**CENTER FOR HEALTH INFORMATION AND ANALYSIS**

957 CMR 10.00

Health Care Payers Premiums and Claims Data Reporting Requirements

Frequently Asked Questions (FAQ)

*Updated: June 16, 2025*

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## Premiums & Claims

1. Is **reporting done on a calendar or policy year basis**?

   *Reporting is done on a calendar year basis.*

2. What is the definition of "**Allowed Claims**"?

   *Allowed claims are the total cost of claims to be paid by the payer (Incurred Claims) and the member (Cost-Sharing) to the provider after the provider or network discount, if any. This should include medical claims, drug claims, capitation payments, withhold amounts, and all other payments to providers, including those paid outside the claims system. This value should include estimates of completed claims for periods that are not yet considered complete. Allowed Claims should be adjusted for (net of) prescription drug rebates.*

3. Should **behavioral health, vision, and dental** claims data be included?

   *Payers should include all expenses that are part of a comprehensive medical policy, either as part of the base policy itself or an attached rider. Incurred and allowed claims should reflect all benefits that are covered by the premium that is paid so that the premiums and claims that are reported reflect consistent benefits.*

   *If the behavioral health, dental, or vision benefits are part of the comprehensive medical policy, either the base policy or attached as a rider, they should be included in the reported premium and claims amounts. This is true even if the services are managed by a vendor based on a capitated arrangement. If, however, the behavioral health, dental or vision benefits are sold entirely separately as standalone policies, then these would fall under the category of "other non-primary, non-medical business" and thus be excluded.*

   *Please also note that, with regard to the "Percent of Benefits Not Carved Out", we would consider behavioral health services to be part of a comprehensive package of benefits similar to Essential Health Benefits. "Mental health and substance abuse services" is one of the categories of benefits that must be covered to meet Massachusetts' Minimum Creditable Coverage standards. It is also an Essential Health Benefit under the Affordable Care Act.*

   *In the merged market, it is expected that this coverage will be included in the comprehensive medical policy. In the larger group markets, if the behavioral health coverage is carved out because the employer purchases the coverage directly from a behavioral health vendor, then payers need to estimate the value of this carved out benefit in populating the "Percent of Benefits Not Carved Out."*

## Percent of Benefits Not Carved Out

4. How is the "**Percent of Benefits Not Carved Out**" calculated?

   *The percent of benefits not carved out must be estimated when the reporting entity does not have access to the actual data for benefits that are carved out to another vendor. A simplified example is provided below.*

   - *1,000 members have comprehensive coverage provided by the reporting entity*
   - *500 members have only medical coverage provided by the reporting entity; pharmacy coverage is carved out to a pharmacy benefits manager*
   - *Based on those members that have comprehensive coverage with the reporting entity, it is known that in this particular year, 80% of total allowed claims were for medical services and 20% of total allowed claims were for pharmacy services. These percentages should be calculated in aggregate across all market sectors, Coverage Type, Product Types, and Benefit Design Types for a given calendar year. If the reporting entity lacks sufficient data for members with comprehensive coverage, it may combine its data with that of any affiliated entities.*

   *The Percent of Benefits Not Carved Out for this segment is 93%. (1,000 * 100% + 500 * 80%) / (1,000 + 500) = 93%.*

5. How will the "**Percent of Benefits Not Carved Out**" value be used for analytic purposes?

   *CHIA may calculate a scaled, "all-inclusive" premium or claims spending measure using this value. Any financial figures reported in this way will be identified explicitly as such.*

**Geographic Area Calculations**

6. What is **Geography** used for?

   *Geography may be used to remove the impact that geographic shifts may have on a premium trend. It may also be used to display membership totals across the state by regions based on the 3-digit zip codes.*

7. For **Member Months by Geographic Area** (Worksheets B1 and B2), should we use the **3-digit zip code based on the member's address**? Is this different from previous years?

   *Yes, member zip code should be used rather than employer zip code. This is consistent with prior years' Requests.*

**Product Type**

8. What is the difference between **Product Type** and **Benefit Design Type**?

   *Product Type is a mutually exclusive, comprehensive grouping of plans based on network/provider access—i.e. whether the provider network is closed or open. Benefit Design Type is not mutually exclusive or comprehensive and is based on plan features such as cost-sharing (HDHPs and Tiered Networks) or network size (Limited Networks).*

9. What are examples of **HMO, PPO, POS, and "Other" plans**?

   *HMO plans utilize a closed network of providers, where selecting a primary care provider may be required; referrals may be needed to see specialists. PPO plans have a network of preferred providers; allow coverage outside that network (at a higher cost); do not require referrals; and a primary care provider is not necessary. POS plans may require members to coordinate care through a primary care provider; have a network of providers; and allow coverage outside that network (at a higher cost). "Other" plans are those that do not fall into the HMO, PPO, or POS categories. An example of an "Other" plan would be Indemnity plans. See the Data Submission Manual for more information.*

10. Can you provide additional clarification on how to classify by **Product Type**?

    *The determination of Product Type should be done at the member level for all reporting (membership, premium, claims, etc.), as based on the benefit plan selected by the member, not the employer level.*

    *Throughout the definition of Product Type, references to "plan" refer to a health benefit plan which is a unique set of network and cost sharing structure. For example, a payer's plans might include the payer's "Broad Network Silver HMO $1,000" and "Broad Network Bronze PPO $5,000." The term "plan" is not intended to refer to an employer arrangement.*

**Benefit Design Type**

11. **HDHPs may also be paired with HSAs and HRAs** to make plans more affordable for employees. Will CHIA note this?

