211 CMR 66.00: SMALL GROUP HEALTH INSURANCE

Section

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.

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, through an association, a group purchasing cooperative, 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 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.

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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 Authority created under M.G.L. c. 176Q.

Connector Seal of Approval: the approval given by the Connector 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 M.G.L. c. 176J, § 10; 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 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

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(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 and who is not seeking individual 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 as defined by Connector regulation 956 CMR 5.00. For the purposes of 211 CMR 66.00, continuation coverage under M.G.L. c. 176J, § 9 or under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), shall not be considered an employer-sponsored health plan.

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 1st 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.

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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;

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(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, certificate holder, 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.

Office of Patient Protection: the office in the Department of Public Health established by M.G.L. c. 111, § 217(a).

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%.

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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. Eligible persons under age 19, including eligible individuals, eligible employees and eligible dependents, and 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 M.G.L. 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 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.

Small Business Group Purchasing Cooperative or Group Purchasing Cooperative: a Massachusetts nonprofit or not-for-profit corporation or association, approved as a qualified association by the commissioner under M.G.L. c. 176J, § 12, that has been certified by the commissioner as a group purchasing cooperative and which negotiates with one or more carriers for the issuance of health benefit plans that cover employees, and the employees' dependents, of qualified association's members.

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.

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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.

Wellness Program or Health Management Program: an organized system designed to improve the overall health of participants through activities that may include, but shall not be limited to, education, health risk assessment, lifestyle coaching, behavior modification and targeted disease management.

66.05: Minimum Coverage Standards

(1) Offerings and Open Enrollment.

(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. Every carrier must accept for enrollment any eligible individual or eligible small business that seeks to enroll in a health benefit plan provided, however, that a carrier shall only contract to sell a health benefit plan to an eligible individual or eligible dependent during the annual mandatory open enrollment period of July 1st to August 15th, except as follows:

1. A carrier shall enroll an eligible individual, as defined in § 2741 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 300gg-41(b) ("HIPAA-eligible individual"), into a health plan if such individual requests coverage within 63 days of termination of any prior creditable coverage.

2. A carrier shall enroll an eligible individual into a health plan if such individual requests coverage within 63 days of experiencing a qualifying event. A carrier shall enroll the eligible dependent(s) of an eligible individual into a health plan if coverage is sought for the eligible dependent(s) within 30 days of a qualifying event. For the purposes of 211 CMR 66.05(1)(a)2., qualifying events shall include, but not be limited to: marriage, birth or adoption of a child, court-ordered care of a child, or any other event as may be designated by the commissioner.

3. A carrier shall enroll an eligible individual who has been granted a waiver by the Office of Patient Protection.

(b) Coverage issued to eligible individuals under 211 CMR 66.05(1)(a) shall become effective on the first day of the month following receipt of a completed application, except for coverage issued pursuant to 211 CMR 66.05(1)(a)1. through 3. which shall become effective within 30 days of the carrier's receipt of a completed application or approved waiver form. For completed applications received in the last five days of a calendar month, carriers shall give eligible individuals the option of whether:

1. coverage will become effective as of the first day of the month following receipt of the completed application; or

2. coverage will become effective as of the first day of the second month following receipt of the completed application. Carriers shall notify applicants that opting to receive coverage effective the first day of the month following submission of a completed application may result in processing delays, including delays in the receipt of an identification card or entry into the carrier's enrollment system, if the carrier is

unable to

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process the completed application by the first of the month. Coverage issued to small businesses under 211 CMR 66.05(1)(a) shall become effective within 30 days of a carrier's receipt of a completed application. Any coverage issued pursuant to 211 CMR 66.05(1)(a)1. through 3. to be effective in any month other than during the annual open enrollment period shall be for a term of less than one year ending July 31st.

(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 but 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.

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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 may implement a policy for issuance of a health benefit plan to an eligible individual who has a demonstrated history of canceling his or her coverage under a health benefit plan with any carrier prior to the end of that eligible individual's contract renewal period, including, but not limited to, a policy that said eligible individual be required to pay a portion of his or her annual premium in advance, provided that said policy is submitted to the division for approval prior to implementation. 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, failure to provide information necessary to determine eligibility, and, for an eligible small business, carrier requirements for employer group premium contributions; or

4. 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)4. 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) 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 the carrier’s 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:

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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.

(o) A carrier that offers a health benefit plan that:

1. provides or arranges for the delivery of health care services through a closed network of health care providers; and

2. has reported in its annual membership filing that as of the close of the preceding calendar year that a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, were enrolled in health benefit plans sold, issued, delivered, made effective or renewed by the carrier to eligible small businesses or eligible individuals, shall, by no later than September 1st of that year, offer to all eligible individual and small businesses in at least one geographic area at least one plan with either a reduced or selective network of providers or a plan in which providers are tiered and member cost sharing is based on the tier placement that meets the standards of 211 CMR 152.04. The goal is for these plans to be available throughout the commonwealth. For the purpose of 211 CMR 66.05(1)(o)2., "geographic area" shall mean the largest metropolitan region in a carrier's service area, subject to the approval of the commissioner. A carrier may use a plan containing multiple networks to meet the geographic area standard described in 211 CMR 66.05(1)(o)2. The benefit rate adjustment factor of this plan will be such that this plan's group base premium shall be at least 12% lower than the group base premium of the carrier's most actuarially similar plan with a non-selective or non-tiered network of providers (a "32A Plan"). On and after January 1, 2012, carriers shall only classify or reclassify providers in a carrier's 32A Plan by benefit level tiers based on quality performance as measured by the standard quality measure set and by cost performance as measured by health status adjusted total medical prices and relative prices. When applicable quality measures are not available, a carrier shall tier providers either solely on adjusted total medical expenses or relative prices or both.

