

Report to the
State of New Hampshire Insurance Department
Analysis of Data Sources to Support Rate Review
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Report to the State of New Hampshire Insurance

Department: Analysis of Data Sources to Support Rate Review

Executive Summary

The New Hampshire Insurance Department (the Department) has received national recognition for its outstanding, leading-edge development and use of health insurance data,¹ and carrying out many of its responsibilities relies on use of these data. Among the data-dependent responsibilities the Department enforces pursuant to state statute are protection of state residents by monitoring and regulating health (and other) insurance companies':

- Solvency, so that consumer claims will be paid;
- Premium rates, to ensure fair prices are paid for coverage; and
- Market conduct, to determine whether carriers comply with New Hampshire insurance laws and treat claimants and policyholders fairly.

Moreover, the federal Patient Protection and Affordable Care Act's² (ACA) goals of expanding affordable coverage are implemented in part by providing resources to help states strengthen their rate review capabilities and to improve the transparency to the public of information regarding health insurance rates, benefits, coverage, and market participants. Improved data capabilities are a key aspect of strengthening state level resources for rate monitoring and review. The State of New Hampshire was awarded a grant under the ACA Rate Review Grant program, the funds from which have supported a number of important studies aimed at strengthening rate review. Compass Health Analytics, Inc. was engaged to review data resources available to the Department, and to make recommendations aimed at improving the reliability, accuracy, usability, and availability of information about rates and other Department responsibilities.

A review of data collected by the Department was conducted, from which we identified the primary data resources useful for the Department's mission, which are:

- *Financial Statements.* The National Association of Insurance Commissioners (NAIC) publishes standard forms ("blanks") for financial statement information. These include the Annual Statement (AS) for life, accident, and health insurers, which may or may not be state-specific or healthcare-specific, depending on the entity, its licensure, and its offered business lines. In 2010, the NAIC Supplemental Health Care Exhibit (SHCE) was introduced, which collects health insurance-specific financial statement information at the state level. The AS contains a balance sheet, income statement, and supporting exhibits. The income statement and supporting exhibits contain information about membership, premium revenue, investment income, claims expenses, administrative expenses, and profits.

¹ http://www.nh.gov/insurance/media/documents/nhhc_ddaward.pdf.

² Public Law 111-148

- *New Hampshire Supplemental Report.* The Supplemental Report (SR) contains a summary for each unique combination of coverage category, market type, and high-level benefit structure offered by each carrier entity in the state, and includes benefit detail, membership, premium, claims, and actuarial value. It provides a single standardized measure of the value of benefits for each combination, and so can be combined with premium information to provide adjusted, standardized price levels across carriers and over time. Premium information by itself can't provide this information owing to differences and changes in benefit levels. The SR contains information for all health insurance products in force, whether actively marketed or not, and also provides claim and premium equivalents for the self-insured population.
- *New Hampshire Comprehensive Health Information System.* The Comprehensive Health Information System (CHIS) contains detailed eligibility and claim data collected from New Hampshire health insurance carriers. The claim detail allows for detailed analysis of health insurance costs, member cost sharing amounts, utilization changes, price levels for specific services, and a variety of other important topics.
- *New Hampshire Line of Business Survey.* The line of business survey contains enrollment and premium information on all underwritten accident and health insurance, as well as other non-health lines, and includes an indicator to identify plans actively marketed during the survey period.
- *Federal Medical Loss Ratio Report.* The Medical Loss Ratio (MLR) report summarizes the ratio of medical expense to premium, and is required to identify plans violating the federally-determined minimum MLR levels. Plans spending less than the minimum required level on medical services are required to provide rebates to subscribers, which are calculated within the report.

This study addressed a number of questions related to the information the Department uses to carry out its mission, including whether data collected are specified and defined clearly, accurate, consistent, and in support of the Department's mission. The following analyses were performed:

- *Review of Required Data Sources.* The documentation for the sources cited above was reviewed in detail, and an analysis was conducted of the populations covered, and the data elements included. Discussions were convened with the four largest New Hampshire carriers, and with Department staff. A framework for visualizing the relationships between the populations was created, and identified gaps, redundancies, and other issues were documented, and recommendations for ways in which to improve the ability to use the data sources in a coordinated manner were formulated.
- *Assessment of Data Quality.* The review of data sources identified key points of conformance between the data sets, that is, those places where the measurement should agree between the sources. We identified areas where this agreement was confirmed and areas where discrepancies exist. Recommendations related to improvements in instructions for data collection and quality control procedures for data intake were developed.

- *Analysis of Applicability to Rate Review Support.* The newly revised rate review process being conducted by the Department was reviewed, and the applicability of NHID and external data sources to support the reviewer was analyzed. The applicability of the various sources to standard rate review tasks was analyzed and summarized, as were considerations in the timing of data source availability and the review process.
- *Consideration of Data Infrastructure to Support Rate Review.* In addition to the improvements in data content, improvements in the data structure and technical environment as a means of improving access to data resources was analyzed.

Key findings of the report include the following.

- *Simple steps to improve the analytical power of existing data sources.* The ability to combine data from two or more of these sources for analytical purposes can be significantly enhanced by making a relatively modest number of changes to the measures and categories included in the data collected. For example, a few minor changes to existing data sources and data integrity processes would allow annually filed financial statements to serve as an audited check on information provided in the Supplemental Report and the New Hampshire CHIS. This would in turn allow these more detailed sources to be used with more confidence in supporting review of rate filings, market conduct studies, and other important analytical tasks. The report includes specific recommendations to improve file links by adding fields and refining categories.
- *Improving data quality.* The use of data to carry out the Department's mission requires accurate data. Data comparisons across sources that are possible with currently available information were conducted and are presented. Potential issues in data accuracy suggested by discrepancies across sources are identified. Straightforward modifications to instructions for the data collection instruments/processes and specific steps taken to quality check data received from carriers can both improve data quality and clarify required reporting for carriers. Suggested instruction modifications and quality checking steps are presented.
- *Enhancing context for data interpretation.* External data and benchmarks, especially from the NAIC, can directly enhance assessment and interpretation of New Hampshire premiums, costs, trends rates, and other important measures.
- *Reducing carrier burden.* Data collection was reviewed for unnecessary duplication, complexity, and ambiguity. Recommendations for reducing these are provided. For example, modifying the methodology required for actuarial value calculations on the SR to conform with the newly-established federal methodology would eliminate the need for carriers to use a New Hampshire-only methodology.
- *Improving technical infrastructure for data handling.* Taking full advantage of the multiple data resources available requires not only improving the content of the data to make data resources linkable to each other, but also providing a technical architecture and related data

analytic resource for easy access to and manipulation of data. Recommendations to further such a resource are provided.

Implementing the recommendations contained in this report will leverage the full potential of the Department's data resources, and further its mission of promoting and protecting the public good by ensuring the existence of a safe and competitive insurance marketplace.

Report to the State of New Hampshire Insurance

Department: Analysis of Data Sources to Support Rate Review

Introduction

Improved transparency in the health insurance system is an important objective for the Department, and is a primary rationale for the Affordable Care Act (ACA) rate review grant funding this study. For this project we considered the following goals:

- Further the transparency goal of ACA,
- Enhance understanding of the NH health insurance market, its participants, and ability to assess rate filings objectively, and
- Increase the accuracy and consistency of data to enhance usability and usefulness for rate review and other important departmental activities.

We can take “transparency” to mean more than “access.” In rate review, transparency can mean providing regulators, consumers, consumer advocates, policy makers, and even the insurance industry the ability to examine the accuracy of numbers supporting rate review and insurance regulation in general. This requires access not just to end-results but to calculations, assumptions, descriptions of the origins of data, and to clear definitions of the data elements presented. The reconciliation of various sources of data about insurers’ medical costs and premiums plays a role as well.

Underlying this potentially public view into the factors driving health insurance rate increases is a more fundamental analytical “transparency”, i.e., clarity and standardization, within the Department’s processes. These processes require quality data, clear definitions, well-understood calculations, and the ability to tie various sources of information to each other. These components of the Department’s analytical support environment are by-products of the process improvement efforts outlined in this report and in other ongoing consultant work to improve the rate review process. In particular, we note that the rate review analysis infrastructure and data integration recommendations in this report, if implemented, would contribute to this environment.

Central to the practicality of any attempt to make the Department’s analytical process more “transparent” is recognizing the demand the rate review process makes on the Department’s resources. Especially as the requirements of ACA mature, the ability to organize and track rate review cases with their supporting data will be essential to efficiently processing the cases and to meeting the HIOS and other reporting requirements. An integrated data environment that supports internal processes and generates as a by-product the information necessary to meet external (initially, federal) reporting requirements, and eventually provide improved public access, will be a significant productivity enhancer.

Improvements in the current data collection process are an important component of improved transparency. While New Hampshire has an exemplary information collection process in many respects, increasing consistency between sources while paying attention to carrier burden and the reduction of redundancies can improve the system.

The scope of this project includes data sources useful for analyzing fully-insured business regulated by the Department and subject to rate review. These data sources include information on other insured blocks (for example, self-insured employers), and many of the recommendations made herein will benefit uses of the data beyond the primary scope of the analysis.

Information Sources Reviewed

Current Data Sources and Documentation

The recommendations resulting from this project stem from analysis of the following catalog of data sources, which was developed through research and verified with NHID staff.

New Hampshire Comprehensive Health Information System

The New Hampshire Comprehensive Health Information System (NHCHIS) was created through statutory authority RSA 400-A:15 I and RSA 420-G:14 and the rules and regulations for the data collection process are found in Chapter INS 4000³. Each health care carrier and health care claims processor not meeting the de minimis exemption must submit claim and membership data for all residents of NH, all members who receive services under a policy issued in NH, and all employees of employment sites physically located in New Hampshire, on a monthly or quarterly basis, with frequency determined by the number of NH covered lives. The claim detail allows for detailed analysis of health insurance costs, utilization changes, price levels for specific services, and a variety of other important topics. All of the data submissions are compiled into a database for use in understanding health care costs and utilization in NH. Additional details on tables, fields, and data elements can be found in the NH CHIS Data Dictionary applicable during the 2010 study period⁴.

Supplemental Report Data Submission

The Supplemental Report (SR) data submission contains a summary for each unique combination of coverage category, market type, and benefit structure offered by each carrier entity in the state, and includes benefit detail, membership, premium, claims, and actuarial value. It provides a single standardized measure of the value of benefits for each combination, and so can be combined with premium information to provide adjusted, standardized price levels across carriers and over time. Premium information by itself can't provide this information owing to differences and changes in benefit levels. The SR contains information for all health insurance products in force, whether actively marketed or not. The SR is collected annually and used to create a summary report which

³ http://www.gencourt.state.nh.us/rules/state_agencies/ins4000.html, accessed 11/13/2012

⁴ Current data submission requirements can be found at <https://nhchis.com/Documents/DataSubmission/NH%20Data%20Submission%20Manual.pdf>, accessed 11/13/2012

paints a picture of the NH health insurance market, both insured and self-funded, in a calendar year. Requirements for this data submission are detailed in an annual bulletin. For purposes of this project, we reference Bulletin INS No. 11-006-AB for the 2010 data submission⁵.

Line of Business Survey

The line of business (LOB) survey is conducted annually and gathers information on all underwritten accident and health insurance in New Hampshire. The primary purpose of this data collection process is to identify which health care carriers are actively marketing certain types of health care products and sharing that information with the public via the NHID web-site. Instructions for completing the LOB Survey are found within the Excel template that is distributed to carriers each year⁶.

NAIC Health Annual Statement Blank

The National Association of Insurance Commissioners (NAIC) publishes standard forms (“blanks”) for financial statement information. These include the Annual Statement for life, accident, and health insurers, which may or may not be state-specific or healthcare-specific, depending on the entity, its licensure, and its offered business lines. The NAIC Health Annual Statement (AS), as well as the annual statements for other lines, contain a balance sheet, income statement, and supporting exhibits. The income statement and supporting exhibits contain information about membership, premium revenue, investment income, claims expenses, administrative expenses, and profits. The Health AS is filed by health carriers annually by March 1st following the reporting year. The information contained in the AS presents an overall financial picture of the carrier as of December 31st of the reporting year. Instructions for completing the AS are available from the NAIC. For this project we relied on the NAIC instructions for the 2010 reporting year, printed September 2010. Although some carriers doing business in NH file a Life Annual Statement Blank instead of a Health Annual Statement Blank, we did not consider the Life Blank in the analysis for this project as the state-specific data related to health coverage was limited.

NAIC Supplemental Health Care Exhibit

Beginning in 2010, carriers are required to file the NAIC Supplemental Health Care Exhibit (SHCE) annually by April 1st. The SHCE is due one month after the AS, but should be based on the same “paid through date” for claims as the AS, and should be consistent with respect to incurred and IBNR levels. Instructions for this exhibit are included in the NAIC instructions for the Health Annual Statement Blank discussed above. This supplemental exhibit is completed at the state level and at the total legal entity level for a particular AS filing. The purpose of the SHCE is to identify the impacts of additional data elements and definitional changes to a traditional medical loss ratio calculation based on the PPACA definition of medical loss ratio. It is important to note that for a variety of reasons the Medical Loss Ratio (MLR) calculated in this exhibit is not the same MLR calculation for rebate purposes, as discussed in detail below under the section addressing required MLR reporting. Among other differences, the federal MLR reporting measure contains information

⁵ The current version can be found at http://www.nh.gov/insurance/media/bulletins/2012/documents/sup_rept_bull-2012.pdf, accessed 11/13/2012

⁶ <http://www.nh.gov/insurance/lah/documents/lobsurv.xls>, accessed 11/13/2012

from multiple years, so the MLR information in the SHCE is likely to be a better measure of the loss ratio for the reporting year a particular SHCE covers. This exhibit is also helpful in understanding the financial results reported in the AS. It could also be used to assess the carrier's allocation of administrative costs to the state level, and provide a general benchmark of administrative costs contained in rate filings against the state-level SHCE.

