Massachusetts High Deductible Health Plan Membership

Data Source

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 of 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 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 was requested and provided by the payers. To the extent final data were unknowingly incomplete or inaccurate, findings may be compromised.

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: AVs 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[2] 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

[2] 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.

High Deductible Health Plans
Plans were classified as HDHPs if they had an individual deductible greater than or equal to the IRS qualifying definition, which was $1,200 for 2012 and $1,250 for 2013 and 2014 (for the most preferred network or tier, if applicable). The plan did not have to be a qualified HDHP in order to be considered an HDHP for this analysis.

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.

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."

Regional Analysis

Regional analysis done using three-digit zip code data, aggregated to regions by DOI small group rating regulations. Self-insured data for CIGNA and United was excluded from this analysis.

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.

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