211 CMR 149.00: ANNUAL REPORTING PURSUANT TO M.G.L. C. 176O, § 21

Section

149.01: Authority

211 CMR 149.00 is promulgated in accordance with the Commissioner of Insurance's authority pursuant to M.G. L. c. 176O, § 21.

149.02: Purpose

211 CMR 149.00 governs the form and content of reports of administrative services submitted pursuant to M.G.L. c. 176O, § 21.

149.03: Applicability

(1) Every Carrier that provides administrative services to one or more Self-insured Groups shall be subject to the requirements of 211 CMR 149.00.

(2) 211 CMR 149.00 shall not prohibit, preclude or in any way limit the Commissioner from ordering, or conducting or performing insurance examinations of Carriers under the Commissioner's jurisdiction as to practices, procedures, financial condition, market conduct and other aspects of insurance operations of such Carriers.

149.04: Definitions

For purposes of 211 CMR 149.00, the following words shall 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.

Carrier: An insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176I; Carrier 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; provided, however, that Carrier shall include an entity that offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services. Carrier 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, or any entity acting solely as a Third-party Administrator.

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

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Commonwealth: The Commonwealth of Massachusetts.

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.

Direct Premium Earned: Direct written premium plus the change in unearned premium reserves and the change in reserve for rate credits, minus the Regulatory authority licenses and fees, less write-offs, as calculated in the Supplemental Health Care Exhibit as adopted by the NAIC on August 17, 2010.

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

Medical Loss Ratio (MLR): The ratio of the incurred loss (or Incurred Claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums, as determined by the Commissioner.

NAIC: The 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 of settling claims on or for residents of the Commonwealth.

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

Third-party Administrator: A person domiciled inside or outside of the Commonwealth who, on behalf of a Carrier 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 does not qualify as creditable coverage as defined in M.G.L. c. 111M, § 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. 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 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.

149.05: Information Relative to Administrative Services Provided to Self-insured Groups

(1) Any Carrier that provides administrative services to one or more Self-insured Groups shall submit to the Division an Annual Self-insured business Report on a form approved by the Commissioner. The Self-insured business Report shall be submitted electronically on or before April 1st for the year ended December 31st immediately preceding and shall include the following information:

(a) The number of the Carrier'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 Carrier'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 for prior calendar year; and

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

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

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(d) The aggregate value of Direct Premiums Earned for all of the Carrier's Self-insured Customers;
(e) The aggregate value of Direct Claims Incurred for all of the Carrier's Self-insured Customers;
(f) The aggregate Medical Loss Ratio for all of the Carrier's Self-insured Customers;
(g) Net income;
(h) Accumulated Surplus;
(i) Accumulated reserves;
(j) The percentage of the Carrier'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 Carrier's Self-insured Customers; and
(l) Any other information requested by the Commissioner.

(2) If a Carrier is unable to provide any of the required information set forth in the Self-insured business Report, the Carrier shall provide a detailed explanation of the reason(s) that such required information is not available.

(3) A Carrier that provides administrative services to one or more Self-insured Groups and fails to submit the Self-insured business Report to the Division on or before April 1st of each year shall be assessed a late penalty by the Commissioner not to exceed $100.00 per day.

149.06: Audit of Self-insured Business Report

(1) The Commissioner may, in his or her discretion, require that a Carrier make available the underlying data used in its calculations for its Self-insured business Report, if applicable, for audit by Division staff or outside consultants or advisors of the Division.

(2) Any and all fees and costs for the Division's audit of the Carrier's Self-insured business Report, shall be borne by the subject Carrier.

149.07: Public Hearing on Carrier's Financial Condition

(1) If, in any year, a Carrier reports that its Risk Based Capital ratio on a combined entity basis exceeds 700%, the Commissioner, or a designated Presiding Officer, shall hold a public hearing to examine the Carrier's overall financial condition and the Carrier's continued need for additional surplus.

(2) The public hearing shall be held within 60 days of the date of the Carrier reporting that its Risk Based Capital ratio on a combined entity basis exceeds 700%.

(3) At the public hearing, the Carrier shall submit testimony on its overall financial condition and its continued need for additional surplus. The Carrier shall also submit testimony on how, and in what proportion to the total surplus accumulated, the Carrier will dedicate any additional surplus to reducing the cost of health benefit plans or health care quality improvement, patient safety or health cost containment activities not conducted in previous years.

149.08: Notice of Public Hearing

(1) The Commissioner shall issue written notice of the public hearing to the subject Carrier no less than 30 days prior to the public hearing.

(2) The Carrier shall arrange for newspaper publication of the written notice of the public hearing in a newspaper or newspapers designated by the Commissioner. Such notice shall be published no less than 21 days prior to the public hearing.

149.09: Pre-hearing Filing by Carrier

(1) No later than 15 days prior to the public hearing, the Carrier shall submit a filing to the Division containing:

(a) The title and docket number of the proceeding, and the complete name and address of the Carrier submitting the filing;

(b) A summary containing a description of the contents of the filing;

(c) A list of the names and occupations of all persons who will present oral testimony, statements or comments on behalf of the Carrier at the public hearing; and

(d) Any other information required by the Commissioner or the Presiding Officer.

(2) The Carrier's filing shall describe the Carrier's overall financial condition and the reasons why the Carrier believes the additional surplus is needed. The filing shall also describe how, and in what proportion to the total surplus accumulated, the Carrier will dedicate any additional surplus to reducing the cost of health benefit plans or health care quality improvement, patient safety or health cost containment activities not conducted in previous years.

149.10: Conduct of Public Hearing

(1) Duties of the Presiding Officer. The Presiding Officer shall conduct the public hearing and take appropriate action to ensure the orderly conduct of the public hearing. Testimony may be taken under oath or affirmation, at the discretion of the Presiding Officer.

(2) Transcript. The Carrier shall arrange that any public hearing be officially recorded by a stenographer. The full cost of the stenographer's fees, along with the cost of providing two copies of the written transcript of the public hearing to the Division, shall be paid by the Carrier.

149.11: Commissioner's Report on Public Hearing

The Commissioner shall review the testimony from the public hearing and issue a final report on the public hearing.

149.12: Severability

If any section or portion of a section of 211 CMR 149.00, or the applicability thereof to any person or circumstance is held invalid by any court of competent jurisdiction, the remainder of 211 CMR 149.00, or the applicability thereof to other persons or circumstances, will not be affected thereby.

REGULATORY AUTHORITY

211 CMR 149.00: M.G. L. c. 176O, § 21.

(PAGES 1061 THROUGH 1064 ARE RESERVED FOR FUTURE USE.)