Data Sources

Payer Data

CHIA received contract-membership, commercial premiums, consumer cost sharing, and benefit level data for 2012, 2013, and 2014 from affiliates of the following eleven (11) payers:

- Aetna
- Anthem (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)
- Network Health
- Tufts Health Plan (Tufts)
- United Healthcare (United)

Payer data was provided in response to the "2015 Annual Premiums Data Request," which was developed with the assistance of Oliver Wyman Actuarial Consulting, Inc. and forwarded to the participating payers. This request provided detailed definitions and specifications for requested membership, premiums, claims, and other pricing data; it requested 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 study were: Medicare Advantage, Commonwealth Care, Medicaid, Medicare supplement, Federal Employee Health Benefit Program (FEHBP), and non-medical (e.g., dental) lines of business.

CHIA requested membership data from payers' fully- and self-insured business, as contracted in Massachusetts. Reported members may, however, reside inside or outside Massachusetts; out-of-state members are most often covered by an employer that is located in Massachusetts. These out-of-state "contract" members were included in all sections of this report related to premium trends.

Payers provided their claims by funding type (fully-/self-insured), market sector (employer size), product type (HMO/PPO), and by benefit design (High Deductible Health Plans (HDHPs) or Tiered Network plans) for 2012 through 2014. Member month information by age, gender, area, group size (small group, fully-insured only), funding type, market sector, product type and HDHP/Tiered Network was also provided.

Payer-provided data were supplemented with reported financial data from the Supplemental Health Care Exhibit (SHCE), the Massachusetts Annual Comprehensive Financial Statement, and the CCIIO Medical Loss Ratio Reporting Form. These resources were also used in data validation.[1]

[1] The analysis in this report relies on premium, claims, and membership data submitted by major Massachusetts payers. These data were reviewed for reasonableness, but they were not audited. When reported data were not consistent, revised data were requested and provided by the payers. To the extent final data were unknowingly incomplete or inaccurate, findings may be compromised.

Understanding the Group Insurance Commission (GIC)

The Group Insurance Commission (GIC) was established by the Legislature in 1955 to provide and administer health insurance and other benefits to the Commonwealth's employees and retirees and their dependents and survivors.[2] In 2004, the GIC launched its Clinical Performance Improvement Initiative (CPII), where, with Mercer, it analyzed its member claims data to categorize physicians by quality and efficiency measures.[3] GIC health plans were then required to use results to tier specialists, assigning members lower copays for selecting the "highest performing quality and/or cost efficient doctors."[4] The CPII created new incentives for members, to select the most efficient providers, and for providers, to examine their practice patterns and challenge their current usage of resources. Most of the GIC's membership has been classified in this brief as being part of a "tiered network,"[5] although the GIC does not consider all of these members to be in a tiered network plan.

GIC Data

The GIC releases payer- and plan-level enrollment data each year as part of its Annual Report. GIC membership totals are reported for the state fiscal year, which runs from July 1 to June 30. For the current analysis, CHIA estimated the proportion of Tiered Network membership that was attributable to GIC enrollment using enrollment counts from the GIC FY2012, FY2013, and FY2014 Annual Reports in combination with payer-reported full-market data from CHIA's "2015 Annual Premiums Data Request", which is reported on a calendar year basis. Calculated totals exclude Fallon Select membership. Differences between fiscal year and calendar year data may affect estimates. Payers were not required to identify GIC membership under the "2015 Annual Premiums Data Request".

---

[2] More information on the GIC can be found here. The Municipal Partnership Act in 2007 allowed Massachusetts cities and towns the option of obtaining health insurance for their employees and retirees through the GIC. Purchasing through the GIC was previously only available to state employees and retirees, retired teachers, and Springfield city employees and retirees.

[3] More information on the GIC's CPI Initiative can be found here.

[4] According to the GIC's 2012 CPII RFR Staff Recommendation (available via CommBuys), the CPII "relies on a database of over 126 million…claims aggregated from the six carriers currently providing health coverage to GIC members. The database is used to make quality and resource efficiency comparisons among providers. The health carriers then use the results of this analysis to design products that incorporate provider 'tiering', using modest co-pay differentials as incentives to encourage members to utilize more cost-efficient and high-quality providers." Further, according to The Commonwealth Fund's 2007 GIC profile, by July 1, 2007, all GIC health plans were "required to have some form of individual provider tiering incorporated into their GIC product, meaning that all GIC members who are not in a Medicare plan will not have a choice between a tiered or non-tiered product." Additional provider-tiering categories have been incorporated in the years since.

[5] CHIA's definition of Tiered Networks was based upon the Massachusetts Division of Insurance definition. See "Definitions and Analytic Detail" section for CHIA's full definition.

Definitions and Analytic Detail

Administrative Service Fees

Payers reported the fees that they received from self-insured employers to provide services such as plan design, claims administration, and the use of networks of negotiated provider rates. When presented as part of premium equivalents, administrative service fees were scaled by the "Percent of Benefits Not Carved Out."

Benefit Levels

Benefit levels were measured by the ratio of paid-to-allowed claims (P/A ratio). (Note: Actuarial Values were also calculated, and produced similar results to those using the P/A ratio.) This calculation method differs from that used in CHIA's 2014 Annual Report on the Massachusetts Health Care Market, though trends remain consistent.

