

957 CMR: Center for Health Information and Analysis

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

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10.01: General Provisions

Scope and Purpose. 957 CMR 10.00 governs the reporting requirements for Private Health Care Payers to submit health care data and information to the Center for Health Information and Analysis in accordance with M.G.L. c. 12C.

10.02: Definitions

All defined terms in 957 CMR 10.00 are capitalized. As used in 957 CMR 10.00, unless the context otherwise requires, terms have the following meanings:

Adjudicatory Proceeding. A proceeding before an agency in which the legal rights, duties or privileges of specifically named persons or entities are required by constitutional right or by any provision of the General Laws to be determined after an opportunity for an agency hearing.

Administrative Service Fees. The fees earned by a Payer for the full administration of a Self-Insured Health Plan, excluding any premiums collected for stop-loss coverage.

Affiliated Payers. Any two or more Payers which, directly or indirectly, are in control of one another, are controlled by each other, or are under common control.

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 and include medical claims, drug claims, capitation payments, and all other payments to providers, including those paid outside of the claims system. This value includes incurred but not reported (IBNR) estimates resulting in approximated completed claims for periods that are not yet considered complete.

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Audit. An examination of a Payer’s health care data, information and supporting documentation against internal and external data sources to evaluate the accuracy of such health care data and information and to also ensure consistency in reporting.

Average Employer Size. For a given category, the number of covered employees divided by the number of employers.

Benefit Design Type. Non-mutually exclusive groupings of Private Commercial Plan membership based on benefit, network, and/or product design, including but not limited to high-deductible health plans (HDHPs) and health plans that utilize tiered or limited provider networks.

Calendar Year. The period beginning January 1st and ending December 31st.

Center. The Center for Health Information and Analysis established under M.G.L. c. 12C.

Data Submission Manual. A data submission manual containing detailed specifications and submission guidelines.

Health Care Services. Supplies, care and services of a medical, surgical, optometric, dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive, or geriatric nature including, but not limited to, inpatient and outpatient acute hospital care and services, services provided by a community health center or by a sanatorium, as included in the definition of “hospital” in Title XVIII of the federal Social Security Act, and treatment and care compatible with such services or by a health maintenance organization.

Health Insurance Plan. An individual or group contract or other plan providing coverage of Health Care Services and which is issued by a Payer, a hospital service corporation, a medical service corporation or a health maintenance organization.

Health Insurance Premiums. The gross premiums earned for providing health insurance coverage, including any portion of the premium that is paid to a third party.

Incurred Claims. The total cost of claims, after the provider/network discount (if any) and after member cost sharing. Incurred claims include medical claims, drug claims, and

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capitation payments, and all other payments to providers including those paid outside of the claims system. This value should include incurred but not reported estimates resulting in approximated completed claims for periods that are not yet considered complete.

Insurance Funding Type. A mutually exclusive grouping of Private Commercial Plan membership based on whether the Payer is financially responsible for paying covered members' medical claims or whether the employer is financially responsible for paying members' claims.

Member. A person covered by an individual contract or a certificate under a group arrangement contracted with a Payer, or their covered dependents.

Member Months. The number of months during which Members are covered, over a specified period of time.

Presiding Officer. The individual(s) authorized by law or designated by the Center to conduct an Adjudicatory Proceeding.

Private Commercial Plans. 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.

Private Health Care Payer ("Payer"). A private entity that contracts to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services. A Private Health Care Payer includes a carrier authorized to transact accident and health insurance under M.G.L. c. 175, a nonprofit hospital service corporation licensed under M.G.L. c. 176A, a nonprofit medical service corporation licensed under M.G.L. c. 176B, a dental service corporation organized under M.G.L. c. 176E, an optometric service corporation organized under M.G.L. c. 176F, a Self-insured Health Plan, a Third-party Administrator, or a health maintenance organization licensed under M.G.L. c. 176G.

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Product Type. A mutually exclusive breakdown of Private Commercial Plans into categories including but not limited to those with closed networks of providers, those with preferred networks of providers, and those without networks of preferred providers.

Rating Factors. Factors that are applied to base rates to develop Health Insurance Premiums, including but not limited to age/gender, area, group size, retention, and contract type.

Reporting Year. The Calendar Year in which the Payer reports.

Self-insured Health Plan. A plan which provides health benefits to the employees of an employer, which is not a health insurance plan, and in which the employer is liable for the actual costs of the Health Care Services provided by the plan and Administrative Service Fees.

Third-party Administrator. Any person or entity that receives or collects charges or contributions for, or adjusts or settles claims for, Self-Insured Health Plans with contract situs in Massachusetts.

Website. The website of the Center for Health Information and Analysis located at www.chiamass.gov.

10.03: Reporting Requirements

(1) Payer Membership Reporting Requirements. All Payers shall provide aggregate Member Months data for the previous three Calendar Years for all Private Commercial Plans by but not limited to the following classifications:

- (a) Insurance Funding Type;
- (b) Product Type;
- (c) Benefit Design Type;
- (d) Geographic area;
- (e) Age and gender groupings; and
- (f) Average Employer Size.

