CENTER FOR HEALTH INFORMATION AND ANALYSIS

PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM

PRIVATE COMMERCIAL ENROLLMENT

COST OF COVERAGE

PAYER USE OF FUNDS

TECHNICAL APPENDIX 2016

CHIA.

Enrollment, Premiums & Payer Use of Funds

TECHNICAL APPENDIX

Table of Contents

Enrollment in the Insurance Market

2016 Annual Premiums Data Request

CHIA received contract-membership, commercial premiums, consumer cost sharing, and benefit level data for 2013, 2014, and 2015 from affiliates of the following eleven (11) payers:

- Aetna
- Anthem (UniCare)
- Blue Cross Blue Shield of Massachusetts (BCBSMA)
- CIGNA
- Fallon Health (Fallon)
- Harvard Pilgrim Health Care, including Health Plans, Inc. (HPHC)
- Health New England (HNE)
- Neighborhood Health Plan (NHP)
- Tufts Health Plan (Tufts), including Tufts Public Plans (previously Network Health)
- United Healthcare (United)

Payer data was provided in response to the "2016 Annual Premiums Data Request", which was developed with the assistance of Oliver Wyman Actuarial Consulting, Inc. and forwarded to the participating payers. This request provided detailed definitions and specifications for requested membership, premiums, claims, and other pricing data; it requested 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 study were: Medicare Advantage, Commonwealth Care, Medicaid, Medicare supplement, Federal Employee Health Benefit Program (FEHBP), and non-medical (e.g., dental) lines of business.

CHIA requested membership data from payers' fully- and self-insured business, as contracted in Massachusetts. Reported members may, however, reside inside or outside of Massachusetts; out-of-state members are most often covered by an employer that is located in Massachusetts. These out-of-state "contract" members were included in all sections of this report related to premium trends.

Payer-provided data were supplemented with reported financial data from the Supplemental Health Care Exhibit (SHCE), the Massachusetts Annual Comprehensive Financial Statement, and the CCIIO Medical Loss Ratio Reporting Form. These resources were also used in data validation. [1]

[1] The analysis in this report relies on premium, claims, and membership data submitted by major Massachusetts payers. These data were reviewed for reasonableness, but they were not audited. When reported data were not consistent, revised data was requested and provided by the payers. To the extent final data were unknowingly incomplete or inaccurate, findings may be compromised.

Payers provided their claims by funding type (fully-/self-insured), market sector (employer size), product type (HMO/PPO), and by benefit design type (High Deductible Health Plans (HDHPs), tiered network plans, and limited network plans).

Commercial Premiums and Member Cost-Sharing

Payer-reported data from the "2016 Annual Premiums Data Request" also allowed CHIA to report on fully-insured commercial premiums, member cost-sharing, and benefit levels.

Administrative Service Fees

Payers reported the fees that they received from self-insured employers to provide services such as plan design, claims administration, and the use of networks of negotiated provider rates. When presented as part of premium equivalents, administrative service fees were scaled by the "Percent of Benefits not Carved Out."

Benefit Levels

Benefit levels were measured by Actuarial Values (AV), a measure of the proportion of expenditures covered by insurance versus patient cost-sharing, which can be calculated by several different methods. Oliver Wyman estimated the AVs using the paid-to-allowed ratios calculated from the payers' reported claims costs, adjusted for the impact of induced demand related to cost sharing levels. An AV of 1.0 represented a plan where 100% of the claims costs are paid for by the plan.

Cost-of-Claims

For self-insured lines of business, payers provided the annual cost-of-claims that self-insured employers paid, net of stop-loss reimbursements, by market sector, product type, and benefit design type for 2013 through 2015. Cost-of-claims were scaled by the "Percent of Benefits not Carved Out" and divided by annual member months to arrive at cost-of-claims per member per month (PMPM).

Cost-of-Coverage

The cost of coverage for the overall commercial market combines the cost trends of both fully- and self-insuring employers to provide an overall market estimate of private commercial health insurance cost growth. Cost-of-coverage was calculated by combining fully-insured premiums and self-insured cost-of-claims data, scaled by the "Percent of Benefits not Carved Out." This measure differs slightly from previous years, as self-insured data no longer includes Administrative Service Fee amounts.

Fully-Insured Premiums

For fully-insured lines of business, payers provided their annual earned premiums net of rebates[2] by market sector, product type and benefit design type for 2013 through 2015, as well as their rating factors used in December 2015.

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

Premiums net of rebates were scaled by the "Percent of Benefits not Carved Out" and divided by annual member months to arrive at premiums per member per month (PMPM).

Fully-Insured Premiums, Adjusted

To calculate payer-specific "adjusted premiums", unadjusted premiums were recalculated to account for membership differences in age, gender, area, group size, and benefits. Adjustments were performed by first adjusting the rating factors to make each payer's factors relative to a common demographic. Age/gender factors were relative to a 35-year-old female, size factors were relative to a group of 51+ enrollees, and area factors were relative to Boston. A member weighted average adjustment factor was calculated for each calendar year. Finally, the unadjusted premiums were divided by the adjustment factor to develop adjusted premiums PMPM, which represent the premiums for a 1.0 factor.

