

**Minnesota's 2010 Health Insurance Market Survey**  
**Frequently Asked Questions**  
**December 10, 2010**

The Minnesota Department of Health (MDH), in partnership with the Minnesota Department of Commerce, is currently collecting information from health plan companies with annual premiums of \$2.5 million or more in either the individual market, small group market, or large group private health insurance market (groups with 51 to 100 employees). The information collected pertains to enrollment, benefits, premiums, and claims in these three market spaces. The purpose of this survey is to monitor trends in the private market and evaluate the impact of insurance market changes.

This data is collected under MDH's statutory authority in Minnesota Statutes, sections 62J.301 and 62J.38. The data is classified as non-public information under Minnesota Statutes, section 62J.321. No health plan or company will be identifiable from any analysis that will be released based on these data.

In response to questions raised by a number of health plans, MDH is providing clarifications and answers to questions, in addition to slightly revised data reporting forms (see updated spreadsheets). In addition, MDH is extending the deadline for reporting the requested information to **February 4, 2011**, recognizing that aggregating this information requires additional time on the part of health plans.

**Individual/Small Group**

Q1: For the purpose of assigning individual members to age categories, which date should be used to determine a member's age? (Part III)

A1: Please use the age of individual(s) at the end of calendar year 2009.

Q2: Is data collection limited to groups that were continuously enrolled for a full calendar year and, if not, should claims be adjusted in some ways to reflect a full 12 month experience? (Part III)

A2: No, data should be reported on all groups, independent of how many months out of a full calendar year they were enrolled in a specific product. However, to maintain the relationship between member months and claims, MDH has changed reporting for Part III to be *member months* specific. **Please use the updated spreadsheets in your reporting.**

Q3: Similarly, is there a need to adjust "allowed annual claimant claims" for members not continuously enrolled for 12 months to reflect a full year experience (Part IV)

A3: The data collection form in Part IV is already tied to member months. No further changes are necessary.

Q4: For groups where employers offer multiple products to their employees, should the number of groups be counted as a fraction of total employees in each product? (Part III)

A4: No, the group should be counted for each product that the employer is offering. We understand the aggregating groups in Part III will not tie to other data in the workbooks.

Q5: For the purpose of calculating a group's average age, which date or age should be used and which population should be considered? (Part III)

A5: Please calculate the average age based on individuals enrolled in the specific product that you are reporting about. Members' age at the end of calendar year 2009 should be used for the calculation.

Q6: Which rating table should be used if multiple tables were in use in calendar year 2009? (Part V)

A6: Please use the last rating table used on the end of calendar year 2009.

Q7: Some carriers do not rate based on group member's smoking status. How should they complete the Health Status/Smoking Adjustment table? (Part V)

A7: Disregard the smoking adjustment table and enter "1" in the smoking adjustment component of the health adjustment table.

Q8: Some carriers compute smoking adjustments at the level of covered lives, not at the subscriber level. How should this data be reported and would it pose a problem that subscribers are potentially split across adjustment levels and no longer tie to covered lives? (Part III)

A8: Please record the adjustment at the covered lives level. We have removed the "subscriber" column from the individual market worksheets to avoid potential confusion. **Please use the updated spreadsheets in your reporting.**

Q9: What claims definitions should carriers use in their reporting on health care claims?

A9: As provided in the definition section, the data collection template distinguishes between *allowed* and *incurred* claims. Under this definition, incurred claims means paid claims for services incurred in calendar year 2009. Because nearly a full year has passed since the end of calendar year 2009, adjustments for IBNR should only be necessary in rare cases. Incurred claims should include all costs related to claims such as estimated risk sharing payments to providers, capitation, management fees, etc. Allowed claims are the sum of incurred claims and member cost sharing for calendar year 2009. No further adjustments of claims are required.

## Groups with 51 to 100 employees

Q1: Many health carriers do not have information on the number of employees in a given group; they know how many employees are enrolled in coverage. What group size categories should health plans use based on the number of enrolled members, and will this information be collected consistently across the market? (Part VI)

A1: In Table 1 of the appendix to this document, MDH is providing categories that provide an approximation of group size on the basis of health plan enrollment. These categories take into consideration information on eligibility and takeup in the employer market for groups with 51 to 100 employees.

Q2: Given the volume of products that are custom-designed for buyers in the group market with 51 to 100 employees, aggregating the information by product would be extremely time consuming. What groupings should carriers use to aggregate the requested information? (Parts I through III)

A2: In Table 2 of the appendix to this document, MDH is providing 13 mutually exclusive categories that health plans are used to aggregated their applicable group market products into.

Q3: What claims definitions should carriers use in their reporting on health care claims?

A3: As provided in the definition section, the data collection template distinguishes between *allowed* and *incurred* claims. Under this definition, incurred claims means paid claims for services incurred in calendar year 2009. Because nearly a full year has passed since the end of calendar year 2009, adjustments for IBNR should only be necessary in rare cases. Incurred claims should include all costs related to claims such as estimated risk sharing payments to providers, capitation, management fees, etc. Allowed claims are the sum of incurred claims and member cost sharing for calendar year 2009. No further adjustments of claims are required.

## Appendix

Table 1: Conversation of Group Size Based on the Number of Employees to the Number of Subscribers (Groups with 51 to 100 employees)

Employees	Subscribers
51 to 55	26 to 30
56 to 60	31 to 35
61 to 70	36 to 45
71 to 80	46 to 55
81 to 90	56 to 65
91 to 100	66 to 75

Table 2: Aggregation categories

	In-network/Single Policy Deductible	
	Min	Max
<u>Any plans w/deductibles and Rx coverage</u>		
Catg. 1	0	250
Catg. 2	251	1,500
Catg. 3	1,501	3,000
Catg. 4	3,001	5,000
Catg. 5	5,000+	
<u>Any plans w/deductible w/o Rx coverage</u>		
Catg. 6	0	250
Catg. 7	251	1,500
Catg. 8	1,501	3,000
Catg. 9	3,001+	
	PCP OV Copay	
	Min	Max
<u>Any plans that are copay-only w/Rx coverage</u>		
Catg. 10	0	20
Catg. 11	20+	
<u>Any plans that are copay-only w/o Rx coverage</u>		
Catg. 12	0	20
Catg. 13	20+	