

211 CMR 151.00: Certified Group Purchasing Cooperatives

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211 CMR 151.01: Authority.

211 CMR 151.00 is promulgated in accordance with the authority granted to the Commissioner of Insurance by SECTIONS 21, 22, 23 and 34 of Chapter 288 of the Acts of 2010 and M.G.L. Chapter 176J, §§ 12 and 13.

151.02: Applicability and Purpose.

211 CMR 151.00 applies to Small Business Group Purchasing Cooperatives and any Carrier that offers for sale, provides or arranges for insured Health Benefit Plans to be offered through Small Business Group Purchasing Cooperatives in the Commonwealth. The purpose of 211 CMR 151.00 is to implement the provisions of SECTION 34 of Chapter 288 of the Acts of 2010 and M.G.L. c. 176J, §§ 12 and 13.

151.03: Definitions.

As used in 211 CMR 151.00, the following words mean:

Association: A chamber of commerce, trade association, or other organization, formed for purposes other than obtaining insurance.

Carrier: An insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization licensed under M.G.L. c. 176G; or an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. As used in 211 CMR 151.00, Carrier shall not include any entity offering a policy, certificate or contract that provides coverage solely for dental care services or vision care services.

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

Commonwealth Health Insurance Connector Authority or Connector: An authority established under M.G.L. c. 176Q to facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and groups.

Covered Benefits or Benefits: Health Care Services to which an Insured is entitled under the terms of a Health Benefit Plan.

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

Eligible Association Member: Any individual member of a Qualified Association who is a Massachusetts resident and who meets all eligibility criteria of the Qualified Association of which he or she is a member, and who meets all eligibility criteria necessary to be offered a Health Benefit Plan through the Group Purchasing Cooperative of which the Qualified Association is a member.

Eligible Dependent: The spouse, child or other dependent of an Eligible Employee or Eligible Association Member, subject to the applicable terms of the Health Benefit Plan covering such Eligible Employee or Eligible Association Member.

Eligible Employee: An employee who: (a) works on a full-time basis with a normal work week of thirty or more hours, including 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 Benefit 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 shall not require that an employee must have worked for an unreasonable length of time in order to qualify as an Eligible Employee. For the purposes of 211 CMR 151.00, five months shall be deemed to be an unreasonable length of time when determining whether an employee is an Eligible Employee.

Eligible Individual: An individual who is a Massachusetts resident and who is not seeking health insurance coverage to replace an employer-sponsored health plan for which the individual is eligible and which provides coverage that is at least actuarially equivalent to minimum creditable coverage.

Eligible Small Business: Any sole proprietorship, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent 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. A sole proprietorship, firm, corporation, partnership or association that was not in existence during the preceding year shall qualify as an Eligible Small Business if it has been in business at least three months and since its inception, on at least 50 percent of its working days, it has employed from among one to not more than 50 Eligible Employees, the majority of whom worked in Massachusetts. An entity is considered to be one Eligible Small Business if it is eligible to file a combined tax return, or if it is a group of affiliated companies with the same corporate parent. Except as otherwise specifically provided, provisions of 211 CMR 151.00 that apply to an Eligible Small Business will continue to apply through the end of the Rating Period in which such entity no longer meets the requirements of an Eligible Small Business.

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).

Finding of Neglect: A written determination by the Commissioner that a Carrier has failed to complete or file required information in the form and/or within the time required by 211 CMR 151.00.

Group Purchasing Cooperative: A Massachusetts nonprofit or not-for-profit corporation or association, approved as a Qualified Association by the Commissioner, all the members of which are part of a Qualified Association which negotiates with one or more Carriers for the issuance of Health Benefit Plans that cover Eligible Employees and Eligible Dependents of the Qualified Association's members.

Health Benefit Plan: A policy, contract, certificate or agreement of health insurance entered into, offered or issued by a Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services, including all Mandated Benefits according to standards identified by state or federal law or regulation.

Health Care Services: Services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

Insured: Any policyholder, certificate holder, subscriber, member or other person on whose behalf the Carrier is obligated to pay for and/or provide Health Care Services.

Mandated Benefit: A Health Care Service or category of health care provider which a Carrier is required by its licensing, or by law or regulation, to include in its Health Benefit Plan.

Material Change: A modification to any procedures or documents that substantially affects the rights or responsibilities of an Insured, Qualified Association, Group Purchasing Cooperative, Carrier or health care provider.

Network: A grouping of health care providers who contract with a Carrier or affiliated Carriers to provide Health Care Services to Insureds covered by any or all of the Carrier's or affiliated Carrier's Health Benefit Plans.