The market total adjusted premium for 2013 was set equal to the weighted average adjusted premiums PMPM of the payers. The percent changes in the total adjusted premiums from 2013 to 2014 to 2015 were calculated as the member weighted average change across all payers. The total adjusted premium PMPM for 2014 and 2015 was calculated as the prior year adjusted premium PMPM times 1+ the percent change in total adjusted premium for the year.

It is possible that using the December 2015 factors for all periods in the study had a slight impact on resulting adjusted premium trends. However, it was determined that it was not feasible to request factors for each month or quarter. Furthermore, the factors are applied based upon effective date of issue or renewal which was not feasible to model in this analysis. This methodological decision is not anticipated to materially skew adjusted premium results.

Note that for this analysis, rating factors applied to Mid-Size, Large, and Jumbo groups reflected a premium based on a manual rate and not on the group's own experience. In the market, actual premiums would be based on a combination of the manual rate and an experience rate with the proportion of each depending on the group's size. The largest groups are typically rated based entirely on their own experience. Therefore, this analysis makes the assumption that actual experience will follow the claim pattern assumed in the manual rating factors. Actual premiums may differ. This approach is not anticipated to have a material impact on results. Rather, it is anticipated that the manual rate would be determined consistent with the overall average experience of the covered groups.

Adjusting the premiums for benefits required a separate analysis from the rating factor adjustments. Benefit levels for this analysis were measured by AV and the unadjusted premiums were divided by the estimated AVs to determine the premiums adjusted for benefits. Given the limitations of the data available, this analysis did not include limited network impact in the AV.

Member Cost-Sharing

Average cost-sharing PMPM was calculated by subtracting incurred claims from allowed claims (both of which were scaled by the "Percent of Benefits not Carved Out") and dividing by annual member months. Subsidies that may offset member cost-sharing (e.g. Health Connector ConnectorCare) were not collected or included in results.

Percent of Benefits Not Carved Out

Payers estimated the approximate percentage of a comprehensive package of benefits that their corresponding allowed claims covered. This value was less than 100% when certain benefits, such as prescription drugs or behavioral health services, were carved out and not paid for by the plan. These percentages were used to scale premiums, premium equivalents, and claims.

Commercial Payer Use of Funds

Finally, payer-reported data from the "2016 Annual Premiums Data Request", along with payer-reported data from the SHCE, allowed CHIA to report on how payers use the premium revenue that they collected from their fully-insured lines of business.

Medical Loss Ratios

While AVs estimate how much an average member can expect a plan to cover of his/her covered medical expenses, Medical Loss Ratios (MLRs) represent the proportion of a plan's total collected premium spent by that plan on member medical claims. MLRs used for rebate calculations also account for quality improvement and fraud detection expenses to adjust claims, and taxes and fees to adjust premiums. Further, in the merged market, adjustments are made for the impact of the 3Rs. (Note: a plan may have a high MLR but a low AV if its administrative costs for a plan are particularly low, and the plan only covers a minimal amount of the member's expected medical expenses.)

Premium Retention

Premium retention was calculated as the difference between the total premiums collected by payers and the total spent on incurred medical claims. Total retention amounts were based on premium and claims data reported by payers in the "2016 Annual Premiums Data Request."

Retention was reported without including transfers associated with the Affordable Care Act's "3R" programs—Risk Adjustment, Reinsurance, and Risk Corridors. Payers did, however, report these amounts, which can be found in the databook.

Retention Decomposition

Findings related to retention breakdown into its components (retention decomposition) were based on SHCE data from 2013, 2014, and 2015, as analyzed by Oliver Wyman. Results are shown for only non-merged market

membership: SHCE data for merged market business included estimates of 3R amounts, which may have deviated significantly from actual amounts.

For questions on Enrollment, Premiums, and Payer Use of Funds, please contact Kevin McAvey, Associate Director of Analytics, at kevin.mcavey@state.ma.us.

Data Submission Manual

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

March 3, 2016

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 member and product design.

CHIA has previously collected this data under the "Annual Premiums Data Request" (Request). CHIA now collects this data under Regulation 957 CMR 10.00. While Regulation 957 CMR 10.00 contains broad reporting guidance, this Data Specification Manual provides technical details to assist payers in reporting and filing data.

