

211 CMR: DIVISION OF INSURANCE

211 CMR 41.00: NONGROUP HEALTH INSURANCE RATE AND POLICY FORM FILINGS, REVIEW, AND HEARING PROCEDURES UNDER M.G.L. C. 176M

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41.01: Purpose, Scope and Authority

211 CMR 41.00, promulgated pursuant to M.G.L. c. 176M and M.G.L. c. 30A, governs the form and content of rate and policy form filings, review, and hearing procedures for closed nongroup health plans and closed guaranteed issue health plans as defined in 211 CMR 41.00 as of July 1, 2007. In accordance with M.G.L. c. 176M, § 5(i), nothing in 211 CMR 41.00 shall be construed to limit the Commissioner's authority to disapprove rates pursuant to M.G.L. chs. 175, 176A, 176B, 176G and 176I.

41.02: Definitions

As used in 211 CMR 41.00, the following words mean:

Actuarial Opinion and Memorandum: A signed written statement by a member of the American Academy of Actuaries based upon the person's examination, including a review of the appropriate records, of the actuarial assumptions and methods utilized by a carrier in establishing premium rates for guaranteed issue health plans or by an intervenor in evaluating proposed premium rates. The actuarial opinion and memorandum must describe any rating methodology or evaluation in detail and must include all calculations, data, experience and rationale supporting each of the actuary's opinions and conclusions.

Adjusted Composite Rate: The composite rate for each guaranteed issue health plan issued by a carrier adjusted pursuant to 211 CMR 41.04 and 41.98 to account for differences in premiums among carriers that are the result of:

- (a) geographic differences in the cost of health care;
- (b) the average age of eligible individuals enrolled in a carrier's guaranteed issue health plan; and
- (c) differences in benefit levels.

Alternative Benefits Plan: A guaranteed issue managed care plan, guaranteed issue medical plan or guaranteed issue preferred provider plan with lower benefits or higher cost-sharing requirements than those contained in the standard benefits plans as allowed by M.G.L. c. 176M, § 2(d).

Average Adjusted Composite Rate: The average of the adjusted composite rates filed by the carriers as calculated by the Commissioner pursuant to M.G.L. c. 176M, § 5.

Average Composite Rate: The average of the composite rates filed by carriers as calculated by the Commissioner.

Base Premium Rate: The midpoint rate within a modified community rate band for each rate basis type of each guaranteed issue health plan of a carrier.

Carrier: An insurer licensed or otherwise authorized to transact accident and health insurance under M.G.L. c. 175 or the laws of any other jurisdiction; a nonprofit hospital service corporation organized under M.G.L. c. 176A or the laws of any other jurisdiction; a nonprofit medical service corporation organized under M.G.L. c. 176B or the laws of any other jurisdiction; a health maintenance organization organized under M.G.L. c. 176G or the laws of any other jurisdiction; and an insured health plan that includes a preferred provider arrangement organized under M.G.L. c. 176I or the laws of any other jurisdiction. For the purposes of 211 CMR 41.00, carriers that are affiliated companies will be treated as one carrier; provided, however, that a carrier shall offer a guaranteed issue health plan in every geographic area served by one or more of its affiliates. Joint marketing ventures between carriers do not constitute an affiliation.

Case Mix Adjustment: The adjustment based upon the diagnosis related group grouper selected by the Division of Health Care Finance and Policy established under M.G.L. c. 118G, § 2 and associated diagnosis related group weights calculated from Massachusetts data, and measuring the differential case mix compared to the case mix of

all privately insured persons discharged from hospitals in Massachusetts, as determined by the Division of Health Care Finance and Policy, or as modified by the Commissioner to ensure that the methodology used is consistent with the most current knowledge and methodologies used for such purposes.

Closed Plan: A nongroup health plan issued by a carrier to a natural person for that person, as well as any covered dependents, before October 1, 1997, the first day of the first open enrollment period specified in M.G.L. c. 176M, § 3(b). A carrier may permit a natural person to continue to add new dependents to a policy issued under a closed plan.

Closed Guaranteed Issue Health Plan: A nongroup health plan issued by a carrier to an individual, as well as any covered dependents, after November 1, 1997 but before July 1, 2007. A carrier may permit an individual to continue to add new dependents to a policy issued under a closed guaranteed issue health plan. On and after July 1, 2007, all references to guaranteed issue health plans shall mean closed guaranteed issue health plans.

Commissioner: The Commissioner of Insurance appointed pursuant to M.G.L. c. 26, § 6.

Composite Rate: The average per member per month premium rate for each type of guaranteed issue health plan.

Connector: The commonwealth health insurance connector, established by M.G.L. c. 176Q, § 2(a).

Creditable Coverage: Coverage of an individual under any of the following:

- (a) a group health plan;
- (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without Massachusetts to a natural person who is enrolled in a qualifying student health insurance program pursuant to M.G.L. c. 15A, § 18 or a qualifying student health program of another state;
- (c) Part A or Part B of Title XVIII of the Social Security Act;
- (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
- (e) 10 U.S.C. chapter 55;
- (f) a medical care program of the Indian Health Service or of a tribal organization;
- (g) a state health benefits risk pool;
- (h) a health plan offered under 5 U.S.C. chapter 89;
- (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(1)(I), as amended by P.L. 104-191;
- (j) a health benefit plan under the Peace Corps Acts, 22 U.S.C. 2504(e);
- (k) Young Adult Coverage offered under M.G.L. c. 176J, § 10; or
- (l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996.

Division: The Division of Insurance established pursuant to M.G.L. c. 26, § 1.

Eligible Dependent: The spouse or children of an Eligible Individual, subject to the applicable terms of the health plan covering such individuals.

Eligible Individual: Between November 1, 2001 and June 30, 2007, any natural person who is a resident of Massachusetts and who is not enrolled for coverage under Part A or Part B of Title XVIII of the federal Social Security Act, or a state plan under Title XIX of such act or any successor program.

Emergency Medical Condition: A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Enhanced Benefits Plan: A guaranteed issue managed care plan, guaranteed issue medical plan or guaranteed issue preferred provider plan with additional benefits or lower cost-sharing requirements (enhancements) than those contained in the standard benefits plans as allowed by M.G.L. c. 176M, § 2(c)(4).

Group Health Plan:

- (a) An employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1002, to the extent that the plan provides medical care, and including items and services paid for as medical care to employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement or otherwise. For the purposes of 211 CMR 41.00, medical care means amounts paid for:
1. the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
 2. amounts paid for transportation primarily for and essential to medical care referred to in 211 CMR 41.02: Group Health Plan(a)1.; and
 3. amounts paid for insurance covering medical care referred to in 211 CMR 41.02: Group Health Plan(a)1. and 2.

Also, for the purposes of 211 CMR 41.00,

- (b) any plan, fund or program that would not be, but for section 2721(e) of the federal Public Health Service Act, an employee welfare benefit plan, and which is established or maintained by a partnership, to the extent that such plan, fund or program provides medical care, including items and services paid for as medical care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to

211 CMR 41.02: Group Health Plan(c), as an employee welfare benefit plan which is a group health plan;

- (c) in the case of a group health plan, the term “employer” also includes the partnership in relation to any partner; and
- (d) in the case of a group health plan, the term “participant” also includes:
 1. in connection with a group health plan maintained by a partnership, an individual who is a partner in relation to the partnership, or
 2. in connection with a group health plan maintained by a self-employed individual, under which one or more employees are participants, the self-employed individual; if such individual is, or may become, eligible to receive a benefit under the plan or such individual’s beneficiaries may be eligible to receive any such benefit.

Guaranteed Issue Health Plan: A guaranteed issue managed care plan, guaranteed issue preferred provider plan or guaranteed issue medical plan, as defined in M.G.L. c. 176M, which is either a standard benefits plan, an enhanced benefits plan or an alternative benefits plan. No guaranteed issue health plan may be issued on or after July 1, 2007.

Guaranteed Issue Managed Care Plan: A nongroup health plan, including a conversion nongroup health plan, sold, issued, delivered, made effective or renewed by a carrier, within or without Massachusetts pursuant to M.G.L. c. 176G or the laws of any other jurisdiction, to any eligible individual for said individual or his or her eligible dependents and for which the carrier may not decline to offer to or deny enrollment of such eligible individual or his or her eligible dependents and which is to be renewed or continued in force at the option of the eligible individual or his or her eligible dependents, subject to the exclusions set forth in M.G.L. c. 176M, that provides the benefits specified in M.G.L. c. 176M, § 2. A carrier offering a guaranteed issue managed care plan may establish no more than one standard or enhanced benefits plan and no more than one alternative benefits plan.

Guaranteed Issue Medical Plan: A nongroup health plan, including a conversion nongroup health plan, sold, issued, delivered, made effective or renewed by a carrier, within or without Massachusetts pursuant to M.G.L. c. 175, 176A or 176B or the laws of any other jurisdiction, to any eligible individual for said individual or his or her eligible dependents and for which the carrier may not decline to offer to or deny enrollment of such eligible individual or his or her eligible dependents and which is to be renewed or continued in force at the option of the eligible individual or his or her eligible dependents, subject to the exclusions set forth in M.G.L. c. 176M, that provides the benefits specified in M.G.L. c. 176M, § 2. A carrier offering a guaranteed issue medical plan may establish no more than one standard or enhanced benefits plan and no more than one alternative benefits plan.

Guaranteed Issue Preferred Provider Plan: A nongroup health plan, including a conversion nongroup health plan, sold, issued, delivered, made effective or renewed by a carrier, within or without Massachusetts pursuant to M.G.L. c. 176I or the laws of any other jurisdiction, to any eligible individual for said individual or his or her eligible

dependents and for which the carrier may not decline to offer to or deny enrollment of such eligible individual or his or her eligible dependents and which is to be renewed or continued in force at the option of the eligible individual or his or her eligible dependents, subject to the exclusions set forth in M.G.L. c. 176M, that provides the benefits specified in M.G.L. c. 176M, § 2. A carrier offering a guaranteed issue preferred provider plan may establish no more than one standard or enhanced benefits plan and no more than one alternative benefits plan.

