SUPPLEMENTAL REPORT
OF THE
2009
HEALTH INSURANCE MARKET
IN
NEW HAMPSHIRE

September 20, 2010

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 2009.

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.

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 = $2,868,280,894
- Total claims = $2,626,146,254
- Average loss ratio = 91.6%
- Average number of members insured = 611,435
- Average member premium per month:
  - Large Group $398
  - Small Group $394
  - Non-Group $261

HIGH DEDUCTIBLE HEALTH PLANS

- Percent of members in an IRS defined High Deductible Health Plan (HDHP) = 7.4%

SELF FUNDED PLANS

- Percent of members covered under employer self-insured plans:

  Large Group = 57.2%

  Overall = 42.3%

DEDUCTIBLES

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

- $0 – 29%
- $250 – 8%
- $500 – 13%
- $1,000 – 11%
- $1,500 – 7%
- $2,000 – 9%

CO-INSURANCE

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

- 0% co-insurance - 60%
- 20% co-insurance - 17%
- 30% co-insurance - 11%

CO-PAYS

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

- $0 – 16%
- $5 – 7%
- $10 – 18%
- $15 – 11%
- $20 – 22%

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 2009. In 2009 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 7.4 percent. This represents a slight drop from 2008, with the majority of members covered through the non-group market segment. There were small shifts to the HDHP rate within each market segment, but overall these data suggest any trend toward HDHPs cannot be detected between 2008 and 2009.

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 2009 and 2008 are below.

2009

HDHP	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
No	92.6%		97.0%	89.3%		94.8%	89.2%	73.0%
Yes	7.4%		3.0%	10.7%		5.2%	10.8%	27.0%
Total Members	611,435		258,790	352,645		452,026	129,553	29,856

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

Observations:

- HDHP overall rate is similar in 2009 to 2008.
- HDHP rate increases in the self-insured and large group market segments.

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 member months. Since carriers utilize different rating factors and product pricing strategies, average premium values are useful for comparisons, but will not represent the actual premium charged for a policy. The average premiums include benefit packages that vary with respect to coverage, member age and gender, and product pricing schemes. The market category and insurance status are important 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	7,313	$533	1,140	$583
	HMO	98,350	$406	131,973	$403
	POS	71,730	$397	8,352	$476
	PPO	77,014	$395	47,263	$350
	EPO	4,107	$344	4,786	$331
Small Group	Indemnity	3	$413	238	$728
	HMO	11	$433	85,936	$398
	POS	50	$726	2,858	$469
	PPO	213	$440	26,041	$378
	EPO	No Membership Reported		14,204	$382
Non-Group	Indemnity			2,546	$177
	HMO			594	$481
	PPO			26,691	$264
	EPO			25	$530
Total Members		258,790		352,645	

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

Observations:

- Most people are covered by HMO plans.
- HMO average premiums are similar among large group self-insured, large group fully-insured, and small group fully-insured. These are the market categories with the largest share of members.
- No POS membership was reported in the non-group segment.
- Several of the indemnity average premium rates are higher than for the managed care products. Indemnity products often had higher cost sharing than managed care products beginning in the mid-1990s and this has typically kept the premiums for indemnity products closer to managed care products. This dynamic may be shifting as managed care product cost sharing has increased substantially in recent years.
- The Indemnity rates suggest that the product design and account specific circumstances are more variable than with other plan types. This is expected to the degree that benefits and health status (medical underwriting is permitted in the large group and non-group markets) may vary extensively among the indemnity insurance populations. The data provided to the NHID through the supplemental report filings are not detailed enough to fully understand the characteristics and trends within the indemnity plans.

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. Using 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 plan that carriers are required to use to calculate the actuarial value is 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 can only be made within the same plan type category (e.g. only compare HMO benefit richness values to other HMO values).

Below is a comparison table of average premiums and actuarial values between the small and large group markets and the non-group market.

