

CENTER FOR HEALTH INFORMATION AND ANALYSIS
957 CMR 10.00
Health Care Payers Premiums and Claims Data Reporting Requirements
Frequently Asked Questions (FAQ)

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Premiums & Claims

1. Is reporting done on a calendar or policy year basis?

Reporting is done on a calendar year basis.

2. What does an “Adjusted Premium” show?

Adjusted premium accounts for changes in demographics, geographic area, benefits, and group size to calculate premium trends on a consistent basis.

3. How will payer-specific rating factors be used in the “Adjusted Premium” calculations?

Payer-specific factors often provide the best indicator of payer-specific adjusted premiums and trends. For some analyses, however, other methods—such as using common factors—more accurately represent market average adjusted premiums. CHIA will continue to assess the most accurate method for each analytic purpose.

4. What is the definition of the “Administrative Service Fees”?

The administrative service fees are the fees earned by the TPA for the full administration of a self-insured health plan; this excludes any premiums for stop-loss coverage. Submission of this data is voluntary, and encouraged, but is no longer required.

5. What is the definition of “Allowed Claims”?

Allowed claims are the total cost of claims after the provider or network discount, if any. 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 the 2016 submission, run-out beyond March 2016 as available, should be noted and estimated for outstanding claims incurred during calendar years 2013 through 2015. 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.

6. Should behavioral health, vision, and dental claims data be included?

Payers should include all expenses that are part of a comprehensive medical policy, either as part of the base policy itself or an attached rider. Incurred and allowed claims should reflect all benefits that are covered by the premium that is paid so that the premiums and claims that are reported reflect consistent benefits.

If the behavioral health, dental, or vision benefits are part of the comprehensive medical policy, either the base policy or attached as a rider, they should be included in the reported premium and claims amounts. If, however, the behavioral health, dental or vision benefits are sold entirely separately as standalone policies, then these would fall under the category of “other non-primary, non-medical business” and thus be excluded.

Please also note that, with regard to the “Percent of Benefits Not Carved Out”, we would consider behavioral health services to be part of a comprehensive package of benefits similar to Essential Health Benefits. “Mental health and substance abuse services” is one of the categories of benefits that must be covered to meet Massachusetts’ Minimum Creditable Coverage standards. It is also an Essential Health Benefit under the Affordable Care Act.

In the merged market, it is expected that this coverage will be included in the comprehensive medical policy. In the larger group markets, if the behavioral health coverage is carved out because the employer purchases the coverage directly from a behavioral health vendor, then payers need to estimate the value of this carved out benefit in populating the “Percent of Benefits Not Carved Out.”

Percent of Benefits Not Carved Out

7. How is the “**Percent of Benefits Not Carved Out**” calculated?

The percent of benefits not carved out must be estimated when the reporting entity does not have access to the actual data for benefits that are carved out to another vendor. A simplified example is provided below.

- 1,000 members have comprehensive coverage provided by the reporting entity
- 500 members have only medical coverage provided by the reporting entity; pharmacy coverage is carved out to a pharmacy benefits manager
- Based on those members that have comprehensive coverage with the reporting entity, it is known that in 2014 80% of total allowed claims were for medical services and 20% of total allowed claims were for pharmacy services. These percentages should be calculated in aggregate across all market sectors, Coverage Type, Product Types, and Benefit Design Types for a given calendar year. If the reporting entity lacks sufficient data for members with comprehensive coverage, it may combine its data with that of any affiliated entities.

*The 2014 Percent of Benefits Not Carved Out for this segment is 93%. $(1,000 * 100\% + 500 * 80\%) / (1,000 + 500) = 93\%$.*

8. How will the “**Percent of Benefits Not Carved Out**” value be used for analytic purposes?

CHLA may calculate an “all-inclusive” premium or premium equivalent using this value. Any premium figures reported in this way will be identified explicitly as such. The premium equivalent field that is calculated by the template does not use this value in the calculation.

Group Size Classifications

9. When discussing our **rating factors**, what “**group size**” definitions should we use?

Only as related to rating factors, payers should define group size ranges as they would apply their rating factors.

10. How do we determine the **group size parameters**? Do we use the actual numbers in the template for reporting any groups that fall into those categories?

