

TRANSITIONAL REINSURANCE PROGRAM IN MASSACHUSETTS AS REQUIRED UNDER THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT

*A report to the
Clerks of the Senate and House of Representatives,
the Senate Committee on Ways and Means and
the House Committee on Ways and Means*

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Acknowledgments

Kevin P. Beagan and Chet Lewandowski, staff members within the Health Care Access Bureau of the Division of Insurance (“Division”), have prepared this report in order to examine a Transitional Reinsurance Program, as required under the federal Patient Protection and Affordable Care Act (“ACA”). This report was developed to respond to Section 33 of Chapter 118 of the Acts of 2012 which, effective June 19, 2012, struck M.G.L. c. 176J, § 8 and replaced it with the following:

The commissioner may study the implementation of, establish, if warranted, and supervise a transitional reinsurance program pursuant to section 1341 of the federal Affordable Care Act or, if the commissioner believes that such program is not appropriate for the commonwealth, to apply for any appropriate waiver from the requirement to implement such program. The commissioner may promulgate regulations to enforce this section; provided, however, that before a waiver is sought or a transitional reinsurance program is to be implemented, the commissioner shall provide a report on the decision and the details of any proposed program to the clerks of the senate and house of representatives and the senate and house committee on ways and means.

Health Care Access Bureau staff have relied on information derived by consulting actuaries and attorneys advising the Division and the Commonwealth Health Insurance Connector Authority (“Connector”) as co-chairs of a working group established within the Massachusetts ACA Implementation Task Force charged with examining the so-called “3R” (Risk Adjustment, Reinsurance and Risk Corridor) Implementation within Massachusetts. Staff also relied on cost estimates derived from conversations with Pool Administrators, Inc., which administered the Massachusetts Small Group Health Reinsurance Program and the Massachusetts Nongroup Health Reinsurance Program, until those programs were terminated in 2008.

Staff further relied on proposed draft guidelines and payment notices issued by the federal Department of Health and Human Services (“HHS”) on November 30, 2012 to explain the federal rules for the implementation of Transitional Reinsurance Program under the ACA.

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Executive Summary

The federal Patient Protection and Affordable Care Act (“ACA”) requires that a federally qualified transitional Reinsurance Program (“Reinsurance Program”) be operational in each state for its individual health coverage market for the period between January 1, 2014 and December 31, 2016.¹ According to Center for Consumer Information and Insurance Oversight (“CCIIO”) within the federal Department of Health and Human Services (“HHS”), the Reinsurance Program is designed to reduce the potential losses of carriers as they shift into the guaranteed issue of individual health coverage. If a state does not apply to operate its own Reinsurance Program, HHS will administer the Reinsurance Program in that state.

The ACA requires that, nationally, group health plans be assessed \$20 billion between 2014 and 2016 to finance the cost of the Reinsurance Programs; Massachusetts health plans are expected to pay over \$100 million in assessments for this program in the Commonwealth. HHS published proposed rules for the Reinsurance Program on November 26, 2012, which delineate baseline standards for reinsurance coverage and administrative operations whether the Reinsurance Program is administered by HHS or by an individual state. Although a state may apply to administer a richer reinsurance program than that required by the federal rules, a state must assess insurers for any additional costs associated with that more generous program.

Massachusetts had reinsurance plans covering the small employer market beginning in 1992 and the individual market beginning in 1996. These state-run plans were terminated in 2008, subsequent to the health reforms set forth in Chapter 58 of the Acts of 2006.

In evaluating whether the Commonwealth should apply to operate its own Reinsurance Program or defer its operation to the federal government, the Division considered the following options:

1. Massachusetts obtains a waiver from the requirement to have a Reinsurance Program.

CCIIO staff has indicated to the Division that it believes that Reinsurance Program waivers are not permitted under the ACA. The Division has submitted a written request to CCIIO for a formal determination as to whether such a waiver request may be submitted for consideration. In response, CCIIO has indicated that HHS has no authority to grant such a waiver.²

¹See 42 U.S.C. § 18061 (Section 1341 of the ACA).

²See Appendix D.

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2. Massachusetts applies to administer its own Reinsurance Program.

HHS would collect assessments on insurers in the same manner in which it does so in other states. The Commonwealth would process reinsurance payments according to HHS rules. Although Massachusetts would pay administrative costs of the program up front and get retroactive transfers from HHS for those costs, these transfers may not be sufficient to pay Massachusetts-specific costs associated with the program. The Commonwealth may increase reinsurance coverage under the program, but the state would need to assess insurers for any costs exceeding the HHS assessment.

3. Massachusetts does not apply to administer its own Reinsurance Program and the federal government administers the Program.

HHS, rather than Massachusetts, is responsible for all administrative costs associated with the program. The Commonwealth may not implement a different reinsurance program until 2017.

Based on the uncertainty associated with the payment of administrative costs, the limitations imposed under the proposed HHS rules, as well as CCIIO's indication that HHS cannot waive the Reinsurance Program requirement, the Division has determined, in accordance with M.G.L. c. 176J, § 8, that it is not warranted for the Division to implement, establish and supervise the transitional Reinsurance Program for Massachusetts. Because the Division will not apply to administer this program, according to the provisions of the ACA, HHS will administer the Commonwealth's Reinsurance Program.

Massachusetts' Guarantee Issue Health Markets

Massachusetts has a strong market for individual and small employer health plans covering approximately 635,000 small employer members and 85,000 individual plan members as of December 31, 2011. Eligible small employers with between one and 50 eligible employees and eligible individuals have equal access to health benefit plans on a guarantee issue basis, with premiums only permitted to vary within a 2:1 permissible range following the application of allowable rating factors.

Small Group Health Insurance

1991 Reforms

When M.G.L. c. 176J³ was implemented on December 31, 1991, Massachusetts required carriers offering coverage to eligible small groups⁴ to offer products on a guaranteed issue basis according to the rate and product standards that were promulgated in 211 CMR 66.00. Generally, any product offered to one eligible small employer was required, by statute, to be offered to all other eligible employers; this included groups of one, which are self-employed individuals.

The premiums charged could not be based on any historic or expected health condition of any individual and could only vary from one small employer to another based on a set of rating factors specified within M.G.L. c. 176J. When the rating factors were applied, combination of the factors could not produce premiums that varied by more than a 2-to-1 ratio from the highest cost employer to the lowest cost employer. In order to minimize disruption in the implementation of M.G.L. c. 176J, carriers were permitted to institute a 3-year transition process to gradually modify rates to meet the rating restrictions so that carriers could minimize potential rate shocks in the small group market. As originally implemented, Massachusetts small group market reforms applied to small employers with between one and 25 eligible employees, but those covered through approved associations were exempt from the restrictions of the law.

³ See the current version of M.G.L. c. 176J at

<http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176J>.

⁴ Defined in M.G.L. c. 176J, § 1 as "any sole proprietorship, firm, corporation, partnership or association actively engaged in business who, on at least fifty percent of its working days during the preceding year employed from among one to not more than twenty-five eligible employees, the majority of whom worked in the commonwealth; provided, however, that a health carrier may offer health insurance to a business of more than twenty-five employees in accordance with the provisions of this chapter. In determining the number of eligible employees, a business shall be considered to be 1 eligible small business or group if: (1) it is eligible to file a combined tax return for purpose of state taxation, or (2) its companies are affiliated companies through the same corporate parent. Except as otherwise specifically provided, provisions of this chapter which apply to an eligible small business shall continue to apply through the end of the rating period in which an eligible insured no longer meets the requirements of this definition. An eligible small business that exists within a MEWA shall be subject to this chapter."

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1996 Reforms

When the 1996 statutory reforms were enacted on August, 15, 1996, the size of the small group market was expanded to groups with up to 50 eligible employees. The statutory changes eliminated all exemptions for association group plans, so that the products and rates offered to eligible employers in association health plans were required to meet the guarantee issue and rate restriction standards that applied to all other small groups.

The premiums charged to all eligible employers were subject to similar rate restrictions that applied prior to the 1996 reforms, including the requirement that the combination of permissible rating factors could not produce premiums that varied by more than a 2-to-1 ratio. Under the August 15 1996 statutory reforms,⁵ however, carriers were no longer able to use gender as an allowable rating factor. In order to minimize disruption, carriers were permitted to institute a 3-year transition process beginning in December 1996 to gradually eliminate the use of gender rating and to apply the rating rules to employers with between 26 and 50 eligible employees. The original reform required that the premium band shrink to a 1.5-to-1 ratio for rates effective beginning December 1, 1999, but this provision was removed from the statute prior to it becoming effective.⁶

Nongroup (Individual) Health Insurance

After M.G.L. c. 176M⁷ was enacted on August 15, 1996 and amended on January 9, 1997,⁸ Massachusetts required carriers offering coverage to eligible individuals⁹ to offer products on a guaranteed issue basis according to the rate and product standards that were promulgated in 211 CMR 41.00. Products were standardized so that carriers were required to include specific benefits and cost sharing, but could add benefits in order to offer an enhanced benefit plan to members. Except for a select group of supplemental accident and sickness plans¹⁰ that were exempt from the statute and could continue to be

⁵ See Bulletin 1996-20 at <http://www.mass.gov/ocabr/business/insurance/doi-regulatory-info/doi-regulatory-bulletins/1996-doi-bulletins/1996-doi-bulletins-18.html>

⁶ See Bulletin 1999-05 at <http://www.mass.gov/ocabr/business/insurance/doi-regulatory-info/doi-regulatory-bulletins/1999-doi-bulletins/1999-doi-bulletins-6.html>

⁷ See the current version of M.G.L. c. 176M at <http://www.malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176M>

⁸ See Bulletin 1997-07 at <http://www.mass.gov/ocabr/business/insurance/doi-regulatory-info/doi-regulatory-bulletins/1997-doi-bulletins/>

and Bulletin 1997-10 at <http://www.mass.gov/ocabr/business/insurance/doi-regulatory-info/doi-regulatory-bulletins/1997-doi-bulletins/1997-doi-bulletins-10.html>

⁹ Defined in M.G.L. c. 176M, § 1 as “any natural person who is a resident of the commonwealth and who is not enrolled for coverage under Part A or Part B of Title XVIII of the federal Social Security Act, or a state plan under Title XIX of such act or any successor program.”

¹⁰ Within the current definition of “health benefit plan” in M.G.L. c. 176M, § 1, the following plans are considered to be exempt health plans and, therefore, not subject to the guarantee issue, rate restrictions or other provisions of M.G.L. c. 176M: accident only, credit, dental, vision, long-term care only or disability income insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment insurance, insurance under which

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offered to eligible individuals, carriers were prohibited from offering any other health plans.

Carriers only were allowed to offer standard nongroup guaranteed issue health plans with a standard set of benefits and standard cost-sharing levels. All in-force individual plans that had been offered prior to November 1, 1997 were required to be continued and were considered to be closed blocks of business that could not be offered to new enrollees.

The premiums that were charged could not be based on any historic or expected health condition of any individual, and could only vary from one individual to another solely based on the age of the eligible individual within 2:1 age rating bands. There was no transition period used when implementing the changes to the rate restrictions in the nongroup market.

Merger of Small Group and Nongroup Markets in July 2007

Chapter 58 of the Acts of 2006¹¹ initiated significant market reforms in Massachusetts which led to the development of the "individual mandate" requirements, premium subsidies for eligible individuals and the state insurance exchange, the Connector. In addition to other provisions of this reform legislation, there were provisions requiring that the guarantee issue and rate restrictions that previously applied only to eligible small employers would also apply to eligible individuals.

On July 1, 2007, the Massachusetts markets for eligible small groups and eligible individuals were merged into one risk pool according to standards promulgated under 211 CMR 66.00.¹² Eligible individuals had access to products previously available only to eligible small employers, with premiums that were based on the collective experience of the combined individual and small employer markets. Individuals who were covered under guaranteed issue nongroup plans prior to July 1, 2007 were permitted to stay in those closed plans or to switch to the new products available under the merged market.

In the merged market, health insurance premiums cannot be based on any historic or expected health condition of any individual and small employer and only can vary from one individual or small employer to another based on permitted rating factors, provided that the combination of rating factors does not produce premiums that varied by more than a 2-to-1 ratio. When the merged market was implemented, there was no transition to the changes to the rate restrictions. Moreover, Massachusetts carriers were permitted to use a group size adjustment factor that permits a rating adjustment of between .95 for the

beneficiaries 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, or any group blanket or general policy which provides supplemental coverage to Medicare or other governmental programs.

¹¹ See <http://www.malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58>.

¹² See <http://www.mass.gov/ocabr/business/insurance/doi-regulatory-info/insurance-regulations-and-laws/doi-insurance-regulations.html>.

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largest small groups to 1.10 for individuals to account for the merging of the individual and small employer experience.

Massachusetts' Statutory Reinsurance Programs

Small Employer Health Reinsurance Plan

When M.G.L. c. 176J was enacted in 1991, section 8 created a non-profit entity known as the Small Employer Health Reinsurance Plan ("SEHRP"). This plan was designed to protect individual commercial insurance companies from unanticipated adverse selection losses as they shifted into a guaranteed issue market for small employers. By statute, all commercial insurance companies offering small group health insurance coverage were required to be members of the SEHRP; however, HMOs and Blue Cross and Blue Shield of Massachusetts, Inc. were not permitted to be members of the SEHRP. Plan members had the right to reinsure some of the risk of small group health plan members through the SEHRP and were responsible to pay assessments to finance any SEHRP losses, based on each carrier's relative share of the small group market insured by commercial insurance carriers.

A seven-member Governing Committee, representing member companies, was appointed by the Massachusetts Governor to manage the SEHRP. The Governing Committee was responsible for managing the operations of the SEHRP, contracting with entities to carry out its administrative duties, establishing reinsurance guidelines and premiums, and making decisions about needed assessments. All of these actions were subject to the approval of the Commissioner of Insurance.

The SEHRP never had a large number of persons reinsured through the program and consistently operated with annual surpluses. The SEHRP even paid taxes to the federal government based on the surpluses carried in its reserves.

Nongroup Health Reinsurance Plan

When M.G.L. c. 176M was enacted in 1996, section 6 created a non-profit entity known as the Nongroup Health Reinsurance Plan ("NHRP"). To protect individual insurance carriers from unanticipated adverse selection losses as they shifted into a guaranteed issue market for individuals. By statute, all insurance carriers offering any health insurance coverage in Massachusetts were required to be members of the NHRP; including HMOs and Blue Cross and Blue Shield of Massachusetts, Inc. Although only those carriers that offered nongroup health coverage had the right to reinsure some of their individual coverage risk through the NHRP, all member carriers were responsible to pay assessments to finance Plan losses, based on their share of the total health insurance market.

A five-member Governing Committee, representing member companies, was appointed by the Massachusetts Governor to manage the NHRP. The Governing Committee was responsible for managing the operations of the NHRP, contracting with entities to carry out NHRP administrative duties, establishing reinsurance guidelines and premiums, and

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making decisions about needed assessments. All of these actions were subject to the approval of the Commissioner of Insurance.

Although the Massachusetts NHRP never had a large number of persons reinsured through the program, those individuals in the program tended to have large losses. Unlike the SEHRP, the NHRP did experience annual losses, and members were annually assessed to cover the NHRP underfunding.

Termination of Small Employer and Nongroup Reinsurance Plans

Within the reforms created under Chapter 58 of the Acts of 2006, there were statutory changes made to both M.G.L. c. 176M and M.G.L. c. 176J to close both the SEHRP and NHRP. The statutes directed the Governing Committees of each plan to phase-out the operations of both plans, bringing about the ultimate closure of each plan in 2008. The plan to phase-out the SEHRP is included in Appendix A and the plan to phase-out the NHRP is included in Appendix B.

Neither the SEHRP nor the NHRP were used significantly by member carriers to reinsure the costs of high-risk members. There was a general perception by the state's health carriers that the SEHRP and NHRP were no longer necessary, as the guarantee issue markets were mature after being in place for small employers for 16 years, and for individuals for 10 years. Carriers suggested that they could handle their own reinsurance needs. When plan operations ceased, SEHRP members received distributions of plan surpluses, and NHRP members were assessed to pay the final costs of the plan.

Federal Requirements for Transitional Reinsurance Program

Sections 1341, 1342, and 1343 of the ACA create national risk reduction methods for transitional reinsurance, risk corridors and risk adjustment¹³, commonly referred to as the “3Rs”. Collectively, these programs are intended to reduce an individual insurance carrier’s risk of incurring high-cost medical claims when shifting to a guaranteed issue market for individuals where the individual insurance carrier is unaware of any enrollee’s risk for future high-cost care. The ACA requires HHS to administer risk corridors, but permits each state to apply to administer the transitional reinsurance and risk adjustment programs according to parameters established under federal rules. If a state does not apply to administer its own reinsurance and risk adjustment programs, HHS will administer these programs on behalf of the state.

The transitional Reinsurance Program (“Reinsurance Program”) is a temporary program to be effective between January 1, 2014 and December 31, 2016 that will distribute payments to carriers that have individual enrollees whose health claim costs fall within the parameters identified within federal rules for the program. The ACA specifies that, nationally, Reinsurance Programs will collect assessments from group health plans and make reinsurance payments of \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016 to fund the reinsurance payments nationwide. Additionally, group health plans will be assessed to fund contributions to the U.S. Treasury of \$2 billion in 2014, \$2 billion in 2015 and \$1 billion in 2016.”¹⁴

The reinsurance payments under the Reinsurance Program are slated to decline from a high of \$10 billion in 2014 to \$4 billion in 2016 because the program is designed to be a transitional bridge for carriers as they develop products and rates in a guaranteed issue market. It is assumed that carriers will have a declining need for reinsurance payments between 2014 and 2016 as they become more familiar with the risks of the market and the features of the other permanent “3R” mechanisms, risk adjustment and risk corridors, which are designed to assist carriers to manage the risk of individual coverage in a guaranteed issue market.

HHS has indicated that due to the temporary nature of the Reinsurance Program, its payments and data collection will not be integrated with the payments and data collection related to the risk adjustment program. As such, the fact that a state chooses to administer its own risk adjustment program does not, in and of itself, weigh in favor of a

¹³ The risk adjustment program is a permanent program that applies to coverage issued through an exchange, and adjusting payments to insurance carriers based on the relative health risk scores of persons covered by those carriers. The Connector was granted authority by Chapter 118 of the Acts of 2012 “to define and establish by regulation a risk adjustment program as required by 42 U.S.C. § 18063.” The Connector has taken steps to make filings to CCIIP to apply to administer Massachusetts’ risk adjustment program for use with coverage issued through the Connector beginning in 2014. See <http://www.malegislature.gov/Laws/SessionLaws/Acts/2012/Chapter118>

¹⁴ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, Published 11/30/12, (CMS-9964-P) Preamble at III (C) (3) (a), Federal Register page 73154.

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state choosing to administer its own Reinsurance Program. In fact, HHS expects that fewer than nine states will elect to implement both a risk adjustment program and a Reinsurance Program.¹⁵

Expected Impact on Market Premiums

Nationally, HHS estimates “reinsurance payments will result in premium decreases in the individual market of between 10 and 15 percent relative to expected premiums without reinsurance.”¹⁶ Those carriers offering individual coverage would have a portion of their costs paid through the assessments levied on group health plans; this would enable these carriers to subsidize individual coverage during the three-year period that the Transitional Reinsurance Program is operational.

Despite these estimates, the noted reinsurance payments are expected to have a muted impact on premiums in Massachusetts due to the merger of the small group and nongroup health insurance markets in 2007.¹⁷ Massachusetts carriers will need to pay assessments on small group health insurance premiums and receive reinsurance payments on high-cost individual coverage claims. It is expected that differing carriers may have net losses or gains from the Reinsurance Program depending on the number of individuals with high-cost claims that may be covered under their plans.

It also should be noted that reinsurance payments in Massachusetts will not have the impact that they may have in other states due to Massachusetts’ merged small group/individual market. In other states, group health plans will make assessments, and reinsurance payments will be paid to carriers with individual coverage; this will enable carriers to reduce the cost of individual coverage. In Massachusetts, since the premiums of the small and individual markets are based on their collective experience and rating rules do not allow individuals to be treated differently, the reinsurance payments will be spread across all individual and small group members. If the reinsurance payments are greater than those of the assessments on small employers, then carriers can reduce premiums for the whole market. Conversely, if the reinsurance payments for a carrier are less than the reinsurance assessments for a particular carrier, that carrier would increase premiums for the merged market.

Separate from the muted impact that the Reinsurance Program will have on small group health cost payments, because the Reinsurance Program is short-term in nature, the Massachusetts Association of Health Plans has stressed that “minimizing administrative and regulatory complexity would be the highest priority, along with timing as long as there is reasonable accuracy.”¹⁸ The preferred program is one that keeps administrative

¹⁵ Id. at IV (A), Federal Register page 73189.

¹⁶ Id. at I (B), Federal Register page 73121.

¹⁷ Policy Framework for Risk Adjustment and Transitional Reinsurance Program, August 22, 2012, p. 17.

