SUPPLEMENTAL REPORT
OF THE
2012
HEALTH INSURANCE MARKET
IN
NEW HAMPSHIRE

April 29, 2014

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 health insurance market. The data are collected annually, and this report is based on activity during the calendar year 2012.

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

The Supplemental Report collects data for both NH situs members and non-NH situs members. Beginning in 2012, to ease the burden on carriers submitting data for the Supplemental Report, the New Hampshire Insurance Department no longer requires carriers to submit benefit option details and premium for non-NH situs membership. Carriers continue to submit membership and claims information for non-NH situs enrollment. Tables from the 2011 Supplemental Report have been restated in Appendix C of this report and will allow for a consistent comparison to the 2012 Supplemental Report.

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

LIMITED COVERAGE AND LIMITED ELIGIBILITY POLICIES

The following heath insurance policies offered in the NH insurance market have limited coverage and/or limited eligibility.

Stand alone stop-loss insurance is an example of an insurance policy with limited coverage. It protects against catastrophic or unpredictable losses. Groups with stand alone stop-loss insurance are liable for all claims up to a specific or aggregate prescribed threshold. The insurance company offering stop-loss coverage only becomes liable for claims after the prescribed threshold has been exceeded.

Student health insurance is an example of a health insurance product where eligibility is limited. Coverage for student health insurance is offered through participating colleges and universities and specific eligibility rules apply.

Insurance offered in a High Risk Pool is another example of insurance coverage where the eligibility is limited, specifically to high risk members. There are two options for high risk members wanting to seek coverage in a High Risk Pool in NH. The New Hampshire Health Plan (NHHP) was established as a high risk pool under state statute to provide health insurance to NH residents who are declined coverage through the private market, members who have a pre-qualifying condition or are otherwise not eligible for health insurance. The NHHP-FED is a federal high risk pool established by the United States Department of Health and Human Services (HHS) to provide access to affordable health insurance coverage for the uninsured regardless of health condition. The NHHP administers the federal plan on behalf of HHS. Both of the high risk pools in existence for 2012 are impacted by the implementation of the Affordable Care Act, and the related changes will appear in subsequent Supplemental Reports.

Due to the unique nature and features of these limited policies, data for these policies have been excluded from the report with the exception of the table below that summarizes the 2012 premium and claim experience of members enrolled in these limited policy types. Please note that the premiums shown for the High Risk Pool reflect what the insured member pays and do not include assessments or government subsidies.

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

Limited Coverage	Members	Premium PMPM	Claims PMPM	Loss Ratio
Stand Alone Stoploss	27,615	$28	$23	81%
Student	1,566	$115	$101	88%
High Risk Pool (NHHP)	2,809	$490	$825	168%
High Risk Pool (NHHP-FED)	506	$473	$4,846	1026%
High Risk Pool Total	**3,316**	**$488**	**$1,181**	**242%**

TRADITIONAL HEALTH INSURANCE POLICIES

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

SUMMARY STATISTICS

NH SITUS STATISTICS

- Total premiums and premium equivalents = $2,660,620,363
- Total claims = $2,287,620,136
- Average loss ratio = 86.0%
- Average number of members insured = 506,580
- Average member premium per month:
    - Large Group $456
    - Small Group $432
    - Non-group $287
- Members

	NH Situs	non-NH Situs	Total
Large Group	373,527	165,824	**539,352**
Small Group	92,084	21,905	**113,989**
Individual	40,969	889	**41,858**
Total	**506,580**	**188,619**	**695,199**

	NH Situs	non-NH Situs	Total
Groups of 1 Employee	2,419	1,750	**4,170**
Groups of 2-50 Employees	89,665	20,155	**109,820**

- Percentage of All Members

	NH Situs	non-NH Situs	Total
Large Group	54%	24%	**78%**
Small Group	13%	3%	**16%**
Individual	6%	0%	**6%**
Total	**73%**	**27%**	**100%**

- Percentage Members that are Fully Insured

	NH Situs	non-NH Situs	Total
Large Group	28%	12%	**23%**
Small Group	99%	40%	**88%**
Individual	100%	100%	**100%**
Total	**47%**	**16%**	**38%**

HIGH DEDUCTIBLE HEALTH PLANS

- Percent of members in an IRS defined High Deductible Health Plan (HDHP) for NH situs members is 15%, compared to 18% in 2011.

DEDUCTIBLES

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

- $0 – 29%
- $500 – 6%
- $1,000 – 8%
- $2,000 – 10%
- $3,000 – 15%
- $5,000 – 5%

CO-INSURANCE

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

- 0% co-insurance - 70%
- 10% co-insurance - 6%
- 20% co-insurance - 18%

CO-PAYS

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

- $0 – 19%
- $10 – 7%
- $15 – 8%
- $20 – 16%
- $25 – 24%
- $40 - 6%

DETAILED ANALYSES

HIGH DEDUCTIBLE HEALTH PLANS (HDHPs)

Data are identified for members enrolled in a high deductible health plan based on whether the policy qualified as an IRS defined high deductible health plan during the calendar year 2012. In 2012, the IRS definition included policies with a minimum deductible of $1,200 for an individual and $2,400 for a family.

The overall percentage of NH-situs members in a HDHP is 15 percent. This represents a decline from 2011, when the percentage of NH-situs members enrolled in an HDHP was

18%. The highest penetration remains in the non-group market segment where 39% of members were enrolled in a HDHP in 2012. Both the large group and small group markets experienced a decline in HDHP penetration in 2012 while the opposite was true for the non-group market.

As with all tables shown in the report, both self-insured and fully-insured members are included in the large and small group columns. Self/Fully-insured columns are NOT mutually exclusive from the Large/Small/Non-Group columns. Percentages are always determined for data within each column. Tables from 2012 and 2011 are below.

2012

Situs	HDHP	All Members	Self-Insured	Fully-Insured	Large Group	Small Group	Non-Group
NH - Situs	No	85%	91%	79%	88%	85%	61%
NH - Situs	Yes	15%	9%	21%	12%	15%	39%
NH - Situs Members		**506,580**	**270,391**	**236,189**	**373,527**	**92,084**	**40,969**

2011

Situs	HDHP	All Members	Self-Insured	Fully-Insured	Large Group	Small Group	Non-Group
NH - Situs	No	82%	92%	70%	85%	73%	68%
NH - Situs	Yes	18%	8%	30%	15%	27%	32%
NH - Situs Members		**514,409**	**272,394**	**242,015**	**374,836**	**93,196**	**46,377**

Observations:

- HDHP overall penetration rate is lower in 2012 as compared to 2011.
- HDHP penetration rates increased in the self-insured and non-group market segments.
- HDHP penetration rates decreased in the fully-insured, Large Group, and Small group market segments. This may be due to movement towards HMO products in both of those market segments. Typically, HMO products do not meet the criteria for high deductible health plans. In 2011, 55% of the fully insured members were in HMO products. In 2012, 58% of the fully insured members were in HMO products.

AVERAGE PREMIUMS

The average premium is a calculated rate, based on the total premium amount received by the carrier/TPA, divided by covered member months. Categorizations by market segment (Non-Group, Small Group, Large Group), insurance status (self-insured, fully-insured), and plan type (HMO, POS, PPO, EPO, Indemnity) are important given that many of the New Hampshire insurance laws differ among the classifications shown. For example, carriers are allowed to adjust individual rates for differences in age, health status, and tobacco use. For 2012, in Small Group, rates may be adjusted for differences in age, number of employees enrolled, and type of industry. In Large Group, the rates

issued to an employer may reflect historical claim experience of that employer group. Since the premiums are aggregated across carriers, average premium values will not represent the actual premium charged for a particular policy, but will reflect the aggregation of the benefit designs, product pricing strategies, and rating factors utilized by all carriers. The NH-situs only average premiums per member per month by market category and plan type are shown below.

		Self-Insured*		Fully-Insured	
Market Category	**Plan Type**	**Members**	**Avg Premium**	**Members**	**Avg Premium**
Large Group	HMO	90,754	$469	62,249	$450
	POS	41,743	$493	2,895	$466
	PPO	131,689	$443	32,114	$430
	EPO	954	$624	5,754	$365
	Indemnity**	4,607	$529	768	$576
Small Group	HMO	169	$522	69,541	$427
	POS	4	$556	1,738	$447
	PPO	409	$534	15,007	$442
	EPO	No Membership Reported		5,154	$458
	Indemnity**	62	$508	No Membership Reported	
Non-Group	HMO	No Membership Reported		4,762	$206
	POS			No Membership Reported	
	PPO			34,640	$302
	EPO			4	$559
	Indemnity**			1,562	$211
Total		**270,391**	**$461**	**236,189**	**$410**

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

Observations:

- In the fully-insured market, most people are covered by HMO plans in the group market while most people are covered by PPO plans in the non-group market.
- The most popular self-insured plans are PPO plans, while the majority of fully-insured members are enrolled in HMO plans.
- HMO average premiums per member in the group market ranged from $427 to $522, compared to only $206 in the non-group market.

- Significantly lower average premiums in the non-group market are likely attributable to the ability of carriers to underwrite for health status and to lower benefit richness in that segment.

