



The State of New Hampshire
Insurance Department
21 South Fruit Street, Suite 14
Concord NH 03301

Roger A. Seigny
Commissioner

Alex Feldvebel
Deputy Commissioner

BULLETIN
Docket No.: INS No. 14-005-AB

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

FROM: Roger A. Seigny [Signature]
Insurance Commissioner

DATE: February 7, 2014

RE: Supplemental Reporting

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Background

Pursuant to RSA 400-A:36 and other provisions of Title XXXVII, 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 required to evaluate the financial solvency of carriers operating in New Hampshire (NH) as well as to understand the characteristics of New Hampshire’s insurance markets.

In 2002, the Commissioner implemented an annual statement supplemental reporting requirement with respect to health insurance coverage. See Bulletin INS No. 02-001-AB.



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The New Hampshire General Court, during its 2003 general session, adopted Senate Bill 110, now codified at RSA 420-G:14-a, which placed further health insurance data collection responsibilities on the Department. On March 22, 2006, the approval of Senate Bill 369 amended RSA 420-G:14-a and broadened the authority of the Commissioner to collect information related to the supplemental report.

This bulletin is issued to update the information requested by the Department. The requirements for submitting data for the supplemental report are very similar to the requirements for submitting claims data according to INS 4000. Carriers should confirm that they have applied the same reporting criteria to both submissions. If the same reporting criteria are not applied, the carrier/Third Party Administrator shall identify and explain the differences.

This bulletin repeals and replaces INS No. **08-001-AB**.

Changes in Requirements

The following is a high-level description of changes made to this bulletin from the previous bulletin. Do not rely on this list exclusively; read the entire bulletin to ensure compliance with reporting requirements.

- Two additional questions are included on the "Transmittal" sheet. Previously, these questions had been asked following the initial data submission.
- Data will now be reported in three separate data collections: (1) the Main Data Collection for policies with a NH situs, (2) the Limited Data Collection for policies without a NH situs, and (3) the Stop Loss Data Collection for policies with Coverage Type Code = "STL". Descriptions of the three data collections are found below in the "Tabulation Methods and Issues" section and separate report specifications have been provided for each in Attachment A.
- Since there is now a separate data collection for Stop Loss, additional data elements specific to stop loss coverage will be reported. These data elements are described in Attachment A for the Stop Loss Data collection.



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- The calculation of the Actuarial Value reported in the Supplemental Report has changed. Refer to the Definitions section and Attachment A for the updated methodology.
- Additional identifiers and benefit design components will now be reported. These additional data elements are described in Attachment A for the Main Data collection.
- Two new Exception Variables have been added to the list of Exception Variables in the Main Data collection. See Attachment A for descriptions.
- Modifications have been made to descriptions for the following Exception Variables: Family Planning Services, Infertility Services, Hearing Aids, and Preventive Services. Refer to Attachment A for revised descriptions.
- A new code, "DM", has been added to the Exception Variables. This new code is to be used when the insurance policy generally covers the service, but does not meet the exact specification in the service description.
- Additional clarification around the reporting of Stop Loss coverage has been provided to ensure that all carriers/TPA's are reporting when applicable.

Purpose of Changes

A special, one-time data collection of 2012 data for the Supplemental Report is necessary to set a baseline for the data with the new requirements for the data structure and data elements. This will allow for consistent year-to-year comparisons to the 2013 data for the 2013 Supplemental Report. As the New Hampshire health insurance market changes due to external forces such as the Affordable Care Act, the new requirements should provide additional insight into the market as a whole. By separating the Stop Loss data and including data elements specific to Stop Loss coverage, the Supplemental Report will be able to include more relevant detail around this product each year. The Actuarial Value methodology was changed in an effort to make it easier to compare the relative benefit richness across market segments and products and how the benefit richness changes over time. Additional data elements have been added to the Supplemental Report in an effort to create consistency across various reporting processes and to allow for monitoring the impacts of the Affordable Care Act on the New Hampshire market.



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Definitions

- (a) “Actuarial Value” – For the purposes of this report, the Actuarial Value will be the Minimum Value measure as outlined in Section 1302 (d)(2)(C) of the Affordable Care Act. Beginning in 2014, insurers and employers or unions with self insured plans must report information to the IRS for each individual covered under a health insurance plan that provides minimum coverage. This information will be used by the IRS to determine whether individuals who purchase insurance on the exchanges will be eligible for a premium tax credit. The minimum value is defined as the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage. In accordance with the HHS regulations there are several options for determining the Minimum Value:
- Determine Minimum Value figure using the most recent version of the publically available **Minimum Value Calculator** Excel model tool which can be downloaded from the CMS website¹. The Department of Health and Human Services has published guidance titled “Minimum Value Calculator Methodology” which is also available on the website. This guidance provides a detailed description of the data underlying the MV Calculator and the calculator’s methodology.
 - Determine Minimum Value figure through any safe harbor established by HHS and IRS.
 - If the plan design is incompatible with the **Minimum Value Calculator** or Safe Harbor Plan, the Minimum Value figure may be determined through an actuarial certification from a member of the American Academy of Actuaries.

For each set of reported coverage options, e.g. each benefit plan, the carrier shall include on the Supplemental Report the Minimum Value figure calculated in accordance to one of the three options mentioned above. The Minimum Value Calculator can be used for a wide variety of health plan designs; however, it is possible some benefit plan

¹ Currently at this link: <http://www.cms.gov/ccio/resources/regulations-and-guidance/index.html>



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designs may not fit into the calculator. In circumstances where this is the case, and the minimum value from the safe harbor or actuarial certification is not readily available, a reasonable estimate based on comparison to similar plan designs may be reported in the Supplemental Report if the carrier receives prior approval from the NHID. If a carrier used a method other than the **Minimum Value Calculator**, the alternate method that was used must be disclosed and described in the notes section of the report submittal form along with documentation of prior approval, if applicable.

Please do not provide figures based on the **Actuarial Value Calculator**. The **Actuarial Value Calculator** uses different population base and different continuance tables than the **Minimum Value Calculator**. The results from the two calculators will be slightly different. For the purposes of this report and stable comparison across coverage segments and carriers, the **Minimum Value Calculator** must be used.

This minimum value as described above is the “actuarial value”.

- (b) “Blanket health insurance” is as defined under RSA 415:18, I-a and means that form of accident and health insurance that is not "health coverage" under RSA 420-G:2, IX, that does not require individual applications from covered persons, and that does not require a carrier to furnish each person with a certificate of coverage.
- (c) “Certificate holder” shall have its standard language meaning for insurance writers and their written coverage. For employer-sponsored group coverage, the employee or subscriber shall be the certificate holder. For individual coverage, the policyholder shall be the certificate holder. For other types of group coverage, the certificate holder shall mean the person who is the principal insured.
- (d) “Claims Incurred” shall reflect total medical expense for services received by the covered members in the reporting class during the calendar year for which the supplemental report is being made. Note that total claims are based on an accrual basis for calendar year, and



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are equal to the sum of (i) claims incurred and paid, (ii) claims incurred and unpaid, and (iii) other payments and credits (see Attachment A for definitions of these sub-components). All claims with a date of service during the reporting year are to be included as claims paid in this field. If necessary, actuarial completion factors should be used to estimate incurred claims and should be based on when the carrier extracts the data for the Supplemental Report. Incurred claims should be consistent with what is reported in Part 1, Line 5 of the NAIC Supplemental Health Care Exhibit, allowing for variances due to any restatement of unpaid claims with additional paid claim runoff. Additional detail regarding how to report Claims Incurred can be found in Attachment A.

- (e) "Covered lives" or "members" shall include all individuals, employees and dependents for which the health carrier has an obligation to adjudicate, pay or disburse claim payments. Data submission requirements apply to all members who receive services under a policy sold to a New Hampshire employer with a business location in New Hampshire, or to a resident of New Hampshire who receives services under a policy issued by the carrier or services by the third party administrator. For employer-sponsored group coverage, covered lives would include certificate holders and their dependents.
- (f) "Creditable coverage" shall have the same meaning as defined in RSA 420-G:2, III.
- (g) "Data" means factual information used as a basis for calculation or measurement.
- (h) "Database" means a collection of data organized especially for search and retrieval.
- (i) "Health carrier" shall mean any licensed insurance company with a Paragraph 4 authorization on its New Hampshire license. Licensed entities include Life Insurance Companies, Property & Casualty Insurance Companies, Health Maintenance Organizations, Fraternal



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Benefit Societies and Nonprofit Health Service Corporations. Health carrier shall also include Third Party Administrators (TPAs).

