SUPPLEMENTAL REPORT
OF THE
2011
HEALTH INSURANCE MARKET
IN
NEW HAMPSHIRE

February 27, 2013

Prepared by the New Hampshire Insurance Department
SUPPLEMENTAL REPORT
OF THE 2011 HEALTH INSURANCE MARKET
IN NEW HAMPSHIRE

By law, the Insurance Commissioner is authorized to prescribe the format and content of financial and other reports filed by insurers licensed in New Hampshire. The data submitted in the Supplemental Report is critical to understanding and evaluating the New Hampshire health insurance market. The data are collected annually, and this report is based on activity during the calendar year 2011.

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 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.

Due to the unique nature and features of these limited policies, data for these policies has been excluded from the report with the exception of the table below that summarizes the 2011 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.

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)	1,585	$ 700	$ 532	76%
High Risk Pool (NHHP-FED)	154	$ 623	$ 5,711	916%
High Risk Pool Total	**20,863**	**$ 693**	**$ 990**	**143%**

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

- Large Group = 483,765
  - 76% of all members
  - 29% fully insured (139,746)

- Small Group = 102,061
  - 16% of all members
  - 99% fully insured
  - 4,508 in groups of one

- Non-group = 46,558
  - 7% of all members
  - 100% fully insured

- Total premiums and premium equivalents = $3,027,585,278
- Total claims = $2,634,642,427
- Average loss ratio = 87.0%
- Average number of members insured = 632,384

- Average member premium per month:
    - Large Group $407
    - Small Group $425
    - Non-Group $256

HIGH DEDUCTIBLE HEALTH PLANS

- Percent of members in an IRS defined High Deductible Health Plan (HDHP) = 18%

SELF FUNDED PLANS

- Percent of members covered under employer self-insured plans:
  Large Group = 71%
  Overall = 55%

DEDUCTIBLES

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

- $0 – 33%
- $250 – 5%
- $500 – 7%
- $1,000 – 9%
- $2,000 – 8%
- $3,000 – 10%

CO-INSURANCE

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

- 0% co-insurance - 63%
- 10% co-insurance - 10%
- 20% co-insurance - 21%

CO-PAYS

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

- $0 – 22%
- $5 – 6%
- $10 – 11%
- $20 – 19%
- $25 – 16%
- $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 2011. In 2011, 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 members in a HDHP is 18 percent. This represents an increase from 2010, with the highest penetration still in the non-group market segment. There were significant increases to the HDHP penetration rate within each market segment, with the largest increase occurring in the small group segment.

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 2011 and 2010 are below.

2011

HDHP	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
No	82%		90%	71%		85%	71%	68%
Yes	18%		10%	29%		15%	29%	32%
Total Members	632,384		345,076	287,307		483,765	102,061	46,557

2010

HDHP	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
No	89%		94%	82%		91%	84%	75%
Yes	11%		6%	18%		9%	16%	25%
Total Members	639,088		340,838	298,250		480,852	112,756	45,480

Observations:

- HDHP overall penetration rate is substantially higher in 2011 as compared to 2010.
- HDHP penetration rates increased in all market segments.

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. 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 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	101,095	$431	77,813	$453
	POS	65,875	$456	7,868	$450
	PPO	167,286	$342	46,006	$397
	EPO	2,027	$421	6,157	$332
	Indemnity**	7,737	$458	1,901	$1,458
Small Group	HMO	523	$478	69,750	$424
	POS	20	$489	3,053	$535
	PPO	515	$533	15,384	$433
	EPO	No Membership Reported		12,360	$390
	Indemnity**			458	$331
Non-Group	HMO	No Membership Reported		9,516	$191
	POS			No Membership Reported	
	PPO			35,026	$275
	EPO			23	$460
	Indemnity**			1,992	$216
Total		**345,076**	**$393**	**287,307**	**$406**

*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:

- Most people are covered by HMO plans in the group market while most people are covered by PPO plans in the non-group market.
- HMO average premiums in the group market ranged from $424 to $478, compared to only $191 in the non-group market.
- No POS membership was reported in the non-group 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 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 providing ten with 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 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	101,095	$431	0.79	77,813	$453	0.67
	Small Group	523	$478	0.86	69,750	$424	0.60
	Non-Group	No Membership Reported			9,516	$191	0.91
POS	Large Group	65,875	$456	0.74	7,868	$450	0.87
	Small Group	20	$489	1.03	3,053	$535	0.70
	Non-Group	No Membership Reported			No Membership Reported		
PPO	Large Group	167,286	$342	0.69	46,006	$397	0.61
	Small Group	515	$533	0.86	15,384	$433	0.54
	Non-Group	No Membership Reported			35,026	$275	0.21
EPO	Large Group	2,027	$421	0.74	6,157	$332	0.77
	Small Group	No Membership Reported			12,360	$390	0.76
	Non-Group				23	$460	0.77
Indemnity**	Large Group	7,737	$458	0.94	1,901	$1,458	0.78
	Small Group	No Membership Reported			458	$331	0.15
	Non-Group				1,992	$216	0.31
Total Members		345,076			287,307		

*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 5 percent less than the average premium for fully-insured, but the value of the self-insured benefits is about 18 percent greater than the value of the fully-insured benefits.
- The self-insured large group POS premiums are about 1 percent more than the fully-insured Large Group POS premiums, while the benefit richness for the self-insured members is 15 percent less than the benefit richness for the fully-insured members.
- For PPO Large Group, the self-insured premium is 14 percent lower than the fully-insured premium; however, self-insured benefits are 13 percent richer. The average premium for PPO Large Group fully-insured is 8 percent lower than the average PPO premium for the Small Group segment, however the richness of the benefit value for Large Group is 13% greater.
- Policies under the Indemnity plan type vary extensively with respect to benefit richness and premiums.

