Data Reporting Manual

Department of Insurance

Division of Health, Life Insurance and Managed Care

2020 Edition

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NARRATIVE

Pursuant to KRS 304.17A-330, insurers authorized to write health insurance in the state, employer-organized associations that are self insured, and Insurance Purchasing Outlets are required to provide data to the Department of Insurance each year identifying premium, enrollment, claims, services, cost of services, and policy cancellation information for the previous calendar year. This data relates to Kentucky Health Benefit Plans issued to Kentucky residents.

This data specification manual has been developed to identify all information that is required to be reported by an insurer, self-insured employer-organized association, or Insurance Purchasing Outlet and to prescribe the reporting format and data elements. The Data Reporting Manual includes:

- **File specifications;**
- **Record counts and control totals; and**
- **Transmission requirements.**

Insurers, self-insured employer-organized associations, or Insurance Purchasing Outlets with more than 500 "Total Unduplicated Covered Persons (subscribers plus dependents)" as indicated on Annual Report 1 (File 1, sheet 1) in Column "P" are required to complete Annual Reports 1 through 9 [~~7~~]. Insurers self-insured employer-organized associations or Insurance Purchasing Outlets with 500 or less "Total Unduplicated Covered Persons (subscribers plus dependents)" as indicated on Annual Report 1 (File 1, sheet 1) in Column "P" are required to complete only Annual Report 1.

The Department of Insurance has developed a database to store the information reported in accordance with this Data Reporting Manual. The database is comprised of all files submitted by insurers, self-insured employer-organized associations, and Insurance Purchasing Outlets and is designed to permit the generation of any report related to the submitted data. Once the data is received from the insurers authorized to write health insurance in this state, the employer-organized associations that self-insure, and the Insurance Purchasing Outlets, the Department intends to produce an annual report based on the data collected pursuant to this Data Reporting Manual.

COMPLETION NOTES

The data reported in accordance with this Data Reporting Manual shall comply with the following reporting rules:

- **Numeric fields shall not be left blank. If there is no data to report for a specific numeric field, zeros shall be used.**
- **If a percentage is required, the percentage shall be expressed by utilizing the percentage sign (%).**
- **If a dollar amount is required, the dollar amount shall be expressed by using a decimal (.).**

DEFINITIONS

(1) "Association" is defined by KRS 304.17A-005(1).

(2) "Billed charges" means the amount that the insurer is billed for a service.

(3) "Capitation" means a stipulated dollar amount established to cover the cost of health care delivered to a person.

(4) "Covered person" is defined by KRS 304.17A-500(3).

(5) Electronic format" means an electronic copy of a Microsoft Excel Spreadsheet.

(6) "Health benefit plan" means a health benefit plan as defined by KRS 304.17A-005(22) and issued within Kentucky to a Kentucky resident.

(7) "Health care provider" is defined by KRS 304.17A-005(23).

(8) “Insured” means a covered person.

(9) "Insurer" is defined by KRS 304.17A-005(29).

(10) "Market segment" as used in this manual means: Individual, Small Group, Large Group, Group Association, Individual Association, Self-Insured Employer Organized Association/Multiple Employer Welfare Arrangement (MEWA), and Insurance Purchasing Outlet.

(11) "Medical service" means the service that was provided by a health care provider to a member of a health benefit plan.

(12) "Member" means a covered person.

(13) "Member month" means a period of time that represents each month that a member or subscriber, depending upon the information request, is enrolled in a health benefit plan.

(14) "Paid claim amount" means the amount paid by an insurer for a claim, excluding the following:

(a) Member deductible;

(b) Member co-pay; and

(c) Member co-insurance.

(15) "Product type" means a health benefit plan that is one of the following:

(a) Fee-for-service or FFS;

(b) Preferred provider organization or PPO;

(c) Point-of-service or POS; or

(d) Health maintenance organization or HMO.

(16) "Self-Insured Employer Organized Association" means an association that holds a certificate of filing according to KRS304-17A-320.

(17) "Subscriber" means the following:

(a) In the individual market, the number of health benefit plan policyholders; or

(b) In the small group, large group, individual association, group association, self-insured employer organized association or the Insurance Purchasing Outlet market, the number of health benefit plan certificate holders.

Insurer Information Report

This report provides basic identifying information regarding the insurer who is submitting the report and control totals for total premiums, subscribers, and covered persons. This report shall be submitted as File 1, sheet 1 of the EXCEL spreadsheet and shall include 33 columns. Row 1 shall contain the field descriptions and row 2 shall contain the data submitted by the insurer.

