THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

21 South Fruit Street Suite 14
Concord, New Hampshire 03301

Roger A. Sevigny
Commissioner

Alexander K. Feldvebel
Deputy Commissioner

July 6, 2010

Director Jay Angoff
Office of Consumer Information and Insurance Oversight
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Premium Review Grant – Application Cover Letter

Dear Director Angoff:

This letter will serve as the New Hampshire Insurance Department's ("NHID") "Application Cover Letter" for the Premium Review Grant.

Eligibility Entity: State of New Hampshire Insurance Department

Title of Project: Premium Review Grant

Project Manager: Leslie Ludtke
21 South Fruit Street, Suite 14
Concord, NH 03301-0000
(603) 271-7973 ext. 246
Leslie.Kudkte@ins.nh.gov

Please be advised that the NHID has existing authority to oversee and coordinate the proposed activities and is capable of convening a suitable working group of all relevant members.

Yours truly,

Alexander Feldvebel

Alexander Feldvebel
Deputy Insurance Commissioner

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

Grant Opportunity: **HHS Health Insurance Rate Review Grants-Cycle I**

DUNS #:_____**8085910510000**_____ Grant Award: \$1 million_____

Applicant:_**State of New Hampshire Insurance Department**_____

Primary Contact Person, Name:_____**Alexander Feldvebel**_____

Telephone Number:_____**(603) 271-2261**_____Fax number:___**(603) 271-1406**_____

Email address:_____**Alexander.Feldvebel@ins.nh.gov**_____

APPLICATION COVER SHEET AND CHECK-OFF LIST

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below: Please ensure that the project narrative is page-numbered. The sequence is:

- x Cover Sheet
- x Forms/Mandatory Documents (Grants.gov).

  The following forms must be completed with an original signature and enclosed as part of the proposal:

- x SF-424: Application for Federal Assistance
- x SF-424A: Budget Information
- x SF-424B: Assurances-Non-Construction Programs
- x SF-LLL: Disclosure of Lobbying Activities
- x Additional Assurance Certifications
- x Required Letter of support and Memorandum of Agreement
- x Applicant's Application Cover Letter
- x Project Abstract
- x Project Narrative
- x Work plan and Time Line
- x Proposed Budget (Narrative/Justifications)
- x Required Appendices
- x Resume/Job Description for Project Director and Assistant Director

JOHN H. LYNCH
Governor

State of New Hampshire
OFFICE OF THE GOVERNOR
107 North Main Street, State House - Rm 208
Concord, New Hampshire 03301
Telephone (603) 271-2121
www.nh.gov/governor
governorlynch@nh.gov

July 1, 2010

Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Grants to States for Health Insurance Premium Review – Cycle 1

Dear Secretary Sebelius:

I am writing to express my support for the grant activities proposed in the New Hampshire Insurance Department's (NHID) application for funding under the "Grants to States for Health Insurance Premium Review – Cycle 1."

The NHID application proposes significant enhancements to the Department's process for reviewing premium rate filings made by health insurance companies. First, the NHID proposes to collect additional information from insurers regarding administrative costs and insurers' finances, which will allow the NHID to more effectively determine whether a health insurer's request for a rate increase is appropriate. Second, the NHID proposes to substantially improve the transparency of the rate review and approval process. These improvements would include the creation of a web portal which consumers could use to access rate filings and the production of plain language summaries and actuarial value assessments of rate submissions to allow consumers to evaluate the financial impact of a rate filing. And third, the NHID seeks funding to implement new federal requirements, including the obligation to report unreasonable rate increases to the United States Department of Health and Human Services.

The proposed enhancements to NHID's rate review process will benefit New Hampshire residents by increasing regulatory oversight of insurance rates and providing greater transparency in health insurance rates and premiums.

I respectfully request that NHID be awarded the funds to carry out these important activities.

Sincerely,

John H. Lynch
Governor

THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

21 South Fruit Street Suite 14
Concord, New Hampshire 03301

Roger A. Sevigny
Commissioner

Alexander K. Feldvebel
Deputy Commissioner

July 6, 2010

The Honorable Kathleen Sebelius
Secretary, Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Grants to States for Health Insurance Premium Review – Cycle 1

Dear Secretary Sebelius:

In conjunction with the application of the New Hampshire Insurance Department ("NHID") for funding under the "Grants to States for Health Insurance Premium Review – Cycle 1" announcement, I am writing to certify that the NHID will maintain its existing, current efforts with respect to the review of health insurance rates, and the Cycle 1 Grant funds will not be used to supplant existing expenditures by the State of New Hampshire.

Please be advised that the New Hampshire General Court has recently enacted SB 392, and this legislation directly relates to and complements the Cycle 1 activities. The responsibilities for amplified rate review and procedural formalities set out in this law have not yet been undertaken by the NHID, and the State of New Hampshire budget for the 2010-2012 biennium does not include any funds for this purpose. Accordingly, some portion of the Cycle 1 Grant funds may be used in efforts that relate to or conjoin the NHID's efforts to implement SB 392.

Yours truly,

Alexander Feldvebel

Alexander Feldvebel
Deputy Insurance Commissioner

Telephone 603-271-2261 • FAX 603-271-1406 • TDD Access Relay NH 1-800-735-2964
Website: www.nh.gov/insurance

BUDGET NARRATIVE

This Budget Narrative references and relies upon information set forth in much greater detail in several other documents included in the Grant Application, including, without limitation, the Budget information (including supporting documentation), Project Abstract, Project Narrative and WorkPlan and Timeline.

The NHID's total budget for the projects described below and in the Abstract, Narrative and WorkPlan will be approximately $945,100.

NHID will require additional staff and/or consultants and other resources to conduct the three (3) projects set out in the Grant Application: (i) Rate Review Enhancements; (ii) Transparency Improvements; and (iii) tasks associated with new federal requirements, including reporting.

With respect to these projects, it is anticipated that direct staffing costs will constitute approximately 21.2% of the total budget or $200,800. These direct staffing costs will result in the hire of a Project Manager who will have both direct substantive responsibilities for completion of the projects, as well as oversight responsibilities over consultants and contractors.

Outside consultants will also be required for the completion of the projects. The anticipated costs of outside consultants (e.g. actuaries, statisticians, economists, attorneys) will be approximately $350,000 or 37% of the total budget.

In addition, NHID will require additional Information Technology infrastructure and staff and/or consultants in order to complete the projects. These should be categorized as technical assistance activities. It is anticipated that technical assistance staffing and infrastructure costs will, in the aggregate, constitute approximately 31.7% of

the total budget or approximately ($300,000). These aggregate costs include NHID activities to support the proposed new web portal, as well as $50,000 to a data center for database improvements and $18,800 to the NAIC for enhancements to the NAIC's System for Electronic Rate and Form Filing ("SERFF").

The remaining budgeted costs ($94,300 or 10% of the budget) include a range of miscellaneous items such as equipment, software, service fees, travel, meeting expense, phone, supplies, postage, printing and duplicating, etc. that are expected to be associated with the three projects.

The NHID will directly administer all of these funds, including funds that are used to pay independent third party contractors, with the possible exception of the $18,800 that NHID intends to transfer to the NAIC for SERFF enhancements. However, even with respect to SERFF, NHID staff will continue to be directly and actively involved in the progress and oversight of this effort.

PROJECT MANAGER
Job Description

SCOPE OF WORK: To perform high level professional duties in implementing the federal Health Care Act in the state of New Hampshire, including health insurance rate review and reporting under the Act, compiling and reporting certain health insurance rate and insurance premium information under the Act, and other similar duties implementing the provisions of the Act in the state of New Hampshire. 100% of time devoted to overseeing implementation of the Act.

ACCOUNTABILITIES:

- Responsible for oversight, planning and development for the New Hampshire Insurance Department enhancements to its existing rate review system, including expanding the existing systems to consider factors such as the profitability of certain lines of business, the surplus levels of the carrier, the carrier's administrative cost structure and the allocation of administrative expenses across different lines of business and different states, the competition in the market or the line of business for which product approval is sought, the investment income earned by the carrier, the executive compensation paid by the carrier, and the carrier's cost containment and quality improvement initiatives.

- Expertise in statistical analysis and the ability to work with large commercial claim data sets, including the ability to design and develop data instruments and methodology to quantify and evaluate premium increases in the respective lines of business and markets.

- Prepare and publish reports identifying and quantifying premium increases by carrier and by line of business.

- Design and prepare an annual report that shall provide comparative information by carrier on administrative costs, requested rate increases, insurance premiums by product type and by line of business, executive compensation, and profitability, surplus, reserves, and investment earnings.

MINIMUM QUALIFICATIONS:

EDUCATION: Master's degree from a recognized college or university in health policy, statistics or a field related to the position's duties

EXPERIENCE: Five years of related professional experience, with responsibility for planning, monitoring and overseeing similar programs.

RECOMMENDED WORK TRAITS: Considerable knowledge of the principles of statistics and health care policy. Ability to research and understand technical literature relative to insurance premium rates and financial markets. Ability to communicate effectively in oral and written form. Ability to establish and maintain effective relationships with colleagues and the general public.

ADMINISTRATIVE ASSISTANT
Job Description

SCOPE OF WORK: To perform high level paraprofessional or professional duties by providing administrative support to the Project Manager in implementing the federal Affordable Care Act in the State of New Hampshire. 100% of time is devoted to assisting Project Manager in overseeing implementation of the Federal Affordable Care Act.

ACCOUNTABILITIES:

- Collects data and conducts research, as assigned, for the Project Manager to oversee the health insurance rate review and reporting process within the NH Insurance Department;

- Presents information to clarify Department policies and procedures and serves as an information contact for various groups and entities concerning health insurance rate review and reporting. Information relayed includes statements as to the jurisdiction of the department, press releases, administrative processes, heath insurance rates approved and denied, guidance as to applicable regulations and statutes and status of pending rate reviews;

- Performs traditional secretarial functions for the Project Manager, including answering telephone calls, typing, filing, taking dictation and transcribing shorthand, scheduling appointments, and completing travel arrangements;

- Maintains frequent communication with key personnel on issues of immediate concern to the Project Manager;

- Reviews and replies to correspondence directed to the Project Manager as appropriate; prepares draft responses when requested by the Project Manager;

- Assists with the layout and development of public information created for dissemination by the Project Manager or consultants, as assigned;

- Carries out mailings, including the distribution of press releases or other documents issued by the Project Manager;

- Maintains a document control and tracking system for rate reviews and Project Manager issued press releases, bulletins, and records of various related proceedings. Coordinates public access to files;

- Maintains a document control and tracking system for right-to-know requests; this includes forwarding requests to Project Manager for responses to data requested, compilation of data or documents approved by Project Manager for release pursuant so such requests; preparing responses to requesting parties;

- Catalogs and archives administrative material; when archiving, determines the length of time material is to be kept before it is destroyed;

- Monitors and responds to general inquiries/requests concerning the project, forwards specific inquiries/requests to the project manager as appropriate;

- Carries out special projects in a periodic basis, such as conducting surveys and preparing reports;

- Recommends policy or procedural changes or alternate work methods to improve project work flow;

MINIMUM QUALIFICATIONS:

EDUCATION: Bachelor's degree from a recognized college or university. Each additional year of approved formal education may be substituted for one year of required work experience.

EXPERIENCE: Two years of professional or paraprofessional experience in an executive office environment, or related business experience, with responsibility for planning, monitoring programs, or performing research. Each additional year of approved work experience may be substituted for one year of required formal education.

RECOMMENDED WORK TRAITS: Considerable knowledge of the principles of administrative work. Ability to write technical information. Ability to communicate effectively in oral and written form. Ability to establish and maintain effective relationships with colleagues and the general public. Must be willing to maintain appearance appropriate to assigned duties and responsibilities as determined by the Project Manager.

PART TIME BOOKKEEPER (20 HRS/WK)
Job Description

SCOPE OF WORK:
Develop and administer a combination of account monitoring and bookkeeping programs for federal grant administration, including financial management, budgetary monitoring, analysis and reporting, financial data entry and personnel data activities. 100% of this position's 20 hour work week is devoted to the implementation of the Federal Affordable Care Act

ACCOUNTABILITIES:

- Completes regular and ongoing systematic analysis of business processes to ensure compliance with State of New Hampshire and Federal requirements and applicable auditing standards with respect to federal grant administration.

- Implements and monitors Insurance Department and federal grant financial and administrative procedures, including monitoring and reporting on federal grant budgets and expenditures.

- Complies with federal and state requirements for internal controls to monitor cash receipts and expenditures for federal grant funds.

- Prepares various State of New Hampshire and Federal financial and business reports, related to federal grant funds.

- Ensures appropriate audit trails, and properly completes assigned State of New Hampshire and Federal financial tasks.

- Completes financial reporting and data entry into applicable systems for Federal grant fund receipts and expenditures.

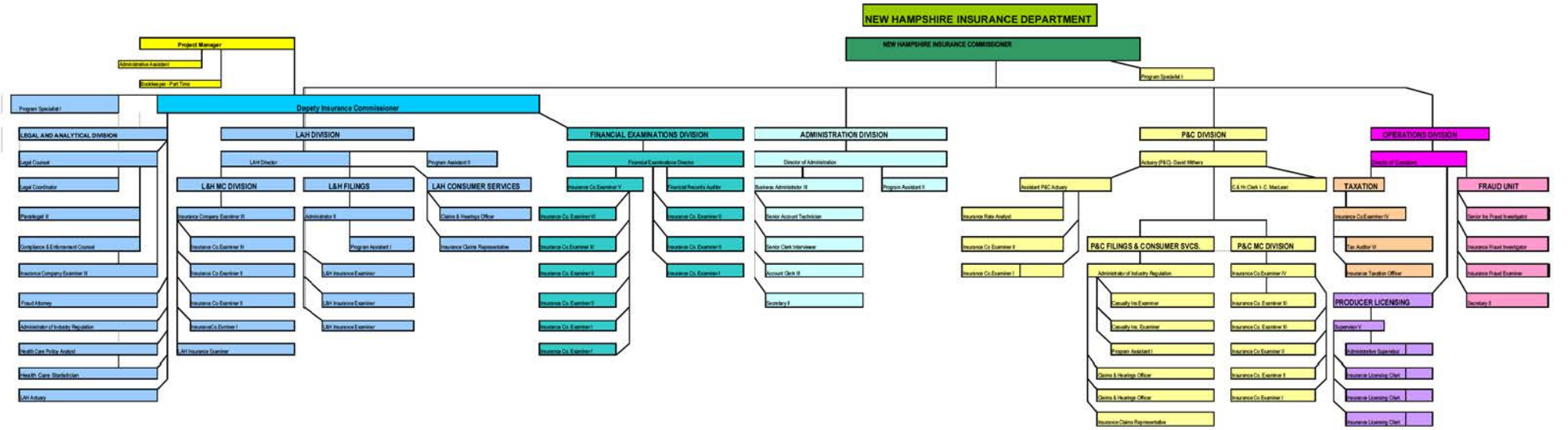
- Completes accounting tasks and financial reporting procedures in compliance with State of New Hampshire and federal grant requirements.

MINIMUM QUALIFICATIONS:

EDUCATION : Associate's degree from a recognized college or university with a major in accounting, bookkeeping, public administration, business administration or related field.

EXPERIENCE: Three years' experience in accounting, bookkeeping or business administration involving financial recordkeeping and reporting, preferably with federal grant bookkeeping and/or financial accounting experience.

RECOMMENDED WORK TRAITS: Experience with and training in Lawson and Excel software applications. Expertise in bookkeeping, accounting and financial reporting.


NEW HAMPSHIRE INSURANCE DEPARTMENT
NEW HAMPSHIRE INSURANCE COMMISSIONER
Program Specialist I
Project Manager
Administrative Assistant
Bookkeeper - Part Time
Program Specialist I
Deputy Insurance Commissioner
LEGAL AND ANALYTICAL DIVISION
Legal Counsel
Legal Coordinator
Paralegal II
Compliance & Enforcement Counsel
Insurance Company Examiner III
Fraud Attorney
Administrator of Industry Regulation
Health Care Policy Analyst
Health Care Statistician
LAH Actuary
LAH DIVISION
LAH Director
Program Assistant II
L&H MC DIVISION
Insurance Company Examiner III
Insurance Co Examiner III
Insurance Co Examiner II
Insurance Co Examiner II
InsuranceCo.Examiner I
LAH Insurance Examiner
L&H FILINGS
Administrator II
Program Assistant I
L&H Insurance Examiner
L&H Insurance Examiner
L&H Insurance Examiner
LAH CONSUMER SERVICES
Claims & Hearings Officer
Insurance Claims Representative
FINANCIAL EXAMINATIONS DIVISION
Financial Examinations Director
Insurance Co.Examiner V
Insurance Co. Examiner III
Insurance Co. Examiner III
Insurance Co. Examiner II
Insurance Co. Examiner II
Insurance Co. Examiner I
Financial Records Auditor
Insurance Co. Examiner II
Insurance Co. Examiner II
Insurance Co. Examiner I
ADMINISTRATION DIVISION
Director of Administration
Business Administrator III
Program Assistant II
Senior Account Technician
Senior Clerk Interviewer
Account Clerk III
Secretary II
P&C DIVISION
Actuary (P&C)- David Withers
Assistant P&C Actuary
C & Hr Clerk I- C. MacLean
Insurance Rate Analyst
Insurance Co. Examiner II
Insurance Co.Examiner I
P&C FILINGS & CONSUMER SVCS.
P&C MC DIVISION
Administrator of Industry Regulation
Casualty Ins.Examiner
Casualty Ins. Examiner
Program Assistant I
Claims & Hearings Officer
Claims & Hearings Officer
Insurance Claims Representative
Insurance Co.Examiner IV
Insurance Co. Examiner III
Insurance Co. Examiner III
Insurance Co Examiner II
Insurance Co. Examiner II
Insurance Co Examiner I
OPERATIONS DIVISION
Director of Operations
TAXATION
Insurance Co.Examiner IV
Tax Auditor VI
Insurance Taxation Officer
PRODUCER LICENSING
Supervisor V
Administrative Supervisor
Insurance Licensing Clerk
Insurance Licensing Clerk
Insurance Licensing Clerk
FRAUD UNIT
Senior Ins Fraud Investigator
Insurance Fraud Investigator
Insurance Fraud Examiner
Secretary II

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	1234-ATTACHMENT-1_COVER_LETTE	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	1235-ATTACHMENT-2_COVER_SHEET	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	1236-ATTACHMENT-3_GOVERNOR'S	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	1237-ATTACHMENT-4_CERTIFICATI	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** 1238-BUDGET NARRATIVE_NHID_Grant 93511.pdf

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

State of New Hampshire Insurance Department

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Project Manager

Prefix:

* First Name: Leslie

Middle Name:

* Last Name: Ludtke

Suffix:

Title: Health Care Policy Analyst

Organizational Affiliation:

State of NH Insurance Department

* Street1: 21 South Fruit Street

Street2: Suite 14

* City: Concord

County:

* State: NH: New Hampshire

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 03301-0000

* Telephone Number: (603)271-7973 ext 246

Fax: (603)271-1406

* Email: Leslie.Ludtke@ins.nh.gov

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

State of New Hampshire Insurance Department

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 2 Project Role:** Actuarial - Rate Review

Prefix:

* First Name: David

Middle Name:

* Last Name: Sky

Suffix:

Title: Life & Health Actuary

Organizational Affiliation:

State of NH Insurance Department

* Street1: 21 South Fruit Street

Street2: Suite 14

* City: Concord

County:

* State: NH: New Hampshire

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 03301-0000

* Telephone Number: (603)271-7973 ext. 239

Fax: (603)271-1406

* Email: David.Sky@ins.nh.gov

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

State of New Hampshire Insurance Department

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 3 Project Role:** AOR

Prefix:

* First Name: Alexander

Middle Name:

* Last Name: Feldvebel

Suffix:

Title: Deputy Commissioner

Organizational Affiliation:

State of NH Insurance Department

* Street1: 21 South Fruit Street

Street2: Suite 14

* City: Concord

County:

* State: NH: New Hampshire

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 03301-0000

* Telephone Number: (603)271-2261

Fax: (603)271-1406

* Email: Alexander.Feldvebel@ins.nh.gov

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

State of New Hampshire Insurance Department

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 4 Project Role:** Fiscal Contact

Prefix:

* First Name: Kathleen

Middle Name:

* Last Name: Belanger

Suffix:

Title: Director of Administration

Organizational Affiliation:

State of NH Insurance Department

* Street1: 21 South Fruit Street

Street2: Suite 14

* City: Concord

County:

* State: NH: New Hampshire

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 03301-0000

* Telephone Number: (603)271-7973 ext. 216

Fax: (603)271-1406

* Email: Kathleen.Belanger@ins.nh.gov

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Premium Review Grant

* Year:

1

* Funding Agency Goal:

Enhance quality & depth of NHID review of health ins. rate increases; Improve consumer understanding of health ins. rates & rate changes; Full NH compliance w/federal requirements

* Objective:

Enhancements to rate review process through increased reporting requirements and consideration of additional information.

* Results or Benefits Expected:

NHID believes these enhancements will permit it to more easily determine whether a rate is appropriate and will assist NHID in assessing whether the rate meets applicable minimum loss ratio requirements.

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Notify carriers of new reporting requirements; establish process for collection and review of additional information; conduct review of additional information as part of rate review process.	Project Manager will be primarily resp. LAH actuary will have substantial role	09/01/2010	09/30/2011	280
Establish web portal to allow consumers to review rate filings.	Overseen by Project Manager. Consultants will be used as well	09/01/2010	09/30/2011	150
Production of plain language summaries of rate filings; production of actuarial value assessments of health insurance products.	PM will oversee & have substantive role. Some work may be done by consultants	09/01/2010	09/30/2011	250
Review of current system to determine capabilities and upgrade as necessary; collection of data and reporting to Secretary as required by law.	PM will oversee & have substantive role.Some work will be done by consultants.	09/01/2010	09/30/2011	325

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

* Criteria for Evaluating Results or Benefits Expected:

NHID receipt of additional expenses, capital costs, nets margins, etc. info from health carriers and the usage of this info in the rate review process including public hearings. Implementation of a web portal providing consumers with greater access to rate information. Meet federal reporting requirements and implement federal standards for medical loss ratio.

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

You may attach up to 17 additional Objective Work Plan forms here. To extract, fill and attach each additional form, follow these steps:

- Select the "Select to Extract the Objective Work Plan Attachment" button below.

- Save the file using a descriptive name to help you remember the content of the supplemental form that you are creating. When assigning a name to the file, please remember to give it the extension ".xfd" (for example, "Objective_1.xfd"). If you do not name your file with the ".xfd" extension you will be unable to open it later, using the PureEdge viewer software.

- Use the "Open Form" tool on the PureEdge viewer to open the new form you just saved.

- Enter your additional Objective information in this supplemental form, similar to the Objective Work Plan form that you see in the main body of your application.

- When you have completed entering information in the supplemental form, save and close it.

- Return to this page and attach the saved supplemental form you just filled in, to one of the blocks provided on this "attachments" form.

Important: Attach additional Objective Work Plan forms, using the blocks below. Please remember that the files you attach must be Objective Work Plan Pure Edge forms that were previously extracted using the process outlined above. Attaching any other type of file may result in the inability to submit your application to Grants.gov. Note: It is important to attach completed forms only. Attach ONLY PureEdge (.xfd) forms where ALL required fields are filled out. Incomplete or missing data will cause your application to be rejected.

1) Please attach Attachment 1
2) Please attach Attachment 2
3) Please attach Attachment 3
4) Please attach Attachment 4
5) Please attach Attachment 5
6) Please attach Attachment 6
7) Please attach Attachment 7
8) Please attach Attachment 8
9) Please attach Attachment 9
10) Please attach Attachment 10
11) Please attach Attachment 11
12) Please attach Attachment 12
13) Please attach Attachment 13
14) Please attach Attachment 14
15) Please attach Attachment 15
16) Please attach Attachment 16
17) Please attach Attachment 17

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: State of New Hampshire Insurance Department

DUNS Number: 8085910510000

* Street1: 21 South Fruit Street

Street2: Suite 14

* City: Concord County:

* State: NH: New Hampshire

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 03301-0000 * Project/ Performance Site Congressional District: NH-002

Project/Performance Site Location 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

OMB Number: 4040-0003
Expiration Date: 09/30/2011

Project Abstract

The Project Abstract must not exceed one page and must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

* Please click the add attachment button to complete this entry.

Add Attachment | Delete Attachment | View Attachment

1243-PROJECT ABSTRACT_NHID_ Grant 935

Close Form

Project Narrative File(s)

* Mandatory Project Narrative File Filename: 1244-PROJECT NARRATIVE_NHID_Grant 93511.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

* 1. Type of Submission:	* 2. Type of Application:	* If Revision, select appropriate letter(s):
☐ Preapplication	☒ New	
☒ Application	☐ Continuation	* Other (Specify):
☐ Changed/Corrected Application	☐ Revision	

* 3. Date Received:	4. Applicant Identifier:
07/06/2010	

5a. Federal Entity Identifier:	5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:	7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name:	State of New Hampshire Insurance Department
* b. Employer/Taxpayer Identification Number (EIN/TIN):	02-6000618
* c. Organizational DUNS:	8085910510000

d. Address:

* Street1:	21 South Fruit Street
Street2:	Suite 14
* City:	Concord
County/Parish:	
* State:	NH: New Hampshire
Province:	
* Country:	USA: UNITED STATES
* Zip / Postal Code:	03301-0000

e. Organizational Unit:

Department Name:	Division Name:
NH Insurance Department	

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:		* First Name:	Alexander
Middle Name:	K.		
* Last Name:	Feldvebel		
Suffix:			

Title:	Deputy Commissioner
Organizational Affiliation:	
* Telephone Number:	(603)271-2261
Fax Number:	(603)271-1406
* Email:	Alexander.Feldvebel@ins.nh.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

"Grants to States for Health Insurance Premium Review-Cycle I" Office of Consumer Information and Insurance Oversight (OCIIO)

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Premium Review Grant

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: NH-002 | b. Program/Project: NH-All

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 09/01/2010 | * b. End Date: 09/30/2011

18. Estimated Funding ($):

* a. Federal	945,100.00
* b. Applicant	0.00
* c. State	0.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	945,100.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:	
* First Name:	Alexander
Middle Name:	K.
* Last Name:	Feldvebel
Suffix:	
* Title:	Deputy Commissioner
* Telephone Number:	(603)271-2261
Fax Number:	(603)271-1406
* Email:	Alexander.Feldvebel@ins.nh.gov
* Signature of Authorized Representative:	Alexander Feldvebel
* Date Signed:	07/06/2010

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Rate Review Enhancements	93.511	$ 175,700.00	$ 0.00	$	$	$ 175,700.00
2. Transparency Improvements	93.511	418,700.00	0.00			418,700.00
3. New Federal Requirements	93.511	350,700.00	0.00			350,700.00
4.						
5. Totals		$ 945,100.00	$	$	$	$ 945,100.00

Standard Form 424A (Rev. 7- 97)
Prescribed by OMB (Circular A -102) Page 1

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) Rate Review Enhancements	(2) Transparency Improvements	(3) New Federal Requirements	(4)	(5)
a. Personnel	$ 45,073.00	$ 45,073.00	$ 45,073.00	$	$ 135,219.00
b. Fringe Benefits	21,860.00	21,860.00	21,861.00		65,581.00
c. Travel	2,000.00	2,000.00	2,000.00		6,000.00
d. Equipment	9,700.00	9,700.00	9,700.00		29,100.00
e. Supplies	2,033.00	2,034.00	2,033.00		6,100.00
f. Contractual	77,867.00	320,866.00	252,867.00		651,600.00
g. Construction	0.00	0.00	0.00		
h. Other	17,167.00	17,167.00	17,166.00		51,500.00
i. Total Direct Charges (sum of 6a-6h)	175,700.00	418,700.00	350,700.00		$ 945,100.00
j. Indirect Charges	0.00	0.00	0.00		$
k. TOTALS (sum of 6i and 6j)	$ 175,700.00	$ 418,700.00	$ 350,700.00	$	$ 945,100.00
7. Program Income	$ 0.00	$ 0.00	$ 0.00	$	$

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Prescribed by OMB (Circular A -102) Page 1A

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8.	$	$	$	$
9.				
10.				
11.				
12. TOTAL (sum of lines 8-11)	$	$	$	$

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 945,100.00	$ 308,250.00	$ 364,150.00	$ 136,350.00	$ 136,350.00
14. Non-Federal	$	0.00			
15. TOTAL (sum of lines 13 and 14)	$ 945,100.00	$ 308,250.00	$ 364,150.00	$ 136,350.00	$ 136,350.00

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Transparency Improvements	$	$	$	$
17. New Federal Requirements				
18.				
19.				
20. TOTAL (sum of lines 16 - 19)	$	$	$	$

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

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OMB Approval No.: 4040-0007
Expiration Date: 07/30/2010

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Alexander Feldvebel	Deputy Commissioner
* APPLICANT ORGANIZATION	* DATE SUBMITTED
State of New Hampshire Insurance Department	07/06/2010

Standard Form 424B (Rev. 7-97) Back

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
0348-0046

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

* Name: State of New Hampshire Insurance Department

* Street 1: 21 South Fruit Street Street 2: Suite 14

* City: Concord State: NH: New Hampshire Zip: 03301-0000

Congressional District, if known: NH-002

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

Department of Health and Services

7. * Federal Program Name/Description:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

CFDA Number, *if applicable:* 93.511

8. Federal Action Number, *if known:*

RFA-FD-10-999

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix * First Name: N/A Middle Name

* Last Name: N/A Suffix

* Street 1 Street 2

* City State Zip

b. Individual Performing Services (including address if different from No. 10a)

Prefix * First Name: N/A Middle Name

* Last Name: N/A Suffix

* Street 1 Street 2

* City State Zip

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Alexander Feldvebel

***Name:** Prefix * First Name: Alexander Middle Name

* Last Name: Feldvebel Suffix

Title: Deputy Commissioner **Telephone No.:** (603)271-2261 **Date:** 07/06/2010

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Standard Form - LLL (Rev. 7-97)

Manifest for Grant Application # GRANT10648097

Grant Application XML file (total 1):

1. GrantApplication.xml. (size 37813 bytes)

Forms Included in Zip File(total 11):

1. Form SF424_2_1-V2.1.pdf (size 39075 bytes)
2. Form Attachments-V1.1.pdf (size 30160 bytes)
3. Form SF424B-V1.1.pdf (size 34691 bytes)
4. Form SF424A-V1.0.pdf (size 36228 bytes)
5. Form SFLLL-V1.1.pdf (size 31157 bytes)
6. Form Key_Contacts-V1.0.pdf (size 34683 bytes)
7. Form ObjectiveWorkPlan-V1.1.pdf (size 6786 bytes)
8. Form Budget-V1.1.pdf (size 25964 bytes)
9. Form Project_Abstract-V1.1.pdf (size 25606 bytes)
10. Form PerformanceSite_1_4-V1.4.pdf (size 27460 bytes)
11. Form Project-V1.1.pdf (size 25434 bytes)

Attachments Included in Zip File (total 16):

1. ProjectNarrativeAttachments ProjectNarrativeAttachments-Attachments-1245-PROJ NARRATIVE-1_CHAPTER 420-G_CHAPTER 4100.pdf application/pdf (size 230218 bytes)
2. Project_Abstract Project_Abstract-ProjectAbstractAddAttachment-1243-PROJECT ABSTRACT_NHID_ Grant 93511.pdf application/pdf (size 8675 bytes)
3. Attachments Attachments-ATT1-1234-ATTACHMENT-1_COVER LETTER.pdf application/pdf (size 33703 bytes)
4. ProjectNarrativeAttachments ProjectNarrativeAttachments-Attachments-1244-PROJECT NARRATIVE_NHID_Grant 93511.pdf application/pdf (size 40946 bytes)
5. BudgetNarrativeAttachments BudgetNarrativeAttachments-Attachments-1238-BUDGET NARRATIVE_NHID_Grant 93511.pdf application/pdf (size 9725 bytes)
6. ProjectNarrativeAttachments ProjectNarrativeAttachments-Attachments-1247-PROJ NARRATIVE-3_SGQ32010Combined.pdf application/pdf (size 340776 bytes)

7. BudgetNarrativeAttachments BudgetNarrativeAttachments-Attachments-1241-BUD NARRATIVE-3_BOOKKEEPER Job Description.pdf application/pdf (size 14719 bytes)

8. ProjectNarrativeAttachments ProjectNarrativeAttachments-Attachments-1248-PROJ NARRATIVE-4_NAIC_SERFF_Proposal.pdf application/pdf (size 55912 bytes)

9. ProjectNarrativeAttachments ProjectNarrativeAttachments-Attachments-1249-PROJ NARRATIVE-5_Data_Center_Fee_Schedule.pdf application/pdf (size 95273 bytes)

10. Attachments Attachments-ATT4-1237-ATTACHMENT-4_CERTIFICATION LETTER.pdf application/pdf (size 43215 bytes)

11. BudgetNarrativeAttachments BudgetNarrativeAttachments-Attachments-1239-BUD NARRATIVE-1_PROJ MANAGER Job Description.pdf application/pdf (size 15086 bytes)

12. ProjectNarrativeAttachments ProjectNarrativeAttachments-Attachments-1246-PROJ NARRATIVE-2_IndivQ12010Combined.pdf application/pdf (size 22684 bytes)

13. BudgetNarrativeAttachments BudgetNarrativeAttachments-Attachments-1242-BUD NARRATIVE-4_NHID ORG CHART.pdf application/pdf (size 19547 bytes)

14. BudgetNarrativeAttachments BudgetNarrativeAttachments-Attachments-1240-BUD NARRATIVE-2_ADM ASSISTANT Job Description.pdf application/pdf (size 16570 bytes)

15. Attachments Attachments-ATT3-1236-ATTACHMENT-3_GOVERNOR'S LETTER.pdf application/pdf (size 64500 bytes)

16. Attachments Attachments-ATT2-1235-ATTACHMENT-2_COVER SHEET and CHECK LIST.pdf application/pdf (size 38457 bytes)

PROJECT ABSTRACT

A. Goals of Project

The New Hampshire Insurance Department (the "NHID") is applying for funding under the Health Insurance Premium Review-Cycle 1 grant (the "Grant") for the purpose of improving its health insurance rate review process by gathering and considering additional information, and enhancing consumer protection by making the rate review process more transparent. Additionally, NHID is seeking funding to allow it to comply with new federal reporting and oversight requirements.

B. Total Budget

It is expected that the total budget for the project will be approximately $945,100. Detail on this figure is presented in the budget, including in the supporting budget documents, and in the budget narrative.

C. Use of Grant to Enhance Current Rate Review System

Under New Hampshire law, the NHID has the authority to review and approve all health insurance rate filings. NHID has the authority to disapprove rate filings in all markets.

NHID believes that two major improvements can be made to its current rate review system. First, NHID proposes to collect additional information from carriers regarding increases and decreases in administrative costs, and to more fully consider the overall finances of each carrier, to enable NHID to more effectively determine whether a rate is appropriate. Second, NHID proposes to increase the transparency of the rate review process by (1) creating a new web portal where consumers will be able to access rate filings, (2) producing plain language summaries for all rate filings and (3) producing actuarial value assessments of different plans to allow consumers to easily compare the value of different plans. In addition, NHID will comply with the new federal reporting requirements regarding excessive rates.

PROJECT NARRATIVE

Per the project narrative instructions, this narrative consists of four parts as follows: (a) current health insurance rate review capacity and process; (b) proposed rate review enhancements; (c) reporting to the Secretary on rate increase patterns; and (d) optional data center funding.

A. Current Health Insurance Rate Review Capacity and Process

1. General Health Insurance Rate Regulation Information

(a) Scope of Regulation by Product/Market

The New Hampshire Insurance Department (the "NHID") licenses and/or regulates the full range of commercial health insurance products in New Hampshire, including traditional accident and health insurance, all managed care products and multiple-employer welfare arrangements. For rating purposes, health insurance products are divided into three market segments: (i) individual; (ii) small employer/group (1-50 employees); and (iii) large employer/group (more than 50 employees). (*See* New Hampshire Revised Statutes Annotated ("NHRSA") 420-G and Chapter 4100 of the New Hampshire Insurance Regulations ("Chapter 4100"), which provide an overview of the rate review requirements in New Hampshire and are attached hereto as pdf file PROJ NARRATIVE-1_CHAPTER 420-G and CHAPTER 4100.pdf.)