The table below provides comparative information for 2010 and 2011 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	2010	2011	2010	2011	2010	2011	Change in Value
HMO	Large Group	191,861	178,908	$468	$440	0.83	0.73	-6%
	Small Group	69,827	70,273	$410	$424	0.68	0.60	-16%
	Non-Group	9,355	9,516	$179	$191	0.94	0.91	-10%
POS	Large Group	72,385	73,743	$460	$455	0.83	0.76	-8%
	Small Group	5,751	3,072	$372	$535	0.79	0.71	-54%
	Non-Group	No Membership Reported						
PPO	Large Group	201,756	213,293	$420	$354	0.75	0.67	5%
	Small Group	18,955	15,898	$415	$436	0.59	0.55	-11%
	Non-Group	33,155	35,026	$269	$275	0.23	0.21	-8%
EPO	Large Group	8,632	8,184	$308	$354	0.63	0.76	6%
	Small Group	16,882	12,360	$371	$390	0.59	0.76	25%
	Non-Group	71	23	$468	$460	0.69	0.77	14%
Indemnity**	Large Group	6,217	9,638	$562	$655	0.92	0.86	-24%
	Small Group	1,341	458	$340	$331	0.16	0.15	-2%
	Non-Group	2,899	1,992	$201	$216	0.25	0.31	14%

*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 28 percent of the membership, and the value of the insurance for these members dropped by about 6 percent from 2010 to 2011 (the difference between 2009 and 2010 was a 20 percent drop[*]).
- Both Non-group and Small Group HMO experienced an increase in average premium levels between 2010 and 2011 while experiencing a decline in benefit richness between 2010 and 2011. The value of insurance for those in the HMO Small Group market declined by 16 percent, while the value of insurance for those in the Non-group market declined by 10 percent.
- The value for POS Small Group appears to have decreased by 54 percent, however, the membership declined by nearly half, which may have resulted in a change in risk in the underlying population that could be reflected in the premium levels.

[*]2010 Supplemental Report

- The majority of Non-Group members are enrolled in PPO products, and this segment saw a reduction in value equal to 8 percent. This is in addition to an 8 percent drop observed between 2009 and 2010*.
- 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: Large Group HMO and POS business and Small Group indemnity premiums decreased, but were outpaced by decreases in benefits, resulting in an apparent reduction in value.
- The value of insurance for the large group PPO segment (representing 32% of covered members) increased by 5 percent. The increased value in this segment was being driven by average premiums declining 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 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.

Observations:

- Within each product market category, fully insured group premiums adjusted for benefit differences are inversely related to group size. Small groups tend to 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 is driven by the Healthy Kids population, so Non-group premiums should not be compared to the group market categories.
- Large Group adjusted premiums are higher for fully-insured members as compared to self-insured members in the HMO, PPO and Indemnity products.

		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	29%	$431	$544	27%	$453	$676
	Small Group	0%	$478	$558	24%	$424	$710
	Non-Group	No Membership Reported			3%	$191	$210
POS	Large Group	19%	$456	$613	3%	$450	$516
	Small Group	0%	$489	$475	1%	$535	$760
	Non-Group	No Membership Reported			No Membership Reported		
PPO	Large Group	48%	$342	$498	16%	$397	$651
	Small Group	0%	$533	$618	5%	$433	$797
	Non-Group	No Membership Reported			12%	$275	$1,285
EPO	Large Group	1%	$421	$568	2%	$332	$428
	Small Group	No Membership Reported			4%	$390	$510
	Non-Group				0%	$460	$594
Indemnity**	Large Group	2%	$458	$490	1%	$1,458	$1,876
	Small Group	No Membership Reported			0%	$331	$2,138
	Non-Group				1%	$216	$698
Total Members		345,076			287,307		

*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.

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%	$425	0.73	$580
	Municipal	7%	$457	0.81	$561
	All Other Accounts	30%	$420	0.66	$633
POS	State	1%	$600	0.87	$691
	Municipal	4%	$489	0.75	$653
	All Other Accounts	7%	$418	0.74	$567
PPO	State	0%	$456	0.77	$595
	Municipal	0%	$494	0.53	$934
	All Other Accounts	40%	$349	0.54	$650
EPO	State	No Membership Reported			
	Municipal	0%	$440	0.85	$520
	All Other Accounts	3%	$375	0.76	$491
Indemnity**	State	No Membership Reported			
	Municipal	1%	$577	0.95	$610
	All Other Accounts	1%	$567	0.61	$934
Total Members		632,384			

*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:

- In 2010, benefit richness for State and Municipal HMO was reported as 0.76 and 0.82, respectively[***]. In 2011, the benefit richness for State and Municipal has remained as relatively stable (0.73 for State and 0.81 for Municipal) as the 2010 level, but for all other accounts the HMO benefit richness has dropped significantly (0.79 in 2010 and 0.66 in 2011).
- 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.