3. A carrier may delay implementation of its 32A Plan as set forth in 211 CMR 66.05(1)(o)2. if the carrier applies for and obtains written approval from the commissioner by no later than May 1st of the year in which the carrier is first required to offer a 32A plan.

(p) A carrier that offers a health benefit plan that has reported in its annual membership filing that as of the close of the preceding calendar year that a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, were enrolled in health benefit plans sold, issued, delivered, made effective or renewed by the carrier to eligible small businesses or eligible individuals, shall be required, as a condition of continued offer of coverage to eligible small employers and eligible individuals outside of group purchasing cooperatives, to respond to all documents from certified group purchasing cooperatives requesting submission of product and rate proposals for offer by the group purchasing cooperative to eligible members of the qualified associations. The responses will be submitted to the group purchasing cooperatives in a timely and complete manner.

(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;

66.05: continued

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.

(e) Nothing in 211 CMR 66.00 shall prohibit a carrier from offering coverage to an eligible individual or eligible dependent who seeks coverage pursuant to 211 CMR 66.05(1)(a)1. through 3.

(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 M.G.L. 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.

(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, provided that the carrier collects sufficient information to make such a determination and makes such information available to the commissioner upon request;

(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 that eligible individual or eligible small business's health benefit plan and the specific reason(s) for the nonrenewal in accordance with the carrier's filed criteria. A carrier must provide at least 90 days prior notice to affected eligible individuals or eligible small businesses of the carrier's intention to discontinue offering a particular type of health benefit plan.

(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).

66.06: continued

(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 M.G.L. c. 176J.

(9) In no event shall a carrier deny an eligible individual renewal of a health benefit plan, except as permitted in 211 CMR 66.06(3), provided, however, that any eligible individual whose policy was issued outside of the annual open enrollment described in 211 CMR 66.05(1) who seeks to renew that policy must renew during the next open enrollment period.

(10) If a carrier re-verifies the eligibility of renewing individuals or small businesses, it shall complete the re-verification at least 90 days prior to renewal.

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 issued to eligible persons aged 19 and over, including eligible individuals, eligible employees, or eligible dependents, 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.

66.07: continued

(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, or the individual seeking coverage is an eligible individual as defined in 211 CMR 66.05(1)(a)1., the previous coverage is presumed to be reasonably actuarially equivalent to the new health benefit plan.

Notwithstanding 211 CMR 66.07(7), a carrier shall not impose on a HIPAA-eligible individual the requirement that said individual's prior creditable coverage be reasonably actuarially equivalent to that individual's new coverage.

(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; however no pre-existing condition limitation shall be imposed on an eligible person under age 19, including an eligible individual, eligible employee, or eligible dependent.

66.08: Restrictions Relating to Premium Rates

Premiums charged to eligible small groups and eligible individuals, excluding eligible small groups within a group purchasing cooperative, shall be based on the collective experience of the covered small groups and individuals enrolled outside group purchasing cooperatives. Premiums charged to eligible small groups within a group purchasing cooperative will be based on premiums available outside of all cooperatives, adjusted by that group purchasing cooperative's specific group purchasing cooperative adjustment factor. 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 group purchasing cooperative, or through the Connector, or directly, also 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, 2011, the group base premium rates charged by a carrier to each eligible small group or eligible individual outside all group purchasing cooperatives 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 outside all group purchasing cooperatives 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) The group base premium rates charged by a carrier to each eligible small group within any group purchasing cooperative 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 within that group purchasing cooperative with the lowest group base premium rate

for that rate basis type within that class of business in that eligible small group.

66.08: continued

(c) 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. An eligible individual or eligible small group's overall increase in the group base premium rate shall not exceed 15% above the increase in the base premium rate for that eligible individual or eligible small group, as established by the commissioner pursuant to St. 2010, c. 288, § 66. All rate adjustment factors applied outside group purchasing cooperatives are to be applied at the same level and in the same manner to similarly situated small groups within a group purchasing cooperative:

1. Age Rate Adjustment Factor. If a carrier applies an age rate adjustment factor to eligible individuals or eligible small groups, the carrier must apply the age rate adjust-ment factor on a year-to-year basis so that it is interpolated gradually for each age between the low and high factors such that the impact of the age rate adjustment is spread across the ages in each range to smooth the overall impact of the application of the age rate adjustment factor to the eligible individuals or eligible small groups.
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.

