SUPPLEMENTAL REPORT
OF THE
2008
HEALTH INSURANCE MARKET
IN
NEW HAMPSHIRE

October 22, 2009

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 2008.

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 = $2,514,958,997
- Total claims = $2,264,100,768
- Average loss ratio = .90
- Average number of members insured = 585,588*
- Average member premium per month:
    - Large Group $364
    - Small Group $368
    - Non-Group $249

*This number is substantially higher than what was reported in 2007 (501,872). Since the 2007 reporting period, the NHID provided carriers with clarification about which policies and members need to be included under NH jurisdiction and this is a possible reason for the difference.

HIGH DEDUCTIBLE HEALTH PLANS

- Percent of members in an IRS defined High Deductible Health Plan (HDHP) = 8.0%

SELF FUNDED PLANS

- Percent of members covered under employer self-insured plans:
  Large Group = 50.5%
  Overall = 34.5%

DEDUCTIBLES

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

- $0 – 31%
- $250 – 6%
- $500 – 15%
- $1,000 – 12%
- $1,500 – 6%
- $2,000 – 8%

CO-INSURANCE

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

- 0% co-insurance - 62%
- 20% co-insurance - 18%
- 30% co-insurance - 10%

CO-PAYS

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

- $0 – 14%
- $5 – 12%
- $10 – 15%
- $15 – 15%
- $20 – 21%

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 2008. In 2008 the IRS definition included policies with a minimum deductible of $1,150 for an individual, and $2,300 for a family.

The overall percentage of members in a HDHP is 8.0 percent. This represents more than a fifty percent increase from 2007, with the majority of members covered through the small group and non-group market segments.

As with all tables shown in the report, 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. Tables from 2008 and 2007 are below.

2008

HDHP	All Members	Self-insured	Fully-insured	Large Group	Small Group	Non-Group
No	92.0%	98.0%	88.8%	95.6%	88.7%	65.1%
Yes	8.0%	2.0%	11.2%	4.4%	11.3%	34.9%
Total Members	585,588	201,874	383,714	399,323	151,464	34,801

2007

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 will not represent the actual premium charged for a policy. The average premiums include packages that vary 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	11,126	$291	257	$465
	HMO	87,562	$368	135,662	$373
	POS	53,228	$403	10,709	$424
	PPO	49,845	$342	50,933	$314
Small Group	Indemnity	6	$314	3,378	$279
	HMO	No Membership Reported		102,387	$375
	POS	37	$464	4,693	$444
	PPO	69	$285	40,895	$349
Non-Group	Indemnity	No Membership Reported		3,531	$174
	HMO			572	$496
	PPO			30,698	$253
Total Members		201,874		383,714	

*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. No POS membership was reported in the non-group segment. The Indemnity rates suggest that the product design and account specific circumstances are more variable than with other plan types. Additional 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 health benefit plan developed by the New Hampshire small employer reinsurance mechanism. Given that the benefit plans differ by plan type, comparisons are only 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 between the small and large group markets and the non-group market. Several key observations:

- The average premium and benefit value for the fully-insured large group and fully-insured small group HMO products are virtually identical, with a slight advantage going to the large group.
- The average premium between the fully-insured HMO large group and the self-insured HMO large group are similar, but the average value of the fully-insured benefits is ten percent less than the self-insured.
- The self-insured large group POS premiums are about five percent less than the fully-insured large group POS premiums and the benefit value of the self-insured POS products is about six percent less than fully-insured products.
- The average benefit value within the PPO product line is similar between the fully-insured and self-insured populations, although premiums differ.
- 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	87,562	$368	0.87	135,662	$373	0.78
	Small Group	No Membership Reported			102,387	$375	0.77
	Non-Group				572	$496	1.09
POS	Large Group	53,228	$403	0.83	10,709	$424	0.88
	Small Group	37	$464	0.96	4,693	$444	0.85
PPO	Large Group	49,845	$342	0.75	50,933	$314	0.72
	Small Group	69	$285	0.72	40,895	$349	0.72
	Non-Group	No Membership Reported			30,698	$253	0.35
Indemnity	Large Group	11,126	$291	1.10	257	$465	0.82
	Small Group	6	$314	0.81	3,378	$279	0.35
	Non-Group	No Membership Reported			3,531	$174	0.40
Total Members		201,874			383,714		

The table below provides comparative information between data reported for 2007 and 2008. Data are only reported for fully-insured members.

