

Data Submission Manual

2019 Annual Premiums Data Request

957 CMR 10.00: Health Care Payers Premiums and Claims Data Reporting
Requirements

March 19, 2019



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Data Submission Manual

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1. Introduction

M.G.L. c. 12C, § 10 requires the Center for Health Information and Analysis (CHIA) to report on changes over time in Massachusetts health insurance premiums, benefit levels, member cost-sharing, and product design. CHIA collects this data under Regulation 957 CMR 10.00. While the Regulation contains broad reporting guidance, this Data Submission Manual provides technical details to assist with data filing.

2. Data Submission Manual Changes: 2019

I. Additions/ Alterations

- Tab A includes additional data validation checks to identify potential data errors prior to submission.
- CHIA will collect data on deductible and out-of-pocket spending levels in new “Member Months by Cost-Sharing Limits” tab.

II. Deletions

- CHIA will no longer collect “Member Months by Rating Size Bands.”
- CHIA will no longer collect Benefit Design Type member months by Geographic Area (3-digit ZIP code).

3. Required Submitters and Submission Instructions

Per 957 CMR 10.00, only payers with at least 50,000 Massachusetts Private Commercial Plan members for the latest quarter, as reported in CHIA's most recently published [Enrollment Trends](#), are required to submit. For the May 2019 Submission, this includes the following payers:

- Aetna: Aetna Health, Inc. and Aetna Life Insurance Company
- AllWays: AllWays Health Partners, Inc. (formerly Neighborhood Health Plan, Inc.)
- BCBSMA: Blue Cross and Blue Shield of Massachusetts, Inc. and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
- BMCHP: Boston Medical Center HealthNet Plan
- Cigna: CIGNA Health and Life Insurance Company
- Fallon: Fallon Community Health Plan, Inc. and Fallon Health & Life Assurance Company, Inc.
- HPHC: Harvard Pilgrim Health Care, Inc.; HPHC Insurance Company, Inc.; and Health Plans, Inc.
- HNE: Health New England, Inc.
- Tufts: Tufts Associated Health Maintenance Organization, Inc.; and Tufts Insurance Company
- THPP: Tufts Health Public Plans, Inc. (formerly Network Health, LLC)
- UniCare: UniCare Life & Health Insurance Company
- United: UnitedHealthcare Insurance Company

The Health Care Payers Premiums and Claims Data Reporting Workbook (Workbook) must be used for data submission. It is available at: <http://www.chiamass.gov/information-for-data-submitters-premiums-data/>. A Workbook must be completed for each legal entity of a payer and saved according to the following file naming convention: 2019-PremiumsReporting-Carrier Designator-**YYYYMMDD**.xlsx. (Standardized "Carrier Designator" abbreviations are listed in the "Naming Conventions" Workbook tab.) Payers are responsible for notifying CHIA of additional legal entities not listed here that may meet filing requirements.

General questions can be submitted anytime to CHIADData@gormanactuarial.com. Completed Workbooks should be sent to CHIADData@gormanactuarial.com no later than Friday, May 17, 2019.

Payers are instructed to report Funding Type as either "Fully-Insured" or "Self-Insured." For those payers wishing to continue submitting data under the previous "Fully-Insured" and "Total" classification system, an alternate submission Workbook is available upon request.

4. Population Specification

Regulation 957 CMR 10.00 requires payers to report aggregate membership, premiums, and claims data for all primary fully- and self-insured members in Private Commercial medical plans situated¹ in Massachusetts. Members of medical plans purchased through the Massachusetts Health Connector and all comprehensive Student Health membership should be included.

Plans Not Included:

- Commonwealth Care
- Federal Employees Health Benefits Program
- Indian Health Service
- MassHealth Managed Care
- Medical Security Program
- Medicare Advantage
- Medi-gap
- One Care, PACE, Senior Care Options
- Tricare
- VA Healthcare

Members Not Included:

- Medical plan enrollees using plan as secondary coverage

¹ “Situs” of a policy is defined as the jurisdiction in which the policy is issued or delivered as stated in the policy. Insurers are instructed to apply the same consideration when determining situs for this report as they do when preparing the NAIC Supplemental Health Care Exhibit. Third party administrators (IPAs) shall determine situs of their contracts in a similar manner. Massachusetts situated members may not necessarily be residents of Massachusetts.

