

# 2018 Annual Report on the Performance of the Massachusetts Health Care System

## Commercial Insurance Dataset: Release Notes

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Updated 9/11/18

### Introduction

These release notes provide information for users of the Center for Health Information's (CHIA) 2018 commercial insurance dataset. This dataset was used for CHIA's *2018 Annual Report on the Performance of the Massachusetts Health Care System* and specifically underlies the analysis presented in the report's following chapters: Private Commercial Contract Enrollment, Private Commercial Coverage Costs, Member Cost-Sharing, A Closer Look: Individual Purchasers, and Private Commercial Payer Use of Funds.

CHIA collected and aggregated data from payers with at least 50,000 Massachusetts private commercial plan members in accordance with 957 CMR 10.00 and performed a number of measures to assess the quality of the data submitted, including comparing it to prior year submissions as well as other external sources. CHIA did not conduct an audit of the submitted data, however, so data errors or anomalies may exist in the dataset. At the end of this document is a listing of known data issues that were not resolved prior to the publication of CHIA's *Annual Report*. For more information about the data collected as part of CHIA's Annual Premiums Data Request, see the [Data Submission Manual](#).

### Overview of Dataset

The commercial insurance dataset contains enrollment and financial data for private commercial health insurance plans effective between 2015 and 2017 and situated in Massachusetts (includes non-Massachusetts residents).

This dataset contains two data tables: "Financial x Prod" and "Financial x Ben". Both data tables contain member months and financial data aggregated by payer entity, funding type, market sector, and year. In addition to these variables, the Financial x Prod table segments enrollment and financial data by Product Type (HMO, PPO, POS, Other), and the Financial x Ben table segments data by Benefit Design Type (HDHP, Limited, Tiered). Product Type categories are mutually exclusive while Benefit Design Types are not (i.e., a single insurance plan may be included under multiple Benefit Design Type categories but can only be included under a single Product Type category). Therefore, any market-wide aggregation and/or analysis should be done using the Financial x Prod table, and the Financial x Ben table should only be used to examine data related to a specific Benefit Design Type category.

Row-level calculations have been included as columns in the dataset as documented in the Field List below. The Aggregate Calculations section provides equations for additional derived measures referenced in CHIA's *2018 Annual Report on the Performance of the Massachusetts Health Care System*.

## Field List

Field Name	Field Description and List of Values	Notes
Payer	Grouped and abbreviated payer name: <ul style="list-style-type: none"> <li>• Aetna: Aetna Health, Inc. and Aetna Life Insurance Company</li> <li>• BCBSMA: Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. and Blue Cross and Blue Shield of Massachusetts, Inc.</li> <li>• BMCHP: Boston Medical Center HealthNet Plan</li> <li>• Cigna: CIGNA Health and Life Insurance Company</li> <li>• Fallon: Fallon Community Health Plan, Inc. and Fallon Health &amp; Life Assurance Company, Inc.</li> <li>• HPHC: Harvard Pilgrim Health Care, Inc.; HPHC Insurance Company, Inc.; and Health Plans, Inc.</li> <li>• HNE: Health New England, Inc.</li> <li>• NHP: Neighborhood Health Plan, Inc.</li> <li>• Tufts: Tufts Associated Health Maintenance Organization, Inc.; Tufts Insurance Company</li> <li>• Tufts Public: Tufts Health Public Plans, Inc. (formerly Network Health, LLC)</li> <li>• UniCare: UniCare Life &amp; Health Insurance Company</li> <li>• United: UnitedHealthcare Insurance Company</li> </ul>	Corresponds to Payer Grouping column in Reference Table A.  Health Plans, Inc. (HPI) is grouped under HPHC, while Tufts Health Public Plans (THPP) is reported separately from Tufts. Tufts Health Public Plans is alternately reported as Tufts Public Plans or THPP in the Annual Report.
Payer Entity	Abbreviated payer entity name: <ul style="list-style-type: none"> <li>• AHI: Aetna Health, Inc.</li> <li>• ALIC: Aetna Life Insurance Company</li> <li>• BCBSMAHMO: Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.</li> <li>• BCBSMAParent: Blue Cross and Blue Shield of Massachusetts, Inc.</li> <li>• BMCHP: Boston Medical Center HealthNet Plan</li> <li>• CIGNA: CIGNA Health and Life Insurance Company</li> <li>• FCHP: Fallon Community Health Plan, Inc.</li> <li>• FHLAC: Fallon Health &amp; Life Assurance Company, Inc.</li> <li>• HPHC: Harvard Pilgrim Health Care, Inc.</li> <li>• HpiC: HPHC Insurance Company, Inc.</li> <li>• HPI: Health Plans, Inc.</li> <li>• HNE: Health New England, Inc.</li> <li>• NHP: Neighborhood Health Plan, Inc.</li> <li>• TAHMO: Tufts Associated Health Maintenance Organization, Inc.</li> <li>• TICO: Tufts Insurance Company</li> <li>• THPP: Tufts Health Public Plans, Inc. (formerly Network Health, LLC)</li> <li>• UniCare: UniCare Life &amp; Health Insurance Company</li> <li>• United: UnitedHealthcare Insurance Company</li> </ul>	Corresponds to Payer Entity Abbreviation column in Reference Table A.
Funding Type	A mutually exclusive categorization based on the entity that is financially responsible for covered members' medical costs:	

