211 CMR 66.00: SMALL GROUP HEALTH INSURANCE

Section

66.01: Purpose

The purpose of 211 CMR 66.00 is to implement the provisions of M.G.L. c. 176J.

66.02: Applicability and Scope

(1) 211 CMR 66.00 applies to all Health Benefit Plans offered, made effective, issued, renewed, delivered or issued for delivery to any Eligible Small Business or to any Eligible Individual under M.G.L. c. 176J, whether issued directly by a Carrier, through the Connector, through an association, a Group Purchasing Cooperative, or through an Intermediary.

(2) Nothing in 211 CMR 66.00 prohibits a Carrier that offers health insurance to a business of more than 50 Eligible Employees from offering insurance in accordance with the provisions of 211 CMR 66.00.

66.03: Definitions

Actuarial Opinion. A signed written statement by a qualified member of the American Academy of Actuaries, which certifies that the actuarial assumptions, methods and contract forms utilized by the Carrier in establishing premium rates for Merged Market Health Benefit Plans comply with all the requirements of 211 CMR 66.00 and any other applicable law.

Affordable Care Act or ACA. The federal Patient Protection and Affordable Care Act, Public Law 111-148, adopted March 23, 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and federal regulations adopted pursuant to those acts.

Benefit Level Rate Adjustment Factor. A number that represents the ratio of the actuarial value of the Benefit Level of a Health Benefit Plan as compared to the average actuarial value of the Benefit Level of all Health Benefit Plans offered by the Carrier to Eligible Individuals and Eligible Small Groups in Massachusetts. The Benefit Level Rate Adjustment Factor is also referred to as "Plan Adjustment Factor" or "Pricing Actuarial Value".

Carrier. An insurer licensed or otherwise authorized to transact accident and health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; or a Health Maintenance Organization organized under M.G.L. c. 176G.

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Catastrophic Health Benefit Plan. A Health Benefit Plan in accordance with the ACA that is offered to individuals who are younger than 30 years old or who have a hardship exemption from individual health plan penalty requirements.

Child-only Health Benefit Plan. A Health Benefit Plan in accordance with the ACA that is offered to individuals younger than 21 years old.

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

Connector. The Commonwealth Health Insurance Connector Authority created under M.G.L. c. 176Q.

Connector Seal of Approval. The approval given by the Connector to indicate that a Health Benefit Plan meets certain standards regarding quality and value.

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

Eligible Child. An Eligible Individual who, as of the beginning of a plan year, has not attained 21 years of age and who is seeking to enroll in a Child-only Health Benefit Plan offered by a Carrier.

Eligible Dependent. The spouse or child of an Eligible Individual or Eligible Employee, subject to the applicable terms of the Health Benefit Plan covering such individual or employee. The child of an Eligible Individual or Eligible Employee shall be considered an Eligible Dependent until at least the child's 26th birthday.

Eligible Employee. Any individual employed by an employer, including seasonal and temporary staff, but excluding business owners and those holding more than 2% of stock ownership.

Eligible Individual. An individual who is a resident of the Commonwealth.

Eligible Small Business or Eligible Small Group. Any sole proprietorship, firm, corporation, partnership or association actively engaged in business who employed not more than 50 Eligible Employees; a business shall be considered to be an Eligible Small Business or Eligible Small Group if:

(a) it is eligible to file a combined tax return for purpose of state taxation; or

(b) its companies are affiliated companies through the same corporate parent. Except as otherwise specifically provided, provisions of 211 CMR 66.00 which apply to an Eligible Small Business will continue to apply through the end of the Rating Period in which an Eligible Small Business no longer meets the requirements of Eligible Small Business or Eligible Small Group. An Eligible Small Business that exists within a MEWA shall be subject to 211 CMR 66.00. Nothing within this definition or within any other provision of 211 CMR 66.00 shall preclude other employer-entities including, but not limited to, government municipalities, from being offered Health Benefit Plans in accordance with 211 CMR 66.00.

Exchange. Public entity that administers a website whereby consumers may purchase health insurance products pursuant to federal law and regulation. In Massachusetts, the Connector is the Exchange.

Financial Impairment. A condition in which, based on the overall condition of the Carrier as determined by the Commissioner, the Carrier is, or if subjected to the provisions of 211 CMR 66.00 could reasonably be expected to be, insolvent, or otherwise in an unsound financial condition such as to render its further transactions of business hazardous to the public or its policyholders or Members, or is compelled to compromise, or attempt to compromise, with its creditors or claimants on the grounds that it is financially unable to pay its claims.

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Group Base Premium Rates. The base premium rate to be charged to Eligible Individuals and their dependents and Eligible Small Businesses for all Eligible Employees and Eligible Dependents prior to the application of Rating Adjustment Factors. These rates are equivalent to the calibrated plan adjusted index rate (CPAIR) as reported in the Federal Unified Rate Review Template.

Group Health Plan.

(a) An employee welfare benefit plan, as defined in the Employee Retirement Income Security Act of 1974, § 3(1), 29 U.S.C. 1002, to the extent that the plan provides Medical Care, and including items and services paid for as Medical Care to plan participants, including employees or their dependents, as defined under the terms of the plan directly or through insurance, reimbursement or otherwise. For the purposes of 211 CMR 66.00, Medical Care means amounts paid for:

1. the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
2. amounts paid for transportation primarily for and essential to Medical Care referred to in 211 CMR 66.03: Group Health Plan(a)1.; and
3. amounts paid for insurance covering Medical Care referred to in 211 CMR 66.03: Group Health Plan(a)1. and 2.

(b) Any plan, fund or program which would not be, but for section 2721(e) of the federal Public Health Service Act, an employee welfare benefit plan, and which is established or maintained by a partnership, to the extent that the plan, fund or program provides Medical Care, including items and services paid for as Medical Care, to present or former partners in the partnership, or to their dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to 211 CMR 66.03: Group Health Plan(c), as an employee welfare benefit plan which is a Group Health Plan.

(c) In a Group Health Plan the term participant, as referenced in 211 CMR 66.03 Group Health Plan(a), also includes:

1. in connection with a Group Health Plan maintained by a partnership, an individual who is a partner of the partnership; or
2. in connection with a Group Health Plan maintained by a self-employed individual, under which one or more employees are participants, the self-employed individual if that individual is, or may become, eligible to receive a benefit under the plan or that individual's beneficiaries may be eligible to receive any benefit.

Health Benefit Plan. Any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under M.G.L. c. 175; an individual or group hospital service plan issued by a nonprofit hospital service corporation under M.G.L. c. 176A; an individual or group nonprofit medical service plan issued by a medical service corporation under M.G.L. c. 176B; and an individual or group health maintenance contract issued by a Health Maintenance Organization under M.G.L. c. 176G.

Health Benefit Plans shall not include those plans whose benefits are for:

(a) accident only;
(b) credit only;
(c) limited scope vision or dental benefits if offered separately;
(d) hospital indemnity insurance policies that provide a benefit 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, that are sold as a supplement and not as a substitute for a Health Benefit Plan and that meet standards consistent with those identified for hospital indemnity insurance within 211 CMR 42.00: *The Form and Contents of Individual Accident and Sickness Insurance*;
(e) disability income insurance;
(f) coverage issued as a supplement to liability insurance;
(g) specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets the requirements of 211 CMR 146.00: *Specified Disease Insurance*;
(h) insurance arising out of a workers' compensation law or similar law;
(i) automobile medical payment insurance;
(j) insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance;

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(k) long-term care insurance if offered separately;
(l) coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy;
(m) any policy subject to M.G.L. c. 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans; or
(n) travel insurance which is insurance coverage for personal risks incident to planned travel including, but not limited to:

1. interruption or cancellation of trip or event;
2. loss of baggage or personal effects;
3. damages to accommodations or rental vehicles; or
4. sickness, accident, disability or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverages and shall not include major medical plans, which provide comprehensive medical protection for travelers with trips lasting six months or longer, including for example, those working overseas as an ex-patriot or military personnel being deployed; or

(o) a health plan issued, renewed or delivered within or without the Commonwealth to an individual who is enrolled in a student health insurance program under M.G.L. c. 15A, § 18 shall not be considered a Health Benefit Plan for the purposes of 211 CMR 66.00, but shall be governed by said M.G.L. c. 15A and the ACA, where applicable.

Health Maintenance Organization or HMO. An entity licensed to do business in Massachusetts under M.G.L. c. 176G.

Insured. Any policyholder, certificate holder, subscriber, Member or other person on whose behalf the Carrier is obligated to pay for and/or provide health care services.

Intermediary. A chamber of commerce, trade association, or other organization, formed for purposes other than obtaining insurance, which has complied with the requirements of 211 CMR 66.12(3), and which offers its members the option of purchasing a Health Benefit Plan.

Late Enrollee. An Eligible Employee or dependent who requests enrollment in an Eligible Small Business' health insurance plan or insurance arrangement after the Group's initial enrollment period, his or her initial eligibility date provided under the terms of the plan or arrangement, or the Group's annual open enrollment period, provided however, that an Eligible Employee or Dependent shall not be considered a late enrollee if the request for enrollment to the insurer is made within 30 days after termination of coverage provided under another health insurance plan or arrangement where such coverage has ceased due to termination of the spouse's employment or death of the spouse.