5. Workbook Overview

Regulation 957 CMR 10.00 requires payers to report aggregate membership, premiums, and claims data by market sector, product type, and benefit design type for the previous three calendar years in the Premiums Workbook (.xlsx). The 2019 Workbook contains the following worksheets:

A. Payer Verification

Worksheet A includes data checks to identify potential errors prior to submission. Below the “Data Validation” table are auto-calculated aggregate and per member per month (PMPM) values based on payer-submitted data (worksheets B-E); these may assist in locating data issues related to a failed check. Data submitters should review the “Data Validation” table and address all items marked “Fail” by either resolving the data issue(s) or providing a written explanation in the box labeled “Explanation of Unresolved Issues.” A submission contact is required.

B. Member Months by Geography and Gender & Age Group

Worksheets B1 & B2 request Member Months data by Geographic Area (3-digit zip) by Year, Funding Type, Product Type, and Market Sector.

Worksheets B3 & B4 request Member Months data by Gender & Age Group by Year, Funding Type, Product Type, Benefit Design Type, and Market Sector.

C. Member Months by Cost-Sharing Limits

Worksheet C requests Member Months data according to members’ deductible and out-of-pocket (OOP) spending limits. Deductible limits and OOP maximums should be reported based on individual (single) policy amounts, even for members enrolled in family policies. In cases of PPO, POS, and/or tiered network products, please report the deductible or OOP limit for the most utilized tier.

D. Member Months by Standard Industrial Classification (SIC) Code

Worksheet D requests Member Months data by SIC code only for fully-insured individual (sole proprietor) and small group accounts, where available. Payers who use industry factors in their rating formula are requested to provide this data for calendar year 2018 only.

Member Months should be reported for distinct, four-digit SIC codes. Payers should use the “Unknown” designation to report Member Months for which industry classification is unavailable (e.g., members purchasing individual plans through the Health Connector).

E. Financials

Worksheet E1 requests the following aggregate financial data for fully-insured plans by Year, Product Type, Benefit Design Type, and Market Sector:

- Earned Premiums (incl. APTC, excl. MLR Rebates)
- MLR Rebates [*Amounts for Individual Purchasers need not be allocated to the three subsidy categories; instead, enter the total amount for the individual market for the applicable year in the ‘No Subsidy/Unknown’ column.*]
- Percent of Benefits Not Carved Out
- Claims
 - Allowed
 - Incurred
- Payer “3R” Totals [*2018 Totals Not Needed w/ May Submission; amounts for Individual Purchasers need not be allocated to the three subsidy categories; instead, enter the total amount for the individual market for the applicable year in the ‘No Subsidy/Unknown’ column.*]
 - Risk Adjustment Transfer Amounts

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- Federal Transitional Reinsurance Amounts
- Risk Corridor Amounts
- ACA/ Health Connector Subsidy Amounts
 - Advance Premium Tax Credit Amounts
 - Cost-Sharing Reduction Amounts

Worksheet E2 requests the following aggregate financial data for self-insured plans by Year, Product Type, Benefit Design Type, and Market Sector:

- Percent of Benefits Not Carved Out
- Claims
 - Allowed
 - Incurred
- Administrative Service Fees [Voluntary]

F. Rating Factors

Worksheet F requests rating factors for fully-insured plans with effective dates in December 2018. Please input rating factors that are applied to base rates to develop premiums by market segment (when no employer-specific experience is available for Mid-Size and Large Groups), including but not limited to age/gender, area, group size, retention, contract type, and industry. Benefit plan factors may be excluded.

G. Reconciliation

Worksheet G requests data reconciliation checks between inputted data and other payer data submissions. Please explain major discrepancies with:

- Massachusetts Division of Insurance's Medical Loss Ratio Reporting Form
- Center for Consumer Information and Insurance Oversight's Medical Loss Ratio Reporting Form
- National Association of Insurance Commissioners' Supplemental Health Care Exhibit (SHCE)
- Prior CHIA Annual Premiums Data Request submissions

A detailed reconciliation is not required. Rather, a listing of reasons for potential discrepancies should be provided.²

² CHIA understands that certain Affordable Care Act provisions (e.g. Premium Stabilization programs) may make comparisons between May submissions and financial statements difficult for individual and small group sectors. CHIA will follow up with payers for final 2018 amounts in July.