    *CHIA will note that the data does not account for corresponding employer HRA or employee HSA adoption, which may mitigate out of pocket expenses.*

12. Should groups that offer a **High Deductible Health Plan (HDHP) option** be reflected under the HDHP option, even if only a small minority of members are actually covered?

    *No; Benefit Design Type, like Product Type, is determined at the member level, as based on the benefit plan selected by the member, not the employer level. Only members covered under the HDHP should be included. For example, if an employer has 40 members, but only 5 are on a HDHP, only those 5 should be included in the HDHP membership counts.*

13. Should **Limited Network plans** be reported under **the Tiered Network** Benefit Design Type category?

    *Plans can be both Limited Networks and Tiered Networks, Limited Networks only, or Tiered Networks only under the following scenarios:*

    *Limited and Tiered*
    *A plan is considered a Limited Network plan if it 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. If a plan meets this criterion AND offers different levels of cost-sharing for the same service across providers within the same provider type, then it would be considered both a Limited Network plan and a Tiered Network plan and should be reported under both the Limited Network and Tiered Network Benefit Design Type categories.*

    *Limited Network Only*
    *If the payer offers a plan with only one level of cost sharing per type of service (e.g., $1,000 inpatient admission copay), but offers it with a network that is smaller than the payer's most comprehensive provider network within a defined geographic area, then this is a Limited Network plan and not a Tiered Network.*

    *Tiered Network Only*
    *If the plan offers different levels of cost-sharing for the same service across providers within the same provider type, but the available provider network is not a subset of the payer's general or regional provider network, then it would be a Tiered Network and not a Limited Network plan.*

14. Should **Group Insurance Commission (GIC)** plans be reported under the **Tiered Network** Benefit Design Type category?

    *Yes, GIC plans should be classified as Tiered based on the definition contained in the Data Submission Manual.*

**Funding Type**

15. Is it possible to continue submitting data under the previous **Funding Type classification** of "Fully-Insured" and "Total Market"?

    *Yes. Beginning with the 2018 Request, payers were instructed to report Funding Type as either "Fully-Insured" or "Self-Insured." This change is expected to improve data submission accuracy and was implemented after consultation with payers. However, those payers that wish to continue submitting data under the previous Funding Type classification system may obtain an alternate Submission Workbook from CHIA.*

**Workbook Use**

16. Do we have to use the **Excel workbook**?

*Yes, data must be submitted in the provided Submission Workbook template. An alternate version is available for payers wishing to continue using the "Fully-Insured" and "Total Market" Funding Type classification. (See response to question 20.)*

17. Who should we contact if we have **questions on the workbook**?

*Technical questions may be submitted to CHIAData@oliverwyman.com.*

**Other Questions**

18. For **Worksheet C**, how should **members enrolled in family policies** be classified?

*Deductible limits and OOP maximums should be reported based on individual (single) policy levels, even for members enrolled in family policies. For example, if a plan includes an individual deductible of $1,750 and a family deductible of $3,500, the appropriate member months should be reported in the "$1,000 - $2,499" range. Likewise, for a plan with an individual out-of-pocket maximum of $7,000 and a family out-of-pocket maximum of $14,000, the member months should be reported in the "$5,000 - $9,999" range.*

19. For Worksheet E1, do the **MLR rebate amounts for Individual Purchasers need to be allocated** to the three subsidy categories?

*No, those amounts do not need to be allocated across the three categories. The total amount for those categories should be input into column H on Worksheets E1. Columns H-J appear merged for this purpose.*

20. Which **Student Health populations should be included** in the request?

*Only Student Health populations where the college/university is located in Massachusetts should be included. This includes students enrolled in the plan but with a permanent residence outside of Massachusetts. In addition, it excludes Massachusetts residents enrolled in a Student Health plan associated with an out-of-state institution.*

**Supplemental Data Request**

21. What is the difference between **Single** and **Family** policies?

*"Single" (or Individual) is defined as policies with only one member and zero dependents. "Family" policies are those where the policy covers a subscriber with one or more dependents.*

22. What is meant by "**most utilized tier**"?

*The definition of "most utilized tier" in the supplemental data request is consistent with the definition of "most utilized tier" in the Premium Data template. In a PPO, POS, and/or tiered-network plan, it refers to the tier that has the highest utilization from members. For example, if a plan has a $1000 in-network deductible and a $2000 out-of-network deductible, the deductible for members on this plan should be reported as $1000 if more member utilization occurs in-network than out-of-network.*

23. Example of reporting the average deductible amount for a Family policy: if a family of 4 each has an **individual deductible** of $1500, but the overall **family plan deductible** is $3000, should we report the family plan level deductible ($3000) or the total of each individual together ($6000)?

    *Please report the family plan deductible amount of $3000.*