THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

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Written testimony of the New Hampshire Insurance Commissioner for the June 17, 2016 National Committee on Vital and Health Statistics hearing on claims based databases for policy development and evaluation.

June 13, 2106

Dear Committee Members:

Thank you for offering the New Hampshire Insurance Department (NHID) the opportunity to provide testimony regarding our experience with constructing and using an all-payer claims database, and the challenges we currently face in continuing this long-standing effort.

A core part of the NHID's mission is to promote and protect the public good by ensuring the existence of a safe and competitive insurance marketplace. In 2003, the New Hampshire legislature enacted NH RSA 420-G:11-a, creating a health claims database as part of the state's Insurance Code. Our database has provided the state with critical information about the health of its citizens and contributed to our understanding of health care utilization, cost, and quality. The NHID uses information from the database to:

- inform consumers about the price of health care services by making information public on the NH HealthCost website
- analyze health care cost drivers and competition, helping us to better understand the operation of our health insurance markets
- provide insight about carrier practices that may violate insurance laws; and
- inform legislative decision-making in the health policy arena.

The biggest challenge to state operation of all-payer claims databases is the U.S. Supreme Court's March 1, 2016 decision in *Gobeille v. Liberty Mutual*, holding that federal law preempts Vermont's law requiring the submission of claims data with respect to self-funded employer coverage that is regulated by the U.S. Department of Labor under ERISA. The state of New Hampshire filed an amicus brief in *Gobeille* outlining the potential effect on insurance market transparency were the New Hampshire law to be preempted. Independently, the National Association of Insurance Commissioners (NAIC), which is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories, wrote and filed a separate amicus brief in the case on behalf of itself, the National Governors Association (NGA), the National Conference of State Legislatures (NCSL) and the Council of State Governments (CSG), to support states' ability to establish all payer claims databases.

Because New Hampshire's data submission requirements are part of our system of insurance regulation, an area of law not addressed in the *Gobeille* decision, there is a greater likelihood that our efforts will be able to continue. The New Hampshire legislature has already passed a bill aimed at clarifying our data submission requirements in view of the decision.

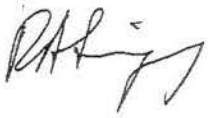
The ability of regulators to perform useful and relevant studies using claims data is dependent on having a robust set of data. The advantages of including fully-insured and self-funded data are similar to those associated with a large sample size when performing health services research. The permeability between the self-funded and fully insured status allows employers to shift back and forth easily, often without the knowledge of the employee, or even moving from the carrier responsible for administering the benefit. In New Hampshire, submissions from self-funded ERISA plans amount to approximately 30% of our claims data. The potential loss of these data carries the potential to undercut our transparency efforts.

While concerns have been raised about varying state data submission requirements, the information in medical claims databases is largely derived from two different standardized medical claims forms (UB-92 and CMS-1500). Insurance carriers and third party administrators (TPAs) have invested in reporting systems to comply with state reporting requirements and other business needs. Since the majority of claims data are standardized, regardless of what state the carrier or TPA is operating in, the economies of scale associated with multiple reporting requirements are high. With an array of reports developed by carriers and TPAs for employer clients and health care providers, data reporting functions tend to be highly automated. For many carrier or TPA organizations, requirements to remove specific accounts or segments of data will actually increase operational costs, rather than decrease them.

Insurance has traditionally been regulated at the state level, and it is critically important to retain a central role for states in this area, including through the use of all-payer claims databases as we have done in New Hampshire. Regulation at the state level is highly coordinated with the activities of state legislatures, and these data have proven essential in providing guidance to legislatures. A weakened ability for states to effectively inform state legislatures will result in an increase in misguided efforts to resolve common health care cost concerns, and could undermine the competitiveness of state insurance markets.

We encourage the Committee, when it makes recommendations, to be mindful of the ways states use these data, and the importance of preserving those systems that are already in place to the benefit of all consumers.

Sincerely,



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