State of New Hampshire Insurance Department
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Paula T. Rogers
Commissioner

BULLETIN
Docket No.: INS No. 02-001-AB

TO: All New Hampshire Licensed Health Insurance Companies, Health Maintenance Organizations, Fraternal Benefit Societies and Third Party Administrators

FROM: Paula T. Rogers
Insurance Commissioner

DATE: January 24, 2002

RE: Supplemental Reporting

Background

Pursuant to RSA Chapter 400, the Insurance Commissioner has the authority to prescribe the format and content of financial and other reports filed by licensed insurers in New Hampshire. The reports submitted by licensed carriers and other entities are important to evaluate the financial solvency of carriers operating in New Hampshire as well as to understand the characteristics of New Hampshire's insurance markets.

Recently, concerns about premium increases in the small and large group employer health insurance markets have made the need for submission of market based information critical. The Insurance Commissioner is responsible for reporting on the condition of these markets to the New Hampshire General Court. Without specific information regarding the loss ratios for different sized groups, geographic differences in cost, and product differences, the Commissioner cannot report on the availability and affordability of health insurance coverage in New Hampshire.

Components of Supplemental Report

To obtain the information necessary to assess the condition of the health insurance markets in New Hampshire, all health carriers will be required to file an annual supplemental report in the form specified herein. As noted in the Supplemental Report Format, the initial filing date for licensed non-profit health service corporations and licensed HMO's will be May 1, 2002. Health carriers subject to this filing date shall use their reasonable best efforts to comply. The initial filing date for all other health carriers shall be May 1, 2003, and those carriers shall also use their reasonable best efforts to comply. The second annual report shall comply fully with the Supplemental Report Format.

As noted in the Supplemental Report Format, Attachment A to this Bulletin, the supplemental report shall consist of an electronic data base that includes the following: 1) the category of coverage; 2) the market category; 3) the geographical location of each policyholder identified by the first 3 digits of the policyholder's zip code; 4) the geographical location of each certificate holder under that policy identified by the first 3 digits of the certificate holder's residence; 5) the number of policyholders; 6) the number of certificate holders and covered persons; 7) the written premium; and 8) the paid health and medical expenses. The instructions for preparing the supplemental report are set forth herein, and must be followed.

Any questions should be directed to Leslie J. Ludtke, Esquire, Health Policy Analyst at 603-271-2261.

Supplemental Report Format

I. Definitions

(a) "Certificate holder" shall have its usual and customary meaning for insurance writers and their written coverage. For group coverage, the employee shall be the certificate holder. For individual coverage, the policyholder shall be the certificate holder. For third party administrators and other health carriers not licensed to write insurance coverage, certificate holder shall mean any person for whom the health carrier has a substantially similar contractual obligation effected through a policy.

(b) "Claims paid" shall be calculated as prescribed for the carrier's Statement of Revenue and Expenses, or its equivalent, which is a required component of the annual statement filing. The commissioner may approve the use of a reasonable proxy upon the carrier's provision of documentation demonstrating that the use of the same does not materially distort the carrier's data submission. For third party administrators, claims paid shall mean amounts disbursed pursuant to contractual requirements.

(c) "Covered lives" shall include all individuals, employees and dependents for which the health carrier has an obligation to adjudicate, pay or disburse claim payments.

(d) "Data" means factual information used as a basis for calculation or measurement.

(e) "Data base" means a collection of data organized especially for search and retrieval.

(f) "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, third party administrator or any other entity arranging or providing health coverage.

(g) "Reporting unit" means aggregated insurance data grouped together by the following four characteristics: insurance market; insurance coverage; policy situs; and insured or certificate holder situs.

(h) "Policy" shall have its traditional meaning for insurance writers. For third party administrators and other health carriers not licensed to write insurance coverage, policy shall mean the contractual relationship effected by the health carrier for which an insurance license is required. For group coverage, the employer shall be the policyholder.

(i) "Premium" shall be calculated as prescribed for the carrier's Statement of Revenue and Expenses, or its equivalent, which is a required component of the annual statement filing. The Commissioner may approve the use of a reasonable proxy upon the carrier's provision of documentation demonstrating that the use of the same does not materially distort the carrier's data submission. For third party administrators, premium shall mean the amount of revenue collected from contracted accounts

II. Annual Supplemental Report Required

(a) Each health carrier that is licensed to conduct business in New Hampshire shall file an annual supplemental report with the commissioner of insurance.

