**Enrollment in the Insurance Market**

**2015 Annual Premiums Data Request**

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.

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]](#footnote-1)

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.

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

**Commercial Premiums and Member Cost-Sharing**

Payer-reported data from the “2015 Annual Premiums Data Request” also allowed CHIA to report on commercial premiums, member cost-sharing, and benefit levels.

**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]](#footnote-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 a common demographic. 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. 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 2012 was set equal to the weighted average adjusted premiums PMPM of the payers. The percent changes in the total adjusted premiums from 2012 to 2013 and 2013 to 2014 were calculated as the member weighted average change across all payers. The total adjusted premium PMPM for 2013 and 2014 was calculated as the prior year adjusted premium PMPM times 1+ the percent change in total adjusted premium for the year. 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 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.

**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.

**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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**Commercial Payer Use of Funds**

Finally, payer-reported data from the “2015 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 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 databook.

**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.”

Retention was reported without including transfers associated with the Affordable Care Act’s “3R” programs—Risk Adjustment, Reinsurance, and Risk Corridors. Payers did, however, report these amounts, which can be found in the databook.

**Retention Decomposition**

Findings related to retention breakdown into its components (retention decomposition) were based on Supplemental Health Care Exhibit (SHCE) data from 2012, 2013, and 2014, 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.

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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. [↑](#footnote-ref-1)
2. Per federal and Massachusetts regulations, payers must provide rebates when their Medical Loss Ratios (MLRs) fall below certain thresholds. [↑](#footnote-ref-2)