Field Name	Field Description and List of Values	Notes
	<ul style="list-style-type: none"> <li>• Fully-Insured: A plan where an employer contracts with a payer to cover pre-specified medical costs for its employees and employee-dependents.</li> <li>• 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 are not included in this dataset.</li> </ul>	
Year	<p>Calendar year of the enrollment and financial data:</p> <ul style="list-style-type: none"> <li>• 2015</li> <li>• 2016</li> <li>• 2017</li> </ul>	
Market Sector	<p>A mutually exclusive categorization of the entity through which the population is insured. For employer-sponsored insurance, this field indicates the employer size.</p> <ul style="list-style-type: none"> <li>• APTC + CSR Subsidies: 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. Synonymous with ConnectorCare.</li> <li>• 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.</li> <li>• No Subsidy/ Unknown: Health insurance plans purchased by individuals either directly from a payer or through the Massachusetts Health Connector without public subsidy.</li> <li>• Small Group: If Fully-Insured, health insurance plans purchased through employer groups with 2-50 eligible enrollees, and that meet the definition of an "Eligible Small Business or Group," per Massachusetts Division of Insurance Regulation 211 CMR 66.04, except as otherwise noted in the Massachusetts Division of Insurance Bulletin 2016-09. Includes any Small Groups that may have purchased health insurance through the Massachusetts Health Connector or through an association. If Self-Insured, plans purchased through employer groups with 2-50 enrolled employees.</li> <li>• Mid-Size Group: If 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). If Self-Insured, plans purchased through employer groups with 51-100 enrolled employees.</li> <li>• Large Group: Health insurance plans and self-insured plans purchased through employer groups with 101-499 enrolled employees.</li> <li>• Jumbo Group: Health insurance plans and self-insured plans purchased through employer groups with 500+ enrolled employees.</li> <li>• MA GIC: Health insurance plans and self-insured plans purchased by individuals from the</li> </ul>	See Reference Table B for groupings.