¹⁸ April 6, 2012 letter from the Massachusetts Association of Health Plans to Kevin Beagan of the Division and Jean Yang of the Connector.

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costs as low as possible so that such costs are not impacting carrier's need to increase premiums to pay for those costs.

National Reinsurance Payment Parameters

In rules published on November 26, 2012, HHS proposed the payment parameters for reinsurance that would apply in 2014.¹⁹ Reinsurance offered under the Reinsurance Program will make payments to the health plans for the claims of high-cost individuals beyond an attachment point of \$60,000 up to a cap of \$250,000, with a uniform coinsurance rate of 80%.²⁰ This means that for an individual with a \$250,000 claim, the Reinsurance Program would pay the individual's insurance carrier a total of \$152,000 ($[\$250,000 - \$60,000] * .80$).

According to HHS, these "three proposed payment parameters would help offset high-cost enrollees, without interfering with traditional commercial reinsurance, which typically has attachment points in the \$250,000 range. [HHS] estimate[s] that these national payment parameters will result in total requests for reinsurance payments of approximately \$10 billion."²¹

National Per Capita Uniform Contribution Rate and Administrative Expense Rate

In addition to the reinsurance payments and the amount required to be contributed to the U.S. Treasury annually, Section 1341 (b)(3)(B)(ii) of the ACA also allows for an assessment of group health plans to fund the administrative expenses of the Reinsurance Program.²² HHS estimates that the amount to be collected for administrative expenses for benefit year 2014 would be \$20.3 million (or 0.2 percent of the \$10 billion dispersed).²³

HHS will set each year's contribution rate in an annual notice of benefit and payment parameters. The national per capita contribution rate will be determined by "dividing the sum of the three amounts (the national reinsurance pool, the U.S. Treasury contribution, and administrative costs) by the estimated number of enrollees in the plan that must make reinsurance contributions."²⁴ Based upon \$10.0 billion in reinsurance payments, a \$2.0 billion contribution to the U.S. Treasury and \$0.023 billion in administrative expenses, there is a proposed per capita contribution rate of \$5.25 per month in benefit year 2014.²⁵ Of this per capita contribution, it is estimated that the administrative expenses of

¹⁹ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, Published 11/30/12, (CMS-9964-P) Preamble at III (C) (6), Federal Register page 73160.

²⁰ Id.

²¹ Id.

²² Id. at III (C) (3)(a), Federal Register page 73154.

²³ Id.

²⁴ Id.

²⁵ Id.

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operating the reinsurance program would be \$0.11 per capita due to the federal government's significant economies of scale.²⁶

Collecting Contributions from Insured Plans and Self-Funded Plans

In order to fund the Reinsurance Program, HHS proposes to collect all reinsurance contributions from all contributing entities to minimize the administrative burden of collecting contributions. CCIIO notes that "[t]his would allow for a centralized and streamlined process for the collection of contributions, and would avoid the inefficiencies related to using different processes in different states."²⁷

HHS proposes that "the reinsurance contribution of a contributing entity be calculated by multiplying the average number of covered lives of reinsurance contribution enrollees during the benefit year for all of the contributing entity's plans and coverage that must pay reinsurance contributions, by the national contribution rate for the applicable benefit year."²⁸

In order to collect contributions in an orderly manner, HHS proposes that "no later than November 15 of benefit year 2014, 2015, and 2016, as applicable, a contributing entity must submit to HHS an annual enrollment count of the average number of covered lives of reinsurance contribution enrollees for each benefit year."²⁹ Then "within 15 days of submission of the annual enrollment count or by December 15, whichever is later, HHS will notify each contributing entity of the reinsurance contribution amounts to be paid based on that annual enrollment count...[and] a contributing entity [is to remit] contributions to HHS within 30 days after the date of the notification of contributions due for the applicable benefit year."³⁰

Making Payments to Reinsurance-Eligible Issuers

Although HHS proposes that contributions be made on a per capita basis across all health plans, it also proposes that the Reinsurance Program "distribute reinsurance payments based on the need for reinsurance payments in each State...[because] a policy of disbursing reinsurance payments solely to a State in which the contributions are collected would not meet the States' individual needs." Payments will vary from state to state and may be more or less than the assessment collected from the state's health plans.

In order to process claims payments, individual coverage carriers would be required to submit data to the Reinsurance Program quarterly of the number and type of claims for care provided after the 2014 ACA reforms that meet the Reinsurance Program coverage

²⁶ Id. at III (C) (3) (b), Federal Register page 73155.

²⁷ Id. at III (C), Federal Register page 73149.

²⁸ Id. at III (C) (4) (a), Federal Register page 73156.

²⁹ Id.

³⁰ Id.

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parameters. This information would be used to “provide issuers of reinsurance-eligible plans with [a] quarterly estimate of the expected requests for reinsurance payments for the reinsurance-eligible plan.”³¹ The quarterly estimates are to be provided to reinsurance-eligible plans within 60 days of the end of the quarter.³²

Annually, the Reinsurance Program will collect final calendar year claims payment filings from individual coverage carriers which will be used to calculate the amount of reinsurance payments. The rule proposes that the reinsurance payments are to be made no later than June 30 of the year after the benefit year.³³

If the total reinsurance requests are greater than the sum of all reinsurance assessments collected, the rules propose to reduce actual reinsurance payments by a pro rata adjustment. As noted by HHS, “[i]f total requests for reinsurance payments under the national reinsurance payment parameters are \$10.1 billion and only \$10 billion is collected from reinsurance payments under the national contribution rate, then all requests for reinsurance payments would be reduced by approximately 1 percent.”³⁴

³¹ Id. at III (C) (1) (b), Federal Register page 73151.

³² Id.

³³ Id. at III (C) (7), Federal Register page 73160.

³⁴ Id. at III (C) (1) (b), Federal Register page 73151.

Options with Respect to Administering Transitional Reinsurance Program in Massachusetts

Option 1: Obtain Waiver from Reinsurance Program

“The Affordable Care Act directs that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016.”³⁵ The program has been established to allow for certain reinsurance dollars collected from assessments on self-insured employers and carrier’s employer coverage to be used to subsidize the cost of individual coverage during a three-year transition period.

Massachusetts is unique among states in that it has had guaranteed issue markets for individuals and small employers with between one and 50 employees since 1997, and further merged its individual and small group markets beginning in July 2007. The Massachusetts markets have been relatively stable since 2000, with the same major carriers participating in the individual, small group and large group markets. Massachusetts terminated its own state reinsurance programs subsequent to the merger of the markets, as the programs were deemed to be no longer necessary in the Commonwealth.

Although the Reinsurance Program is designed to reduce the premium costs of individuals in a guaranteed issue market, in Massachusetts, the small group and individual markets already have been merged. As such, small employers already are subsidizing the premiums of individuals, as identified in recent Annual Comprehensive Financial Statement Summary Report produced by the Division in 2011.³⁶ Consequently, the Reinsurance Program will not reduce premiums for individuals in Massachusetts, as it would in other states.

Because the Reinsurance Program is unlikely to have an impact on premiums or the availability of coverage in the Massachusetts merged market, the Division has contacted CCIIO a number of times to determine if the Commonwealth may forego the cost of the program. Although neither ACA or nor subsequent rules issued by CCIIO specifically indicate that a state may request a waiver from the Reinsurance Program, they also do not specifically prohibit a state from submitting such a request.

Communications with Federal Regulators

On November 9, 2012, Division staff held a conference call with Dr. Sharon B. Arnold, Acting Director of CCIIO’s Payment Policy and Financial Management Group, as well as

³⁵ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, Published 11/30/12, (CMS-9964-P), Preamble at Federal Register page 73120.

³⁶ See <http://www.mass.gov/ocabr/consumer/insurance/health-insurance/health-care-access-bureau/>.

Transitional Reinsurance Program in Massachusetts

Diane Gerrits and Nancy Goetschius of CCIIO's Division of Reinsurance Operations. The purpose of the call was to determine whether a state could seek a waiver from the ACA Reinsurance Program. Dr. Arnold indicated that CCIIO staff believed that such waivers are not permitted by the ACA, but further stated that she would be willing to elevate a formal request for a determination on the issue to policy officials at the agency.

Consequently, on December 5, 2012, the Division submitted a formal written request to CCIIO for a determination of whether the Commonwealth may seek a waiver of the Reinsurance Program requirement. A copy of this request is included in Appendix C.

On January 14, 2013, the Division received a written response to its request for a determination of whether the Commonwealth may seek a waiver from the Reinsurance Program requirement. In that letter, Dr. Sharon B. Arnold indicated, in part, that CCIIO had "determined that HHS has no authority to grant a State a waiver from the transitional Reinsurance Program requirements of Section 1341 of the ACA." A copy of this response, dated January 10, 2013, is included in Appendix D.

Option 2: State Applies to Administer Own Reinsurance Program

The proposed rules that HHS published on November 26, 2012 made significant changes to previously proposed rules. Specifically, the November 26 publication identified a standard approach that would uniformly apply across the country and would drastically reduce the ways a state could develop a Reinsurance Program that may be tailored to its particular needs.

Increased Reinsurance Coverage with Adjusted Payment Parameters

According to the November 26 proposed rule, states that administer their own Reinsurance Program are not permitted to reduce the reinsurance coverage available to individual coverage carriers. As noted, a state only may "modify the national reinsurance payment parameters established in the HHS notice of benefit and payment parameters...by establishing State supplemental payment parameters that cover an issuer's claim costs beyond the national reinsurance payments parameters."³⁷ If a state elects to expand the available reinsurance coverage beyond the national parameters, the state would be solely responsible to fund the additional coverage with assessments collected on its own health insurers for their insured business.³⁸ Moreover, the state would not have the authority to levy any assessment on self-funded employer-sponsored plans to cover these costs.³⁹ All such state supplemental assessments would be subject to

³⁷ Id. at III (C) (8), Federal Register page 73161: "a state may set supplemental reinsurance payments parameters by adjusting the national reinsurance payment parameters in one or more of the following ways: (1) decreasing the national attachment point; (2) increasing the national reinsurance cap; or (3) increasing the national coinsurance rate. In other words, a State may not alter the national reinsurance payment parameters in a manner that could result in reduced reinsurance payments."

³⁸ Id.

³⁹ Id. at III (C) (2), Federal Register page 73152.

Transitional Reinsurance Program in Massachusetts

an annual notice to and approval by CCHIO, and states further would “be required to separate in its reporting to issuers the reinsurance payments paid under the national reinsurance payment parameters and State supplemental reinsurance payment parameters.”⁴⁰

State-Specific Administrative Expenses

A state that elects to administer the Reinsurance Program will not be responsible for collecting assessments to fund the program, unless the state is collecting assessments to fund any supplemental state reinsurance coverage. The state would be responsible, however, to fund the cost of administering the data collection necessary for the calculation of payments to insurance carriers.

Obtaining Transfer of Administrative Amount from Federal Program

Although the federal government will collect all assessments for the Reinsurance Program, it will transfer a portion of the administrative expense assessment to the states if states operate their own Reinsurance Program. “HHS [intends to] transfer \$0.55 of the per capita administrative fee to the State for purposes of administrative expenses incurred in making reinsurance payments...[but] the administrative expense for reinsurance payment will be distributed in proportion to the State-by-State total requires for reinsurance payments made under the national payment parameters.”⁴¹

HHS has clarified that a state would be expected to pay its administrative costs in a calendar year and would not receive a transfer from HHS until the middle of the following calendar year. It is also possible that the HHS transfer may not be sufficient to reimburse a state for the actual administrative cost of operating its own Reinsurance Program.

A state may collect additional contributions to provide funding for administrative expenses which must be collected by the Reinsurance Program. HHS stressed that a “State that operates the reinsurance program bears the administrative costs of the applicable reinsurance entity, and must ensure that the reinsurance entity complies with the program requirements.”⁴² A State will be required to “notify HHS if it intends to collect additional administrative expenses and provide justification for the additional collection.”⁴³

⁴⁰ Id. at III (C) (8), Federal Register page 73161.

⁴¹ Id. at III (C) (3) (b), Federal Register page 73155.

⁴² Id. at VI (B), Federal Register page 73198.

⁴³ Id.

Transitional Reinsurance Program in Massachusetts

Submitting Reports to Federal Government

If a state does establish its own Reinsurance Program, it will need to comply with HHS parameters and regularly report its reinsurance payments and administrative expenses to HHS. The state also would need to require that its Reinsurance Program collect all the data necessary to report to HHS and ensure that the “collection of personally identifiable information is limited to information reasonably necessary to use in the calculation of reinsurance payments, and that use and disclosure of personally identifiable information is limited to those purposes for which the personally identifiable information was collected....”⁴⁴

HHS has indicated to the Division that if the Commonwealth chooses to administer its own Reinsurance Program, it may use information from the All-Payer Claims Database to collect and report information about claims that qualify for reinsurance payments. If HHS administers the Reinsurance Program, however, participating carriers would be required to purchase specific data servers (estimated to cost between \$10,000 and \$40,000 depending on the size of the carrier) to upload claims information directly to the HHS data warehouse.⁴⁵

Cost of Administering Transitional Reinsurance Program

The ACA specifies an administrative cost of \$20.3 million to administer the Reinsurance Program. HHS has assumed that half of that cost (\$10.15 million) will be used to collect contributions from insurance carriers and self-funded plans. The remaining \$10.15 million will be used to fund the cost of administering reinsurance payments.

Although the federal transfer to an individual state administering a Reinsurance Program will differ with the level of reinsurance payments, the estimate is for a \$0.055 per capita payment. Assuming that there are approximately 4.0 million adults in Massachusetts between the ages of 18 and 65, this could be estimated to be \$200,000-\$300,000 per year in potential federal transfer to Massachusetts.

Massachusetts does not have an existing Reinsurance Program since it closed down its Small Employer and Nongroup Health Reinsurance Plans in 2008. As such, there would be administrative start-up costs associated with restarting a Massachusetts-specific program.

For calendar year 2005, the Nongroup Health Reinsurance Plan had an operating expense of \$40,000 to administer a program that covered a total of 32 ceded lives and \$624,000 in claims payments. Although there may be economies of scale in operating an expanded

⁴⁴ See 45 CFR 153.240(d), Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, Published 11/30/12, (CMS-9964-P) at Federal Register page 73206.

⁴⁵ Meeting between Dr. Sharon B. Arnold, Acting Director of CCIIO's Payment Policy and Financial Management Group and Kevin Beagan, Deputy Commissioner of Health Care Access Bureau on February 14, 2013.

Transitional Reinsurance Program in Massachusetts

reinsurance program, if it is estimated that Massachusetts' health plans will be assessed over \$100.0 million and that claims payments may be close to that, the cost to administer a Massachusetts Reinsurance Program could be more than \$200,000 per year.

It should be noted that HHS has identified in its rules that the cost of administering the Reinsurance Program would be borne by the state. If the administration cost is greater than the federal transfer, the state would be responsible for the difference. The state may assess insurers for this additional expense, provided that such expense is approved by HHS.

Option 3: State Does Not Apply to Administer Own Reinsurance Program and Federal Government Administers Program

Under this option, HHS would collect all of the required assessments, would run the Reinsurance Program, and would be responsible for all administrative costs involved in operating the program. As noted above, participating carriers would be required to buy specific data servers and would be required to use those servers to upload claims information to the HHS data warehouse.

Although Massachusetts would not be able to implement a different reinsurance program until 2017, it is unlikely that the Commonwealth would want or need to operate any additional reinsurance program for all of the reasons noted above.

Decision Regarding Transitional Reinsurance Program in Massachusetts

Based on the Division's review, it appears that the Reinsurance Program is unlikely to have a significant impact on expanding the number of carriers participating in the small group/individual market in the Commonwealth. This is due not only to the limited duration of the program, but also to the statutorily declining amount of reinsurance coverage that would be available in each of the program's three years of operation. Additionally, the Reinsurance Program is likely to have a redistributive effect to the benefit of certain carriers that provide health insurance coverage to more than their share of high-risk individuals, relative to the number of small employer groups to which they provide such coverage.

Based upon this information, if it were permitted, the Division would elect to waive the Commonwealth's participation in the Reinsurance Program in its entirety. Pursuant to the January 10, 2013 letter from CCIIO, however, it appears that HHS will be unable to grant the Commonwealth a waiver from the Reinsurance Program requirement. As such, the Division has examined whether Massachusetts should administer the program on its own, or whether the Commonwealth should not make such an election, which will result in the federal government administering the program in the Commonwealth.

First, the federal rules provide very little flexibility if a state elects to administer its own Reinsurance Program, unless the state decides to expand coverage available under the program and assesses its own state insurers for the additional cost of this coverage. This lack of flexibility in running the Reinsurance Program is a substantial disincentive to Massachusetts running the program on its own.

Second, Federal guidelines indicate that HHS will be responsible for the collection of all assessments, and that HHS will make a transfer to states only after the year has been closed and only for the amount HHS determines is the state's share of the federal administrative expense. This means that there is no guarantee that this retroactive payment will be enough to cover the actual costs that Massachusetts would incur in running the Reinsurance Program on its own.

Because there would not be sufficient flexibility in Massachusetts running the Reinsurance Program, and because the costs for Massachusetts in administering the Reinsurance Program would likely exceed the monies collected to run the program, the Division has determined it is not warranted for Massachusetts to implement, establish and supervise a transitional Reinsurance Program at this time. As such, the Division will notify HHS that it will not apply to administer a transitional Reinsurance Program for Massachusetts and, therefore, HHS will administer that program in Massachusetts.

Appendix A



MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE

One South Station • Boston, MA 02110 - 2208
(617) 521-7794 • FAX (617) 521-7773
TTY/TDD (617) 521-7490
<http://www.state.ma.us/doi>

JANICE S. TATARKA
DIRECTOR, CONSUMER AFFAIRS
AND BUSINESS REGULATION

JULIANNE M. BOWLER
COMMISSIONER OF INSURANCE

August 11, 2006

Mr. Manuel D. Chrobak
Tufts Health Plan
333 Wyman Street
P.O. Box 9112
Waltham, MA 02454-9112

Re: Massachusetts Small Group Health Reinsurance Plan Phase-Out

Dear Mr. Chrobak:

The Division of Insurance ("Division") received the August 10, 2006 letter that you forwarded on behalf of the Governing Committee of the Massachusetts Small Group Health Reinsurance Plan ("MSGHRP"). Your letter presents the Governing Committee's proposed phase-out of the MSGHRP ("Proposal") and amendments to the Plan of Operations ("the Plan"). As you are aware, amendments to the Plan are subject to the Commissioner's review. According to the provisions of M.G.L. c. 176J, § 8, such amendments may be deemed approved by the Commissioner if not expressly disapproved in writing within thirty days (30) from the date of filing.

The Division has reviewed the MSGHRP Proposal and the amendments to the Plan pursuant to M.G.L. c. 176J, as recently amended by Section 88 of Chapter 58 of the Acts of 2006. As you know, Section 88 requires that "by no later than July 1, 2006, the governing committee shall establish a proposal to phase-out the operations of the [MSGHRP] and submit a copy of said proposal to the commissioner for approval. The proposal shall include a method for closing the plan by June 30, 2007. The governing committee shall execute the phase-out of the plan." Although the Governing Committee of the MSGHRP did submit to the Commissioner a proposal to phase-out the operations of the MSGHRP by July 1, 2006, the Division asked the Governing Committee to resubmit such proposal with the addition of an amended Plan. The Proposal is subject to the Commissioner's approval under Ma. Stt. 2006, Ch. 58, § 88; and the amended Plan is subject to her separate approval pursuant to M.G.L. c. 176J, §8.

The Division understands that the Plan has been amended to incorporate, by reference, the terms of the Proposal. The Proposal has been designated "Appendix A," and supersedes and governs the articles of the Plan. Accordingly, the Division understands that any and all outstanding contracts, obligations and entitlements that exist pursuant to the Plan shall be properly

Mr. Manuel D. Chrobak

August 11, 2006

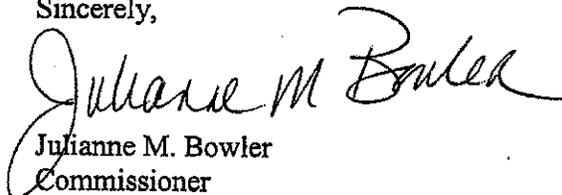
Page 2

maintained subject to the eventual phase-out process and final closing of MSGHRP as reflected in Appendix A. The Governing Committee, members of MSGHRP, insured and ceded risks, as well as any vendor arrangements established pursuant to the MSGHRP will be governed by the Plan as amended, and if any conflict arises between the Plan and Appendix A, Appendix A will govern.

Based on the above understandings, I hereby approve the Proposal and the amended Plan pursuant to Ma. Stt. 2006, Ch. 58, § 88 and M.G.L. c. 176J, §8.

If you have any questions, please contact Nancy Schwartz, Director, Bureau of Managed Care at 617-521-7347.

