830 CMR 176I.00: PREFERRED PROVIDER ARRANGEMENTS

Section

176I.1.1: Taxation of Insurers of Preferred Provider Arrangements

176I.1.1: Taxation of Insurers of Preferred Provider Arrangements

(1) General.

(a) Purpose. The Commissioner of Revenue is responsible for the administration and collection of the excise imposed under M.G.L. c. 176I, § 11, on all gross premiums received by insurers for coverage of persons residing in the Commonwealth. The purpose of 830 CMR 176I.1.1 is to describe the procedures for the administration, payment, and collection of the excise imposed under M.G.L. c. 176I, § 11, upon insurers offering insured health benefit plans that include preferred provider arrangements.

(b) Scope. The excise imposed on the gross premiums received by insurers of insured health benefit plans that include a preferred provider arrangement is an excise within the meaning of the "duties and excises" clause of the MASS CONST c. 1, § 1, art. 4.

The determination of the excise due under M.G.L. c. 176I, § 11, is governed exclusively by 830 CMR 176I.1.1 and the provisions of M.G.L. c. 176I. The administration, payment, and collection of the excise imposed under M.G.L. c. 176I, § 11, is governed by the provisions of M.G.L. chs. 62C, 63B, as amended. The Commissioner will apply the provisions of Chapters 62C, 63B, the same as any other tax subject to the Commissioner's authority, to the extent that such provisions are consistent with M.G.L. c. 176I. *See generally*, M.G.L. c. 62C, §§ 2, 3.

(c) Outline of topics. In order to facilitate the use of 830 CMR 176I.1.1, 830 CMR 176I.1.1(1)(c) lists the sections contained in 830 CMR 176I.1.1.

1. General
2. Definitions
3. Imposition of the Excise
4. Filing of Return
5. Payment and Collection of Excise

(d) Effective date. 830 CMR 176I.1.1 applies to all gross premiums received after December 31, 1988.

(2) Definitions. For the purposes of 830 CMR 176I.1.1, the following terms will have the following meanings, unless the context requires otherwise:

Calendar year, any taxable year beginning on or after January 1 and ending on or before December 31 of the same year or fraction thereof.

Commissioner, the Commissioner of Revenue or the Commissioner's designee duly authorized to perform the duties of the Commissioner.

Covered person, any policyholder, subscriber, member, or other person on whose behalf an insurer is obligated to pay for and/or provide health care services.

Health benefit plan, a health insurance policy, subscriber agreement, or contract between a covered person or health care purchaser and an insurer that defines the covered services and benefits levels available.

Insured health benefit plan. An insured health benefit plan is a health benefit plan that has one or more of the following characteristics:

(a) Assumption by the insurer of financial risk arising out of contractual liability to pay for or reimburse covered persons for covered services;

(b) Participation by the insurer in financial gains or losses of the health benefit plan based on aggregate measures of expenditures and/or utilization;

(c) Participation by the insurer in the overall financial risk of the health benefit plan by placing upper limits on future premium increases;

(d) Other characteristics that create a financial risk to the insurer arising out of the health benefit plan, including, but not limited to, stop-loss insurance provided to underwrite the financial risk of the health care services provided to covered persons.

The term does not include a health benefit plan in which an insurer functions solely as a third party administrator.

Insurer, a company authorized to write accident and health insurance pursuant to M.G.L. c. 175; a hospital service corporation as defined by M.G.L. c. 176A; a nonprofit medical service corporation as defined by M.G.L. c. 176B; a dental service corporation as defined by M.G.L. c. 176E; an optometric service corporation as defined by M.G.L. c. 176F; or a health maintenance organization as defined in M.G.L. c. 176G, that also offers to persons in the Commonwealth a health benefit plan that includes a preferred provider arrangement.

Organization, an insurer, as defined above, or any other entity that establishes, administers, and/or operates a preferred provider arrangement.

Preferred provider, a health care provider or group of health care providers who have contracted to provide specified services in the context of a preferred provider arrangement.

Preferred provider arrangement, an arrangement established, operated, maintained, administered, and/or underwritten in whole or in part by, or on behalf of, or in association with, an organization in which the organization contracts with preferred providers, and which is offered as part of a health benefit plan that includes incentives for covered persons to use covered health care services rendered by preferred providers.

Previous calendar year, the calendar year ending immediately before the current calendar year.

(3) Imposition of the Excise.

(a) General rule. Every insurer offering an insured health benefit plan that includes a preferred provider arrangement, as provided by M.G.L. c. 176I, and 830 CMR 176I.1.1, to persons residing in the Commonwealth must pay annually an excise equal to 2.28% of the gross premiums received during the previous calendar year, less deductions allowed under M.G.L. c. 63, § 24, and 830 CMR 176I.1.1(3)(c), for such previous calendar year.

(b) Determination of gross premiums. The amount of gross premiums subject to the excise imposed under M.G.L. c. 176I, § 11, include all amounts received from, for, or on behalf, of, covered persons under an insured health benefit plan that includes a preferred provider arrangement that represent premiums for covered persons to use covered health case services rendered by preferred providers, excluding, however premiums received for Medicare supplemental coverage.

(c) Deductions allowed. In determining the amount of gross premiums subject to the excise imposed by M.G.L. c. 176I, § 11, an insurer may deduct from the amount of gross premiums received from, for, or on behalf of, covered persons during the previous calendar year, as determined under 830 CMR 176I.1.1(3)(b), the following amounts:

1. all premiums on insured health benefit plans that include a preferred provider arrangement written or not taken, or canceled through default, and,
2. all premiums returned or credited to covered persons during the taxable year for which the excise imposed under M.G.L. c. 176I is assessed against the insurer.

See M.G.L. c. 63, § 24.

An insurer may not deduct premiums returned or credited on reinsurance assumed.

(4) Filing a Return. Any insurer subject to the provisions of this regulation, 830 CMR 176I.1.1, is required to file annually, on or before March 15, a return on DOR Form 176I, and make all estimated tax payments, as required by M.G.L. chs. 62B and 63B, as amended, and 830 CMR 63B.2.1. DOR Form 176I is a return within the meaning of M.G.L. c. 62C.

176I.1.1: continued

(5) Payment and Collection of Excise.

(a) General rule. The payment and collection of the excise imposed by 830 CMR 176I.1.1 is governed by the provisions of M.G.L. chs. 62C, 63B, as amended. The term "governed by" means that the Commissioner will apply all the provisions of M.G.L. chs. 62C, 63B, relevant to the payment and collection of the excise imposed by 830 CMR 176I.1.1 to the extent that such provisions are not inconsistent with the provisions of M.G.L. c. 176I.

(b) Payment of excise. The payment of the excise required by 830 CMR 176I.1.1 is due and payable at the time the return is filed or required to be filed. If an insurer reasonably expects that in any calendar year its liability relative to the excise imposed by 830 CMR 176I.1.1 will exceed $1,000, such insurer must make payments of estimated tax in accordance with M.G.L. c. 176I, § 11, and M.G.L. chs. 62B and 63B, as amended, and, if applicable, 830 CMR 63B.2.2.

REGULATORY AUTHORITY

830 CMR 176I.00: M.G.L. c. 176I, § 11; c. 62C, §§ 2 and 3; c. 14, § 6(1).

NON-TEXT PAGE