Mandated Benefit. A health service or category of health service provider which a Carrier is required by its licensing or other statute to include in its Health Benefit Plan.

Member. Any person enrolled in a Health Benefit Plan.

Merged Market. The combined market of Eligible Individuals and Eligible Small Groups.

MEWA or Multiple Employer Welfare Arrangement or Multiple Employer Trust. Either:
(a) a fully-insured Multiple Employer Welfare Arrangement as defined in §§ 3 and 514 of the Employee Retirement Income Security Act (ERISA) of 1974, §§ 3 and 514, 29 USC 1002 and 1144; or
(b) an entity holding itself out to be a MEWA, Multiple Employer Welfare Arrangement or Multiple Employer Trust which is not fully insured and, therefore, shall be required to be licensed under M.G.L. c. 175. An arrangement that constitutes a MEWA is considered a separate Group Health Plan with respect to each employer maintaining the arrangement agreement.

Office of Patient Protection. The office in the Health Policy Commission established by M.G.L. c. 6D, § 16(a).

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Participation Rate. The percentage of Eligible Employees electing to participate in a Health Benefit Plan out of all Eligible Employees, or the percentage of the sum of Eligible Employees and Eligible Dependents electing to participate in a Health Benefit Plan out of the sum of all Eligible Employees and Eligible Dependents, at the election of the Carrier, as referenced in 211 CMR 66.04(1)(j). In either case, the numbers used to compute these percentages shall not include:

(a) any Eligible Employee or Eligible Dependent who is ineligible to enroll in the Eligible Small Business' Health Benefit Plan according to the Carrier's service plan requirements; and

(b) any Eligible Employee or Eligible Dependent who does not participate in the Eligible Small Business' Health Benefit Plan, but who is enrolled in another Health Benefit Plan through a source other than the Eligible Small Business.

Participation Requirement. A policy provision, or a Carrier's underwriting guideline if there is no such policy provision, that requires that a group attain a certain Participation Rate in order for a Carrier to accept the group for enrollment in the Health Benefit Plan, as referenced in 211 CMR 66.04(1)(j). For groups of five or fewer eligible persons, a Carrier may require a Participation Rate up to 100%. For groups of six or more eligible persons, a Carrier may require a Participation Rate up to 75%.

Qualifying Health Plan. Any blanket or general policy of medical, surgical or hospital insurance described in M.G.L. c. 175, § 110(A), (C) or (D); policy of accident or sickness insurance as described in M.G.L. c. 175, § 108 which provides hospital or surgical expense coverage; nongroup or group hospital or medical service plan issued by a nonprofit hospital or medical service corporation under M.G.L. c. 176A and M.G.L. c. 176B; nongroup or group health maintenance contract issued by an HMO under M.G.L. c. 176G; nongroup or group preferred provider plan issued under M.G.L. c. 176I; self-insured or self-funded health plans offered by an employer or union health and welfare fund; health coverage provided to persons serving in the armed forces of the United States; or government-sponsored health coverage including, but not limited to, Medicare and medical assistance provided under M.G.L. c. 118E.

Rating Adjustment Factor. A factor permitted by state law and by the Center for Medicare & Medicaid Services that is applied to a Group Base Premium Rate to derive the premium that is charged to a particular Eligible Individual or Eligible Small Business.

Rating Period. The period for which premium rates established by a Carrier are in effect.

Resident. A natural person living in the Commonwealth, but the confinement of a person in a nursing home, hospital or other institution shall not by itself be sufficient to qualify a person as a Resident.

Small Business Group Purchasing Cooperative or Group Purchasing Cooperative. A Massachusetts nonprofit or not-for-profit corporation or an association that is approved as a qualified association by the Commissioner, all the members of which are part of a qualified association under M.G.L. c. 176J, § 12, that has been certified by the Commissioner as a Group Purchasing Cooperative that negotiates with one or more Carriers for the issuance of Health Benefit Plans that cover Eligible Employees, and the Eligible Dependents of the qualified association's members.

Tobacco Product. A product that contains tobacco in any of its forms including, but not limited to, cigarettes, bidi cigarettes, clove cigarettes, cigars, pipe tobacco, smokeless tobacco, chewing tobacco, or snuff.

Trend in Health Plan Expenses. The projected change in health plan expenses.

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

66.04: Minimum Coverage Standards

(1) Offerings and Open Enrollment.

(a) Unless otherwise provided in 211 CMR 66.04, every Carrier shall make available to every Eligible Individual and every Eligible Small Business a certificate that evidences coverage for every Health Benefit Plan that it provides to any other Eligible Individual or Eligible Small Business whether issued or renewed to a trust, association or other entity that is not a Group Health Plan, as well as to their Eligible Dependents. Additionally, a Carrier may offer certain Health Benefit Plans, including Catastrophic Health Benefit Plans and Child-only Health Benefit Plans. Every Carrier must accept for enrollment any Eligible Individual or Eligible Small Business that seeks to enroll in a Health Benefit Plan as provided herein; however, a Carrier shall only contract to sell a Health Benefit Plan to cover an Eligible Individual and Eligible Dependents during an annual open enrollment period, except as follows:

1. A Carrier shall enroll an Eligible Individual into a health plan if such individual requests coverage within 63 days of termination of any prior coverage that meets the ACA minimum essential coverage requirements.

2. A Carrier shall enroll an Eligible Individual into a health plan if such individual requests coverage within 63 days of experiencing another qualifying or ACA triggering event, and in doing so the Carrier must comply with the ACA and Exchange enrollment requirements, as applicable.

3. A Carrier shall enroll an Eligible Individual who has been granted a waiver by the Office of Patient Protection.

(b) Coverage issued to Eligible Small Businesses under 211 CMR 66.04(1)(a) shall become effective within 30 days of a Carrier's receipt of a completed application.

(c) Upon the request of an Eligible Small Business or Eligible Individual, a Carrier shall provide that Eligible Small Business or Eligible Individual with a sample of Health Benefit Plans and prices and, upon request, a price for every Health Benefit Plan that it makes available to any Eligible Small Business or Eligible Individual. The Carrier may satisfy such a request for information on Health Benefit Plan offerings by referring the Eligible Small Business or Eligible Individual to resources where the information can be accessed including, but not limited to, an internet website, and the term internet website shall include intranet website and electronic mail or e-mail. The Carrier must provide free of charge a paper copy of this information if the Eligible Small Business or Eligible Individual requests such a paper copy. The Carrier shall provide a toll-free telephone number for the Eligible Individual and Eligible Small Business to call with any questions or requests.

(d) A Carrier may decide to limit its sale of any Health Benefit Plan to Eligible Small Businesses by requiring that an Eligible Small Business have Eligible Employees that reside or work in the Carrier's service area; provided, however, the Eligible Small Business shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each Health Benefit Plan for all employees. Notwithstanding the foregoing, a Carrier may sell, issue, market or deliver a Health Benefit Plan to an employer that establishes separate contribution percentages for employees covered by collective bargaining agreements.

(e) If a Carrier is not accepting every new Eligible Small Group or Eligible Individual, it may not accept any new Eligible Small Groups or Eligible Individuals either directly, through an association or through an Intermediary or through the Connector. However, if a Carrier issued a health insurance product which is not available to Eligible Small Groups or Eligible Individuals but is available to a group with 51 or more employees and the size of that group declined to 50 or fewer employees during the term of the policy, the Carrier is not required to make that particular health insurance product available to Eligible Small Groups or Eligible Individuals.

(f) A Carrier may deny an Eligible Individual or an Eligible Small Group of five or fewer Eligible Employees enrollment in a Health Benefit Plan unless the Eligible Individual or the Eligible Small Group enrolls through an Intermediary or through the Connector, provided that the Carrier complies with all of the following requirements:

1. For Eligible Individuals and Eligible Small Groups of five or fewer Eligible Employees, every Carrier must make coverage available either directly or through an Intermediary or through the Connector; however, such coverage shall be at no higher cost than if the Eligible Individual or Eligible Employer had purchased the coverage directly from the Carrier.

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2. No Carrier may require an Eligible Individual or an Eligible Small Group of five or fewer Eligible Employees to join an Intermediary if the Intermediary has unreasonable barriers to membership including, but not limited to, unreasonable fees or unreasonable membership requirements. If an Eligible Individual or a Eligible Small Group is precluded from joining an Intermediary due to unreasonable membership barriers, the Carrier must enroll the Eligible Individual or Eligible Small Group directly. Nothing in 211 CMR 66.04(1)(f) shall prohibit a Carrier from enrolling Eligible Individuals or Eligible Small Groups directly or through the Connector.

3. If an Eligible Individual or an Eligible Small Group of five or fewer Eligible Employees elects to enroll through an Intermediary or through the Connector, a Carrier may not deny that Eligible Small Group enrollment.

4. The Carrier must implement the requirements in 211 CMR 66.04(1)(f) consistently, treating all similarly situated individuals or groups in a similar manner.