Field Name	Field Description and List of Values	Notes
	<p>selection negotiated and administered by the Massachusetts Group Insurance Commission (GIC).</p> <ul style="list-style-type: none"> <li>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.</li> </ul>	
Product Type	<p>A mutually exclusive categorization of enrollment by members' selected health insurance products. All Private Commercial plans are 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.</p> <ul style="list-style-type: none"> <li>Health Maintenance Organization (HMO): Plans that have a closed network of providers, outside of which non-emergency coverage is not provided; generally requires members to coordinate care through a primary care provider.</li> <li>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.</li> <li>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.</li> <li>Other: Plan types other than HMO, PPO, and POS, including, but not limited to, Exclusive Provider Organization (EPO) plans and Indemnity plans.</li> </ul>	
Benefit Design Type	<p>Benefit and network design characteristics that are not exclusive to a given Product Type. These categories are <u>not</u> mutually exclusive.</p> <ul style="list-style-type: none"> <li>High Deductible Health Plan (HDHP): Plans with an individual deductible greater than or equal to the IRS definition for a high deductible health plan, which is \$1,300 for 2015–2017 (for the most preferred network or tier, if applicable). Only a plan's individual deductible level must be satisfied to be categorized as an HDHP; the deductible for the family plan is not taken into consideration.</li> <li>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.</li> <li>Limited Networks: Plans that offer 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.</li> </ul>	<p>Because benefit design type categories are not mutually exclusive e.g. a plan can be categorized as both HDHP and limited, the Financial x Ben table should only be used to examine data related to a specific Benefit Design Type category. Any market-wide aggregation and/or analysis should be done using the Financial x Prod table.</p>
Member Months	Reported covered member months for the given year and population.	
Members	<p>Estimated covered members.</p> <p>Calculated by dividing Member Months by 12.</p>	
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 is less	All financial fields denoted as "Scaled" below are scaled by the percent of benefits not carved out to reflect the

Field Name	Field Description and List of Values	Notes
	than 100% when certain benefits, such as prescription drugs or behavioral health services, are carved-out and not paid for by the plan.	estimated financial value of a comprehensive benefit package in which all services are administered by the payer.
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). Does not include any amounts related to risk adjustment. Premium amounts include the full amount collected by the payer, including member contributions, employer contributions, advance premium tax credit amounts, and/or state premium subsidies.	Applies to Fully-Insured plans only.
Scaled Premiums	Represents the estimated premiums that would have been earned by a payer under a comprehensive benefit package in which all services were administered by the payer.  Calculated by dividing Earned Premiums by Percent of Benefits Not Carved Out.	Applies to Fully-Insured plans only.
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. This proportion is known as the Medical Loss Ratio (MLR). If state and federal MLR ratios or thresholds are not met, payers must provide rebates to members for the excess premium retention. Across this three year period, the Massachusetts MLR threshold for fully-insured plans was 88% in the Merged Market and 85% for larger group plans outside the Merged Market. MLR Rebates owed to members are reported as a positive amount (+) in the dataset.	MLR rebate amounts for the 2017 plan year were not available at the time of data collection and are therefore not reported in the dataset.  Applies to Fully-Insured plans only.
Scaled MLR Rebates	Represents the estimated MLR Rebate that would have been owed by the payer for a comprehensive benefit package in which all services were administered by the payer.  Calculated by dividing MLR Rebates by Percent of Benefits Not Carved Out.	Applies to Fully-Insured plans only.
Fully-Insured Scaled Premiums Net MLR	Represents the estimated premiums that would have been earned by a payer for a comprehensive benefit package in which all services were administered by the payer, net of any scaled MLR rebates owed to members.  Calculated by subtracting Scaled MLR Rebates from Scaled Premiums.	Applies to Fully-Insured plans only.
Allowed Claims	The medical, pharmacy, and behavioral health claims cost paid by the payer (Incurred Claims) and the member (Cost-Sharing) and the federal or state governments (CSR Amounts) to the provider after the provider or network discount, if any. Allowed Claims include capitation payments, withhold amounts, and all other payments to providers including those paid outside the claims system.	
Scaled Allowed Claims	Represents the estimated Allowed Claims that would have been paid to providers under a comprehensive benefit package in which all services were administered by the payer.  Calculated by dividing Allowed Claims by Percent of Benefits Not Carved Out.	
Incurred Claims	The medical, pharmacy, and behavioral health claims cost paid by the payer to the provider after the provider or network discount, if any. Incurred Claims include capitation payments, withhold amounts,	

