

211 CMR: DIVISION OF INSURANCE

211 CMR 66.00: SMALL GROUP HEALTH INSURANCE

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66.01: Authority

211 CMR 66.00 is promulgated in accordance with the authority granted to the Commissioner of Insurance by M.G.L. chs. 175, 176A, 176B, 176D, 176G, 176I and 176J.

66.02: Purpose

The purpose of 211 CMR 66.00 is to implement the provisions of M.G.L. c. 176J effective July 1, 2007.

66.03: Applicability and Scope

(1) 211 CMR 66.00 applies to all health benefit plans offered, made effective, issued, renewed, delivered or issued for delivery to any eligible small business or to any eligible individual under M.G.L. c. 176J on or after July 1, 2007 whether issued directly by a carrier, through the Connector, or through an association or through an intermediary.

(2) Nothing in 211 CMR 66.00 prohibits a carrier that offers health insurance to a business of more than 50 eligible employees from offering insurance in accordance with the provisions of 211 CMR 66.00.

66.04: Definitions

Actuarial Equivalence: refers to two health benefit plans that have the same Benefit Level Rate Adjustment factor.

Actuarial Opinion: a signed written statement by a qualified member of the American Academy of Actuaries, as prescribed in 211 CMR 66.90: *Appendix A*, which certifies that the actuarial
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assumptions, methods and contract forms utilized by the carrier in establishing premium rates for small group health benefit plans comply with all the requirements of 211 CMR 66.00 and any other applicable law.

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

Benefit Level: the health benefits, including the benefit payment structure or service delivery and network, provided by a health benefit plan.

Benefit Level Rate Adjustment: a number that represents the ratio of the actuarial value of the benefit level of one health benefit plan as compared to the actuarial value of the benefit level of another health benefit plan that is measured on the basis of a group census that is representative of Massachusetts small groups for that carrier.

Carrier: an insurer licensed or otherwise authorized to transact accident and health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a non-profit medical service corporation organized under M.G.L. c. 176B; or a health maintenance organization organized under M.G.L. c. 176G.

Class of Business: all or a distinct grouping of eligible insureds as shown on the records of the carrier which is provided with a health benefit plan through a health care delivery system operating under a license distinct from that of another grouping. For the purposes of 211 CMR 66.00, only the following three classes of business shall be recognized: persons covered through plans offered by health maintenance organizations licensed under M.G.L. c. 176G, persons covered through preferred provider plans approved under M.G.L. c. 176I and persons covered through other indemnity plans organized under M.G.L. chs. 175, 176A, and 176B.

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

Connector: the Commonwealth Health Insurance Connector created under M.G.L. c. 176Q.

Connector Seal of Approval: the approval given by the Connector Board to indicate that a health benefit plan meets certain standards regarding quality and value.

Creditable Coverage: coverage of an individual under any of the following health plans with no lapse of coverage of more than 63 days:

- (a) a group health plan;
- (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under 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. 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. 89;

- (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(I)(I), as amended by Public Law 104-191;
- (j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e);
- (k) coverage for young adults as offered under section 10 of chapter 176J; or
- (l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act.

211 CMR 66.04: Creditable Coverage applies to creditable coverage for portability as used in 211 CMR 66.00 in relation to any pre-existing condition provision or waiting period. It is not intended to define creditable coverage as it is defined by the Connector Board for purposes of determining individual responsibility for maintaining health coverage.

Date of Enrollment: with respect to an individual covered under a group health plan or health insurance coverage, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

Eligible Dependent: the spouse or child of an eligible individual or eligible employee, subject to the applicable terms of the health benefit plan covering such individual or employee.

Eligible Employee: an employee who:

- (a) works on a full-time basis with a normal work week of 30 or more hours, and includes an owner, a sole proprietor or a partner of a partnership; provided however, that such owner, sole proprietor or partner is included as an employee under a health care plan of an eligible small business; and provided, however, that "eligible employee" does not include an employee who works on a temporary or substitute basis; and
- (b) is hired to work for a period of not less than five months, provided, however, that a carrier cannot require that a person must have worked for an unreasonable length of time in order to qualify as an "eligible employee." For the purposes of 211 CMR 66.00, five months shall be deemed to be an unreasonable length of time when determining "eligible employee."

Eligible Individual: an individual who is a resident of the commonwealth.

Eligible Small Business or Group: any sole proprietorship, firm, corporation, partnership or association actively engaged in business who, on at least 50% of its working days during the preceding year, employed from among one to not more than 50 eligible employees, the majority of whom worked in Massachusetts; provided, however, that the sole proprietorship, firm, corporation, partnership or association need not have been in existence during the preceding year in order to qualify as an "eligible small business or group." A business shall be considered to be one eligible small business or group if:

- (a) it is eligible to file a combined tax return for purpose of state taxation; or
- (b) its companies are affiliated companies through the same corporate parent.

Except as otherwise specifically provided, provisions of 211 CMR 66.00 which apply to an eligible small business will continue to apply through the end of the rating period in which an eligible small business no longer meets the requirements of "eligible small business or group." An eligible small business that exists within a MEWA shall be subject to 211 CMR 66.00.

Emergency Services: services to treat 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 section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. 1395dd(e)(1)(B).

Financial Impairment: a condition in which, based on the overall condition of the carrier as determined by the commissioner, the carrier is, or if subjected to the provisions of 211 CMR 66.00 could reasonably be expected to be, insolvent, or otherwise in an unsound financial condition such as to render its further transactions of business hazardous to the public or its policyholders or members, or is compelled to compromise, or attempt to compromise, with its creditors or claimants on the grounds that it is financially unable to pay its claims.

Group Average Premium Rates: a set of numbers, one for each rate basis type, where each number is the total of the premiums charged to an eligible small business for all eligible employees and eligible dependents or eligible individuals and their dependents of that rate basis type, divided by the number of insured eligible employees of that rate basis type.

Group Base Premium Rates: the group average premium rates that would be charged by a carrier at the beginning of the rating period if the premiums were based solely upon the age, industry, participation rate, wellness program usage, tobacco usage and rate basis type of the members of the group. The group base premium rates for every group will be adjusted to a January first basis by dividing each group base premium rate by a deflator. The deflator equals the sum of trend for that carrier and the number one, raised to the power of the fraction of the calendar year which has elapsed at the time the new rating period begins.