66.08: continued

(2) Additional Rate Adjustments. Carriers may apply the additional factors identified in 211 CMR 66.08(2) outside the 0.66 to 1.32 equivalent rate band.

(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.

66.08: continued

(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.

(f) Group Purchasing Cooperative Adjustment Factor. A carrier may apply a group purchasing cooperative adjustment factor that is specific to one group purchasing cooperative and based on the actuarially projected different experience of that cooperative's potential covered members compared to the experience of those eligible individuals and eligible employers who have coverage outside all of the group purchasing cooperatives. Any such group purchasing cooperative adjustment factor must be applied uniformly to the rates of all persons who obtain coverage through that group purchasing cooperative. Notwithstanding the requirements of 211 CMR 66.09(2)(a), a carrier shall submit all group purchasing cooperative adjustment factors to the division for review upon request.

(3) In addition to the factors identified in 211 CMR 66.08(1) and (2), the commissioner annually may adopt changes to the permissible rating factors to modify the derivation of group base premium rates on or before July 1st that will apply to rates effective the following January 1st.

(4) 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,
multiplied by the group purchasing cooperative adjustment factor,
as may be applicable pursuant to 211 CMR 66.08.

66.09: Submission and Review of Rate Filings

(1) Definitions. For rate filings submitted pursuant to 211 CMR 66.09(2), the following definitions also shall apply:

(a) Adjusted Minimum Medical Loss Ratio: a specific carrier's aggregated medical loss ratio for all its merged market plans which was less than the minimum medical loss ratio, but at least 1% greater than the carrier's equivalent loss ratio for the 12-months prior to the carrier's present rate filing.

(b) Capital Costs and Depreciation Expenses: all expenses associated with depreciation (depreciation for EDP, equipment, software, and occupancy); capital acquisitions (acquisition of capital assets, including lease payments that were paid or incurred during the year); capital costs on behalf of a hospital or clinic (expenditures for capital and lease payments incurred or paid during the year on behalf of a hospital or clinic (or part of a partnership, joint venture, integration or affiliation agreement); and other capital (other costs that are directly associated with the incurring of capital costs, such as legal or administrative costs, incurred or paid during the year).

(c) Charitable Contributions Expenses: all contributions to tax-exempt foundations and charities, not related to the company business enterprises.

(d) Claim Completion Method: any actuarial method used to quantify claims which

have been incurred but not yet paid.

66.09: continued

(e) Claims Operations Expenses: all expenses associated with claims adjudication and adjustment of claims, appeals, claims settlement, coordination of benefits processing, maintenance of the claims system, printing of claims forms, claim audit function, electronic data interchange expenses associated with claims processing and fraud investigation.

(f) Distribution Expenses: all expenses associated with distribution and sale of products, including commissions, producer, broker and benefit consultant fees, other fees, commission processing and account reporting to brokers, agents and producers.

(g) Financial Administration Expenses: all expenses associated with underwriting, auditing, actuarial, financial analysis, investment-related expenses (not included elsewhere), treasury, and reinsurance.

(h) General Administration Expenses: all expenses associated with payroll administration expenses and payroll taxes (salaries, benefits and payroll taxes); real estate expenses (company building and other taxes and expenses of owned real estate, excluding home office employee expenses and rent (not allocated elsewhere) and insurance on real estate); regulatory compliance and government relations (Federal and State reporting, rate filing, state and federal audits, tax accounting, lobbying, licensing and filing fees, preparation and filing of financial, utilization, statistical and quality reports and administration of government programs); board, bureau or association fees (Board of Directors, Bureau and association fees paid or expensed during the calendar year); other administration (information technology, senior management, outsourcing (not allocated elsewhere), insurance except on real estate, equipment rental, travel (not allocated elsewhere), certification and accreditation fees, legal fees and expenses before administrative and legal bodies, and other general administrative expenses); and negative adjustment for reimbursement from uninsured plans (all revenue receipts from uninsured plans (including excess pharmaceutical rebates and administrative fees net of expenses) and reimbursements from fiscal intermediaries including administrative fees net of expenses from the government).

(i) Marketing and Sales Expenses: all expenses associated with billing and member enrollment (group and individual billing, member enrollment, premium collection and reconciliation functions); customer service and member relations (individual, group or provider support relating to membership, enrollment, grievance resolution, specialized phone services and equipment, consumer services and consumer information); product management, marketing and sales (management and marketing of current products, including product promotion and advertising, marketing materials, changes or additions to current products, sales, pricing and enrollee education regarding coverage prior to the sale); and product development: (product design and development for new products not currently offered, major systems development associated with the new products and integrated system network development).

(j) Medical Administration Expenses: all expenses associated with quality assurance and cost containment (health and disease management and wellness initiatives (other than for education), health care quality assurance, appeals, case management, fraud detection and prevention, utilization review, practice protocol development, peer review, outcomes analysis related to existing products, nurse triage, medical management and other medical care evaluation activities); wellness and health education (wellness and health promotion, disease prevention, member education and materials, provide education and outreach services); and medical research (outcomes research, medical research programs and development of new medical management programs not currently offered, major systems development and integrated system network development).

