



The State of New Hampshire Insurance Department

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Commissioner

The Department is developing revisions to Bulletin 04-007-AB, Supplemental Reporting, and seeks comments prior to the promulgation of a revised bulletin. The revisions include the collection of additional information in response to the new reporting requirements enacted in conjunction with SB 110. These reporting requirements require the collection of more detailed information on health insurance products, including the type of coverage and rating factors applied.

In response to these new reporting requirements, the Department proposes to eliminate reporting on other types of health insurance products, such as long-term care insurance, Medicare Supplement coverage, and credit insurance. Reporting on managed care and indemnity health insurance products would be expanded.

The revisions proposed would require carriers to report data on the following types of health coverages in New Hampshire:

- 1) group health insurance policies;
- 2) individual health insurance policies, including short-term, nonrenewable individual health insurance policies;
- 3) self-funded employer sponsored health insurance plans that are administered by Department licensed third party administrators; and
- 4) stop-loss insurance, or group excess loss insurance.

Carriers issuing evidentiary certificates of coverage in New Hampshire for group health policies that are situated out of state will also be required to report data on those policies.

The data reported will be expanded to include a data report characterizing the type of policies or coverages being sold. Carriers should carefully review the MS Excel Template, Proposed Template.xls, and the attached documentation regarding Policy Type Data. If adopted, carriers will be expected to develop unique policy type identifications to uniquely characterize the plans sold by the identified variables.

Carriers would be expected to file a unique record for each policy, or each employer group. These policy records would include a unique identifier, which would identify the policyholder or group to the carrier but not to anyone else. These policy records would include a policy type field that would cross reference the policy type data filed in a separate worksheet. These policy records would also include information regarding certain rating factors used by the carrier to calculate the policyholder's premium.

Carriers would then file certificate holder records to characterize the covered population associated with the issued policy.

In addition to these changes, the Department is considering a change to the technical requirements. The Department seeks a uniform filing format. Some companies have found the

ASCII requirements to be challenging. Please comment on whether an MS Excel format would be preferable.

Your thoughts and comments would be appreciated on or before June 24, 2004. Please respond via e-mail to David.Sky@ins.nh.gov.

Attachment
Policy Type Data

- I. Policy Type – A unique code for each and every Policy Type Record submitted by the carrier.
- II. Network Restrictions – Use one of the following codes:
 - a. A – For plans with no network restrictions and with no financial incentives to use one provider over another, e.g. Indemnity Plans.
 - b. B – For plans with no gatekeepers or network restrictions, but that do use financial incentives to steer participants to certain providers, e.g. PPO plans.
 - c. C – For plans with gatekeepers and network restrictions, but that also provide coverage to participants that use non-network providers, e.g. POS plans.
 - d. D – For plans with gatekeepers and network restrictions. These plans generally do not provide coverage to participants that use non-network providers, e.g. HMO plans.
- III. Outpatient/Physician Cost Sharing Type
 - a. A - If the plan utilizes copays.
 - b. B – If the plan utilizes a deductible.
- IV. Outpatient/Physician Cost Sharing Amount
 - a. If the plan utilizes copays, enter the copay amount per service or visit.
 - b. If the plan utilizes a deductible, enter the amount.
- V. Physician/Outpatient Coinsurance - If the plan has coinsurance for these services, enter the percentage amount. For example, a 20% coinsurance payment requirement on the part of the insured would be entered as 20. If there is no coinsurance, enter 00.
- VI. Physician/Outpatient Coinsurance Amount - If the plan has coinsurance for these services, enter the dollar amount of incurred claims for which the coinsurance is applicable. If there is no coinsurance, enter 0.
- VII. Hospital Cost Sharing Indicator
 - a. A – If the plan has a separate inside deductible based on each separate hospital stay.
 - b. B – If the plan has a separate inside deductible based on each inpatient day.
 - c. C – If the plan has a deductible that is bundled with the physician/outpatient deductible.
- VIII. Hospital Cost Sharing Amount – Enter the amount corresponding to the type selected.
- IX. Hospital Coinsurance - If the plan has coinsurance for these services, enter the percentage amount. For example, a 20% coinsurance payment requirement on the part of the insured would be entered as 20. If there is no coinsurance, enter 00.
- X. Hospital Coinsurance Amount - If the plan has coinsurance for these services, enter the dollar amount of incurred claims for which the coinsurance is applicable. If there is no coinsurance, enter 0.
- XI. Prescription Drug Indicator –
 - a. A – If prescription drugs are covered without restrictions, other than cost sharing restrictions, e.g. deductibles, co-pays, coinsurance and maximums.
 - b. B – If prescription drugs are covered through a formulary, with no formulary exclusions.
 - c. C – If prescription drugs are covered through a formulary, with formulary exclusions.
 - d. X – If there is no prescription drug coverage.

- XII. Prescription Drug Coverage Cost Sharing Indicator
 - a. A – If the cost sharing is copay based.
 - b. B – If the cost sharing is deductible based.
- XIII. Prescription Drug Calendar Year Maximum – Enter the calendar year maximum amount of claims for which prescription drug coverage is provided. If there is no calendar year maximum, but there is a lifetime maximum, enter that amount. Do not enter policy maximums in this field. If there is no prescription drug maximum, enter 0.
- XIV. Policy Year or Calendar Year Maximum – Enter the calendar year maximum amount of claims for which coverage is provided. If there is no calendar year maximum, but there is a lifetime maximum, enter that amount. If there is no maximum, enter 0.
- XV. Cost Sharing Interaction Indicator
 - a. A – If cost sharing requirements are independent of one another.
 - b. B – If costs paid by the insured are pooled for purposes of satisfying the physician/outpatient and hospital requirements.
 - c. C – If costs paid by the insured are pooled for purposes of satisfying all of the cost sharing requirements.
- XVI. Maternity Coverage Indicator –
 - a. A – No maternity coverage
 - b. B – Maternity covered.
- XVII. MSA/HAS Indicator –
 - a. Q – If the plan is qualified, as defined by the IRS, for use with MSAs or HSAs.
 - b. N – If the plan is not qualified.
- XVIII. Base Rate PMPM – The base rate used for the characterized coverage.