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6. Definitions

“3 R” Amounts *[2018 Totals Not Needed w/ May 17th Submission; amounts for Individual Purchasers need not be allocated to the three subsidy categories; instead, enter the total amount for the individual market for the applicable year]*

- **Risk Adjustment Transfer Amount:** The amount that is received (+) or owed (-) as a result of the risk adjustment program that was put into place in Massachusetts’ individual and small group markets effective in 2014. Risk adjustment transfers should reflect the year in which the amount was *incurred*, not when the payment was *received*. For example, if a payment was received in 2017 for the 2016 benefit year, then it would fall under 2016 for CHIA’s collection purposes.
- **Federal Transitional Reinsurance Amount** *[2016 only]*: The amount that is received (+) as a result of the federal transitional reinsurance program that was put into place in the individual market effective 2014. This amount includes only recoveries received and not any required contributions to the program. Reinsurance amounts should reflect the year in which the amount was *incurred*, not when the payment was *received*. For example, if a payment was received in 2017 for the 2016 benefit year, then it would fall under 2016 for CHIA’s collection purposes.
- **Risk Corridor Amount** *[2016 only]*: The amount that is received (+) or owed (-) as a result of the risk corridor program that was put into place in the individual and small group markets effective in 2014. Amounts *owed* by the payer should be reported in the year for which the amounts were owed. If reporting amounts *received*, please report the actual amount received after the reduction of the originally calculated amounts. CHIA expects no positive payments received from the risk corridor program for 2016, as funds collected this year went towards fulfilling risk corridor payments due to payers based on 2014 claims experiences.³

Affordable Care Act/ Massachusetts Health Connector Subsidies

- **Advance Premium Tax Credit (APTC) Amounts:** The total amount of federal tax credits and state funded premium subsidies individuals received to lower their health insurance payments while enrolled in qualifying Massachusetts Health Connector plans. Eligibility determined based on expected annual income, and credit may have been taken in advance to lower monthly payments.
- **Cost Sharing Reduction (CSR) Amounts:** The total estimated federal and state funded reductions payers received to lower individuals’ health insurance deductibles, copayments, and coinsurance payments while enrolled in qualifying Massachusetts Health Connector plans (ConnectorCare). Eligibility determined based on expected annual income.

Administrative Service Fees: The fees earned by a payer or Third Party Administrator for the full administration of a self-insured health plan excluding any premiums collected for stop-loss coverage. This data is appreciated, though submission is voluntary.

Benefit Design Type: Benefit and network design characteristics that are not exclusive to a given Product Type. These categories are not mutually exclusive. Benefit Design Type should be determined at the member level.

- **High Deductible Health Plans (HDHPs)—as defined by individual deductible level only:** Plans with an individual deductible greater than or equal to the qualifying definition for a high deductible health plan, which is \$1,350 for 2018, and \$1,300 for 2016–2017 (for the most preferred network or tier, if applicable). The plan does not need to be a qualified high deductible health plan in order to be considered an HDHP for this purpose. Only a plan’s individual deductible level must be satisfied to be included in this breakout for our purposes. For example, four members of a

³ “Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year.” <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf>

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family plan would only be considered to be in an HDHP in 2016 for this data request's purpose if the individual deductible for that product is equal to or exceeds \$1,300 in 2016; the deductible for the family plan itself is inconsequential.

- **Tiered Networks:** Plans that segment their provider networks into tiers, with tiers typically based on differences in the quality and/or the cost of care provided. Tiers are not considered separate networks but rather sub-segments of a payer's HMO or PPO network. A Tiered Network is different than a plan only splitting benefits by in-network vs. out-of-network; a Tiered Network will have varying degrees of payments for in-network providers.

A plan that has different cost-sharing for different types of providers is not, by default, considered a Tiered Network (i.e. a plan that has a different copay for primary care physicians than specialists would not be considered a tiered network on that criterion alone). However, if the plan has different cost-sharing within a provider type depending upon the provider selected, then the plan would be considered a Tiered Network plan.

A plan need not have all provider types subject to tiering in order to be considered a Tiered Network plan for this Request (i.e. a plan that tiers only hospitals is a Tiered Network; a plan that tiers only physicians is also here considered a Tiered Network).

For additional Tiered Network information, please see the 2019 Premiums FAQ.

- **Limited Networks:** A limited network plan is a health insurance plan that offers members access to a reduced or selective provider network that is smaller than the payer's most comprehensive provider network within a defined geographic area. This definition, like that contained within Massachusetts Division of Insurance regulation 211 CMR 152.00, does not require a plan to offer a specific level of cost (premium) savings in order to qualify.