Participation Rate: The percentage of all Eligible Employees or Eligible Association Members electing to participate in a Health Benefit Plan; or the percentage of the sum of Eligible Employees and Eligible Dependents or the sum of Eligible Association Members and Eligible Dependents electing to participate in a Health Benefit Plan, out of the sum of all Eligible Employees and Eligible Dependents or out of the sum of all Eligible Association Members and Eligible Dependents, respectively. In any case, the numbers used to compute the percentage shall not include any Eligible Employee, Eligible Association Member, or Eligible Dependent who does not participate in the Group Purchasing Cooperative Health Benefit Plan, but who is enrolled in an employer-sponsored health plan.

Qualified Association: A Massachusetts nonprofit or not-for-profit corporation or other entity organized and maintained for the purpose of advancing the occupational, professional, trade, or industry interests of Association members, other than that of obtaining health insurance, and which has been in active existence for at least five years, which comprises at least 100 Association members, and membership in which is generally available to potential Association members of such occupation, profession, trade or industry without regard to the health condition or status of a prospective Association member, or the employees and dependents of a prospective Association member.

Qualified Association Member: An individual member or small business that is actively enrolled or registered as a member of a Qualified Association according to the bylaws of the Qualified Association and, where necessary, has paid any dues that are required by the Qualified Association for membership.

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

Service Area: The geographic area, as approved by the Commissioner, within which the Carrier has developed a Network of health care providers to afford adequate access to members for Covered Benefits.

Small Business Group Purchasing Cooperative: See definition of Group Purchasing Cooperative.

Waiting Period: A period immediately subsequent to the effective date of an Insured's coverage under a Health Benefit Plan during which the Health Benefit Plan does not pay for some or all Covered Benefits.

Wellness Program: A program designed to measure and improve individual health by identifying risk factors through diagnostic testing, establishing plans to meet specific health goals which include appropriate preventive measures, and/or other programs or plans that are designed to enhance health. For the purposes of 211 CMR 151.00, such risk factors may include, but shall not be limited to, demographics, family history, behaviors and measured biometrics.

Working Day: A day when a sole proprietorship, firm, corporation, partnership or association is actively engaged in business, with one or more employees working.

151.04: Approval as a Qualified Association.

- (1) An Association must be approved by the Commissioner as a Qualified Association according to the requirements set forth in 211 CMR 151.00 in order for its Eligible Association Members or its Qualified Association Members' Eligible Employees and Eligible Dependents to be offered Health Benefit Plans through a certified Group Purchasing Cooperative.
- (2) Approval as a Qualified Association pursuant to 211 CMR 151.00 shall remain in effect for 12 months, unless sooner suspended or revoked by the Commissioner. A Qualified Association's approval will expire after twelve months if the Qualified Association does not timely file its annual filing.
- (3) A Qualified Association may file an application to be a certified Group Purchasing Cooperative or participate in a Massachusetts nonprofit or a not-for-profit corporation that files an application to be a certified Group Purchasing Cooperative.
- (4) If the Commissioner determines that a Qualified Association has become ineligible to be a Qualified Association, he or she shall notify the Association of such determination, in writing, stating the reason(s) for such determination.

151.05: Application to be Approved as a Qualified Association.

- (1) An Association may file an application with the Commissioner to be approved as a Qualified Association. The application shall contain at least the following information, certified by an officer of the Association, in the format specified by the Commissioner:
 - (a) A narrative description of the Association, including the state in which the Association has been formed and headquartered;
 - (b) A copy of the basic organizational documents of the Association, such as the articles of incorporation, partnership agreement, or similar documentation and any amendments thereto;
 - (c) A copy of the bylaws, rules, regulations or other similar documents regulating the conduct of the affairs of the Association;
 - (d) A statement of the purpose of the Association that demonstrates that the Association was formed for the purpose of advancing the occupational, professional, trade, or industry interests of association members, other than that of obtaining health insurance;
 - (e) The number of Eligible Association Members and Eligible Small Businesses that are members of the Association;
 - (f) A listing of the services, other than health insurance, which the Association offers to its members;
 - (g) The fees paid by members of the Association to join or maintain membership in the Association;
 - (h) A statement, certified by an officer of the Association, indicating that the Association does not condition membership in the Association or the offer of any Association benefits on health status, claims experience, or duration of coverage since issue, and that the Association does not discriminate based on age, sex, race, creed, ethnicity, racial background, religious preference or any criteria that is not related to the occupational, professional, trade or industry interests of association members;
 - (i) A statement affirming that the Association was not formed for the purposes of obtaining insurance; and
 - (j) Any other information required by the Commissioner.
- (2) Any material change(s) to an application to be an approved Qualified Association shall be submitted to the Commissioner, along with a statement certified by an officer of the Qualified Association, within 30 days of such change(s).