[***] 2010 Supplemental Report

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 2011 self-insured and fully-insured policies. A comparison of 2011 to 2010 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	**76%**	**0.89**	**100%**	**0.93**	**49%**	**0.80**
Employers with 51-99 Employees	6%	0.83	1%	0.86	12%	0.83
Employers with >=100 Employees	65%	0.89	90%	0.93	35%	0.79
Employers through Qualified Trust	5%	0.92	8%	0.93	2%	0.85
Total Small Group	**16%**	**0.83**	**0%**	**0.80**	**35%**	**0.83**
Employers with 1 Employee	1%	1.04	None Reported		2%	1.04
Employers with 2-9 Employees	6%	0.81	0%	0.93	14%	0.81
Employers with 10-25 Employees	6%	0.81	0%	0.90	12%	0.80
Employers with 26-50 Employees	4%	0.87	0%	0.77	8%	0.87
Total Individual	**7%**	**0.72**			**16%**	**0.72**
Individual Policy	7%	0.71	None Reported		16%	0.71
Individual as Group Conversion	0%	3.03			0%	3.03
Grand Total	**632,384**	**0.87**	**345,076**	**0.93**	**287,307**	**0.80**

Overall Comparison –2010 and 2011

The following table compares the membership distribution and loss ratios by market category for 2010 versus 2011.

	Percent of Members		Loss Ratio	
Market Category	**2010**	**2011**	**2010**	**2011**
Total Large Group	**75%**	**76%**	**0.87**	**0.89**
Employers with 51-99 Employees	5%	6%	0.89	0.83
Employers with >=100 Employees	65%	65%	0.88	0.89
Employers through Qualified Trust	5%	5%	0.79	0.92
Total Small Group	**18%**	**16%**	**0.88**	**0.83**
Employers with 1 Employee	1%	1%	0.97	1.04
Employers with 2-9 Employees	7%	6%	0.85	0.81
Employers with 10-25 Employees	6%	6%	0.87	0.81
Employers with 26-50 Employees	4%	4%	0.91	0.87
Total Individual	**7%**	**7%**	**0.67**	**0.72**
Individual Policy	7%	7%	0.66	0.71
Individual as Group Conversion	0%	0%	1.84	3.03
Grand Total	**639,088**	**632,384**	**0.87**	**0.87**

Observations:

- Overall, the loss ratio for the entire market held stable from 2010 through 2011 at the 87% level.
- The Large Group market's loss ratio increased by 2% between 2010 and 2011. Within the Large Group segment, employer groups 51 -99 employees experienced a decline in loss ratio which was offset by the increase in loss ratio in both the employer groups with 100+ employees and employers with coverage through a qualified trust.
- The Small Group experienced a 5% decline in the overall loss ratio between 2010 and 2011. Within the Small Group segment, the loss ratio for employers with one employee increased from 97% in 2010 to 104% in 2011. The loss ratio for all other group sizes within Small Group declined from 2010 to 2011.
- The Non-group loss ratio was 72% in 2011, which is up 5% from where it was in 2010.
- Group conversion policies show dramatically higher loss ratios for 2011 compared to 2010. 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 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	33%		**48%**	13%		**40%**	2%	21%
$1-250	2%		**4%**	0%		**3%**	0%	0%
$251-500	8%		**14%**	1%		**11%**	0%	0%
$501-750	7%		**10%**	4%		**8%**	3%	0%
$751-1,000	2%		3%	2%		**3%**	0%	0%
$1,001-1,500	12%		8%	**17%**		10%	18%	**21%**
$1,501-3,000	18%		8%	**31%**		13%	**39%**	26%
$3,001-5,000	12%		5%	**21%**		10%	**29%**	2%
$5,001-7,500	4%		1%	**8%**		2%	5%	**25%**
$7,501-10,000	1%		0%	1%		0%	2%	1%
$10,001+	0%		0%	1%		0%	0%	**4%**
Grand Total	**632,384**		**345,076**	**287,307**		**483,765**	**102,061**	**46,557**

	All Members		Large Group		Small Group		Non-group	
Deductible	**2010**	**2011**	**2010**	**2011**	**2010**	**2011**	**2010**	**2011**
$0	37%	33%	46%	40%	4%	2%	21%	21%
$1-250	2%	2%	3%	3%	0%	0%	0%	0%
$251-500	9%	8%	12%	11%	2%	0%	0%	0%
$501-750	9%	7%	10%	8%	10%	3%	1%	0%
$751-1,000	3%	2%	4%	3%	1%	0%	0%	0%
$1,001-1,500	11%	12%	8%	10%	22%	18%	23%	21%
$1,501-3,000	17%	18%	11%	13%	40%	39%	27%	26%
$3,001-5,000	7%	12%	6%	10%	14%	29%	2%	2%
$5,001-7,500	3%	4%	1%	2%	3%	5%	21%	25%
$7,501-10,000	1%	1%	1%	0%	3%	2%	1%	1%
$10,001+	0%	0%	0%	0%	0%	0%	4%	4%
Average Deductible	**$1,042**	**$1,249**	**$687**	**$886**	**$1,978**	**$2,337**	**$2,476**	**$2,636**
Annual Deductible Increase		**20%**		**29%**		**18%**		**6%**

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 2010 and 2011, average deductibles grew $207 or by 20% overall. Large groups experienced the largest percentage change in deductible, but small groups experienced the largest change in deductible amount.
- The most common deductible for large groups is $0 and the most common deductible for small groups and individuals is in the $1,501-$3,000 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	48%		**100%**	85%	30%
$1-250	4%		0%	0%	**5%**
$251-500	14%		0%	5%	**19%**
$501-750	10%		0%	6%	**13%**
$751-1,000	3%		0%	0%	**4%**
$1,001-1,500	8%		0%	1%	**11%**
$1,501-3,000	8%		0%	1%	**11%**
$3,001-5,000	5%		0%	1%	**5%**
$5,001-7,500	1%		0%	0%	1%
Grand Total	**345,076**		**31,984**	**75,665**	**232,101**

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 (i.e. lowest member coinsurance %) within network is reported.