(k) Minimum Medical Loss Ratio: the higher of the medical loss ratio in state or federal law that applies to individual and small group health insurance premiums. The minimum medical loss ratio for small group health insurance is 88% for coverage issued in 2011, 90% for coverage issued through September 30, 2012 and the minimum medical loss ratio in the current NAIC methodology for calculating medical loss ratio in all other years.

(l) Miscellaneous Expenditures Expenses: all other not classified expenses including all collection and bank service charges, printing, office supplies, postage and telephone (not allocated elsewhere).

(m) Network Operations Expenses: all expenses associated with provider contracting negotiation and preparation, monitoring of provider compliance, field training with

providers, provider communication materials and bulletins, administration of provider capitation and settlements, hospital and physician relations, medical policy procedures, network access fees and credentialing.

66.09: continued

(n) Normalized per Member per Month Claim Cost: claim cost expressed per member per month adjusted to represent a member whose rating factors equal one.

(o) Taxes, Assessments and Fines Paid to Federal, State or Local Governments (as Expenses): all expenses associated with taxes (state premium taxes, state and local insurance taxes, federal taxes, except taxes on capital gains, state income tax, state sales tax and other sales taxes not included with the cost of goods purchased); assessments, fees and other amounts paid to regulatory agencies (assessments, fees or other amounts paid to state or local government and does not include taxes or fines or penalties paid to any government agency); and fines and penalties paid to regulatory agencies (penalties and fines paid to government agencies).

(2) Submission of Rate Filings.

(a) Every carrier, as a condition of doing business under M.G.L. c. 176J and 211 CMR 66.00, must file all changes to small group base premium rates and to small group rating factors electronically at least 90 days before their proposed effective dates. All base premium rates and rating factors are subject to disapproval if they do not meet the requirements of M.G.L. c. 176J.

(b) Small group rate filing materials submitted for review by the Division shall be deemed confidential and exempt from the definition of public records in M.G.L. c. 4, § 7, clause 26.

(3) Content of Rate Filings. A carrier's submission shall be submitted in a format specified by the commissioner and shall show the company's development of the filed rates and contain at least the following information:

(a) Summary rate information for each product, including:

1. proposed rate increase over rates in effect 12 months before proposed effective date;
2. number of currently enrolled groups/members impacted by the proposed increase:
   a. number of employer groups and covered employees/dependents renewing by month; and
   b. individual accounts and covered individuals/dependents renewing by month;
3. average effective rate increase for all persons covered under proposed rate changes; and
4. maximum increase for any group or individual covered under the proposed rate change.

(b) Changes to cost-sharing and/or benefits for each product relative to the 12 month period prior to the proposed effective date of the filed rates for the following:

1. inpatient hospital care;
2. outpatient hospital care, with separate experience for:
   a. radiological/laboratory/pathology costs; and
   b. all other outpatient costs;
3. health care providers, with separate experience for:
   a. medical and osteopathic physicians;
   b. mental health providers; and
   c. all other health care practitioners;
4. outpatient prescription drugs; and
5. supplies.

For information submitted pursuant to 211 CMR 66.09(3)(c) through (j), a carrier's submission shall provide details in aggregate.

(c) Number of member months of coverage reported for each of the latest available 12 months for products issued or renewed according to M.G.L. c. 176J, as well as the number of member months projected to be impacted by the proposed rate increase.

(d) Actual premium revenue per member per month reported for each of the latest available 12 months for products issued or renewed according to M.G.L. c. 176J, as well as projected premium revenue per member per month based on the proposed rates and the projected membership impacted by the rate increase. The premium revenue also should be shown on a normalized per member per month basis with a description of normalization factors that are used and how they take into account the average enrollee risk for the permitted risk characteristics. The statement of actual premium revenue should explain any differences between what is included in this filing and what normally

is included in the carrier's reported financial statements.

66.09: continued

(e) Actual fee-for-service claims payment experience and utilization experience reported for each of the latest available 12 months for products issued or renewed according to M.G.L. c. 176J, on both an aggregate and normalized per member per month basis, that was used in the development of the filing's rate filing and the projected claims payments and utilization experience for the period impacted for the proposed rate increase, differentiating among:

1. inpatient hospital care;
2. outpatient hospital care, with separate experience for:
   a. radiological/laboratory/pathology costs; and
   b. all other outpatient costs;
3. health care providers, with separate experience for:
   a. medical and osteopathic physicians;
   b. mental health providers; and
   c. all other health care practitioners.
4. outpatient prescription drugs; and
5. supplies.

The analysis should explain any differences between what is included in this filing and what normally is included in the carrier's financial statements. The carrier also should submit projected trends in fee-for-service utilization per thousand members, costs per service and per member per month costs for each of the noted service types that the carrier is using to project historic claims forward to the period for which the rates will be effective. The trend information should include the actuarial basis for all changes in fee-for-service trends, including all relevant studies used to derive the factors. The analysis also should explain the completion method used to derive the incurred-but-not-reported (IBNR) claims for the claim experience study.

