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

Section

149.01: Authority

211 CMR 149.00 is promulgated in accordance with the Commissioner of Insurance's authority pursuant to ~~St. 2010, c. 288 and~~ M.G. L. c. 176O, § 21.

149.02: Purpose

211 CMR 149.00 governs the form and content of reports of administrative services ~~Annual Comprehensive Financial Statements and appendices thereto~~ submitted pursuant to M.G.L. c. 176O, § 21~~, and any and all public hearings commenced in connection therewith~~.

149.03: Applicability

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

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

149.04: Definitions

For purposes of 211 CMR 149.00, the following words shall mean:

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

Carrier: An insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176I~~;~~. ~~but not including 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. Unless otherwise noted, the term Carrier shall not include any entity to the extent it offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services. The term Carrier 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.~~Carrier shall not include any entity to the extent it offers a policy, certificate or contract that is not a health benefit plan, as

defined in section 1 of chapter 176J; provided, however, that Carrier shall include an entity that offers a policy, certificate or contract that provides coverage solely for dental care services or vision care services. Carrier shall not include an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, or any entity acting solely as a Third-party Administrator.

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

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Commonwealth: The Commonwealth of Massachusetts.

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

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

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

Medical Loss Ratio (MLR): The ratio of the incurred loss (or Incurred Claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums, ~~according to current NAIC methodology, or~~ as ~~otherwise~~ determined by the Commissioner. ~~The MLR shall be calculated and submitted to the Division pursuant to St. 2010, c. 288 and 211 CMR 147.00.~~

NAIC: The National Association of Insurance Commissioners.

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

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

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

~~149.05: General Requirements Related to Filing of Annual Comprehensive Financial Statement~~

~~All Carriers shall file with the Division an Annual Comprehensive Financial Statement on or before April 1st for the year ended December 31st immediately preceding. The Annual Comprehensive Financial Statement shall be submitted electronically in a form approved by the Commissioner.~~

~~149.06: Form and Content of Annual Comprehensive Financial Statement~~

~~The Annual Comprehensive Financial Statement shall provide a detailed report on a form approved by the Commissioner of the costs incurred by the Carrier as of December 31st of the most recent calendar year.~~

~~(1) The Annual Comprehensive Financial Statement shall be itemized, where applicable, by:~~
~~(a) Market group size, including:~~
~~1. Individual;~~
~~2. Small groups of one to five, six to ten, 11 to 25 and 26 to 50; and~~

~~3. Large groups of 51 to 100, 101 to 500, 501 to 1000 and greater than 1000.~~

~~(b) Lines of business, including:~~

~~1. Individual, general, blanket or group policies of health, accident or sickness insurance issued by an insurer licensed under M.G.L. c. 175;~~

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2. Hospital service plans issued by a nonprofit hospital service corporation under M.G.L. c. 176A;
3. Medical service plans issued by a nonprofit hospital service corporation under M.G.L. c. 176B;
4. Health maintenance contracts issued by a health maintenance organization under M.G.L. c. 176G;
5. Insured health benefit plans that include a preferred provider arrangement issued under M.G.L. c. 176I;
6. Group health insurance plans issued by the commission under M.G.L. c. 32A;
7. Insured health benefit plans available to commercial accounts, including:
   a. closed network plans;
   b. point-of-service network plans; and
   c. open or any-willing-provider network plans;
8. Insured health benefit plans available only to students at post-secondary institutions;
9. Insured health benefit plans available only to eligible young adults; and
10. Insured health benefit plans available only through government programs, including:
    a. Medicare Advantage plans under 42 U.S.C. 1395w-28(b)(1);
    b. other Medicare plans under 42 U.S.C. § 1395 *et seq*.;
    c. Commonwealth Care Program plans under M.G.L. c. 118H; and
    d. MassHealth (Medicaid) Program plans under Title XIX of the Social Security Act and M.G.L. c. 118E *et seq*.

(c) The company will provide a detailed description of any method of allocation employed to attribute expenses that are not directly assigned to a group size or line of business, and the expenses, group sizes, and lines of business to which the allocation is applied.

(2) The Annual Comprehensive Financial Statement shall also include the following information:

(a) Enrollment Information.
1. Number of distinct employment-based groups covered on December 31st;
2. Number of subscriber members covered; including:
   a. Number of subscriber members covered on December 31st;
   b. Number of subscriber member months covered in prior calendar year; and
   c. Average number of subscriber members for prior calendar year.
3. Number of total subscriber and dependent lives covered, including:
   a. Number of total subscriber and dependent covered lives on December 31st;
   b. Number of total subscriber and dependent covered life months covered in calendar year; and
   c. Average number of subscriber and dependent covered lives in calendar year.