Coinsurance	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
0%	63%		54%	**75%**		59%	**87%**	54%
5%	0%		1%	0%		0%	0%	0%
10%	10%		**14%**	4%		**12%**	2%	0%
15%	1%		**2%**	0%		1%	0%	0%
20%	21%		**23%**	18%		21%	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%		0%	0%	0%
50%	0%		0%	1%		0%	0%	**3%**
Total Members	**632,384**		**345,076**	**287,307**		**483,765**	**102,061**	**46,557**

	All Members		Large Group		Small Group		Non-group	
Coinsurance	**2010**	**2011**	**2010**	**2011**	**2010**	**2011**	**2010**	**2011**
0%	66%	63%	64%	59%	83%	87%	48%	54%
5%	0%	0%	0%	0%	0%	0%	0%	0%
10%	9%	10%	12%	12%	2%	2%	0%	0%
15%	0%	1%	1%	1%	0%	0%	0%	0%
20%	21%	21%	21%	21%	14%	12%	43%	35%
25%	0%	1%	0%	2%	0%	0%	0%	0%
30%	2%	3%	2%	3%	0%	0%	6%	7%
35%	0%	0%	0%	0%	0%	0%	0%	0%
40%	0%	0%	1%	0%	0%	0%	0%	0%
50%	0%	0%	0%	0%	0%	0%	3%	3%
Average Coinsurance	**6.2%**	**6.7%**	**6.3%**	**7.2%**	**3.1%**	**2.6%**	**11.9%**	**10.9%**
Annual Coinsurance Increase		**9%**		**13%**		**-19%**		**-9%**

Observations:

- Much of the Non-group market has higher coinsurance percentages than Large and Small Group, with 46 percent of individual members having to pay 20% or more co-insurance. The average coinsurance for the Non-group market is around 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.

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 2011 to 2010, 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	22%		**22%**	**22%**		21%	15%	**51%**
$5	6%		**11%**	0%		**8%**	0%	0%
$10	11%		**19%**	1%		**14%**	0%	0%
$15	5%		**7%**	3%		**6%**	3%	1%
$20	19%		13%	**26%**		17%	22%	**36%**
$25	16%		8%	**26%**		12%	**40%**	0%
$30	5%		**7%**	4%		**6%**	2%	4%
$35	2%		**4%**	1%		**3%**	0%	0%
$40	6%		5%	**8%**		6%	6%	**8%**
$45	1%		**2%**	0%		1%	0%	0%
$50	5%		2%	**9%**		5%	**11%**	0%
$55	0%		0%	0%		0%	0%	0%
$60	0%		1%	0%		1%	0%	0%
$65	0%		0%	0%		0%	0%	0%
$70	0%		1%	0%		1%	0%	0%
$75	0%		0%	0%		0%	0%	0%
$100	0%		0%	0%		0%	0%	0%
Total Members	**632,384**		**345,076**	**287,307**		**483,765**	**102,061**	**46,557**
Average Copay	**$ 18.60**		**$ 16.30**	**$ 21.37**		**$ 18.16**	**$ 23.74**	**$ 11.94**

	All Members	
Copay	**2010**	**2011**
$0	19%	22%
$5	7%	6%
$10	14%	11%
$15	8%	5%
$20	19%	19%
$25	11%	16%
$30	8%	5%
$35	2%	2%
$40	5%	6%
$45	1%	1%
$50	5%	5%
$55	0%	0%
$60	0%	0%
$65	0%	0%
$70	0%	0%
$75	0%	0%
$100	0%	0%
Total Members	**639,088**	**632,384**
Average Copay	**$ 17.97**	**$ 18.60**

Observations:

- Overall the average co-pay increased by 3% which appears be to driven by movement out of the $10 and $15 co-pay levels and into the $25 co-pay level. The self-insured market tends to have lower co-pays than the fully insured market.
- 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 than the employer market does.

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.

