

CENTER FOR HEALTH INFORMATION AND ANALYSIS

ANNUAL PREMIUMS DATA REQUEST: 2014

The 2014 Center for Health Information and Analysis' (CHIA) Annual Premiums Data Request (Request) asks for payer and administrator information on commercial health insurance products issued in Massachusetts. This Request allows for the annual analysis of membership concentration, premium values, benefit levels, cost sharing, medical expenses, and payer retention.

For 2014, CHIA has requested membership, premiums, and claims summary data by managed care type (HMOs, PPOs) and product type (high-deductible health plans, tiered networks), and additional information on self-insured membership levels. These data will allow CHIA to better inform the public of the evolving health care landscape in Massachusetts, while allowing policymakers valuable insight into how recent state and federal reforms (e.g. Chapter 224 of the Acts of 2012, Patient Protection and Affordable Care Act) have impacted health care access and affordability.

As with previous Requests, **data are requested for the prior three calendar year period - 2011, 2012, and 2013** - for all members who are covered under a policy issued in Massachusetts, including those members that reside outside of Massachusetts; and including all group sizes and all commercial medical products. Excluded from this Request are the following types of business: Medicare Advantage, Commonwealth Care, Medicaid Managed Care (including MassHealth PCC Plan), Medicare Supplement, FEHBP, and non-medical (e.g. dental) lines of business. Also excluded are individual products issued prior to the merging of the individual and small group markets.

Note that CHIA is not requesting payer expense information this year. Instead, CHIA will be using the expense information provided in the Supplemental Health Care Exhibit and the Annual Comprehensive Financial Statement in its analyses.

The attached Excel-based workbook will serve as a template for data submission with **separate files to be submitted by each payer or administrator for each legal company, including affiliates that write only self-insured business.**

All quality checked data submissions should be sent to Dianna Welch of Oliver Wyman Actuarial Consulting, Inc., at dianna.welch@oliverwyman.com or at (414) 277-4657 by Thursday, May 1, 2014 at 5pm.

If you have any technical questions relating to the specifications or workbook format of this Data Request, please contact Dianna Welch at any time.



ANNUAL PREMIUMS DATA REQUEST: 2014

DEFINITIONS

Average Employer Size: Equal to the number of **covered** employees divided by the number of employers. If multiple group IDs are maintained for a given employer, please use the number of employers in this calculation and not the number of group IDs.

Claims:

- **Allowed Claims:** The total cost of claims after the provider or network discount. Allowed Claims are equal to Incurred Claims plus member cost sharing; this should include medical claims, drug claims, capitation payments, and all other payments to providers, including those paid outside of the claims system. This value should include estimates of completed claims for periods that are not yet considered complete. **For this Request, run-out beyond February 2014 (or March 2014, as available) should be noted and estimated for outstanding claims incurred during calendar years 2011 through 2013.** This value should **not** include medical management expenses for medical management performed in-house or by third parties other than the providers, or any other payments to other entities besides the providers.
- **Incurred Claims:** The total cost of claims, after the provider/network discount and after member cost sharing. This value should include medical claims, drug claims, and capitation payments, and all other payments to providers including those paid outside of the claims system. This value should include estimates of completed claims for periods that are not yet considered complete. **For this Request, run-out beyond February 2014 (or March 2014, as available) should be noted and estimated for outstanding claims incurred during calendar years 2011 through 2013.** This value should **not** include medical management expenses for medical management performed in-house or by third parties other than the providers, or any other payments to other entities besides the providers.

Earned Premiums:

- **Earned Premiums:** Represents the **total gross premiums** earned prior to any Medical Loss Ratio (MLR) rebate payments, including any portion of the premium that is paid to a third party (e.g. Connector fees, reinsurance).
- **Earned Premiums Net of Rebates:** Represents the **total gross premiums** earned after removing Medical Loss Ratio (MLR) rebates incurred during the year (though not necessarily paid during the year), including any portion of the premium that is paid to a third party (e.g. Connector fees, reinsurance). **For calendar year 2013, please include the best estimate for MLR rebates.**

Geographic Area: The 3-digit zip code of the member.