Sincerely,

A handwritten signature in cursive script that reads "Julianne M. Bowler". The signature is written in dark ink and is positioned above the printed name and title.

Julianne M. Bowler
Commissioner

July 14, 2006

Ms. Julianne M. Bowler
Commissioner of Insurance
Massachusetts Division of Insurance
One South Station
Boston, MA 02110-2208

RE: Massachusetts Small Employer Health Reinsurance Plan
Proposal for Closing Plan

Dear Commissioner Bowler:

According to M.G.L. c. 176J, § 8, as recently amended by Section 88 of the Healthcare Reform legislation of 2006, "By no later than July 1, 2006, the Governing Committee shall establish a proposal to phase-out the operations of the plan and submit a copy of said proposal to the commissioner for approval. The proposal shall include a method for closing the plan by June 30, 2007. The Governing Committee shall execute the phase-out of the plan."

During an open meeting of the Governing Committee on May 9, 2006 the Governing Committee of the Massachusetts Small Employer Health Reinsurance Plan ("the Program") approved a proposal to phase-out the operations of the Program in the manner summarized below. With your approval:

1. The Governing Committee will amend the Plan of Operations to end all ceding of risks into the Massachusetts Small Employer Health Reinsurance Plan as of midnight August 31, 2006.
2. The Governing Committee will amend the Plan of Operations to end all coverage for risks ceded into the Massachusetts Small Employer Health Reinsurance Plan as of midnight, December 31, 2006.
3. The Governing Committee will amend the Plan of Operations to end the claim filing period (run-off period) for claims incurred through December 31, 2006 to claims postmarked to the administrator's offices no later than midnight December 31, 2007.
4. The Governing Committee will amend the Plan of Operations to allow for a final accounting of the Program by no later than June 30, 2008.
5. Pool Administrators, Inc., the administrator of the Program, will notify by U.S. mail all Massachusetts Small Employer group carriers of the above changes by releasing:
 - By July 31, 2006, written notice that all further ceding to the Massachusetts Small Employer Health reinsurance Plan will cease on June 30, 2006. They will also inform these carriers of dates when coverage under the Program will terminate (December 31, 2006) and when the claims run-off period will end (December 31, 2007). Pool Administrators, Inc. will include a copy of the Amendment to the Plan of Operations (copy attached) and your letter approving these changes.



Ms. Julianne M. Bowler, Commissioner of Insurance

July 14, 2006

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- Pool Administrators will thereafter provide timely reminders (at least 30 day advance written notice) of later key dates (termination of coverage at midnight December 31, 2006, and the end of the claim run-out period at midnight December 31, 2007).
- 6. The Governing Committee does expect a surplus (premiums minus claims) to accrue through the claims run-off period and will determine refunds in a manner proportionate to the actual premiums plus assessments paid by Massachusetts small employer group carriers.

As noted, in order to implement this plan to close the Program, the Governing Committee requests your approval of this proposal. Please contact me at (781) 466-9400 x2103 should you require additional information regarding this request.

Very truly yours,



Manuel D. Chrobak
Chairman

cc: Walter Morris, Governing Committee member
Barbara Hennessey, Governing Committee member
Thomas Nyzio, Governing Committee member
Gary Lin, F.S.A., M.A.A.A., Governing Committee member
Charles Boutin, Governing Committee member
Nancy Schwartz, Massachusetts Division of Insurance
Karl Ideman, Pool Administrators, inc.

Attachment

MASSACHUSETTS SMALL EMPLOYER HEALTH REINSURANCE PLAN

PLAN OF OPERATION

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Article I	Statutory and Regulatory Authority
Article II	Definitions
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Article VI	Governing Committee and Annual Meeting
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Article VIII	Administrator: Selection and Duties
Article IX	Eligibility for Reinsurance
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Article XI	Reinsurance Claims
Article XII	Net Fund Earnings, Assessments, Late Payments and Definition of Earned Premium
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MASSACHUSETTS SMALL EMPLOYER HEALTH REINSURANCE PLAN
PLAN OF OPERATION ("PLAN")

Article I - Statutory and Regulatory Authority

The Massachusetts Small Employee Health Reinsurance Plan, hereinafter referred to as "The Program", is a nonprofit entity created pursuant to the provisions of ST. 1991, c. 495, Section forty-two, which was codified as c. 176J, Section eight hereinafter referred to as "The Act". The Plan of Operation shall be subject to 211 CMR 66, hereinafter referred to as "The Regulations", and any amendments to the Regulations. On April 12, 2006, Section 88 of Chapter 58 of the Acts of 2006 amended The Act to require the governing committee to execute the phase-out of The Program. The phase-out is provided by an appendix to this Plan according to Article V.

Article II - Definitions

As used in this Plan of Operation:

- A. Carrier means an entity licensed or otherwise authorized to transact accident and health insurance business under M.G. L. C. 175.
- B. Child means a natural Child, a legally adopted Child, a Child placed in the home of the employee for the purposes of adoption, a child supported by the employee pursuant to a valid court order, or a Child for whom the employee is the legal guardian. It also includes a stepchild who lives with the employee.
- C. Commissioner means the Commissioner of Insurance of the Commonwealth of Massachusetts.
- D. Division means the Division of Insurance of the Commonwealth of Massachusetts.
- E. Eligible Dependent means the Spouse or Child of an Eligible Employee, or child of a child of an eligible employee, subject to applicable terms of the Health Benefit Plan covering that Eligible Employee, including a spouse or child whose coverage is required to be made available under the provisions of federal or state law.
- F. Eligible Employee means an employee who:
 - 1. Works on a full-time basis with a normal work week of 30 or more hours and is hired to work for a period of not less than five months;

2. Eligible Employee includes an owner, a sole proprietor or a partner of a partnership provided that the owner, sole proprietor or Partner is included as an Eligible Employee under a Health Benefit plan of an Eligible Small Employer;
 3. Eligible Employee does not in any event include an employee who works on a temporary or substitute basis or as an independent contractor consultant.
- G. Extra Insureds means employees who are covered under a Small Employer's Health Benefit Plan, but who do not meet the requirements defined for coverage as Eligible Employees. These may include part-time employees or retirees providing occasional service.
- H. Governing Committee means the committee that prepares the Plan of Operation and administers the Program. Governing Committee Members are appointed by the governor and represent Small Employer Carriers participating in the Program.
- I. Health Benefit plan means any general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under M.G.L. c. 175; a group hospital service plan issued by a non-profit hospital service corporation under M.G.L. c. 176A; a group medical service plan issued by a non-profit hospital service corporation under M.G.L. c. 176B; a group health maintenance contract issued by a health maintenance organization under M.G.L. c. 176G; an insured group health benefit plan that includes a preferred provider arrangement under M.G.L. c. 176I; and any multiple employer welfare arrangement (MEWA) required to be licensed under M.G.L. c. 175; offered to an eligible small business. The term "health benefit plan" shall not include accident only, credit, dental, or disability income insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, insurance under which beneficiaries 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, long-term care only insurance, or any group blanket or general policy which provides supplemental coverage to Medicare or other governmental programs.
- J. Late Enrollee means an Eligible Employee or Dependent who requests enrollment in a Health Benefit Plan of a Small Employer after his or her initial enrollment period provided under the terms of the Health Benefit Plan, after his or her initial eligibility date, or after any applicable annual open enrollment period. An Eligible Employee or Dependent shall not be considered a Late Enrollee, however, in any of the following situations:
1. If the individual requests enrollment within 30 days after termination of coverage under a previous qualifying health plan, including coverage under COBRA, and
 - a. The individual was covered under a previous qualifying health benefit plan at the time of the initial eligibility for the Small Employer Health Benefit Plan; or

- b. The individual lost coverage under the previous qualifying Health Benefit 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 or 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.

K. MEWA or Multiple Employer Welfare Arrangement also called a "multiple employer trust", means either:

- 1. A fully-insured multiple employer welfare arrangement as defined in sections 3 and 514 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 USC 1002 and 1144, as amended; or,
- 2. An entity holding itself out to be a multiple employer welfare arrangement or so-called "multiple employer trust" which is not fully insured and, therefore, shall be required to be licensed under MGL c. 175.

An arrangement that constitutes a MEWA is considered a separate group Health Benefit Plan with respect to each Employer maintaining the arrangement.

L. Pre-existing condition Provision means a provision which excludes coverage or limits benefits for charges or expenses incurred during a specified period following the Eligible Employee or Eligible Dependent's effective date of coverage:

- 1. As to a condition which, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received, or
- 2. As to a pregnancy existing on the effective date of the coverage.

M. Prototype Health Benefit Plan means a Health Benefit Plan adopted by the Governing Committee for the purpose of determination of the benefits reinsured under the Program.

N. Qualifying Health Plan means any (1) blanket or general policy of medical, surgical or hospital insurance described in M.G.L. c. 175, s. 110(A), (C) or (D); (2) policy of accident or sickness insurance as described in M.G.L. c. 175, s. 108 which provides hospital or

surgical expense coverage; (3) non-group or group hospital or medical service plan issued by a nonprofit hospital or medical service corporation under M.G.L. c. 176A and c. 176B; (4) non-group or group health maintenance contract issued by a health maintenance organization under M.G.L. 176G; (5) insured group health benefit plan that includes a preferred provider arrangement under M.G.L. c. 176I; (6) self-insured or self-funded employer group health plan; (7) health coverage provided to persons serving in the armed forces of the United States; (8) Medical assistance provided under M.G.L. c. 11SE; (9) health coverage through the Medicare program; or (10) self-insured or self-funded union health and welfare fund.

- O. Eligible Small Business means 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 1 to not more than 50 Eligible Employees, the majority of whom worked in the Commonwealth; provided, however, that the sole proprietorship, firm, corporation, or partnership need not have been in existence during the preceding year. In determining the number of Eligible Employees, companies which are affiliated companies or which are eligible to file a combined tax return for Purposes of state taxation are considered one Small Employer. Except as otherwise specifically provided, provisions of the Act which apply to an Eligible Small Employer will continue to apply through the end of the period covered by the current rates during which an Eligible Small Employer no longer meets the requirements of this definition.
- P. Small Employer Carrier means any carrier which offers Health Benefit Plans covering Eligible Employees of one or more Eligible Small Employers.
- Q. Small Employer Health Benefit Plan means a Health Benefit plan for small Employers, established in accordance with the Act.
- R. Spouse includes a former Spouse of an Eligible Employee for whom a Carrier is obligated to continue existing coverage following divorce or legal separation under COBRA or other similar law or court decree or contractual provision, as an Eligible Dependent for the period of that contractual obligation.

Article III - Members of the Program

All Carriers licensed pursuant to M.G. L. c. 175 issuing Health Benefit plans covering Eligible Small Employers, on and after April 1, 1992 shall be Members of the Program.

Article IV - Powers of the Program

The Program has the authority to:

- A. Provide reinsurance and establish rules, conditions, and procedures, in accordance with the requirements of the Act and applicable regulations.
- B. Establish appropriate rates, rate schedules, rate adjustments, rate classifications and any other actuarial functions appropriate to the operation of the Program.
- C. Assess Carriers in accordance with the provisions of the Act, and make interim assessments as may be reasonable and necessary for expenses, claim reimbursement and other purposes.
- D. Subject to approval of the Commissioner, change the \$5,000 deductible requirement for benefit payments eligible for reinsurance reimbursement.
- E. Enter into contracts as necessary or proper to carry out the duties of the Program, including contracts with similar programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions.
- F. Borrow money to effect the purposes of the Program, from Carriers or other institutions. Any notes or evidences of indebtedness of the Program which are not in default constitute legal investments for Carriers and may be carried as admitted assets.
- G. Appoint legal, actuarial, and other subcommittees, to provide technical assistance in the operation of the Program.
- H. Take any action necessary to avoid the payment of improper claims against the Program.
- I. Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against the Program or any Carrier.
- J. Advise the Massachusetts Legislature and the Commissioner on necessary and/or desirable change in the laws under which the Program operates.
- K. Execute the Phase-out of The Program according to Section 88 of Chapter 58 of the Acts of 2006.
- L. Take any other action not otherwise prohibited by law which is necessary or desirable for the administration of the Program.

Article V - Plan of Operation

The Program performs its functions under this Plan of Operation (The Plan), and in accordance with The Act and The Regulations, as amended by Section 88 of Chapter 58 of the Acts of 2006. The plan of operation includes these articles, and such operating rules as may have been adopted by the Governing Committee. In accordance with Section 88 of Chapter 58 of the

Acts of 2006, The Program will be phased-out as provided in Appendix A. All articles of The Plan and any operating rules as may exist under The Program shall comply with the provisions of Appendix A. The Governing Committee shall adhere to Section 88 of Chapter 58 of the Acts of 2006 as reflected in Appendix A in carrying out its remaining duties under The Plan. If a conflict arises between any of the articles, provisions or terms of The Plan and the Terms of Appendix A, or if a conflict arises between any operating rules as there may be and the terms of Appendix A, then the provisions of Appendix A shall supersede The Plan and govern The Program.

The Plan of Operation is intended to assure the fair, reasonable and equitable administration of the Program, and the sharing of program gains or losses in accordance with the provisions of the Act.

The Plan of Operation becomes effective upon approval in writing by the Commissioner, as provided in the Act. Subsequent Amendments to the plan of Operation will be deemed approved by the Commissioner if not expressly disapproved by the Commissioner within 30 days from the date of filing.

The Program operates for the benefit of Members of the Program who provide coverage to Small Employers as required under the Act. A Member shall have enforceable rights under the Program only if it has fulfilled all of its obligations under the Program. A Member may not transfer, assign, convey, or take any action which may result in the voluntary or involuntary transfer, Assignment, or conveyance of the rights of the Member to any third party who is not a Member of the Program. A person or party who is not a Member of the Program shall have enforceable rights against the Program only if, and only to the extent, the Act, this Plan of Operation, or any written agreement entered into with the Program explicitly confers upon or provides to such person or party specific rights or protections; the provisions of Article VIII, Subarticle F (privacy of information), of this Plan of Operation explicitly confer upon and provide specific rights and protections to persons and parties, who are not Members of the Program. Except as provided herein, the Program and this Plan of Operation do not create or confer upon any other person any direct or indirect rights or claims or action in connection with or arising from the operation of the Program.

Article VI - Governing Committee and Annual Meeting

- A. The Program exercises its powers through a Governing Committee appointed by the Governor of the Commonwealth of Massachusetts for terms of three years.
 - 1. The Governing Committee consists of seven members representing Small Employer Carriers participating in the Program.
 - 2. The Governing Committee shall elect a Chairman and Secretary from among its membership, as well as other officers as it deems appropriate.

3. Vacancies occurring on the Governing Committee between annual meetings will be filled in the same manner as the original appointment, for the unexpired portion of the term.
 4. Governing Committee Members shall be eligible for reappointment.
- B. The votes of the Governing Committee shall be on a one person, one vote basis.
- C. A majority of the Governing committee Members shall constitute a quorum for the transaction of business. The acts of the majority of the Members present at a meeting at which a quorum is present shall be the acts of the Governing Committee, except as provided in the Act.
- D. An annual meeting shall be held at a location selected by the Governing Committee on the first Tuesday in May, 1993, and on the first Tuesday in May in each subsequent year, unless the Governing Committee, upon at least a 30 calendar days notice, designates some other date.
- E. At each annual meeting the Governing Committee shall:
1. Review the Plan of operation and submit proposed amendments, if any, to the Commissioner for approval.
 2. Review reports on administration of the Program, including audited financial reports on contracts and obligations, and all other material matters.
 3. Review reports of the subcommittee established by the Governing Committee.
 4. Establish and review procedures, including limitation on allowable investments for the investment of available funds.
 5. Approve the rates for reinsurance coverage.
 6. Consider possible change in the Reinsurance Deductible.
 7. Review the earned premiums, the expenses of Program administration, and the incurred losses for the prior year, taking into account investment income and other appropriate items.
 8. Determine if an assessment is necessary for the proper administration of the Program, and, by June 1, file an estimate of the needed assessment with the commissioner at least 30 days prior to the issuance of the assessment, including the total amount to be assessed, the total amount of assessment as a percentage of premium earned by all. Small Employer Carriers as calculated in Article XI. G. of this Plan, and the actual assessment for each member carrier.

9. Determine whether any technical corrections or amendments to the Act should be recommended to the legislature.
 10. Review, consider, and act on any matters deemed by the Governing Committee to be necessary and proper for the administration of the Program.
- F. The Governing Committee shall hold other meetings upon the request of the Chairman or of three or more Governing Committee Members, at appropriate times and frequency.

Meetings of the Governing Committee will be held in person and shall be conducted in accordance with the open meeting law as found in M.G.L. c. 30A. Section 11A 1/2.

Notice of such a meeting and its purpose shall be provided to the Governing Committee Members, at least 7 days prior to the meeting. At meetings other than the annual meeting, the Governing Committee may also perform any of the functions authorized by the Act or in Paragraph E above.

A Governing Committee Member shall be responsible for discharging his/her obligations when the Governing committee Member is unable to act in person he/she shall have the right to act by proxy . The proxy will be effective only if: (a) The Governing Committee Member has filed a written, proxy with the Governing Committee, designating one person to exercise all rights, powers, and obligations of the Governing Committee Member, in the Member's absence, (b) The Governing Committee Member and his/her designee are affiliated with the same Small Employer Carrier, (c) The Governing Committee has accepted the proxy, and (d) the Governing Committee has sent the name of the proxy to the Governor. The proxy shall terminate when and if: (a) The Governing Committee Member and his/her designee are no longer affiliated with the same Small Employer Carrier, or (b) ,The Governing Committee revokes its acceptance of the proxy.

- G. Minutes of the proceedings of each Governing Committee meeting shall be made. The original of the record shall be retained by the Secretary of the Governing Committee.
- H. The Governing Committee may establish administrative rules of practice of the Program consistent with the Act and this Plan of operation.
- I. Under the Art, the Governing Committee has been assigned various other responsibilities relating to Small Employer access. The Governing Committee may undertake, assign, or contract for administration of these duties.
- J. The Governing Committee shall report annually to the Commissioner and the Joint Committee on the Program's experience, the effect of reinsurance and Small Group rates on individual ceding and recommendations, if any, on additional funding sources, if needed.

- K. Amendments to the Plan of Operation or suggestions of technical corrections to the Act shall require the concurrence of a majority of the entire Governing Committee.
- L. Governing Committee Members may be reimbursed from the monies of the Program for reasonable expenses incurred by them as Governing Committee Members, upon approval of such expenses by the Governing Committee, but they shall not otherwise be compensated by the Program for their services.
- M. The Governing Committee is responsible for hiring the employee of the Program, if any.

Article VII - Subcommittees

Each Governing Committee Member shall be entitled to participate personally on any subcommittee established under this Plan of Operation or by the Governing Committee.

Minutes of the proceedings of each subcommittee shall be maintained by a secretary appointed from the membership of the subcommittee. Subcommittee Members are responsible for providing staff support, but may recommend that the Governing Committee provide funding for outside contractors. Subcommittees will initially include the following:

A. Actuarial Subcommittee

The mission of the Actuarial subcommittee is to:

1. Recommend to the Governing Committee appropriate reinsurance premium rates, methodologies, rate schedules, rate adjustments, and rate classifications for individuals and groups reinsured with the Program.
2. Recommend to the Governing Committee any appropriate increase in the reinsurance deductible.
3. Determine the incurred claim losses of the Program including amounts for incurred but not reported claims.
4. Recommend to the Governing Committee reports to be made by Small Employer Carriers and any parties retained to provide service to the Governing Committee and/or the Program.
5. Provide reports and other recommendations as directed by the Governing Committee.
6. Recommend assessment methodology and assessments.

7. Fulfill other responsibilities as deemed appropriate by the Governing Committee.

B. Operations Subcommittee

The mission of the operations Subcommittee is to:

1. Review the Plan of operation periodically and make recommendations to the Governing Committee.
2. Provide administrative interpretation as to the intent of the Plan of Operation, and direction on issues referred to it by the Governing Committee, the Administrator, or any other carrier.
3. Identify additional items for which operating rules are needed and propose changes in the Plan of Operation for adoption by the Governing Committee.
4. Fulfill other responsibilities as deemed appropriate by the Governing Committee.

C. Legal Subcommittee

The mission of the Legal Subcommittee is to:

1. Interpret the provisions of the Act.
2. Review the Plan of Operation, and proposed amendments to the Plan of Operation, and make appropriate recommendations to the Governing Committee.
3. Prepare contracts and legal documents for the Program as requested by the Governing Committee.
4. Be familiar with and provide assistance to the Governing Committee concerning all litigation and other disputes involving the Program and its operations.
5. Maintain a written record of all legal questions referred to the Legal Subcommittee and the responses provided, and provide copies of all such responses to the Governing Committee.
6. Coordinate with legal counsel for the Governing Committee, as needed on other routine legal matters relating to the Program operations, including proposed contracts and operational practices.
7. Fulfill other responsibilities as deemed appropriate by the Governing Committee.