Additional Review of Documentation Only

The data sources described immediately above are also analyzed quantitatively in the section "Review of Instructions and Quantitative Analysis" later in this report. There were several newer sources for which data were not available in time to analyze for this report, but which have been included in the conceptual analysis of required content contained in the section "Analysis of Required Data Content." These newer sources are discussed next.

New Rate Filing Requirements

Insurance carriers selling accident and health insurance in New Hampshire are required to submit a rate filing whenever a new policy, rider, or endorsement form that affects benefits is submitted for approval or whenever there is a change in the rates applicable to a previously approved form⁷. For the individual and small group health insurance markets, new rate filing requirements⁸ became effective November 1, 2012, to increase the standardization and transparency of the rate review process. Included in the new requirements are a set of rate filing exhibits that support the proposed rates⁹. It is expected that a single set of exhibits will be provided for the corresponding market segment and legal entity. Some of the exhibits contain narrative describing the actuarial assumptions in the filing, while others contain the numerical data and formulae underlying the rates. A user guide has been developed to aid carriers in completing the exhibits and to support NHID staff in reviewing the rate filing data¹⁰.

Federal Medical Loss Ratio Reporting

Section 2718 of the Public Health Service Act and the implementing regulation 45 CFR Part 158¹¹ require a report to the Secretary of a carrier's medical loss ratio (MLR) and provision of rebates to enrollees. Since the Federal Medical Loss Ratio Reporting (MLR Report) was first required in 2012 for the 2011 reporting year, we did not include this data source in our analysis. However, this data source will be available going forward and could provide useful information to the NHID. The Federal Centers for Medicare and Medicaid (CMS) has published instructions¹² for the 2010 reporting year and provided a template¹³ for carriers to populate.

⁷ New Hampshire administrative rule Chapter Ins 4100, Part 4101.6

⁸ New Hampshire adopted administrative rule Chapter Ins 4100 on 10/22/12. Part Ins 4102 and Part Ins 4103 are specific to individual and small group.

⁹ http://www.nh.gov/insurance/legal/documents/RateFilingExhibitTemplate_v3.xltx, accessed 11/30/2012

¹⁰ http://www.nh.gov/insurance/legal/documents/user_guide-08.12.pdf, accessed 11/30/2012

¹¹ <http://www.gpo.gov/fdsys/pkg/CFR-2011-title45-vol1/xml/CFR-2011-title45-vol1-part158.xml>, accessed 11/30/2012

¹² <http://cciio.cms.gov/resources/files/mlr-annual-form-instructions051612.pdf>, accessed 12/13/2012

¹³ <http://cciio.cms.gov/resources/files/mlr-annual-form.xlsx>, accessed 12/13/2012

While many of the data elements in the MLR Report are similar to those included in the SHCE, some definitional differences exist.¹⁴ The following differences due to adjustments should also be considered. First, the SHCE reports on a single calendar year. The MLR Report, after its first year of use, will contain data combined from multiple years in the rebate calculation. Additionally, in certain situations, the premium and claims for the current reporting year may be adjusted to exclude new business and add it back in the subsequent years. Second, the MLR Report includes claim run out through March 31st of the following year to increase the accuracy of the reported incurred claims. While these incurred claim dollars may still include some reserves for incurred but not paid claims, the incurred claim levels are very likely to be somewhat different than those in the SHCE as a result of the additional runout. Third, in the case of dual-contract group health coverage, coverage provided by an affiliated issuer may be aggregated in the MLR Report so that the experience is pooled for rebate purposes. In the SHCE this experience is reported separately under the issuing legal entity. Finally, the final MLR reported in the MLR Report and used for rebate calculation purposes includes a credibility adjustment to the MLR for market segments with less than 75,000 member years, while the SHCE does not make such an adjustment. This credibility adjustment is based on the number of member years within the market segment and added on to the preliminary MLR. The adjusted MLR is then used for comparison to the MLR standard and for the subsequent rebate calculation.

Federal Actuarial Value Rules

CMS recently issued several proposed rules that will, subject to comment and revision, guide the implementation of the ACA on topics which include the approach to calculating actuarial value for policies sold inside and outside the ACA Exchanges.¹⁵ CMS has provided an actuarial value calculator, which can be used by carriers and regulators to calculate the actuarial value of non-grandfathered benefit packages offered beginning January 1, 2013. The federal actuarial value calculations are likely to become the industry standard going forward.

Carrier Discussions

As part of the project, separate meetings were conducted with each of the four carriers that have the largest market-share in New Hampshire to discuss current data reporting requirements, issues from the carriers' perspective, areas where they felt redundancies exist or there is excess burden, and the ease or difficulty of implementing specific possible changes to the reporting requirements. Carriers were represented by a variety of staff who help with the various reporting requirements, including staff from actuarial services, finance, accounting, IT, reporting, and government relations. One important result of the meetings was that in some cases the individuals responsible for the various reports had not previously consulted each other about consistency of results, and some discussion ensued which should have beneficial consequences for future reporting. Key input received during the discussions includes the following points:

¹⁴http://www.naic.org/documents/committees_e_health_reform_solveny_impact_exposure_related_doc_shc_e_preliminary_mlr_cautionary_statement.pdf, accessed 8/2/2012

¹⁵ 45 CFR Parts 147, 155, and 156, November 26, 2012.

- New Hampshire was cited as both one of the easiest states to work with for data requests, and as ahead of other states in consolidating and coordinating data collection.
- The quality of carrier data systems varies greatly, with commensurate variation in work required by the carrier to produce the reporting. We note that those carriers expressing confidence in their information systems that produced the results easily also tended to have the most consistent information across data collection processes.
- The ACA is introducing national standardization which will make it easier to comply with NH requirements in the future. For example, the establishment of national standards for actuarial value calculations and the establishment of a national plan code should improve the ability of the carriers to comply with state requirements for the same information when it is aligned with federal definitions.
- Some but not all carriers have difficulty producing the Supplemental Report, particularly the information for individuals covered by policies with situs outside New Hampshire. In particular, the premium and actuarial value data for non-New Hampshire situs are challenging (though standardization of actuarial value, cited above, may help).
- Several carriers commented that with the advent of the SHCE, the data request for the annual hearing is redundant.
- There were several comments to the effect that more standardized reporting requirements across states would make it much easier, and that past efforts to be more consistent have been helpful.
- Most carriers indicated that it would be straightforward to add policy situs state to data submission files.
- It was noted that NAIC documents are audited and thus should be the standard against which other sources are measured for items like medical expenses (allowing for differences in claim runout and IBNR estimates), and that the inclusion of items such as surcharges and incentive payments in medical expenses will make these totals larger than those provided by claim-only sources like the NHCHIS. It was noted that owing to timing differences of report submission dates, that different lengths of claim run out were used in some sources (e.g., the supplemental report) as compared to the NAIC reports. This causes some differences stemming from adjustments to incurred claim levels. Including a purpose in the instructions for data collection would allow carriers to be more compliant with intent.
- Identifying individuals who are not state residents and who are working at the New Hampshire location of an out-of-state-based employer is very difficult for carriers, and is not compliant with the X12 standard that has been developed.

The input received from the carriers was very valuable and many of the comments are reflected in the recommendations in this report.

NHID Staff Interviews

We also conducted interviews with NHID staff members, both individually and as a group, to get a better understanding of how the various data sources are currently being used, if there are any data not getting used (and why), desired uses of the data, and suggestions for improvement to the data collection and use. This input was also very valuable and is reflected in the report.

Analysis of Required Data Content

As part of reviewing the current data sources, the work was divided into two separate but related processes:

- 1.) The content of the data as defined by its documentation was evaluated. This defined “what should be true” about the data, from which we identified recommended modifications to address gaps and other issues in what the Department currently requests.
- 2.) The quality of the data as determined by its consistency with what is requested in the documentation was assessed. This defined the “what is actually true” and involved a quantitative analysis of actual submitted data, which allowed us to identify data quality issues and related recommendations about data collection instructions and data intake processes.

This section, “Analysis of Required Data Content,” addresses the first process which analyzes the required data content. The next major section, “Quantitative Analysis” addresses the quantitative analysis of the data and data quality issues.

Populations

The data contained within each data source vary from one another due to differing requirements related to the populations for whom data must be included. The requirements for the NHCHIS data submission include fully-insured and self-insured policies with situs in NH and NH residents with policies issued out of state, as well as a “bricks and mortar” requirement for employees of employment sites physically located in New Hampshire. The SR data submission requirements explicitly state that the reporting criteria are the same as that for the NHCHIS and the carrier “should confirm that they have applied the same reporting criteria to both submissions.¹⁶” The LOB Survey collects data related to underwritten policies issued and delivered in NH. Where there is state-specific data within the NAIC AS and SHCE, it is for fully-insured policies issued and delivered in NH.

The purpose or goal of the data collection will dictate the requirement for the population to be included. In order to take advantage of the available data sources, it should be possible to subset the data into the desired populations based on indicators within the data, and compare

¹⁶ Although the lines of business included in the two data sources are not identical, the populations within overlapping lines of business should be identical.

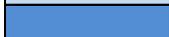
definitionally equivalent populations and measures across data sources. Some of the information needed to do so is not currently available within the data sources. Recommendations on additional identifiers that would allow such comparisons are included later in this section.

Analysis of Populations Included by Data Source

This section presents tables that have been created for each data source in an effort to visually depict what data populations are included in each of the data sources. Each cell in the table represents a subset of the population defined by a combination of:

1. whether or not the policy was issued in NH (“policy situs” in NH),
2. if the carrier is licensed in NH only, multiple states including NH, or not in NH,
3. whether or not the insured is a NH resident, and
4. line of business.

The shading of the cell indicates whether or not data for that particular subset is included in the data source. The various shades have the following meanings:

	indicates data for this subset is included in the data source
	indicates data for this subset is included and represents rate review populations in scope
	indicates data for this subset is not included in the data source
	indicates data for this subset is not separately identifiable
	not applicable, does not exist, or combination is not possible

The tables have two rows of identifiers for line of business. The bottom row is consistent between the six tables, while the top row shows the line of business in which the subset is reported in the data source if it is different from the bottom row. This is useful when two or more lines of business are grouped together when reported in the data source. The lines of business are described using two character codes with the following definitions:

DI <i>Disability Income</i>	IC <i>Individual Comprehensive</i>	OB <i>Other Business</i>
DO <i>Dental Only</i>	LG <i>Large Group</i>	OH <i>Other Health Business</i>
FH <i>Federal Employee Health Benefit Plan</i>	LT <i>Long Term Care</i>	OT <i>Other</i>
GB <i>Government Business</i>	MC <i>Medicaid Title XIX</i>	SG <i>Small Group</i>
GC <i>Group Comprehensive</i>	MD <i>Medicare Title XVIII</i>	SI <i>Self-Insured</i>
GP <i>Government Program Plans</i>	MS <i>Medicare Supplement</i>	SL <i>Stop Loss</i>
HK <i>Healthy Kids</i>	NG <i>Individual (Non-Group)</i>	UP <i>Uninsured (Self Funded) Plans</i>
		VO <i>Vision Only</i>

Numbered items in each table are discussed below the table, providing additional insight into how the data are reported.

NHCHIS Population

The NHCHIS includes data for all individuals with a policy issued in New Hampshire, New Hampshire residents with policies issued in another state, and individuals employed at an out-of-state employer’s branch location in New Hampshire (also known as “bricks and mortar” criteria).

The following issues were identified in reviewing the NHCHIS (with corresponding numbered identifiers in Table 1):

- 1.) Policy situs state is not identified in the data set, making it not possible to identify those records with a policy situs in New Hampshire, which is necessary to line up with the other data sources, such as AS and SHCE, that only include policy situs in New Hampshire.
- 2.) While carrier name is available in NHCHIS, it is not possible to identify legal entity in all cases making it difficult to compare the data to other data sources that are at legal entity level such as AS and SHCE.
- 3.) Within NHCHIS, Healthy Kids business is categorized with MKTCATCDE (market category code) equal to "OTH" and not separately identifiable except by examining the GRPNM field for values that contain "Healthy Kids". The Healthy Kids population and benefits are unique and should not be included in some analyses; therefore, it is important to be able to easily separate the data for this population.
- 4.) Medicare Supplement data is not required to be submitted, however the database contains data from some carriers. Since not all carriers are submitting Medicare Supplement data, this population is incomplete.
- 5.) Data for policies issued in another state are incomplete because carriers not licensed in New Hampshire may or may not be submitting the required data.

Table 1
NHCHIS Population

CRITERIA			LINE OF BUSINESS													
POLICY ISSUED IN NH ¹	CARRIER LICENSE ²	NH RESIDENT						OT ³								
			NG	SG	LG	SI	FH	HK	SL	MS ⁴	MD	MC	DO	VO	DI	LT
Y	NH ONLY	Y	█	█				█								
Y	MULTIPLE	Y	█	█				█								
Y	NH ONLY	N	█	█				█								
Y	MULTIPLE	N	█	█				█								
N	MULTIPLE	Y						█								
N	NON-NH ⁵	Y						█								
N	MULTIPLE	N						█								
N	NON-NH ⁵	N						█								

In addition, plan level, or benefit level, information is not sufficient in NHCHIS to allow for isolation of the data in order to tie to rate review populations. Finally, student and blanket coverage types are not separately identifiable, although they are in the SR.