Plan Type	Market Category	Self-insured* Members	Self-insured* Avg Premium	Self-insured* Benefit Richness	Fully-insured Members	Fully-insured Avg Premium	Fully-insured Benefit Richness
HMO	Large Group	98,350	$406	0.94	131,973	$403	0.80
	Small Group	11	$433	0.92	85,936	$398	0.74
	Non-Group	No Membership Reported			594	$481	1.02
POS	Large Group	71,730	$397	0.82	8,352	$476	0.86
	Small Group	50	$726	1.06	2,858	$469	0.85
PPO	Large Group	77,014	$395	0.72	47,263	$350	0.66
	Small Group	213	$440	0.83	26,041	$378	0.63
	Non-Group	No Membership Reported			26,691	$264	0.28
EPO	Large Group	4,107	$344	0.81	4,786	$331	0.78
	Small Group	No Membership Reported			14,204	$382	0.78
	Non-Group				25	$530	0.75
Indemnity	Large Group	7,313	$533	0.96	1,140	$583	0.78
	Small Group	3	$413	0.96	238	$728	1.01
	Non-Group	No Membership Reported			2,546	$177	0.45
Total Members		258,790			352,645		

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

Observations:

- The average premium for the fully-insured large group and fully-insured small group HMO products are very similar, but the benefits are weaker for the small group market.
- The average premium between the fully-insured HMO large group and the self-insured HMO large group are similar, but the value of the fully-insured benefits is fifteen percent less than the self-insured.
- The self-insured large group POS premiums are about seventeen percent less than the fully-insured large group POS premiums, but the benefit value of the self-insured POS products is only five percent less than the fully-insured products.
- Policies under the Indemnity plan type vary extensively with respect to benefit richness and premiums.

The table below provides comparative information for 2008 and 2009 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 adjustment for inflation is made.

Plan Type	Market Category	2009 Members	2008 Avg Premium*	2009 Avg Premium*	2008 Benefit Richness	2009 Benefit Richness	Change in Value
HMO	Large Group	230,322	$371	$405	0.81	0.86	-3.0%
	Small Group	85,946	$375	$398	0.77	0.74	-9.9%
	Non-Group	594	$496	$481	1.09	1.02	-3.0%
POS	Large Group	80,082	$406	$405	0.84	0.83	-1.3%
	Small Group	2,908	$444	$473	0.85	0.85	-6.8%
PPO	Large Group	133,170	$328	$375	0.74	0.70	-19.0%
	Small Group	40,458	$349	$379	0.72	0.68	-14.2%
	Non-Group	26,716	$253	$264	0.35	0.28	-22.7%
Indemnity	Large Group	8,452	$295	$540	1.09	0.93	-97.5%
	Small Group	241	$279	$724	0.35	1.01	26.5%
	Non-Group	2,546	$174	$177	0.40	0.45	10.6%

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

Observations include:

- The HMO Large Group has the most members within the categories shown, and the value of the insurance for these members dropped by about three percent (the difference between 2007 and 2008 was a 15 percent drop*).
- The majority of non-group members are enrolled in PPO products, and this segment saw a reduction in value equal to almost 23 percent. This is in addition to a -16.2% drop observed between 2007 and 2008.
- 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 the large group market category value decreased almost 98 percent. However, this category had a population change from 257 in 2008 to 8,452 in 2009. This is also in contrast to the indemnity small group and non-group markets where value improved substantially.

*2008 Supplemental Report

- In many cases, the value of benefits decreased while premiums increased.
- In two cases the average premium went down: HMO non-group and POS large group. Both of these market categories allow medical underwriting and both of these examples saw a reduction in benefits resulting in a lower value overall. Additionally, the year to year comparison reported a year ago showed substantial decreases in value for these categories (HMO non-group = -42.2%, POS large group = -8.5%).
- The large group PPO segment is 22 percent of all covered members and they faced a decrease in value equal to 19 percent.

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 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	38%	$406	$431	37%	$403	$502
	Small Group	0%	$433	$471	24%	$398	$539
	Non-Group	No Membership Reported			0%	$481	$471
POS	Large Group	28%	$397	$483	2%	$476	$553
	Small Group	0%	$726	$685	1%	$469	$552
PPO	Large Group	30%	$395	$551	13%	$350	$528
	Small Group	0%	$440	$528	7%	$378	$601
	Non-Group	No Membership Reported			8%	$264	$930
EPO	Large Group	2%	$344	$427	1%	$331	$426
	Small Group	No Membership Reported			4%	$382	$492
	Non-Group				0%	$530	$709
FFS	Large Group	3%	$533	$558	0%	$583	$750
	Small Group	0%	$413	$431	0%	$728	$721
	Non-Group	No Membership Reported			1%	$177	$390
Total Members		258,790			352,645		

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

Observations:

- Fully-insured large group adjusted HMO premium is clearly more expensive than self-insured, when similar without the adjustment.
- Fully-insured small group HMO premium is less expensive than fully insured small group HMO premium, but once benefits are adjusted for the premium is much higher than the self-insured premium.
- Within the PPO market category, fully insured premiums are inversely related to group size. Non-group and small group have a higher premium than large groups.
- EPO fully-insured adjusted average premium pattern is similar to the PPO category.

