CENTER FOR HEALTH INFORMATION AND ANALYSIS

PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM

PRIVATE COMMERCIAL CONTRACT ENROLLMENT

COVERAGE COSTS

COST-SHARING

PAYER USE OF FUNDS

TECHNICAL APPENDIX 2017

CHIA.

Private Commercial Enrollment, Coverage Costs, Cost-Sharing, and Payer Use of Funds

TECHNICAL APPENDIX

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Background

CHIA received summarized contract-membership, commercial premiums, consumer cost-sharing, and benefit level data for calendar years 2014, 2015, and 2016 from the following payers:

- Aetna: Aetna Health, Inc. and Aetna Life Insurance Company
- BCBSMA: Blue Cross and Blue Shield of Massachusetts, Inc. and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
- Cigna: CIGNA Health and Life Insurance Company
- Fallon: Fallon Community Health Plan, Inc. and Fallon Health & Life Assurance Company, Inc.
- HPHC: Harvard Pilgrim Health Care, Inc.; HPHC Insurance Company, Inc.; and Health Plans, Inc.
- HNE: Health New England, Inc.
- NHP: Neighborhood Health Plan, Inc.
- Tufts: Tufts Associated Health Maintenance Organization, Inc.; Tufts Insurance Company; and Tufts Health Public Plans, Inc. (formerly Network Health, LLC)
- UniCare: UniCare Life & Health Insurance Company
- United: UnitedHealthcare Insurance Company

Payer data was provided in response to the "2017 Annual Premiums Data Request," which was developed with the assistance of Oliver Wyman Actuarial Consulting. This request included detailed definitions and specifications for membership, premiums, claims, and other pricing data. It specified that payers provide data on their primary, medical, private commercial membership for all group sizes, including the individual and small group segments of the merged market. Products that were specifically excluded from this report were: Medicare Advantage, Commonwealth Care, Medicaid, Medicare supplement, and non-medical (e.g., dental) lines of business.[1]

CHIA requested that payers submit summarized data for their fully- and self-insured lines of business, contracted in Massachusetts. Payers' data submissions encompassed "contracted members" who may have resided inside or outside of Massachusetts; out-of-state members were most often covered by an employer that is located in Massachusetts. Both in-state and out-of-state "contract members" were included in the "Private Commercial Contract Enrollment," "Private Commercial Coverage Costs," "Member Cost-Sharing," and "Private Commercial Payer Use of Funds" sections of the report.

[1] CHIA collected data on Federal Employees Health Benefits Program (FEHBP) members as part of the Annual Premiums Data Request for the first time in 2017. FEHB enrollment and financial data may be included in future reporting.

Payer-provided data was validated against reported financial data from the Supplemental Health Care Exhibit (SHCE), the Massachusetts Annual Comprehensive Financial Statement, and the CCIIO Medical Loss Ratio Reporting Form.[2]

CHIA collected summarized enrollment, premiums, and claims data by funding type (fully-insured or self-insured), employer size (market sector), product type (health maintenance organization, preferred provider organization, point-of-service, and "other" plans), and benefit design type (high deductible health plans, tiered network plans, and limited network plans). Within the Individual Purchasers (non-group) market sector, data was further categorized into members with and without Cost-Sharing Reduction (CSR) subsidies. Data for student health plans sold through Massachusetts colleges and universities was not included in the main report but may be found in the accompanying databook.

Private Commercial Coverage Costs and Member Cost-Sharing

Payer-reported data from the "2017 Annual Premiums Data Request" enabled CHIA to report on fully-insured commercial premiums, self-insured premium equivalents, benefit levels, and member cost-sharing.

Administrative Service Fees

Payers and their associated third party administrators reported the fees that they received from self-insured employers to provide services such as plan design, claims administration, and access to networks of negotiated provider rates. This was a voluntary section of the "2017 Annual Premiums Data Request." In 2017, BCBS, HNE, HPHC, Tufts, UniCare, and United provided ASF data to CHIA.