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 up to ten physical therapy (PT) visits per year, and is compared to a policy that has the same benefits except coverage is allowed for only five PT visits per year, then the difference in the actuarial value would reflect the difference in the cost of providing coverage for an additional five PT visits allowed.

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. Using the example above with up to five PT visits that are fully covered, the value of that plan can be compared against another plan that covers up to 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 fifty percent cost sharing.

For the actuarial values in this report, carriers are required to calculate the actuarial value as follows:

1) Calculate health coverage plan rates for each coverage option,
2) Calculate health coverage plan rates for the four standard health benefit plan designs (HMO, PPO, POS, Indemnity) as defined for the New Hampshire small employer reinsurance pool
3) Calculate the actuarial value as the ratio of the health coverage plan rate from step 1 to the health coverage plan rate of the same plan type from step 2

Given that the benefit plans differ by plan type, comparisons can only be made within the same plan type category (e.g. only compare HMO benefit richness values to other HMO values).

In November of 2012, the Department of Health and Human Services (HHS) released a long awaited proposed rule that gives clarification of the concept of Actuarial Value under the ACA. This new rule gives actuaries and other interested parties a proposed methodology along with a model that calculates the expected actuarial value for a

specific selected benefit design. Under the ACA, this actuarial value concept will be used to aid in the development of plan designs along with allowing for consistent comparison of plan value across different plan designs for consumers.

It is important to note the methodology used to calculate the actuarial values presented in this report was developed several years ago, before the proposed methodology under the ACA guidelines, and therefore will not line up exactly. For example, plan designs with a 60% actuarial value using the proposed ACA ruling methodology will result in the plan being a **bronze** level plan. It would not be correct to assume that the plan designs in this report with a 60% actuarial value would be **bronze** level plans under the ACA.

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

		Self-Insured*			Fully-Insured		
Plan Type	Market Category	Members	Avg Premium	Benefit Richness	Members	Avg Premium	Benefit Richness
HMO	Large Group	90,754	$469	0.78	62,249	$450	0.66
	Small Group	169	$522	0.86	69,541	$427	0.56
	Non-Group	No Membership Reported			4,762	$206	0.93
POS	Large Group	41,743	$493	0.74	2,895	$466	0.62
	Small Group	4	$556	1.01	1,738	$447	0.43
	Non-Group	No Membership Reported			No Membership Reported		
PPO	Large Group	131,689	$443	0.75	32,114	$430	0.65
	Small Group	409	$534	0.79	15,007	$442	0.53
	Non-Group	No Membership Reported			34,640	$302	0.18
EPO	Large Group	954	$624	0.80	5,754	$365	0.76
	Small Group	No Membership Reported			5,154	$458	0.77
	Non-Group				4	$559	0.71
Indemnity**	Large Group	4,607	$529	0.96	768	$576	0.85
	Small Group	62	$508	0.90	No Membership Reported		
	Non-Group	No Membership Reported			1,562	$211	0.38
Total Members		**270,391**			**236,189**		

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

Observations:

- For the HMO products, the average premium for fully-insured Large Group is higher than for fully-insured Small Group, but some of the difference can be explained by the less rich benefits in the Small Group market.
- For HMO Large Group, the average premium for self-insured is 4% percent higher than the average premium for fully-insured HMO, but the value of the self-insured benefits is about 18 percent greater than the value of the fully-insured benefits.
- The fully-insured large group POS premiums are about 5 percent less than the self-insured Large Group POS premiums, and the benefit richness for the fully-insured members is 16 percent less than the benefit richness for the self-insured members.
- For PPO Large Group, the self-insured premium is 3 percent higher than the fully-insured premium; however, self-insured benefits are 15 percent richer. The average premium for PPO Large Group fully-insured is 3 percent lower than the average PPO premium for the Small Group segment, however the richness of the benefit value for Large Group is about 23% greater.
- The average premium for PPO Non-group is 30% lower than for PPO Large Group, however the benefits for PPO Non-group are 72% less rich than for PPO Large Group. The lower benefit richness in the Non-group segment is likely attributable to more members being enrolled in high deductible plans and enrolled in plan designs with higher coinsurance percentages.
- Policies under the Indemnity plan type vary extensively with respect to benefit richness and premiums.

The table below provides comparative information of NH-situs only for 2011 and 2012 data. The "Change in Value" reflects the total overall change in both premiums and benefit richness. If premiums go up by five percent and benefit richness goes down by five percent, the total change in value is equal to negative ten percent. No adjustments are made for inflation or for changes in the underlying risk of the members (due to factors such as age, health status, etc.), which may also be contributing factors to the change in average premium.

		Members		Avg Premium*		Benefit Richness		
Plan Type	Market Category	2011	2012	2011	2012	2011	2012	Change in Value
HMO	Large Group	154,484	153,004	$434	$461	0.73	0.73	-6%
	Small Group	64,471	69,710	$423	$427	0.60	0.56	-8%
	Non-Group	9,481	4,762	$187	$206	0.91	0.93	-8%
POS	Large Group	66,649	44,638	$459	$491	0.75	0.73	-10%
	Small Group	720	1,742	$580	$447	0.67	0.43	-13%
	Non-Group	No Membership Reported						
PPO	Large Group	139,225	163,803	$359	$440	0.66	0.73	-12%
	Small Group	15,292	15,416	$436	$445	0.55	0.54	-4%
	Non-Group	34,891	34,640	$276	$302	0.21	0.18	-25%
EPO	Large Group	8,184	6,708	$354	$402	0.76	0.77	-13%
	Small Group	12,258	5,154	$389	$458	0.76	0.77	-17%
	Non-Group	23	4	$460	$559	0.77	0.71	-30%
Indemnity**	Large Group	6,294	5,375	$544	$536	0.95	0.94	1%
	Small Group	455	62	$332	$508	0.15	0.90	428%
	Non-Group	1,982	1,562	$217	$211	0.31	0.38	27%

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

Observations include:

- HMO Large Group represents 30 percent of the membership, and the value of the insurance for these members dropped by about 6 percent from 2011 to 2012.
- Both Non-group and Small Group HMO experienced an increase in average premium levels between 2011 and 2012. Small Group HMO experienced a decline in benefit richness between 2011 and 2012, while Non-group HMO experienced an increase. The value of insurance for those in the HMO Small Group and Non-group markets each declined by 8 percent.
- The value for POS Small Group decreased by 13 percent, while the value for POS Large Group decreased by 10 percent between 2011 and 2012.
- The majority of Non-Group members are enrolled in PPO products, and this segment saw a reduction in value equal to 25 percent.
- The Indemnity plan type saw extensive variability with respect to average premiums and benefit richness often observed when analyzing plans with small membership populations and shifting membership.
- In many cases, the value of benefits decreased while premiums increased, which will always result in a reduction in the value of the insurance coverage.

- In some cases the average premium went down: Small Group POS, Large Group Indemnity and Non-Group Indemnity premiums decreased. Small Group POS saw a dramatic decrease in benefit richness from 2011 to 2012, while the Large Group Indemnity plans held relatively flat across the two years and the Non-Group Indemnity plans show an increase in benefit richness.
- The value of insurance for the Large Group PPO segment (representing 32% of covered members) decreased by 12 percent. The decline in value in this segment was being driven by average premiums increasing more than the average benefit richness.

Average Premium and Adjusted Premium

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

		Self-Insured*			Fully-Insured		
Plan Type	**Market Category**	**Percent of Members**	**Avg Premium**	**Adjusted Premium**	**Percent of Members**	**Avg Premium**	**Adjusted Premium**
HMO	Large Group	34%	$469	$603	26%	$450	$681
	Small Group	0%	$522	$606	29%	$427	$769
	Non-Group	No Membership Reported			2%	$206	$222
POS	Large Group	15%	$493	$670	1%	$466	$754
	Small Group	0%	$556	$550	1%	$447	$1,031
	Non-Group	No Membership Reported			No Membership Reported		
PPO	Large Group	49%	$443	$591	14%	$430	$661
	Small Group	0%	$534	$678	6%	$442	$828
	Non-Group	No Membership Reported			15%	$302	$1,667
EPO	Large Group	0%	$624	$780	2%	$365	$479
	Small Group	No Membership Reported			2%	$458	$591
	Non-Group				0%	$559	$786
Indemnity**	Large Group	2%	$529	$553	0%	$576	$682
	Small Group	0%	$508	$565	No Membership Reported		
	Non-Group	No Membership Reported			1%	$211	$549
Total Members		**270,391**			**236,189**		

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

Observations:

- For all fully insured group plans, the premiums adjusted for benefit differences is inversely correlated with group size. Small groups have a higher adjusted premium than large groups.
- Adjusted Non-Group premiums are higher than adjusted Small Group premiums in the PPO and EPO product lines. Non-Group HMO premiums are much lower than the group premiums due to the Healthy Kids population, which only covers children under age 19. Since children on average are much healthier and less costly to insure than adults, the Non-group HMO premiums should not be compared to the group HMO premiums. Starting July 1, 2012, children covered by Healthy Kids Silver through Harvard Pilgrim Health Care were moved to Medicaid. The Supplemental Report does not include data for members enrolled in plans administered by Medicaid. Therefore caution must be used when comparing the results from the 2011 Supplemental Report to the 2012 Supplemental Report because the 2012 Supplemental Report includes half a year's worth of Healthy Kids enrollment while the 2011 Supplemental Report includes a full year's worth of Healthy Kids enrollment.

