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### **I. Form Filings**

#### **Chapter 152: Section 54A. Necessity of insurance contract insuring payment of compensation**

\_\_\_\_\_ Every contract or agreement the purpose of which is to insure an employer in whole or in part against liability on account of injury or death of an employee, other than seasonal or casual farm laborers and seasonal or casual or part-time domestic servants who work in the employ of the employer less than 16 hours a week for whom insurance under this chapter remains elective, shall be void unless it also insures the payment of the compensation provided for by this chapter. The 2<sup>nd</sup> paragraph of section 55 shall not apply in case of a contract or agreement made void by this section.

**Chapter 152: Section 55. Approval of policy by Commissioner; review; issuance of policy in violation of statute**

No policy of workers' compensation insurance shall be issued or delivered:

(a) until a copy thereof has been filed with the Commissioner at least 30 days prior to such issue or delivery, unless before the expiration of the 30 days the said Commissioner shall have approved the form of the policy in writing, or

(b) if the Commissioner notifies the company in writing that in her opinion the form of said policy does not comply with the laws of the Commonwealth, specifying the reasons for her opinion.

Any policy of insurance issued in violation of this section or of any other provision of this chapter shall nevertheless be valid and binding upon the company issuing it, and the rights, duties and obligations of the parties thereto shall be determined by this chapter and MGL c. 175.

**Excess Workers' Compensation.**

Rates need not be filed. Forms and rules should be filed for prior approval in compliance with the following:

As of June 15, 1995, the Division of Insurance has not approved any excess workers' compensation policy that does not meet the minimum retention criteria set forth below: Any workers' compensation policy failing to meet these criteria will qualify as a primary policy, subject to assessments for the costs of the residual market pursuant to the Massachusetts Assigned Risk Pool Plan. In addition, rates for all primary workers' compensation policies must receive prior by the Commissioner of Insurance prior to use.

In order to qualify as excess workers' compensation, a policy must require an insured to retain the following risk:

\_\_\_\_\_ At least \$300,000 in workers' compensation losses; or

\_\_\_\_\_ At least 75% of the manual premium, (or if an experience modification has been calculated for the employer by the Workers' Compensation Rating and Inspection Bureau of Massachusetts, the standard premium plus ARAP). The applicable premium may be reduced by any applicable premium discount, but should not reflect any deviations from the approved workers' compensation rates.

**Please note:**

If the self-insured retention is below \$300,000, all premium and (if applicable) experience modification calculations must be verified annually through an audit of the insured's records, with retentions adjusted retroactively, if necessary.

**Chapter 152: Section 53. Mutual companies; distribution of risks into groups**

\_\_\_\_\_ Any mutual liability insurance company authorized to do business in this Commonwealth may with the approval of the commissioner of insurance distribute its risks into groups in accordance with the nature of the business and the degree of the liability of injury and with the like approval fix by and for such groups in accordance with the experience of each group al premiums, assessments and dividends; but all the funds of the company both actual and contingent shall be available for the payment of any claim against the company.

**[Note: No company may offer dividends without a participatory endorsement on file with the division. Dividends may not be promised or paid in advance of the conclusion of the policy year. Except as provided above, workers' compensation dividend filings need not receive prior approval, but they should be made on an informational basis so that the Division can ascertain that they are not actually deviation or schedule rating filings, which, under Section 53A, do require prior approval.]**

## **II. Miscellaneous Provisions**

### **A. Preferred Provider Arrangements (211 CMR 51.00 et seq.).**

No preferred provider organization may enter into a preferred provider agreement pursuant to the provisions of MGL c. 152, s. 30, without complying with the filing and other requirements set forth in 211 CMR 51.00 *et seq.*

#### **211 CMR 112.04: Filing Requirements and Review by the Commissioner**

##### **(1) Application Filing Requirements.**

Each applicant shall submit the following information required by 211 CMR 51.04(1)(a) through (h) and 211 CMR 51.04(3)(a) through (i) The submitted documentation shall be considered the applicant's PPA application.