(b) Rating Rules in Each Market Segment

i. Individual and Small Group Markets

Policies issued in the individual and small group markets in New Hampshire are subject to modified community rating standards. Carriers must establish a base plan rate for each coverage written by the carrier in the individual or small group market and rates, as adjusted in accordance with the provisions below, must be guaranteed for at least 12

months.[1] In establishing premiums for individual market policies a carrier may consider the following rating factors: (1) age; (2) health status; and (3) tobacco use.[2] The maximum premium differential based on age is a ratio of 4 to 1 (except for rates for an attained age of less than 19).[3] The maximum premium differential based on health status or tobacco use is a ratio of 1.5 to 1. Changes in health status after issue may not be considered in the rate.[4] There is no guaranteed issue requirement for the individual market, and carriers may reject applicants due to health status.

In establishing premiums for small group market policies a carrier may consider the following rating factors: (1) age; (2) group size; and (3) industry classification.[5] A carrier may not consider health status, claims experience, duration of coverage, geographic location or any other characteristic of the group.[6] Small groups are not permitted to obtain their own claims experience. Adjustments for age may be made using only the following age brackets: 0-18, 19-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64 and 65+.[7] The maximum premium differential based on all case characteristics is a ratio of 3.5 to 1 (except for rates for an attained age of less than 19).[8] Carriers are also permitted to make premium adjustments based upon family composition.[9] The small group market is subject to a guaranteed issue requirement.[10] Self-employed individuals (so-called "groups of one") are considered small groups; however, the guaranteed issue rights of groups of one are limited to the months of March and September to limit adverse selection.

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[1] NHRSA 420-G:4, I(a), (c).
[2] NHRSA 420-G:4, I(d).
[3] *Id.*
[4] *Id.*
[5] NHRSA 420-G:4, I(e).
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] NHRSA 420-G:6.

The Commissioner of Insurance may not approve any rate filing submitted by a carrier for an individual or small group market product if the rate is excessive, inadequate or contrary to law.[11] This is the general rating principle that underlies all rate reviews and determinations.

ii. Large Group Market

Policies issued in the large group market in New Hampshire are not subject to community rating standards and may be experience rated (i.e., rated in part on the basis of the actual prior claims of the particular large group being rated). However, a large group carrier may not require any person, as a condition of receiving or continuing coverage, to "pay a premium or contribution that is greater than that of similarly situated persons based on any health status related factor of that person or that person's dependents."[12]

iii. Self-Insured/Stop Loss Market

The NHID does not review the rates or other provisions of self-insured plans. However, the NHID reviews and approves stop loss insurance rates.

2. Rate Review and Filing Requirements

Attached hereto as pdf files PROJ NARATIVE-2_IndivQ12010Combined.pdf and PROJ NARRATIVE-3_SGQ3Combined.pdf is an example of a representative rate filing of Anthem Blue Cross Blue Shield of New Hampshire, Inc. Although there is no standardized format for rate filings, Chapter 4100 sets out a number of required data elements. In addition, rate filings have some uniformity due to standardized or representative actuarial and/or business practices. These rate filings are not particularly useful to consumers.

[11] NHRSA 420-G:4, I(h).
[12] NHRSA 420-G:4, II.

Rate filings are submitted via the National Association of Insurance Commissioners' ("NAIC") System for Electronic Rate and Form Filing ("SERFF"). An administrative assistant makes an assessment to determine whether the filing complies with the NHID's technical requirements. A staff actuary then reviews the documentation. The staff actuary acts largely autonomously. The NHID has the authority to review all health insurance rates in the large group, small group and individual markets, and all such rate filings are reviewed prior to being used by carriers in New Hampshire.

The NHRSA authorize the NHID to review and approve both large group rates[13] and small group and individual rates.[14] The NHID may disapprove a large group rate if "benefits provided therein are unreasonable in relation to the premium charged."[15] The NHID may disapprove small group or individual rates if they are excessive, inadequate or contrary to law.[16] The NHID, through the recent promulgation of Chapter 4100, has established loss ratio standards to determine whether rates are excessive. If the anticipated loss ratio is at least as great as the loss ratio standard, rates are generally deemed not to be excessive, regardless of the allocated administrative overhead costs or the profit that may be generated. Rates are inadequate if the total loss ratio, claims plus expenses, divided by premium, exceeds 1.0. The unfairly discriminatory standard addresses rate differentials between similarly situated individuals or groups, giving application to allowable rating variations.

In 2010, the NHID adopted, through Chapter 4100, comprehensive enhancements to the rate review process, including the use of factors and methodology. As noted

[13] NHRSA 415:1.
[14] *Id.*; NHRSA 420-G:13.
[15] NHRSA 415:2, I(a).
[16] NHRSA 420-G:13.

above, we have attached a copy of Chapter 4100 for your consideration. The NHID has not increased its staffing to implement Chapter 4100.

Health insurance rates must be filed with and approved by the NHID prior to implementation.[17] In addition, the NHID has the authority to subsequently disapprove rates that were previously approved.[18] Generally, the factors that trigger retrospective review of rates are: (i) the benefits provided are not reasonable in relation to the premium charged; (ii) the rates are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation; or (iii) the rate does not comply with law. Given the NHID's limited resources, such retrospective review has not been considered in the past.

3. Current Level of Resources and Capacity: Information Technology and Systems Capacity

SERFF supports the administrative flow but does not support cross-referencing between successive filings, financial statements or with other market participants. NHID's life, accident and health (LAH) actuary uses MS Excel to track high-level information on all rate filings. This process involves manual entry of data from electronically submitted filings.

4. Current Level of Resources and Capacity: Budget and Staffing

(a) Annual Budget and Revenue for NHID

The NHID's annual budget as authorized by the New Hampshire legislature for Fiscal Year 2011 is $9.98 million, with offsetting revenue collected via an annual assessment on insurance companies regulated in the same amount. Thus, the NHID is not dependent for its funding on general revenues of the State of New Hampshire. An itemization of the NHID's budget follows:

[17] NHRSA 415:1; NHRSA 420-G:13.
[18] NHRSA 415:3.

Personnel Services	$5,230,026
Current Expenses (phone, supplies, postage)	$210,553
Equipment Rents and Leases	$22,767
Equipment Maintenance	$6,478
Organizational Dues	$20,407
Information Technology	$338,125
General Services (rent)	$272,495
Equipment (excluding IT)	$75,401
Indirect costs (other state services)	$323,158
Consultants	$340,225
Transfers to Other Agencies	$1,626
Temporary Personnel Svcs.	$16,052
Books, Subscriptions, Periodicals	$13,249
Benefits	$2,351,148
Retiree pension & benefits	$216,837
Employee Training	$55,405
Promotional/Marketing	$69,435
In State Travel	$21,530
Out of State Travel	$100,000
Contracts for Program Services	$190,000
Hearing Expense	$57,271
Transcription Services	$3,700
Workers Compensation	$40,000
Unemployment	$5,000
TOTAL	$9,980,888
REVENUE from Annual Assessment	$9,980,888

(b) Resources Allocated to Health Insurance Rate Review

The NHID's annual budget currently includes resources allocated to rate review for health insurance premium filings. Within this category are the salary and benefits of a full-time LAH actuary and administrative assistant to the LAH actuary. Costs for the salary of the LAH actuary and administrative assistant attributable to the percentage of time each devotes to the review and approval of health insurance premium filings are set forth below, and are calculated at 40% and 20%, respectively. The LAH actuary currently also reviews rate filings for other types of insurance, including life insurance, annuities and similar products. The remaining 60% of the LAH actuary's time is

currently devoted to review of these other insurance products. We estimate that a minimum of 60% of the LAH actuary's time would become devoted to rate review of health insurance products were it not for the addition of a project manager, with a concomitant increase in the current administrative assistant's salary attributable to health insurance premium review support to the LAH actuary. Some of the tasks necessary to complete rate reviews would be reassigned to the project manager and administrative assistant contemplated by the grant application. However, even with the addition of a project manager, it is likely that certain new tasks will require the time and attention of the LAH actuary.

FY 2011 Resources Currently Allocated to Rate Review for Health Insurance
(Direct Costs)

Actuary Salary (40%)	$39,476
Actuary Benefits (48.5% of salary)	$19,147
Support Staff Salary (20%)	$6,329
Support Staff Benefits (48.5% of salary)	$3,069
TOTAL DIRECT COSTS	$68,021
% OF TOTAL NHID BUDGET	.68%

(c) Qualifications of Actuary

The LAH actuary for NHID graduated from Bucknell University, Magna Cum Laude, with a BS in Math. He has an MA in Math with a Statistics minor from Penn State University. He is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. He has been a practicing actuary for more than 25 years.

(d) Annual Rate Filings for 2009

Rate Filings for 2009:

	Total	Small Group	Individual
Approved	163	89	39
Approved w/ Change	2	0	2
Approved w/ Correspondence	37	0	5
Approved As IS	124	89	32
Disapproved	27	13	5
TOTAL	190	102	44

That average rate increase filed for 2009 was +16.6%, and the median increase was +14.6%. The average rate increase approved was +11.4%, and the median increase approved was +12.7%.

5. Consumer Protections

(a) Availability of Rate Information

In general, all records of the NHID are available for public inspection pursuant to New Hampshire's "Right to Know Law," including health insurance rate filings.[19] If a member of the public wishes to review a rate filing, the individual must make an appointment with the designated individual at the NHID to come to the offices of NHID and review the filings on a computer set aside for that purpose. Members of the public may print rate filings at NHID or copy them on to a CD-ROM. This policy was established by the NHID through an Administrative Notice.[20] New Hampshire law also provides generally that carriers in the small group and individual markets must disclose in solicitation and sales materials the methodology by which premium rates are established.[21] The NHID does not currently provide analysis or descriptions of such filings or offer plain language summaries of rate changes to consumers, but these sorts of

[19] NHRSA 400-A:25; NHRSA Chapter 91-A.
[20] NHID Administrative Notice dated January 25, 2008.
[21] NHRSA 420-G:11, I(a).

plain language summaries are part of NHID's proposal for improving its rate review process.

(b) Advance Notice of Rate Changes

Rate modifications may not be made in the individual market unless the individual has been provided with at least 30 days notice of the proposed rate change.[22] Large and small groups must be provided with renewal premium quotes at least 60 days prior to the expiration of the current policy.[23]

(c) Public Hearings and Comment on Rates

Until recently, there was no process of any kind in New Hampshire for public hearings or comment on rate filings. A law enacted by the New Hampshire Legislature in its 2010 session requires the Commissioner of NHID to hold an annual public hearing to discuss health insurance premium rates and factors that have contributed to rate increases during the prior year.[24] The law permits the Commissioner to require carriers to produce information to NHID in preparation for the hearing and to compel attendance and testimony at the hearing by carriers.[25] The law also requires the Commissioner to prepare an annual report regarding health insurance premium rates and factors that have contributed to increases in rates.[26] However, no funds were included in the State's budget for the 2010-2012 biennium to provide staffing for these public reviews and hearings.

(d) Consumer Inquiries and Complaints

The NHID received 143 telephonic inquiries from consumers with respect to health insurance premium rate increases during the period from June 1, 2008 thru June

[22] NHRSA 415:24, II(f).
[23] NHRSA 420-G:12, IV.
[24] New Hampshire Senate Bill 392, which awaits signature by the Governor.
[25] *Id.*
[26] *Id.*

30, 2010. During this same period, the NHID received 137 formal complaints from consumers with respect to a variety of health insurance products and matters. These complaints did not all necessarily relate to major medical health insurance coverage or to rate increases.

6. Examination and Oversight

The NHID cited John Alden Life Insurance Company and Time Insurance Company for alleged violations of New Hampshire law with respect to: (i) issuing or renewing riders on health insurance policies that had been prohibited; (ii) failing to file special exception riders and associated premium rates for prior approval by the NHID; (iii) issuing condition specific deductibles without prior approval of the NHID; and (iv) utilizing extended rate guarantee options without prior approval of the NHID. As a result, these companies entered into a voluntary Consent Order under which they agreed: (i) to pay a total of $900,000 to the NHID to reimburse the NHID for expenses incurred in the investigation and to settle the claimed violations; and (ii) to make restitution to the affected insureds on all individual policies with special exception riders by re-adjudicating affected claims. The total number of policies affected was over 600.

7. Accomplishments and Challenges

(a) Accomplishments

As described above, the New Hampshire and the NHID have established a number of procedural and substantive safeguards for consumers with respect to health insurance rate increases.

(b) Challenges

Although NHID has relatively expansive rate review authority and currently conducts thorough reviews of rate filings, there are challenges with respect to the rate

review process, both immediate and anticipated. First, NHID lacks the resources and staff to collect and review all of the information necessary to make determinations as to the appropriateness of every rate filing and/or applied rate. Second, there is a current lack of transparency in terms of the general public's understanding of rates, the rate approval process and the process by which rates are translated into premiums charged to individuals or groups. Finally, new requirements of federal law, such as the new minimum loss ratio standards, will require additional review of rates and coordination with State requirements. The proposed means for addressing these challenges are discussed in Section B below.

B. Proposed Rate Review Enhancements for Health Insurance

NHID proposes to enhance its rate review process in two principal respects. First, the NHID proposes to improve rate-filing requirements by collecting additional information and data on filed rates, including the possibility of supplemental rate filings. This may also involve more comprehensive comparison with prior rate filings, review of already approved rates, and more aggressive review of how approved rates are used to generate actual premium charges to individuals and groups. NHID also anticipates additional review related to the new federal minimum loss ratio standards, including efforts to align definitions of appropriate medical loss costs, etc. The collection of additional information and further review will require additional actuarial staff and additional Information Technology staff and resources. Second, the NHID proposes to improve transparency for consumers by making rate information more publicly available (e.g., through a website) and more easily understood. This will require additional Information Technology resources, new infrastructure and additional resources to provide analysis of rates to produce summary information in plain English.

1. Improvements in Rate Filing Requirements

NHID believes that it can improve the effectiveness of its health insurance rate review process if it seeks additional information from carriers and uses that information to conduct a more comprehensive review. Specifically, NHID proposes to require carriers to separately report and justify increases and decreases in administrative expenses (such as salaries, marketing, office expenses, etc.) Review of this additional information will permit the NHID to more easily determine whether a rate is appropriate, and will assist NHID in assessing whether the rate meets applicable minimum loss ratio requirements. In addition, the NHID proposes to more fully consider a carrier's overall finances, including profits, investment income and surplus, when reviewing proposed rates. NHID would request additional information from carriers as necessary to consider the carrier's overall finances. NHID believes that existing legal authority would permit NHID to collect the additional information from carriers and consider the additional factors, as proposed.

As discussed more fully in paragraph 3 below, NHID believes that these enhancements would require additional staff and/or consultants. However, NHID believes that it could begin implementing these enhancements in a relatively short timeframe and could fully implement them once the additional staffing needs are met.

2. Enhancing Consumer Protection Standards

NHID would like to enhance consumer protections by increasing the transparency of the rate process. Currently, consumers can only review rate filings by making an appointment to come to the NHID offices and accessing the SERFF system through an

NHID computer terminal. NHID proposes to create, or to coordinate with the NAIC through SERFF to establish, a new web portal through which consumers could access rate information via any computer with an Internet connection. The proposal from the NAIC regarding SERFF is set forth attached hereto as pdf file PROJ NARRATIVE-4_NAIC_SERFF_Proposal.pdf. In addition to making rates more accessible through a web portal, NHID also proposes to make the information more meaningful to consumers by including plain language summaries of rate filings that explain changes in rates, key drivers and anticipated impacts on premiums that consumers will be paying.

Second, NHID proposes to include information about the actuarial value of coverages, so that consumers can make informed judgments about the true value of a particular plan, independent of the nominal cost of the plan. This is important because even though a particular plan may be more expensive, it may provide greater actuarial value, dollar-for-dollar, than a less expensive plan.

Third, the NHID expects to contract with the University of New Hampshire (UNH) to enhance and/or construct a further database for a fixed fee of $50,000. This work would include enhancements to the existing NHID health cost websites that provide healthcare cost information to consumers. Additional information is attached hereto as pdf file PROJ NARRATIVE-5_Data_Center_Fee_Schedule.pdf.

It is anticipated that, upon receiving funding under this grant, NHID or the NAIC through SERFF could likely have the web portal up and running within 12 to 18 months and definitely within the period defined by Cycle 1 and ending September 30, 2011. As discussed more fully in paragraph 3 below, NHID believes that preparation of the plain language summaries and actuarial values would require additional staff and/or consultants. NHID would begin preparing this information immediately upon adding the

additional staffing capacity, and would begin posting the information on the web portal once it is up and running. Prior to the availability of the web portal, NHID would make any available summaries and actuarial information available to the public through alternative sources. Finally, UNH staff have agreed that they could commence work immediately on the enhancements to the NHID health cost databases.

3. Additional Staffing/IT Capacity

In connection with its proposed improvements to its rate filing requirements and consumer protections, NHID believes that it would need to hire additional staff and/or retain outside consultants. Specifically, NHID would anticipate hiring additional actuarial staff or hiring outside actuarial, accounting, legal or healthcare consultants, both for the purpose of conducting the enhanced rate review and preparing the plain language rate summaries and actuarial value comparisons. (The increased staffing needs and the budget for the additional staff are more fully discussed in the Budget and Budget Narrative, including the supporting documentation for the Budget.)

NHID believes it would need additional Information Technology resources as well, both in the form of new infrastructure and new staff and/or consultant services. NHID would need to hire new staff and/or retain a consultant to develop and maintain the proposed web portal and would need to purchase any additional hardware and software necessary to support the web portal.

C. <u>Reporting to Secretary on Rate Increase Patterns</u>

The NHID attests that it will comply with the reporting requirements outlined in Section 2794 of the Public Health Service Act, as amended by the Patient Protection and Affordable Care Act of 2010, and any implementing regulations promulgated by the Secretary.

NHID will review its current rate review process to determine whether it is able to report all information required to be reported under Section 2794 and, if not, NHID will implement additional reporting requirements for carriers. NHID will collect all required information through the SERFF reporting system. Rate information will be analyzed to isolate the required data elements and translate them into an appropriate format. This information will then be reported electronically to the Secretary for each New Hampshire rate filing.

The required reporting will require additional Information Technology resources to produce and report the data to the Secretary. It is anticipated that the total cost for the required IT improvements will be approximately $18,800. (The increased IT resources and the budget for these resources are more fully discussed in the Budget and the Budget Narrative.)

TITLE XXXVII
INSURANCE

CHAPTER 420-G
PORTABILITY, AVAILABILITY, AND RENEWABILITY OF HEALTH COVERAGE

Section 420-G:1

420-G:1 Purpose. – The purpose of this chapter is to:

I. Facilitate the portability, availability, and renewability of health coverage for all New Hampshire residents and persons principally employed in New Hampshire who wish to obtain health coverage or maintain it as individuals or as employees of large and small employers.

II. To promote competition among health carriers on the basis of efficient claims handling, ability to manage health care services, consumer satisfaction, and low administrative costs.

III. To regulate underwriting and rating practices in the small employer and individual markets so as to promote access to affordable coverage for higher risk groups or individuals.

Source. 1997, 344:1. 1998, 340:7. 2001, 295:1, eff. July 1, 2002.

Section 420-G:2

420-G:2 Definitions. – In this chapter:

I. ""Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer health carrier is in compliance with the provisions of and the rules adopted by the commissioner, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer health carrier in establishing premium rates for applicable health benefit plans.

I-a. ""Case characteristics" means demographic or other relevant characteristics of a small employer group that may be considered by the health carrier in the determination of premium rates for that group.

II. ""Commissioner" means the commissioner of insurance.

II-a. ""Composite billing" means a method of calculating premium rates for small employer groups in which each enrolled employee's rate varies only by the enrolled employee's family composition.

III. ""Creditable coverage" means any public or private health insurance or health benefit plan, whether insured or self-insured, unless that coverage consists solely of benefits excluded from the definitions of ""health coverage" in paragraph IX or ""individual health coverage" in paragraph XI. Notwithstanding the exclusion in

paragraph IX, short-term, nonrenewable individual policies for medical, hospital, or major medical coverage issued pursuant to RSA 415:5, III or other law shall be considered ""creditable coverage."

III-a. ""Date of enrollment" means the first day of coverage under the plan, or, if there is a waiting period, the first day of the waiting period, which is typically the first day of work.

IV. ""Department" means the department of insurance.

V. ""Eligible dependents" means those persons who may be included under a covered person's health coverage by the terms of the policy or plan and in accordance with this chapter.

VI. ""Eligible employee" means an employee who meets the requirements for eligibility set forth by the employer, the health coverage plan and state law.

VII. ""Exclusion period" means the length of time that must expire before a health carrier will cover medical treatment expense relating to a preexisting condition.

VII-a. ""Family composition" means health plan membership type, including: enrollee only; enrollee and spouse; enrollee and children; enrollee, spouse, and children; and other similar membership types.

VIII. ""Health carrier" means any entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to provide, deliver, arrange for, pay for or reimburse any of the costs of health services; including an insurance company, a health maintenance organization, a nonprofit health services corporation, or any other entity providing health coverage.

IX. ""Health coverage" means any hospital or medical expense incurred policy or certificate, nonprofit health services corporation subscriber contract, or health maintenance organization subscriber contract and any other health insurance plan or health benefit plan. For the purposes of this chapter, health coverage does not include:

(a) Accident-only or disability income insurance.

(b) Coverage issued as a supplement to liability insurance.

(c) Liability insurance, including general liability insurance and automobile liability insurance.

(d) Workers' compensation or similar insurance.

(e) Automobile medical-payment insurance.

(f) Credit only insurance.

(g) Coverage for on-site medical clinics.

(h) Short-term, individual, nonrenewable medical, hospital, or major medical policies.

(i) Other similar insurance coverage, specified in rules, under which benefits for medical care are secondary or incidental to other insurance benefits.

(j) If offered separately:

(1) Limited scope dental or vision benefits.

(2) Long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(3) Prescription drug benefits.

(4) Other similar, limited benefits as are specified in rules.

(k) If offered as independent, noncoordinated benefits:

(1) Specified disease or illness benefits.

(2) Hospital or surgical indemnity benefits.

(l) If offered as a separate insurance policy, Medicare supplemental health insurance, coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code, and similar supplemental coverage as specified in regulations.

IX-a. ""Health coverage plan rate" means a rate that is uniquely determined for each of the coverages or health benefit plans a health carrier writes and that is derived from the market rate through the application of plan factors that reflect actuarially demonstrated differences in expected utilization and health care costs attributable to differences in the coverage design and/or the provider contracts that support the coverage and by including provisions for administrative costs and loads. The health coverage plan rate is periodically adjusted to reflect expected changes in the market rate, utilization, health care costs, administrative costs, and loads.

X. ""Individual" means a person who is not eligible for health coverage through employment and that person's dependents.

XI. ""Individual health coverage" means health coverage issued by a health carrier directly to an individual and not on a group or group remittance basis. For the purposes of this chapter, franchise insurance, as defined in RSA 415:19, shall be considered individual health coverage.

XII. (a) ""Large employer" means an employer that employed on average at least 51 persons, on business days, during the previous calendar year.

(b) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

XII-a. ""List billing" means a method of calculating premium rates for small employer groups in which each enrolled employee's rate varies only by the enrolled employee's attained age and the enrolled employee's family composition.

XII-aa. ""Loss information" means the aggregate claims experience and shall include, but not be limited to, the number of covered lives, the amount of premium received, the amount of total claims paid, and the claims loss ratio. ""Loss information" shall not include any information or data pertaining to the medical diagnosis, treatment, or health status that identifies an individual covered under the group contract or policy. Catastrophic claim information shall be provided as long as the provision of this information would not compromise any covered individual's privacy.

XII-b. ""Loss ratio" means the ratio between the amount of premium received and the amount of claims paid by the health carrier under the group insurance contract or policy.

XII-c. ""Market rate" means a single rate reflecting the carrier's average cost of actual or anticipated claims for all health coverages or health benefit plans the carrier writes and maintains in a market, including the nongroup individual health insurance market and, separately, the small employer group health insurance market, and which is periodically adjusted by the carrier to reflect changes in actual or anticipated claims.

XIII. ""Medical underwriting" means the use of health status related information to establish or modify health coverage premium rates.

XIII-a. ""Modified experience rating" means a rating methodology to apply only to individual policies sold in the nongroup market, which modifies community rating to allow for limited consideration of health status, as detailed in RSA 420-G:4, I(a).

XIV. ""Preexisting condition" means a condition, whether physical or mental, for which medical advice, diagnosis, care or treatment was recommended or received during the 3 months immediately preceding the enrollment date of health coverage.

XIV-a. ""Purchasing alliance" means a non-risk bearing corporation or other entity licensed pursuant to RSA 420-G:10-a that provides, on a voluntary basis, health insurance coverage through a single participating carrier or multiple unaffiliated participating carriers to member small employers and their employees within a defined service area authorized by the commissioner.

XIV-b. ""Premium rate" means the rates used by a carrier to calculate the premium. For group coverage, premium rates shall be expressed as a rate per enrolled employee.

XV. ""Qualified association trust or other entity" means an association established trust or other entity in existence on January 1, 1995, and providing health coverage within the state of New Hampshire to at least 1,000 employees and/or the dependents of association members, which association:

(a) Was established and maintained for a primary purpose other than the provision of health coverage;

(b) Was in existence for at least 10 years prior to January 1, 1995; and

(c) Conducts regular meetings within the state of New Hampshire designed to further the interests of its members, and all members shall be given notice of such meetings at least 30 days prior to the date of any meeting.

XV-a. ""Rating period" means the time period for which the premium rate charged by a health carrier to an individual or a small employer for a health benefit plan is in effect.

XVI. (a) ""Small employer" means a business or organization which employed on average, one and up to 50 employees, including owners and self-employed persons, on business days during the previous calendar year. A small employer is subject to this chapter whether or not it becomes part of an association, multi-employer plan, trust, or any other entity cited in RSA 420-G:3 provided it meets this definition.

(b) In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

XVII. ""Waiting period" means a period of time, determined by the employer, which must expire before an employee is eligible for health coverage as a condition of employment.

Source. 1997, 344:1. 1998, 340:8; 375:1. 2000, 2:1. 2001, 120:1. 2003, 188:1-4. 2005, 225:1-8, eff. Jan. 1, 2006; 248:14, eff. Sept. 12, 2005. 2007, 289:21, 22, eff. Jan. 1, 2008.

Section 420-G:3

420-G:3 Applicability and Scope of Chapter. –

I. This chapter shall apply to any entity licensed, controlled or regulated by RSA 415, RSA 415-E, RSA 420-A, RSA 420-B, or RSA 420-C which offers or provides health coverage for delivery in this state. This chapter shall also apply to any multi-employer plan, trust, association, claims administrator, claims paying agent or any other entity whether fully insured, partially insured, or self-funded which offers or provides health

coverage for delivery in this state.

(a) This chapter shall not apply to pooled risk management programs which meet the standards established by RSA 5-B.

(b) This chapter shall not apply to short-term student insurance where the policyholder is the school, except student insurance shall be given credit and shall count as credit for previous health coverage as defined in RSA 420-G:7, III.

(c) Notwithstanding any other provision of this chapter, any multiple employer welfare arrangement which meets the requirements of RSA 415-E:2, III shall be exempt from the provisions of this chapter until January 1, 1998.

II. A qualified association trust or other entity, as defined by RSA 420-G:2, XV, shall comply with the requirements stated in RSA 420-G:10.

III. Notwithstanding any law to the contrary, the provisions of this chapter shall prevail with respect to the subject matter within this chapter.

Source. 1997, 344:1; 344:11. 2002, 207:10, eff. May 16, 2002.

Section 420-G:4

420-G:4 Premium Rates. –

I. Health carriers providing health coverage to individuals and small employers under this chapter shall be subject to the following:

(a) All premium rates charged shall be guaranteed for a rating period of at least 12 months, and shall not be changed for any reason, including but not limited to a change in the group's case characteristics.

(b) Market rate shall be established by each health carrier for all of its health coverages offered to individuals and, separately, for all of its health coverages offered to small employers.

(c) Health carriers shall calculate health coverage plan rates for each of the coverages or health benefit plans written by that carrier. Variations in health coverage plan rates shall be solely attributable to variations in expected utilization or cost due to differences in coverage design and/or the provider contracts or other provider costs associated with specific coverages and shall not reflect differences due to the nature of the groups or eligible persons assumed to select particular health coverages.

(d) In establishing the premium charged, health carriers providing coverage to individuals shall calculate a rate that is derived from the health coverage plan rate through the application of rating factors that the carrier chooses to utilize for age, health status, and tobacco use. Such factors may be utilized only in accordance with the following limitations:

(1) The maximum premium differential for age as determined by ratio shall be 4 to 1. The limitation shall not apply for determining rates for an attained age of less than 19.

(2) The maximum differential due to health status shall be 1.5 to 1 and the maximum differential rate due to tobacco use shall be 1.5 to 1. Rate limitations based on health status do not apply to rate variations based on an insured's status as a tobacco user.

(3) Permissible rating characteristics shall not include changes in health status after issue.

(e) In establishing the premium charged, health carriers offering coverage to small

employers shall calculate premium rates that are derived from the health coverage plan rate by making adjustments to reflect one or more case characteristics. Such adjustments from the health coverage plan rate may be made only in accordance with the following limitations:

(1) In establishing the premium rates, health carriers offering coverage to small employers may use only age, group size, and industry classification as case characteristics. No consideration shall be given to health status, claim experience, duration of coverage, geographic location, or any other characteristic of the group.

(2) Carriers making adjustments from the health coverage plan rate for age may do so only by using the following age brackets:

0 - 18
19 - 24
25 - 29
30 - 34
35 - 39
40 - 44
45 - 49
50 - 54
55 - 59
60 - 64
65 +

(3) The maximum premium rate differential after adjusting for all case characteristics as determined by ratio shall be 3.5 to 1. This limitation shall not apply for determining premium rates for covered persons whose attained age is less than 19.

(4) In establishing the premium rates, health carriers offering coverage to small employers may make further adjustments based on family composition.

(5) The small employer health carrier shall set premium rates for small employers after consideration of case characteristics of the small employer group as well as family composition. No small employer health carrier shall inquire regarding health status or claims experience of the small employer or its employees or dependents until after the premium rates have been agreed upon by the carrier and the employer.

(6) Carriers may calculate premium rates using either list billing or composite billing. Carriers shall use the same billing method in all succeeding rating periods unless the small employer agrees to allow the carrier to change the methodology.

(7) [Repealed.]

(f) Each rating factor that a carrier chooses to utilize in the individual market shall be reflective of claim cost variations that correlate with that factor independently of claim cost variations that correlate with any of the other allowable factors.

(g) The same rating methodology shall apply to newly covered individuals and to individuals renewing at each annual renewal date, or to new small employers and small employers renewing at each annual renewal date or anniversary date. Rating methodology shall not be construed to include health carrier incentives to individual subscribers or members to participate in wellness and fitness programs provided such incentives are approved by the insurance department.

(h) The commissioner shall not approve any filing if such filing is excessive, inadequate, or contrary to the intent of this chapter.

II. (a) Health carriers providing health coverage to large employers may not require

any person, as a condition of receiving health coverage or continued health coverage, to pay a premium or contribution that is greater than that of similarly situated persons based on any health status related factor of that person or that person's dependents.

(b) Nothing in subparagraph (a) shall be construed to restrict the amount that a health carrier may charge a large employer, nor to prevent a health carrier from establishing premium discounts or rebates or modifying copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

III. [Repealed.]

Source. 1997, 344:1. 1998, 340:9, 10. 2001, 295:2; 296:1, 2. 2003, 188:5, 6; 188:15. 2005, 225:9, 10, 15, eff. Jan. 1, 2006; 225:13, eff. Jan. 1, 2007.

Section 420-G:4-a

420-G:4-a Rating Factor for Qualified Wellness or Disease Management Programs. –

I. In addition to the rating factors permitted in RSA 420-G:4, an insurer that offers a health benefit plan to individuals or small groups that includes a qualified wellness or disease management program may employ a rating factor that reflects the expected level of participation in the program and the anticipated effect the program will have on utilization or medical claim costs. The maximum differential attributed to this factor, as measured by ratio, shall not exceed 1.25 to 1.

II. Program materials shall be submitted to the commissioner for approval as a qualified program prior to the insurer's implementation of the rating factor. A qualified wellness or disease management program shall meet the following standards, to the extent applicable:

(a) The program shall meet the requirements set forth in the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) for bona fide wellness programs.

(b) The program shall provide significant financial incentives to covered employees or individuals for participating in the program and may also include special financial incentives to providers of wellness or disease management services.

(c) The program shall provide to covered employees or individuals for whom it is unreasonably difficult to satisfy the program's applicable standards reasonable alternative methods for achieving program participation.

III. The methodology proposed by the insurer for establishing rating factors for individuals or small groups shall be submitted to the commissioner for approval prior to implementation. The methodology shall specify how the rating factor will vary based on the anticipated efficacy of the program in reducing expected utilization or medical claim costs. The methodology may take into consideration:

(a) The anticipated average percentage of employees or individuals eligible to participate in the program.

(b) The anticipated efficacy of the financial incentives in producing high levels of program participation.

(c) The level of program participation achieved in prior coverage periods.

(d) The expected success rate for program participants.

(e) Clinical studies.

(f) The insurer's experience in the use of the program.

Source. 2004, 43:1, eff. May 3, 2004.

Section 420-G:4-b

420-G:4-b New Hampshire HealthFirst; Standard Wellness Plan for Small Employers. –

I. The purpose of this section is to:

(a) Promote the availability of more affordable health coverage in the small employer market by engaging consumers, health care providers, insurers, and small employers to address the underlying costs of health care through better care management and more efficient utilization of health care services without increasing overall cost sharing requirements or reducing coverage for services essential to health and wellness.

(b) Enhance competition among health carriers in the small employer market by facilitating comparison of a standard plan.

II. If a health carrier offers coverage in the small employer market in this state and had at least 1,000 covered lives in this market at the end of the prior calendar year, such carrier shall be required to offer the standard wellness plan to small employers. The standard wellness plan shall be offered on a guaranteed issue basis to all small employers in the state. If a health carrier is part of an insurance holding company system, as defined in RSA 401-B:1, IV, in which 2 or more affiliates, as defined in RSA 401-B:1, I, are licensed health carriers in the state with a combined New Hampshire small group membership of at least 1,000 covered lives at the end of the prior calendar year, the requirement in this paragraph to offer the standard wellness plan to all small employers shall apply. However, only one such health carrier affiliate in the holding company group shall be subject to the requirement.

III. The commissioner shall adopt rules, pursuant to RSA 541-A, relative to the requirements for the standard wellness plan. Before adopting rules, the commissioner shall convene a standing advisory committee to include representatives of small employers, business groups and associations of small employers, consumers who obtain their coverage through the small employer market, one representative, appointed by the speaker of the house of representatives and one member of the senate, appointed by the president of the senate. The advisory committee shall, at least once every 3 years, make recommendations to the insurance commissioner on the requirements for the standard wellness plan. The standard wellness plan requirements shall be established so that small employer health insurance carriers would be reasonably expected to set the plan's health coverage plan rate, as defined in RSA 420-G:4, I(c), at or below the target rate of 10 percent of the prior year's median statewide wage as reported by the United States Department of Labor. In order to assist the advisory committee in making its recommendations, the commissioner shall engage an actuarial expert at the expense of the small employer carriers that are subject to RSA 420-G:4-b, II to confirm that the proposed standard wellness plan requirements are reasonable in relation to the target health plan coverage rate. The plan shall include benefit structure, cost sharing requirements, and provider payment initiatives consistent with the incentive required in

RSA 420-G:46, IV. The committee shall recommend an out-of-pocket maximum for the standard wellness plan. Throughout the process of developing its recommendations, the advisory committee shall consult with interested health carriers, health insurance producers, health care providers, the actuarial expert retained by the commissioner, and, as necessary and appropriate, other available experts.

