CENTER FOR HEALTH INFORMATION AND ANALYSIS

Performance of the Massachusetts Health Care System

Enrollment
Premiums
Member Cost-Sharing
Payer Use of Funds

Technical Appendix March 2022

CHIA.

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Private Commercial Enrollment, Premiums, Member Cost-Sharing, & Payer Use of Funds

TECHNICAL APPENDIX

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Background

CHIA received summarized contract-membership, commercial premiums, member cost-sharing, and benefit level data for calendar years 2018, 2019, and 2020 from the following payers:

- **Aetna:** Aetna Health, Inc. and Aetna Life Insurance Company
- **AllWays:** AllWays Health Partners, Inc. and AllWays Health Partners Insurance Company
- **BCBSMA:** Blue Cross and Blue Shield of Massachusetts, Inc. and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
- **BMCHP:** Boston Medical Center Health 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.; Tufts Insurance Company
- **THPP:** Tufts Health Public Plans, Inc.
- **UniCare:** UniCare Life & Health Insurance Company
- **United:** UnitedHealthcare Insurance Company

Payer data was provided in response to the "2021 Annual Premiums Data Request," which was developed with the assistance of Gorman Actuarial, Inc. This request included detailed definitions and specifications for membership, premiums, claims, and other cost data. It specified that payers provide data on their primary, medical, private commercial membership for all group sizes, including the individual and small group segments of the merged market. Products that were specifically excluded from this report were: Medicare Advantage, Medicaid, Medicare supplement, Federal Employees Health Benefits Program, and non-medical (e.g., dental) lines of business.

CHIA requested that payers submit summarized data for their fully- and self-insured lines of business as contracted in Massachusetts. Payers' data submissions encompassed "contract members" who may have resided inside or outside of Massachusetts; out-of-state members are most often covered by an employer that is located in Massachusetts. This data for "contract members" was included in the "Private Commercial Contract Enrollment," "Private Commercial Premiums," and "Private Commercial Member Cost-Sharing" sections of the report.

Payer-provided data was validated against reported financial data from the Massachusetts Division of Insurance's Medical Loss Ratio Reporting Form, the CCIIO Medical Loss Ratio Reporting Form, and prior CHIA Annual Premiums Data Request Submissions.[1]

CHIA collected aggregate enrollment, premiums, and claims data by funding type (fully-insured or self-insured), market sector (employer size), product type (health maintenance organization, preferred provider organization, point-of-service, and "other" plans), and benefit design type (high deductible health plans, tiered network plans, and limited network plans). Within the individual purchasers (non-group) market sector, data was further categorized into

[1] The analysis in this report relies on premium, claims, and membership data submitted by major Massachusetts payers. Payer data submissions were reviewed for reasonableness but were not audited. When reported data was not consistent, revised data was requested and provided by the payers. To the extent that final payer submitted data was unknowingly incomplete or inaccurate, findings in this report may not align with other payer filings.

unsubsidized and ConnectorCare membership. Unsubsidized membership included all non-ConnectorCare individual plans; however, some individuals purchasing these plans also received federal tax credits to lower their monthly premium contributions. Data for student health plans sold through Massachusetts colleges and universities was not included in the main report but may be found in the accompanying dataset.

Annual enrollment was reported as average membership within each year, derived by dividing annual member months by 12.

Private Commercial Premiums and Member Cost-Sharing

Payer-reported data from the "2021 Annual Premiums Data Request" enabled CHIA to report on commercial premiums, benefit levels, member cost-sharing, and allowed and incurred claims.

Benefit Levels

Benefit levels were measured as the percentage of total medical claims covered by the health plan, calculated as the ratio of the total paid (incurred) amount to the total allowed amount. For ConnectorCare members, cost-sharing reduction (CSR) subsidies were included in total paid amount to reflect the plan's benefit level as experienced by the member.

Fully-Insured Premiums

For fully-insured lines of business, payers provided annual earned premiums by employer size, product type and benefit design type for 2018 through 2020, as well as Medical Loss Ratio (MLR) rebate amounts for the reporting years.[2] Premiums net of MLR rebates were divided by annual member months to arrive at premiums per member per month (PMPM).

Massachusetts residents with household incomes less than or equal to 400% of the Federal Poverty Level and who are not eligible for MassHealth, Medicare, or employer-sponsored insurance may qualify for advance premium tax credits (APTCs) to reduce premiums. Reported premiums for unsubsidized individuals and ConnectorCare members include members' monthly premium contributions as well as any federal and state tax credits and/or subsidies received on members' behalf.