\_\_\_\_\_ (a) A copy of the basic organizational documents of the applicant, such as the articles of incorporation, and amendments thereto;

\_\_\_\_\_ (b) A copy of the bylaws, rules, regulations or other similar documents regulating the internal affairs of the applicant;

\_\_\_\_\_ (c) A list of the names, business addresses and official positions of members of the board of directors or similar policymaking body of the applicant, and of persons who are responsible for the conduct of applicant's affairs;

\_\_\_\_\_ (d) A list of the names and business addresses of every health care provider proposed to be included in the preferred provider organization, along with the provider type or medical specialty of each such provider;

\_\_\_\_\_ (e) A list of each type of provider and medical specialty represented by the applicant and the number of individuals representing each such type of practice and specialty, along with the approximate total number of hours per week that the applicant will make available in such types of practice and specialties for the treatment of covered persons subject to the preferred provider arrangement;

\_\_\_\_\_ (f) A general narrative description of the financial arrangements between the applicant and the insurer, self-insurer or self-insurance group that is a party to the proposed arrangement. This description need not include any specific details of the financial terms between the applicant and the insurer, self-insurer or self-insurance group, but must indicate, for example if the arrangement is on a fee-for-service basis, or if volume discounts will be given;

\_\_\_\_\_ (g) A general narrative description of the financial arrangements between the applicant and the health care providers proposed to be the preferred providers upon approval of the application. This description need not include any specific details of the financial arrangements between the applicant and such health care providers;

\_\_\_\_\_ (h) A list of each insurer, self-insurer, and self-insurance group with which the applicant has previously entered into a workers' compensation preferred provider arrangement, and of each insurer, self-insurer, and self-insurance group with which the applicant has a pending application for a workers' compensation preferred provider arrangement;

\_\_\_\_\_ (i) A written description and a map of the geographical areas proposed to be covered by the preferred provider arrangement and the locations of the main concentrations of covered persons subject to the arrangement;

\_\_\_\_\_ (j) A description of the manner in which covered health care services and other benefits may be obtained by covered persons, including any requirement that covered persons select a gatekeeper provider;

\_\_\_\_\_ (k) A copy of the information annually distributed to covered persons which shall include clear reference to the following facts:

\_\_\_\_\_ 1. that a covered person is required to obtain treatment within the preferred provider organization for the first scheduled appointment or incur the responsibility to pay for such appointment, provided that such person may seek health care service for a compensable injury outside the preferred provider organization for the initial scheduled appointment without incurring any financial obligation when such appointment is with a licensed or registered health care provider of a type or specialty not represented within the preferred provider organization;

\_\_\_\_\_ 2. that a covered person may seek health care service for a compensable injury outside the preferred provider organization after the initial scheduled appointment without incurring any obligation to pay for such subsequent visit according to the provisions of MGL c. 152, § 30; and

\_\_\_\_\_ 3. that no co-payments or deductibles may be charged covered persons with compensable injuries who utilize the preferred provider organization or any other health care provider under the provisions of MGL c. 152, §§ 13 and 30;

(l) A description of:

\_\_\_\_\_ 1. the Department of Industrial Accidents (DIA) approved utilization review and quality assessment program along with a copy of the DIA's letter of current authorization for said program;

\_\_\_\_\_ 2. the Return to Work program that will be used by the application; and

\_\_\_\_\_ 3. the applicant's written agreement to abide by any treatment guidelines or protocols promulgated by the DIA pursuant to MGL c. 152, §§ 13 and 30; and

**211 CMR 112.05: Standards of Review by the Commissioner**

Upon receipt of a complete application for approval of a workers' compensation preferred provider arrangement the Commissioner will review the submitted material to determine that the following standards are met:

\_\_\_\_\_ (a) The preferred provider arrangement makes available a sufficient number and range of providers by specialty and geographic area to provide covered persons with industrial accidents or diseases, timely access to and availability of preferred providers for emergency care, urgent care and elective care;

\_\_\_\_\_ (b) A procedure exists for distributing to each covered person, after any alleged workplace injury to such person, the names of all current preferred providers within the geographic region of such covered person or of all current preferred providers arranged geographically. The names on such list shall be arranged in order of medical specialty or provider type. A current list shall also be posted at a convenient and prominent place for covered persons to examine at work sites, and shall be given to any covered person upon request. In addition, a document clearly setting forth the rights and responsibilities of covered persons under the preferred provider arrangement and under MGL c. 152, §§ 13 and 30, including the right to take complaints regarding the provision of health care services to the Health Care Services Board, shall be distributed to covered persons upon initial approval of the preferred provider arrangement and annually thereafter, posted in a prominent place in workplaces where covered workers are employed, and given to any covered person alleging to have suffered a workplace injury. Such information shall indicate the method of obtaining a current list of preferred providers;