Below is a listing of mutually exclusive Market Sector definitions used throughout the request:

- a. Individual
- b. Small Group
 - i. Fully-Insured (1-50 eligible enrollees, see 211 CMR 66.04)
 - ii. Not Fully-Insured (1-50 enrolled employees)
- c. Mid-Size Group (51-100 enrolled employees)
- d. Large Group (101-499 enrolled employees)
- e. Jumbo Group (500+ enrolled employees)
- f. Group Insurance Commission (GIC)

In the fully-insured Small Group market sector, 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.

Small Group, as defined by regulation, is defined by number of eligible employees. If it doesn't satisfy 211 CMR 66.00, but has fewer than 51 enrolled employees, then it should be classified as Mid-Size Group. Larger groups (Mid-Size, Large, Jumbo) are

defined by number of enrolled employees. For the non-fully-insured segment of the market, all employer-based market sectors are determined based on the number of enrolled employees.

11. Are these “**market sector**” definitions consistent with prior years?

Yes, with the exception of the addition of a category for the Massachusetts Group Insurance Commission (GIC).

Geographic Area Calculations

12. What is **Geography** used for?

Geography is used to remove the impact that geographic shifts may have on a premium trend. It may also be used to display membership totals across the state by regions based on the 3-digit zip codes.

13. For **Member Months by Geographic Area** (Worksheets B1 and B2 in Option #1, Worksheet B in Option #2), should we use the **3 digit zip code based on the member’s address**? Is this different from previous years?

Yes, member zip code should be used. This is consistent with the 2015 and 2014 Requests, when the change was made to request member zip code rather than employer zip code.

Product Type & Benefit Design Type

14. What is the difference between **Product Type** and **Benefit Design Type**?

Product Type is a mutually exclusive, comprehensive grouping of plans based on network/provider access—i.e. whether the provider network is closed or open. Benefit Design Type is not mutually exclusive or comprehensive and is based on plan features such as cost-sharing (HDHPs and Tiered Networks) or network size (Limited Networks).

15. What are examples of **HMO, PPO, and “Other” plans**?

HMO plans utilize a closed network of providers, where selecting a PCP may be required; referrals may be needed to see specialists. PPO plans have a network of preferred providers; allow coverage outside that network (at a higher cost); do not require referrals; and a primary care physician is not necessary. “Other” plans are those that do not fall into the HMO or PPO categories. An example of an “Other” plan would be Indemnity plans. See Definitions for more information.

16. Is **HMO/ PPO defined solely by whether a member is assigned a PCP**? What if a member is assigned a PCP, but has a more open network (such as with tiering)?

HMO/PPO split is not solely dependent on whether a member is assigned a PCP.

17. Can you provide additional clarification on how to classify by **Product Type**?

The determination of Product Type should be done at the member level, as based on the benefit plan selected by the member, not the employer level.

The following example shows how multiple plans under one employer would be grouped into the different Product Type buckets. Please note that the “member months” field in the Tables below includes both employees and dependents. Plans 1-3 are fairly straight-forward as there is only one Product Type for each of those plans, HMO, PPO, and Other respectively. Plan 4, however, a POS plan that combines HMO and Indemnity components, has multiple Product Types at the member level and, as a result, it

would be grouped into the Product Type with the most allowed dollars, which is shown in the “Plan 4 Detail” Table. The Plan 4 Detail Table contains the allowed claims experience for ALL members covered under that plan, such that all members in the plan are reported under the same Product Type even if a subset of the members experience an allowed claims percent that would result in a different Product Type if measured at the member level. In this example, Plan 4 would be considered HMO, since the HMO Product Type had the most allowed dollars, and would be grouped under HMO for all reporting (membership, premium, claims, etc.).

For this one employer with four plans, the summation by Product Type is shown in the “Final Product Type Information” Table below.

Examples of Multiple Plans for One Employer					
Plan	Description	ember Mont	Allowed Claims	Premium	
1	HMO	180	\$54,400	\$67,500	
2	PPO	120	\$44,100	\$42,000	
3	Indemnity	96	\$30,240	\$43,200	
4	POS	48	\$14,000	\$19,200	

Plan 4 Detail		
Product Type	Allowed \$	Allowed %
HMO	\$9,000	64.3%
Indemnity	\$5,000	35.7%

As the majority of Allowed Claims for Plan 4 falls under HMO, it would be considered an HMO for all reporting (Member Months, Premiums, Claims, et. al).