IV. The commissioner shall ensure that the standard wellness plan creates incentives for consumers, health care providers, employers, and/or health carriers to:

(a) Promote wellness.

(b) Promote primary care, preventive care, and a medical home model.

(c) Manage and coordinate care for persons with chronic health conditions or acute illness.

(d) Promote the use of cost effective care.

(e) Promote quality of care by the use of evidence-based, best practice standards and patient-centered care.

V. To the extent practicable, health carriers shall be permitted to utilize existing programs to meet the requirements for the standard wellness plan.

VI. The plan shall be made available in accordance with this section on October 1, 2009, or as soon thereafter as practicable and shall be reviewed and revised as necessary, but no less frequently than once every 3 years after the date of initial offer.

VII. (a) Small employer carriers shall be required to file their standard wellness plan rates 60 days prior to the date on which the plan is to be made available. If at least one small employer carrier files a health coverage plan rate at or below the stated target, then each carrier subject to RSA 420-G:4-b, II shall offer the standard wellness plan at its own filed and approved rate. If no small employer carrier files a health coverage plan rate at or below the stated target, then the commissioner shall hold a hearing on the reasonableness of the proposed standard wellness plan benefits in relation to the target health plan coverage rate to determine whether small employer carriers subject to RSA 420-G:4-b, II shall be required to offer the standard wellness plan at a health coverage plan rate equal to the target rate or whether changes should be made to the standard wellness plan requirements to adjust benefits or cost sharing requirements.

(b) Between plan revisions, carriers may request rate adjustments with appropriate supporting documentation. However, the commissioner shall not grant any rate adjustment in excess of the carrier's overall small group trend.

(c) All small employer carrier filings made in accordance with this section shall be subject to approval under RSA 420-G:4, I(h).

VIII. In establishing the requirements for the standard wellness plan, the commissioner:

(a) May require the use of qualified wellness or disease management programs and the use of rating factors for such programs as provided in RSA 420-G:4-a.

(b) Shall prohibit small employer carriers from offering nonconforming products with similar benefit designs with the intent or likely effect of undermining the purposes of this section.

(c) Shall require small employer carriers to illustrate or quote the standard wellness plan together with any proposal or quote provided to any small employer.

IX. Except as specifically provided in this section, all statutory and regulatory

requirements applicable to small employer health benefit plans shall apply to the standard wellness plan.

Source. 2008, 56:1, eff. July 18, 2008.

Section 420-G:5

420-G:5 Medical Underwriting. –

I. Health carriers providing health coverage for individuals may perform medical underwriting, including the use of health statements or screenings or the use of prior claims history, to the extent necessary to establish or modify premium rates as provided in RSA 420-G:4.

II. Health carriers providing health coverage for individuals may refuse to write or issue coverage to an individual because of his or her health status. Regardless of claim experience, health status, or medical history, health carriers providing health coverage for small employers shall not refuse to write or issue any of their available coverages or health benefit plans to any small employer group that elects to be covered under that plan and agrees to make premium payments and meet the other requirements of the plan.

III. Health carriers providing health coverage for small employer groups shall not knowingly provide health coverage to groups where the employer has discriminated based on health status or claims history against any employee or potential employee or his or her dependents with respect to participation in an employer-sponsored health benefit plan.

IV. Health carriers shall not offer riders or endorsements to exclude certain illnesses or health conditions in order to avoid the purpose of this chapter.

V. Individual health insurance carriers shall be responsible for ascertaining the eligibility of any individual applicant or insured for high risk pool coverage. If a carrier determines that an individual meets any of the eligibility criteria set forth in RSA 404-G:5-e, the carrier shall give the individual written notice, with the declination of coverage, the coverage offering or upon a rate increase at renewal. The notice shall include information about available benefits and exclusions of high risk pool coverage and the name, address, and telephone number of the pool administrator or the administrator's designee.

VI. It shall constitute an unfair trade practice under RSA 417 for an insurer, insurance producer, or third party administrator to refer an individual employee to the pool, or arrange for an individual employee to apply to the pool, for the purpose of separating that employee from group health insurance coverage provided in connection with the employee's employment.

VII. Health carriers and health insurance producers shall ensure that persons seeking coverage through a small employer group who are required to complete a health statement have an option to convey the required information directly to the carrier or the producer through a secure means and bypassing the employer.

Source. 1997, 344:1. 1998, 340:11. 2001, 295:12. 2003, 188:7; 201:1, 2. 2004, 251:10, 11. 2005, 225:11, eff. Jan. 1, 2006. 2006, 125:1, eff. July 14, 2006. 2009, 235:15, eff. Sept. 14, 2009.

Section 420-G:6

420-G:6 Guaranteed Issue and Renewability. –

I. Health carriers shall not establish rules of eligibility, including continued eligibility, for health coverage in relation to the following health status related factors of any employee or dependent:

(a) Health status.

(b) Medical condition, including both physical and mental illness.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of domestic violence.

(h) Disability.

II. Paragraph I shall not be construed to require health carriers to provide particular benefits under the terms of such health coverage, or to prevent health carriers from limiting or restricting the amount, level, extent or nature of the benefits for similarly situated persons under the health coverage. Paragraph I shall also not be construed to require health carriers to issue health coverage to an individual with existing health coverage, except where the individual indicates an intent to replace the existing health coverage.

II-a. [Repealed.]

III. Health carriers shall actively market, issue, and renew all of the health coverages they sell in the small employer market to all small employers.

IV. [Repealed.]

V. Health coverages subject to this chapter shall be renewable to all individuals, regardless of age or eligibility for Medicare, or to employees and eligible dependents at the option of the small or large employer, except for the following reasons:

(a) Nonpayment of required premiums.

(b) Fraud or intentional misrepresentation on the part of an individual or an individual's representative, or on the part of an employer, employee, dependent, or an employee's representative.

(c) [Repealed.]

(d) Failure to meet the minimum employee participation number or percentage requirement of the health coverage.

(e) The small employer is no longer actively engaged in the business that it was engaged in on the effective date of the health coverage.

(f) The employer medically underwrites or otherwise violates a provision of this chapter.

(g) The health carrier is ceasing to offer health coverage in such market, in accordance with paragraph VII.

V-a. Health carriers shall not underwrite insureds at time of renewal unless an insured has applied for an increase in his or her coverage.

VI. Where a health carrier decides to discontinue a particular type of health coverage offered in the individual, large employer or small employer market, the health carrier must:

(a) Provide at least 90-days notice of such discontinuation to each individual or employer with such health coverage and to all covered persons;

(b) Offer to each individual or employer with such health coverage, the option to purchase any other health coverage currently being offered by the health carrier in the relevant market;

(c) Act uniformly without regard to the claims experience of those employers, and without regard to any health status related factor of any covered person or any individual, employee, or eligible dependent who may become a covered person; and

(d) Make no adjustments in the health status factor applied to individuals moving from a discontinued product of that health carrier to another product of that health carrier if the individual was newly covered under the previous product within the last 5 years, or a health status factor adjustment was made with respect to that individual within the last 5 years.

VII. Where a health carrier decides to discontinue all of its health coverage in the individual market, small employer market, large employer market or any combination thereof, the health carrier must provide at least 180-days notice of such discontinuation to the commissioner, to each individual or employer with such health coverage and to all covered persons; and

(a) The health carrier may not renew any health coverages issued, or delivered for issuance, in such discontinued market or markets; and

(b) The health carrier may not provide health coverage in such discontinued market or markets during the 5-year period beginning on the date of the discontinuation of the last health coverage not so renewed except that the commissioner may waive or otherwise reduce the 5-year period in which the health carrier may not provide coverage in the discontinued market for good cause shown.

VIII. A health carrier may, at the time of coverage renewal, modify the health coverage it offers to:

(a) Large employers; and to

(b) Small employers and individuals, provided that such modification is in accordance with state law and applied uniformly among all small employers and/or individuals with such health coverage.

IX. A health carrier which has discontinued coverage in the individual market, the small employer market, or any combination thereof, in accordance with paragraph VII, shall continue to be liable for the payment of claims in accordance with the following:

(a) This section shall apply only to terminating carriers of insureds who obtain creditable replacement health coverage. This paragraph shall be effective with respect to all in-force policies, certificates, or other evidences of coverage as of the effective date of this paragraph.

(b) The terminating carrier shall continue to be liable for the payment of claims if the succeeding carrier's policy requires the satisfaction of any deductibles, individual or family stop-loss provisions limiting out-of-pocket payments, or waiting periods in its plan but only to the extent satisfaction or partial satisfaction of the same or similar provisions were included in the terminated plan providing similar benefits. In the case of deductible provisions and stop-loss provisions, the liability shall be for the same or overlapping benefit periods and shall be for expenses actually incurred and applied against the deductible and stop-loss provisions of the terminating carrier's plan but only to the extent

those expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar stop-loss or deductible provision. The terminating company shall inform its insureds at the time of cancellation that this provision is applicable to them and that this is a requirement of New Hampshire statute. The provision should also appear in all policies or certificates where the provision about termination of the insurance company appears. Nothing in this subparagraph shall be deemed to prevent a succeeding carrier's plan from having stop-loss levels or deductible amounts that are higher than those specified in the terminating carrier's plan.

(c) Whenever a determination of the terminating carrier's benefits is required by the succeeding carrier, at the succeeding carrier's request the terminating carrier shall furnish, in a timely manner, but in no event later than 30 days, a statement of the benefits available or pertinent information, sufficient to permit verification of the terminating carrier's liability to the succeeding carrier. Any determination of the liability of the terminating plan shall be made in accordance with all the definitions, conditions, and covered expense provisions of the terminating plan rather than those of the succeeding plan. The benefit determination shall be made as if coverage had not been replaced by the succeeding carrier. The succeeding carrier shall notify the terminating carrier as to its liabilities pursuant to RSA 420-G:6, IX(b) and shall indemnify the insured for the same. Upon determination of any liability of the terminating plan, the terminating plan shall pay the succeeding plan in a timely manner, in no event later than 15 days, upon receipt of said claim information.

Source. 1997, 344:1. 1998, 158:1; 329:2; 340:12-14; 375:2-4. 2001, 295:3, 13. 2002, 1:1. 2005, 248:17, eff. Sept. 12, 2005. 2009, 235:16, eff. Sept. 14, 2009.

Section 420-G:7

420-G:7 Preexisting Condition Exclusion Periods. –

I. A health carrier providing health coverage to large employers may impose a preexisting condition exclusion period, but only if it is at least as favorable to covered persons as the following:

(a) No preexisting condition exclusion shall extend beyond a period of 9 consecutive months after the date of enrollment of the person's health coverage; and

(b) Such preexisting condition exclusion period may only apply to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received during the 3 months immediately preceding the enrollment date of health coverage.

II. A health carrier providing health coverage to individuals or small employers may impose a preexisting condition exclusion period, but only if it is at least as favorable to covered persons as the following:

(a) No preexisting condition exclusion period shall extend beyond a period of 9 consecutive months after the date of enrollment of the person's health coverage.

(b) Such preexisting condition exclusion period may only apply to a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was received or recommended during the 3 months immediately preceding the date of enrollment of the person's health coverage.

III. In applying a preexisting condition exclusion period, a health carrier shall credit the time the person was covered under previous health coverage subject to the following:

(a) A period of otherwise creditable coverage shall not be counted if, after such period and before the enrollment date or application date of new health coverage, there was a 63-day period during all of which the person was not covered under any creditable coverage; except that

(b) Any length of time that a person is in an employer imposed waiting period for health coverage shall not be counted toward the 63-day period described above; and

(c) If a person did not have health coverage during a period of unemployment prior to the effective date of new employer-based group health coverage, the lack of health coverage during the period of unemployment shall be disregarded and, for the purposes of crediting coverage, coverage shall be considered to have been continuous from the date of termination of the person's health coverage immediately prior to the period of unemployment to the effective date of the new employer-based group health coverage.

IV. Health carriers providing health coverage in the large employer market may use the alternative method of crediting coverage as specified in rules.

V. Health carriers shall provide written certification of the period of creditable coverage which accumulated while a person was under the health coverage plan, and shall also state any waiting period which was imposed prior to receiving health coverage.

(a) The written certification shall be provided at the time a person ceases to be covered under a health coverage plan, and on a request made on behalf of the person made not later than 24 months after the date of the cessation of coverage.

(b) A health carrier, which elects to credit coverage under the method set forth in rules pursuant to paragraph IV that enrolls a person with a certificate of creditable coverage, may request of the entity that issued the certificate the additional information required under the rules. The issuing entity shall promptly disclose such information to the health carrier, but may charge the reasonable costs of disclosing such information.

VI. A health carrier providing health coverage to large or small employer groups shall not:

(a) Treat genetic information as a condition subject to a preexisting condition exclusion period in the absence of a diagnosis of the condition related to such information.

(b) Impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(c) (1) Subject to subparagraph (3), impose any preexisting condition exclusion in the case of a newborn who, as of the last day of the 30-day period beginning with the date of birth, is covered under creditable coverage.

(2) Subject to subparagraph (3), impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to health coverage before the date of such adoption or placement for adoption.

(3) Subparagraphs (1) and (2) shall no longer apply to the person after the end of the first 63-day period during all of which the person was not covered under any creditable coverage.

Source. 1997, 344:1. 2003, 188:11, 12, eff. Jan. 1, 2004. 2007, 289:23, eff. Jan. 1, 2008.

Section 420-G:8

420-G:8 Open Enrollment and Late Enrollment. –

I. Each small employer group shall have an annual open enrollment period 60 days in length, occurring prior to the small employer group's anniversary date. During open enrollment, employees or eligible dependents may apply to the small employer for health coverage or make a change in their membership status becoming effective upon the small employer group's anniversary date, subject to providing the health carrier 30-days notice.

(a) A health carrier shall not refuse any small employer employees or eligible dependents applying for health coverage during the open enrollment period.

(b) [Repealed.]

(c) Employees or eligible dependents coming on at the time of an open enrollment period shall have the same premiums as the rest of the small employer group shall have upon the new or renewal effective date.

I-a. Small employers who are self-employed individuals shall have 2 open enrollment periods that shall occur during the months of March and September of each calendar year. During these periods, health carriers shall make their plans available to these employers for effective dates beginning on the first day of the month following the open enrollment period. Self-employed individuals who seek coverage during other times of the year shall be treated as late enrollees.

II. A small employer employee who has met any employer imposed waiting period and is otherwise eligible for health coverage, who declines a small employer's health coverage plan during the initial offering or subsequent open enrollment period, shall be a late enrollee and shall not be allowed on the plan until the next open enrollment period.

II-a. Notwithstanding the provisions of paragraphs I-a and II, small employers who are self-employed individuals shall have 90 days from the date their business is first established to enroll in a plan. Health carriers shall make their plans available to such individuals for effective dates beginning on the first day of the month following enrollment.

III. A large employer employee, who has met any employer imposed waiting period and is otherwise eligible for health coverage, may enroll within 31 days of becoming eligible and shall not be required to submit evidence of insurability based on medical conditions. If a person does not enroll at this time, that person is a late enrollee.

(a) Each large employer group shall have an open enrollment period during which late enrollees may enroll and shall not be required to submit evidence of insurability based on medical conditions.

(b) For late enrollees in a large employer group only, a preexisting condition exclusion period may extend up to 18 months after the effective date of the person's health coverage.

IV. Paragraphs II and III notwithstanding, an eligible employee or eligible dependent shall not be considered a late enrollee if:

(a) The person was covered under public or private health coverage at the time the person was able to enroll; and

(1) Has lost public or private health coverage as a result of termination of

employment or eligibility, the termination of the other plan's coverage, death of a spouse, or divorce; and

(2) Requests enrollment within 30 days after termination of such health coverage; or

(b) Is employed by an employer that offers multiple health coverages and the person elects a different plan during an open enrollment period; or

(c) Was ordered by a court to provide health coverage for an ex-spouse or a minor child under a covered employee's plan and request for enrollment is made within 30 days after issuance of such court order.

V. (a) If a large or small employer group's health coverage plan offers dependent coverage and the employee is enrolled or has met any applicable waiting period and is eligible to be enrolled, but for a failure to do so during a previous open enrollment period, a person who becomes a dependent of the employee through marriage, birth, adoption or placement for adoption, and the employee if not otherwise enrolled, shall be provided with a special enrollment period.

(b) The special enrollment period shall be at least 30 days in length and shall begin on the later of:

(1) The date dependent health coverage is made available; or

(2) The date of the marriage, birth, adoption or placement for adoption, as the case may be.

(c) If the person seeks enrollment during the first 30 days of such special enrollment period, the health coverage shall become effective:

(1) In the case of marriage, on or before the first day of the first month following the completed request for enrollment;

(2) In the case of birth, as of the date of birth; or

(3) In the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

Source. 1997, 344:1. 2001, 296:3. 2003, 188:16, eff. Jan. 1, 2004. 2007, 289:39, eff. Jan. 1, 2008.

Section 420-G:9

420-G:9 Minimum Participation Requirements. –

I. A health carrier may not require more than the minimum participation percentage of the employees eligible for health coverage in a small employer group to participate in the health carrier's health coverage plan. The minimum participation percentage shall be 75 percent when the health carrier's plan is the sole health coverage plan being sponsored by the employer group, and 37.5 percent when the health carrier's plan is not the sole health coverage plan being sponsored by the employer group.

II. For the purpose of calculating whether or not a small employer group's enrollment meets a carrier's minimum participation requirements:

(a) Any full-time or part-time employees who are covered as a dependent on another person's health coverage shall be excluded from the count.

(b) The total number of full-time employees and part-time employees who are otherwise eligible for health coverage shall be counted.

III. The minimum participation requirements shall be calculated on an employer-by-employer basis if the small employer is part of an association, trust, or other similar arrangement.

IV. In performing the computation to determine the actual enrollment necessary to meet the minimum participation requirement as a small employer group, the health carrier shall round any fractional number to the higher integer.

Source. 1997, 344:1. 1998, 340:15, eff. Aug. 25, 1998.

Section 420-G:10

420-G:10 Qualified Association Trust. –

I. A qualified association trust or other entity, as defined in RSA 420-G:2, XV, shall:

(a) Comply with the rating restrictions outlined in RSA 420-G:4 for all small employer members with 50 or fewer employees based upon the association's group experience, except that no rating factor shall be utilized without the express written consent of the association.

(b) Offer all eligible members, as defined under the applicable trust or other documents, coverage and rates on a guaranteed issue and renewable basis.

(c) Comply with the regulations concerning medical underwriting in RSA 420-G:5.

(d) Comply with the preexisting conditions provision of RSA 420-G:7.

II. Nothing in this chapter shall be interpreted to limit the size of employers who may participate in coverage with a qualified association trust.

Source. 1997, 344:1. 2003, 188:8, eff. Jan. 1, 2004.

Section 420-G:10-a

420-G:10-a Voluntary Small Employer Health Insurance Purchasing Alliances; Rulemaking. –

I. The commissioner shall have the regulatory oversight authority to set standards for the licensure and conduct of purchasing alliances authorized under this section and to enforce such standards.

II. Each applicant and each duly licensed purchasing alliance shall file with the commissioner such information or documents as the commissioner shall adopt by rule as necessary to perform oversight function.

III. A purchasing alliance shall offer health benefit plans and establish conditions of participation for small employers, employees, and participating carriers that conform to the requirements of this chapter.

IV. Nothing in this section shall require 2 or more small employers to join a purchasing alliance as a condition of jointly purchasing health insurance coverage. Any such coverage jointly purchased by 2 or more small employers who do not join a purchasing alliance shall conform to the requirements of this chapter.

V. The commissioner shall adopt such rules, under RSA 541-A, and issue such orders as may be necessary to carry out the commissioner's oversight responsibilities under this section.

Source. 2000, 2:2, eff. Jan. 1, 2001.

Section 420-G:11

420-G:11 Disclosure. –

I. Health carriers operating in the small employer and/or individual markets shall make reasonable disclosure in solicitation and sales materials provided to individuals and small employers of the following:

(a) The methodology by which premium rates for an individual or specific small employer are established. Each health carrier shall state that rates and practices are in full compliance with this chapter.

(b) The provisions concerning the health carrier's right to change premium rates and the factors which affect changes in premium rates.

(c) The provisions relating to renewability of health coverage.

(d) The provisions relating to any preexisting condition exclusions.

(e) The benefits and premiums available under all health insurance coverage for which the employer is qualified.

II. (a) All health carriers, licensed third party administrators, and any entity required to be registered with the commissioner pursuant to RSA 402-H, shall electronically provide:

(1) Their encrypted claims data to the department and to the department of health and human services in accordance with rules approved by the commissioner of health and humans services and adopted under RSA 420-G:14.

(2) To the department of health and human services, cross-matched claims data on requested policyholders, and subscriber information necessary for third party liability for benefits provided under RSA 167, filed in accordance with rules adopted under RSA 167:3-c.

(b) Notwithstanding RSA 91-A:10, the collection storage and release of health care data and statistical information that is subject to the federal requirements of the Health Information Privacy and Accountability Act (HIPAA) shall be governed exclusively by the rules adopted thereunder in 45 CFR Parts 160 and 164.

II-a. All health carriers and other health plans that collect the Health Employer Data and Information Set (HEDIS) shall annually submit the HEDIS information to the department.

III. All health carriers shall accept electronic claims submitted in Centers for Medicare and Medicaid Services (CMS) format for UB-92 or HCFA-1500 records, or as amended by CMS.

Source. 1997, 344:1. 1999, 318:4. 2003, 145:3, 4, eff. Aug. 16, 2003; 292:3, 4, eff. July 18, 2003; 292:7, eff. Aug. 16, 2003 at 12:01 a.m. 2006, 271:13, eff. Aug. 8, 2006.

Section 420-G:11-a

420-G:11-a Development of a Comprehensive Health Care Information System. –

I. The department and the department of health and human services shall enter into a memorandum of understanding for collaboration in the development of a comprehensive health care information system. The memorandum of understanding shall include a

description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of limited use data sets, the criteria and procedures to ensure that Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant limited use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system. To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors, and institutional size. Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not include or disclose any data that contains direct personal identifiers. For the purposes of this section, ""direct personal identifiers" include information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and social security number.

II. The commissioner of the department of health and human services, with the approval of the commissioner of the insurance department, shall adopt rules, under RSA 541-A, as may be necessary to provide for the release of claims data from the comprehensive health care information system (CHIS).

Source. 2003, 292:6. 2005, 248:19, eff. Sept. 12, 2005.

Section 420-G:12

420-G:12 Rating Practices and Filings. –

I. Each health carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

II. Each health carrier shall file each March 1, with the commissioner, an actuarial certification stating that the health carrier is in compliance with this section and that the rating methods of the health carrier are actuarially sound.

III. A health carrier shall make the information and documentation described in paragraph I available to the commissioner upon request.

IV. Each health carrier shall provide, at the time it gives a premium quote to a group, a rating disclosure form that identifies the health coverage plan rate and any adjustments to that rate resulting from the application of rating factors, including age, industry, and group size. The health carrier shall submit the rate disclosure form to the department for approval. Health carriers shall provide their insureds with renewal premium quotes at least 60 days prior to the expiration date of the policy.

Source. 1997, 344:1, eff. July 1, 1997. 2006, 125:2, eff. July 14, 2006.

Section 420-G:12-a

420-G:12-a Health Plan Loss Information. –

I. To ensure maximum competition in the purchase of group health insurance, all large employers shall be entitled to receive their specific health plan loss information upon request and without charge. No contract between any health carrier, third-party administrator, employer group, or pool of employers shall abridge this right in any manner.

II. Upon written request from any large employer, every health carrier, third-party administrator, pooled risk management program under RSA 5-B or any other type of multiple employer health plan shall provide that employer's loss information within 30 calendar days of receipt of the request. The loss information shall include all physician, hospital, prescription drug, and other covered medical claims specific to the employer's group plan incurred for the 12-month period paid through the 14 months which end within the 60-day period prior to the date of the request. An employer shall not be entitled by this section to more than 2 loss information requests in any 12-month period; however, nothing shall prohibit a carrier from fulfilling more frequent requests on a mutually agreed-upon basis.

III. If an employer requests loss information from an insurance agent or other authorized representative, including an administrator of a pooled risk management program or a multiple employer health plan, the agent or authorized representative shall transmit the request to the health carrier or carriers or third-party administrator within 4 working days.

Source. 2001, 120:2. 2003, 127:1; 188:9. 2004, 187:14, eff. July 31, 2004.

Section 420-G:13

420-G:13 Approval of Rate Filings. – No policy or contract of insurance or any certificate under such policy or contract or other evidence of coverage shall be issued to a small employer or an individual under this chapter until the premium rates have been filed and approved by the commissioner. The commissioner shall approve or disapprove such rates within 30 days of receipt. The commissioner may disapprove rate filings if the commissioner finds such rates to be excessive, inadequate, or contrary to the intent of this chapter.

Source. 1997, 344:1, eff. July 1, 1997.

Section 420-G:14

420-G:14 Rulemaking Authority. –

I. The commissioner may adopt rules, under RSA 541-A, necessary to the proper administration of this chapter.

II. The commissioner, with the approval of the commissioner of the department of health and human services, shall adopt rules, under RSA 541-A, defining the content,

format, and schedule for the filing of encrypted claims data and HEDIS information under RSA 420-G:11.

Source. 1997, 344:1. 2002, 207:50. 2003, 292:5, eff. July 18, 2003.

Section 420-G:14-a

420-G:14-a Requested Information. –

I. As authorized in accordance with RSA 420-G:14, the commissioner may request the submission of such information by carriers as is necessary to better understand the coverage history and choices of participants in the nongroup market. The commissioner shall make every attempt to ensure the reasonableness of such request, both in terms of scope and timeframe, and to limit this request to information the commissioner deems necessary to better understand the dynamics of the nongroup health insurance market and to assess the appropriateness of alternative sources of funding for the nongroup subsidy.

II. The commissioner shall request and health carriers shall supply information and data no later than June 1 of each year sufficient to report on the small employer health insurance market. Such information shall be reported for the market as a whole and by market segment. At the commissioner's discretion, such information may include, but not be limited to, information relating to premium rates and rating practices, the number of groups and individuals insured, availability of coverage and benefit plans, trend, loss ratios, administration costs, and profitability. The commissioner shall file a report of the information by December 1 of each year with the president of the senate, the speaker of the house of representatives, the chairperson of the house commerce committee, and the chairperson of the senate banks and insurance committee.

III. The commissioner shall request and health carriers shall supply information no later than June 1 of each year sufficient to report on the types of health coverage being purchased by individuals and employers by geographic area. The report shall include specific details regarding the type of coverage, including, but not limited to, co-pays, out-of-pocket maximums, network restrictions, and deductibles.

IV. The commissioner shall file the required reports by September 1 of each year with the senate president, the speaker of the house, the chairperson of the house commerce committee, and the chairperson of the senate insurance committee.

Source. 1998, 340:16. 2003, 188:10, eff. Jan. 1, 2004. 2006, 125:3, eff. July 14, 2006. 2007, 289:24, eff. Jan. 1, 2008.

Section 420-G:14-b

420-G:14-b Prohibited Transactions. – No health care provider shall submit a claim for reimbursement, or otherwise accept payment, for health care services provided to a patient covered by individual health insurance if the provider has paid the premium for such individual health insurance.

Source. 1998, 340:16, eff. Aug. 25, 1998.

Section 420-G:14-c

420-G:14-c Legislative Oversight Committee. – [Repealed 2003, 188:17, eff. Jan. 1, 2009.]

Section 420-G:15

420-G:15 Severability. – If any provision of this chapter or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provisions or applications, and to this end the provisions of this chapter are severable.

Source. 1997, 344:1, eff. July 1, 1997.

Section 420-G:16

420-G:16 Penalties for Violations. – Any health carrier who proposes, advertises, solicits, issues or delivers to any person or entity in this state any form which does not comply with this chapter or who shall in any way violate this chapter may:

I. Be prohibited from marketing, selling, or otherwise administering to the individual or small employer market if the commissioner finds a health carrier to be in violation of RSA 420-G.

II. Be subject to an administrative fine not to exceed $2,500 for each violation. Repeated violations of the same chapter shall constitute separate fineable offenses.

III. Have its certificate of authority indefinitely suspended or revoked at the discretion of the commissioner.

Source. 1997, 344:1, eff. Jul

CHAPTER Ins 400 FILINGS FOR LIFE, ACCIDENT AND HEALTH INSURANCE

Statutory Authority: RSA 400-A:15

PART Ins 401 FORM AND RATE FILINGS

Ins 401.01 Purpose and Scope.

(a) The purpose of this chapter is to establish standards and procedures for the filing of life, accident and health insurance forms to be used within the state.

(b) This chapter shall apply to all licensed writers of life, accident and health insurance in this state, including health service organizations, health maintenance organizations, third party administrators.

Source. #1900, eff 1-1-82; amd by #2372, eff 5-31-83; ss by #4287, eff 7-1-87; ss by #5653, eff 7-1-93; ss by #7016, INTERIM, eff 7-1-99, EXPIRED: 10-29-99

New. #8726, eff 9-18-06

Ins 401.02 Definitions.

(a) "Commissioner" means the insurance commissioner.

(b) "Department" means the New Hampshire insurance department.

(c) "NAIC" means the National Association of Insurance Commissioners.

(d) "Tricare Supplemental Insurance" means the health insurance program for military personnel and their families.

(e) "System for Electronic Rate and Form Filing" (SERFF) means the system for electronic rate and form filing supported by the NAIC.

Source. #1900, eff 1-1-82; amd by #2049, eff 7-1-82; amd by #2226, eff 1-1-83; amd by #2372, eff 6-1-83; ss by #4287, eff 7-1-87; ss by #5653, eff 7-1-93; ss by #7016, INTERIM, eff 7-1-99, EXPIRED: 10-29-99

New. #8726, eff 9-18-06; amd by #9334, eff 12-5-08

Ins 401.03 Rules Applicable to All Forms.

(a) Each form shall be designated by a form number composed of either figures or letters or both.

(1) The form number shall be:

a. Sufficient to distinguish the form from all other forms used by the company;

b. Placed in the lower lefthand corner on the front of each form;

(2) The form number for a policy form may contain the prefix "Form No.";

(3) Policy forms utilizing less than a full sheet as the face page or cover page shall place the form number in the lower lefthand corner of the specifications page;

(4) Any time any change is made, the form shall be resubmitted as a new form with a new form number.

(b) Each policy and certificate shall recite on the back page or specifications page the:

(1) Full corporate or legal title of the company, association, exchange or society;

(2) Official home address, including city and state or province;

(3) Administrative office address if different from address in (2) above;

(4) Toll-free telephone number of the company and, if available, a facsimile number and website address.

(c) Each policy and certificate shall provide a brief description of the nature of the policy, as follows:

(1) The brief description shall be printed on:

a. The face page, specifications page, or the back page if the policy form has a full size cover page; or

b. On the specifications page so that the description is visible, if the policy form has less than a full size cover page; and

(2) In the instance of individual life or individual annuity contracts, the brief description shall contain a statement indicating whether the policy is "participating" or "nonparticipating";

(d) The words, "preferred," "special," "unlimited," "union," "labor," "New Hampshire," or any other words or combination of words shall not be used in any way that might reasonably cause anyone to believe that they are receiving or shall receive preferential treatment unless that person is, in fact, receiving preferential treatment or will receive preferential treatment;

(e) No policy or group certificate providing accident and health insurance benefits shall use the terms "major," "comprehensive," "catastrophic" or words of similar import in its title or brief description unless such policy or certificate satisfies the minimum benefit standards for major medical expense coverage as prescribed by Ins 1901.06 (f).

(f) The word "compensation" shall not be used in any way that might reasonably cause the policyholder to be confused with workers' compensation coverage;

(g) The word "medicare" shall not be used in any way that might reasonably cause anyone to believe that the policyholder is participating in a government program; and

(h) If the policy contains an exception for injury arising out of riots, the exception shall be confined to those instances in which the insured is injured while participating in such riot;

(i) Any policy or certificate that contains exclusions, limitations, reductions, or conditions of such a restrictive nature that the payment of benefits under such policies is limited in frequency or in amounts shall carry the legend "This is a Limited Policy - Read it Carefully" imprinted in not less than 18-point outline type of contrasting color or not less than 24-point outline type of non-contrasting color diagonally across the face and filing back, if any, of the policy;

(j) Any provision, requirement, or other document standard contained in this part shall not act to prevent the use of any other language that is at least as favorable to any insured or group policyholder.

(k) Except as otherwise specifically provided by New Hampshire statutes or this part, any contract or policy of insurance or annuity contract issued, delivered, used, or sold in this state that violates any of the provisions of New Hampshire statutes or this part shall be:

(1) Valid and binding upon the insurer making or issuing the policy; and

(2) Enforceable as if it conformed with such requirements or prohibitions.

(l) Discretionary clauses relating to life, accident or health policies shall be approved by the department only when such clauses are:

(1) Contained in a separate endorsement containing no other language, terms or provisions;

(2) Offered on an optional basis to the plan sponsor;

(3) Implementing a policy governed by the Employment Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq. and those policies contain the following language:

"The following applies only when the administration of the policy is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.:

Under ERISA, [the Company] is hereby designated by the plan sponsor as a claim fiduciary with discretionary authority to determine eligibility for benefits and to interpret and construe the terms and provisions of the policy. As claim fiduciary, [the Company] has a duty to administer claims solely in the interest of the [participants and beneficiaries] of the employee benefit plan and in accordance with the documents and instruments governing the plan. This assignment of discretionary authority does not prohibit a participant or beneficiary from seeking judicial review of [the Company's] benefit eligibility determination after exhausting administrative remedies. The assignment of discretionary authority made under this provision may affect the standard of review that a court will use in reviewing the appropriateness of [the

Company's] determination. In order to prevail, a plan participant or beneficiary may be required to prove that [the Company's] determination was arbitrary and capricious or an abuse of discretion."; and

(4) Pursuant to (l)(3) above, include the following sentence at the end of the second paragraph in (l)(3) above, if a health carrier, as this term is defined in RSA 420-J:3:

"This designation as a claim fiduciary under ERISA does not apply to determinations that health carriers make as to whether a health care service, supply or drug meets requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness."

(m) Policies providing disability income protection as defined in Ins 1901.06 (h) shall not in any way condition benefit payments for "total disability" on "continuous confinement within doors" or language of similar import.

(n) Short term major medical shall comply with RSA 415:5 III.

(o) Tricare supplement policies and certificates programs shall comply with RSA 415:18.

(p) All policy forms and certificates issued on or after January 1, 2010 that provide coverage as defined in RSA 420-G:2, IX. or prescription drug and dental benefits offered separately as described in RSA 420-G:2, IX. (j), issued on or after January 1, 2010, shall clearly state that the benefit plan or coverage represented by the policy is under the jurisdiction of the New Hampshire insurance commissioner pursuant to RSA 400-A:15-c.

Source. #1900, eff 1-1-82; amd by #5117, eff 5-1-91; ss by #4287, eff 7-1-87; ss by #5653, eff 7-1-93; ss by #7016, INTERIM, eff 7-1-99, EXPIRED: 10-29-99

New. #8726, eff 9-18-06; ss by #9602, eff 12-1-09

Ins 401.04 Individual Life and Annuity Contracts.

(a) All individual life policies and individual annuity contracts shall contain the following provisions:

(1) All premiums shall be payable in advance either at the home office of the company or to the company's appointed producer upon delivery of the policy or contract, and:

a. If requested, the policy or contract shall be signed by one or more of the officers of the company who shall be designated by title in the policy; and countersigned by the appointed producer; and

b. The policy itself shall be a receipt for the first premium payment.