- Large Group adjusted premiums are higher for fully-insured members as compared to self-insured members in the HMO, POS, PPO, and Indemnity products.

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

State and Municipal Account Comparison

Plan Type	Account Type	Percent of Members	Avg Premium*	Benefit Richness	Adjusted Premium*
HMO	State	5%	$440	0.80	$550
	Municipal	9%	$459	0.78	$588
	All Other Accounts	31%	$442	0.63	$708
POS	State	1%	$627	0.84	$748
	Municipal	5%	$520	0.68	$767
	All Other Accounts	3%	$400	0.72	$560
PPO	State	0%	$529	1.10	$481
	Municipal	0%	$575	0.69	$839
	All Other Accounts	42%	$417	0.53	$793
EPO	State	No Membership Reported			
	Municipal	0%	$486	0.87	$557
	All Other Accounts	2%	$426	0.77	$552
Indemnity**	State	No Membership Reported			
	Municipal	1%	$718	0.96	$745
	All Other Accounts	1%	$289	0.65	$443
Total Members		**506,580**			

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

** Due to limited membership, indemnity values are disproportionately affected by outlier data. Please see Data Notes section for additional information on outlier data.

Observations include:

- State HMO plans had an increase in benefit richness between 2011 and 2012, with the benefit richness increasing to 0.80 in 2012 from 0.73 (see Appendix C) in 2011. Municipal HMO plans and All Other Accounts HMO plans experienced a slight decline in benefit richness between 2011 and 2012. Municipal HMO plan benefit richness decreased from 0.81(see Appendix C) in 2011 to 0.78 in 2012 while All Other Accounts HMO plans benefit richness decreased from 0.65 in 2011 (see Appendix C) to 0.63 in 2012. Although fewer State covered members

are enrolled in POS products, both the average premium and adjusted premium are substantially higher than for All Other POS policies. Municipal covered members enrolled in POS products remains stable, but the adjusted premium is higher than the adjusted premium for State POS plans.

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 2012 self-insured and fully-insured policies. A comparison of 2012 to 2011 is made in total.

All Members, by Insured Status and Market Category

Market Category	All Members	Loss Ratio	Self-Insured Members	Loss Ratio	Fully-Insured Members	Loss Ratio
Total Large Group	**68%**	**0.88**	**88%**	**0.90**	**44%**	**0.84**
Employers with 51-99 Employees	7%	0.84	1%	0.94	14%	0.83
Employers with >=100 Employees	61%	0.89	87%	0.90	30%	0.84
Qualified Association Trust	**7%**	**0.93**	**11%**	**0.94**	**2%**	**0.84**
Total Small Group	**17%**	**0.81**	**0%**	**0.80**	**37%**	**0.81**
Employers with 1 Employee	0%	1.07	None Reported		1%	1.07
Employers with 2-9 Employees	7%	0.79	0%	0.91	15%	0.79
Employers with 10-25 Employees	6%	0.81	0%	0.96	14%	0.81
Employers with 26-50 Employees	3%	0.77	0%	0.77	7%	0.77
Total Individual	**8%**	**0.63**			**17%**	**0.63**
Individual Policy	8%	0.62	None Reported		17%	0.62
Individual as Group Conversion	0%	2.06			0%	2.06
Grand Total	**506,580**	**0.86**	**270,391**	**0.91**	**236,189**	**0.80**

Overall Comparison –2011 and 2012

The following table compares the membership distribution and loss ratios by market category for 2011 versus 2012.

	Percent of Members		Loss Ratio	
Market Category	**2011**	**2012**	**2011**	**2012**
Total Large Group	**66%**	**68%**	**0.91**	**0.88**
Employers with 51-99 Employees	7%	7%	0.85	0.84
Employers with >=100 Employees	59%	61%	0.91	0.89
Qualified Association Trust	**7%**	**7%**	**0.92**	**0.93**
Total Small Group	**18%**	**17%**	**0.84**	**0.81**
Employers with 1 Employee	1%	0%	1.08	1.07
Employers with 2-9 Employees	7%	7%	0.81	0.79
Employers with 10-25 Employees	6%	6%	0.81	0.81
Employers with 26-50 Employees	4%	3%	0.88	0.77
Total Individual	**9%**	**8%**	**0.71**	**0.63**
Individual Policy	9%	8%	0.71	0.62
Individual as Group Conversion	0%	0%	2.76	2.06
Grand Total	**514,409**	**506,580**	**0.88**	**0.86**

Observations:

- Overall, the loss ratio for the entire market decreased slightly from 2011 to 2012, dropping 2% from 88% to 86%.
- The Large Group market's loss ratio decreased by 3% between 2011 and 2012. Within the Large Group segment, both employer groups with 51 -99 employees and employer groups with 100+ employees experienced a slight decline in loss ratio. Employers obtaining insurance through Qualified Association Trusts experienced a slight increase in loss ratio, from 92% in 2011 to 93% in 2012.
- The Small Group market experienced a 3% decline in the overall loss ratio between 2011 and 2012. Within the Small Group segment, the loss ratio for employers with 26-50 employees decreased from 88% in 2011 to 78% in 2012. The loss ratio for employers with 10-25 employees remained stable at the 81% level. The loss ratio for groups with only one employee declined, but is still running well over 100% at the 104% level.
- The Non-group loss ratio was 63% in 2012, which is a decrease of 8% from the 2011 loss ratio of 71%.
- Group conversion policies show lower loss ratios for 2012 compared to 2011, but continue to run at a very high level of 200%. The conversion pool is small, and prone to high loss ratios due to the inability to medically underwrite.

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 of coverage for medical services (i.e. the lowest deductible) within the network is used. Dollar amounts refer to individual deductibles, not family deductibles.

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

Deductible	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$0	29%		**51%**	5%		**39%**	0%	12%
$1-249	2%		**4%**	0%		**3%**	0%	0%
$250-499	5%		**9%**	1%		**7%**	0%	0%
$500-749	6%		**10%**	2%		**8%**	1%	1%
$750-999	2%		**3%**	2%		**3%**	0%	0%
$1,000-1,499	10%		7%	**15%**		8%	15%	**19%**
$1,500-2,999	18%		8%	**31%**		14%	**34%**	27%
$3,000-4,999	19%		7%	**32%**		15%	**43%**	4%
$5,000-7,499	6%		1%	**12%**		3%	7%	**30%**
$7,500-9,999	0%		0%	0%		0%	0%	1%
$10,000+	1%		0%	1%		0%	0%	**7%**
Grand Total	**506,580**		**270,391**	**236,189**		**373,527**	**92,084**	**40,969**

	All Members		Large Group		Small Group		Non-group	
Deductible	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
$0	32%	29%	41%	39%	0%	0%	21%	12%
$1-249	1%	2%	2%	3%	0%	0%	0%	0%
$250-499	7%	5%	10%	7%	0%	0%	0%	0%
$500-749	7%	6%	9%	8%	3%	1%	0%	1%
$750-999	2%	2%	3%	3%	0%	0%	0%	0%
$1,000-1,499	12%	10%	10%	8%	18%	15%	21%	19%
$1,500-2,999	19%	18%	14%	14%	38%	34%	26%	27%
$3,000-4,999	13%	19%	10%	15%	32%	43%	2%	4%
$5,000-7,499	5%	6%	2%	3%	6%	7%	24%	30%
$7,500-9,999	1%	0%	0%	0%	2%	0%	1%	1%
$10,000+	0%	1%	0%	0%	0%	0%	4%	7%
Average Deductible	**$1,340**	**$1,528**	**$908**	**$1,082**	**$2,438**	**$2,564**	**$2,632**	**$3,265**
Annual Deductible Increase		**14%**		**19%**		**5%**		**24%**

Observations:

- The self-insured population benefits reflect lower deductibles than the fully-insured population.
- Generally, the large groups have lower deductibles, while individuals and small groups have higher deductibles.
- Between 2011 and 2012, average deductibles grew $188 or by 14% overall. Non-group experienced the largest change and percentage change in deductible. The average deductible for members enrolled in Non-group policies in 2012 is $3,265 compared to $1,082 in the Large Group market and $2,564 in the Small Group Market.
- The most common deductible for large groups is $0, while the most common deductible for small groups and individuals is much higher. Almost all small group members (99%) have deductibles in the $1,000-$7,499 range compared with approximately 79% of individual members in the same range.
- The high percentage of members covered by a self-insured account without any deductible is partly the result of the state of NH employee plan and the benefit plans covering municipal employees. See chart below.

			Self-Insured		
Deductible	**All Self-Insured Members**		**State**	**Municipal**	**Other**
$0	51%		**88%**	80%	33%
$1-249	4%		0%	1%	**7%**
$250-499	9%		0%	8%	**12%**
$500-749	10%		**12%**	5%	11%
$750-999	3%		0%	0%	**5%**
$1,000-1,499	7%		0%	4%	**9%**
$1,500-2,999	8%		0%	3%	**11%**
$3,000-4,999	7%		0%	0%	**12%**
$5,000-7,499	1%		0%	0%	2%
Grand Total	**270,391**		**29,466**	**71,287**	**169,638**

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 coverage level for medical services (i.e. lowest member coinsurance %) within network is reported.