Row/ Column	Field Description	Valid Values
2/A	Company Name	Alpha-numeric, maximum 150 characters
2/B	DBA Name	Alpha-numeric, maximum 150 characters
2/C	Contact person	Alpha-numeric, maximum 150 characters
2/D	Insurer's telephone number	Must be 10 digits numeric (do not include dashes, etc)
2/E	First line of mailing address	Alpha-numeric, maximum 150 characters
2/F	Second line of mailing address	Alpha-numeric, maximum 150 characters
2/G	City	Alpha-numeric, maximum 150 characters
2/H	State	Must be 2 digits alphabetic
2/I	Zip code	Must be 5 or 9 digits numeric (do not include dashes, etc.)
2/J	NAIC number	Must be 5 digits numeric
2/K	NAIC Group number	Must be 4 digits numeric
2/L	Federal tax ID number	Must be 9 digits numeric (do not include dashes, etc.)
2/M	Total Premium earned	Must be numeric representing dollars and cents. This is the total dollar amount of premiums earned from the sale of health benefit plans during the reporting year. This amount shall be expressed using a decimal.
2/N	Total subscribers (as member months)	Must be numeric. This is the total number of subscribers during the reporting year. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months. 2 X 12 = 24 member months. The entry would be 24.
2/O	Total covered persons (subscribers plus dependents) (as member months)	Must be numeric. This is the total number of subscribers plus their dependents during the reporting year. This should be expressed as member months. Example: Two subscribers with each having 1 dependent were insured for the entire 12 months. 4 X 12 = 48 member months. The entry would be 48.
2/P	Total unduplicated covered persons (subscribers plus dependents).	Must be numeric. This is the total number of subscribers plus their dependents covered by a health benefit plan at any time during the reporting year.

Row/ Column	Field Description	Valid Values
2/Q	**Total actual covered persons (subscribers plus dependents) during January of the reporting year.**	**Must be numeric. This is the total number of subscribers plus their dependents covered by a health benefit plan during January of the reporting year.**
2/R	**Total actual covered persons (subscribers plus dependents) during February of the reporting year.**	**Must be numeric. This is the total number of subscribers plus their dependents covered by a health benefit plan during February of the reporting year.**
2/S	**Total actual covered persons (subscribers plus dependents) during March of the reporting year.**	**Must be numeric. This is the total number of subscribers plus their dependents covered by a health benefit plan during March of the reporting year.**
2/T	**Total actual covered persons (subscribers plus dependents) during April of the reporting year.**	**Must be numeric. This is the total number of subscribers plus their dependents covered by a health benefit plan during April of the reporting year.**
2/U	**Total actual covered persons (subscribers plus dependents) during May of the reporting year.**	**Must be numeric. This is the total number of subscribers plus their dependents covered by a health benefit plan during May of the reporting year.**
2/V	**Total actual covered persons (subscribers plus dependents) during June of the reporting year.**	**Must be numeric. This is the total number of subscribers plus their dependents covered by a health benefit plan during June of the reporting year.**
2/W	**Total actual covered persons (subscribers plus dependents) during July of the reporting year.**	**Must be numeric. This is the total number of subscribers plus their dependents covered by a health benefit plan during July of the reporting year.**
2/X	**Total actual covered persons (subscribers plus dependents) during August of the reporting year.**	**Must be numeric. This is the total number of subscribers plus their dependents covered by a health benefit plan during August of the reporting year.**
2/Y	**Total actual covered persons (subscribers plus dependents) during September of the reporting year.**	**Must be numeric. This is the total number of subscribers plus their dependents covered by a health benefit plan during September of the reporting year.**
2/Z	**Total actual covered persons (subscribers plus dependents) during October of the reporting year.**	**Must be numeric. This is the total number of subscribers plus their dependents covered by a health benefit plan during October of the reporting year.**
2/AA	**Total actual covered persons (subscribers plus dependents) during November of the reporting year.**	**Must be numeric. This is the total number of subscribers plus their dependents covered by a health benefit plan during November of the reporting year.**

2/AB	**Total actual covered persons (subscribers plus dependents) during December of the reporting year.**	**Must be numeric. This is the total number of subscribers plus their dependents covered by a health benefit plan during December of the reporting year.**
2/AC	**Total costs of Billed Charges of Claims**	**Must be numeric representing dollars and cents. This is the total dollar amount of billed charges of claims submitted for all health benefit plans during the reporting year. This amount shall be expressed by using a decimal.**
2/AD	**Total costs paid by insurer (this is total paid claims)**	**Must be numeric representing dollars and cents. This is the total amount of claims costs paid by the insurer during the reporting year. This amount shall be expressed by using a decimal.**
2/AE	**Total costs paid by insured**	**Must be numeric representing dollars and cents. This is the total amount of claims costs paid by the insured during the reporting year. This amount shall be expressed by using a decimal.**
2/AF	**Total number of insureds receiving services during the reporting year.**	**Must be numeric. This is the number of insureds receiving services during the reporting year. This is the unduplicated number of insureds that received any service during the reporting year.**
2/AG	**Total number of policies (for individual market segment) or certificates (for all other market segments) cancelled or discontinued.**	**Must be 6 digits numeric.**

Annual Report 2

Premium and Enrollment Report as Member Months

This report provides information regarding an insurer's total number of members (stated as member months) and premiums collected by market segment and product type for a calendar year. This report shall be submitted as File 1, sheet 2. Row 1 and Column A shall contain field descriptions and row 2 through row 29, columns B through D shall contain the data submitted by the insurer.