Managed Care Type: A **mutually exclusive** breakdown of managed care type by Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and "Other". All plans should be included in one of these three categories, such that summing values across all Managed Care Types produces totals equal to those for a given Market Sector. **For plans that include multiple managed care types, the plan should be reported under the managed care type wherein most care is provided, where care is measured by allowed claims total dollar value.** For example, a Point of Service plan that uses a closed HMO network, but allows for indemnity coverage outside of the network, and provides roughly 95% of care (allowed claims total dollar value) through the HMO network, would be considered an HMO plan type.

- **HMO:** Plans that have a closed network of providers, outside of which coverage is not provided, except in emergencies. The plan may require members to coordinate care through a primary care physician, but may also provide open access to in-network providers.

- **PPO:** Plans that identify a network of “preferred providers”, but that allow members to obtain coverage outside of the network, though to typically higher levels of cost-sharing. PPO plans generally do not require enrollees to select a primary care physician.
- **Other:** Plan types other than HMO and PPO, such as indemnity plans, which do not have networks of preferred providers.

Market Sector: Average employer size segregated into the following categories: Individual products (post-merger), Small Group (1-50 enrollees), Mid-Size Group (51-100 employees)¹, Large Group (101-499 employees), and Jumbo Group (500+ employees). In the Small Group market segment, please include **only those small employers that meet the definition of “Eligible Small Business or Group” per Massachusetts Division of Insurance Regulation 211 CMR 66.04.**

Product Type: Groupings based upon whether plans are high-deductible health plans (HDHPs) and/or health plans that utilize tiered networks. These groupings are not mutually exclusive, nor will they include all plans.

- **HDHPs (as defined by individual deductible level only):** Plans with an individual deductible greater than or equal to the qualifying definition for a high deductible health plan, which is \$1,200 for 2011 and 2012, and \$1,250 for 2013 (for the most preferred network or tier, if applicable). The plan **does not** need to be a qualified high deductible health plan in order to be considered an HDHP for this purpose. **Only a plan’s individual deductible level must be satisfied to be included in this breakout for our purposes.** For example, four members of a family plan would only be considered to be in an HDHP for this data request’s purpose if the individual deductible for that product is equal to or exceeds \$1,250 in 2013; the deductible for the family plan itself is inconsequential.
- **Tiered Networks:** Plans that segment their provider networks into tiers, with tiers typically based on differences in the quality or the cost of care they provide. Tiers are not considered separate networks, but rather sub-segments of a payer’s HMO or PPO network. A Tiered Network is different than a plan only splitting benefits by in-network vs. out-of-network; a Tiered Network will have varying degrees of payments for in-network providers. For example, a tiered HMO plan may segment a payer’s HMO network into two tiers, with a member paying a \$500 inpatient copay per non-emergency admission at a Tier 1 hospital and a \$1,000 inpatient copay per non-emergency admission at a Tier 2 hospital.

A plan that has different cost sharing for different **types** of providers is not, by default, considered a Tiered Network (i.e. a plan that has a different copay for primary care physicians than specialists would not be considered a tiered network on that criterion alone). However, if the plan has different cost sharing **within** a provider type depending upon the provider selected, then the plan would be considered a Tiered Network plan.

A plan need not have all provider types subject to tiering in order to be considered a Tiered Network plan for this purpose (i.e. a plan that tiers only hospitals is a Tiered Network, similarly, a plan that tiers only physicians is also here considered a Tiered Network).

¹ Employers that have fewer than 51 enrollees, but do not meet the definition of an “Eligible Small Business or Group”, should be included in the Mid-Size Group

ANNUAL PREMIUMS DATA REQUEST: 2014

REQUEST SPECIFICATIONS

Please input the following data, as ordered by tab in the attached Excel workbook (e.g. Tab “A” through Tab “T”), **for each calendar year 2011, 2012, and 2013**, for all members who receive services under a commercial medical policy issued in Massachusetts, including those members that reside outside of Massachusetts:

- A. Please provide the following information for **fully-insured employers** in total and also by Market Sector, Managed Care Type, and Product Type:
- Earned Premiums:
 - Earned Premiums
 - Earned Premiums Net of MLR Rebates
 - Claims:
 - Allowed Claims
 - Incurred Claims
- B. Please provide **Member Months** information for **both fully-insured and self-insured employers** by Market Sector, Managed Care Type, Product Type, and Geographic Area.
- C. Please provide the annual Massachusetts member month information for **fully-insured and self-insured employers** separately by Market Sector, Managed Care Type, and Product Type, by 5-year age bands (0-4, 5-9, . . . , 60-64, 65+) and by gender. Also provide the annual Massachusetts **average employer size** separately by Market Sector, Managed Care Type, and Product Type.
- D. Reconciliation of information provided in (A), (B), and (C) with “Annual Comprehensive Financial Statement” data as provided to the Massachusetts Division of Insurance. A detailed reconciliation is not required; rather, a listing of the major reasons for potential discrepancies between these sources should be provided.