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 about 15 percent (the difference between 2006 and 2007 was greater than a 16 percent drop).
- The majority of non-group members are enrolled in PPO products, and this segment saw a reduction in value greater than 16 percent.
- The Indemnity plan type experienced extensive variability with respect to average premiums and benefit richness often observed when analyzing plans with small membership populations, but in all market categories the value has decreased extensively. The average benefit design in the indemnity small group market fell to a value less than that observed in the indemnity non-group market, despite having sixty percent higher average premiums.
- In general, small group members experienced a greater erosion of value than large group members. This is opposite of the finding between 2006 and 2007.
- In many cases, benefits decreased less than premiums increased. This is the opposite of what was observed between 2006 and 2007.
- In the large group PPO segment, premiums went down slightly, but the average value of the benefits eroded by nine percent.

Plan Type	Market Category	2008 Members	2007 Avg Premium	2008 Avg Premium	2007 Benefit Richness	2008 Benefit Richness	Change in Value
HMO	Large Group	135,662	$340	$373	0.82	0.78	-14.7%
HMO	Small Group	102,387	$344	$375	0.83	0.77	-16.2%
HMO	Non-Group	572	$310	$496	0.93	1.09	-42.2%
POS	Large Group	10,709	$403	$424	0.91	0.88	-8.5%
POS	Small Group	4,693	$415	$444	0.90	0.85	-11.7%
PPO	Large Group	50,933	$319	$314	0.79	0.72	-7.7%
PPO	Small Group	40,895	$335	$349	0.78	0.72	-11.6%
PPO	Non-Group	30,698	$223	$253	0.36	0.35	-16.2%

Plan Type	Market Category	2008 Members	2007 Avg Premium	2008 Avg Premium	2007 Benefit Richness	2008 Benefit Richness	Change in Value
Indemnity	Large Group	257	$159	$465	0.99	0.82	-209.7%
Indemnity	Small Group	3,378	$239	$279	0.47	0.35	-42.1%
Indemnity	Non-Group	3,531	$157	$174	0.41	0.40	-11.5%

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 premiums in the PPO non-group market are actually some of the most expensive insurance premiums once adjustments are made for the weak benefits. 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	43%	$368	$423	35%	$373	$480
	Small Group	No Membership Reported			27%	$375	$489
	Non-Group				0%	$496	$456
POS	Large Group	26%	$403	$485	3%	$424	$481
	Small Group	0%	$464	$483	1%	$444	$520
PPO	Large Group	25%	$342	$455	13%	$314	$435
	Small Group	0%	$285	$398	11%	$349	$485
	Non-Group	No Membership Reported			8%	$253	$728
Indemnity	Large Group	6%	$291	$266	0%	$465	$565
	Small Group	0%	$314	$388	1%	$279	$793
	Non-Group	No Membership Reported			1%	$174	$431
Total Members		201,874			383,714		

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	5.9%	0.59	None Reported		8.9%	0.59
Individual (as group conversion)	0.1%	1.53			0.1%	1.53
Employers with 1 Employee	1.8%	1.04	0.0%	0.89	2.8%	1.04
Employers with 2-9 Employees	9.1%	0.85	0.0%	0.39	13.9%	0.85
Employers with 10-25 Employees	8.1%	0.87	None Reported		12.4%	0.87
Employers with 26-50 Employees	6.8%	0.92	0.0%	0.96	10.4%	0.92
Employers with 51-99 Employees	6.6%	0.88	0.4%	0.79	9.8%	0.89
Employers with >=100 Employees	60.0%	0.93	99.0%	0.93	39.4%	0.92
Employers thru Qualified Trust	1.7%	0.91	0.5%	1.02	2.3%	0.90
Total Members	585,588	.90	201,874	.93	83,714	.88