Health Plan: Any individual, general, blanket, or group policy of health, accident or sickness insurance issued by an insurer licensed under M.G.L. c. 175 or the laws of any other jurisdiction; a hospital service plan issued by a nonprofit hospital service corporation pursuant to M.G.L. c. 176A or the laws of any other jurisdiction; a medical service plan issued by a nonprofit medical service corporation pursuant to M.G.L. c. 176B or the laws of any other jurisdiction; a health maintenance contract issued by a health maintenance organization pursuant to M.G.L. c. 176G or the laws of any other jurisdiction; and an insured health benefit plan that includes a preferred provider arrangement issued pursuant to M.G.L. c. 176I or the laws of any other jurisdiction.

The words "health plan" shall not include

- (a) accident only;
- (b) credit-only;
- (c) limited scope dental benefits if offered separately;
- (d) limited scope vision benefits if offered separately;
- (e) hospital indemnity insurance policies if offered as independent, non-coordinated benefits which, for the purposes of 211 CMR 41.00, mean policies issued pursuant to M.G.L. c. 175 which provide a benefit not to exceed \$500.00 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in Massachusetts as defined in M.G.L. c. 152, § 1, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent;
- (f) disability income insurance;
- (g) coverage issued as a supplement to liability insurance; specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set;
- (h) insurance arising out of a workers' compensation law or similar law;
- (i) automobile medical payment insurance;
- (j) insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance;
- (k) long-term care if offered separately;
- (l) coverage supplemental to the coverage provided under 10 U.S.C. chapter 55 if offered as a separate insurance policy; or
- (m) any other policy subject to the provisions of M.G.L. c. 176K.

Hearing: The part of a proceeding consisting of public comment, testimony of witnesses and oral and written argument of the parties.

Hearing Request: A request by a carrier for a proceeding to consider its proposed rates for a guaranteed issue health plan following disapproval by the Commissioner after further review.

Information Request: A written request made to a party for production of documents or tangible things or answers to interrogatories.

Informational Hearing: A public forum convened by the Commissioner to obtain unsworn written or oral comment from the public concerning the further review of a proposed rate.

Intervenor: A person, agency or organization substantially and specifically affected by a carrier's proposed rate who has been granted permission to appear as a party in a proceeding, including, unless otherwise specified, the State Rating Bureau and all statutory intervenors.

Loss Ratio: The ratio of the incurred costs of hospital, medical, or health care services for the relevant period to the premium earned for the same period.

Modified Community Rate: A rate resulting from a rating methodology in which the premium for all persons within the same rate basis type who are covered under a guaranteed issue health plan is the same without regard to health status; provided, however, that premiums may vary due to age, geographic area or premium payment mode for each rate basis type as permitted by M.G.L. c. 176M and 211 CMR 41.00. For the purpose of rates filed on and after May 1, 2001 to be effective on and after December 1, 2001, the modified community rate is the rate resulting from a rating methodology in which the premium for all persons within the same rate basis type who are covered under a guaranteed issue health plan is the same without regard to health status; provided, however, that premiums may vary due to age, geographic area, premium payment mode or benefit level for each rate basis type as permitted by M.G.L. c. 176M and 211 CMR 41.00.

Nongroup Health Plan: Any health plan, issued, renewed or delivered within or without Massachusetts to a natural person who is a resident of Massachusetts, including a certificate issued to an eligible natural person which evidences coverage under a policy or contract issued to a trust or association, for that person and his or her spouse and other dependents; provided, that a health plan issued, renewed or delivered within or without Massachusetts to a natural person who is enrolled in a qualifying student health insurance program pursuant to M.G.L. c. 15A, § 18 will not be considered a nongroup health plan for the purposes of 211 CMR 41.00 and will be governed by the provisions of M.G.L. c. 15A and the regulations promulgated thereunder. "Nongroup health plan" includes a conversion nongroup health plan as defined in M.G.L. c. 176M, but does not include a health benefit plan issued or renewed to a natural person pursuant to M.G.L. c. 176J.

Papers: All documents filed in a proceeding, including rate filings, responsive filings, motions, pleadings, briefs, memoranda and other communications.

Participant: A person, agency, or organization interested in a carrier's proposed rate which is granted permission to submit written or oral argument at the close of the hearing, or otherwise participate on a limited basis in a proceeding as set forth in 211 CMR 41.11.

Party: A carrier submitting a hearing request, statutory intervenors and intervenors. The Presiding Officer, in his or her discretion, may determine, based on the level of participation allowed, that a participant will be treated as a party in a proceeding. For purposes of 211 CMR 41.00, the State Rating Bureau will be considered a party.

Pre-existing Condition Limitation: With respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information. No Trade Act/Health Coverage Tax Credit-eligible person shall be subject to a pre-existing condition limitation.

Premium Payment Mode: The method by which premiums for a guaranteed issue health plan or closed plan are paid or the frequency of premium payment installments.

Presiding Officer: The Commissioner, or any person or persons designated by the Commissioner, who conducts proceedings pursuant to 211 CMR 41.00.

Proceeding: The adjudicatory process initiated by a hearing request by which a Presiding Officer considers a proposed rate for a guaranteed issue health plan, including pre-hearing, discovery, hearing and post-hearing matters.

Rate Basis Type: Each category of individual or family composition for which separate rates are charged for a guaranteed issue health plan as determined by the carrier. Beginning with rates filed as of May 1, 2001, to be offered as of November 1, 2001 and to be effective as of December 1, 2001, carriers must offer a minimum of four rate basis type categories for which separate rates are charged. One required category must be for a single parent with dependents.

Rate Filing: Papers constituting a carrier's submission of a proposed rate for a particular closed guaranteed issue health plan or closed plan.

Rating Factor: Characteristics including, but not limited to age, occupation, sex, geography, premium payment mode, actual or expected health condition, medical history, claims history, or duration of coverage.

Record Request: An oral request, made to a party during the course of a hearing or conference, for production of documents or tangible things or answers to interrogatories.

Resident: A natural person living in Massachusetts; however, the confinement of a person in a nursing home, hospital or other institution is not by itself sufficient to qualify that person as a resident.

Responsive Filing: Papers by which an intervenor introduces its evidence concerning a rate filing and identifies issues which it intends to raise in the proceeding.

Revised Rate Filing: Papers by which a proposed rate is revised after a decision in a proceeding on a hearing request disapproving a proposed rate to respond to the issues upon which the disapproval was based.

Service Area: The geographic area within which a health maintenance organization or preferred provider plan has developed a network of providers who provide covered health services in accordance with 211 CMR 43.00 or 211 CMR 51.00.

Standard Benefits Plan: The minimum level of benefits to be provided in each guaranteed issue managed care plan, guaranteed issue medical plan and guaranteed issue preferred provider plan on a reasonably actuarially equivalent basis, as determined pursuant to M.G.L. c. 176M, § 2.

Standard Deviation: The square root of the average of the squares of the differences between each adjusted composite rate and the average adjusted composite rate.

State Rating Bureau: The rating bureau in the Division established pursuant to M.G.L. c. 26, § 8E.

Statutory Intervenor: A person, agency or organization, including, but not limited to, the Attorney General, which has a statutory right to appear as an intervenor in a proceeding.

Subsidization Factor: A factor to be applied to the rates, based upon individual or household income and assets criteria which are used by the carrier to assess economic need.

Trade Act/Health Coverage Tax Credit-Eligible Person: Any eligible Trade Adjustment Assistance recipient as defined in 35(c)(2) of section 201 of Title II of Public Law 107-210, eligible alternative Trade Adjustment Assistance recipient as defined in section 35(c)(2) of section 201 of Title II of Public Law 107-210, or an eligible Pension Benefit Guarantee Corporation pension recipient who is at least 55 years old and who has qualified health coverage, does not have other specified coverage, and is not imprisoned, under Public Law 107-210.

Waiting Period: A period immediately subsequent to the effective date of an insured's coverage under a health benefit plan during which the plan does not pay for some or all hospital or medical expenses.

41.03: Geographic Regions for Area Rate Adjustments

(1) A carrier may establish an area rate adjustment for each different geographic region designated in 211 CMR 41.03(2), which must range from .80 to 1.20. If a carrier chooses to establish area rate adjustments, it shall apply the adjustments to every eligible individual within each region.

(2) The regions of Massachusetts described below are established for use in making area rate adjustments. The regions are based on zip code groupings which refer to the first three digits of the zip code for each eligible individual.

- (a) 010 through 013;
- (b) 014 through 016;
- (c) 017 and 020;
- (d) 018 through 019;
- (e) 021 through 022 and 024;
- (f) 023 and 027; and
- (g) 025 through 026.

(3) A carrier may combine the zip code groupings outlined in 211 CMR 41.03(2)(c) and (d) into one region or combine the zip code groupings outlined in 211 CMR 41.03(2)(c), (d) and (e) into one region for all of its guaranteed issue health plans or use regions based on groupings for counties that approximate the zip code groupings.

41.04: Pre-existing Condition Limitations and Waiting Periods

(1) No carrier may exclude any eligible individual or eligible dependent from a guaranteed issue health plan on the basis of an actual or expected health condition of such person.

(2) No carrier may modify the coverage of an eligible individual or eligible dependent through riders or endorsements, or otherwise restrict or exclude coverage for certain diseases or medical conditions otherwise covered by a guaranteed issue health plan.

(3) For guaranteed issue health plans issued to eligible individuals and their eligible dependents from November 1, 2001, until June 30, 2007, and for eligible dependents added to a closed plan or a closed guaranteed issue health plan on and after July 1, 2007, a carrier may, but is not required to, impose either a provision for a pre-existing condition limitation or a provision for a waiting period, provided that:

- (a) The pre-existing condition limitation or waiting period does not limit or exclude coverage for a period beyond six months following the eligible individual's or eligible dependent's effective date of coverage.

