Report Documentation

About the 2014 Annual Paid Claims & Enrollment Report (APCER) for VHCURES

This document was prepared by Onpoint Health Data September 2014

What is the Annual Paid Claims & Enrollment Report?

The Vermont Department of Taxes is responsible for administering the Health Care Claims Tax (32 V.S.A. § 10402). The tax is imposed on every health insurer in an amount equal to 0.999 of one percent of all health insurance claims paid by the insurer for its Vermont members in the previous fiscal year ending June 30. The tax applies to all health care and dental claims that are not financed through a federal program. The Health Care Claims Tax does not include an exemption for smaller insurers that insure fewer than 200 lives.

The Vermont Department of Taxes uses the Annual Paid Claims and Enrollment Report (APCER) created from data collected by Health Insurers in the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES). The APCER provides the most current fiscal year paid claims data available. Insurers subject to the Health Care Claims Tax who are not submitting data to VHCURES are required to self-report their annual paid claims amount to the Vermont Department of Taxes. Additional information about these taxes including the report form required for submitting annual paid amounts is posted at http://www.state.vt.us/tax/majorvttaxeshcca.shtml.

The purpose of this report is to describe how the annual paid claims amount is generated from VHCURES using the claims data submitted to the State of Vermont by insurers that meet an enrollment threshold of a minimum of 200 lives.

Consolidation

Claims Consolidation

On a quarterly basis, Onpoint applies consolidation methods to claims data contained in VHCURES, placing adjudicated claims into a final service-line claim version. These quarterly consolidations provide a view of the data at a fixed point; their data may not match the most contemporary data held by any payer. The current APCER is based on claims paid date, not incurred date of service, through paid date June 30, 2014.

MEMBERSHIP Consolidation

Payers are asked to submit only one record per member per month. These membership data sometimes include duplicates of three common types:

Entire duplicates — These wholly redundant records contain entirely duplicated data. One of these redundant records is carried for use, while the other is discarded.

Intrapayer duplicates — These partially redundant records, which contain only a portion of duplicated data, are generated by a single payer and cover a single member — often due to a midmonth change in a member's data (e.g., product code or ZIP code). Intrapayer duplicates are assigned a Use Flag code of 1.

Interpayer duplicates — These partially redundant records, which also contain only a portion of duplicated data, are generated by multiple payers and cover a single member — often due to a special relationship between payers (e.g., behavioral carve-outs). Onpoint assigns a Use Flag code of 2 for these records, which comprise a set of special relationships where it is known that an entire large subset of the population exists within another payer.

Use Flag

Onpoint creates a Use Flag field for membership and claims data (both medical and pharmacy). Valid codes include:

0 ..... Okay to use [e.g., commercial/major medical, ages 0–64 years]

1 ..... Intrapayer duplicate

2 ..... Interpayer duplicate

3 ..... Medicare [created from the Medicare product codes submitted by payers]

4 ..... Age 65+ [e.g., product code was not Medicare]

5 ..... [Reserved for internal use]

6 ..... Claim paid as secondary

7 ..... Denied claim

8 ..... [Reserved for internal use]

9 ..... Non-Vermont ZIP code

22 ..... Indicates adjustment / reversal claim only; no other associated claim found

APCER Reporting

Membership and claims records with a Use Flag value of 0, 3, 4, and 6 are selected for the Annual Paid Claims & Enrollment Report (APCER). Other criteria include:

- Claims are based on paid date, not incurred date.
- Membership and claims records that include product codes HM (HMO), PS (Point of Service), PR (Preferred Provider Organization), IN (Indemnity), and EP (Exclusive Provider Organization) are reported as major medical/commercial.
- Medicare product codes are used for Medicare supplemental reporting, Medicare Part C reporting, and Medicare Part D reporting.

Possible Causes of Differences

There are multiple factors that may explain differences between the data reported in the APCER and the data held by a payer. Among them:

- The quarterly consolidation process reflects the best possible view of the data held in VHCURES. These quarterly consolidations provide a view of the data at a fixed point and may not match the most contemporary data held by a payer.
- Only Vermont residents as recorded in VHCURES are included in the APCER. Payers' membership and claims data may include non-Vermont residents (e.g., employees who work in Vermont but live out of state).
- The VHCURES product codes in both membership and claims records are a key component in the creation of the Use Flag and in the APCER reporting. Any variation in product code reporting to VHCURES by payers could result in differences.