Claims: Total medical, pharmacy, and behavioral health claims, as described. Amounts should include estimates of completed claims for any period not yet considered complete. Run-out beyond the date through which claims were paid when the claims data were accessed should be estimated and incorporated into results. Amounts should not include expenses for medical management performed in-house or by third parties other than providers, or any other payments to entities besides providers.

- **Allowed Claims:** The claim cost to be paid by the payer (Incurred Claims) and the member (Cost-Sharing) and the federal or state governments (CSR Amounts) to the provider after the provider or network discount, if any. Total Allowed Claims should include capitation payments, withhold amounts, and all other payments to providers including those paid outside the claims system.
- **Incurred Claims:** The claim cost to be paid by the payer to the provider after the provider or network discount, if any. Total Incurred Claims should include capitation payments, withhold amounts, and all other payments to providers including those paid outside the claims system. Incurred Claims should reflect only those amounts that are the liability of the payer, **excluding payments from both the member (Cost-Sharing) and the federal or state governments (CSR Amounts)**, such that the Incurred Claims are reported in a manner consistent with amounts expected to be funded by the Premiums earned.

Deductible: The dollar amount of the in-network, individual (single) policy deductible. This is the medical deductible for policies with a medical-only deductible, and the integrated medical and pharmacy deductible for policies that have an integrated medical and pharmacy deductible. In cases of PPO, POS, and/or tiered network products, please report the deductible for the most utilized tier.

Funding Type⁴

⁴ CHIA will provide an alternate Workbook for payers wishing to continue submitting data under the previous "Fully-

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- **Fully-Insured:** A plan where an employer contracts with a payer to cover pre-specified medical costs for its employees and employee-dependents.
- **Self-Insured:** A plan where employers take on the financial responsibility and risk for their employees' and employee-dependents' medical costs, paying payers or third party administrators to administer their claims. These employers may or may not also purchase stop-loss coverage to protect against large claims; stop-loss premiums and employer-reimbursements should not be included in this Request.

Geographic Area: The 3-digit zip code of the member.

Market Sector: Market Sector includes four employer-sponsored plan categories, one student health category, three individual-purchaser plan categories, and one category for state employee plans, as described below.

Market Sector	Category	Description
Individual Purchasers	No Subsidy/Unknown	Health insurance plans purchased by individuals either directly from a payer or through the Massachusetts Health Connector without public subsidy.
	APTC Subsidy Only	Health insurance plans purchased by individuals through the Massachusetts Health Connector and qualified for an Advance Premium Tax Credit (APTC) subsidy <u>but not</u> qualified for a Cost-Sharing Reduction (CSR) subsidy.
	ConnectorCare	Health insurance plans purchased by individuals through the Massachusetts Health Connector and qualified for an Advance Premium Tax Credit (APTC) subsidy <u>and</u> a Cost-Sharing Reduction (CSR) subsidy.
Student Health	Student Health	Health insurance plans purchased by students through their school for primary, medical coverage. The ACA considers student health insurance purchasers to be non-group purchasers.
Employer-Sponsored Plans	Small Group ⁵	Fully-Insured: health insurance plans purchased through employer groups with 2-50 <u>eligible</u> employees, and that meet the definition of an "Eligible Small Business or Group," per Massachusetts Division of Insurance Regulation 211 CMR 66.04. Includes any Small Groups that may have purchased health insurance through the Massachusetts Health Connector. Includes any Small Groups that may have purchased health insurance through an association. ⁶

Insured" and "Total" classification system.

⁵ Fully-Insured small employers that met the definition of an Eligible Small Group Business or Group under 211 CMR 66.04 but became large employers under the full-time equivalent counting method implemented by the ACA and further discussed in Bulletin 2016-09 (<http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2016-doi-bulletins/bulletin-2016-09.html>) should be reported under the Small Group category during the time they were covered by a plan marketed and regulated as a small group plan, and reported under the applicable category (e.g., Mid-Size Group) during the time they were covered by a plan marketed and regulated as a large group plan.