5. Any Carrier that enrolls Eligible Individuals or Eligible Small Businesses through an Intermediary or through the Connector must comply with all provisions of 211 CMR 66.00.

6. Nothing in 211 CMR 66.04(1)(f) prohibits an Eligible Individual or an Eligible Small Business with six to 50 employees from electing to enroll through an Intermediary or through the Connector for coverage under a Health Benefit Plan.

7. Nothing in 211 CMR 66.04(1)(f) permits a Carrier to require an Eligible Small Business with six to 50 employees to enroll through an Intermediary or through the Connector for coverage under a Health Benefit Plan.

(g) A Carrier may implement a policy for issuance of a Health Benefit Plan to an Eligible Individual who has a demonstrated history of canceling his or her coverage under a Health Benefit Plan with any Carrier prior to the end of that Eligible Individual's contract renewal period including, but not limited to, a policy that said Eligible Individual be required to pay a portion of his or her annual premium in advance, provided that said policy is submitted to the Division for approval prior to implementation. A Carrier is not required to issue a Health Benefit Plan to an Eligible Individual or an Eligible Small Business if the Carrier can demonstrate to the satisfaction of the Commissioner that:

1. the Eligible Individual or Eligible Small Business has made at least three or more late payments in a 12-month period; or

2. within the prior 12 months, the Eligible Individual or Eligible Small Business has committed fraud, misrepresented the eligibility of an employee or of an individual, or misrepresented information necessary to determine group size, group Participation Rate, the group premium rate, or individual rate; or

3. within the prior 12 months, the Eligible Individual or Eligible Small Business has failed to comply in a material manner with a Health Benefit Plan provision, including, failure to provide information necessary to determine eligibility, and, for an Eligible Small Business, Carrier requirements for employer group premium contributions; but

4. nothing in 211 CMR 66.04(1)(g)1. through 3. may be used by a Carrier to refuse acceptance of an Eligible Small Business solely because the Eligible Small Business offers multiple Health Benefit Plans at the same time.

(h) A Carrier may request information from other Carriers regarding the items listed in 211 CMR 66.04(1)(g) provided that the request does not violate any applicable state or federal law. The Carrier receiving such a request from another Carrier may provide the information consistent with state or federal law.

(i) A Carrier is not required to issue a Health Benefit Plan to an Eligible Small Business or Eligible Individual if the Eligible Small Business or Eligible Individual fails to comply with reasonable requests by the Carrier for information necessary to verify the application for coverage including, but not limited to, information regarding the prior health insurance coverage of the Eligible Small Business or Eligible Individual. Requests for information may also include information reasonably necessary for the Carrier to determine whether the small business is an Eligible Small Business or whether a person is an Eligible Employee or an Eligible Individual.

(j) Except during an open enrollment period and as otherwise required by the ACA, a Carrier is not required to issue a Health Benefit Plan to an Eligible Small Business if the Carrier can demonstrate, to the satisfaction of the Commissioner, that the small business fails at the time of issuance or renewal to meet a Participation Rate requirement established under the definition of Participation Rate. However, if an Eligible Small Business does not meet a Carrier's minimum Participation Rate requirement, the Carrier may separately rate each employee as an Eligible Individual.

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(k) A Carrier is not required to issue a Health Benefit Plan to an Eligible Individual or Eligible Small Business if acceptance of an application or applications would create for the Carrier a condition of Financial Impairment. The Carrier must file with the Commissioner at least 30 days in advance of any such denial, or as soon as the Carrier's financial position becomes known to the Carrier, a certified statement by the Chief Financial Officer attesting to the Carrier's presentation of information evidencing a likely conclusion of Financial Impairment and accompanied by supporting documentation. Any Carrier found to be in a condition of Financially Impairment by the Commissioner must immediately cease issuing Health Benefit Plans on an initial basis to Eligible Individuals and Eligible Small Businesses in accordance with the provisions of 211 CMR 66.04(4).

(l) Every Carrier must apply participation and employer contribution requirements in a uniform manner to all groups of the same size. Carriers may not increase participation or employer contribution requirements where the size of the group has changed until the group's renewal date of the Health Benefit Plan.

(m) Any Carrier that denies coverage to an Eligible Small Business or Eligible Individual under the provisions of 211 CMR 66.04 must:

1. provide to the Eligible Small Business or Eligible Individual, in writing, the specific reason(s) for the denial of coverage; and
2. make available to the Commissioner, upon request, the documentation for the denial.

(n) An HMO is not required to accept applications from or offer coverage:

1. to an Eligible Individual or an Eligible Small Group, where the Eligible Individual or Eligible Small Group is not physically located in the HMO's approved service area; or
2. within an area, where the HMO reasonably anticipates, and receives prior approval by demonstrating to the satisfaction of the Commissioner, that it will not, within that area, have the capacity in its network of providers to deliver services adequately to the Members because of its obligations to existing contract holders and enrollees. The HMO may not offer coverage in that area to any new cases of individuals or business groups of any size until the later of 90 days after each refusal or the date on which the Carrier notifies the Commissioner that it has regained capacity to deliver services to Eligible Small Businesses and Eligible Employees.

(o) A Carrier that offers a Health Benefit Plan that:

1. provides or arranges for the delivery of health care services through a closed network of health care providers; and
2. has reported in its annual Membership filing that as of the close of the preceding calendar year that a combined total of 5,000 or more Eligible Individuals, Eligible Employees and Eligible Dependents, were enrolled in Health Benefit Plans sold, issued, delivered, made effective or renewed by the Carrier to Eligible Small Businesses or Eligible Individuals, shall, by no later than January 1st of the following year, offer to all Eligible Individuals and small businesses in at least one geographic area at least one plan with either a limited network of providers or a plan in which providers are tiered and Member cost sharing is based on the tier placement that meets the standards of 211 CMR 152.04: *Tiered Provider Network Plans*. The goal is for these plans to be available throughout the Commonwealth. For the purpose of 211 CMR 66.04(1)(o)2., "geographic area" shall mean the largest metropolitan region in a Carrier's service area, subject to the approval of the Commissioner. A Carrier may use a plan containing multiple networks to meet the geographic area standard described in 211 CMR 66.04(1)(o)2. The Benefit Level Rate Adjustment Factor of this plan will be such that this plan's Eligible Small Group Base Premium shall be at least 14% lower than the Group Base Premium Rate of the Carrier's most actuarially similar plan with a non-limited or non-tiered network of providers (a "32A Plan"). Carriers shall only classify or reclassify providers in a Carrier's 32A Plan by Benefit Level tiers based on quality performance as measured by the standard quality measure set as authorized under M.G.L. c. 12C, § 14(a) and by cost performance as measured by health status adjusted total medical prices and relative prices. When applicable quality measures are not available, a Carrier shall tier providers either solely on adjusted total medical expenses or relative prices or both.
3. If the Carrier applies for and obtains written approval from the Commissioner by no later than May 1st of the year in which the carrier is first required to offer a 32A Plan, then the Carrier may delay implementation of its 32A Plan as set forth in 211 CMR 66.04(1)(o)2.

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(p) A Carrier that offers a Health Benefit Plan that has reported in its annual Membership filing that, as of the close of the preceding calendar year, a combined total of 5,000 or more Eligible Individuals, Eligible Employees and Eligible Dependents, were enrolled in Health Benefit Plans sold, issued, delivered, made effective or renewed by the Carrier to Eligible Small Businesses or Eligible Individuals, shall be required, as a condition of continued offer of coverage to Eligible Small Business and Eligible Individuals outside of Group Purchasing Cooperatives, to respond to all documents from certified Group Purchasing Cooperatives requesting submission of product and rate proposals for offer by the Group Purchasing Cooperative to eligible Members of the qualified associations. The responses will be submitted to the Group Purchasing Cooperatives in a timely and complete manner.

(2) Reduced or Selective Network Plans; Tiered Network Plans.

(a) Unless the Carrier has a waiver from the Commissioner, any Carrier that offers a Health Benefit Plan that:

1. provides or arranges for the delivery of health care services through a closed network of health care providers; and
2. as of the close of any preceding calendar year, has a combined total of 5,000 or more Eligible Individuals, Eligible Employees and Eligible Dependents, who are enrolled in Health Benefit Plans sold, issued, delivered, made effective or renewed to Eligible Small Businesses or Eligible Individuals, shall offer to all Eligible Individuals and Eligible Small Businesses in at least one geographic area at least one plan with either:
   a. a reduced or selective network of providers; or
   b. a plan in which providers are tiered and Member cost sharing is based on the tier placement of the provider.

A tiered network plan shall only include variations in Member cost-sharing between provider tiers which are reasonable in relation to the premium charged and ensure adequate access to covered services. Carriers shall tier providers, or type of service if a "smart tier" plan, based on quality performance as measured by the standard quality measure set and by cost performance as measured by health status adjusted total medical expenses and relative prices, according to the Center for Health Information and Analysis. Where applicable quality measures are not available, tiering may be based solely on health status adjusted total medical expenses or relative prices or both.

(3) Eligible Employees, Eligible Individuals and Eligible Dependents.