\_\_\_\_\_ (c) Each preferred provider is given a clear description of the rights of covered persons and the obligations of the applicant to covered persons; and

\_\_\_\_\_ (d) There is a DIA approved utilization review and quality assessment program (UR & QA) in place to ensure appropriate and efficient provision of high quality health services. Said program shall incorporate any protocols or treatment guidelines promulgated by the DIA pursuant to MGL c. 152, §§ 13 and 30. Any restrictions or

requirements imposed on covered persons by the UR & QA program must be adequately explained in the materials annually distributed to covered persons. There must be procedures to guarantee cooperation by preferred providers with the UR & QA program, which allow for the removal of noncomplying providers from the arrangement. There must be a procedure for referring covered persons to health care services outside the preferred provider organization when indicated by diagnosis, excessive travel time, and presence of any pre-existing medical condition which would make treatment substantially more difficult.

\_\_\_\_\_ (e) The PPA application must contain a position statement indicating how the applicant intends to facilitate the return to work of injured employees in a rapid, cost-effective and safe manner.

### **211 CMR 112.06: Approval or Disapproval of Application**

The Commissioner shall review any application in accordance with the criteria set forth in 211 CMR 112.04(1) and shall determine whether approval shall be granted or denied. If approval of the application is granted, a copy of the approval application must then be forwarded to the Office of Health Policy at the Department of Industrial Accidents. If an application is denied, the Commissioner shall notify the applicant in writing of the reason(s) for the denial. The applicant shall have the right to a hearing on its application within 45 days of its receipt of such notice by filing a written request for hearing within 15 days of its receipt of such notice. Within 30 days after the conclusion of the hearing, the Commissioner shall either grant approval or shall notify the applicant in writing of the denial of its application, stating the reason(s) for the denial. The applicant shall have the right to judicial review of the Commissioner's decision in accordance with the provisions of MGL c. 30A, s.14.

### **211 CMR 112.07: Ongoing Review of Preferred Provider Arrangements**

\_\_\_\_\_ (1) **Material Changes:** Each preferred provider organization shall file with the Commissioner within 30 days any material changes to the approved preferred provider arrangement or the information submitted pursuant to 211 CMR 112.00. Any substantial change in the number, type or geographical location of covered persons shall be reported on or before July 30 of each year.

\_\_\_\_\_ (2) **Changes to the List of Preferred Providers:** Each preferred provider organization shall file changes to its list of preferred providers with the Commissioner on or before July 30 of each year.

\_\_\_\_\_ (3) **Additional Reports:** The Commissioner, in her discretion, may require preferred provider organizations to submit additional reports in addition to those specifically required by 211 CMR 51.00 *et seq.* Such reports may include surveys of covered persons conducted in a method prescribed by the Commissioner.

## **B. Self Insurance Groups [“SIGs”] (Chapter 152, Section 25E—Section 25U)**

(see Forms at the end of this section)

### **Chapter 152: Section 25F. Certification to act as self-insurance group**

No person, association, or entity shall act as a workers' compensation self-insurance group unless it has been issued a certificate of approval by the commissioner of insurance.

### **211 CMR 67.03 General provisions**

#### **Appointment of Commissioner as Attorney for Service of Process**

\_\_\_\_\_ A group shall appoint the Commissioner as its attorney to receive service of legal process issued against it in the commonwealth, in accordance with the provisions of MGL c. 175, § 151, Clause Third. The appointment shall be irrevocable, shall bind any successor in interest and shall remain in effect as long as there remain any obligations or liabilities of the group for workers' compensation benefits.

#### **Other Requirements**

\_\_\_\_\_ At least 70% of the members of a group shall be experience rated pursuant to the uniform experience rating plan filed with and approved by the Commissioner.

\_\_\_\_\_ No group may have less than \$250,000 of annual gross premium nor a combined provable net worth of all its members of less than \$1,000,000.

\_\_\_\_\_ The principal office of the group shall be located in the Commonwealth.

### **211 CMR 67.05: Certification to Act as a Self-Insurance Group**

No person, association, or entity shall act as a workers' compensation self-insurance group unless it has been approved by the Commissioner.

The Commissioner may decline to approve an application for a certificate of approval if the group is unable to demonstrate that it is able to meet all obligations and requirements of MGL c. 152 and 211CMR 67.00.

On finding that the proposed group has met all requirements of the law and of 211 CMR 67.00, the Commissioner shall issue the group a certificate of approval.