(2) There shall be a grace period of 30 days or one month within which the payment of any premium after the first may be made, during which period of grace:

a. The policy shall continue in force;

b. The amount of such premiums in arrears plus accrued interest, at a rate not exceeding the policy loan rate, shall be deducted from any claim arising in such period; and

c. This premium provision shall not be applicable to single premium contracts, or to flexible payment annuity contracts that do not default upon nonpayment of premium.

(3) Pursuant to the provisions of RSA 408:9, the entire contract between the parties shall consist of the policy together with a copy of the signed and completed application.

(4) No statement made by the insured or on his behalf shall be used in defense of a claim under the policy unless it is contained in a written application and a copy endorsed upon or attached to the policy when issued.

(5) All statements made by, or by the authority of, the applicant for the issuance, reinstatement, or renewal of the contract shall, in the absence of fraud, be deemed representations and not warranties.

(6) Pursuant to the provisions of RSA 408:10, the policy shall be incontestable after it has been in force during the lifetime of the insured for 2 years from its date, except for:

a. The nonpayment of premiums;

b. Violations of the policy relating to naval or military service in time of war; and

c. At the option of the company, provisions granting or increasing benefits in the event of total and permanent disability; and

d. At the option of the company, provisions that grant additional insurance specifically against death by accident.

(7) An incontestable provision is not required in any policy or contract where the only statements required as a condition of issuing the contract are those pertaining to age, sex and identity.

(8) If the insured's age or sex has been misstated, any benefit under the policy shall be such as the premiums would have purchased for the correct age or sex; and

(9) The policy or contract shall participate in its share of the divisible surplus of the company at annual intervals that begin no later than the fifth policy year, unless such

policies or contracts are nonparticipating, issued as sub-standard or provide nonforfeiture benefits in exchange for lapsed or surrendered policies or contracts.

(b) Policy loan values and policy loan provisions for individual life insurance shall provide that:

(1) After the policy has been in force for 3 full years with all premiums due having been paid, the insurer shall advance an amount up to but not exceeding the loan value of the policy upon proper assignment or pledge of the policy and on the sole security thereof;

(2) The loan value shall be at least equal to the cash surrender value available at the end of the policy year, less the sum of premiums falling due from the date of the loan to the end of the policy year, less any existing indebtedness, less the interest on any existing indebtedness to the end of the policy year;

(3) Interest due at the end of the policy year if not paid when due, shall be added to the existing loan payable at the same interest rate as the existing loan or in advance at the equivalent effective rate;

(4) Policy provisions reserve to the insurer the right to defer loan grants for up to 6 months after the application is filed, other than for the payment of premiums;

(5) The provisions of Ins 401.02 (b)(1) and (2) shall not be applicable to term insurance or to any policy or contract of pure endowment, variable annuity, annuity or reversionary annuity; and

(6) The provisions of Ins401.02 (b)(1) and (2) shall not be construed as prohibiting policy loan provisions in any annuity contract.

(c) Rates of interest charged on life insurance policy loans shall provide:

(1) A provision permitting a maximum interest rate of not more than 8 percent per annum;

(2) A provision permitting an adjustable maximum interest rate established from time to time by the life insurer, which interest rate shall not exceed the higher of a. or b. below:

a. The Published Monthly Average for the calendar month ending 2 months before the date on which the rate is determined. For purposes of this rule, "Published Monthly Average" means the Moody's Corporate Bond Yield Average - Monthly Averages Corporates as published by Moody's Investors Service, Inc. or any equivalent or successor thereto; or

b. The rate used to compute the cash surrender values under the policy during the applicable period plus one percent per annum.

(3) If the maximum rate of interest to be charged on a policy loan is subject to (2) above, the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy;

(4) If the maximum rate of interest to be charged on a policy loan is subject to (2) above, the maximum rate for each policy shall be determined:

a. At regular intervals at least once every 12 months, but not more frequently than once in any 3-month period;

b. At the intervals specified in the policy, wherein the rate being charged may be increased whenever such increase as determined pursuant to (2) above would increase that rate by 1/2 percent or more per annum; and

c. At the same intervals, wherein there is a reduction in the rate being charged whenever such reduction as determined pursuant to (2) above would decrease the rate being charged by 1/2 percent or more per annum.

(5) The insurer shall:

a. Notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;

b. Notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is practical to do so after making the initial loan. Notice to the policyholder shall not be required when a further premium loan is added, except as provided in c. below;

c. Send advance notice of any increase in the rate to policyholders with outstanding loans; and

d. Include in the notices required in c. above the policy loan interest rates and if an adjustable interest rate, the frequency at which the rate will change;

(6) No policy shall terminate nor shall the insurer deny or fail to provide coverage during the policy term solely as a result of a change in the policy loan interest rate, and the life insurer shall maintain coverage during that policy year until the time at which the policy would otherwise have terminated if there had been no change during that policy year.

(7) For purposes of this part:

a. The rate of interest on policy loans permitted by the rules stated above includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy;

b. The term "policy loan" shall include any premium loan made under a policy to pay one or more premiums that were not paid to the life insurer as they fell due;

c. The term "policyholder" shall include the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer; and

d. The term "policy" shall include certificates issued by a fraternal benefit society and annuity contracts that provide for policy loans.

(d) Upon the request of the policyholder, unless the cash surrender value of a permanent life insurance policy has been paid out in full or the period of extended insurance has expired, any life insurance policy shall be reinstated during the life of the insured anytime within 3 years of the date of default if:

(1) Evidence of insurability satisfactory to the insurer is provided to the insurer;

(2) Payment is tendered to the insurer in an amount not to exceed the larger of:

a. The sum of:

1. Overdue premiums, including interest at a rate not to exceed 8 percent per annum compounded annually; and

2. Any outstanding policy loans, including interest at a rate that would be permitted under this rule if the policy had not lapsed; or

b. One hundred ten percent of the increase in cash surrender value resulting from reinstatement.

(e) Term life insurance policies shall provide for reinstatement subject to the same requirements set forth in (1) and (2) a.1. and b. above, any time during the life of the insured and prior to the policy expiration date.

(f) The following provision or its equivalent shall appear in a conspicuous place on the face page of the policy:

> "This policy may, at any time within 10 days after its receipt by the policyholder, be returned by delivering it or mailing it to the company or to the agent through whom it was purchased. Immediately upon delivery or mailing, the policy will be deemed void from the beginning, and any premium paid on it will be refunded."

(g) Direct response insurers may delete from the statement in (f) above the reference to "the agent through whom it was purchased" and require a written request for cancellation from policyholders returning their policies for cancellation under the terms of Ins 401.04(f) above.

(h) Unless the insurer has adopted a procedure to obtain a policyholder's dated and signed receipt for the delivery of the policy pursuant to (f) above, it shall be presumed that the date of delivery is the date shown in the policyholder's records or by his memory unless there is evidence sufficient to void this presumption.

(i) Life insurance policies designed to permit increases or decreases in the premiums payable shall state in the policy the maximum premium or the schedule of maximum premiums applicable for the entire duration of the policy.

(j) Supplemental contracts referred to in RSA 415:14 shall be subject to all insurance laws and parts that would be applicable to accident and health insurance forms containing similar provisions or benefits.

(k) Arbitration provisions shall be prohibited.

(l) Graded death benefits life insurance policies shall pay the policy face value after 2 years.

(m) The following exclusions shall be the only exclusions permitted in an individual life policy or individual annuity contract:

(1) Except for those exclusions that relate to accidental death benefits, any policies that contain any exclusions violating this part shall be operative as if such prohibited exclusions were not included.

(2) Policy exclusion provisions shall:

a. Contain language substantially similar to the language of the following subclauses;

b. Be set out in a separately titled policy section; and

c. Prominently display reference to exclusion (3) c. below in the letter of transmittal and on the policy face in type at least as large as 12-point boldface type;

(3) If a policy includes an exclusion it shall contain only those exclusions listed below:

a. Death resulting from suicide within 2 years of the issue date of the policy, or, if later, the last date on which reinstatement was applied for in writing and accepted by the insurer;

b. Death resulting from a declared or undeclared war, if death occurs:

1. While the insured is outside the 50 states of the United States, D.C. and Canada and is in military service or a civilian unit required to serve with a military force;

2. Within 6 months after the insured returns to the United States, D.C. or Canada from military service or from service in a civilian unit required to serve with a military force, provided the insured is still in military service at the time of death; or

3. Within 6 months after the insured returns from service in a civilian unit required to serve with a military force outside the 50 states of the United States, D.C. or Canada, provided the insured is still in such service at the time of death; and

c. Death as a result of aviation, other than as a farepaying passenger, or other than military personnel, except the crew, aboard military multi-engined fixed wing air transports within the United States; and

(4) In the event of death occurring from one of the causes delineated in (3) above the premium shall be returned in at least the following manner:

a. The amount of the gross premiums paid, less dividends applicable, and less any indebtedness for policies up to and including 2 years from the date of issue; and

b. After 2 years from date of issue, the greater of:

1. The reserve on the face amount of the policy together with the reserve for any dividend additions, less indebtedness and including interest; or

2. Due and accrued of gross premiums paid, less dividends applicable, and less any indebtedness.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5653, eff 7-1-93; ss by #7016, INTERIM, eff 7-1-99, EXPIRED: 10-29-99

New. #8726, eff 9-18-06

Ins 401.05 Individual Accident and Health.

(a) All individual accident and health policy forms submitted shall comply with the provisions of RSA 415 and RSA 415-A.

(b) Additional policy form filing standards shall be as follows:

(1) Policies that supplement or complement Medicare or any government program shall not have policy titles, or headings or descriptions that might confuse them with or relate them in a misleading manner to the Federal Medicare Program or any government program;

(2) If the policy provides for any reduction in benefits or benefit period because of the attainment of a specified age limit, reference thereto shall be set forth on the first or specifications page;

(3) Loss of time policies shall not require that the loss from accidental injury commence within less than 30 days after the date of an accident;

(4) No policy of health and accident insurance shall be approved that contains a provision that the disability period shall be considered to commence with the date on which written notice is actually received by the company;

(5) Noncancellable policies with premium rates that are not presumed level but are expected to change periodically with the insured's attained age shall include the entire premium scale applicable to the insured;

(6) All other policies with premium rates that are not presumed level but are expected to change periodically with the insured's attained age shall not be required to include the entire premium scale applicable to the insured but shall disclose on the face page or the specifications page that the premium rates are subject to change based on the attained age of the insured and also identify the attained ages at which such changes will occur;

(7) With respect to policies where there exists an option for continuation of coverage at a specified time after attainment of age 65 or commencement of medicare coverage, whichever is earlier, and where the insurer reserves the right to change the coverages and/or the premium scale for such continuation, such premium scale may be omitted from the policy;

(8) For the purposes of paragraphs (6) and (7) above all conditions pertaining to the option of continuation of coverage and any changes in coverage shall be contained in the policy;

(9) Except in those instances where riders are prohibited by RSA 420-G:5 IV, any rider or endorsement that reduces or eliminates coverage under the policy shall provide for signed acceptance by the policyholder except in the case of a rider or endorsement that is used only at the time of policy issue;

(10) Any individual accident and health policy insuring against loss resulting from accidental bodily injuries only, shall specify on the face of the policy in no less than 14 point, bold face type, "This policy does not insure against loss resulting from sickness."

(11) The following provision shall appear in a conspicuous place on the face page of all accident and health policies except for nonrenewable travel insurance policies written for terms of less than one year:

"This policy may, at any time within 30 days after its receipt by the policyholder, be returned by delivering it or mailing it to the company or the agent through whom it was purchased. Immediately upon such delivery or mailing, the policy will be deemed void from the beginning, and any premium paid on it will be refunded."

(12) Direct response insurers may delete the reference in (11) above to "the agent through whom it was purchased";

(13) Unless the insurer has adopted a procedure to obtain a policyholder's dated and signed receipt for the delivery of the policy, it shall be presumed that the date of delivery is the date shown by the policyholder's records or by his memory;

(14) Any exception that excludes coverage by use of the terms "chronic disease" or "organic disease" shall not be permitted;

(15) Diseases sought to be excluded from coverage shall be stated with sufficient clarity to be readily identifiable;

(16) Common terms such as "heart disease," "pulmonary disease" or "disease of the generative organs" shall be acceptable.

(17) A policy may:

a. Require that the insured incur expenses that he is legally required to pay; and

b. Exclude charges that would not have been made if no insurance existed;

(18) Where the insurer reserves the right to cancel, the provisions of RSA 415:6, II (8) or RSA 420-G:6 VI. or VII. shall be delineated in the policy;

(19) Where the insurer's right to terminate the policy is restricted to premium due dates, the following, in addition to the renewal provision of the policy may be substituted for RSA 415:6, II (8):

a. The use of wording normally expressed as part of the grace period provision shall include:

"Unless not less than 10 days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address, as shown by the records of the insurer, written notice of its intention not to renew this policy beyond the period for which this premium has been accepted."

b. An appropriate definition of the classifications used in determining the policies to be nonrenewed.

(20) In order to secure the approval required in (19) b. above, the insurer shall make such request in writing and include in such request:

a. The number of New Hampshire policies currently in force;

b. An explanation of the classification of risk involved therein to indicate that such classification is reasonable and nondiscriminatory; and

c. Statistical data sufficient to indicate that the cancellation or nonrenewal requested is reasonable and nondiscriminatory;

(21) With respect to all individual accident and health policies, including those sold on a franchise basis, to which the refund provisions of RSA 415:6, II(8) do not apply, the insurer shall provide:

a. A refund of unearned premium upon a request for cancellation of the policy by the insured;

b. The period for which a refund is to be made measured from the date the request for cancellation is received by the insurer, or such later date as may be specified in the request, to the date to which premiums have been paid;

c. A refund amount of not less than 80 percent of the pro-rata unearned premium for such period; and

d. That no refund need be made if premiums are payable monthly.

(22) In the event of any renewal rate increase, insurers shall provide policyholders with prior notice of any such increase such that:

a. A 30 days notice is provided for policies subject to RSA 415; and

b. A 60 days notice is provided for policies subject to RSA 420-G;

(23) All policies of accident and health insurance, whether subject to Ins 1901 or not, shall define terms in the policy in a manner at least as favorable as the policy definitions contained in Ins 1901.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5653, eff 7-1-93; ss by #7016, INTERIM, eff 7-1-99, EXPIRED: 10-29-99

New. #8726, eff 9-18-06; ss by #9334, eff 12-5-08

Ins 401.06 Group Life Policies.

(a) The required provisions for group life policies shall be established in RSA 408:16;

(b) Other required policy standards shall be as follows:

(1) The policy shall apply to a group qualified for such insurance as provided by RSA 408:15;

(2) All group life certificates filed with this department shall provide for the identification of the individual(s) insured by having the name(s) of the insured(s) stated on the certificate or any code in the certificate sufficient to identify the insured(s);

(3) As an alternative to (2) above, any group life certificate shall define eligibility and benefit amounts;

(4) Each employee insured under a form of group life insurance shall be given evidence of his beneficiary in the certificate;

(5) In the case of a group life insurance plan that contains a disability benefit extension of any type including, but not limited to, premium waiver extension, extended death benefit in event of total disability, or payment of income for a specified period during total disability, the discontinuance of the group policy shall not operate to terminate such extension;

(6) Coverage may be provided to dependents in a contract of group life insurance pursuant to RSA 408:15, VIII; and

(7) Arbitration provisions shall be prohibited.

Source. #8726, eff 9-18-06

Ins 401.07 Group and Blanket Accident and Health.

(a) The required provisions for group and blanket accident and health insurance policies shall be those established in RSA 415:18;

(b) Other policy standards shall be as follows:

(1) Exclusions that are ambiguous or unfairly discriminatory shall be prohibited;

(2) All master policies and certificates shall contain a clear explanation as to continuance of coverage after termination of the policy;

(3) No group accident and health policy shall contain a provision for automatic termination of an individual's coverage upon the happening of a loss, except a loss that has exhausted all possible benefits under the policy;

(4) A certificate shall state the benefits applicable to the person insured or state the schedule of benefits applicable to the class to which he belongs;

(5) As an alternative to 4 above, any group accident and health certificate shall define eligibility and benefit amounts clearly enough for a person to determine whether he or she is an insured and the amount of any benefits to which he or she is entitled;

(6) Policies that are to be issued to supplement or complement Medicare shall not have policy titles, headings or descriptions that could confuse them with or relate them in a misleading manner to the federal Medicare program or any government program;

(7) A policy may require that the insured:

a. Incur expenses that the insured is legally responsible to pay for;

b. Exclude charges that would not have been made if no insurance existed; and

c. Be responsible for non-covered services;

(8) All group or blanket certificates shall include a complete statement of the policy provisions regarding coordination or nonduplication of benefits in the event of other coverage;

(9) In the event of any renewal rate increase, insurers shall provide policyholders with prior notice of any such increase such that:

a. A 30 days notice is provided for policies subject to RSA 415; and

b. A 60 days notice is provided for policies subject to RSA 420-G;

(10) Declination of renewal or termination of insurance provisions shall be as follows:

a. No insurer shall decline to renew a group policy unless the cause of its action is based on one or more of the reasons for declination of renewal stated in the policy;

b. Any such reason shall be stated in a group policy and shall be objective in nature;

c. Declination of renewal shall be defined so as to include any termination of a group policy by the insurer for any reason except for nonpayment of premiums; and

d. Notice of nonrenewal or termination of a group or blanket policy by the insurer shall provide for at least 45 days prior notice, except policies subject to RSA 420-G:6 VI. and VII;

(11) Non-duplication of coverage and subrogation provisions shall be as follows:

a. Benefit provisions for group or blanket medical expense insurance coverages may provide for non-duplication or coordination with any plan or government program providing benefits or services for medical or dental care and treatment;

b. All policies with non-duplication or coordination of benefit provisions shall:

1. Clearly stipulate how these provisions will be administered; and

2. Be at least as favorable to the insured as the provisions of Ins 1904;

c. Group or blanket policies providing medical expense insurance coverages may include subrogation provisions or provisions that are similar in their intent and purpose; and

d. Group or blanket excess policies that provide insurance for only part of a loss in excess of coverage provided by other insurance carriers shall be prohibited except as follows:

1. Student accident only insurance policies written on either a group or blanket basis, may include a non-duplication provision stating that covered medical expenses shall not include any charges or medical expenses to the extent that they are compensable under any other group or blanket health insurance plan in this or any other insurer or service organization if total covered expenses exceeds $100. Such student accident policies shall be considered primary with respect to covered expenses of $100 or less regardless of other insurance;

2. Any policy that excludes coverage payable under another policy issued to the policyholder on behalf of the same, or a class of, insureds under another policy; and

3. Group or blanket policies providing insurance to community-based volunteer groups such as youth groups, volunteer fire departments or youth athletic teams may be written on an excess basis provided that all premiums due under the policy are paid entirely by the sponsoring organization; and

(12) In no case shall the benefits provided under the policy, or the definitions contained in the policy be less favorable to the insured than the minimum standards for individual accident and health benefits set forth in Ins 1901.

Source. #8726, eff 9-18-06

Ins 401.08 Group Annuity Contracts.

(a) The following provisions shall be required in group annuity contracts:

(1) A provision that there shall be a grace period of, either 30 days or one month, within which any stipulated payment to be remitted by the policyholder to the insurer, falling due after one year from date of issue, may be made, subject to the option of the insurer, to an interest charge thereon, at a rate to be specified in the contract, for the number of days elapsing before such payment is received by the insurer;

(2) A provision specifying the document or documents constituting the entire contract between the parties that shall only include:

a. The contract, the contract together with the application of the policyholder, or the contract together with the application of the policyholder; and

b. The individual applications of annuitants on file with the insurer; and

(3) A provision for the equitable adjustment of benefits payable under the policy if sex, age, service, salary or any other factor determining the amount of any stipulated payment or the amount or dates of payment of any benefit with respect to any annuitant covered thereby, has been misstated.

(b) A group shall be qualified for such annuity if it meets one of the following requirements:

(1) Under a contract issued to an employer if:

a. The stipulated payments are to be remitted by the employer; and

b. The contract permits all of the employees of such employer, or any specified class or classes thereof, to become annuitants; and any such group of employees may include:

1. Retired employees;

2. Officers and managers as employees;

3. The employees of subsidiary or affiliated corporations of a corporation employer; and

4. The individual proprietors, partners and employees of affiliated individuals and firms controlled by the holder through stock ownership, contract or otherwise;

(2) Under a contract issued to an employers' association, that:

a. May, but shall not be required to, provide for the representation of annuitants on its board of directors;

b. Permits all of the employees of such employers, or of any specified class or classes thereof, to become annuitants; and

c. Requires that the stipulated payments under such contract shall be remitted by such employers' association;

(3) Under a contract issued to a labor union that:

a. Permits all of the members of such union, or of any specified class or classes thereof, to become annuitants;

b. Requires that the stipulated payments under such contract shall be remitted by such union;

(4) Under a contract issued to an association or to trustees of a fund established by such an association, if the persons in the association have a common interest, calling or profession and constitute a homogeneous group and the association:

a. Has a constitution and bylaws; and

b. Is organized and maintained in good faith for purposes other than obtaining annuities;

and

c. Permits all members of the association and their employees, or any specified class or

classes thereof, to become annuitants; and

(5) Under a contract issued to the trustees of a fund established by an employer, or by an employers' association, or by one or more labor unions or by one or more employers and one or more labor unions if:

a. The trustees are deemed the contractholder;

b. The contract permits all of the employees of the employers or all of the members of the

unions, or all of any class or classes thereof, to become annuitants; and

c. The stipulated payments under such contract remitted by the trustees are not derived

wholly from funds contributed by the person covered thereunder.

(c) The contract in (b)(5)b. above may provide that the term "employees" shall include retired employees, officers and managers of an employer.

Source. #8726, eff 9-18-06

Ins 401.09 Variable Contracts.

(a) Variable contracts shall include all contracts that do either or both of the following:

(1) Place funds in any separate account or accounts maintained by the insurance company for accumulation purposes and where the value of the funds being accumulated may vary according to the investment experience of the separate account or accounts; and

(2) Provide annuity benefit payments to annuitants from any separate account or accounts maintained by the insurance company and where the value of the annuity benefit payments can vary according to the investment experience of the separate account or accounts.

(b) Individual variable annuity contracts shall be subject to the applicable provisions of RSA 408 and all of the provisions of Ins 401.04 except for Ins 401.04 (f).

(c) Group variable annuity contracts shall be subject to the applicable provisions of RSA 408 and all of the provisions of Ins 401.08.

(d) Additional provisions required for variable annuity contracts shall include that:

(1) Any variable contract providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of such variable benefits;

(2) Any such contract, including a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that such dollar amount may vary to reflect investment experience;

(3) Any such contract shall contain on its first page a clear statement to the effect that the benefits thereunder are on a variable basis;

(4) No individual variable annuity contract calling for the payment of periodic stipulated payments shall be delivered or issued for delivery in this state unless it contains in substance the following provision or provisions:

a. A provision that there shall be a grace period of 30 days or of one month, within which any stipulated payment to the insurer falling due after the first may be made, and during which period of grace the contract shall continue in force;

b. For the purposes of a. above, the contract may include a statement of the basis for determining the date as of which any such payment received during the grace period shall be applied to produce the values under the contract arising therefrom;

c. A provision that, at any time within 3 years from the date of default, in making periodic stipulated payments to the insurer during the life of the annuitant and unless the cash surrender value has been paid, the contract may

be reinstated upon payment to the insurer of such overdue payments as required by the contract, including interest;

d. For the purposes of c. above, the contract may include a statement of the basis for determining the date as of which the amount to cover such overdue payments and indebtedness shall be applied to produce the values under the contract arising therefrom; and

e. A provision specifying the options available in the event of default in a periodic stipulated payment, such as an option to surrender the contract for a cash value as determined by the contract, including an option to receive a paid-up annuity if the contract is not surrendered for cash, the amount of which is determined under the terms of the contract by applying the value of the contract at the annuity commencement date;

(5) No individual variable life insurance policy shall be delivered or issued for delivery in this state unless it contains in substance the following:

a. A provision that there shall be a grace period of 30 days or one month, within which payment of any premium after the first may be made, and during which grace period the policy shall continue in force;

b. A provision that if a claim arises under the policy during the grace period and before the overdue premiums or the deferred premiums of the current policy year, if any, are paid, the amount of such premiums, together with interest not to exceed 6 per centum per annum compounded annually may be deducted from any amount payable under the policy in settlement;

c. A statement of the basis for determining any variation in benefits that may occur as a result of the payment of premium during the grace period;

d. Upon the request of the policyholder, unless the cash surrender value of a variable life insurance policy has been paid out in full or the period of extended insurance has expired, any variable life insurance policy shall be reinstated during the life of the insured anytime within 3 years of the date of default if:

1. Evidence of insurability satisfactory to the insurer is provided to the insurer;

2. Payment is tendered to the insurer in an amount not to exceed the larger of the:

(i) Sum of:

i. Overdue premiums, including interest at a rate not to exceed 8 percent per annum compounded annually; and

ii. Any outstanding policy loans, including interest at a rate that would be permitted under this rule if the policy had not lapsed; and

(ii) One hundred ten percent of the increase in cash surrender value resulting from reinstatement; and

e. A provision for cash surrender values and paid-up insurance benefits available as nonforfeiture options under the policy in the event of default in a premium payment after premiums have been paid for a specified period pursuant to Ins 401.10.

(6) Any variable annuity contract delivered or issued for delivery in this state shall stipulate the investment in increment factors to be used in computing the dollar amount of variable benefits or other variable contractual payments or values thereunder, and may guarantee that expense and/or mortality results shall not adversely affect such dollar amounts; and

(7) In the case of an individual variable annuity contract under which the expense and mortality results could adversely affect the dollar amount of benefits, the expense and mortality factors shall be stipulated in the contract as follows:

a. In computing the dollar amount of variable benefits or other contractual payments or values under an individual variable annuity contract;

1. The annual net investment increment assumption shall not exceed 5 percent, except;

2. To the extent that the level of benefits may be affected by future mortality results, the mortality factor shall be determined from the Annuity Mortality Table for 1949, Ultimate, or any modification of that table not having a lower life expectancy at any age; and

3. "Expense," as used in this paragraph may exclude some or all taxes, as stipulated in the contract; and

b. Any individual variable life insurance policy delivered or issued for delivery in this state shall stipulate the investment increment factor to be used in computing the dollar amount of variable benefits or other variable contractual payments or values thereunder and shall guarantee that expense and mortality results shall not adversely affect such dollar amounts.

Source. #8726, eff 9-18-06

Ins 401.10 Computation of Cash Values for Variable Annuities.

(a) If the variable annuity policy does not include a table of figures for the options so available, the policy shall provide that the company will furnish at least once in each policy year a statement showing the cash value as of a date no earlier than the prior policy anniversary.

(b) The method of computation of cash values and other nonforfeiture benefits, as described either in the policy or in a statement filed with the commissioner of the jurisdiction in which the policy is delivered, shall be in accordance with actuarial procedures that recognize the variable nature of the policy.

(c) The method of computation shall be such that, if the net investment return credited to the contract at all times from the date of issue should be equal to the assumed investment increment factor if the contract provides for such a factor or 3-1/2 percent if not, with premiums and benefits determined accordingly under the terms of the policy, the resulting cash values and other nonforfeiture benefits would be at least equal to the minimum values required by RSA 409 Standard Nonforfeiture Law, for a fixed dollar policy with such premiums and benefits.

(d) The method of computation may disregard incidental minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees shall include, for example, but shall not be limited to, a guarantee under a policy that provides for an assumed investment increment factor that the amount payable at death or maturity shall be at least equal to the amount that otherwise would have been payable if the net investment return credited to the contract at all times from the date of issue had been equal to such factor.

Source. #8726, eff 9-18-06

Ins 401.11 Applications.

(a) The following standards shall apply to all application forms used in connection with the offer and acceptance of insurance, whether or not attached to the contract:

(1) The declarative portion of the application, if any, shall imply a representation of facts to the best of the applicant's knowledge. "I represent," or "To the best of my knowledge and belief," shall be examples of such wording. Wording implying a warranty shall be prohibited. "I Certify" shall be such an example:

(2) There shall be no provisions for automatic rejection;

(3) Medical questions of a technical nature beyond the capability of the average applicant, such as a detailed gastrointestinal questionnaire, shall be prohibited;

(4) No provision shall be permitted in an application that changes the terms of the policy to which it is attached;

(5) Questions as to race or color shall be prohibited;

(6) All applications shall contain a question inquiring whether the policy sought is intended to replace an existing policy.

(7) The requirement in (6) above shall not apply to applications for:

a. Group insurance;

b. Group annuity policies;

c. Individual accident only policies; or

d. Policies solicited by direct-response means; and

(8) No application or any detachable part thereof that contains an advertisement that is directed toward effecting a policy sale without opportunity for additional explanation of the coverage advertised, shall:

a. Offer any reduced initial premium without stating all subsequent premium changes applicable to the insured;

b. State or imply falsely that prospective policyholders become group or quasi-group members and as such enjoy special rates or underwriting privileges; or

c. State or imply falsely that a particular policy or combination of policies is an:

1. Introductory;

2. Initial;

3. Special; or

4. Limited enrollment offer and that the applicant will receive advantages by accepting the offer.

Source. #8726, eff 9-18-06

Ins 401.12 Forms Filing, Review and Inventory Procedures.

(a) Pursuant to the provisions of RSA 408, RSA 408-A, RSA 409, RSA 415, RSA 415-A, RSA 415-D, RSA 415-F, RSA 415-H, RSA 420-A, RSA 420-B, RSA 420-F, RSA 420-G, RSA 420-J, all policies, contracts, certificates, endorsements, riders, applications and other forms used in connection therewith, shall be submitted to the insurance department for approval prior to their use.

(b) All submissions shall be made by the home office of the company.

(c) In instances where a filing is being made on behalf of a company, a letter or other documentation authorizing the firm to file on behalf of the company shall be attached to the supporting documentation tab in SERFF.

(d) All submissions and associated fees shall be submitted electronically through SERFF and electronic funds transfer (EFT).

(e) A certification of compliance statement shall be signed by a representative of the company authorized to certify compliance and attached to the supporting document tab in SERFF.

(f) All filings shall include the following:

(1) A brief description of each form, including any new or unusual features, and a listing of forms to which it will be attached;

(2) A statement indicating the current submission's filing status in the state of domicile, the date approved by the state of domicile, and state of domicile status comments shall be completed on the general information tab in SERFF;

(3) If this form is replacing another form, said other form shall be identified. If this form is not replacing another form, it shall be so stated; and

(4) Where a form is replacing another form, a letter shall itemize each of the differences between the new form and the form being replaced which shall be attached to the supporting documentation tab in SERFF. A copy of the new form showing each change highlighted or otherwise indicated shall also be attached to the supporting documentation tab in SERFF.

(g) All forms shall be submitted for review in the same layout as sold to consumers in New Hampshire. Multiple product line filings shall not be submitted as a single policy if any product line in the filing may be marketed or issued as a separate policy.

(h) All policy forms containing 3,000 or more words or printed on 3 or more pages shall contain a table of contents or an index of the principal sections of the policy and shall be electronically bookmarked.

(i) All submitted forms shall be filled out in "John/Jane Doe" fashion where appropriate.

(j) The specifications page of a policy or contract shall be completed with hypothetical data that is realistic and consistent with the other contents of the policy or contract.

(k) With respect to any submission of a company domiciled in a state or country where the state insurance department or comparable agency requires foreign or alien insurers to pay any

fees for the filing or examination of policy forms, the submission shall include an EFT payment of the retaliatory fee due to the state of New Hampshire pursuant to RSA 400-A:35.

(l) All forms shall be filed as intended for use, with all necessary related forms.

(m) Policies shall include "John/Jane Doe" application forms.

(n) Certificates shall include enrollment forms.

(o) Policies, certificates and rates shall be submitted together to the department.

(p) Where amendatory pages are submitted, those pages shall be properly executed as such.

(q) A rider, amendment, or endorsement, that changes or addds language to another form shall be filed together with the complete form it is replacing or amending, including the underlying policy form, showing all changes highlighted or otherwise indicated on the supporting document tab in SERFF.

(r) All variable language shall be identified by the use of brackets, accompanied by a statement of variability, and attached on the supporting document tab in SERFF which shall describe the full range of variability. Variable language shall not be approved if the variable language prevents review of the policy for compliance with minimum standards or the requirements of RSA 415:2.

(s) Complete revised forms including amendments shall be submitted with a distinguishing form number.

(t) All forms submitted shall be in final print.

(u) Forms shall be submitted with the exact content as intended for use by the company and shall bear facsimile signatures of corporate officers. However, facsimile signatures shall not be required on group certificates.

(v) Because of the many variations possible in group policies, their certificates and all of the intended insert pages reflecting possible variations shall be reviewed, provided that such filing is accompanied by a statement of variability describing all combinations used for the different types of policies.

(w) Every filing of a group policy or group policy page shall include the simultaneous filing of the corresponding group certificate page. In addition, every filing of a group certificate or group certificate page shall include the simultaneous filing of the corresponding group policy or group policy page.

(x) Any submission of a "blank" rider, amendment or endorsement form shall in all instances be accompanied by a listing of all intended uses attached to the supporting document tab in SERFF.

(y) In the event that forms submitted to this department by an insurer are not approved, and such forms are thereafter corrected and resubmitted, the previous submission's SERFF number shall be given, all previous correspondence attached to the supporting document tab in SERFF. The filing description for the resubmission shall comply with all the provisions of Ins 401.12 and include a description of each correction made in reference to the prior submission. A copy of the new form showing each change highlighted or otherwise indicated shall also be attached to the supporting document tab in SERFF.

(z) Submissions that comply with the foregoing requirements of this rule, and the requirements of (ab) below if applicable, shall be accepted for filing and review by the commissioner.

(aa) Submissions that do not comply with these requirements shall be immediately rejected.

(ab) Policy forms that are resubmitted and disapproved 2 times by the department under (y) above due to non-compliance with statutes and rules shall not be given further consideration until a company representative personally attends a compliance conference at the department to discuss the form submission.

(ac) File and use provisions for complete filings shall be as follows:

(1) After any forms have been received and pending with the commissioner for more than 30 days and if the forms have not been objected to by the commissioner, the company may deem or otherwise use such forms in this state;

(2) When a company decides to deem a form pursuant to this paragraph, the company shall immediately advise the commissioner in writing of the date such form was so deemed;

(3) After a form has been filed with the commissioner, the company may withdraw that form from consideration if it has not already been approved, disapproved, or deemed pursuant to this paragraph, provided written notice of such withdrawal is given to the commissioner;

(4) When a company withdraws from use any form that it has used in this state, written notice of such withdrawal shall be provided to the commissioner advising the commissioner of the date of such withdrawal.

Source. #8726, eff 9-18-06; ss by #9334, eff 12-5-08

Ins 401.13 Penalty; Generally.

(a) Any insurer, producer, or any person, firm, association or corporation knowingly violating any provisions of this part shall be subject to the provisions of RSA 400-A:15 III.

Source. #8726, eff 9-18-06

APPENDIX I.

Life, Accident & Health, Annuity, Credit Transmittal Document (Revised 1/1/06)

1.	**Prepared for the State of**	

2.	**Department Use Only**
	State Tracking ID

3.	**Insurer Name & Address**	**Domicile**	**Insurer License Type**	**NAIC Group #**	**NAIC #**	**FEIN #**

4.	**Contact Name & Address**	**Telephone #**	**Fax #**	**E-mail Address**

5.	**Requested Filing Mode**	☐ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	**Company Tracking Number**		
7.	☐ **New Submission** ☐ **Resubmission** Previous file # _____		
8.	**Market**	☐ Individual ☐ Franchise	
		Group	☐ Small ☐ Large ☐ Small and Large ☐ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	**Type of Insurance**		
10.	**Product Coding Matrix Filing Code**		

11.	**Submitted Documents**	☐ **FORMS** ☐ Policy ☐ Outline of Coverage ☐ Certificate ☐ Application/Enrollment ☐ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other **Rates** ☐ New Rate ☐ Revised Rate ☐ **FILING OTHER THAN FORM OR RATE:** Please explain: _____ **SUPPORTING DOCUMENTATION** ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreements ☐ Statement of Variability ☐ Certifications ☐ Actuarial Memorandum ☐ Other_____
12.	**Filing Submission Date**	
13	**Filing Fee** **(If required)**	Amount _____ Check Date _____ Retaliatory ☐ Yes ☐ No Check Number _____
14.	**Date of Domiciliary Approval**	
15.	**Filing Description:**	

16.	Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of _____.