Coinsurance	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
0%	70%		65%	**76%**		67%	**87%**	56%
10%	6%		**8%**	4%		**9%**	1%	0%
20%	18%		17%	**18%**		17%	12%	**32%**
30%	5%		**8%**	2%		6%	0%	**8%**
40%	1%		1%	0%		1%	0%	0%
50%	0%		0%	1%		0%	0%	**5%**
Total Members	**506,580**		**270,391**	**236,189**		**373,527**	**92,084**	**40,969**

	All Members		Large Group		Small Group		Non-group	
Coinsurance	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**	**2011**	**2012**
0%	68%	70%	65%	67%	87%	87%	54%	56%
5%	0%	0%	1%	0%	0%	0%	0%	0%
10%	7%	6%	9%	9%	1%	1%	0%	0%
15%	1%	0%	1%	0%	0%	0%	0%	0%
20%	19%	18%	19%	17%	12%	12%	35%	32%
25%	1%	0%	2%	0%	0%	0%	0%	0%
30%	3%	5%	3%	6%	0%	0%	7%	8%
35%	0%	0%	0%	0%	0%	0%	0%	0%
40%	0%	1%	1%	1%	0%	0%	0%	0%
50%	0%	0%	0%	0%	0%	0%	4%	5%
Average Coinsurance	**6%**	**6%**	**6%**	**7%**	**2%**	**3%**	**11%**	**11%**
Annual Coinsurance Increase		**1%**		**2%**		**3%**		**2%**

Observations:

- Much of the Non-group market has higher coinsurance percentages than Large and Small Group, with 45 percent of individual members having to pay 20% or more co-insurance. The average coinsurance for the Non-group market is 11%, which is significantly higher than the average coinsurance in both the Small Group and Large Group markets.
- The coinsurance levels of the Small Group market are lower than the coinsurance levels in the Large Group market. It is important to note that coinsurance is only one measure of benefit richness. The Small Group market's members tend to have much higher deductibles than the Large Group market's members. The overall benefit richness of the Small Group market is much lower than the Large Group market since the higher deductibles more than offset the lower coinsurance levels that only apply after the deductible has been met.

CO-PAYS

Co-pays represent the dollar amount of the highest office visit member contribution for services within network. The distribution of co-pay amounts is similar in 2012 to 2011, but some co-pays experienced membership increases while others experienced membership declines.

Copay	All Members	Self-Insured	Fully-Insured	Large Group	Small Group	Non-Group
$0	19%	17%	**22%**	17%	13%	**51%**
$5	6%	**12%**	0%	**9%**	0%	0%
$10	7%	**12%**	1%	**10%**	0%	0%
$15	8%	**13%**	2%	**11%**	1%	0%
$20	16%	**18%**	14%	18%	4%	**26%**
$25	24%	10%	**40%**	16%	**67%**	0%
$30	4%	**4%**	3%	4%	0%	**6%**
$35	1%	**2%**	1%	1%	0%	**3%**
$40	6%	6%	**6%**	6%	5%	**8%**
$45	1%	1%	0%	1%	0%	0%
$50	6%	2%	**10%**	6%	**8%**	2%
$55	0%	0%	0%	0%	0%	0%
$60	1%	1%	0%	1%	0%	0%
$65	0%	0%	0%	0%	0%	0%
$70	0%	1%	0%	0%	0%	0%
$75	0%	0%	1%	0%	0%	**4%**
Total Members	**506,580**	**270,391**	**236,189**	**373,527**	**92,084**	**40,969**
Average Copay	**$ 20**	**$ 17**	**$ 23**	**$ 19**	**$ 24**	**$ 15**

	All Members	
Copay	**2011**	**2012**
$0	20%	19%
$5	7%	6%
$10	13%	7%
$15	5%	8%
$20	18%	16%
$25	18%	24%
$30	4%	4%
$35	2%	1%
$40	6%	6%
$45	1%	1%
$50	6%	6%
$55	0%	0%
$60	0%	1%
$65	0%	0%
$70	1%	0%
$75	0%	0%
Total Members	**514,409**	**506,580**
Average Copay	**$ 18**	**$ 20**

Observations:

- Overall the average co-pay increased by 7% which appears to be driven by movement out of the $0, $5, $10, and $20 co-pay levels and into the $15 and $25 co-pay levels. The self-insured market tends to have lower co-pays than the fully-insured market with 61% of fully-insured members having co-pays of $25 or more compared to only 27% of self-insured members.
- Co-pay levels represent one indicator of benefit richness. Although the Non-group market tends to have lower co-pay levels, the overall benefit richness in the Non-group market is dramatically lower than in the employer market since the Non-group benefit designs have significantly higher coinsurance and deductible levels relative to the employer market.

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 B for all 26 benefit categories included in the Supplemental Report filing. A few of these categories had none or very few members without coverage, but all are listed in the table below.

Covered benefits are subject to greater reporting variation. This variation is due to differences in how carriers interpret policy coverage and the definition of the benefits which is described in the bulletin. For example, if a carrier generally covers the benefit, but not to the exact specifications in the Supplemental Report bulletin definition, the carrier may not report that benefit as being covered by the policy. 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 include mental health benefits and prescription drug coverage provided by an organization external to the employer or insurance carrier.

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%	100%
	No	0%	0%	0%	0%	0%	0%
Audiology Screening of Newborns	Yes	99%	100%	97%	100%	100%	85%
	No	1%	0%	3%	0%	0%	15%
Blood and Blood Products	Yes	83%	73%	94%	77%	100%	100%
	No	17%	27%	6%	23%	0%	0%
Case Management Programs	Yes	100%	100%	100%	100%	100%	100%
	No	0%	0%	0%	0%	0%	0%
Chiropractic Services	Yes	93%	99%	85%	99%	98%	24%
	No	7%	1%	15%	1%	2%	76%
Durable Medical Equipment	Yes	100%	100%	100%	100%	100%	99%
	No	0%	0%	0%	0%	0%	1%
Emergency Room Services	Yes	100%	100%	100%	100%	100%	100%
	No	0%	0%	0%	0%	0%	0%
Family Planning Services	Yes	82%	74%	92%	78%	99%	81%
	No	18%	26%	8%	22%	1%	19%
Habilitative Services	Yes	93%	98%	88%	98%	100%	28%
	No	7%	2%	12%	2%	0%	72%
Hearing Aids	Yes	71%	51%	94%	61%	98%	100%
	No	29%	49%	6%	39%	2%	0%
Home Health Care	Yes	100%	100%	100%	100%	100%	100%
	No	0%	0%	0%	0%	0%	0%
Hospice	Yes	83%	73%	94%	77%	100%	99%
	No	17%	27%	6%	23%	0%	1%
Hospitalization	Yes	100%	100%	99%	100%	100%	94%
	No	0%	0%	1%	0%	0%	6%
Infertility Services	Yes	46%	45%	46%	46%	66%	0%
	No	54%	55%	54%	54%	34%	100%
Medical Food	Yes	99%	99%	99%	99%	100%	94%
	No	1%	1%	1%	1%	0%	6%
Mental Health and Substance Abuse	Yes	80%	73%	88%	77%	94%	74%
	No	20%	27%	12%	23%	6%	26%
Nutritional Services	Yes	79%	68%	91%	73%	99%	85%
	No	21%	32%	9%	27%	1%	15%
Outpatient Hospital Services and Surgery	Yes	100%	100%	100%	100%	100%	100%
	No	0%	0%	0%	0%	0%	0%
Outpatient Laboratory and Diagnostic Services	Yes	100%	100%	100%	100%	100%	100%
	No	0%	0%	0%	0%	0%	0%

Coverage Category	Covered	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
Outpatient Rehabilitation Services	Yes	99%		100%	99%		100%	100%	92%
	No	1%		0%	1%		0%	0%	8%
Pregnancy and Maternity Services	Yes	99%		100%	97%		100%	100%	84%
	No	1%		0%	3%		0%	0%	16%
Preventive Services	Yes	87%		80%	95%		83%	100%	97%
	No	13%		20%	5%		17%	0%	3%
Prescription Drugs	Yes	94%		90%	99%		92%	100%	94%
	No	6%		10%	1%		8%	0%	6%
Skilled Nursing Facility	Yes	90%		88%	92%		88%	94%	100%
	No	10%		12%	8%		12%	6%	0%
Transplants	Yes	100%		100%	100%		100%	100%	100%
	No	0%		0%	0%		0%	0%	0%
Well Child and Immunization Services	Yes	87%		80%	95%		83%	100%	96%
	No	13%		20%	5%		17%	0%	4%

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

There was a noticeable increase in the percentage of members with coverage for infertility services. In 2011, 41% had coverage compared to 46% in 2012.

Another category with a noticeable increase was Medical Foods. Almost all members had coverage for Medical Foods in 2012 with carriers reporting 99% of all New Hampshire situs members had medical food coverage. This is up from 94% in 2011.

The category with the largest decrease in percentage of enrollees with coverage was Well Child and Immunization Services. In 2011, carriers reported that 94% of enrollees had Well Child and Immunization Services covered. In 2012, the percentage has dropped to 87%. This decline is driven by self funded large groups not offering this coverage at the same level as fully insured Small Group and Non-Group markets.