Field Name	Field Description and List of Values	Notes
	and all other payments to providers including those paid outside the claims system. Incurred Claims reflect only those amounts that are the liability of the payer, i.e., net of payments by both the member (Cost-Sharing) and the federal or state governments (CSR Amounts), such that the Incurred Claims are reported in a manner consistent with amounts expected to be funded by the Premiums earned.	
Scaled Incurred Claims	Represents the estimated Incurred Claims that would have been paid by the payer under a comprehensive benefit package in which all services were administered by the payer.  Calculated by dividing Incurred Claims by Percent of Benefits Not Carved Out.	
Member Cost-Sharing	Represents the medical, pharmacy, and behavioral health expenses allowed under the member's plan but not paid for by the payer, including copayments, coinsurance, and deductibles paid by the member as well as cost-sharing reduction (CSR) subsidies paid to the payer by state and federal governments. Member Cost-Sharing does not include out-of-pocket payments for goods and services not covered by the members' health insurance policies (e.g., over-the-counter medicines, vision, and dental care) and does not account for employer offsets, such as health reimbursement arrangements or health savings accounts.  Calculated by subtracting Incurred Claims from Allowed Claims.	For members with APTC + CSR Subsidies (ConnectorCare), this field will overestimate the member's cost-sharing responsibility. Reported cost-sharing in the <i>Annual Report</i> was based on "Scaled Member Cost-Sharing Net CSR."
Scaled Member Cost-Sharing	Represents the estimated medical, pharmacy, and behavioral expenses that would have been allowed under the member's plan but not paid for by the payer under a comprehensive benefit package in which all services were administered by the payer. Includes copayments, coinsurance, and deductibles paid by the member as well as cost-sharing reduction (CSR) subsidies paid to the payer by state and federal governments. Does not include out-of-pocket payments for goods and services not covered by the members' health insurance policies (e.g., over-the-counter medicines, vision, and dental care) and does not account for employer offsets, such as health reimbursement arrangements or health savings accounts.  Calculated by dividing Member Cost-Sharing by Percent of Benefits Not Carved Out.	For members with APTC + CSR Subsidies (ConnectorCare), this field will overestimate the member's cost-sharing responsibility. Reported cost-sharing in the <i>Annual Report</i> was based on "Scaled Member Cost-Sharing Net CSR."
Cost-Sharing Reduction Amts	The total estimated federal and state payments received by payers to lower individuals' health insurance deductibles, copayments, and coinsurance payments while enrolled in qualifying Massachusetts Health Connector plans. Eligibility is determined based on expected annual income. Maximum out-of-pocket amounts may also be reduced.	Applies to APTC + CSR Subsidies Market Sector only.
Scaled Member Cost-Sharing Net CSR	Represents the estimated medical expenses that would have been paid by the member under a comprehensive benefit package in which all services were administered by the payer. Includes copayments, coinsurance, and deductibles paid by the member. Does not include out-of-pocket payments for goods and services not covered by the members' health insurance policies (e.g., over-the-counter medicines, vision, and dental care) and does not account for employer offsets, such as health reimbursement arrangements or health savings accounts.  Calculated by subtracting Cost Sharing Reduction Amts from Scaled Member Cost-Sharing.	