For breakouts by Market Sector, CHIA will also reference the “Supplemental Health Care Exhibit”. Please explain any known discrepancies between the data provided and this Exhibit.

- E. Reconciliation of information provided in (A), (B), and (C) to similar information previously provided to CHIA. The overlap from previous Premiums Requests would only encompass year 2011. CHIA is not looking for a detailed reconciliation, and anticipates slight changes in Incurred Claims; rather, CHIA requests reasons as to why larger differences may be observed.
- F. Benefit descriptions, including drug coverage, for each **fully-insured**, merged market plan offering that represents at least 5% of the individual post-merger member months or 5% of the small group member months in a given calendar quarter. Please provide quarterly member months by plan offering, separately for individual and small group market segments. If a given plan offering meets the 5% threshold in any calendar quarter in 2011 through 2013, please provide the quarterly member months for every calendar quarter in 2011 through 2013. For example, if a plan offering represented 8% of individual post-merger enrollment in 2011 and 2012, then declined to 4% of membership in first quarter 2013, please still provide the quarterly individual post-merger member months for all 12 quarters, including those in 2013.
- G. Please provide the annual small group Massachusetts **Member Months** information for **fully-insured employers** broken down by Managed Care Type and Product Type, by size (using size bands that correspond to the payer’s rating bands and excluding individual policies in the merged market from membership). For employer groups with multiple product types or

managed care types, the size band should be based on the total employer size, and not the size of the population enrolled in each type. For example, an employer group of size 20 has 5 employees enrolled in a PPO and 15 enrolled in an HMO for the entire year: 60 member months (5*12) would be reported in the size band including size 20 under Managed Care Type “PPO”, while 180 member months (15*12) would be reported in the size band including size 20 under Managed Care Type “HMO”.

H. Rating factors, for **fully-insured plans only**, in effect for effective dates in December 2013 as follows:

- Rating factors that are applied to base rates to develop premiums by market segment (when no employer-specific experience is available for Mid-Size and Large Groups), including but not limited to age/gender, area, group size, retention, and contract type. **Include benefit plan factors** for the merged market plan offerings. **Industry factors may be excluded.**
- Sample rate calculation showing how individual and family rates are developed from the base rate and applicable rating factors for a sample census for each rating methodology employed.

I. For **fully-insured employer** plans, the number of groups and number of members, separately for Small Group, Mid-Size Group, and Large Group market sectors², renewing by rate increase for renewals in each calendar quarter of 2012 and 2013. The renewal rate increase should reflect the quoted increase prior to changes in benefits. Please include groups that terminated coverage at renewal.

CHIA will be hosting two Technical Assistance Group (TAG) Question & Answer conference calls in March to answer any and all questions you and your staff may have about these specifications. Questions may also be submitted at any time to Dianna Welch of Oliver Wyman Actuarial Consulting for quicker responses; all answers to received questions may be shared at the start of each TAG call.

The attached Excel workbook should serve as a template for data submission. **Separate files should be submitted by each payer or administrator for each legal company, including affiliates that write only self-insured business.** Any Tabs/requests not applicable to an entity’s line of business should be noted; any challenges in providing specific breakouts of data should be discussed with Dianna Welch as soon as possible.

**Questions, Clarifications, or
Inquiries about Alternate Data Fields
May be Directed to:**

Dianna Welch, FSA, MAAA
Oliver Wyman Actuarial Consulting, Inc.
dianna.welch@oliverwyman.com
(414) 277-4657

All quality checked, data submissions should be submitted to Dianna Welch by May 1, 2014. All submissions received after this date, as well as any incomplete data submitted, will be considered late and/or missing.

² This excludes the “Jumbo Group” market sector