Print Name _____ Title _____

Date: _____

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01			☐ Initial ☐ Revised ☐ Other _____	
02			☐ Initial ☐ Revised ☐ Other _____	
03			☐ Initial ☐ Revised ☐ Other _____	
04			☐ Initial ☐ Revised ☐ Other _____	
05			☐ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	

09			☐ Initial ☐ Revised ☐ Other	
10			☐ Initial ☐ Revised ☐ Other _____	

18.	Rate Filing Attachment			
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number				
Overall percentage rate impact for this filing			%	
	Document Name Description	Affected Form Numbers		Previous State Filing Number
01			☐ New ☐ Revised Request +____% -____% ☐ Other _____	
02			☐ New ☐ Revised Request +____% -____% ☐ Other _____	
03			☐ New ☐ Revised Request +____% -____% ☐ Other _____	

04			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
05			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
06			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
07			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
08			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
09			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	

10			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	

Instruction Sheet for Life, Accident and Health, Annuity, Credit Transmittal Document

(*See state specific requirements prior to submitting filings to the respective state)

1. Prepared for the State of: _____— Indicate for which state the filing is being prepared.

2. Department Use Only—

- State Tracking ID – State assigned ID for internal purposes, if applicable.
- Space available for state to input

3. Insurer Name & Address – Provide the insurance company name and address. This is the licensee name on the submitted forms.

- State of Domicile – State of domicile for company.
- Insurer License Type – The type of entity as listed on the Certificate of Authority or as licensed by the state to which the filing is being submitted. Examples include Life, HMO, Fraternal, Accident & Health, and Property & Casualty.
- NAIC Group # – NAIC Group number (3 digits).
- NAIC #—NAIC Company code number (5 digits).
- FEIN #—Federal identification number.

4. Contact Name and Address - Compliance contact(s) for submission, company's name (if other than the insurer), and address for correspondence.

- Telephone Number—Telephone number of the contact person.

- Fax Number—Fax number of the contact person.
- E-mail—E-mail address of the contact person.
- If contact person is a third party filer, a letter of authorization must be submitted.

5. Requested Filing Mode – Indicate the type of filing review requested. Only one option may be selected. If Combination or Other is selected, an explanation is required.

6. Company Tracking Number—Company's internal filing number or identifier. (If applicable)

7. New Submission or Resubmission – If resubmission, provide the state tracking number for the prior submission if it was provided by the state. If no state tracking number is available, and the prior filing was made in SERFF, provide the prior filing's SERFF Tracking Number. If neither is available, leave this blank.

8. Market—An identification of the targeted group or individuals. If Group, first select group size, then select one or more group types. If Other is selected, an explanation must be provided.

9. Type of Insurance—List all applicable types utilizing the NAIC Uniform Life, Accident & Health, Annuity, Credit Product Coding Matrix. [Drafters note: To be provided upon adoption from the NAIC Product Coding sub group committee.]

10. Product Coding Matrix Filing Code — Refer to the NAIC Uniform Life, Accident & Health, Annuity, Credit Product Coding Matrix. (www.naic.org)

11. Submitted Documents-

- Mark ALL applicable boxes.
- If filing forms, complete the Form Filing Attachment.
- If filing rates, complete the Rate Filing Attachment.
- If Filing Other Than Form or Rate is selected, identify what is being submitted and provide any required documents according to state regulations.

- Provide explanation whenever Other is selected.
- Submit the required number of copies according to state specific instructions

12. Filing Submission Date—Date the filing is being submitted by the company.

13. Filing Fee (If required) – If a filing fee is required by the state for which the filing is being prepared, indicate the amount, whether retaliatory, check date, and check number. See State specific instructions.

14. Date of Domiciliary Approval—Date filing was approved in domicile. If not approved, provide clarification.

15. Filing Description—General description of the filing. This section replaces the body of the cover letter, and should be completed according to state specific instructions.

16. Certification (If required)-

- A Certification indicating you have reviewed state filing requirements and complied with all applicable statutory and regulatory provisions for the state for which the filing is being prepared. See State specific instructions.
- Provide name, title, date, and signature.

NOTE: No changes were required for the instructions to the Form and Rate schedules.

PART Ins 402 STANDARDS FOR FILINGS PROVIDING A RETURN OF PREMIUM OR CASH BENEFITS

Ins 402.01 Scope.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5653, eff 7-1-93; ss by #7016, INTERIM, eff 7-1-99, EXPIRED: 10-29-99

Ins 402.02 Standards Required.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5653, eff 7-1-93; ss by #7016, INTERIM, eff 7-1-99, EXPIRED: 10-29-99

Ins 402.03 Rate Filings.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5653, eff 7-1-93; ss by #7016, INTERIM, eff 7-1-99, EXPIRED: 10-29-99

Ins 402.04 Nonconforming Forms Subject to This Part.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5653, eff 7-1-93; ss by #7016, INTERIM, eff 7-1-99, EXPIRED: 10-29-99

Ins 402.05 Penalties.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5653, eff 7-1-93; ss by #7016, INTERIM, eff 7-1-99, EXPIRED: 10-29-99

Ins 402.06 Separability.

Source. #1900, eff 1-1-82; ss by #4287, eff 7-1-87; ss by #5653, eff 7-1-93; ss by #7016, INTERIM, eff 7-1-99, EXPIRED: 10-29-99

PART Ins 403 STANDARD WELLNESS PLAN RATE AND FORM FILING STANDARDS

Statutory Authority: RSA 400-A:15, I.; RSA 420-G:4-b, III.

Ins 403.01 Purpose. The purpose of this part is to establish guidelines and standards for the standard wellness plan under RSA 420-G:4-b.

Source. #9511, eff 7-10-09

Ins 403.02 Applicability and Scope. This part applies to all rate and form filings for the standard wellness plan under RSA 420-G:4-b.

Source. #9511, eff 7-10-09

Ins 403.03 Definitions. For the purposes of this chapter:

(a) "Care navigator" means an informed decision-making resource provided by the carrier that is designed to provide members with information about treatment options, identify and assist members in navigating through the healthcare system and to direct the member to related resources within the healthcare community.

(b) "Carrier" means any entity that offers health coverage in the small employer market in this state and has at least 1,000 covered lives as of the first day of the calendar year and that is subject to the requirement of offering the standard wellness plan.

(c) "Commissioner" means the insurance commissioner.

(d) "Department" means the New Hampshire insurance department.

(e) "Health coverage plan target rate" means the health coverage plan rate that is set at or below 10 percent of the prior year's median wage based on the occupation employment statistics maintained by the U.S. Department of Labor and adjusted by the state department of labor to reflect the median hourly wage of full time New Hampshire employees.

(f) "HealthFirst benefit plan" means the HealthFirst standard benefit design, including the HealthFirst wellness incentives as set forth in the HealthFirst benefit description.

(g) "Prescription drugs" means covered medications, diabetic supplies and contraceptive devices purchased at a network pharmacy.

(h) "Preventive care services" mean:

(1) Immunizations;

(2) Lead screening;

(3) PSA tests;

(4) Routine physical exams, including family planning, pre-natal visits and well child care;

(5) Annual ob-gyn visits, including mammography;

(6) Routine hearing tests;

(7) Routine laboratory tests; and

(8) Annual care plan for chronic illnesses.

(i) "Standard wellness plan" means the benefit plan developed by the commissioner pursuant to RSA 420-G:4-b.

Source. #9511, eff 7-10-09

Ins 403.04 Standard Wellness Plan. The standard wellness plan shall include the following benefit structure as described herein and as set forth in Appendix A:

(a) Benefits shall include:

(1) Full coverage for preventive care services;

(2) Primary care visits covered with a $20.00 per visit copay;

(3) Specialist visits covered with a $50.00 per visit copay;

(4) Full coverage for inpatient and outpatient hospital care, including diagnostic laboratory work, after the deductible has been met;

(5) Skilled nursing facility care for a period of up to 100 days within each policy year, subject to the deductible;

(6) Rehabilitation facility care for a period of up to 60 days within each policy year, subject to the deductible;

(7) Full coverage for diagnostic laboratory work;

(8) Diagnostic radiology, including x-rays, MRI's, CT scans, and PET scans, subject to the deductible, except for mammograms which are preventive care shall not be subject to the deductible;

(9) Outpatient surgery performed in a physician's office, subject to the office visit copay of $20 for a primary care provider and $50 for a specialist;

(10) Outpatient surgery performed in a hospital or surgical center, subject to the deductible;

(11) Urgent care facility care, subject to a $100 per visit copay for the facility charge with other covered services subject to the tier 1 or tier 2 deductible for facilities that are hospital owned. If the urgent care facility is not hospital owned, the services shall be subject to the tier 1 deductible;

(12) Emergency care facility care, subject to a $200 per visit copay for the emergency room facility charge. Other covered services, including radiology and laboratory work, delivered at the emergency room shall be subject to the tier 1 deductible;

(13) Ambulance services, subject to the deductible;

(14) Short-term therapy, including physical therapy, speech therapy, and occupational therapy, subject to a $50 per visit copay;

(15) Mental health and substance abuse services, subject to a $20 per visit copay for office visits and subject to the inpatient and outpatient deductible when the services are provided at a hospital or outpatient care facility;

(16) Durable medical equipment, subject to the deductible and limited to a calendar year maximum of $3,000;

(17) Prescription drugs including covered medications, diabetic supplies and contraceptive devices purchased at a network pharmacy, subject to:

a. The following copays:

1. A $10 copay for generic drugs;

2. A $35 copay for non-generic formulary drug brands; and

3. A $50 copay for non-formulary brand drugs.

b. Drugs that are considered maintenance shall be available for a supply greater than 30 days;

c. The copay shall be applied to each 30 day supply of the drugs except when drugs are purchased through a mail-order facility that offers a reduction of copay(s) for purchasing through the mail-order facility; and

d. For formulary brand and non-formulary brand at least 2 brand drugs shall be available for each therapeutic class covered under the HealthFirst benefit plan.

(18) Full coverage for screening and brief intervention for alcohol and drug abuse;

(19) Full coverage for body mass index screening; and

(20) Colonoscopy, subject to a $250 copay.

(b) The standard wellness plan shall use hospital tiering of acute care hospitals to determine the amount of the hospital deductible, so that:

(1) The deductible for tier 1 facilities shall be $2,500 per member and $5,000 per family; and

(2) The deductible for tier 2 facilities shall be $4,000 per member and $8,000 per family.

(c) The annual out of pocket maximum for the standard wellness plan shall be $5,000 per member and $10,000 per family. There shall not be a lifetime maximum amount.

(d) A separate annual out-of-pocket maximum for prescription drugs may be offered with an annual out-of-pocket of $5,000 per member and $10,000 per family. There shall not be a lifetime maximum amount.

(e) The standard wellness plan shall comply with all state laws and rules related to small group accident and health insurance coverage, including, but not limited to state mandated benefits in RSA 415, 420-B, 420-J and Ins 1900.

(f) The use of a telecommunications or telehealth system shall be defined by the insurer and may substitute for an in-person visit for consultations, office and outpatient visits, psychiatric diagnostic interviews, individual psychotherapy, individual medical nutrition therapy, end-stage renal disease (ESRD) services, and pharmacologic management. Telehealth shall not be used for group visits.

(g) The care navigator shall be included in the benefit design; and

(h) The care navigator shall specifically describe:

(1) The application of the care navigator in the HealthFirst benefit plan; and

(2) How the care navigator shall be used in each applicable benefit description.

Source. #9511, eff 7-10-09

Ins 403.05 Wellness Incentive Plan.

(a) The standard wellness plan shall include a standard wellness incentive program. In administering the standard wellness incentive program, a carrier may utilize existing programs to the extent practicable.

(b) The standard wellness program shall include the following incentives described herein and set forth in Appendix B:

(1) In year one, a cash payment of $200.00 shall be paid to both the subscriber and the spouse or civil union partner of a subscriber on a plan that covers 2 or more people when the subscriber and spouse or civil union partner:

a. Establish and maintain a relationship with a primary care provider;

b. Complete a health risk questionnaire;

c. Do not smoke or participate in a smoking cessation program;

d. Each have a body mass index measurement lower than 25 and a blood pressure reading lower than 140/90 or participate in a health management program for blood pressure or weight loss; and

e. Each have acceptable blood glucose and cholesterol levels as determined by the health carrier, or participate in a health management program;

(2) In years 2 and 3, the certificateholder who fulfills the requirements of Ins 403.05 (b) for year one shall receive a credit in the amount of $1,000 against the deductible for the product;

(3) To receive the amount of $1,000 per adult subscriber against the deductible in subsequent years, on a policy that covers 2 or more persons, the subscriber and spouse or civil union partner shall both be required to fulfill the requirements to obtain any benefit. A maximum credit of $2,000 shall be allowed on any policy that covers 2 or more people; and

(4) In the event that both the subscriber and the spouse or civil union partner covered by the policy fail to fulfill the requirements, there shall be no reduction of the deductible, and there shall be no payment of $200.00 in the first year.

Source. #9511, eff 7-10-09

Ins 403.06 Hospital Tiering.

(a) Hospital tiers shall be incorporated into the HealthFirst standard benefit design. The member deductible for hospital services shall be based on whether the member obtains services from a tier 1or a tier 2 hospital. A listing of the hospitals in each tier shall be provided in the HealthFirst benefit description.

(b) The HealthFirst standard benefit design shall require greater cost sharing for members seeking services from a tier 2 hospital than for those who obtain services from a tier 1 hospital.

(c) The procedure for the assignment of hospitals to tiers shall be as follows:

(1) The department shall use the all payer claims data base for the previous calendar year, collected pursuant to RSA 420-G:11, and the New Hampshire health care facility data, collected pursuant to He-C 1500, to determine historical pricing and payment differences among hospitals;

(2) Assignment to a tier shall be based on relative payment differences among the hospitals as well as geographical proximity and access;

(3) A hospital in close proximity to a lower cost hospital that provides services within the same hospital service area may be assigned to tier 2 despite its overall cost ranking across all hospitals in the state. The assignment of a hospital to tier 2 shall be based on geographical location;

(4) All hospitals located out of state shall be assigned to tier 2; and

(5) The department shall publish the hospital tiering by December 1st of each year. The hospital tiers shall be effective on a calendar year basis beginning on January 1st of each year.

Source. #9511, eff 7-10-09

Ins 403.07 Application for Carrier Specific Hospital Tiering.

(a) A carrier may submit an application to the department to use carrier specific hospital tiering.

(b) The application for carrier specific tiering shall establish that carrier specific deviations from the department's tiering will result in reduced expenditures to the carrier based on the carrier's payment for specific services, admissions to hospitals, utilization of specific services and quality measures.

(c) The application shall contain:

(1) Historical data as well as current information on contract reimbursement levels;

(2) A detailed explanation of the methodology used, including:

a. The time frame of the data;

b. The membership included; and

c. A description of the analytic tools used including:

1. Case-mix adjustment;

2. The number of observations;

3. The weighting used relative to outpatient and inpatient services;

4. Contact information for the analyst preparing the application; and

5. Hospital specific relative rankings for each hospital for which a tier change is requested; and

(3) The application may include a request for tier changes to out of state as well as in state hospitals.

(c) A carrier seeking approval for carrier specific hospital tiering shall submit the application to the department no more than 7 days following the publication date of the department's tiering.

Source. #9511, eff 7-10-09

Ins 403.08 Standard for Approval of Tier Change. The department shall grant approval for carrier specific tiers when the department finds based on substantial evidence that the requested tier change is cost effective to the carrier requesting the change.

Source. #9511, eff 7-10-09

Ins 403.09 Applications for Tier Changes. All applications for tier changes submitted by carriers shall be maintained as confidential documents by the department, and the information contained in the application shall not be released.

Source. #9511, eff 7-10-09

Ins 403.10 Required Reporting. Each carrier shall submit to the department the following reports:

(a) Quarterly trend information on small group HealthFirst business and comparative small group trend information on other small group products no later than 30 days after the end of each calendar year quarter. Trend information shall include the total trend and detailed numerical information on utilization, cost, technology and other factors comprising total trend numbers.

(b) Quarterly total enrollment information on the HealthFirst product no later than 30 days after the end of the calendar year quarter. Enrollment information shall include the number of subscribers, the number of spouses or civil union partners, and the number of dependent children or other dependents by enrollment classification.

(c) Quarterly, no later than 30 days after the end of the calendar year quarter, the total premium earned and total paid claims for the preceding quarter.

Source. #9511, eff 7-10-09

Appendix A

NH HealthFirst Program Benefit Summary

Benefits	HealthFirst Plan
Preventive Care Services: Immunizations, Lead Screenings, PSA, Routine Physical Exams (including family planning, pre-natal & well child care), annual ob-gyn visits (including mammography), Routine Hearing Laboratory and an Annual Care Plan for Chronic Illnesses	Covered in Full
Other Office Visits: Primary Care Copay Specialist Copay Colonoscopy	 $20 per visit $50 per visit Subject to $250 copay
Deductible (single family traditional) **Coinsurance** **Max out of pocket (single/family traditional)**	Tier 1 Facilities: $2,500/$5,000 Tier 2 Facilities: $4,000/$8,000 None $5,000/$10,000
Lifetime Maximum	No maximum
In/Out Patient Hospital Care	Subject to deductible, including diagnostic lab
Skilled Nursing & Rehab Facilities: SNF limited to 100 days/CY, Rehabilitation Facility limited to 60 days/CY	Subject to deductible
Diagnostic Labs and X-Rays:	Covered in full

Labs X-Rays MRI, CT and PET Scans	Subject to deductible Subject to deductible
Outpatient Surgery: Doctor's Office Hospital/Surgical Day Care	 $20/$50 per visit Subject to deductible
Urgent/Emergency Room Care: Urgent Care Facility Copay Emergency Room Facility Copay	 $100 per visit for the facility charge. All other services are subject to the Tier 1 or Tier 2 deductible. $200 per visit
Ambulance (medically necessary)	Subject to deductible
Short Term Therapy (PT, OT, ST)	$50 per visit
Chiropractic	Not covered
Mental Health/Substance Abuse Services: Office Visits Facility	 $20 per visit Subject to deductible
Durable Medical Equipment: Limited to $3,000/Mbr/CY	 Subject to deductible
Prescription Drugs: Covered medication, diabetic supplies and contraception devices purchased at a network pharmacy	 $10 copay/generic $35 copay/formulary brand $50 copay/non-formulary brand

	No Max
Certain maintenance drugs are available for a supply greater than 30 days.	Copayment applies to each 30 day supply.
Maximum out-of-pocket (single/family traditional)	$5,000/$10,000
Important Notes: If, due to medical necessity, your physician prescribes a brand drug, you pay only the formulary or non-formulary brand copay shown on this summary. For formulary brand and non-formulary brand at least 2 brand drugs shall be available for each covered benefit therapeutic class.	
Members are required to work with a care navigator for certain tests and procedures.	
Members shall establish a relationship with a primary care provider.	
The benefit plan shall additionally cover the following services: Screening and Brief Intervention for Alcohol and Drug Abuse Body Mass Index Screening After-hours care	

Appendix B

NH HealthFirst Wellness Design

Employees and Spouses		Reward Per Adult
Year One	Establish and continue relationship with a Primary Care Provider Complete a Health Risk Questionnaire Remain Smoke-Free or Participate in a Smoking Cessation Program Get a BMI measurement and Blood Pressure reading, and maintain a BMI of <25 and BP of <140/90 or participate in a health management program Get your Blood Glucose and Cholesterol levels checked, and maintain acceptable levels or participate in a health management program	$200 for Meeting All Requirements
Year One - Within 8 Months of Employee's Effective Date	Submit a Wellness Verification Form for Year 2 Deductible Credit	
	Complete a Health Risk Questionnaire	

Year Two	Remain Smoke-Free or Participate in a Smoking Cessation Program Maintain a BMI of <25 and a BP of <140/90 or participate in a health management program Maintain acceptable Blood Glucose and Cholesterol levels or participate in a health management program	$1,000 Deductible Credit for Meeting All Requirements
Year Two - Within 8 Months of Benefit Year Start Date	Submit a Wellness Verification Form for Year 3 Deductible Credit	
Year Three	Complete Health Risk Questionnaire Remain Smoke-Free or Participate in Smoking Cessation Program Maintain a BMI of <25 and BP of <140/90 or participate in a health management program Maintain acceptable Blood Glucose and Cholesterol levels or participate in a health management program	$1,000 Deductible Credit for Meeting All Requirements

(1) $200 reward is granted to the subscriber, or to both the subscriber and the spouse or civil union partner, upon completion of all requirements and submission of the Wellness Verification Form. To receive the $200.00 reward for a family policy, both

the subscriber and spouse or civil union partner shall establish compliance with all requirements.

(2) Deductible Credits are awarded for the benefit year period following submission of the form.

(3) For policies that cover 2 or more persons, the subscriber and spouse or civil union partner shall comply to obtain the deductible credit. If both satisfy the requirements, then the single deductible amount is reduced by 1 x the credit, and the family is reduced by 2 x the credit (i.e., one credit for each adult parent)

(4) The deductible for children covered under a family plan shall match that of the parents.

(5) The Form shall be submitted within 8 months of the benefit year start date to obtain the rewards.

APPENDIX

RULE	STATUTE
Ins 401.01	RSA 400-A:15, I; 408; 408-A; 409-A; 415:1
Ins 401.02	RSA 400-A:15, I.
Ins 401.02 (e)	RSA 400-A:15, I.
Ins 401.03	RSA 400-A:15, I.; 408:9; 408-A:7; 409-A:3; 415:1
Ins 401.03(p)	RSA 400-A:15-c
Ins 401.04	RSA 400-A:15, I.; 408:9; 409-A:3
Ins 401.05	RSA 400-A:15, I.; 408:16
Ins 401.05 (b)(11)	RSA 400-A:15, I.; 408:16; 415:1
Ins 401.07	RSA 400-A:15, I.; 415:1
Ins 401.08	RSA 400-A:15, I.; 409-A:3
Ins 401.08	RSA 400-A:15, I.; 408:29
Ins 401.10	RSA 400-A:15, I.; 408:9; 409-A:3; 415:1
Ins 401.11	RSA 400-A:15, I.; 408:9; 408-A:7; 409-A:3; 415:1
Ins 401.12	RSA 400-A:15, I., III.; 408:8; 408-A:12; 415:20
Ins 401.13	RSA 400-A:15, I.; 408-A:15
Ins 403.01	RSA 400-A:15, I; 420-G:4-a; 420-G:4-b
Ins 403.02	RSA 400-A:15, I.; 420-G:4-a; 420-G:4-b
Ins 403.03	RSA 400-A:15, I.; 420-G:4-a; 420-G:4-b
Ins 403.04	RSA 400-A:15, I.; 420-G:4-a; 420-G:4-b
Ins 403.05	RSA 400-A:15, I.; 420-G:4-a; 420-G:4-b
Ins 403.06	RSA 400-A:15, I.; 420-G:4-a; 420-G:4-b
Ins 403.07	RSA 400-A:15, I.; 420-G:4-a; 420-G:4-b
Ins 403.08	RSA 400-A:15, I.; 420-G:4-a; 420-G:4-b
Ins 403.09	RSA 400-A:15, I.; 420-G:4-a; 420-G:4-b
Ins 403.10	RSA 400-A:15, I.; 420-G:4-a; 420-G:4-b
Appendix A	RSA 400-A:15, I.; 420-G:4-a; 420-G:4-b
Appendix B	RSA 400-A:15, I.; 420-G:4-a; 420-G:4-b

Anthem

Actuarial

September 8, 2009

Mr. David Sky, FSA, MAAA
Life, Accident and Health Actuary
New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301-2430

Re: Anthem Blue Cross Blue Shield of New Hampshire
Proposed Rates for Direct Pay Products: Blue Direct (Non-HSA and HSA plans), Lumenos and Tonik Effective January 1, 2010

Dear Mr. Sky:

Submitted for your information are proposed rates for our Blue Direct, Blue Direct H.S.A., Lumenos CDHP, and Tonik individual health insurance plans effective January 1, 2010. The purpose of this submission is to provide the department with the proposed rates for the above products; this information may not be appropriate for other purposes.

Anthem BCBS is proposing to leave premium rates at current levels and adjust our quarterly premium trend in order to reflect our recent favorable claims experience for the individual portfolio in New Hampshire. Maintaining rates at current levels will both recognize this recent favorable claims experience and mitigate future rate increases when claim experience is less favorable. The relatively small size of the Anthem individual block and the nature of individual health coverage are likely to result in continued claim volatility. Therefore, this brief halt and subsequent continuation of our quarterly trend steps will not only allow premiums to keep pace with claim cost trends but also protect against future volatility.

Exhibit I shows claim cost trends for the New Hampshire individual products based on data through August 2008 which guided our presently filed and approved rates and for claims paid through July 2009 which has guided the current 1/1/2010 trend modification. As you will observe, recent claim cost trends have restated favorably and continue to decrease in comparison to observed experience at the time of the last rate filing.

Anthem BCBS proposes to hold premium rates flat through the first quarter of 2010 (0% over 4th quarter 2009 rates) and then resume quarterly trend steps in the second quarter. Beginning April 1, 2010, we plan to apply a 3% quarterly trend factor every three months until rates are otherwise filed and approved by the Department. For example, the premium rates effective April 1, 2010 would equal 1.03 times the premium rate effective January 1, 2010. Rate Appendix A through D display the Preferred rate tables for each product and deductible option for effective dates January 1, 2010 through March 31, 2010.

Closing

Thank you for your attention to this submission. If you have any questions regarding this matter, please feel free to contact me directly at (312) 234-7814 or jennie.casaday@anthem.com.

Sincerely,

Jennie Keith Casaday, F.S.A., M.A.A.A.
Associate Actuary, Individual Product Pricing

Enclosures

Exhibit I

Anthem Blue Cross and Blue Shield of New Hampshire

Observed Claims Experience and Trends for Direct Pay (Individual) Products

CONFIDENTIAL AND PROPRIETARY INFORMATION

	Paid thru August 2008 (4/1/09 Filing)		Paid thru July 2009 (1/1/10 Filing)	
Incurred Month	Rolling 12-Month Claims PMPM	Rolling 12-Month Claim Cost Trend	Rolling 12-Month Claims PMPM	Rolling 12-Month Claim Cost Trend
Dec-06	$128.84		$129.11	
Jan-07	$128.98		$129.18	
Feb-07	$129.58		$129.74	
Mar-07	$131.04		$131.14	
Apr-07	$131.99		$131.99	
May-07	$132.69		$132.77	
Jun-07	$133.66		$133.73	
Jul-07	$135.57		$135.54	
Aug-07	$138.05		$137.91	
Sep-07	$140.00		$139.80	
Oct-07	$143.28		$143.02	
Nov-07	$146.84		$146.53	
Dec-07	$148.89	15.6%	$148.45	15.0%
Jan-08	$150.68	16.8%	$150.25	16.3%
Feb-08	$151.73	17.1%	$151.43	16.7%
Mar-08	$153.28	17.0%	$152.34	16.2%
Apr-08	$155.69	18.0%	$154.70	17.2%
May-08	$156.63	18.0%	$155.72	17.3%
Jun-08	$158.55	18.6%	$156.67	17.2%
Jul-08	$160.27	18.2%	$157.58	16.3%
Aug-08	$159.52	15.5%	$155.35	12.6%
Sep-08			$156.27	11.8%
Oct-08			$157.53	10.1%
Nov-08			$157.74	7.6%
Dec-08			$158.03	6.5%
Jan-09			$157.35	4.7%
Feb-09			$156.67	3.5%
Mar-09			$159.56	4.7%
Apr-09			$160.27	3.6%
May-09			$160.40	3.0%
Jun-09			$164.89	5.2%
Jul-09			$167.68	6.4%

Products include Blue Direct PPO and H.S.A, Lumenos CDHP, Tonik, Closed FFS and Short-Term Medical

March 18, 2010

Mr. David Sky, FSA, MAAA
Life, Accident and Health Actuary
New Hampshire Insurance Department
21 South Fruit Street
Suite 14
Concord, NH 03301-2430

Form # 0083

RE: Anthem Health Plans of New Hampshire, Inc (Anthem) Small Group Rate Filing for Effective Date of July 1, 2010 through September 30, 2010

Dear Mr. Sky:

Submitted herein for your review and approval are small group rates for all of PPO and CDHP products to be offered effective July 1, 2010.

The purpose of this filing is to develop premium rates for new and renewal business with effective dates beginning July 1, 2010 through September 30, 2010. The proposed rates reflect updated claims experience, as well as revised medical and prescription drug trends.

Anthem is retaining the currently approved rate ratios, age and industry factors as well as the existing 3.5:1 band of 0.620 and 2.170. Conversion factor and group size factors were revised to reflect the most recent member and subscriber enrollment. In addition, size factor for groups of 2 was increased by 5.4% and the relativity for a $2,000 deductible was adjusted to reflect recent experience. The impact of these two modifications was normalized to derive premium neutral effect.

Anthem is increasing the administrative expense PMPM charges by 1% from the approved level for 2Q10 as described in the administrative expense analysis dated September 11, 2009. Assessment of $0.04 PMPM for the Vermont Health IT Reinvestment Fund was implemented in 2010 and was added in the proposed rates starting in July of 2010.

Factors

As described in Section 10(e)(1) of SB125, age, group size and industry classifications are the only allowable case characteristics of a group that can be used to vary premium rates in the small group market. A group's health status and geographic location are not allowed as rating variables in the small group market.

Anthem retains the previously approved age and industry factors and updates group size factors to reflect recent experience. These allowable rating factors have been normalized to produce a revenue neutral adjustment across our entire book of business.

Source Data

The proposed rates are based on the experience period January 1, 2009 through December 31, 2009 (paid through January, 2010 and completed) and member months from January 1, 2009 through December 31, 2009. The per member per month (PMPM) results are summarized in Appendix 1. The experience period has been updated from the data used in our previous filing.

Adjustments to the Source Data

Consistent with prior filings, we have made several adjustments to the source data in developing a starting base cost for the rating model. We have used an HMO product as the pivot point in our calculations, which better reflects the composition of our risk pool. Indemnity, PPO and BlueChoice products are all adjusted to the HMO utilization and cost per service level. These were determined based upon the age/gender, medical management and provider contracting differences between products.

- Demographic Factors – We adjusted each product's experience from its actual age/gender composition to the age and gender composition of the entire demographically rated pool.[1] Details of the adjustments are shown in Appendix 2. The demographically adjusted PMPM results are summarized in Appendix 3.

- Industry Code – We adjusted each product's experience from its actual industry code experience to the industry code experience of the entire rated pool. Details of the adjustments are shown in Appendix 4. The industry code adjusted PMPM results are summarized in Appendix 5.

- Provider Contracts – We adjusted for differences in provider contracts, based upon information from our provider contracting staff. The resulting PMPM costs are summarized in Appendix 6.

[1] We understand that gender is not a permitted cost factor in demographic rates. However, we included gender and age factors because the purpose of this step was to analyze the underlying utilization and cost patterns of each product absent demographic differences.

- Utilization Management – A further adjustment relates to relative medical management. The assumptions we made are listed below and have not changed from those identified in the most recently approved filing. These assumptions were based on our review of the product specific utilization data. The resulting PMPM costs by product are summarized in Appendix 7.

Utilization Assumptions Relative to HMO Experience		
	In-of-Network	Out-of-Network
Indemnity*	1.300	1.300
PPO	1.160	1.300
BlueChoice	1.120	1.300
HMO	1.000	N/A

The adjusted data by type of service category were combined for all products and the resultant total PMPM allowed charge is $333.84. This is the starting medical pure premium used to generate rates for each product and benefit plan.[2]

Rating Model

The rating model starts by establishing experience period utilization and cost assumptions for each product and benefit tier. It then adjusts the starting pure premiums to normalize the utilization to the zero cost sharing level.

Finally, the results are projected to the rating period using the trend factor developed from an analysis of trends for underwritten business only.

Utilization by Benefit Tier

Anthem continues to use the weighting assumptions by benefit tier as approved by the New Hampshire Insurance Department in prior filings. These assumptions are used both in the starting base costs when adjusting the data to an HMO product and in the final step where the costs by product are developed.

[2] This includes all medical services with the exception of pharmacy benefits.

Trends in Allowed Charges

Resulting from an analysis of our claims experience, we propose to trend the base medical cost from the experience period to the projection period at 12.5 percent which is a blended average of our projected 2010 and 2011 trends.

Prescription Drugs

The experience period used in developing of the drug base rates coincides with the medical experience period of January 1, 2009 through December 31, 2009 (paid through January 2010 and completed). Relativities for different drug benefits were developed using Milliman drug pricing model.

The revised prescription drug trend includes a component for leveraging, and accounts for 18.5 months at an annualized trend of 14.2 percent. The revised prescription drug PMPMs which reflects a change in the base experience and updated trend can be viewed in Exhibit IV.

Results of Rating Model

Using the results of the analysis discussed above in developing projected medical and prescription drug pure premiums, several of our current small group benefit plans were priced for comparison against currently approved rates.

The development of these projected base rates for a sample of our most popular products is shown on Exhibit I. These rates were then compared to the currently approved April 1, 2010 and July 1, 2009 rates. The comparison of these sample plans to similar plans from prior periods is shown in Exhibit II.

These rates will be adjusted for group specific demographics, industry classification and group size as allowed under SB125.

Lumenos CDHP

Lumenos CDHP plans continue to be developed using the starting utilization assumption of the HMO plan with a downward adjustment by 8.2% for the impact of consumerism. Anthem is also charging $2.47 PMPM for using Lumenos' services and online tools. Rates for the CDHP plans are shown in Exhibits III(b) and III(c). To convert from a traditional embedded deductible to an aggregate deductible structure, our previously approved adjustment factors are applied to the rates of the traditional PPO coverage as follows:

	Single	Couple	Par/child(ren)	Family
Adjustment factor	1.00	0.90	0.94	1.00

The adjustment is separate from the rate ratios and only applicable to the CDHP options.

Below are previously approved charges for the Health Incentive Account[3]:

	Single	Couple	Par/child(ren)	Family
Charges	$2.52	$5.04	$5.04	$5.04

Premium tax is already included and retention will not be loaded. These charges will not be adjusted for case characteristics.

Enhanced Vision Benefit

Effective July 1, 2009 Anthem began offering an enhancement to the existing vision benefit of our small group products for Preferred Blue and CDHP plans. The existing vision coverage is one routine eye examination per every twenty four months. A summary of the enhanced benefits is as follows:

1. Routine eye examinations once every twelve months.

2. Frames, lens, and/or contacts once every twenty four months.

3. $100 and $80 allowances for frames and contacts respectively.

The cost associated with this enhancement will be the previously approved $2.10 PMPM. There will be no additional administrative expense loaded to the rate except the standard premium tax and profit of 6%. Previously approved rate ratios and industry factors will be applied to this rate along with the changes to age, size, and conversion factors proposed herein. The proposed 3.5:1 band will also be applied to the rate.

Composite Rating Factor Limitation

Section 10(e)(3) of SB125 mandates that the maximum premium rate differential after adjusting for all case characteristics as determined by a ratio shall be 3.5 to 1.0. Anthem continues to use the previously approved lower and upper bands of 0.620 and 2.170, respectively. This limitation shall not apply for determining premium rates for covered persons whose attained age is less than 19.

In compliance with this mandate Anthem applies a Restricted Composite Rating Factor (RCRF) as defined below:

1. Anthem limits the premium rate differential to the proposed lower and upper bounds of 0.620 and 2.170, respectively. This composite rating band yields a ratio of 3.5 to 1.0 as allowed under SB125.

[3] These charges are not applicable for HRA since the employer funds this account or HSA without Health Incentive Account.