Benefit Levels

Benefit levels were measured by Actuarial Value (AV), a measure of the proportion of covered medical expenses paid by insurance, which can be calculated by several different methods. Oliver Wyman estimated AVs using plan paid-to-allowed claims ratios calculated from payers' reported claims costs, adjusted for the impact of induced demand related to cost-sharing levels. Calculated benefit levels reflected the payer's liability for covered medical and pharmacy claims—excluding any CSR subsidies that may have lowered members' out-of-pocket costs. An AV of 1.0 would indicate a plan where 100% of the claims costs were paid for by the plan (i.e., no member cost-sharing or CSR subsidies).

Fully-Insured Premiums

For fully-insured lines of business, payers provided annual earned premiums by employer size, product type and benefit design type for 2014 through 2016, as well as their rating factors used in December 2016 and estimated

[2] The analysis in this report relies on premium, claims, and membership data submitted by major Massachusetts payers. Payer data submissions were reviewed for reasonableness but were not audited. When reported data was not consistent, revised data was requested and provided by the payers. To the extent that final payer submitted data was unknowingly incomplete or inaccurate, findings in this report may not align with other payer filings.

rebate amounts for the reporting years.[3] Premiums net of rebates were scaled by the "Percent of Benefits Not Carved Out" and divided by annual member months to arrive at premiums per member per month (PMPM).

Member Cost-Sharing

Average cost-sharing PMPM was calculated by subtracting incurred amounts and CSR subsidy amounts if applicable from allowed amounts (all of which were scaled by the "Percent of Benefits not Carved Out") and dividing by annual member months.

Percent of Benefits Not Carved Out

Payers estimated the approximate percentage of a comprehensive package of benefits that their corresponding allowed claims covered. This value was less than 100% when certain benefits, such as prescription drugs or behavioral health services, were carved out and not paid for by the plan. These percentages were used to scale premiums, premium equivalents, and claims.

Self-Insured Premium Equivalents

For self-insured lines of business, premium equivalents were calculated by adding the value of incurred claims to the ASFs that payers received from self-insured employers. Reported premium equivalents include data submitted by BCBSMA, HNE, HPHC, Tufts, and UniCare.[4] Together, these payers enrolled 68.8% of all Massachusetts self-insured members in 2016. Premium equivalents were scaled by the "Percent of Benefits Not Carved Out" and divided by annual member months to arrive at premium equivalents PMPM.

Private Commercial Payer Use of Funds

Payer-reported data from the "2017 Annual Premiums Data Request," along with payer-reported data from the SHCE, allowed CHIA to report on how payers used the premium revenue that they collected from their fully-insured lines of business.

Medical Loss Ratios

While AVs estimate how much an average member may expect a plan to cover of his/her allowed medical expenses, Medical Loss Ratios (MLRs) represent the proportion of a plan's total collected premium spent by that plan on member medical claims. MLR calculations include plan expenses for quality improvement and fraud detection activities as well as taxes and administrative fees. Further, in the merged market, adjustments are made for the impact of the Affordable Care Act's "3R" programs—Risk Adjustment, Reinsurance, and Risk Corridors. (Note: a plan may have a high MLR but a low AV if its administrative costs for a plan are particularly low, and the plan only covers a minimal amount of the member's expected medical expenses.)

[3] Per federal and Massachusetts regulations, payers must provide rebates when their Medical Loss Ratios (MLRs) fall below certain thresholds.

[4] Aetna, Cigna, and Fallon declined to provide ASF data to CHIA. While United provided ASFs, its finalized financial data was not received in time for inclusion in the report.

Premium Retention

Premium retention was calculated as the difference between the total premiums collected by payers[5] and the total spent by payers on incurred medical claims. Total retention amounts were based on premium and claims data reported by payers in the "2017 Annual Premiums Data Request."

Due to data availability and timing constraints, 3R transfer payments within the merged market were not available for all reporting years. For consistency, premium retention is reported prior to any 3R transfers.