(a) Every Carrier must provide coverage to all Eligible Employees, all Eligible Individuals, and all Eligible Dependents except:

1. in the case of a closed network HMO product, where the Eligible Employee or Eligible Individual or Eligible Dependent does not meet the HMO's requirements regarding residence or employment within the HMO's approved service area;
2. in the case of an Eligible Small Business, when an Eligible Employee seeks to enroll in a Health Benefit Plan significantly later than he or she was initially eligible to enroll.

However, an Eligible Employee or Eligible Dependent will not be considered a Late Enrollee if the individual requests enrollment within 63 days after termination of a previous Qualifying Health Plan; or a court has ordered coverage be provided for a spouse, former spouse, minor or dependent child under a covered employee's Health Benefit Plan and request for enrollment is made within 30 days after issuance of the court order.

(b) A Carrier that does not provide coverage to a late entrant because an Eligible Employee or Eligible Dependent did not meet the conditions of 211 CMR 66.04(3)(a)2., must make coverage available to that person at the Eligible Small Group's next renewal date and may not deny that person coverage at the next renewal date except for reasons otherwise allowed by 211 CMR 66.00.

(c) A Carrier may not require that a person must have worked for an unreasonable length of time in order to qualify as an Eligible Employee. For the purposes of 211 CMR 66.00, more than 90 days is considered to be an unreasonable length of time when determining employee eligibility to be offered health insurance.

66.04: continued

(d) Nothing in 211 CMR 66.00 shall prohibit a Carrier from offering coverage in an Eligible Small Group to a person, and his or her dependents, who does not satisfy the definition of Eligible Employee, provided that the Carrier applies these standards consistently across the Eligible Small Group to all such persons and their dependents who do not meet the definition of an Eligible Employee.

(e) Nothing in 211 CMR 66.00 shall prohibit a Carrier from offering coverage to an Eligible Individual or Eligible Dependent who seeks coverage pursuant to 211 CMR 66.04(1)(a)1. through 3.

(4) Discontinuance Provisions.

(a) Filing Requirements. Notwithstanding any other provision in 211 CMR 66.04, a Carrier may deny an Eligible Individual or Eligible Small Business enrollment in a Health Benefit Plan if the Carrier certifies to the Commissioner that the Carrier intends to discontinue selling that Health Benefit Plan to new Eligible Individuals and Eligible Small Businesses.

(b) Material to Be Submitted. A Carrier that intends to discontinue selling a Health Benefit Plan to new Eligible Individuals and Eligible Small Businesses must, at least 30 days in advance of discontinuing the sale of the Health Benefit Plan, submit to the Commissioner a statement certified by an officer of the Carrier that specifies all of the following:

1. The date by which it will discontinue selling the Health Benefit Plan to all new individuals and groups.
2. The reason(s) for the discontinuance of the Health Benefit Plan.
3. A list of any other Health Benefit Plans it continues to sell in Massachusetts.
4. The number of groups and individuals covered by the discontinued Health Benefit Plan, both in Massachusetts and in its total book of business.
5. An acknowledgment that the Carrier is prohibited from selling the particular Health Benefit Plan again in Massachusetts to new individuals and groups for a period of not less than three years.

(c) The Commissioner may disapprove, within 21 days of receiving notice under 211 CMR 66.04(4)(b), a Carrier's election to discontinue the sale of the Health Benefit Plan if the Carrier fails to comply with 211 CMR 66.04(4)(b) or is in violation of 211 CMR 66.04(5).

(d) Notwithstanding any other provision in 211 CMR 66.04, Carriers are required to renew coverage, as described in 211 CMR 66.05, under an otherwise discontinued Health Benefit Plan for existing groups.

(5) In no event may a Carrier deny an Eligible Individual or Eligible Small Group enrollment in a Health Benefit Plan as part of an effort to circumvent the intent of M.G.L. c. 176J.

66.05: Renewability

(1) Except as provided in 211 CMR 66.05(2), every Health Benefit Plan shall be renewable as required by the Health Insurance Portability and Accountability Act of 1996.

(2) A Carrier is not required to renew the Health Benefit Plan of an Eligible Small Business if the small business:

(a) has not paid the required premiums; or

(b) has committed fraud, misrepresented whether a person is an Eligible Employee, or misrepresented information necessary to determine the size of a group, the Participation Rate of a group, or the premium for a group; or

(c) failed to comply in a material manner with Health Benefit Plan provisions including Carrier requirements regarding employer contributions to group premiums; or

(d) fails, at the time of renewal, to satisfy the definition of an Eligible Small Business or meet the Participation Requirements of the Health Benefit Plan; or

(e) fails to comply with reasonable requests to verify the information described in 211 CMR 66.04(1)(g); or

(f) is not actively engaged in business.

(3) A Carrier is not required to renew the Health Benefit Plan of an Eligible Individual, Eligible Employee, or Eligible Dependent if said person:

(a) has not paid the required premiums;

66.05: continued

(b) has committed fraud or misrepresented whether he or she qualifies as an Eligible Individual, Eligible Employee, Eligible Dependent, or misrepresented information necessary to determine his or her eligibility for a Health Benefit Plan or for specific health benefits;
(c) has failed to comply in a material way with the provisions of the Health Benefit Plan, the Member contract or the subscriber agreement including, but not limited to, relocation of the individual, employee, or dependent, outside the service area of the Carrier;
(d) fails, at the time of renewal, to satisfy the definition of an Eligible Individual, Eligible Employee, or Eligible Dependent, provided that the Carrier collects sufficient information to make such a determination and makes such information available to the Commissioner upon request; or
(e) has failed to comply with the Carrier's reasonable request for information in an application for coverage.

(4) A Carrier must file with the Commissioner any material changes in the criteria it uses under 211 CMR 66.05(2) and/or (3) to determine the nonrenewability of a Health Benefit Plan for an Eligible Small Business, Eligible Individual, Eligible Employee, or Eligible Dependent, as applicable, as part of the annual filing required by 211 CMR 66.12.

(5) A Carrier must provide at least 60 days prior notice to an Eligible Individual or Eligible Small Business of the Carrier's intention not to renew that Eligible Individual or Eligible Small Business's Health Benefit Plan and the specific reason(s) for the nonrenewal in accordance with the Carrier's filed criteria. A Carrier must provide at least 90 days prior notice to affected Eligible Individuals or Eligible Small Businesses of the Carrier's intention to discontinue offering a particular type of Health Benefit Plan.

(6) A Carrier that elects to nonrenew all of its Health Benefit Plans delivered or issued for delivery to Eligible Individuals and Eligible Small Businesses in Massachusetts:
(a) must submit to the Commissioner, 30 days in advance of providing notice required under 211 CMR 66.05(6)(c) a statement certified by an officer of the Carrier that specifies:
1. The date by which it will nonrenew all of its Health Benefit Plans to all groups;
2. The reason(s) for the nonrenewal of all Health Benefit Plans;
3. The number of groups and individuals covered by the nonrenewed Health Benefit Plans, both in Massachusetts and in its total book of business; and
4. An acknowledgment that the Carrier is prohibited from writing new business in the individual and small group market in Massachusetts for a period of five years from the date of notice to the Commissioner, unless the Commissioner has determined, in his or her discretion, that the Carrier is entitled to an exemption from the requirements of 211 CMR 66.05(6)(a)(4) pursuant to 211 CMR 66.05(6)(e).
(b) The Commissioner may disapprove, within 21 days of receiving notice under 211 CMR 66.05(6)(a), a Carrier's election to nonrenew if the Carrier fails to comply with 211 CMR 66.05(6)(a) or is in violation of 211 CMR 66.05(8).
(c) A Carrier must provide notice of the decision not to renew coverage to all affected Eligible Individuals or Eligible Small Businesses at least 180 days prior to the nonrenewal of any Health Benefit Plan by the Carrier in the event the Commissioner has not disapproved the Carrier's election to nonrenew;
(d) After the 180-day notification period, a Carrier must nonrenew coverage to Eligible Individuals or Eligible Small Businesses only on the date of renewal for each individual or small business. and
(e) A Carrier may request a waiver from the requirements of 211 CMR 66.05(6), if the Carrier is a member of an insurance holding company system or health maintenance organization holding company system as defined by M.G.L. c. 175, § 206 and M.G.L. c. 176G, § 1 and at least one Health Benefit Plan that is considered to be substantively similar, pursuant to M.G.L. c. 176J and 211 CMR 66.00, to the Health Benefit Plan(s) to be non-renewed by the Carrier will continue to be offered by an affiliate of the Carrier as defined by M.G.L. c. 175, § 206 and M.G.L. c. 176G, § 1. A waiver provided under 211 CMR 66.05(6)(e) will be at the Commissioner’s discretion.

66.05: continued

(7) Nothing in 211 CMR 66.05 prohibits a Carrier from canceling during the term of the policy a Health Benefit Plan issued to an Eligible Individual or Eligible Small Business for the reasons outlined in 211 CMR 66.05(2)(a) through (c) or (f) or (3)(a) through (c); provided that if the Carrier cancels the Health Benefit Plan for the reason found in 211 CMR 66.05(2)(a) or in 211 CMR 66.05(3)(a) during the policy term, a Carrier must provide the Eligible Individual or Eligible Small Business with any grace period as provided in the Eligible Individual's or Eligible Small Business's Health Benefit Plan, including any prior notification requirements.