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	4%	$386	0.98	$394
	Municipal	7%	$351	0.97	$362
	All Other Accounts	41%	$413	0.79	$523
POS	State	1%	$527	0.82	$640
	Municipal	5%	$430	0.84	$513
	All Other Accounts	7%	$376	0.82	$459
PPO	State	0%	$575	0.84	$688
	Municipal	0%	$421	0.80	$526
	All Other Accounts	33%	$361	0.64	$562
FFS	Municipal	1%	$567	0.94	$602
	All Other Accounts	1%	$346	0.70	$497
Total Members		611,435			

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

Observations include:

- Very rich benefits are seen for both state and municipal employees enrolled in HMO products. Both the average premium and the adjusted premium are lower than for other accounts.
- Although fewer state and municipal covered members are enrolled in POS products, both the average premium and adjusted premium are substantially higher than for other POS policies.

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
2009

Market Category	All Members	Loss Ratio	Self-insured Members	Loss Ratio	Fully-insured Members	Loss Ratio
Employers with 1 Employee	1.0%	1.07	None Reported		1.7%	1.07
Employers with 2-9 Employees	7.8%	0.89			13.5%	0.89
Employers with 10-25 Employees	7.3%	0.91	0.0%	0.47	12.6%	0.91
Employers with 26-50 Employees	5.1%	0.98	0.1%	0.61	8.8%	0.98
Employers with 51-99 Employees	7.1%	0.90	0.7%	0.83	11.7%	0.91
Employers with >=100 Employees	61.7%	0.93	89.9%	0.94	41.0%	0.92
Individual policy	4.8%	0.66	None Reported		8.3%	0.66
Individual (as group conversion)	0.1%	1.30			0.2%	1.30
Employers thru Qualified Trust	5.1%	0.84	9.3%	0.84	2.1%	0.85
Totals	611,435	0.92	258,790	0.93	352,645	0.90

Large Group, Small Group, and Non-Group
2009

Market Category	Large Group Members	Loss Ratio	Small Group Members	Loss Ratio	Non-Group Members	Loss Ratio
Employers with 1 Employee	Not Applicable		4.6%	1.07	Not Applicable	
Employers with 2-9 Employees			36.8%	0.89		
Employers with 10-25 Employees			34.4%	0.91		
Employers with 26-50 Employees			24.2%	0.98		
Employers with 51-99 Employees	9.6%	0.90	Not Applicable			
Employers with >=100 Employees	83.5%	0.93				
Individual policy	Not Applicable				97.8%	0.66
Individual (as group conversion)					2.2%	1.30
Employers thru Qualified Trust	6.9%	0.84			Not Applicable	
Totals	452,026	0.92	129,553	0.93	29,856	0.68

Overall Comparison – 2008 and 2009

Market Category	2008 Percent of Members	2009 Percent of Members	2008 Loss Ratio	2009 Loss Ratio
Employers with 1 Employee	1.8%	1.0%	1.04	1.07
Employers with 2-9 Employees	9.1%	7.8%	0.85	0.89
Employers with 10-25 Employees	8.1%	7.3%	0.87	0.91
Employers with 26-50 Employees	6.8%	5.1%	0.92	0.98
Employers with 51-99 Employees	6.6%	7.1%	0.88	0.90
Employers with >=100 Employees	60.0%	61.7%	0.93	0.93
Individual policy	5.9%	4.8%	0.59	0.66
Individual (as group conversion)	0.1%	0.1%	1.53	1.30
Employers thru Qualified Trust	1.7%	5.1%	0.91	0.84
Totals	585,588	611,435	0.90	0.92

Observations:

- In most cases the market category loss ratios were higher in 2009 than 2008, as was the aggregate loss ratio for all categories.
- The individual market continues to have a comparatively low loss ratio, although higher than in 2008.
- The small group category of "1 Employee" continues to have a comparatively high loss ratio, and the loss ratio increased in 2009.
- 2009 shows a higher loss ratio for 51-99 employee large group policies than in 2008. 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 two percent.