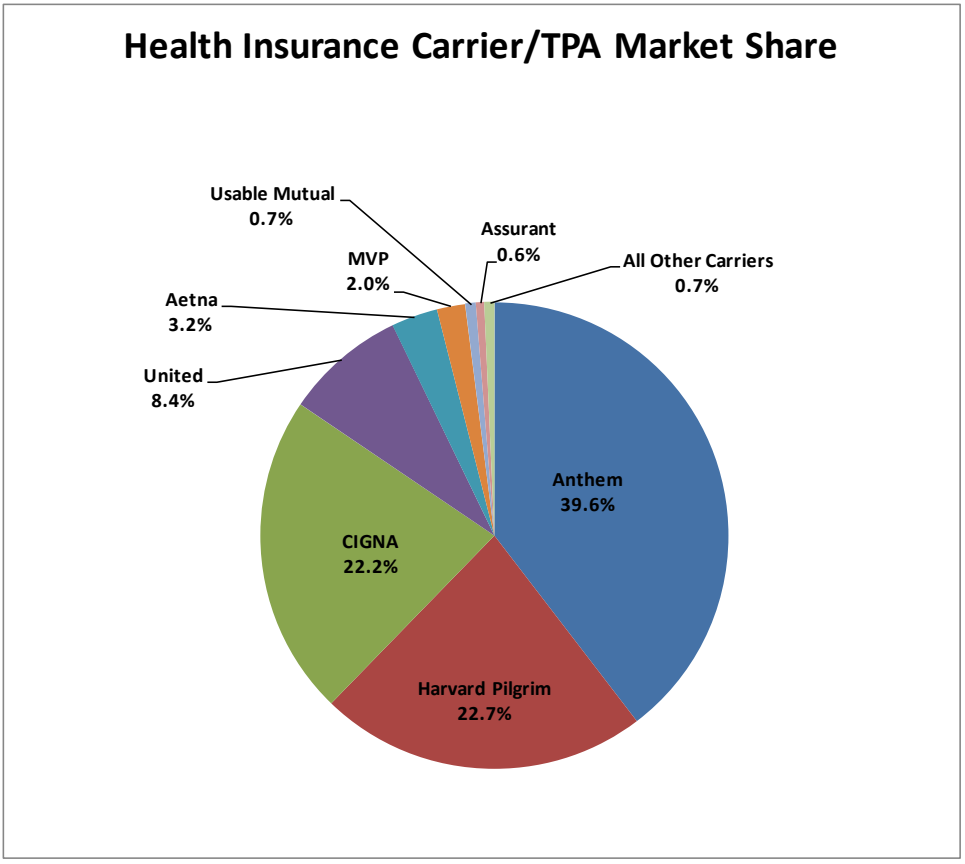
CARRIER MEMBERSHIP DISTRIBUTION

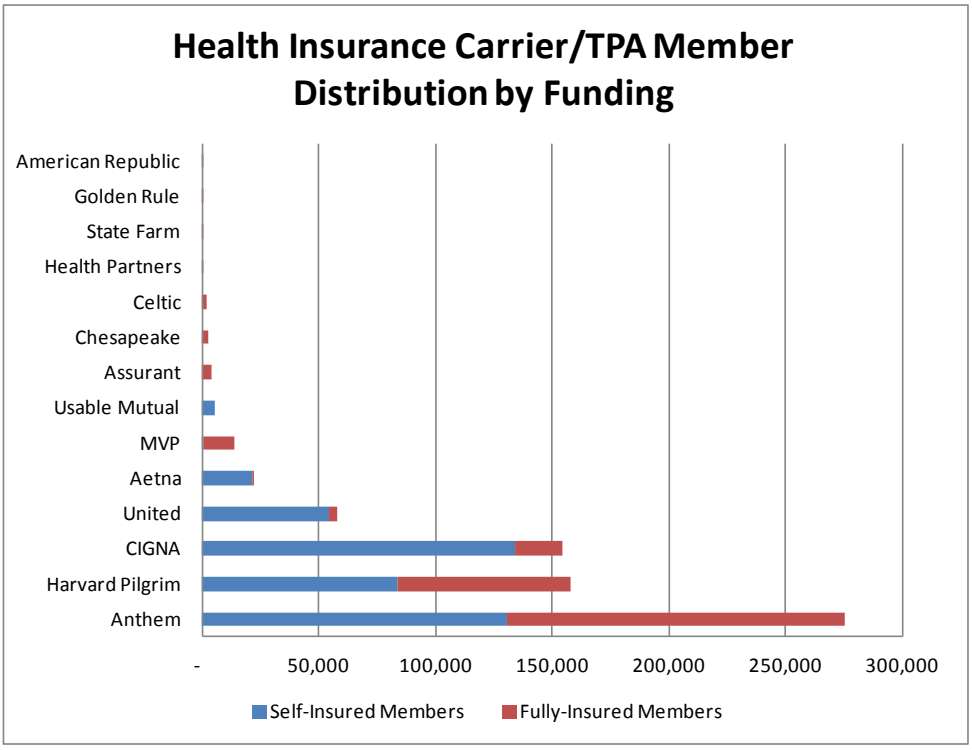
Data submitted for the Supplemental Report is based on policyholder and New Hampshire residents. The data include insured members who reside outside of NH if covered under a NH policy as well as insured members employed in a NH branch location but covered under an out-of-state health policy. These data include self-funded accounts.
The following companies have been grouped into one "family" company name for the tables below:

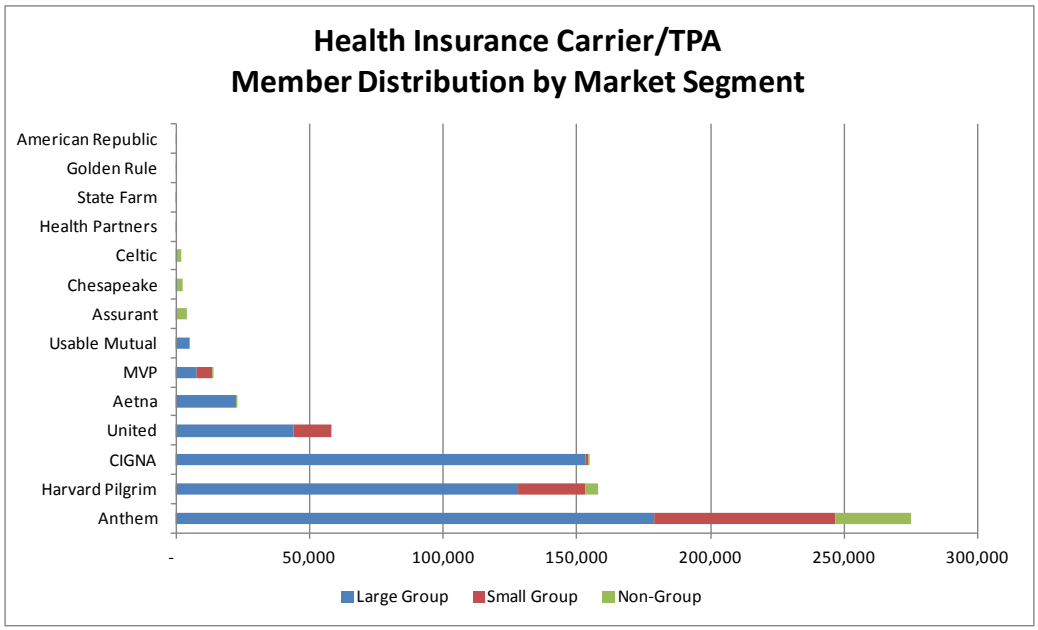
- Anthem includes: Anthem Health Plans of NH and Matthew Thornton
- Assurant includes: Time Life Insurance Company and John Alden Life Insurance Company
- CIGNA includes: CIGNA Health and Life Insurance Company and Connecticut General Life Insurance Company
- Harvard Pilgrim includes: Harvard Pilgrim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

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

Health Insurance Carrier/TPA	Self-Insured Members	Fully-Insured Members	Total Members	Percent of Total
Anthem	130,412	144,773	275,184	**39.6%**
Harvard Pilgrim	83,626	74,194	157,820	**22.7%**
CIGNA	133,833	20,434	154,267	**22.2%**
United	54,421	3,663	58,084	**8.4%**
Aetna	21,154	1,161	22,315	**3.2%**
MVP	358	13,260	13,618	**2.0%**
Usable Mutual	5,054	-	5,054	**0.7%**
Assurant	-	4,007	4,007	**0.6%**
Chesapeake	-	2,520	2,520	**0.4%**
Celtic	-	1,696	1,696	**0.2%**
Health Partners	265	-	265	**0.0%**
State Farm	-	184	184	**0.0%**
Golden Rule	-	130	130	**0.0%**
American Republic	-	55	55	**0.0%**
Total	**429,122**	**266,077**	**695,199**	**100.0%**


Health Insurance Carrier/TPA Market Share
Usable Mutual 0.7%
Assurant 0.6%
MVP 2.0%
All Other Carriers 0.7%
Aetna 3.2%
United 8.4%
Anthem 39.6%
CIGNA 22.2%
Harvard Pilgrim 22.7%


Health Insurance Carrier/TPA Member Distribution by Funding
American Republic
Golden Rule
State Farm
Health Partners
Celtic
Chesapeake
Assurant
Usable Mutual
MVP
Aetna
United
CIGNA
Harvard Pilgrim
Anthem
-
50,000
100,000
150,000
200,000
250,000
300,000
Self-Insured Members
Fully-Insured Members



Note: The Healthy Kids population is reported under Harvard Pilgrim's Non-group segment.