(8) In no event may a Carrier deny an Eligible Individual or Eligible Small Group renewal of a Health Benefit Plan as part of an effort to circumvent the intent of M.G.L. c. 176J.

(9) In no event shall a Carrier deny an Eligible Individual renewal of a Health Benefit Plan, except as permitted in 211 CMR 66.05(3), provided, however, that any Eligible Individual whose policy was issued outside of the annual open enrollment described in 211 CMR 66.04(1) who seeks to renew that policy must renew during the next open enrollment period.

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

66.06: Nondiscriminatory Offer of Coverage

(1) No Carrier may exclude any Eligible Individual, Eligible Employee, or Eligible Dependent from a Health Benefit Plan on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage, or medical condition, except that a Carrier may offer a Catastrophic Health Benefit Plan or a Child-only Health Benefit Plan in accordance with the ACA requirements.

(2) No Carrier may modify the coverage of an Eligible Individual, Eligible Employee, or Eligible Dependent through riders or endorsements, or otherwise restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the Health Benefit Plan except as permitted under 211 CMR 66.00.

(3) No Health Benefit Plan issued to Eligible Individuals, Eligible Employees, or Eligible Dependents may include preexisting condition provisions that exclude coverage.

(4) No Health Benefit Plan may include waiting periods.

66.07: Restrictions Relating to Premium Rates

Premiums charged to Eligible Small Groups and Eligible Individuals shall be based on the collective experience of the covered small groups and individuals. Premiums charged to every Eligible Small Business or Eligible Individual for a Health Benefit Plan, whether through a trust or association or through an Intermediary or Group Purchasing Cooperative, or through the Connector, or directly, also must satisfy the following requirements:

(1) Premium Calculations.

(a) In calculating the premium to be charged to each Eligible Small Group or Eligible Individual, a Carrier shall develop a Group Base Premium Rate and may develop and use one or more of the Rating Adjustment Factors, provided that such Rating Adjustment Factors are used in connection with all products offered to Eligible Small Groups and Eligible Individuals.

(b) In calculating the premium to be charged to each Eligible Small Group or Eligible Individual, a Carrier shall develop a Group Base Premium Rate and may develop and use only the Rating Adjustment Factors set forth in 211 CMR 66.07(1)(b):

1. Age Rating Adjustment Factor. If a Carrier applies an age Rating Adjustment Factor to Eligible Individuals or Eligible Small Groups, the Carrier must apply the Age Rating Adjustment Factor in accordance with both the ACA and any guidance provided by the Commissioner such that the ratio of the highest factor for adults older than 20 years of age compared to the lowest factor for adults older than 20 years of age shall not exceed a ratio of 2-to-1.

66.07: continued

2. Area Rating Adjustment Factors.
   a. The area Rating Adjustment Factor for each distinct region in 211 CMR 66.07(1)(b)2. must range from not less than 0.8 to not more than 1.2.
   b. The permissible regions are based on the following zip code groupings which refer to the first three digits of the zip code for each Eligible Small Business or Eligible Individual:
      i. 010 through 013;
      ii. 014 through 016;
      iii. 017 and 020;
      iv. 018 through 019;
      v. 021 through 022 and 024;
      vi. 023 and 027; and
      vii. 025 through 026,
      except that a Carrier may combine the zip code groupings outlined in 211 CMR 66.07(1)(b)2.b.iii. and iv. into one region or combine the zip code groupings outlined in 211 CMR 66.07(1)(b)2.b.iii. through v. into one region for all of its Health Benefit Plans subject to 211 CMR 66.00, or use regions based on groupings of counties that roughly approximate the zip code groupings.
   c. If a Carrier chooses to establish an area Rating Adjustment Factor, it must apply the Rating Adjustment Factor to every Eligible Small Business and Eligible Individual within each area. The area Rating Adjustment Factor for an Eligible Small Group will be based upon the head office location of the Eligible Small Group and the area Rating Adjustment Factor for an Eligible Individual will be based on the primary residence of the Eligible Individual.
3. Tobacco Use Rating Adjustment Factor.
   a. The tobacco use Rating Adjustment Factor, which may only be applied when expressly permitted by the Commissioner, will consistently apply to all Eligible Individuals and Eligible Small Groups.
   b. Eligible Individuals and Eligible Small Groups must certify, in a method approved by the Commissioner, that Eligible Individuals and/or their Eligible Dependents or Eligible Small Group employees and/or their Eligible Dependents have not used Tobacco Products during the previous 12 months.
4. Benefit Level Rating Adjustment Factor. If a Carrier chooses to establish a Benefit Level Rating Adjustment Factor, it must apply the Rating Adjustment Factor with respect to every Eligible Individual and Eligible Small Business.

(2) Premium Rate Calculation Not Experience Based. No Carrier may charge a premium rate to an Eligible Individual or Eligible Small Business that is based upon the Eligible Individual's or Eligible Small Business's Eligible Employees' or Eligible Dependents' health status, duration of coverage, or actual or expected claims experience.

(3) Additional Information regarding Premium Rate Calculation. The premium charged by a Carrier to each Eligible Individual or Eligible Small Business on the date the Eligible Individual's or Eligible Small Business' Health Benefit Plan is issued or renewed shall be established as follows:

the Group Base Premium Rate;
multiplied by the Benefit Level Rating Adjustment Factor;
multiplied by the area Rating Adjustment Factor;
multiplied by the age Rating Adjustment Factor.

66.08: Submission and Review of Rate Filings

(1) Definitions. For rate filings submitted pursuant to 211 CMR 66.08(2), the following definitions also shall apply:

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

66.08: continued

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

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

(d) Claim Completion Method. Any actuarial method used to quantify claims which have been incurred but not yet paid.

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

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

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

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

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

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

66.08: continued

(k) Minimum Medical Loss Ratio. The Minimum Medical Loss Ratio for the Merged Market is 88%.

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

(m) Network Operations Expenses. All expenses associated with provider contracting negotiation and preparation, monitoring of provider compliance, field training with providers, provider communication materials and bulletins, administration of provider capitation and settlements, hospital and physician relations, medical policy procedures, network access fees and credentialing.

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

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

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

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

1. proposed rate change compared to rates in effect 12 months before proposed effective date;
2. number of currently enrolled Members impacted by the proposed rate change presented as:
    a. number of employer groups and covered employees/dependents renewing by month; and
    b. individual accounts and covered individuals/dependents renewing by month; and
3. maximum increase for any employer group or individual covered under the proposed rate change.

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

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

For information submitted pursuant to 211 CMR 66.08(2)(c) through (h), a Carrier's submission shall provide details in aggregate.

(c) Actual fee-for-service claims payment experience, utilization experience, and claims cost for each of the latest available 12 months on both an actual and per Member per month basis for products issued or renewed according to M.G.L. c. 176J, on an aggregate basis for the period impacted for the proposed rate change, differentiating among:

1. inpatient hospital care;
2. outpatient hospital care, with separate experience for:
    a. radiological/laboratory/pathology costs; and
    b. all other outpatient costs;
3. health care providers, with separate experience for:
    a. medical and osteopathic physicians;

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b. behavioral health providers; and
c. all other health care practitioners.
4. outpatient prescription drugs; and
5. supplies.

The analysis should explain any differences between what is included in this filing and what normally is included in the Carrier's financial statements. The Carrier also should submit projected Trend in Health Plan Expenses for fee-for-service utilization per 1,000 Members, price per service and per Member per month costs for each of the noted service types that the Carrier is using to project historic claims forward to the period for which the rates will be effective. Annual price and use assumptions for Trend in Health Plan Expenses for fee-for-service expenses should be provided for each year in the projection period and the carrier must indicate how many months of each year are used in the analysis. Trend in Health Plan Expenses for fee-for-service expenses should reflect provider price increases whereas utilization may include mix of services and mix of providers. The Trend in Health Plan Expenses for fee-for-service expenses information should include the actuarial basis for all changes in Trend in Health Plan Expenses for fee-for-service expenses, including all relevant studies used to derive the factors.

(d) The Carrier's historic capitation, as well as per Member per month cost experience, for the latest available 12 months and projected capitation on a per Member per month basis for the period impacted for the proposed rate change, differentiating among:

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

The analysis should explain any differences between what is included in this filing and what normally is included in the Carrier's financial statements. The Carrier also should submit projected factors for Trends in Health Plan Expenses for capitation payments that the Carrier is using to project capitation costs forward to the period for which the rates will be effective. Annual Trends in Health Plan Expenses for capitation payments assumptions should be provided for each year in the projection period and the Carrier must indicate how many months of each year are used in the analysis. Trends in Health Plan Expenses for capitation should reflect provider price increases whereas utilization may include mix of services and mix of providers. The Trend in Health Plan Expenses for capitation payments to providers information should include the actuarial basis for all changes, including all relevant studies or information that the Carrier believes will lead to changes in capitation costs.