Deductible	All Members	Self-insured	Fully-insured	Large Group	Small Group	Non-Group
$0	29%	**43%**	18%	37%	5%	3%
$1-250	14%	**27%**	5%	18%	5%	0%
$251-500	15%	**17%**	14%	16%	17%	2%
$501-750	3%	3%	3%	**3%**	3%	0%
$751-1,000	12%	2%	19%	9%	**21%**	2%
$1,001-1,500	8%	3%	11%	5%	**19%**	8%
$1,501-3,000	9%	1%	15%	5%	17%	**37%**
$3001-5,000	9%	2%	14%	6%	13%	**40%**
$5,001-7,500	0%	0%	1%	0%	0%	**7%**
$7,501-10,000	0%	0%	0%	0%	0%	1%
$10,001+	0%	0%	0%	0%	0%	0%
Totals	611,435	258,790	352,645	452,026	129,553	29,856

Deductible	2008 All Members	2009 All Members
$0	31%	29%
$1-250	14%	14%
$251-500	17%	15%
$501-750	3%	3%
$751-1,000	12%	12%
$1,001-1,500	7%	8%
$1,501-3,000	8%	9%
$3001-5,000	8%	9%
$5,001-7,500	1%	0%
$7,501-10,000	0%	0%
Totals	585,588	611,435

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.

After clear increases to the reported deductible amounts in recent years, there are only minor differences in the 2008 to 2009 comparison. The non-group market has the greatest proportion of members with high deductibles, and the distribution within the small group market falls between the non-group and large group markets.

A detailed comparison is set forth below:

Deductible	All Members		Self-insured	Fully-insured		Large Group	Small Group	Non-Group
$0	29%		**43%**	18%		37%	5%	3%
$50	0%		0%	0%		0%	0%	0%
$100	1%		2%	0%		1%	0%	0%
$150	5%		**11%**	0%		6%	0%	0%
$200	1%		1%	1%		1%	1%	0%
$250	8%		**13%**	4%		9%	4%	0%
$300	2%		**5%**	0%		3%	0%	0%
$350	0%		1%	0%		0%	0%	0%
$400	0%		0%	0%		0%	0%	0%
$450	0%		0%	0%		0%	0%	0%
$500	13%		12%	13%		13%	**17%**	2%
$550	0%		0%	0%		0%	0%	0%
$600	0%		0%	0%		0%	0%	0%
$750	3%		2%	**3%**		3%	3%	0%
$900	0%		0%	1%		1%	0%	0%
$1,000	11%		2%	18%		9%	**21%**	2%
$1,100	0%		0%	0%		0%	0%	0%
$1,150	0%		0%	0%		0%	0%	0%
$1,200	1%		1%	0%		1%	0%	0%
$1,250	1%		1%	1%		0%	0%	6%
$1,350	0%		0%	0%		0%	0%	0%
$1,500	7%		2%	11%		4%	**18%**	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	9%		1%	15%		5%	17%	**37%**
$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%
$2,300	0%		0%	0%		0%	0%	0%
$2,400	0%		0%	0%		0%	0%	0%
$2,500	4%		0%	6%		2%	7%	**13%**
$2,550	0%		0%	0%		0%	0%	1%
$2,600	0%		0%	0%		0%	0%	1%
$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	2%		1%	3%		1%	2%	**11%**
$3,500	0%		0%	0%		0%	1%	1%
$3,750	0%		0%	0%		0%	0%	1%
$4,000	1%		0%	2%		1%	**2%**	0%
$4,500	0%		0%	0%		0%	0%	0%
$4,950	0%		0%	0%		0%	0%	0%
$5,000	1%		1%	1%		1%	1%	**10%**
$5,100	0%		0%	0%		0%	0%	0%

Deductible	All Members		Self-insured	Fully-insured		Large Group	Small Group	Non-Group
$6,000	0%		0%	0%		0%	0%	1%
$7,500	0%		0%	1%		0%	0%	**7%**
$10,000	0%		0%	0%		0%	0%	1%
$15,000	0%		0%	0%		0%	0%	0%
$25,000	0%		0%	0%		0%	0%	0%
Totals	611,435		258,790	352,645		452,026	129,553	29,856

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 shift in 2008 to higher amounts, suggesting that co-insurance was being used as a method of shifting costs to the member, there are only minor changes in 2009.