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. 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 66.00, 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 66.04: Group Health Plan (a)1.; and
 - 3. amounts paid for insurance covering medical care referred to in 211 CMR 66.04: Group Health Plan (a)1. and 2.
- (b) Any plan, fund or program which 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 the 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 66.04: Group Health Plan(c), as an employee welfare benefit plan which is a group health plan.
- (c) In a group health plan, the term “employer” also includes the partnership in relation to any partner; and
- (d) the term “participant” also includes:—
 - 1. in connection with a group health plan maintained by a partnership, an individual who is a partner of 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 that individual is, or may become, eligible to receive a benefit under the plan or that individual's beneficiaries may be eligible to receive any benefit.

Health Benefit Plan: Any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under M.G.L. c. 175; an individual or group hospital service plan issued by a non-profit hospital service corporation under M.G.L. c. 176A; an individual or group medical service plan issued by a nonprofit medical service corporation under M.G.L. c. 176B; and an individual or group health maintenance contract issued by a health maintenance organization under M.G.L. c. 176G.

Health benefit plans shall not include those plans whose benefits are for:

- (a) accident only;
- (b) credit only;
- (c) limited scope vision or dental benefits if offered separately;
- (d) hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of 211 CMR 66.00 shall mean policies issued under M.G.L. c. 175 which provide a benefit not to exceed \$500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth 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;
- (e) disability income insurance;
- (f) coverage issued as a supplement to liability insurance;
- (g) specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets the requirements of 211 CMR 146.00;
- (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. 55 if offered as a separate insurance policy;
- (m) any policy subject to M.G.L. c. 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans; or
- (n) a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under M.G.L. c. 15A, § 18 shall not be considered a health plan for the purposes of 211 CMR 66.00 and shall be governed by said M.G.L. c. 15A.

Health Maintenance Organization or HMO: an entity licensed to do business in Massachusetts under M.G.L. c. 176G.

Insured: any policyholder, certificateholder, subscriber, member or other person on whose behalf the carrier is obligated to pay for and/or provide health care services.

Intermediary: a chamber of commerce, trade association, or other organization, formed for purposes other than obtaining insurance, which has complied with the requirements of 211 CMR 66.13(3), and which offers its members the option of purchasing a health benefit plan.

Late Enrollee: an eligible employee or dependent who requests enrollment in an eligible small

business' health insurance plan or insurance arrangement after the group's initial enrollment period, his or her initial eligibility date provided under the terms of the plan or arrangement, or the group's annual open enrollment period.

Mandated Benefit: a health service or category of health service provider which a carrier is required by its licensing or other statute to include in its health benefit plan.

Member: any person enrolled in a health benefit plan.

MEWA or Multiple Employer Welfare Arrangement or Multiple Employer Trust either:

(a) a fully-insured multiple employer welfare arrangement as defined in §§ 3 and 514 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 USC 1002 and 1144; or

(b) an entity holding itself out to be a MEWA, multiple employer welfare arrangement or multiple employer trust that is not fully insured and, therefore, shall be required to be licensed under M.G.L. c. 175. An arrangement that constitutes a MEWA is considered a separate group health plan with respect to each employer maintaining the agreement.

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 health benefit plan is the same without regard to health status, but premiums may vary due to factors such as age, group size, industry, participation rate, geographic area, wellness program usage, tobacco usage, or benefit level for each rate basis type as permitted by M.G.L. c. 176J and 211 CMR 66.00.

Participation Rate: the percentage of eligible employees electing to participate in a health benefit plan out of all eligible employees, or the percentage of the sum of eligible employees and eligible dependents electing to participate in a health benefit plan out of the sum of all eligible employees and eligible dependents, at the election of the carrier. In either case, the numbers used to compute these percentages may not include any eligible employee or eligible dependent who does not participate in the eligible small business' health benefit plan, but who is enrolled in another health benefit plan as a spouse or dependent.

Participation Requirement: a policy provision, or a carrier's underwriting guideline if there is no such policy provision, that requires that a group attain a certain participation rate in order for a carrier to accept the group for enrollment in the health benefit plan. For groups of five or fewer eligible persons, a carrier may require a participation rate not to exceed 100%. For groups of six or more eligible persons, a carrier may require a participation rate not to exceed 75%.

Pre-existing Conditions Provision: 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 the coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before the date. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to that information. Pregnancy shall not be a pre-existing condition. Trade Act/HCTC-eligible persons shall not be subject to any pre-existing conditions provision.

Qualifying Health Plan: any blanket or general policy of medical, surgical or hospital insurance described in M.G.L. c. 175, § 110(A), (C) or (D); policy of accident or sickness insurance as described in M.G.L. c. 175, §108 which provides hospital or surgical expense coverage; nongroup or group hospital or medical service plan issued by a non-profit hospital or medical service corporation under M.G.L. c. 176A and c. 176B; nongroup or group health maintenance contract

issued by an HMO under M.G.L. c. 176G; nongroup or group preferred provider plan issued under M.G.L. c. 176I; self-insured or self-funded health plans offered by an employer or union health and welfare fund; health coverage provided to persons serving in the armed forces of the United States; or government-sponsored health coverage including but not limited to Medicare and medical assistance provided under M.G.L. c. 118E.

Rate Basis Type: each category of single or multi-party composition for which a carrier charges separate rates. For the purpose of 211 CMR 66.00, carriers shall use at least any combination of the following categories:

- (a) single;
- (b) two adults;
- (c) one adult and one or more children; and
- (d) two adults and one or more children.

Nothing in 211 CMR 66.04: Rate Basis Type prohibits a carrier from establishing separate rates for active employees and retirees, or for Medicare-eligible insureds, or for any other categories to the extent otherwise required by state or federal law, such as persons for continued group health coverage under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) or M.G.L. c. 176J, § 9. Carriers may offer any rate basis types, but rate basis types that are offered to any eligible small employer or eligible individual shall be offered to every eligible small employer or eligible individual for all coverage issued or renewed on or after July 1, 2007.

Rating Factor: characteristics including, but not limited to, age, industry, rate basis type, geography, wellness program usage or tobacco usage.

Rating Period: the period for which premium rates established by a carrier are in effect, as determined by the carrier.

Resident: a natural person living in the commonwealth, but the confinement of a person in a nursing home, hospital or other institution shall not by itself be sufficient to qualify a person as a resident.

Tobacco Product: a product that contains tobacco in any of its forms, including, but not limited to, cigarettes, bidi cigarettes, clove cigarettes, cigars, pipe tobacco, smokeless tobacco, chewing tobacco, or snuff.

Trade Act/HCTC-eligible Person: or TA/HCTC-eligible Person: any eligible trade adjustment assistance recipient or any 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.

Trend: the annual change, from the first day of a group's prior rating period to the first day of that group's new rating period, in the average of all groups' base premium rates attributable to factors other than changes in benefit levels and rate basis types, adjusted for rating periods greater or lesser than one year.

