

Rhode Island Annual Health Statement Supplement

Instructions

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1. Rhode Island Annual Health Statement Supplement – Introduction

The Rhode Island Annual Health Statement Supplement is comprised of two exhibits. The Line of Business Exhibit (Exhibit #1) provides for disclosure of enrollment, premiums, and medical expenses by health lines of business. The Market Exhibit (Exhibit #2) provides for disclosure of enrollment, premiums, and medical expenses by market for only the reporting company's comprehensive/major medical line of business. The types of lines of business and markets are defined in Sections 4 and 5 below. The information required for the Health Statement Supplement refers to **calendar year 2014**.

1.1 Which Entities Must File

- a. All health insurance companies doing business in the state of Rhode Island are required, pursuant to R.I. Gen. Laws §§ 27-12-1 et seq., 27-12.1-2 et seq., 27-1-11, 27-2-2, and 42-14.5-1 et seq., and 42-14-5(c) and (d), to complete and submit the health statement supplement regardless of the situs of the contract. Thus, if a health insurance company outside of the state of Rhode Island issues a policy contract to a Rhode Island individual, business, or other entity, then the health insurance company must report information on this coverage.
- b. Health insurance companies include entities doing any health insurance business of any name, kind, or description, including but not limited to for profit and not for profit corporations, nonprofit hospital, medical and dental service corporations, health maintenance organizations and every other form of entity.
- c. Health insurance companies must file if they are doing any health insurance business of any name, kind, or description, including the types of health insurance business identified as a Line of Business in Exhibit 1.
- d. All third party administrators required to file an annual report under R.I. Gen. Laws § 27-20.7-14 are required to complete and submit the health statement supplement.

1.2 Guidance for Filing the Health Statement Supplement

The Annual Health Statement Supplement worksheet was created in Microsoft Excel® format. The entities required to file the Annual Health Statement Supplement should do so via email to HealthInsInquiry@ohic.ri.gov by April 1st, 2015. Please state the company name and "OHIC Annual Health Statement Supplement" in the subject line. Only filings in Microsoft Excel® format will be accepted. Please read the instructions carefully. The reporter may also file an addendum, if necessary, expressing concerns, caveats, and exceptions made for the purposes of reporting data and filing the form. For questions please call The Office of the Health Insurance Commissioner at (401) 462-9517 or email HealthInsInquiry@ohic.ri.gov. **Note that companies with a monthly average of fewer than 200 RI resident covered lives are exempt from this reporting requirement.**

2. General Instructions and Outline of the Form

Data must be reported for all covered members who are either Rhode Island residents or non-Rhode Island residents who are covered members of a policy or plan in which the policyholder or plan sponsor is a Rhode Island individual, business, or other entity. The annual health statement supplement form provides cells under each line of business (Exhibit #1) and market (Exhibit #2) to report information for Rhode Island resident and non-resident covered members separately.

For the inpatient facility, outpatient facility, and medical/surgical other than primary care data fields, medical expenses must be reported separately for health care providers whose place of business is the state of Rhode Island and those providers whose place of business is not the state of Rhode Island.

As used in this Rhode Island Annual Health Statement Supplement:

- (2.a) “Health insurance company” means any company of any kind doing health insurance or health benefit administration business in this state, including any person who offers, issues, renews or administers a health insurance policy, contract, or other health benefit plan in connection with covered members, including but not limited to:
1. A health insurance company.
 2. A nonprofit hospital or medical service corporation.
 3. A health maintenance organization.
 4. A third party administrator or a pharmacy benefit manager that provides administrative services for a health insurance company offering coverage in this state. The term does not include a third party administrator or pharmacy benefit manager to the extent that a health insurance company has reported the data required for this statement.
 5. The term also does not include a health insurance company with a monthly average of fewer than 200 Rhode Island covered lives.

As used in this Rhode Island Annual Health Statement Supplement:

- (2.b) “Policyholder” means a Rhode Island individual, business, or other entity to whom a health insurance policy or contract is sold or for whom a health insurance policy or contract is written.
- (2.c) “Plan sponsor” means an employer, association, trust or other entity providing health care coverage to covered members by means other than an insurance policy or contract.
- (2.d) “Covered member” means a Rhode Island resident or a non-Rhode Island (i.e. out-of-state) member covered by a health insurance company, or covered by a self-insured plan, provided that the policyholder or plan sponsor is a Rhode Island individual, business, or other entity.

