with accepted medical practice.
Skilled Nursing Facility	Includes: 100 days as an alternative to otherwise covered care in a hospital or other related institution.
Transplants	Includes: for bone marrow, cornea, kidney, liver, lung, heart, pancreas, and pancreas/kidney transplants.
Well Child & Immunization Benefits	Includes: for children 0 – 13 years of age.