COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
1000 Washington Street, Suite 810 • Boston, MA 02118-6200
(617) 521-7794 • FAX (617) 521-7758
http://www.mass.gov/doi

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

GREGORY BIALECKI
SECRETARY OF HOUSING AND ECONOMIC DEVELOPMENT

BARBARA ANTHONY
UNDERSECRETARY OF CONSUMER AFFAIRS AND BUSINESS REGULATION

JOSEPH G. MURPHY
COMMISSIONER OF INSURANCE

BULLETIN 2012-02

TO: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc., and Health Maintenance Organizations Offering or Renewing Insured Health Products in Massachusetts

FROM: Joseph G. Murphy, Commissioner of Insurance

DATE: April 23, 2012

RE: Methodology for Calculating and Reporting Medical Loss Ratio Rebate or Credit Calculations in Massachusetts

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Background

The Division of Insurance ("Division") issues this Bulletin to instruct commercial health insurers, Blue Cross and Blue Shield of Massachusetts, Inc. and Health Maintenance Organizations (hereinafter "Carriers") regarding compliance with 211 CMR 66.09(8), and to clarify the requirements of 211 CMR 66.00 associated with Medical Loss Ratio ("MLR") calculations.

Insured Health Benefit Plans Subject to 211 CMR 66.00

Submission of Forms

Pursuant to M.G.L. c. 176J, §6(d), and 211 CMR 66.09(8)(a), Carriers who have issued nongroup/small group (hereinafter "merged market") insured Health Benefit Plans, as defined in 211 CMR 66.04, are required to calculate and submit a rebate calculation form each calendar year by May 31 for the preceding calendar year in accordance with the current NAIC methodology for calculating rebates for each company in which such coverage was issued. Rebate calculation forms shall be submitted to the Division via the SERFF system[1] and shall include the rebate calculation form designated by the Division in both a pdf file and a standard Excel® spreadsheet file.

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[1] The rebate calculation form shall be submitted on the SERFF system as a "rule filing" with a note at the General Information Tab that the filing is an information-only filing and not subject to the rate filing fee.

Required Information

Carriers shall include only revenue, claim payments or proportional administrative expenses for coverage that is provided through an insured Health Benefit Plan offered in the merged market. The Division will consider it appropriate for rebate calculation forms submitted for the 2012 and 2013 calendar years to include ICD-10 (International Classification of Disease, 10th edition) conversion costs incurred during those years as expenses to improve health care quality for the MLR calculation, provided such costs are not more than 0.3% of the reported earned premium.

When using the rebate calculation form required under 211 CMR 66.09(8), Carriers shall report Direct Premium Earned[2], incurred claims payments and administrative expenses that are associated with coverage issued to individuals and groups who qualify as Eligible Individuals or Eligible Small Groups, as defined in 211 CMR 66.04. If a rebate is warranted and the Carrier elects to apply credits to premium in lieu of a rebate, as set forth in the *Rebate Plan* section below, such credit-reduced premium shall not be utilized for purposes of the rebate calculation under 211 CMR 66.09(8). Although the actual size of an individual group may change during the reporting year, a group will be considered an Eligible Small Group based on whether the coverage was for a group that was considered an Eligible Small Group when the coverage was issued or renewed. The premium revenue, claim experience and relevant expenses to improve health care quality shall be counted on the rebate calculation form required under 211 CMR 66.09(8)(a) to be reported for coverage issued to Eligible Individuals and Eligible Small Employers.

Rebate Plan

As noted in 211 CMR 66.09(8)(b), "[i]f the calculation illustrates that a refund or rebate is warranted, the [C]arrier shall submit a detailed plan, for the [C]ommissioner's approval, that will provide a detailed description of the manner in which the [C]arrier 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 [C]arrier proposes not to make a refund or rebate. A Carrier may elect to apply credits to future premium in lieu of a refund or rebate. The amount of the rebate or credit will be based on the individual's or small employer's relative share of the premiums that were paid to the [C]arrier during the calendar year." The plan shall be submitted as an attachment on the SERFF record and shall explain the process the Carrier intends to use to refund or credit accounts that are still covered by the Carrier, as well as the method to be used to refund or credit amounts to individuals and group policyholders through the Carrier and through its intermediaries.