Supplemental Report Population

Like NHCHIS, SR includes data for all individuals with a policy issued in New Hampshire, New Hampshire residents with a policy issued in another state, and individuals who meet the “bricks and mortar” criteria.

The following issues were identified in reviewing the SR (with corresponding numbered identifiers in Table 2):

- 1.) Data are not available to distinguish member state of residence; however, this information may not be necessary for rate review purposes.
- 2.) The Healthy Kids business is embedded in Individual business and not separately identifiable, which affects the ability to compare data for the Individual population to other data sources¹⁷.
- 3.) Stop Loss data is part of the SR data submission; however, membership, premium and claims are not reported with other health coverage lines.
- 4.) Data for policies issued in another state are incomplete because carriers not licensed in New Hampshire may or may not be submitting the required data. Unlike NHCHIS, SR data does include information allowing identification of whether or not the policy was issued in New Hampshire.

Table 2
Supplemental Report Population

CRITERIA			LINE OF BUSINESS													
POLICY ISSUED IN NH	CARRIER LICENSE	NH RESIDENT ¹	NG ²					NG ²								
			NG	SG	LG	SI	FH	HK	SL ³	MS	MD	MC	DO	VO	DI	LT
Y	NH ONLY	Y														
Y	MULTIPLE	Y														
Y	NH ONLY	N														
Y	MULTIPLE	N														
N	MULTIPLE	Y														
N	NON-NH ⁴	Y														
N	MULTIPLE	N														
N	NON-NH ⁴	N														

While SR contains some detailed benefit-level information, plan-level identification does not exist that would allow for aligning with rate review data. It should also be noted that in addition to Stop Loss, data related to student and blanket coverage types are collected but not reported with the health lines of business.

¹⁷ In 2009, Healthy Kids was included in the large group category.

LOB Survey Population

The LOB Survey includes data on underwritten accident and health policies issued in NH.

The following items were noted when reviewing the LOB Survey (with corresponding numbered identifiers in Table 3):

- 1.) The data cannot be subset by member state of residence; however, this may not be an issue for rate review purposes.
- 2.) Vision Only policies appear to be included in the 'All Other Products' category of business with other types of coverage that are not shown on the grid below (AD&D, credit disability, and others).
- 3.) Healthy Kids is reported in Group Size 50+, Managed Care, HMO for 2010 (legal entity 18975) but is not separately identifiable, which makes comparison of Large Group data difficult across data sources.

Table 3
Line of Business Survey Population

CRITERIA			LINE OF BUSINESS													
POLICY ISSUED IN NH	CARRIER LICENSE	NH RESIDENT ¹	LG ³			LG ³						OT ²				
			NG	SG	LG	SI	FH	HK	SL	MS	MD	MC	DO	VO	DI	LT
Y	NH ONLY	Y														
Y	MULTIPLE	Y														
Y	NH ONLY	N														
Y	MULTIPLE	N														
N	MULTIPLE	Y														
N	NON-NH	Y														
N	MULTIPLE	N														
N	NON-NH	N														

CMS MLR Report Population

The CMS MLR Report includes data on policies issued in New Hampshire.

The following items were noted when reviewing the MLR (with corresponding numbered identifiers in Table 4):

- 1.) The data cannot be subset by member state of residence; however, this may not be an issue for rate review purposes.
- 2.) Within the MLR data, business related to Federal Employee Health Benefit Plans (FEHBP) is embedded in the Large Group category. This can make comparison of Large Group data difficult across data sources, particularly if they do not include FEHBP.

- 3.) Other lines of business are grouped together within the MLR reporting, Government Program Plans includes Healthy Kids, Medicare Title XVIII and Medicaid Title XIX . These lines of business are not subject to the MLR requirements.
- 4.) Other Health Business includes Stop Loss, Medicare Supplement, Dental Only, Vision Only, Disability Income, and Long Term Care. These lines of business are not subject to the MLR requirements.
- 5.) The MLR Report includes a category for Self-Insured business; however, only income from fees, administrative expense, and membership data are available, no premium or claim data are reported.

**Table 4
MLR Report Population**

CRITERIA			LINE OF BUSINESS														
POLICY ISSUED IN NH	CARRIER LICENSE	NH RESIDENT ¹	NG	SG	LG ²	UP	LG ²	GP ³	OH ⁴	OH ⁴	GP ³	GP ³	OH ⁴	OH ⁴	OH ⁴	OH ⁴	
			NG	SG	LG	SI ⁵	FH	HK	SL	MS	MD	MC	DO	VO	DI	LT	
Y	NH ONLY	Y															
Y	MULTIPLE	Y															
Y	NH ONLY	N															
Y	MULTIPLE	N															
N	MULTIPLE	Y															
N	NON-NH	Y															
N	MULTIPLE	N															
N	NON-NH	N															

Health AS Exhibit of Premium, Enrollment and Utilization Population (NH State Page)

The Health AS contains many different exhibits and data elements. This table reflects data available in the Exhibit of Premium, Enrollment and Utilization for the state of New Hampshire. The exhibit includes data on policies issued in NH.

The following items were noted when reviewing the exhibit (with corresponding numbered identifiers in Table 5):

- 1.) The data cannot be subset by member state of residence; however, this may not be an issue for rate review purposes.
- 2.) Small Group and Large Group are reported together in Group Comprehensive line of business, making it impossible to separately identify the Small Group population for rate review purposes.
- 3.) Additionally, Healthy Kids is reported in Group Comprehensive (based on analysis of 2010 AS for legal entity 18975).
- 4.) The “Other” line of business includes Stop Loss, Disability Income, and Long Term Care.

**Table 5
Annual Statement Population**

CRITERIA			LINE OF BUSINESS													
POLICY ISSUED IN NH	CARRIER LICENSE	NH RESIDENT ¹	IC	GC ²	GC ²	--	FH	GC ³	OT ⁴	MS	MD	MC	DO	VO	OT ⁴	OT ⁴
			NG	SG	LG	SI	FH	HK	SL	MS	MD	MC	DO	VO	DI	LT
Y	NH ONLY	Y														
Y	MULTIPLE	Y														
Y	NH ONLY	N														
Y	MULTIPLE	N														
N	MULTIPLE	Y														
N	NON-NH	Y														
N	MULTIPLE	N														
N	NON-NH	N														

SHCE Population (New Hampshire Exhibit)

Like the AS, the SHCE includes data on policies issued in NH.

The following items were noted when reviewing the SHCE (with corresponding numbered identifiers in Table 6):

- 1.) The data cannot be subset by member state of residence; however, this may not be an issue for rate review purposes.
- 2.) Business related to Federal Employee Health Benefit Plans is embedded in the Large Group category. This can make comparison of Large Group data difficult across data sources.
- 3.) The data cannot be subset by member state of residence; however, this may not be an issue for rate review purposes.
- 4.) Business related to Federal Employee Health Benefit Plans is embedded in the Large Group category. This can make comparison of Large Group data difficult across data sources.
- 5.) The “Government Business” category in SHCE includes Healthy Kids, Medicare Title XVIII and Medicaid Title XIX.
- 6.) The “Other Business” category includes Medicare Supplement.
- 7.) The “Other Health” category includes Stop Loss, Dental Only, Vision Only, Disability Income, and Long Term Care.
- 8.) SHCE includes a category for Self-Insured business; however, only income from fees, administrative expense, and membership data are available. No premium or claim data are reported.

**Table 6
Supplemental Health Care Exhibit Population**

CRITERIA			LINE OF BUSINESS														
POLICY ISSUED IN NH	CARRIER LICENSE	NH RESIDENT ¹	NG	SG	LG ²	UP	LG ²	GB ³	OH ⁵	OB ⁴	GB ³	GB ³	OH ⁵	OH ⁵	OH ⁵	OH ⁵	
			NG	SG	LG	SI ⁶	FH	HK	SL	MS	MD	MC	DO	VO	DI	LT	
Y	NH ONLY	Y															
Y	MULTIPLE	Y															
Y	NH ONLY	N															
Y	MULTIPLE	N															
N	MULTIPLE	Y															
N	NON-NH	Y															
N	MULTIPLE	N															
N	NON-NH	N															

Data Elements by Data Source

Each data source has its own purpose, which in turn drives the particular data elements collected. Table 7 below shows at a high level the various data elements included in each data source. This table provides a starting point to identify areas of data collection that may be redundant and also

areas where the data may be lacking. Even if data sources contain the same data elements, other differences, such as population definitions and timing of reporting, may exist. Furthermore, cross-checking key data elements, such as membership, provides a means of quality-testing the data submissions.

Appendix A displays a detailed guide to finding, calculating, and comparing data elements between data sources.

**Table 7
Available Data Types by Source**

DATA ELEMENT	DATA SOURCE						NOTES
	NHCHIS	SR	LOB	AS	SHCE	MLR	
Member Months	By Member	By unique high-level benefit structure	By Segment and Product	By Segment (but not SG/LG)	By Segment	By Segment	LOB Survey includes Subscribers and Covered Lives as of 12/31 of the reporting year (a snapshot instead of a count of member months throughout the year).
Fully Insured vs. Self Insured	Y	Y	FI only	FI only	Y*	Y*	NHCHIS began requiring an FI/SI indicator in 2010, not able to separate FI/SI prior to 2010. * Some information related to self-insured plans is available in the SHCE and MLR, however premium and claims are not included for self-insured.
Carrier Paid Claims	Line Item Detail	By unique high-level benefit structure	N	By Segment (but not SG/LG)	By Segment *	By Segment *	"Claims" may be defined differently by source. NHCHIS contains raw claims; Other sources contain incurred claims. * Claims are not reported for self-insured plans.
Allowed Claims	Line Item Detail	N	N	N	N	N	Can be calculated in NHCHIS, not a specific field.
Product Detail	Y	Y	Y	N	N	N	HMO, POS, PPO, etc.
Benefit Detail	N	By unique high-level benefit structure	N	N	N	N	
Premium	N	By unique high-level benefit structure	By Segment and Product	By Segment (but not SG/LG)	By Segment *	By Segment *	"Premium" may be defined differently by source and is discussed later in this report. * "Income from fees" is reported for self-insured plans.
Administrative Expenses	N	N	N	Total Legal Entity	By Segment	By Segment	
Profit	N	N	N	Total Legal Entity	Total State	Total State	

NHCHIS: *New Hampshire Comprehensive Health Care Information System database*
 SR: *NHID Supplemental Report data submission*
 LOB: *NHID Line of Business Survey*
 AS: *NAIC Health Company Annual Statutory Financial Statement (Orange Blank)*
 SHCE: *NAIC Supplemental Health Care Exhibit*
 MLR: *CMS Medical Loss Ratio Reporting*

Recommendation Set 1: Filling Gaps in Data Collection

Several places have been identified within the data sources where additional information would make the data easier to use, more useful, or provide information related to the Affordable Care Act. Changes related to the carrier rate filings have been addressed by a separate project. The NAIC data sources are not within the NHID's scope of authority therefore no changes have been recommended to NAIC data sources. Additionally, no "gaps" were identified within the LOB Survey, however we do make one definitional recommendation and one general recommendation related to the instructions.

NHCHIS

After reviewing the data documentation and obtaining input from the carriers and the Department, we make the following recommendations for the NHCHIS.

- Rethink composition of the "Use Flag" field. The current codes are not mutually exclusive – a particular member could fall into two or more categories but only one code is assigned. For example, members who are coded with USEFLAG = 9 (non-NH zip) but who would also be USEFLAG = 4 (Age 65+) are coded with 9, resulting in attempts to screen out persons over 65 by selecting USEFLAG =4 leaving some 65+ persons in the sample.
- Enforce referential integrity between eligibility and claim records, so that all member IDs on claims have a matching membership record with eligibility on the date of service.
- Add an indicator for policy situs state to the eligibility tables.¹⁸ This will allow the user to subset the data for NH-issued policies and align the data with rate filings and the SHCE, both of which only include policies issued under a New Hampshire license.
- Add a field for the "Plan Code" identifier used in rate filings to the membership tables. Note that this field may not be available for all market segments, so an option of "N/A" should be included. Benefit detail does not currently exist in NHCHIS. Adding the "Plan Code" would allow the user to align claims and membership with the level of detail included in the individual and small group rate filings, making analysis at a detailed benefit level possible. This could be helpful for assessing actuarial values.
- Add a field for the federally required Product ID to the membership tables. Note that this field may not be available for all market segments, so an option of "N/A" should be included. This would allow data to be grouped consistently with the benefit level reported at the federal level. This would also be helpful in performing benefit analysis.
- Add a single categorical indicator to identify Healthy Kids, Federal, State, or Municipal to the membership records. If possible to include FEHBP data in NHCHIS, include FEHBP in this indicator. This indicator should be consistent with the "State, Federal, or Municipal Account" indicator in Supplemental Report (discussed below). These populations are unique and for some analyses should not be included.

¹⁸ For this recommendation and others which recommend adding fields to the membership records, the field should be added to claim records if the referential integrity noted in the first recommendation can't be achieved.

