MARKETSCAN RESEARCH DATABASES

Benefit Plan Design Database User Guide

Data year 2022

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Contents

Introduction

The Merative™ MarketScan® Benefit Plan Design Database represents the benefit plans for large employers whose claims data make up portions of the Merative MarketScan Commercial Database. This information is abstracted from plan-by-plan statistical analysis of claims and enrollment data submitted by large employers.

Note: Some benefit plan provisions may not send a sufficiently strong statistical signal to be represented in the Benefit Plan Design Database.

Identifying plan provisions for an enrolled individual

The Benefit Plan Design Database links to the Merative MarketScan Research Databases using the enrollee identifier (ENROLID) field. There is one record in the Benefit Plan Design Database for each linked ENROLID. The record contains the plan provisions of that individual's medical plan.

Plan design variables

The Benefit Plan Design Database defines four basic categories of plan provision for all plans:

- → Deductibles
- → Coinsurance
- → Copayments
- → Maximum out-of-pocket amount

The **deductible** is the amount that the enrollee pays before the plan begins to pay for certain covered services during a plan year. **Coinsurance** is the percentage of medical costs that the enrollee pays, usually after the deductible has been met. **Copayments** are fixed dollar amounts that the enrollee pays for specific services, such as physician office visits. The **maximum out-of-pocket amount** is the limit on costs that an enrollee must pay during a plan year. This amount is reached when the enrollee has paid both the deductible and the required copayments and coinsurance amounts (up to the maximum out-of-pocket amount). After an enrollee reaches the maximum out-of-pocket amount, the plan pays 100 percent of the remaining covered medical costs for the plan year.

Plan enrollment dates are included for each enrollee:

PLAN_BEG_DT = Plan Enrollment Start Date

PLAN_END_DT = Plan Enrollment End Date

The plan enrollment dates for individuals who are enrolled for only part of the year are limited to the portion of the year that the individual is enrolled in the plan. For individuals who change plans during the year, the plan enrollment dates reflect the first plan in which they were enrolled during that year and the plan end date (PLAN_END_DT) represents the date that they changed plans. Claims outside the plan end date for that individual are provided according to the different, unreported plan provisions.

The Benefit Plan Design Database includes information from calendar year plans only. All plan variables report in-network plan provisions, and some report out-of-network plan provisions.

Deductibles

Some medical plans have two deductible amounts: the amount that an individual must pay and the amount that a family must pay before the plan begins to pay for medical coverage:

DEDUCT_IND = Deductible Individual

DEDUCT_FAM = Deductible Family

Note about deductible fields

The fields DEDUCT_IND and DEDUCT_FAM contain the normal deductible amount for medical services. The normal amount may be $0.

For some plans, the family deductible is the only relevant deductible. In these plans the individual deductible only applies when the contract is not for a family.

In some cases, it is possible for an individual member of a family to have deductible amounts that exceed the individual deductible. In these cases, an individual could bear the entire family deductible.

In and out of network

Some plans use a network of preferred providers ("In Network"), and those that do not have an In/Out of network provision are included in the In-Network fields.

Coinsurance

The percentage of medical costs that the enrollee pays for certain medical services after the deductible has been met is called coinsurance. The following variables represent in-network coinsurance costs:

COINS_ER = Coinsurance Emergency Room, In-Network

COINS_INP = Coinsurance Inpatient Admission, In-Network

COINS_OV = Coinsurance Office Visit, In-Network

COINS_ER_OON = Coinsurance Emergency Room, Out of Network

COINS_OV_OON = Coinsurance Office Visit, Out of Network

Note about coinsurance fields

There are different coinsurance fields for different types of services. All coinsurance fields will be completed if a plan covers that type of service, unless there was not a strong enough statistical signal present in the source data.

Only nonzero amounts are reported. If a person's plan does not require coinsurance, the coinsurance will be reported as missing in the database.

Copayments

Enrollees often pay a fixed copayment for certain services.

COPAY_PC = Copayment Primary Care Visit, In-Network

COPAY_SP = Copayment Specialist Visit, In-Network

COPAY_PC_OON = Copayment Primary Care Visit, Out of Network

COPAY_SP_OON = Copayment Specialist Visit, Out of Network.

Plans may require copayment amounts for certain services, even if the plan does not completely cover these services. The typical services requiring these copayments are emergency room (ER) visits and hospital admissions:

COPAY_ER = Copayment Emergency Room, In-Network

COPAY_INP = Copayment Hospital Admission, In-Network

COPAY_ER_OON = Copayment Emergency Room, Out of Network

Note about emergency room visits

Most plans waive the ER copayment (COINS_ER) if the patient is admitted to the hospital from the ER. Many plans also review ER visits and apply a different copayment or coinsurance amount if the patient's medical condition is determined not to have constituted a medical emergency.

Only nonzero amounts are reported. If a person's plan does not require a copayment, the copayment will be reported as missing in the Benefit Plan Design Database.

Maximum out-of-pocket amount

In the Benefit Plan Design Database, all maximum out-of-pocket fields include the copay, coinsurance, and deductible amounts.

There are two types of maximum out-of-pocket amounts: the amount that an **individual** must pay, and the amount that a **family** must pay before the plan pays 100 percent of the remaining covered medical costs for the plan year:

OOP_MAX_IND = Annual Maximum Out-of-Pocket Individual

OOP_MAX_FAM = Annual Maximum Out-of-Pocket Family

Flags measuring signal volume

Flags are also included to indicate when claim information is available but did not meet the inclusion criteria. These flags were added for three Benefit Plan Design Database categories: coinsurance, copayments, and deductibles. Inclusion criteria and plan size exclusions are based on the plan design measure.

- → When no information was available for a given characteristic (for example, no copayments were found in the plan), the flag is set to **9 – No data available**.
- → When information was detected, but plan size or statistical signals were insufficient (for example, copayments found, but plan size was small), the flag is set to **0 – Criteria not met to calculate BPD characteristic**.

The following flags are constructed for both in-network and out-of-network Benefit Plan Design Database variables:

COINS_ER_FLAG = Coinsurance Emergency Room, In-Network Flag

COINS_ INP_FLAG = Coinsurance Inpatient Admission, In-Network Flag

COINS_OV_FLAG = Coinsurance Office Visit, In-Network Flag

COINS_ER_FLAG_OON = Coinsurance Emergency Room, Out of Network Flag

COINS_OV_FLAG_OON = Coinsurance Office Visit, Out of Network Flag

COPAY_ER_FLAG = Copayment Emergency Room, In-Network Flag

COPAY_PC_FLAG = Copayment Primary Care Visit, In-Network Flag

COPAY_SP_FLAG = Copayment Specialist Visit, In-Network Flag

COPAY_ER_FLAG_OON = Copayment Emergency Room, Out of Network Flag

COPAY_PC_FLAG_OON = Copayment Primary Care Visit, Out of Network Flag

COPAY_SP_FLAG_OON = Copayment Specialist Visit, Out of Network Flag

DED_FAM_FLAG = Deductible Family Flag

DED_IND_FLAG = Deductible Individual Flag

Note about flags

Out-of-network measures and flags have not been created for inpatient copayments and coinsurance.

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Produced in the United States of America
January 2024

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