- (j) “Policy” shall have its standard language meaning for insurance writers. For employer-sponsored group coverage, where the coverage is written directly for the employer’s benefit plan, the employer shall be considered the policyholder. A policy that is issued in New Hampshire shall include any policy that provides coverage to the employees of a New Hampshire employer that has a business location in New Hampshire. An employer's branch location in New Hampshire shall be considered a New Hampshire employer, and the carrier/TPA shall submit data for all members who are employed at that branch location. For employer-sponsored group coverage, issued to a qualified association trust, each member employer shall be considered a separate policyholder. For all association business, each member employer shall be considered as a separate policyholder. TPAs shall report policyholders in a like manner.
- (k) “Premium” shall be calculated as “earned” premium, or the total amount of premium from policyholders to provide insurance coverage during the reporting year. $\text{Earned premium} = \text{premiums collected} + \text{change in due and uncollected} - \text{change in unearned and advance premium}$. If premium is collected prior to January 1, to provide insurance coverage during the reported calendar year, then it must be included in this column. 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 TPAs, premium shall mean the funds collected from contracted accounts to provide for all claims and expenses associated with the administration of the employer’s benefit plan. Additional detail regarding how to report Premium can be found in Attachment A.
- (l) “Situs” of a policy shall be defined as the jurisdiction in which the policy is issued or delivered as stated in the policy. For employer business issued through a qualified association trust, the situs shall be



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based on the location of each member employer. The intent of this definition is to be consistent with the instructions for the NAIC Supplemental Health Care Exhibit. Carriers should apply the same consideration when determining situs for this report as they do for the Supplemental Health Care Exhibit. TPAs shall determine situs of their contracts in a like manner.

- (m) “Subcontractor” shall be defined as a vendor or contractor who manages carved out categories of services such as mental health services or pharmacy services. Since the subcontractor may be required by the carrier/TPA to satisfy state reporting requirements for the subcontracted services, the Department needs to understand what carriers or TPAs are including data from a subcontractor in order to avoid double counting multiple submissions. The carrier/TPA is ultimately responsible for a complete submission without duplicate data, and is most often better served by submitting one filing rather than relying on the subcontractor to fulfill the carrier/TPAs obligations.

Applicability

All carriers licensed to write accident and health insurance in the state of New Hampshire and meeting minimum premium thresholds must submit a supplemental report. A carrier is licensed to write accident and health insurance if it has a Paragraph 4 authorization on its New Hampshire license. A licensed or registered Third Party Administrator (TPA) must file a supplemental report only if it exceeds the *de minimis* exemption criteria described below. Covered lives/members are individual members eligible to have claims paid for them, not accounts. Membership is determined based on the definition of covered lives as defined herein, and will include New Hampshire residents with an account that is located out of state.

Exemptions

All carriers and TPAs must submit a supplemental report unless they meet the *de minimis* exemption described below.



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De Minimis Exemption

Carriers writing a *de minimis* amount of creditable coverage are not required to submit a null supplemental report. The class of carriers qualifying for the *de minimis* exception includes any carrier that writes less than \$250,000 in accident and health insurance premiums in New Hampshire in the calendar year. TPAs required to submit a supplemental report include any TPA that provides administrative services for coverage that constitutes creditable coverage for 2400 or more covered life months, e.g. 200 covered lives for the given calendar year. If the actual number of covered lives is not available to the TPA, the TPA shall estimate the number of covered lives, and provide the Department with an explanation for the estimation in the notes section of the report submittal form. In determining the number method for covered lives, carriers shall include all persons meeting the definition of "covered lives" as defined herein.

Creditable Coverage

A carrier writes creditable coverage when it issues a policy for coverage that meets the definition of creditable coverage in RSA 420- G:2, III. A TPA administers creditable coverage when it provides administrative services to either an insurer or an employer that has assumed the risk for an employer-sponsored or other sponsored plan that provides creditable coverage. In addition, carriers writing stop-loss or group excess loss insurance to employers whose self-insured plans meet the definition of creditable coverage must file a supplemental report. Throughout this bulletin, references to writing carriers shall include all of the activities referenced in this paragraph. All of these carriers and TPAs must submit a supplemental report with the policy data tabulated as prescribed.

Stop loss and group excess coverage shall be reported, both by carriers issuing stand-alone stop loss coverage and carriers issuing stop loss coverage to the employer groups for which they administer the self-insured health benefits.



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Due Date

Carriers and TPAs are required to submit an annual supplemental report on or before July 15th of each year summarizing the carrier's business from the immediately preceding calendar year. For example, the data submission due July 15, 2014 shall summarize the carrier's business for the preceding calendar year, ending on December 31, 2013.

A special, one-time supplemental report will be required to be submitted by March 15, 2014 for the 2012 reporting year to support changes in the data being requested. The two reports due in 2014 are necessary due to the analysis of changes from one year to the next that is performed within the Supplemental Report. Additional changes to the data requirements from the previous reporting format to this new reporting format are described in this bulletin.

This annual reporting requirement shall continue in perpetuity unless and until explicit revocation by the NHID. For future years it is anticipated that the revised format for reporting described within this bulletin will be used, but only one data collection process due July 15th will be conducted.

Upon receiving a report submission, the NHID will confirm receipt by e-mail. The submission will be reviewed for completeness. Insurance carriers and TPAs are required to submit a filing which satisfies NHID standards for completeness and compliance by July 15 (March 15, 2014 for a one-time special report). Incomplete or non-compliant filings on July 15 (March 15, 2014 for a one-time special report) will be subject to an administrative fine.

Fines

Fines will be assessed for failure to meet the submission deadline of July 15th or the special March 15, 2014 deadline, for filing an incomplete supplemental report, or for filing a report that is inaccurate. Fines shall accrue on a daily basis. There will be no grace period to achieve compliance. All reports are expected to be complete and accurate submissions on the date of submission.



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Tabulation Methods and Issues

Data shall be tabulated in three separate, mutually exclusive data collections: (1) the Main Data collection, (2) the Limited Data collection, and (3) the Stop Loss Data collection. The Main Data collection shall include data for all members who receive services under a policy (whether individual or employer-sponsored) with a New Hampshire situs or through a contract with a New Hampshire situs issued by a third party administrator. The Limited Data collection shall include data for all New Hampshire residents, or members who have a work location in New Hampshire (e.g. an out-of-state employer with a branch location in New Hampshire), with a policy that does not have a New Hampshire situs. The carrier/TPA shall submit data for all members who are employed at the New Hampshire branch location. The following chart provides a visual description of the Main and Limited data collections:

Breakdown of Data Collection Population			
<i>M = Main data collection, L = Limited data collection</i>			
Member Residence	Member Work Location*	Policy/Contract Situs	
		NH	Non-NH
NH	NH	M	L
NH	Non-NH	M	L
Non-NH	NH	M	L
Non-NH	Non-NH	M	--

** only considered for employer-sponsored coverage*

The Stop Loss Data collection shall include data for all policies with Coverage Type Code = “STL” (as defined in Attachment B-1). No policies with Coverage Type Code = “STL” should be included in either the Main Data collection or the Limited Data collection.

The tabulation information and issues below should be considered within each data collection separately.



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Tabulation of Information

A reporting record shall include unique combinations of the coverage category, market type (market category code), and benefit structure. Any difference in benefit structure due to covered benefits specified as “exception variables,” member liabilities (i.e. copay, deductible, and coinsurance) or any other variable listed in this report, means that data needs to be reported on a separate row.

Carriers shall submit one record for each type of coverage and benefit structure. For example, if a carrier provides multiple employers with only two types of HMO policies, one an HMO with a low deductible and another with a high deductible, the carrier shall submit two separate records with the corresponding member months, premium, and claims.

Carriers issuing stop loss coverage to the employer groups for which they also administer the self-insured health benefits shall submit one record for each type of coverage: the self-insured health coverage and the stop loss coverage.

The information described below shall be submitted in the format prescribed in Attachment A. Please note that there are a series of Exception Variables (EV) listed in Attachment A and in the report template. When the insurance policy covers the indicated service, leave the field blank in the report submission. When the insurance policy does not offer coverage for the indicated service at all, submit “NC” in the appropriate field for that policy. If the insurance policy generally covers the indicated service but the coverage does not meet the coverage definition provided in Attachment A, submit “DM” in the appropriate field for that policy. Do NOT substitute field requirements with “Y”, “N”, “NA”, or anything not specified in the reporting requirement. Do not change column headings. Do not insert or delete columns.