Final Product Type Information				
Final Product Type	Grouping	Members	Allowed Claims	Premium
HMO	Plans 1 & 4	228	\$68,000	\$86,700
PPO	Plan 2	120	\$44,100	\$42,000
Other	Plan 3	96	\$30,240	\$43,200

Throughout the definition of Product Type, references to “plan” refer to a health benefit plan which is a unique set of network and cost sharing structure. For example, a payer’s plans might include the payer’s “Broad Network Silver HMO \$1,000” and “Broad Network Bronze PPO \$5,000.” The term “plan” is not intended to refer to an employer arrangement.

Benefit Design Type

18. **HDHPs may also be paired with HSAs and HRAs** to make plans more affordable for employees. Will CHIA note this?

CHIA will note that the data does not account for corresponding employer HRA or employee HSA adoption, which may mitigate out of pocket expenses.

19. Groups that offer a **High Deductible Health Plan (HDHP) options** should be reflected under the HDHP option, even if only a small minority of members are actually covered. Is this accurate?

Benefit Design Type, just like Product Type, is determined at the member level, as based on the benefit plan selected by the member, not the employer level. Only members covered under the HDHP should be included. For example, if an employer has 40 members, but only 5 are on a HDHP, only those 5 should be included in the HDHP membership counts.

20. Should **limited network plans** be reported under the **Tiered Network** Benefit Design Type category?

Plans can be both Limited Networks and Tiered Networks, Limited Networks only, and Tiered Networks only under the following scenarios:

Limited and Tiered

A plan is considered a Limited Network plan if it offers members access to a reduced or selective provider network relative to the payer's general or regional provider network. If a plan meets this criterion AND offers different levels of cost-sharing for the same service across providers, then it would be considered both a Limited Network plan and a Tiered Network plan.

Limited Network Only

If the payer offers a plan with only one level of cost sharing per type of service (e.g., \$1,000 inpatient admission copay), but offers it with a network that is a subset of the payer's general or regional provider network, then this is a Limited Network plan and not a Tiered Network.

Tiered Network Only

If the plan offers different levels of cost-sharing for the same service across providers, but the available provider network is not a subset of the payer's general or regional provider network, then it would be a Tiered Network and not a Limited Network plan.

21. Should **Group Insurance Commission (GIC)** plans be reported under the **Tiered Network** Benefit Design Type category?

GIC plans should be classified as Tiered based on the definition contained in the Data Submission Manual.

Data Reconciliation

22. If we do not have any **previous CHIA premium data reports to reconcile against** should we leave this section blank?

Since this is your first submission, this Worksheet (G2) does not need to be completed. However, please provide a response for Worksheet (G1) that reconciles the information provided to the "Annual Comprehensive Financial Statement," "Medical Loss Ratio Reporting Form," and "Supplemental Health Care Exhibits" data.

23. **What is the submission time period we need to reconcile to?**

For past Premium Request data, 2013 and 2014. For the "Supplemental Health Care Exhibits" data, please reconcile to-be-submitted Premiums-data for 2013, 2014, and 2015, with the last, as publicly available as of the submission date (May 2016). For the "Annual Comprehensive Financial Statement" and "Medical Loss Ratio Reporting Form," please do the same for only 2013 and 2014 (as 2015 data will not be available as of the submission date).

Workbook Use

24. Do we have to use one of the two **Excel workbooks**?

Yes.

25. Do we have to submit **both workbooks**?

*No. You only need to submit **one** of the two workbooks.*

26. Who should we contact if we have **questions on either workbook?**

Contact Dianna Welch for technical questions at dianna.welch@oliverwyman.com.

Other Questions

27. For Worksheet C, is CHIA looking for information by payer **rating size bands?** Is it okay to populate the spreadsheet using our rating bands?

That is correct. Payers should populate the spreadsheet with their own rating bands. Please see the bolded instructions in cell A7 of Worksheet C.

28. Merged market plans underwent significant changes starting January 1, 2014 to comply with the Affordable Care Act. What is the **value of requiring data on plans back to 2013?**

Historical information is used to calculate adjusted premiums, which account for changes in demographics, geographic area, benefits, and group size, which allow for a properly calculated premium trend.