Retention Decomposition

Findings related to retention breakdown into its components (retention decomposition) were based on SHCE data from 2014, 2015, and 2016, as analyzed by Oliver Wyman. Results are shown for only non-merged market membership. SHCE data for merged market business included estimates of 3R amounts, which may have deviated significantly from actual amounts.

[5] Including Advance Premium Tax Credits, where applicable

Data Submission Manual

957 CMR 10.00: Health Care Payers Premiums and Claims Data Reporting Requirements

February 28, 2017

1. Introduction

M.G.L. c. 12C, § 10 requires the Center for Health Information and Analysis (CHIA) to report on changes over time in Massachusetts health insurance premiums, benefit levels, member cost-sharing, and product design. CHIA collects this data under Regulation 957 CMR 10.00. While the Regulation contains broad reporting guidance, this Data Specification Manual provides technical details to assist with data filing.

2. Data Submission Manual Changes: 2017

I. Content

A. Additions/ Alterations

- Breakouts
  - Product Type: Added category for "Point of Service" plans
  - Market Sector: Renamed "Individual Purchasers" as "Direct Purchasers" and split by "No Subsidy/Unknown", "APTC Subsidy Only", and "APTC + CSR Subsidies".
  - Market Sector: Added explicit categories for "Student Health Insurance" (under Direct Purchasers) and "Federal Employees Health Benefits Program" (under Government Employee Plans)
- Data
  - Advance Premium Tax Credits (APTC) and Cost Sharing Reduction (CSR) subsidy amounts, where applicable

B. Deletions

- There are no content deletions proposed for 2017.

C. Terminology

- Slight modifications made for clarity and definitional alignment throughout

II. Format

A. Alterations

- Streamlined Workbook: The "traditional" Premiums workbook has been modified to reduce submitter confusion and to increase analytic efficiency.

B. Deletions

- In 2016, in response to payer feedback, CHIA created an optional "flat file" submission format. No payers submitted using this method. Given the lack of demand and due to resource constraints, CHIA has discontinued this submission option for 2017. Please notify your liaison if a flat file submission method is desired in future years.

C. Additional Note

- In 2016, CHIA provided payers the option of filling out a workbook with fully- and self-insured tabs, or one with fully-insured and full-market (fully- plus self-insured) tabs. The "full-market" option was the desired choice and will be continued for 2017 submissions.

3. Required Submitters and Submission Instructions

Per 957 CMR 10.00, only payers with at least 50,000 Massachusetts Private Commercial Plan members for the latest quarter, as reported in CHIA's most recently published Enrollment Trends, are required to submit. As of February 15, 2017, this includes the following payers:

- Aetna
- Anthem, including UniCare
- Blue Cross Blue Shield of Massachusetts (BCBSMA)
- Cigna
- Fallon Health (Fallon)
- Harvard Pilgrim Health Care, including Health Plans, Inc. (HPHC)
- Health New England (HNE)
- Neighborhood Health Plan (NHP)
- Tufts Health Plan, including Tufts Health Public Plans (Tufts)
- United Healthcare (United)

No payers were added for the 2017 Submission.

The Health Care Payers Premiums and Claims Data Reporting Workbook (Workbook) must be used for data submission. It is available through your CHIA liaison or at: http://www.chiamass.gov/information-for-data-submitters-premiums-data/. A Workbook must be completed for each legal entity of a payer.

The Workbook contains aggregate financial data breakouts by funding type and must be used for data submission. General questions and completed Workbooks should be sent to Dianna Welch of Oliver Wyman Actuarial Consulting, Inc., at dianna.welch@oliverwyman.com no later than Friday, May 12th, 2017.

4. Population Specification

Regulation 957 CMR 10.00 requires payers to report aggregate membership, premiums, and claims data for all primary fully- or self-insured members in Private Commercial medical plans sitused or administered in Massachusetts. Members of medical plans purchased through the Massachusetts Health Connector and all comprehensive Student Health and Federal Employees Health Benefits Program membership should be included.