Tabulation Issues – Multiple Carriers

The Department recognizes that there may be instances where more than one carrier is involved in administering policies for a common employer in conjunction with that employer’s health insurance benefits. For self-insured plans, both the



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carrier administering the plan and the carrier writing the stop loss coverage shall submit a supplemental report.

The following guidelines clarify, in those instances when more than one carrier is involved with providing coverage to a single employer, which carrier has the responsibility to include the coverage in its tabulation.

- Data on reinsurance policies, insurance policies written by a carrier to another carrier, shall not be tabulated and shall not be included with the required supplemental report.
- Stop-loss insurance, or group excess loss insurance issued to an employer or other group, shall be reported by the writing carrier. It is considered direct insurance and carriers writing such coverage shall be responsible for submitting information on their written policies.
- In the event that the entity administering coverage is different than the carrier writing coverage, the writing carrier shall be responsible for submitting the required information. Carriers writing risks shall be responsible for submitting information on policies covering the underwritten risks. Entities responsible only for policy administration shall not be responsible for tabulating data on policies that they administer when such coverage is written on another carrier's paper and reported by that carrier.
- TPAs or carriers administering an employer-sponsored health insurance benefit plan shall submit records for all self-insured plans that they administer. TPAs must file a supplemental report for this type of activity regardless of whether a stop-loss writer is filing information for the same employer.
- Similarly, a stop loss carrier must file the information prescribed in this section regardless of whether a TPA, or some other carrier, is filing a supplemental report for the same employer.

Tabulation Issues – Geographic Location

The policy geographic location code shall be based on the specific business location of the policyholders; where the policy is situated (refer to "Situs" in the Definitions section of this bulletin). For NH residents working at a branch location in NH, the policyholder location may be out of state. All codes are specified in Attachment D.



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All policies included in the Main Data collection should be NH policies with a geographic location code other than 'Y', while all policies included in the Limited Data collection should be non-NH policies with a geographic location code of 'Y'. Policies included in the Stop Loss Data collection should use the appropriate code from Attachment D, whether 'Y' or another value.

Carriers shall use a county code of 'Z' to identify NH locations for which there is no county code mapped to the NH zip code that is stored by the carrier. Whenever a code of 'Z' is used, the carrier shall include a note record specifying the NH zip code for which there is no county code match.

Acceptable Methods for Estimating Data

In certain instances, a carrier may not have the information it needs to tabulate data as prescribed. For example, a carrier writing stop loss, or group excess insurance may not know who the employer's employees are. Carriers and TPAs shall provide data at the most detailed level at which the carrier or TPA keeps the data. For this example, the number of certificate holders, e.g. employees, and the number of covered lives shall be estimated based on data used by the carrier to price the business.

Where carriers use estimation methods, the carrier shall include, as part of its supplemental report, an explanation in the notes section to explain why estimation methods were necessary and the methods used to generate the estimates. The NHID reserves the right to approve or disapprove the method of estimation.

Acceptable Methods for Submission

All supplemental reports will be processed electronically. Carriers are required to submit the supplemental report in an MS Excel Workbook format provided by the Department. The Department created templates that are available for download from the Department's website.

The templates are in the Excel file called Supplemental Report Template 2013 Jul.xlsm (Supplemental Report Template 2012 Mar.xlsm for the special submission due March 15, 2014). This file shall be used as a template for creating new



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spreadsheets. After downloading this file to a local directory in Windows Explorer, right click on the downloaded file, and select New. This will create a new workbook file based on the downloaded template. Do not change the worksheet names or column headings in the template.

All carriers shall create a workbook using the Supplemental Report Excel Template. **Carriers shall name the workbook SIR<cocode>.xls based on the carrier NAIC code.** The naming is important for processing purposes.

After data have been input into the worksheet, please use the button on the "Transmittal" sheet to check that data fields are formatted correctly and only valid codes have been reported. Any possibly invalid entries will be highlighted and should be reviewed and, if necessary, corrected prior to submission. Note that macros must be enabled in order to run the validity check.

All supplemental reports shall be transmitted via electronic mail to the Insurance Department. Supplemental Reports shall be electronically mailed to **nhsuppreport@ins.nh.gov**. All such correspondence shall use the following text as the subject header, "ATTN: Statistician, Insurance Department Supplemental Report."

Data Reconciliation

To assist carriers in ensuring consistent reporting practices and that the data submission is reasonable in relation to the reporting requirements, we have included additional data reconciliation checks. These data checks compare the data in this submission to carrier reported data in two additional reports, specifically the NAIC Supplemental Health Care Exhibit (SHCE) for New Hampshire and the NH Comprehensive Health Information System (CHIS). Instructions and a template for the data reconciliations can be found on the "Data Reconciliation" sheet in the Supplemental Report Excel Template. These reconciliations should be performed prior to the template being submitted to the Department. While the data submission is not required to reconcile exactly to the other data sources, explanations of differences must be provided. For example, claims in the SHCE may reflect paid claims plus the change in unpaid claims (current year end minus prior year end), while the Supplemental Report may reflect incurred and paid claims plus



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an estimate for unpaid claims, which may result in a difference that can be explained. Please note that comparisons are made only on the data that overlap between the reports and should reconcile. There will be some data that are included in the Supplemental Report and are not included in the SHCE (e.g. claims and premium with Coverage Type Code = 'ASO' or 'ASW').

If either the SHCE or CHIS data are not available for use in the comparison, the reason for which must be provided on the "Notes" sheet in the Supplemental Report Excel Template.

Confidentiality

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

(b) The Supplemental Report filed by each health carrier shall be subject to the New Hampshire Right-to-Know law, RSA 91-A. The Right-to-Know law 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.

Any questions should be directed to Tyler Brannen, Health Policy Analyst at tyler.brannen@ins.nh.gov.



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Attachment A Supplemental Report Specifications

Transmittal

There shall be one worksheet in the workbook named "Transmittal." The worksheet shall contain the following information.

Field Name	Description
Company Code	Please be sure to enter as text, e.g. for 01234, type '01234' in the cell.
Company Name	
Reporting Year	Four-digit years for the calendar year from which this report is based.
Fiscal Year End Date	Use MMDD format. For most companies, this will be 1231.
Contact Person First Name	
Contact Person Last Name	
Contact Person Mailing Address Line One	
Contact Person Mailing Address Line Two	
Contact Person Mailing City	
Contact Person Mailing 2-Letter State Abbreviation	
Contact Person Mailing Zip Code	Enter as text (see Company Code above).
Contact Person Direct Voice Phone Number	If there is an extension, use the character 'x' to separate the phone number from the extension.
Contact Person e-mail address	
Identify all subcontractors and the services that are subcontracted.	List all subcontractors and the services that are subcontracted (e.g. prescription drugs, mental health/substance abuse).
Are all claims for subcontracted services included in the submitted data?	Input "Y" for yes, "N" for no. If "N" please explain what has been included and/or excluded.



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Main Data Collection

The main data collection worksheet shall be called "Main Data" and shall include data for policies with a NH situs with the exception of those with coverage type "STL". The first row of the Main Data worksheet shall contain the labels listed in the Variable column below. Subsequent rows shall contain the data prescribed. The data must be provided at the most specific level in order to accurately recognize the health plan product characteristics and benefit differences, including those based on member/patient liabilities.

All numeric data, such as member months and dollar totals must be reported on an accrual basis in a number format. Dates of coverage, premium collected, claims paid, and all determinations are based on a calendar year. Since determinations are made based on the calendar year, the data will include any changes in enrolled membership, premiums, and claims, such as when a group renews mid-year. Data specific to individual groups will be summarized and combined with all other groups with similar benefit characteristics (as determined by the variables listed below).

Variable	Description
Coverage Type	Three digit character code for coverage type: UND, ASW, ASO, STN, or MCD as fully described in Attachment B-1.
Plan Type	Three digit character code for plan type: HMO, POS, PPO, EPO, or FFS as fully described in Attachment B-2. When determining the plan type as HMO, POS, PPO, EPO, or FFS, carriers shall use the same definition as what is applied in field MC802 in the Uniform Reporting System for Health Care Claims Data Sets.
Market Category Code	Three or four digit character code for identifying employer size, student insurance policies, or blanket insurance. Employer size is based on the number of eligible employees in the group. For qualified association trusts, assign the group size applicable to each subgroup within the association. Codes are in Attachment C.