Allowed and Incurred Claims

Allowed and incurred claims were reported net of pharmacy rebates; this was a change from previous reports. If payers indicated that their submitted claims amounts had not already been adjusted for pharmacy rebates, CHIA adjusted submitted claims values using the commercial rebate percentages reported in payers' Prescription Drug Rebate data submissions. Within each payer and year, the same adjustment was applied across all market sectors, funding types, and product types/benefit design types. Allowed and incurred claims net of pharmacy rebates were divided by annual member months to arrive at allowed claims per member per month (PMPM) and incurred claims PMPM.

[2] Per federal and Massachusetts regulations, payers must provide rebates when their MLRs fall below certain thresholds.

Member Cost-Sharing

Average cost-sharing PMPM was calculated by subtracting incurred claims amounts and CSR subsidy amounts, if applicable, from allowed claims amounts and dividing by annual member months.

Payers also reported enrollment based on members' deductible and out-of-pocket spending limits. CHIA provided deductible and out-of-pocket maximum ranges for member month reporting. To enable comparisons across plans, payers were instructed to report based on individual (single) policy amounts, even for members enrolled in family policies with higher limits. This data was profiled on page 111 of the report.

Private Commercial Payer Use of Funds

This chapter reports on how payers used the premium revenue that they collected from their commercial fully-insured lines of business for 2018-2020. CHIA analyzed financial data from payer-submitted Massachusetts Division of Insurance's Medical Loss Ratio Reporting Forms and CCIIO Medical Loss Ratio Reporting Forms. The data included publicly available filings from all licensed payers offering plans in Massachusetts, including ConnectiCare of Massachusetts for 2018-2019 and Reliance Standard Life Insurance Company for 2018, both of which fell below the "2021 Annual Premiums Data Request" membership reporting threshold.

Non-Medical Expenses and Surplus

CHIA's Annual Financial Loss Ratio formula, which represents the percentage of premiums spent on members' medical costs, was developed in accordance with actuarial principles and methods for the purpose of measuring how much of an insurer's premium was retained in a given year. CHIA's Annual Financial Loss Ratio differs from the federal MLR formula and cannot be used to determine whether MLR thresholds were met. Any MLR rebates paid for each reporting year were subtracted from the premiums for that year. Incurred claims were adjusted for pharmacy rebates, CSR subsidy payments, and risk adjustment and high cost risk pool payments.

$$CHIA's\ Annual\ Financial\ Loss\ Ratio\ (\%) = \frac{Incurred\ Claims^{*}}{Earned\ Premiums - MLR\ Rebates}$$

The portion of premiums not spent on fully-insured members' medical costs is classified as "non-medical expenses and surplus." This metric can be expressed either as a percentage of premiums (the Annual Financial Loss Ratio) or as a dollar amount per member per month. Non-medical expenses and surplus amounts are calculated within the merged market, within fully-insured large group, and in total for all payers within a given calendar year.

$$Non-Medical\ Expenses\ and\ Surplus\ PMPM\ (\$) = \frac{Earned\ Premiums - MLR\ Rebates - \ Incurred\ Claims^{*}}{Member\ Months}$$

*Incurred claims were adjusted for pharmacy rebates, CSR subsidy payments, and risk adjustment and high risk cost pool payments.

Private Commercial Payer Use of Funds and the net cost of private health insurance (NCPHI), which captures the PMPM costs associated with the administration of private health insurance, use the same data source and similar methodology.[3] However, the Private Commercial Payer Use of Funds chapter only includes members of fully-insured

[3] See Total Health Care Expenditures, Total Medical Expenses, and Alternative Payment Methods Technical Appendix.

private commercial plans sitused in Massachusetts, which may include non-Massachusetts residents. NCPHI reflects the administrative costs of all Massachusetts residents enrolled with private payers, including self-insured commercial members and Medicaid and Medicare beneficiaries enrolled in private managed care plans.

Non-Medical Expense Components and Surplus

Non-medical expense components shown in the report can be further decomposed to the categories detailed below. These categories are based on aggregations of MLR Reporting Form line items for the 2018- 2020 reporting years. Any excess premium funds not allocated by payers to non-medical expenses are reported by CHIA as surplus (net gains).