(2) Payer Financial Reporting Requirements. All Payers shall provide aggregate financial data for the previous three Calendar Years by Insurance Funding Type, Product Type, and Benefit Design Type classifications for all Private Commercial Plans, including but not limited to the following:

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- (a) Health Insurance Premiums;
- (b) Administrative Service Fees;
- (c) Health insurance claim amounts, including but not limited to the Allowed Claims and Incurred Claims amounts; and
- (d) Rating Factors.

(3) Payers Subject to Reporting Requirements. A Payer is subject to the reporting requirements in 957 CMR 10.00 if the Payer, including Affiliated Payers, had at least 50,000 Massachusetts Private Commercial Plan members for the latest quarter as reported in the Center's most recently published Enrollment Trends report as of February 1st of the Reporting Year and posted on the Center's website. If a Payer is subject to the reporting requirements of 957 CMR 10.00, it shall file the required data for all of its Private Commercial Plans, clients, and Affiliated Payers.

(4) Use of Existing Data. Where feasible, the Center may use currently reported and available data in addition to, or in place of, data elements that Payers must submit in accordance with 957 CMR 10.03(1) or (2).

10.04 Data Submission Procedures

(1) General. Payers shall submit annually health care data and information to the Center in accordance with the procedures provided in 957 CMR 10.00, a Data Submission Manual, or an Administrative Bulletin.

(2) Data Submission Manual. The Center will release a draft Data Submission Manual prior to requiring data submissions from Payers. Payers will be given at least 14 days to submit written comments on the draft Data Submission Manual. The Center will issue a final Data Submission Manual following the deadline for written comments and will notify Payers of its availability.

(3) Data Submission Process. Each Payer shall submit data directly to the Center or the Center's designated contractor in the format specified by the Data Submission Manual. Data submissions must conform to specifications set forth in the Data Submission Manual by the Center. The Center or its contractor will notify a Payer whether the submission has been accepted or rejected. Payers must correct and resubmit rejected data in a timely manner until notified that the submission has been accepted.

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(4) Data Review and Verification. Data submissions are subject to review and verification through whatever mechanisms the Center deems necessary, including but not limited to matching and validating data from the Massachusetts Division of Insurance's "Annual Comprehensive Financial Statement," the US Consumer Information and Insurance Oversight's (CCIIO) "Medical Loss Ratio Reporting Form," the National Association of Insurance Commissioners (NAIC) "Supplemental Health Care Exhibit," the Center's "Enrollment Trends" reporting, and the Center's "Total Medical Expenses" reporting.

(5) Filing Deadlines. Each Reporting Year, Payers must submit finalized, acceptable data (per 957 CMR 10.04(3)) for the previous three Calendar Years by May 10th, unless otherwise instructed in the Data Submission Manual or by Administrative Bulletin.

(6) Extension Requests. The Center may grant, for good cause, data submission extensions for Payers to submit health care data and information.

10.05: Audits

(1) General. Submissions under 957 CMR 10.00 may be subject to Audit by the Center to ensure accuracy and consistency in reporting. Payers must submit additional data, information and related documentation as requested by the Center.

(2) Audit Adjustment. If necessary, the Center will work with Payers to adjust reporting to address discrepancies uncovered through the Audit process.

10.06: Other Provisions

(1) Administrative and Technical Information Bulletins. The Center may revise the specifications or other administrative requirements from time to time by notice or Administrative Bulletin.

(2) Confidentiality. Except as specifically provided otherwise by the Center or M.G.L. c. 12C, health care data and information collected pursuant to M.G.L. c. 12C, § 10 and 957 CMR 10.00 shall not be a public record. Except as otherwise provided, the Center will not disclose or release specific health plan actuarial assumptions submitted in accordance with 957 CMR 10.00.

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10.07: Compliance and Penalties

- (1) The Center will provide written notice to Payers that fail to comply with the reporting deadlines established in 957 CMR 10.00. The Center will notify Payers that failure to provide reportable data, including corrected data as described in 957 CMR 10.04(3), within two weeks of the written notice, without just cause, may result in penalties. In accordance with M.G.L. c. 12C, § 11, Payers may be subject to a penalty of up to \$1,000 per week for each week that the Payer fails to provide the required health care data and information, up to an annual maximum of \$50,000.
- (2) Any remedy available under 957 CMR 10.07 is in addition to other sanctions and penalties that may apply under the provisions of other statutes and regulations.
- (3) The Center may notify the Attorney General's Office to enforce the provisions of 957 CMR 10.07.
- (4) Before assessing a penalty, the Center shall notify the Payer that has failed to comply with the requirements of 957 CMR 10.00 that it has the right to request a hearing in accordance with M.G.L. c. 30A, § 10.
- (5) If a hearing is timely requested in writing, the Center, including through a Presiding Officer, will conduct the hearing in accordance with 801 CMR 1.00: *Standard Adjudicatory Rules of Practice and Procedure*. After the hearing, the Center shall render a written decision and may assess a civil penalty pursuant to 957 CMR 10.07(1).
- (6) After the issuance of a final decision, except where any provision of law precludes judicial review, a Payer aggrieved by such final decision may seek judicial review thereof in accordance with M.G.L. c. 30A, § 14.

10.08: Severability

The provisions of 957 CMR 10.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 957 CMR 10.00 or the application of such provisions.

REGULATORY AUTHORITY

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957 CMR 10.00: M.G.L. c. 12C