- Add fields for NAIC Company Code and NAIC Group Code to allow for better identification of the legal entity. This would allow for comparison of NHCHIS members and claims to the SR, AS, SHCE, and rate filings.
- Add an indicator of whether policy was sold in or out of the exchange to the claim and membership tables. Operation of the exchange environment begins in 2014. The ‘Exchange versus non-exchange’ field will allow users to distinguish between plan designs that are required to meet requirements of the Exchange versus those plans that are not required to meet Exchange requirements.
- Add a field to indicate grandfathered versus non-grandfathered plan status to the claim and membership tables. The ‘grandfathered versus non-grandfathered’ field will allow users to distinguish plan designs that are affected by market reform and those that are not, along with allowing the user to identify plans that the reinsurance and risk adjustment programs apply to.
- Add a tobacco use flag to the membership table for the individual market segment. Currently in NH, smoking status is an allowable case characteristic in the individual market (but not in the small group market), thus rates may differ in the individual market based on smoking status, but not in the small group market. Tobacco use is an allowed rating factor for individual and small employer groups under the ACA health insurance market reforms. Including this flag would allow analysis related to this rating classification to the extent that it is collected by the carriers.
- Add a field for renewal month to the membership table. This would enable checking the impacted membership included in the small group and individual rate filings. It would also assist with quantifying the impact of mandates or other benefit changes if they are implemented on renewal.
- Add a field for the policy first effective date to the membership table. This would allow the user to perform durational studies.
- Consider dropping the requirement for including information for the “Bricks and Mortar” population of individuals who are not New Hampshire residents and not covered by New Hampshire policies, but physically work in New Hampshire. This provision is difficult for carriers to comply with accurately, and even when complied with and accurate, it is incomplete because it only covers carriers offering policies in New Hampshire.

Supplemental Report

After reviewing the data documentation and obtaining input from the carriers and the Department, we make the following recommendations for the SR.

- Modify the “State, Federal, or Municipal Account” field to include an indicator for Healthy Kids. This indicator should be consistent with indicator in NHCHIS (recommended above). The Healthy Kids population and the benefits are unique, and should not be included in some analyses, so separately identifying them allows that segregation.
- Add a field for Member Responsibility. Member Responsibility shall be defined as the total amount of deductibles, coinsurance amounts, and copayments for which member is responsible on the claims which are included in the “Total Claims” field. This would enable the user to

calculate allowed trends and analyze the change in total cost of health care, not just the insurer responsibility.

- Separate the ‘Total Claims’ into three columns: 1) claims incurred and paid, 2) claims incurred and unpaid, and 3) other payments (such as capitation, incentive payments, etc.). The sum of the three claim components should be consistent with the amount on line 16 of the Statement of Revenue and Expenses (if filing an NAIC Health blank) or line 1.1 of Exhibit 8, Part 2 (if filing an NAIC Life blank). The first column, claims incurred and paid, should tie to the claims in NHCHIS.
- Add a field for the federally required Product ID. Note that this field may not be available for all market segments, so an option of “N/A” should be included.
- Add a field for the “Plan Code” identifier used in rate filings. Note that this field may not be available for all market segments, so an option of “N/A” should be included. Adding the “Plan Code” would allow the user to align claims and membership with the level of detail included in the individual and small group rate filings, making use of the detailed benefit level information already reported. This information could be helpful for assessing actuarial values.
- Update benefit design schemes in the SR to be consistent with those in new rate filings. Relative to the scheme currently in place in the SR, the benefit detail included in the new individual and small group rate filing requirements provides better focus on the benefit components that are likely to have a material cost impact. Aligning the benefit detail scheme in the SR with the scheme used in the rate filings will allow analysis of plan relativity factors that are reported in the rate filings and used to develop rates for each unique plan design.
- Add an indicator of whether policy was sold in or out of the exchange. Operation of the exchange environment begins in 2014. The ‘Exchange versus non-exchange’ field will allow users to distinguish between plan designs that are required to meet requirements of the Exchange versus those plans that are not required to meet Exchange requirements.
- Add a field to indicate grandfathered versus non-grandfathered plan status. The ‘grandfathered versus non-grandfathered’ field will allow users to distinguish plan designs that are affected by market reform and those that are not, along with allowing the user to identify plans that the reinsurance and risk adjustment programs apply to.
- Remove “GSA” value from “Market Category Code” field. Currently, this value should represent “policies sold and issued directly to small employers through a qualified association trust”; however, this information can also be determined from the “Qualified Association Trust” field (which contains values of “Y” or “N”), leaving the “Market Category Code” field to more clearly describe the market category into which the data falls. This change should also improve the data quality and consistency. In 2010 some of the data records with a “Market Category Code” of “GSA” had a “Qualified Association Trust” value of “N,” which is conflicting information. Removing the “GSA” value from the “Market Category Code” will eliminate the opportunity for conflicting information without the loss of any important data.
- Replace NH-defined actuarial value with federally-defined actuarial value. The actuarial value calculation within the SR should be formulated to be in line with recently published federal guidelines¹⁹.

¹⁹ 45 CFR Parts 147, 155, and 156, November 26, 2012.

- Consider dropping the requirement for including information for the “Bricks and Mortar” population of individuals who are not New Hampshire residents and not covered by New Hampshire policies, but physically work in New Hampshire. This provision is difficult for carriers to comply with accurately, and even when complied with and accurate, it is incomplete because it only covers carriers offering policies in New Hampshire.

Another issue raised by carriers regarding the SR is the data required for New Hampshire residents covered by policies with situs outside New Hampshire. These data are captured (incompletely, owing to non-New Hampshire carriers providing some of the coverage) in the NHCHIS, and also in the SR, maintaining the parallel populations of the two data resources. Carriers are generally able to select claims to capture this population using the member address. However, the premium and actuarial value data are more difficult to capture for some carriers because their billing systems organize data by employer and do not easily link to members. Given that arguments on both sides of this issue have merit, we recommend that the Department consider this issue further.

Line of Business Survey

It is unclear whether the premium reported in the LOB is direct or net of reinsurance as the 2010 instructions appear to be contradictory and confusing. The 2010 instructions state that premium is “to be calculated as prescribed for the carrier’s Statement of Revenue and Expenses, or its equivalent, which is a required component of the annual statement filing. For carriers filing the NAIC’s blanks, premium shall be calculated in a manner consistent with the amount reported on Schedule T.”²⁰ The Statement of Revenue and Expenses in the NAIC Annual Statement reports premium net of reinsurance. Further, the instructions for the AS state that the premium in the Statement of Revenue and Expenses should tie to the premium reported in the Underwriting and Investment Exhibit, Part 1, Line 12, Column 4, which is the direct premium plus reinsurance assumed less reinsurance ceded. Conversely, the AS instructions state that the premiums reported in Schedule T are gross of reinsurance and the total premiums should tie to the total premium reported in the Underwriting and Investment Exhibit, Part 1, Line 12, Column 1, which is the direct premium. It is important to note that the premium definition in the 2011 LOB instructions has been modified and now simply states “Premium should be reported based on policies issued or delivered in NH.”²¹ While this change removes the contradictory statements, it does not provide a level of instruction that would result in consistency between carriers when reporting premium. The Department may want to reconsider the instructions in the LOB template for the reporting of premium. If these instructions are made more clear, specifically indicating whether to report on a direct or net of reinsurance basis, these data made be used as an additional source in the triangulation described in the “Recommendation Set 2” later in this report.

The LOB includes a section titled “Questionnaire” which includes information related to certain types of policies such as association and franchise plans. We are unable to determine from the instructions if the information contained in the responses to these questions is a subset of the data

²⁰ <http://www.nh.gov/insurance/lah/documents/lobsurv.xls>, accessed 11/13/2012

²¹ http://www.nh.gov/insurance/media/bulletins/2012/documents/2011_lobsurvey.xls, accessed 11/13/2012

contained above in the product-level detail or if this information is in addition to the data above. The Department should consider clarifying the relationship between the data in these two portions of the survey.

Timing

One challenge in comparing enrollment, claim, or premium data from rate filings to various data sources is the difference in timing of availability and difference in the time period of the data (such as incurred period and paid through period for claims) caused by different submission dates and reporting requirements. Therefore it may not be possible to get an exact match between sources; however there should be an ability to perform some basic reasonability checks on enrollment, claims, and premium. For example, the NAIC annual statement claim data reflects calendar year paid claims as of December 31, adjusted for change in incurred but not paid (IBNP) claims.

Table 8
Timing of Data Sources

Data Source	Frequency of Updates	Incurred Period	Paid through Date	Date Submitted	Date Available to Use	"Incurred" Notes
NAIC Annual Statement	Annual	Jan - Dec	Dec	Mar	Mar	incurred includes paid in the calendar year plus change in IBNP (IBNP at end of calendar year just ended minus IBNP at end of prior calendar year)
NAIC Supplemental Health Care Exhibit	Annual	Jan - Dec	Dec	Apr	Apr	incurred includes paid in the calendar year plus change in IBNP (IBNP at end of calendar year just ended minus IBNP at end of prior calendar year)
NHCHIS	Quarterly	flexible, through paid month	Dec Mar Jun Sep	Jan Apr Jul Oct	May Aug Nov Feb	no IBNP included in NHCHIS; data needs to be completed for runout by user
NHID Supplemental Report	Annual	Jan - Dec	flexible	Jul	Nov	amount of paid claim runout is not specified, however carriers are instructed to use actuarial completion factors based on when the carrier extracts the data
Small Group Rate Filing	Typically Quarterly	Jan - Dec historical; base period used in projection is flexible	flexible	typical: Mar Jun Sep Dec	NHID upon submission; public after rate effective date	Defined in NHCAR Part INS Chapter 4100 and consistent with the incurred claims used in the federal medical loss ratio calculation
Individual Rate Filing	Typically Annual	Jan - Dec historical; base period used in projection is flexible	flexible	flexible	NHID upon submission; public after rate effective date	Defined in NHCAR Part INS Chapter 4100 and consistent with the incurred claims used in the federal medical loss ratio calculation

The Supplemental Report also reports calendar year claims data, however, since it does not have to be submitted until July, the claims may reflect paid claim runout through as late as June 30, adjusted for IBNP. Therefore there may not be an exact match of the claims, but they should be within a reasonable tolerance. Small group and individual rate filings must include historical calendar year claims, premium, and membership, specific to NH. However the experience period used in the projection of claims is up to the discretion of the actuary preparing the filing. The NHCHIS claim data is updated quarterly, but contains no provision for IBNP, so the user must make an appropriate adjustment to complete the claims if comparing to incurred claims from another source. Table 8 below summarizes and compares the timing of the data sources one might use to triangulate key components of a rate filing to ensure consistency and reasonability of assumptions.

Non-Medical Expense Items

In addition to membership, premium, and medical expense information, the SHCE includes non-medical expense information that is reported separately for Individual, Small Group, and Large Group. This provides additional transparency not found in the AS, where expenses are reported in total for the carrier. There is a lot of detail around expenses related to improving health care quality. Other expenses reported include claims adjustment expenses, direct sales salaries and benefits, agents and brokers fees and commissions, taxes, and other general and administrative expenses.

Several other items are reported in total, not separately for Individual, Small Group, and Large Group. These items include income from fees of uninsured plans, net investment and other gain(loss), and federal income taxes.

Other data sources considered in this project (NHCHIS, SR, LOB) do not include information related to non-medical expense items. A quantitative assessment of the SHCE, and of the other data sources, follows.

Quantitative Assessment of Data Collected

As noted previously, the work was divided into two separate but related processes:

- 1.) The content of the data as defined by its documentation was evaluated. This defined “what should be true” about the data, from which we identified recommended modifications to address gaps and other issues in what the Department currently requests.
- 2.) The quality of the data as determined by its consistency with what is requested in the documentation was assessed. This defined the “what is actually true” and involved a quantitative analysis of actual submitted data, which allowed us to identify data quality issues, and related recommendations about data collection instructions and data intake processes.

This section addresses the second process assessing the quality of the data collected through quantitative analysis.

Analyzing What Does, and Does Not, Agree that Should Agree

Given what we have discussed above in our conceptual assessment of the various data sources we looked at the data quantitatively to see if what we thought should agree actually does. For this analysis we considered the populations currently subject to rate review, Individual (NG) and Small Group (SG), for the top four carriers in NH. Locations within each data source of the specific data elements being compared, and the method for calculating specific measures from the sources, can be found in Appendix A.

While it is important to look at the variances in the values across data sources, it is also just as important, if not more so, to consider the relationships between the data elements and how the variances impact those results. For example, if the member months in one data source are lower than the member months in another data source but the claims vary between the data sources by the same percentage as the member months, then the resulting per member per month (PMPM) claim costs will be comparable. Conversely, if premium is higher in one data source and claims are lower, then the resulting loss ratios (claims/premium) will have a greater variance.

Comparing Membership for the Rate Regulation (NG and SG) Population

Member month information is available in the NHCHIS, SR, and SHCE. Based on the reporting requirements for each of the data sources, we would expect the member months in the NHCHIS and the SR²² to be very similar. Also, we expect to find similar results in the SHCE and the SR if we limit the SR to policies issues in the state of NH.

Table 9 shows the member months across the various data sources for each of the major carriers.²³ While none of the data sources match the others exactly, many of the variances are within a reasonable tolerance. In the Individual line of business we find a large variance for Harvard Pilgrim. This is due to the categorization of the Healthy Kids block of business as Individual in the SR. This variance is also seen below when we compare premium and claims. It is important to note that while we learned through research that Healthy Kids was causing the difference, the Healthy Kids data is not separately identifiable in the SR at this time.