- (b) No pre-existing condition limitation or waiting period may apply to a Trade Act/Health Coverage Tax Credit-eligible person.
 - (c) If a policy includes a waiting period, emergency services shall be covered during the waiting period.
- (4) In determining whether a pre-existing condition limitation or waiting period applies to an eligible individual or eligible dependent:
- (a) if the person meets the requirements of an eligible individual as defined in § 2741 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. section 300gg-41(b) and requests coverage in a Guaranteed Issue Health Plan within 63 days of termination of any prior creditable coverage, the carrier shall make his or her coverage effective within 30 days of the date of the application, subject to the reasonable verification of eligibility, without any pre-existing condition limitations or waiting periods.
 - (b) if the person does not meet the requirements of an eligible individual as defined in section 2741 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. section 300gg-41(b) and requests coverage in a Guaranteed Issue Health Plan, the carrier may impose either a pre-existing condition limitation for no more than six months or a waiting period, which shall be applied uniformly without regard to any health status-related factors, for no more than six months following the person's effective date of coverage; provided, that all guaranteed issue health plans must credit the time such person was covered under prior creditable coverage provided by a carrier if the previous coverage was continuous to a date not more than 63 days prior to the date of the request for the new coverage and if the previous coverage was reasonably actuarially equivalent to the new coverage. If prior creditable coverage is not reasonably actuarially equivalent to the new coverage, the covered person must receive the benefits of the previous health benefit plan during the term of the pre-existing condition period or waiting period. If the previous coverage is under Medicare or Medicaid, the previous coverage is presumed to be reasonably actuarially equivalent to the new health benefit plan.
- (5) If a policy includes a waiting period, treatment for an emergency medical condition must be covered during the waiting period.
- (6) Any pre-existing condition limitation period or waiting period may not extend more than six months beyond the insured's effective date of coverage, and in no event may a carrier impose both a pre-existing condition exclusion and a waiting period.
- (7) For the purposes of 211 CMR 41.04(4), "effective date of coverage" is defined as the date the individual is enrolled by the carrier in the health benefit plan.

41.05: Calculation of Adjusted Composite Rate

(1) To derive the adjusted composite rate for each guaranteed issue health plan, carriers shall adjust the composite rate to account for differences in premiums among carriers that are the result of geographic differences in the cost of health care, the average age of eligible individuals enrolled in a carrier's guaranteed issue health plan, and differences in benefit levels as permitted by M.G.L. c. 176M, § 2(c)(4) or M.G.L. c. 176M, § 2(d).

(2) Worksheet. A carrier shall use the worksheet contained in 211 CMR 41.98: *Appendix A* to calculate the adjusted composite rate for each type of guaranteed issue health plan it offers. For all noted adjustments, carriers shall submit documentation reasonably necessary to substantiate the adjustments made, including:

- (a) a specific explanation, and all calculations, of the method by which the adjusted composite rate was determined;
- (b) a list of all adjustments based upon age, geographic area, premium payment mode, and enhancements or alternative benefits; and
- (c) explanation of the actuarial value and actuarial basis for adjustments made for each age band, geographic area, premium payment mode, and enhancements or alternative benefits.

41.06: Content and Timing of Rate Filings

(1) General Instructions.

(a) A separate rate filing must be submitted for each closed guaranteed issue health plan, including separate filings for standard benefits plan or enhanced benefits plans and any alternative benefits plan, and for each closed plan; provided that a carrier with more than one closed plan may combine rate filings for its closed plans if the plans' benefits vary by no more than the following extent: any deductibles for the combined plans do not vary by more than \$1,000; any coinsurance percentage amounts for the combined plans do not vary by more than 10%; and any copayments (excluding for emergency room visits) for the combined plans do not vary by more than \$50; and, provided further, that a rate filing for a closed plan with outpatient prescription drug benefits may not be combined with a rate filing for a closed plan without outpatient prescription drug benefits, and a rate filing for a closed plan with medical/surgical and hospital benefits may not be combined with a rate filing for a closed plan with only hospital benefits. For each plan, carriers shall also submit data and documentation reasonably necessary to substantiate all calculations and adjustments made. Carriers shall comply with all applicable filing fee requirements for each rate filing.

(b) A carrier may establish a premium rate adjustment based upon the age of an insured individual, the age rate adjustment, which may range from 0.67 to 1.33. If a carrier chooses to establish age rate adjustments, the premium charge to every individual enrolled in a guaranteed issue health plan shall be subject to the applicable age rate adjustment.

(c) Carriers shall submit rate filings no later than May 1st of each year. A carrier shall submit three copies of each rate filing and one copy on a computer disk readable in IBM format, ASCII only, unless otherwise specified by the

Commissioner. All rate filings must be sent to the State Rating Bureau, at the Division's principal office.

(d) All rate filings must comply with the provisions of the rate and filing requirements of the carrier's licensing statutes which are not inconsistent with M.G.L. c. 176M and 211 CMR 41.00.

(2) Closed Guaranteed Issue Health Plans. All rate filings for guaranteed issue health plans must contain at least the following information.

(a) A list and definition of each rate basis type that the carrier has established; provided, however, that for the purpose of rates to be filed on and after May 1, 2001, each carrier shall offer a minimum of four rate basis type categories with one of these categories required to be for a single parent with more than one dependent.

(b) The base premium rate to be charged for each rate basis type;

(c) The adjustments to be applied to each rate basis type's base premium rate based upon age, geographic area, premium payment mode or subsidization factor.

For each rate basis type, the filing must contain:

1. a list and definition of each age band for which adjustments will be made for each rate basis type;
2. a list of each geographic region for which area adjustments are based for each rate basis type in accordance with 211 CMR 41.03;
3. a list and description of each premium payment mode for which adjustments will be made for each rate basis type, and the premium refund policy, if any, for each; and
4. a list and description of each subsidization factor to be applied to the plan, including the specific eligibility criteria that will be used by the carrier for each subsidization factor.

(d) A complete set of proposed rate schedules, showing the proposed rates for each eligible individual based upon age, geographic area, premium payment mode, subsidization factor, where applicable, and rate basis type;

(e) The composite rate, including a detailed explanation of the method by which the carrier determined the composite rate, including all calculations and data used for the projected distribution of covered lives by age, geographic area and premium payment mode for each rate basis type and developed in the manner prescribed by 211 CMR 41.98;

(f) For enhanced benefits plans, a list and description of each additional benefit or lower cost-sharing requirement included in the plan and the proportion of the proposed premium, if any, associated with each enhancement;

(g) For alternative benefits plans,

1. a list and description of each lower benefit or higher cost-sharing requirement than that is provided in the carrier's standard benefits plan or enhanced benefits plan, as well as details regarding how the alternative benefits plan's base premium rate differs from that of the standard benefits plan's or enhanced benefits plan's rates for each difference in benefits or cost-sharing requirement. The filing should also include a benefit level rate adjustment that shall represent the

actuarial value of the benefit level of the alternative benefits plan as compared to the benefit level of the standard benefits plan or enhanced benefits plan offered by the carrier. The premium charged to every individual enrolled in an alternative benefits plan shall be subject to the applicable benefit level rate adjustment and there shall be no benefit level rate adjustment to a standard benefits plan.

2. an actuarial opinion and certification signed by a member of the American Academy of Actuaries. The certification shall indicate that the alternative benefits plan's benefit level rate adjustment was developed assuming no difference in the expected costs and utilization for those in the alternative benefits plan as compared with those in the standard benefits plan or enhanced benefits plan. The opinion shall also provide sufficient documentation to support the benefit level rate adjustment.

(h) The adjusted composite rate for each closed guaranteed issue health plan, developed in the manner prescribed by 211 CMR 41.05 and 41.98;

(i) For carriers that base payments on usual and customary charges for non-contracting providers for guaranteed issue medical plans and for the out-of-network benefits of guaranteed issue preferred provider plans, an actuarial opinion certifying that the carrier has used a methodology to determine its usual and customary charges that results in usual and customary charges that are, in the aggregate, at least comparable to, and not lower than, the 80th percentile of charges based on Health Insurance Association of America data that are not more than 18 months old, as well as a description of the methodology;

(j) An actuarial opinion and memorandum certifying that the rates have been developed in compliance with M.G.L. c. 176M, § 4, including the specified rate bands and multipliers, and that the proposed rates are reasonable in relation to the benefits provided. The actuarial opinion and memorandum must include an explanation of the basis for the actuary's opinions, with consideration of the actuarial basis for each age, area, premium payment mode and enhancement or alternative benefit in light of the value of benefits and the effects on utilization;

(k) The actual loss ratio for the previous year and the projected loss ratios for the present year and the year for which the rate is being filed;

(l) A comparison of current and proposed rates which shows premium cost components, including expenses, hospital inpatient costs, outpatient costs, the cost of prescription drugs administered on an outpatient basis, and the cost of other medical services, each stated as a percentage of premium;

(m) The name, address and telephone and facsimile transmission numbers of the person responsible for the rate filing, if different from the actuary who signed the actuarial opinion and memorandum required in 211 CMR 41.06(2)(i);

(n) A copy of the carrier's most recent statutory annual report, unless already on file with the Division; and

(o) For newly offered guaranteed issue health plans, the applicable policy form filing specified in 211 CMR 41.07. For existing guaranteed issue health plans, a carrier shall provide a certification by a corporate officer stating when the policy form was last filed with the Division, and stating that the policy form has not

changed since it was previously filed. If the policy form must be modified to comply with Massachusetts statutory changes, including new mandated benefits or changes to the standard benefits plans, the filing must include revised policy forms, or policy form riders or endorsements necessary to respond to the statutory changes.

(3) Closed Plans. All rate filings for closed plans must contain at least the following information.

- (a) A list and definition of each rate basis type which the carrier has established;
- (b) The base premium rate to be charged for each rate basis type;
- (c) The adjustments to be applied to each rate basis type's base premium Rate based upon age, geographic area, premium payment mode, health benefit, or other rating factor. For each rate basis type, the filing must contain:
 - 1. a list and definition of each age band for which adjustments are made;
 - 2. a list of each geographic area on which adjustments are based;
 - 3. a list and description of each premium payment mode for which adjustments are made; and
 - 4. a list and definition of any other rating factor to be charged.
- (d) A complete set of proposed rate schedules for each plan, showing proposed rates applicable to each eligible individual based upon age, geographic area, premium payment mode, rate basis type, health benefit or any other rating factor;
- (e) An actuarial opinion and memorandum certifying that the rates for each plan have been developed in compliance with the requirement that no carrier shall add any new rating factor to the rating methodology other than that which was applicable to its closed plan as of August 15, 1996 ;
- (f) For each plan, the actual loss ratio for the previous year and the projected loss ratios for the present year and the year for which the rate is being filed;
- (g) A copy of the carrier's most recent statutory annual report unless already on file with the Division;
- (h) For the first rate filing, the total number of insureds, the total number of policies issued, the total number of policies issued within each rate basis type, and the rates charged for each closed plan offered by the carrier as of August 15, 1996, as well as the same information as of the end of each calendar year since August 15, 1996; and
- (i) A certification by a corporate officer stating when the policy form was last filed with the Division, and stating that the policy form has not changed since it was previously filed. If the policy form must be modified to comply with Massachusetts statutory changes, including new mandated benefits, the filing must include revised policy forms, or policy form riders or endorsements necessary to respond to the statutory changes.