For the purpose of reporting data by Rhode Island and non-Rhode Island resident covered members in this Rhode Island Health Statement Supplement:

- (2.e) “Rhode Island resident covered member” is defined as an enrollee or member listed in your company’s enrollment records as having a zip code in Rhode Island and who is a covered member of a policy or plan that is issued or administered by your company to a policyholder or plan sponsor who is a Rhode Island individual, business, or other entity.
- (2.f) “Non-Rhode Island resident covered member” is defined as an enrollee or member listed in your company’s enrollment records who does not have a Rhode Island zip code but who is a covered member of a policy or plan that is issued or administered by your company to a policyholder or plan sponsor who is a Rhode Island individual, business, or other entity.

For the purpose of reporting medical expenses within the inpatient facility, outpatient facility, and medical/surgical other than primary care data fields by Rhode Island (i.e. in-state) and non-Rhode Island (i.e. out-of-state) health care providers in this Rhode Island Health Statement Supplement:

- (2.g) “Rhode Island (or in-state) provider” is defined as a health care provider whose place of business is the state of Rhode Island and who possesses a Rhode Island zip code.
- (2.h) “Non-Rhode Island (or out-of-state) provider” is defined as a health care provider whose place of business is a state or other legal jurisdiction other than Rhode Island.

2.1 Outline of the Form

2.2 Fields Common to Both Exhibits

The following eight fields are common to both exhibits in the Health Statement Supplement. Definitions are found in Section 3 below.

(Field 1) Membership data: In the membership data field the required information is the number of policies or certificates, the number of covered lives, and member months. Each of these three elements of membership data must be reported for all plans (those with and without prescription drug coverage) and for plans that include prescription drug coverage (excluding plans that do not include this coverage).

(Field 2) Premiums/Claims: In this field report premiums and claims as defined in Section 3. Definitions of premiums and claims are based on the NAIC Supplemental Health Care Exhibit – Part 1. Companies with administrative services only/third party administrator lines of business are required to report premium equivalents collected and attributable to the reporting year.

Medical Expenses by select categories:

(Field 3) Inpatient Facility: In this field report inpatient facility expenses as defined in Section 3. Inpatient facility denotes the category of medical expenses for services rendered in an inpatient setting. Inpatient facility is broken down into three subcategories: hospital, skilled nursing facility, and other. Each of these subcategories is defined in Section 3 below.

In addition to reporting expenses separately for Rhode Island resident and non-resident covered members, inpatient facility expenses and expenses in each subcategory, must be reported by whether the services were rendered by a health care provider in Rhode Island (i.e. an in-state provider) or in another state or legal jurisdiction (i.e. an out-of state provider).

(Field 4) Outpatient Facility: In this field report outpatient facility expenses as defined in Section 3. Outpatient facility denotes the category of medical expenses for services rendered in an outpatient setting. Outpatient facility is broken down into four subcategories: hospital, skilled nursing facility, freestanding ambulatory care facility, and other. Each of these subcategories is defined in Section 3 below.

In addition to reporting expenses separately for Rhode Island resident and non-resident covered members, outpatient facility expenses and expenses in each subcategory, must be reported by whether the services were rendered by a health care provider in Rhode Island (i.e. an in-state provider) or in another state or legal jurisdiction (i.e. an out-of state provider).

(Field 5) Primary care: In this field report primary care expenses as defined in Section 3. Primary care expenses do not have to be reported separately for in-state and out-of-state providers.

(Field 6) Pharmacy: In this field report prescription drug expenses as defined in Section 3. Prescription drug expenses do not have to be reported separately for in-state and out-of-state providers.

(Field 7) Medical/Surgical other than primary care: In this field report other medical/surgical expenses as defined in Section 3. Section 3 will give directions on some of the specific services that should be reported in this category. This category consists of all medical expenses not reported in the previous four. Specifically, medical expenses that do not fall in the inpatient facility, outpatient facility,

primary care, or pharmacy categories must be reported here. Medical/surgical other than primary care expenses must be reported separately for in-state and out-of-state providers.