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, but in all cases pays for emergency services. Trade Act/HCTC-eligible persons shall not be subject to any waiting period.

66.05: Minimum Coverage Standards

(1) Offerings.

(a) Unless otherwise provided in 211 CMR 66.05, every carrier shall make available to every eligible individual and every eligible small business a certificate that evidences coverage for every health benefit plan that it provides to any other eligible individual or eligible small business whether issued or renewed to a trust, association or other entity that is not a group health plan, as well as to their eligible dependents and must accept for enrollment any eligible individual or eligible small business that seeks to enroll in a health benefit plan. The products offered to all eligible individuals and eligible small groups may differ by benefit level and may include networks that differ from those of a health benefit plan's overall network.

(b) Coverage shall become effective within 30 days of the date of application.

(c) Upon the request of an eligible small business or eligible individual, a carrier shall provide that eligible small business or eligible individual with a sample of health benefit plans and prices and, upon request, a price for every health benefit plan that it makes available to any eligible small business or eligible individual. The carrier may satisfy such a request for information on health benefit plan offerings by referring the eligible small business or eligible individual to resources where the information can be accessed, including by not limited to, an internet website. The term "internet website" shall include "intranet website" and "electronic mail" or "e-mail". The carrier must 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.

(d) A carrier may only contract to sell any health benefit plan with an employer if said insurance is offered by that employer to all full-time employees who live in the commonwealth; provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each health benefit plan for all employees. Notwithstanding the foregoing, a carrier may sell, issue, market or deliver a health benefit plan to an employer that establishes separate contribution percentages for employees covered by collective bargaining agreements.

(e) If a carrier is not accepting every new eligible small group or eligible individual, it may not accept any new eligible small groups or eligible individuals either directly, through an association or through an intermediary or through the Connector.

However, if a carrier issued a health insurance product which is not available to eligible small groups or eligible individuals but is available to a group with 51 or more employees and the size of that group declined to 50 or fewer employees during the term of the policy, the carrier is not required to make that particular health insurance product available to eligible small groups or eligible individuals.

(f) A carrier may deny an eligible individual or a group of five or fewer eligible employees enrollment in a health benefit plan unless the eligible individual or the group enrolls through an intermediary or through the Connector, provided that the carrier complies with all of the following requirements:

1. For eligible individuals and groups of five or fewer eligible employees, every carrier must make coverage available either directly or through an intermediary or through the Connector.

2. No carrier may require an eligible individual or a group of five or fewer eligible employees to join an intermediary if the intermediary has unreasonable barriers to membership, including, but not limited to, unreasonable fees or unreasonable membership requirements. If an eligible individual or a small group is precluded from joining an intermediary due to unreasonable membership barriers, the carrier must enroll the eligible individual or eligible small group directly. Nothing in 211 CMR 66.05(1)(f) shall prohibit a carrier from enrolling eligible individuals or eligible groups directly or through the Connector.
3. If an eligible individual or a group of five or fewer eligible employees elects to enroll through an intermediary or through the Connector, a carrier may not deny that group enrollment.
4. The carrier must implement the requirements in 211 CMR 66.05(1)(f) consistently, treating all similarly situated individuals or groups in a similar manner.
5. Any carrier that enrolls eligible individuals or eligible small businesses through an intermediary or through the Connector must comply with all provisions of 211 CMR 66.00.
6. Nothing in 211 CMR 66.05(1)(f) prohibits an eligible individual or an eligible small business with six to 50 employees from electing to enroll through an intermediary or through the Connector for coverage under a health benefit plan.
7. Nothing in 211 CMR 66.05(1)(f) permits a carrier to require an eligible small business with six to 50 employees to enroll through an intermediary or through the Connector for coverage under a health benefit plan.

(g) A carrier is not required to issue a health benefit plan to an eligible individual or an eligible small business if the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12 months:

1. the eligible individual or eligible small business has made at least three or more late payments in a 12 month period; or
2. the eligible individual or eligible small business has committed fraud, misrepresented the eligibility of an employee or of an individual, or misrepresented information necessary to determine group size, group participation rate, the group premium rate, or individual rate; or
3. the eligible individual or eligible small business has failed to comply in a material manner with a health benefit plan provision, including, for an eligible small business, carrier requirements for employer group premium contributions; or
4. the eligible individual has voluntarily ceased coverage under that carrier's health benefit plan before the contract renewal date, provided that a carrier shall be required to 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; or
5. the eligible small business has been covered by three or more health benefit plans within the same class of business during the four years immediately preceding the date of application for coverage. However, nothing in 211 CMR 66.05(1)(g)5. may be used by a carrier to refuse acceptance of an eligible small business solely because the eligible small business offers multiple health benefit plans at the same time.

(h) A carrier may request information from other carriers regarding the items listed in 211 CMR 66.05(1)(g)1. through 5. provided that the request does not violate any applicable state or federal law. The carrier receiving such a request from another carrier may provide the information consistent with state or federal law.

(i) A carrier is not required to issue a health benefit plan to an eligible small business or eligible individual if the eligible small business or eligible individual fails to comply with reasonable requests by the carrier for information necessary to verify the application for coverage, including but not limited to information regarding the prior health insurance coverage of the eligible small business or eligible individual. Requests for information may also include information reasonably necessary for the carrier to determine whether the small business is an "eligible small business" or whether a person is an "eligible employee" or an "eligible individual" as defined in 211 CMR 66.04.

(j) A carrier is not required to issue a health benefit plan to an eligible small business if the carrier can demonstrate, to the satisfaction of the commissioner, that the small business fails at the time of issuance or renewal to meet a participation rate requirement established under the definition of participation rate, as defined in 211 CMR 66.04. However, if an eligible business does not meet a carrier's minimum participation rate requirement, the carrier may separately rate each employee as an eligible individual.

(k) A carrier is not required to issue a health benefit plan to an eligible individual or eligible small business if acceptance of an application or applications would create for the carrier a condition of financial impairment. The carrier must file with the commissioner, at least 30 days in advance of any such denial or as soon as its financial position becomes known to the carrier, a certified statement by the Chief Financial Officer attesting to the carrier's overall financial impairment and accompanied by supporting documentation. Any carrier found to be financially impaired by the commissioner must immediately cease issuing health benefit plans on an initial basis to eligible individuals and eligible small businesses in accordance with the provisions of 211 CMR 66.05(3).

(l) Every carrier must apply participation and employer contribution requirements in a uniform manner to all groups of the same size. Carriers may not increase participation or employer contribution requirements where the size of the group has changed until the group's renewal date of the health benefit plan.