²² For purposes of the comparisons in this report data associated with a Market Category Code of “GSA” in the SR data has been categorized as “Small Group”. This treatment varies from the results in the published Supplemental Report, which categorizes “GSA” as “Large Group”.

²³ The SHCE defines Small Group as “groups with up to 100 employees, except in states exercising an option under PPACA Section 1304(b)(3) to define small group as groups up to 50 employees until 2016.” We are assuming Small Group in NH is up to 50 employees based on the definition in RSA 420-G:2 (<http://nhrsa.org/law/420-g-2-definitions/>).

**Table 9
Comparison of Member Months across Data Sources**

INDIVIDUAL MEMBER MONTHS	LEGAL ENTITY	WOULD EXPECT THESE TO BE SIMILAR		WOULD EXPECT THESE TO BE SIMILAR	
		NHCHIS	SR ALL	SR NH ONLY	SHCE
<i>Anthem-NH</i>	53759		276,460	276,460	277,039
<i>Anthem-NH Matthew Thornton</i>	95527		-	-	-
Anthem		278,536	276,460	276,460	277,039
<i>Harvard Pilgrim Health Care Insurance Company</i>	18975		109,826	109,826	-
<i>Harvard Pilgrim Health Care New England</i>	96717		1,546	730	612
<i>Harvard Pilgrim Health Care</i>	96911		-	-	-
Harvard Pilgrim		1,110	111,372	110,556	612
<i>Conn Gen Life Ins</i>	62308		-	-	32
<i>Cigna</i>	95493		886	886	870
<i>Great West</i>	68322		-	-	-
Cigna		-	886	886	902
<i>MVP</i>	10135		956	956	-
<i>MVP</i>	10141		-	-	-
MVP		-	956	956	-

SMALL GROUP MEMBER MONTHS	LEGAL ENTITY	WOULD EXPECT THESE TO BE SIMILAR		WOULD EXPECT THESE TO BE SIMILAR	
		NHCHIS	SR ALL	SR NH ONLY	SHCE
<i>Anthem-NH</i>	53759		159,632	159,569	155,661
<i>Anthem-NH Matthew Thornton</i>	95527		625,968	625,871	619,237
Anthem		656,190	785,600	785,440	774,898
<i>Harvard Pilgrim Health Care Insurance Company</i>	18975		62,473	57,538	56,367
<i>Harvard Pilgrim Health Care New England</i>	96717		205,723	200,731	206,515
<i>Harvard Pilgrim Health Care</i>	96911		62,488	1,921	-
Harvard Pilgrim		337,573	330,684	260,190	262,882
<i>Conn Gen Life Ins</i>	62308		12,557	12,345	12,377
<i>Cigna</i>	95493		3,362	3,362	3,114
<i>Great West</i>	68322		-	-	-
Cigna		16,022	15,919	15,707	15,491
<i>MVP</i>	10135		212,760	212,760	211,374
<i>MVP</i>	10141		592	592	598
MVP		202,737	213,352	213,352	211,972

Comparing Premium for the Rate Regulation (NG and SG) Population

For the premium comparison we do not have data from NHCHIS since premium is not collected. We expect the data from the SR for policies issued in NH to be reasonably similar to the SHCE. Given the contradictory statements within the LOB instructions discussed earlier in the report, we cannot state with certainty whether the premium in the LOB is gross or net of reinsurance; however, we have included the data in Table 10 below for comparison purposes. Also, we have not included any data from the “Questionnaire” section of the LOB so data related to association business may or may not be included in this comparison. As we see in Table 10 below, the Small Group premium from LOB is exactly the same as the Small Group premium from SHCE in the case of Cigna and MVP.

Table 10
Comparison of Premium across Data Sources

INDIVIDUAL PREMIUM	LEGAL		WOULD EXPECT THESE TO BE SIMILAR		LOB
	ENTITY	SR ALL	SR NH ONLY	SHCE	
<i>Anthem-NH</i>	53759	81,907,294	81,907,294	81,696,065	81,956,549
<i>Anthem-NH Matthew Thornton</i>	95527	-	-	-	-
Anthem		81,907,294	81,907,294	81,696,065	81,956,549
<i>Harvard Pilgrim Health Care Insurance Company</i>	18975	18,856,134	18,856,134	-	-
<i>Harvard Pilgrim Health Care New England</i>	96717	1,016,624	328,876	611,219	610,097
<i>Harvard Pilgrim Health Care</i>	96911	-	-	-	-
Harvard Pilgrim		19,872,759	19,185,010	611,219	610,097
<i>Conn Gen Life Ins</i>	62308	-	-	7,181	7,181
<i>Cigna</i>	95493	209,068	209,068	203,446	-
<i>Great West</i>	68322	-	-	-	-
Cigna		209,068	209,068	210,627	7,181
<i>MVP</i>	10135	433,597	433,597	-	-
<i>MVP</i>	10141	-	-	-	-
MVP		433,597	433,597	-	-

SMALL GROUP PREMIUM	LEGAL		WOULD EXPECT THESE TO BE SIMILAR		LOB
	ENTITY	SR ALL	SR NH ONLY	SHCE	
<i>Anthem-NH</i>	53759	66,238,201	66,209,635	65,847,380	45,771,766
<i>Anthem-NH Matthew Thornton</i>	95527	257,241,884	257,206,118	253,766,277	200,953,533
Anthem		323,480,085	323,415,753	319,613,657	246,725,299
<i>Harvard Pilgrim Health Care Insurance Company</i>	18975	24,934,707	23,118,783	23,654,406	23,641,427
<i>Harvard Pilgrim Health Care New England</i>	96717	84,656,950	82,732,799	83,250,682	85,194,041
<i>Harvard Pilgrim Health Care</i>	96911	26,106,237	802,555	-	-
Harvard Pilgrim		135,697,893	106,654,137	106,905,088	108,835,468
<i>Conn Gen Life Ins</i>	62308	5,820,087	5,721,696	5,752,422	5,752,422
<i>Cigna</i>	95493	1,841,223	1,841,223	1,688,350	1,688,350
<i>Great West</i>	68322	-	-	-	-
Cigna		7,661,310	7,562,920	7,440,772	7,440,772
<i>MVP</i>	10135	79,361,593	79,361,593	77,321,299	77,321,300
<i>MVP</i>	10141	288,453	288,453	422,526	422,526
MVP		79,650,046	79,650,046	77,743,825	77,743,826

Comparing Claims in the Rate Regulation (NG and SG) Population

While claim data are available in NHCHIS it is difficult to compare it to the other data sources for a couple of reasons. First, the claim data included in NHCHIS is “raw” claim data, meaning it is only claim amounts that are recorded on claim records as paid amounts. Claims in the other data sources are calculated as claims paid plus the change in reserve. As a result, the other sources may include restatements to IBNP for prior periods. Also, they include other payments made such as capitation, incentive payments, and surcharges that are not captured in the NHCHIS “raw” claim data. For this reason, we would expect to see higher claim dollars reported in SR and SHCE than in NHCHIS.

The second difficulty with comparing NHCHIS claims to other sources is that the information needed to subset the claim data in NHCHIS by line of business (field name “MKTCATCDE”) is not available on the claim table. It is, however, on the membership table. By joining the claim table to the membership table we should be able to pull in the MKTCATCDE and subset the claims appropriately. However, when joining claims to membership using the recommended joining methodology, many of the claim records dropped because a match was not found on the membership table.

Of the claims available in the data sources, we would expect the data from the SR for policies issued in NH to be similar to the SHCE on a direct basis. We would expect claims in SR and SHCE to be larger than claims in NHCHIS because of the inclusion of additional paid amounts that are not attached to specific claim records. For the rate review populations shown below in Table 11, this appears to be the case except for Harvard Pilgrim. Because of the challenges described above in working with the NHCHIS data we are not able to explain why this is so at this time.

Comparing Data for Other Populations not Subject to Rate Review

In addition to looking at the rate review populations, we looked at the total fully-insured commercial major medical (including Individual, Small Group, and Large Group) member months across data sources for the top four carriers in NH. This comparison is displayed in Table 12. The way certain blocks of business (Federal Employee Health Benefit Plans and Healthy Kids) are categorized in the SHCE caused variances when comparing to other data sources.

The Anthem SHCE member month value includes FEHBP since that block of business is reported as “Large Group” in this particular data source but is not included in the other data sources. From the AS Exhibit of Premium, Enrollment, and Utilization we find that FEHBP member months are 417,707 for 2010. Subtracting this amount from the SHCE value we get 1,614,550 which is more in line with the other data sources.

The Harvard Pilgrim member months reported in NHCHIS and SR include the Healthy Kids block of business. The SHCE member months shown in Table 12 below do not include Healthy Kids as the value shown is a sum of Individual, Small Group, and Large Group and Healthy Kids is reported as “Government Business (excluded by statute)” in the SHCE. Assuming all of the member months reported as “Government Business (excluded by statute)” in the SHCE are Healthy Kids, we see 109,826 additional member months. (Note that this value is consistent with what was reported in the SR as Individual business for legal entity 18975.) Adding these member months to the Individual, Small Group, and Large Group member months from the SHCE we get a total value of 929,899 for comparison to the other data sources.

Table 11
Comparison of Claims across Data Sources

INDIVIDUAL CLAIMS	LEGAL			WOULD EXPECT THESE TO BE SIMILAR	
	ENTITY	NHCHIS *	SR ALL	SR NH ONLY	SHCE
Anthem-NH	53759		50,874,256	50,874,256	50,296,082
Anthem-NH Matthew Thornton	95527		-	-	-
Anthem		50,137,826	50,874,256	50,874,256	50,296,082
Harvard Pilgrim Health Care Insurance Company	18975		17,038,486	17,038,486	-
Harvard Pilgrim Health Care New England	96717		963,176	435,604	578,815
Harvard Pilgrim Health Care	96911		-	-	-
Harvard Pilgrim		606,266	18,001,662	17,474,090	578,815
Conn Gen Life Ins	62308		-	-	6,082
Cigna	95493		645,032	645,032	572,080
Great West	68322		-	-	-
Cigna		-	645,032	645,032	578,162
MVP	10135		732,556	732,556	-
MVP	10141		-	-	-
MVP		-	732,556	732,556	-

SMALL GROUP CLAIMS	LEGAL			WOULD EXPECT THESE TO BE SIMILAR	
	ENTITY	NHCHIS *	SR ALL	SR NH ONLY	SHCE
Anthem-NH	53759		56,856,261	56,823,673	54,885,532
Anthem-NH Matthew Thornton	95527		212,822,745	212,789,354	208,959,572
Anthem		217,790,847	269,679,005	269,613,027	263,845,104
Harvard Pilgrim Health Care Insurance Company	18975		24,899,701	21,647,773	21,399,568
Harvard Pilgrim Health Care New England	96717		79,179,879	77,896,319	79,108,638
Harvard Pilgrim Health Care	96911		19,304,605	521,445	-
Harvard Pilgrim		110,928,304	123,384,185	100,065,537	100,508,206
Conn Gen Life Ins	62308		6,136,108	6,015,060	6,769,358
Cigna	95493		1,856,344	1,856,344	1,277,323
Great West	68322		-	-	-
Cigna		7,493,372	7,992,452	7,871,403	8,046,681
MVP	10135		76,130,957	76,130,957	76,302,683
MVP	10141		215,775	215,775	210,342
MVP		69,253,387	76,346,732	76,346,732	76,513,025

* The MKTCATCDE field which is used to determine Individual or Small Group is not available on the claim tables in NHCHIS. In order to categorize the claims by MKTCATCDE the claims must be joined to the eligibility records. In performing this join we found claim records that did not join to the eligibility records and were therefore excluded from the amounts above. We are unable to determine if any of these claim records should be included in this comparison.

Table 12

Comparison of Fully-Insured Commercial Major Medical Member Months across Data

FULLY INSURED COMMERCIAL MAJOR MEDICAL * MEMBER MONTHS	LEGAL ENTITY	WOULD EXPECT THESE TO BE SIMILAR		WOULD EXPECT THESE TO BE SIMILAR	
		NHCHIS	SR ALL	SR NH ONLY	SHCE
		<i>Anthem-NH</i>	53759		644,504
<i>Anthem-NH Matthew Thornton</i>	95527		966,400	961,970	969,390
Anthem		1,666,332	1,610,904	1,606,411	2,032,257
<i>Harvard Pilgrim Health Care Insurance Company</i>	18975		329,170	295,147	219,435
<i>Harvard Pilgrim Health Care New England</i>	96717		600,564	569,514	600,638
<i>Harvard Pilgrim Health Care</i>	96911		177,933	6,118	-
Harvard Pilgrim		1,105,463	1,107,667	870,779	820,073
<i>Conn Gen Life Ins</i>	62308		302,986	159,949	234,693
<i>Cigna</i>	95493		5,470	5,227	5,467
<i>Great West</i>	68322		328	-	-
Cigna		305,258	308,784	165,176	240,160
<i>MVP</i>	10135		310,780	310,780	311,056
<i>MVP</i>	10141		592	592	598
MVP		301,719	311,372	311,372	311,654

Sources * SHCE data is the sum of Individual, Small Group, and Large Group (which includes FEHBP) categories

Annual Statement and the Supplemental Health Care Exhibit: Revenues, Claims, and Non-Claims Expenses

As discussed above, the NAIC statements (AS and SHCE) contain financial statement and supporting data. These financial statement data include membership, claims, and premium, but also include other non-claim expenses and other revenues, primarily investment income. All these categories of information also have value in rate review and other market monitoring functions.