(f) The carrier's historic capitation or global payments, as well as calculated normalized per member per month cost experience, relevant to products issued or renewed according to M.G.L. c. 176J and used in the development of the filing's rate making, reported for each of the latest available 12 months of experience, differentiating among:

1. inpatient hospital care;
2. outpatient hospital care, with separate experience for:
   a. radiological/laboratory/pathology costs; and
   b. all other outpatient costs;
3. health care providers, with separate experience for:
   a. medical and osteopathic physicians;
   b. mental health providers; and
   c. all other health care practitioners;
4. outpatient prescription drugs; and
5. supplies.

The analysis should explain any differences between what is included in this filing and what normally is included in the carrier's financial statements. The carrier also should submit projected trend factors that the carrier is using to project historic claims forward to the period for which the rates will be effective. The trend information should include the actuarial basis for all changes in capitation or global payments trends, including all relevant studies or information that the carrier believes will lead to changes in capitation and global payments costs.

(g) The carrier's other non-fee-for-service and non-capitation payments to providers, as well as calculated normalized per member per month cost experience, relevant to products issued or renewed according to M.G.L. c. 176J and used in the development of the filing's rate making, for at least the latest available 12 months of experience. The other payments would include all bonus/incentives tied to provider performance and other payments not tied to service or performance. The carrier also should submit the projected trends factor in the other provider payments per member per month costs that the carrier is using to project historic claims forward to the period for which the rates will be effective. The trend information should include the actuarial basis for all changes in these payments, including all relevant studies or information that the carrier believes will lead to changes in these other provider payment costs.

66.09: continued

(h) The carrier's administrative expenses and per member per month administrative expenses relevant to products issued or renewed according to M.G.L. c. 176J and used in the development of the filing's rate making, for the two years prior to the submission of the rate filing for each of the following categories:

1. expenses for financial administration;
2. expenses for marketing and sales;
3. expenses for distribution;
4. expenses for claims operations;
5. expenses for medical administration, with specific detail on costs related to programs that improve health care quality;
6. expenses for network operations;
7. expenses for charitable contributions;
8. expenses for general administration;
9. expenses for taxes, assessments and fines paid to federal, state or local governments;
10. expenses for capital costs and depreciation;
11. expenses for miscellaneous expenditures described in detail; and
12. total administrative expenses [subtotaling 211 CMR 66.09(3)(h)1. through 11.].

The carrier also should submit projected increases in administrative expenses per member per month costs that the carrier is using to project historic claims forward to the period for which the rates will be effective. The trend information should include an explanation for all significant changes in the company's administrative expenses due to one-time costs, including where changes in administrative expenses may be caused by regulatory requirements or efforts to contain health care delivery costs, an explanation of the projected cost and cost per member per month that can be attributed to each regulatory requirement or effort to contain health care delivery costs and the method that the carrier is using to allocate any companywide expenses to the small group line of business.

(i) The carrier's contribution-to-surplus, relevant to products issued or renewed according to M.G.L. c. 176J, both in the aggregate, on a normalized per member per month basis and as a per cent of premium for the two years prior to the submission of the rate filing. The carrier also should identify the contribution-to-surplus included in the rate filing on a per member per month basis and as a per cent of premium and should provide a detailed explanation of the reasons that the contribution-to-surplus has been filed at that level, as well as the contribution-to-surplus levels that the carrier is using in all other lines of coverage. The carrier should describe the method used to quantify the contribution-to-surplus in the proposed rates.

(j) The three-year historic medical loss ratio for the rates, relevant to products issued or renewed according to M.G.L c. 176J and the projected medical loss ratios for the one year period during which rates will be in effect.

(k) A detailed description of all cost containment programs the carrier is employing or will employ during the rating period to address health care delivery costs and the realized past savings and projected savings from all such programs.

(l) If the carrier intends to pay similarly situated providers within its provider networks different rates of reimbursement, a detailed description of the bases for the different rates including, but not limited to:

1. quality of care delivered;
2. mix of patients;
3. geographic location at which care is provided; and
4. intensity of services provided.

(m) Interrogatories, including:

1. Detailed explanations of methodological changes that have been employed by the carrier in development of rates, loads or factors since most recent filing, including:
    a. pricing methodology;
    b. administrative expense loads;
    c. contribution-to-surplus loads;
    d. rating factors;
    e. cost containment and quality improvement efforts;
    f. provider contracting initiatives;
    g. methodology for setting claim reserves;
    h. size of the claim reserve relative to the total incurred claims estimate for the

most recent year of experience; and

66.09: continued

i. reconciliation of claim payments in filing to claims system and recorded claim payments in filed financial statements.

2. Detailed explanations of the development of claims completion factors, including:

a. explanation of the source of the filing's completion factor;

b. high level analysis of derivation of factor;

c. explanation of whether factor is consistent with reserve development for financial reporting;

d. explanation of level of conservatism used in developing factor;

e. demonstration for each calendar month in the claim experience period of how any incurred but unreported claims were estimated using the carrier's completion factor(s); and

f. a comparison of estimated claim payments provided in the most recent prior filing to current estimated claims costs for the same time period.