Row 2 represents data for Individual/Fee-for Service.
Row 3 represents data for Individual/PPO.
Row 4 represents data for Individual/HMO.
Row 5 represents data for Individual/POS.
Row 6 represents data for Small Group/Fee-for Service.
Row 7 represents data for Small Group/PPO.
Row 8 represents data for Small Group/HMO.
Row 9 represents data for Small Group/POS.
Row 10 represents data for Large Group/Fee-for Service.
Row 11 represents data for Large Group/PPO.
Row 12 represents data for Large Group/HMO.
Row 13 represents data for Large Group/POS.
Row 14 represents data for Group Association/Fee-for Service.
Row 15 represents data for Group Association/PPO.
Row 16 represents data for Group Association/HMO.
Row 17 represents data for Group Association POS.
Row 18 represents data for Individual Association/Fee-for Service.
Row 19 represents data for Individual Association/PPO.
Row 20 represents data for Individual Association/HMO.
Row 21 represents data for Individual Association/POS.
Row 22 represents data for Self-Insured Employer Organized Association/Fee-for Service.
Row 23 represents data for Self-Insured Employer Organized Association/PPO.
Row 24 represents data for Self-Insured Employer Organized Association/HMO.
Row 25 represents data for Self-Insured Employer Organized Association/POS.
Row 26 represents data for Insurance Purchasing Outlet/Fee-for Service.
Row 27 represents data for Insurance Purchasing Outlet /PPO.
Row 28 represents data for Insurance Purchasing Outlet /HMO.
Row 29 represents data for Insurance Purchasing Outlet /POS.

Column	Field Description	Valid Values
B	**Number of subscribers during the reporting year (as member months)**	**Must be numeric. This is the total number of subscribers during the reporting year with a health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months. 2 X 12 = 24 member months. The entry would be 24.**
C	**Number of covered persons during the reporting year (as member months**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96**
D	**Total Premium**	**Must be numeric. This is the total dollar amount of premiums earned from the sale of plans during the reporting year. This amount shall be expressed by using a decimal.**

Demographic Report as Member Months

Annual Report 3 provided information regarding an insurer's total number of members (stated as member months) by market segment and product type for a calendar year. This report further provides information regarding members (stated as member months) receiving a health benefit plan from an insurer by county for a calendar year. This report shall be submitted as File 1, sheet 3 of the EXCEL spreadsheet and shall contain 121 rows. Row 1 and column A shall contain field descriptions. Rows 2 through 121 and columns B through AC shall represent data for the specific county as indicated in column A. See attachment A for a list of the 120 Kentucky counties.

Row/ Column	Field Description	Valid Values
2 to 121/ B	Number of Individual/Fee-for-Service covered persons during the reporting year (as member months).	Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with an Individual/Fee-for-Service health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.
2 to 121/ C	Number of Individual/PPO covered persons during the reporting year (as member months).	Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with an Individual/PPO. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.
2 to 121/ D	Number of Individual/HMO covered persons during the reporting year (as member months).	Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with an Individual/HMO health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.

2 to 121/ E	**Number of Individual/POS covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with an Individual/POS health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ F	**Number of Small Group/Fee-for-Service covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Small Group/Fee-for-Service health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ G	**Number of Small Group/PPO covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Small Group/PPO health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ H	**Number of Small Group/HMO covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Small Group/HMO health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ I	**Number of Small Group/POS covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Small Group/POS health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ J	**Number of Large Group/Fee-for- Service covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Large Group/Fee-for-Service/ health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**

2 to 121/ K	**Number of Large Group/PPO covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Large Group/PPO health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ L	**Number of Large Group/HMO covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Large Group/HMO health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ M	**Number of Large Group/POS covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Large Group/POS health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ N	**Number of Group Association /Fee-for-Service covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Group Association /Fee-for-Service health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ O	**Number of Group Association /PPO covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Group Association /PPO health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ P	**Number of Group Association /HMO covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Group Association /HMO health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**

2 to 121/ Q	**Number of Group Association /POS covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Group Association /POS health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ R	**Number of Individual Association /Fee-for-Service covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with an Individual Association /Fee-for-Service health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ S	**Number of Individual Association /PPO covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with an Individual Association /PPO health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ T	**Number of Individual Association /HMO covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with an Individual Association /HMO health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ U	**Number of Individual Association /POS covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with an Individual Association /POS health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ V	**Number of Self-Insured Employer Organized Association/Fee-for-Service covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Self-Insured Employer Organized Association/Fee-for-Service health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**