Per Regulation 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 data. As of February 17, 2016, this includes the following list of payers. These payers and their affiliated legal entities are required to submit in 2016:

- Aetna
- Anthem (UniCare)
- Blue Cross Blue Shield of Massachusetts (BCBSMA)
- CIGNA
- Fallon Health (Fallon)
- Harvard Pilgrim Health Care, including Health Plans, Inc. (HPHC)
- Health New England (HNE)
- Neighborhood Health Plan (NHP)
- Tufts Health Plan (Tufts), including Network Health/Tufts Public
- United Healthcare (United)

2. Summary of Changes and New Requirements

I. Content

A. Additions:

- Within Benefit Design Type, a category for "Limited Network" plans
- Within Market Sector, a category for Group Insurance Commission (GIC) plans

B. Deletions

- Within Allowed and Incurred Claims, the In-/Out-of-Network subcategories
- Within Average Employer Size, reporting by Product Type or Benefit Design Type

C. Terminology

- To ensure consistency across CHIA reporting, some terminology has changed: "Managed Care Type" (HMO, PPO) is now referred to as "Product Type"; "Product Type" (HDHPs, tiered networks) is now referred to as "Benefit Design Type."

II. Submission Format

A. Additional Submission Format

- An alternative reporting template ("Workbook #2") has been developed that allows most of the data to be reported in flat tables (see Data Submission Guidelines – Workbook #2 for more details).

  Payers may still submit data using the traditional template ("Workbook #1").

  Payers are required to submit only one of the two workbooks.

B. Per Member per Month (PMPM) Payer Verification

- Payers are provided certain auto-calculated per member per month (PMPM) figures to assist with quality review.

C. Contact Person

- Payers are required to report a contact person in the Payer Verification section.

3. File Submission Instructions

One Health Care Payers Premiums and Claims Data Reporting Workbooks (Workbook #1 or Workbook #2) must be used for data submission. The Workbooks can be accessed at: http://www.chiamass.gov/information-for-data-submitters-premiums-data/.

Data must be submitted for all legal entities that are included under the Payer as defined in Enrollment Trends, including affiliates that write only self-insured business. Under both Options #1 and #2, separate Workbooks must be submitted for each legal entity.

All quality-checked Workbooks should be sent to Dianna Welch of Oliver Wyman Actuarial Consulting, Inc., at dianna.welch@oliverwyman.com by Tuesday, May 10th, 2016 at 5pm. Any technical questions relating to specifications or the Workbook should be directed to Dianna Welch at dianna.welch@oliverwyman.com or at (414) 277-4657.

4. Overview, Population Specifications, and Definitions

Regulation 957 CMR 10.00 requires payers to report aggregate member months, claims, and premiums data by market sector (employer group size), product type (HMO, PPO), and benefit design type (high-deductible health plans, tiered networks, limited networks).

Payers must report this data for the previous three calendar years – 2013, 2014, and 2015 – for all Private Commercial Plans. Private Commercial Plans encompass all primary, medical Health Insurance Plans or Self-Insured Health Plans, provided by Private Health Care Payers, with contract situs or administration based in Massachusetts. The following types of business are not considered to be Private Commercial Plans under 957 CMR 10.00: Medicare Advantage, Commonwealth Care, Medicaid Managed Care, Medicare Supplement, Federal Employee Health Benefit Plan (FEHBP), Medical Security Program, and other non-primary, non-medical business.

Specifications

The Workbooks consist of seven sections:

A. Payer Verification

B. Membership

C. Membership by Payer-Specific Size Bands (Small Group Fully-Insured Only)

D. Average Employer Size

E. Premiums and Claims

F. Rating Factors

G. Reconciliation

A. Payer Verification

Based on data reported in Worksheets B and E, Worksheet A calculates aggregate and per member per month (PMPM) figures for certain key breakouts. Payers must verify the accuracy of these amounts and indicate a contact person should questions arise.

B. Membership

Report Member Months information by Year, Geographic Area (3-digit zip), Age Group, Gender, Funding Type, Product Type, Benefit Design Type, and Market Sector.

C. Membership by Payer-Specific Size Bands (Small Group Fully-Insured Only)

Report **Member Months** information for **small group**, **fully-insured accounts** broken down by Product Type and Benefit Design Type, by size (**using size bands that correspond to the payer's rating bands** and excluding individual policies in the merged market from membership). For employer groups with multiple product or managed care types, the size band should be based on the total employer size, and not the size of the population enrolled in each type. For example, for an employer group of size 20 that has 5 employees enrolled in a PPO for the entire year and 15 enrolled in an HMO for the entire year: 60 member months (5*12) would be reported in the size band including size 20 under Managed Care Type "PPO", while 180 member months (15*12) would be reported in the size band including size 20 under "HMO."

D. Average Employer Size

Report **the Average Employer Size** by Funding Type and Market Sector.

E. Premiums and Claims

Report the following information for **fully- and self-insured accounts** by Year, Funding Type, Product Type, Benefit Design Type, and Market Sector:

- Earned Premiums [Fully-Insured Only]
  - Earned Premiums
  - Earned Premiums Net of MLR Rebates3
- Administrative Service Fees [Self-Insured Only]
- Percent of Benefits Not Carved Out
- Claims:
  - Allowed
  - Incurred
- 2014 and 2015 Payer "3R" Totals4 [2015 Totals Not Needed w/ May 10th Submission]

F. Rating Factors

Report rating factors for **fully-insured plans only** in effect for effective dates in December 2015 as follows: 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,

[3] For the May submission, payers should reflect their best estimates of 2015 MLR rebates within the Mid-Size, Large, and Jumbo Market Sectors. CHIA will request 2015 MLR rebates for the Individual and Small Group Market Sectors at a later date.