41.07: Annual Notice to Insureds

- (1) Annually, as of May 1st, carriers shall provide to the Division a sample copy of the Notice that describes all of the carrier's health benefit plans and corresponding premiums for which the insured is eligible under M.G.L. c. 176J.

- (a) The Notice must be sent to insureds at least at the time that carriers send notice of premium rate changes.
- (b) The Notice shall include the following information:
 - 1. A brief description of the plans.
 - 2. An explanation of the premium for each plan. A carrier may meet the requirement of 211 CMR 41.07(1)(b) by including in the notice language that refers the insured to resources where the information can be accessed, including but not limited to an internet website. The term “internet website” shall include “intranet website” and “electronic mail” or “e-mail”. The carrier shall provide free of charge a paper copy of this information if the eligible small business or eligible individual requests such a paper copy. The carrier shall provide a toll-free telephone number for the insured to call with any questions or requests.

(2) Carriers shall certify to the Division that they will deliver to every subscriber the Annual Notice provided in 211 CMR 41.07(1). Carriers shall file with the Division the certification required by 211 CMR 41.07(2) annually but no later than 45 days prior to a change in rates.

41.08: Content and Timing of Policy Form Filings

(1) As of July 1, 2007, a carrier shall no longer offer, sell, or deliver a health plan to any person to whom it does not have such an obligation pursuant to an individual policy, contract or agreement with an employer or through a trust or association.

(a) Notwithstanding 211 CMR 41.08(1), a closed guaranteed issue plan or a closed health plan shall be subject to all the other requirements of 211 CMR 41.06.

(b) All closed guaranteed issue health plans and closed plans shall be renewable.

- 1. A carrier may discontinue a closed guaranteed issue health plan or a closed plan when the number of subscribers in a closed guaranteed issue plan or a closed plan is less than 25% of such plan’s subscriber total as of December 31, 2004.
- 2. The commissioner shall approve or disapprove of a carrier’s written request, submitted to the commissioner, to discontinue a closed plan or a closed guaranteed issue health plan based on the most recent membership figure submitted to the Division.
- 3. A carrier may discontinue a closed guaranteed issue health plan or a closed plan according to the provisions that are included within the enrolled person's health plan contract.

(2) Carriers shall submit to the Division three copies of the policy, certificate of coverage or evidence of coverage for each of its closed guaranteed issue health plans and closed plans with the associated rate filing for each plan submitted pursuant to 211 CMR 41.06. As part of the policy form filing for each guaranteed issue health plan, carriers

shall submit the applicable application or enrollment form, replacement form and outline of coverage or disclosure statement.

(3) Policy forms for all closed guaranteed issue health plans and closed plans must comply with all applicable provisions in M.G.L. c. 176M and 211 CMR 41.00 and any other applicable Massachusetts statutes and regulations, including 211 CMR 42.00, 211 CMR 43.00, 211 CMR 51.00 and 211 CMR 52.00, which are not inconsistent with M.G.L. c. 176M and 211 CMR 41.00, as well as any applicable federal statutes and regulations. Policy forms for closed guaranteed issue health plans and closed plans must include all benefits required under the carrier's licensing statutes.

(4) Policy forms for standard benefits plans must contain all benefits required to be included in the standard benefits plans approved by the Commissioner pursuant to M.G.L. c. 176M, § 2(c). Policy forms for closed guaranteed issue health plans with enhanced benefits plans must contain the benefits of the comparable standard benefits plans and must identify each additional benefit or lower cost-sharing requirement that the carrier proposes to include in the plans.

(5) Policy forms for alternative benefits plans must contain coverage for the same services and supplies as the standard benefits plans, except for the prescription drug benefit, but may include higher cost-sharing requirements than the standard benefits plans. All filings of alternative benefits plans must identify each benefit that is lower than or each cost-sharing requirement that is higher than what is being offered in the carrier's standard benefits plan or enhanced benefits plan.

(6) Carriers shall comply with all form filing fee requirements.

41.09: Review of Policy Forms and Rate Filings and Notification to Carriers

(1) Policy Forms. The Commissioner shall notify a carrier if he or she determines that the policy form filing submitted pursuant to 211 CMR 41.07 does not comply with applicable Massachusetts laws and regulations or otherwise fails to comply with M.G.L. c. 176M or 211 CMR 41.07. For guaranteed issue health plans, the Commissioner shall also notify a carrier if he or she determines that the plan's design may have the effect of minimizing the number of eligible individuals who will enroll in the plan. The Commissioner may prohibit a carrier from offering an enhanced benefits plan if the plan's design may have the effect of discouraging enrollment by eligible individuals. Upon such notice, a carrier shall amend and resubmit its policy form filing for review within the time period specified by the Commissioner.

(2) Rate Filings for Closed Guaranteed Issue Health Plans.

(a) With respect to Rate Filings for Closed Guaranteed Issue Health Plans, the Commissioner shall notify a carrier if he or she determines that the rate filing does not comply with 211 CMR 41.05 and 41.06, contains discrepancies or

inaccuracies, or otherwise is incomplete. Upon such notice, a carrier shall amend and resubmit its rate filing within the time period specified by the Commissioner.

(b) After the Commissioner has computed an average adjusted composite rate for each type of closed guaranteed issue health plan, and has calculated the standard deviation for the submitted adjusted composite rates, the average adjusted composite rate and standard deviation will be final and will not be changed if any carrier's rates are modified as a result of further review or a proceeding.

(c) For a carrier whose rate filing is an initial offering of a guaranteed issue health plan, the Commissioner shall, no later than June 15, 2007 issue to a carrier his or her determination of whether the rate filing is subject to further review. The rate filing will be subject to further review if the Commissioner determines that the adjusted composite rate filed by the carrier exceeds the average adjusted composite rate for that type of guaranteed issue health plan by more than two standard deviations.

(d) For a carrier whose rate filing is for an existing closed guaranteed issue health plan, the Commissioner shall, no later than June 15th of each year, issue to a carrier his or her determination of whether the rate filing is subject to further review. The rate filing will be subject to further review if the Commissioner determines that the adjusted composite rate filed by a carrier exceeds the average adjusted composite rate for that type of guaranteed issue health plan or closed guaranteed issue health plan by more than two standard deviations and the proposed composite rate also exceeds 110% of the carrier's current composite rate for the plan.

(e) If the Commissioner issues a notice to a carrier by June 15th that its rate filing is not subject to further review, the carrier shall implement the filed rates the following December 1st.

(3) Rate Filings for Closed Plans Only. The Commissioner shall notify the carrier if its rate filing does not comply with 211 CMR 41.06, contains discrepancies or inaccuracies, or otherwise is incomplete. Upon such notice, a carrier shall amend and resubmit its rate filing within the time period specified by the Commissioner. The Commissioner's review of rate filings for closed plans will proceed in accordance with the applicable provisions of the carrier's licensing statutes.

41.10: Further Review

(1) Amended Rate Filing. A carrier that is notified that its rate filing for a closed guaranteed issue health plan is subject to further review may, no later than 21 days following that notice, submit an amended rate filing in which its rates for that plan have been reduced by an amount to cause its adjusted composite rate to be less than the average adjusted composite rate plus two standard deviations. The amended rate filing shall then be reviewed in accordance with the standards in 211 CMR 41.08(2)(c) or 211 CMR 41.08(2)(d), whichever is applicable.

(2) Carrier's Submission of Additional Evidence. If a carrier that is notified that its rate filing for a closed guaranteed issue health plan is subject to further review does not submit an amended rate filing pursuant to 211 CMR 41.09(1), such carrier may, no later than 21 days following that notice, submit additional evidence, including an actuarial opinion and memorandum, to show that:

- (a) the rate filed is reasonable in relation to the benefits provided; or
- (b) its adjusted composite rate would not have exceeded the average adjusted composite rate for that type of closed guaranteed issue health plan by more than two standard deviations if its adjusted composite rate had been further adjusted for the case mix of persons insured in that carrier's nongroup health plans in operation as of August 15, 1996, whom the carrier anticipates will be covered in its closed guaranteed issue health plan during the period of the proposed rates.

(3) Commissioner's Request for Additional Information.

- (a) If the Commissioner requires additional information to make his or her determination on further review, he or she shall, no later than 20 days after the submission of the carrier's additional evidence, notify the carrier in writing of the additional information required.
- (b) A carrier shall furnish the additional information ordered pursuant to 211 CMR 41.09(4)(a) no later than ten days after receipt of the Commissioner's notice.
- (c) If, following receipt of the information furnished pursuant to 211 CMR 41.09(4)(b), the Commissioner requires further additional information to make his or her determination, he or she shall, within ten days, notify the carrier in writing of the additional information required.
- (d) The Commissioner may continue to request, and the carrier shall continue to provide, additional information according to the timetables established in 211 CMR 41.09(4)(b) and (c) until the Commissioner has received sufficient information to make his or her determination.

(4) Informational Hearing. The Commissioner may hold an informational hearing on the rate filing before making a determination on further review. The informational hearing will be stenographically recorded. The carrier shall comply with 211 CMR 41.17(14) regarding the engagement of a stenographer and the provision of copies of the transcript. The Commissioner shall publish notice of the informational hearing in a newspaper of general circulation within the Carrier's service area.

(5) Commissioner's Determination on Further Review. No later than ten days after either the Commissioner's receipt of the last submission of further information from the carrier or the date of an informational hearing on the rate filing, he or she shall make a written determination regarding:

- (a) whether the adjusted composite rate filed, further adjusted for case mix pursuant to 211 CMR 41.09(1)(b) if the carrier so proposes, would not have

exceeded the average adjusted composite rate for that type of closed guaranteed issue health plan by more than two standard deviations; or

(b) in the case of an adjusted composite rate that exceeds the average adjusted composite rate by more than two standard deviations either because the rate, although further adjusted for case mix would still have exceeded the average adjusted composite rate for that type of closed guaranteed issue health plan by more than two standard deviations or because the carrier does not propose an adjustment for case mix, whether the rate filed is reasonable in relation to the benefits provided.