D. Audit Subcommittee

The mission of the Audit Subcommittee is to:

1. Approve a uniform audit program to be utilized by independent auditors in their review of items related to reinsurance with the Program and assessments for each affected Member.
2. Establish standards of acceptability for the selection of independent auditors with regard to 1, above.
3. Assist the Governing Committee in the selection of an independent auditor for the annual audit of the Program operations.
4. Assist the Governing Committee in the review of the reports prepared by the independent auditors in conjunction with 1. and 3., above, and any other audit-related matters the Governing Committee deems necessary.
5. Fulfill other responsibilities as deemed appropriate by the Governing Committee.

Article VIII Administrator: Selection and Duties

The Administrator is jointly responsible, with the Governing Committee and all Small Employer Carriers, for the fair, equitable, and reasonable administration of the Program.

- A. In this Article VIII, Section A, the term "Company" shall mean any corporation, partnership or other recognized legal entity which (1) is appropriately registered and/or licensed to do business in Massachusetts and (2) has the appropriate experience, skill, resources and personnel to administer the program. Any entity meeting the definition of Company will be invited to express intent to accept an opportunity to administer the program. From among those expressing intent, the Governing Committee shall select the Administrator to act on its behalf. If two or more Companies express intent, the selection may be based upon responses to a formal Request for Proposal.

The Company will submit a written proposal for providing the administrative services required by this Plan of Operation and approved by the Governing Committee. Once chosen, the Administrator shall be reimbursed for its cost of administration in accordance with arrangements agreed to between the Administrator and the Governing Committee.

In selecting the Administrator, the Governing Committee shall consider the following factors:

- the expertise of the Company in performing the tasks necessary to administer the program on behalf of the Governing Committee

- the Company's experience (through its personnel and otherwise) with relevant Massachusetts law; and
- any other facts it deems appropriate or relevant to the role to be assumed by the Administrator

B. The Administrator shall perform functions, as directed by the Governing Committee, including:

1. Establish procedures and install the systems needed to administer the operations of the Program in accordance with the Act, the Regulations, and the Plan of Operation:
 - a. Accept, on behalf of the Program, risks that are ceded by Small Employer Carriers.
 - b. On a timely basis, collect reinsurance premium for ceded risks and all other amounts due to the Program.
 - c. Design forms for reinsurance reporting, and submit the proposed forms to the Governing Committee for approval.
 - d. Perform reinsurance reimbursement for claims paid on ceded risks.
 - e. Calculate assessments as specified in this Plan of Operation, and collect appropriate amounts due. Recommend to the Governing Committee any reports necessary to facilitate such calculations, and any procedures needed to implement interim assessments.
2. Establish on behalf of the Program one or more bank accounts for the transaction of Program business. These bank accounts will be approved by the Governing Committee.
3. Deposit all cash collected on behalf of the Program in the established bank accounts on a timely basis.
4. Invest available cash in accordance with any investment directions and limitations established by the Governing Committee.
5. Issue checks or drafts on and/or approve charges against bank accounts of the Program.
6. Keep all accounting, administrative and financial records of the Program in accordance with this Plan of Operation.

7. Prepare an annual estimate of operating costs for the administration of Program operations.
 8. Act as a communications resource for reinsuring Carriers in review their administrative operations under the Act and the Plan.
 9. Perform other functions as agreed to between the Administrator and the Governing Committee.
- C. The Administrator shall maintain all records as to premiums, investment income, reimbursements, and administrative expenses during each fiscal or calendar year, as appropriate, for a period of seven years following the end of the year. Such records shall be made available on request to the Division.
- D. The Administrator shall serve until the appointment by the Governing Committee of a successor Administrator, until its resignation, or until it is otherwise removed by the Governing Committee. The Administrator shall give the Governing Committee 180 days notice of its decision to resign. The Governing Committee shall give the Administrator 90 days notice of its decision to remove the Administrator.
- E. The Administrator may subcontract for services, but must obtain the Governing Committee's approval for any subcontracts in excess of \$10,000.
- F. In performing its duties, the Administrator shall maintain the confidentiality of all information pertaining to insureds and Small Employer Carriers, in accordance with all applicable statutes, regulations and principles of common law pertaining to confidentiality and trade secrets. Such information shall be used only for the purposes necessary for the operation of the Program, and shall be strictly segregated from other records, data, and operations of the Administrator. Unless specifically required under the Plan, under the Act, or under other applicable laws, no information shall be retained or used by the Administrator, or disclosed to any third party, if it identifies a specific insured or Small Employer Carrier.

Article IX - Eligibility for Reinsurance

- A. Except as provided in the last sentence of this section A, Members of the Program may reinsure with the Program:
1. Coverage of an Eligible Employee of an Eligible Small Business and/or the coverage of any Eligible Dependents (also referred to as Individual Reinsurance) or
 2. Coverage for all enrolled Eligible Employees of an Eligible Small Business and all Eligible Dependents of those enrolled Eligible Employees (also referred to as Whole Group Reinsurance) Reinsurance is not available to a carrier in connection

with any individual or group insured through a policy which is not subject to or governed by the rating, guarantee issue, and all other provisions of the Act.

B. Identifying Eligible Small Employers

1. Whether a firm is a Small Employer is determined as of the effective date and a each renewal date thereafter of a Small Employer Carrier's coverage of the firm's Health Benefit Plan.

The determination of the number of Eligible Employees, may be based on the most recent Federal or Commonwealth filing which reflects the number of full-time employees, accompanied by a Small Employer certification of this information, unless the Small Employer submits other verifiable information to the Small Employer Carrier which modifies a previous filing.

2. Reinsurance is available only if the Small Employer satisfies eligibility, contribution and participation specified in the Small Employer Carrier's Benefit Plan.
3. Each Small Employer Carrier is responsible for determining whether a firm is a Small Employer as of the effective date of coverage, for updating that determination as of each renewal date, and for obtaining information from the Small Employer to document that determination. The Small Employer carrier must obtain from the Small Employer a signed statement containing the certifications and acknowledgments listed in the Act and in the Plan of Operation.

The Small Employer Carrier is also responsible for certifying the above determination to the Administrator, if any coverage under a Small Employer's Health Benefit Plan is to be reinsured. If a Small Employer Carrier erroneously certifies a firm to be a Small Employer and promptly notifies the Administrator, any reinsurance of employees of that firm is nullified; provided, however, that if the Small Employer Carrier has acted in good faith, reinsurance shall cease on a prospective basis.

C. Identifying Eligible Employees and Dependents

1. If a Small Employer Carrier offers coverage to a Small Employer, it must offer coverage to all the Small Employer's Eligible Employees and Dependents. A Small Employer Carrier may not offer coverage limited to certain persons in a group, except for allowable exclusions with respect to Late Enrollees.
2. Coverage of Extra Eligibles and their dependents does not qualify for reinsurance.

3. Subject to applicable notice within thirty days to the Administrator, any material statement by an Employer or employee which falsely certifies as to an individual's eligibility for coverage constitutes cause for termination of reinsurance, without penalty to the Small Employer Carrier; provided, however, that if the Small Employer Carrier has acted in good faith, reinsurance cease on a prospective basis.

D. Late Enrollee Provisions

1. A small Employer Carrier has the right to decline or limit coverage for a Late Enrollee in accordance with the Act, the Regulations and the Plan of Operation and reinsurance is not available for Late Enrollees, whose coverage is subject to declination or limitation.
2. For the purpose of determining Late Enrollee status, the initial enrollment period refers to the enrollee's earliest opportunity to enroll for coverage under any Health Benefit Plan sponsored by the employee's current Small Employer.

A special rule shall apply if an individual is not covered under the Health Benefit Plan of a Small Employer ("prior plan") which is replaced by a Health Benefit plan provided by a different Small Employer Carrier ("replacement plan"). The first open enrollment period available to such individual shall be the first renewal date of the replacement plan.

However, if the individual is able to establish the next scheduled renewal date of the prior plan (if it had remained in force), and the next scheduled renewal date of the prior plan is earlier than the only open enrollment periods of the replacement plan, he/she may enroll under the replacement plan at the next scheduled renewal date of the prior plan, if it had remained in force. If an individual does not obtain coverage under this special rule, the open enrollment period available to him/her shall be the period of the replacement plan.

E. Effective Date of Coverage

1. The Small Employer's Health Benefit Plan must specify the period of full-time employment which must be completed by newly hired Eligible Employees before coverage starts. Such period must be applied uniformly to all classes of Eligible Employees, and be determined without regard to the actual or expected health conditions of Eligible Employees or Dependents.
2. Reinsurance is not available for Pre-existing Conditions to the extent coverage for Pre-existing conditions may be excluded under the Small Employer's Plan in accordance with the Act or the Regulations. In determining whether a Pre-existing Condition Provision applies to an Eligible Employee or Dependent, credit must be given for coverage under a previous Qualifying Health Plan in accordance with the applicable requirements as set forth in the Regulations.

Article X - Procedures for Ceding Risks

A. Reinsurance Rules and Premium Levels

1. Each Small Employer Carrier proposing to cede reinsurance of the coverage for any group or individual is responsible for ascertaining and certifying that:
 - a. The group is an Eligible Small Employer;
 - b. The individual is an Eligible Employee or an Eligible Dependent,
 - c. The Health Benefit Plan coverage meets all other requirements for reinsurance, including but not limited to cost containment and managed care techniques established by the Program.
 - d. The reinsurance premium rate level payable to the Program for that group or individual has been correctly determined in accordance with this Article; and
 - e. The Health Benefit Plan contains a participation requirement of at least 75% of Eligible Employees, at issuance and at renewal.

Each Small Employer Carrier must document these determinations in reporting reinsurance census data and reinsurance premiums to the Administrator.

2. A Small Employer Carrier may cede all enrolled Eligible Employees and their Eligible Dependents for coverage under a Health Benefit Plan covering Eligible Employees of a Small Employer (Whole Group Reinsurance). Alternatively, a Small Employer Carrier may cede individual coverage for a specific person covered as an Eligible Employee or an Eligible Dependent under a Small Employer's Health Benefit Plan (Individual Reinsurance).
3. Whole Group Reinsurance can be effective on or after April 1, 1992, and only as of one of the follow dates:
 - a. the initial effective date of the Small Employer's Health Benefit Plan.
 - b. the effective date of transfer of the group from a prior Carrier.

Reinsurance of an otherwise eligible individual covered under a Small Employer's Health Benefit Plan may be effective either on one of the above dates or on the effective date of the individual's coverage, if later.

4. Availability of reinsurance is subject to the following additional rules:
 - a. The group must be a Small Employer on the effective date of reinsurance.

- b. Reinsurance as not available with respect to existing insureds in the case of an employer which becomes a Small Employer due to a decrease in the number of Eligible Employees employed by such employer; however, individual reinsurance is available with respect to new Eligible Employees employed by such Small Employer and after the date such employer attains Small Employer status.
- c. Each individual whose coverage is reinsured must be an Eligible Employee or Eligible Dependent.
- d. New entrants to groups may be reinsured at the effective dates of their insurance coverage. Part time, temporary, or substitute employees who are insured under a Small Employer's plan are not eligible to be reinsured as of the date they change status and become Eligible Employees.
- e. The Small Employer Carrier may reinsure individual coverage of an Eligible Employee without reinsuring coverage of any specific Dependent of that employee, and may reinsure coverage of a specific Eligible Dependent without reinsuring coverage of the Employee. A newborn's coverage may be reinsured if and only if the mother's coverage was reinsured prior to the date of birth.
- f. The Small Employer Carrier may choose either monthly or quarterly reporting of reinsurance claims, but must use the same reporting for all transactions.
- g. A renewal, reissue, policy anniversary, amendment, rider or other change in the Employer's Health Benefit Plan does not qualify an individual or group for reinsurance.

B. Level of Coverage

For Prototype Plans, the program will reinsure the level of coverage provided to the employee subject to the reason deductible.

For other plans, the Program will reinsure the level of coverage provided to the employee up to, but not exceeding, the level provided in the applicable Prototype Health Benefit plan for the applicable services or benefits.

C. Notification of Reinsurance

For reinsurance to become effective, notice must be provided to the Administrator within 60 days after the effective date of the group's, employee's, or dependent's coverage, as the case may be. Notice must include all required information with respect to each individual whose coverage is to be reinsured.

D. Period of Reinsurance

1. Reinsurance may continue for as long as the Eligible Employee's and/or Dependent's coverage remains in effect under a Small Employer Health Benefit Plan; provided, however, when the number of Eligible Employees increases to more than 50, reinsurance may be continued until the first of the following occurs:
 - a. The number of Eligible Employees reaches 55 as of the applicable renewal date.
 - b. The number of Eligible Employees exceeds 50 for two consecutive renewal determination dates.
 - c. The Small Employer Carrier takes a rating, access, or other action which would be prohibited for a group of 50 or fewer Eligible Employees under the Act or Regulation.
2. A Small Employer Carrier may withdraw a group or individual from the Program while coverage continues under the Small Employer's Health Benefit Plan. Withdrawals will be effective on a Health Benefit Plan renewal date. Written notice must be provided at least 30 days in advance of the withdrawal. No reinstatement of a withdrawn group or individual will be allowed.
3. Reinsurance of an individual's coverage under a Small Employer's Health Benefit Plan ceases at the termination of the individual's status as an Eligible Employee or Eligible Dependent (e.g., at retirement or other termination of active employment, divorce of a Spouse, a Child's attainment of limiting age, or employee's cessation of full-time employment (30 or more hours), except to the extent that coverage continues as required by law).

If the Small Employer Carrier provides coverage for such persons beyond the date indicated above, for contractual or other reasons, reinsurance will be available for a maximum of an additional 30 days.

4. Reinsurance ceases for an individual covered under a Small Employer's Health Benefit Plan (including an individual whose coverage under that Health Benefit Plan has continued as required by law) at termination of the Small Employer Carrier's coverage of the group in which that individual was covered as an Eligible Employee or Eligible Dependent.

E. Determination of Reinsurance Premium

1. Tables of reinsurance premium rates, as determined by the Actuarial Subcommittee and approved by the Governing Committee, will be filed with the Division at least 30 days prior to the effective date and will be communicated to Small Employer Carriers.

2. For any reinsured individual, the reinsurance premium is 500% of the adjusted Average Market Premium Price established for the prototype plan for that classification or group with similar characteristics and coverage, minus any ceding expense factor authorized by the Actuarial Subcommittee. The Small Employer carrier will base the reason premium for each individual reinsured on the appropriate Table. A member is not required to pay reinsurance premium for covered individuals beyond the amount which would have been paid if all Eligible Employees and Dependents had been reinsured as an entire group.
3. For any reinsured group, the reinsurance premium is 150% of the adjusted Average Market Premium Price established for the prototype plan for that classification or group with similar characteristics and coverage, minus any ceding expense factor authorized by the Actuarial Subcommittee. For each group reinsured, the Small Employer Carrier will base the reinsurance premium on the appropriate Table.

F. Billing and Payment

1. Premiums are determined as of the first of the month or first day of the first month in a quarter, and are due by the twentieth of the month, for the applicable month or quarter. Interest on late premiums will be charged at 1.5% per month.
2. The reinsurance premiums charged for each individual will be determined by the Table of Rates in effect on the later of the effective date of the Employers Health Benefit Plan with the Small Employer Carrier or the most recent Health Benefit Plan renewal.
3. Reinsurance bills will be handled on a "self-billed" basis. Monthly or quarterly if selected by the Small Employer Carrier, the Small Employer Carrier will provide the Administrator with a list of groups and individuals reinsured, the premium for each individual (for the month(s) covered), and such other information as may be required by the Program. The Administrator will make any necessary corrections and send the corrected statement to the Small Employer Carrier.
4. Reinsurance premium amounts are to be based on whole month increments only. If reinsured coverage is effective between the 1st and the 15th of the month, the entire month is paid in full. When coverage becomes effective after the 15th of the month, no premium will be payable until the first month following the effective date.
5. Terminations effective between the 1st and the 15th of the month will be allowed refunds for the entire month, and terminations effective after the 15th of the month will not be allowed a premium refund.

6. Reinsurance premium is due to the Program for as long as the Health Benefit Plan remains in force regardless of the Small Employer Carrier's ability to collect the Small Employer's premiums. The Program has no responsibility for the Small Employer Carrier's collection of premiums.

Article XI - Reinsurance Claims

A. Statement of Reinsurance

After the deductible amount, the Program will identify Small Employer Carriers subject to the following:

1. Covered Claims are amounts in excess of the deductible amount in benefit payments made by the Small Employer Carrier, for medical service and supplies provided during a calendar year for a reinsured Eligible Employee or Dependent. The initial deductible amount shall be \$5,000 of benefit payments.

In addition, the Small Employer Carrier shall retain 10% of the next \$50,000 of benefit payments during a calendar year. The Program shall reinsure the remainder, provided that initially the Small Employer Carrier's liability shall not exceed \$10,000 in any one calendar year with respect to any one person reinsured.

The deductible amount, the coinsurance percentage and the maximum Small Employer Carrier liability may be changed by the Governing Committee at any time subject to the approval of the Commissioner.

2. Coverage provided by a Small Employer Carrier under a plan other than the applicable prototype plans shall be reinsured up to the lesser of the benefits provided and the benefits included under the prototype Health Benefit Plan for which reinsurance premium have been Paid.
3. For the purposes of this Act, "Covered Claims" shall mean only amounts actually paid by Small Employer Carriers for benefits provided for individuals reinsured by the Program, including payments for medical services and supplies made under case management programs or other cost management programs. Covered Claims shall not include:
 - a. Claim expenses or salaries paid to employees of Small Employer Carriers other than for provisions of health services directly to eligible employees and dependents.
 - b. Court costs, attorney's fees or other legal expenses, whether incurred by the insured or Small Employer Carrier.

- c. Any amount paid by Small Employer Carriers for:
 - (1) Extra-contractual, punitive or exemplary damages; or
 - (2) Compensatory or other damages awarded to the Insured, arising out of the conduct of the Carriers in the investigation, trial, or settlement of any claim for failure to pay or delay in payment of any benefits under any policy; or
 - (3) Compensatory or other damages awarded to the Insured, arising out of the operation of any managed care, cost containment, or related programs.
- d. Any statutory or other penalty imposed upon or agreed to by a Small Employer Carrier included but not limited to a penalty arising from any alleged unfair trade practice or unfair insurance practice.

B. General Requirements

- 1. Small Employer Carriers agree that they will promptly investigate, settle, or defend all claims arising under the risks reinsured and that they will forward copies of such reports of investigation promptly, as may be requested by the Administrator.
- 2. Small Employer Carriers will adjudicate all claims on ceded individuals. They will be required to assure that their claim management practices are consistent for reinsured and non-reinsured individuals. The failure to follow such procedures will result in the denial or reduction of reinsurance claim payments, as determined by the Governing Committee.
- 3. Small Employer Carriers agree to use their usual case management and claim handling techniques, including utilization review, preferred provider provisions, and other managed care provisions on reinsured business. The failure to follow such procedures will result in the denial or reduction of reinsurance claim payments, as determined by the Governing Committee.
- 4. The program shall have the right, at its own expense, to participate jointly with a Small Employer Carrier in the investigation, adjustment or defense of any claim.
- 5. The Program shall have the right to inspect the records of the Small Employer Carrier connection with reinsured individuals. The Small Employer Carrier shall submit any additional information required in connection with claims submitted for reimbursement. Where required by law, carriers shall secure necessary authorizations from insureds for this purpose.

6. All information disclosed between the Program (or the Administrator) and Small Employer Carriers, in connection with this Plan of Operation, shall be considered to be proprietary information by the Carriers and by the Program.
7. If any payment is made by the Program and the Small Employer Carrier is reimbursed by another party for the same expenses, any reinsured claim shall be appropriately adjusted. The Small Employer Carrier shall do whatever is necessary to preserve and secure its usual reimbursement rights.
8. Except as approved by the Governing Committee reinsurance will be provided only for covered claims submitted within two years from the date the expenses on which the claim is based were incurred.

C. Claims Reporting

1. Within 20 days after the close of each quarter (or month, as each Carrier chooses), the Small Employer Carrier shall furnish to the Administrator the information required with respect to reinsured losses during the period. The information shall be conveyed using forms approved by the Governing Committee and furnished by the Administrator.
2. Each Small Employer Carrier shall notify the Administrator as soon as reasonably possible if claims for a reinsured individual are expected to exceed \$100,000.

Article XII - Net Fund Earnings, Assessments, Late Payments and Definition of Earned Premium

A. Net Fund Earnings and Assessments

1. Following the close of each fiscal year, the Governing Committee shall determine the net gain or loss for the year taking into account earned premiums for reinsurance coverage, the reinsurance Program expenses for administration, incurred losses, investment income and other appropriate gains and losses.
2. Any net loss for a year shall be recouped by assessment of members of the Program. The assessments will be apportioned in proportion to the Members respective shares of the total premiums earned in the Commonwealth from Health Benefit Plans covering Eligible Small Employers for such year. Such assessments should not exceed five percent of such premiums from such health benefit plans.
3. If the assessment level is inadequate, the Governing Committee may adjust reinsurance thresholds, retention levels or consider other forms of reinsurance. The Governing Committee shall report annually to Commissioner and the Joint Committee on its experience, the effect of reinsurance and small group rates on

individual ceding and recommendations, if any, on additional funding sources, if needed.