[4] 3R totals - Risk Adjustment Transfer, Federal Transitional Reinsurance, and Risk Corridor amounts – for 2015 are not required with the May submission. See Definitions. CHIA will collect 2015 data in July.

group size, retention, and contract type. **Industry factors and benefit plan factors may be excluded**. Payers should define group size ranges as they would apply their rating factors, which should include the same bands as reported on Section C.

G. Reconciliation

1) Please explain any known discrepancies between the data provided in (B) and (E) with those provided in the following documents for 2013, 2014, and 2015 (where available by May 2016):

- Massachusetts Division of Insurance's "Annual Comprehensive Financial Statement"
- US Center for Consumer Information and Insurance Oversight's (CCIIO) "Medical Loss Ratio Reporting Form"
- National Association of Insurance Commissioners' (NAIC) "Supplemental Health Care Exhibit"

Certain Affordable Care Act provisions (such as 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 2015 amounts in July.

2) Also, please explain any known discrepancies between the data provided in (B) and (E) and previously submitted:

- CHIA Annual Premiums Data Requests

A detailed reconciliation is not required with previous submissions; rather, a listing of reasons for potential discrepancies should be provided.

For payer convenience, public payer data, where available, will be provided in the "Reconciliation Reference" workbook sent to each payer upon request.

Definitions:

"3 R" Amounts: *3R amounts - Risk Adjustment Transfer, Federal Transitional Reinsurance, and Risk Corridor amounts – for 2015 only are not expected to be submitted with the Workbook. CHIA will follow-up with payers to collect this data after the reconciliation process in July. Report 2014 amounts in the Workbook.*

- **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. Only the 2014 amount is required on the initial submission date.
- **Federal Transitional Reinsurance Amount:** 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. Only the 2014 amount is required on the initial submission date.
- **Risk Corridor Amount:** 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. Only the 2014 amount is required on the initial submission date. If reporting amounts *received*, please report the actual amount received after the reduction to 12.6% of the originally calculated amounts.

Administrative Service Fees: The fees earned by the payers/ASOs/TPAs for the full administration of a self-insured health plan, excluding any premiums collected for stop-loss coverage.

Average Employer Size: Equal to the number of covered employees divided by the number of employers. If multiple group IDs are maintained for a given employer, please use the number of employers in this calculation and not the number of group IDs. For a given employer, the number of covered employees should be the average for the calendar year.

Claims:

- **Allowed Claims**: The total cost of claims after the provider or network discount, **if any**. Allowed Claims are equal to Incurred Claims plus member cost sharing; this should include medical claims, drug claims, capitation payments, and all other payments to providers, including those paid outside of the claims system. This value should include estimates of completed claims for periods that are not yet considered complete. **For the 2016 submission, run-out beyond March 2016, as available, should be noted and estimated for outstanding claims incurred during calendar years 2013, 2014, and 2015.** This value should **not** include medical management expenses for medical management performed in-house or by third parties other than the providers, or any other payments to other entities besides the providers.
- **Incurred Claims**: The total cost of claims, after the provider/network discount **(if any)** and after member cost sharing. This value should include medical claims, drug claims, and capitation payments, and all other payments to providers including those paid outside of the claims system. This value should include estimates of completed claims for periods that are not yet considered complete **For the 2016 submission, run-out beyond March 2016, as available, should be noted and estimated for outstanding claims incurred during calendar years 2013, 2014, and 2015.** This value should **not**

include medical management expenses for medical management performed in-house or by third parties other than the providers, or any other payments to other entities besides the providers.

Funding Type:

- **FI =** (Fully-Insured): A plan where the employer contracts with an insurer to have that organization assume financial responsibility for employees' and their employees' dependents' medical claims and for all administrative costs.
- **SI =** (Self-Insured): A plan offered by employers who directly assume the cost of their employees' and their employees' dependents' medical claims. Employers that contract with insurance carriers or third party administrators for administrative services only (ASO) or claims processing should be included under Self-Insured; these employers may or may not also purchase stop-loss coverage to protect against large claims.

Earned Premiums:

- **Earned Premiums:** Represents the total gross premiums earned prior to any Medical Loss Ratio (MLR) rebate payments, 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 in earned premium. For 2014 and 2015, this will be a reconciling item when compared to financial statement amounts such as the Supplemental Health Care Exhibit. Earned premiums include the portion of premiums paid on behalf of the members by advance premium tax credits.
- **Earned Premiums Net of Rebates**: Represents the total gross premiums earned after removing Medical Loss Ratio (MLR) rebates incurred during the year (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 in earned premium. For 2014 and 2015, this will be a reconciling item when compared to financial statement amounts such as the Supplemental Health Care Exhibit. Earned premiums include the portion of premiums paid on behalf of the members by advance premium tax credits. **For calendar year 2015, please include the best estimates for non-Merged Market MLR rebates; fully-insured Individual and Small Group market sector rebates may be left blank for May submission** as payers may not know their risk adjustment transfer amounts. CHIA will request this data at a later date.