Plans Not Included:

- Commonwealth Care
- Indian Health Service
- MassHealth Managed Care
- Medical Security Program
- Medicare Advantage
- Medi-gap
- One Care, PACE, Senior Care Options
- Tricare
- VA Healthcare

Members Not Included:

- Medical plan enrollees using plan as secondary coverage

5. Workbook Overview

Regulation 957 CMR 10.00 requires payers to report aggregate membership, premiums, and claims data by market sector, product type, and benefit design type for the previous three calendar years in the Premiums Workbook (.xlsx). The 2017 Workbook contains the following worksheets:

A. Payer Verification

Worksheet A calculates aggregate and per member per month (PMPM) values based on payer-submitted data (worksheets B-E) for payer verification. A submission contact is required.

B. Membership by Geography and Gender & Age Group

Worksheets B1 & B2 request Member Months data by Geographic Area (3-digit zip) by Year, Funding Type, Product Type, Benefit Design Type, and Market Sector.

Worksheets B3 & B4 request Member Months data by Age Group & Gender by Year, Funding Type, Product Type, Benefit Design Type, and Market Sector.

C. Membership by Rating Size Bands

Worksheet C1 requests the size bands that correspond to a payer's rating bands, excluding individual policies in the Merged Market. These values are then automatically populated in worksheet C2.

Worksheet C2 requests Members Months data only for small group, fully-insured accounts by Product Type and Benefit Design Type, by the size bands inputted in C1. For employer groups with multiple product types, the size band used should be based on the total employer size, not the size of the population enrolled in each type. For example, for an employer group of size 20 that has 5 employees enrolled in a PPO for the entire year and has 15 employees in an HMO for the entire year: 60 member months would be reported in size band "20" under "PPO", while 180 member months would be reported in size band "20" under "HMO."

D. Average Group Subscriber Count

Worksheet D requests Average Group Subscriber Count by Funding Type and Market Sector (employer-sponsored plans only).

E. Financials

Worksheet E1 requests the following aggregate financial data for fully-insured plans by Year, Product Type, Benefit Design Type, and Market Sector:

- Earned Premiums (incl. APTC, excl. MLR Rebates)
- MLR Rebates [Amounts for Direct Purchasers need not be allocated to the three subsidy categories; instead, enter the total amount for the individual market for the applicable year in the 'No Subsidy/Unknown' column.]
- Percent of Benefits Not Carved Out
- Claims
    - Allowed
    - Incurred
- Payer "3R" Totals [2016 Totals Not Needed w/ May 12th Submission; amounts for Direct Purchasers need not be allocated to the three subsidy categories; instead, enter the total amount for the individual market for the applicable year in the 'No Subsidy/Unknown' column.]

    - Risk Adjustment Transfer Amounts
    - Federal Transitional Reinsurance Amounts
    - Risk Corridor Amounts
- ACA/ Health Connector Subsidy Amounts
    - Advance Premium Tax Credit Amounts
    - Cost-Sharing Reduction Amounts

Worksheet E2 requests the following aggregate financial data in total by Year, Product Type, Benefit Design Type, and Market Sector:

- Earned Premiums (incl. APTC, excl. MLR Rebates)
- MLR Rebates [Amounts for Direct Purchasers need not be allocated to the three subsidy categories; instead, enter the total amount for the individual market for the applicable year in the 'No Subsidy/Unknown' column]
- Percent of Benefits Not Carved Out
- Claims
    - Allowed
    - Incurred
- Payer "3R" Totals [2016 Totals Not Needed w/ May 12th Submission; amounts for Direct Purchasers need not be allocated to the three subsidy categories; instead, enter the total amount for the individual market for the applicable year in the 'No Subsidy/Unknown' column]
    - Risk Adjustment Transfer Amounts
    - Federal Transitional Reinsurance Amounts
    - Risk Corridor Amounts
- ACA/ Health Connector Subsidy Amounts
- Administrative Service Fees [Voluntary]

F. Rating Factors

Worksheet F requests rating factors for fully-insured plans with effective dates in December 2016. Please input 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. Industry factors and benefit plan factors may be excluded. Payers should define group size ranges as they would apply their rating factors, which should include the same bands as reported on Worksheet C.