(6) Approval of Proposed Rate. If, after completion of the further review, the Commissioner determines that the carrier has demonstrated that: the adjusted composite rate, further adjusted for case mix, would not have exceeded the average adjusted composite rate for that type of closed guaranteed issue health plan by more than two standard deviations; or the rate is reasonable in relation to the benefits provided, he or she shall notify the carrier that the rate is approved.

(7) Disapproval of Proposed Rate. If after completion of the further review, the Commissioner determines that the carrier has not demonstrated that: the adjusted composite rate, further adjusted for case mix, would not have exceeded the average adjusted composite rate for that type of closed guaranteed issue health plan by more than two standard deviations; and the rate filed is reasonable in relation to the benefits provided, he or she shall notify the carrier that the rate is disapproved and of its right to request a proceeding.

(8) A carrier whose rate filing is subject to further review or who has exercised its right to a proceeding may implement a composite rate no greater than the average composite rate, provided that it is exercising good faith in its participation in the further review or proceeding.

41.11: Hearing Request

(1) A carrier whose proposed rate for a closed guaranteed issue health plan has been disapproved by the Commissioner pursuant to 211 CMR 41.09(7) may, within 21 days of the Commissioner's decision, request the initiation of a proceeding.

(2) Contents. The hearing request constitutes the carrier's direct case in the proceeding. The hearing request must consist of sequentially numbered pages, must use any format previously prescribed by the Presiding Officer or the Commissioner and must contain:

(a) a title stating the nature of the proceeding, and the complete name and address of the party submitting the request;

(b) the name and address of counsel or other authorized representative as prescribed in 211 CMR 41.11(7);

(c) an executive summary describing, in narrative form, the reasons for the hearing request, including a description of errors the carrier believes may have

been made by the Commissioner in the review process, a description of the grounds in support of the rate requested, and the specific relief sought;

(d) a copy of the rate filing;

(e) a copy of all materials submitted as part of the further review;

(f) a copy of all written communications between the carrier and the Division as part of the review process;

(g) identification of each witness on whose testimony the carrier intends to rely in support of its request for relief, and identification of the subject matter of the witness' testimony, with sufficient clarity to enable the Presiding Officer to determine his or her qualifications to testify on that subject matter;

(h) the sworn written direct testimony of each witness in narrative form, including all information and commentary submitted in support of each issue the carrier intends to raise in the proceeding;

(i) all additional information, including data, statistics, schedules and exhibits which the carrier intends to present for consideration at the hearing and upon which its recommendations are based;

(j) other information as prescribed from time to time by the Commissioner or the Presiding Officer by order, decision or bulletin.

(3) Failure to Submit Complete Hearing Request. If within 21 days after the Commissioner's decision, a carrier submits an incomplete hearing request, the Presiding Officer may, upon determining that the carrier has attempted in good faith to comply with the requirements of 211 CMR 41.10(2), order the carrier to supplement the hearing request in accordance with 211 CMR 41.10(4) and delay the effective date of filing for purposes of determining the date of the commencement of the hearing.

(4) Amendments. No additions, amendments, or corrections may be allowed after the submission described in 211 CMR 41.10, except as permitted or ordered by the Presiding Officer or in accordance with 211 CMR 41.10(5), 41.15, 41.16 or 41.17.

(5) Supporting Information. The Presiding Officer may require a carrier to furnish any data or information which he or she determines necessary or appropriate in connection with the submission of a hearing request.

(6) Rejection of Hearing Request. The Presiding Officer may, before issuance of the hearing notice, reject a hearing request if he or she determines that it does not comply with M.G.L. c. 176M or 211 CMR 41.00. A carrier whose hearing request has been rejected may resubmit a hearing request with appropriate modifications within the time period determined by the Presiding Officer.

41.12: General Provisions Governing Rate Proceedings

(1) Filings. All papers relating to a proceeding must be timely filed with the Docket Clerk, Hearings and Appeals, at the Division's principal office during business hours. For filings of papers other than hearing requests or responsive filings, an original and one copy must be filed, unless otherwise provided by the Presiding Officer. Concurrently

with filing papers, a party or participant shall serve a copy of the papers on all parties to the proceeding by hand delivery, or by facsimile transmission promptly followed by first-class postage pre-paid mail delivery, unless otherwise permitted by the Presiding Officer. Service of papers on participants is required only as ordered by the Presiding Officer. Failure to comply with 211 CMR 41.11(1) will be grounds for refusal by the Presiding Officer to accept papers for filing.

(2) Copies of Hearing Requests, Responsive Filings and Revised Rate Filings. Six copies of all hearing requests, responsive filings and revised rate filings must be filed, unless the Presiding Officer directs otherwise. Copies of text and data included in the filings must also be submitted on a computer disk or by other electronic means in a format determined by the Presiding Officer. Concurrently with filing, the carrier or intervenor shall serve a copy to all other parties, and shall serve a copy on any person subsequently permitted to intervene in the proceeding within two days after issuance of an order granting the person permission to intervene.

(3) Timely Filing. Papers in a proceeding must be filed within the specified time limits. The date of filing will be determined as follows:

- (a) Papers delivered by hand or by facsimile during regular business hours will be deemed filed on that day.
- (b) Papers delivered by hand or by facsimile at other times will be deemed filed on the next business day.
- (c) Papers mailed to the Division's principal office will be deemed filed on the day the Division receives them.

(4) Computation of Time. Computation of any time period referred to in 211 CMR 41.00 begins with the first day after the date of the initiating act. The last day of the period so computed is included unless it is a day when the Division's principal office is closed, in which case the period runs until the end of the next business day. When the period is five days or fewer, Saturdays, Sundays and legal holidays are excluded from the computation.

(5) Extensions of Time. The Presiding Officer has the discretion to extend for good cause any time limit prescribed or allowed by 211 CMR 41.00. All requests for extensions of time must be made by motion before the expiration of the period originally prescribed or previously extended.

(6) Signatures. All papers must be signed by the filing party or its counsel or authorized representative.

(7) Notice of Appointment of Counsel or other Representative and Appearances. Other than the State Rating Bureau, each party or participant to a proceeding shall enter an appearance by filing and serving a notice which contains the name, address and telephone number of the party or participant's counsel or authorized representative. All papers served on a party or participant must be given to the counsel or representative named in that party or participant's notice.

(8) Notices for Hearings on a Hearing Request. At least 21 days before the scheduled date of the hearing on a hearing request, the carrier shall publish the hearing notice issued by the Commissioner in newspapers of general circulation in Boston, Brockton, Fall River, Lowell, New Bedford, Pittsfield, Springfield and Worcester; provided that a carrier shall not be required to publish notice in those cities and towns, other than Boston, that are not included in the service area of the guaranteed issue preferred provider plan or guaranteed issue managed care plan whose rate is the subject of the hearing request. Concurrently with publication of the notice, the carrier shall give notice to the State Rating Bureau and to all statutory intervenors. The carrier shall file proof of publication within 21 days of publication. The Presiding Officer may require additional evidence of compliance with 211 CMR 41.11(8).

41.13: Intervention and Participation

(1) At any time after the filing of the hearing request, but no more than four days after publication of the hearing notice in accordance with 211 CMR 41.11(8), a statutory intervenor intending to participate in the proceeding shall file and serve on the carrier, the State Rating Bureau, and any other statutory intervenors, a notice of intent to participate.

(2) No more than ten days after publication of the hearing notice in accordance with 211 CMR 41.11(8), a person who wishes to intervene or participate on a limited basis in the proceeding, other than the State Rating Bureau, statutory intervenors, or the carrier, shall simultaneously file, and serve upon the carrier, the State Rating Bureau and all statutory intervenors and already permitted intervenors, a petition for leave to participate as an intervenor or participant. The petition must state the name and address of the petitioner; its grounds for seeking leave to intervene or participate on a limited basis, including the manner in which it is affected by or interested in the proceeding; the contentions of, and relief sought by, the petitioner; the statutory or other authority in support of the petition; a description of the extent of the petitioner's proposed intervention or limited participation, including the nature, if any, of the evidence the petitioner seeks to present if the petition is granted; and a statement explaining why the petitioner's interests would not be adequately represented by the carrier or intervenors already participating and how the petitioner will avoid introduction of repetitive testimony and not unduly delay the hearing.

(3) A party opposing a petition to intervene or participate on a limited basis shall file a written objection, setting forth the grounds for its objection, no later than two days after service of the petition.

(4) The Presiding Officer may schedule a hearing on the petition. The Presiding Officer shall determine whether the petitioner will be allowed to participate, and if so, as an intervenor or participant, and the extent of its participation in the proceeding. The Presiding Officer may order two or more intervenors or participants to consolidate their appearances or presentations if consolidation will facilitate and expedite the proceeding.

41.14: Responsive Filings

(1) Purpose. Each intervenor in a proceeding shall submit a responsive filing which identifies the grounds upon which the intervenor supports or contests the issues raised by the carrier in its hearing request. The responsive filing constitutes the direct case of an intervenor.

(2) Timing. Each intervenor, other than the State Rating Bureau, shall file a responsive filing no later than ten days after the conclusion of the examination of the carrier's witnesses, unless the Presiding Officer, in his or her discretion, orders another time period. The State Rating Bureau shall file a responsive filing two days after the other intervenors' responsive filings are due, unless the Presiding Officer, in his or her discretion, orders another time period.

(3) Contents. Every responsive filing must consist of sequentially numbered pages, must use any format previously prescribed by the Presiding Officer and, subject to limits on intervention set pursuant to 211 CMR 41.12, must contain:

- (a) a title stating the nature of the proceeding, and the complete name and address of the intervenor submitting the filing;
- (b) the name and address of counsel, or other representative, if the intervenor is represented, as prescribed in 211 CMR 41.11(7);
- (c) a statement of the issues the intervenor intends to present for consideration in the proceeding;
- (d) a statement in short and plain terms of the specific components of the hearing request which the intervenor intends to address;
- (e) a statement in short and plain terms of the legal grounds pursuant to which the intervenor intends to support or oppose the proposed rate, in whole or in part;
- (f) at the intervenor's option, any recommended alternative rate adjustment or methodology, which the intervenor contends is supported in the record;
- (g) identification of each witness who submits testimony as part of the responsive filing and identification of the subject matter of the witness' testimony, with sufficient clarity to enable the Presiding Officer to determine which witness is testifying about each component of the responsive filing, and his or her qualifications to testify on that subject matter;
- (h) sworn written testimony of all witnesses including all information and commentary submitted in support of any recommendations;
- (i) all information, including data, statistics, schedules, and exhibits, submitted in support of any recommendations;
- (j) other information as prescribed from time to time by the Commissioner or the Presiding Officer by order, decision or bulletin.