(m) Any carrier who denies coverage to an eligible small business or eligible individual under the provisions of 211 CMR 66.05 must:

1. provide to the small business or eligible individual, in writing, the specific reason(s) for the denial of coverage; and
2. make available to the commissioner, upon request, the documentation for the denial.

(n) An HMO is not required to accept applications from or offer coverage:

1. to an eligible individual or an eligible small group, where the eligible individual or eligible small group is not physically located in the HMO's approved service area; or
2. within an area, where the HMO reasonably anticipates, and receives prior approval by demonstrating to the satisfaction of the commissioner, that it will not, within that area, have the capacity in its network of providers to deliver services adequately to the members because of its obligations to existing contract holders and enrollees. The HMO may not offer coverage in that area to any new cases of individuals or business groups of any size until the later of 90 days after each refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to eligible small business groups.

(2) Eligible Employees, Eligible Individuals and Eligible Dependents.

(a) Every carrier must provide coverage to all eligible employees, all eligible individuals, and

all eligible dependents except:

1. in the case of an HMO, where the eligible employee or eligible individual or eligible dependent does not meet the HMO's requirements regarding residence or employment within the HMO's approved service area;
2. in the case of a small group when an eligible employee seeks to enroll in a health benefit plan significantly later than it was initially eligible to enroll. However, an eligible employee or dependent will not be considered a late enrollee if the individual requests enrollment within 30 days after termination of a previous qualifying health plan, and
 - a. The employee or dependent was covered under a previous qualifying health plan at the time of the initial eligibility for the eligible small business' health benefit plan; or
 - b. The employee or dependent lost coverage under the previous qualifying health plan as a result of the termination of his or her spouse's employment or eligibility, death of a spouse, divorce, loss of dependent status or the involuntary termination of the qualifying previous coverage; or
 - c. A court has ordered coverage be provided for a spouse, former spouse, minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of the court order; or
 - d. The loss of prior coverage was due to the insolvency of the former carrier.

(b) A carrier that does not provide coverage to a late entrant because an eligible employee or eligible dependent did not meet the conditions of 211 CMR 66.05(2)(a)2.a. through d., must make coverage available to that person at the group's next renewal date and may not deny that person coverage at the next renewal date except for reasons otherwise allowed by 211 CMR 66.00.

(c) A carrier may not require that a person must have worked for an unreasonable length of time in order to qualify as an "eligible employee." For the purposes of 211 CMR 66.00, five months is considered to be an unreasonable length of time when determining employee eligibility.

(d) Nothing in 211 CMR 66.00 shall prohibit a carrier from offering coverage in a group to a person, and his dependents, who does not satisfy the hours per week or period employed portions of the definition of eligible employee provided that the carrier applies these standards consistently to all such persons and their dependents who do not meet the definition of an eligible employee.

(3) Discontinuance Provisions.

(a) Filing Requirements. Notwithstanding any other provision in 211 CMR 66.05, a carrier may deny an eligible individual or eligible small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that health benefit plan to new eligible individuals and eligible small businesses.

(b) Material to Be Submitted. A carrier that intends to discontinue selling a health benefit plan to new eligible individuals and eligible small businesses must, at least 30 days in advance of discontinuing the sale of the health benefit plan, submit to the commissioner a statement certified by an officer of the carrier that specifies all of the following:

1. The date by which it will discontinue selling the health benefit plan to all new individuals and groups.
2. The reason(s) for the discontinuance of the health benefit plan.
3. A list of any other health benefit plans it continues to sell in Massachusetts.
4. The number of groups and individuals covered by the discontinued health benefit plan, both in Massachusetts and in its total book of business.

5. An acknowledgment that the carrier is prohibited from selling the particular health benefit plan again in Massachusetts to new individuals and groups for a period of not less than three years.

(c) The commissioner may disapprove, within 21 days of receiving notice under 211 CMR 66.05(3)(b), a carrier's election to discontinue the sale of the health benefit plan if the carrier fails to comply with 211 CMR 66.05(3)(b) or is in violation of 211 CMR 66.05(4).

(d) Notwithstanding any other provision in 211 CMR 66.05, carriers are required to renew coverage, as described in 211 CMR 66.06, under an otherwise discontinued health benefit plan for existing groups.

(4) In no event may a carrier deny an eligible individual or eligible small group enrollment in a health benefit plan as part of an effort to circumvent the intent of c. 176J.

66.06: Renewability

(1) Except as provided in 211 CMR 66.06(2), every health benefit plan shall be renewable as required by the Health Insurance Portability and Accountability Act of 1996, or by regulations promulgated under that act.

(2) A carrier is not required to renew the health benefit plan of an eligible small business if the small business:

(a) has not paid the required premiums; or,

(b) has committed fraud, misrepresented whether a person is an eligible employee, or misrepresented information necessary to determine the size of a group, the participation rate of a group, or the premium rate for a group; or,

(c) failed to comply in a material manner with health benefit plan provisions, including carrier requirements regarding employer contributions to group premiums; or,

(d) fails, at the time of renewal, to satisfy the definition of an eligible small business or meet the participation requirements of the health benefit plan; or,

(e) fails to comply with reasonable requests to verify the information described in 211 CMR 66.05(1)(g); or

(f) is not actively engaged in business.

(3) A carrier is not required to renew the health benefit plan of an eligible individual, eligible employee, or eligible dependent if said person:

(a) has not paid the required premiums;

(b) has committed fraud or misrepresented whether he or she qualifies as an eligible individual, eligible employee, eligible dependent, or misrepresented information necessary to determine his or her eligibility for a health benefit plan or for specific health benefits;

(c) has failed to comply in a material way with the provisions of the health benefit plan, the member contract or the subscriber agreement, including but not limited to relocation of the individual, employee, or dependent, outside the service area of the carrier;

(d) fails, at the time of renewal, to satisfy the definition of an eligible individual, eligible employee, or eligible dependent;

(e) has failed to comply with the carrier's reasonable request for information in an application for coverage.

(4) A carrier must file with the commissioner any material changes in the criteria it uses under 211 CMR 66.06(2) and/or 211 CMR 66.06(3) to determine the nonrenewability of a health benefit plan for an eligible small business as part of the annual filing required by 211 CMR 66.13.

(5) A carrier must provide at least 60 days prior notice to an eligible individual or eligible small business of the carrier's intention not to renew the health benefit plan and the specific reason(s) for the nonrenewal in accordance with the carrier's filed criteria.