G. Reconciliation

Worksheet G requests data reconciliation checks between inputted data and other payer data submissions. Please explain major discrepancies with:

- Massachusetts Division of Insurance's "Annual Comprehensive Financial Statement"
- Center for Consumer Information and Insurance Oversight's "Medical Loss Ratio Reporting Form"
- National Association of Insurance Commissioners' "Supplemental Health Care Exhibit"
- Prior CHIA Annual Premiums Data Request submissions

A detailed reconciliation is not required. Rather, a listing of reasons for potential discrepancies should be provided.[6]

For payer convenience, referenced and public payer data may be made available upon request.

[6] CHIA understands that certain Affordable Care Act provisions (e.g. Premium Stabilization programs) may make comparisons between May submissions and financial statements difficult for individual and small group sectors. CHIA will follow up with payers for final 2016 amounts in July.

6. Definitions

"3 R" Amounts [2016 Totals Not Needed w/ May 12th Submission; amounts for Direct Purchasers need not be allocated to the three subsidy categories; instead, enter the total amount for the individual market for the applicable year]

- Risk Adjustment Transfer Amount: The amount that is received (+) or owed (-) as a result of the risk adjustment program that was put into place in Massachusetts' individual and small group markets effective in 2014.
- Federal Transitional Reinsurance Amount: The amount that is received (+) as a result of the federal transitional reinsurance program that was put into place in the individual market effective 2014. This amount includes only recoveries received and not any required contributions to the program.
- Risk Corridor Amount: The amount that is received (+) or owed (-) as a result of the risk corridor program that was put into place in the individual and small group markets effective in 2014. Amounts owed should be reported in the year for which the amounts were owed. If reporting amounts received, please report the actual amount received after the reduction of the originally calculated amounts. The amount received in 2014 is expected to reflect 12.6% of the originally reported amount owed to the payer plus any additional amounts received from payer payments made for the 2015 benefit year. The total receipt should be reflected in the calendar year 2014 reported amounts since 2015 funds paid in will first be used to fulfill 2014 amounts owed.

Affordable Care Act/ Massachusetts Health Connector Subsidies

- Advance Premium Tax Credit (APTC) Amounts: The total amount of tax credits individuals received to lower their health insurance payments while enrolled in qualifying Massachusetts Health Connector plans. Eligibility determined based on expected annual income, and credit may have been taken in advance to lower monthly payments.
- Cost Sharing Reduction (CSR) Amounts: The total estimated reductions payers received to lower individuals' health insurance deductibles, copayments, and coinsurance payments while enrolled in qualifying Massachusetts Health Connector plans. Eligibility determined based on expected annual income. Maximum out-of-pocket amounts may also be reduced.

Administrative Service Fees: The fees earned by a payer or Third Party Administrator for the full administration of a self-insured health plan excluding any premiums collected for stop-loss coverage. This data is appreciated, though submission is voluntary.

Claims: Total medical, pharmacy, and behavioral health claims, as described. Amounts should include estimates of completed claims for any period not yet considered complete. For the 2017 submission, run-out beyond the date through which claims were paid when the claims data were accessed, as available, should be estimated and incorporated into results. Amounts should not include expenses for medical management performed in-house or by third parties other than providers, or any other payments to entities besides providers.

- Allowed Claims: The claim cost 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. Total Allowed Claims should include capitation payments, withhold amounts, and all other payments to providers including those paid outside the claims system.
- Incurred Claims: The claim cost to be paid by the payer to the provider after the provider or network discount, if any. Total Incurred Claims should include capitation payments, withhold amounts, and all

other payments to providers including those paid outside the claims system. Incurred Claims should reflect only those amounts that are the liability of the payer, i.e., net of payments by both the member (Cost-Sharing) and the federal or state governments (CSR Amounts), such that the Incurred Claims are reported in a manner consistent with amounts expected to be funded by the Premiums earned.