(Field 8) All other payments to medical providers: In this field please report all other payments categorized as medical expenses not captured in the above fields. Examples include health information technology, off line settlements, etc.

2.3 Exhibit #1-The Line of Business Exhibit

In the Line of Business Exhibit (Exhibit #1) data for the previous eight fields must be reported by the following lines of business. Detailed definitions of these lines of business are found in Section 4 below. The column numbers identify where the line of business appears on Exhibit #1 of the form. Under each line of business column in the form there are three sub-columns: “RI,” “Non-RI,” and “All.” These sub-column headings refer to “Rhode Island,” “Non-Rhode Island,” and “All” covered members, respectively. “All” covered members is simply the sum of “Rhode Island” and “Non-Rhode Island” covered members. Report the information for the eight data fields listed under Section 2.2 (Fields Common to Both Forms) in the appropriate covered member sub-column.

(Column 1) Comprehensive/Major Medical

(Column 2) Administrative Services Only/Third Party Administrator (ASO/TPA)

(Column 3) Stop Loss, Excess Loss, Reinsurance

(Column 4) Medicare Part C

(Column 5) Medicare Part D

(Column 6) Medicare Supplement Policies

(Column 7) Medicaid/Other public

(Column 8) Student Blanket

(Column 9) Dental Only

(Column 10) Other Medical Non-Comprehensive

(Column 11) Total across all lines of business: The form is pre-programmed to calculate the totals across all lines of business based on data entered in other cells.

2.4 Exhibit #2-The Market Exhibit

In the Market Exhibit (Exhibit #2) the reporter is required to take their company’s comprehensive/major medical line of business and report information in the eight data fields by the following markets. Detailed definitions of these markets are found in Section 5 below. The column numbers identify where the market appears on Exhibit #2 of the form. Under each market column in the form there are three sub-columns: “RI,” “Non-RI,” and “All.” These sub-column headings refer to “Rhode Island,” “Non-Rhode Island,” and “All” covered members, respectively. “All” covered members is simply the sum of “Rhode Island” and “Non-Rhode Island” covered members. Report the information for the eight data fields listed under Section 2.2 (Fields Common to Both Forms) in the appropriate covered member sub-column.

(Column 1) Individual

(Column 2) Small Group

(Column 3) Large Group

(Column 4) Association

(Column 5) Trust

(Column 6) Federal Employee Health Benefit Plan

(Column 7) Other Market

(Column 8) Total across all markets for comprehensive/major medical line of business: The form is pre-programmed to calculate the totals across all markets based on data entered in other cells. The

information reported this column (Column 8) of Exhibit #2 should be the same as the information reported in Column 1 (The Comprehensive/Major Medical Line of Business) in Exhibit #1.

3. Rhode Island Annual Health Statement Supplement – Definitions of Fields Common to Both Exhibits

As used in this Rhode Island Annual Health Statement Supplement the eight fields common to both exhibits for which data are required to be reported for covered members are defined below.

3.1 (*Field 1*) Membership Data

Number of Policies or Certificates: This is the number of individual policies or group certificates issued to individuals covered under a group policy in force as of December 31 of the reporting year. It is not the number of persons covered under individual policies or group certificates.

Covered lives: This is the total number of lives insured or whose coverage is administered, including dependents, under individual policies, group certificates, contracts and plans as of December 31 of the reporting year.

Member months: The sum of total number of lives insured on a pre-specified day of each month of the reported year.

3.2 (*Field 2*) Revenues and Claims

Premium: Line 1.1 on the NAIC Supplemental Health Care Exhibit – Part 1. For ASO/TPA lines of business report the total amount of premium equivalent collected and attributable to the reporting year.

Claims/Medical Expenses: Lines 2.1 through 2.4 on the NAIC Supplemental Health Care Exhibit – Part 1.

Medical Expense Data by Select Categories

3.3 (*Field 3*) Inpatient Facility: The inpatient facility field refers to medical claims for services rendered in an inpatient setting. The inpatient facility field is divided into three subcategories: hospital, skilled nursing facility (SNF), and other. These expenses must be reported separately by in-state and out-of-state providers. Please report information in the following subcategories as accurately as possible. Hospital and SNF claims may be identified by the Type of Bill (TOB) code located in field 4 of the UB-04/CMS-1450 claim form. The relevant codes are listed next to the appropriate subcategories below. Place of service codes that are used on the CMS 1500 claim form may also be used to report claims in the appropriate subcategories.

