211 CMR 148.00: REGISTRATION AND REPORTING REQUIREMENTS FOR THIRD-PARTY ADMINISTRATORS

Section

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148.01: Purpose and Scope

211 CMR 148.00 governs the registration and reporting requirements applicable to Third- party Administrators, including pharmacy benefit managers and other entities with claims data, eligibility data, provider files and other information relating to health care provided to residents of the Commonwealth and health care provided by health care providers in the Commonwealth.

148.02: Definitions

As used in 211 CMR 148.00, the following words mean:

Accumulated Surplus. Unassigned Funds (Surplus), defined as the undistributed and unappropriated amounts of surplus, in Statement of Statutory Accounting Principle No. 72 of the *NAIC Accounting Practices and Procedure Manual* of March 2011.

Commissioner. The Commissioner of Insurance appointed pursuant to M.G.L. c. 26, § 6, or his or her designee.

Direct Claims Incurred. Paid claims during the year, plus net change in the direct claim liability, plus the change in direct claim reserves, plus the change in direct contract reserves, plus incurred medical incentive pools, plus change in net healthcare receivables and net reinsurance recoverables, as calculated in the Supplemental Health Care Exhibit as adopted by the NAIC on August 17, 2010.

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

Health Insurer. An insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization licensed under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176I. Health Insurer shall not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Health Insurer also shall not include any entity to the extent it offers a policy, certificate or contract that is not a health benefit plan, as defined in M.G.L. c. 176J, § 1.

Medical Loss Ratio. The ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums, according to current National Association of Insurance Commissioners' methodology, or as otherwise determined by the Commissioner. The Medical Loss Ratio shall be calculated and submitted to the Division pursuant to 211 CMR 147.00: *Methodology for Calculating and Reporting Medical Loss Ratios (MLRSs) of Health Benefit Plans*.

NAIC. National Association of Insurance Commissioners.

Self-insured Customer. A Self-insured Group for which a Third-party Administrator provides administrative services related to receiving or collecting charges, contributions or premiums for, or adjusting or settling claims on or for residents of the Commonwealth.

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Self-insured Group Plan. A self-insured or self-funded employment based group health plan.

Third-party Administrator. A person or entity domiciled inside or outside of the Commonwealth who, on behalf of a Health Insurer or purchaser of health benefits, receives or collects charges, contributions or premiums for, or adjusts or settles claims on or for residents of the Commonwealth. Unless noted otherwise, a purchaser of health benefits shall not include an entity to the extent it offers a policy, certificate or contract that is not a health benefit plan, as defined in M.G.L. c. 176J, § 1; provided, however, that a purchaser of health benefits shall include an entity that offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services. The Third-party Administrator shall also include pharmacy benefit managers and any other entity with claims data, eligibility data, provider files and other information relating to health care provided to residents of the Commonwealth and health care provided by health care providers in the Commonwealth, except that the Third-party Administrator shall not include an entity that administers only claims data, eligibility data, provider files and other information for its own employees and dependents. The Third-party Administrator further shall not include "intermediary", as defined in M.G.L. c. 176J, § 1 and 211 CMR 66.04: *Definitions*.

148.03: Initial Registration and Annual Renewal of Registration

(1) No Third-party Administrator shall do business in the Commonwealth prior to registering with the Division. Such registration shall be renewed on an annual basis no later than April 1st of each year and shall require the submission of the annual report described in 211 CMR 148.04.

(2) All Third-party Administrators shall register and renew registration with the Division in a form and method prescribed by the Commissioner. All registration and renewal of registration forms shall be completed in their entirety in order to be considered by the Division. Incomplete forms may not be considered and may be returned to the Third-party Administrator seeking to register in accordance with 211 CMR 148.00.

(3) All registration forms and renewal of registration forms shall include, but may not be limited to, the following information certified by an officer of the Third-party Administrator: A narrative description of the Third-party Administrator and its activities, including the identity of the state(s) in which it has been formed, headquartered and in which its operates, as well as a designated contact person for the Third-party Administrator, including said person's phone number, email and mailing address.

148.04: Annual Reporting Requirements

(1) All Third-party Administrators, as a condition of registration, shall submit an annual report to the Division in a form approved by the Commissioner, no later than April 1st of each year, for the year ended December 31st immediately preceding which shall include; or in the following alternative, as authorized by the Commissioner, the Division may obtain certain annual reporting information regarding the Third-party Administrator's Self-insured Customers from an alternate source.

Third-party Administrators may notify the Division on or before April 1st of any year regarding the Third-party Administrator's customer accounts that had fewer than 100 members who were Massachusetts residents as of December 31st of the previous year. Third-party Administrators that provide the Division with information regarding numbers of members in such customer accounts shall be exempt from reporting under 211 CMR 148.04(1) for those customer accounts for so long as such Massachusetts membership remains below 100 members in those customer accounts.