For groups, the plan shall describe whether such rebates or credits will be given to group members or, if given to group policyholders, the manner in which the Carrier will be made aware that rebates or credits have been transmitted to group members. The plan shall explain the process that will be used to locate individuals or other parties in the event they no longer reside

[2] Direct Premium Earned is defined in 211 CMR 149.04 as "[d]irect 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."

where the refund check has been sent. The plan shall also explain the rate of interest to be applied to any refunds transmitted after June 30, which shall be at minimum equivalent to the average rate of interest for the 13-week Treasury bills from the end of the calendar year to the date of the refund.

Pursuant to 211 CMR 66.09(8)(d), "the [C]ommissioner may authorize a waiver or adjustment of the refund requirement if the [C]ommissioner determines that issuing such refunds would result in financial impairment for the [C]arrier or if the [C]ommissioner determines that such refunds are *de minimus*. The aggregate of any *de minimus* amount not refunded shall be used to reduce overall premiums." For the purpose of distributing excess premium payments for coverage offered in the merged market, the Division considers a refund or credit to be *de minimus* if, for individuals, the refund or credit is for less than $5.00 and if, for groups, the refund or credit is for less than $20.00.

Timing of Rebates

According to M.G.L. c. 176J, § 6 "[a] [C]arrier shall communicate within 30 days to all individuals and small employers that were covered under plans during the relevant 12-month period that such individuals and small groups qualify for a refund." 211 CMR 66.09(8)(c) provides that such refund "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 [C]arrier, a credit on the premium for the subsequent 12-month period." Carriers will be considered compliant with these requirements if communications are made at the same time as refund payments and, for those enrolled in small employer plans, if individual notices are sent to individual subscribers of those plans.

According to 211 CMR 66.09(8)(e), "[r]efunds shall be paid annually by June 30th of the year following the calendar year of the rebate calculation." The Division will consider a Carrier compliant with the provisions of 211 CMR 66.09(8)(e) if refunds are electronically transmitted as of close of business on June 30 or, if sent via regular mail, refunds are in envelopes that are postmarked by no later than June 30. If a Carrier elects to apply credits to premium payments, the Division will consider a Carrier compliant with the provisions of 211 CMR 66.09(8)(e) if the credits are reflected on premium invoices electronically transmitted as of close of business on June 30, or, if sent via regular mail, invoices that include the credit are in envelopes postmarked by no later than June 30.

Federal Rebate Methodologies

Carriers are required under the federal Patient Protection and Affordable Care Act of 2010 ("ACA") to submit financial reports and MLR rebate calculation forms according to regulations and guidelines developed by the federal government. The MLR rebate calculation forms for insured Health Benefit Plans subject to 211 CMR 66.00 are separate and distinct from the reports and forms that are required to be submitted to the federal government under guidelines issued by the federal Center for Consumer Information and Insurance Oversight (CCIIO) within the Centers for Medicare and Medicaid Services. Carriers are expected to submit all federal reports and rebate calculation forms according to the timelines and guidelines identified by CCIIO.

The Division requests that all Carriers who issue health coverage in Massachusetts that is subject to federal CCIIO rebate provisions, including coverage issued to large employers (with more than 50 eligible employees) and students through student health plans, submit copies of all federal CCIIO rebate calculation forms to the Division as information filings via the SERFF system so that the Division is aware of such filings. When submitting these forms as informational filings, please include materials that describe the plan the Carrier will use in refunding or crediting amounts to accounts.

If you have any question about this bulletin, please contact Kevin P. Beagan, Deputy Commissioner of the Health Care Access Bureau at (617) 521-7323 or kevin.beagan@state.ma.us.