151.06: Annual Filing by Qualified Association.

- (1) Every Qualified Association must submit to the Division, on or before April 1 of each year, an annual filing that contains at least the following information, in a format specified by the Commissioner:
 - (a) The number of Massachusetts members in the Qualified Association as of the preceding December 31;
 - (b) A description of the services, other than the offering of the purchase of health insurance, which the Qualified Association offers to its members;
 - (c) The fees paid by members to join and maintain membership in the Qualified Association;
 - (d) The number of Qualified Association Members' Eligible Employees and Eligible Dependents as of the preceding December 31;
 - (e) The number of Eligible Association Members, Eligible Employees and Eligible Dependents who are covered by Health Benefit Plans offered by a certified Group Purchasing Cooperative as of the preceding December 31;
 - (f) A statement, certified by an officer of the Qualified Association, indicating that the Qualified Association does not condition membership in the association or the offer of any association benefits on health status, claims experience, or duration of coverage since issue, and that the Qualified Association does not discriminate based on age, sex, race, creed, ethnicity, racial background, religious preference or any criteria that is not related to the occupational, professional, trade or industry interests of Qualified Association members;
 - (g) A statement affirming that the Qualified Association was not formed for the purposes of obtaining insurance;
 - (h) If the Qualified Association is a participant in a Massachusetts nonprofit or a not-for-profit corporation that has applied for or been certified as a Group Purchasing Cooperative, then the Association shall identify said Massachusetts nonprofit or not-for-profit corporation; and
 - (i) Any other information required by the Commissioner.
- (2) Any material change(s) to an annual filing by a Qualified Association shall be submitted to the Commissioner, along with a statement certified by an officer of the Qualified Association, within 30 days of such change(s).

151.07: Certification as Group Purchasing Cooperative.

- (1) A Group Purchasing Cooperative must be certified by the Commissioner according to the requirements set forth in 211 CMR 151.00 in order to procure Health Benefit Plans for Eligible Association Members or Qualified Association Members' Eligible Employees and Eligible Dependents.
- (2) Certification as a Group Purchasing Cooperative pursuant to 211 CMR 151.00 shall remain in effect for 12 months, unless sooner suspended or revoked by the Commissioner.
- (3) There shall be no more than six certified Group Purchasing Cooperatives operating in the Commonwealth at the same time.
- (4) Certified Group Purchasing Cooperatives may offer Health Benefit Plans only to Eligible Association Members and Qualified Association Members' Eligible Employees and Eligible Dependents.
- (5) The Commissioner shall have the discretion to limit the number of Insureds to whom a certified Group Purchasing Cooperative may offer a Health Benefit Plan.
- (6) A nonprofit or not-for-profit corporation or approved Qualified Association may submit an application to be a certified Group Purchasing Cooperative at any time after June 1, 2011, but applications only will be considered if there are fewer than six certified Group Purchasing Cooperatives in existence on the date of receipt of such application by the Division and if there are fewer than 85,000 Insureds participating in certified Group Purchasing Cooperatives.
- (7) An application to be a certified Group Purchasing Cooperative must be submitted to the Division at least 90 days prior to the date upon which the applicant, if so certified, intends to offer Health Benefit Plans in the Commonwealth.

151.08: Application to be Certified Group Purchasing Cooperative.

- (1) Any Qualified Association, nonprofit, or not-for-profit corporation seeking certification as a Group Purchasing Cooperative pursuant to M.G.L. c. 176J, § 12 shall submit to the Division an application that contains at least the following, and any other information required by the Commissioner, in a format specified by the Commissioner.
 - (a) Internal Operations Plan.
 1. A copy of basic organizational documents, such as articles of incorporation, articles of association, partnership agreement, trust

agreement or any other applicable documents establishing the applicant and all amendments thereto;