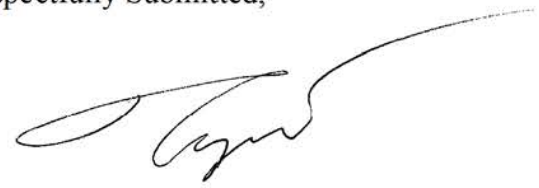
2. The product of the group size factor, composite age factor and industry factor is set to equal the RCRF

    a. If the RCRF < 0.620, then the RCRF is set to 0.620.
    b. If the RCRF > 2.170, then the RCRF is set to 2.170.
    c. If the RCRF is within the premium rate differential of 0.620 to 2.170 (inclusive of the endpoints), then make no adjustment to the calculated RCRF.

Summary

The proposed rates, rating factors and rating formula comply with SB125. In my opinion, the proposed rates are neither inadequate nor excessive, and bear a reasonable relation to the benefits provided. This rate filing was prepared in compliance with the provisions of the Qualification Standards and Code of Professional Conduct published by the American Academy of Actuaries.
If you have any questions during your review of this filing please contact me via telephone at 695-7833 or e-mail me at Tu.Nguyen@anthem.com. You may also contact Lucy Drozd at 695-7882 or via e-mail at Lucy.Drozd@anthem.com.

Respectfully Submitted,



Tu Nguyen, A.S.A., M.A.A.A.
Associate Actuary, Local Group Pricing
Anthem Health Plans of New Hampshire, Inc.

Enclosures:
cc: Lucy Drozd, Local Group Pricing

Appendix 1: 01/09 - 12/09 Starting Assumptions
(Excluding Prescription Drugs)

		PMPM						
PMPMCATC	PMPMCAT	BASIC/COMP	BC2	BC-Reg	HMO	HMO-Reg	PPO	TOTAL
INPATIENT	HOSPITAL INPAT MATERNITY MOTHER	-	3.80	10.16	3.41	4.70	4.72	4.15
	HOSPITAL INPAT MATERNITY NON DELIVERIES	-	0.74	-	0.07	0.21	0.15	0.17
	HOSPITAL INPAT MATERNITY WELL NEW BORN	-	2.19	3.56	2.50	3.20	2.05	2.75
	HOSPITAL INPAT NON-MATERNITY ALCOHOL & DRUG ABUSE	3.33	-	-	0.50	0.68	0.48	0.57
	HOSPITAL INPAT NON-MATERNITY MEDICAL	17.06	23.49	12.98	19.79	20.12	31.23	21.30
	HOSPITAL INPAT NON-MATERNITY PSYCHIATRIC	-	11.01	-	1.73	1.91	4.86	2.49
	HOSPITAL INPAT NON-MATERNITY SURGICAL	168.17	30.76	63.23	36.18	37.74	57.78	39.75
	HOSPITAL INPAT OTHER	-	-	-	0.04	-	-	0.02
	HOSPITAL INPAT SKILLED NURSING FACILITY	-	0.10	-	0.40	0.86	0.08	0.56
INPATIENT Total		188.56	72.10	89.93	64.62	69.43	101.36	71.73
OUTPATIENT	HOSPITAL OUTPAT CARDIOVASCULAR	2.84	2.74	1.68	2.40	2.21	2.02	2.28
	HOSPITAL OUTPAT ER	16.21	14.12	3.03	12.99	12.83	14.17	13.07
	HOSPITAL OUTPAT OTHER	14.12	6.14	2.60	2.52	3.47	4.48	3.35
	HOSPITAL OUTPAT OTHER (EEG, 740-749)	4.30	1.75	-	1.99	1.47	1.86	1.74
	HOSPITAL OUTPAT OTHER (GASTROINTESTINAL, 750-759)	4.65	-	-	0.29	0.19	0.18	0.24
	HOSPITAL OUTPAT OTHER (MED/SURG GEN SUPPLIES,270-272)	0.75	1.17	0.65	0.76	0.73	1.58	0.85
	HOSPITAL OUTPAT OTHER ALCOHOL/SUBSTANCE ABUSE	-	-	-	0.03	0.02	-	0.02
	HOSPITAL OUTPAT OTHER DIALYSIS	-	-	-	-	-	0.01	0.00
	HOSPITAL OUTPAT OTHER HOME HEALTH	-	0.16	-	0.10	0.10	0.09	0.10
	HOSPITAL OUTPAT OTHER PSYCHIATRIC	0.26	3.30	0.73	0.43	0.79	0.42	0.70
	HOSPITAL OUTPAT PATHOLOGY	26.91	13.38	6.48	13.31	11.33	11.03	12.22
	HOSPITAL OUTPAT PHARMACY & BLOOD	4.24	36.07	14.69	15.50	12.55	14.82	14.83
	HOSPITAL OUTPAT PT/OT/ST	2.73	4.11	7.13	4.31	4.08	4.71	4.24
	HOSPITAL OUTPAT RADIOLOGY	38.44	31.60	10.49	18.32	19.66	20.96	19.77
	HOSPITAL OUTPAT RADIOLOGY (CAT)	10.52	13.05	14.70	11.57	9.86	9.95	10.69
	HOSPITAL OUTPAT RADIOLOGY (MRI)	13.97	9.33	12.21	10.54	9.02	11.77	9.97
	HOSPITAL OUTPAT SURGERY	79.79	59.53	36.70	45.79	41.64	56.26	45.73
	HOSPITAL OUTPT OTHER (IV THERAPY)	1.18	-	-	0.02	0.03	0.09	0.03
OUTPATIENT Total		220.90	196.44	111.10	140.88	129.98	154.40	139.85

Appendix 1: 01/09 - 12/09 Starting Assumptions
(Excluding Prescription Drugs)

		PMPM						
PMPMCATC	PMPMCAT	BASIC/COMP	BC2	BC-Reg	HMO	HMO-Reg	PPO	TOTAL
PROFESSIONAL	PHARMACY INTEGRATED DRUGS	-	-	-	-	-	-	-
	PHYSICIAN ADDITIONAL BNFTS ALCOHOL & DRUG	0.11	0.21	0.29	0.32	0.22	0.18	0.26
	PHYSICIAN ADDITIONAL BNFTS CHIROPRACTOR	2.52	3.22	6.72	1.98	2.98	2.70	2.57
	PHYSICIAN ADDITIONAL BNFTS GLASSES/CONTACTS	-	0.02	-	0.01	0.00	0.00	0.01
	PHYSICIAN ADDITIONAL BNFTS HEARING/SPEECH EXAMS	0.35	0.93	0.92	0.42	0.51	0.61	0.50
	PHYSICIAN ADDITIONAL BNFTS IMMUNIZATIONS	1.48	1.64	1.87	1.42	1.74	2.11	1.65
	PHYSICIAN ADDITIONAL BNFTS PHYSICAL EXAMS	9.37	8.45	7.93	7.62	7.96	7.32	7.78
	PHYSICIAN ADDITIONAL BNFTS PODIATRIST	1.66	1.21	0.36	1.04	1.08	1.39	1.11
	PHYSICIAN ADDITIONAL BNFTS PSYCHIATRIC	7.67	8.88	8.56	5.94	6.11	8.58	6.43
	PHYSICIAN ADDITIONAL BNFTS VISION EXAMS	1.53	2.14	2.78	1.91	2.06	2.08	2.01
	PHYSICIAN ADDITIONAL BNFTS WELL BABY EXAMS	0.32	0.46	0.82	0.34	0.56	0.57	0.47
	PHYSICIAN ALLERGY IMMUNOTHERAPY	0.67	0.45	0.32	0.40	0.53	0.50	0.47
	PHYSICIAN ALLERGY TESTING	0.30	0.32	0.26	0.25	0.45	0.44	0.36
	PHYSICIAN INPAT SURGERY ANESTHESIA	6.81	2.69	2.71	2.10	2.15	2.58	2.22
	PHYSICIAN INPAT SURGERY ASSISTANT SURGEON	-	0.28	0.31	0.31	0.30	0.26	0.30
	PHYSICIAN INPAT SURGERY PRIMARY SURGEON	23.59	4.46	6.91	4.40	3.83	6.02	4.42
	PHYSICIAN INPAT VISITS	4.46	1.84	1.58	2.10	2.33	3.79	2.39
	PHYSICIAN MATERNITY CESAREAN DELIVERIES	-	0.85	1.80	1.19	1.31	1.21	1.23
	PHYSICIAN MATERNITY GENERAL CARE	-	0.35	-	0.12	0.18	0.13	0.16
	PHYSICIAN MATERNITY NON-DELIVERIES	-	0.29	-	0.20	0.31	0.24	0.26
	PHYSICIAN MATERNITY NORMAL DELIVERIES	-	1.91	2.63	1.82	2.59	2.12	2.19
	PHYSICIAN MISC MEDICAL	0.24	0.56	0.24	0.44	0.44	0.56	0.45
	PHYSICIAN MISC MEDICAL CENTRAL NERV SYSTEM TESTS	-	0.16	-	0.13	0.24	0.25	0.19
	PHYSICIAN MISC MEDICAL CHEMOTHERAPY	-	0.25	0.01	1.78	0.95	1.60	1.32
	PHYSICIAN MISC MEDICAL DERMATOLOGY	-	0.14	-	0.04	0.04	0.08	0.05
	PHYSICIAN MISC MEDICAL DIALYSIS	-	-	-	0.02	0.02	0.06	0.03
	PHYSICIAN MISC MEDICAL GASTROENTEROLOGY	0.09	0.02	-	0.07	0.06	0.13	0.07
	PHYSICIAN MISC MEDICAL NEUROLOGY	1.23	0.99	1.04	1.18	1.09	1.37	1.15
	PHYSICIAN MISC MEDICAL NON-INVASIVE VASCULAR	0.65	0.30	0.24	0.32	0.27	0.35	0.30
	PHYSICIAN MISC MEDICAL OPHTHALMOLOGY	0.69	0.42	0.50	0.44	0.44	0.56	0.45
	PHYSICIAN MISC MEDICAL OTORHINOLARYNGOLOGY	-	0.12	-	0.05	0.08	0.18	0.08
	PHYSICIAN MISC MEDICAL PULMONOLOGY	0.57	0.20	0.28	0.17	0.24	0.34	0.22
	PHYSICIAN MISC MEDICAL VENIPUNCTURE	0.04	0.04	0.09	0.03	0.09	0.09	0.07
	PHYSICIAN MISC MEDICAL VESIBULAR FUNCTION TEST	-	0.02	-	0.04	0.02	0.04	0.03
	PHYSICIAN OFFICE/HOME VISITS	34.19	30.21	26.72	25.56	25.91	28.28	26.23
	PHYSICIAN OTHER	0.96	0.59	6.33	0.49	2.90	0.47	1.59
	PHYSICIAN OTHER AMBULANCE	1.53	1.36	-	1.67	2.11	2.00	1.88
	PHYSICIAN OTHER DURABLE MEDICAL EQUIPMENT	20.40	9.49	5.88	2.61	2.58	3.21	3.01
	PHYSICIAN OTHER PRIVATE DUTY NURSING/HOME	1.88	0.34	0.07	0.45	0.49	0.45	0.47
	PHYSICIAN OTHER PROSTHETICS	1.90	0.09	-	0.10	0.49	0.07	0.28
	PHYSICIAN OTHER SERVICES CARDIOVASCULAR	4.29	2.09	1.45	1.48	1.60	2.18	1.65
	PHYSICIAN OTHER SERVICES CONSULTS	8.06	6.97	5.37	5.63	5.94	6.35	5.91
	PHYSICIAN OTHER SERVICES ER VISITS	2.88	3.00	1.46	2.79	2.64	2.74	2.72
	PHYSICIAN OTHER SERVICES PATHOLOGY INPAT	0.51	0.37	0.33	0.20	0.20	0.30	0.22
	PHYSICIAN OTHER SERVICES PATHOLOGY OFFICE	2.71	3.38	2.97	2.89	3.36	3.44	3.18
	PHYSICIAN OTHER SERVICES PATHOLOGY OUTPAT	4.29	4.63	5.87	3.69	4.42	5.39	4.25
	PHYSICIAN OTHER SERVICES PHYSICAL MEDICINE	11.74	5.27	5.62	4.10	4.35	6.05	4.51
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT	0.41	0.15	0.10	0.21	0.24	0.37	0.24
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT (CAT)	0.20	0.20	0.27	0.24	0.19	0.34	0.23
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT (MRI)	0.14	0.13	-	0.09	0.06	0.09	0.08
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE	7.30	4.59	3.79	3.65	4.34	4.56	4.11
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE (CAT)	1.87	0.86	-	0.62	0.54	0.93	0.63
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE (MRI)	3.08	1.94	-	1.51	1.89	2.43	1.79
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT	3.36	3.96	1.64	2.88	3.07	2.89	3.00
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT (CAT)	1.87	1.23	0.90	1.08	1.03	1.11	1.07
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT (MRI)	0.71	0.95	1.15	0.81	0.77	0.98	0.82
	PHYSICIAN OUTPAT SURGERY (ANESTHESIA)	8.96	5.27	5.35	4.86	4.59	4.77	4.76
	PHYSICIAN OUTPAT SURGERY (OFFICE)	12.77	8.61	3.41	5.63	5.79	6.91	5.98
	PHYSICIAN OUTPAT SURGERY OUTPAT (SURGICAL CENTER)	15.13	14.78	6.81	11.03	10.59	11.05	10.98
	PHYSICIAN PRESCRIPTION DRUGS OFFICE	0.00	0.00	0.00	0.01	0.00	0.04	0.01
	PHYSICIAN THERAPEUTIC INJECTIONS	0.25	10.73	39.08	2.47	1.53	2.85	2.52
	PHYSICIAN UNCLASSIFIED	5.85	2.35	1.25	2.56	2.65	3.41	2.70
	PHYSICIAN URGENT CARE VISITS	0.13	0.09	0.06	0.14	0.12	0.10	0.13
PROFESSIONAL Total		221.71	167.44	175.01	128.05	135.57	152.16	136.12
Grand Total		**631.17**	**435.97**	**376.05**	**333.55**	**334.97**	**407.92**	**347.70**

Appendix 2: Demographic Factor Calculation

Based on 01/09-12/09 Exposure(Member Months Distribution)

	Age	Factor	BASIC/COMP	BC2	BC-Reg	HMO	HMO-Reg	PPO	TOTAL
MALE	0 - 18	0.52	0.1%	0.5%	0.1%	4.0%	5.3%	1.5%	11.4%
	19 - 24	0.46	0.0%	0.1%	0.0%	1.7%	1.9%	0.5%	4.3%
	25 - 29	0.49	0.0%	0.1%	0.0%	1.4%	1.6%	0.3%	3.4%
	30 - 34	0.59	0.0%	0.1%	0.0%	1.3%	1.6%	0.4%	3.4%
	35 - 39	0.70	0.0%	0.1%	0.0%	1.7%	1.9%	0.4%	4.2%
	40 - 44	0.88	0.0%	0.2%	0.0%	2.0%	2.3%	0.5%	5.1%
	45 - 49	1.13	0.0%	0.2%	0.0%	2.4%	2.5%	0.6%	5.7%
	50 - 54	1.51	0.0%	0.2%	0.0%	2.2%	2.2%	0.6%	5.3%
	55 - 59	2.06	0.0%	0.2%	0.0%	1.7%	1.7%	0.4%	4.1%
	60 - 64	2.71	0.0%	0.1%	0.0%	1.1%	1.1%	0.3%	2.6%
	65 +	3.65	0.0%	0.0%	0.0%	0.2%	0.2%	0.1%	0.5%
FEMALE	0 - 18	0.52	0.1%	0.4%	0.0%	3.8%	5.0%	1.4%	10.7%
	19 - 24	0.99	0.0%	0.1%	0.0%	1.7%	1.9%	0.4%	4.2%
	25 - 29	1.21	0.0%	0.1%	0.0%	1.4%	1.5%	0.3%	3.3%
	30 - 34	1.29	0.0%	0.1%	0.0%	1.4%	1.5%	0.3%	3.4%
	35 - 39	1.24	0.0%	0.2%	0.0%	1.7%	2.0%	0.5%	4.4%
	40 - 44	1.23	0.0%	0.2%	0.0%	2.1%	2.3%	0.5%	5.2%
	45 - 49	1.36	0.0%	0.2%	0.0%	2.5%	2.6%	0.6%	6.0%
	50 - 54	1.65	0.0%	0.2%	0.0%	2.3%	2.2%	0.5%	5.3%
	55 - 59	1.96	0.0%	0.2%	0.0%	1.7%	1.8%	0.4%	4.1%
	60 - 64	2.43	0.0%	0.1%	0.0%	1.2%	1.1%	0.3%	2.8%
	65 +	3.17	0.0%	0.0%	0.0%	0.2%	0.2%	0.1%	0.4%
Total Exposure			0.5%	3.7%	0.4%	40.0%	44.5%	11.0%	100.0%
Average Factor			1.347	1.201	1.060	1.165	1.118	1.114	1.140
Normalized Average Factors									
	Non-Maternity		1.181	1.054	0.929	1.022	0.980	0.977	1.000
	Maternity*		0.846	0.949	1.076	0.979	1.020	1.024	1.000

**Estimated as 1 ÷ Non-Maternity Factor*

Appendix 3: 01/09 - 12/09 Starting Assumptions
(Excluding Prescription Drugs)
Adjusted for Average Age

		PMPM						
PMPMCATC	PMPMCAT	BASIC/COMP	BC2	BC-Reg	HMO	HMO-Reg	PPO	TOTAL
INPATIENT	HOSPITAL INPAT MATERNITY MOTHER	-	4.00	9.44	3.48	4.61	4.61	4.13
	HOSPITAL INPAT MATERNITY NON DELIVERIES	-	0.78	-	0.07	0.21	0.15	0.17
	HOSPITAL INPAT MATERNITY WELL NEW BORN	-	2.31	3.31	2.56	3.14	2.00	2.74
	HOSPITAL INPAT NON-MATERNITY ALCOHOL & DRUG ABUSE	2.82	-	-	0.49	0.69	0.49	0.57
	HOSPITAL INPAT NON-MATERNITY MEDICAL	14.44	22.29	13.97	19.37	20.52	31.97	21.33
	HOSPITAL INPAT NON-MATERNITY PSYCHIATRIC	-	10.45	-	1.69	1.95	4.98	2.48
	HOSPITAL INPAT NON-MATERNITY SURGICAL	142.35	29.19	68.03	35.42	38.49	59.14	39.77
	HOSPITAL INPAT OTHER	-	-	-	0.04	-	-	0.02
	HOSPITAL INPAT SKILLED NURSING FACILITY	-	0.10	-	0.39	0.88	0.08	0.56
INPATIENT Total		159.61	69.13	94.75	63.51	70.49	103.42	71.76
OUTPATIENT	HOSPITAL OUTPAT CARDIOVASCULAR	2.40	2.60	1.81	2.35	2.25	2.06	2.28
	HOSPITAL OUTPAT ER	13.72	13.40	3.26	12.72	13.08	14.50	13.07
	HOSPITAL OUTPAT OTHER	11.95	5.83	2.79	2.47	3.54	4.59	3.35
	HOSPITAL OUTPAT OTHER (EEG, 740-749)	3.64	1.66	-	1.95	1.50	1.90	1.73
	HOSPITAL OUTPAT OTHER (GASTROINTESTINAL, 750-759)	3.94	-	-	0.28	0.20	0.18	0.24
	HOSPITAL OUTPAT OTHER (MED/SURG GEN SUPPLIES,270-272)	0.63	1.11	0.70	0.75	0.75	1.62	0.86
	HOSPITAL OUTPAT OTHER ALCOHOL/SUBSTANCE ABUSE	-	-	-	0.03	0.02	-	0.02
	HOSPITAL OUTPAT OTHER DIALYSIS	-	-	-	-	-	0.01	0.00
	HOSPITAL OUTPAT OTHER HOME HEALTH	-	0.16	-	0.10	0.10	0.10	0.10
	HOSPITAL OUTPAT OTHER PSYCHIATRIC	0.22	3.13	0.78	0.42	0.81	0.43	0.70
	HOSPITAL OUTPAT PATHOLOGY	22.78	12.69	6.97	13.03	11.55	11.29	12.19
	HOSPITAL OUTPAT PHARMACY & BLOOD	3.59	34.24	15.81	15.17	12.80	15.17	14.78
	HOSPITAL OUTPAT PT/OT/ST	2.31	3.90	7.68	4.22	4.16	4.82	4.25
	HOSPITAL OUTPAT RADIOLOGY	32.54	30.00	11.29	17.94	20.05	21.45	19.76
	HOSPITAL OUTPAT RADIOLOGY (CAT)	8.90	12.38	15.81	11.32	10.06	10.18	10.68
	HOSPITAL OUTPAT RADIOLOGY (MRI)	11.83	8.85	13.14	10.32	9.20	12.05	9.97
	HOSPITAL OUTPAT SURGERY	67.54	56.50	39.49	44.83	42.47	57.59	45.70
	HOSPITAL OUTPT OTHER (IV THERAPY)	0.99	-	-	0.01	0.03	0.10	0.03
OUTPATIENT Total		186.99	186.44	119.54	137.91	132.56	158.03	139.71

Appendix 3: 01/09 - 12/09 Starting Assumptions
(Excluding Prescription Drugs)
Adjusted for Average Age

		PMPM						
PMPMCATC	PMPMCAT	BASIC/COMP	BC2	BC-Reg	HMO	HMO-Reg	PPO	TOTAL
PROFESSIONAL	PHARMACY INTEGRATED DRUGS	-	-	-	-	-	-	-
	PHYSICIAN ADDITIONAL BNFTS ALCOHOL & DRUG	0.10	0.20	0.31	0.32	0.23	0.18	0.26
	PHYSICIAN ADDITIONAL BNFTS CHIROPRACTOR	2.13	3.06	7.23	1.94	3.03	2.77	2.58
	PHYSICIAN ADDITIONAL BNFTS GLASSES/CONTACTS	-	0.02	-	0.01	0.00	0.00	0.01
	PHYSICIAN ADDITIONAL BNFTS HEARING/SPEECH EXAMS	0.30	0.88	0.99	0.41	0.52	0.62	0.50
	PHYSICIAN ADDITIONAL BNFTS IMMUNIZATIONS	1.25	1.56	2.01	1.39	1.78	2.16	1.66
	PHYSICIAN ADDITIONAL BNFTS PHYSICAL EXAMS	7.93	8.02	8.53	7.46	8.12	7.49	7.78
	PHYSICIAN ADDITIONAL BNFTS PODIATRIST	1.40	1.15	0.38	1.02	1.10	1.42	1.11
	PHYSICIAN ADDITIONAL BNFTS PSYCHIATRIC	6.49	8.43	9.21	5.81	6.23	8.78	6.44
	PHYSICIAN ADDITIONAL BNFTS VISION EXAMS	1.29	2.03	2.99	1.87	2.10	2.13	2.01
	PHYSICIAN ADDITIONAL BNFTS WELL BABY EXAMS	0.27	0.44	0.89	0.34	0.57	0.58	0.47
	PHYSICIAN ALLERGY IMMUNOTHERAPY	0.56	0.43	0.34	0.39	0.54	0.52	0.47
	PHYSICIAN ALLERGY TESTING	0.25	0.30	0.28	0.25	0.46	0.45	0.36
	PHYSICIAN INPAT SURGERY ANESTHESIA	5.77	2.55	2.92	2.05	2.19	2.64	2.22
	PHYSICIAN INPAT SURGERY ASSISTANT SURGEON	-	0.27	0.33	0.30	0.31	0.27	0.30
	PHYSICIAN INPAT SURGERY PRIMARY SURGEON	19.97	4.23	7.44	4.31	3.90	6.16	4.41
	PHYSICIAN INPAT VISITS	3.77	1.74	1.70	2.06	2.37	3.88	2.39
	PHYSICIAN MATERNITY CESAREAN DELIVERIES	-	0.89	1.68	1.22	1.28	1.18	1.23
	PHYSICIAN MATERNITY GENERAL CARE	-	0.37	-	0.12	0.18	0.12	0.16
	PHYSICIAN MATERNITY NON-DELIVERIES	-	0.30	-	0.20	0.31	0.23	0.26
	PHYSICIAN MATERNITY NORMAL DELIVERIES	-	2.02	2.44	1.86	2.54	2.07	2.18
	PHYSICIAN MISC MEDICAL	0.20	0.54	0.26	0.43	0.45	0.57	0.46
	PHYSICIAN MISC MEDICAL CENTRAL NERV SYSTEM TESTS	-	0.15	-	0.13	0.24	0.25	0.19
	PHYSICIAN MISC MEDICAL CHEMOTHERAPY	-	0.24	0.01	1.74	0.97	1.64	1.31
	PHYSICIAN MISC MEDICAL DERMATOLOGY	-	0.13	-	0.03	0.04	0.08	0.05
	PHYSICIAN MISC MEDICAL DIALYSIS	-	-	-	0.02	0.02	0.06	0.03
	PHYSICIAN MISC MEDICAL GASTROENTEROLOGY	0.08	0.02	-	0.07	0.06	0.13	0.07
	PHYSICIAN MISC MEDICAL NEUROLOGY	1.04	0.94	1.12	1.15	1.12	1.41	1.16
	PHYSICIAN MISC MEDICAL NON-INVASIVE VASCULAR	0.55	0.28	0.26	0.31	0.27	0.35	0.30
	PHYSICIAN MISC MEDICAL OPHTHALMOLOGY	0.58	0.40	0.53	0.43	0.45	0.57	0.45
	PHYSICIAN MISC MEDICAL OTORHINOLARYNGOLOGY	-	0.12	-	0.05	0.08	0.18	0.08
	PHYSICIAN MISC MEDICAL PULMONOLOGY	0.48	0.19	0.30	0.17	0.24	0.35	0.22
	PHYSICIAN MISC MEDICAL VENIPUNCTURE	0.04	0.04	0.10	0.03	0.09	0.09	0.07
	PHYSICIAN MISC MEDICAL VESIBULAR FUNCTION TEST	-	0.02	-	0.04	0.02	0.04	0.03
	PHYSICIAN OFFICE/HOME VISITS	28.94	28.68	28.75	25.02	26.43	28.94	26.24
	PHYSICIAN OTHER	0.81	0.56	6.82	0.48	2.96	0.49	1.61
	PHYSICIAN OTHER AMBULANCE	1.29	1.29	-	1.63	2.15	2.05	1.89
	PHYSICIAN OTHER DURABLE MEDICAL EQUIPMENT	17.27	9.01	6.33	2.56	2.63	3.29	2.99
	PHYSICIAN OTHER PRIVATE DUTY NURSING/HOME	1.59	0.32	0.07	0.44	0.50	0.46	0.47
	PHYSICIAN OTHER PROSTHETICS	1.61	0.08	-	0.09	0.50	0.07	0.28
	PHYSICIAN OTHER SERVICES CARDIOVASCULAR	3.63	1.98	1.56	1.45	1.64	2.23	1.65
	PHYSICIAN OTHER SERVICES CONSULTS	6.83	6.62	5.77	5.51	6.05	6.50	5.91
	PHYSICIAN OTHER SERVICES ER VISITS	2.44	2.84	1.57	2.73	2.69	2.80	2.72
	PHYSICIAN OTHER SERVICES PATHOLOGY INPAT	0.43	0.35	0.35	0.20	0.20	0.30	0.22
	PHYSICIAN OTHER SERVICES PATHOLOGY OFFICE	2.29	3.20	3.19	2.83	3.43	3.52	3.18
	PHYSICIAN OTHER SERVICES PATHOLOGY OUTPAT	3.63	4.39	6.31	3.61	4.51	5.51	4.26
	PHYSICIAN OTHER SERVICES PHYSICAL MEDICINE	9.94	5.00	6.05	4.01	4.44	6.19	4.51
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT	0.35	0.14	0.11	0.20	0.24	0.38	0.24
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT (CAT)	0.17	0.19	0.29	0.23	0.19	0.35	0.23
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT (MRI)	0.12	0.13	-	0.09	0.07	0.09	0.08
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE	6.18	4.36	4.08	3.57	4.42	4.67	4.11
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE (CAT)	1.58	0.82	-	0.61	0.55	0.95	0.63
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE (MRI)	2.60	1.85	-	1.47	1.92	2.49	1.80
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT	2.84	3.76	1.77	2.82	3.13	2.96	3.00
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT (CAT)	1.58	1.17	0.97	1.06	1.05	1.14	1.07
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT (MRI)	0.60	0.90	1.24	0.80	0.78	1.01	0.82
	PHYSICIAN OUTPAT SURGERY (ANESTHESIA)	7.58	5.00	5.76	4.75	4.68	4.88	4.76
	PHYSICIAN OUTPAT SURGERY (OFFICE)	10.81	8.17	3.67	5.51	5.91	7.07	5.98
	PHYSICIAN OUTPAT SURGERY OUTPAT (SURGICAL CENTER)	12.81	14.03	7.32	10.80	10.80	11.31	10.97
	PHYSICIAN PRESCRIPTION DRUGS OFFICE	0.00	0.00	0.00	0.01	0.00	0.04	0.01
	PHYSICIAN THERAPEUTIC INJECTIONS	0.21	10.19	42.05	2.42	1.56	2.92	2.51
	PHYSICIAN UNCLASSIFIED	4.95	2.23	1.34	2.50	2.71	3.49	2.70
	PHYSICIAN URGENT CARE VISITS	0.11	0.09	0.06	0.14	0.12	0.11	0.13
PROFESSIONAL Total		187.67	159.27	187.65	125.49	138.09	155.57	136.17
Grand Total		**534.27**	**414.84**	**401.94**	**326.91**	**341.14**	**417.02**	**347.65**

Appendix 4: SIC Factor Calculation

Based on 01/09 - 12/09 Exposure (Member Month Distribution)

SIC	Factor	BASIC/COMP	BC2	BC-Reg	HMO Blue	HMO-Reg	PPO	TOTAL
01	1.00	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
02	1.00	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%
07	1.00	0.0%	0.0%	0.0%	1.1%	0.8%	0.4%	2.3%
08	1.00	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.1%
09	1.00	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
10	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
11	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
12	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
13	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
14	1.05	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%
15	1.00	0.0%	0.1%	0.0%	1.3%	1.8%	0.2%	3.4%
16	1.00	0.0%	0.2%	0.0%	0.6%	0.4%	0.0%	1.1%
17	1.00	0.0%	0.2%	0.0%	3.7%	3.2%	0.3%	7.5%
20	0.95	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.3%
21	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
22	0.95	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.3%
23	0.95	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.2%
24	1.05	0.0%	0.0%	0.0%	0.4%	0.4%	0.1%	0.9%
25	0.95	0.0%	0.0%	0.0%	0.2%	0.1%	0.0%	0.4%
26	1.00	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%
27	0.95	0.0%	0.0%	0.0%	0.6%	1.0%	0.1%	1.8%
28	1.00	0.0%	0.0%	0.0%	0.2%	0.2%	0.0%	0.4%
29	1.05	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.1%
30	1.00	0.0%	0.0%	0.0%	0.3%	0.7%	0.0%	1.0%
31	1.00	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
32	1.05	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
33	1.05	0.0%	0.0%	0.0%	0.3%	0.1%	0.0%	0.3%
34	1.00	0.0%	0.0%	0.0%	0.4%	0.5%	0.1%	1.0%
35	1.00	0.1%	0.3%	0.0%	1.0%	1.2%	0.1%	2.7%
36	0.95	0.0%	0.0%	0.0%	1.0%	1.2%	0.3%	2.5%
37	0.95	0.0%	0.0%	0.0%	0.0%	0.2%	0.1%	0.3%
38	0.95	0.0%	0.0%	0.0%	0.5%	0.3%	0.1%	0.9%
39	0.95	0.0%	0.0%	0.0%	0.8%	0.8%	0.3%	1.9%
40	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
41	1.05	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.2%
42	1.05	0.0%	0.0%	0.0%	0.4%	0.3%	0.0%	0.8%
43	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
44	1.05	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.3%
45	0.95	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.2%
46	1.00	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
47	1.00	0.0%	0.0%	0.0%	0.2%	0.2%	0.0%	0.4%
48	0.95	0.0%	0.0%	0.0%	0.3%	0.2%	0.0%	0.6%
49	0.95	0.0%	0.0%	0.0%	0.4%	0.4%	0.1%	0.9%
50	1.00	0.0%	0.0%	0.0%	1.7%	2.4%	0.5%	4.7%
51	1.00	0.0%	0.0%	0.0%	0.6%	0.6%	0.5%	1.8%
52	1.00	0.0%	0.2%	0.0%	0.7%	0.7%	0.1%	1.7%
53	0.95	0.0%	0.0%	0.0%	0.1%	0.2%	0.0%	0.3%
54	0.95	0.0%	0.0%	0.0%	0.9%	0.6%	0.1%	1.7%
55	1.05	0.0%	0.0%	0.0%	0.6%	0.7%	0.1%	1.3%
56	0.95	0.0%	0.0%	0.0%	0.3%	0.1%	0.0%	0.4%
57	1.00	0.0%	0.0%	0.1%	0.5%	0.6%	0.3%	1.5%
58	1.05	0.0%	0.0%	0.0%	1.4%	0.9%	0.1%	2.4%
59	1.00	0.0%	0.3%	0.0%	1.3%	1.2%	0.2%	3.1%
60	0.95	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.3%
61	0.95	0.0%	0.1%	0.0%	0.4%	0.2%	0.1%	0.7%
62	1.00	0.0%	0.0%	0.0%	0.2%	0.2%	0.5%	1.0%
63	0.95	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.2%
64	1.00	0.0%	0.0%	0.0%	0.4%	0.4%	0.1%	1.0%
65	1.00	0.0%	0.1%	0.0%	1.1%	1.4%	0.5%	3.1%
67	0.95	0.0%	0.1%	0.0%	0.2%	0.2%	0.2%	0.6%
70	1.05	0.0%	0.1%	0.0%	0.7%	0.5%	0.1%	1.3%
72	1.05	0.0%	0.0%	0.0%	0.5%	0.6%	0.0%	1.3%

Appendix 4: SIC Factor Calculation

Based on 01/09 - 12/09 Exposure (Member Month Distribution)

73	1.00	0.0%	0.2%	0.1%	1.7%	3.9%	1.9%	7.9%
75	1.05	0.0%	0.0%	0.0%	0.5%	0.6%	0.0%	1.1%
76	1.00	0.0%	0.0%	0.0%	0.2%	0.4%	0.1%	0.7%
78	0.95	0.0%	0.0%	0.0%	0.1%	0.1%	0.0%	0.2%
79	1.05	0.0%	0.1%	0.0%	0.5%	0.9%	0.2%	1.6%
80	1.10	0.1%	0.4%	0.0%	2.7%	2.5%	0.7%	6.4%
81	1.00	0.0%	0.4%	0.0%	1.4%	1.4%	0.2%	3.5%
82	1.00	0.0%	0.0%	0.0%	0.5%	0.3%	0.1%	0.8%
83	1.00	0.0%	0.1%	0.0%	2.5%	1.7%	0.0%	4.3%
84	1.05	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.1%
86	1.05	0.0%	0.0%	0.0%	0.3%	0.6%	0.0%	0.9%
87	0.95	0.1%	0.4%	0.1%	2.5%	4.8%	1.5%	9.3%
88	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
89	1.00	0.0%	0.0%	0.0%	0.1%	0.3%	0.1%	0.4%
91	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
92	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
93	1.05	0.0%	0.0%	0.0%	0.3%	0.1%	0.0%	0.5%
94	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
95	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
96	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
97	1.05	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
99	1.00	0.0%	0.0%	0.0%	0.2%	0.1%	0.0%	0.4%
Total Exposure		0.5%	3.7%	0.4%	40.0%	44.5%	11.0%	100.0%
Average Factor		1.006	1.005	0.989	1.003	1.000	0.995	1.001
Normalized Average Factors		1.005	1.004	0.988	1.002	0.999	0.994	1.000

Appendix 5: 01/09 - 12/09 Starting Assumptions
(Excluding Prescription Drugs)
Adjusted for Average Age and Industry