Large Group, Small Group, and Non-Group 2008

Market Category	Large Group	Loss Ratio	Small Group	Loss Ratio	Non-Group	Loss Ratio
Individual policy	Not Applicable		Not Applicable		98.5%	0.59
Individual (as group conversion)					1.5%	1.53
Employers with 1 Employee			7.0%	1.04	Not Applicable	
Employers with 2-9 Employees			35.2%	0.85		
Employers with 10-25 Employees			31.3%	0.87		
Employers with 26-50 Employees			26.4%	0.92		
Employers with 51-99 Employees	9.6%	0.88	Not Applicable			
Employers with >=100 Employees	87.9%	0.93				
Employers thru Qualified Trust	2.4%	0.91				
Total Members	399,323	0.92	151,464	0.89	34,801	0.61

Overall Comparison – 2007 and 2008

Market Category	2007 Percent of Members	2008 Percent of Members	2007 Loss Ratio	2008 Loss Ratio
Individual policy	6.60%	5.86%	0.62	0.59
Individual (as group conversion)	0.10%	0.09%	2.29	1.53
Employers with 1 Employee	2.30%	1.82%	0.95	1.04
Employers with 2-9 Employees	8.10%	9.10%	0.81	0.85
Employers with 10-25 Employees	7.50%	8.11%	0.87	0.87
Employers with 26-50 Employees	4.50%	6.84%	0.90	0.92
Employers with 51-99 Employees	6.60%	6.55%	0.83	0.88
Employers with >=100 Employees	62.40%	59.97%	0.91	0.93
Employers thru Qualified Trust	1.90%	1.67%	0.88	0.91

Key findings:

- 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.
- 2008 shows a higher loss ratio for large group policies than in 2007. 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 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.

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

Deductible	All Members	Self-insured	Fully-insured	Large Group	Small Group	Non-Group
$0	31%	**49%**	22%	43%	8%	3%
$1-250	14%	**24%**	9%	17%	9%	0%
$251-500	17%	11%	20%	16%	**24%**	1%
$501-750	3%	2%	3%	3%	**3%**	0%
$751-1,000	12%	7%	14%	10%	**20%**	2%
$1,001-1,500	7%	3%	9%	4%	**14%**	5%
$1,501-3,000	8%	1%	11%	4%	11%	**41%**
$3001-5,000	8%	3%	10%	4%	10%	**38%**
$5,001-7,500	1%	0%	1%	0%	0%	**7%**
$7,501-10,000	0%		0%		1%	**3%**
$10,001+	0%		0%		0%	0%
Total Members	585,588	201,874	383,714	399,323	151,464	34,801

Deductible	2007 All Members	2008 All Members
$0	46%	31%
$1-250	9%	14%
$251-500	17%	17%
$501-750	1%	3%
$751-1,000	12%	12%
$1,001-1,500	2%	7%
$1,501-3,000	6%	8%
$3001-5,000	6%	8%
$5,001-7,500	0%	1%
$7,501-10,000	1%	0%
$10,001+	0%	0%

The high percentage of members covered by a self-insured account without any deductible is partly the result of the state of NH state employee plan. Between 2007 and 2008, there was a 33 percent reduction in the rate of members without a deductible.

In general, we continue to see a greater percentage of members with higher deductibles each year. 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 the 36 percent of small group members with a $1,000 deductible or higher, and ten percent of the fully-insured members with a deductible of at least $3,000.

A detailed comparison is set forth below:

Deductible	All Members	Self-insured	Fully-insured	Large Group	Small Group	Non-Group
$0	31%	**49%**	22%	43%	8%	3%
$50	0%	0%	0%	0%	0%	0%
$100	2%	2%	2%	2%	3%	0%
$150	5%	13%	0%	7%	0%	0%
$200	2%	2%	1%	2%	2%	0%
$250	6%	7%	5%	7%	5%	0%
$300	2%	5%	0%	3%	0%	0%
$350	0%	0%	0%	0%	0%	0%
$400	0%	0%	0%	0%	0%	0%
$450	0%	0%	0%	0%	0%	0%
$500	15%	6%	19%	12%	24%	1%
$600	0%	0%	0%	0%	0%	0%
$750	2%	2%	2%	2%	3%	0%
$800	0%	0%	0%	0%	0%	0%
$900	0%	0%	0%	0%	0%	0%
$1,000	12%	7%	14%	9%	20%	2%
$1,100	0%	0%	0%	0%	0%	0%
$1,200	0%	1%	0%	0%	0%	0%
$1,250	0%	0%	0%	0%	0%	3%
$1,350	0%	0%	0%	0%	0%	0%
$1,500	6%	2%	8%	4%	13%	2%
$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	8%	1%	11%	4%	11%	41%
$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	4%	1%	6%	3%	7%	13%
$2,550	0%	0%	0%	0%	0%	1%