Comparison Table

Coinsurance	All Members		Self-insured	Fully-insured		Large Group	Small Group	Non-Group
0%	60%		44%	72%		58%	**78%**	13%
10%	5%		**11%**	2%		7%	0%	0%
15%	0%		1%	0%		1%	0%	0%
20%	17%		**26%**	11%		20%	11%	8%
25%	0%		0%	0%		0%	0%	0%
30%	11%		15%	8%		12%	9%	**17%**
35%	0%		0%	0%		0%	0%	0%
40%	4%		3%	5%		3%	2%	**39%**
50%	1%		0%	2%		0%	0%	**22%**
Totals	611,435		258,790	352,645		452,026	129,553	29,856

Coinsurance	2008 All Members	2009 All Members
0%	62%	60%
10%	4%	5%
15%	0%	0%
20%	18%	17%
25%	0%	0%
30%	10%	11%
35%	0%	0%
40%	5%	4%
50%	1%	1%
Totals	585,588	611,435

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 2009 to 2008, but with some increases and some decreases.

Copay	All Members		Self-insured	Fully-insured		Large Group	Small Group	Non-Group
0	16%		19%	14%		16%	10%	**48%**
5	7%		**16%**	0%		9%	0%	0%
10	18%		**31%**	9%		22%	7%	0%
15	11%		9%	13%		10%	**17%**	1%
20	22%		8%	31%		21%	20%	**38%**
25	7%		6%	7%		6%	**8%**	0%
30	5%		4%	5%		4%	**8%**	0%
35	2%		**3%**	1%		2%	1%	0%
40	6%		3%	8%		4%	9%	**12%**
45	0%		0%	0%		0%	0%	0%
50	7%		1%	12%		5%	**19%**	0%
60	0%		0%	0%		0%	0%	0%
65	0%		0%	0%		0%	0%	0%
Totals	611,435		258,790	352,645		452,026	129,553	29,856

Copay Amount	2008 All Members	2009 All Members
0	14%	16%
5	12%	7%
10	15%	18%
15	15%	11%
20	21%	22%
25	5%	7%
30	4%	5%
35	2%	2%
40	5%	6%
50	6%	7%
Totals	585,588	611,435

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, but all are listed in the table.

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 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%	99%
	No	0%	0%	0%	0%	0%	1%
Audiology Screening of Newborns	Yes	98%	99%	98%	99%	100%	81%
	No	2%	1%	2%	1%	0%	19%
Blood and Blood Products	Yes	84%	73%	92%	80%	95%	99%
	No	16%	27%	8%	20%	5%	1%
Case Management Programs	Yes	100%	100%	100%	100%	100%	100%
	No	0%	0%	0%	0%	0%	0%
Chiropractic Services	Yes	95%	100%	91%	99%	97%	21%
	No	5%	0%	9%	1%	3%	79%
Durable Medical Equipment	Yes	100%	100%	100%	100%	100%	100%
	No	0%	0%	0%	0%	0%	0%
Emergency Room Services	Yes	100%	100%	100%	100%	100%	100%
	No	0%	0%	0%	0%	0%	0%
Family Planning Services	Yes	93%	94%	93%	93%	97%	79%
	No	7%	6%	7%	7%	3%	21%
Habilitative Services	Yes	48%	34%	58%	48%	57%	15%
	No	52%	66%	42%	52%	43%	85%
Hearing Aids	Yes	57%	66%	51%	60%	43%	77%
	No	43%	34%	49%	40%	57%	23%
Home Health Care	Yes	100%	100%	100%	100%	100%	100%
	No	0%	0%	0%	0%	0%	0%
Hospice	Yes	84%	74%	92%	80%	95%	94%
	No	16%	26%	8%	20%	5%	6%
Hospitalization	Yes	100%	100%	100%	100%	100%	100%
	No	0%	0%	0%	0%	0%	0%
Infertility Services	Yes	64%	82%	51%	69%	44%	79%
	No	36%	18%	49%	31%	56%	21%