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Policyholder Geographic Location	One digit county codes assigned based on the location of the policyholder (not member). Codes are in Attachment D.
State, Federal, Municipal, or Healthy Kids Account	Are the data for the state of NH, federal, municipal or Healthy Kids account? Input "S" for State, "F" for federal, "M" for municipal, "H" for Healthy Kids, or "O" for all other accounts.
Qualified Association Trust	Are the data for a Qualified Association Trust? Input "Y" for yes, "N" for no.
Professional Employer Organization	Are the data for a Professional Employer Organization? Input "Y" for yes, "N" for no.
HealthFirst	Are the data for a HealthFirst product(s)? Input "Y" for yes, "N" for no.
Calendar Year	Calendar year the data is reported for.
Number of Policyholder Months	Total number of covered months for the policyholder (usually employer for group policies, or individual for non-group policies). One policyholder covered for one full year would be equal to 12. Policy months may not be additive. If an account has two rows because of the purchase of multiple products, the policy months will be the same.
Number of Subscriber Months	Total number of covered months for the subscriber (employee or individual). One employee covered for one full year would be equal to 12.
Number of Member Months	Includes both the total number of covered life months for the subscriber and for any covered spouses and dependents.
Total Premium	"Premium" shall be calculated as "earned" premium, or the total amount of premium from policyholders to provide insurance coverage during the reporting year. Earned



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	<p>premium = premiums collected + change in due and uncollected – change in unearned and advance premium. If premium is collected prior to January 1, to provide insurance coverage during the reported calendar year, than it must be included in this column. 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.</p> <p>For self-insured business, TPAs and carriers shall calculate earned premium by aggregating the total funds collected from contracted accounts to provide for all claims and expenses associated with the administration of the employer’s benefit plan. These funds include provisions for claims (net of stop-loss recoveries), administration, premium for stop-loss coverage (for policies with Coverage Type of “ASW”), profit margins, commissions, wellness programs, network fees, and disease management programs.</p>
<p>Total Claims</p>	<p>Total claims incurred on behalf of the covered members in the reporting class during the calendar year for which the supplemental report is being made. Note that total claims are reported on an accrual basis for calendar year. All claims with a date of service during the reporting year are to be included as claims paid in this field. If necessary, actuarial completion factors should be used to estimate incurred claims and should be based on when the carrier extracts the data for the Supplemental Report.</p> <p>Incurred claims shall include:</p> <ul style="list-style-type: none"> • claims incurred during the reporting period and paid prior to the report date • claims incurred and reported during the reporting period but unpaid prior to the report date • claims incurred but not reported during the reporting period.



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	<ul style="list-style-type: none"> • other payments and credits such as capitation, incentive payments, prescription drug rebates, etc. <p>For insured business, incurred claims should be consistent with what is reported in Part 1, Line 5 of the NAIC Supplemental Health Care Exhibit, allowing for variances due to any restatement of unpaid claims with additional paid claim runoff.</p> <p>For self-insured business, TPAs and carriers shall calculate incurred claims on a similar basis with the following additions:</p> <ul style="list-style-type: none"> • incurred claims shall be net of any stop-loss recoveries. • include amounts paid for stop-loss coverage. <p>The amount reported in this field should be the sum of the following three fields: (1) Claims Incurred and Paid, (2) Claims Incurred and Unpaid, and (3) Other Payments and Credits.</p>
<p>Claims Incurred and Paid</p>	<p>Includes claims incurred during the reporting period and paid prior to when the carrier extracts the data for the Supplemental Report.</p>
<p>Claims Incurred and Unpaid</p>	<p>Claims incurred during the reporting period and unpaid (payable) as of the data extract including both (1) claims reported but still payable (sometimes referred to as in course of settlement) and (2) claims not reported and payable (sometimes referred to as incurred but not reported).</p>



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Other Payments and Credits	Includes other payments made such as capitation, incentive payments, etc. or credits received such as prescription drug rebates which are included in medical expense as reported for the carrier's Statement of Revenue and Expenses, or its equivalent, which is a required component of the annual statement filing. For policies with Coverage Type = "ASW", TPAs and carriers should report any stop-loss recoveries and stop-loss premiums in this field.
Member Responsibility	For the claims included in the "Total Claims" field, report the total known amount (that is, those associated with incurred and paid claims) of deductibles, coinsurance amounts, and copayments or any balance-billing for which the member is responsible. This field should not include amounts for denied claims or claims covered by another payer due to coordination of benefits.
Plan ID	This is the 14-character HIOS Plan ID (Standard component). This field may not be available for all market segments; input "N/A" where not available. Note: this field does not need to be populated for 2012 data, but will be required beginning with 2013 data. Until that time, input "N/A".
Plan Code	This identifier should be the same Plan Code or Name used in the NH Individual and Small Group rate filings, which is described in the Requirements for Accident and Health Insurance Rate Submissions User Manual (found on the NHID website ²). This field may not be available for all market segments; input "N/A" where not available. Note: this field does not need to be populated for 2012 data, but will be required beginning with 2013 data. Until that time, input "N/A".

²http://www.nh.gov/insurance/legal/documents/user_guide-v4.pdf or updated version, if available



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Policy Form Number	Policy Form Number associated with this health plan coverage.
Exchange Indicator	Is this health coverage plan available on the Exchange? Input "Y" for yes, "N" for no. Note: data for this field will not be available until 2014. Until that time, input "N/A".
Grandfathered Indicator	Is this health coverage plan Grandfathered per the ACA definition? Input "Y" for Grandfathered plans or "N" for Non-Grandfathered plans.
HDHP	Does the policy meet the IRS definition of a HDHP? Input "Y" for yes, "N" for no.
Is this health coverage plan open?	Is this health coverage plan open or closed? Input "Y" if open, "N" for closed. In closed blocks, only existing contracts are allowed to renew. Benefit options in closed blocks are not marketed or being sold to new customers. If at any time in the reporting year a block becomes closed, it should be considered closed for the purpose of this report.
Is this a new health coverage plan?	Was this health coverage plan new in the calendar year for which the supplemental report is being made? Input "Y" for yes, "N" for no. A new health coverage plan is a benefit design that is being offered/marketed for the first time in this reporting year.
Does Deductible apply to all Medical Services?	Input "Y" for yes, "N" for no. Since many plans will be covering preventative office visits at 100%, consider only other types of medical services when responding to this question.
Does Deductible apply to Pharmacy Services?	Input "Y" for yes, "N" for no. The Deductible in this question refers to the Medical Deductible, not a Pharmacy-specific Deductible.



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Are Preventive Services Covered 100%?	Input "Y" for yes, "N" for no. Preventive Services refers to the preventive services as defined and required in the Affordable Care Act as of the reporting year.
Does this health coverage plan provide coverage for MH/SA?	Input "Y" for yes, "N" for no.
Does this health coverage plan have a Tiered Network component?	Input "Y" for yes, "N" for no. A Tiered Network is defined as varying levels of cost sharing based on different networks of providers set up to cover a broad range of services that are considered in-network. An arrangement that is specific to a limited number of services, such as gastric bypass or transplants, would not be considered a Tiered Network for the purposes of this report.
PCP Office Visit Copay	Dollar amount of the PCP office visit copay for services within network. If this service has no cost sharing, input 0 (zero). If this service does not have a copay but is subject to the deductible and/or coinsurance, input "D/C". For Tiered Network HMO products, provide cost sharing for most utilized tier.
Specialist Office Visit Copay	Dollar amount of the Specialist office visit copay for services within network. If this service has no cost sharing, input 0 (zero). If this service does not have a copay but is subject to the deductible and/or coinsurance, input "D/C". For Tiered Network HMO products, provide cost sharing for most utilized tier.