If other funding sources are not made available, the Governing Committee may enter into negotiations with Members to resolve any deficit through reductions in future payment levels for reinsurance plans. Any such recommendations must take into account the findings of an actuarial study to be undertaken within the first three years of the Program's operation to evaluate and measure the relative risks being assumed by differing types of Carriers. The study must be conducted by 3 Actuaries appointed by the Commissioner, one of whom shall represent the risk assuming carriers, one of whom shall represent reinsuring carriers and one of whom shall represent the Commissioner.

B. Assessment Deferral

1. On application to the Governing Committee, assessments may be deferred whenever a Carrier's statutory net worth is at or below the minimum required by the Division of Insurance and the Carrier, with the approval of the Commissioner, has ceased issuing new business. The deferral will continue for the period approved by the Governing Committee or until the Carrier's net worth exceeds statutory requirements.
2. When the deferral period is over, the Carrier must pay the accumulated assessments over a three year period, and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments. No interest will be charged on deferral for financial impairment.
3. If an assessment against a Carrier is deferred, in whole or in part, the amount by which the assessments deferred may be assessed against the other Carriers. When paid, these delayed assessments will be treated as other income to the Program.

C. De Minimis Assessments

Assessments of less than \$100 shall not be billed, but will be deferred until the cumulative amount due from a Carrier exceeds \$100. Any assessment of less than \$10 shall be forgiven.

D. Late Payments

Assessments shall be paid when billed. If the assessment is not received by the Administrator within 30 days of the billing date, the Carrier shall pay interest on the assessment from the billing date at the rate of 1.5% per month. In the case of a Small Employer Carrier, the Governing Committee may suspend reinsurance rights if payments are not made in accordance with this Article.

E. Earned Premium

Earned premium shall include all premiums and/or subscriber payments for Health Benefit Plans earned during an accounting period. It does not include:

1. Accident only
2. Credit, dental, disability or vision insurance as separate policies or riders
3. Coverage issued as a supplement to liability insurance
4. Workers' compensation
5. Automobile medical-payment insurance
6. Insurance statutorily required in liability insurance policies

Article XIII - Reporting Requirements

A. The Division of Insurance

From reports filed by Small Employer Carriers, the Division shall provide the Administrator with the premiums needed to calculate interim and final assessments for a period.

B. Small Employer Carriers

1. Unless otherwise specified by the Governing Committee, the following information be required by the Program for reinsured risks:
 - a. Identification of the Small Employer Carrier
 - b. Name, date of birth, sex, and the Carrier identification (certificate) number of the person being reinsured
 - c. Identification of the reinsured as an employee, Spouse, or Child
 - d. Employee name and social security number
 - e. Health Benefit Plan anniversary date
 - f. Employer's name, address, zip code, and SIC code
 - g. Health Benefit Plan Version
 - h. Effective date of Small Employer coverage

- i. Effective date of reinsurance
 - j. Date of applicable employee's full-time employment
 - k. Status code as required by the Governing Committee
 - l. Other information required by the Governing Committee
2. When a change in Reinsurance Coverage occurs, the Small Employer Carrier shall notify the Administrator of changes by including:
 - a. The reinsured's name and identification number
 - b. The employee's name and social security number
 - c. Effective date of status change
 - d. Status code for change as required by the Governing Committee
 - e. Other information required by the Governing Committee
3. Each Small Employer Carrier shall notify the Division, by April 1 of each year, in such form as approved by the Commissioner, of its earned premiums for the prior year (beginning with 1992) for Employer business.

C. Administrator

1. By April 1 of each year, the Administrator shall report the financial results of the prior year's Program operations to the Governing Committee.
2. By June 1 of each year, the Administrator shall recommend the amount of assessment due from each Member, and report all results to the Governing Committee.

Article XIV - Financial Administration

A. Books and Records

The Administrator shall maintain the book and records of the Program so that financial statements can be prepared to satisfy the Act. Further, these books shall satisfy any additional requirements as may be deemed necessary to meet the needs of the Governing Committee and the outside auditors.

1. The receipt and disbursement of cash by the Program shall be recorded as it occurs.

2. Non-cash transactions shall be recorded when the asset or the liability should be realized by the Program in accordance with generally accepted accounting principles.
3. Assets and liabilities of the Program, other than cash, shall be accounted for and described in itemized records.
4. The net balance due to or from the Program shall be calculated for each Small Employer Carrier and confirmed as deemed appropriate by the Governing Committee or when requested by the respective Carrier. These balances should be supported by a record of each individual Small Employer Carrier's financial transactions with the Program. These records include:
 - a. Net earnings/losses of the Program based upon the assessments calculated in accordance with this Plan of Operation.
 - b. Any adjustments to assessments as explained in this Plan of operation.
 - c. The amount of reinsurance premium due to the Program for individuals whose coverage is ceded
 - d. The amount of reimbursement due to/from the Program for reinsured claims paid by the Small Employer Carrier.
 - e. Adjustment to the amount due to/from the Program based upon corrections to the Small Employer Carrier submissions.
 - f. Interest charges due from the Small Employer Carrier for late payment of amounts due to the Program.
 - g. Other records required by the Governing Committee.
5. The Administrator shall maintain a general ledger whose balances are used to produce the Program's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger shall agree with the corresponding balances in subsidiary ledgers or journals.

B. Handling and Accounting of Assets and Money

Money and marketable securities be kept in bank accounts and investment accounts as approved by the Governing Committee. The Administrator shall deposit receipts and rake disbursements from all these accounts.

C. Bank Accounts

All bank accounts/checking accounts be established in the name of the Massachusetts Small Employer Health Reinsurance Program, and shall be approved by the Governing Committee. Authorized check signers shall be approved by the Governing Committee.

D. Lines of Credit

All lines of credit shall be established in the name of the Massachusetts Small Employer Health Reinsurance Program, and shall be approved by the Governing Committee.

Lines of credit may be obtained to pay any obligations and/or expenses which the Program has incurred, is obliged to incur, or is reasonably expected to incur. Such obligations and expenses may include those which the Program is required to incur (including, but not limited to reinsurance of health benefit plans) those considered reasonable by the Governing Committee for the administration of the Program and any other expenses reasonably related to the Program.

E. Investment Policy

All cash shall be invested in available investment vehicles approved by the Governing Committee.

Article XV - Audit Functions

A. Audits of Small Employer Carriers and Reinsurance Claims

1. Audits prescribed by the Governing Committee shall be conducted by or under the direction of the Administrator in accordance with a uniform audit program ("Standard") for Small Employer Carriers, as developed by the Governing Committee. This Standard shall clearly specify all items to be audited. It shall include a certification statement form to be completed by the auditor, to verify the completion of all prescribed procedures. A copy of this report and the certification statement shall be submitted to the Governing Committee by the auditor.
2. The Standard may include testing of representative samples of the following:
 - a. Reinsurance claims submitted to the Program, in particular:
 - (1) Eligibility of claimants and their Small Employers for reinsurance by the Program,
 - (2) Proper determination of reinsurance claim amounts by Small Employer Carriers, and
 - (3) Normal administration of managed care and claim adjudication procedures.

- b. Reinsurance premiums submitted to the Program, including:
 - (1) Eligibility of those for whom reinsurance premium is paid, and
 - (2) Proper determination of reinsurance premiums paid.
 - c. Data submitted to the Program for use in the calculation of assessments for net losses.
-
- 3. Random audits of provider bills or other records may be conducted by or under the direction as deemed necessary by the Audit Committee, to verify the accuracy and appropriateness of reinsurance claim submissions.
 - 4. The frequency of audits shall be determined by the Audit Committee. The cost of the audit of a Small Employer Carrier shall be borne by that Carrier. The Governing Committee shall have the right to conduct appropriate additional audits of Small Employer Carriers.
 - 5. All information disclosed in the course of the audit of a Small Employer Carrier shall be considered privileged information by the Carrier, the auditing firm, and the Program and shall be made available upon request to the Division.

B. Audits of the Program

The Administrator shall arrange for an annual audit of the Program conducted by an independent Certified Public Accountant approved by the Governing Committee. The Governing Committee shall file this annual audit with the Commissioner for his review.

This audit shall encompass at least the following items:

- 1. The handling and accounting of assets and money for the Program.
- 2. The annual fiscal report of the Program.
- 3. The calculation of the premium rates charged for reinsurance by the Program.
- 4. The calculation and the collection of any assessments of Small Employer Carriers for net losses.
- 5. The reinsurance premiums due to the Program and the claim reimbursements made to the Small Employer Carriers.

The Commissioner may, at his or her discretion, prescribe audits of the Program to be paid for by the Program. The Program shall cooperate with any such audit.

Article XVI - Penalties/Adjustments and Dispute Resolution

A. Penalties/Adjustments

1. Numerous factual determinations and tasks must be performed by Small Employer Carriers relative to their participation in the Program. It is expected that all Small Employer Carriers will exercise good faith and due diligence in all aspects of their relationship with the Program. Errors will occur, however, and it is appropriate that the sanctions applicable to such errors be detailed.

2. Errors related to reinsurance:

a. A Small Employer Carrier reinsures an ineligible Small Employer/Employee/Dependent (initial placement of an ineligible person or failure to remove a person who becomes ineligible).

Reinsurance coverage for the individuals involved shall be terminated as of the first date of ineligibility. Claims paid by the Program in excess of premiums received are to be returned to the Program with interest. Premiums paid in excess of claims will be refunded without interest. An administrative charge may be assessed if the Governing Committee so determine.

b. A Small Employer Carrier reinsures an Employee/Dependent at the incorrect premium rate (failure to use correct Program rates, to make a proper Benefit Plan adjustment, and/or to apply correct rates to persons reinsured)

Reinsurance premiums for the individuals involved should be recalculated and immediate payment of additional premiums, interest, and an administrative charge must be made. Excess payments shall be refunded without interest.

c. Small Employer Carrier reinsures incorrect claim payments.

The claim will be recalculated and any amount due to the program will be repaid immediately, with interest and an administrative charge. Adjustments of claim payments for amounts recovered by the Small Employer Carrier under coordination of benefit, subrogation or similar provisions shall not be considered errors for which any interest or administrative charge would be due. Amounts due a Small Employer Carrier shall be refunded without interest.

3. Errors related to assessments:

Carrier errors related to assessments shall require the immediate payment of additional amounts due plus interest, calculated from the date such sum should have been paid, plus any administrative charge established by the Governing Committee.

4. Errors not listed:

All additional sums due to the Program as a result of errors made by Carriers shall be paid immediately, with interest and any applicable administrative charge.

5. Gross negligence and intentional misconduct:

If the Governing Committee determines that the nature or extent of the errors related to the use of the reinsurance mechanism or otherwise by a particular Small Employer Carrier evidences gross negligence or intentional misconduct, the Governing committee may, after notice and a hearing, terminate some or all current reinsurance for the Carrier and/or suspend the right of the carrier to use the reinsurance mechanism for an appropriate period of time. All such actions shall require the concurrence of the Commissioner before becoming effective. The Governing Committee will ensure, to the extent possible, that the suspension or termination of reinsurance shall not adversely affect individuals already insured by the Small Employer Carrier.

B. Interest and Administrative Charges

All Interest payments required under this Article shall be calculated from the date the incorrect payment occurred or correct payment should have been made through the date of payment. The rate of interest and any Administrative Charges with respect to the Program shall be established by the Governing Committee and may be waived by the Governing Committee. Errors reported by Small Employer Carriers within 90 days of the occurrence shall not be subject to interest or any charges.

C. Limitation on Premium Refund

All premium refunds due under this Article shall be limited to a period of 12 months from the date the error was corrected unless otherwise agreed to by the Governing Committee.

D. Appeal of Disputes to Governing Committee

The Administrator will act on behalf of the Governing Committee in the attempt to resolve disputes between a Small Employer Carrier and the Program; however, Carriers may request permission to appear before the Governing Committee at any time in connection with any dispute with the Program.

Article XVII - Claims and Causes of Action; Indemnification

A. The Program (as opposed to the Governing Committee, Members of the Governing Committee and the Carriers with whom they are affiliated, Small Employer Carriers which are or have been Members of the program, and any and all other persons and parties) is exclusively responsible for any and all claims and causes of action of any kind arising out of establishment and operation of the Program, including but not limited to any civil, criminal, or administrative proceedings.

B. Except and unless specifically provided herein, this Plan of Operation does not create or confer upon any party any new or additional claim or causes of action, criminal or civil liability, or penalty against the Members of the Governing Committee and the Carriers with whom they are affiliated, or any Small Employer Carriers which are or have been Members of the Program, in connection with establishment, operation, administration, management, oversight, or participation of or in the Program, including but not limited to the establishment of rates or any joint or collective action taken under or required by the Act or this Plan of operation.

C. Persons or Carriers made a party to any action, suit, or proceeding because the person or carrier serves on the Governing Committee or on a subcommittee, or was an officer or employee of the Program, shall be held harmless and be indemnified by the Program against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit or proceeding. This indemnification shall not be provided on any issue on which liability is imposed because the person or member is finally adjudged in the action, suit or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance or reckless disregard of the responsibilities of office. Indemnification may be provided in whole or in part by one or more policies of insurance which may be obtained by the Program. Costs and expenses of the indemnification shall be prorated and paid for by all Small Employer Carriers.

Article XVIII - Amendment, Termination

A. Amendments

Amendments to this Plan of operation may be suggested by any Small Employer Carrier and may be made by majority vote of the Governing Committee at any time, subject to the approval of the Commissioner. Amendments submitted to the Commissioner shall become effective upon the earlier of written approval by the Commissioner expiration the of 30 days without by the Commissioner.

B. Termination

The Program shall continue in existence subject to termination in accordance with the requirements of a law or laws of the Commonwealth of Massachusetts or The United States of America. In case of enactment of a law or laws which, in determination of the Governing Committee and the Commissioner, shall result in termination of the Program, the Program shall

terminate and conclude its affairs. Any funds or assets held by the Program following the payment of all claims and expenses of the Program shall be distributed to the Members of the Program at that time in accordance with the then-existing assessment formula.

Appendix A – Phase-out of The Program

According to Section 88 of Chapter 58 of the Act of 2006, amending M.G.L. c. 176J, the Governing Committee of the Massachusetts Small Group Health Reinsurance Plan (“The Program”) will execute the phase-out of the Program according to the following requirements:

- A. Carriers will end all ceding of risks into The Program as of midnight August 31, 2006.
- B. All coverage for risks ceded into The Program will end as of midnight, December 31, 2006.
- C. The claim filing period (run-off period) will end no later than midnight December 31, 2007 for claims incurred through December 31, 2006 postmarked no later than December 31, 2007. .
- D. A final accounting of The Program will be held by no later than June 30, 2008.
- E. The Administrator of The Program, Pool Administrators, Inc., or its duly appointed successor, assignee or designee if any, will notify all Massachusetts-licensed or -authorized small group carriers (“Carriers”) of the above changes by U.S. Mail to such Carriers according to the following requirements:
 - 1. By August 11, 2006, the Administrator shall mail written notice that all further ceding to the Massachusetts Small Group Health Reinsurance Plan will cease on August 31, 2006.
 - i. At this time, the Administrator shall will also inform these Carriers:
 - 1. Coverage under The Program will terminate on December 31, 2006
 - 2. Claims payments will cease on December 31, 2007.
 - 3. The Administrator shall also include in the mailing a copy of this Appendix A the Plan of Operations as recently amended to incorporate Appendix A.
 - 2. Thereafter, the Administrator shall mail to all Carriers timely reminders (at least 30 day advance written notice) of the later key dates:
 - i. Termination of coverage at midnight December 31, 2006,
 - ii. The end of the claim run-out period at midnight December 31, 2007.
- F. In the event that The Program experiences a residual surplus (premiums less claims at the final accounting, such surplus shall be distributed to the Carriers who are or were at any time members of The Program in accordance with the assessment formula outlined in Article XII, section A.2 of The Plan.
- G. In the event that The Program experiences a net loss at the final accounting, such net loss shall be recouped from the Carriers who are currently members of The Program

in accordance with the assessment formula outlined in Article XII, section A.2. of The Plan.

- H. The provisions of this Appendix A will supersede any inconsistent provisions within The Plan and any conflict between any articles of The Plan and this Appendix A shall be resolved by adhering to Section 88 of Chapter 58 of the Acts of 2006 as reflected in this Appendix A.

Appendix B



MITT ROMNEY
GOVERNOR

KERRY HEALEY
LIEUTENANT GOVERNOR

COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE

One South Station • Boston, MA 02110 - 2208
(617) 521-7794 • FAX (617) 521-7773
TTY/TDD (617) 521-7490
<http://www.state.ma.us/doi>

JANICE S. TATARKA
DIRECTOR, CONSUMER AFFAIRS
AND BUSINESS REGULATION

JULIANNE M. BOWLER
COMMISSIONER OF INSURANCE

August 11, 2006

Mr. Manuel D. Chrobak
Tufts Health Plan
333 Wyman Street
P.O. Box 9112
Waltham, MA 02454-9112

Re: Massachusetts Nongroup Health Reinsurance Plan Phase-Out

Dear Mr. Chrobak:

The Division of Insurance ("Division") received the August 10, 2006 letter that you forwarded on behalf of the Governing Committee of the Massachusetts Nongroup Health Reinsurance Plan ("MNHRP"). Your letter presents the Governing Committee's proposed phase-out of the MNHRP ("Proposal") and amendments to the Plan of Operations ("the Plan"). As you are aware, amendments to the Plan are subject to Commissioner's review. According to the provisions of M.G.L. c. 176M, § 6(c), such amendments may be deemed approved by the Commissioner if not expressly disapproved in writing within thirty days (30) from the date of filing.

The Division has reviewed the MNHRP Proposal and the amendments to the Plan pursuant to M.G.L. c. 176M, as recently amended by Section 95 of Chapter 58 of the Acts of 2006. As you know, Section 95 requires that "by no later than July 1, 2006, the governing committee shall establish a proposal to phase-out the operations of the [MNHRP] and submit a copy of said proposal to the commissioner for approval. The proposal shall include a method for closing the plan by June 30, 2007. The governing committee shall execute the phase-out of the plan." Although the Governing Committee of the MNHRP did submit to the Commissioner a proposal to phase-out the operations of the MNHRP by July 1, 2006, the Division asked the Governing Committee to resubmit such proposal with the addition of an amended Plan. The Proposal is subject to the Commissioner's approval under Ma. Stt. 2006, Ch. 58, § 95; and the amended Plan is subject to her separate approval pursuant to M.G.L. c. 176M, §6(c).

The Division understands that the Plan has been amended to incorporate, by reference, the terms of the Proposal. The Proposal has been designated "Appendix A," and supersedes and governs the articles of the Plan. Accordingly, the Division understands that any and all outstanding contracts, obligations and entitlements that exist pursuant to the plan shall be properly

Mr. Manuel D. Chrobak

August 11, 2006

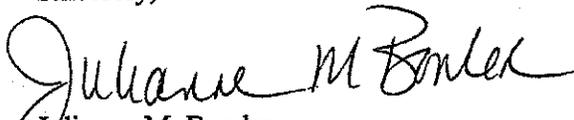
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maintained subject to the eventual phase-out process and final closing of MNHRP as reflected in Appendix A. The Governing Committee, members of MNHRP, insured and ceded risks, as well as any vendor arrangements established pursuant to the MNHRP will be governed by the Plan as amended, and if any conflict arises between the Plan and Appendix A, Appendix A will govern.

Based on the understandings, I hereby approve the Proposal and the amended Plan pursuant to the Ma. Stt. 2006, Ch.58 § 95 and M.G.L. c. 176M, §6(c).

If you have any questions, please contact Nancy Schwartz, Director, Bureau of Managed Care at 617-521-7347.

Sincerely,



Julianne M. Bowler
Commissioner

July 14, 2006

Ms. Julianne M. Bowler
Commissioner of Insurance
Massachusetts Division of Insurance
One South Station
Boston, MA 02110-2208

RE: Massachusetts Nongroup Health Reinsurance Plan
Proposal for Closing Plan

Dear Commissioner Bowler:

According to M.G.L. c. 176M, § 6, as recently amended by Section 95 of the Healthcare Reform legislation of 2006, "By no later than July 1, 2006, the Governing Committee shall establish a proposal to phase-out the operations of the plan and submit a copy of said proposal to the commissioner for approval. The proposal shall include a method for closing the plan by June 30, 2007. The Governing Committee shall execute the phase-out of the plan."