Coverage Category	Covered	All Members		Self-insured	Fully-insured		Large Group	Small Group	Non-Group
Medical Food	Yes	98%		98%	98%		98%	100%	94%
	No	2%		2%	2%		2%		6%
Mental Health/Substance Abuse	Yes	84%		73%	92%		80%	95%	93%
	No	16%		27%	8%		20%	5%	7%
Nutritional Services	Yes	80%		69%	89%		77%	94%	79%
	No	20%		31%	11%		23%	6%	21%
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%
Outpatient Rehabilitation Services	Yes	100%		100%	100%		100%	100%	98%
	No	0%		0%	0%		0%	0%	2%
Pregnancy and Maternity Services	Yes	100%		100%	99%		100%	100%	93%
	No	0%		0%	1%		0%	0%	7%
Preventive Services	Yes	87%		79%	93%		84%	95%	92%
	No	13%		21%	7%		16%	5%	8%
Prescription Drugs	Yes	95%		88%	100%		93%	100%	99%
	No	5%		12%	0%		7%	0%	1%
Skilled Nursing Facility	Yes	91%		85%	95%		89%	95%	94%
	No	9%		15%	5%		11%	5%	6%
Transplants	Yes	100%		100%	100%		100%	100%	98%
	No	0%		0%	0%		0%	0%	2%
Well Child and Immunization Services	Yes	92%		84%	98%		90%	99%	92%
	No	8%		16%	2%		10%	1%	8%

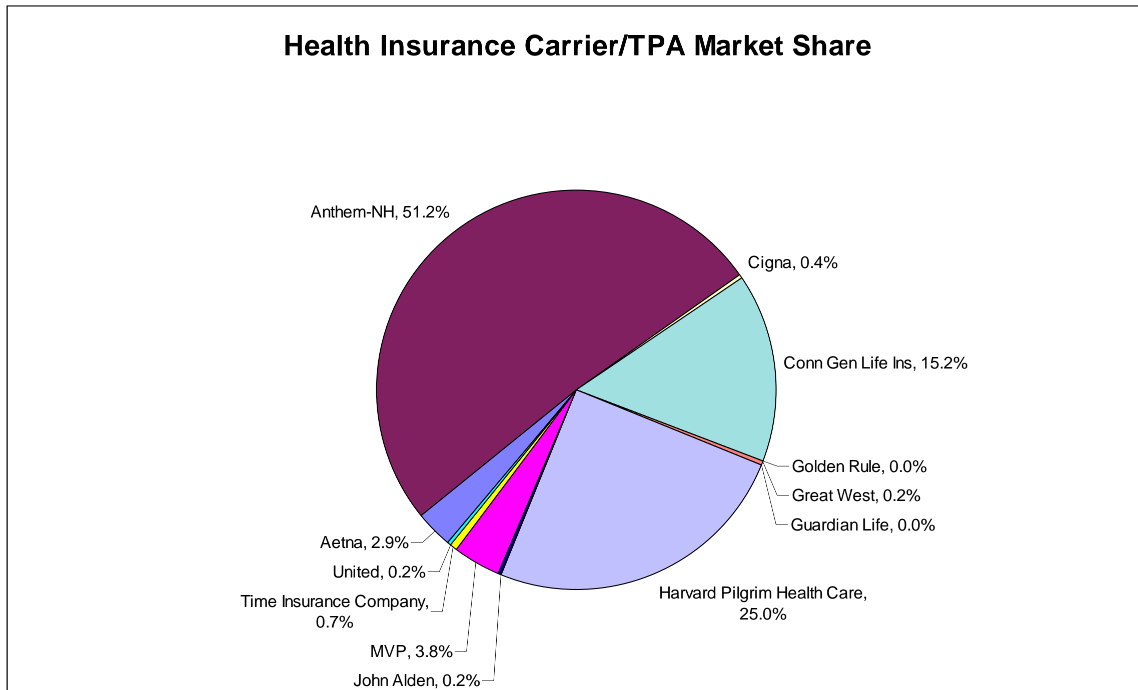
Sometimes fewer fully-insured or small group members are without coverage for a particular benefit. This is probably due to NH laws for mandated benefits. Larger employers are more likely to be self-insured and have more flexibility to negotiate which benefits will be covered under their policy.

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. These 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	17,979	2.9%
Anthem-NH	313,014	51.2%
Cigna	2,374	0.4%
Conn Gen Life Ins	93,206	15.2%
Golden Rule	266	0.0%
Great West	1,447	0.2%
Guardian Life	152	0.0%
Harvard Pilgrim Health Care	152,883	25.0%
John Alden	1,484	0.2%
MVP	23,503	3.8%
Time Insurance Company	3,986	0.7%
United	1,142	0.2%
Total Membership	611,435	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 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/lah/documents/suprpt_bull2010.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. 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 .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 two carriers for health insurance plans were inconsistent with other submissions. The explanation provided by the carriers was that the insurance filings were for student health plans. Due to the unique nature of these carrier products, the data were removed from the statistics and calculations in this report.

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- 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.