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	98%		99%	97%		99%	100%	85%
	No	2%		1%	3%		1%	0%	15%
Blood and Blood Products	Yes	76%		63%	91%		69%	99%	100%
	No	24%		37%	9%		31%	1%	0%
Case Management Programs	Yes	100%		100%	100%		100%	100%	100%
	No	0%		0%	0%		0%	0%	0%
Chiropractic Services	Yes	93%		99%	85%		98%	92%	36%
	No	7%		1%	15%		2%	8%	64%
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	81%		75%	88%		77%	99%	77%
	No	19%		25%	12%		23%	1%	23%
Habilitative Services	Yes	92%		94%	90%		96%	100%	37%
	No	8%		6%	10%		4%	0%	63%
Hearing Aids	Yes	64%		47%	84%		55%	90%	96%
	No	36%		53%	16%		45%	10%	4%
Home Health Care	Yes	100%		100%	99%		100%	100%	98%
	No	0%		0%	1%		0%	0%	2%
Hospice	Yes	75%		63%	90%		69%	99%	93%
	No	25%		37%	10%		31%	1%	7%
Hospitalization	Yes	99%		100%	99%		100%	100%	93%
	No	1%		0%	1%		0%	0%	7%
Infertility Services	Yes	42%		45%	38%		44%	50%	0%
	No	58%		55%	62%		56%	50%	100%
Medical Food	Yes	95%		93%	98%		95%	99%	90%
	No	5%		7%	2%		5%	1%	10%
Mental Health and Substance Abuse	Yes	74%		62%	89%		68%	99%	87%
	No	26%		38%	11%		32%	1%	13%
Nutritional Services	Yes	72%		58%	88%		65%	96%	85%
	No	28%		42%	12%		35%	4%	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%	89%
	No	1%		0%	2%		0%	0%	11%
Pregnancy and Maternity Services	Yes	99%		100%	97%		100%	100%	83%
	No	1%		0%	3%		0%	0%	17%
Preventive Services	Yes	79%		69%	92%		74%	99%	94%
	No	21%		31%	8%		26%	1%	6%
Prescription Drugs	Yes	86%		76%	99%		83%	99%	95%
	No	14%		24%	1%		17%	1%	5%
Skilled Nursing Facility	Yes	89%		84%	95%		86%	100%	97%
	No	11%		16%	5%		14%	0%	3%
Transplants	Yes	100%		100%	100%		100%	100%	100%
	No	0%		0%	0%		0%	0%	0%
Well Child and Immunization Services	Yes	91%		87%	96%		89%	99%	94%
	No	9%		13%	4%		11%	1%	6%

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.

The effects of two mandates effective January 1, 2011 can be seen when comparing values to 2010. In 2011, a greater percentage of group members have coverage for Habilitative Services and a greater percentage of Small Group and individual members have coverage for Hearing Aids.

There was a noticeable decrease in the percentage of members with coverage for infertility services. In 2010, 59% had coverage compared to 42% in 2011.

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.

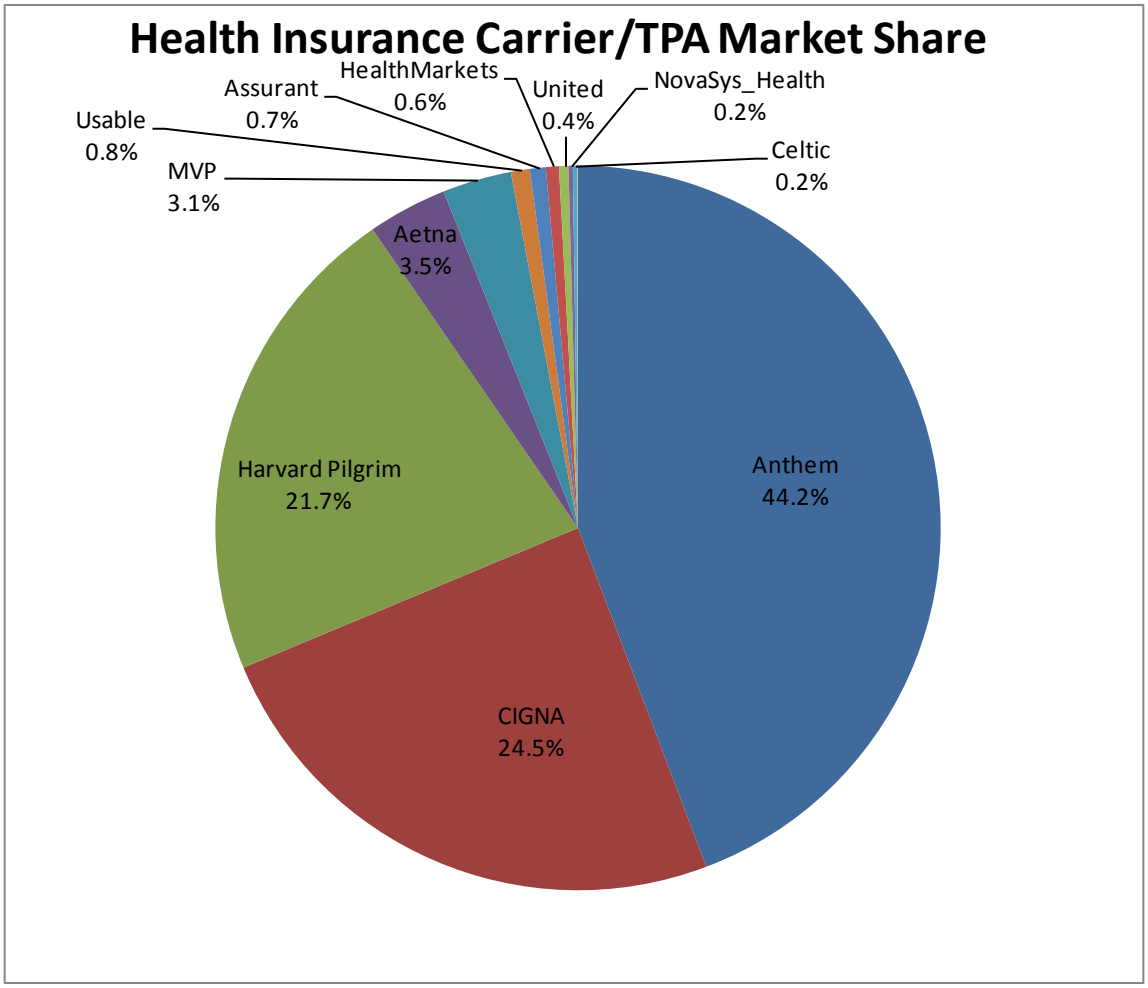
The following companies have been grouped into one "family" company name for the tables below:

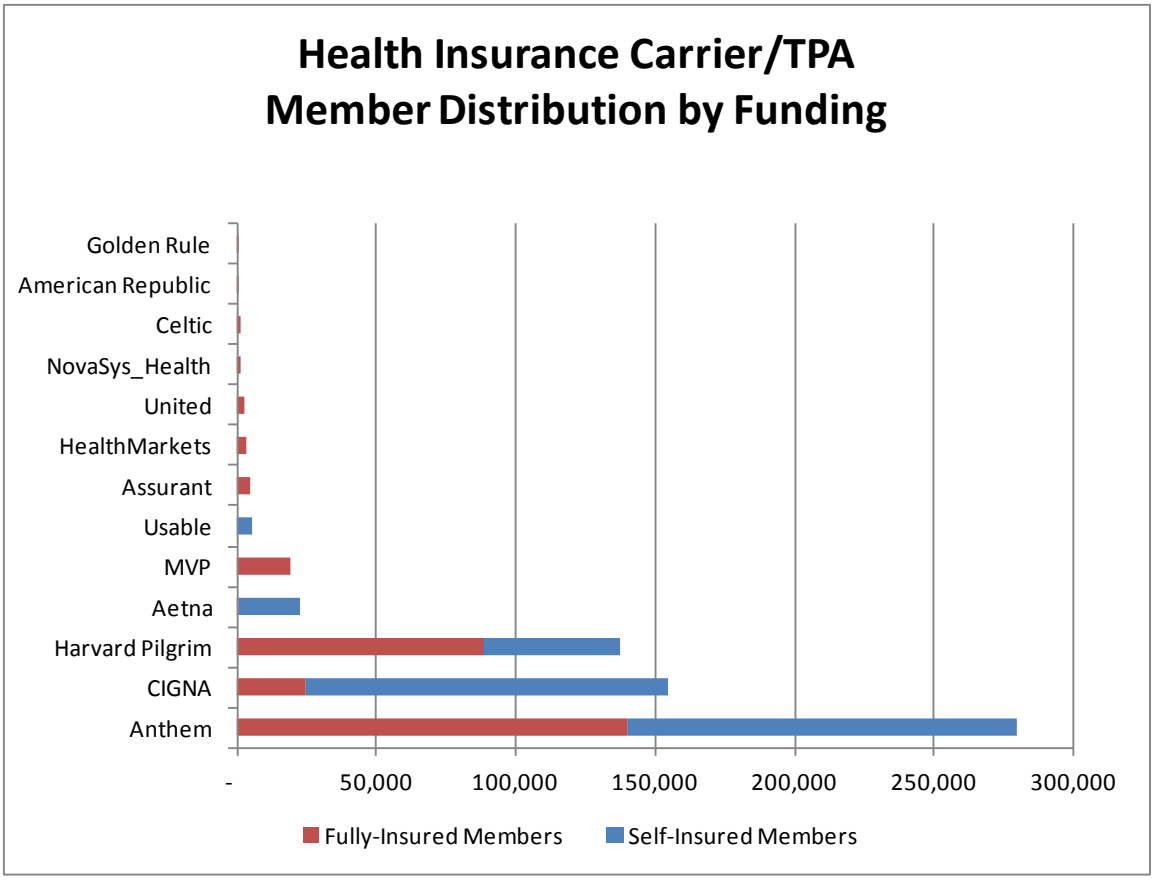
- Anthem includes: Anthem Health Plans of NH and Matthew Thornton
- Assurant includes: Time Life Insurance Company and John Alden Life Insurance Company
- CIGNA includes: CIGNA HealthCare of NH and Connecticut General Life Insurance Company