SUPPLEMENTAL REPORT HISTORY

The first round of Supplemental Report filings occurred on May 1, 2002, and included data from calendar year 2001. The first data submission applied only to licensed non-profit health service corporations and licensed health maintenance organizations. All other licensed health carriers filed in 2003. In 2006, the department substantially revised the bulletin that describes how data need to be submitted to the NHID. For this reason, the 2006 report cannot be compared to prior submissions. The 2007 bulletin had minor changes, but included a separate variable for self-insured vs. fully-insured data. This separation allows greater insight into the market dynamics of the differing policy types. The 2009 bulletin clarified that out-of-state employer's branch location in NH shall be considered a New Hampshire employer, and the carrier/TPA shall submit data for all members who are employed at that branch location. Beginning in 2012, to ease the burden on carriers submitting data for the Supplemental Report, the New Hampshire Insurance Department no longer requires carriers to submit benefit option details and premium for non-NH situs membership. Carriers continue to submit membership and claims information for non-NH situs enrollment. Tables from the 2011 Supplemental Report have been restated in Appendix C of this report and will allow for a consistent comparison to the 2012 Supplemental Report.

DATA COLLECTED

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

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

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

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

Data are collected for New Hampshire policies, including when an organization has "bricks and mortar" in New Hampshire. For example, assume a TPA administers a health benefit plan. This plan covers a New Hampshire employer and there are 250 lives associated with this employer's plan of which 100 of the 250 lives are Massachusetts

residents, and the remaining 150 lives are New Hampshire residents. This TPA is required to report all lives, regardless of the state of residency, covered through this plan as they are all associated with a NH employer's health benefit plan.

In another example, assume a TPA administers a health benefit plan. This plan is for a Massachusetts employer and there are 500 lives associated with this employer's plan and the employer has no facilities in NH. Half of these lives are New Hampshire residents whose principal place of employment is in Massachusetts. This TPA would not be required to report these lives 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 or that cover members who have a work location in New Hampshire should be reported in the New Hampshire Supplemental Report.

For an explanation of the data fields used in the Supplemental Report, please see the Supplemental Report bulletin on the NHID website that describes how the data must be submitted to the NHID: http://www.nh.gov/insurance/media/bulletins/2012/documents/sup_rept_bull-2012.pdf.

DATA NOTES

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

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

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

persons insured by counting membership on a pro-rated basis. As members can be counted on a partial basis, summary totals may differ due to rounding errors.

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

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

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

Analysis of the carrier 2011 submissions revealed one large carrier with a low loss ratio in their Large Group underwritten line of business that remained unexplained after repeated inquiries. This introduces some uncertainty in the loss ratios provided in this report. The overall Large Group underwritten loss ratio including this suspect data is 80% while if the suspect data is excluded, that loss ratio is elevated to 85%. This suspect data remains part of the 2011 comparisons in this report, however, caution should be used when comparing to the 2011 loss ratios in the Large Group underwritten segment.

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

The actuarial value is a factor representative of the relative value of the benefits being reported against a standardized set of benefits. RSA 420-G:4 I (c) requires carriers to calculate a health coverage plan rate for each of its coverage options. The New Hampshire Small Employer Reinsurance Pool developed four benefit plans that ceding carriers used to adjudicate claims (indemnity, PPO, POS, and HMO). Carriers calculate the health coverage plan rate for these four plans (called standardized plans). Then, for each reported coverage type, the carrier calculates the health coverage plan rate. The actuarial value is the ratio of the health coverage plan rate for each reported coverage type to the health coverage plan rate for the corresponding standardized plan. As part of the quality assurance process, some actuarial values were identified as anomalies (outside

the range of expected values). Questions were posed to carriers providing those anomalous values, resulting in some corrections, however some seemingly anomalous actuarial values remain in the data used for this report.

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

Starting July 1, 2012, children using Healthy Kids Silver through Harvard Pilgrim Health Care were moved to Medicaid. The Supplemental Report does not include data for members enrolled in plans administered by Medicaid. Caution must be used when comparing the results from the 2011 Supplemental Report to the 2012 Supplemental Report since the 2012 Supplemental Report includes half a year's worth of Healthy Kids enrollment while the 2011 Supplemental Report includes a full year's worth of Healthy Kids enrollment.

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

Due to the unique nature of these products and to avoid double counting stop-loss, data related to policies for stop-loss, student coverage, blanket insurance, and the high risk pool was included only in the table titled 'LIMITED COVERAGE AND LIMITED ELIGIBILITY POLICIES', and was excluded from the remainder of the report. The stop loss data in the 2012 Supplemental Report is based only on a portion of the stop loss market in New Hampshire. A couple of the largest carriers did not submit stop loss claims and premium data despite reporting a significant amount of self-insured membership with stop loss coverage.

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

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

Appendix A – Detailed Distribution of Members by Deductible

Deductible	All Members	Self-Insured	Fully-Insured	Large Group	Small Group	Non-Group
$0	29%	**69%**	15%	**39%**	0%	12%
$100	1%	1%	0%	1%	0%	0%
$125	0%	0%	0%	0%	0%	0%
$150	0%	0%	0%	0%	0%	0%
$200	1%	**2%**	0%	**2%**	0%	0%
$250	5%	**5%**	0%	**6%**	0%	0%
$300	0%	0%	0%	1%	0%	0%
$400	0%	0%	0%	0%	0%	0%
$500	6%	**6%**	2%	**8%**	1%	1%
$600	0%	0%	0%	0%	0%	0%
$750	2%	**2%**	1%	**3%**	0%	0%
$900	0%	0%	1%	0%	0%	0%
$1,000	8%	2%	**12%**	6%	**14%**	14%
$1,100	0%	0%	0%	0%	0%	0%
$1,200	2%	**2%**	0%	**2%**	0%	0%
$1,250	1%	0%	1%	0%	0%	**5%**
$1,300	0%	0%	0%	0%	0%	0%
$1,350	0%	0%	0%	0%	0%	0%
$1,500	4%	2%	**4%**	**4%**	3%	3%
$1,600	0%	0%	0%	0%	0%	0%
$1,700	0%	0%	0%	0%	0%	0%
$1,750	0%	0%	0%	0%	0%	0%
$2,000	10%	1%	**17%**	6%	**27%**	6%
$2,100	0%	0%	0%	0%	0%	0%
$2,150	0%	0%	0%	0%	0%	0%
$2,250	0%	0%	0%	0%	0%	0%
$2,400	0%	0%	0%	0%	0%	0%
$2,500	5%	2%	**6%**	3%	4%	**17%**
$2,550	0%	0%	0%	0%	0%	0%
$2,600	0%	0%	0%	0%	0%	0%
$2,700	0%	0%	0%	0%	0%	0%
$2,800	0%	0%	0%	0%	0%	0%
$2,850	0%	**0%**	0%	0%	0%	0%
$3,000	15%	3%	**24%**	11%	**37%**	1%
$3,050	0%	0%	0%	0%	0%	0%
$3,500	1%	1%	0%	**2%**	0%	1%
$3,750	0%	0%	0%	0%	0%	0%
$4,000	3%	0%	**5%**	2%	**6%**	2%
$4,500	0%	0%	0%	0%	0%	0%
$4,950	0%	0%	0%	0%	0%	0%

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

Appendix B- Benefit Category Descriptions

Ambulance Service	Includes: ambulance transportation.
Audiology Screening for Newborns	Includes: covered for one screening and one confirming screening.
Blood and Blood Products	Includes: fees associated with the collection or donation of blood or blood products, all cost recovery expenses for blood, blood derivatives, components, biologics, and serums to include autologous services and albumin.
Case Management Program	Includes: available for medically complex and costly services.
Chiropractic Services	Includes chiropractic services.
Durable Medical Equipment (DME)	Includes: nebulizers, peak flow meters, and diabetes glucose monitoring equipment.
Emergency Room	Includes: emergency room treatment.
Family Planning Services	Full range of services including: Counseling services and patient education; examination and treatment by medical professionals; laboratory examinations and tests; medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception; 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.

Appendix C – 2011 Supplemental Report Restated Tables

Appendix C shows tables from the 2011 Supplemental Report that have been restated and will allow for a consistent comparison to the tables in the 2012 Supplemental Report.