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ED Copay	Dollar amount of the Emergency Department copay for services within network. If this service has no cost sharing, input 0 (zero). If this service does not have a copay but is subject to the deductible and/or coinsurance, input "D/C". For Tiered Network HMO products, provide cost sharing for most utilized tier.
Outpatient Surgery Copay	Dollar amount of the Outpatient Surgery copay for services within network. If this service has no cost sharing, input 0 (zero). If this service does not have a copay but is subject to the deductible and/or coinsurance, input "D/C". For Tiered Network HMO products, provide cost sharing for most utilized tier.
Inpatient Copay	Dollar amount of the Inpatient copay for services within network. If this service has no cost sharing, input 0 (zero). If this service does not have a copay but is subject to the deductible and/or coinsurance, input "D/C". For Tiered Network HMO products, provide cost sharing for most utilized tier.
In-Network Single Deductible	Dollar amount of the in-network, single tier type policy deductible. For Tiered Network HMO products, provide cost sharing for most utilized tier. For FFS products, provide the overall cost sharing information.
In-Network Coinsurance	Percentage figure of total plan and patient liability that the member is responsible for paying. For example, if the insurer pays 80% and the member pays 20%, a value of 0.20 should be reported. If the plan has more than one co-insurance, use the highest level for services within network. For Tiered Network HMO products, provide cost sharing for most utilized tier. For FFS products, provide the overall cost sharing information. This value shall be in numeric decimal format with a value between 0 and 1.



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In-Network Single OOP Max	Dollar amount of the maximum out of pocket expenses for services within network for a single tier type policy. The out of pocket maximum should include any deductibles, where applicable. For Tiered Network HMO products, provide cost sharing for most utilized tier. For FFS products, provide the overall cost sharing information. If there is no maximum, enter: 9,999,999.
Retail Pharmacy Single Deductible Generic	Dollar amount of the single tier type policy deductible for generic prescriptions dispensed at an in-network retail pharmacy. If there is no deductible, input 0 (zero).
Retail Pharmacy Single Deductible Brand Formulary	Dollar amount of the single tier type policy deductible for brand prescriptions on the formulary dispensed at an in-network retail pharmacy. If there is no deductible, input 0 (zero).
Retail Pharmacy Single Deductible Brand Non-Formulary	Dollar amount of the single tier type policy deductible for brand prescriptions not on the formulary dispensed at an in-network retail pharmacy. If there is no deductible, input 0 (zero).
Retail Pharmacy Copay Generic	Dollar amount of the copay for 30-day supply generic prescriptions dispensed at an in-network retail pharmacy. If this service does not have a copay, input 0 (zero).
Retail Pharmacy Copay Brand Formulary	Dollar amount of the copay for 30-day supply brand prescriptions on the formulary dispensed at an in-network retail pharmacy. If this service does not have a copay, input 0 (zero).
Retail Pharmacy Copay Brand Non-Formulary	Dollar amount of the copay for 30-day supply brand prescriptions not on the formulary dispensed at an in-network retail pharmacy. If this service does not have a copay, input 0 (zero).



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Actuarial Value	<p>“Actuarial Value” – For the purposes of this report, the Actuarial Value will be the Minimum Value measure as outlined in Section 1302 (d)(2)(C) of the Affordable Care Act. Beginning in 2014, insurers and employers or unions with self insured plans must report information to the IRS for each individual covered under a health insurance plan that provides minimum coverage. This information will be used by the IRS to determine whether individuals who purchase insurance on the exchanges will be eligible for a premium tax credit. The minimum value is defined as the percentage of the total allowed costs of benefits provided under a group health plan or health insurance coverage. In accordance with the HHS regulations there are several options for determining the Minimum Value:</p> <ul style="list-style-type: none"> • Determine Minimum Value figure using publically available Minimum Value Calculator excel model tool which can be downloaded from the following website: http://www.cms.gov/ccio/resources/regulations-and-guidance/index.html . The Department of Health and Human Services has published guidance titled “Minimum Value Calculator Methodology” which is also available on the website. This guidance provides a detailed description of the data underlying the MV Calculator and the calculator’s methodology. • Determine Minimum Value figure through any safe harbor established by HHS and IRS. • If the plan design is incompatible with the Minimum Value Calculator or Safe Harbor Plan, the Minimum Value figure may be determined through an actuarial certification from a member of the American Academy of Actuaries. <p>For each set of reported coverage options, e.g. each benefit</p>
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	<p>plan, the carrier shall include on the Supplemental Report the Minimum Value figure calculated in accordance to one of the three options mentioned above. The Minimum Value Calculator can be used for a wide variety of health plan designs; however, it is possible some benefit plan designs may not fit into the calculator. In circumstances where this is the case, and the minimum value from the safe harbor or actuarial certification is not readily available, it is recommended that a reasonable estimate based on comparison to similar plan designs be reported in the Supplemental Report. If a method other than the Minimum Value Calculator is used, the alternate method that was used must be disclosed and described in the notes section of the report submittal form.</p> <p>Please do not provide figures based on the Actuarial Value Calculator. The Actuarial Value Calculator uses different population base and different continuance tables than the Minimum Value Calculator. The results from the two calculators will be slightly different. For the purposes of this report and stable comparison across coverage segments and carriers, the Minimum Value Calculator must be used.</p> <p>This minimum value as described above is the “actuarial value”.</p>
	<p>The remaining variables are Exception Variables (EV). Enter “NC” if the policy does not cover this service. Enter “DM” if the policy generally covers this service, but does not meet the exact service description. Leave blank if this is a covered item.</p>
Ambulance Service	EV



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Audiology Screening for Newborns	EV - Includes: covered for one screening and one confirming screening.
Blood and Blood Products	EV - Includes: fees associated with the collection or donation of blood or blood products, all cost recovery expenses for blood, blood derivatives, components, biologics, and serums to include autologous services and albumin.
Case Management Program	EV - Includes: available for medically complex and costly services.
Chiropractic Services	EV
Durable Medical Equipment (DME)	EV - Includes: nebulizers, peak flow meters, and diabetes glucose monitoring equipment.
Emergency Room	EV
Family Planning Services	EV – full range of services including: counseling services and patient education; examination and treatment by medical professionals; laboratory examinations and tests; and medically approved methods, procedures, pharmaceutical supplies and devices to prevent conception. <i>This category does not include infertility services; these services are covered under a separate benefit category.</i>
Habilitative Services	EV - Includes: coverage for children 0-19 years of age for treatment of congenital and genetic birth defects.
Hearing Aids	EV - Includes: coverage and services as defined by NH State Law; including hearing aid for each hearing-impaired ear every 60 months.
Home Health Care	EV - Includes: coverage as an alternative to otherwise covered services in a hospital or other related institution.



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Hospice	EV - Includes: coverage same as Medicare, including nursing care, medical social services, physicians' services, counseling services, short-term inpatient care, medical appliances and supplies, home health aide services, physical therapy, occupational therapy, speech-language pathology, and other items and services.
Hospitalization	EV - Includes: unlimited (includes detoxification)
Infertility Services	EV - Includes: coverage for services obtained after diagnosis of infertility including all non-experimental infertility procedures including, but not limited to, artificial insemination and intrauterine insemination, in vitro fertilization and embryo transfer, gamete intrafallopian transfer, sperm and/or egg procurement and processing, intracytoplasmic sperm injection, zygote intrafallopian transfer, assisted hatching, cryopreservation of eggs, and infertility-related drugs. Does not include any experimental infertility procedure, surrogacy, or reversal of voluntary sterilization.
Medical Food	EV - Includes: for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis or treatment in the field of metabolic disorders
Mental Health and Substance Abuse	EV - Includes: when delivered through a managed care system for 60 inpatient days with partial hospitalization traded on a 2 to 1 basis and unlimited outpatient visits
Nutritional Services	EV - Includes: six visits per year for cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease.



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Outpatient Hospital Services & Surgery	EV
Outpatient Laboratory & Diagnostic Services	EV
Outpatient Short-Term Rehabilitative Services	EV - Includes: physical therapy, speech therapy, and occupational therapy
Pediatric Dental Services	EV – Includes: coverage for diagnostic, preventative services minor and major restorative services, implants and orthodontia. Minor restorative services include but aren't limited to filings, crowns and oral surgery for impacted teeth. Major restorative services include inlays, root canals and fixed prosthesis. Leave blank when covered under the medical policy. Input "NC" if the medical policy does not cover these services.
Pediatric Vision Services	EV – Includes: but is not limited to, diagnostic services, frames & prescription lenses or contract lenses. Leave blank when covered under the medical policy. Input "NC" if the medical policy does not cover these services.
Pregnancy and Maternity	EV
Prescription Drugs (Rx)	EV - Includes: prescriptions available on an open formulary with coverage at least the generic drug equivalent amount when the brand name drug is prescribed.
Preventive Services	EV - Includes: preventive services as defined and required in the Affordable Care Act as of the reporting year.



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Skilled Nursing Facility	EV - Includes: 100 days as an alternative to otherwise covered care in a hospital or other related institution.
Transplants	EV - Includes: for bone marrow, cornea, kidney, liver, lung, heart, pancreas, and pancreas/kidney transplants.
Well Child & Immunization Benefits	EV - Includes: for children 0 – 13 years of age.