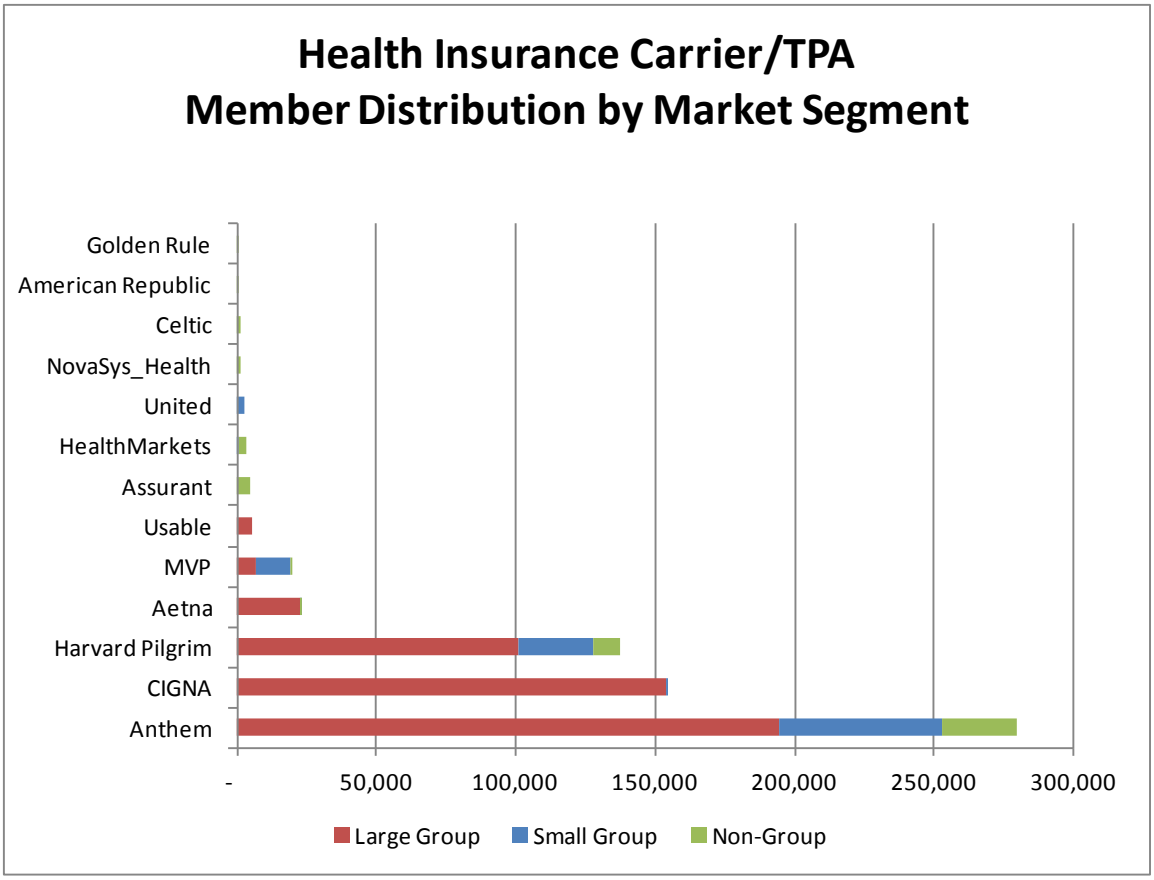
- Harvard Pilgrim includes: Harvard Pilgrim HealthCare NE, HPHC, Harvard Pilgrim Health Care, and Health Plans, Inc.
- HealthMarkets includes: The Chesapeake Life Insurance Company and The Mega Life and Health Insurance Company
- MVP includes: MVP Health Insurance Company of NH and MVP Health Plan of NH

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	139,634	140,142	279,776	44.2%
CIGNA	129,917	24,752	154,669	24.5%
Harvard Pilgrim	48,693	88,609	137,302	21.7%
Aetna	21,506	910	22,416	3.5%
MVP	-	19,443	19,443	3.1%
Usable	5,326	-	5,326	0.8%
Assurant	-	4,477	4,477	0.7%
HealthMarkets	-	3,672	3,672	0.6%
United	-	2,656	2,656	0.4%
NovaSys_Health	-	1,206	1,206	0.2%
Celtic	-	1,206	1,206	0.2%
American Republic	-	124	124	0.0%
Golden Rule	-	109	109	0.0%
Total	**345,076**	**287,307**	**632,384**	**100.0%**


Health Insurance Carrier/TPA Market Share
Assurant 0.7%
HealthMarkets 0.6%
United 0.4%
NovaSys_Health 0.2%
Usable 0.8%
Celtic 0.2%
MVP 3.1%
Aetna 3.5%
Harvard Pilgrim 21.7%
Anthem 44.2%
CIGNA 24.5%


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


Health Insurance Carrier/TPA
Member Distribution by Market Segment
Golden Rule
American Republic
Celtic
NovaSys_Health
United
HealthMarkets
Assurant
Usable
MVP
Aetna
Harvard Pilgrim
CIGNA
Anthem
-
50,000
100,000
150,000
200,000
250,000
300,000
Large Group
Small Group
Non-Group

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.

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 must file a null 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 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 this report, however, caution should be used when reviewing 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.

During the analysis phase of the carrier submissions, it was discovered that one large carrier did not initially develop the 2011 ASO/ASW premium equivalents in the manner described in the bulletin instructions. In working with this carrier, it was discovered that 2010 and prior premium equivalent levels were calculated in a similar manner as 2011. At the request of the NHID, the carrier resubmitted the 2011 premium equivalent data, however, 2010 premium equivalents remain as originally reported and are likely higher than they would have been if they were developed according to bulletin instructions. Caution should be used when comparing ASO/ASW premium levels in 2010 to 2011.

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.

Last year, during the quality assurance process, a large increase in membership was observed in the Non-group HMO segment when comparing 2009 and 2010. The explanation provided by the carrier is that Healthy Kids was classified as group in 2009 and was changed to Non-group in 2010. In 2011, Healthy Kids remains classified in the Non-group segment.

One major carrier changed how they report deductible and coinsurance levels in 2010. In 2009, they reported out-of-network deductible and coinsurance levels. In 2010, they reported in-network deductible and coinsurance levels. 2011 and 2010 deductible and co-insurance levels are reported on a consistent basis, however, caution should be exercised when comparing the 2009 to 2010 or 2011 distributions of members by deductible and coinsurance level.