(6) A carrier that elects to nonrenew all of its health benefit plans delivered or issued for delivery to eligible individuals and eligible small businesses in Massachusetts:

(a) must submit to the commissioner, 30 days in advance of providing notice required under 211 CMR 66.06(6)(c) a statement certified by an officer of the carrier that specifies:

1. The date by which it will nonrenew all of its health benefit plans to all new groups;
2. The reason(s) for the nonrenewal of all health benefit plans;
3. The number of groups and individuals covered by the nonrenewed health benefit plans, both in Massachusetts and in its total book of business; and
4. An acknowledgment that the carrier is prohibited from writing new business in the individual and small group market in Massachusetts for a period of five years from the date of notice to the commissioner.

(b) The commissioner may disapprove, within 21 days of receiving notice under 211 CMR 66.06(6)(a), a carrier's election to nonrenew if the carrier fails to comply with 211 CMR 66.06(6)(a) or is in violation of 211 CMR 66.06(8).

(c) A carrier must provide notice of the decision not to renew coverage to all affected eligible individuals or eligible small businesses at least 180 days prior to the nonrenewal of any health benefit plan by the carrier in the event the commissioner has not disapproved the carrier's election to nonrenew; and

(d) after the 180 day notification period, must nonrenew coverage to eligible individuals or eligible small businesses only on the date of renewal for each individual or small business.

(7) Nothing in 211 CMR 66.06 prohibits a carrier from canceling during the term of the policy a health benefit plan issued to an eligible individual or eligible small business for the reasons outlined in 211 CMR 66.06(2)(a), (b), (c) or (f) or in 211 CMR 66.06(3)(a), (b), or (c); provided that if the carrier cancels the health benefit plan for the reason found in 211 CMR 66.06(2)(a) or in 211 CMR 66.06(3)(a) during the policy term, a carrier must provide the eligible individual or eligible small business with any grace period as provided in the group's health benefit plan, including any prior notification requirements.

(8) In no event may a carrier deny an eligible individual or eligible small group renewal of a health benefit plan as part of an effort to circumvent the intent of c. 176J.

66.07: Pre-existing Conditions and Waiting Periods

(1) No carrier may exclude any eligible individual, eligible employee, or eligible dependent from a health benefit plan on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage, or medical condition.

(2) No carrier may modify the coverage of an eligible individual, eligible employee, or eligible dependent through riders or endorsements, or otherwise restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan except as permitted under 211 CMR 66.00.

(3) No health benefit plan may include pre-existing condition provisions that exclude coverage for a period beyond six months following the eligible individual's, eligible employee's, or eligible dependent's date of enrollment. The pre-existing condition provision shall only relate to 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 and for which any medical advice, diagnosis, care or treatment was recommended or received during the six months before the eligible individual's, eligible employee's, or eligible dependent's date of enrollment. Pregnancy shall not be a pre-existing condition.

(4) No health benefit plan may include waiting periods that exclude coverage for a period beyond four months following the eligible individual's, eligible employee's, or eligible dependent's date of enrollment. Notwithstanding 211 CMR 66.07(4), no waiting period may be imposed if an eligible individual, eligible employee, or eligible dependent lacked creditable coverage for 18 months or more immediately prior to the date of enrollment.

(5) When a eligible individual or eligible small group changes from one health benefit plan to another, whether such health benefit plan is with the same carrier or a different carrier, the carrier may impose a new waiting period of not more than four months on the eligible individual or on all members of the eligible small group for only those services covered under the new health benefit plan that were not covered under the old health benefit plan.

(6) With respect to TA/HCTC-eligible persons, a carrier may not impose any pre-existing condition exclusion or waiting period following the TA/HCTC-eligible person's date of enrollment.

(7) In determining whether a pre-existing condition provision or waiting period applies to an eligible individual, eligible employee, or eligible dependent, all health benefit plans must credit the time the person was covered under prior creditable coverage if the prior creditable coverage was continuous to a date not more than 63 days prior to the request for new coverage, exclusive of any applicable services waiting period under the new coverage, provided that the prior creditable coverage was reasonably actuarially equivalent to the new coverage. For the purpose of 211 CMR 66.07(6), "reasonably actuarially equivalent" means the following:

(a) the Benefit Level Rate Adjustment factor for the new health benefit plan is no more than ten percentage points greater than the Benefit Level Rate Adjustment factor of the previous health benefit plan; provided, however, that if the Benefit Level Rate Adjustment factor for the new health benefit plan is more than ten percentage points greater than the Benefit Level Rate Adjustment factor of the previous health benefit plan, the eligible individual, eligible employee, or eligible dependent must receive at least the actuarially equivalent benefits of the previous health benefit plan during the term of the preexisting condition period or waiting period; or

(b) 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.

(8) If a health benefit plan includes a waiting period, emergency services must be covered during the waiting period.

(9) A carrier may only impose either a pre-existing condition limitation or a waiting period.

66.08: Restrictions Relating to Premium Rates

Premiums charged to every eligible small business or eligible individual for a health benefit plan issued or renewed on or after July 1, 2007, whether through a trust or association or through an intermediary, or through the Connector, or directly, must satisfy the following requirements:

(1) The Premium Band for Group Base Premium Rates.

(a) For every health benefit plan issued or renewed to an eligible small group or eligible

individual on or after July 1, 2007, the group base premium rates charged by a carrier to each eligible small group or eligible individual during a rating period may not exceed two times the group base premium rate which could be charged by that carrier to the eligible small group or eligible individual with the lowest group base premium rate for that rate basis type within that class of business in that group's or individual's geographic area.

(b) In calculating the premium to be charged to each eligible small group or eligible individual, a carrier shall develop a base premium rate for each rate basis type and may develop and use one or more of the following rate adjustment factors, provided that after multiplying any of the used rate adjustment factors by the base premium rate, the resulting product for all adjusted group base premium rate combinations fall within rate bands that are equivalent to a range between 0.66 and 1.32 that is required of all products offered to eligible small groups and eligible individuals:

1. Age Rate Adjustment Factor

2. Industry Rate Adjustment Factor

- a. If used for eligible individuals, the industry rate adjustment applicable to an eligible individual must be based on the industry of the eligible individual's primary employer and must be the same adjustment applied to eligible small groups in the same industry.
- b. A carrier may not apply an industry rate adjustment to an eligible individual who is not employed.
- c. If a carrier establishes an industry rate adjustment, it must be applied to every eligible small group in an industry.
- d. If a carrier uses an industry rate adjustment for eligible individuals, it must be applied to all eligible individuals based on the industry of an individual's identified primary employer.