Limited Coverage	Members	Premium PMPM	Claims PMPM	Loss Ratio
Stand Alone Stoploss	61,196	$17	$13	77%
Student	2,327	$100	$87	87%
High Risk Pool (NHHP)	1,573	$698	$508	73%
High Risk Pool (NHHP-FED)	153	$625	$5,742	919%
High Risk Pool Total	**1,725**	**$692**	**$971**	**140%**

SUMMARY STATISTICS

NH SITUS ONLY STATISTICS

- Total premiums and premium equivalents = $2,459,351,481
- Total claims = $2,172,983,593
- Average loss ratio = 88.4%
- Average number of members insured = 514,409
- Average member premium per month:
    - Large Group $410
    - Small Group $421
    - Non-group $255

- Members

	NH Situs	non-NH Situs	Total
Large Group	374,836	108,929	**483,765**
Small Group	93,196	8,865	**102,061**
Individual	46,377	180	**46,557**
Total	**514,409**	**117,975**	**632,384**

	NH Situs	non-NH Situs	Total
Groups of 1 Employee	3,612	897	**4,508**
Groups of 2-50 Employees	89,584	7,969	**97,553**

- Percentage of All Members

	NH Situs	non-NH Situs	Total
Large Group	59%	17%	**76%**
Small Group	15%	1%	**16%**
Individual	7%	0%	**7%**
Total	**81%**	**19%**	**100%**

- Percentage Members that are Fully Insured

	NH Situs	non-NH Situs	Total
Large Group	28%	33%	**29%**
Small Group	99%	100%	**99%**
Individual	100%	100%	**100%**
Total	**47%**	**38%**	**45%**

HIGH DEDUCTIBLE HEALTH PLANS

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

DEDUCTIBLES

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

- $0 – 32%
- $500 – 7%
- $1,000 – 10%
- $2,000 – 9%
- $2,500 – 5%
- $3,000 – 11%

CO-INSURANCE

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

- 0% co-insurance - 68%
- 10% co-insurance - 7%
- 20% co-insurance - 19%

CO-PAYS

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

- $0 – 20%
- $5 – 7%
- $10 – 13%
- $20 – 18%
- $25 – 18%
- $40 - 6%

DETAILED ANALYSES

AVERAGE PREMIUMS

Table from 2011 Report Restated to be based on NH-situs Membership Only

		Self-Insured*		Fully-Insured	
Market Category	**Plan Type**	**Members**	**Avg Premium**	**Members**	**Avg Premium**
Large Group	HMO	94,720	$432	59,764	$436
	POS	63,840	$456	2,809	$510
	PPO	105,401	$345	33,824	$402
	EPO	2,027	$421	6,157	$332
	Indemnity**	5,392	$604	902	$188
Small Group	HMO	523	$478	63,948	$422
	POS	20	$489	700	$582
	PPO	472	$463	14,819	$435
	EPO	No Membership Reported		12,258	$389
	Indemnity**	No Membership Reported		455	$332
Non-Group	HMO	No Membership Reported		9,481	$187
	POS			No Membership Reported	
	PPO			34,891	$276
	EPO			23	$460
	Indemnity**			1,982	$217
Total		**272,394**	**$408**	**242,015**	**$388**

Average Premiums with Benefit Richness
Table from 2011 Report Restated to be based on NH-situs Membership Only

		Self-Insured*			Fully-Insured		
Plan Type	Market Category	Members	Avg Premium	Benefit Richness	Members	Avg Premium	Benefit Richness
HMO	Large Group	94,720	$432	0.80	59,764	$436	0.64
	Small Group	523	$478	0.86	63,948	$422	0.59
	Non-Group	No Membership Reported			9,481	$187	0.91
POS	Large Group	63,840	$456	0.74	2,809	$510	0.86
	Small Group	20	$489	1.03	700	$582	0.67
	Non-Group	No Membership Reported			No Membership Reported		
PPO	Large Group	105,401	$345	0.69	33,824	$402	0.58
	Small Group	472	$463	0.85	14,819	$435	0.54
	Non-Group	No Membership Reported			34,891	$276	0.21
EPO	Large Group	2,027	$421	0.74	6,157	$332	0.77
	Small Group	No Membership Reported			12,258	$389	0.76
	Non-Group				23	$460	0.77
Indemnity**	Large Group	5,392	$604	0.94	902	$188	0.99
	Small Group	No Membership Reported			455	$332	0.15
	Non-Group				1,982	$217	0.31
Total Members		**272,394**			**242,015**		

Average Premium and Adjusted Premium

Table from 2011 Report Restated to be based on NH-situs Membership Only

		Self-Insured*			Fully-Insured		
Plan Type	**Market Category**	**Percent of Members**	**Avg Premium**	**Adjusted Premium**	**Percent of Members**	**Avg Premium**	**Adjusted Premium**
HMO	Large Group	35%	$432	$542	25%	$436	$686
	Small Group	0%	$478	$558	26%	$422	$711
	Non-Group	No Membership Reported			4%	$187	$205
POS	Large Group	23%	$456	$614	1%	$510	$591
	Small Group	0%	$489	$475	0%	$582	$870
	Non-Group	No Membership Reported			No Membership Reported		
PPO	Large Group	39%	$345	$499	14%	$402	$689
	Small Group	0%	$463	$544	6%	$435	$798
	Non-Group	No Membership Reported			14%	$276	$1,289
EPO	Large Group	1%	$421	$568	3%	$332	$428
	Small Group	No Membership Reported			5%	$389	$508
	Non-Group				0%	$460	$594
Indemnity**	Large Group	2%	$604	$639	0%	$188	$189
	Small Group	No Membership Reported			0%	$332	$2,141
	Non-Group				1%	$217	$699
Total Members		**272,394**			**242,015**		

State and Municipal Account Comparison

Plan Type	Account Type	Percent of Members	Avg Premium*	Benefit Richness	Adjusted Premium*
HMO	State	5%	$425	0.73	$580
	Municipal	8%	$457	0.81	$561
	All Other Accounts	31%	$410	0.65	$632
POS	State	1%	$602	0.87	$693
	Municipal	5%	$489	0.75	$653
	All Other Accounts	6%	$409	0.72	$570
PPO	State	0%	$598	0.87	$688
	Municipal	0%	$495	0.52	$948
	All Other Accounts	36%	$348	0.50	$700
EPO	State	No Membership Reported			
	Municipal	0%	$440	0.85	$520
	All Other Accounts	4%	$374	0.76	$490
Indemnity**	State	No Membership Reported			
	Municipal	1%	$577	0.95	$610
	All Other Accounts	1%	$312	0.40	$777
Total Members		**514,409**			

MARKET CATEGORY

All Members, by Insured Status and Market Category
Table from 2011 Report Restated to be based on NH-situs Membership Only

Market Category	All Members	Loss Ratio	Self-Insured Members	Loss Ratio	Fully-Insured Members	Loss Ratio
Total Large Group	**66%**	**0.91**	**89%**	**0.94**	**40%**	**0.84**
Employers with 51-99 Employees	7%	0.85	2%	0.89	13%	0.84
Employers with >=100 Employees	59%	0.91	87%	0.94	28%	0.83
Qualified Association Trust	**7%**	**0.92**	**11%**	**0.93**	**2%**	**0.85**
Total Small Group	**18%**	**0.84**	**0%**	**0.86**	**38%**	**0.84**
Employers with 1 Employee	1%	1.08	None Reported		1%	1.08
Employers with 2-9 Employees	7%	0.81	0%	0.92	15%	0.81
Employers with 10-25 Employees	6%	0.81	0%	0.95	14%	0.81
Employers with 26-50 Employees	4%	0.88	0%	0.84	8%	0.88
Total Individual	**9%**	**0.71**			**19%**	**0.71**
Individual Policy	9%	0.71	None Reported		19%	0.71
Individual as Group Conversion	0%	2.76			0%	2.76
Grand Total	**514,409**	**0.88**	**272,394**	**0.94**	**242,015**	**0.82**

DEDUCTIBLES
Table from 2011 Report Restated to be based on NH-situs Membership Only

Deductible	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$0	32%		**54%**	7%		**41%**	0%	21%
$1-249	1%		**2%**	0%		**2%**	0%	0%
$250-499	7%		**13%**	1%		**10%**	0%	0%
$500-749	7%		**11%**	3%		**9%**	3%	0%
$750-999	2%		**3%**	1%		**3%**	0%	0%
$1,000-1,499	12%		6%	**19%**		10%	18%	**21%**
$1,500-2,999	19%		8%	**33%**		14%	**38%**	26%
$3,000-4,999	13%		3%	**24%**		10%	**32%**	2%
$5,000-7,499	5%		1%	**9%**		2%	6%	**24%**
$7,500-9,999	1%		0%	2%		0%	2%	1%
$10,000+	0%		0%	1%		0%	0%	**4%**
Grand Total	**514,409**		**272,394**	**242,015**		**374,836**	**93,196**	**46,377**

			Self-Insured		
Deductible	**All Self-Insured Members**		**State**	**Municipal**	**Other**
$0	54%		**100%**	85%	31%
$1-249	2%		0%	0%	**4%**
$250-499	13%		0%	5%	**19%**
$500-749	11%		0%	6%	**15%**
$750-999	3%		0%	0%	**5%**
$1,000-1,499	6%		0%	1%	**9%**
$1,500-2,999	8%		0%	1%	**12%**
$3,000-4,999	3%		0%	1%	**4%**
$5,000-7,499	1%		0%	0%	2%
Grand Total	**272,394**		**31,455**	**75,608**	**165,330**

CO-INSURANCE
Table from 2011 Report Restated to be based on NH-situs Membership Only