Should the Commissioner find that the proposed group does not meet such requirements, she shall issue an order denying the group a certificate, setting forth the reasons for the refusal.

The certificate of approval shall not become effective until the group notifies the Office of Insurance of the Department of Industrial Accidents of the names and addresses of the members of the group, their policy numbers, and the effective date of such coverage.

A group shall notify the Commissioner if the group fails to commence operations within 60 days of approval. Such notification shall be in writing and shall state the reasons therefore.

A group shall forfeit its certificate of approval if it fails to commence operations, as constituted in the form approved by the Commissioner, within 90 days of its approval.

### **Factors in Determining Whether A Group Can Meet Its Obligations**

In addition to the filing requirements described in 211 CMR 67.06, the following factors, where applicable, shall be considered in determining whether or not the group will be able to meet its obligations:

- \_\_\_\_\_ (a) ratio of net worth to annual self-insured retention;
- \_\_\_\_\_ (b) ratio of current assets to current liabilities;
- \_\_\_\_\_ (c) ratio of debt to net worth;
- \_\_\_\_\_ (d) history of profitability of the members;
- \_\_\_\_\_ (e) organizational structure, risk management programs and loss control programs, including services contracted for by the board of trustees or administrator;
- \_\_\_\_\_ (f) background, experience and financial condition of the administrator;
- \_\_\_\_\_ (g) composition of the board of trustees;
- \_\_\_\_\_ (h) claims history of the members;
- \_\_\_\_\_ (i) source and reliability of financial information;
- \_\_\_\_\_ (j) ratio of net worth to annual premium contribution;
- \_\_\_\_\_ (k) number of employees and payroll data by workers' compensation class code;
- \_\_\_\_\_ (l) ability to meet the financial requirements prescribed in 211 CMR 67.08;
- \_\_\_\_\_ (m) excess insurance coverages and proposed excess insurer;
- \_\_\_\_\_ (n) relationship of self-insured retention and claims history to excess insurance coverages;
- \_\_\_\_\_ (o) amount of the group's security bond or deposit;

- \_\_\_\_\_ (p) guarantee by parent company;
- \_\_\_\_\_ (q) SEC Form 10K or 10Q, where applicable;
- \_\_\_\_\_ (r) reasonableness of administrative and other expenses;
- \_\_\_\_\_ (s) any other factors which may affect the ability of a group to meet its workers' compensation obligations.

## **211 CMR 67.06: Application for certificate of approval**

### **Filing Fee**

\_\_\_\_\_ A proposed workers' compensation self-insurance group shall file with the Commissioner its application for a certificate of approval accompanied by a non-refundable filing fee in the amount of \$100.00.

### **Evaluation of Filing / Time for Review**

The Commissioner shall evaluate the information provided in the application to assure that no gaps in funding exist and that funds necessary to pay workers' compensation benefits shall be available on a timely basis.

The Commissioner shall conduct an initial review of each application to determine if it is complete. The Commissioner shall act upon a completed application for a certificate of approval within 90 days.

### **Changes in Information Filed**

The group shall immediately notify the Commissioner of any change in the information required to be filed by 211 CMR 67.06.

### **Confidentiality**

All information provided by an applicant during the application process shall be given confidential treatment and shall not be subject to subpoena or made public by the Commissioner or any other person, except by the applicant, without the prior written consent of such applicant, unless the Commissioner, after giving the applicant notice and opportunity to be heard, determines that the public interest would be served by the publication thereof, in which event she may publish all or any part thereof in such manner as he or she may consider appropriate.

Notwithstanding the foregoing, once an application has been approved by the Commissioner it shall be made available to the public; provided, however, that if a group wishes, it may submit two complete sets of statements, one with all identifying information blacked out or deleted, and the other set complete with all the identifying information, and the group's underwriting guidelines, for inclusion in the financial examination file.

### **Application Requirements**

The Application for a Certificate of Approval shall be on a form prescribed by the Commissioner and shall include:

- \_\_\_\_\_ 1. the name of the group;
- \_\_\_\_\_ 2. the address and telephone number of the group's principal office;
- \_\_\_\_\_ 3. the date of organization of the group;
- \_\_\_\_\_ 4. the name and address of each member of the group;
- \_\_\_\_\_ 5. the name, address and date of organization of the industry, trade or professional organization to which all the members of the group belong, or identification of the collective bargaining agreement to which all group members are parties;
- \_\_\_\_\_ 6. the types of business in which employers in the proposed group are engaged and an explanation of how they are the same or similar;
- \_\_\_\_\_ 7. a listing of the names and addresses of the initial board of trustees and the name and address of the administrator in accordance with the provisions of 211 CMR 67.07.