Cost of Coverage

The cost of coverage for the overall commercial market—both fully- and self-insured—was calculated by combining premium and premium equivalent data, scaled by the "Percent of Benefits Not Carved Out."

Fully-Insured Premiums

For fully-insured lines of business, payers provided their annual earned premiums net of rebates[6] by market sector, product type and HDHP/tiered network for 2012 through 2014, as well as their rating factors used in December 2014. 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).

Fully-Insured Premiums, Adjusted

To calculate payer-specific "adjusted premiums," unadjusted premiums were recalculated to account for membership differences in age, gender, area, group size, and benefits. Adjustments were performed by first adjusting the rating factors to make each payer's factors relative to the same demographic to create normalized factors. Age/gender factors were relative to a 35-year-old female, size factors were relative to a group of 51+ enrollees, and area factors were relative to Boston. Second, a common set of rating factors was calculated as the average of the payers' normalized factors, removing the highest and lowest factors. These common rating factors were used to adjust all payers' premiums. Next, a member weighted average adjusted factor was calculated for each calendar year. Finally, the unadjusted premiums were divided by the average rating factors to develop expected premiums PMPM, adjusted to the demographics represented by a 1.0 factor.

The market total adjusted premium for all years was set equal to the weighted average adjusted premiums PMPM of the payers. This is a different methodology than was used in prior reports and was intended to remove any skewing of the results from using payer-specific rating factors rather than a common set of rating factors in performing the adjustments.

It is possible that using the December 2014 factors for all periods in the study had a slight impact on resulting adjusted premium trends. However, it was determined that it was not feasible to request factors for each month or quarter. Furthermore, the factors are applied based upon effective date of issue or renewal which

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

was not feasible to model in this analysis. This methodological decision is not anticipated to materially skew adjusted premium results.

Note that for this analysis, rating factors applied to Mid-Size, Large, and Jumbo groups reflected a premium based on a manual rate and not on the group's own experience. In the market, actual premiums would be based on a combination of the manual rate and an experience rate with the proportion of each depending on the group's size. The largest groups are typically rated based entirely on their own experience. Therefore, this analysis makes the assumption that actual experience will follow the claim pattern assumed in the manual rating factors. Actual premiums may differ. This approach is not anticipated to have a material impact on results. Rather, it is anticipated that the manual rate would be determined consistent with the overall average experience of the covered groups.

Adjusting the premiums for benefits required a separate analysis from the rating factor adjustments. Benefit levels for this analysis were measured by **Actuarial Values (AV)**, a measure of the proportion of expenditures covered by insurance versus patient cost-sharing, which can be calculated by several different methods. For the "adjusted premiums" analysis, Oliver Wyman estimated the AVs using the paid-to-allowed ratios calculated from the payers' reported claims costs, adjusted for the impact of induced demand related to cost sharing levels. The unadjusted premiums were divided by the estimated AVs to determine the premiums adjusted for benefits. An AV of 1.0 represented a plan where 100% of the claims' costs are paid for by the plan. Given the limitations of the data available, this analysis did not include limited network impact in the AV.

Medical Loss Ratios

While AVs estimate how much an average member can expect a plan to cover of his/her covered medical expenses, Medical Loss Ratios (MLRs) represent the proportion of a plan's total collected premium spent by that plan on member medical claims. MLRs used for rebate calculations also account for quality improvement and fraud detection expenses to adjust claims, and taxes and fees to adjust premiums. Further, in the merged market, adjustments are made for the impact of the 3Rs. (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.)

CHIA's 2014 Annual Report used MLR data from Massachusetts MLR Reports filed with the Division of Insurance; 2014 data, however, was not available in time for inclusion in this Report. Simple loss ratios (premiums divided by paid claims, with no adjustments) calculated from the "2015 Annual Premiums Data Request" are included in the data book.

Member Cost-Sharing

Average cost-sharing PMPM was calculated by subtracting incurred claims from allowed claims (both of which were scaled by the "Percent of Benefits not Carved Out") and dividing by annual member months.

Percent 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.

Annual Report Series 2015: Performance of the Massachusetts Health Care System

Massachusetts Tiered Network Membership

Premium Retention

Premium retention was calculated as the difference between the total premiums collected by payers and the total spent on incurred medical claims. Total retention amounts were based on premium and claims data reported by payers in the "2015 Annual Premiums Data Request."

Self-Insured "Premium Equivalents"

For self-insured lines of business, "premium equivalents" were calculated by adding the value of incurred claims to the administrative service fees that payers receive from self-insured employers. Premium equivalents were scaled by the "Percent of Benefits not Carved Out" and divided by annual member months to arrive at premium equivalents PMPM.

Tiered Network Plans

Under Tiered Network plans, payers "tier" service providers by quality and/or cost-efficiency measures and hold members responsible for paying higher levels of cost-sharing for utilizing providers in lower-rated tiers.

Tiers are not considered separate networks, but rather sub-segments of a payer's HMO or PPO network. A Tiered Network plan 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 tiered HMO plan, for example, may segment a payer's HMO network into two tiers, with members 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). If, however, 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 qualify as a Tiered Network plan (e.g. a plan that tiers only hospitals, and not physicians, would still be considered a Tiered Network plan).

[For questions, contact: Kevin Meives, Senior Health System Policy Analyst, at Kevin.Meives@state.ma.us]