2. A list of the Board of Directors or similar policy-making body of the applicant, including the name, principal occupation and employer of each person;
3. A copy of the bylaws, rules and regulations, or other similar document regulating the conduct of the applicant's internal affairs;
4. A copy of the organizational chart of the applicant, including titles in the areas of marketing, administration, enrollment, grievance procedures, contract negotiation and financial matters;
5. A narrative of the facilities and personnel of the applicant, including but not limited to the organizational structure of the applicant;
6. A description and map of the Service Area in which the applicant would propose to offer Health Benefit Plans and Wellness Programs to Eligible Association Members and Qualified Association Members' Eligible Employees and Eligible Dependents;
7. A power of attorney authorizing the Commissioner to accept service of process for any legal actions commenced against the applicant, if the applicant is not domiciled in the Commonwealth;
8. A plan for the yearly publication and distribution to Insureds of health insurance rates, and the location of and telephone number(s) for Covered Benefits, including Emergency Services;
9. A statement of the procedures used to maintain member confidentiality involving medical records, and procedures for maintaining quality assurance studies and contractual provisions in provider agreements; and
10. A detailed description of the formal internal grievance systems, including procedures for the registration of grievances and procedures for resolution of grievances.

(b) Wellness Program.

1. A statement of inpatient and outpatient utilization review measures;
2. A statement of actuarial review and certification of actuarial assumptions made regarding utilization as applied to projected financial statements; and

3. A description of wellness monitoring and information technology systems that are consistent with the requirements of 211 CMR 151.15.

(c) Marketing Plan.

1. A marketing plan describing the Service Area population and existing medical care utilization rates for inpatient and outpatient services in existing facilities in the Service Area;
2. The anticipated enrollment in Health Benefit Plans offered by the applicant in each Service Area in which the applicant will operate; and
3. A statement of the size, organization, accountability and marketing methods of the marketing staff of the applicant.

(d) Member Agreements and Services.

1. A copy of the proposed agreement between the applicant and the Qualified Association(s), which agreement shall not have rules that are more restrictive than the following:
 - a. The Group Purchasing Cooperative shall not charge a Qualified Association a fee greater than \$10,000 to join the Group Purchasing Cooperative;
 - b. The Group Purchasing Cooperative shall not charge a Qualified Association an annual enrollment fee that is greater than the reasonable cost of administering group purchasing programs;
 - c. The Group Purchasing Cooperative shall not require more than 180 days notice from a Qualified Association that it intends to withdraw from the Group Purchasing Cooperative; and
 - d. The Group Purchasing Cooperative shall not impose penalties on a Qualified Association that withdraws from the Group Purchasing Cooperative that are more restrictive than precluding such Qualified Association from contracting with the same Group Purchasing Cooperative for a period of three years after withdrawal.
2. A copy of all proposed agreement(s) between the applicant and the Qualified Association Members, which agreement(s) shall not have rules that are more restrictive than the following:
 - a. The Group Purchasing Cooperative shall not charge a Qualified Association Member a fee greater than \$500 per Eligible Employee or Eligible Association Member to join the Group Purchasing Cooperative;

- b. The Group Purchasing Cooperative shall not charge a Qualified Association Member an annual health plan administration fee that is greater than the reasonable cost of administering group purchasing programs;
- c. The Group Purchasing Cooperative shall not require more than 30 days notice from a Qualified Association Member that the member intends to terminate the health coverage obtained through the Group Purchasing Cooperative; and
- d. The Group Purchasing Cooperative shall not impose penalties on a Qualified Association Member terminating health coverage obtained through the Group Purchasing Cooperative that are more restrictive than precluding such Qualified Association Member from obtaining health coverage through the same Group Purchasing Cooperative for a period of three years.

(e) Contractual Arrangements.

1. Contracts between the applicant and any entity that is responsible for conducting member enrollment, administration, coordination of Wellness Programs, or similar activities; and
2. Written procedures the applicant will employ to determine Qualified Association Member eligibility to obtain health coverage through the certified Group Purchasing Cooperative.

(f) Financial Plan.

1. Audited financial reports for at least the prior three fiscal years of the applicant's existence;
2. Business plan regarding the fees that the applicant will charge Qualified Associations, Eligible Association Members, Eligible Small Businesses, Eligible Employees and Eligible Dependents who obtain health coverage through the applicant;
3. Financial statements, as listed below, which project the results of the applicant's operations for the next three calendar years:
 - a. Balance sheet;
 - b. Statement of income and expense;
 - c. Statement of changes in capital and surplus;
 - d. Statement of cash flow;
 - e. Capital expenditure; and
 - f. Repayment schedule for any existing or anticipated loans or alternative financing arrangements.