Deductible	All Members		Self-insured	Fully-insured		Large Group	Small Group	Non-Group
$2,600	0%		0%	0%		0%	0%	2%
$2,700	0%		0%	0%		0%	0%	1%
$2,800	0%		0%	0%		0%	0%	0%
$2,850	0%		0%	0%		0%	0%	1%
$3,000	1%		1%	2%		1%	1%	9%
$3,500	0%		0%	0%		0%	1%	0%
$3,750	0%		0%	0%		0%	0%	0%
$4,000	0%		0%	0%		0%	0%	0%
$4,800	0%		0%	0%		0%	0%	0%
$4,950	0%		0%	0%		0%	0%	0%
$5,000	1%		1%	1%		0%	1%	9%
$5,100	0%		0%	0%		0%	0%	0%
$5,400	0%		0%	0%		0%	0%	0%
$6,000	0%		0%	0%		0%	0%	1%
$7,000	0%		0%	0%		0%	0%	0%
$7,500	0%		0%	1%		0%	0%	7%
$10,000	0%		0%	0%		0%	1%	3%
$12,000	0%		0%	0%		0%	0%	0%
Total Members	585,588		201,874	383,714		399,323	151,464	34,801

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.

After observing a similar distribution of co-insurance amounts between 2006 and 2007, we are seeing a shift in 2008 to higher amounts, suggesting that co-insurance being used as a method of shifting costs to the member. Overall, approximately one percent of members in 2007 had a coinsurance amount above twenty percent. In 2008 the rate was 16 percent.

Comparison Table

Coinsurance	All Members		Self-insured	Fully-insured		Large Group	Small Group	Non-Group
0%	62%		47%	69%		61%	74%	13%
5%	0%			0%		0%	0%	0%
10%	4%		8%	2%		6%	0%	0%
15%	0%			0%		0%	0%	0%
20%	18%		29%	13%		20%	13%	19%
25%	0%			0%		0%	0%	0%
30%	10%		12%	9%		10%	10%	9%
35%	0%			0%		0%	0%	0%
40%	5%		3%	6%		3%	2%	42%
50%	1%		0%	2%		0%	1%	18%
Total Members	585,588		201,874	383,714		399,323	151,464	34,801

Coinsurance Amount	2007 All Members	2008 All Members
0%	65%	62%
5%	0%	0%
10%	6%	4%
20%	28%	18%
25%	0%	0%
30%	1%	10%
35%	0%	0%
40%	0%	5%
50%	0%	1%

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 2008 to 2007, but with an increase in the percentage of members with a $50 co-pay.

Co-pay Amount	All Members		Self-insured	Fully-insured		Large Group	Small Group	Non-Group
0	14%		15%	14%		13%	12%	48%
5	12%		34%	0%		17%	0%	0%
10	15%		19%	13%		18%	11%	0%
15	15%		9%	19%		14%	21%	1%
20	21%		9%	27%		19%	20%	41%
25	5%		6%	4%		5%	4%	0%
30	4%		3%	5%		3%	8%	0%
35	2%		2%	2%		2%	3%	0%
40	5%		3%	7%		4%	7%	9%
50	6%		0%	9%		4%	13%	0%
60	0%		0%	0%		0%	0%	0%
Total Members	585,588		201,874	383,714		399,323	151,464	34,801

Copay Amount	2007 All Members	2008 All Members
0	11%	14%
5	14%	12%
10	19%	15%
15	19%	15%
20	20%	21%
25	4%	5%
30	3%	4%
35	2%	2%
40	5%	5%
50	2%	6%

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 with at least one percent of members without coverage.

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 described in the bulletin.