Field Name	Field Description and List of Values	Notes
Advance Premium Tax Credit Amts	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 is determined based on expected annual income, and credit may have been taken in advance to lower monthly payments.	Applies to APTC + CSR Subsidies and APTC Subsidy Only Market Sectors.
Federal Transitional Reinsurance Amts	The amount that was received (+) as a result of the federal transitional reinsurance program that was put into place in the individual market effective 2014. This amount includes only recoveries received and not any required contributions to the program. Reinsurance amounts reflect the year in which the amount was incurred, not when the payment was received. For example, a payment received in 2016 for the 2015 benefit year falls under 2015 in the dataset.	<p>Reported for 2015 and 2016 only since this temporary reinsurance program ended in 2016.</p> <p>Applies to No Subsidy/ Unknown Market Sector only.</p>
Risk Adjustment Transfer Amts	The amount that was received (+) or owed (-) as a result of the risk adjustment program that was put into place in Massachusetts' individual and small group markets effective in 2014. Risk adjustment transfers reflect the year in which the amount was incurred, not when the payment was received. For example, a payment received in 2016 for the 2015 benefit year falls under 2015 in the dataset.	<p>Final risk adjustment amounts for the 2017 plan year were not available at the time of data collection. The 2017 values in the dataset are estimated amounts and were only reported by a subset of payers. Final 2017 risk adjustment amounts were <a href="#">released</a> by CMS on July 9, 2018. CMS data should be used in lieu of the Risk Adjustment Transfer Amts values in the dataset for all calculations involving 2017 risk adjustment.</p> <p>Applies to No Subsidy/ Unknown and Small Group Market Sectors only.</p>

## Reference Tables

The following reference tables can be used to create additional groupings for analysis:

### Reference Table A: Payer Entity Abbreviations and Groupings

Payer Entity	Payer Entity Abbreviation	Payer Grouping
Aetna Health, Inc.	AHI	Aetna
Aetna Life Insurance Company	ALIC	Aetna
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	BCBSMAHMO	BCBSMA
Blue Cross and Blue Shield of Massachusetts, Inc.	BCBSMAParent	BCBSMA
Boston Medical Center HealthNet Plan	BMCHP	BMCHP
CIGNA Health and Life Insurance Company	CIGNA	Cigna
Fallon Community Health Plan, Inc.	FCHP	Fallon
Fallon Health & Life Assurance Company, Inc.	FHLAC	Fallon
Harvard Pilgrim Health Care, Inc.	HPHC	HPHC
HPHC Insurance Company, Inc.	HpiC	HPHC
Health Plans, Inc.	HPI	HPHC
Health New England, Inc.	HNE	HNE
Neighborhood Health Plan, Inc.	NHP	NHP
Tufts Associated Health Maintenance Organization, Inc.	TAHMO	Tufts
Tufts Insurance Company	TICO	Tufts
Tufts Health Public Plans, Inc. (formerly Network Health, LLC)	THPP	Tufts Public
UniCare Life & Health Insurance Company	UniCare	UniCare
UnitedHealthcare Insurance Company	United	United

### Reference Table B: Market Sector Groupings

Full descriptions of each Market Sector are listed in the Field List. Groupings are listed from most granular to most inclusive. Note that the Unsubsidized category in Grouping 1 includes members receiving federal premium tax credits.

Market Sector	Grouping 1	Grouping 2	Grouping 3	Grouping 4
No Subsidy/ Unknown	Unsubsidized	Individual	Merged Market	Individual
APTC Subsidy Only	Unsubsidized	Individual	Merged Market	Individual
APTC + CSR Subsidies	ConnectorCare	Individual	Merged Market	Individual
Small Group	Small Group	Small Group	Merged Market	Employer-Sponsored Insurance (ESI)
Mid-Size Group	Mid-Size Group	Mid-Size Group	>50 Employees	Employer-Sponsored Insurance (ESI)
Large Group	Large Group	Large Group	>50 Employees	Employer-Sponsored Insurance (ESI)
Jumbo Group	Jumbo Group	Jumbo Group	>50 Employees	Employer-Sponsored Insurance (ESI)
MA GIC	MA GIC	MA GIC	>50 Employees	Employer-Sponsored Insurance (ESI)
Student Health	Student Health	Student Health	Student Health	Student Health

## Aggregate Calculations

This section contains information on additional derived measures referenced in CHIA's 2018 Annual Report:

### Benefit Level (before CSR subsidies)

This calculation represents the portion of covered members' medical costs paid by the payer.