3. Detailed explanations of planned changes in methods of paying providers, including:

a. Three year historical analysis of the proportion of provider services reimbursed according to the following methodologies:

i. discounted or undiscounted charges;

ii. payment based on fee schedules;

iii. incentive-based fee-for-service (payment is initially withheld and repaid to provider based on provider performance);

iv. fee-for-service payments with bonus/incentives tied to performance (additional payments above and beyond the standard payment where the amount of the additional payment is based on provider performance;

v. capitation payments (fixed payment per member per month for a specified set of services);

vi. risk sharing adjustment to provider payments made in a fiscal year-end settlement whereby provider payments are increased or decreased based on provider performance that is shared with the health plan; and

vii. payments not tied to provision of specific service or performance.

b. Explanation of projected distribution of provider services to be reimbursed using these methodologies in the rating period and an explanation of the impact on expected costs for covered member services.

c. Explanation of the weighting of the criteria that the plan uses for evaluating performance-based provider payments, including:

i. patient satisfaction;

ii. outcomes measurement;

iii. participation or adherence to processes to improve quality;

iv. measured achievement of quality standards;

v. measured achievement of utilization efficiency standards;

vi. measured achievement of cost containment goals; and

vii. measured implementation of technology necessary to improve efficiency.

d. Explanation of a carrier's plan to change the distribution of payment systems to providers in the future and how this will impact future rate filings.

4. Benefit level rate adjustment factors, including:

a. explanation of the process used to ensure that the benefit level rate adjustment factor reflects the actuarial value of benefits in one plan versus another;

b. explanation of any effect that Connector-offered plans may have on plans not offered through the Connector; and

c. explanation of any reasons that a filing may reflect different benefit level trends for different products and how this may be incorporated into the rate analysis.

5. Rate adjustment factors, including:

a. illustration of how a sample member's factor is calculated for each rate adjustment factor (*i.e.*, age, industry, participation rate, group size, participation in wellness programs, participation in smoking cessation programs, geographic region, group purchasing cooperative); and

b. explanation of the methodology used to aggregate each member's factors to arrive at a total rate adjustment factor for the individual or small group, showing how the factors are applied to arrive at the final premium charged to each

dependent coverage tier in an individual contract or small group policy.

66.09: continued

6. Credibility analyses, including:
   a. explanation of how actuary conducted a credibility analysis of available data; and
   b. explanation of adjustments made due to concerns over the credibility of available data and basis for said adjustments, including an explanation of national or regional data that was used in place or in combination with plan data when developing factors.
7. A discussion of the impact of overestimates or underestimates of medical trend in prior year rate filings on the development of the current proposed rate.
8. A calculation of the carrier's risk-based capital level at the end of the most recent calendar quarter and the risk-based capital level for the prior calendar year.
9. Overall rate impacts, including:
   a. Illustration of rate changes for each product, after application of the rating factors, and any changes in the demographic make-up of the individual or group contract using the following ranges:
      i. reduction of 10% or more;
      ii. reduction between 5.01% and 9.99%;
      iii. reduction of 5% or less (including no change);
      iv. increase of less than 5%;
      v. increase of between 5.01% and 9.99%;
      vi. increase of between 10.0% and 14.99%; and
      vii. increase of 15% or more.
   b. Explanation of the reasons, distinguishing by base rate changes and the application of rate adjustment factors, for which rates of any groups increase by more than 15%.

(n) Any other information requested by the commissioner, including, but not limited to, any information requested by the commissioner on behalf of the National Association of Insurance Commissioners.

(o) Each rate filing shall be accompanied by a supporting actuarial memorandum prepared and certified by a qualified member of the American Academy of Actuaries and an Actuarial Opinion.

(4) Review of Filing.

(a) A carrier's filing will not be considered to be complete until all materials required by M.G.L. c. 176J and 211 CMR 66.00 have been received by the Division.

(b) A carrier shall respond to any request for additional information by the Division within five days of the date of the Division's request. Failure to respond to the Division's request within five business days may result in a delay of the Division's review of the filing and a delay in the proposed effective date of the filed small group rates.

(c) Every carrier shall include with any submission under 211 CMR 66.09(3) a cover letter summarizing the content in 211 CMR 66.09(3)(h)12., 66.09(3)(i) and 66.09(3)(j), and a statement indicating whether the carrier consents to a designation of presumptive disapproval pursuant to M.G.L. c. 176J, § 6(d). Group base premium rates will be presumptively disapproved as excessive if the rate filing does not meet the following standards:

1. Administrative Expense Standards. Group base premium rates will be presumptively disapproved if the filing's projected administrative expense loading component, not including taxes and assessments, increases by more than the most recent calendar year's increase in the New England medical CPI.
   a. The projected administrative expense loading component is the per member per month administrative expense described in 211 CMR 66.09(3)(h)12.
   b. The most recent calendar year's increase in the New England medical CPI shall be calculated by dividing the index value for the November period preceding the date of the filing by the same index value from the November period one year earlier. For the purpose of 211 CMR 66.09(4)(c)1.b., the New England medical CPI shall reflect the Consumer Price Indexes for All Urban Consumers (CPI-U), U.S. city averages and selected areas, for the Boston-Brockton-Nashua area.
2. Contribution-to-surplus Standards. Group base premium rates will be presumptively disapproved as excessive if the rate filing's contribution-to-surplus loading component exceeds 1.9% of the total filed group base premium rate.

a. The contribution-to-surplus loading component shall represent the per member per month contribution-to-surplus amount submitted in 211CMR 66.09(3)(i).