Limited Data Collection

The limited data collection worksheet shall be called “Limited Data” and shall include data for policies with a non-NH situs with the exception of those with coverage type “STL”. The first row of the Limited Data worksheet shall contain the labels listed in the Variable column below. Subsequent rows shall contain the data prescribed. The data must be provided at the most specific level in order to accurately recognize the health plan product characteristics.

All numeric data, such as member months and dollar totals must be reported on an accrual basis in a number format. Dates of coverage, claims paid, and all determinations are based on a calendar year. Since determinations are made based on the calendar year, the data will include any changes in enrolled membership, premiums, and claims, such as when a group renews mid-year. Data specific to individual groups will be summarized and combined with all other groups with similar characteristics (as determined by the variables listed below).

Variable	Description
Coverage Type	Three digit character code for coverage type: UND, ASW, ASO, STN, or MCD as fully described in Attachment B-1.
Plan Type	Three digit character code for plan type: HMO, POS, PPO, EPO, or FFS as fully described in Attachment B-2. When determining the plan type as HMO, POS, PPO, EPO, or FFS, carriers shall use the same definition as what is applied in field MC802 in the Uniform Reporting System for Health Care Claims Data Sets.



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Market Category Code	Three or four digit character code for identifying employer size, student insurance policies, or blanket insurance. Employer size is based on the number of eligible employees in the group. For qualified association trusts, assign the group size applicable to each subgroup within the association. Codes are in Attachment C.
Policyholder Geographic Location	One digit county codes assigned based on the location of the policyholder (not member). Codes are in Attachment D. Only policies with a Policyholder Geographic Location code of "Y" (a non-NH situated policy) should be reported on the "Limited Data" tab.
Qualified Association Trust	Are the data for a Qualified Association Trust? Input "Y" for yes, "N" for no.
Professional Employer Organization	Are the data for a Professional Employer Organization? Input "Y" for yes, "N" for no.
HealthFirst	Are the data for a HealthFirst product(s)? Input "Y" for yes, "N" for no.
State, Federal, Municipal or Healthy Kids Account	Are the data for the state of NH, federal, municipal, or Healthy Kids account? Input "S" for State, "F" for federal, "M" for municipal, "H" for Healthy Kids, or "O" for all other accounts.
Number of Policyholder Months	Total number of covered months for the policyholder (usually employer for group policies, or individual for non-group policies). One policyholder covered for one full year would be equal to 12. Policy months may not be additive. If an account has two rows because of the purchase of multiple products, the policy months will be the same.



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Number of Subscriber Months	Total number of covered months for the subscriber (employee or individual). One employee covered for one full year would be equal to 12.
Number of Member Months	Includes both the total number of covered life months for the subscriber and for any covered spouses and dependents.
Calendar Year	Calendar year the data is reported for.
Total Claims	<p>Total claims incurred on behalf of the covered members in the reporting class during the calendar year for which the supplemental report is being made. Note that total claims are reported on an accrual basis for calendar year. All claims with a date of service during the reporting year are to be included as claims paid in this field. If necessary, actuarial completion factors should be used to estimate incurred claims and should be based on when the carrier extracts the data for the Supplemental Report.</p> <p>Incurred claims shall include:</p> <ul style="list-style-type: none"> • claims incurred during the reporting period and paid prior to the report date • claims incurred and reported during the reporting period but unpaid prior to the report date • claims incurred but not reported during the reporting period. • other payments and credits such as capitation, incentive payments, prescription drug rebates, etc. <p>For self-insured business, TPAs and carriers shall calculate incurred claims on a similar basis with the following additions:</p> <ul style="list-style-type: none"> • incurred claims shall be net of any stop-loss recoveries. • include amounts paid for stop-loss coverage



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	The amount reported in this field should be the sum of the following three fields: (1) Claims Incurred and Paid, (2) Claims Incurred and Unpaid, and (3) Other Payments and Credits.
Claims Incurred and Paid	Includes claims incurred during the reporting period and paid prior to when the carrier extracts the data for the Supplemental Report.
Claims Incurred and Unpaid	Claims incurred during the reporting period and unpaid (payable) as of the data extract including both (1) claims reported but still payable (sometimes referred to as in course of settlement) and (2) claims not reported and payable (sometimes referred to as incurred but not reported).
Other Payments and Credits	Includes other payments made such as capitation, incentive payments, etc. or credits received such as prescription drug rebates which are included in medical expense as reported for the carrier's Statement of Revenue and Expenses, or its equivalent, which is a required component of the annual statement filing. For policies with Coverage Type = "ASW", TPAs and carriers should report any stop-loss recoveries and stop-loss premiums in this field.
Member Responsibility	For the claims included in the "Total Claims" field, report the total known amount (that is, those associated with incurred and paid claims) of deductibles, coinsurance amounts, and copayments or any balance-billing for which the member is responsible. This field should not include amounts for denied claims or claims covered by another payer due to coordination of benefits.



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Stop Loss Data Collection

The stop loss data collection worksheet shall be called “Stop Loss Data” and shall include all data related to “STL” coverage type (both NH and non-NH situs). The first row of the Stop Loss Data worksheet shall contain the labels listed in the Variable column below. Subsequent rows shall contain the data prescribed. The data must be provided at the most specific level in order to accurately recognize the product characteristics.

All numeric data, such as member months and dollar totals must be reported on an accrual basis in a number format. Dates of coverage, claims paid, and all determinations are based on a calendar year. Since determinations are made based on the calendar year, the data will include any changes in enrolled membership, premiums, and claims, such as when a group renews mid-year. Data specific to individual groups will be summarized and combined with all other groups with similar characteristics (as determined by the variables listed below).

Variable	Description
Coverage Type	Three digit character code for coverage type as fully described in Attachment B-1. All policies in the Stop Loss Data collection should have coverage type = “STL”.
Plan Type	Three digit character code for plan type of the underlying health plan: HMO, POS, PPO, EPO, or FFS as fully described in Attachment B-2. When determining the plan type as HMO, POS, PPO, EPO, or FFS, carriers shall use the same definition as what is applied in field MC802 in the Uniform Reporting System for Health Care Claims Data Sets. If plan type of the underlying health plan is not available, input “N/A”.
Market Category Code	Three or four digit character code for identifying employer size, student insurance policies, or blanket insurance. Employer size is based on the number of eligible employees in the group. For qualified association trusts, assign the group size applicable to each subgroup within the association. Codes are in Attachment C.



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Policyholder Geographic Location	One digit county codes assigned based on the location of the policyholder (not member). Codes are in Attachment D.
Qualified Association Trust	Are the data for a Qualified Association Trust? Input “Y” for yes, “N” for no.
Professional Employer Organization	Are the data for a Professional Employer Organization? Input “Y” for yes, “N” for no.
State, Federal, Municipal or Healthy Kids Account	Are the data for the state of NH, federal, municipal, or Healthy Kids account? Input “S” for State, “F” for federal, “M” for municipal, “H” for Healthy Kids, or “O” for all other accounts.
Number of Policyholder Months	Total number of covered months for the policyholder (usually employer for group policies, or individual for non-group policies). One policyholder covered for one full year would be equal to 12. Policy months may not be additive. If an account has two rows because of the purchase of multiple products, the policy months will be the same.
Number of Subscriber Months	Total number of covered months for the subscriber (employee or individual). One employee covered for one full year would be equal to 12.
Number of Member Months	Includes both the total number of covered life months for the subscriber and for any covered spouses and dependents.
Calendar Year	Calendar year the data is reported for.
Specific Premium	Premium for specific stop loss coverage provided in the reported calendar year. “Premium” shall be calculated as “earned” premium, or the total amount of premium from policyholders to provide insurance coverage during the reporting year. Earned



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	<p>premium = premiums collected + change in due and uncollected – change in unearned and advance premium. If premium is collected prior to January 1, to provide insurance coverage during the reported calendar year, then it must be included in this column. 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.</p>
Specific Claims	<p>Total specific stop loss claims incurred during the calendar year for which the supplemental report is being made. Note that claims are reported on an accrual basis for calendar year. If necessary, actuarial completion factors should be used to estimate incurred claims and should be based on when the carrier extracts the data for the Supplemental Report.</p> <p>Incurred claims shall include:</p> <ul style="list-style-type: none">• claims incurred during the reporting period and paid prior to the report date• claims incurred and reported during the reporting period but unpaid prior to the report date• claims incurred but not reported during the reporting period.
Specific Attachment Point	<p>Dollar amount of claim threshold level for an individual at which specific stop loss coverage begins.</p>
Specific % Reimbursable	<p>Portion of the claims above the attachment point to be reimbursed by the specific stop loss coverage. This value shall be in numeric decimal format with a value between 0 and 1. For example, if 80% of claims over the attachment point are covered by stop loss insurance, enter 0.80.</p>