$$\frac{\sum(\text{Incurred Claims})}{\sum(\text{Allowed Claims})}$$

### Benefit Level (after CSR subsidies)

This calculation represents the portion of medical costs that are covered either by the payer or by government subsidies i.e., the portion of medical costs not paid by the member.

$$\frac{\sum(\text{Incurred Claims}) + \sum(\text{CSR})}{\sum(\text{Allowed Claims})}$$

### Fully-Insured Retention (after 3R transfers) PMPM

This calculation represents the premium dollars per member per month that were retained by payers after covering members' medical costs and after accounting for risk adjustment and reinsurance transfers. This calculation can only be performed on the Fully-Insured population as Earned Premiums are not applicable to Self-Insured plans. Final risk adjustment amounts for the 2017 plan year were not available at the time of data collection. The 2017 risk adjustment values in the dataset are estimated amounts and were only reported by a subset of payers. Final 2017 risk adjustment amounts were [released](#) by CMS on July 9, 2018, and CMS data should be used in lieu of the Risk Adjustment Transfer Amt values in the dataset for all calculations involving 2017 risk adjustment. Risk Corridor amounts paid to payers in 2015 and 2016 count towards claims costs incurred in the 2014 plan year and are therefore excluded from this dataset.

$$\frac{\sum(\text{Earned Premiums}) - \sum(\text{Incurred Claims}) + \sum(\text{Risk Adjustment Transfer Amts}) + \sum(\text{Federal Transitional Reinsurance Amts})}{\sum(\text{Member Months})}$$

### HDHP Percent of Total Enrollment

This calculation represents the percent of members enrolled in a High Deductible Health Plan (HDHP). First sum the Member Months with Benefit Design Type category HDHP, then divide by the sum of total member months in the Financial x Prod table. Benefit Design Type categories are not mutually exclusive, so the Member Months in the denominator must come from the Financial x Prod table.

$$\frac{\sum(\text{Member Months})_{\text{HDHP}}}{\sum(\text{Member Months})_{\text{Financial x Prod}}}$$

### Non-HDHP Member Cost-Sharing PMPM

This calculation represents the per member per month member cost-sharing amounts for non-HDHP members (enrolled in plans with individual deductibles of less than \$1,300). In order to derive the cost-sharing amounts and member months for non-HDHP members, subtract HDHP cost-sharing amounts and member months in the Financial x Ben table from the total cost-sharing amounts and member months in the Financial x Prod table. Benefit Design Type categories are not mutually exclusive, so totals must come from the Financial x Prod table.

$$\frac{\sum(\text{Scaled Member Cost Sharing Net CSR})_{\text{Financial x Prod}} - \sum(\text{Scaled Member Cost Sharing Net CSR})_{\text{HDHP}}}{\sum(\text{Member Months})_{\text{Financial x Prod}} - \sum(\text{Member Months})_{\text{HDHP}}}$$

## Payer-Specific Notes

Not all data issues identified as part of the quality assurance process were resolved prior to the creation of this dataset. As a result, this section includes a listing of known data anomalies that users should be aware of when conducting analysis.

- United claims and member cost-sharing data was excluded from the *Annual Report* due to data quality concerns. Reported member cost-sharing PMPM increased significantly between 2016 and 2017, and United was unable to provide an explanation for the shift.
- United HDHP enrollment data was also excluded due to data quality concerns. United advised that methodology for identifying HDHP plans in 2017 changed compared to prior years, leading to an observed increase in 2017 HDHP enrollment.
- Fallon's ConnectorCare population was excluded from charts showing Member Cost-Sharing by Market Sector due to data quality concerns. Fallon's reported ConnectorCare Member Cost-Sharing amounts (after CSR subsidies) were unusually high considering that ConnectorCare plans are designed to have limited member cost-sharing.
- Fallon advised that HDHP enrollment was under-reported but was not able to provide a corrected submission prior to publication.
- NHP advised that APTC only membership was not reported because NHP is unable to report financials for this population.