(e) The Carrier's other non-fee-for-service and non-capitation payments to providers, as well as per Member per month experience, and projected non-fee-for-service and non-capitation payments to providers for the period impacted for the proposed rate change, differentiating among.

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

66.08: continued

The other payments should include all bonus/incentives tied to provider performance and other payments not tied to service or performance. The Carrier also should submit the projected Trends in Health Plan Expenses for non-fee-for-services and non-capitation payments to providers factor in the other provider payments per Member per month costs that the Carrier is using to project other costs forward to the period for which the rates will be effective. Annual assumptions for Trend in Health Plan Expenses for non-fee-for-services and non-capitation payments to providers should be provided for each year in the projection period and the Carrier must indicate how many months of each year are used in the trend analysis. Trend in Health Plan Expenses for non-fee-for-services and non-capitation payments to providers should reflect provider price increases whereas utilization may include mix of services and mix of providers. The Trend in Health Plan Expenses for non-fee-for-services and non-capitation payments to providers information should include the actuarial basis for all changes in these payments, including all relevant studies or information that the Carrier believes will lead to changes in these other provider payment costs.

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

1. expenses for capital costs and depreciation;
2. expenses for charitable contributions;
3. expenses for claims operations;
4. expenses for distribution;
5. expenses for financial administration;
6. expenses for general administration;
7. expenses for marketing and sales;
8. expenses for medical administration, with specific detail on costs related to programs that improve health care quality;
9. expenses for miscellaneous expenditures described in detail;
10. expenses for network operations;
11. expenses for taxes, assessments and fines paid to federal, state or local governments; and
12. total administrative expenses [subtotaling 211 CMR 66.08(2)(f)1. through 11.].

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

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

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

(i) A detailed description of all cost containment programs the Carrier is employing or will employ during the Rating Period to address health care delivery costs and the realized past savings and projected savings from all such programs.

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

66.08: continued

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

(k) Interrogatories including, but not limited to:

1. Detailed explanations of methodological changes that have been employed by the Carrier in development of rates, loads or factors since most recent filing, including:
   a. pricing methodology;
   b. administrative expense loads;
   c. contribution to surplus loads;
   d. Rating Adjustment Factors;
   e. cost containment and quality improvement efforts;
   f. provider contracting initiatives;
   g. methodology for setting claim reserves;
   h. size of the claim reserve relative to the total incurred claims estimate for the most recent year of experience; and
   i. reconciliation of claim payments in filing to claims system and recorded claim payments in filed financial statements.
2. Detailed explanations of the development of the filing's claims completion factor(s) including, but not limited to:
   a. explanation of the Claim Completion Method and the source of the filing's completion factor(s);
   b. high level analysis of derivation of factor;
   c. explanation of whether factor(s) is consistent with reserve development for financial reporting;
   d. explanation of level of conservatism used in developing factor(s);
   e. demonstration for each calendar month in the claim experience period of how any incurred but unreported claims were estimated using the Carrier's completion factor(s); and
   f. a comparison of estimated claim payments provided in the most recent prior filing to current estimated claims costs for the same time period.
3. Detailed explanations of planned changes in methods of paying providers, including:
   a. Three-year historical analysis of the proportion of provider services reimbursed according to the following methodologies:
      i. discounted or undiscounted charges;
      ii. payment based on fee schedules;
      iii. incentive-based fee-for-service (payment is initially withheld and repaid to provider based on provider performance);
      iv. fee-for-service payments with bonus/incentives tied to performance (additional payments above and beyond the standard payment where the amount of the additional payment is based on provider performance;
      v. capitation payments (fixed payment per Member per month for a specified set of services);
      vi. risk sharing adjustment to provider payments made in a fiscal year-end settlement whereby provider payments are increased or decreased based on provider performance that is shared with the health plan; and
      vii. payments not tied to provision of specific service or performance.
   b. Explanation of projected distribution of provider services to be reimbursed using these methodologies in the Rating Period and an explanation of the impact on expected costs for covered Member services.
   c. Explanation of the weighting of the criteria that the plan uses for evaluating performance based provider payments, including:
      i. patient satisfaction;
      ii. outcomes measurement;
      iii. participation or adherence to processes to improve quality;
      iv. measured achievement of quality standards;
      v. measured achievement of utilization efficiency standards;
      vi. measured achievement of cost containment goals; and
      vii. measured implementation of technology necessary to improve efficiency.

66.08: continued

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

4. Benefit Level Rate Adjustment Factors, including:

a. explanation of the process used to ensure that the Benefit Level Rate Adjustment Factor reflects the actuarial value of benefits in one plan versus another;

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

c. explanation of any reasons that a filing may reflect different Benefit Level Trends for different products and how this may be incorporated into the rate analysis.

5. Rating Adjustment Factors, including an illustration of how a sample Member's premium is calculated based on that Member's permissible Rating Adjustment Factors;

6. Credibility analyses, including:

a. explanation of how the actuary conducted a credibility analysis of available data; and

b. explanation of adjustments made due to concerns over the credibility of available data and basis for said adjustments, including an explanation of national or regional data that was used in place of or in combination with plan data when developing factors.

7. A discussion of the impact of overestimates or underestimates of Trend in Health Plan Expenses in prior year rate filings on the development of the current proposed rate.

8. Overall rate impacts, including:

a. Illustration of rate changes for each product, after application of the Rating Adjustment Factors and any changes in the demographic make-up of the individual or group contract, using the following ranges:

i. reduction of 10% or more;
ii. reduction between 5.01% and 9.99%;
iii. reduction of 5% or less (including no change);
iv. increase of less than 5%;
v. increase of between 5.01% and 9.99%;
vi. increase of between 10.0% and 14.99%; and
vii. increase of 15% or more.

b. Explanation of the reasons, distinguishing by Group Base Premium Rate changes and the application of Rating Adjustment Factors, for which rates of any Eligible Individuals or Eligible Small Groups increase by more than 15%.

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

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

(3) Timing of Submission and Opportunity for Public Comment.

(a) Every Carrier, as a condition of doing business under M.G.L. c. 176J and 211 CMR 66.00, must submit a complete annual rate filing for their Group Base Premium Rates and Rating Adjustment Factors. Such rate filings must be submitted on or before May 15th for rates intended to be effective on or after January 1st of the following calendar year.

(b) Any provider-specific rates of reimbursement or Rating Adjustment Factors included in the Merged Market rate filing materials submitted for review by the Division shall be deemed confidential and exempt from the definition of public records in M.G.L. c. 4, § 7, clause 26.

(c) In addition to the rate filing required by 211 CMR 66.08, each Carrier shall submit a rate filing summary that will be available for public inspection while the rate filing is reviewed by the Division. The rate filing summary should be submitted in a format determined by the Commissioner and must include:

1. An overview of the rate filing, including an identification of the products that are subject to the rate filing, key drivers for the proposed rate change, the range of rate changes and the overall average proposed rate change, and the number of renewing Eligible Individuals and the number of renewing Eligible Small Groups and Small Group Members.

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2. A summary of the cost-sharing and benefits for each product, as proposed in the rate filing for
   a. inpatient hospital care
   b. outpatient hospital care
      i. radiological/laboratory/pathology costs
      ii. all other outpatient costs
   c. health care providers
      i. medical and osteopathic physicians
      ii. behavioral health providers
      iii. all other health care practitioners
   d. outpatient prescription drugs
   e. supplies.

3. An explanation of the general methodology for establishing rates of reimbursement for providers; any proposed changes in the methods of paying providers or provider contracting initiatives; the basis for paying similarly situated providers within a provider network different rates of reimbursement including, but not limited to, quality of care delivered, mix of patients, geographic location at which care is provided and intensity of services provided; and any non-fee-for-service and non-capitation payments to providers included in the rate filing including, but not limited to, bonuses and incentives tied to provider performance and other payments not tied to service or performance.

4. A summary of the administrative expenses, in the aggregate and per Member per month, used in the development of the rate filing and the projected increases for the period in which the filed rates will be in effect, including an explanation for significant changes in the Carrier's administrative expenses due to one-time costs.

5. Medical loss ratios, including three-year historic ratios for Merged Market products and the projected medical loss ratio for the period during which the filed rates will be in effect.

6. Contribution to surplus and the reasons why the Carrier filed at that level.

7. An explanation of how or why information contained in the rate filing is different from information contained in the Carrier's filed financial statements.

8. A description of cost containment programs the Carrier is employing to address health care delivery costs and a summary of the realized past savings and projected savings from all such programs.

9. Any other information required by the Commissioner.

(d) Within ten business days of the annual rate filing submission deadline, the Division will prepare and post to its website a summary of the rate filings received, along with copies of the rate filing summaries submitted by the Carriers pursuant to 211 CMR 66.08(3)(c). This summary will include a table of the rate change requests with the rate changes requested and approved for the last two years.

