211 CMR: DIVISION OF INSURANCE

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

Section

148.01: Purpose, Scope and Authority

211 CMR 148.00, promulgated pursuant to the Commissioner of Insurance's authority under St. 2010, c. 288 and M.G.L. c. 176O, § 21(c), governs the registration and reporting requirements applicable to Third-party Administrators, including pharmacy benefit managers and other entities with claims data, eligibility data, provider files and other information relating to health care provided to residents of the Commonwealth and health care provided by health care providers in the Commonwealth.

148.02: Definitions

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

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

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

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

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

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

Health Insurer: An insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization licensed under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176*I*. Health Insurer shall not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Health Insurer also shall not include any entity to the extent it offers a policy, certificate or contract that does not qualify as creditable coverage as defined in M.G.L. c. 111M, §1; provided, however; that "Health Insurer" shall include an entity that offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services.

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

NAIC: National Association of Insurance Commissioners.

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

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

Third-party Administrator: A person domiciled inside or outside of the Commonwealth who, on behalf of a Health Insurer or purchaser of health benefits, receives or collects charges, contributions or premiums for, or adjusts or settles claims on or for residents of the Commonwealth. Unless noted otherwise, a purchaser of health benefits shall not include an entity to the extent it offers a policy, certificate or contract that does not qualify as creditable coverage as defined in M.G.L. c. 111M, §1; provided, however, that a purchaser of health benefits shall include an entity that offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services. Third-party Administrator shall also include pharmacy benefit managers and any other entity with claims data, eligibility data, provider files and other information relating to health care provided to residents of the Commonwealth and health care provided by health care providers in the Commonwealth, except that Third-party Administrator shall not include an entity that administers only claims data, eligibility data, provider files and other information for its own employees and dependents. Third-party Administrator further shall not include "intermediary", as defined in M.G.L. c. 176J, § 1 and 211 CMR 66.04: *Definitions*.

148.03: Initial Registration and Annual Renewal of Registration

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

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

(3) All registration forms and renewal of registration forms shall include, but may not be limited to, the following information certified by an officer of the Third-party Administrator:

(a) A narrative description of the Third-party Administrator and its activities, including the identity of the state(s) in which it has been formed, headquartered and in which its operates;

(b) A copy of the basic organizational documents of the Third-party Administrator, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement and other applicable documents and all amendments to such documents;

(c) A copy of the bylaws, rules, regulations or similar documents regulating the internal affairs of the Third-party Administrator;

(d) A listing of the services, other than those related to the receipt or collection of charges, contributions or premiums for, or adjustment or settlement of claims, on or for residents of the Commonwealth, that the Third-party Administrator offers to Self-insured Customers; and

(e) If the Third-party Administrator will be managing the solicitation of new or renewal business on behalf of a Health Insurer, proof that it employs or has contracted with an insurance producer licensed in the Commonwealth for solicitation and taking of applications. Any Third-party Administrator which intends to directly solicit insurance contracts or to otherwise act as an insurance producer shall provide proof that it has a license as an insurance producer in the Commonwealth.

(4) A Third-party Administrator shall report to the Division any material change(s) to the information contained in its initial registration or renewal registration, certified by an officer of the Third-party Administrator, within 30 days of such changes.

148.04: Annual Reporting Requirements

(1) All Third-party Administrators, as a condition of registration, shall submit an annual report to the Division in a form approved by the Commissioner, no later than April 1st of each year, for the year ended December 31st immediately preceding, which shall include the following information regarding the Third-party Administrator's Self-insured Customers:

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

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

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

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

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

(d) The aggregate value of Direct Premiums Earned for all of the Third-Party Administrator's Self-Insured Customers;

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

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

(g) Net income;

(h) Accumulated Surplus;

(i) Accumulated reserves;

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

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

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

(2) The annual report shall be certified by at least two officers of the Third-party Administrator.

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

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

(5) The Commissioner may, in his or her discretion, require the Third-party Administrator make available the underlying data used in its calculations for its annual report for audit by Division staff or outside consultants or advisors of the Division. Any and all fees and costs for the Division's audit of the Third-party Administrator's annual report shall be borne by the subject Third-party Administrator.

(6) If a Third-party Administrator is unable to provide any of the required information set forth in 211 CMR 148.04 in the annual report, the Third-party Administrator shall provide a detailed explanation, within the annual report, of the reason(s) that such required information is not available.

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

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

(9) Any Third-party Administrator which receives or collects charges, contributions or premiums for, or adjusts or settles claims on or for residents of the Commonwealth on behalf of a Health Insurer that itself is required to submit an Annual Comprehensive Financial Statement to the Division in accordance with

M.G.L. c. 176O, § 21(a) and 211 CMR 149.00 shall be exempt from the annual reporting requirements set forth in 211 CMR 148.04 for those services that the Third-party Administrator provides on behalf of the Health Insurer.

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

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

(a) The Third-party Administrator fails to submit to the Division the annual report required by 211 CMR 148.04; or

(b) The Third-party Administrator has its license or registration to do business suspended or revoked by any state, including its home state; or

(c) The Third-party Administrator is insolvent or impaired; or

(d) A proceeding for receivership, conservatorship, rehabilitation or other delinquency proceeding regarding the Third-party Administrator has been commenced in any state; or

(e) The financial condition or business practices of the Third-party Administrator otherwise pose an imminent threat to the public health, safety or welfare of the residents of the Commonwealth.

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

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

148.06: Severability

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