Funding Type

- Fully-Insured: A plan where an employer contracts with a payer to cover pre-specified medical costs for its employees and employee-dependents.
- Total: All Massachusetts members with primary, medical insurance contracted or administered in Massachusetts. Fully-insured members are a subset of this population. Self-insured employers, who take on the financial responsibility and risk for their employees' and employee-dependents' medical costs, paying payers or third party administrators to administer their claims, are also a subset of this population and may or may not also purchase stop-loss coverage to protect against large claims; stop-loss premiums and employer-reimbursements should not be included in this Request.

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

Group Subscriber Count, Average: Equal to the number of covered subscribers 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. For a given employer, the number of covered subscribers should be the average for the calendar year.

Market Sector: Market Sector includes four employer-sponsored plan categories, four direct-purchaser plan categories, and two categories for state and federal employee plans, as described below.

Market Sector	Category	Description
Direct Purchasers	No Subsidy/Unknown	Health insurance plans purchased by individuals either directly from a payer or through the Massachusetts Health Connector without public subsidy.
	APTC Subsidy Only	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.
	APTC + CSR Subsidies	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 (ConnectorCare plans).
	Student Health	Health insurance plans purchased by students through their school for primary, medical coverage. The ACA considers student health insurance purchasers to be individual, non-group purchasers.
Employer-	Small Group[7]	Fully-Insured: health insurance plans purchased through employer

[5] Fully-Insured small employers that met the definition of an Eligible Small Group Business or Group under 211 CMR 66.04 but became large employers under the full-time equivalent counting method implemented by the ACA and further discussed in Bulletin 2016-09 (http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2016-doi-bulletins/bulletin-2016-09.html) should be reported under the Small Group category during the time they were covered by a plan marketed and regulated as a small group plan, and reported under the applicable category (e.g., Mid-Size Group) during the time they were covered by a plan marketed and regulated as a large group plan.

Sponsored Plans		groups with 2-50 eligible enrollees, and that meet the definition of an "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. Includes any Small Groups that may have purchased health insurance through the Massachusetts Health Connector. Includes any Small Groups that may have purchased health insurance through an association.[8] Non Fully-Insured: plans purchased through employer groups with 2-50 enrolled employees.
	Mid-Size Group	Fully-Insured: health insurance plans purchased through employer groups with 51-100 enrolled employees, and those employer groups with fewer than 51 enrollees that would not otherwise meet the definition of a Small Group (e.g., an employer with 150 total employees but only 40 enrolled employees). Non Fully-Insured: plans purchased through employer groups with 51-100 enrolled employees.
	Large Group	All: health insurance plans and non-fully insured plans purchased through employer groups with 101-499 enrolled employees.
	Jumbo Group	All: health insurance plans and non-fully insured plans purchased through employer groups with 500+ enrolled employees.
Government Employee Plans[9]	Massachusetts Group Insurance Commission (GIC)	Health insurance plans and non-fully insured plans purchased by individuals from the selection negotiated and administered by the Massachusetts Group Insurance Commission.
	Federal Employees Health Benefits Program (FEHBP)	Health insurance plans and non-fully insured plans purchased by individuals from the selection negotiated and administered by the US Office of Personnel Management.

Medical Loss Ratio (MLR) Rebates: Massachusetts health insurers are required to submit data on the proportion of premium revenues spent on health care services and quality improvement initiatives for several business lines, including for private commercial fully-insured groups. If state- and federal-MLR ratios or thresholds are not met, payers must provide members rebates for the excess premium retention. Massachusetts MLR threshold for the fully-insured Small Group market sector was 89% in 2014 and 88% in 2015 and 2016; for the Large Group market sector, the threshold was 85% across the three year period.