(e) The Division will provide notice of an opportunity for the public to comment on the Carriers' proposed rate changes. No later than June 5th, on an annual basis, unless otherwise determined by the Commissioner, the Division will schedule during the course of review a public information session to accept comments from interested parties on the proposed rate changes submitted under 211 CMR 66.08(3)(a). At the public information session, Carriers will be expected to present the information contained in their rate filing summaries submitted under 211 CMR 66.08(3)(c) and may be asked to respond to questions from the Division. Interested parties will be invited to present oral or written comments on the Carriers' proposed rate changes to the Division. At the hearing officer's discretion, the Division will accept written comments from interested parties from the date notice of the public information session is given for at least ten days following the public information session. While written and oral comments on the Carriers' proposed rate changes will be considered by the Division as part of the public information session, the Division's review of a specific rate filing will at all times be governed by the requirements of 211 CMR 66.08.

(f) The Division will develop and post to its website a set of frequently asked questions about the rate review process for Merged-Market rates.

(g) Following the Division's review of the rate filings and no later than August 31st each year, unless otherwise determined by the Commissioner, the Division will update the table posted to its website to reflect the rate changes that were not disapproved and which will be used by Carriers on and after the succeeding January 1st.

66.08: continued

(4) Review of Rate Filings.

(a) All Group Base Premium Rates and Rating Adjustment Factors are subject to disapproval if they do not meet the requirements of M.G.L. c. 176J and 211 CMR 66.00.

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

(c) Every Carrier shall include with any submission under 211 CMR 66.08(3) a cover letter summarizing the content in 211 CMR 66.08(2)(g)12., (h) and (i). Group Base Premium Rates will be presumptively disapproved as excessive if the rate filing does not meet the following standards:

1. Administrative Expense Standards. Group Base Premium Rates will be presumptively disapproved if the filing's projected administrative expense loading component, not including taxes and assessments, health care quality improvement expenses, and fraud and abuse detection, increases by more than the most recent calendar year's increase in the New England medical CPI.

a. The projected administrative expense loading component is the per Member per month administrative expense described in 211 CMR 66.08(2)(g)12. plus the producer commission expense.

b. The most recent calendar year's increase in the New England medical CPI shall be calculated by dividing the index value for the November period preceding the date of the filing by the same index value from the November period one year earlier. For the purpose of 211 CMR 66.08(4)(d)1.b., the New England medical CPI shall reflect the Consumer Price Indexes for All Urban Consumers (CPI-U), U.S. city averages and selected areas, for the Boston-Brockton-Nashua area.

2. Contribution to Surplus Standards. Group Base Premium Rates will be presumptively disapproved as excessive if the rate filing's contribution-to-surplus loading component exceeds 1.9% of the total filed Group Base Premium Rate.

a. The contribution-to-surplus loading component shall represent the per Member per month contribution-to-surplus amount submitted in 211CMR 66.08(2)(h).

b. If a Carrier's Risk-Based Capital Ratio, calculated according to the provisions of 211 CMR 25.00: *Risk-based Capital (RBC) for Health Organizations*, falls below 300% for the four most recent consecutive quarters, the Group Base Premium Rates will be presumptively disapproved as excessive if the filing's contribution-to-surplus loading component exceeds 2.5% of premium.

3. Medical Loss Ratio Standards. Group Base Premium Rates will be presumptively disapproved as excessive if the rate filing's projected aggregate medical loss ratio for all plans offered in the Merged Market is less than the Minimum Medical Loss Ratio.

a. The projected aggregate medical loss ratio shall be reported as submitted in 211 CMR 66.08(2)(i).

b. When a Carrier's Merged Market Group Base Premium Rates for a Rating Period would have been presumptively disapproved for failure only to meet the aggregate Minimum Medical Loss Ratio, the Group Base Premium Rate will not be presumptively disapproved if the aggregate loss ratio for all of the Carrier's Merged Market plans was at least 1% higher than the Carrier's equivalent medical loss ratio in the 12 months prior to the present filing. In this case, the filed medical loss ratio will be considered the Adjusted Minimum Medical Loss Ratio.

(5) Presumptive Disapprovals Issued Pursuant to M.G.L. c. 176J, § 6(g).

(a) Rate filings may be presumptively disapproved by the Commissioner as described in 211 CMR 66.08(4)(d).

(b) If a Carrier's filing is presumptively disapproved, the Commissioner shall notify the Carrier in writing within five business days of the annual rate filing submission stating the reason(s) for the presumptive disapproval.

(c) New Health Benefit Plans whose initial Group Base Premium Rates are presumptively disapproved may not be offered.

(d) Within ten days of receipt of the presumptive disapproval, the Carrier shall communicate to all employers and individuals covered under a Health Benefit Plan approved under M.G.L. c. 176J that the proposed rate change has been presumptively disapproved and will be subject to a public hearing at the Division.

66.08: continued

(e) In the event of a presumptive disapproval, Carrier shall comply with the following procedures:

1. the Carrier shall not quote, issue, make effective, deliver, or renew Health Benefit Plans in the Commonwealth using disapproved Group Base Premium Rates. The Carrier shall quote, issue, make effective, deliver or renew all Health Benefit Plans using Group Base Premium Rates in effect 12 months prior to the proposed effective date of the presumptively disapproved Group Base Premium Rates. In recalculating premiums, the Carrier must apply the age and geographic Rating Adjustment Factors in effect 12 months prior to the proposed effective date of the presumptively disapproved Group Base Premium Rates;

2. the Carrier shall recalculate applicable rates for all affected Health Benefit Plans and shall issue rate quotes and make all Health Benefit Plans available through all distribution channels, including Intermediaries, the Connector, licensed insurance producers and the Carrier's website, but in no event more than ten calendar days after the Carrier's receipt of the presumptive disapproval;

3. the Carrier shall promptly provide notice of all material changes to the evidence(s) of coverage to all affected individuals and groups in accordance with M.G.L. c. 176O, § 6(a) and 211 CMR 52.12(6): *General Notice of Material Changes*.

(f) With respect to the hearing for the presumptive disapproval:

1. the public hearing shall be scheduled within 15 calendar days of the submission of a complete rate filing; and

2. notice of the public hearing will be given to, or advertised in, newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford, and Lowell and posted to the Division's website.

3. The purpose of the public hearing will be to provide the Carrier with the opportunity to rebut the reasons for the presumptive disapproval. For purposes of 211 CMR 66.08(5)(f)3., the administrative record to be considered at the public hearing will be limited to the materials and information included in the Carrier's presumptively disapproved rate filing submitted pursuant to 211 CMR 66.08.

(6) Disapprovals Issued Pursuant to M.G.L. c. 176J, § 6(h).

(a) Rate filings also shall be disapproved by the Commissioner if the benefits provided therein are unreasonable in relation to the rate charged, or if the rates are excessive, inadequate or unfairly discriminatory or do not otherwise comply with the requirements of M.G.L. c. 176J or 211 CMR 66.00.

(b) Changes to filed Rating Adjustment Factors shall be disapproved by the Commissioner if found to be discriminatory or not actuarially sound.

(c) New Health Benefit Plans whose initial Group Base Premium Rates are disapproved may not be offered.

(d) 1. If the Commissioner disapproves a Carrier's proposed Group Base Premium Rate(s) or proposed changes to rating factors or Rating Adjustment Factor(s), the Commissioner shall notify the Carrier no later than 75 days prior to the effective date of the Carrier's filing, and he shall state the reason(s) for the disapproval, including whether the disapproval is presumptive.

2. Unless otherwise determined by the Commissioner, if the Commissioner disapproves a Carrier's proposed Group Base Premium Rate(s) or proposed changes to Rating Adjustment Factor(s), the Commissioner shall notify the Carrier in writing no later than July 5th of the year preceding the rates' effective date, stating the reason(s) for the disapproval.

(e) In the event of a disapproval, Carrier shall comply with the following procedures:

1. the Carrier shall not quote, issue, make effective, deliver or renew Health Benefit Plans in the Commonwealth using disapproved Group Base Premium Rates. The Carrier shall quote, issue, make effective, deliver or renew all Health Benefit Plans using Group Base Premium Rates as in effect 12 months prior to the proposed effective date of the disapproved Group Base Premium Rates. In recalculating premiums, the Carrier may apply the age and geographic Rating Adjustment Factors;

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

3. the Carrier shall promptly provide notice of all material changes to the evidence(s) of coverage to all affected individuals and groups in accordance with M.G.L. c. 176O, § 6(a) and 211 CMR 52.12(6): *General Notice of Material Changes*.

(f) The Commissioner retains the right to disapprove a rate filing for reasons other than those identified upon review of the rate filing.

(g) Hearings on Disapprovals issued pursuant to M.G.L. c. 176J, § 6(h)

1. within ten days of receipt of the disapproval, the Carrier may request a hearing on the disapproval;

2. the Division shall schedule a hearing within 15 calendar days of receipt of the Carrier's request;

3. the purpose of the hearing will be to consider whether the disapproval is supported by substantial evidence and not based upon an error of law; and

4. The Commissioner shall issue a written decision either affirming or rejecting the disapproval within 30 days after the conclusion of the hearing.

(7) Appeals. Any final order, decree, or judgment of the Massachusetts Superior Court or appellate court modifying, amending, annulling, or reversing a decision of the Commissioner disapproving a rate filing, and any further decision of the Commissioner pursuant to such an order, decree, or judgment that affects the overall rate not disapproved shall be effective as ordered.