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%			1%
Audiology Screening for Newborns	Yes	98%	100%	96%	100%	98%	71%
	No	2%		4%	0%	2%	29%
Blood and Blood Products	Yes	85%	78%	89%	82%	89%	99%
	No	15%	22%	11%	18%	11%	1%
Chiropractic Services	Yes	94%	100%	91%	100%	95%	18%
	No	6%	0%	9%	0%	5%	82%
Emergency Room	Yes	100%	100%	100%	100%	100%	99%
	No	0%		0%			1%
Family Planning Services	Yes	91%	92%	90%	91%	93%	70%
	No	9%	8%	10%	9%	7%	30%
Habilitative Services	Yes	43%	24%	53%	41%	57%	13%
	No	57%	76%	47%	59%	43%	87%
Hearing Aids	Yes	59%	70%	53%	65%	42%	68%
	No	41%	30%	47%	35%	58%	32%
Home Health Care	Yes	99%	100%	99%	100%	98%	97%
	No	1%		1%		2%	3%

Coverage Category	Covered	All Members	Self-insured	Fully-insured	Large Group	Small Group	Non-Group
Hospice	Yes	84%	78%	88%	82%	87%	93%
	No	16%	22%	12%	18%	13%	7%
Hospitalization	Yes	99%	100%	98%	100%	98%	88%
	No	1%		2%		2%	12%
Infertility Services	Yes	63%	83%	52%	70%	43%	70%
	No	37%	17%	48%	30%	57%	30%
Medical Food	Yes	97%	100%	95%	97%	98%	82%
	No	3%	0%	5%	3%	2%	18%
Mental Health and SA Treatment	Yes	84%	78%	87%	82%	87%	81%
	No	16%	22%	13%	18%	13%	19%
Nutritional Services	Yes	80%	74%	83%	78%	87%	69%
	No	20%	26%	17%	22%	13%	31%
OP Short Term Rehabilitation Services	Yes	99%	100%	99%	100%	98%	93%
	No	1%		1%		2%	7%
Pregnancy & Maternity	Yes	98%	100%	97%	100%	98%	79%
	No	2%		3%		2%	21%
Preventive Services	Yes	86%	83%	88%	85%	87%	88%
	No	14%	17%	12%	15%	13%	12%
Prescription Drug Coverage	Yes	99%	98%	99%	99%	98%	94%
	No	1%	2%	1%	1%	2%	6%
Skilled Nursing Facility	Yes	90%	88%	92%	90%	89%	95%
	No	10%	12%	8%	10%	11%	5%
Transplants	Yes	100%	100%	100%	100%	100%	98%
	No	0%		0%			2%
Well Child and Immunization Benefits	Yes	88%	85%	90%	88%	89%	86%
	No	12%	15%	10%	12%	11%	14%

Sometimes fewer fully-insured or small group members are without coverage for a particular benefit. This is probably due to the requirements of 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.

CARRIER MEMBERSHIP DISTRIBUTION

Data submitted for the Supplemental Report is based on policyholder. The data include insured members who reside outside of NH if covered under a NH policy. "Anthem-NH" includes both Anthem-NH products and Matthew Thornton Health Care products. Connecticut General Life Insurance is displayed separately from Cigna. 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	723	0.1%
American Trust Administrators	203	0.0%
Anthem-NH	321,216	54.9%
Chesapeake Life	3,543	0.6%
Cigna	11,979	2.0%
Conn Gen Life Ins (Cigna)	74,575	12.7%
Fidelity	406	0.1%
Golden Rule	332	0.1%
Guardian Life	461	0.1%
Harvard Pilgrim Health Care	148,174	25.3%
John Alden	1,681	0.3%
Mega Life & Health	3,811	0.7%
MVP	13,946	2.4%
Time Insurance Company	3,754	0.6%
United	786	0.1%
Total Membership	585,588	100.0%

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 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/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 in this report 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. As 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 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.

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 the statistics and calculations in this report.

The higher number of members included in the 2008 submission (585,588) means that this report may reflect population characteristics that differ from those reported in 2007 (501,872) that are unrelated to trends. Since the 2007 reporting period, the NHID provided carriers with clarification about which policies and members should be included and this is the most likely reason for the difference.

Included in the data was evidence of four member months associated with a small group HMO member with an average monthly premium of $1,586 and a benefit actuarial value of .83. This was seen as an anomaly and not reported in the output tables.

The total number of companies included in the data is 18 (determined by distinct NAIC numbers).

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 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.