Premiums, Earned: Represents the total gross earned premiums earned prior to Medical Loss Ratio (MLR) rebate payments incurred, though not necessarily paid, during the year, including any portion of the premium that is paid to a

[8] Small Groups that purchase coverage through an association are to be included in the Small Group category per Massachusetts 211 CMR66 and federal CCIIO guidance.

[9] Non-GIC municipal employer groups should be counted under "Employer-sponsored plans" for the purposes of this request

third party (e.g. Connector fees, reinsurance). Do not include any amounts related to risk adjustment. Premium amounts should include any advance premium tax credit amounts.

Product Type: A mutually exclusive categorization of enrollment by members' selected health insurance products: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point-of-Service (POS), and "Other" plans. All Private Commercial plans should be included in one of these four categories, such that summing values across all Product Types produces totals equal to those for a given Market Sector. For plans that may be considered under more than one Product Type, the plan should be reported under the Product Type wherein most care is provided, as measured by Allowed Claims value.

- Health Maintenance Organization (HMO): Plans that have a closed network of providers, outside of which non-emergency coverage is not provided; generally requires members to coordinate care through a primary care provider.
- Preferred Provider Organization (PPO): Plans that have a network of "preferred providers", although members may obtain coverage outside the network at higher levels of cost-sharing; generally does not require members to select a primary care provider.
- Point-of-Service (POS): Plans that require members to coordinate care through a primary care provider and use in-network providers for the lowest cost-sharing. As with a PPO plan, out-of-network providers are covered, though at a higher cost to members.
- Other: Plan types other than HMO, PPO, and POS, including, but not limited to, Exclusive Provider Organization (EPO) plans and Indemnity plans.

For additional membership categorization examples, please see the 2017 Premiums FAQ.

Percent of Benefits Not Carved Out: The ratio of a membership's actual Allowed Claims, as compared to that membership's estimated Allowed Claims, had all members administered had a comprehensive benefit package (i.e., all Essential Health Benefits, and benefit claims, administered and paid by the submitted payer). This value will be less than 100% when certain benefits, such as prescription drugs or behavioral health services, are carved-out and not paid for by the plan. These values should have general alignment to the partial-/full-claims data submitted as part of CHIA's Total Medical Expense (TME) request.

Payers should provide their best estimates based upon available data for similar populations. For example:

- A payer administers 1,500 members: 1,000 members have comprehensive coverage; 500 members have comprehensive coverage minus pharmacy
- Based on comprehensive coverage member experiences, the payer estimates that approximately 20% of Allowed Claims PMPM are for pharmacy services (with variations across years, market sectors, funding types, product types, and benefit design types, per Workbook requirements)
- These best-estimate member experiences should be used to "scale up" estimated Allowed Claims for members where pharmacy claims data is not available
- Percent of Benefits Not Carved Out: [((1,000 * 100%) + (500 * 80%)) / (1,000 + 500)] = 93%

Benefit Design Type: Benefit and network design characteristics that are not exclusive to a given Product Type. These categories are not mutually exclusive, nor exhaustive. Benefit Design Type should be determined at the member level.

- 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 $1,250 for 2014 and

$1,300 for 2015 and 2016 (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 in 2014 for this data request's purpose if the individual deductible for that product is equal to or exceeds $1,250 in 2014; 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 and/or the cost of care provided. 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.

  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 Request (i.e., a plan that tiers only hospitals is a Tiered Network; a plan that tiers only physicians is also here considered a Tiered Network).

  For additional Tiered Network information, please see the 2017 Premiums FAQ.

- Limited Networks: A limited network plan is a health insurance plan that 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. This definition, like that contained within Massachusetts Division of Insurance regulation 211 CMR 152.00, does not require a plan to offer a specific level of cost (premium) savings in order to qualify.

If there are circumstances where this definition appears to include plans that are not truly "limited network" plans, please contact Dianna Welch to discuss at dianna.welch@oliverwyman.com.

For more information, please contact:

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