(8) Maintaining Records. Every Carrier must maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation which demonstrates that its rating methods and practices are based upon commonly accepted actuarial assumptions, are in accordance with sound actuarial principles, and comply with the provisions of 211 CMR 66.00.

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

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

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

(c) A Carrier shall communicate within 30 days to all individuals and small employers that were covered under plans during the relevant 12-month calendar year that such individuals and small employers qualify for a refund which may take the form of either a refund on the premium for the applicable 12-month period, or if the individual or small employer are still covered by the Carrier, a credit on the premium for the subsequent 12-month period.

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

66.08: continued

(e) Refunds shall be paid annually by August 31st or another date as determined by the Commissioner, following the calendar year of the rebate calculation.
(f) Carriers who issue refunds shall keep records of all refunds made to affected individuals and small groups for inspection by the Division.
(g) No individual or small employer may assign his or her or its rights to such premium adjustments to another person or entity.
(h) If a Carrier fails to make refunds, rebates or premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds or premium credits he or she deems necessary.

(10) Implementation. The provisions of 211 CMR 66.08(3), 211 CMR 66.08(5) and 211 CMR 66.08(6) shall only apply to merged-market rates to be effective on or after January 1, 2024. For merged-market rates with effective dates prior to January 1, 2024, the requirements of the most recent prior version of 211 CMR 66.08 relative to the submission and disapproval of merged-market rate filings shall apply.

66.09: Eligibility Criteria: Exclusion/Limitation of Mandated Benefits in Health Benefit Plans

(1) Notwithstanding any law to the contrary, Carriers may offer, as permitted under M.G.L. c. 176J, § 6, to Eligible Small Businesses Health Benefit Plans that exclude some or all Mandated Benefits, provided, however, that Carriers offer such Health Benefit Plans only to Eligible Small Businesses which did not provide health insurance to their employees as of April 1, 1992 and that such Health Benefit Plans shall not exclude or limit Mandated Benefits for more than a five-year period. An Eligible Small Business must have existed in 1992 in order to be subject to 211 CMR 66.09(1).

(2) Notwithstanding 211 CMR 66.09(1), all Health Benefit Plans offered to Eligible Small Businesses must include the following:
(a) dependent coverage for newborn infants, adoptive children and newborn infants of a dependent as described in M.G.L. chs. 175, § 47C; 176A, § 8B; 176B, § 4C and 176G, § 4;
(b) continued health care coverage for divorced or separated spouses as described in M.G.L. chs. 175, § 110I; 176A, § 8F; 176B, § 6B and 176G, § 5A; and
(c) coverage for a certain period after an Insured leaves insured group/limited extension of benefits as described in M.G.L. chs. 175, §§ 110D and 110G; 176A, § 8D; 176B, § 6A and 176G, § 4A.

66.10: Connector Seal of Approval Plans

(1) A Carrier that marketed a Health Benefit Plan subject to M.G.L. c. 176J, and as of the close of any preceding calendar year, has a combined total of 5,000 or more Eligible Individuals, Eligible Employees and Eligible Dependents, who are enrolled in Health Benefit Plans sold, issued, delivered, made effective or renewed to Eligible Small Businesses or Eligible Individual pursuant to its license under M.G.L. chs. 175, 176A, 176B or 176G, must file a Health Benefit Plan with the Connector each calendar year.

(3) Neither an Eligible Individual or Eligible Employee, nor an Eligible Dependent shall be considered to be enrolled in a Health Benefit Plan issued pursuant to the Carrier's authority under M.G.L. chs. 175, 176A or 176B if the Health Benefit Plan is sold, issued, delivered, made effective or renewed to said employee or Eligible Dependent as a supplement to a Health Benefit Plan subject to licensure under M.G.L. c. 176G.

66.11: Disclosure

Every Carrier must make reasonable disclosure in plain English to prospective small group Insureds and prospective individual Insureds, as part of its solicitation and sales material, of:

(1) for a small group, the Participation Requirements of the Carrier with regard to each Health Benefit Plan;

(2) for a small group, exclusion or limitation of Mandated Benefits;

(3) mandatory offer and renewal provisions;

(4) rating limitations according to 211 CMR 66.07; and

(5) availability of Health Benefit Plans; and any health insurance coverage offering that is limited to a particular service area or to employees that live in the service area, provided, however, the employer shall not make a smaller health insurance premium contribution percentage amount to an employee than the employer makes to any other employee who receives an equal or greater total hourly or annual salary for each specific or general blanket policy of insurance for all employees.

66.12: Health Plan Filing and Reporting Requirements

(1) Carriers must file all Health Benefit Plans offered under 211 CMR 66.00 with the Division. A Carrier that may require Eligible Small Groups with five or fewer Eligible Employees and/or Eligible Individuals to obtain coverage through an Intermediary, shall file a list of those Intermediaries, with associated contact information as further provided in 211 CMR 66.12(3), prior to requiring those Eligible Small Groups or individuals to go through an Intermediary to obtain health coverage.

(2) Carrier Reporting Requirements. On or before March 31st, the Division will collect reports that contain at least the following information in a format specified by the Commissioner:

(a) Total number of Health Benefit Plans subject to M.G.L. c. 176J offered in Massachusetts during the preceding calendar year;

(b) Total number of lives covered under Health Benefit Plans subject to M.G.L. c. 176J offered in Massachusetts, as of the close of the preceding calendar year;

(c) Number of Eligible Individuals and their Eligible Dependents covered under Health Benefit Plans subject to M.G.L. c. 176J offered in Massachusetts, as of the close of the preceding calendar year;

(d) Number of Eligible Employees and their Eligible Dependents covered under Health Benefit Plans subject to M.G.L. c. 176J offered in Massachusetts, as of the close of the preceding calendar year;

(e) Number of Eligible Employees and their eligible dependents covered under Health Benefit Plans subject to M.G.L. c. 176J with limited or no mandated benefits offered in Massachusetts, as of the close of the preceding calendar year;

(f) A statement as to whether a Carrier requires Eligible Individuals and/or Eligible Small Groups of five or fewer Eligible Employees to enroll through an Intermediary or through the Connector. If the Carrier requires Eligible Individuals and/or Eligible Small Groups of five or fewer Eligible Employees to enroll through an Intermediary the report must also contain:

1. The name, address and phone number of the Intermediary; and
2. The Intermediary's membership requirements, including any fees paid by members to join or maintain membership in the Intermediary.

(3) Intermediary Requirements.

(a) Initial Filing. Prior to enrolling Eligible Small Businesses or Eligible Individuals within a Health Benefit Plan, an Intermediary is to file with the Commissioner a report that contains at least the following information certified by an officer of the organization:

1. A narrative description of the Intermediary;
2. A copy of the basic organizational documents of the Intermediary, such as the articles of incorporation, and amendments thereto;

66.12: continued

3. A copy of the bylaws, rules, regulations or other similar documents regulating the conduct of the internal affairs of the Intermediary;

4. A copy of the eligibility criteria for individuals or groups seeking to join the Intermediary including, but not limited to, the forms that individuals or Members must complete prior to enrollment in the Intermediary;

5. The number of Massachusetts Members in the Intermediary who buy health insurance through the Intermediary, broken out by Eligible Small Groups and Eligible Individuals;

6. A listing of the services, other than health insurance, which the Intermediary offers to its members;

7. The fees paid by members to join or maintain membership in the Intermediary;

8. A description of each Health Benefit Plan offered by the Intermediary to the Intermediary's members who are Residents of Massachusetts;

9. A statement declaring that the Intermediary does not condition enrollment in a Health Benefit Plan on health status, claims experience, Wellness Program usage, tobacco usage, or duration of coverage since issue; and

10. A statement affirming that the Intermediary was not formed for the purposes of obtaining insurance.

(b) Annual Filing. Every Intermediary which has met the filing requirements of 211 CMR 66.12(3)(a) must, on or before April 1st of each year, file a report that contains at least the following information.

1. The number of Massachusetts Members in the organization who buy health insurance through the Intermediary, broken out by Eligible Small Groups and Eligible Individuals;

2. A listing of the services, other than health insurance, which the Intermediary offers to its members;

3. The fees paid by members to join or maintain membership in the Intermediary;

4. A description of each Health Benefit Plan offered by the Intermediary to its members who are Residents of Massachusetts;

5. A statement declaring that the Intermediary does not condition enrollment in a Health Benefit Plan on health status, claims experience, or duration of coverage since issue; and

6. A statement affirming that the Intermediary was not formed for the purposes of obtaining insurance.

(c) Material Changes. Every Intermediary must file with the Commissioner any material changes to the information on file within 30 days of the changes. Such material changes must be on a statement certified by an officer of the organization.

66.13: Severability

If any section or portion of a section of 211 CMR 66.00, or the applicability thereof to any person or circumstance is held invalid by any court of competent jurisdiction, the remainder of 211 CMR 66.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.

REGULATORY AUTHORITY

211 CMR 66.00: M.G.L. chs. 175, 176A, 176B, 176D, 176G, 176I and 176J.