66.09: continued

b. If a carrier's Risk Based Capital Ratio, calculated according to the provisions of 211 CMR 25.00, falls below 300% for the four most recent consecutive quarters, the group base premium rates will be presumptively disapproved as excessive if the filing's contribution-to-surplus loading component exceeds 2.5% of premium.

3. Medical Loss Ratio Standards. Group base premium rates will be presumptively disapproved as excessive if the rate filing's projected aggregate medical loss ratio for all plans offered in the individual-small employer market is less than the Minimum Medical Loss Ratio.

a. The aggregate medical loss ratio shall be reported as submitted in 211 CMR 66.09(3)(j).

b. When a carrier's individual/small group base premium rates for a rating period would have been presumptively disapproved for failure only to meet the aggregate Minimum Medical Loss Ratio, the group base premium will not be presumptively disapproved if the aggregate loss ratio for all of the carrier's individual/small group plans was at least 1% higher than the carrier's equivalent medical loss ratio in the 12-months prior to the present filing. In this case, the filed medical loss ratio will be considered the Adjusted Minimum Medical Loss Ratio.

(5) Disapprovals.

(a) Rate filings may be presumptively disapproved with the consent of the carrier or presumptively disapproved by the commissioner as described in 211 CMR 66.09(4)(c). Rate filings also shall be disapproved by the commissioner if the benefits provided therein are unreasonable in relation to the rate charged, or if the rates are excessive, inadequate or unfairly discriminatory or do not otherwise comply with the requirements of M.G.L. c. 176J or 211 CMR 66.00. Changes to filed small group rating factors shall be disapproved by the Commissioner if found to be discriminatory or not actuarially sound. Notwithstanding the foregoing, where applicable, rate filings made under 211 CMR 66.00 also are subject to the provisions of regulations specifying the procedures for rate hearings on such rate filings.

(b) If a carrier's filing is presumptively disapproved with the carrier's consent, it shall be subject to a hearing to be scheduled to commence within 45 days of the carrier's submission of a complete filing. The commissioner retains the right to presumptively disapprove or disapprove the subject filing for reasons other than those identified by the carrier and to provide notice of such presumptive disapproval or disapproval to the carrier.

(c) If a carrier's filing is presumptively disapproved by the commissioner, it shall be considered disapproved.

(d) If the commissioner disapproves a carrier's proposed base rate(s) or proposed changes to rate adjustment factor(s), he shall notify the carrier in writing in accordance with the timing described below and he shall state the reason(s) for the disapproval, including whether the disapproval is presumptive.

1. If a carrier's submission is deemed complete and filed at least 120 days in advance of its proposed effective date, the commissioner shall notify the carrier of any disapproval no later than 75 days prior to the effective date of the carrier's filing.

2. If a carrier's submission is deemed complete and filed between 119 and 105 days in advance of its proposed effective date, the commissioner shall notify the carrier of any disapproval no later than 60 days prior to the effective date of the carrier's filing.

3. If a carrier's submission is deemed complete and filed between 104 and 90 days in advance of its proposed effective date, the commissioner shall notify the carrier of any disapproval no later than 45 days prior to the effective date of the carrier's filing.

(e) In the event of a disapproval under 211 CMR 66.09(5)(a) through (d), a carrier shall comply with the following procedures:

1. the carrier shall not quote, issue, make effective, deliver or renew health benefit plans in the Commonwealth using disapproved base rates. The carrier shall quote, issue, make effective, deliver or renew all health benefit plans using base rates as in effect 12 months prior to the proposed effective date of the disapproved base rates. 211 CMR 66.09(5)(a) through (d) also applies to new health benefit plans whose base rates are disapproved. In calculating premiums, the carrier may apply any applicable, but not previously disapproved, base rate adjustment factors;

66.09: continued

2. the carrier shall recalculate applicable rates for all affected health benefit plans and shall issue rate quotes and make all health benefit plans available through all distribution channels, including intermediaries, the Connector, licensed insurance producers and the carrier's website, but in no event more than ten calendar days after the carrier's receipt of the disapproval;

3. the carrier shall notify all affected policyholders of the disapproval within ten calendar days of the carrier's receipt of the disapproval;

4. the carrier shall promptly provide notice of all material changes to the evidence(s) of coverage to all affected individuals and groups in accordance with M.G.L. c. 176O, § 6(a) and 211 CMR 52.13(6);

5. within ten days of receipt of the disapproval, the carrier may request a hearing on the disapproval. The hearing shall be adjudicatory and de novo;

6. presumptive disapproval hearings shall commence within 45 days of the submission of a complete rate filing and other disapproval hearings shall commence within 15 days of the commissioner's receipt of the carrier's request for a rate hearing. In either case, notice of the public hearing will be given to, or advertised in, newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford, and Lowell. The commissioner shall issue a written decision within 30 days after the conclusion of the hearing.