2 to 121/ W	**Number of Self-Insured Employer Organized Association/PPO covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Self-Insured Employer Organized Association/PPO health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ X	**Number of Self-Insured Employer Organized Association Group /HMO covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Self-Insured Employer Organized Association/HMO health benefit plan. This should be expressed as member months. Example Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ Y	**Number of Self-Insured Employer Organized Association Group /POS covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with a Self-Insured Employer Organized Association/POS health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ Z	**Number of Insurance Purchasing Outlet/Fee-for-Service covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with an Insurance Purchasing Outlet /Fee-for-Service health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ AA	**Number of Insurance Purchasing Outlet/PPO covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with an Insurance Purchasing Outlet /PPO health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**
2 to 121/ AB	**Number of Insurance Purchasing Outlet/HMO covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with an Insurance Purchasing Outlet/HMO health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**

2 to 121/ AC	**Number of Insurance Purchasing Outlet/POS covered persons during the reporting year (as member months).**	**Must be numeric. This is the total number of subscribers plus any dependents during the reporting year with an Insurance Purchasing Outlet/POS health benefit plan. This should be expressed as member months. Example: Two subscribers were insured for the entire 12 months with 3 dependents each. 8 X 12 = 96 member months. The entry would be 96.**

Attachment A Commonwealth of Kentucky Listing

Name	Row
Adair	2
Allen	3
Anderson	4
Ballard	5
Barren	6
Bath	7
Bell	8
Boone	9
Bourbon	10
Boyd	11
Boyle	12
Bracken	13
Breathitt	14
Breckinridge	15
Bullitt	16
Butler	17
Caldwell	18
Calloway	19
Campbell	20
Carlisle	21
Carroll	22
Carter	23
Casey	24
Christian	25
Clark	26
Clay	27
Clinton	28
Crittenden	29
Cumberland	39
Daviess	31
Edmonson	32
Elliott	33
Estill	34
Grant	42
Graves	43
Grayson	44
Green	45
Greenup	46
Hancock	47
Hardin	48
Harlan	49
Harrison	50
Hart	51
Henderson	52
Henry	53
Hickman	54
Hopkins	55
Jackson	56
Jefferson	57
Jessamine	58
Johnson	59
Kenton	60
Knott	61
Knox	62
LaRue	63
Laurel	64
Lawrence	65
Lee	66
Leslie	67
Letcher	68
Lewis	69
Lincoln	70
Livingston	71
Logan	72
Lyon	73
McCracken	74
Mason	82
Meade	83
Menifee	84
Mercer	85
Metcalfe	86
Monroe	87
Montgomery	88
Morgan	89
Muhlenberg	90
Nelson	91
Nicholas	92
Ohio	93
Oldham	94
Owen	95
Owsley	96
Pendleton	97
Perry	98
Pike	99
Powell	100
Pulaski	101
Robertson	102
Rockcastle	103
Rowan	104
Russell	105
Scott	106
Shelby	107
Simpson	108
Spencer	109
Taylor	110
Todd	111
Trigg	112
Trimble	113
Union	114

Fayette	**35**	**McCreary**	**75**	**Warren**	**115**
Fleming	**36**	**McLean**	**76**	**Washington**	**116**
Floyd	**37**	**Madison**	**77**	**Wayne**	**117**
Franklin	**38**	**Magoffin**	**78**	**Webster**	**118**
Fulton	**39**	**Marion**	**79**	**Whitley**	**119**
Gallatin	**40**	**Marshall**	**80**	**Wolfe**	**120**
Garrard	**41**	**Martin**	**81**	**Woodford**	**121**

Annual Report 4

Billed Charge and Paid Claim Report

This report provides information regarding the total billed charge amounts, the total paid claim amounts, and capitation payments by market type and product type. This report shall be submitted as File 1, sheet 4 of the EXCEL spreadsheet and shall include columns B through E and Rows 1 through 29. Row 1 and column A shall contain the field descriptions and rows 2 through 29 and columns A through E shall contain the data submitted by the insurer.