Non-Medical Expense Components	Non-Medical Expense Component Details
General Administration	Community Benefit Expenditures Cost Containment Direct Sales Salaries & Benefits Other Claims Adjustment Expenses Other General Administration
Health Care Quality Improvement Expenses (HCQI) & Fraud Reduction Expenses	Health Care Quality Improvement Expenses (HCQI) Fraud Reduction Expenses
Commissions	Broker Fees & Commissions
Federal and State Taxes & Fees	ACA Charges Other Federal & State Taxes

Data Submission Manual

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

July 15, 2021

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: 2021

I. Additions/ Alterations

- CHIA requests that payers submit a copy of their completed Centers for Medicare & Medicaid Services (CMS) Medical Loss Ratio (MLR) Annual Reporting Form for the 2020 MLR Reporting Year.
- For the 2020 benefit year, plans that provided temporary premium credits should adjust earned premiums for these credits. CHIA expects these credits to reduce earned premiums.

II. Deletions

- CHIA will no longer collect Risk Adjustment Transfer Amounts.
- CHIA will no longer collect Rating Factors.

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 September 2021 Submission, this includes the following payers:

- Aetna: Aetna Health, Inc. and Aetna Life Insurance Company
- AllWays: AllWays Health Partners, Inc. and AllWays Health Partners Insurance Company
- 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.
- 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: 2021-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.

In addition to the Workbook, payers should submit a copy (in PDF and Excel format) of their completed Centers for Medicare & Medicaid Services (CMS) Medical Loss Ratio (MLR) Annual Reporting Form for the 2020 MLR Reporting Year.

General questions can be submitted anytime to CHIAData@gormanactuarial.com. Completed Workbooks and MLR Forms should be sent to CHIAData@gormanactuarial.com no later than Wednesday, September 15, 2021.

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 sitused[4] in Massachusetts. Members of medical plans purchased through the Massachusetts Health Connector and all comprehensive Student Health membership should be included.

Plans Not Included:

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

Members Not Included:

- Medical plan enrollees using plan as secondary coverage

[4] "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 (TPAs) shall determine situs of their contracts in a similar manner. Massachusetts sitused 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 2021 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. Filler

Do not populate with any data.

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
- 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
- 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

CHIA will no longer collect the following data types. Data submitters are instructed to leave these rows blank:

- Risk Adjustment Transfer Amounts

- Federal Transitional Reinsurance Amounts
- Risk Corridor Amounts
- Administrative Service Fees

F. Filler

Do not populate with any data.

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.

Hospital and Health System Financial Performance

6. Definitions

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.

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 $1,400 for 2020, and $1,350 for 2018-2019 (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 family plan would only be considered to be in an HDHP in 2020 for this data request's purpose if the individual deductible for that product is equal to or exceeds $1,400 in 2020; 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 Premiums FAQ document.

- **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 Type[5]

- **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 but not 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 and 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[6]	Fully-Insured: health insurance plans purchased through employer groups with 2-50 employees. Employees are derived using a Full-Time-Equivalent ("FTE") count for

[5] CHIA will provide an alternate Workbook for payers wishing to continue submitting data under the previous "Fully-Insured" and "Total" classification system.
[6] See 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).

		employers based on the federal method for counting employees.[7] 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.[8] Self-Insured: plans purchased through employer groups with 2-50 enrolled employees.
	Mid-Size Group	Fully-Insured: health insurance plans purchased through employer groups with 51-100 enrolled 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 enrolled employees.
	Large Group	Health insurance plans and self-insured plans purchased through employer groups with 101-499 enrolled employees.
	Jumbo Group	Health insurance plans and self-insured plans purchased through employer groups with 500+ enrolled employees.
Government Employee Plans[9]	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

[7] https://www.healthcare.gov/shop-calculators-fte/
[8] Small Groups that purchase coverage through an association are to be included in the Small Group category per Massachusetts 211 CMR66 and federal CCIIO guidance.
[9] Non-GIC municipal employer groups should be counted under "Employer-sponsored plans" for the purposes of this request.

- 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)
- CHIA or Gorman Actuarial may 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.[10] For the 2020 benefit year, plans that provided temporary premium credits should adjust earned premiums for those credits. CHIA expects these credits to reduce earned premiums.

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 document.

[10] Premium amounts should not include member cost-sharing for health care services.