CENTER FOR HEALTH INFORMATION AND ANALYSIS

Data Submission Manual

2025 Annual Premiums Data Request

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

May 19, 2025

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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: 2025

I. Additions/ Alterations

- Completed MLR Forms and a completed Premium Reporting workbook should be sent to CHIAData@oliverwyman.com no later than Wednesday, September 10, 2025.
- A supplemental data request is added in the 2025 reporting cycle. The completed supplemental data workbook should be sent to CHIAData@oliverwyman.com no later than Wednesday, September 24, 2025.

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 2025 Submission, this includes the following payers:

- Aetna: Aetna Health, Inc. and Aetna Life Insurance Company
- BCBSMA: Blue Cross and Blue Shield of Massachusetts, Inc. and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
- Cigna: CIGNA Health and Life Insurance Company
- HPHC: Harvard Pilgrim Health Care, Inc.; HPHC Insurance Company, Inc.; and Health Plans, Inc.
- HNE: Health New England, Inc.
- MGBHP (formerly AllWays): Mass General Brigham Health Plan, Inc. and Mass General Brigham Health Insurance Company
- Tufts: Tufts Associated Health Maintenance Organization, Inc. and Tufts Insurance Company
- THPP: Tufts Health Public Plans, Inc.
- United: UnitedHealthcare Insurance Company
- Wellpoint (formerly UniCare): Wellpoint Life & Health Insurance Company
- WellSense (formerly BMCHP): WellSense Health Plan, Inc.

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: 2025-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 2024 MLR Reporting Year no later than Wednesday, September 10, 2025.

General questions can be submitted anytime to CHIAData@oliverwyman.com. Completed Workbooks and MLR Forms should be sent to CHIAData@oliverwyman.com no later than Wednesday, September 10, 2025.

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[1] 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

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 2025 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.

[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 (TPAs) shall determine situs of their contracts in a similar manner. Massachusetts sitused members may not necessarily be residents of Massachusetts.

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 (Net of Prescription Drug Rebates)
    - Incurred (Net of Prescription Drug Rebates)
- 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 (Net of Prescription Drug Rebates)
    - Incurred (Net of Prescription Drug Rebates)

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
- Confirmation of whether data is gross or net of pharmacy rebates

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

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 2022, $1,500 for 2023, and $1,600 for 2024 (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 2024 for this data request's purpose if the individual deductible for that product is equal to or exceeds $1,600 in 2024; 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. Claims should be adjusted for (net of) prescription drug rebates.

- **Allowed Claims**: The claim cost to be paid by the payer (Incurred Claims) and the member (Cost-Sharing) 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, **including (gross of) payments from the federal or state governments (CSR Amounts) and excluding payments from the member (Cost-Sharing).**

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[2]

- **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
	No Subsidy/Unknown	Health insurance plans purchased by individuals either directly from a payer or through the

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

Individual Purchasers		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[3]	Fully-Insured: health insurance plans purchased through employer groups with 2-50 employees. Employees are derived using a Full-Time-Equivalent ("FTE") count for employers based on the federal method for counting employees.[4] 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.[5] 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.

[3] 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).
[4] https://www.healthcare.gov/shop-calculators-fte/
[5] 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.

Government Employee Plans[6]	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)
- CHIA 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%

Earned Premiums: 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.[7]

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

[6] Non-GIC municipal employer groups should be counted under "Employer-sponsored plans" for the purposes of this request.
[7] Premium amounts should not include member cost-sharing for health care services.

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.

7. Supplemental Data Request (New in 2025)

Workbook Overview

New to the 2025 reporting cycle, this additional data request is designed to collect data metrics including member months, member cost sharing, Earned Premium, and average deductible at the 5-digit zip code level, segmented by market sector. In addition, it requests statewide member months, average family size, average deductible, and average Earned Premium PMPM separately for single and family policies.

Data Definitions and Submission Instructions

Data definitions of data fields collected in the supplemental data request are consistent with the definitions of the same data fields in the main Premium Reporting Data template. This supplemental data request should only include data for Fully-Insured members. Self-Insured members are excluded in this supplemental data request. Additional instructions and clarifications are stated below.