Row 2 represents data for Individual/Fee-for Service.
Row 3 represents data for Individual/PPO.
Row 4 represents data for Individual/HMO.
Row 5 represents data for Individual/ POS.
Row 6 represents data for Small Group/Fee-for Service.
Row 7 represents data for Small Group/PPO.
Row 8 represents data for Small Group/HMO.
Row 9 represents data for Small Group/ POS.
Row 10 represents data for Large Group/Fee-for Service.
Row 11 represents data for Large Group/PPO.
Row 12 represents data for Large Group/HMO.
Row 13 represents data for Large Group/ POS.
Row 14 represents data for Group Association/Fee-for Service.
Row 15 represents data for Group Association/PPO.
Row 16 represents data for Group Association/HMO.
Row 17 represents data for Group Association/ POS.
Row 18 represents data for Individual Association/Fee-for Service.
Row 19 represents data for Individual Association/PPO.
Row 20 represents data for Individual Association/HMO.
Row 21 represents data for Individual Association/ POS.
Row 22 represents data for Self-Insured Employer Organized Association/Fee-for Service.
Row 23 represents data for Self-Insured Employer Organized Association/PPO.
Row 24 represents data for Self-Insured Employer Organized Association/HMO.
Row 25 represents data for Self-Insured Employer Organized Association/POS.
Row 26 represents data for Insurance Purchasing Outlet/Fee-for Service.
Row 27 represents data for Insurance Purchasing Outlet /PPO.
Row 28 represents data for Insurance Purchasing Outlet /HMO.
Row 29 represents data for Insurance Purchasing Outlet /POS.

Column	Field Description	Valid Values
B	**Cost of billed charges of claims submitted during the reporting year.**	**Must be numeric. This is the total dollar amount of billed charges of claims submitted in health benefit plans during the reporting year. This amount shall be expressed by using a decimal.**
C	**Cost of claims paid by the insurer during the reporting year.**	**Must be numeric. This is the total dollar amount of claims paid by the insurer in health benefit plans during the reporting year. The amount shall be expressed by using a decimal. Must be numeric. This is the total dollar amount of the claims.**
D	**Cost of claims paid by the insured during the reporting year.**	**Must be numeric. This is the total dollar amount of claims paid by the insured in health benefit plans during the reporting year. The amount shall be expressed by using a decimal.**
E	**Amount of capitation payments paid during the reporting year.**	**Must be numeric. This is the total dollar amount of capitation payments paid during the reporting year. This amount shall be expressed by using a decimal.**

Annual Report 5

Medical Service Cost Report by Market Segment

This report provides information regarding the type of service and the paid cost of the services by Market Segment (Individual, Small Group, Large Group, Group Association, Individual Association, Self-Insured Employer Organized Association or Insurance Purchasing Outlet) for a calendar year. This report shall be submitted as File 1, sheet 5. Row 1 and column A contain field descriptions. Rows 2 through 45 and columns B through H shall represent data for the specific information as indicated. Rows 16 and 31 will be blank.

Column B represents data for Individual.
Column C represents data for Small Group.
Column D represents data for Large Group.
Column E represents data for Group Association.
Column F represents data for Individual Association.
Column G represents data for Self-Insured Employer Organized Association
Column H represents data for Insurance Purchasing Outlets.

Rows 2 through 15 represent costs paid by INSURER during the reporting year. This must be numeric representing dollars and cents. This is the total amount of claims costs paid by the INSURER during the reporting year for specified services. This amount shall be expressed by using a decimal.

Rows 17 through 30 represent costs paid by INSURED during the reporting year. This must be numeric representing dollars and cents. This is the total amount of claims costs paid by the INSURED during the reporting year for specified services. This amount shall be expressed by using a decimal.

Rows 32 through 45 represent the unduplicated number of insureds receiving services during the reporting year. This must be numeric.

Specified Services for costs paid by the INSURER for rows 2 through 15:

Row	Service
2	Inpatient hospital - costs paid by insurer during the reporting year
3	Outpatient hospital - costs paid by insurer during the reporting year
4	Physician Services - costs paid by insurer during the reporting year
5	Pharmacy Services - costs paid by insurer during the reporting year
6	Behavioral Health Services (Excluding Autism Services) - costs paid by insurer during the reporting year
7	Home Health Care Services - costs paid by insurer during the reporting year
8	Ambulatory Surgical Services - costs paid by insurer during the reporting year

9	**Laboratory Services - costs paid by insurer during the reporting year**
10	**X-Ray Services - costs paid by insurer during the reporting year**
11	**Durable Medical Equipment - costs paid by insurer during the reporting year**
12	**Autism Services - costs paid by insurer during the reporting year**
13	**Emergency Department Services - costs paid by insurer during the reporting year**
14	**Chiropractic Services - costs paid by insurer during the reporting year**
15	**All Other Services - costs paid by insurer during the reporting year**

Specified Services for costs paid by the INSURED for rows 17 through 30:

Row	Service
17	**Inpatient hospital - costs paid by insured during the reporting year**
18	**Outpatient hospital - costs paid by insured during the reporting year**
19	**Physician Services - costs paid by insured during the reporting year**
20	**Pharmacy Services - costs paid by insured during the reporting year**
21	**Behavioral Health Services (Excluding Autism Services) - costs paid by insured during the reporting year**
22	**Home Health Care Services - costs paid by insured during the reporting year**
23	**Ambulatory Surgical Services - costs paid by insured during the reporting year**
24	**Laboratory Services - costs paid by insured during the reporting year**
25	**X-Ray Services - costs paid by insured during the reporting year**
26	**Durable Medical Equipment - costs paid by insured during the reporting year**
27	**Autism Services - costs paid by insured during the reporting year**
28	**Emergency Department Services - costs paid by insured during the reporting year**
29	**Chiropractic Services - costs paid by insured during the reporting year**
30	**All Other Services - costs paid by insured during the reporting year**

Specified Services for Unduplicated number of insureds receiving services for rows 32 through 45:

Row	Services
32	**Inpatient hospital - unduplicated number of insureds receiving services during the reporting year**
33	**Outpatient hospital - unduplicated number of insureds receiving services during the reporting year**
34	**Physician Services - unduplicated number of insureds receiving services during the reporting year**
35	**Pharmacy Services - unduplicated number of insureds receiving services during the reporting year**
36	**Behavioral Health Services (Excluding Autism Services) - unduplicated number of insureds receiving services during the reporting year**
37	**Home Health Care Services - unduplicated number of insureds receiving services during the reporting year**

38	**Ambulatory Surgical Services - unduplicated number of insureds receiving services during the reporting year**
39	**Laboratory Services - unduplicated number of insureds receiving services during the reporting year**
40	**X-Ray Services - unduplicated number of insureds receiving services during the reporting year**
41	**Durable Medical Equipment - unduplicated number of insureds receiving services during the reporting year**
42	**Autism Services - unduplicated number of insureds receiving services during the reporting year**
43	**Emergency Department Services - unduplicated number of insureds receiving services during the reporting year**
44	**Chiropractic Services - unduplicated number of insureds receiving services during the reporting year.**
45	**All Other Services - unduplicated number of insureds receiving services during the reporting year**

Annual Report 6

Medical Service Cost Report by Product Type

This report provides information regarding the type of service and the paid cost of the services by Product Type (Fee for Service, PPO, HMO, or POS) for a calendar year. This report shall be submitted as File 1, sheet 6. Row 1 and column A contain field descriptions. Rows 2 through 45 and columns B through E shall represent data for the specific information as indicated. Rows 16 and 31 will be blank.

Column B represents data for Fee for Service.
Column C represents data for PPO.
Column D represents data for HMO.
Column E represents data for POS.

Rows 2 through 15 represent costs paid by INSURER during the reporting year. This must be numeric representing dollars and cents. This is the total amount of claims costs paid by the INSURER during the reporting year for specified services. This amount shall be expressed by using a decimal.

Rows 17 through 30 represent costs paid by INSURED during the reporting year. This must be numeric representing dollars and cents. This is the total amount of claims costs paid by the INSURED during the reporting year for specified services. This amount shall be expressed by using a decimal.

Rows 32 through 45 represent the unduplicated number of insureds receiving services during the reporting year. This must be numeric.

Specified Services for costs paid by the INSURER for rows 2 through 15:

Row	Service
2	Inpatient hospital - costs paid by insurer during the reporting year
3	Outpatient hospital - costs paid by insurer during the reporting year
4	Physician Services - costs paid by insurer during the reporting year
5	Pharmacy Services (Excluding Autism Services) - costs paid by insurer during the reporting year
6	Behavioral Health Services - costs paid by insurer during the reporting year
7	Home Health Care Services - costs paid by insurer during the reporting year
8	Ambulatory Surgical Services - costs paid by insurer during the reporting year
9	Laboratory Services - costs paid by insurer during the reporting year
10	X-Ray Services - costs paid by insurer during the reporting year
11	Durable Medical Equipment - costs paid by insurer during the reporting year
12	Autism Services - costs paid by insurer during the reporting year
13	Emergency Department Services - costs paid by insurer during the reporting year
14	Chiropractic Services – costs paid by insurer during the reporting year.
15	All Other Services - costs paid by insurer during the reporting year

Specified Services for costs paid by the INSURED for rows 17 through 30:

Row	Service
17	Inpatient hospital - costs paid by insured during the reporting year
18	Outpatient hospital - costs paid by insured during the reporting year
19	Physician Services - costs paid by insured during the reporting year
20	Pharmacy Services (Excluding Autism Services) - costs paid by insured during the reporting year
21	Behavioral Health Services - costs paid by insured during the reporting year
22	Home Health Care Services - costs paid by insured during the reporting year
23	Ambulatory Surgical Services - costs paid by insured during the reporting year
24	Laboratory Services - costs paid by insured during the reporting year
25	X-Ray Services - costs paid by insured during the reporting year
26	Durable Medical Equipment - costs paid by insured during the reporting year
27	Autism Services - costs paid by insured during the reporting year
28	Emergency Department Services - costs paid by insured during the reporting year
29	Chiropractic Services – costs paid by insured during the reporting year.
30	All Other Services - costs paid by insured during the reporting year