(4) Form of Evidence. In his or her discretion, the Presiding Officer may order that evidence introduced by intervenors be submitted orally rather than in pre-filed format.

(5) Amendments. No additions, amendments, or corrections may be allowed after the submission described in 211 CMR 41.09, except as permitted or ordered by the Presiding Officer or in accordance with 211 CMR 41.13(6), 41.15, 41.16 or 41.17.

(6) Supporting Information. The Presiding Officer may require an intervenor to furnish any data or information which he or she determines necessary or appropriate in connection with the submission of a responsive filing.

(7) Rejection of Responsive Filings. The Presiding Officer may, within five days after its filing, reject any responsive filing if he or she determines that it does not comply with 211 CMR 41.00. An intervenor whose responsive filing has been rejected may resubmit a responsive filing only in accordance with the orders of the Presiding Officer.

41.15: Scheduling of Hearing

Timing and Order of Presentation of the Hearing. The hearing will begin within 30 days after the submission of a complete hearing request. The hearing will be conducted in the following order, and in accordance with orders issued by the Presiding Officer:

(1) Public Comment. Unsworn oral statements as described in 211 CMR 41.17(5) may be made at the start of the hearing or at any other time permitted by the Presiding Officer.

(2) Hearing on the Carrier's Case. Intervenors are permitted to cross-examine the carrier's witnesses, subject to any limits on intervention pursuant to 211 CMR 41.12. No more than ten hearing days may be devoted to the examination. The Presiding Officer has the discretion to limit examination by parties. The Presiding Officer may ask questions of the carrier's witnesses regardless of whether a party has intervened.

(3) Hearing on the Intervenors' Evidence. Cross-examination, redirect and recross-examination of an intervenors' witnesses will begin within six days after the submission of that intervenor's responsive filing, unless the Presiding Officer, in his or her discretion, orders another time period. If the Presiding Officer orders or permits an intervenor to present oral direct evidence, examination of the intervenors' witnesses will begin within six days of the completion of direct testimony. No more than seven hearing days may be devoted to the examination. The Presiding Officer has the discretion to limit examination by parties.

41.16: Discovery

(1) Information Requests.

(a) Subject to any limits on intervention pursuant to 211 CMR 41.12, a party to a proceeding may serve upon another party that has submitted a hearing request or responsive filing written information requests to produce or make available documents or tangible things, not privileged, and not previously supplied, which are in the custody or control of the party upon whom the request is made. The

information request must set forth the items to be provided with reasonable particularity. With the permission of the Presiding Officer, an information request may consist of interrogatories to another party. The Presiding Officer, in his or her discretion, may permit information requests at any time before the close of the evidentiary record and may permit information requests to be served upon another party after the start of the examination of that party's witnesses. A need for discovery will not be grounds to delay the hearing except for good cause. Discovery must be conducted expeditiously.

(b) All information requests must be filed and served upon all parties. A party requesting documents from the Division or the State Rating Bureau shall pay the Division the fee per page for copies determined from time to time by the Executive Office for Administration and Finance, unless the Presiding Officer, in his or her discretion, waives the fee.

(2) Record Requests. Subject to any limits on intervention pursuant to 211 CMR 41.12, a party may, at the discretion of the Presiding Officer, make oral record requests of another party during testimony or conferences, seeking discovery in the manner and scope permitted for information requests in 211 CMR 41.15(1).

(3) Discovery Requests from the Presiding Officer. The Presiding Officer may, in the form of information or record requests, seek information of a party at any time and may order a party to respond to questions or requests for documents at any time.

(4) Responses to Discovery.

(a) Answers to information or record requests must be filed and served upon all parties no more than five days after receipt of the request unless the Presiding Officer establishes a shorter or longer time period. A party upon which a request for discovery is served may, within the time period established for response, file objections or a motion for protective order with respect to specified portions of the request, if it has first attempted in good faith to resolve the grounds for its objection or motion with the party seeking discovery.

(b) If a party's discovery request is not honored in whole or in part, or if it opposes an objection or motion for protective order, it must first attempt in good faith to resolve the issue with the objecting party. If it cannot do so, it may, within three days of service of the objection or motion, file a motion to compel a response. The Presiding Officer may schedule a hearing on the motion.

(5) Rulings on Discovery Disputes. The Presiding Officer may compel a response to the discovery sought, and may, where justice requires, issue protective orders to protect a party from annoyance, embarrassment, oppression or undue burden or expense or to prevent undue delay in the proceeding. The Presiding Officer may order limits on the scope, method, time and place for discovery or provisions for protecting confidential or privileged information or documents, consistent with applicable statutes. The Presiding Officer has the authority to compel production of non-privileged information requested by a party.

(6) Additional Discovery. The Presiding Officer may, in his or her discretion, allow additional discovery if a party is permitted to amend or supplement a filing.

41.17: Pre-hearing Motions and Conferences

(1) Pre-hearing Motions. Pre-hearing motions must be filed in accordance with the following schedule:

(a) No later than 21 days following the date the hearing notice is issued, an intervenor may move to dismiss the hearing request or for a decision on any or all issues raised by the hearing request on the ground that the hearing request contains insufficient evidence to substantiate claims it makes, or otherwise fails to comply with the filing requirements established in 211 CMR 41.00.

(b) No later than three days following the filing of a responsive filing, a party may move to dismiss the responsive filing or for a decision on any or all issues raised by that filing on the ground that it contains insufficient description of the basis on which an intervenor supports or contests the rate filing.

(c) The Presiding Officer may, in his or her discretion, permit a party to amend its hearing request or responsive filing in order to address the issues raised by pre-hearing motions, including motions to dismiss, or to add or revise data.

(d) All other pre-hearing motions not specifically addressed in 211 CMR 41.00 must be filed at least three days before the date set for public comment.

The filing of any pre-hearing motion will not affect any of the time periods set in 211 CMR 41.00 unless so ordered by the Presiding Officer.

(2) Pre-hearing Conferences. The Presiding Officer may hold one or more pre-hearing conferences to consider: the simplification or clarification of the issues; the possibility of obtaining stipulations, admissions of fact, and agreements on documents to avoid unnecessary proof or to dispose of any or all disputed issues; limits on the number of witnesses and avoidance of cumulative evidence; the schedule of testimony in subsequent conferences or hearings; the organization of exhibits; the conduct and format of the hearing; and any other matters that may assist in the expeditious disposition of the proceeding.

41.18: Conduct of Proceedings

(1) Presiding Officer. The Presiding Officer conducts the proceeding and makes all decisions on the admission or exclusion of evidence and other procedural matters that arise during the proceeding. The Presiding Officer may issue orders he or she finds proper, expedient or necessary to enforce and administer the provisions of 211 CMR 41.00, M.G.L. c. 176M and M.G.L. c. 30A. The Presiding Officer administers oaths and affirmations, schedules hearings and may order the consolidation of related proceedings. The Presiding Officer may impose sanctions on a party that does not comply with his or her orders, including entering orders for decision on one or more issues, limiting the introduction of evidence or a party's participation in the proceeding, and addressing other matters he or she deems appropriate. The Presiding Officer may shorten or terminate any phase of the proceeding for a party's failure, without good cause, to comply with the

schedule or to proceed with expedition. At any time during the proceeding, the Presiding Officer may extend or shorten a time period at the request of a party or may do so on his or her own if he or she determines that an extended or shortened time period is appropriate.

(2) Ex Parte Communications. From the start of the proceeding until the rendering of a final decision no person who is not employed by the Division may communicate *ex parte* with the Presiding Officer, the Commissioner, or any employee of the Division involved in the decision process for the proceeding regarding the merits of that proceeding. An inquiry about the status of a proceeding is not considered an *ex parte* communication. If the Presiding Officer determines that a party has violated 211 CMR 41.17(2), he or she may impose appropriate sanctions against that party, which may include excluding the party from the proceeding or deciding against it with prejudice. If the Presiding Officer determines that a person not a party has violated 211 CMR 41.17(2), he or she may impose appropriate sanctions against that person, which may include excluding that person from the hearing.

(3) Cross-Examination. Subject to any limits on intervention pursuant to 211 CMR 41.11, a party may request that another party's witnesses be made available for examination, provided the party has timely informed the Presiding Officer and the other parties of its request to conduct the examination to permit the orderly and expeditious conduct of the proceeding.

(4) Rebuttal and Surrebuttal Filings. A party seeking to submit additional evidence to rebut an affirmative fact which another party has sought to prove may move to submit rebuttal or surrebuttal evidence. A party seeking to introduce rebuttal or surrebuttal evidence shall move for leave to do so as soon as practical, and shall include in its motion the subject of the proposed evidence, the necessity for further testimony at this stage of the proceeding and the identity and availability of witnesses offering the testimony. The Presiding Officer may, in his or her discretion, grant or deny the motion, and may order such evidence to be submitted orally or in writing.

(5) Unsworn Oral and Written Statements. The Presiding Officer may specify the amount of time allowed to any speaker for an oral statement. Although oral and written statements must generally be heard or submitted at the start of a hearing, the Presiding Officer may grant permission to a person to make statements at any time during the proceeding. If the Presiding Officer determines that an oral statement is irrelevant, immaterial or unduly repetitious, he or she may further restrict the time allowed to a speaker. The Presiding Officer may permit the submission of written statements instead of or in addition to oral statements.

(6) Motions. A party requesting a ruling shall make a motion which states the ruling sought and the grounds for the request. The Presiding Officer may require that a motion be presented in writing. A party opposing a written motion shall file an opposition no later than two days after the filing and service of the motion. The Presiding Officer may hear oral argument on a motion.

(7) Official Notice. The Presiding Officer may take official notice of a fact which may be judicially noticed by the Massachusetts courts and may take official notice of general, technical or scientific facts within his or her specialized knowledge or experience. The Presiding Officer shall notify all parties of the material so noticed and shall permit a party, upon timely request, to contest the facts noticed. The Presiding Officer may use his or her technical experience, technical competence, and specialized knowledge in the evaluation of the evidence presented.