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Specific Reimbursement Maximum	Dollar amount of the maximum amount reimbursable for a specific stop loss claim. If there is no maximum, enter: 9,999,999.
Aggregate Premium	<p>Premium for aggregate stop loss coverage provided in the reported calendar year.</p> <p>“Premium” shall be calculated as “earned” premium, or the total amount of premium from policyholders to provide insurance coverage during the reporting year. Earned premium = premiums collected + change in due and uncollected – change in unearned and advance premium. If premium is collected prior to January 1, to provide insurance coverage during the reported calendar year, then it must be included in this column. 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.</p>
Aggregate Claims	<p>Total aggregate stop loss claims incurred during the calendar year for which the supplemental report is being made. Note that claims are reported on an accrual basis for calendar year. If necessary, actuarial completion factors should be used to estimate incurred claims and should be based on when the carrier extracts the data for the Supplemental Report.</p> <p>Incurred claims shall include:</p> <ul style="list-style-type: none"> • claims incurred during the reporting period and paid prior to the report date • claims incurred and reported during the reporting period but unpaid prior to the report date • claims incurred but not reported during the reporting period.



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Aggregate Attachment Point	Multiple of expected claims at which aggregate stop loss coverage begins. This value shall be in numeric decimal format with a value greater than 1. For example, if the attachment point is 110% of expected claims, input 1.10.
Aggregate % Reimbursable	Portion of the claims above the attachment point to be reimbursed by the aggregate stop loss coverage. This value shall be in numeric decimal format with a value between 0 and 1. For example, if 80% of claims over the attachment point are covered by stop loss insurance, enter 0.80.
Aggregate Reimbursement Maximum	Dollar amount of the maximum amount reimbursable under aggregate coverage. If there is no maximum, enter: 9,999,999.
Medical	Do Medical claims apply toward the stop loss limit? Input "Y" if yes, "N" if no.
Pharmacy	Do Pharmacy claims apply toward the stop loss limit? Input "Y" if yes, "N" if no.
Dental	Do Dental claims apply toward the stop loss limit? Input "Y" if yes, "N" if no.
Vision	Do Vision claims apply toward the stop loss limit? Input "Y" if yes, "N" if no.
Disability	Do Disability claims apply toward the stop loss limit? Input "Y" if yes, "N" if no.



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Data Checks

The carrier/TPA shall perform the validation check provided within the Supplemental Report Template prior to submitting the data to the New Hampshire Insurance Department. The template contains an automated process, or data validation tool, for checking the validity of some, but not all data on the 'Main Data', 'Limited Data' and 'Stop Loss Data' tabs. The data validation tool checks specific columns for specific values and should not be substituted for an extensive data review using the provided instructional information. This process is only a tool to facilitate the overall data validation process.

The 'Transmittal' tab contains a button labeled 'Click to Run Data Validation Checks' in the C19:G21 cell range. This button is provided to facilitate the verification process of data input into the 'Main Data', 'Limited Data' and 'Stop Loss Data' tabs. Please note that the data validation process can be run multiple times.

When pressed, the workbook will scan the 'Main Data', 'Limited Data' and 'Stop Loss Data' tabs and provide a brief summary on the 'Transmittal' tab of invalid and potentially invalid data. Additionally, the scan will highlight invalid or potentially invalid fields within the data tabs themselves. Finally, pressing the button scans the 'Main Data' and 'Limited Data' tabs and populates the Supplemental Report data in the exhibits on the 'Data Reconciliation' tab. To assist the carriers in populating the fields correctly, instructions for all reported fields have been included in tabs within the Supplemental Report Template. If there are any discrepancies between the instructions in the template and this bulletin, the bulletin instructions supersede the template.

The 'Transmittal' tab contains several reports on invalid or potentially invalid data arranged in several blocks. Column C displays counts for the 'Main Data', column I displays counts for the 'Limited Data' and column O displays counts for the 'Stop Loss Data'.



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The first set of blocks below the validation button displays an overview of potential errors:

- Row 25 reports a count of 'Null', or empty, cells where null cells are not expected.
- Row 26 reports a count of potentially invalid data, not including nulls.

The second set of blocks contains specifics on potential issues involving Coverage Type, Plan Type, and Market Category Code:

- Rows 31, 32 and 33 contain a count of invalid Coverage Type, Plan Type and Market Category Codes for both data tabs. These should be counted as invalid and fixed according to the respective tabs in the instruction section of the workbook.

The third set of blocks contains additional specifics on potential issues relating to the remaining data fields:

- Row 35 checks that appropriate rules are followed regarding the 'Policyholder Geographic Location' column of the two data tabs. Any possible inconsistencies are highlighted in yellow on the respective data tabs.
- Rows 37, 39, 41 and 43 are specific to the 'Main Data' tab.
- Row 37 checks for an appropriate In-Network Coinsurance level. A cell highlighted in yellow may potentially be acceptable, but the 'Coinsurance' Instruction tab should be referenced to make sure the meaning is fully understood.
- Row 39 checks for an appropriate Actuarial Value. A number higher than 1.0 will be highlighted in yellow as it is unexpected and should be double checked.



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- Row 41 checks for an In-Network Deductible inconsistency based on IRS rules for High Deductible Health Plans. Please see the 'Deductible' Instruction tab for more details.
- Row 43 checks for an In-Network Out of Pocket Maximum inconsistency based on IRS rules for High Deductible Health Plans. Please see the 'OOP Max' Instruction tab for more details.
- Each of the checks in Rows 35 through 43 has additional notes provided at the bottom of the 'Transmittal' tab.

Please note that while the data validation tool can provide the user with potential errors, it is possible that not all errors or warnings are invalid, and it is also possible that the tool overlooks actual errors. The tool should be used in addition to a reasonable data validation process, and not as the only method of validating data.

For technical issues you may encounter when performing the validation step, please refer to the 'Technical Troubleshooting' tab in the workbook.

Data Reconciliation

The "Data reconciliation" sheet contains two sections of comparisons to be performed. The first section compares the data to be submitted for the Supplemental Report to data reported in the NAIC Supplemental Health Care Exhibit (SHCE) for New Hampshire. The data from the Supplemental Report is pulled from the "Main Data" collection. Carriers/TPA's shall populate the highlighted cells with the requested data as reported in their SHCE for New Hampshire. Any differences greater than the percentage shown in the template must be explained in the space provided.

The second section compares the data to be submitted for the Supplemental Report to data submitted for the NH Comprehensive Health Information System (CHIS). The data from the Supplemental Report is pulled from both the "Main Data" collection and the "Limited Data" collection. Carriers/TPA's shall populate the highlighted cells with the requested data as submitted to NH CHIS. Any differences greater than the percentage shown in the template must be explained in the space provided.



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Values from the Supplemental Report data submission in both sections will be populated by pressing the button on the “Transmittal” tab. There is also a button labeled “Click to Populate Report Exhibits Below” located on the “Data Reconciliation” tab in cells E3 and E4. Clicking this button will recalculate the values from the Supplemental Report data in both sections of the report on the “Data Reconciliation” tab.

If either the SHCE or CHIS data are not available for use in the comparison, the reason for which must be provided on the “Notes” sheet in the Supplemental Report Excel Template.



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Attachment B-1
Coverage Type Codes

All coverage type character codes are exactly three characters. Carriers shall use the codes listed herein.

For self-funded plans that are administered by a third-party administrator, where the employer has purchased stop-loss, or group excess, insurance coverage, carriers shall use a code of ASW.

For self-funded plans that are administered by a third-party administrator, where the employer has not purchased stop-loss, or group excess insurance coverage, carriers shall use a code of ASO.

For stop-loss, or group excess loss insurance, carriers shall use STL.

For short-term non-renewable health insurance, as defined per RSA 415:5 III, carriers shall use a code of STN.

Insurance sold to protect the health of Medicaid eligible individuals, generally purchased by state governments, shall not be considered major medical expense. Carriers shall report such business as other than major medical expense coverage and use the Medicaid related insurance code of MCD.