3. Participation-Rate Rate Adjustment Factor.

- a. A carrier may establish participation-rate rate adjustments for any health benefit plan or plans for any ranges of participation rates below the following minimum participation requirements:
 - i. For groups of five or fewer: not to exceed 100%.
 - ii. For groups of six or more: not to exceed 75%.
- b. The participation-rate rate adjustments must be based upon actuarially sound analysis of the differences in the experience of eligible small businesses with different participation rates.
- c. If a carrier chooses to establish participation-rate rate adjustments, it must apply the adjustment to every eligible small business within the ranges defined by the carrier.
- d. If an eligible small employer does not meet a carrier's minimum participation or contribution requirements, the carrier may separately rate each employee as an eligible individual.

4. Wellness Program Rate Adjustment Factor

- a. The wellness program rate adjustment factor applies to both eligible individuals and eligible small groups
- b. Wellness programs must be approved by the Commissioner
- c. If a carrier chooses to establish a wellness program rate adjustment factor, it must apply the adjustment to every eligible individual and eligible small group

5. Tobacco Use Rate Adjustment Factor

- a. The tobacco usage rate adjustment factor, when used, will consistently apply to all eligible individuals and eligible small groups.
- b. Eligible individuals and eligible small groups must certify, in a method approved by the Commissioner, that eligible individuals and/or their dependents or eligible small group employees and/or their eligible dependents have not used tobacco products within the past year.

(2) Additional Rate Adjustments.

Carriers may apply additional factors, that would apply outside the 0.66 to 1.32 equivalent rate band. All other rating adjustments are prohibited.

(a) Benefit Level Rate Adjustment.

1. The benefit level rate adjustment for all eligible individuals and all eligible small businesses must represent the ratio of the actuarial value of the benefit level, including the health care delivery network, of one health benefit plan as compared to the actuarial value of the benefit level of another health benefit plan, measured on the basis of a census that is representative of Massachusetts eligible individuals and eligible small businesses for that carrier.
2. If a carrier chooses to establish a benefit level rate adjustment, it must apply the adjustment to every eligible individual and eligible small business.

(b) Area Rate Adjustments.

1. The area rate adjustment for each distinct region in 211 CMR 66.08(2)(b)2., must range from not less than 0.8 to not more than 1.2.
2. The permissible regions are based on the following zip code groupings which refer to the first three digits of the zip code for each eligible small business or 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
 - g. 025 through 026

except that a carrier may combine the zip code groupings outlined in 211 CMR 66.08(2)(b)2.c. and d. into one region or combine the zip code groupings outlined in 211 CMR 66.08(2)(b)2.c., d. and e. into one region for all of its health benefit plans subject to 211 CMR 66.00, or use regions based on groupings of counties that roughly approximate the zip code groupings.

3. If a carrier chooses to establish an area rate adjustment, it must apply the adjustment to every eligible small business and eligible individual within each area. The area rate adjustment for an eligible small group will be based on the location of the eligible small group and the area rate adjustment for an eligible individual will be based on the primary residence of the eligible individual.

(c) Rate Basis Type Adjustment Factor

1. The rate basis types that are offered to any eligible small employer or eligible individual must be offered to every eligible small employer or eligible individual for all coverage issued or renewed on and after July 1, 2007.
2. The rate basis type adjustment factor for eligible individuals and eligible small groups must represent the relative actuarial value of the rate basis type, which shall

include at least any combination of the following:

- a. Single,
- b. Two adults,
- c. One adult and child(ren),
- d. Family.

(d) Group Size Rate Adjustment

1. If a carrier chooses to establish group size rate adjustments, every eligible individual and eligible small group shall be subject to the applicable group size rate adjustment.
2. The group size rate adjustment applies to both eligible individuals and eligible small groups, the value of which shall range from 0.95 to 1.10 and for eligible small groups must be based on the number of eligible employees who are enrolled in an eligible small business.
3. If an eligible small business does not meet a carrier's participation or contribution requirements, the carrier may apply the group size adjustment that applies to eligible individuals to each employee who enrolls through the eligible small business.

(e) Intermediary Discount. If a carrier provides coverage to eligible small businesses and eligible individuals through an intermediary, the carrier may apply a discount factor to the total premium for each eligible small business and eligible individuals. The factor must be calculated to account only for the savings to the carrier due to the administrative and marketing activities of the intermediary which are related to the purchase of health benefit plans for its members from that carrier. The factor may not be calculated based on the claims experience, duration of coverage, health status or case characteristics of the eligible small businesses enrolled in the carrier's health benefit plan through the intermediary. The discount may be negotiated between the carrier and each individual intermediary according to the range of services offered by each intermediary.

(3) Premium Rate Calculation. No carrier may charge a premium rate to an eligible individual or eligible small business that is based upon the eligible individual's or eligible small business' health status, duration of coverage, or actual or expected claims experience.

The premium charged by a carrier to each eligible individual or eligible small business on the date the eligible individual's or eligible small business' health benefit plan is issued or renewed shall be established such that the premium rates charged for each rate basis type at the beginning of the rating period adjusted to a January 1st basis, equals:

the group base premium rate for the single rate basis type, multiplied by the rate basis type adjustment factor
multiplied by the benefit level rate adjustment,
multiplied by the area rate adjustment,
multiplied by the group size rate adjustment,
as may be applicable pursuant to 211 CMR 66.08.

66.09: Actuarial Filings

(1) Every carrier, as a condition of doing business under M.G.L. c. 176J and 211 CMR 66.00, must file an actuarial opinion as set forth in 211 CMR 66.90: *Appendix A* that the carrier's rating methodologies and rates comply with the requirements of M.G.L. c. 176J and 211 CMR 66.00. The actuarial opinion must be filed electronically to the Division of Insurance as of July 1, 2007, and for each year following, at least annually by January 1st for rates to be effective in the following period.

(2) Every carrier must maintain at its principal place of business a complete and detailed description of its rating practices including information and documentation which demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions, are in accordance with sound actuarial principles, and comply with the provisions of 211 CMR 66.00. This information must be made available to the commissioner upon request, but will remain confidential.

(3) Material Changes. Each carrier doing business under M.G.L. c. 176J and 211 CMR 66.00 shall notify the Commissioner regarding any material changes or additions to the actuarial methodology that is part of the annual filing described in 211 CMR 66.09 at least 30 days prior to the effective date of the change or addition, including amendments to rate basis types, rating factors, intermediary relationships, distribution networks and products offered within this market.

66.10: Eligibility Criteria: Exclusion/Limitation of Mandated Benefits in Health Benefit Plans

(1) Notwithstanding any law to the contrary, carriers may offer, as permitted under M.G.L. c. 176J, § 6, to eligible small businesses health benefit plans that exclude some or all mandated benefits, provided, however, that carriers offer such health benefit plans only to eligible small businesses which did not provide health insurance to their employees as of April 1, 1992.