The projection for year one shall consist of projected results for quarters one, two, three and four;

4. A statement indicating when the applicant estimates that enrollment and other income from operations will equal expenses;
5. Projections must be accompanied by detailed statements of underlying assumptions used and the bases thereof, including, but not limited to, projected administrative fees and documentation of the method used to derive the administrative fees and the number of Qualified Associations, Eligible Association Members, Eligible Small Businesses, Eligible Employees and Eligible Dependents that pay those fees. If available, independent evaluations and assessment of these statements also should be included;
6. A copy of the vote, or portion thereof, of the applicant's board of directors or governing body designating the permissible forms of investments of the Group Purchasing Cooperative's funds and any limitations thereon;
7. Letters of financial support, credit, bond, or loan guarantee or other financial guarantee to the applicant;
8. A detailed statement of the applicant's plan to establish and maintain reserves or other funds as determined necessary to cover any risks projected and not otherwise assumed by a Carrier, reinsurer, or other entity;
9. A detailed statement of current and projected reserve establishment calculations, amounts, purpose and use of reserve, and assumptions and bases thereof, including, but not limited to, identification of reserves set aside to meet uncovered reinsurance items;
10. A statement of the applicant's plans for a surety bond or a deposit of cash or sureties as a guarantee that the obligation to the members will be performed;
11. A statement of insurance or funded self-insurance coverage for:
 - a. Protection against loss of property and liability; and
 - b. Worker's compensation to protect against claims arising from work-related injuries;
12. A listing of the applicant's legal, accounting and actuarial representatives by name and address;

13. A statement of the applicant's accounting system and organization, management and internal controls, and method of estimating and handling incurred but not reported liabilities; and
 14. A statement of fidelity bond coverage of all of the applicant's officers and employees entrusted with the handling of funds.
- (2) A Group Purchasing Cooperative's application will not be considered complete until all information required by 211 CMR 151.00 has been received by the Division. The applicant shall respond to any request for additional information from the Division within 15 days of receipt of the request.
 - (3) A Group Purchasing Cooperative applicant shall submit any material change(s) to the application to the Division within 30 days after any officer or employee first becomes aware of the material change(s) to the application.
 - (4) The Division shall notify an applicant, in writing, that it has been certified as a Group Purchasing Cooperative or denied certification as a Group Purchasing Cooperative.

151.09: Review of Application to be Certified Group Purchasing Cooperative.

- (1) The Commissioner shall review complete applications to be a certified Group Purchasing Cooperative only if fewer than six Group Purchasing Cooperatives are then so certified and if there are fewer than 85,000 Insureds participating in such certified Group Purchasing Cooperatives. If fewer than six Group Purchasing Cooperatives are so certified and if there are fewer than 85,000 Insureds participating in such certified Group Purchasing Cooperatives, then the Commissioner shall provide notice that applications to be a certified Group Purchasing Cooperative will be reviewed, if such applications are submitted to the Division during the time period established by the Commissioner.
- (2) If, at any time, the number of applicants to be a certified Group Purchasing Cooperative exceeds the six Group Purchasing Cooperatives permitted by M.G.L. c. 176J, § 12(b), the Commissioner will consider which of the applicants better satisfies the criteria set forth in 211 CMR 151.00 and provides access to Group Purchasing Cooperative Health Benefit Plans in a geographic area or to a type of small business or to a type of Association not currently served by other certified Group Purchasing Cooperatives.
- (3) Upon receipt of a complete application to be a certified Group Purchasing Cooperative, the Commissioner shall review the submitted materials to determine whether the applicant meets the following requirements:
 - (a) The applicant has a corporate and organizational structure capable of supporting the Covered Benefits to be offered;

- (b) The applicant has authorized the Commissioner to accept service of process for any legal actions commenced against the Group Purchasing Cooperative if it is not domiciled in Massachusetts;
- (c) The applicant has a business plan to administer the Group Purchasing Cooperative and its Wellness Program such that Group Purchasing Cooperative's Health Benefit Plans and Wellness Program are available and accessible to Insureds;
- (d) The applicant has enrollment systems that:
 - 1. Ensure that no Qualified Associations, Eligible Association Members, Eligible Small Businesses, Eligible Employees or Eligible Dependents are denied coverage due to health condition, age, race or sex, and ensure that Health Benefit Plans are not made available to other than Eligible Association Members, Eligible Small Businesses, Eligible Employees and Eligible Dependents;
 - 2. Ensure that those Eligible Small Businesses that purchase Health Benefit Plans through the Group Purchasing Cooperative do not have more than 50 Eligible Employees and ensure that those Eligible Small Businesses will be disenrolled at the end of the current plan year if the number of Eligible Employees increases beyond 50 in total; and
 - 3. Ensure consistent application of open enrollment rules and periods according to documented procedures for Qualified Association Members to enter and exit Group Purchasing Cooperatives for the purchase of Health Benefit Plans;
- c. The applicant has marketing systems that present Group Purchasing Cooperative Health Benefit Plans to Eligible Association Members and Qualified Association Members' Eligible Employees and Eligible Dependents, which may include marketing through duly licensed insurance producers, the Commonwealth Health Insurance Connector Authority, and direct sales through mass marketing and internet sales;
- d. The applicant has billing systems that ensure that no Eligible Small Business in a Group Purchasing Cooperative is charged a rate higher than what the Carrier would charge to a similarly situated Eligible Small Business that is not a participant in a Group Purchasing Cooperative;
- e. The applicant has contractual agreements that adequately protect the interests of Group Purchasing Cooperative Insureds, including agreements with Carriers to offer Health Benefit Plans to Group Purchasing Cooperative Insureds that ensure that all such Health Benefit Plans include coverage for state Mandated Benefits;