Specified Services for Unduplicated number of insureds receiving services for rows 32 through 45:

Row	Services
32	Inpatient hospital - unduplicated number of insureds receiving services during the reporting year
33	Outpatient hospital - unduplicated number of insureds receiving services during the reporting year
34	Physician Services - unduplicated number of insureds receiving services during the reporting year
35	Pharmacy Services - unduplicated number of insureds receiving services during the reporting year
36	Behavioral Health Services (Excluding Autism Services) - unduplicated number of insureds receiving services during the reporting year
37	Home Health Care Services - unduplicated number of insureds receiving services during the reporting year
38	Ambulatory Surgical Services - unduplicated number of insureds receiving services during the reporting year
39	Laboratory Services - unduplicated number of insureds receiving services during the reporting year
40	X-Ray Services - unduplicated number of insureds receiving services during the reporting year
41	Durable Medical Equipment - unduplicated number of insureds receiving services during the reporting year
42	Autism Services - unduplicated number of insureds receiving services during the reporting year
43	Emergency Department Services - unduplicated number of insureds receiving services during the reporting year

44	**Chiropractic Services - unduplicated number of insureds receiving services during the reporting year.**
45	**All Other Services - unduplicated number of insureds receiving services during the reporting year**

Policy Discontinuance and Denial Reason Report

This report provides information regarding the type of policy and the reason the policy was discontinued for a calendar year. This report shall be submitted as File 1, sheet 7 of the EXCEL spreadsheet. Row 1 shall contain the field descriptions and row 2, columns A through J shall contain the data submitted by the insurer.

Row/ Column	Field Description	Valid Values
2/A	Number of policies (for individuals) or certificates cancelled or discontinued due to death of subscriber	Must be numeric. This is the number of policies or certificates discontinued due to the death of the subscriber.
2/B	Number of policies (for individuals) or certificates cancelled or discontinued due to subscriber moved out of state	Must be numeric. This is the number of policies or certificates discontinued due to the subscriber moving out of state.
2/C	Number of policies (for individuals) or certificates cancelled or discontinued due to subscriber moved out of service area	Must be numeric. This is the number of policies or certificates discontinued due to the subscriber moving out of service area.
2/D	Number of policies (for individuals) or certificates cancelled or discontinued due to subscriber selected another product from existing carrier	Must be numeric. This is the number of policies or certificates discontinued due to the subscriber selecting another product from the existing carrier.
2/E	Number of policies (for individuals) or certificates cancelled or discontinued due to subscriber request	Must be numeric. This is the number of policies or certificates discontinued due to the request of the subscriber.
2/F	Number of policies (for individuals) or certificates cancelled or discontinued due to subscriber non-payment of premiums	Must be numeric. This is the number of policies or certificates discontinued due to non-payment of premiums by the subscriber.

Row/ Colu	Field Description	Valid Values
2/G	**Number of policies (for individuals) or certificates cancelled or discontinued due to fraud or intentional misrepresentation of material facts under the terms of the coverage.**	**Must be numeric. This is the number of policies or certificates discontinued due to fraud or intentional misrepresentation of material facts under the terms of the coverage.**
2/H	**Number of policies (for individuals) or certificates cancelled or discontinued due to intentional and abusive non-compliance with material provisions of the health benefit plan.**	**Must be numeric. This is the number of policies or certificates discontinued due to intentional and abusive non-compliance with material provisions of the health benefit plan.**
2/I	**Number of policies (for individuals) or certificates cancelled or discontinued due to discontinuance of a product.**	**Must be numeric. This is the number of policies or certificates discontinued due to discontinuance of a product.**
2/J	**Number of policies (for individuals) or certificates cancelled or discontinued due to other or unknown reasons.**	**Must be numeric. This is the number of policies or certificates discontinued due to other or unknown reasons.**

Annual Report 8

Mental Health Service Cost Report by Market Segment

This report provides information regarding the type of service and the paid cost of the services by Market Segment (Individual, Small Group, Large Group, Group Association, Individual Association, Self-Insured Employer Organized Association or Insurance Purchasing Outlet) for a calendar year. This report shall be submitted as File 1, sheet 8. Row 1 and column A contain field descriptions. Rows 2 through 22 and columns B through H shall represent data for the specific information as indicated. Row 12 will be blank.

Column B represents data for Individual.
Column C represents data for Small Group.
Column D represents data for Large Group.
Column E represents data for Group Association.
Column F represents data for Individual Association.
Column G represents data for Self-Insured Employer Organized Association
Column H represents data for Insurance Purchasing Outlets.