(2) Notwithstanding 211 CMR 66.10(1), all health benefit plans offered to eligible small business must include the following:

(a) dependent coverage for newborn infants, adoptive children and newborn infants of a dependent as described in M.G.L. chs. 175, § 47C; 176A, § 8B; 176B, § 4C and 176G, § 4;

(b) continued health care coverage for divorced or separated spouses as described in M.G.L. chs. 175, § 110I; 176A, § 8F; 176B, § 6B and 176G, § 5A; and

(c) coverage for certain period after insured leaves insured group/limited extension of benefits as described in M.G.L. chs. 175, §§ 110D and 110G; 176A, § 8D; 176B, § 6A and 176G, § 4A.

(3) Carriers may require employers to contribute at least 50% of the health insurance premium for employees where the health benefit plan excludes some or all mandated benefits.

(4) A carrier may not issue or renew coverage for an eligible small business that excludes or limits mandated benefits if the eligible small business has had coverage that excludes or limits mandated benefits which has been in effect for a five year period.

66.11 Connector Seal of Approval Plans

(1) A carrier that actively markets or marketed a health benefit plan subject to M.G.L. c. 176J, and as of the close of the calendar year 2005, had a combined total of 5,000 or more eligible employees and eligible dependents who were enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses pursuant to its license under chapters 175, 176A, 176B or 176G, must file a health benefit plan with the Connector by the date established by the Connector. Enrollment in closed plans may be included in the total of 5,000.

(2) Effective January 1, 2007, a carrier that marketed a health benefit plan subject to M.G.L. c. 176J, and as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individual pursuant to its license under

chapter 175, 176A, 176B or 176G, must file a health benefit plan with the Connector by October 1st of the calendar year.

(3) Neither an eligible individual or eligible employee, nor an eligible dependent shall be considered to be enrolled in a health benefit plan issued pursuant to the carrier's authority under chapter 175, 176A or 176B if the health benefit plan is sold, issued, delivered, made effective or renewed to said employee or eligible dependent as a supplement to a health benefit plan subject to licensure under chapter 176G.

66.12: Disclosure

Every carrier must make reasonable disclosure in plain English to prospective small business insureds and prospective individual insureds, as part of its solicitation and sales material, of:

(1) for a small group, the participation requirements or participation rate adjustments of the carrier with regard to each health benefit plan;

(2) permissible limits on pre-existing conditions and waiting periods;

(3) for a small group, exclusion or limitation of mandated benefits;

(4) mandatory offer and renewal provisions; and

(5) rating limitations according to 211 CMR 66.08,

(6) requirements to phase-out any surcharge, or refund, that may be applied if one or more members were covered in the closed "Massachusetts Small Employer Health Reinsurance Plan" set forth in M.G.L. c. 176J, § 8 and

(7) availability of health benefit plans only to employers if said health benefit plans are offered by the employer to all full-time employees who live in the commonwealth; provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each specific or general blanket policy of insurance for all employees.

66.13: Filing and Reporting Requirements

(1) Carriers must file all health benefit plans offered under 211 CMR 66.00 with the Division of Insurance. A carrier that may require eligible small groups with five or fewer eligible employees and/or eligible individuals to obtain coverage through an intermediary, shall file a list of those intermediaries, with associated contact information as further provided in 211 CMR 66.13(3), prior to requiring those small groups or individuals to go through an intermediary to obtain small group health coverage.

(2) Carrier Reporting Requirements. Beginning March 31, 2008 and on or before March 31st each year thereafter, every carrier doing business under M.G.L. c. 176J and 211 CMR 66.00 must file electronically with the commissioner two copies of a report verified by at least two principal officers and covering its preceding calendar year; provided that, if the commissioner determines that a threat of financial impairment exists to the carrier, he or she may require that the report be made available prior to the March 31st deadline; provided further, Young Adult coverage data shall also be reported. In addition, every carrier shall file electronically an annual statement of the number of eligible individuals, eligible employees and eligible dependents, as of the close of the preceding calendar year, enrolled in a health benefit plan offered by the carrier.

The report must contain at least the following information in a format specified by the commissioner:

- (a) Total number of health benefit plans subject to M.G.L. c. 176J offered in Massachusetts during the preceding calendar year;
- (b) Number of Young Adult health benefit plans offered in Massachusetts during the preceding calendar year;
- (c) Number of health benefit plans subject to M.G.L. c. 176J, not including Young Adult health benefit plans, offered in Massachusetts during the preceding calendar year;
- (d) Total number of lives covered under health benefit plans subject to M.G.L. c. 176J offered in Massachusetts, as of the close of the preceding calendar year;
- (e) Number of young adults and their dependents covered under Young Adult health benefit plans offered in Massachusetts, as of the close of the preceding calendar year;
- (f) Number of eligible individuals and their eligible dependents covered under health benefit plans subject to M.G.L. c. 176J offered in Massachusetts, as of the close of the preceding calendar year;
- (g) Number of eligible employees and their eligible dependents covered under health benefit plans subject to M.G.L. c. 176J offered in Massachusetts, as of the close of the preceding calendar year;
- (h) Number of eligible employees and their eligible dependents covered under health benefit plans subject to M.G.L. c. 176J with limited or no mandated benefits offered in Massachusetts, as of the close of the preceding calendar year;
- (i) A statement as to whether a carrier requires individuals and/or groups of five or fewer eligible employees to enroll through an intermediary or through the Connector. If the carrier requires individuals and/or groups of five or fewer eligible employees to enroll through an intermediary the report must also contain:
 1. The name, address and phone number of the intermediary; and
 2. The intermediary's membership requirements, including any fees paid by members to join or maintain membership in the intermediary.

(3) Intermediary Requirements.

(a) Initial Filing. A carrier may condition the enrollment of an individual and/or a group of five or fewer eligible persons on the group enrolling through an intermediary only if the intermediary has at least 30 days prior to enrolling eligible individuals and/or eligible small businesses filed with the commissioner two copies of a report that contains at least the following information certified by an officer of the organization in a format specified by the commissioner:

1. A narrative description of the intermediary;
2. A copy of the basic organizational documents of the intermediary, such as the articles of incorporation, and amendments thereto;
3. A copy of the bylaws, rules, regulations or other similar documents regulating the conduct of the internal affairs of the intermediary;
4. A copy of the eligibility criteria for individuals or groups seeking to join the intermediary, including, but not limited to, the forms that individuals or members must complete prior to enrollment in the intermediary;
5. The number of Massachusetts members in the intermediary who buy health insurance through the intermediary, broken out by eligible groups and eligible individuals;
6. A listing of the services, other than health insurance, which the intermediary offers to its members;
7. The fees paid by members to join or maintain membership in the intermediary;
8. A description of each health benefit plan offered by the intermediary to the intermediary's members who are residents of Massachusetts;

9. A statement describing whether the intermediary conditions health benefit plan coverage on health status, claims experience, wellness program usage, tobacco usage, or duration of coverage since issue; and
10. A statement affirming that the intermediary was not formed for the purposes of obtaining insurance.