(a) The Third-party Administrator Annual Report. The number of the Third-party Administrator's Self-insured Customers as of December 31st;

(b) The aggregate number of subscriber members enrolled in the benefit plans administered for all of the Third-party Administrator's Self-insured Customers, including:

1. Number of subscriber members covered on December 31st;
2. Number of subscriber member months covered in prior calendar year; and
3. Average number of subscriber members in prior calendar year.

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(c) The aggregate number of subscriber and dependent lives covered in the benefit plans administered for all of the Third-party Administrator's Self-insured Customers, including:

1. Number of subscriber and dependent covered lives on December 31st;
2. Number of subscriber and dependent covered life member months in prior calendar year; and
3. Average number of subscriber and dependent covered lives in prior calendar year.

(d) The aggregate value of direct premiums earned for all of the Third-party Administrator's Self-insured Customers;

(e) The aggregate value of Direct Claims Incurred for all of the Third-party Administrator's Self-insured Customers;

(f) The aggregate Medical Loss Ratio for all of the Third-party Administrator's Self-insured Customers;

(g) Net income;

(h) Accumulated Surplus;

(i) Accumulated reserves;

(j) The percentage of the Third-party Administrator's Self-insured Customers that include each of the benefits mandated for health benefit plans under M.G.L. chs. 175, 176A, 176B and 176G;

(k) The aggregated administrative service fees paid by all of the Third-party Administrator's Self-insured Customers to the Third-party Administrator; and

(l) Any other information deemed necessary by the Commissioner.

(2) Annual reports submitted by Third-party Administrators shall be certified by at least two officers of the Third-party Administrator.

(3) All information submitted to the Division in the annual report shall be a public record.

(4) If a Third-party Administrator contracts with another Third-party Administrator to provide services on behalf of a Self-insured Customer, such information shall be included in the annual report for Third-party Administrator that contracts with the Self-insured Customer.

(5) If a Third-party Administrator is unable to provide any of the required information set forth in 211 CMR 148.04 in the annual report and the Commissioner has not authorized the Division to obtain the information from an alternate source, the Third-party Administrator shall provide a detailed explanation, within the annual report, of the reason(s) that such required information is not available.

(6) Any Third-party Administrator which is required to submit an annual report and which fails to submit the annual report to the Division in the form and within the time provided shall be subject to a late penalty of not more than $100 per day.

(7) Any Third-party Administrator which also is a Health Insurer that is required to submit an Annual Comprehensive Financial Statement to the Division in accordance with M.G.L. c. 176O, § 21(a) and 211 CMR 149.00: *Annual Comprehensive Financial Statements Pursuant to M.G.L. c. 176O, § 21* shall be exempt from the annual reporting requirements set forth in 211 CMR 148.04.

(8) Any Third-party Administrator which receives or collects charges, contributions or premiums for, or adjusts or settles claims on or for residents of the Commonwealth on behalf of a Health Insurer that itself is required to submit an Annual Comprehensive Financial Statement to the Division in accordance with M.G.L. c. 176O, § 21(a) and 211 CMR 149.00: *Annual Comprehensive Financial Statements Pursuant to M.G.L. c. 176O, § 21* shall be exempt from the annual reporting requirements set forth in 211 CMR 148.04 for those services that the Third-party Administrator provides on behalf of the Health Insurer.

148.05: Grounds for Suspension or Revocation of Registration and Imposition of Fines

(1) The Commissioner may, after a hearing, suspend or revoke the registration of any Third- party Administrator if the Commissioner finds that:

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(a) The Third-party Administrator has failed to submit to the Division required annual reporting information as set forth in 211 CMR 148.04;
(b) The Third-party Administrator has its license or registration to do business suspended or revoked by any state, including its home state;
(c) The Third-party Administrator is insolvent or impaired;
(d) A proceeding for receivership, conservatorship, rehabilitation or other delinquency proceeding regarding the Third-party Administrator has been commenced in any state; or
(e) The financial condition or business practices of the Third-party Administrator otherwise pose an imminent threat to the public health, safety or welfare of the residents of the Commonwealth.

(2) If the Commissioner finds that one or more grounds exist for the suspension or revocation of a registration issued under 211 CMR 148.00, the Commissioner may, in *lieu* of, or in addition to, suspension or revocation, impose a fine of not more than $1,000 for each and every violation upon the Third-party Administrator.

(3) Any Third-party Administrator which engages in business in the Commonwealth without registering in accordance with 211 CMR 148.00 may, after a hearing, be subject to a fine of not more than $1,000 for each and every violation.

148.06: Severability

If any section or portion of a section of 211 CMR 148.00, or the applicability thereof to any person or circumstance is held invalid by any Court of competent jurisdiction, the remainder of 211 CMR 148.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

REGULATORY AUTHORITY

211 CMR 148.00: St. 2010, c. 288 and M.G.L. c. 176O, § 21(c).