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

Product Type: A **mutually exclusive** breakdown of membership by Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and "Other". All plans should be included in one of these three 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 multiple Product Types, the plan should be reported under the Product Type wherein most care is provided, where care is measured by Allowed Claims total dollar value**. For example, a Point of Service plan that uses a closed HMO network, but allows for indemnity

coverage outside of the network, though provides roughly 95% of care (allowed claims total dollar value) through the HMO network, would be considered an HMO plan type. Please note that **Product Type should be determined at the member level**, as based on the benefit plan selected by the member, and not the employer level. The allowed claims total dollar value of ALL members within a given benefit plan determine the Product Type of that plan.

- **HMO:** Plans that have a closed network of providers, outside of which coverage is not provided, except in emergencies. The plan may require members to coordinate care through a primary care physician, but may also provide open access to in-network providers.
- **PPO:** Plans that identify a network of "preferred providers", but that allow members to obtain coverage outside of the network, though typically at higher levels of cost-sharing. PPO plans generally do not require enrollees to select a primary care physician.
- **Other:** Plan types other than HMO and PPO, such as indemnity plans, which do not have networks of preferred providers.

The following example shows how multiple plans under one employer would be grouped into the different Product Type buckets. Please note that the "member months" field in the tables below includes both employees and dependents. Plans 1-3 are fairly straight-forward as there is only one Product Type for each of those plans, HMO, PPO, and Other respectively.

Plan 4, however, a POS plan that combines HMO and Indemnity components, has multiple Product Types at the member level and, as a result, it would be grouped into the Product Type with the most allowed dollars, as shown in the "Plan 4 Detail" table. The Plan 4 Detail table contains the allowed claims experience for ALL members covered under that plan, such that all members in the plan are reported under the same Product Type even if a subset of the members experience an allowed claims percent that would result in a different Product Type if measured at the member level. In this example, plan 4 would be considered HMO, since the HMO Product Type had the most allowed dollars, and would be grouped under HMO for all reporting (membership, premium, claims, etc.).

For this one employer with four plans, the summation by Product Type is shown in the "Final Product Type Information" table below.

Examples of Multiple Plans for One Employer				
Plan	Description	ember Mont	Allowed Claims	Premium
1	HMO	180	$54,400	$67,500
2	PPO	120	$44,100	$42,000
3	Indemnity	96	$30,240	$43,200
4	**POS**	**48**	**$14,000**	**$19,200**

Plan 4 Detail		
Product Type	Allowed $	Allowed %
HMO	$9,000	64.3%
Indemnity	$5,000	35.7%

As the majority of Allowed Claims for Plan 4 falls under HMO, it would be considered an HMO for all reporting (Member Months, Premiums, Claims, et. al.).

Final Product Type Information				
Final Product Type	Grouping	Members	Allowed Claims	Premium
HMO	Plans 1 & 4	228	$68,000	$86,700
PPO	Plan 2	120	$44,100	$42,000
Other	Plan 3	96	$30,240	$43,200

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 their "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.

Market Sector: Excluding Group Insurance Commission (GIC) membership, average employer size segregated into the following mutually exclusive categories: Individual products, **Small Group (1-50 eligible enrollees if fully-insured, 1-50 enrolled employees if self-insured)**, Mid-Size Group (51-100 enrolled employees)[5], Large Group (101-499 enrolled employees), and Jumbo Group (500+ enrolled employees). Report **GIC membership separately**. In the **Small Group fully-insured market segment**, please include **only those small employers that meet the definition of "Eligible Small Business or Group" per Massachusetts Division of Insurance Regulation 211 CMR 66.04**.

Percent of Benefits Not Carved Out: The approximate percentage of a comprehensive package of benefits (similar to Essential Health Benefits) that the corresponding Allowed Claims cover. This value should be less than 100% when certain coverage, such as prescription drugs or behavioral health services, are carved out

[5] Fully-insured employers that have fewer than 51 enrollees, but do not meet the definition of an "Eligible Small Business or Group", should be included in the Mid-Size Group

and not paid for by the plan. This value should be similar to the comparison of "Partial Claims" to "Full Claims" in the CHIA Total Medical Expense (TME) request.

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 2014 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, funding 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 2014 Percent of Benefits Not Carved Out for this segment is 93%. (1,000 * 100% + 500 * 80%) / (1,000 + 500) = 93%

Benefit Design Type: Groupings based upon whether plans are high-deductible health plans (HDHPs) and/or health plans that utilize tiered or limited networks. These groupings **are not mutually exclusive**, nor will they include all plans. Please note that the **Benefit Design Type should be determined at the member level**, as based on the benefit plan selected by the member, and not the employer level.