- f. The applicant has Wellness Programs administered by the Group Purchasing Cooperative or its designees that, at a minimum:
 - 1. Are actuarially similar to Wellness Programs that may be offered through the Commonwealth Health Insurance Connector Authority and meet the standards of 211 CMR 151.15;
 - 2. Have received an enrollment commitment from at least 33 percent of all Eligible Association Members and Eligible Employees; and
 - 3. Have reasonable systems, which shall comply with any applicable sections of the Americans with Disability Act and any other federal requirements, under which Wellness Program participants may record their participation in, and the Group Purchasing Cooperative may monitor Wellness Program participants' participation in available health management programs;
 - g. The applicant has informational systems ensuring the appropriate and efficient use of Covered Benefits;
 - h. The applicant has operations financially capable of coordinating the Group Purchasing Cooperative's Wellness Program with Eligible Association Members or Eligible Small Businesses;
 - i. The applicant has a plan for marketing the Group Purchasing Cooperative and for attracting Eligible Association Members and Eligible Small Businesses to obtain coverage from the Group Purchasing Cooperative;
 - j. The applicant has adequate provider networks to guarantee that all services contracted for will be accessible to Insureds without delays detrimental to health; and
 - k. The applicant has sufficient financial reserves or other resources to meet financial obligations.
- (4) The Commissioner shall notify an applicant to become a certified Group Purchasing Cooperative in writing if the reviewed application is denied, and the Commissioner shall state the reasons for the denial of the reviewed application.

151.10: Renewal Application for Certified Group Purchasing Cooperative.

- (1) Each year, at least 90 days prior to the anniversary of the certified Group Purchasing Cooperative's certification date, in a format specified by the Commissioner, every certified Group Purchasing Cooperative must file with the Commissioner a renewal application verified by at least two principal officers of the certified Group Purchasing Cooperative, covering the preceding calendar year.

- (2) Failure on the part of a certified Group Purchasing Cooperative to timely file its annual renewal application shall result in the expiration of such Group Purchasing Cooperative's certification.
- (3) The renewal application must contain the following information, and any other information requested by the Commissioner, in a format specified by the Commissioner:
 - (a) The number of Health Benefit Plans offered through the certified Group Purchasing Cooperative during the preceding calendar year;
 - (b) The number, as of the close of the preceding calendar year, of Qualified Associations through which the certified Group Purchasing Cooperative offers coverage;
 - (c) The total number, as of the close of the preceding calendar year, of Eligible Association Members, Eligible Small Businesses, Eligible Employees, and Eligible Dependents in each Qualified Association;
 - (d) The number, as of the close of the preceding calendar year, of Eligible Association Members, Eligible Employees and Eligible Dependents in each Qualified Association that are covered by a Health Benefit Plan through the certified Group Purchasing Cooperative;
 - (e) The number, as of the close of the preceding calendar year, of total lives covered by a Health Benefit Plan through the certified Group Purchasing Cooperative;
 - (f) The number, on a per-monthly basis over the preceding calendar year, of Eligible Association Members, Eligible Employees and Eligible Dependents that participated in a Wellness Program offered through the certified Group Purchasing Cooperative;
 - (g) Aggregated statistical information collected by the certified Group Purchasing Cooperative regarding the effectiveness of each measured element of the Wellness Program(s); and
 - (h) A compilation by Service Area of all oral and written complaints and grievances received by the certified Group Purchasing Cooperative during the preceding calendar year.

151.11: Material Changes to Certified Group Purchasing Cooperative.

Certified Group Purchasing Cooperatives shall submit material changes to their initial or renewal application for certification as a Group Purchasing Cooperative at least 30 days before the effective date of such changes.