Coinsurance	**All Members**		**Self-Insured**	**Fully-Insured**		**Large Group**	**Small Group**	**Non-Group**
0%	68%		62%	**76%**		65%	**87%**	54%
5%	0%		1%	0%		1%	0%	0%
10%	7%		**10%**	4%		**9%**	1%	0%
15%	1%		1%	0%		1%	0%	0%
20%	19%		**19%**	18%		19%	12%	**35%**
25%	1%		**2%**	0%		2%	0%	0%
30%	3%		**4%**	2%		3%	0%	**7%**
35%	0%		0%	0%		0%	0%	0%
40%	0%		1%	0%		1%	0%	0%
50%	0%		0%	1%		0%	0%	**4%**
Total Members	**514,409**		**272,394**	**242,015**		**374,836**	**93,196**	**46,377**

CO-PAYS
Table from 2011 Report Restated to be based on NH-situs Membership Only

Copay	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$0	20%		17%	**24%**		18%	16%	**51%**
$5	7%		**14%**	0%		**10%**	0%	0%
$10	13%		**23%**	1%		**17%**	0%	0%
$15	5%		**6%**	3%		**5%**	3%	1%
$20	18%		14%	**23%**		16%	18%	**36%**
$25	18%		8%	**29%**		14%	**42%**	0%
$30	4%		**4%**	3%		**4%**	2%	4%
$35	2%		**3%**	0%		**2%**	0%	0%
$40	6%		5%	**7%**		5%	7%	**8%**
$45	1%		**2%**	0%		1%	0%	0%
$50	6%		3%	**9%**		5%	**11%**	0%
$55	0%		0%	0%		0%	0%	0%
$60	0%		0%	0%		0%	0%	0%
$65	0%		0%	0%		0%	0%	0%
$70	1%		1%	0%		1%	0%	0%
$75	0%		0%	0%		0%	0%	0%
Total Members	**514,409**		**272,394**	**242,015**		**374,836**	**93,196**	**46,377**
Average Copay	**$ 18**		**$ 16**	**$ 21**		**$ 18**	**$ 24**	**$ 12**

2011 Restated- Detailed Benefit Category Table:

Table from 2011 Report Restated to be based on NH-situs Membership Only

Coverage Category	Covered	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
Ambulance Services	Yes	100%		100%	100%		100%	100%	100%
	No	0%		0%	0%		0%	0%	0%
Audiology Screening of Newborns	Yes	98%		98%	97%		99%	100%	85%
	No	2%		2%	3%		1%	0%	15%
Blood and Blood Products	Yes	84%		75%	95%		79%	99%	100%
	No	16%		25%	5%		21%	1%	0%
Case Management Programs	Yes	100%		100%	100%		100%	100%	100%
	No	0%		0%	0%		0%	0%	0%
Chiropractic Services	Yes	92%		100%	84%		99%	93%	35%
	No	8%		0%	16%		1%	7%	65%
Durable Medical Equipment	Yes	100%		100%	99%		100%	100%	97%
	No	0%		0%	1%		0%	0%	3%
Emergency Room Services	Yes	100%		100%	100%		100%	100%	99%
	No	0%		0%	0%		0%	0%	1%
Family Planning Services	Yes	85%		80%	91%		83%	99%	78%
	No	15%		20%	9%		17%	1%	22%
Habilitative Services	Yes	90%		93%	88%		95%	100%	37%
	No	10%		7%	12%		5%	0%	63%
Hearing Aids	Yes	74%		56%	93%		65%	98%	96%
	No	26%		44%	7%		35%	2%	4%
Home Health Care	Yes	100%		100%	99%		100%	100%	98%
	No	0%		0%	1%		0%	0%	2%
Hospice	Yes	84%		75%	94%		79%	99%	94%
	No	16%		25%	6%		21%	1%	6%
Hospitalization	Yes	99%		100%	98%		100%	100%	93%
	No	1%		0%	2%		0%	0%	7%
Infertility Services	Yes	41%		45%	36%		44%	48%	0%
	No	59%		55%	64%		56%	52%	100%
Medical Food	Yes	94%		91%	98%		94%	99%	90%
	No	6%		9%	2%		6%	1%	10%
Mental Health and Substance Abuse	Yes	83%		74%	92%		78%	99%	87%
	No	17%		26%	8%		22%	1%	13%
Nutritional Services	Yes	80%		69%	92%		74%	98%	85%
	No	20%		31%	8%		26%	2%	15%
Outpatient Hospital Services and Surgery	Yes	100%		100%	100%		100%	100%	100%
	No	0%		0%	0%		0%	0%	0%
Outpatient Laboratory and Diagnostic Services	Yes	100%		100%	100%		100%	100%	100%
	No	0%		0%	0%		0%	0%	0%

Coverage Category	Covered	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
Outpatient Rehabilitation Services	Yes	99%		100%	98%		100%	100%	90%
	No	1%		0%	2%		0%	0%	10%
Pregnancy and Maternity Services	Yes	98%		100%	97%		100%	100%	83%
	No	2%		0%	3%		0%	0%	17%
Preventive Services	Yes	88%		81%	96%		84%	99%	94%
	No	12%		19%	4%		16%	1%	6%
Prescription Drugs	Yes	92%		86%	98%		89%	99%	96%
	No	8%		14%	2%		11%	1%	4%
Skilled Nursing Facility	Yes	93%		89%	96%		90%	100%	97%
	No	7%		11%	4%		10%	0%	3%
Transplants	Yes	100%		100%	100%		100%	100%	100%
	No	0%		0%	0%		0%	0%	0%
Well Child and Immunization Services	Yes	94%		91%	97%		92%	99%	94%
	No	6%		9%	3%		8%	1%	6%

Appendix A 2011 Restated to be based on NH-situs only

Appendix A - Detailed Distribution of Members by Deductible

Deductible	All Members	Self-Insured	Fully-Insured	Large Group	Small Group	Non-Group
$0	32%	**54%**	7%	**41%**	0%	21%
$100	1%	1%	0%	1%	0%	0%
$125	0%	0%	0%	0%	0%	0%
$150	0%	1%	0%	1%	0%	0%
$200	0%	0%	0%	0%	0%	0%
$250	5%	**8%**	1%	**6%**	0%	0%
$300	1%	**2%**	0%	**2%**	0%	0%
$322	0%	0%	0%	0%	0%	0%
$350	1%	1%	0%	1%	0%	0%
$375	0%	1%	0%	0%	0%	0%
$400	0%	0%	0%	0%	0%	0%
$450	0%	0%	0%	0%	0%	0%
$500	7%	**10%**	3%	**9%**	3%	0%
$550	0%	0%	0%	0%	0%	0%
$600	0%	0%	0%	0%	0%	0%
$750	2%	**3%**	1%	**3%**	0%	0%
$800	0%	0%	0%	0%	0%	0%
$1,000	10%	3%	**18%**	7%	**18%**	15%
$1,100	0%	0%	0%	0%	0%	0%
$1,200	1%	**3%**	0%	**2%**	0%	0%
$1,250	1%	0%	1%	0%	0%	5%
$1,300	0%	0%	0%	0%	0%	0%
$1,350	0%	0%	0%	0%	0%	0%
$1,400	0%	0%	0%	0%	0%	0%
$1,500	5%	3%	**7%**	4%	**8%**	3%
$1,600	0%	0%	0%	0%	0%	0%
$1,700	0%	0%	0%	0%	0%	0%
$1,750	0%	0%	0%	0%	0%	0%
$2,000	9%	2%	**16%**	6%	**20%**	6%
$2,050	0%	0%	0%	0%	0%	0%
$2,100	0%	0%	0%	0%	0%	0%
$2,150	0%	0%	0%	0%	0%	0%
$2,250	0%	0%	0%	0%	0%	0%
$2,400	0%	0%	0%	0%	0%	0%
$2,500	5%	2%	**10%**	3%	10%	**16%**
$2,550	0%	0%	0%	0%	0%	0%
$2,600	0%	0%	0%	0%	0%	0%
$2,700	0%	0%	0%	0%	0%	0%
$2,800	0%	0%	0%	0%	0%	0%
$2,850	0%	0%	0%	0%	0%	0%

Deductible	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$3,000	11%		2%	**21%**		8%	**27%**	1%
$3,050	0%		0%	0%		0%	0%	0%
$3,500	0%		0%	1%		0%	1%	0%
$3,750	0%		0%	0%		0%	0%	0%
$4,000	2%		0%	**3%**		1%	**4%**	0%
$4,800	0%		0%	0%		0%	0%	0%
$4,950	0%		0%	0%		0%	0%	0%
$5,000	5%		1%	**9%**		2%	6%	**24%**
$5,100	0%		0%	0%		0%	0%	0%
$5,150	0%		0%	0%		0%	0%	0%
$5,600	0%		0%	0%		0%	0%	0%
$5,950	0%		0%	0%		0%	0%	0%
$6,000	0%		0%	0%		0%	0%	0%
$7,500	1%		0%	**2%**		0%	**2%**	1%
$10,000	0%		0%	1%		0%	0%	**4%**
$12,000	0%		0%	0%		0%	0%	0%
$15,000	0%		0%	0%		0%	0%	0%
$20,000	0%		0%	0%		0%	0%	0%
$24,000	0%		0%	0%		0%	0%	0%
$25,000	0%		0%	0%		0%	0%	0%