During an open meeting of the Governing Committee on May 9, 2006 the Governing Committee of the Massachusetts Nongroup Health Reinsurance Plan ("the Program") approved a proposal to phase-out the operations of the Program in the manner summarized below. With your approval:

1. The Governing Committee will amend the Plan of Operations to end all ceding of risks into the Massachusetts Nongroup Health Reinsurance Plan as of midnight August 31, 2006.
2. The Governing Committee will amend the Plan of Operations to end all coverage for risks ceded into the Massachusetts Nongroup Health Reinsurance Plan as of midnight, December 31, 2006.
3. The Governing Committee will amend the Plan of Operations to end the claim filing period (run-off period) for claims incurred through December 31, 2006 to claims postmarked to the administrator's offices no later than midnight December 31, 2007.
4. The Governing Committee will amend the Plan of Operations to allow for a final accounting of the Program by no later than June 30, 2008.
5. Pool Administrators, Inc., the administrator of the Program, will notify by U.S. mail all Massachusetts Non-group carriers of the above changes by releasing:
 - By July 31, 2006, written notice that all further ceding to the Massachusetts Nongroup Health Reinsurance Plan will cease on June 30, 2006. They will also inform these carriers of dates when coverage under the Program will terminate (December 31, 2006) and when the claims run-off period will end (December 31, 2007). Pool Administrators, Inc. will include a copy of the Amendment to the Plan of Operations (copy attached) and your letter approving these changes.
 - They with thereafter provide to Massachusetts Non-group carriers timely reminders (at least 30 day advance written notice) of later key dates (termination of coverage at



Ms. Julianne M. Bowler, Commissioner of Insurance
July 14, 2006
Page 2

midnight December 31, 2006, and the end of the claim run-out period at midnight December 31, 2007).

6. The Governing Committee does not expect a residual surplus (premiums less claims) to accrue through the claims run-off period. As a result the Governing Committee has not established a process to cover that unlikely event. Should such a surplus become likely, the Governing Committee believes that it will have adequate time to develop an equitable refund arrangement, and we will bring this plan to you for your prior approval.

As noted, in order to implement this plan to close the Program, the Governing Committee requests your approval of this proposal. Please contact me at (781) 466-9400 x2103 should you require additional information regarding this request.

Very truly yours,



Manuel D. Chrobak
Chairman

cc: Walter Morris, Governing Committee member
Andreana Shanley, F.S.A., M.A.A.A., Governing Committee member
Gary Lin, F.S.A., M.A.A.A., Governing Committee member
Thomas Nyzio, Governing Committee member
Nancy Schwartz, Massachusetts Division of Insurance
Karl Ideman, Pool Administrators, Inc.

Attachment

**MASSACHUSETTS NONGROUP HEALTH REINSURANCE PLAN
PLAN OF OPERATION (“THE PLAN”)**

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**MASSACHUSETTS NONGROUP HEALTH REINSURANCE PLAN
PLAN OF OPERATION ("THE PLAN")**

Article I - Statutory and Regulatory Authority

The Massachusetts Nongroup Health Reinsurance Plan, hereinafter referred to as "The Program," is a nonprofit entity created pursuant to the provisions of section eighteen of Chapter 140 of the Acts of 2000, which was codified as M.G.L. c. 176M, § 6; M.G.L. c. 176M shall hereinafter be referred to as "The Act." On April 12, 2006, Section 95 of Chapter 58 of the Acts of 2006 amended The Act to require the governing committee to execute the phase-out of the Program. The phase-out is provided by an appendix to this Plan according to Article V.

Article II - Definitions

As used in the Plan of Operation:

- A. Alternative Benefit Plan means a guaranteed issue managed care plan, guaranteed issue medical plan or guaranteed issue preferred provider plan as allowed by M.G.L. c. 176M, § 2(d).
- B. Carrier means an insurer licensed or otherwise authorized to transact accident and health insurance under M.G.L. c. 175 or the laws of any other jurisdiction; a nonprofit hospital service corporation organized under M.G.L. c. 176A or the laws of any other jurisdiction; a nonprofit medical service corporation organized under M.G.L. c. 176B or the laws of any other jurisdiction; a health maintenance organization organized under M.G.L. c. 176G or the laws of any other jurisdiction; and an insured health plan that includes a preferred provider arrangement organized under M.G.L. c. 176I or the laws of any other jurisdiction. For the purposes of 211 CMR 41.00, carriers that are affiliated companies will be treated as one carrier; provided however, that a carrier shall offer a guaranteed issue health plan in every geographic area served by one or more of its affiliates. Joint marketing ventures between carriers do not constitute an affiliation.
- C. Child means a natural Child, a legally adopted Child, a Child placed in the home of the Eligible Individual for the purposes of adoption, a Child supported by the Eligible Individual pursuant to a valid court order, or a Child for whom the Eligible Individual is the legal guardian. It also includes a stepchild who lives with the Eligible Individual.
- D. Commissioner means the Commissioner of Insurance appointed pursuant to M.G.L. c. 26, § 6.
- E. Creditable Coverage means coverage of an individual under any of the following:
 - (a) a group health plan;
 - (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without Massachusetts to a natural person who is enrolled in a qualifying student health insurance program pursuant to M.G.L. c. 15A, § 18 or a

- qualifying student health program of another state;
- (c) Part A or Part B of Title XVIII of the Social Security Act;
- (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
- (e) 10 U.S.C. chapter 55;
- (f) a medical care program of the Indian Health Service or of a tribal organization;
- (g) a state health benefits risk pool;
- (h) a health plan offered under 5 U.S.C. chapter 89;
- (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(1)(I), as amended by P.L. 104-191; or
- (j) a health benefit plan under the Peace Corps Acts, 22 U.S.C. 2504(e).

- F. Deductible means the initial Carrier liability which will be deducted from total claims in determining benefit payments to Nongroup Carriers under The Plan. Effective December 1, 2001 the Deductible amount shall be the first \$10,000 of claims plus 10% of the next \$40,000 in claims for a total of up to \$14,000 per covered member per Fiscal Year.
- G. Division means the Division of Insurance established pursuant to M.G.L. c. 26, § 1.
- H. Eligible Dependent means the spouse or Child of an Eligible Individual, subject to the applicable terms of the Health Plan covering such individuals.
- I. Eligible Individual means, on and after November 1, 2001, any natural person who is a resident of Massachusetts and who is not enrolled for coverage under part A or part B of Title XVIII of the federal Social Security Act, or a state plan under Title XIX of such act or any successor program.
- J. Fiscal Year means, for the first year of The Program, December 1, 2001 through December 31, 2002; thereafter, Fiscal Year means a calendar year.
- K. Governing Committee means the committee that prepares the Plan of Operation and administers The Program pursuant to M.G.L. c. 176M, § 6. Members of the Governing Committee are appointed by the governor and represent Nongroup Carriers participating in The Program.
- L. Health Plan means any individual, general, blanket, or group policy of health, accident and sickness insurance issued by an insurer licensed under M.G.L. c. 175 or the laws of any other jurisdiction; a hospital service plan issued by a nonprofit hospital service corporation pursuant to M.G.L. c. 176A or the laws of any other jurisdiction; a medical service plan issued by a nonprofit hospital service corporation pursuant to M.G.L. c. 176B or the laws of any other jurisdiction; a health maintenance contract issued by a health maintenance organization pursuant to M.G.L. C. 176G or the laws of any other jurisdiction; and an insured health benefit plan that includes a preferred provider arrangement issued pursuant to M.G.L. c. 176I or the laws of any other jurisdiction. The

words "Health Plan" shall not include accident only, credit-only, limited scope dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, noncoordinated benefits which for the purposes of 211 CMR 41.00 shall mean policies issued pursuant to 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 wage 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, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets the requirements of 211 CMR 42.00, insurance arising out of a worker's compensation law or similar law, automobile medical payment insurance, 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, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. chapter 55 if offered as a separate insurance policy, or any policy subject to M.G.L. c. 176K.

- M. Nongroup Carrier means any Carrier which issues, renews, or offers Guaranteed Issue Nongroup Health Plans according to the provisions of M.G.L. c. 176M.
- N. Nongroup Health Plan means a Guaranteed Issue Nongroup Health Plan, established in accordance with The Act which is issued, renewed, or delivered within or without Massachusetts to a natural person who is a resident of Massachusetts, including a certificate issued to an eligible natural person which evidences coverage under a policy or contract issued to a trust or association, for that person and his or her spouse and other dependents; provided that a health plan issued, renewed or delivered within or without Massachusetts to a natural person who is enrolled in a qualifying student health insurance program pursuant to M.G.L. c. 15A, § 18 will not be considered a Nongroup Health Plan for the purposes of 211 CMR 41.00 and will be governed by the provisions of M.G.L. c. 15A and the regulations promulgated thereunder. "Nongroup Health Plan" includes a conversion Nongroup Health Plan as defined in M.G.L. c. 176M, but does not include a health benefit plan issued or renewed to a natural person pursuant to M.G.L. c. 176J.
- O. Pre-existing Condition Limitation means with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to such information.
- P. Prototype Health Benefit Plan means a Health Plan that may be adopted by the Governing Committee for the purpose of determination of the benefits reinsured under The Program.

Article III - Members of The Program

All Carriers issuing or renewing Nongroup Health Plans, on and after November 1, 2001, shall be members of The Program.

Article IV - Powers of The Program

The Program has the authority to:

- A. Provide reinsurance and establish rules, conditions, and procedures, in accordance with the requirements of The Act and applicable regulations.
- B. Establish appropriate rates, rate schedules, rate adjustments, rate classifications and any other actuarial functions appropriate to the operation of The Program.
- C. Assess Carriers in accordance with the provisions of The Act, and make interim assessments as may be reasonable and necessary for expenses, claim reimbursement and other purposes.
- D. Establish or modify a Deductible requirement for benefit payments eligible for reinsurance reimbursement, subject to approval of the Commissioner, and develop and approve fee-for-service charge mechanisms which are actuarially equivalent to capitated contract costs.
- E. Enter into contracts as necessary or proper to carry out the duties of The Program, including contracts with similar programs of other states for the joint performance of common functions, or with persons or other organizations for the performance of administrative functions.
- F. Borrow money to effect the purposes of The Program, from Carriers or other institutions. Any notes or evidences of indebtedness of The Program which are not in default constitute legal investments for Carriers and may be carried as admitted assets.
- G. Appoint legal, actuarial, and other subcommittees, to provide technical assistance in the operation of The Program.
- H. Take any action necessary to avoid the payment of improper claims against The Program.
- I. Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against The Program or any Carrier.
- J. Advise the Massachusetts Legislature and the Commissioner on necessary and/or desirable change(s) in the laws under which The Program operates.

- K. Execute the phase-out of the Program according to Section 95 of Chapter 58 of the Acts of 2006.
- L. Take any other action not otherwise prohibited by law, which is necessary or desirable for the administration of The Program.

Article V - Plan of Operation

The Program performs its functions under The Plan of Operation ("The Plan"), and in accordance with The Act, as amended by Section 95 of Chapter 58 of the Acts of 2006. The Plan includes these articles and such operating rules as may have been adopted by the Governing Committee. In accordance with Section 95 of the Acts of 2006, the Program will be phased-out as provided in Appendix A. All articles of The Plan and any operating rules as may exist under The Program shall comply with the provisions of Appendix A. The Governing Committee shall adhere to Section 95 of Chapter 58 of the Acts of 2006 as reflected in Appendix A in carrying out its remaining duties under The Plan. If a conflict arises between any of the articles, provisions or terms of The Plan and the Terms of Appendix A, or if a conflict arises between any operating rules as there may be and the terms of Appendix A, then the provisions of Appendix A shall supersede The Plan and govern The Program.

The Plan is intended to assure the fair, reasonable and equitable administration of The Program, and the sharing of program gains or losses in accordance with the provisions of The Act. The Plan is established by the Commissioner on March 1, 2001. Subsequent Amendments to The Plan will be deemed approved by the Commissioner if not expressly disapproved in writing by the Commissioner within 30 days from the date of filing.

The Program operates for the benefit of Nongroup Carriers who are members of The Program and who provide coverage for guaranteed issue nongroup health insurance coverage as required under The Act. A Nongroup Carrier shall have enforceable rights under The Program only if it has fulfilled all of its obligations under The Program. A Nongroup Carrier may not transfer, assign, convey, or take any action that may result in the voluntary or involuntary transfer, assignment, or conveyance of the rights of the Nongroup Carrier to any third party who is not a Nongroup Carrier. A person or party who is not a Member of The Program shall have enforceable rights against the Nongroup Carrier only if, and only to the extent, The Act, The Plan, or any written agreement entered into with The Program explicitly confers upon or provides to such person or party specific rights or protections. The provisions of Article VIII, Sub-article F ("privacy of information") of The Plan explicitly confer upon and provide specific rights and protections to persons and parties who are Nongroup Carriers. Except as provided herein, The Program and The Plan do not create or confer upon any other person any direct or indirect rights or claims or action in connection with or arising from the operation of The Program. While The Plan does not prevent a Nongroup Carrier from selling its nongroup health business, the acquiring Nongroup Carrier may continue coverage under the Massachusetts Nongroup Health Reinsurance Plan for only those members covered on the day prior to the date of purchase and sale.

Article VI - Governing Committee and Annual Meeting

- A. The Program exercises its powers through a Governing Committee appointed by the Governor of the Commonwealth of Massachusetts.

1. The Governing Committee consists of five persons representing Nongroup Carriers of which at least one appointee shall represent a foreign Nongroup Carrier. The initial appointment of two such appointees shall be for a term of three years; the initial appointment of two such appointees shall be for a term of two years; and the initial appointment of the remaining appointee shall be for a term of one year. All appointment thereafter shall be for a term of three years.
 2. The Governing Committee shall elect a Chairman and Secretary from among its membership, as well as other officers as it deems appropriate.
 3. Vacancies occurring on the Governing Committee between annual meetings will be filled in the same manner as the original appointment, for the unexpired portion of the term.
 4. Members of the Governing Committee shall be eligible for reappointment.
- B. The votes of the Governing Committee shall be on a one-person, one-vote basis.
- C. A majority of the Governing Committee shall constitute a quorum for the transaction of business. The acts of the majority of the Governing Committee present at a meeting at which a quorum is present shall be the acts of the Governing Committee.
- D. An annual meeting shall be held on a date and at a location selected by the Governing Committee.
- E. At each annual meeting the Governing Committee shall:
1. Review The Plan and submit proposed amendments, if any, to the Commissioner for approval.
 2. Review reports on administration of The Program, including audited financial reports on contracts and obligations, and all other material matters.
 3. Review reports of the subcommittees established by the Governing Committee.
 4. Establish and review procedures, including limitation on allowable investments for the investment of available funds.
 5. Approve the rates for reinsurance coverage.
 6. Consider possible changes in any reinsurance Deductibles that may be established by the Governing Committee.

7. Review the earned premiums, the expenses of The Program administration, and the incurred losses for the prior Fiscal Year, taking into account investment income and other appropriate gains and losses.
8. Determine if an assessment is necessary for the proper administration of The Program, and, by a date determined by the Governing Committee, file an estimate of the needed assessment with the Commissioner at least 30 days prior to the issuance of the assessment, including the total amount to be assessed, the total amount of assessment as a percentage of premium earned by all Nongroup Carriers as calculated in Article XII of The Plan, and the actual assessment for each member Carrier.
9. Determine whether any technical corrections or amendments to The Act should be recommended to the Legislature.
10. Review, consider, and act on any matters deemed by the Governing Committee to be necessary and proper for the administration of The Program.

- F. The Governing Committee shall hold other meetings upon the request of the Chairman or of three or more members of the Governing Committee, at appropriate times and frequency.

Meetings of the Governing Committee will be held and conducted in accordance with the open meeting law as found in M.G.L. c. 30A, section 11A 1/2.

Notice of such a meeting and its purpose shall be provided to the members of the Governing Committee at least 7 days prior to the meeting. At meetings other than the annual meeting, the Governing Committee may also perform any of the functions authorized by The Act or in Paragraph E above.

A member of the Governing Committee shall be responsible for discharging his or her obligations when he or she is unable to act in person and shall have the right to act by proxy. The proxy will be effective only if: (a) the member of the Governing Committee has filed a written proxy with the Governing Committee, designating one person to exercise all rights, powers, and obligations of the Governing Committee, in the person's absence, (b) the member of the Governing Committee and his or her designee are affiliated with the same Nongroup Carrier, (c) the Governing Committee has accepted the proxy and (d) the Governing Committee has sent the name of the proxy to the Governor. The proxy shall terminate when and if: (a) the member of the Governing Committee and his or her designee are no longer affiliated with the same Nongroup Carrier or (b) the Governing Committee revokes its acceptance of the proxy.

- G. Minutes of the proceedings of each Governing Committee meeting shall be made. The original of the record shall be retained by the Secretary of the Governing Committee.

- H. The Governing Committee may establish administrative rules of practice for The Program consistent with The Act and The Plan.
- I. The Governing Committee may consider other responsibilities relating to access to nongroup health coverage and may undertake, assign or contract for administration of these duties.
- J. The Governing Committee shall report annually to the Commissioner and the Joint Legislative Committee on Insurance on The Program's experience, the effect of The Program on Nongroup Health Plan rates, and recommendations, if necessary, relative to sustaining the viability of The Program.
- K. Amendments to The Plan or suggestions of technical corrections to The Act shall require the concurrence of a majority of the entire Governing Committee.
- L. Members of the Governing Committee may be reimbursed from the monies of The Program for reasonable expenses incurred by them as members of the Governing Committee, upon approval of such expenses by the Governing Committee, but they shall not otherwise be compensated by The Program for their services.
- M. The Governing Committee is responsible for hiring employees of The Program, if any.

Article VII - Subcommittees

Each member of the Governing Committee shall be entitled to participate personally on any subcommittee established under The Plan or by the Governing Committee.

Minutes of the proceedings of each subcommittee shall be maintained by a secretary appointed from the membership of the subcommittee. Subcommittee members are responsible for providing staff support, but may recommend that the Governing Committee provide funding for outside contractors. Subcommittees will initially include the following:

A. Actuarial Subcommittee

The mission of the Actuarial Subcommittee is to:

1. Recommend to the Governing Committee appropriate reinsurance premium rates, methodologies, rate schedules, rate adjustments, and rate classifications for individuals and Eligible Dependents reinsured with The Program.
2. Recommend to the Governing Committee any appropriate increase in the reinsurance Deductible.
3. Determine the incurred claim losses of The Program including amounts for incurred but not reported claims.

4. Recommend to the Governing Committee reports to be made by Nongroup Carriers and any parties retained to provide service to the Governing Committee and/or The Program.
5. Provide reports and other recommendations as directed by the Governing Committee.
6. Recommend assessment methodology and assessments.
7. Fulfill other responsibilities as deemed appropriate by the Governing Committee.

B. Operations Subcommittee

The mission of the Operations Subcommittee is to:

1. Review The Plan periodically and make recommendations to the Governing Committee.
2. Provide administrative interpretation as to the intent of The Plan, and direction on issues referred to it by the Governing Committee, the Administrator described in Article VIII, or any other Carrier.
3. Identify additional items for which operating rules are needed and propose changes in The Plan for adoption by the Governing Committee.
4. Fulfill other responsibilities as deemed appropriate by the Governing Committee.

C. Legal Subcommittee

The mission of the Legal Subcommittee is to:

1. Interpret the provisions of The Act.
2. Review The Plan, and proposed amendments to The Plan, and make appropriate recommendations to the Governing Committee.
3. Prepare contracts and legal documents for The Program as requested by the Governing Committee.
4. Be familiar with and provide assistance to the Governing Committee concerning all litigation and other disputes involving The Program and its operations.
5. Maintain a written record of all legal questions referred to the Legal Subcommittee and the responses provided and provide copies of all such responses to the Governing Committee.

6. Coordinate with legal counsel for the Governing Committee, as needed, on other routine legal matters relating to The Program operations, including proposed contracts and operational practices.
7. Fulfill other responsibilities as deemed appropriate by the Governing Committee.

D. Audit Subcommittee

The mission of the Audit Subcommittee is to:

1. Approve a uniform audit program to be utilized by independent auditors in their review of items related to reinsurance with The Program and assessments for each affected Member.
2. Establish standards of acceptability for the selection of independent auditors with regard to 1, above.
3. Assist the Governing Committee in the selection of an independent auditor for the annual audit of The Program operations.
4. Assist the Governing Committee in the review of the reports prepared by the independent auditors in conjunction with 1. and 3., above, and any other audit-related matters the Governing Committee deems necessary.
5. Fulfill other responsibilities as deemed appropriate by the Governing Committee.

Article VIII Administrator: Selection and Duties

The Administrator is jointly responsible, with the Governing Committee and all Nongroup Carriers, for the fair, equitable, and reasonable administration of The Program.

- A. In this Article VIII, Section A, the term "Company" shall mean any corporation, partnership or other recognized legal entity which (1) is appropriately registered and/or licensed to do business in Massachusetts and (2) has the appropriate experience, skill, resources and personnel to administer the program. Any entity meeting the definition of Company will be invited to express intent to accept an opportunity to administer the program. From among those expressing intent, the Governing Committee shall select the Administrator to act on its behalf. If two or more Companies express intent, the selection may be based upon responses to a formal Request for Proposal.