(8) Evidence. The Presiding Officer need not observe the rules of evidence observed by the Massachusetts or United States courts, but shall observe the rules of privilege recognized by Massachusetts law. Evidence may be admitted and given probative effect only if it is the kind of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs. The Presiding Officer may exclude evidence which he or she determines to be unduly repetitious or likely to delay the proceeding unnecessarily, or which he or she determines should have been submitted earlier in the proceeding. All evidence on which the Presiding Officer's decision is based, including records and documents in the Division's possession, will be made a part of the record, and no other factual information may be considered.

(9) Control of Evidence. The Presiding Officer may question witnesses at any time in the course of their testimony. At any stage of the proceeding, the Presiding Officer may recall witnesses for further examination, call for further written evidence on an issue, and require that evidence be presented by any party. The Presiding Officer may limit, strike or terminate irrelevant, immaterial or repetitious evidence. The Presiding Officer may, in his or her discretion and for good cause shown, permit a party to introduce exhibits and raise issues not included in its rate filing or responsive filing. If, despite an order from the Presiding Officer, a witness fails to be present for his or her cross-examination or unreasonably obstructs cross-examination, the Presiding Officer may find the witness to be unavailable. If the Presiding Officer finds a witness to be unavailable, he or she may order all previous testimony or evidence for which the witness is responsible stricken from the record unless the Presiding Officer determines that no party would be unduly prejudiced by its inclusion.

(10) Offers of Proof. A party may make an offer of proof following a ruling by the Presiding Officer excluding proposed evidence. The offer of proof includes a statement of the substance of proposed oral testimony and copies of proffered documents. The Presiding Officer may require that offers of proof be made in writing.

(11) Stipulations. At any stage of the proceeding, the parties may stipulate to a pertinent fact. If the Presiding Officer rejects a stipulation, he or she shall so state on the record and, if appropriate, permit the parties to present evidence and argument on the issue.

(12) Oral Argument. The Presiding Officer may allow or require oral argument. In determining whether to allow oral argument, the Presiding Officer may consider matters

including the complexity or importance of the issues, the necessity for clarification of issues, the public interest, and the availability of time.

(13) Conduct of Persons Present. All persons present at a hearing shall conduct themselves in a manner consistent with the standards of decorum commonly observed in the Massachusetts courts. The Presiding Officer may issue orders appropriate to maintain order, including the exclusion of a disorderly person from the hearing. If the person excluded is a party or its representative, the Presiding Officer may decide against the party with prejudice.

(14) Transcripts. The carrier shall engage a qualified stenographer subject to the approval of the Presiding Officer to record and transcribe the proceeding. The carrier shall pay the cost of the stenographer's fees, and the cost of providing the Division with copies of the transcript in the quantity and format determined by the Presiding Officer, which may include computer disk, and of providing the State Rating Bureau and each Statutory intervenor with one copy. Other parties may obtain copies of the transcript from the stenographer at cost, unless the Presiding Officer determines that the carrier should provide the transcript to that party.

41.19: Briefs

(1) Parties and participants shall file briefs within a period set by the Presiding Officer, which will be no more than 14 days following the close of the evidentiary record. Parties and participants shall file five copies of briefs and serve one copy on each party, unless the Presiding Officer directs that a different number of copies be provided. The Presiding Officer may set a page limit for briefs and may require parties and participants to file a copy of briefs on computer disk or by other electronic means in a format determined by the Presiding Officer. Each brief must include:

- (a) a concise statement of the case;
- (b) a clear and specific identification of all evidence relied upon by the filing party, with references to the pages in the record where the evidence appears;
- (c) arguments and supporting authorities;
- (d) a statement of the specific relief requested on each contested issue; and
- (e) any other information required by the Presiding Officer.

(2) Parties may submit reply briefs at the discretion of the Presiding Officer, within a period set by the Presiding Officer, which will be no more than four days following the filing of an opposing party's brief. Reply briefs must comply with the format, filing and service requirements of 211 CMR 41.18(1).

41.20: Decisions

(1) The final decision of the Presiding Officer will be in writing or stated in the record no more than 30 days following the parties' final oral or written submissions or arguments in the proceeding.

(2) The decision will be accompanied by a statement of reasons, including a determination of each necessary issue of fact or law. Rates that are approved will be effective no earlier than 30 days after the issuance of the final written decision. For a filed rate that is disapproved, the Presiding Officer may indicate an alternative rate or rate component, if any, that he or she finds reasonable. If a filed rate is disapproved, the carrier may make a revised rate filing that conforms with the alternative rate or rate components that the Presiding Officer indicated are reasonable.

(3) The submission and approval of a revised rate filing will not affect the carrier's right to appeal from those elements of the hearing request that were disapproved or denied as provided in 211 CMR 41.20.

41.21: Revised Rate Filings

(1) Contents. A carrier shall file any revised rate filing within the time period specified in the Presiding Officer's decision. The revised rate filing must meet the requirements set forth in the decision, must contain all information required by the decision, and must comply with the format, filing and service requirements of 211 CMR 41.10, but need not otherwise comply with 211 CMR 41.10.

(2) Hearing on Revised Rate Filing. The Presiding Officer shall promptly hold a hearing to consider the revised rate filing. The Presiding Officer may hear argument and receive evidence regarding compliance with the Presiding Officer's decision, and may permit the carrier to revise the filing further to meet the decision's requirements. If the Presiding Officer determines that the revised rate filing complies with the decision, he or she shall approve the revised rate filing.

41.22: Appeals

A carrier aggrieved by a final decision of the Presiding Officer not affirmed by the Commissioner may appeal that decision in accordance with M.G.L. c. 26, § 7. A carrier aggrieved by the final decision of the Commissioner may, within 20 days after the decision, file a petition in the Supreme Judicial Court for Suffolk County for review of the decision. A rate approved following the conclusion of all appeals of a final decision will be effective as of the effective date permitted by that decision unless a different date is specified by the Supreme Judicial Court.

41.23: Severability

If any section or portion of a section of 211 CMR 41.00, or the applicability thereof to any person or circumstance is held invalid by any court of competent jurisdiction, the remainder of 211 CMR 41.00, or the applicability thereof to other persons or circumstances, will not be affected thereby.

41.98: Appendix A: Adjusted Composite Rate Worksheet

Worksheet for Calculating the Composite Rate and Adjusted Composite Rate

Carrier's Legal Name _____

NAIC Company Code _____

Person Completing Worksheet _____

Title _____

Address _____

Telephone and FAX Numbers _____

General Instructions: When calculating factors, all figures should be rounded at the fourth decimal place. For all noted adjustments, carriers shall submit documentation reasonably necessary to substantiate the adjustments made. The documentation must be provided as an attachment to this Worksheet. "Contractholder," as used in this worksheet, means an eligible individual who has enrolled alone, or with his or her eligible dependents, in a closed guaranteed issue health plan. Examples of how to complete the worksheet, including the derivation of the Benefits Factor, Geographic Differences Factor and the Common-Age Factor, are provided in 211 CMR 41.99: *Appendix B: Adjusted Composite Rate Worksheet Examples.*

1. Type of Closed Guaranteed Issue Health Plan. (*Check one*):

Closed guaranteed issue managed care plan

____ Standard benefits plan

____ Alternative benefits plan

Closed guaranteed issue preferred provider plan

____ Standard benefits plan

____ Alternative benefits plan

Closed guaranteed issue medical plan

____ Standard benefits plan

____ Alternative benefits plan

2a. Enhanced Benefits Plan. If the plan is an enhanced benefits plan, describe each additional benefit or lower cost-sharing requirement in detail:

2b. Alternative Benefits Plan. If the plan is an alternative benefits plan, describe each lower benefit or higher cost-sharing requirement in detail:

3. Service Area. Describe the plan's service area, specifically noting any Massachusetts counties, cities or towns in which the plan is *not* available.

4. Composite Rate for Closed Guaranteed Issue Health Plan (average per member per month premium rate).

The Composite Rate is to be calculated as follows (rounded to the fourth decimal place):

$$\text{Composite Rate} = \frac{\text{(a) Projected Premium Revenue}}{\text{(b) Projected Member Months}} = \underline{\hspace{2cm}}$$

(a) Projected Premium Revenue =
Projected plan contractholders distributed by age, premium payment mode (relevant only if carrier uses other than monthly rates), geographic rating region and rate basis type
multiplied by
Proposed annualized premium rates by age, premium payment mode, geographic rating region and rate basis type

(b) Projected Member Months =
Projected plan average membership multiplied by number of months in rating period

5. Benefits Factor. If the Closed Guaranteed Issue Health Plan is a standard benefits plan, the Benefits Factor is equal to 1.0000.

If the Closed Guaranteed Issue Health Plan is an Enhanced Benefits Plan, the Benefits Factor must be calculated as follows: identify all additional benefits and lower-cost sharing requirements that differ from the comparable Standard Benefits Plan. Calculate the percentage of total premium that is attributable solely to the enhancements; the Benefits Factor equals 1.0 minus that percentage.

If the Closed Guaranteed Issue Health Plan is an Alternative Benefits Plan, the Benefits Factor must be calculated as follows: identify all benefits reductions and

higher-cost sharing requirements that differ from the comparable Standard Benefits Plan. Calculate the percentage of total premium attributable solely to the benefit reductions and higher cost-sharing requirements of the Alternative Benefits Plan; the Benefits Factor equals 1.0 plus that percentage.

Benefits Factor = _____ (rounded at the fourth decimal place)

6. Geographic Differences Factor. If the plan is available in all geographic regions and contractholders are distributed equally among all geographic rating regions, and the proposed premium rates do not differ by geographic rating regions, the Geographic Differences Factor is equal to 1.0000.

