

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 is the definition of the “Administrative Service Fees”?

Administrative Service Fees are the fees earned by a payer or Third Party Administrator for the full administration of a self-insured health plan; this excludes any premiums for stop-loss coverage. Submission of this data is voluntary.

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

Allowed claims are the total cost of claims to be paid by the payer (Incurred Claims) and the member (Cost-Sharing) and the federal or state governments (CSR Amounts) to the provider after the provider or network discount, if any. This should include medical claims, drug claims, capitation payments, withhold amounts, and all other payments to providers, including those paid outside the claims system. This value should include estimates of completed claims for periods that are not yet considered complete.

4. 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. This is true even if the services are managed by a vendor based on a capitated arrangement. 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

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

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

CHLA will calculate a scaled, “all-inclusive” premium or premium equivalent using this value. Any premium figures reported in this way will be identified explicitly as such.

Group Size Classifications

7. 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. In all other areas of the Data Submission Workbook, payers should adhere to the Market Sector groupings defined by CHLA.

8. 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 (see the Data Submission Manual for more information):

- a. Individual Purchasers
 - i. No Subsidy / Unknown
 - 1. Health insurance plans purchased by individuals either directly from a payer or through the Massachusetts Health Connector without public subsidy
 - ii. APTC Subsidy Only
 - 1. Health insurance plans purchased by individuals through the Massachusetts Health Connector and qualified for an Advance Premium Tax Credit (APTC) subsidy but not qualified for a Cost-Sharing Reduction (CSR) subsidy
 - iii. ConnectorCare
 - 1. Health insurance plans purchased by individuals through the Massachusetts Health Connector and qualified for an Advance Premium Tax Credit (APTC) subsidy and a Cost-Sharing Reduction (CSR) subsidy
- b. Student Health
 - i. Student Health
 - 1. Health insurance plans purchased by students through their school for primary, medical coverage
- c. Employer-Sponsored Plans
 - i. Small Group
 - 1. Fully-Insured (2-50 eligible enrollees, see 211 CMR 66.04)
 - 2. Self-Insured (2-50 enrolled employees)
 - ii. Mid-Size Group (51-100 enrolled employees)
 - iii. Large Group (101-499 enrolled employees)
 - iv. Jumbo Group (500+ enrolled employees)
- d. Government Employee Plans
 - i. 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, except as otherwise noted in the Massachusetts Division of Insurance Bulletin 2016-09.

Small Group, as defined by regulation, is defined by number of full time equivalent employees. If the group 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 self-insured portion of the market, all employer-based market sectors are determined based on the number of enrolled employees.

Geographic Area Calculations

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

Geography may be 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.

10. For **Member Months by Geographic Area** (Worksheets B1 and B2), 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 rather than employer zip code. This is consistent with prior years' Requests.

Product Type

11. 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).

12. What are examples of **HMO, PPO, POS, and "Other" plans**?

HMO plans utilize a closed network of providers, where selecting a primary care provider 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 provider is not necessary. POS plans may require members to coordinate care through a primary care provider; have a network of providers; and allow coverage outside that network (at a higher cost). "Other" plans are those that do not fall into the HMO, PPO, or POS categories. An example of an "Other" plan would be Indemnity plans. See the Data Submission Manual for more information.

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

The determination of Product Type should be done at the member level for all reporting (membership, premium, claims, etc.), as based on the benefit plan selected by the member, not the employer level.

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

14. **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.

15. Should groups that offer a **High Deductible Health Plan (HDHP) option** be reflected under the HDHP option, even if only a small minority of members are actually covered?

No; 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.

16. 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, or 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 that is smaller than the payer's most comprehensive provider network within a defined geographic area. If a plan meets this criterion AND offers different levels of cost-sharing for the same service across providers within the same provider type, 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 smaller than the payer's most comprehensive provider network within a defined geographic area, 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 within the same provider type, 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.

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

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

Funding Type

18. Is it possible to continue submitting data under the previous **Funding Type classification** of "Fully-Insured" and "Total Market"?

Yes. Beginning with the 2018 Request, payers were instructed to report Funding Type as either "Fully-Insured" or "Self-Insured." This change is expected to improve data submission accuracy and was implemented after consultation with payers. However, those payers that wish to continue submitting data under the previous Funding Type classification system may obtain an alternate Submission Workbook from CHLA.

Workbook Use

19. Do we have to use the **Excel workbook**?

Yes, data must be submitted in the provided Submission Workbook template. An alternate version is available for payers wishing to continue using the "Fully-Insured" and "Total Market" Funding Type classification. (See response to question 20.)

20. Who should we contact if we have **questions on the workbook**?

Technical questions may be submitted to CHLAData@gormanactuarial.com.

Other Questions

21. For Worksheet C, how should members enrolled in family policies be classified?

Deductible limits and OOP maximums should be reported based on individual (single) policy levels, even for members enrolled in family policies.

22. For Worksheet E1, do the **MLR rebate and 3R amounts for Direct Purchasers need to be allocated** to the three subsidy categories?

No, those amounts do not need to be allocated across the three categories. The total amount for those categories should be input into column H on Worksheets E1. Columns H-J appear merged for this purpose.

23. Which **Student Health populations should be included** in the request?

Only Student Health populations where the college/university is located in Massachusetts should be included. This includes students enrolled in the plan but with a permanent residence outside of Massachusetts. In addition, it excludes Massachusetts residents enrolled in a Student Health plan associated with an out-of-state institution.

24. Under what circumstances are payers expected to report **Member Months by Standard Industrial Classification (SIC) code** on Worksheet D?

Payers are expected to report Member Months by distinct, four-digit SIC code only for fully-insured individual (sole proprietor) and small group membership. If payers do not collect industry information for sole proprietor and/or small group accounts, all Member Months for individual purchasers and small groups should be reported under the "Unknown" designation. Similarly, if industry codes are only collected under certain circumstances, payers should report SIC codes where available and categorize the remaining Member Months as "Unknown."