(b) The annual supplemental report shall be filed not later than April 1 of each year in the format specified by the commissioner. For the calendar year 2001 supplemental report, which is due May 1, 2002, licensed HMOs and non-profit health service corporations shall file a supplemental report using their reasonable best efforts to comply. For the calendar year 2002 supplemental report, licensed HMOs and non-profit health service corporations shall file a supplemental report that fully complies with the requirements set forth herein. For the calendar year 2002 supplemental report, all other health carriers shall file a supplemental report using their reasonable best efforts to comply. For the calendar years subsequent to 2002, all health carriers shall file supplemental reports that fully comply with the requirements set forth herein.

(c) Beginning in 2003, the annual supplemental report for all health carriers shall be filed not later than April 1st of each year and shall include information for the previous calendar year ending December 31st.

III. Data Format

(a) Data shall be provided in electronic format in accordance with the methods and technical specifications set forth in Appendix A.

(b) Data collected for each policy of insurance written by a health carrier shall be compiled into a data base that shall include the following:

(1) The category of coverage;

(2) The market category;

(3) The geographical location of each policyholder identified by the first 3 digits of the policyholder's zip code;

(4) The geographical location of each certificate holder under that policy identified by the first 3 digits of the certificate holder's residence;

(5) The number of policyholders;

(6) The number of certificate holders;

(7) The premium;

(8) The claims paid;

(9) For third party administrators, billed premium shall mean the amount of revenue collected from contracted accounts, and paid claims shall mean amounts disbursed pursuant to contractual requirements;

(10) The number of covered lives for which the carrier had an obligation under those certificates in the reporting unit at any time during the reporting year. When

tabulating this field, if a carrier had obligation for a covered life for only one month during the reporting year, count that exposure as 1/12.

IV. Data Reporting

(a) The data shall be reported based upon a reporting unit. The reporting unit shall be a data set that consists of aggregated data grouped together by 4 shared characteristics. The 4 shared characteristics that shall define each reporting unit are as follows:

(1) The first 3 digits of the policyholder's zip code;

(2) The first 3 digits of the certificate holder's zip code;

(3) The coverage category; and

(4) The market category.

(b) The following data elements shall be reported for each reporting unit:

(1) The premiums for the certificates in the reporting unit;

(2) The number of certificate holders;

(3) For reporting units where the policyholder zip code and the certificate zip code are identical, carriers shall record the number of policies in effect at any time during the reporting year as the number of policyholders, otherwise a zero shall be coded for the number of policyholders;

(4) The claims paid for the certificates in the reporting unit; and

(5) The number of covered lives for which the carrier had an obligation under those certificates in the reporting unit at any time during the reporting year. When tabulating this field for each covered life for which the carrier had an obligation for one month during the reporting year, the exposure is counted as 1/12.

V. Categories of Coverage

(a) The categories of insurance shall include:

(1) Indemnity insurance;

(2) Managed care plans, including network based plans, point of service plans and PPO plans;

(4) Group excess loss insurance, e.g. stop loss;

(5) Stand-alone dental insurance;

(6) Specified disease insurance;

(7) Accident only insurance;

(8) Short-term disability insurance;

(9) Other limited benefit insurance;

(10) Long-term disability insurance;

(11) Long-term care insurance;

(12) Medicare supplement insurance, including Medicare Select;

(13) Medicare+Choice;

(14) Credit, accident and health insurance;

(15) Administrative Services Only, e.g. Third Party Administrators where the plan has purchased stop loss coverage;

(16) Administrative Services Only, e.g. Third Party Administrators, where the plan has not purchased stop loss coverage;

(17) Short Term Non-Renewable Health Insurance; and

(18) Other, e.g. non-comprehensive medical insurance.

(b) The market categories shall include:

(1) The individual market, not including group conversion policies;

(2) Group conversion policies;

(3) The small employer group market where the employers employ 1 employee and where the coverage is not obtained through a qualified association trust;

(4) The small employer group market where the employers employ 2 to 9 employees and where the coverage is not obtained through a qualified association trust;

(5) The small employer group market where the employers employ 10 to 25 employees and where the coverage is not obtained through a qualified association trust;

(6) The small employer group market where the employers employ 26 to 50 employees and where the coverage is not obtained through a qualified association trust;

(7) The small employer group market where the employers employ 51 to 75 employees and where the coverage is not obtained through a qualified association trust;

(8) The small employer group market where the employers employ 76 to 99 employees and where the coverage is not obtained through a qualified association trust;

(9) The small employer group market where coverage is written through a qualified association trust;

(10) The large employer group market where the employers employ 100 or more employees;

(11) Medicare related markets;

(12) Medicaid;

(13) The federal employee health plan;

(14) Group Blanket Accident and Health, e.g. student policies, discretionary group or other non-employer groups.

(c) For the initial report only, where the health carrier is not able to classify the small employer market into the segments established by this bulletin, the health carrier may report using a bundled code.