If the plan is available in all geographic rating regions and the proposed premium rates differ by geographic rating regions, or if the plan is available in all geographic rating regions, but contractholders are not equally distributed among the geographic rating regions, or if the plan is not available in all geographic regions, the Geographic Differences Factor is to reflect the assumption that the plan will cover insureds equally distributed throughout all the geographic regions identified in 211 CMR 41.03, including geographic rating regions in which the plan is not available. The Geographic Difference Factor must be calculated as follows:

- (a) Derive Statewide Projected Contractholders, using the same projected contractholder base employed in deriving the Composite Rate, assuming that the projected contractholders' distribution by age, premium payment mode and rate basis type remains the same, and assuming that the projected contractholders are equally distributed among all the geographic regions identified in 211 CMR 41.03, even in geographic rating regions where the plan is not available.
- (b) Derive Statewide Projected Revenue that is a combination of revenue derived for geographic regions in which the plan is available, as well as for regions in which the plan is not available. It is to be derived by multiplying Statewide Projected Contractholders, Item 6(a), distributed by age, geographic rating region and premium payment mode by:
 - (i) For All Geographic Rating Regions in Which the Plan Is Available: the proposed annual premium rates by age, geographic rating region and premium payment mode or
 - (ii) For All Geographic Rating Regions in Which the Plan is Not Available: estimated annual regional premium rates by age, geographic rating region, and premium payment mode, assuming (1) that age and premium payment mode distributions are the same as for all regions in

which the plan is available, and (2) that rates for any region in which the plan is not available, take into account the carrier's assumption about relative health costs between regions in which the plan is and is not available, based upon the carrier's own experience, health industry experience, or published sources, including for example, information from the Health Insurance Association of America.

- (c) Derive Statewide Composite Rate by dividing the Statewide Projected Revenue, Item 6(b), by the plan's total projected member months, Item 4(b).
- (d) Divide Statewide Composite Rate, Item 6(c) _____ (rounded at the fourth decimal place)
by the Composite Rate, Item 4(c) _____ to obtain the
Geographic Differences Factor _____ (rounded at the fourth decimal place)

7. Common-Age Factor. If the proposed rates do not differ by age and the plan's contractholders are projected to have an average age of 35, the plan's Common-Age Factor is equal to 1.0000.

If the proposed rates do not differ by age and the plan's contractholders are projected to have an average age other than 35, the Common-Age Factor is to be calculated as follows:

- (a) Derive Common-Age Projected Contractholders, using the same projected contractholder base employed in deriving the Composite Rate, assuming that the projected contractholders' distribution by geographic region, premium payment mode and rate basis type remains the same, and assuming that all projected contractholders are 35 years old.
- (b) Estimate the carrier's Common-Age Premium Rates assuming that the carrier offers the same rates to all age groups and that all contractholders are 35 years old, instead of the age used in deriving the proposed rates. In deriving the rates, the carrier shall base the estimated rates on the carrier's own experience, health industry experience, or published sources, including for example, information from the Health Insurance Association of America.
- (c) Derive the Common-Age Projected Revenue by multiplying Common-Age Projected Contractholders, Item 7(a), distributed by geographic rating region and premium payment mode by the estimated Common-Age Premium Rates by geographic rating region and premium payment mode for a 35 year old contractholder.
- (d) Derive a Common-Age Composite Rate by dividing the Common-Age Projected Revenue, Item 7(b), by the plan's total projected member months, Item 4(b).
- (e) Divide Common-Age Composite Rate, Item 7(c) _____ (rounded at the fourth decimal place)
by the Composite Rate, Item 4(c) _____ to obtain the

$$\text{Common-Age Factor} = \frac{\text{Common-Age Projected Revenue}}{\text{Common-Age Projected Contractholders}} \text{ (rounded at the fourth decimal place)}$$

If the proposed rates differ by age, the Common-Age Factor must reflect the assumption that the average age of plan contractholders is 35. Under these circumstances, the Common-Age composite rate is to be calculated as follows:

- (a) Derive Common-Age Projected Contractholders using the same projected contractholder base employed in deriving the Composite Rate, assuming that the projected contractholders' distribution by geographic region, premium payment mode and rate basis type remains the same, but assuming that all projected contractholders are 35 years old.
- (b) Derive Common-Age Projected Revenue by multiplying Common-Age Projected Contractholders, Item 7(a), distributed by geographic rating region and premium payment mode by the proposed annual premium rates by geographic rating region and premium payment mode for a 35 year old contractholder.
- (c) Derive a Common-Age Composite Rate by dividing the Common-Age Projected Revenue, Item 7(b), by the plan's total projected member months, Item 4(b).
- (d) Divide Common-Age Composite Rate, Item 7(c) _____ (rounded at the fourth decimal place)
by the Composite Rate, Item 4(c) _____ to obtain the
Common-Age Factor = _____ (rounded at the fourth decimal place)

8. Monthly Premium Mode Factor. If the carrier proposes to offer monthly rates as the only premium payment mode, the plan's Monthly Premium Mode Factor is equal to 1.0000.

If the carrier proposes to offer any premium payment mode other than the monthly rate, the Monthly Premium Mode Factor is to be calculated as follows:

- (a) Derive Monthly Premium Mode Projected Contractholders using the same projected contractholder base employed in deriving the Composite Rate, assuming that the projected contractholders' distribution by age, geographic region and rate basis type remains the same, but assuming that all contractholders have a monthly premium payment mode.
- (b) Estimate the carrier's Monthly Premium Mode Rates assuming that the carrier only offers a monthly rate to all contractholders.
- (c) Derive the Monthly Premium Mode Projected Revenue by multiplying Monthly Premium Mode Projected Contractholders, Item 8(a), distributed by age, geographic rating region and rate basis type by the carrier's Monthly Premium Mode Rates by age, geographic rating region and rate basis type, Item 8(b).
- (d) Derive a Monthly Premium Mode Rate by dividing the Monthly Premium Mode Projected Revenue, Item 8(c), by the plan's total projected member months, Item 4(b).

(e) Divide Monthly Premium Mode Rate, Item 8(d) _____ (rounded at the fourth decimal place)
by the Composite Rate, Item 4(c) _____ to obtain the
Monthly Premium Mode Factor = _____ (rounded at the fourth decimal place)

9. Adjusted Composite Rate. Calculate the Adjusted Composite Rate by multiplying the Composite Rate (Item 4) by the Benefits Factor (Item 5), the Geographic Differences Factor (Item 6), the Common-Age Factor (Item 7) and the Monthly Premium Mode Factor (Item 8).

Adjusted Composite Rate = _____ (rounded at the fourth decimal place)

Signature of Person Completing Worksheet _____

Date _____

I have reviewed the worksheet and agree that it includes the required information.

Signature of Actuary (*if different from Person Completing Worksheet*)

Date

41.99: Appendix B: Adjusted Composite Rate Worksheet Examples

(1) Benefits Factor. The following example addresses the derivation of the factor. It assumes that the plan includes an eyeglasses benefit that is not part of the standard benefits plan and that the benefit will be used equally by members regardless of age, premium payment mode, rate basis type, or geographic rating region, and that the proposed premiums reflect this assumption.

The carrier assumes that the eyeglasses benefit represents 0.5% of each of the proposed premiums and, therefore, 0.5% of the composite rate. The Benefits Factor equals 0.9550 (which is 1 - 0.0050).

(2) Geographic Differences Factor. Examples 1 and 2 below address the derivation of the Geographic Differences Factor assuming that there are only two geographic rating regions - eastern and western Massachusetts, and that both Company X and Y offer standard benefits plans with only one rate basis type and one premium payment mode (annual).

Example 1: Company X markets throughout Massachusetts, but proposes that its annual premium rate be \$1,800 in western Massachusetts and \$2,400 in eastern Massachusetts. Company X projects that 100 eligible individuals will enroll in Company X from western Massachusetts and 200 eligible individuals will enroll in Company X from eastern Massachusetts.

$$\begin{aligned} \text{Composite Rate} &= \\ &\frac{\text{West} \quad \text{East}}{(\$1800 \times 100) + (\$2400 \times 200)} = \$2,200 \\ &\quad (100 + 200) \\ \text{Statewide Composite Rate} &= \\ &\frac{\text{West} \quad \text{East}}{(\$1800 \times 150) + (\$2400 \times 150)} = \$2,100 \\ &\quad (150 + 150) \\ \text{Geographic Differences Factor} &= \\ &\frac{\text{Statewide Composite Rate}}{\text{Composite Rate}} = \frac{\$2,100}{\$2,200} = .9545 \end{aligned}$$

Example 2: Company Y markets a closed network plan in eastern Massachusetts and proposes that its annual premium rate be \$2,500 in eastern Massachusetts. Company Y projects that 200 eligible individuals will enroll in Company Y from eastern Massachusetts.

$$\begin{aligned} \text{Composite Rate (East)} &= \\ &\frac{\text{East}}{(\$2500 \times 200)} = \$2,500 \\ &\quad (200) \\ \text{Composite Rate (West)} &= \\ &\text{Company Y examines industry data and estimates} \\ &\text{that health costs in West are 80\% of Eastern costs} \\ &\quad \$2,500 \times 80\% = \$2,000 \\ \text{Statewide Composite Rate} &= \end{aligned}$$

$$\begin{array}{r}
 \text{West} \qquad \text{East} \\
 (\$2000 \times 100) + (\$2500 \times 100) = \$2,250 \\
 (100 + 100) \\
 \text{Geographic Differences Factor} = \\
 \frac{\text{Statewide Composite Rate}}{\text{Composite Rate}} = \frac{\$2,250}{\$2,500} = .9000
 \end{array}$$

(3) Common-Age Factor. The following example addresses the derivation of the factor. It assumes that there are only two age bands -- 40 and under, and over 40 -- and that the carrier offers a standard benefits plan with the same rates statewide with one rate basis type and one premium payment mode (annual).

Example: Company Z proposes that its annual premium rate is \$1,800 for contractholders age 40 and under and \$2,100 for contractholders over 40 years old. Company Z projects that 100 eligible individuals 40 and under will enroll in Company Z and 200 eligible individuals over 40 years old will enroll in Company Z.

$$\begin{array}{r}
 \text{Composite Rate} = \\
 \begin{array}{r}
 40 \text{ and under} \quad \text{over 40} \\
 (\$1800 \times 100) + (\$2100 \times 200) = \$2,000 \\
 (100 + 200)
 \end{array} \\
 \text{Common-Age Composite Rate} = \\
 \frac{(\$1800 \times 300)}{(300)} = \$1,800 \\
 \text{Common-Age Factor} = \\
 \frac{\text{Common-Age Composite Rate}}{\text{Composite Rate}} = \frac{\$1,800}{\$2,000} = .9000
 \end{array}$$

REGULATORY AUTHORITY

211 CMR 41.00: M.G.L. chs. 176M and 30A.