⁶ Small Groups that purchase coverage through an association are to be included in the Small Group category per

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		Self-Insured: plans purchased through employer groups with 2-50 <u>enrolled</u> employees.
	Mid-Size Group	Fully-Insured: health insurance plans purchased through employer groups with 51-100 <u>enrolled</u> employees, and those employer groups with fewer than 51 enrollees that would not otherwise meet the definition of a Small Group (e.g., an employer with 150 total employees but only 40 enrolled employees). Self-Insured: plans purchased through employer groups with 51-100 <u>enrolled</u> employees.
	Large Group	All: health insurance plans and self-insured plans purchased through employer groups with 101-499 <u>enrolled</u> employees.
	Jumbo Group	All: health insurance plans and self-insured plans purchased through employer groups with 500+ <u>enrolled</u> employees.
Government Employee Plans⁷	Massachusetts Group Insurance Commission (GIC)	Health insurance plans and self-insured plans purchased by individuals from the selection negotiated and administered by the Massachusetts Group Insurance Commission.

Medical Loss Ratio (MLR) Rebates: Massachusetts health insurers are required to submit data on the proportion of premium revenues spent on health care services and quality improvement initiatives for several business lines, including for private commercial fully-insured groups. If state- and federal-MLR ratios or thresholds are not met, payers must provide members rebates for the excess premium retention.

Out-of-Pocket (OOP) Maximum: The dollar amount of the maximum OOP expenses for services within network for an individual (single) policy. The OOP maximum should include any deductibles, where applicable. In cases of PPO, POS, and/or tiered network products, please report the OOP limit for the most utilized tier.

Percent of Benefits Not Carved Out: The ratio of a membership's actual Allowed Claims, as compared to that membership's estimated Allowed Claims, had all members administered had a comprehensive benefit package (i.e. all Essential Health Benefit, and benefit claims, administered and paid by the submitted payer). This value will be less than 100% when certain benefits, such as prescription drugs or behavioral health services, are carved-out and not paid for by the plan.

Payers should provide their best estimates based upon available data for similar populations. For example:

- A payer administers 1,500 members: 1,000 members have comprehensive coverage; 500 members have comprehensive coverage minus pharmacy
- Based on comprehensive coverage member experiences, the payer estimates that approximately 20% of Allowed Claims PMPM are for pharmacy services (with variations across years, market sectors, funding types, product types, and benefit design types, per Workbook requirements)

Massachusetts 211 CMR66 and federal [CCHIO](#) guidance.

⁷ Non-GIC municipal employer groups should be counted under "Employer-sponsored plans" for the purposes of this request.

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- CHIA or Gorman Actuarial will use best-estimate member experiences to “scale up” estimated Allowed Claims for members where pharmacy claims data is not available
- Percent of Benefits Not Carved Out: $(((1,000 * 100\%) + (500 * 80\%)) / (1,000 + 500)) = 93\%$

Premiums, Earned: Represents the total gross earned premiums earned prior to Medical Loss Ratio (MLR) rebate payments incurred, though not necessarily paid, during the year, including any portion of the premium that is paid to a third party (e.g. Connector fees, reinsurance). Do not include any amounts related to risk adjustment. Premium amounts should include the full amount collected by the payer, including employee contributions, employer contributions, advance premium tax credit amounts, and/or state premium subsidies.⁸

Product Type: A mutually exclusive categorization of enrollment by members’ selected health insurance products: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Point-of-Service (POS), and “Other” plans. All Private Commercial plans should be included in one of these four categories, such that summing values across all Product Types produces totals equal to those for a given Market Sector. For plans that may be considered under more than one Product Type, the plan should be reported under the Product Type wherein most care is provided, as measured by Allowed Claims value.

- **Health Maintenance Organization (HMO):** Plans that have a closed network of providers, outside of which non-emergency coverage is not provided; generally requires members to coordinate care through a primary care provider.
- **Preferred Provider Organization (PPO):** Plans that have a network of “preferred providers,” although members may obtain coverage outside the network at higher levels of cost-sharing; generally does not require members to select a primary care provider.
- **Point-of-Service (POS):** Plans that require members to coordinate care through a primary care provider and use in-network providers for the lowest cost-sharing. As with a PPO plan, out-of-network providers are covered, though at a higher cost to members.
- **Other:** Plan types other than HMO, PPO, and POS, including, but not limited to, Exclusive Provider Organization (EPO) plans and Indemnity plans.

For additional membership categorization examples, please see the Premiums Frequently Asked Questions.

⁸ Premium amounts should not include member cost-sharing for health care services.