The Company will submit a written proposal for providing the administrative services required by The Plan and approved by the Governing Committee. Once chosen, the Administrator shall be reimbursed for its cost of administration in accordance with arrangements agreed to between the Administrator and the Governing Committee.

In selecting the Administrator, the Governing Committee shall consider the following factors:

- the expertise of the Company in performing the tasks necessary to administer the program on behalf of the Governing Committee

- the Company's experience (through its personnel and otherwise) with relevant Massachusetts law; and
 - any other facts it deems appropriate or relevant to the role to be assumed by the Administrator.
- B. The Administrator shall perform functions, as directed by the Governing Committee, including:
1. Establish procedures and install the systems needed to administer the operations of The Program in accordance with The Act and The Plan:
 - a. Accept, on behalf of The Program, risks that are ceded by Nongroup Carriers.
 - b. On a timely basis, collect reinsurance premium for ceded risks and all other amounts due to The Program.
 - c. Design forms for reinsurance reporting, and submit the proposed forms to the Governing Committee for approval.
 - d. Perform reinsurance reimbursement for claims paid on ceded risks.
 - e. Calculate assessments as specified in The Plan, and collect appropriate amounts due. Recommend to the Governing Committee any reports necessary to facilitate such calculations and any procedures needed to implement interim assessments.
 2. Establish on behalf of The Program one or more bank accounts for the transaction of The Program business. These bank accounts will be approved by the Governing Committee.
 3. Deposit all cash collected on behalf of The Program in the established bank accounts on a timely basis.
 4. Invest available cash in accordance with any investment directions and limitations established by the Governing Committee.
 5. Issue checks or drafts on and/or approve charges against bank accounts of The Program.
 6. Keep all accounting, administrative and financial records of The Program in accordance with The Plan.

7. Prepare an annual estimate of operating costs for the administration of The Program operations.
 8. Act as a communications resource for reinsuring Nongroup Carriers in review of their administrative operations under The Act and The Plan.
 9. Perform other functions as agreed to between the Administrator and the Governing Committee.
- C. The Administrator shall maintain all records as to premiums, investment income, reimbursements and administrative expenses during each Fiscal Year, as appropriate, for a period of seven years following the end of the year. Such records shall be made available on request to the Division.
- D. The Administrator shall serve until the appointment by the Governing Committee of a successor Administrator, until its resignation, or until it is otherwise removed by the Governing Committee. The Administrator shall give the Governing Committee 180 days notice of its decision to resign. The Governing Committee shall give the Administrator 90 days notice of its decision to remove the Administrator.
- E. The Administrator may subcontract for services, but must obtain the Governing Committee's approval for any subcontracts in excess of \$10,000.
- F. In performing its duties, the Administrator shall maintain the confidentiality of all information pertaining to insureds and Nongroup Carriers, in accordance with all applicable statutes, regulations and principles of common law pertaining to confidentiality and trade secrets. Such information shall be used only for the purposes necessary for the operation of The Program, and shall be strictly segregated from other records, data, and operations of the Administrator. Unless specifically required under The Plan, under The Act, or under other applicable laws, no information shall be retained or used by the Administrator, or disclosed to any third party, if it identifies a specific insured or Nongroup Carrier.

Article IX - Eligibility for Reinsurance

- A. Nongroup Carriers belonging to The Program may reinsure with The Program coverage of any Eligible Individual or any Eligible Dependents (also referred to as Individual Reinsurance) enrolled in a Nongroup Health Plan on or after November 1, 2001, with an effective date of coverage on or after December 1, 2001.
- B. Identifying Eligible Individuals
1. Whether a person is an Eligible Individual is determined as of the effective date of a Nongroup Carrier's coverage of the Eligible Individual.

2. Reinsurance is available only if the Eligible Individual satisfies eligibility requirements specified in the Nongroup Health Plan. Reinsurance is available to Nongroup Carriers for Eligible Individuals whose coverage with a Nongroup Carrier becomes effective on or after December 1, 2001. Previously insured nongroup members, including individual members previously covered under a Nongroup Carrier's closed Nongroup Plans, shall not be considered new members until they experience a break in coverage with the Nongroup Carrier of more than 63 calendar days.
3. Each Nongroup Carrier is responsible for determining whether a person is an Eligible Individual for Reinsurance as of the effective date of coverage, and for obtaining information from the Eligible Individual, including health statements, to document that determination.

The Nongroup Carrier is also responsible for certifying the above determination to the Administrator, if any coverage under an Eligible Individual's Health Plan is to be reinsured. If a Nongroup Carrier erroneously certifies a person to be an Eligible Individual and promptly notifies the Administrator, any reinsurance of that Eligible Individual is nullified; provided, however, that if the Nongroup Carrier has acted in good faith, reinsurance shall cease on a prospective basis.

C. Identifying Eligible Dependents

1. If a Nongroup Carrier offers coverage to an Eligible Individual, it must offer coverage to all the Eligible Individual's Eligible Dependents. Reinsurance is also available to Nongroup Carriers for Eligible Dependents whose coverage with a Nongroup Carrier becomes effective on or after December 1, 2001. Previously insured nongroup dependent members, including dependent members previously covered under a Nongroup Carrier's closed Nongroup Plans, shall not be considered new dependent members until they experience a break in coverage with the Nongroup Carrier of more than 63 calendar days.
2. Subject to applicable notice sent within thirty days to the Administrator, any material statement by an Eligible Individual or Eligible Dependent which falsely certifies as to a person's eligibility for coverage constitutes cause for termination of reinsurance, without penalty to the Nongroup Carrier; provided, however, that if the Nongroup Carrier has acted in good faith, reinsurance ceases on a prospective basis.

D. Effective Date of Coverage

According to The Act, coverage under a Nongroup Health Plan shall become effective within 30 days of the date of application. Reinsurance is available on the date coverage becomes effective, but no earlier than December 1, 2001.

Reinsurance is not available for Pre-existing Conditions to the extent coverage for Pre-existing Conditions may be excluded under the Nongroup Health Plan in accordance with The Act. In determining whether a Pre-existing Condition Limitation applies to an Eligible Individual or Eligible Dependent, credit must be given for coverage under a previous evidence of Creditable Coverage in accordance with the applicable requirements as set forth in the Regulations.

Article X - Procedures for Ceding Risks

A. Reinsurance Rules and Premium Levels

1. Each Nongroup Carrier proposing to cede the coverage for any Eligible Individual or Eligible Dependent is responsible for ascertaining and certifying that:
 - a. The individual is an Eligible Individual or an Eligible Dependent,
 - b. The Health Plan coverage meets all other requirements for reinsurance, including but not limited to cost containment and managed care techniques established by The Program.
 - c. The reinsurance premium rate level payable to The Program for that group or individual has been correctly determined in accordance with this Article. The child rate shall be used for children up until the January 1st coincident with or next following his/her attainment of age 18.
2. Reinsurance can be effective on or after December 1, 2001, and only as of the latter of one of the following dates:
 - a. the initial effective date of the Nongroup Health Plan; or
 - b. the effective date of transfer of the Eligible Individual or Eligible Dependent from a prior Carrier.
3. Availability of reinsurance is subject to the following additional rules:
 - a. The person must be an Eligible Individual or Eligible Dependent on the effective date of reinsurance.

- b. The Nongroup Carrier may reinsure individual coverage of an Eligible Individual without reinsuring coverage of any specific Eligible Dependent of that Eligible Individual, and may reinsure coverage of a specific Eligible Dependent without reinsuring coverage of the Eligible Individual. A newborn's coverage may be reinsured if and only if the mother's coverage was reinsured prior to the date of birth.
- c. The Nongroup Carrier may choose either monthly or quarterly reporting of reinsurance claims, but must use the same reporting for all transactions.
- d. Nongroup Carriers cannot cede coverage for any Eligible Individual or Eligible Dependent who is covered under a book of Nongroup Health Plan business that was not being actively marketed to residents of Massachusetts on or after November 1, 2001. Nor will The Program accept such risks from an Affiliated Plan of a Nongroup Carrier to which such business had been transferred after November 1, 2001. An "Affiliated Plan" is a plan that is controlled by a Nongroup Carrier, or which controls the Nongroup Carrier, or which is controlled by the same entity that has control of the Nongroup Carrier.

B. Level of Coverage

For any Prototype Health Benefit Plan established by the Governing Committee, subject to the approval of the Commissioner, The Program will reinsure the level of coverage provided to the Eligible Individual or Eligible Dependent subject to a reasonable Deductible.

For guaranteed issue Health Plans that are richer than the Prototype Health Benefit Plans, the Carrier will re-adjudicate claims according to the appropriate prototype plan. For Alternative Benefit Plans that are less rich than the prototype plans, it will not be necessary to re-adjudicate claims.

C. Notification of Reinsurance

For reinsurance to become effective, notice must be provided to the Administrator within 60 days after the effective date of the Eligible Individual's or Eligible Dependent's coverage, as the case may be. Notice must include all required information with respect to each individual whose coverage is to be reinsured. To facilitate the introduction of this Reinsurance Plan a 90-day notice period will be allowed to Nongroup Carriers from December 1, 2001 through February 28, 2002 for Reinsurance effective December 1, 2001.

D. Period of Reinsurance

1. Reinsurance may continue for as long as the Eligible Individual's and/or Eligible Dependent's coverage remains in effect under a Nongroup Health Plan.

2. A Nongroup Carrier may withdraw an Eligible Individual and/or Eligible Dependent(s) from The Program while coverage continues under the Carrier's Nongroup Health Plan. Withdrawals will be effective on the January 1st following timely notification of withdrawal from The Program. Written notice must be provided at least 30 days in advance of the withdrawal. No reinstatement of a withdrawn Eligible Individual and/or Eligible Dependent(s) will be allowed.
3. Reinsurance of an Eligible Dependent's coverage under a Nongroup Health Plan ceases at the termination of the individual's status as an Eligible Dependent

If the Nongroup Carrier provides coverage for such persons beyond the date indicated above, for contractual or other reasons, reinsurance will be available for a maximum of an additional 30 days.

4. Reinsurance ceases for a person covered under a Nongroup Health Plan at termination of the Nongroup Carrier's coverage of Eligible Individual and/or Eligible Dependent(s).

E. Determination of Reinsurance Premium

1. Tables of reinsurance premium rates, as determined by the Actuarial Subcommittee and approved by the Governing Committee, will be filed with the Division at least 30 days prior to the effective date and will be communicated to Nongroup Carriers.
2. Reinsurance rates for the period December 1, 2001 through December 31, 2002 will be effective on December 1, 2001 even if filed on or after that date.

F. Billing and Payment

1. Premiums are determined as of the first of the month or first day of the first month in a quarter, and are due by the twentieth of the month, for the applicable month or quarter. Interest on late premiums will be charged at 1.5% per month.
2. The reinsurance premiums charged for a given month for each individual will be determined by the Table of Rates in effect for that month.
3. Reinsurance bills will be handled on a "self-billed" basis. Monthly or quarterly, if selected by the Nongroup Carrier, the Nongroup Carrier will provide the Administrator with a list of individuals reinsured, the premium for each Eligible Individual and/or Eligible Dependent(s) for the month(s) covered and such other information as may be required by The Program. The Administrator will make any necessary corrections and send the corrected statement to the Nongroup Carrier.
4. Reinsurance premium amounts are to be based on whole month increments only. If reinsured coverage is effective between the 1st and the 15th of the month, the entire

month is paid in full. When coverage becomes effective after the 15th of the month, no premium will be payable until the first month following the effective date.

5. Terminations effective between the 1st and the 15th of the month will be allowed refunds for the entire month, and terminations effective after the 15th of the month will not be allowed a premium refund.
6. Reinsurance premium is due to The Program for as long as the Health Plan remains in force.

Article XI - Reinsurance Claims

A. Statement of Reinsurance

After any Deductible amount, The Program will indemnify Nongroup Carriers subject to the following:

1. Covered Claims are amounts in excess of the Deductible amount in benefit payments made by the Nongroup Carrier, for medical service and supplies provided during a Fiscal Year for a reinsured Eligible Individual or Eligible Dependent. Any initial Deductible amount that will be consistently applied shall be determined by the Governing Committee, subject to the approval of the Commissioner.

In addition, if the Governing Committee establishes other elements of the reinsurance coverage, including coinsurance percentages or maximum Nongroup Carrier liability amounts, they are subject to the approval of the Commissioner.

The Deductible will apply each Fiscal Year for any ceded individual or dependent with the following exception. If an individual or dependent is a patient in a hospital for a certain condition on the last day of a Fiscal Year, and the hospitalization continues into a subsequent Fiscal Year and the hospital stay is for the same condition, the new Deductible will not apply to that hospitalization for that subsequent Fiscal Year. If a ceded individual or dependent is in the hospital on the last day of a Fiscal Year and a new condition arises on or after the first day of a subsequent Fiscal Year, the new Deductible will apply for that subsequent Fiscal Year for the new condition.

2. For the purposes of this Act, "Covered Claims" shall mean only amounts actually paid by Nongroup Carriers for benefits provided for individuals reinsured by The Program, including payments for medical services and supplies made under case management programs or other cost management programs. Covered claims also include pharmaceutical payments. Expenses covered under capitated arrangements will be valued using a fee-for-service equivalency methodology submitted by the ceding Nongroup Carrier and approved by the Governing Committee of the Massachusetts Nongroup Reinsurance Plan. "Covered Claims" shall include, for all claims pertaining to the same condition, the charges incurred while in the hospital

which a Carrier is required to pay for reinsured members for whom insurance terminated before their release from the hospital. Covered Claims shall not include:

- a. Claim expenses or salaries paid to employees of Nongroup Carriers other than for provisions of health services directly to Eligible Individuals and Dependents.
- b. Court costs, attorney's fees or other legal expenses, whether incurred by the insured or Nongroup Carrier.
- c. Any amount paid by Nongroup Carriers for:
 - (1) Extra-contractual, punitive or exemplary damages; or
 - (2) Compensatory or other damages awarded to the Insured, arising out of the conduct of the Carriers in the investigation, litigation, or settlement of any claim for failure to pay or delay in payment of any benefits under any policy; or
 - (3) Compensatory or other damages awarded to the Insured, arising out of the operation of any managed care, cost containment, or related programs.
- d. Any statutory or other penalty imposed upon or agreed to by a Nongroup Carrier including but not limited to a penalty arising from any alleged unfair trade practice or unfair insurance practice.
- e. The Massachusetts Nongroup Health Reinsurance Plan is not established to provide duplicate payment of claims. Amounts received as reimbursements from reinsurance coverage, subrogation, coordination of benefits, no fault insurance, fraud recovery or other recovery shall be netted out of claims submitted to the Massachusetts Nongroup Health Reinsurance Plan unless otherwise established in contracts.

B. General Requirements

1. Nongroup Carriers agree that they will promptly investigate, settle, or defend all claims arising under the risks reinsured and that they will forward copies of such reports of investigation promptly, as may be requested by the Administrator.
2. Nongroup Carriers will adjudicate all claims on ceded persons. They will be required to assure that their claim management practices are consistent for reinsured and non-reinsured individuals. The failure to follow such procedures will result in the denial or reduction of reinsurance claim payments, as determined by the Governing Committee.
3. Nongroup Carriers agree to use their usual case management and claim handling techniques, including, but not limited to, utilization review, preferred provider provisions, and other managed care provisions on reinsured business. The failure to follow such procedures will result in the denial or reduction of reinsurance claim payments, as determined by the Governing Committee.
4. The Program shall have the right, at its own expense, to participate jointly with a Nongroup Carrier in the investigation, adjustment or defense of any claim.
5. The Program shall have the right to inspect the records of the Nongroup Carrier in connection with reinsured individuals at the Nongroup Carrier's usual place of business during normal business hours. The Nongroup Carrier shall submit any additional information required in connection with claims submitted for reimbursement. Where required by law, Carriers shall secure necessary authorizations from Eligible Individuals and/or Eligible Dependents for this purpose.
6. All information disclosed between The Program (or the Administrator) and Nongroup Carriers, in connection with The Plan, shall be considered to be proprietary information by the Nongroup Carriers and by The Program.
7. If any payment is made by The Program and the Nongroup Carrier is reimbursed by another party for the same expenses, any reinsured claim shall be appropriately adjusted. The Nongroup Carrier shall do whatever is necessary to preserve and secure its usual reimbursement rights.
8. Except as approved by the Governing Committee reinsurance will be provided only for covered claims submitted within two years from the date on which the expenses were incurred for which the claim is based.

C. Claims Reporting

1. Within 20 days after the close of each quarter (or month, as each Carrier chooses), the Nongroup Carrier shall furnish to the Administrator the information required with respect to reinsured losses during the period. The information shall be conveyed using forms approved by the Governing Committee and furnished by the Administrator.
2. Each Nongroup Carrier shall notify the Administrator as soon as reasonably possible if claims for a reinsured individual are expected to exceed \$100,000.

Article XII - Net Fund Earnings, Assessments, Late Payments and Definition of Earned Premium

A. Net Fund Earnings and Assessments

1. Following the close of each Fiscal Year, the Governing Committee shall determine the premiums charged for reinsurance coverage, The Program expenses for administration and the incurred losses, if any, for the Fiscal Year, taking into account investment income and other appropriate gains and losses.
2. Any net loss for a Fiscal Year shall be recouped by assessment of Nongroup Carriers which shall be apportioned in proportion to each Nongroup Carrier's respective shares of the total premiums earned in Massachusetts from all its Health Plans. In no event shall such assessments exceed one percent of the premiums earned from such Health Plans. Premium means the amount of fee charged by a Nongroup Carrier to the policyholders or subscribers exclusive of co-payment or other charges related to the receipt of health care services. For the purpose of this section, premium shall not include premiums collected for Medicaid, Medicare Supplement and Medicare + Choice plans.
3. If the assessment level is inadequate, the Governing Committee may adjust reinsurance thresholds, retention levels or consider other forms of reinsurance.

If other funding sources are not made available, the Governing Committee may enter into negotiations with Nongroup Carriers to resolve any deficit through reductions in future payment levels for reinsurance plans. Any such recommendations must take into account the findings of an actuarial study to be undertaken after the first three years of The Program's operation to evaluate and measure the relative risks being assumed by differing types of Nongroup Carriers. The study must be conducted by three Actuaries appointed by the Commissioner,

one of whom shall represent the risk assuming Carriers, one of whom shall represent reinsuring Carriers and one of whom shall represent the Commissioner.

4. Interim assessments for the purposes of working capital or immediate cash needs may be made at any time based upon a methodology the Governing Committee considers equitable. Any such assessments paid by the Carriers shall be credited to the Carriers' future assessments or may be refunded as the Governing Committee deems appropriate.

B. Assessment Deferral

1. On application to the Governing Committee, assessments may be deferred whenever a Nongroup Carrier's statutory net worth is at or below the minimum required by the Division of Insurance and the Nongroup Carrier, with the approval of the Commissioner, has ceased issuing new business. The deferral will continue for the period approved by the Governing Committee or until the Nongroup Carrier's net worth exceeds statutory requirements.
2. When the deferral period is over, the Nongroup Carrier must pay the accumulated assessments over a three-year period, and is prohibited from reinsuring any individuals in the program during periods when the Nongroup Carrier fails to pay assessments. Interest at the rate of "prime" +1% determined and compounded monthly will be charged on deferral for financial impairment.
3. If an assessment against a Nongroup Carrier is deferred, in whole or in part, that deferred amount may be assessed against the other Nongroup Carriers. When paid, these delayed assessments will be treated as other income to The Program.

C. De Minimis Assessments

Assessments of less than \$100 shall not be billed, but will be deferred until the cumulative amount due from a Nongroup Carrier exceeds \$100. Any assessment of less than \$10 shall be forgiven.

D. Late Payments

Assessments shall be paid when billed. If the assessment is not received by the Administrator within 30 days of the billing date, the Nongroup Carrier shall pay interest on the assessment from the billing date at the rate of 1.5% per month. The Governing Committee may suspend reinsurance rights if payments are not made in accordance with this Article.

E. Earned Premium

Earned premium shall include all premiums and/or subscriber payments for all group and nongroup Health Plans earned during an accounting period. It does not include:

1. Accident only insurance;
2. Credit-only insurance;
3. Limited scope dental benefits if offered separately;
4. Hospital indemnity insurance policies if offered as independent, noncoordinated benefits which for the purposes of The Plan shall mean policies issued pursuant to 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 wage 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;
5. Disability income insurance;
6. Coverage issued as a supplement to liability insurance;
7. Specified disease insurance that is purchased as a supplement and not as a substitute for a Health Plan;
8. Insurance arising out of a worker's compensation law or similar law;
9. Automobile medical payment insurance;
10. 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;
11. Long-term care insurance if offered separately;
12. Coverage supplemental to the coverage provided under 10 U.S.C. chapter 55 if offered as a separate insurance policy, or any policy subject to M.G.L. c. 176K (including Medicare Supplement and Medicare + Choice) or a state plan under Title XIX of the federal Social Security Act.