[Verification and Reconciliation] tab

1. Legal entity, contact name, and contact email should be entered on the top of this tab.
2. The main section of this tab performs multiple internal and external data validation checks:

Member Month Consistency section:

This section first checks for internal consistency between calendar year total member months reported on the [Member Months by Zip Code] tab and member months reported on the [Single vs. Family] tab. It then requires carriers to check for external consistency between the calendar year total member months reported in the [Member Months by Zip Code] tab and the Fully-Insured member months aggregated in Tab A of the Premium Reporting Data Template. The carrier is asked to explain any inconsistency in rows 21 and 27.

Earned Premium Consistency section:

This section requires the carrier to check for external consistency between calendar year total Earned Premium reported on the [Premium by Zip Code] tab and the Fully-Insured Earned Premium

aggregated in Tab A of the Premium Reporting Data Template. The carrier is asked to explain any inconsistency in row 38.

Cost Sharing Consistency section:

This section requires the carrier to check for external consistency between calendar year total member cost sharing reported on the [Member Cost Sharing by Zip Code] tab and the Fully-Insured member cost sharing aggregated in Tab A of the Premium Reporting Data Template. The carrier is asked to explain any inconsistency in row 49.

[Member Months by Zip Code] tab

1. Three years of member month data are collected at the 5-digit zip code level.
2. Specifications and data definitions used to populate in this tab should be consistent with that from the Premium Reporting Data template, tab B1.
3. Total member months by year and by market segment should match member months reported in the Premium Reporting Data template, tab B1. Our team will reach out with questions and potentially request re-submissions if there are inconsistencies between the two forms.

[Premium by Zip Code] tab

1. Three years of Earned Premium data are collected at the 5-digit zip code level.
2. The definition of Earned Premium in this tab is consistent with that of the Premium Reporting Data template, tab E1.
3. Total Earned Premium amounts by year and by market segment should match the Earned Premiums reported in the Premium Reporting Data template, tab E1. Our team will reach out with questions and potentially request re-submissions if there are inconsistencies between the two forms.

[Member Cost Sharing by Zip Code] tab

1. Three years of total actual member cost sharing amounts are collected at the 5-digit zip code level.
2. The member cost sharing amounts should be reported under two non-overlapping categories: member cost sharing spent towards deductibles and any member cost sharing spent outside of deductibles such as coinsurance and copayments (non-deductible).
3. The total member cost sharing amounts when combining the two categories should reflect the difference between Incurred Claims and Allowed Claims as reported in the Premium Reporting Data template on tab E1.

[Deductible by Zip Code] tab

1. Deductibles reported in this tab should reflect average insurance plan deductible amounts per member, as opposed to the cost sharing amounts spent towards the plan deductible requested in the [Member Cost Sharing by Zip Code] tab.
2. The average deductible amount reported should reflect deductibles only of Single (or Individual) policies and the most utilized tier.
3. The "All" rows should be reported as the average deductible amount across all zip codes for each calendar year.
4. Carriers should enter $0 for an average deductible of $0 and "NA" if there are no members in a specific zip code for which to report an average deductible.

4. Columns O to V are used to check that only zip codes reported with zero member months are entered with "NA" as the average deductible. Numerical entries are expected for all zip codes with non-zero member months. Please explain any fail marks in column X of the tab. Our team will reach out with questions and potentially request re-submissions if there are any unexplained inconsistencies.

[Single vs. Family] tab

1. Data in this tab are collected on a statewide aggregated basis.
2. Reporting is split by Single policies and Family policies for which Family policies are plan enrollments with a subscriber that has one or more dependents.
3. Deductibles reported in this tab should reflect average insurance plan deductible amount per member, as opposed to the cost sharing amounts spent towards deductible requested in the [Member Cost Sharing by Zip Code] tab.
4. The average deductible amount reported should reflect Single and Family deductibles, where applicable, both under the most utilized tier.
5. Total member months reported in this tab combining Single and Family policies should tie to the member months reported in the [Member Months by Zip Code] tab of this supplemental data request, as well as Fully-Insured member months reported in the Premium Reporting data template, tab B1. Our team will reach out with questions and potentially request re-submissions if there are inconsistencies between the two forms.