151.12: Audit of Certified Group Purchasing Cooperative.

The Commissioner may at any time authorize an audit of any certified Group Purchasing Cooperative in order to verify compliance with the provisions of 211 CMR 151.00. All costs associated with such audit shall be borne by the subject certified Group Purchasing Cooperative.

151.13: Non-renewal of Certification of Group Purchasing Cooperative.

- (1) If a renewal application for certification as a Group Purchasing Cooperative is denied, the Commissioner shall notify the Group Purchasing Cooperative, in writing, stating the reason(s) for such denial.
- (2) A certified Group Purchasing Cooperative whose renewal application has been denied shall cease offering new Health Benefit Plans in the Commonwealth.
- (3) A certified Group Purchasing Cooperative whose renewal application has been denied may request a hearing on such denial within 30 days of the date of the denial.

151.14: Suspension or Revocation of Certification of Group Purchasing Cooperative.

If any certified Group Purchasing Cooperative is in a financially unsound condition, or if it substantively fails to comply with any of the requirements of M.G.L. c. 176J, 211 CMR 151.00, or any other provision of law or regulation, the Commissioner may, after a hearing, suspend or revoke the certification of such Group Purchasing Cooperative.

151.15: Standards for Certified Group Purchasing Cooperative Wellness Programs.

- (1) The Wellness Program shall be administered by the certified Group Purchasing Cooperative or by an entity that has contracted with the certified Group Purchasing Cooperative. The certified Group Purchasing Cooperative shall be responsible for all the features of the Wellness Program, which shall be conducted pursuant to a written plan, under the supervision of a properly trained health practitioner and staffed by appropriately trained and qualified personnel, and shall include a documented process to:
 - (a) Conduct health risk assessments, at least annually, of all Insureds participating in the Wellness Program, according to a tool that has been accredited by the National Committee on Quality Assurance;
 - (b) Develop health maintenance or improvement goals with each Wellness Program participant based upon factors derived from the participant's health risk assessment;

- (c) Record each participant's activities designed to address wellness goals and, as appropriate, provide workplace or other geographically convenient locations to monitor;
 - (d) Monitor participants' progress toward meeting wellness goals and assign trained and qualified lifestyle coaches to assist participants to keep on track with goals and develop ways to encourage continued activities to achieve desired goals through financial or other incentives, periodic reminders and/or motivational interviewing;
 - (e) Measure, at least annually, the Wellness Program's effectiveness at developing goals that improve participants' health status, promoting adherence to planned goals and changing overall trends in health status; redesigning the program to address new or persistent health issues;
 - (f) Maintain the confidentiality of each participant's health risk assessment and progress toward reaching the participant's individualized health goals; and
 - (g) Maintain Wellness Programs consistent with state and federal statutes, regulations and guidelines, including required accommodations made to those with physical or other disabilities that could prevent participation in standard programs.
- (2) The Wellness Program shall, at minimum, be designed to address the prevention and management of heart disease, stroke, diabetes, asthma, cancer and the following risk factors:
- (a) High blood pressure;
 - (b) Smoking;
 - (c) Adult and child obesity;
 - (d) Stress and work-life balance;
 - (e) Inactivity;
 - (f) Unhealthy diets (high sugar, high sodium, high saturated fat and low fiber);
 - (g) Elevated cholesterol;
 - (h) Elevated blood glucose; and
 - (i) Workplace policies/environments that may impact individual health.

- (3) The criteria for the Wellness Program shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of appropriate medical professionals.
- (4) A certified Group Purchasing Cooperative shall comply with a Carrier's Wellness Program data processing systems to the maximum extent possible so as to enable the certified Group Purchasing Cooperative to effectively provide guidance to Eligible Association Members, Eligible Small Businesses, Eligible Employees and Eligible Dependents regarding targeted Wellness Programs.

151.16: Health Benefit Plans Offered By Carriers through Certified Group Purchasing Cooperatives.