The SHCE was first required for the 2010 reporting year. In an effort to better understand the data contained in the exhibit we compared some of the data elements to data in other exhibits in the AS where we felt they should line up. Due to the small amount of state-specific data in the AS we limited the comparison to legal entities with only NH-issued business. This allowed us to compare the NH page of the SHCE to the AS.

The data elements we looked at for comparison include Total Revenue, Medical Expense, Other Expenses, Underwriting Gain/Loss (as reported on Page 7 Analysis of Operations by Line of Business), and Total Member Months. References and formulas for each of the data elements can be found in the table at the top of Appendix B. We compared in total and for a subset including Comprehensive Major Medical and FEHBP lines of business. We needed to include the FEHBP line of business in the comparison because it is part of the “Large Group” category on the SHCE.

Results of the comparisons can be found in Appendix B. A “Y” indicates that the data elements matched as expected, while “N” indicates they did not. Where possible, we have identified what is

driving any variance from the expected result. If no explanation is provided, we were unable to uncover the driver of the variance with the data on hand.

Given that this was the first time this exhibit was required, variances may exist due to lack of clarity in the instructions or carriers' different interpretations of the instructions. Some variances may be caused by underlying business reasons, which are not evident in the data provided and may lead to different comparisons than those conducted here. It is also possible that the data quality is simply poor.

As a next step, it would be useful to compare the data elements for the 2011 reporting year (noting that some of the data references may have changed with the updated instructions) to see if the same variances emerge. Additionally, one could work directly with the carriers to learn why the variances exist.

Recommendation Set 2: Changes to Instructions and Data Quality Checks

From a broader perspective, to ensure data quality we recommend triangulation of data, within a reasonable tolerance, between the Supplemental Report, Supplemental Health Care Exhibit, and NHCHIS. The SHCE, if determined to agree with the audited Annual Statement from which it is derived, should serve as the baseline against which the NHCHIS and SR data can be compared. Some of these comparisons could only be made if our recommended changes/additions are implemented to more closely align populations and data elements. Specifically and most importantly, to successfully compare NHCHIS data to the SHCE there must exist an ability to separate out the data for NH policy situs only. With respect to claims, the SHCE and SR claims may include payments to providers outside the claim payment system as well as an adjustment for unpaid claims, while the NHCHIS does not. Therefore in the SR, separation of claims into raw paid claims and other payments to providers would make such a comparison possible and is therefore also very important. The NHID should consider requiring a reconciliation of claims and members between the SR, SHCE, and NHCHIS and a reconciliation of premium between the SR and SHCE as part of the SR submission. This would ensure improved accuracy and consistency between data sources which would significantly cut down on the number of hours spent validating the data after submission. This would allow more time for analysis of the data and more timely production of the Supplemental Report.

It is recommended that the following items be added to the SR instructions. Additionally, the NHID should review these reasonability checks and work with carriers toward resolution when necessary. Some resulting variances may be explainable and justified; others may require a correction and resubmission of one or more data source.

- Member months reported in the SR should be reasonably close to the member months reported to NHCHIS for the reporting year. Member months from these two data sources should be compared for the Individual, Small Group, Large Group, and Self-Insured market segments. Carriers should describe and explain any large variances.
- Member months reported in the SR excluding policies issued out of state should be reasonably close to member months reported in the SHCE for the reporting year [SHCE

Page 10TH Line 4]. Member months from these two data sources should be compared for Individual, Small Group, Large Group, and Self-Insured market segments. Carriers should describe and explain any large variances. Note that variances are expected when the carrier reports FEHBP in Large Group on the SHCE or when Healthy Kids is reported in the Government Business category on the SHCE.

- Premium reported in the SR excluding policies issued out of state should be reasonably close to premium reported in the SHCE for the reporting year [SHCE Page 1 Line 1.1]. Premium from these two data sources should be compared for Individual, Small Group, and Large Group market segments. Carriers should describe and explain any large variances. Note that variances are expected when the carrier reports FEHBP in Large Group on the SHCE or when Healthy Kids is reported in the Government Business category on the SHCE.
- Total Claims reported in the SR excluding policies issued out of state should be reasonably close to claims reported in the SHCE for the reporting year [SHCE Page 1 Line 5.0]. Claims from these two data sources should be compared for Individual, Small Group, and Large Group market segments. Carriers should describe and explain any large variances. Note that variances are expected when the carrier reports FEHBP in Large Group on the SHCE or when Healthy Kids is reported in the Government Business category on the SHCE.
- If ‘Total Claims’ in SR is reported as separate components, the ‘claims incurred and paid’ should be reasonably close to claims reported in NHCHIS for the reporting year. ‘Claims incurred and paid’ from these two data sources should be compared for Individual, Small Group, Large Group, and Self-Insured market segments. Carriers should describe and explain any large variances.

As an additional data quality check, the Department should consider comparing the data in the SHCE to the other exhibits within the AS in a manner similar to what was done as a part of this project with the 2010 data. Details regarding the comparisons made can be found in Appendix B.

Outside Data Sources

In addition to the comparison of internal data sources described above, external data sources can be used to enhance the understanding of the NH health insurance market, and whether its growth, in total and at more detailed levels, is above or below regional or national averages. Two excellent sources are discussed below.

NAIC Regional and National Data

Each year the NAIC publishes its “Statistical Compilation of Annual Statement Information,” which includes exhibits from the Health Annual Statements aggregated nationwide. Some exhibits are also provided at the state level. This data can be useful in comparing results for the NH health insurance market to regional or national benchmarks. It is important to note that it will not provide a complete picture of the NH health insurance market as the data only represent legal entities that complete Health Annual Statement blanks.

Looking at the Statistical Compilation of Annual Statement Information for the 2010 reporting year we see the results in Table 13 for the Comprehensive Major Medical line of business in NH compared to the same in New England (a sum of results for CT, MA, ME, NH, RI, and VT) and the overall National data.

Table 13

Comparison of New Hampshire to Regional and National Benchmarks

*All data from NAIC Statistical Compilation of Annual Statement Information for Health Insurance Companies in 2010
New England represents the sum of reported data for CT, MA, ME, NH, RI, and VT*

Comprehensive Major Medical only

Premium = "Health premiums earned" from Line 15 of Exhibit for Premiums, Enrollment and Utilization

Claims = "Amount Incurred for Provision of Health Care Services" from Line 18 of Exhibit for Premiums, Enrollment and Utilization

Medical Loss Ratio = Claims / Premium

	NATIONAL	NEW ENGLAND	NH
2010 Premium PMPM	\$299.32	\$395.54	\$389.21
2010 Claims PMPM	\$252.50	\$344.41	\$333.42
2010 Medical Loss Ratio	84.4%	87.1%	85.7%

Health Care Cost Institute Cost & Utilization Report

The Health Care Cost Institute's (HCCI) Health Care Cost and Utilization Report: 2011 tracks changes in health care prices, utilization, and spending on people younger than 65 covered by employer-sponsored private health insurance (ESI).²⁴ The underlying data for the report represent claims experience from 2007-2011 for over 25% of the entire national under-65 ESI population, over 40 million persons. Both aggregate growth rates and more detailed break-outs of service category-specific costs are included, further broken down by utilization and unit cost growth.

This information can provide another benchmark against which to assess New Hampshire-specific cost growth experience.

²⁴ http://www.healthcostinstitute.org/files/HCCI_HCCUR2011.pdf, downloaded 10/17/2012.

Augmenting the Rate Review Process with Data Resources

Insurance carriers selling accident and health insurance in New Hampshire are required to submit a rate filing to the NHID whenever a new policy, rider, or endorsement form that affects benefits is submitted for approval or whenever there is a change in the rates applicable to a previously approved form²⁵. The carrier is required to submit the rate filings and all related correspondence via SERFF.

All rate filings must include:

- All rates and rating formulae
- Carrier information
- Scope and purpose of filing
- Description of benefits provided by each policy form
- In-force business statistics
- Proposed effective date
- Reasons for the revision, if the filing is for a rate revision

With respect to the individual and small employer markets, New Hampshire law dictates that the premium rates must be filed and approved by the commissioner before the policy is issued. The commissioner must approve rates within 30 days of receipt. The commissioner may disapprove rate filings if the rates are found to be excessive or inadequate.²⁶ Additional rate filing requirements for the individual and small employer market segments are detailed in Part Ins 4102 and Part Ins 4103, which includes the new requirements effective November 1, 2012 mentioned earlier in this report. After a carrier submits the rate filing, the NHID actuary reviews the filing and may request further explanation and/or additional information from the carrier to make an assessment of the rates. Based on that assessment, the commissioner will then either approve or disapprove the rate filing.

We examined the required rate filing exhibits (for individual and small employer markets) to determine if data sources available to the reviewer beyond the rate filing would be helpful to the NHID reviewer in 1) checking the accuracy of the information presented and 2) making an independent assessment of the actuarial assumptions inherent in the filing. While carriers have flexibility in how they develop the rating assumptions, the process generally involves the following components:

- Enrollment (member or contract counts)
- Base period raw paid claims
- Estimation of incurred but not paid claims
- Large claim analysis
- Base period incurred claims per member or per contract
- Claim trend assumption applied from base period to projected period
 - Changes in utilization
 - Changes in provider reimbursement

²⁵ New Hampshire administrative rule Chapter Ins 4100, Part 4101

²⁶ RSA Chapter 420-G:13

- Changes in mix of services/severity
- Changes in demographics
- Leveraging due to fixed cost sharing (deductibles, copays, out-of-pocket maximums)
- Estimate of benefit changes (mandates or other)
- Administrative expenses and commissions
- Profit and risk
- Taxes and assessments

The internal data sources that we have determined would be most useful for assessing the above rate calculation steps are NHCHIS, Supplemental Report, and Supplemental Health Care Exhibit. In some cases, these data sources do not currently have sufficient detail to support this effort, although implementation of the recommendations made in this report would enable additional use of the data. Therefore we have suggested modifications to those data sources to support this effort. Table 14 summarizes the information included in the exhibits that could potentially be matched up with data from other independent sources.

Having these data resources available, particularly if ad hoc requests can be bolstered by standard reports that are created and made available to the reviewing actuary, could enhance the rate review process. Creating and generating this type of information can be done more easily and quickly in a structured data environment of the type discussed in the next section.

Table 14
Application of NHID Data Resources to Rate Review

New Hampshire Individual/Small Group Filing Requirements (effective 11/1/2012)			Alternate Data Source available to check reasonability D = Detail, H = High Level				
Rate Filing Exhibit	Exhibit Name	Recommended Data/Assumptions to Check	NHCHIS	NHCHIS with suggested modifications	SR	SR with suggested modifications	SHCE
A2	Proposed Rate Change and Enrollment by Health Coverage Plan	1) total members/subscribers/groups 2) impacted members/subscribers/groups	1) H	1) D and 2) D if add renewal month and benefit level detail to match rate filing	1) H	1) D if add benefit level detail to match rate filing	1) H
A5	Components of the Average Proposed Rate Change	claim restatement	H		H		H
B1	Plan Design and Plan Relativity Factors	plan relativity factors		D if add benefit level detail to match rate filing	H	D if add benefit level detail to match rate filing	
C2	Experience Used in the Rate Development	1) incurred claims 2) membership	1) D 2) D		1) H 2) H		1) H 2) H
D3	Detail on Final Trend Assumptions	1) Utilization Trends by COS 2) Allowed Cost Trends by COS	1) D 2) D			H Allowed PMPM trend if add member cost share dollars	
E2	Administrative Charges	1) administrative expenses 2) membership					1) D 2) D
E3	Retention Charges	1) investment income credit 2) profit 3) other					H only available for total company
H4	Expected Distribution of Rating Factors	membership by rating factor categories	D age and member geography are available, but smoking status and employer geography are not	D if add smoking status and employer geography			
M1	Medical Loss Ratio for Individual Market	Historical only: 1) member months 2) incurred claims 3) earned premium 4) quality improvement expenses 5) adjustments to earned premium			1) D 2) D 3) D		1) D 2) D 3) D 4) D 5) D only back to 2010
M2	Medical Loss Ratio for Small Group Market	Historical only: 1) member months 2) incurred claims 3) earned premium 4) quality improvement expenses 5) adjustments to earned premium			1) D 2) D 3) D		1) D 2) D 3) D 4) D 5) D only back to 2010

Moving Toward a Data System

Following the recommendations provided in the preceding sections of this report with respect to data content and data quality would provide the Department with two of the three legs on a three-legged stool of informational power. The third leg is a structured database design and technical environment that would allow efficient, accurate use of the data. The Department could pursue changes in processes and data infrastructure to standardize data about carrier claims, administrative expenses, revenue, and profits.