		PMPM						
PMPMCATC	PMPMCAT	BASIC/COMP	BC2	BC-Reg	HMO	HMO-Reg	PPO	TOTAL
INPATIENT	HOSPITAL INPAT MATERNITY MOTHER	-	3.99	9.56	3.47	4.61	4.64	4.13
	HOSPITAL INPAT MATERNITY NON DELIVERIES	-	0.78	-	0.07	0.21	0.15	0.17
	HOSPITAL INPAT MATERNITY WELL NEW BORN	-	2.30	3.35	2.55	3.14	2.02	2.74
	HOSPITAL INPAT NON-MATERNITY ALCOHOL & DRUG ABUSE	2.81	-	-	0.48	0.69	0.49	0.57
	HOSPITAL INPAT NON-MATERNITY MEDICAL	14.37	22.21	14.14	19.33	20.54	32.17	21.34
	HOSPITAL INPAT NON-MATERNITY PSYCHIATRIC	-	10.41	-	1.69	1.95	5.01	2.48
	HOSPITAL INPAT NON-MATERNITY SURGICAL	141.67	29.08	68.85	35.33	38.53	59.51	39.78
	HOSPITAL INPAT OTHER	-	-	-	0.04	-	-	0.02
	HOSPITAL INPAT SKILLED NURSING FACILITY	-	0.10	-	0.39	0.88	0.08	0.56
INPATIENT Total		158.85	68.86	95.89	63.35	70.56	104.07	71.79
OUTPATIENT	HOSPITAL OUTPAT CARDIOVASCULAR	2.39	2.59	1.83	2.34	2.25	2.08	2.28
	HOSPITAL OUTPAT ER	13.66	13.35	3.30	12.68	13.09	14.59	13.07
	HOSPITAL OUTPAT OTHER	11.90	5.81	2.83	2.46	3.54	4.62	3.35
	HOSPITAL OUTPAT OTHER (EEG, 740-749)	3.63	1.65	-	1.94	1.50	1.91	1.73
	HOSPITAL OUTPAT OTHER (GASTROINTESTINAL, 750-759)	3.92	-	-	0.28	0.20	0.18	0.24
	HOSPITAL OUTPAT OTHER (MED/SURG GEN SUPPLIES,270-272)	0.63	1.10	0.70	0.75	0.75	1.63	0.86
	HOSPITAL OUTPAT OTHER ALCOHOL/SUBSTANCE ABUSE	-	-	-	0.03	0.02	-	0.02
	HOSPITAL OUTPAT OTHER DIALYSIS	-	-	-	-	-	0.01	0.00
	HOSPITAL OUTPAT OTHER HOME HEALTH	-	0.16	-	0.10	0.10	0.10	0.10
	HOSPITAL OUTPAT OTHER PSYCHIATRIC	0.22	3.12	0.79	0.42	0.81	0.44	0.70
	HOSPITAL OUTPAT PATHOLOGY	22.67	12.65	7.05	13.00	11.56	11.36	12.19
	HOSPITAL OUTPAT PHARMACY & BLOOD	3.58	34.10	16.00	15.13	12.81	15.26	14.77
	HOSPITAL OUTPAT PT/OT/ST	2.30	3.89	7.77	4.21	4.16	4.85	4.25
	HOSPITAL OUTPAT RADIOLOGY	32.38	29.88	11.42	17.89	20.07	21.58	19.76
	HOSPITAL OUTPAT RADIOLOGY (CAT)	8.86	12.34	16.00	11.29	10.07	10.25	10.68
	HOSPITAL OUTPAT RADIOLOGY (MRI)	11.77	8.82	13.30	10.29	9.21	12.12	9.97
	HOSPITAL OUTPAT SURGERY	67.22	56.28	39.97	44.72	42.51	57.95	45.71
	HOSPITAL OUTPT OTHER (IV THERAPY)	0.99	-	-	0.01	0.03	0.10	0.03
OUTPATIENT Total		186.11	185.72	120.98	137.57	132.69	159.03	139.72

Appendix 5: 01/09 - 12/09 Starting Assumptions
(Excluding Prescription Drugs)
Adjusted for Average Age and Industry

		PMPM						
PMPMCATC	PMPMCAT	BASIC/COMP	BC2	BC-Reg	HMO	HMO-Reg	PPO	TOTAL
PROFESSIONAL	PHARMACY INTEGRATED DRUGS	-	-	-	-	-	-	-
	PHYSICIAN ADDITIONAL BNFTS ALCOHOL & DRUG	0.10	0.20	0.31	0.32	0.23	0.18	0.26
	PHYSICIAN ADDITIONAL BNFTS CHIROPRACTOR	2.12	3.04	7.32	1.93	3.04	2.78	2.58
	PHYSICIAN ADDITIONAL BNFTS GLASSES/CONTACTS	-	0.02	-	0.01	0.00	0.00	0.01
	PHYSICIAN ADDITIONAL BNFTS HEARING/SPEECH EXAMS	0.30	0.88	1.00	0.41	0.52	0.62	0.50
	PHYSICIAN ADDITIONAL BNFTS IMMUNIZATIONS	1.25	1.55	2.04	1.39	1.78	2.17	1.66
	PHYSICIAN ADDITIONAL BNFTS PHYSICAL EXAMS	7.89	7.99	8.63	7.44	8.13	7.54	7.78
	PHYSICIAN ADDITIONAL BNFTS PODIATRIST	1.40	1.15	0.39	1.02	1.11	1.43	1.11
	PHYSICIAN ADDITIONAL BNFTS PSYCHIATRIC	6.46	8.39	9.32	5.80	6.24	8.84	6.44
	PHYSICIAN ADDITIONAL BNFTS VISION EXAMS	1.29	2.02	3.02	1.87	2.11	2.15	2.01
	PHYSICIAN ADDITIONAL BNFTS WELL BABY EXAMS	0.27	0.43	0.90	0.34	0.57	0.58	0.48
	PHYSICIAN ALLERGY IMMUNOTHERAPY	0.56	0.43	0.34	0.39	0.54	0.52	0.47
	PHYSICIAN ALLERGY TESTING	0.25	0.30	0.28	0.25	0.46	0.45	0.36
	PHYSICIAN INPAT SURGERY ANESTHESIA	5.74	2.54	2.95	2.05	2.19	2.66	2.22
	PHYSICIAN INPAT SURGERY ASSISTANT SURGEON	-	0.27	0.33	0.30	0.31	0.27	0.30
	PHYSICIAN INPAT SURGERY PRIMARY SURGEON	19.88	4.21	7.53	4.30	3.91	6.20	4.41
	PHYSICIAN INPAT VISITS	3.75	1.74	1.72	2.05	2.38	3.90	2.39
	PHYSICIAN MATERNITY CESAREAN DELIVERIES	-	0.89	1.70	1.21	1.28	1.19	1.23
	PHYSICIAN MATERNITY GENERAL CARE	-	0.37	-	0.12	0.18	0.12	0.16
	PHYSICIAN MATERNITY NON-DELIVERIES	-	0.30	-	0.20	0.31	0.23	0.26
	PHYSICIAN MATERNITY NORMAL DELIVERIES	-	2.01	2.47	1.86	2.54	2.08	2.18
	PHYSICIAN MISC MEDICAL	0.20	0.53	0.26	0.43	0.45	0.57	0.46
	PHYSICIAN MISC MEDICAL CENTRAL NERV SYSTEM TESTS	-	0.15	-	0.13	0.24	0.25	0.19
	PHYSICIAN MISC MEDICAL CHEMOTHERAPY	-	0.24	0.01	1.74	0.97	1.65	1.31
	PHYSICIAN MISC MEDICAL DERMATOLOGY	-	0.13	-	0.03	0.04	0.08	0.05
	PHYSICIAN MISC MEDICAL DIALYSIS	-	-	-	0.02	0.02	0.06	0.03
	PHYSICIAN MISC MEDICAL GASTROENTEROLOGY	0.07	0.02	-	0.07	0.06	0.13	0.07
	PHYSICIAN MISC MEDICAL NEUROLOGY	1.03	0.93	1.13	1.15	1.12	1.41	1.16
	PHYSICIAN MISC MEDICAL NON-INVASIVE VASCULAR	0.55	0.28	0.26	0.31	0.27	0.36	0.30
	PHYSICIAN MISC MEDICAL OPHTHALMOLOGY	0.58	0.40	0.54	0.43	0.45	0.57	0.45
	PHYSICIAN MISC MEDICAL OTORHINOLARYNGOLOGY	-	0.12	-	0.05	0.08	0.18	0.08
	PHYSICIAN MISC MEDICAL PULMONOLOGY	0.48	0.18	0.31	0.17	0.24	0.35	0.22
	PHYSICIAN MISC MEDICAL VENIPUNCTURE	0.04	0.04	0.10	0.03	0.09	0.09	0.07
	PHYSICIAN MISC MEDICAL VESIBULAR FUNCTION TEST	-	0.02	-	0.04	0.02	0.04	0.03
	PHYSICIAN OFFICE/HOME VISITS	28.81	28.56	29.09	24.95	26.45	29.12	26.25
	PHYSICIAN OTHER	0.81	0.56	6.90	0.48	2.96	0.49	1.61
	PHYSICIAN OTHER AMBULANCE	1.29	1.28	-	1.63	2.16	2.06	1.89
	PHYSICIAN OTHER DURABLE MEDICAL EQUIPMENT	17.19	8.97	6.41	2.55	2.63	3.31	2.99
	PHYSICIAN OTHER PRIVATE DUTY NURSING/HOME	1.56	0.32	0.07	0.43	0.50	0.47	0.47
	PHYSICIAN OTHER PROSTHETICS	1.60	0.08	-	0.09	0.50	0.07	0.28
	PHYSICIAN OTHER SERVICES CARDIOVASCULAR	3.61	1.97	1.58	1.44	1.64	2.24	1.65
	PHYSICIAN OTHER SERVICES CONSULTS	6.79	6.59	5.84	5.50	6.06	6.54	5.91
	PHYSICIAN OTHER SERVICES ER VISITS	2.43	2.83	1.59	2.72	2.70	2.82	2.72
	PHYSICIAN OTHER SERVICES PATHOLOGY INPAT	0.43	0.35	0.36	0.20	0.20	0.31	0.22
	PHYSICIAN OTHER SERVICES PATHOLOGY OFFICE	2.28	3.19	3.23	2.82	3.43	3.54	3.19
	PHYSICIAN OTHER SERVICES PATHOLOGY OUTPAT	3.61	4.38	6.39	3.61	4.51	5.55	4.26
	PHYSICIAN OTHER SERVICES PHYSICAL MEDICINE	9.89	4.98	6.12	4.00	4.44	6.23	4.51
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT	0.35	0.14	0.11	0.20	0.24	0.38	0.24
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT (CAT)	0.16	0.18	0.29	0.23	0.19	0.35	0.23
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT (MRI)	0.12	0.13	-	0.08	0.07	0.09	0.08
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE	6.15	4.34	4.13	3.56	4.43	4.70	4.11
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE (CAT)	1.57	0.81	-	0.61	0.55	0.96	0.63
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE (MRI)	2.59	1.84	-	1.47	1.93	2.50	1.80
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT	2.83	3.74	1.79	2.81	3.13	2.97	3.00
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT (CAT)	1.58	1.17	0.98	1.06	1.05	1.15	1.07
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT (MRI)	0.60	0.90	1.25	0.79	0.78	1.01	0.82
	PHYSICIAN OUTPAT SURGERY (ANESTHESIA)	7.55	4.99	5.83	4.74	4.69	4.91	4.76
	PHYSICIAN OUTPAT SURGERY (OFFICE)	10.76	8.14	3.71	5.50	5.91	7.12	5.98
	PHYSICIAN OUTPAT SURGERY OUTPAT (SURGICAL CENTER)	12.75	13.98	7.41	10.77	10.81	11.38	10.97
	PHYSICIAN PRESCRIPTION DRUGS OFFICE	0.00	0.00	0.00	0.01	0.00	0.04	0.01
	PHYSICIAN THERAPEUTIC INJECTIONS	0.21	10.15	42.55	2.41	1.56	2.93	2.52
	PHYSICIAN UNCLASSIFIED	4.93	2.22	1.36	2.50	2.71	3.51	2.70
	PHYSICIAN URGENT CARE VISITS	0.11	0.09	0.06	0.14	0.12	0.11	0.13
PROFESSIONAL Total		186.79	158.65	189.91	125.18	138.22	156.54	136.20
Grand Total		**531.75**	**413.24**	**406.79**	**326.10**	**341.47**	**419.64**	**347.70**

Appendix 6: 01/09 - 12/09 Starting Assumptions
(Excluding Prescription Drugs)
Adjusted for Average Age, Industry and HMO Hospital Discounts

		PMPM						
PMPMCATC	PMPMCAT	BASIC/COMP	BC2	BC-Reg	HMO	HMO-Reg	PPO	TOTAL
INPATIENT	HOSPITAL INPAT MATERNITY MOTHER	-	3.99	9.56	3.47	4.61	3.55	4.01
	HOSPITAL INPAT MATERNITY NON DELIVERIES	-	0.78	-	0.07	0.21	0.12	0.16
	HOSPITAL INPAT MATERNITY WELL NEW BORN	-	2.30	3.35	2.55	3.14	1.54	2.69
	HOSPITAL INPAT NON-MATERNITY ALCOHOL & DRUG ABUSE	1.69	-	-	0.48	0.69	0.37	0.55
	HOSPITAL INPAT NON-MATERNITY MEDICAL	8.65	22.21	14.14	19.33	20.54	24.65	20.49
	HOSPITAL INPAT NON-MATERNITY PSYCHIATRIC	-	10.41	-	1.69	1.95	3.83	2.35
	HOSPITAL INPAT NON-MATERNITY SURGICAL	85.31	29.08	68.85	35.33	38.53	45.60	38.00
	HOSPITAL INPAT OTHER	-	-	-	0.04	-	-	0.02
	HOSPITAL INPAT SKILLED NURSING FACILITY	-	0.10	-	0.39	0.88	0.06	0.56
INPATIENT Total		95.65	68.86	95.89	63.35	70.56	79.73	68.83
OUTPATIENT	HOSPITAL OUTPAT CARDIOVASCULAR	1.69	2.59	1.83	2.34	2.25	1.76	2.24
	HOSPITAL OUTPAT ER	9.66	13.35	3.30	12.68	13.09	12.33	12.80
	HOSPITAL OUTPAT OTHER	8.42	5.81	2.83	2.46	3.54	3.90	3.25
	HOSPITAL OUTPAT OTHER (EEG, 740-749)	2.57	1.65	-	1.94	1.50	1.62	1.69
	HOSPITAL OUTPAT OTHER (GASTROINTESTINAL, 750-759)	2.77	-	-	0.28	0.20	0.15	0.23
	HOSPITAL OUTPAT OTHER (MED/SURG GEN SUPPLIES,270-272)	0.44	1.10	0.70	0.75	0.75	1.37	0.83
	HOSPITAL OUTPAT OTHER ALCOHOL/SUBSTANCE ABUSE	-	-	-	0.03	0.02	-	0.02
	HOSPITAL OUTPAT OTHER DIALYSIS	-	-	-	-	-	0.01	0.00
	HOSPITAL OUTPAT OTHER HOME HEALTH	-	0.16	-	0.10	0.10	0.08	0.10
	HOSPITAL OUTPAT OTHER PSYCHIATRIC	0.15	3.12	0.79	0.42	0.81	0.36	0.69
	HOSPITAL OUTPAT PATHOLOGY	16.04	12.65	7.05	13.00	11.56	9.59	11.96
	HOSPITAL OUTPAT PHARMACY & BLOOD	2.53	34.10	16.00	15.13	12.81	12.89	14.51
	HOSPITAL OUTPAT PT/OT/ST	1.62	3.89	7.77	4.21	4.16	4.08	4.16
	HOSPITAL OUTPAT RADIOLOGY	22.91	29.88	11.42	17.89	20.07	18.24	19.35
	HOSPITAL OUTPAT RADIOLOGY (CAT)	6.27	12.34	16.00	11.29	10.07	8.66	10.49
	HOSPITAL OUTPAT RADIOLOGY (MRI)	8.33	8.82	13.30	10.29	9.21	10.24	9.75
	HOSPITAL OUTPAT SURGERY	47.56	56.28	39.97	44.72	42.51	48.75	44.61
	HOSPITAL OUTPT OTHER (IV THERAPY)	0.70	-	-	0.01	0.03	0.08	0.03
OUTPATIENT Total		131.67	185.72	120.98	137.57	132.69	134.12	136.74

Appendix 6: 01/09 - 12/09 Starting Assumptions
(Excluding Prescription Drugs)
Adjusted for Average Age, Industry and HMO Hospital Discounts

		PMPM						
PMPMCATC	PMPMCAT	BASIC/COMP	BC2	BC-Reg	HMO	HMO-Reg	PPO	TOTAL
PROFESSIONAL	PHARMACY INTEGRATED DRUGS	-	-	-	-	-	-	-
	PHYSICIAN ADDITIONAL BNFTS ALCOHOL & DRUG	0.10	0.20	0.31	0.32	0.23	0.18	0.26
	PHYSICIAN ADDITIONAL BNFTS CHIROPRACTOR	2.12	3.04	7.32	1.93	3.04	2.78	2.58
	PHYSICIAN ADDITIONAL BNFTS GLASSES/CONTACTS	-	0.02	-	0.01	0.00	0.00	0.01
	PHYSICIAN ADDITIONAL BNFTS HEARING/SPEECH EXAMS	0.30	0.88	1.00	0.41	0.52	0.62	0.50
	PHYSICIAN ADDITIONAL BNFTS IMMUNIZATIONS	1.25	1.55	2.04	1.39	1.78	2.17	1.66
	PHYSICIAN ADDITIONAL BNFTS PHYSICAL EXAMS	7.89	7.99	8.63	7.44	8.13	7.54	7.78
	PHYSICIAN ADDITIONAL BNFTS PODIATRIST	1.40	1.15	0.39	1.02	1.11	1.43	1.11
	PHYSICIAN ADDITIONAL BNFTS PSYCHIATRIC	6.46	8.39	9.32	5.80	6.24	8.84	6.44
	PHYSICIAN ADDITIONAL BNFTS VISION EXAMS	1.29	2.02	3.02	1.87	2.11	2.15	2.01
	PHYSICIAN ADDITIONAL BNFTS WELL BABY EXAMS	0.27	0.43	0.90	0.34	0.57	0.58	0.48
	PHYSICIAN ALLERGY IMMUNOTHERAPY	0.56	0.43	0.34	0.39	0.54	0.52	0.47
	PHYSICIAN ALLERGY TESTING	0.25	0.30	0.28	0.25	0.46	0.45	0.36
	PHYSICIAN INPAT SURGERY ANESTHESIA	5.74	2.54	2.95	2.05	2.19	2.66	2.22
	PHYSICIAN INPAT SURGERY ASSISTANT SURGEON	-	0.27	0.33	0.30	0.31	0.27	0.30
	PHYSICIAN INPAT SURGERY PRIMARY SURGEON	19.88	4.21	7.53	4.30	3.91	6.20	4.41
	PHYSICIAN INPAT VISITS	3.75	1.74	1.72	2.05	2.38	3.90	2.39
	PHYSICIAN MATERNITY CESAREAN DELIVERIES	-	0.89	1.70	1.21	1.28	1.19	1.23
	PHYSICIAN MATERNITY GENERAL CARE	-	0.37	-	0.12	0.18	0.12	0.16
	PHYSICIAN MATERNITY NON-DELIVERIES	-	0.30	-	0.20	0.31	0.23	0.26
	PHYSICIAN MATERNITY NORMAL DELIVERIES	-	2.01	2.47	1.86	2.54	2.08	2.18
	PHYSICIAN MISC MEDICAL	0.20	0.53	0.26	0.43	0.45	0.57	0.46
	PHYSICIAN MISC MEDICAL CENTRAL NERV SYSTEM TESTS	-	0.15	-	0.13	0.24	0.25	0.19
	PHYSICIAN MISC MEDICAL CHEMOTHERAPY	-	0.24	0.01	1.74	0.97	1.65	1.31
	PHYSICIAN MISC MEDICAL DERMATOLOGY	-	0.13	-	0.03	0.04	0.08	0.05
	PHYSICIAN MISC MEDICAL DIALYSIS	-	-	-	0.02	0.02	0.06	0.03
	PHYSICIAN MISC MEDICAL GASTROENTEROLOGY	0.07	0.02	-	0.07	0.06	0.13	0.07
	PHYSICIAN MISC MEDICAL NEUROLOGY	1.03	0.93	1.13	1.15	1.12	1.41	1.16
	PHYSICIAN MISC MEDICAL NON-INVASIVE VASCULAR	0.55	0.28	0.26	0.31	0.27	0.36	0.30
	PHYSICIAN MISC MEDICAL OPHTHALMOLOGY	0.58	0.40	0.54	0.43	0.45	0.57	0.45
	PHYSICIAN MISC MEDICAL OTORHINOLARYNGOLOGY	-	0.12	-	0.05	0.08	0.18	0.08
	PHYSICIAN MISC MEDICAL PULMONOLOGY	0.48	0.18	0.31	0.17	0.24	0.35	0.22
	PHYSICIAN MISC MEDICAL VENIPUNCTURE	0.04	0.04	0.10	0.03	0.09	0.09	0.07
	PHYSICIAN MISC MEDICAL VESIBULAR FUNCTION TEST	-	0.02	-	0.04	0.02	0.04	0.03
	PHYSICIAN OFFICE/HOME VISITS	28.81	28.56	29.09	24.95	26.45	29.12	26.25
	PHYSICIAN OTHER	0.81	0.56	6.90	0.48	2.96	0.49	1.61
	PHYSICIAN OTHER AMBULANCE	1.29	1.28	-	1.63	2.16	2.06	1.89
	PHYSICIAN OTHER DURABLE MEDICAL EQUIPMENT	17.19	8.97	6.41	2.55	2.63	3.31	2.99
	PHYSICIAN OTHER PRIVATE DUTY NURSING/HOME	1.56	0.32	0.07	0.43	0.50	0.47	0.47
	PHYSICIAN OTHER PROSTHETICS	1.60	0.08	-	0.09	0.50	0.07	0.28
	PHYSICIAN OTHER SERVICES CARDIOVASCULAR	3.61	1.97	1.58	1.44	1.64	2.24	1.65
	PHYSICIAN OTHER SERVICES CONSULTS	6.79	6.59	5.84	5.50	6.06	6.54	5.91
	PHYSICIAN OTHER SERVICES ER VISITS	2.43	2.83	1.59	2.72	2.70	2.82	2.72
	PHYSICIAN OTHER SERVICES PATHOLOGY INPAT	0.43	0.35	0.36	0.20	0.20	0.31	0.22
	PHYSICIAN OTHER SERVICES PATHOLOGY OFFICE	2.28	3.19	3.23	2.82	3.43	3.54	3.19
	PHYSICIAN OTHER SERVICES PATHOLOGY OUTPAT	3.61	4.38	6.39	3.61	4.51	5.55	4.26
	PHYSICIAN OTHER SERVICES PHYSICAL MEDICINE	9.89	4.98	6.12	4.00	4.44	6.23	4.51
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT	0.35	0.14	0.11	0.20	0.24	0.38	0.24
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT (CAT)	0.16	0.18	0.29	0.23	0.19	0.35	0.23
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT (MRI)	0.12	0.13	-	0.08	0.07	0.09	0.08
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE	6.15	4.34	4.13	3.56	4.43	4.70	4.11
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE (CAT)	1.57	0.81	-	0.61	0.55	0.96	0.63
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE (MRI)	2.59	1.84	-	1.47	1.93	2.50	1.80
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT	2.83	3.74	1.79	2.81	3.13	2.97	3.00
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT (CAT)	1.58	1.17	0.98	1.06	1.05	1.15	1.07
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT (MRI)	0.60	0.90	1.25	0.79	0.78	1.01	0.82
	PHYSICIAN OUTPAT SURGERY (ANESTHESIA)	7.55	4.99	5.83	4.74	4.69	4.91	4.76
	PHYSICIAN OUTPAT SURGERY (OFFICE)	10.76	8.14	3.71	5.50	5.91	7.12	5.98
	PHYSICIAN OUTPAT SURGERY OUTPAT (SURGICAL CENTER)	12.75	13.98	7.41	10.77	10.81	11.38	10.97
	PHYSICIAN PRESCRIPTION DRUGS OFFICE	0.00	0.00	0.00	0.01	0.00	0.04	0.01
	PHYSICIAN THERAPEUTIC INJECTIONS	0.21	10.15	42.55	2.41	1.56	2.93	2.52
	PHYSICIAN UNCLASSIFIED	4.93	2.22	1.36	2.50	2.71	3.51	2.70
	PHYSICIAN URGENT CARE VISITS	0.11	0.09	0.06	0.14	0.12	0.11	0.13
PROFESSIONAL Total		186.79	158.65	189.91	125.18	138.22	156.54	136.20
Grand Total		**414.11**	**413.24**	**406.79**	**326.10**	**341.47**	**370.39**	**341.76**

Appendix 7: 01/09 - 12/09 Starting Assumptions
(Excluding Prescription Drugs)
Adjusted for Average Age, Industry, HMO Hospital Discounts and Utilization

		PMPM						
PMPMCATC	PMPMCAT	BASIC/COMP	BC2	BC-Reg	HMO	HMO-Reg	PPO	TOTAL
INPATIENT	HOSPITAL INPAT MATERNITY MOTHER	-	3.56	8.53	3.47	4.61	3.06	3.94
	HOSPITAL INPAT MATERNITY NON DELIVERIES	-	0.69	-	0.07	0.21	0.10	0.16
	HOSPITAL INPAT MATERNITY WELL NEW BORN	-	2.06	2.99	2.55	3.14	1.33	2.65
	HOSPITAL INPAT NON-MATERNITY ALCOHOL & DRUG ABUSE	1.30	-	-	0.48	0.69	0.32	0.54
	HOSPITAL INPAT NON-MATERNITY MEDICAL	6.66	19.83	12.62	19.33	20.54	21.25	20.01
	HOSPITAL INPAT NON-MATERNITY PSYCHIATRIC	-	9.30	-	1.69	1.95	3.30	2.25
	HOSPITAL INPAT NON-MATERNITY SURGICAL	65.62	25.96	61.47	35.33	38.53	39.31	37.07
	HOSPITAL INPAT OTHER	-	-	-	0.04	-	-	0.02
	HOSPITAL INPAT SKILLED NURSING FACILITY	-	0.09	-	0.39	0.88	0.05	0.56
INPATIENT Total		73.58	61.49	85.62	63.35	70.56	68.72	67.21
OUTPATIENT	HOSPITAL OUTPAT CARDIOVASCULAR	1.30	2.31	1.64	2.34	2.25	1.51	2.20
	HOSPITAL OUTPAT ER	7.43	11.92	2.95	12.68	13.09	10.63	12.55
	HOSPITAL OUTPAT OTHER	6.47	5.19	2.52	2.46	3.54	3.36	3.16
	HOSPITAL OUTPAT OTHER (EEG, 740-749)	1.97	1.47	-	1.94	1.50	1.39	1.66
	HOSPITAL OUTPAT OTHER (GASTROINTESTINAL, 750-759)	2.13	-	-	0.28	0.20	0.13	0.23
	HOSPITAL OUTPAT OTHER (MED/SURG GEN SUPPLIES,270-272)	0.34	0.99	0.63	0.75	0.75	1.18	0.80
	HOSPITAL OUTPAT OTHER ALCOHOL/SUBSTANCE ABUSE	-	-	-	0.03	0.02	-	0.02
	HOSPITAL OUTPAT OTHER DIALYSIS	-	-	-	-	-	0.01	0.00
	HOSPITAL OUTPAT OTHER HOME HEALTH	-	0.14	-	0.10	0.10	0.07	0.10
	HOSPITAL OUTPAT OTHER PSYCHIATRIC	0.12	2.78	0.71	0.42	0.81	0.30	0.67
	HOSPITAL OUTPAT PATHOLOGY	12.34	11.29	6.30	13.00	11.56	8.27	11.75
	HOSPITAL OUTPAT PHARMACY & BLOOD	1.95	30.45	14.29	15.13	12.81	11.12	14.17
	HOSPITAL OUTPAT PT/OT/ST	1.25	3.47	6.94	4.21	4.16	3.51	4.08
	HOSPITAL OUTPAT RADIOLOGY	17.62	26.68	10.20	17.89	20.07	15.72	18.92
	HOSPITAL OUTPAT RADIOLOGY (CAT)	4.82	11.02	14.29	11.29	10.07	7.46	10.30
	HOSPITAL OUTPAT RADIOLOGY (MRI)	6.41	7.87	11.87	10.29	9.21	8.83	9.54
	HOSPITAL OUTPAT SURGERY	36.58	50.25	35.69	44.72	42.51	41.93	43.57
	HOSPITAL OUTPT OTHER (IV THERAPY)	0.54	-	-	0.01	0.03	0.07	0.03
OUTPATIENT Total		101.28	165.82	108.02	137.57	132.69	115.50	133.76

Appendix 7: 01/09 - 12/09 Starting Assumptions
(Excluding Prescription Drugs)
Adjusted for Average Age, Industry, HMO Hospital Discounts and Utilization

		PMPM						
PMPMCATC	PMPMCAT	BASIC/COMP	BC2	BC-Reg	HMO	HMO-Reg	PPO	TOTAL
PROFESSIONAL	PHARMACY INTEGRATED DRUGS	-	-	-	-	-	-	-
	PHYSICIAN ADDITIONAL BNFTS ALCOHOL & DRUG	0.07	0.18	0.28	0.32	0.23	0.16	0.25
	PHYSICIAN ADDITIONAL BNFTS CHIROPRACTOR	1.63	2.72	6.53	1.93	3.04	2.39	2.52
	PHYSICIAN ADDITIONAL BNFTS GLASSES/CONTACTS	-	0.02	-	0.01	0.00	0.00	0.01
	PHYSICIAN ADDITIONAL BNFTS HEARING/SPEECH EXAMS	0.23	0.79	0.89	0.41	0.52	0.54	0.48
	PHYSICIAN ADDITIONAL BNFTS IMMUNIZATIONS	0.96	1.38	1.82	1.39	1.78	1.87	1.61
	PHYSICIAN ADDITIONAL BNFTS PHYSICAL EXAMS	6.07	7.13	7.71	7.44	8.13	6.50	7.63
	PHYSICIAN ADDITIONAL BNFTS PODIATRIST	1.08	1.02	0.35	1.02	1.11	1.23	1.08
	PHYSICIAN ADDITIONAL BNFTS PSYCHIATRIC	4.97	7.49	8.32	5.80	6.24	7.50	6.25
	PHYSICIAN ADDITIONAL BNFTS VISION EXAMS	0.99	1.81	2.70	1.87	2.11	1.85	1.97
	PHYSICIAN ADDITIONAL BNFTS WELL BABY EXAMS	0.21	0.39	0.80	0.34	0.57	0.50	0.46
	PHYSICIAN ALLERGY IMMUNOTHERAPY	0.43	0.38	0.31	0.39	0.54	0.45	0.46
	PHYSICIAN ALLERGY TESTING	0.20	0.27	0.25	0.25	0.46	0.39	0.36
	PHYSICIAN INPAT SURGERY ANESTHESIA	4.42	2.27	2.63	2.05	2.19	2.28	2.16
	PHYSICIAN INPAT SURGERY ASSISTANT SURGEON	-	0.24	0.30	0.30	0.31	0.23	0.29
	PHYSICIAN INPAT SURGERY PRIMARY SURGEON	15.29	3.76	6.72	4.30	3.91	5.28	4.27
	PHYSICIAN INPAT VISITS	2.89	1.55	1.54	2.05	2.38	3.35	2.32
	PHYSICIAN MATERNITY CESAREAN DELIVERIES	-	0.79	1.52	1.21	1.28	1.02	1.20
	PHYSICIAN MATERNITY GENERAL CARE	-	0.33	-	0.12	0.18	0.11	0.15
	PHYSICIAN MATERNITY NON-DELIVERIES	-	0.27	-	0.20	0.31	0.20	0.25
	PHYSICIAN MATERNITY NORMAL DELIVERIES	-	1.79	2.21	1.86	2.54	1.80	2.14
	PHYSICIAN MISC MEDICAL	0.16	0.48	0.24	0.43	0.45	0.49	0.44
	PHYSICIAN MISC MEDICAL CENTRAL NERV SYSTEM TESTS	-	0.13	-	0.13	0.24	0.22	0.19
	PHYSICIAN MISC MEDICAL CHEMOTHERAPY	-	0.21	0.01	1.74	0.97	1.42	1.29
	PHYSICIAN MISC MEDICAL DERMATOLOGY	-	0.12	-	0.03	0.04	0.07	0.04
	PHYSICIAN MISC MEDICAL DIALYSIS	-	-	-	0.02	0.02	0.05	0.03
	PHYSICIAN MISC MEDICAL GASTROENTEROLOGY	0.06	0.02	-	0.07	0.06	0.11	0.07
	PHYSICIAN MISC MEDICAL NEUROLOGY	0.79	0.83	1.01	1.15	1.12	1.21	1.13
	PHYSICIAN MISC MEDICAL NON-INVASIVE VASCULAR	0.42	0.25	0.23	0.31	0.27	0.31	0.29
	PHYSICIAN MISC MEDICAL OPHTHALMOLOGY	0.45	0.36	0.48	0.43	0.45	0.49	0.44
	PHYSICIAN MISC MEDICAL OTORHINOLARYNGOLOGY	-	0.10	-	0.05	0.08	0.16	0.08
	PHYSICIAN MISC MEDICAL PULMONOLOGY	0.37	0.16	0.27	0.17	0.24	0.30	0.22
	PHYSICIAN MISC MEDICAL VENIPUNCTURE	0.03	0.03	0.09	0.03	0.09	0.08	0.06
	PHYSICIAN MISC MEDICAL VESIBULAR FUNCTION TEST	-	0.01	-	0.04	0.02	0.04	0.03
	PHYSICIAN OFFICE/HOME VISITS	22.16	25.50	25.98	24.95	26.45	25.08	25.65
	PHYSICIAN OTHER	0.62	0.50	6.16	0.48	2.96	0.40	1.60
	PHYSICIAN OTHER AMBULANCE	0.99	1.15	-	1.63	2.16	1.77	1.85
	PHYSICIAN OTHER DURABLE MEDICAL EQUIPMENT	13.22	8.01	5.72	2.55	2.63	2.84	2.88
	PHYSICIAN OTHER PRIVATE DUTY NURSING/HOME	1.22	0.28	0.06	0.43	0.50	0.40	0.46
	PHYSICIAN OTHER PROSTHETICS	1.23	0.07	-	0.09	0.50	0.06	0.28
	PHYSICIAN OTHER SERVICES CARDIOVASCULAR	2.78	1.76	1.41	1.44	1.64	1.93	1.60
	PHYSICIAN OTHER SERVICES CONSULTS	5.23	5.88	5.22	5.50	6.06	5.63	5.77
	PHYSICIAN OTHER SERVICES ER VISITS	1.87	2.53	1.42	2.72	2.70	2.43	2.66
	PHYSICIAN OTHER SERVICES PATHOLOGY INPAT	0.33	0.31	0.32	0.20	0.20	0.26	0.21
	PHYSICIAN OTHER SERVICES PATHOLOGY OFFICE	1.76	2.85	2.89	2.82	3.43	3.05	3.11
	PHYSICIAN OTHER SERVICES PATHOLOGY OUTPAT	2.78	3.91	5.70	3.61	4.51	4.77	4.15
	PHYSICIAN OTHER SERVICES PHYSICAL MEDICINE	7.61	4.45	5.47	4.00	4.44	5.36	4.38
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT	0.27	0.13	0.10	0.20	0.24	0.33	0.23
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT (CAT)	0.13	0.16	0.26	0.23	0.19	0.31	0.22
	PHYSICIAN OTHER SERVICES RADIOLOGY INPAT (MRI)	0.09	0.11	-	0.08	0.07	0.08	0.08
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE	4.73	3.87	3.69	3.56	4.43	4.05	4.02
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE (CAT)	1.21	0.73	-	0.61	0.55	0.83	0.61
	PHYSICIAN OTHER SERVICES RADIOLOGY OFFICE (MRI)	1.99	1.64	-	1.47	1.93	2.16	1.75
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT	2.18	3.34	1.60	2.81	3.13	2.56	2.94
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT (CAT)	1.21	1.04	0.88	1.06	1.05	0.99	1.05
	PHYSICIAN OTHER SERVICES RADIOLOGY OUTPAT (MRI)	0.46	0.80	1.12	0.79	0.78	0.87	0.80
	PHYSICIAN OUTPAT SURGERY (ANESTHESIA)	5.81	4.45	5.21	4.74	4.69	4.22	4.66
	PHYSICIAN OUTPAT SURGERY (OFFICE)	8.28	7.26	3.31	5.50	5.91	6.13	5.82
	PHYSICIAN OUTPAT SURGERY OUTPAT (SURGICAL CENTER)	9.81	12.48	6.62	10.77	10.81	9.80	10.73
	PHYSICIAN PRESCRIPTION DRUGS OFFICE	0.00	0.00	0.00	0.01	0.00	0.04	0.01
	PHYSICIAN THERAPEUTIC INJECTIONS	0.16	9.06	37.99	2.41	1.56	2.51	2.41
	PHYSICIAN UNCLASSIFIED	3.79	1.98	1.21	2.50	2.71	3.02	2.63
	PHYSICIAN URGENT CARE VISITS	0.08	0.08	0.06	0.14	0.12	0.09	0.12
PROFESSIONAL Total		143.68	141.66	169.57	125.18	138.22	134.54	132.87
Grand Total		**318.54**	**368.96**	**363.20**	**326.10**	**341.47**	**318.77**	**333.84**