(b) Income Statement Information.
1. Premiums, including earned premiums (Premium earned during the calendar year) and net earned premiums (Direct premiums earned plus premium assumed and less reinsurance ceded).
2. Incurred claims, including direct claims paid during the calendar year on services rendered during the calendar year, unpaid claims reserves on service rendered or claims incurred during the calendar year, changes in contract reserves, the claims-related portion of reserves for contingent benefits and lawsuits, and experience rating refunds paid or received and reserves for experience rating refunds with negative adjustment for healthcare receivables and for reinsurance recoverables.
3. Medical Loss Ratio (MLR), as defined in accordance with 211 CMR 147.00.
4. Investment Gains and Losses:
   a. Investment income, including that part of a Carrier's income that stems from the interest and dividends earned on the stocks and bonds it owns or the return on any other invested funds; and
   b. Net Realized capital gains and losses, including the difference between the amount received from the sale or disposal of an asset and its carrying value.
5. Financial administration expenses, including all costs associated with underwriting, auditing, actuarial, financial analysis, investment-related expenses (not included elsewhere), treasury, reinsurance and outside benefit consultants.

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6. Marketing and Sales Expenses:
   a. Billing and member enrollment, including all costs associated with group and individual billing, member enrollment, premium collection and reconciliation functions;
   b. Customer services and member relations, including all costs associated with individual, group or provider support relating to membership, enrollment, grievance resolution, specialized phone services and equipment, consumer services and consumer information;
   c. Product management, marketing and sales, including all costs associated with the 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
   d. Product Development, including all costs associated with product design and development for new products not currently offered, major systems development associated with the new products and integrated system network development.
7. Distribution expenses, including all costs associated with the distribution and sale of products, including commissions, insurance producer and benefit consultant fees, intermediary fees, commission processing and account reporting to insurance producers.
8. Claims operations expenses, including all costs 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.
9. Medical Administration Expenses:
   a. Quality assurance and cost containment, including all costs associated with health and disease management and wellness initiatives (other than for education), health care quality assurance, appeals, case management, network access fees, 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;
   b. Wellness and health education, including all costs associated with wellness and health promotion, disease prevention, member education and materials, provide education and outreach services; and
   c. Medical research, including all costs associated with outcomes research, medical research programs and development of new medical management programs not currently offered, major systems development and integrated system network development.
10. Network operational expenses, including all costs 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, medical policy procedures, hospital and physician relations, medical policy procedures, network access fees, and credentialing.
11. Charitable expenses, including all costs associated with contributions to tax exempt foundations, charities, not related to the company business enterprises and community benefits.
12. Taxes, Assessments and Fines Paid to Federal, State or Local Government:
   a. Taxes (premium, real estate, other non-payroll) paid, including all costs associated with 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;
   b. Assessments, fees and other amounts paid to government agencies, including all assessments, fees or other amounts paid to state or local government and does not include any taxes or fines or penalties paid to any government agency; and
   c. Fines and penalties paid to government agencies, including all costs associated with penalties and fines paid to government agencies.
13. General Administration:
   a. Payroll administration expenses and payroll taxes, including all costs associated with salaries, benefits and payroll taxes (not allocated elsewhere);

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b. Real estate expenses, including all costs associated with 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;

c. Regulatory compliance and government relations, including all costs associated with 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;

d. Board, bureau or association fees, including all board of directors, bureau and association fees paid or expensed during the calendar year;

e. Other administration, including all cost associated with 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;

f. Reimbursement from uninsured plans, representing a negative adjustment that would include 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); and

g. Number of employees on the Carrier's payroll on December 31st of the preceding year, including the number of full-time employees whose normal work week is 30 or more hours, but not including any employee who works on a part-time, temporary or substitute basis.

14. Detailed miscellaneous expenses, including, but not limited to, all collection and bank service charges, printing and office supplies not allocated elsewhere, postage and telephone not allocated elsewhere.

15. Capital Expenses and Depreciation:

a. Depreciation, including all costs associated with depreciation for electronic data processing, equipment, software, and occupancy;

b. Capital acquisitions, including all expenditures for the acquisition of capital assets, including lease payments that were paid or incurred during the calendar year;

c. Capital costs on behalf of a hospital or clinic, including all expenditures for capital and lease payments incurred or paid during the calendar year on behalf of a hospital or clinic (or part of a partnership, joint venture, integration or affiliation agreement); and

d. Other capital costs, including expenditures for other costs that are directly associated with the incurring of capital costs, such as legal or administrative costs, incurred or paid during the calendar year.