The goals of such an endeavor would be to improve:

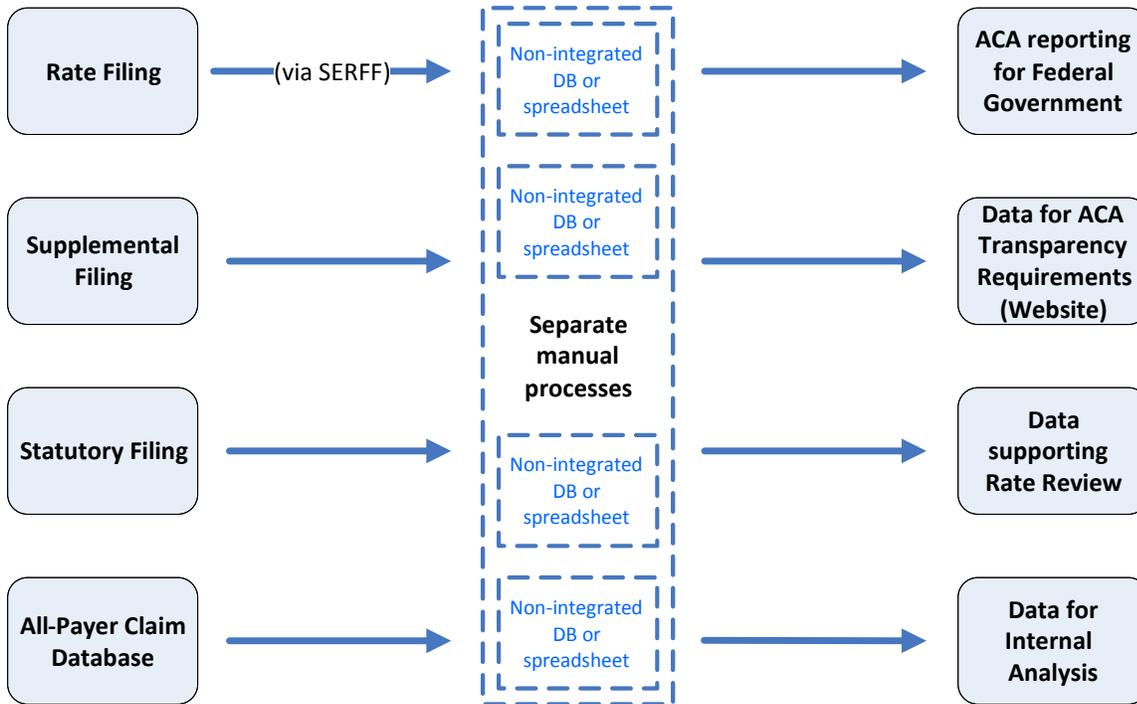
- The efficiency of how the Department processes and evaluates data, rate reviews, and other financial information
- The range and depth of analytical tools available to the Department in its review of insurer financial information
- The content and efficiency of insurer information the Department reports to the public and/or reports to other governmental agencies.

Creation of this type of infrastructure is consistent with the goals of the ACA to enhance state-level rate review capabilities, and would have the following benefits:

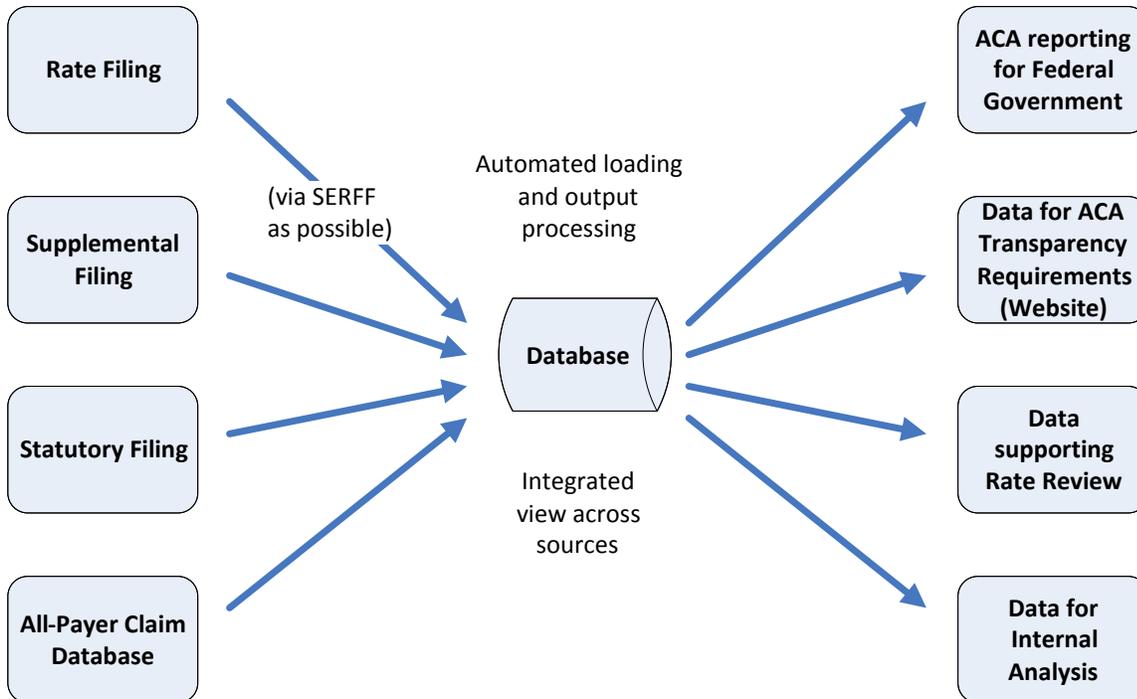
- Improve quality control and validation for rate filing data, by reducing manual processing and enabling more automated QC
- Mitigate the effort required to process/analyze rate filing data as the ACA or other drivers subject more plans to more intensive review and reporting
- Find efficiencies through automation of selected routine processes and reporting within the rate filing review, allowing leveraging into long run staffing efficiencies
- Include analysis of the full marketplace among review inputs; e.g., selectively consider trends or other measures from other carriers when reviewing an individual filing
- Feed data to web-based transparency reporting required under the ACA

The diagrams on the next page illustrate the advantages an integrated database would provide over the current manual system. Current data collection and storage processes are largely manual and non-integrated. Information submitted by carriers for their annual filings, rate filings, and supplemental filings required by New Hampshire law, as well as their claim submissions to our state-level all-payer database are all separate and not easily drawn on for analyses that require multiple sources or the same source over time. The ability to quality-check and cross-validate different submissions is very limited. These limitations would be significantly curtailed by a well-designed integrated database fed by automated data streams and producing automated reporting streams.

Current Non-Integrated Manual Processes



Integrated System: Data Integrity and Efficiency



Conclusion and Summary of Recommendations

Improved data capabilities are a key aspect of strengthening state level resources for rate monitoring and review. This study reviewed data collected by the Department, from which we identified the primary data resources useful for the Department's mission, which are:

- *Financial Statements.* The National Association of Insurance Commissioners (NAIC) publishes standard forms (“blanks”) for financial statement information. These include the Annual Statement (AS) for life, accident, and health insurers, which may or may not be state-specific or healthcare-specific, depending on the entity, its licensure, and its offered business lines. In 2010, the NAIC Supplemental Health Care Exhibit (SHCE) was introduced, which collects health insurance-specific financial statement information at the state level. The AS contains a balance sheet, income statement, and supporting exhibits. The income statement and supporting exhibits contain information about membership, premium revenue, investment income, claims expenses, administrative expenses, and profits.
- *New Hampshire Supplemental Report.* The Supplemental Report (SR) contains a summary for each unique combination of coverage category, market type, and high-level benefit structure offered by each carrier entity in the state, and includes benefit detail, membership, premium, claims, and actuarial value. It provides a single standardized measure of the value of benefits for each combination, and so can be combined with premium information to provide adjusted, standardized price levels across carriers and over time. Premium information by itself can't provide this information owing to differences and changes in benefit levels. The SR contains information for all health insurance products in force, whether actively marketed or not, and also provides claim and premium equivalents for the self-insured population.
- *New Hampshire Comprehensive Health Information System.* The Comprehensive Health Information System (CHIS) contains detailed eligibility and claim data collected from New Hampshire health insurance carriers. The claim detail allows for detailed analysis of health insurance costs, member cost sharing amounts, utilization changes, price levels for specific services, and a variety of other important topics.
- *New Hampshire Line of Business Survey.* The line of business survey contains enrollment and premium information on all underwritten accident and health insurance, as well as other non-health lines, and includes an indicator to identify plans actively marketed during the survey period.
- *Federal Medical Loss Ratio Report.* The Medical Loss Ratio (MLR) report summarizes the ratio of medical expense to premium, and is required to identify plans violating the federally-determined minimum MLR levels. Plans spending less than the minimum required level on medical services are required to provide rebates to subscribers, which are calculated within the report.

Key findings of the report include the following.

- *Simple steps to improve the analytical power of existing data sources.* The ability to combine data from two or more of these sources for analytical purposes can be significantly enhanced by making a relatively modest number of changes to the measures and categories included in the data collected. For example, a few minor changes to existing data sources and data integrity processes would allow annually filed financial statements to serve as an audited check on information provided in the Supplemental Report and the New Hampshire CHIS. This would in turn allow these more detailed sources to be used with more confidence in supporting review of rate filings, market conduct studies, and other important analytical tasks. The report includes specific recommendations to improve file links by adding fields and refining categories.
- *Improving data quality.* The use of data to carry out the Department's mission requires accurate data. Data comparisons across sources that are possible with currently available information were conducted and are presented. Potential issues in data accuracy suggested by discrepancies across sources are identified. Straightforward modifications to instructions for the data collection instruments/processes and specific steps taken to quality check data received from carriers can both improve data quality and clarify required reporting for carriers. Suggested instruction modifications and quality checking steps are presented.
- *Enhancing context for data interpretation.* External data and benchmarks, especially from the NAIC, can directly enhance assessment and interpretation of New Hampshire premiums, costs, trends rates, and other important measures.
- *Reducing carrier burden.* Data collection was reviewed for unnecessary duplication, complexity, and ambiguity. Recommendations for reducing these are provided. For example, modifying the methodology required for actuarial value calculations on the SR to conform with the newly-established federal methodology would eliminate the need for carriers to use a New Hampshire-only methodology.
- *Improving technical infrastructure for data handling.* Taking full advantage of the multiple data resources available requires not only improving the content of the data to make data resources linkable to each other, but also providing a technical architecture and related data analytic resource for easy access to and manipulation of data. Recommendations to further such a resource are provided.

Implementing the recommendations contained in this report will leverage the full potential of the Department's data resources, and further its mission of promoting and protecting the public good by ensuring the existence of a safe and competitive insurance marketplace.

Appendices

Appendix A: Location of Specific Data Elements within Sources

Appendix B: Comparison of Supplemental Health Care Exhibit to the Annual Statement

Appendix A: Location of Specific Data Elements within Sources

DATA ELEMENT: MEMBER MONTHS				
DATA SOURCE	LINE OF BUSINESS			
	INDIVIDUAL	SMALL GROUP	LARGE GROUP	SELF-INSURED
NEW HAMPSHIRE COMPREHENSIVE HEALTH INFORMATION SYSTEM	from the MEDICAL_MEMBERSHIP_2010 table SELECT on HAS_MEDICAL_COVERAGE = 'Y', USEFLAG IN (0, 9), member age less than 65, XTYPE = 'UND', PRODUCT IN ('EP', 'HM', 'IN', 'PR', 'PS'), and MKTCATCDE IN ('IND', 'GCV')	from the MEDICAL_MEMBERSHIP_2010 table SELECT on HAS_MEDICAL_COVERAGE = 'Y', USEFLAG IN (0, 9), member age less than 65, XTYPE = 'UND', PRODUCT IN ('EP', 'HM', 'IN', 'PR', 'PS'), and MKTCATCDE IN ('GS1', 'GS2', 'GS3', 'GS4', 'GSA')	from the MEDICAL_MEMBERSHIP_2010 table SELECT on HAS_MEDICAL_COVERAGE = 'Y', USEFLAG IN (0, 9), member age less than 65, XTYPE = 'UND', PRODUCT IN ('EP', 'HM', 'IN', 'PR', 'PS'), and MKTCATCDE IN ('GLG1', 'GLG2')	from the MEDICAL_MEMBERSHIP_2010 table SELECT on HAS_MEDICAL_COVERAGE = 'Y', USEFLAG IN (0, 9), member age less than 65, XTYPE IN ('ASO', 'ASW'), PRODUCT IN ('EP', 'HM', 'IN', 'PR', 'PS')
NHID SUPPLEMENTAL REPORT	from the merged raw data file, Number of Member Months; SELECT Coverage Type of 'UND', Market Category Code in list ('IND', 'GCV'); if want NH policy situs only, exclude Policyholder Geographic Location of 'Y'	from the merged raw data file, Number of Member Months; SELECT Coverage Type of 'UND', Market Category Code in list ('GS1', 'GS2', 'GS3', 'GS4', 'GSA'); if want NH policy situs only, exclude Policyholder Geographic Location of 'Y'	from the merged raw data file, Number of Member Months; SELECT Coverage Type of 'UND', Market Category Code in list ('GLG1', 'GLG2'); if want NH policy situs only, exclude Policyholder Geographic Location of 'Y'	from the merged raw data file, Number of Member Months; SELECT Coverage Type in list ('ASW', 'ASO'); if want NH policy situs only, exclude Policyholder Geographic Location of 'Y'
CARRIER RATE FILING	Rate Filing Exhibit A2, column D Total Number of Members Rate Filing Exhibit M1, column A	Rate Filing Exhibit A2, column D Total Number of Members Rate Filing Exhibit M2, column A	No template is available	
CMS MEDICAL LOSS RATIO REPORT	Pt 1 Ln 11.4 Col 5	Pt 1 Ln 11.4 Col 10	Pt 1 Ln 11.4 Col 15	Pt 1 Ln 11.4 Col 35
NAIC SUPPLEMENTAL HEALTH CARE EXHIBIT	2010: Pg 10TH Ln 4 Col 1 2011: Pg 10TH Ln 4 Col 1	2010: Pg 10TH Ln 4 Col 2 2011: Pg 10TH Ln 4 Col 2	2010: Pg 10TH Ln 4 Col 3 2011: Pg 10TH Ln 4 Col 3	2010: Pg 10TH Ln 4 Col 8 2011: Pg 10TH Ln 4 Col 13