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.

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	33%	**48%**	13%	**40%**	2%	21%
$50	0%	0%	0%	0%	0%	0%
$60	0%	0%	0%	0%	0%	0%
$75	1%	1%	0%	1%	0%	0%
$100	0%	0%	0%	0%	0%	0%
$125	0%	0%	0%	0%	0%	0%
$150	1%	1%	0%	1%	0%	0%
$175	0%	0%	0%	0%	0%	0%
$200	1%	1%	0%	1%	0%	0%
$250	0%	0%	0%	0%	0%	0%
$275	5%	**8%**	1%	**6%**	0%	0%
$300	0%	0%	0%	0%	0%	0%
$321	0%	0%	0%	0%	0%	0%
$325	1%	**2%**	0%	**2%**	0%	0%
$350	0%	0%	0%	0%	0%	0%
$400	0%	0%	0%	0%	0%	0%
$450	0%	0%	0%	0%	0%	0%
$500	0%	0%	0%	0%	0%	0%
$525	1%	**2%**	0%	1%	0%	0%
$550	0%	0%	0%	0%	0%	0%
$575	0%	0%	0%	0%	0%	0%
$600	1%	1%	0%	1%	0%	0%
$650	0%	0%	0%	0%	0%	0%
$666	0%	0%	0%	0%	0%	0%
$700	7%	**9%**	3%	**8%**	3%	0%
$750	0%	0%	0%	0%	0%	0%
$800	0%	0%	0%	0%	0%	0%
$825	0%	0%	0%	0%	0%	0%
$850	0%	0%	0%	0%	0%	0%
$900	0%	0%	0%	0%	0%	0%
$901	0%	0%	0%	0%	0%	0%
$1,000	0%	0%	0%	0%	0%	0%
$1,100	2%	**2%**	1%	**2%**	0%	0%
$1,150	0%	0%	0%	0%	0%	0%
$1,200	0%	0%	0%	0%	0%	0%
$1,250	0%	0%	0%	0%	0%	0%
$1,300	1%	0%	1%	1%	0%	0%
$1,350	9%	3%	**16%**	7%	**18%**	15%
$1,400	0%	0%	0%	0%	0%	0%
$1,500	0%	0%	0%	0%	0%	0%

Deductible	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$1,525	2%		**4%**	0%		**3%**	0%	0%
$1,600	1%		0%	1%		0%	0%	**5%**
$1,650	0%		0%	0%		0%	0%	0%
$1,700	0%		0%	0%		0%	0%	0%
$1,750	0%		0%	0%		0%	0%	0%
$1,800	5%		3%	**7%**		4%	**10%**	3%
$1,834	0%		0%	0%		0%	0%	0%
$1,875	0%		0%	0%		0%	0%	0%
$1,950	0%		0%	0%		0%	0%	0%
$2,000	0%		0%	0%		0%	0%	0%
$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%
$2,300	8%		2%	**15%**		6%	**20%**	6%
$2,400	0%		0%	0%		0%	0%	0%
$2,450	0%		0%	0%		0%	0%	0%
$2,500	0%		0%	0%		0%	0%	0%
$2,550	0%		0%	0%		0%	0%	0%
$2,600	0%		0%	0%		0%	0%	0%
$2,625	0%		0%	0%		0%	0%	0%
$2,700	0%		0%	0%		0%	0%	0%
$2,800	0%		0%	0%		0%	0%	0%
$2,850	5%		2%	**8%**		3%	9%	**16%**
$3,000	0%		0%	0%		0%	0%	0%
$3,050	0%		0%	0%		0%	0%	0%
$3,075	0%		0%	0%		0%	0%	0%
$3,200	0%		0%	0%		0%	0%	0%
$3,375	0%		0%	0%		0%	0%	0%
$3,400	0%		0%	0%		0%	0%	0%
$3,450	0%		0%	0%		0%	0%	0%
$3,500	10%		4%	**18%**		8%	**25%**	1%
$3,600	0%		0%	0%		0%	0%	0%
$3,750	0%		0%	0%		0%	0%	0%
$4,000	0%		0%	0%		0%	0%	0%
$4,200	0%		0%	0%		0%	0%	0%
$4,500	0%		0%	0%		0%	0%	0%
$4,800	0%		0%	0%		0%	0%	0%
$4,950	0%		0%	0%		0%	1%	0%

Deductible	All Members		Self-Insured	Fully-Insured		Large Group	Small Group	Non-Group
$5,000	0%		0%	0%		0%	0%	0%
$5,100	0%		0%	0%		0%	0%	0%
$5,150	1%		0%	**3%**		1%	**3%**	0%
$5,400	0%		0%	0%		0%	0%	0%
$5,450	0%		0%	0%		0%	0%	0%
$5,600	0%		0%	0%		0%	0%	0%
$5,650	0%		0%	0%		0%	0%	0%
$6,000	0%		0%	0%		0%	0%	0%
$6,150	4%		1%	**7%**		2%	5%	**24%**
$6,400	0%		0%	0%		0%	0%	0%
$7,500	0%		0%	0%		0%	0%	0%
$10,000	0%		0%	0%		0%	0%	0%
$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%
Total Members	**632,384**		**345,076**	**287,307**		**483,765**	**102,061**	**46,557**

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.