7. the commissioner shall issue an order as to the requested rates within 30 days following the conclusion of the public hearing. The commissioner may base a final disapproval of the filing on reason(s) other than those identified in the initial disapproval. If the filing is disapproved and a revised filing conforming to the terms of the decision is resubmitted in accordance with applicable regulations specifying the procedures for rate hearings on such rate filings, it shall be placed on file, thereby making those rates available for use.

(6) Appeals. Any order, decree, or judgment of the Supreme Judicial Court modifying, amending, annulling, or reversing a decision of the commissioner disapproving a rate filing, and any further decision of the commissioner pursuant to such an order, decree, or judgment that affects the overall rate not disapproved shall be effective as ordered.

(7) Maintaining Records. 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.

(8) Methodology for Calculating and Reporting Refund, Rebate or Credit Calculations.

(a) Unless otherwise determined by the Commissioner, for the purposes of M.G.L. c. 176J, § 6, carriers are to calculate and submit a rebate calculation form each calendar year by May 31st for the previous calendar year in accordance with the current NAIC methodology for calculating rebates. When completing the form for Massachusetts, carriers are to use the Minimum Medical Loss Ratio, or if applicable, the Adjusted Minimum Medical Loss Ratio, that applies in the year for which the calculation was completed.

(b) If the calculation illustrates that a refund or rebate is warranted, the carrier shall submit a detailed plan, for the commissioner's approval, that will provide a detailed description of the manner in which the carrier will refund the excess premium to those individuals or small employers who were covered during the prior calendar year or an explanation of the reasons that the carrier proposes not to make a refund or rebate. The amount of the rebate will be based on the individual's or small employer's relative share of the premiums that were paid to the carrier during the calendar year.

(c) A carrier shall communicate within 60 days to all individuals and small employers that were covered under plans during the relevant 12-month calendar year that such individuals and small employers qualify for a refund which may take the form of either a refund on the premium for the applicable 12-month period, or if the individual or small employer are still covered by the carrier, a credit on the premium for the subsequent 12-month period.

66.09: continued

(d) The basis for all refunds issued shall equal the amount of a carrier's earned premium that exceeds that amount necessary to achieve the Minimum Medical Loss Ratio, or if applicable, the Adjusted Minimum Medical Loss Ratio, calculated using data reported by the commissioner. The commissioner may authorize a waiver or adjustment of the refund requirement if the commissioner determines that issuing such refunds would result in financial impairment for the carrier or if the commissioner determines that such refunds are *de minimus*. The aggregate of any *de minimus* amount not refunded shall be used to reduce overall premiums.

(e) Refunds shall be paid annually by June 30th of the year following the calendar year of the rebate calculation.

(f) Carriers who issue refunds shall keep records of all refunds made to affected individuals and small groups for inspection by the Division of Insurance.

(g) No individual or small employer may assign his or her or its rights to such premium adjustments to another person or entity.

(h) If a carrier fails to make refunds, rebates or premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits he deems necessary.

(9) Actuarial Opinion. 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 at least annually by January 1st for rates to be effective in the following period.

(10) Information. 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.

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 and that such health benefit plans shall not exclude or limit mandated benefits for more than a five year period.

(2) Notwithstanding 211 CMR 66.10(1), all health benefit plans offered to eligible small businesses 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 a certain period after an 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.

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 M.G.L. chs. 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.

66.11: continued

(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 M.G.L. chs. 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 M.G.L. c. 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 M.G.L. c. 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;

(5) rating limitations according to 211 CMR 66.08; and

(6) 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: Health Plan 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. On or before March 31st every carrier doing business under M.G.L. c. 176J and 211 CMR 66.00 annually 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.

66.13: continued

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 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.

66.13: continued

(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 outside group purchasing cooperatives 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]:

66.90: continued

[ ] 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):
___ Age ___ Wellness Program
___ Participation Rate _____ Tobacco Usage
___ Industry

[ ] Additional rate adjustments, as specified in 211 CMR 66.08(2)___ Benefit Level Rate __ Rate Basis Type
___ Area Rate __ Group Size Rate
___ Intermediary Discount

[ ] 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: _____

66.90: continued

[ ] 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:

[ ] I have also examined any group purchasing cooperative adjustment factors used by _____ (name of insurer) _____ and certify that any factor of less than 1.0 is based on the actuarially projected different experience of that cooperative's potential covered members compared to the experience of those eligible individuals and eligible employers who have coverage outside all of the group purchasing cooperatives and that such factor is applied uniformly to the rates of all persons who obtain coverage through that group purchasing cooperative.

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.

NON-TEXT PAGE