VI. Confidentiality

(a) Each company or person from whom information is sought shall provide the information to the commissioner.

(b) The Supplemental Report filed by each health carrier shall be maintained as a confidential document, but shall not be deemed to limit the commissioner's authority to use or disclose such information which the commissioner in the exercise of his/her duty may deem appropriate pursuant to RSA 400-A:25.

APPENDIX A
State of New Hampshire
Supplemental Report

Instructions:

Data should be submitted in a manner that is suitable for electronic processing. All files shall be submitted via E-mail to requests@ins.state.nh.us. The subject line should read: "ATTN: Statistician, Insurance Department Supplemental Report"

All submissions shall be an ASCII fixed length file where the required data elements are recorded in the byte locations shown below.

The file shall be named SIR<cocode>.txt and conform to the following:

The first record shall include the required transmittal information and conform to the following:

Field Number	Start Byte	End Byte	Field Name	Field Type	Field Length	Description
1	1	1	Data Type	Char	1	Set to "T"
2	2	6	CoCode	Char	5	NAIC Company Code
3	7	10	Report Year Submission	Char	4	
4	11	18	Date Fiscal End	Num	8	MMDDYYYY
5	19	22	Date	Num	4	MMDD; Date Fiscal Year Ends
6	23	72	Contact	Char	50	Name of Contact Person; Format FirstName Space LastName [, Suffix]
7	73	122	ContactAD1	Char	50	FirstLine of Mailing Address for Contact Person
8	123	172	ContactAd2	Char	50	SecondLine of Mailing Address for Contact Person
9	173	197	Contact City	Char	25	Mailing City for Contact Person
10	198	199	STABBR	Char	2	2 letter std abbreviation for Mailing State for Contact Person
11	200	209	Contact Zip	Num	10	xxxxx[xxxx]
12	210	219	Phone Contact	Num	10	Contact Voice Phone xxxxxxxxxx
13	220	244	E-Mail	Char	25	

Records following the transmittal record shall be for notes.

Field Number	Start Byte	End Byte	Field Name	Field Type	Field Length	Description
1	1	1	DataType	Char	1	Set to "N"
2	2	255	Notes	Char	254	

The data records shall follow the note records.

Field Number	Start Byte	End Byte	Field Name	Field Type	Field Length	Description
1	1	1	Data Type	Char	1	Set to "D"
2	2	6	CoCode	Char	5	NAIC Company Code
3	7	9	CovCat	Char	3	Coverage Category (See Table for Valid Codes)
4	10	12	MktCat	Char	3	Market Category (See Table for Valid Codes)
5	13	15	Policy Zip	Num	3	First Three Digits of ZipCode where Policy is sitused
6	16	18	CertZip	Num	3	First Three Digits of ZipCode where Certificate holder resides
7	19	28	Policy Count	Num	10	Number of Policies in the reporting unit
8	29	38	Cert Count	Num	10	Number of Certificate holders in the reporting unit
9	39	48	CovLiveCount	Num	10	Number of Covered Lives in the reporting unit
10	49	63	Premium	Num	15	Round to nearest whole dollar
11	64	78	Claims	Num	15	Round to nearest whole dollar

The following values shall be used for the CovCat field to reflect the coverage category:

Coverage Category Code	Coverage Category Description
IND	Indemnity Insurance
HMO	Managed care plans
STL	Group Excess Loss
DEN	Stand-alone Dental
DIS	Specified Disease
ACC	Accident Only
STD	Short-term Disability
LTB	Other limited benefit
LTD	Long term Disability
LTC	Long term care
MGP	Medicare supplement
M+C	Medicare+Choice
CRD	Credit, accident and health
ASW	Administrative Services Only with Stop Loss
ASO	Administrative Services Only with out Stop Loss
STN	Short-term non-renewable health insurance
OTH	Other

The following values shall be used for the MktCat field to record the Market Category:

Market Category Code	Market Category Description
IND	Individuala
GCV	Group Conversion
GS1	Small Employer Group Market - One Employee
GS2	Small Employer Group Market - 2-9 Employee
GS3	Small Employer Group Market - 10-25 Employee
GS4	Small Employer Group Market - 26-50 Employee
GS5	Small Employer Group Market - 51-75 Employee
GS6	Small Employer Group Market - 76-99 Employee
GSA	Small Employer Group Market - Qualified Association Trust
GSU	Small Employer Group Market - Unknown
GLG	Large Employer Group Market
MSR	Medicare Related
MCD	Medicaid
FEP	Federal Employee Health Plan
BLK	Group Blanket Accident and Health

The Department may facilitate data submissions in other file formats. Contact the Department for prior approval and instructions.