- **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 $1,250 for 2013 and 2014 and $1,300 for 2015 (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 2014 for this data request's purpose if the individual deductible for that product is equal to or exceeds $1,250 in 2014; 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. For example, a tiered HMO plan may segment a payer's HMO network into two tiers, with a member paying a $500 inpatient copay per non-emergency admission at a Tier 1 hospital and a $1,000 inpatient copay per non-emergency admission at a Tier 2 hospital.

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 purpose (i.e. a plan that tiers only hospitals is a Tiered Network, similarly, a plan that tiers only physicians is also here considered a Tiered Network).

Please see the FAQ (Product Type and Benefit Design Type Clarification section) for further information on what types of plans should be considered Tiered Network.

- **Limited Networks:** A limited network plan is a health insurance plan that offers members access to a reduced or selective provider network, which is smaller than the payer's most comprehensive provider network within a defined geographic area and from which the payer may choose to exclude from participation other providers who participate in the payer's general or regional provider network. 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 as a limited network plan.

  If there are any special circumstances where this definition appears to include plans that are not truly limited network plans, please contact Dianna Welch to discuss at dianna.welch@oliverwyman.com or at (414) 277-4657.

Data Submission Guidelines

Workbook #1

Submitters that opt to complete Workbook #1 (available at http://www.chiamass.gov/information-for-data-submitters-premiums-data/) should report based on the instructions and formatting contained within the Workbook.

Workbook #2

Submitters that opt to complete Workbook #2 should consult this table for guidance on completing the Workbook (available at http://www.chiamass.gov/information-for-data-submitters-premiums-data/)

Worksheet	Column	Data Element Name	Type	Format	Guideline
See Worksheet A for guidelines for completing the payer verification.					
B. Member Months	1	Company Name	Text	Free Text	Enter the company or parent company name of the submitter.
B. Member Months	2	Company Detail	Text	Free Text	If applicable, enter the affiliate or subsidiary of the parent company.
B. Member Months	3	Year	Text	YYYY	Enter the calendar year in YYYY format
B. Member Months	4	Geographic Area	Text	See "Guideline"	Enter the first three digits of the member's zip code, if the member is a Massachusetts resident. If the member is not a Massachusetts resident, enter "Other." Must report one of the following: • **010** • **011** • **012** • **013** • **014** • **015** • **016** • **017** • **018** • **019**

					• **020** • **021** • **022** • **023** • **024** • **025** • **026** • **027** • **Other**
B. Member Months	5	Age Group	Text	See "Guideline"	Report the age of the member within the following bands: • **0-4** • **5-9** • **10-14** • **15-19** • **20-24** • **25-29** • **30-34** • **35-39** • **40-44** • **45-49** • **50-54** • **55-59** • **60-64** • **65+**
B. Member Months	6	Gender	Text	See "Guideline"	Report the gender of the member: • **M** = male • **F** = female
B. Member Months	7	Funding Type	Text	See "Guideline"	Indicate the Funding Type of the plan. Must report one of the following: • **FI =** (Fully-Insured): A plan where the employer contracts with an insurer to have that organization assume financial responsibility for employees' and their employees'

					dependents' medical claims and for all administrative costs. • **SI =** (Self-Insured): A plan offered by employers who directly assume the cost of their employees' and their employees' dependents' medical claims. Employers that contract with insurance carriers or third party administrators for administrative services only (ASO) or claims processing should be included under Self-Insured; these employers may or may not also purchase stop-loss coverage to protect against large claims.
B. Member Months	8	Product Type	Text	See "Guideline"	Indicate the Product Type of the plan. Must report one of the following: ■ **HMO:** Plans that have a closed network of providers, outside of which coverage is not provided, except in emergencies. The plan may require members to coordinate care through a primary care physician, but may also provide open access to in-network providers. ■ **PPO:** Plans that identify a network of "preferred providers", but that allow members to obtain coverage outside of the network, though typically at higher levels of cost-sharing. PPO plans generally do not require enrollees to select a primary care physician. ■ **Other:** Plan types other than HMO and PPO, such as indemnity plans, which do not have networks of preferred providers.
B. Member Months	9	HDHP Flag	Integer	Flag	Report: • **1** when the plan meets the definition of a High Deductible Health Plan (HDHP) • **0** when the plan does not meet the definition of a HDHP **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 $1,250 for 2013 and 2014 and $1,300 for 2015 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 2014 for this data request's purpose if the individual deductible for that product is equal to or exceeds $1,250 in 2014; the deductible for the family plan itself is inconsequential.
B. Member Months	10	Tiered Network Flag	Integer	Flag	Report: • **1** when the plan meets the definition of a Tiered Network • **0** when the plan does not meet the definition of a Tiered Network **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. For example, a tiered HMO plan may segment a payer's HMO network into two tiers, with a member paying a $500 inpatient copay per non-emergency admission at a Tier 1 hospital and a $1,000 inpatient copay per non-emergency admission at a Tier 2 hospital.
B. Member Months	11	Limited Network Flag	Integer	Flag	Report: • **1** when the plan meets the definition of a Limited Network • **0** when the plan does not meet the definition of a Limited Network **Limited Networks:** A limited network plan is a health insurance plan that offers members access to a reduced or selective provider network, which is smaller than the payer's most comprehensive