- (1) As a condition of continued offer of small group insured Health Benefit Plans, a Carrier that, as of the close of the preceding calendar year, has a combined total of at least 5,000 eligible individuals, Eligible Employees and Eligible Dependents who are enrolled in Health Benefit Plans sold, issued, delivered, made effective or renewed shall be required to annually file a Health Benefit Plan and accompanying rates according to the Health Benefit Plan's specifications developed by a certified Group Purchasing Cooperative for the Group Purchasing Cooperative's consideration, if said certified Group Purchasing Cooperative requests such Health Benefit Plan proposals for its next plan year.
- (2) Acceptable Health Benefit Plan features shall include, but not be limited to, the following:
 - (a) All Health Benefit Plans offered by a Carrier through each certified Group Purchasing Cooperative are to include Covered Benefits required for Health Benefit Plans offered by the Carrier and comply with all relevant statutory and regulatory requirements for insured Health Benefit Plans.
 - (b) For Eligible Small Businesses or Qualified Associations of five or fewer Eligible Employees or Eligible Association Members, a Carrier may require a Participation Rate not to exceed 100 percent. For Eligible Small Businesses or Qualified Associations of six or more Eligible Employees or Eligible Association Members, a Carrier may require a Participation Rate not to exceed 75 percent.
 - (c) Pre-existing condition limitations and Waiting Periods are to be applied by a Carrier in Health Benefit Plans offered through each certified Group Purchasing Cooperative in the same manner that they are applied to individuals and small employer groups enrolling in coverage outside the certified Group Purchasing Cooperative.
 - (d) Continuation of coverage provisions are to be applied by a Carrier in Health Benefit Plans offered through each certified Group Purchasing Cooperative in the

same manner that they are applied to individuals and small employer groups enrolling in coverage outside the certified Group Purchasing Cooperative.

- (e) Managed care practices, including utilization review, quality assurance, credentialing of health plan providers, and dissemination of required consumer materials are to be applied by a Carrier in a Health Benefit Plan offered through each certified Group Purchasing Cooperative in the same manner that they are applied to individuals and small employer groups enrolling in coverage outside the certified Group Purchasing Cooperative.
- (3) Requirements of Premium Rates Offered by Carriers are as follows:
- (a) For all rates offered by a Carrier through each certified Group Purchasing Cooperative, the Carrier shall apply rating rules, including rating bands, rating factors and the value of rating factors in the same manner as the Carrier applies those rules to insured Health Benefit Plans offered to individuals and small employer groups outside the certified Group Purchasing Cooperative.
 - (b) Carriers may apply for the Commissioner's approval to make limited deviations from required application of rating factors.
 - (c) The rates offered by a Carrier through each certified Group Purchasing Cooperative are to be based on those group base premium rates that apply to individuals and small employer groups enrolling outside the Group Purchasing Cooperative but may differ based on the following:
 - 1. A benefit rate adjustment factor that would apply to the certified Group Purchasing Cooperative product if its Covered Benefits are different than those that apply outside the certified Group Purchasing Cooperative;
 - 2. A cooperative adjustment factor that would reflect the relative difference in the projected experience of the members projected to be enrolled in Health Benefit Plans through the certified Group Purchasing Cooperative relative to the projected experience of the members projected to be enrolled in Health Benefit Plans outside the certified Group Purchasing Cooperative; and
 - 3. Any other rate adjustment factor that has received prior approval in writing from the Commissioner.

151.17: Carrier Filing and Reporting Requirements.

- (1) On or before April 1 of each year, in a format specified by the Commissioner, every Carrier doing business in the Commonwealth through a certified Group Purchasing Cooperative must file with the Commissioner a report verified by at least two principal officers of the Carrier and covering its preceding calendar year.

- (2) The report must contain the following information, and any other information requested by the Commissioner, in a format specified by the Commissioner; provided that the report shall also include Young Adult Coverage data, if applicable.
 - (a) The number of Health Benefit Plans offered by the Carrier through a certified Group Purchasing Cooperative during the preceding calendar year;
 - (b) The number, as of the close of the preceding calendar year, of Eligible Association Members, Eligible Employees and Eligible Dependents covered by a Health Benefit Plan from the Carrier through each certified Group Purchasing Cooperative; and
 - (c) The number, as of the close of the preceding calendar year, of total lives covered by a Health Benefit Plan from the Carrier through each certified Group Purchasing Cooperative.
- (3) The Commissioner may issue a Finding of Neglect to a Carrier for failure to complete or to file required information in the form and/or within in the time required by 211 CMR 151.00.
- (4) Upon a Finding of Neglect, the Carrier's ability to offer Health Benefit Plans to certified Group Purchasing Cooperatives may be limited at the discretion of the Commissioner.
- (5) If the Commissioner determines that a threat of financial impairment exists to the Carrier, the Commissioner may require that the Carrier's report be made available prior to the April 1 deadline.

151.18: Severability.

If any section or portion of a section of 211 CMR 151.00, or the applicability thereof to any person or circumstance is held invalid by any court of competent jurisdiction, the remainder of 211 CMR 151.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.