(b) Annual Filing. Every intermediary which has met the filing requirements of 211 CMR 66.13(3)(a) must, on or before April 1st of each year, file two copies of a report that contains at least the following information, in a format specified by the Commissioner:

1. The number of Massachusetts members in the organization who buy health insurance through the intermediary, broken out by eligible groups and eligible individuals;
2. A listing of the services, other than health insurance, which the intermediary offers to its members;
3. The fees paid by members to join or maintain membership in the intermediary;
4. A description of each health benefit plan offered by the intermediary to its members who are residents of Massachusetts;
5. A statement describing whether the intermediary conditions health benefit plan coverage on health status, claims experience, or duration of coverage since issue; and
6. A statement affirming that the intermediary was not formed for the purposes of obtaining insurance.

(c) Material changes. Every intermediary must file with the commissioner any material changes to the information on file within 30 days of the changes. Such material changes must be on a statement certified by an officer of the organization.

66.14: Severability

If any section or portion of a section of 211 CMR 66.00, or the applicability thereof to any person or circumstance is held invalid by any court of competent jurisdiction, the remainder of 211 CMR 66.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

66.90: Appendix A: Actuarial Opinion

CONTENTS OF ACTUARIAL OPINION TO BE FILED UNDER 211 CMR 66.09
ACTUARIAL OPINION

[For a company actuary]:

[I, _____(name and title of actuary)_____, am an _____(officer) (employee) _____ of _____(name of insurer)_____ and am a member of the American Academy of Actuaries. I am familiar with the applicable statutory provisions of M.G.L. 176J and 211 CMR 66.00.]

[For a consulting actuary]:

[I, _____(name and title of consulting actuary)_____ am associated with the firm of _____ (name of consulting actuarial firm)_____ and am a member of the American Academy of Actuaries. I have been involved in the preparation of the small employer and eligible individual health insurance premium rates under M.G.L. c. 176J of the _____ (name of insurer) _____ and am familiar with the applicable statutory provisions of M.G.L. 176J and 211 CMR 66.00.]

I have examined the actuarial assumptions and actuarial methodologies under M.G.L. c. 176J to be used by _____ (name of insurer) _____ in setting small employer and eligible individual health insurance premium rates and the procedures used by _(name of insurer)_ in implementing small employer and eligible individual health insurance rating plans under M.G.L. c. 176J. I have used one of the following methods as the basis of my opinion that the premium rates under M.G.L. c. 176J and procedures are in compliance with M.G.L 176J and 211 CMR 66.00 (check box that applies):

[If the actuary examined rating policies and procedures]:

1. I determined that nothing in the rating policies and procedures would allow an individual employer group's or eligible individual's claim experience, health history, or duration of coverage to be used in a manner that violates the rate restrictions of M.G.L. c. 176J and 211 CMR 66.00.

[If the actuary tested the results of rating procedures on the distribution of rates and renewal increases]:

2. I relied on listings and summaries of relevant data prepared by _____ (name and title of company officer responsible for preparing the underlying records if different from the certifying actuary). I tested a sample in each class of business and verified that, after being reclassified to common rate basis types and benefit design characteristics, the resultant rate differences were in compliance with M.G.L. 176J and 211 CMR 66.00.

In other respects, my examination included a review of the actuarial assumptions and actuarial methods and the tests of the actuarial calculations that I considered necessary.

I certify that for the period _____ to _____ the premium rates and rating plan under M.G.L. c. 176J of _____(insurer)_____ met the following requirements:

Check off the boxes to indicate that the carrier's actuarial assumptions, methods and rates comply with the relevant requirements of 211 CMR 66.00 in each specific area. Please use separate sheets for each class of business.

Class of business: _____

___ eligible employees and eligible individuals covered through plans offered by HMOs licensed under M.G.L. c. 176G

___ eligible employees and eligible individuals covered through preferred provider plans approved under M.G.L. c. 176I

___ eligible employees and eligible individuals covered through other indemnity plans licensed under M.G.L. c. 175, or organized M.G.L. c. 176A and 176B

Premium band, as specified in 211 CMR 66.08(1)

Rate basis categories (list):

- Single
- Two Adults
- One Adult and child(ren)
- Family

[] Please provide the ratio of the highest to lowest base premium rate for each rate basis type listed above for the health benefit plan with the greatest premium band differential:

Rate Basis Type	Ratio
-----------------	-------

[] Indicate which case characteristics are used in the premium band specified in 211 CMR 66.08(1):

- | | |
|---|---|
| <input type="checkbox"/> Age | <input type="checkbox"/> Wellness Program |
| <input type="checkbox"/> Participation Rate | <input type="checkbox"/> Tobacco Usage |
| <input type="checkbox"/> Industry | |

[] Additional rate adjustments, as specified in 211 CMR 66.08(2)

- | | |
|---|--|
| <input type="checkbox"/> Benefit Level Rate | <input type="checkbox"/> Rate Basis Type |
| <input type="checkbox"/> Area Rate | <input type="checkbox"/> Group Size Rate |

[] The range of Benefit Level Rate Adjustments is: _____

[] The range of Rate Basis Type Adjustments is:

- Single
- Two Adults
- One Adult (and children)
- Family

[] The range of Area Rate Adjustments is: _____

[] The range of Group Size Rate Adjustments is: _____

[] Do the Areas used comply with the areas listed in 211 CMR 66.08(2)(b)2.a. through g. ? (yes or no) If the answer is no, please list the areas used:

Please provide any further written comments regarding any information or statement made in this certification on separate attached sheets of paper.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, which standards form the basis of this statement of opinion.

[] This Opinion was filed electronically with the Division of Insurance on _____ [date] _____

_____ Signature of Actuary _____ Date

REGULATORY AUTHORITY

211 CMR 66.00: M.G.L. chs. 175, 176A, 176B, 176D, 176G, 176I and 176J.

(PAGES 415 THROUGH 422 ARE RESERVED FOR FUTURE USE.)