VHCURES

Vermont Healthcare Claims Uniform Reporting & Evaluation System

VERMONT

State of Vermont Department of Financial Regulation

Report Documentation

About the 2012 Annual Paid Claims & Enrollment Report (APCER) for VHCURES

This document was prepared by Onpoint Health Data

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What is the Annual Paid Claims & Enrollment Report?

The Vermont Department of Financial Regulation (DFR) is mandated by state law under 8 V.S.A. § §4089k and 4089l to provide an annual report every October 1 to the Secretary of Administration that includes a list of health insurers and paid claims amounts attributable to each health insurer for the previous fiscal year. This supports the Secretary of Administration in the effort to collect the annual assessments, including the Health Information Technology Reinvestment Fund and the Health Care Claims Assessment.

The most current fiscal year paid claims data available to DFR on an annual basis to support a reporting deadline of October 1 through the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) is for the period of July 1, 2011, through June 30, 2012. Insurers subject to either or both assessments who are not submitting data to VHCURES are required to self-report their annual paid claims amounts to the agency administering the assessment programs. Additional information about these State of Vermont assessments is posted at http://hcr.vermont.gov/hit/IT_fund.

DFR does not administer the assessment programs but does provide reporting from VHCURES and other administrative sources. The purpose of this report is to describe how the annual paid claims amount is generated from VHCURES from the claims data submitted to the State of Vermont by insurers that meet an enrollment threshold of a minimum of 200 Vermont covered 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 byany payer. The current APCER is based on claims paid date, not incurred date of service, through paid date June 30, 2012.

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 theAnnual 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.