					provider network within a defined geographic area and from which the payer may choose to exclude from participation other providers who participate in the payer's general or regional provider network. 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 as a limited network plan. If there are any special circumstances where this definition appears to include plans that are not truly limited network plans, please contact Dianna Welch to discuss at dianna.welch@oliverwyman.com or at (414) 277-4657.
B. Member Months	12	Market Sector	Text	See "Guideline"	Report the employer size in one of the following categories: • **IND =** Individual products • **SG** = Small Group (1-50 eligible enrollees if fully-insured, 1-50 enrolled employees if self-insured) • **MS =** Mid-Size Group (51-100 enrolled employees)[6] • **LG =** Large Group (101-499 enrolled employees) • **JG =** Jumbo Group (500+ enrolled employees) • **GIC** = Group Insurance Commission In the Small Group fully-insured market segment, please include only those small employers that meet the definition of "Eligible Small Business or Group" per Massachusetts Division of Insurance Regulation 211 CMR 66.04.
B. Member Months	13	Member Months	Integer	XXXXXXX	The number of months during which Members are covered, over a

[6] Fully-insured employers that have fewer than 51 enrollees, but do not meet the definition of an "Eligible Small Business or Group", should be included in the Mid-Size Group

					specified period of time.
See Worksheet C for guidelines for reporting Member Months for Fully-Insured Small Group employers by size bands that correspond to the payer's rating bands.					
See Worksheet D for guidelines for reporting Average Employer Size.					
E. Premiums & Claims	1	Company Name	Text	Free Text	Enter the company or parent company name of the submitter.
E. Premiums & Claims	2	Company Detail	Text	Free Text	If applicable, enter the affiliate or subsidiary of the parent company.
E. Premiums & Claims	3	Year	Text	YYYY	Enter the calendar year in YYYY format
E. Premiums & Claims	4	Funding Type	Text	See "Guideline"	Indicate the Funding Type of the plan. Must report one of the following: • **FI =** (Fully-Insured): A plan where the employer contracts with an insurer to have that organization assume financial responsibility for employees' and their employees' dependents' medical claims and for all administrative costs. • **SI =** (Self-Insured): A plan offered by employers who directly assume the cost of their employees' and their employees' dependents' medical claims. Employers that contract with insurance carriers or third party administrators for administrative services only (ASO) or claims processing should be included under Self-Insured; these employers may or may not also purchase stop-loss coverage to protect against large claims.
E. Premiums & Claims	5	Product Type	Text	See "Guideline"	Indicate the Product Type of the plan. Must report one of the following: ■ **HMO:** Plans that have a closed network of providers, outside of which coverage is not provided, except in emergencies. The plan may require members to coordinate care through a

					primary care physician, but may also provide open access to in-network providers. ■ **PPO:** Plans that identify a network of "preferred providers", but that allow members to obtain coverage outside of the network, though typically at higher levels of cost-sharing. PPO plans generally do not require enrollees to select a primary care physician. ■ **Other:** Plan types other than HMO and PPO, such as indemnity plans, which do not have networks of preferred providers.
E. Premiums & Claims	6	HDHP Flag	Integer	Flag	Report: • **1** when the plan meets the definition of a High Deductible Health Plan (HDHP) • **0** when the plan does not meet the definition of a HDHP **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 $1,250 for 2013 and 2014 and $1,300 for 2015 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 2014 for this data request's purpose if the individual deductible for that product is equal to or exceeds $1,250 in 2014; the deductible for the family plan itself is inconsequential.
E. Premiums & Claims	7	Tiered Network Flag	Integer	Flag	Report: • **1** when the plan meets the definition of a Tiered Network • **0** when the plan does not meet the definition of a Tiered Network **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. For example, a tiered HMO plan may segment a payer's HMO network into two tiers, with a member paying a $500 inpatient copay per non-emergency admission at a Tier 1 hospital and a $1,000 inpatient copay per non-emergency admission at a Tier 2 hospital.
E. Premiums & Claims	8	Limited Network Flag	Integer	Flag	Report: • **1** when the plan meets the definition of a Limited Network • **0** when the plan does not meet the definition of a Limited Network **Limited Networks:** A limited network plan is a health insurance plan that offers members access to a reduced or selective provider network, which is smaller than the payer's most comprehensive provider network within a defined geographic area and from which the payer may choose to exclude from participation other providers who participate in the payer's general or regional provider network. 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 as a limited network plan. If there are any special circumstances where this definition appears to include plans that are not truly limited network plans, please contact Dianna Welch to discuss at dianna.welch@oliverwyman.com or at (414) 277-4657.
E. Premiums & Claims	9	Market Sector	Text	See "Guideline"	Report the employer size in one of the following categories: • **IND =** Individual products • **SG** = Small Group (1-50 eligible enrollees if fully-