16. Net income, which equals direct premiums earned less direct claims incurred less expenses plus investment gains and losses.

(c) Balance Sheet.

1. Accumulated surplus, including common stock, preferred stock, gross paid in and contributed surplus, surplus notes, unassigned funds and other capital or surplus items.

2. Accumulated reserves, including all reserves, including claim reserves, premium reserves and contract reserves.

3. Risk based capital ratio, as derived in accordance with 211 CMR 25.00.

(d) Any other information requested by the Commissioner.

(3) If a Carrier is unable to provide any of the required information set forth in 211 CMR 149.06 in its Annual Comprehensive Financial Statement, the Carrier shall provide a detailed explanation, within the Annual Comprehensive Financial Statement, of the reason(s) that such required information is not available.

(4) A Carrier that fails to submit its Annual Comprehensive Financial Statement to the Division on or before April 1st of each year shall be assessed a late penalty by the Commissioner not to exceed $100.00 per day.

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

~~(1) For the purposes of 211 CMR 149.07 only, the following words shall mean:~~

~~(a) Carrier or 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. 176I. Carrier or Health Insurer 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 "Carrier or 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. Carrier or 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, or any entity acting solely as a Third-party Administrator.~~

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

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

~~(d) 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~~.

(1~~2~~) ~~—~~Any Carrier ~~which is required to file an Annual Comprehensive Financial Statement pursuant to M.G.L. c. 176O, § 21(a) and which~~that provides administrative services to one or more Self-insured Groups shall submit to the Division an ~~appendix to the~~ Annual ~~Comprehensive Financial~~Self-insured business Report~~Statement~~ on a form approved by the Commissioner. The ~~appendix to the Annual Comprehensive Financial~~ Self-insured business Report~~Statement~~ shall be submitted electronically on or before April 1st for the year ended December 31st immediately preceding and shall include the following information:

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

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

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

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

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

(d) The aggregate value of D~~d~~irect ~~p~~Premiums ~~e~~Earned for all of the Carrier's Self-insured Customers;

(e) The aggregate value of ~~d~~Direct ~~c~~Claims ~~i~~Incurred for all of the Carrier's Self-insured Customers;

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

(g) Net income;

(h) Accumulated ~~s~~Surplus;

(i) Accumulated reserves;

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(j) The percentage of the Carrier's Self-insured Customers that include each of the benefits mandated for health benefit plans under M.G.L. chs. 175, 176A, 176B and 176G;
(k) The aggregated administrative service fees paid by all of the Carrier's Self-insured Customers; and
(l) Any other information requested by the Commissioner.

(2~~3~~) If a Carrier is unable to provide any of the required information set forth in the Self-insured business ~~211 CMR 149.07(2) in the appendix to its Annual Comprehensive Financial~~ Report~~Statement~~, the Carrier shall provide a detailed explanation~~, within the Annual Comprehensive Financial Statement,~~ of the reason(s) that such required information is not available.

(3~~4~~) A Carrier that provides administrative services to one or more Self-insured Groups and fails to submit the Self-insured business ~~appendix to its Annual Comprehensive Financial~~ Report~~Statement~~ to the Division on or before April 1st of each year shall be assessed a late penalty by the Commissioner not to exceed $100.00 per day.

149.0~~86~~: Audit of Self-insured Business ~~Annual Comprehensive Financial~~ Report ~~Statement and Appendix to Annual Comprehensive Financial Statement~~

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

(2) Any and all fees and costs for the Division's audit of the Carrier's Self-insured business~~Annual Comprehensive Financial Statement, or the appendix to its Annual Comprehensive Financial~~ Report~~Statement~~, shall be borne by the subject Carrier.

149.0~~79~~: Public Hearing on Carrier's Financial Condition

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

(2) The public hearing shall be held within 60 days of the date of the Carrier~~s filing of its report~~reporting that its Risk Based Capital ratio on a combined entity basis exceeds 700%~~fully completed Annual Comprehensive Financial Statement~~.

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

149.0~~810~~: Notice of Public Hearing

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

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

149.0~~911~~: Pre-hearing Filing by Carrier

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

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

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(b) A summary containing a description of the contents of the filing;
(c) A list of the names and occupations of all persons who will present oral testimony, statements or comments on behalf of the Carrier at the public hearing; and
(d) Any other information required by the Commissioner or the Presiding Officer.

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

149.102: Conduct of Public Hearing

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

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

149.113: Commissioner's Report on Public Hearing

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

149.124: Severability

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

REGULATORY AUTHORITY

211 CMR 149.00: ~~St. 2010, c. 288 and~~ M.G. L. c. 176O, § 21.