Anthem Blue Cross Blue Shield New Hampshire

Exhibit I

Projected Preferred Blue Rates for Group Size 1 - 50
Effective July 1, 2010

3000 Goffs Falls Road
Manchester, NH 03111-0001

		Projected Medical Pure Premium PMPM	Projected Prescription Drug PMPM	Projected Total PMPM	Projected Income PMPM Including Retention
BENEFIT DESCRIPTION					
Matthew Thornton Blue					
PCP Referred	$15 PCP OV, $30 SPC OV; $150 ER; IP/OP $500 Ded (1st Lab/X-ray); Rx $10/30/40 Retail $10/60/120 Mail	$402.88	$74.26	$477.14	$570.43
PCP Referred	$20 PCP OV, $40 SPC OV; $200 ER; IP/OP $1,000 Ded 20% to $2,000(1st $ Lab/X-ray) Rx $10/30/40 Retail $10/60/120 Mail	$285.56	$74.26	$359.82	$442.91
PCP Referred	$25 PCP OV, $50 SPC OV; $250 ER; IP/OP $2,000 Ded (1st Lab/X-ray); Rx $10/30/40 Retail $10/60/120 Mail	$253.07	$74.26	$327.33	$407.60
Preferred Blue					
Network OON	$50 OV; $100 ER; IP/OP $500 Ded, 80/20 to 1000 (1st $ Lab/X-ray); Rx $10/30/40 Retail $10/60/120 Mail $750 Ded; 30% to $1500	$494.56	$74.26	$569.12	$670.41
Network OON	$20 OV; $100 ER; IP/OP $1000 Ded, 80/20 to 2000 (1st $ Lab/X-ray), Rx $10/30/40 Retail $10/60/120 Mail $6000 Ded; 40% to $7,000	$394.52	$74.26	$469.08	$561.67
BlueChoice 2 - Tier					
PCP Referred Self Referred	$15 PCP OV, $30 SPC OV; $150 ER; IP/OP $500 Ded (1st $ Lab/X-ray); Rx $10/30/40 Retail $10/60/120 Mail $750 Ded; 30% to $1,500	$454.23	$74.26	$528.49	$626.25
PCP Referred Self Referred	$20 PCP OV, $40 SPC OV; $150 ER; IP/OP $1,000 Ded (Lab/X-ray); Rx $10/30/40 Retail $10/60/120 Mail $2,000 Ded; 40% to $3,000	$280.34	$74.26	$354.60	$437.24

Anthem Blue Cross Blue Shield New Hampshire

Exhibit II

Preferred Blue Rate Comparison for Group Size 1 - 50
Effective July 1, 2010
3000 Goffs Falls Road
Manchester, NH 03111-0001

		07/01/2009 Income PMPM Including Retention	04/01/2010 Income PMPM Including Retention	Projected 07/01/2010 Income PMPM Including Retention	Projected 07/01/2010 vs. 07/01/2009 Including Retention	Projected 07/01/2010 vs. 04/01/2010 Including Retention
BENEFIT DESCRIPTION						
Matthew Thornton Blue						
PCP Referred	$15 PCP OV, $30 SPC OV; $150 ER; IP/OP $500 Ded (1st Lab/X-ray); Rx $10/30/40 Retail $10/60/120 Mail	$476.66	$549.38	$570.43	19.7%	3.8%
PCP Referred	$20 PCP OV, $40 SPC OV; $200 ER; IP/OP $1,000 Ded 20% to $2,000(1st $ Lab/X-ray) Rx $10/30/40 Retail $10/60/120 Mail	$371.86	$425.90	$442.91	19.1%	4.0%
PCP Referred	$25 PCP OV, $50 SPC OV; $250 ER; IP/OP $2,000 Ded (1st Lab/X-ray); Rx $10/30/40 Retail $10/60/120 Mail	$354.43	$383.87	$407.60	15.0%	6.2%
Preferred Blue						
Network OON	$50 OV; $100 ER; IP/OP $500 Ded, 80/20 to 1000 (1st $ Lab/X-ray); Rx $10/30/40 Retail $10/60/120 Mail $750 Ded; 30% to $1500	$546.67	$644.36	$670.41	22.6%	4.0%
Network OON	$20 OV; $100 ER; IP/OP $1000 Ded, 80/20 to 2000 (1st $ Lab/X-ray), Rx $10/30/40 Retail $10/60/120 Mail $6000 Ded; 40% to $7,000	$463.49	$539.36	$561.67	21.2%	4.1%
BlueChoice 2 - Tier						
PCP Referred Self Referred	$15 PCP OV, $30 SPC OV; $150 ER; IP/OP $500 Ded (1st $ Lab/X-ray); Rx $10/30/40 Retail $10/60/120 Mail $750 Ded; 30% to $1,500	$523.41	$602.83	$626.25	19.6%	3.9%
PCP Referred Self Referred	$20 PCP OV, $40 SPC OV; $150 ER; IP/OP $1,000 Ded (Lab/X-ray); Rx $10/30/40 Retail $10/60/120 Mail $2,000 Ded; 40% to $3,000	$372.78	$422.10	$437.24	17.3%	3.6%

Anthem Blue Cross Blue Shield New Hampshire

Exhibit III(a)

Preferred Blue Per Member Per Month Base Rates
Effective July 1, 2010

3000 Goffs Falls Road
Manchester, NH 03111-0001

Product*		Benefit Description	Proposed PMPM [1]
Preferred Blue	Network:	$15 OV; $100 ER; IP/OP $500 Ded (1 st Lab/X-ray); Unlimited Lifetime Max	$550.86
	OON:	$750 Ded 70/30 to $1,500; $250,000/mem Lifetime Max	
Preferred Blue	Network:	$15 OV; $100 ER; IP/OP $500 Ded 80/20 to $1,000 (1st $ Lab/X-ray); Unlimited Lifetime Max	$494.86
	OON:	$750 Ded 70/30 to $1,500; $250,000/mem Lifetime Max	
Preferred Blue	Network:	$20 OV; $100 ER; IP/OP $1000 Ded (1st $ Lab/X-ray); Umlimited Lifetime Max	$444.95
	OON:	$2000 Ded 60/40 to $3,000; $250,000/mem Lifetime Max	
Preferred Blue	Network:	$20 OV; $100 ER; IP/OP $1,000 Ded 80/20 to $2,000 (1st $ Lab/X-ray); Umlimited lifetime Ma	$394.82
	OON:	$2,000 Ded 60/40 to $3,000; $250,000/mem Lifetime Max	
Preferred Blue	Network:	$20 OV; $100 ER; IP/OP $1500 Ded (1st $ Lab/X-ray); Umlimited Lifetime Max	$398.34
	OON:	$3000 Ded 60/40 to $4,000; $250,000/mem Lifetime Max	
Preferred Blue	Network:	$25 OV; $100 ER; IP/OP $2500 Ded (1st $ Lab/X-ray); Umlimited Lifetime Max	$319.26
	OON:	$4000 Ded 60/40 to $5,000; $250,000/mem Lifetime Max	
Preferred Blue	Network:	$25 OV; $100 ER; IP/OP $2,500 Ded 80/20 to $5,000 (1st $Lab/X-ray); Unlimited Lifetime Ma	$287.62
	OON:	$4000 Ded 60/40 to $5,000; $250,000/mem Lifetime Max	
Preferred Blue	Network:	$25 OV; $100 ER; IP/OP $2000 Ded (1st $ Lab/X-ray); Umlimited Lifetime Max	$351.97
	OON:	$3500 Ded 60/40 to $4,500; $250,000/mem Lifetime Max	
Preferred Blue	Network:	$25 OV; $100 ER; IP/OP $3500 Ded (1st $ Lab/X-ray); Umlimited Lifetime Max	$303.39
	OON:	$5000 Ded 60/40 to $6,000; $250,000/mem Lifetime Max	
Preferred Blue	Network:	$25 OV; $100 ER; IP/OP $5000 Ded (1st $ Lab/X-ray); Umlimited Lifetime Max	$287.56
	OON:	$6000 Ded 60/40 to $7,000; $250,000/mem Lifetime Max	
Preferred Blue	Network:	$20 PCP OV, 40 SPC OV; $100 ER; IP/OP $1,000 Ded 80/20 to $2,000 (1st $ Lab at Independent Center or Provider Office); Unlimited Lifetime Max	$324.73
	OON:	$2,000 Ded 60/40 to $3,000; $250,000/mem Lifetime Max	
Preferred Blue	Network:	$25 PCP OV, 50 SPC OV; $150 ER; IP/OP $3,000 Ded (1st $ Lab at Independent Center or Provider Office); Unlimited Lifetime Max	$212.77
	OON:	$6,000 Ded 60/40 to $7,000; $250,000/mem Lifetime Max	
Preferred Blue	Network:	$25 PCP OV, 50 SPC OV; $150 ER; IP/OP $5,000 Ded (1st $ Lab at Independent Center or Provider Office); Unlimited Lifetime Max	$182.41
	OON:	$10,000 Ded 60/40 to $11,000; $250,000/mem Lifetime Max	
Preferred Blue	Network:	$20 PCP OV, 40 SPC OV; $100 ER; IP/OP $1,000 Ded (1st $ Lab at Independent Center or Provider Office); Unlimited Lifetime Max	$393.08
	OON:	$2,000 Ded 60/40 to $3,000; $250,000/mem Lifetime Max	

*Rates do not include enhanced vision benefit.

[1] The benefit variations are based on medical costs, MH/SA costs, and chiropractic costs excluding prescription drug and administrative costs.

Anthem Blue Cross Blue Shield New Hampshire

Exhibit III(b)

Lumenos CDHP Per Member Per Month Base Rates
Effective July 1, 2010

3000 Goffs Falls Road
Manchester, NH 03111-0001

Product*		Benefit Description	Proposed* PMPM [1]
Lumenos HSA	Network:	Ind: $1,500 Ded 90/10 to $1,500; Family: $3,000 Ded 90/10 to $3,000; 100% Preventive Car	$370.73
	OON:	Ind: $1,500 Ded 70/30 to $4,500; Family: $3,000 Ded 70/30 to $9,000; $1M Lifetime Ma	
Lumenos HSA	Network:	Ind: $1,500 Ded 80/20 to $3,500; Family: $3,000 Ded 80/20 to $7,000; 100% Preventive Car	$300.44
	OON:	Ind: $1,500 Ded 60/40 to $8,500; Family: $3,000 Ded 60/40 to $9,000; $1M Lifetime Ma	
Lumenos HSA	Network:	Ind: $2,000 Ded 90/10 to $2,000; Family: $4,000 Ded 90/10 to $4,000; 100% Preventive Car	$329.63
	OON:	Ind: $2,000 Ded 70/30 to $6,000; Family: $4,000 Ded 70/30 to $12,000; $1M Lifetime Ma	
Lumenos HSA	Network:	Ind: $2,000 Ded 80/20 to $3,000; Family: $4,000 Ded 80/20 to $6,000; 100% Preventive Car	$279.00
	OON:	Ind: $2,000 Ded 60/40 to $8,000; Family: $4,000 Ded 60/40 to $16,000; $1M Lifetime Ma	
Lumenos HSA	Network:	Ind: $2,500 Ded; Family: $5,000 Ded ; 100% Preventive Care	$339.55
	OON:	Ind: $2,500 Ded 70/30 to $2,500; Family: $5,000 Ded 70/30 to $5,000; $1M Lifetime Ma	
Lumenos HSA	Network:	Ind: $2,500 Ded 80/20 to $2,500; Family: $5,000 Ded 80/20 to $5,000; 100% Preventive Car	$257.70
	OON:	Ind: $2,500 Ded 60/40 to $7,500; Family: $5,000 Ded 60/40 to $15,000; $1M Lifetime Ma	
Lumenos HSA	Network:	Ind: $3,000 Ded; Family: $6,000 Ded; 100% Preventive Care	$313.07
	OON:	Ind: $3,000 Ded 70/30 to $3,000; Family: $6,000 Ded 70/30 to $6,000; $1M Lifetime Ma	
Lumenos HSA	Network:	Ind: $3,000 Ded 80/20 to $2,000; Family: $6,000 Ded 80/20 to $4000; 100% Preventive Car	$248.51
	OON:	Ind: $3,000 Ded 60/40 to $7,000; Family: $6,000 Ded 60/40 to $14,000; $1M Lifetime Ma	
Lumenos HSA	Network:	Ind: $5,000 Ded; Family: $10,000 Ded; 100% Preventive Care	$234.17
	OON:	Ind: $5,000 Ded 70/30 to $5,000; Family: $10,000 Ded 70/30 to $10,000; $1M Lifetime Ma	

Note: * Rates shown on this exhibit do not include a charge for Health Incentive Account and enhanced vision benefit

[1] The benefit variations are based on medical costs, MH/SA costs, and chiropractic costs excluding prescription drug and administrative costs.

Anthem Blue Cross Blue Shield New Hampshire

Exhibit III(c)

Lumenos CDHP Per Member Per Month Base Rates
Effective July 1, 2010

3000 Goffs Falls Road
Manchester, NH 03111-0001

Product*	Benefit Description		Proposed PMPM [1]
Lumenos HRA	Network:	Ind: $1,000 Ded 80/20 to $4,000; Family: $2,000 Ded 80/20 to $8,000; 100% Preventive Car	$323.61
	OON:	Ind: $1,000 Ded 60/40 to $9,000; Family: $2,000 Ded 60/40 to $18,000; 1M Lifetime Ma	
Lumenos HRA	Network:	Ind: $1,500 Ded 80/20 to $3,500; Family: $3,000 Ded 80/20 to $7,000; 100% Preventive Car	$300.44
	OON:	Ind: $1,500 Ded 60/40 to $8,500; Family: $3,000 Ded 60/40 to $17,000; 1M Lifetime Ma	
Lumenos HRA	Network:	Ind: $2,000 Ded 80/20 to $3,000; Family: $4,000 Ded 80/20 to $6,000; 100% Preventive Car	$279.00
	OON:	Ind: $2,000 Ded 60/40 to $8,000; Family: $4,000 Ded 60/40 to $16,000; $1M Lifetime Ma	
Lumenos HRA	Network:	Ind: $2,500 Ded 80/20 to $2,500; Family: $5,000 Ded 80/20 to $5,000; 100% Preventive Car	$257.70
	OON:	Ind: $2,500 Ded 60/40 to $7,500; Family: $5,000 Ded 60/40 to $15,000; $1M Lifetime Ma	
Lumenos HRA	Network:	Ind: $3,000 Ded 80/20 to $2,000; Family: $6,000 Ded 80/20 to $4,000; 100% Preventive Car	$248.51
	OON:	Ind: $3,000 Ded 60/40 to $7,000; Family: $6,000 Ded 60/40 to $14,000; $1M Lifetime Ma	

*Rates do not include enhanced vision benefit.

[1] The benefit variations are based on medical costs, MH/SA costs, and chiropractic costs excluding prescription drug and administrative costs.

Anthem Blue Cross Blue Shield New Hampshire

Exhibit IV

Preferred Blue Prescription Drug Rider Cost

Effective July 1, 2010

3000 Goffs Falls Road
Manchester, NH 03111-0001

PRESCRIPTION DRUG RIDER PMPM				
Deductible/Copayment/Coinsurance				
	Generic/Formulary/NonFormulary			
Deductible	Retail	Mail	Maximum	Final PMPM
	$10/30/40	$10/60/120	Unlimited	$74.26

Anthem Blue Cross Blue Shield New Hampshire

Exhibit V

Conversion Factor
Effective July 1, 2010
December 2009 Membership

Contract Type	Subscribers	Average Contract Size	4-Tier Rate Ratios	3-Tier Rate Ratios	2-Tier Rate Ratios
Single	62.3%	1.000	1.0000	1.0000	1.0000
Couple	12.2%	2.000	2.2190	2.1800	2.6020
Parent/Child	2.9%	2.000	2.0200	2.1800	2.6020
Parent/Children	3.4%	3.389	2.0200	2.8850	2.6020
Family	19.1%	4.100	3.0400	2.8850	2.6020
	100.0%	1.827	1.6041	1.6042	1.6042
Conversion Factor			1.139	1.139	1.139

Anthem Blue Cross Blue Shield New Hampshire

Exhibit VI - Age Factors

Subscriber Distribution: January 1, 2008 - December 31, 2008

Effective July 1, 2010

(A)

Subscriber Age	Distribution of Subscriber			
	Single	Couple	Par/Chldrn	Family
00 - 18	0.0%	0.0%	0.0%	0.0%
19 - 24	5.8%	0.1%	0.1%	0.1%
25 - 29	8.6%	0.5%	0.4%	0.6%
30 - 34	6.1%	0.7%	0.7%	1.9%
35 - 39	6.1%	0.8%	1.2%	4.0%
40 - 44	6.8%	1.1%	1.5%	5.0%
45 - 49	8.1%	1.7%	1.4%	4.7%
50 - 54	7.6%	2.2%	0.8%	3.0%
55 - 59	6.4%	2.4%	0.3%	1.0%
60 - 64	4.9%	1.7%	0.1%	0.3%
65 +	0.7%	0.4%	0.0%	0.0%
		(B)		
Total	61.2%	11.7%	6.5%	20.6%
		(C)		
Rate Ratios	1.000	2.219	2.020	3.040

(D)

Subscriber Age	Age Factors			
	Single	Couple	Par/Chldrn	Family
00 - 18	0.5021	1.1679	1.0523	1.8427
19 - 24	0.5021	1.1679	1.0523	1.8427
25 - 29	0.6020	1.3695	1.1837	2.0659
30 - 34	0.6858	1.4794	1.3130	2.2416
35 - 39	0.7339	1.5621	1.4364	2.4310
40 - 44	0.8444	1.7220	1.5410	2.5893
45 - 49	1.0236	2.0584	1.6511	2.9219
50 - 54	1.3089	2.6141	1.9038	3.4264
55 - 59	1.6503	3.3006	2.2373	4.0089
60 - 64	2.0591	4.1395	2.6233	4.8725
65 +	2.6632	5.3572	3.2659	6.1662

Composite Age Factor: Sumproduct (A) x (D) / Sumproduct (B) x (C) 1.0000

Anthem Blue Cross Blue Shield New Hampshire

Exhibit VII - Current vs. Proposed Retention for Small Group Business

Effective July 1, 2010

3000 Goffs Falls Road
Manchester, NH 03111-0001

	Approved Retentions for 2Q10						
Retentions	Matthew Thornton Blue	BlueChoice	Preferred Blue	Indemnity	BlueChoice New England	HMO Blue New England	CDHP
A. Administrative Expense (PMPM)	$43.68	$43.68	$43.68	$43.68	$44.15	$44.15	$46.13
B. Nongroup Assessment	$1.58	$1.58	$1.58	$1.58	$1.58	$1.58	$1.58
C. Vaccine Assessment	$1.92	$1.92	$1.92	$1.92	$1.92	$1.92	$1.92
D. Profit and Contingency	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%
E. Premium Tax	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

	Proposed Retentions for 3Q2010						
Retentions	Matthew Thornton Blue	BlueChoice	Preferred Blue	Indemnity	BlueChoice New England	HMO Blue New England	CDHP
A. Administrative Expense (PMPM)	$44.12	$44.12	$44.12	$44.12	$44.59	$44.59	$46.59
B. Nongroup Assessment	$1.58	$1.58	$1.58	$1.58	$1.58	$1.58	$1.58
C. Vaccine Assessment	$1.92	$1.92	$1.92	$1.92	$1.92	$1.92	$1.92
D. VT Health IT Reinvestment Fund	$0.04	$0.04	$0.04	$0.04	$0.04	$0.04	$0.04
E. Profit and Contingency	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%
F. Premium Tax	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%

Group Size Factors

Group Size	Member Distribution	Existing Factors	Proposed Factors
1	5%	1.650	1.650
2	8%	1.110	1.170
3 - 4	11%	1.050	1.050
5 - 9	21%	0.990	0.990
10 - 25	38%	0.910	0.910
26 - 50	17%	0.910	0.910
Total	100.0%	0.995	1.000

Anthem Blue Cross Blue Shield New Hampshire

Exhibit VIII - Industry Factors
Membership Distribution: October 1, 2007 - September 30, 2008
Effective July 1, 2010

SIC	3Q09 Factor	%Mem	SIC	3Q09 Factor	%Mem
01	1.00	0.1%	49	0.95	1.0%
02	1.00	0.1%	50	1.00	4.6%
07	1.00	2.0%	51	1.00	1.8%
08	1.00	0.0%	52	1.00	1.4%
09	1.00	0.1%	53	0.95	0.3%
10	1.05	0.0%	54	0.95	1.7%
11	1.05	0.0%	55	1.05	1.0%
12	1.05	0.0%	56	0.95	0.4%
13	1.05	0.0%	57	1.00	1.6%
14	1.05	0.1%	58	1.05	2.4%
15	1.00	3.2%	59	1.00	3.4%
16	1.00	1.1%	60	0.95	0.2%
17	1.00	8.1%	61	0.95	0.8%
20	0.95	0.3%	62	1.00	1.1%
21	1.05	0.0%	63	0.95	0.4%
22	0.95	0.3%	64	1.00	1.0%
23	0.95	0.2%	65	1.00	3.2%
24	1.05	0.5%	67	0.95	0.7%
25	0.95	0.4%	70	1.05	1.3%
26	1.00	0.1%	72	1.05	1.5%
27	0.95	1.4%	73	1.00	7.9%
28	1.00	0.6%	75	1.05	1.2%
29	1.05	0.0%	76	1.00	0.7%
30	1.00	0.8%	78	0.95	0.2%
31	1.00	0.0%	79	1.05	1.4%
32	1.05	0.2%	80	1.10	6.5%
33	1.05	0.2%	81	1.00	3.8%
34	1.00	0.7%	82	1.00	0.8%
35	1.00	2.9%	83	1.00	3.4%
36	0.95	2.3%	84	1.05	0.0%
37	0.95	0.2%	86	1.05	0.9%
38	0.95	1.1%	87	0.95	10.1%
39	0.95	2.0%	88	1.05	0.0%
40	1.05	0.0%	89	1.00	0.6%
41	1.05	0.2%	91	1.05	0.1%
42	1.05	0.9%	92	1.05	0.0%
43	1.05	0.0%	93	1.05	0.5%
44	1.05	0.3%	94	1.05	0.0%
45	0.95	0.2%	95	1.05	0.1%
46	1.00	0.0%	96	1.05	0.0%
47	1.00	0.4%	97	1.05	0.0%
48	0.95	0.7%	99	1.00	0.3%
Average				1.000	100.0%

March 10, 2010

Mr. David Sky, FSA, MAAA
Life, Accident and Health Actuary
New Hampshire Insurance Department
21 South Fruit Street
Suite 14
Concord, NH 03301-2430

RE: Anthem Health Plans of New Hampshire, Inc (Anthem) Small Group Rate Filing for Effective Date of June 1, 2010 through September 30, 2010
SERFF #AN05-126500575

Dear Mr. Sky:

Thank you for your review of our Small Group Rate Filing with a proposed effective date of June 1, 2010. Responses to your questions are presented in the same order as received.

1. Vermont Health IT Reinvestment Fund assessment was implemented starting in 2010. State of Vermont began assessing carriers for incurring health care services in Vermont where claims processed and paid on behalf of NH Anthem members residing in that state. The total annual cost is estimated at approximately $120,000. Anthem proposes to spread the cost of this assessment across all existing members resulting in a $0.04 PMPM charge.

2. (a) As demonstrated by the information below, our loss ratio is showing an accelerating loss ratio deterioration starting in second half of 2009. The emerging experience necessitates a correction to the current rate level.

Anthem BCBSNH - Small Group Experience

Incurred Month	Loss Ratio
Jan-09	75.5%
Feb-09	83.1%
Mar-09	90.1%
Apr-09	83.5%
May-09	84.0%
Jun-09	87.2%
Jul-09	92.7%
Aug-09	89.1%
Sep-09	91.4%
Oct-09	91.9%
Nov-09	91.4%
Dec-09	98.0%
Total	88.3%

(b) Size factor for groups of 2 was increased by 5.4% to reflect recent experience. The experience by group size demonstrates that groups of 2 generate an overall loss ratio that is less favorable than that of the total block.

Group Size	Loss Ratio
01-01	104.9%
02-02	96.2%
03-04	91.1%
05-09	81.7%
10-25	86.5%
26-50	86.3%
Total	88.3%

The relativity for a $2,000 deductible was also updated to reflect recent experience. Loss ratio by deductible shows that benefits priced with the current relativity is not in line with our utilization assumptions warranting an upward adjustment.

Deductible	Loss Ratio
$0, $250	94.6%
$500, $750	89.4%
$1000, $1250	83.7%
$1500	84.4%
$2000	96.2%
$2000+	72.5%
Total	88.3%

(c) Anthem normalizes rating factors such as group size to an average of 1.000 to ensure revenue neutrality. As shown below the proposed change brings the group size factors across the entire book to a premium neutral level with a weighted average of 1.000 based on the current membership distribution.

Group Size	Member Distribution	Existing Factors	Proposed Factors
1	5%	1.650	1.650
2	8%	1.110	1.170
3 - 4	11%	1.050	1.050
5 - 9	21%	0.990	0.990
10 - 25	38%	0.910	0.910
26 - 50	17%	0.910	0.910
Total	100.0%	0.995	1.000

As to cost sharing relativity, the base rates were developed such that the total revenue PMPM for the entire small group book of business prior to the change in cost sharing relativity and following the change that would result in the same PMPM level.

Average Premium PMPM prior to relativity change:	$517.49
Average Premium PMPM with relativity change:	$517.62

d) Historical allowed medical claim costs and the combined medical/drugs trends assumption are specified below. The starting allowed medical cost PMPM is based on actual experience while trends reflect projected changes in utilization and unit costs taking into considerations of future provider contracts, Cobra, and H1N1.

	Starting Claim Costs	Annualized Trend
1Q 2009	278.93	12.0%
2Q 2009	288.59	12.6%
3Q 2009	296.91	12.8%
4Q 2009	306.74	12.8%
1Q 2010	317.04	12.8%
2Q 2010	327.48	12.8%
3Q 2010	333.84	12.8%

3. The necessary rate adjustment causes by significant benefit buy-down on premium. However, Anthem experiences minimal impact on paid claims. Based on 2009 data, benefit buy-downs reduced premium by approximately 6.6% but less than 2.0% on paid claims. The impact of buy-downs on premium was significantly higher than on claims implying that utilization assumptions in our pricing model did not match the actual benefit utilization.

   During the first two months of 2010, our analysis is showing even higher buy-downs at approximately 7.5% of premium, and we expect this pattern to continue throughout 2010. We also anticipate similar lower impact on paid claims. The loss ratio deterioration provided in 2(a) confirms benefit buy-down impacted more on premium more than on paid claims.

We hope these address your questions and we look forward to your approval of this filing. If you have any other questions, you may contact me at either 695-7833 or e-mail at Tu.Nguyen@anthem.com or contact Lucy Drozd at Lucy.Drozd@anthem.com.

Respectfully Submitted,

Tu Nguyen, A.S.A., M.A.A.A.
Associate Actuary, Local Group Pricing
Anthem Health Plans of New Hampshire, Inc.

Enclosures:
cc: Lucy Drozd, Local Group Pricing

NAIC National Association of Insurance Commissioners & The Center for Insurance Policy and Research

DATE: June 25, 2010

TO: All Commissioners

FROM: Julienne L. Fritz, Director of Insurance Products and Services

RE: Department of Health and Human Services (HHS) Grants to States for Health Insurance Premium Review-Cycle I – Estimate for leveraging SERFF

Given the NAIC's Speed to Market initiatives and the role SERFF plays in the rate and form filing and review process, it has been considered logical and cost effective to utilize SERFF in meeting many IT requirements as outlined in the grant. Based on the provisions of the grant and at the request of states, the NAIC has estimated the cost of leveraging SERFF. To that end, the NAIC has provided a description of deliverables, timeline and estimated cost, which are outlined below, and may be incorporated into a grant application. It should be noted that the information provided by the NAIC is based on limited knowledge of the HHS reporting requirements and will be refined once the uniform template and definitions for data reporting are provided, which are tentatively scheduled for availability in early August.

The NAIC is comfortable with our ability to meet HHS requirements and has received information that suggests HHS would accept the proposed delivery timelines. It may be valuable to know that, while not required, HHS has indicated interest in being able to collect data/reports through a uniform system implementation, which the NAIC is willing to facilitate and is contemplated below. HHS has also indicated that there is no intention to build any restrictions into a grant acceptance agreement which would limit the states ability to use grant funds for this purpose.

Grant Application Information:

Cost: $18,808

Description of Deliverables:

1) Requirements defined in Section A.1(c)(1) and A.1(c)(2) on pages 15, 16 and 17. Specifically, the estimate covers the expenses associated with modifying SERFF to address data collection and reporting requirements, such as:
    a. State options to indicate premium review grant participation
    b. Company profile changes to incorporate company type
    c. State-maintained indicator for rate filing requests meeting the HHS threshold for 'unreasonable'.
    d. Addition of field to indicate product types
    e. Company-maintained product information including product name, HHS id, and product status that will allow the companies to track products and apply them to filings.
    f. A new set of fields added to the Rate/Rule schedule items to provide HIPR data on a policy form basis.
    g. Changes to the State API to accommodate retrieval of the data elements added above and to allow for updates of appropriate data elements via the State API.
2) Incorporating the submission of a federally mandated Rate Filing Disclosure Form and Justification (currently being reviewed by the B Committee) that is required to be filed under provisions of the Affordable Care Act if a rate request falls under the definition of 'unreasonable'. The estimate provided by the NAIC would also allow the Rate Filing Disclosure Form, or similar document, to be filed regardless of whether the rate request falls under the definition of 'unreasonable' in the event the states wanted to include this in their submission requirements to facilitate meeting the requirement that consumer friendly descriptions of rate filings be made available publicly.
3) Additional SERFF state training that will support the grant requirements.

4) Support for making non-confidential consumer friendly rate disclosures and/or rate filing information available publicly, as required and permitted.
5) Support the ability to satisfy reporting requirements of the uniform template for data reporting within the SERFF system, if HHS will accept reports directly from SERFF, including basic trending reports.

The workflow on a Health filing that requires the enhanced data reporting fields will vary from the existing SERFF workflow. States will set preferences that will indicate the level of data they would like to require. Fields exposed to the industry during the filing creation process are determined by these state preferences. The overall workflow will be changed in that the filer will now be required to tie schedule items (such as rates and policy forms) to a specific product. This will allow for the reporting of data based on the product the consumer will ultimately be offered. A significant portion of the project hours will be devoted to aggregating the collected data into the reports required by HHS. An interface to allow HHS to get reports from SERFF is included within the estimate should that prove a requirement.

Delivery Timeline:

The SERFF enhancements incorporating HHS reporting requirements will be implemented in a phased approach with the first release to occur within 3 months of the receipt of HHS requirements for the uniform template for reporting. The initial release will focus on implementing the means for data collection; subsequent releases will incorporate reporting needs. Releasing functionality in this manner will allow a period of time during which data can then be submitted by insurers prior to any required reporting to HHS, thus avoiding manual data collection processes. Based on the requirements known at this time, the development will occur over an 8 month period beginning when the NAIC receives the reporting template and supporting documentation.

Data Center Funding Proposal – Publication of health care cost Information

Background:

New Hampshire is one of 11 states to have an All-Payer Claims Database (APCD) that contains claims data from commercial health insurers, third party administrators, and Medicaid, for New Hampshire residents and NH certificate holders. This information has been used to develop consumer information websites, inform public policy, regulate and develop innovative insurance products, and enable patients as consumers and employers as purchasers to view cost and quality information. The NH Institute for Health Policy and Practice at the University of New Hampshire (UNH NHIHPP) has had significant experience working with APCD data, and has been a partner with the New Hampshire Insurance Department (NHID) on projects involving APCD data.

Concept:

Per RFA-FD-10-999's request under section V. A. 1. c) 2) d), this proposal intends to use the APCD data to increase transparency of health care payments that lead to the medical trends impacting health insurance premium increases. Building on the successful NH Insurance Department's consumer transparency website called NH Health Cost[1] (www.nhhealthcost.org), payment information will be mined from New Hampshire's APCD and displayed to consumers, brokers, small businesses, and policymakers. The intention would be for health care service cost information to be displayed by payer. The data reported would translate the current payment systems, including fee schedules, into health care cost categories and display the major medical costs that contribute to health insurance premiums. The data would be updated on a periodic basis.

The information could be displayed on a relative scale, such as the portion of the "health care dollar." Users of the website would be able to see differences among health insurance carriers.
The methodology for displaying these data will be critical to the success of the project. Insurers have different payment systems, payment levels, health status, as well as different business strategies for different health insurance products. Allowing users of the data to evaluate health care costs using different approaches will greatly enhance the versatility of the product produced, and there will be testing of multiple methodologies in preliminary data analysis. There will also need to be consideration for how the data are queried and displayed, given the number of procedures, diagnoses, and health care categories that can be included. The display features will likely include multiple points of "drill down" to allow the user to arrive at an effective understanding of the health care costs driving premium rates.

Timeline:

1. August 9, 2010 – Kick off (grant period begins)
2. August 15, 2010 – data submission request completed; contract with web design team
3. October 15, 2010 – Specifications completed for analysis and web design

[1] NH Health Cost provides consumers with pricing information for their particular insurance company, insurance product, and medical procedure. It has been operational for three and a half years. Employer-specific versions have also been developed, and the state of Maine has also created a version of the website for residents of Maine. The NH Health Cost website has a section for employers and brokers who can view information on the value of different insurance products across different market segments. The information is derived from both APCD data and rate and benefit information submitted to the NH Insurance Department by the insurers.

4. October 30, 2010 – Data analysis complete
5. November 30, 2010 – Web development complete; initial data set loaded; site released
6. April 28, 2011 – Website update completed
7. August 31, 2011 – Website update completed
8. September 30, 2011 – Project end date (grant period ends)

Budget:

ITEM	COST	NOTES
Personnel	$ 25,500	Project Manager and Data Analyst
Fringe	$ 11,305	44.4%
Travel	$ 1,000	
Materials and Supplies	$ 692	
Technology Services	$ 5,000	WebSolutions
Indirect Costs (15%)	$ 6,503	15%
Total	**$ 50,000**	