Article XIII - Reporting Requirements

A. The Division of Insurance

From reports filed by Nongroup Carriers, the Division shall provide the Administrator with the premiums needed to calculate interim and final assessments for a period.

B. Nongroup Carriers

1. Unless otherwise specified by the Governing Committee, the following information is required by The Program for reinsured risks:
 - a. Identification of the Nongroup Carrier;
 - b. Name, address (including zip code), date of birth, sex, and the Carrier identification (certificate) number of the person being reinsured;
 - c. Identification of the reinsured as an Eligible Individual or Eligible Dependent;
 - d. Health Plan, including description of cost-sharing features;
 - e. Effective date of Eligible Individual's or Eligible Dependent's coverage;
 - f. Effective date of reinsurance;
 - g. Status code as required by the Governing Committee; and
 - h. Other information required by the Governing Committee.
2. When a change in reinsurance coverage occurs, the Nongroup Carrier shall notify the Administrator of changes by including:
 - a. The reinsured's name and identification number;
 - b. The Eligible Individual's name and social security number;
 - c. Effective date of status change;
 - d. Status code for change as required by the Governing Committee; and
 - e. Other information required by the Governing Committee.
3. Each Nongroup Carrier shall notify the Division, by April 1 of each year (beginning April 1, 2003), in such form as approved by the Commissioner, of its earned

premiums for the prior calendar year for all insured policies issued in Massachusetts.

C. Administrator

1. By a date determined by the Governing Committee and approved by the Commissioner, the Administrator shall report the financial results of the prior Fiscal Year's Program operations to the Governing Committee.
2. By a date determined by the Governing Committee and approved by the Commissioner, the Administrator shall recommend the amount of assessment due from each Nongroup Carrier, and report all results to the Governing Committee.

Article XIV - Financial Administration

A. Books and Records

The Administrator shall maintain the book and records of The Program so that financial statements can be prepared to satisfy The Act. Further, these books shall satisfy any additional requirements as may be deemed necessary to meet the needs of the Governing Committee and the outside auditors.

1. The receipt and disbursement of cash by The Program shall be recorded as it occurs.
2. Non-cash transactions shall be recorded when the asset or the liability should be realized by The Program in accordance with generally accepted accounting principles.
3. Assets and liabilities of The Program, other than cash, shall be accounted for and described in itemized records.
4. The net balance due to or from The Program shall be calculated for each Nongroup Carrier and confirmed as deemed appropriate by the Governing Committee or when requested by the respective Carrier. These balances should be supported by a record of each individual Nongroup Carrier's financial transactions with The Program. These records include:
 - a. Net earnings/losses of The Program based upon the assessments calculated in accordance with The Plan;
 - b. Any adjustments to assessments as explained in The Plan of operation;
 - c. The amount of reinsurance premium due to The Program for individuals whose coverage is ceded;

- d. The amount of reimbursement due to/from The Program for reinsured claims paid by the Nongroup Carrier;
 - e. Adjustment to the amount due to/from The Program based upon corrections to the Nongroup Carrier submissions;
 - f. Interest charges due from the Nongroup Carrier for late payment of amounts due to The Program; and
 - g. Other records required by the Governing Committee.
5. The Administrator shall maintain a general ledger whose balances are used to produce The Program's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger shall agree with the corresponding balances in subsidiary ledgers or journals.

B. Handling and Accounting of Assets and Money

Money and marketable securities shall be kept in bank accounts and investment accounts as approved by the Governing Committee. The Administrator shall deposit receipts and make disbursements from all these accounts.

C. Bank Accounts

All bank accounts/checking accounts shall be established in the name of the Massachusetts Nongroup Health Reinsurance Plan, and shall be approved by the Governing Committee. Authorized check signers shall be approved by the Governing Committee.

D. Lines of Credit

All lines of credit shall be established in the name of the Massachusetts Nongroup Health Reinsurance Plan, and shall be approved by the Governing Committee.

Lines of credit may be obtained to pay any obligations and/or expenses that The Program has incurred, is obliged to incur, or is reasonably expected to incur. Such obligations and expenses may include those which The Program is required to incur (including, but not limited to reinsurance of Health Plans), those considered reasonable by the Governing Committee for the administration of The Program and any other expenses reasonably related to The Program.

E. Investment Policy

All cash shall be invested in available investment vehicles approved by the Governing Committee.

Article XV - Audit Functions

A. Audits of Nongroup Carriers and Reinsurance Claims

1. Audits prescribed by the Governing Committee shall be conducted by or under the direction of the Administrator in accordance with a uniform audit program ("Standard") for Nongroup Carriers, as developed by the Governing Committee. This Standard shall clearly specify all items to be audited. It shall include a certification statement form to be completed by the auditor, to verify the completion of all prescribed procedures. A copy of this report and the certification statement shall be submitted to the Governing Committee by the auditor.
2. The Standard may include testing of representative samples of the following:
 - a. Reinsurance claims submitted to The Program, in particular:
 - (1) Eligibility of claimants and their Covered Persons for reinsurance by The Program;
 - (2) proper determination of reinsurance claim amounts by Nongroup Carriers; and
 - (3) Normal administration of managed care and claim adjudication procedures.
 - b. Reinsurance premiums submitted to The Program, including:
 - (1) Eligibility of those for whom reinsurance premium is paid; and
 - (2) Proper determination of reinsurance premiums paid.
 - c. Data submitted to The Program for use in the calculation of assessments for net losses.
3. Random audits of provider bills or other records may be conducted by or under the direction as deemed necessary by the Audit Committee, to verify the accuracy and appropriateness of reinsurance claim submissions.
4. The frequency of audits shall be determined by the Audit Committee. The cost of the audit of a Nongroup Carrier shall be borne by that Carrier. The Governing Committee shall have the right to conduct appropriate additional audits of Nongroup Carriers.

5. All information disclosed in the course of the audit of a Nongroup Carrier shall be considered privileged information by the Carrier, the auditing firm, and The Program and shall be made available upon request to the Division.

B. Audits of The Program

The Administrator shall arrange for an annual audit of The Program conducted by an independent certified Public Accountant approved by the Governing Committee. The Governing Committee shall file this annual audit with the Commissioner for his/her review.

This audit shall encompass at least the following items:

1. The handling and accounting of assets and money for The Program;
2. The annual fiscal report of The Program;
3. The calculation of the premium rates charged for reinsurance by The Program;
4. The calculation and the collection of any assessments of Nongroup Carriers for net losses; and
5. The reinsurance premiums due to The Program and the claim reimbursements made to the Nongroup Carriers.

The Commissioner may, at his or her discretion, prescribe audits of The Program to be paid for by The Program. The Program shall cooperate with any such audit.

Article XVI - Penalties/Adjustments and Dispute Resolution

A. Penalties/Adjustments

1. Numerous factual determinations and tasks must be performed by Nongroup Carriers relative to their participation in The Program. It is expected that all Nongroup Carriers will exercise good faith and due diligence in all aspects of their relationship with The Program. Errors will occur, however, and it is appropriate that the sanctions applicable to such errors be detailed.
2. Errors related to reinsurance:
 - a. A Nongroup Carrier reinsures someone who is not an Eligible Individual or Eligible Dependent (initial placement of an ineligible person or failure to remove an Eligible Dependent who becomes ineligible).

Reinsurance coverage for the individuals involved shall be terminated as of the first date of ineligibility. Claims paid by The Program in excess of premiums received are to be returned to The Program with interest. Premiums paid in excess of claims will be refunded without interest. An administrative charge may be assessed if the Governing Committee so determines.

- b. A Nongroup Carrier reinsures an Eligible Individual and/or Eligible Dependent at the incorrect premium rate (failure to use correct Program rates, to make a proper Benefit Plan adjustment, and/or to apply correct rates to persons reinsured)

Reinsurance premiums for the reinsured persons involved should be recalculated and immediate payment of additional premiums, interest, and an administrative charge must be made. Excess payments shall be refunded without interest.

- c. Nongroup Carrier reinsures incorrect claim payments.

The claim will be recalculated and any amount due to the program will be repaid immediately, with interest and an administrative charge. Adjustments of claim payments for amounts recovered by the Nongroup Carrier under subrogation or similar provisions shall not be considered errors for which any interest or administrative charge would be due. Amounts due a Nongroup Carrier shall be refunded without interest.

3. Errors related to assessments:

Nongroup Carrier errors related to assessments shall require the immediate payment of additional amounts due plus interest, calculated from the date such sum should have been paid, plus any administrative charge established by the Governing Committee.

4. Errors not listed:

All additional sums due to The Program as a result of errors made by Nongroup Carriers shall be paid immediately, with interest and any applicable administrative charge.

5. Gross negligence and intentional misconduct:

If the Governing Committee determines that the nature or extent of the errors related to the use of the reinsurance mechanism or otherwise by a particular Nongroup Carrier evidences gross negligence or intentional misconduct, the Governing Committee may, after notice and a hearing, terminate some or all

current reinsurance for the Nongroup Carrier and/or suspend the right of the Carrier to use the reinsurance mechanism for an appropriate period of time. All such actions shall require the concurrence of the Commissioner before becoming effective. The Governing Committee will ensure, to the extent possible, that the suspension or termination of reinsurance shall not adversely affect individuals already insured by the Nongroup Carrier.

B. Interest and Administrative Charges

All Interest payments required under this Article shall be calculated from the date the incorrect payment occurred or correct payment should have been made through the date of payment. The rate of interest and any Administrative Charges with respect to The Program shall be established by the Governing Committee and may be waived by the Governing Committee. Errors reported by Nongroup Carriers within 90 days of the occurrence shall not be subject to interest or any charges.

C. Limitation on Premium Refund

All premium refunds due under this Article shall be limited to a period of 12 months from the date the error was corrected unless otherwise agreed to by the Governing Committee.

D. Appeal of Disputes to Governing Committee

The Administrator will act on behalf of the Governing Committee in the attempt to resolve disputes between a Nongroup Carrier and The Program; however, Nongroup Carriers may request permission to appear before the Governing Committee at any time in connection with any dispute with The Program.

Article XVII - Claims and Causes of Action; Indemnification

- A. The Program is exclusively responsible for any and all claims and causes of action of any kind arising out of establishment and operation of The Program, including but not limited to any civil, criminal or administrative proceedings.
- B. Except and unless specifically provided herein, The Plan does not create or confer upon any party any new or additional claim or causes of action, criminal or civil liability, or penalty against the Governing Committee and the Nongroup Carriers with whom they are affiliated, or any Nongroup Carriers which are or have been members of The Program, in connection with establishment, operation, administration, management, oversight, or participation of or in The Program, including but not limited to the establishment of rates or any joint or collective action taken under or required by The Act or The Plan.
- C. Persons or Carriers made a party to any action, suit, or proceeding because the person or Carrier serves on the Governing Committee or on a subcommittee, or was an officer or

employee of The Program, shall be held harmless and be indemnified by The Program against all liability and costs, including the amounts of judgments, settlements, fines or penalties, and expenses and reasonable attorney's fees incurred in connection with the action, suit or proceeding. This indemnification shall not be provided on any issue on which liability is imposed because the person or member is finally adjudged in the action, suit or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance or reckless disregard of the responsibilities of office. Indemnification may be provided in whole or in part by one or more policies of insurance that may be obtained by The Program. Costs and expenses of the indemnification shall be prorated and paid for by all Nongroup Carriers.

Article XVIII – Amendment or Termination

A. Amendments

Amendments to The Plan may be suggested by any Nongroup Carrier and may be made by majority vote of the Governing Committee at any time, subject to the approval of the Commissioner. Amendments submitted to the Commissioner shall become effective upon the earlier of written approval by the Commissioner or expiration of 30 days following submission without disapproval by the Commissioner.

B. Termination

The Program shall continue in existence subject to termination in accordance with the requirements of a law or laws of the Commonwealth of Massachusetts or The United States of America. In case of enactment of a law or laws which, in determination of the Governing Committee and the Commissioner, shall result in termination of The Program, The Program shall terminate and conclude its affairs. Any funds or assets held by The Program following the payment of all claims and expenses of The Program shall be distributed to the Nongroup Carriers who are members of The Program at that time in accordance with the then-existing assessment formula.

Article XIX – Conformity with Law

If any Article, paragraph or provision of The Plan, or the applicability thereof to any person or circumstance is held invalid by any court of competent jurisdiction, the remainder of The Plan, or the applicability thereof to other person or circumstances, will not be affected thereby.

Unless otherwise specified by the Governing Committee, any provision of The Plan that conflicts with any applicable requirement of federal or state law or regulation shall be deemed amended to comply with such requirement.

Appendix A – Phase-out of The Program

According to Section 95 of Chapter 58 of the Acts of 2006, amending M.G.L. c. 176M §6, The Governing Committee of the Massachusetts Nongroup Health Reinsurance Plan (“The Program”) will execute the phase-out of The Program according to the following requirements:

- A. Carriers will end all ceding of risks into The Program as of midnight August 31, 2006.
- B. All coverage for risks ceded into The Program will end as of midnight, December 31, 2006.
- C. The claim filing period (run-off period) will end no later than midnight December 31, 2007 for claims incurred through December 31, 2006 and postmarked no later than December 31, 2007.
- D. A final accounting of The Program will be held by no later than June 30, 2008.
- E. The Administrator of The Program, Pool Administrators, Inc., or its duly appointed successor, assignee or designee if any, will notify all Massachusetts-licensed or -authorized nongroup carriers (“Carriers”) of the above changes by U.S. mail to such Carriers according to the following requirements:
 - 1. By August 11, 2006, the Administrator shall mail written notice that all further ceding to the Massachusetts Nongroup Health Reinsurance Plan will cease on August 31, 2006.
 - i. At this time the Administrator shall also inform these Carriers of the dates:
 - 1. Coverage under The Program will terminate on December 31, 2006; and
 - 2. Claim payments under The Program will cease on December 31, 2007.
 - ii. The Administrator shall also include in this August 4, 2006 mailing a copy of this Appendix A and the Plan of Operations as recently amended to incorporate this Appendix A.
 - 2. Thereafter, the Administrator shall mail to all Carriers timely reminders (at least 30 day advance written notice) of the later key dates:
 - i. Termination of coverage at midnight December 31, 2006, and
 - ii. The end of the claim run-out period at midnight December 31, 2007.
- F. In the event that The Program experiences a residual surplus (premiums less claims) at the final accounting, such surplus shall be distributed to the Carriers who are or were at any time members of The Program in accordance with the assessment formula outlined in Article XII, section A.2. of this Plan.

- G. In the event that The Program experiences a net loss at the final accounting, such net loss shall be recouped from the Carriers who are currently members of The Program in accordance with the assessment formula outlined in Article XII, section A.2. of this Plan.

- H. The provisions of this Appendix A will supersede any inconsistent provisions within The Plan and any conflict between any articles of The Plan and this Appendix A shall be resolved by adhering to Section 95 of Chapter 58 of the Acts of 2006 as reflected in this Appendix A.

Appendix C



COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE

1000 Washington Street, Suite 810 • Boston, MA 02118-6200
(817) 521-7794 • FAX (817) 521-7475
TTY/TDD (817) 521-7490
<http://www.state.ma.us/doi>

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

GREGORY BIALECKI
SECRETARY OF HOUSING AND
ECONOMIC DEVELOPMENT

BARBARA ANTHONY
UNDERSECRETARY

JOSEPH G. MURPHY
COMMISSIONER OF INSURANCE

December 5, 2012

Sharon B. Arnold, Ph.D.
Acting Director, Payment Policy and Financial Management Group
Center for Consumer Information and Insurance Oversight (CCIIO)
7501 Wisconsin Avenue
Bethesda, MD 20814

Re: Waiver from Affordable Care Act Transitional Reinsurance Program

Dear Dr. Arnold:

I write regarding the transitional Reinsurance Program established by Section 1341 of the Affordable Care Act ("ACA"), which you discussed in a conference call with Kevin Beagan of this office on November 9, 2012, along with Diane Gerrits and Nancy Goetschius of the Center for Consumer Information and Insurance Oversight's ("CCIIO") Division of Reinsurance Operations.

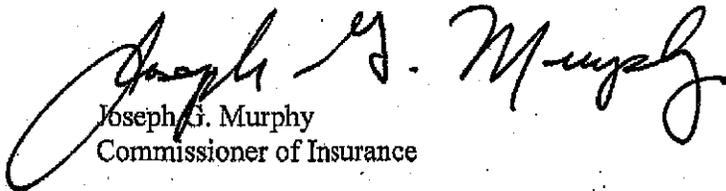
As you know, the Massachusetts Division of Insurance ("Division") is directed by M.G.L. c. 176J, § 8 to "...study the implementation of, establish, if warranted, and supervise a transitional reinsurance program pursuant to section 1341 of the federal Affordable Care Act or, if the commissioner believes that such program is not appropriate for the commonwealth, to apply for any appropriate waiver from the requirement to implement such program." The law further provides that "...before a waiver is sought or a transitional reinsurance program is to be implemented, the commissioner shall provide a report on the decision and the details of any proposed program... [to the state legislature]." Mr. Beagan inquired during the conference call whether individual states could seek a waiver from the Section 1341 transitional Reinsurance Program. Although you responded that CCIIO staff believes that such waivers are not permitted by the ACA, you further indicated that you would be willing to elevate a formal written request for a determination on this issue to policy officials at the agency.

Letter to Sharon B. Arnold, Ph.D.
Acting Director, Payment Policy and Financial Management Group
Center for Consumer Information and Insurance Oversight
December 5, 2012
Page 2 of 2

Please consider this letter to constitute the Division's formal request to CCIIO for a determination of whether the Commonwealth of Massachusetts may seek a waiver of the transitional Reinsurance Program requirement, as set forth in Section 1341 of ACA.

I thank you advance for CCIIO's prompt consideration of this request. If you have any questions, please contact me directly at (617) 521-7302, or Kevin P. Beagan, Deputy Commissioner of the Health Care Access Bureau, at (617) 521-7323.

Sincerely,



Joseph G. Murphy
Commissioner of Insurance

cc: Kevin P. Beagan, Deputy Commissioner, Health Care Access Bureau
Robert A. Whitney, Deputy Commissioner and General Counsel

Appendix D



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

January 10, 2013

Joseph G. Murphy
Commissioner of Insurance
Division of Insurance
Commonwealth of Massachusetts
1000 Washington Street, Suite 810
Boston, MA 02118-6200

DIVISION OF INSURANCE

JAN 14 2013

OFFICE OF THE
COMMISSIONER

Dear Mr. Murphy:

Thank you for your letter dated December 5, 2012 in which you formally requested the Center for Consumer Information and Insurance Oversight (CCIIO), in the Centers for Medicare & Medicaid Services (CMS) at the US Department of Health and Human Services (HHS), to provide you with a determination of whether the Commonwealth of Massachusetts may seek a waiver of the transitional Reinsurance Program requirement as set forth in Section 1341 for the Patient Protection and Affordable Care Act (ACA).

In your letter, you requested a formal response so that the Division of Insurance may fully comply with the requirements of Massachusetts General Law Chapter 176J, Section 8, effective June 19, 2012. This law requires that the commissioner of the Division of Insurance to "apply for any appropriate waiver from the requirement to implement [the Transitional Reinsurance] program."

We have reviewed your request, and determined that HHS has no authority to grant to a State a waiver from the transitional Reinsurance Program requirements of Section 1341 of the ACA. There is no express authority for such a waiver in Section 1341 or any other provision of the ACA. Moreover, Section 1341(a)(1) requires each State to establish a transitional Reinsurance Program that includes "in the Federal standards or State law or regulation the State adopts and has in effect under section 1321(b) the provisions described in [Section 1341(b) of the ACA]..." Therefore, we believe that Massachusetts must establish a transitional Reinsurance Program that meets the requirements of Section 1341(b) of the ACA, as well as any federal standards set forth in the Final Rules of the Standards Related to Reinsurance, Risk Corridors and Risk Adjustment published in the Federal Register on March 23, 2012, as well as the upcoming Final HHS Notice of Benefit and Payment Parameters for 2014. As set forth in the Final Rules of the Standards Related to Reinsurance, Risk Corridors and Risk Adjustment published in the Federal Register on March 23, 2012, if Massachusetts does not elect to establish a Reinsurance Program, HHS will establish a Reinsurance Program for Massachusetts.

Page 2—Mr. Murphy

Please feel free to contact me if you would like to discuss this further. I can be reached on my direct line at 301-492-4286.

Sincerely,



Sharon B. Arnold Ph. D., Acting Director
Payment Policy & Financial Management Group
Center for Consumer Information & Insurance Oversight

cc: Kevin P. Beagan, Deputy Commissioner, Health Care Access Bureau
Robert A. Whitney, Deputy Commissioner and General Counsel