Rows 2 through 11 represent costs paid by the insurer for in-network services during the reporting year. This must be numeric representing dollars and cents. This is the total amount of in-network claims costs paid by the insurer during the reporting year for specified services. This amount shall be expressed by using a decimal.

Rows 13 through 22 represent costs paid by the insurer for out of network services during the reporting year. This must be numeric representing dollars and cents. This is the total amount of out of network claims costs paid by the insurer during the reporting year for specified services. This amount shall be expressed by using a decimal.

Specified Services for costs paid In-Network for rows 2 through 11:

Row	Service
2	Total claims paid inpatient for medical/surgical in-network services
3	Total claims paid for inpatient mental health/substance use disorder in-network services
4	Total claims paid for outpatient office visits for medical/surgical in-network services
5	Total claims paid for outpatient office visits for mental health/substance use disorder in-network services
6	Total claims paid for outpatient other services for medical/surgical in-network services
7	Total claims paid for outpatient other services for mental health/substance use disorder in-network services
8	Total claims paid for emergency care for medical/surgical in-network services
9	Total claims paid for emergency care for mental health/substance use disorder in-network services
10	Total claims paid for pharmacy for medical/surgical in-network services
11	Total claims paid for pharmacy for mental health/substance use disorder in-network services

Specified Services for costs paid Out of Network for rows 13 through 22:

Row	Service
13	Total claims paid inpatient for medical/surgical out of network services
14	Total claims paid for inpatient mental health/substance use disorder out of network services
15	Total claims paid for outpatient office visits for medical/surgical out of network services
16	Total claims paid for outpatient office visits for mental health/substance use disorder out of network services
17	Total claims paid for outpatient other services for medical/surgical out of network services

18	**Total claims paid for outpatient other services for mental health/substance use disorder out of network services**
19	**Total claims paid for emergency care for medical/surgical out of network services**
20	**Total claims paid for emergency care for mental health/substance use disorder out of network services**
21	**Total claims paid for pharmacy for medical/surgical out of network services**
22	**Total claims paid for pharmacy for mental health/substance use disorder out of network services**

Annual Report 9

Mental Health Service Cost Report by Product Type

This report provides information regarding the type of service and the paid cost of the services by Product Type (Fee for Service, PPO, HMO, or POS) for a calendar year. This report shall be submitted as File 1, sheet 9. Row 1 and column A contain field descriptions. Rows 2 through 22 and columns B through E shall represent data for the specific information as indicated. Row 12 will be blank.

Column B represents data for Fee for Service.

Column C represents data for PPO.

Column D represents data for HMO.

Column E represents data for POS.

Rows 2 through 11 represent costs paid by the insurer for in-network services during the reporting year. This must be numeric representing dollars and cents. This is the total amount of in-network claims costs paid by the insurer during the reporting year for specified services. This amount shall be expressed by using a decimal.

Rows 13 through 22 represent costs paid by the insurer for out of network services during the reporting year. This must be numeric representing dollars and cents. This is the total amount of out of network claims costs paid by the insurer during the reporting year for specified services. This amount shall be expressed by using a decimal.

Specified Services for costs paid In-Network for rows 2 through 11:

Row	Service
2	Total claims paid inpatient for medical/surgical in-network services
3	Total claims paid for inpatient mental health/substance use disorder in-network services
4	Total claims paid for outpatient office visits for medical/surgical in-network services
5	Total claims paid for outpatient office visits for mental health/substance use disorder in-network services

6	**Total claims paid for outpatient other services for medical/surgical in-network services**
7	**Total claims paid for outpatient other services for mental health/substance use disorder in-network services**
8	**Total claims paid for emergency care for medical/surgical in-network services**
9	**Total claims paid for emergency care for mental health/substance use disorder in-network services**
10	**Total claims paid for pharmacy for medical/surgical in-network services**
11	**Total claims paid for pharmacy for mental health/substance use disorder in-network services**

Specified Services for costs paid Out of Network for rows 13 through 22:

Row **Service**

13	**Total claims paid inpatient for medical/surgical out of network services**
14	**Total claims paid for inpatient mental health/substance use disorder out of network services**
15	**Total claims paid for outpatient office visits for medical/surgical out of network services**
16	**Total claims paid for outpatient office visits for mental health/substance use disorder out of network services**
17	**Total claims paid for outpatient other services for medical/surgical out of network services**
18	**Total claims paid for outpatient other services for mental health/substance use disorder out of network services**
19	**Total claims paid for emergency care for medical/surgical out of network services**
20	**Total claims paid for emergency care for mental health/substance use disorder out of network services**

21	**Total claims paid for pharmacy for medical/surgical out of network services**
22	**Total claims paid for pharmacy for mental health/substance use disorder out of network services**