					insured, 1-50 enrolled employees if self-insured) • **MS =** Mid-Size Group (51-100 enrolled employees)[7] • **LG =** Large Group (101-499 enrolled employees) • **JG =** Jumbo Group (500+ enrolled employees) • **GIC** = Group Insurance Commission In the Small Group fully-insured market segment, please include only those small employers that meet the definition of "Eligible Small Business or Group" per Massachusetts Division of Insurance Regulation 211 CMR 66.04.
E. Premiums & Claims	10	Allowed Claims	Money	XXXX.XX	The total cost of claims after the provider or network discount, **if any**. Allowed Claims are equal to Incurred Claims plus member cost sharing; this should include medical claims, drug claims, capitation payments, and all other payments to providers, including those paid outside of the claims system. This value should include estimates of completed claims for periods that are not yet considered complete. **For the 2016 submission, run-out beyond March 2016, as available, should be noted and estimated for outstanding claims incurred during calendar years 2013, 2014, and 2015.** This value should **not** include medical management expenses for medical management performed in-house or by third parties other than the providers, or any other payments to other entities besides the providers.
E. Premiums & Claims	11	Incurred Claims	Money	XXXX.XX	The total cost of claims, after the provider/network discount **(if any)** and after member cost sharing. This value should include medical claims, drug claims, and capitation payments, and all other payments

[7] Fully-insured employers that have fewer than 51 enrollees, but do not meet the definition of an "Eligible Small Business or Group", should be included in the Mid-Size Group

					to providers including those paid outside of the claims system. This value should include estimates of completed claims for periods that are not yet considered complete. **For the 2016 submission, run-out beyond March 2016, as available, should be noted and estimated for outstanding claims incurred during calendar years 2013, 2014, and 2015.** This value should **not** include medical management expenses for medical management performed in-house or by third parties other than the providers, or any other payments to other entities besides the providers.
E. Premiums & Claims	12	Percent Benefits Not Carved Out	Percent	XX.XX%	The approximate percentage of a comprehensive package of benefits (similar to Essential Health Benefits) that the corresponding Allowed Claims cover. This value should be less than 100% when certain coverage, such as prescription drugs or behavioral health services, are carved out and not paid for by the plan. This value should be similar to the comparison of "Partial Claims" to "Full Claims" in the CHIA Total Medical Expense (TME) request. 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 2014 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, funding 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 2014 Percent of Benefits Not Carved Out for this segment is 93%. (1,000 * 100% + 500 * 80%) / (1,000 + 500) = 93%
E. Premiums & Claims	13	Earned Premium	Money	XXXX.XX	Required only when Funding Type = 'FI' **Earned Premiums:** Represents the total gross premiums earned prior to any Medical Loss Ratio (MLR) rebate payments, 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 in earned premium. For 2014 and 2015, this will be a reconciling item when compared to financial statement amounts such as the Supplemental Health Care Exhibit. Earned premiums include the portion of premiums paid on behalf of the members by advance premium tax credits.
E. Premiums & Claims	14	Earned Premium Net of MLR Rebates	Money	XXXX.XX	Required only when Funding Type = 'FI' **Earned Premiums Net of Rebates**: Represents the total gross premiums earned after removing Medical Loss Ratio (MLR) rebates incurred during the year (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 in earned premium. For 2014 and 2015, this will be a reconciling item when compared to financial statement amounts such as the Supplemental Health Care Exhibit. Earned premiums include the portion of premiums paid on behalf of the members by advance premium tax credits. **For calendar year 2015, please include the best estimates for non-Merged Market MLR rebates; fully-insured Individual and Small Group market sector rebates may be left blank for May submission** as payers may not know their risk

					adjustment transfer amounts. CHIA will request this data at a later date.
E. Premiums & Claims	15	Administrative Service Fees	Money	XXXX.XX	Required only when Funding Type = 'SI' **Administrative Service Fees**: The fees earned by the payers/ASOs/TPAs for the full administration of a self-insured health plan, excluding any premiums collected for stop-loss coverage.
E. Premiums & Claims	16	Risk Adjustment Transfer Amount	Money	XXXX.XX	**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. Only the 2014 amount is required on the initial submission date.
E. Premiums & Claims	17	Federal Transitional Reinsurance Amount	Money	XXXX.XX	**Federal Transitional Reinsurance Amount:** 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. Only the 2014 amount is required on the initial submission date.
E. Premiums & Claims	18	Risk Corridor Amount	Money	XXXX.XX	**Risk Corridor Amount:** 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. Only the 2014 amount is required on the initial submission date. If reporting amounts received, please report the actual amount received after the reduction to 12.6% of the originally calculated amounts.
See Worksheet F for guidelines for reporting Rating Factors.					

For more information, please contact:

CENTER FOR HEALTH INFORMATION AND ANALYSIS

501 Boylston Street
Boston, MA 02116

www.chiamass.gov
@Mass_CHIA

(617) 701-8100

Publication Number: 16-222-CHIA-01B