Hospital: Inpatient services rendered in a hospital. Relevant TOB codes (11X, 12X, 18X)

SNF: Inpatient services rendered in a SNF. Relevant TOB codes (21X, 22X, 28X)

Other: All other inpatient services. Reporters should submit a description of the major service areas, as their organization defines them, included in the Inpatient Facility “other” subcategory. This information should be conveyed in a footnote on the worksheet or in a written addendum. Please label this note as “Service areas reported under “Other” Inpatient Facility subcategory.”

3.4 (Field 4) Outpatient Facility: The outpatient facility field refers to medical claims for services rendered in an outpatient setting. The outpatient facility field is divided into four subcategories: hospital, skilled nursing facility (SNF), freestanding ambulatory care facility, and other. These expenses must be reported separately by in-state and out-of-state providers. Please report information in the following subcategories as accurately as possible. Outpatient hospital and SNF claims be identified by the Type of Bill (TOB) code located in field 4 of the UB-04/CMS-1450 claim form. The relevant codes are listed next to the appropriate subcategories below. Place of service codes that are used on the CMS 1500 claim form may also be used to report claims in the appropriate subcategories.

Hospital: Outpatient services rendered in a hospital. Relevant TOB codes (13X, 14X).

SNF: Outpatient services rendered in a SNF. Relevant TOB codes (23X).

Freestanding Ambulatory Care Facility: Outpatient services rendered at a free standing ambulatory care facility. These freestanding ambulatory care facilities do not operate under and are not affiliated in any legal way with an acute care hospital license. The freestanding ambulatory care facility services that should be reported here include outpatient surgery and diagnostics (imaging, laboratory, and machine tests).

Other: All other outpatient services that do not fall into the three subcategories listed above. Reporters should submit a description of the major service areas, as their organization defines them, included in the Outpatient Facility “other” subcategory. This information should be conveyed in a footnote on the worksheet or in a written addendum. Please label this note as “Service areas reported under “Other” Outpatient Facility subcategory.”

3.5 (Field 5) Primary care: The sum of medical expenses paid to primary care providers. “Primary care provider” means providers within the following practice type: Family Practice, Internal Medicine and Pediatrics; and providers with the following professional credentials: Doctors of Medicine and Osteopathy, Nurse Practitioners, and Physicians’ Assistants. The term shall not include “dual” providers (i.e., those who deliver both primary and specialty care), except in those instances where the specialist is paid on a primary care provider fee schedule.

Primary care expenses do not have to be reported separately for in-state and out-of-state providers.

3.6 (Field 6) Pharmacy: Medical expenses for prescription drugs dispensed at a pharmacy. *Please note that injectable or infused drugs administered in another care setting (such as inpatient or outpatient) should be reported in the category appropriate to that setting.*

Pharmacy expenses do not have to be reported separately for in-state and out-of-state providers.

3.7 (Field 7) Medical/ Surgical other than primary care: All medical expenses not in the other four categories. These expenses must be reported separately by in-state and out-of-state providers. The following items should be included in this category: dental, birthing centers, durable medical equipment, home health, and hospice. In addition to these services the reporter should submit a description of the major services areas, as their organization defines them, included in the Medical/Surgical other than primary care field. This information should be conveyed in a footnote on the worksheet or in a written addendum. Please label this note as “Service areas reported under Medical/Surgical other than primary care category.”

3.8 (Field 8) All other payments to medical providers: In this field please report all other payments categorized as medical expenses not captured in the above fields. Examples include health information technology, off line settlements, etc.

4. Rhode Island Annual Health Statement Supplement – Definitions of Lines of Business for Exhibit 1

As used in the Line of Business Exhibit (Exhibit #1) of this Rhode Island Health Statement Supplement the health lines of business for which data must be reported are defined as follows:

Administrative services only (ASO)/ Third party administrator (TPA): ASO/TPA entities include health insurance companies and third party administrators as defined under Rhode Island general laws Chapter 27-20.7. This means an entity or person contracting to provide any combination of services in administering health benefits for a health insurer or other entity such as self-insured employer plans, to include claims processing, underwriting, premium collection, case management, authorizations and customer service where the entity providing ASO or acting as a TPA is not responsible for all or substantially all of the risk.