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DATA ELEMENT: PREMIUM				
DATA SOURCE	LINE OF BUSINESS			
	INDIVIDUAL	SMALL GROUP	LARGE GROUP	SELF-INSURED
NEW HAMPSHIRE COMPREHENSIVE HEALTH INFORMATION SYSTEM				
NHID SUPPLEMENTAL REPORT	from the merged raw data file, Total Premium; SELECT Coverage Type of 'UND', Market Category Code in list ('IND', 'GCV'); if want NH policy situs only, exclude Policyholder Geographic Location of 'Y'	from the merged raw data file, Total Premium; SELECT Coverage Type of 'UND', Market Category Code in list ('GS1', 'GS2', 'GS3', 'GS4', 'GSA'); if want NH policy situs only, exclude Policyholder Geographic	from the merged raw data file, Total Premium; SELECT Coverage Type of 'UND', Market Category Code in list ('GLG1', 'GLG2'); if want NH policy situs only, exclude Policyholder Geographic Location of 'Y'	from the merged raw data file, Total Premium; SELECT Coverage Type in list ('ASW', 'ASO'); if want NH policy situs only, exclude Policyholder Geographic Location of 'Y'
CARRIER RATE FILING	Rate Filing Exhibit M1, column C	Rate Filing Exhibit M2, column C	No template is available	
CMS MEDICAL LOSS RATIO REPORT	Pt 2 Ln 1.11 Col 5 (direct basis)	Pt 2 Ln 1.11 Col 10 (direct basis)	Pt 2 Ln 1.11 Col 15 (direct basis)	
NAIC SUPPLEMENTAL HEALTH CARE EXHIBIT	2010: Pg 1 Ln 1.1 Col 1 OR Pg 2 Ln 1.8 Col 1 2011: Pg 1 Ln 1.1 Col 1 OR Pg 2 Ln 1.11 Col 1 (direct basis)	2010: Pg 1 Ln 1.1 Col 2 OR Pg 2 Ln 1.8 Col 2 2011: Pg 1 Ln 1.1 Col 2 OR Pg 2 Ln 1.11 Col 2 (direct basis)	2010: Pg 1 Ln 1.1 Col 3 OR Pg 2 Ln 1.8 Col 3 2011: Pg 1 Ln 1.1 Col 3 OR Pg 2 Ln 1.11 Col 3 (direct basis)	

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DATA ELEMENT:	CLAIMS
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DATA SOURCE	LINE OF BUSINESS			
	INDIVIDUAL	SMALL GROUP	LARGE GROUP	SELF-INSURED
<p>NEW HAMPSHIRE COMPREHENSIVE HEALTH INFORMATION SYSTEM</p> <p><i>Note that some claims do not join to the membership table and are therefore dropped.</i></p>	<p>JOIN MEDICAL_DETAIL_2010 table and PHARMACY_DETAIL_2010 table to the MEDICAL_MEMBERSHIP_2010 table SELECT on MEDICAL(PHARMACY)_DETAIL_2010.USEFLAG NOT IN (1, 2, 5, 7, 8, 22), MEDICAL_MEMBERSHIP_2010.USEFLAG IN (0, 9), member age less than 65, XTYPE = 'UND', MEDICAL_MEMBERSHIP_2010.PRODUCT IN ('EP', 'HM', 'IN', 'PR', 'PS'), and MKTCATCDE IN ('IND', 'GCV')</p>	<p>JOIN MEDICAL_DETAIL_2010 table and PHARMACY_DETAIL_2010 table to the MEDICAL_MEMBERSHIP_2010 table SELECT on MEDICAL(PHARMACY)_DETAIL_2010.USEFLAG NOT IN (1, 2, 5, 7, 8, 22), MEDICAL_MEMBERSHIP_2010.USEFLAG IN (0, 9), member age less than 65, XTYPE = 'UND', MEDICAL_MEMBERSHIP_2010.PRODUCT IN ('EP', 'HM', 'IN', 'PR', 'PS'), and MKTCATCDE IN ('GS1', 'GS2', 'GS3', 'GS4', 'GSA')</p>	<p>JOIN MEDICAL_DETAIL_2010 table and PHARMACY_DETAIL_2010 table to the MEDICAL_MEMBERSHIP_2010 table SELECT on MEDICAL(PHARMACY)_DETAIL_2010.USEFLAG NOT IN (1, 2, 5, 7, 8, 22), MEDICAL_MEMBERSHIP_2010.USEFLAG IN (0, 9), member age less than 65, XTYPE = 'UND', MEDICAL_MEMBERSHIP_2010.PRODUCT IN ('EP', 'HM', 'IN', 'PR', 'PS'), and MKTCATCDE IN ('GLG1', 'GLG2')</p>	<p>JOIN MEDICAL_DETAIL_2010 table and PHARMACY_DETAIL_2010 table to the MEDICAL_MEMBERSHIP_2010 table SELECT on MEDICAL(PHARMACY)_DETAIL_2010.USEFLAG NOT IN (1, 2, 5, 7, 8, 22), MEDICAL_MEMBERSHIP_2010.USEFLAG IN (0, 9), member age less than 65, XTYPE IN ('ASO', 'ASW'), MEDICAL_MEMBERSHIP_2010.PRODUCT IN ('EP', 'HM', 'IN', 'PR', 'PS')</p>
NHID SUPPLEMENTAL REPORT	from the merged raw data file, Total Claims; SELECT Coverage Type of 'UND', Market Category Code in list ('IND', 'GCV'); if want NH policy situs only, exclude Policyholder Geographic Location of 'Y'	from the merged raw data file, Total Claims; SELECT Coverage Type of 'UND', Market Category Code in list ('GS1', 'GS2', 'GS3', 'GS4', 'GSA'); if want NH policy situs only, exclude Policyholder Geographic Location of 'Y'	from the merged raw data file, Total Claims; SELECT Coverage Type of 'UND', Market Category Code in list ('GLG1', 'GLG2'); if want NH policy situs only, exclude Policyholder Geographic Location of 'Y'	from the merged raw data file, Total Claims; SELECT Coverage Type in list ('ASW', 'ASO'); if want NH policy situs only, exclude Policyholder Geographic Location of 'Y'
CARRIER RATE FILING	Rate Filing Exhibit M1, column B	Rate Filing Exhibit M2, column B	No template is available	
CMS MEDICAL LOSS RATIO REPORT	Pt 2 (Lines 2.1b + 2.2 + 2.4 + 2.6 - 2.7 + 2.8b + 2.9 + 2.11a + 2.11b - 2.12a + 2.13 + 2.14 + 2.15) Col 5 (direct basis)	Pt 2 (Lines 2.1b + 2.2 + 2.4 + 2.6 - 2.7 + 2.8b + 2.9 + 2.11a + 2.11b - 2.12a + 2.13 + 2.14 + 2.15) Col 10 (direct basis)	Pt 2 (Lines 2.1b + 2.2 + 2.4 + 2.6 - 2.7 + 2.8b + 2.9 + 2.11a + 2.11b - 2.12a + 2.13 + 2.14 + 2.15) Col 15 (direct basis)	
NAIC SUPPLEMENTAL HEALTH CARE EXHIBIT	2010: Pg 1 Ln 5.0 Col 1OR Pg 2 Ln 2.10 Col 1 2011: Pg 1 Ln 5.0 Col 1OR Pg 2 Ln 2.15 Col 1 (direct basis)	2010: Pg 1 Ln 5.0 Col 2 OR Pg 2 Ln 2.10 Col 2 2011: Pg 1 Ln 5.0 Col 2 OR Pg 2 Ln 2.15 Col 2 (direct basis)	2010: Pg 1 Ln 5.0 Col 3 OR Pg 2 Ln 2.10 Col 3 2011: Pg 1 Ln 5.0 Col 3 OR Pg 2 Ln 2.15 Col 3 (direct basis)	

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Appendix B: Comparison of SHCE to AS

Comparison of 2010 Supplemental Health Care Exhibit (SHCE) to Health Annual Statement (AS)

	Comparing SHCE Source	to AS Source
Total Revenue	Pt 1 Ln 1.12 - Pt 1 Ln 1.2 - Pt 1 Ln 1.3 + Pt 1 Ln 1.5 + Pt 1 Ln 1.6 + Pt 1 Ln 1.7 OR Pt 2 Ln 1.13	Pg 7 Ln 7
Medical Expense	Pt 1 Ln 5.7	Pg 7 Ln 17 + Pg 7 Ln 21
Other Expenses	Pt 1 Ln 6.3 + Pt 1 Ln 8.3 + Pt 1 Ln 10.5 + -(Pt 1 Ln 1.3) + Pt 1 Ln 1.6 + Pt 1 Ln 1.7	Pg 7 Ln 19 + Pg 7 Ln 20
UWGL (as reported on Pg 7)	Calculated as Total Revenue less Medical Expense less Other Expenses	Pg 7 Ln 24
Member Months (Total)	Pt 10TH Ln 4	Pg 4 Ln 1 Col 2

Comparing SHCE [Individual, Small Group, and Large Group (incl. FEHBP)] to AS [Comprehensive Major Medical and FEHBP]

Legal Entity	FEHBP?	Total Revenue	Medical Expense	Other Expenses	UWGL	Member Months (Total)
10135	N	Y	Y	Y	Y	Y
10141	N	Y	Y	Y	Y	Y
53759	Y	N	N	N	N	N
95493	N	Y if 'Other Health' LOB is included in SHCE	N difference due to SHCE Pt 1 Ln 2.4 'State Stop Loss, Market Stabilization and Claim/Census Based Assessments', which appears to be included as Medical Expense in AS but Admin Expense in SHCE	N > most of difference due to SHCE Pt 1 Ln 2.4 'State Stop Loss, Market Stabilization and Claim/Census Based Assessments', which appears to be included as Medical Expense in AS but Admin Expense in SHCE > remaining difference appears to be due to exclusion of 'Payroll Taxes' from SHCE	N if 'Other Health' LOB is included in SHCE, remaining difference appears to be due to exclusion of 'Payroll Taxes' from SHCE	Y
95527	N	Y	Y	N	N	N unless 'Other Health' is removed from the SHCE
96717	N	Y	N appears to be offset in 'Other Expenses' for SHCE Pt 1 Ln 2.4 'State Stop Loss, Market Stabilization and Claim/Census Based Assessments'	N appears to be offset in 'Medical Expense' for SHCE Pt 1 Ln 2.4 'State Stop Loss, Market Stabilization and Claim/Census Based Assessments'	Y	Y

Comparison of 2010 Supplemental Health Care Exhibit (SHCE) to Health Annual Statement (AS)

	Comparing SHCE Source	to AS Source
Total Revenue	Pt 1 Ln 1.12 - Pt 1 Ln 1.2 - Pt 1 Ln 1.3 + Pt 1 Ln 1.5 + Pt 1 Ln 1.6 + Pt 1 Ln 1.7 OR Pt 2 Ln 1.13	Pg 7 Ln 7
Medical Expense	Pt 1 Ln 5.7	Pg 7 Ln 17 + Pg 7 Ln 21
Other Expenses	Pt 1 Ln 6.3 + Pt 1 Ln 8.3 + Pt 1 Ln 10.5 + -(Pt 1 Ln 1.3) + Pt 1 Ln 1.6 + Pt 1 Ln 1.7	Pg 7 Ln 19 + Pg 7 Ln 20
UWGL (as reported on Pg 7)	Calculated as Total Revenue less Medical Expense less Other Expenses	Pg 7 Ln 24
Member Months (Total)	Pt 10TH Ln 4	Pg 4 Ln 1 Col 2

Comparing Totals [excludes Uninsured Plans except in Other Expenses]

Legal Entity	FEHBP?	Total Revenue	Medical Expense	Other Expenses	UWGL	Member Months
10135	N	Y	Y	Y	Y	Y
10141	N	Y	Y	Y	Y	Y
53759	Y	N difference due to 'Aggregate write-ins for other non-health revenues' in AS but not in SHCE	N difference due to PDR in AS but not in SHCE	N	N	N
95493	N	Y	N difference due to SHCE Pt 1 Ln 2.4 'State Stop Loss, Market Stabilization and Claim/Census Based Assessments', which appears to be included as Medical Expense in AS but Admin Expense in SHCE	N > most of difference due to SHCE Pt 1 Ln 2.4 'State Stop Loss, Market Stabilization and Claim/Census Based Assessments', which appears to be included as Medical Expense in AS but Admin Expense in SHCE > remaining difference appears to be due to exclusion of 'Payroll Taxes' from SHCE	N difference appears to be due to exclusion of 'Payroll Taxes' from SHCE	Y
95527	N	Y	Y	N	N	N unless 'Other Health' is removed from the SHCE
96717	N	Y	N difference due to SHCE Pt 1 Ln 2.4 'State Stop Loss, Market Stabilization and Claim/Census Based Assessments'	N difference due to SHCE Pt 1 Ln 2.4 'State Stop Loss, Market Stabilization and Claim/Census Based Assessments'	Y	Y

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