For plans underwritten by the carrier and not referenced above, use code UND.

For any other plan, use OTH. Carriers using this code shall provide an explanation on the Notes worksheet.



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**Attachment B-2
Plan Type Codes**

All plan type character codes are exactly three characters. Carriers shall use the codes listed herein.

For indemnity-type plans, with no managed care features, carriers shall use a code of FFS, (Fee-for-Service).

For Preferred Provider Organization type plans, carriers shall use a code of PPO.

For Exclusive Provider Organization type plans, carriers shall use a code of EPO.

For Point of Service type plans, carriers shall use a code of POS.

For Health Maintenance Organizations managed care plans, carriers shall use a code of HMO.



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Attachment C
Market Category Codes

All market category character codes below. Carriers shall use the codes listed herein. For policies sold and issued through a qualified association trust, carriers shall assign the code based on the employee count of the employer sub-group.

For policies sold and issued directly to individuals, other than those sold on a franchise basis, as defined per RSA 415:19, or as group conversion policies, previously required per RSA 415:18, VII (a), carriers shall use a code of IND.

For policies sold and issued directly to individuals on a franchise basis, as defined per RSA 415:19, carriers shall use a code of FCH.

For policies sold and issued directly to individuals as group conversion policies, as previously required per RSA 415:18, VII (a), carriers shall use a code of GCV.

For policies sold and issued directly to employers having exactly one employee, carriers shall use a code of GS1.

For policies sold and issued directly to employers having between two and nine employees, carriers shall use a code of GS2.

For policies sold and issued directly to employers having between 10 and 25 employees, carriers shall use a code of GS3.

For policies sold and issued directly to employers having between 26 and 50 employees, carriers shall use a code of GS4.

For policies sold and issued directly to employers having between 51 and 99 employees, carriers shall use a code of GLG1.

For policies sold and issued directly to employers having 100 or more employees, carriers shall use a code of GLG2.



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For policies sold and issued as blanket health insurance policies to a common carrier, carriers shall use a code of BLC.

For policies sold and issued as blanket health insurance policies to an employer, carriers shall use a code of BLE.

For policies sold and issued as blanket health insurance policies to a volunteer fire department, first aid, or other such volunteer group, carriers shall use a code of BLV.

For policies sold and issued as blanket health insurance policies to a sports team or a camp, carriers shall use a code of BLS.

For policies sold and issued as blanket health insurance policies to a travel agency, or other organization that provides travel-related services, carriers shall use a code of BLT.

For policies sold and issued as blanket health insurance policies to a university or college, carriers shall use a code of BLU.

For policies sold and issued as student major medical expense large group coverage to enrolled students at an accredited college, university, or other educational institution, carriers shall use a code of SLG.

For policies sold and issued as group short term student health insurance, carriers shall use a code of STS.

For policies sold and issued as student major medical group health insurance, carriers shall use code SMG.

For policies sold and issued as student group health insurance that is not major medical coverage, carriers shall use a code of SNM.

For policies sold and issued as student individual major medical health insurance, carriers shall use a code of SIM.



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For policies sold and issued as student individual health insurance that is not major medical coverage, carriers shall use a code of SIN.

For policies sold to other types of entities, carriers shall use a code of OTH. Carriers using this market code shall provide an explanation on the Notes worksheet.



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Attachment D
Policyholder Geographic Location

<u>County</u>	<u>County Code</u>
Belknap	B
Carroll	L
Cheshire	E
Coos	S
Grafton	G
Hillsborough	H
Merrimack	M
Rockingham	R
Strafford	D
Sullivan	N
Non-NH	Y
NH; unable to match zip code to county code³	Z

Note: The above codes should be assigned based on the location of the policyholder (not the member). Non-NH policyholder data (with County Code of “Y”) shall be reported on the Limited Data tab and all other data shall be reported on the Main Data tab.

³ Zip code(s) must be provided to the NHID.



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Attachment E

Translation Table – Zip Codes to NH County Codes

From	Through	County
03031		Hillsborough
03032		Rockingham
03033		Hillsborough
03034	03042	Rockingham
03043		Hillsborough
03044		Rockingham
03045		Hillsborough
03046		Merrimack
03047	03052	Hillsborough
03053		Rockingham
03054	03071	Hillsborough
03073		Rockingham
03076		Hillsborough
03077	03079	Rockingham
03082	03086	Hillsborough
03087		Rockingham
03101	03105	Hillsborough
03106		Merrimack
03107	03111	Hillsborough
03215		Grafton
03216		Merrimack
03217		Grafton
03218	03220	Belknap
03221		Merrimack
03222	03223	Grafton
03224		Merrimack
03225	03226	Belknap
03227		Carroll
03229	03231	Merrimack
03232		Grafton
03233	03235	Merrimack



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From	Through	County
03237		Belknap
03238	03241	Grafton
03242	03243	Merrimack
03244		Hillsborough
03245		Grafton
03246	03249	Belknap
03251		Grafton
03252	03253	Belknap
03254		Carroll
03255		Merrimack
03256		Belknap
03257	03258	Merrimack
03259		Carroll
03260		Merrimack
03261		Rockingham
03262		Grafton
03263		Merrimack
03264	03266	Grafton
03268		Merrimack
03269		Belknap
03272	03273	Merrimack
03274		Grafton
03275		Merrimack
03276		Belknap
03278		Merrimack
03279		Grafton
03280		Sullivan
03281		Hillsborough
03282		Grafton
03284		Sullivan
03287		Merrimack
03289		Belknap
03290	03291	Rockingham
03293		Grafton



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From	Through	County
03298	03299	Belknap
03301	03307	Merrimack
03431	03435	Cheshire
03440		Hillsborough
03441		Cheshire
03442		Hillsborough
03443	03448	Cheshire
03449		Hillsborough
03450	03457	Cheshire
03458		Hillsborough
03461	03467	Cheshire
03468		Hillsborough
03469	03470	Cheshire
03561		Grafton
03570		Coos
03574		Grafton
03575	03579	Coos
03580		Grafton
03581	03584	Coos
03585		Grafton
03587	03598	Coos
03601		Sullivan
03602		Cheshire
03603		Sullivan
03604		Cheshire
03605	03607	Sullivan
03608	03609	Cheshire
03740	03741	Grafton
03743	03746	Sullivan
03748	03750	Grafton
03751	03754	Sullivan
03755	03769	Grafton
03770		Sullivan
03771		Grafton



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From	Through	County
03772	03773	Sullivan
03774	03780	Grafton
03781	03782	Sullivan
03784	03785	Grafton
03801	03804	Rockingham
03805		Strafford
03809	03810	Belknap
03811		Rockingham
03812	03814	Carroll
03815		Strafford
03816	03818	Carroll
03819		Rockingham
03820	03825	Strafford
03826	03827	Rockingham
03830	03832	Carroll
03833		Rockingham
03835		Strafford
03836		Carroll
03837		Belknap
03838		Carroll
03839		Strafford
03840	03844	Rockingham
03845	03847	Carroll
03848		Rockingham
03849	03850	Carroll
03851	03852	Strafford
03853		Carroll
03854		Rockingham
03855		Strafford
03856	03859	Rockingham
03860		Carroll
03862		Rockingham
03864		Carroll
03865		Rockingham



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From	Through	County
03866	03869	Strafford
03870	03871	Rockingham
03872		Carroll
03873	03874	Rockingham
03875		Carroll
03878		Strafford
03882	03883	Carroll
03884		Strafford
03885		Rockingham
03886		Carroll
03887		Carroll
03890	03897	Carroll



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Attachment F

Notes – Explanations as required in Instructions

Included in the Excel workbook is a worksheet for carriers/TPAs to include notes on any explanations as required in the instructions. For example, if data are submitted with Coverage Type Code of “OTH” an explanation of what this represents should be included on the “Notes” sheet in the data submission file. Another example is if a carrier/TPA used a method other than the Minimum Value Calculator for the “actuarial value”, the reason and method used must be described in the notes section.

Carriers/TPAs should include notes on any membership not included in the report submission, and the approximate total membership on December 31 of the calendar year included in the report filing. These may include covered lives for additional lines of business that do not meet the supplemental report criteria but that are covered as risks in some form by the carrier/TPA. Examples include dental insurance, Medicare supplemental insurance, or pharmacy benefit management services when not provided in conjunction with health insurance benefits.

The notes section of the submission template can also be used to include additional information relevant to the report submission.