Comprehensive/Major medical: Policies that provide fully insured indemnity, HMO, PPO, or Fee for Service coverage for hospital, medical, and surgical expenses. This category excludes limited benefit plans, Short Term Medical Insurance, the Federal Employees Health Benefit Program and non-comprehensive coverage such as basic hospital only, medical only, hospital confinement indemnity, surgical, outpatient indemnity, specified disease, intensive care, and organ and tissue transplant coverage as well as any other coverage described in the other categories of this exhibit.

Dental: Policies providing only dental treatment benefits such as routine dental examinations, preventive dental work, and dental procedures needed to treat tooth decay and diseases of the teeth and jaw. If dental benefits are part of a comprehensive/major medical plan, then data should reported under the comprehensive/major medical category.

Medicare Part C: Policies issued as Medicare Advantage Plans providing Medicare benefits to Medicare eligible beneficiaries created by Title XVIII of the Social Security Act of 1965. This includes Medicare Managed Care Plans (i.e., HMO and PPO) and Medicare Private Fee-for-Service Plans. This also includes all Medicare Part D Prescription Drug Coverage through a Medicare Advantage product and whether sold directly to an individual or through a group.

Medicare Part D: Stand-alone Part D coverage written through individual contracts; stand-alone Part D coverage written through group contracts and certificates; and Part D coverage written on employer groups where the reporting entity is responsible for reporting claims to the Centers for Medicare & Medicaid Services (CMS).

Medicare supplement policies: Pursuant to Rhode Island general laws Chapter 27-18.2 "Medicare supplement policy" means a group or individual policy of accident and sickness insurance, as defined in § 27-18-1, or a subscriber contract of a nonprofit hospital service corporation or of a nonprofit medical service corporation or an evidence of coverage of a health maintenance organization as defined in § 42-62-4(5) or as licensed under chapter 41 of this title, other than a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act, 42 U.S.C. § 1395mm, or an issued policy under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

Medicaid and other public plans: Includes any health insurance company under contract by the state of Rhode Island to cover beneficiaries of Title XIX Medicaid (Medical Assistance Fee-for-Service or Rite Care options). Other public (non-Medicare) plans should be included.

Stop loss/Excess loss/Reinsurance: Any insurance or other risk-transfer arrangement that is purchased by an individual or group health plan or a self-insured employer plan or by the sponsor or trustee of such plan to limit the exposure of such person against losses sustained by such plan.

Student blanket: Includes policies that cover students while they are enrolled and attending school or college. These can be either individual policies or group policies sponsored by the school or college.

Other Medical (Non Comprehensive) Plans: This includes policies such as limited benefit plans, hospital only, hospital confinement, surgical, outpatient indemnity, intensive care, mental health/substance abuse, and organ and tissue transplant (including scheduled type policies). Expense reimbursement and indemnity plans should be included. This category does not include any of the other plans listed above.

5. Rhode Island Annual Health Statement Supplement – Definitions of Markets for Exhibit 2

As used in this Rhode Island Health Statement Supplement, “market” is defined in terms of the entity to which a health insurance policy is sold or for whom it is written. For the purpose of reporting data in the required fields in Exhibit #2, take only the company’s comprehensive/major medical line of business and report enrollment, premiums, and medical expense data by the following markets. The markets for which this data must be reported are defined as follows:

Association: Policies sold to an association.

Federal employees: Coverage provided to Federal employees, retirees and their survivors, and administered by the Office of Personnel Management under the Federal Employees Health Benefit Program.

Individual: Pursuant to Rhode Island general laws Chapter 27-18.5 individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

Large group: Pursuant to the requirements of Rhode Island general laws Chapter 27-18.6-2 "Large group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer. "Large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least fifty-one (51) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year.

Small group: Pursuant to the requirements of Rhode Island general laws Chapter 27-50 the small group market is defined as policies sold to groups of 1 to 50 members. Groups of one refer to sole proprietors who can elect to join the small group rather than the individual (non-group) market.

Trust: Policies sold to a trust.

Other health market: Report data for health plans not in the other market categories.

Questions or Concerns:

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