### **Additional Documentation Needed**

The following additional documents must also be filed by the group:

- \_\_\_\_\_ 1. a copy of the by-laws of the group;
- \_\_\_\_\_ 2. a copy of the articles of association, trust agreement, or articles of organization;
- \_\_\_\_\_ 3. a completed and signed application by the administrator to serve as the administrator of the group, on a form prescribed by the Commissioner;
- \_\_\_\_\_ 4. a certificate indicating that the Commissioner has been appointed the group's agent for service of legal process as required by 211 CMR 67.03(3);
- \_\_\_\_\_ 5. a schedule of all projected administrative expenses for the group in dollar amount and as a percentage of the estimated standard premium for the group;
- \_\_\_\_\_ 6. a composite listing of the estimated standard premium and annual net premium to be developed for each member individually and in total for the group amounting to not less than \$250,000. The listing shall include and reflect experience modification factors, All Risk Adjustment Program (ARAP) factors, such other rating plan(s) the Commissioner may approve, and any applicable premium discounts. At least 70% of the members of a group shall be experience rated pursuant to the uniform experience rating plan filed with and approved by the Commissioner;

\_\_\_\_\_ 7. a listing of payroll data, by workers' compensation class code, for the combined group and for each member of the group for each of the three preceding years;

\_\_\_\_\_ 8. a confirmation of required specific and aggregate excess insurance or reinsurance, by an insurer licensed, approved or otherwise authorized to transact excess insurance or reinsurance in the commonwealth. Such confirmation shall include a description of the coverages offered, the terms and conditions of the coverages and the expected premium charges for the coverages. The amount and the terms of the specific and aggregate excess insurance or reinsurance shall comply with the requirements of 211 CMR 67.21;

\_\_\_\_\_ 9. a copy of the fidelity bond, binder, or commitment letter from the surety relating to the fidelity bond for the administrator, on a form prescribed or approved by the Commissioner, in an amount not less than the administrator's total annual compensation for all the groups it administers or \$1,000,000, whichever is less. If the group submits a binder, or commitment letter, it must submit a copy of the actual bond to the Division of Insurance within 60 days after the group is approved;

\_\_\_\_\_ 10. the proposed underwriting guidelines for the group;

\_\_\_\_\_ 11. a premium payment plan requiring each member to pay the group not less than 25% of the member's estimated annual net premium not later than the initial day of coverage provided by the group. The premium payment plan of a group containing private employers shall also provide that the balance of each member's annual premium be paid in cash within the first eight months of that fund year in monthly or quarterly installments. A public employer group shall establish a premium payment plan acceptable to the Commissioner;

\_\_\_\_\_ 12. a detailed written description of the group's safety and loss prevention program(s);

\_\_\_\_\_ 13. a refund and assessment plan for the group;

\_\_\_\_\_ 14. an actuarial study displaying adequacy of program funding, including loss reserves, prepared and signed by a qualified actuary. The actuarial study shall show that the group is actuarially fully funded, and shall include any and all data, assumptions and other information used to develop such study;

\_\_\_\_\_ 15. a pro forma financial statement for the group's first five years of operation, showing the financial ability of the group to pay the workers' compensation obligations of its members, including any and all assumptions relied upon to develop such statement;

\_\_\_\_\_ 16. for a group containing private employers, a statement showing the combined provable net worth of all members applying for coverage on the inception date of the group. Such combined provable net worth shall be the amount that establishes the financial strength and liquidity of the members and shall be at least one million dollars;

\_\_\_\_\_ 17. for a group containing private employers, a specimen indemnity agreement jointly and severally binding the members of a group to comply with the provisions of

211 CMR 67.00 which shall be executed by the members upon approval of the group by the Commissioner and prior to the commencement of operations. Such indemnity agreement may be included as a provision of the group's membership or participation or similar agreement which each member of a proposed group shall assent to in writing as a prerequisite to membership in the group; provided that the membership, participation or other similar agreement, clearly discloses, as the first provision and in at least ten point type, the member's obligations under the indemnity agreement, including, at a minimum, the provisions of 211 CMR 67.11(3), (4) and (5).

### **Filing Requirements for Group Members**

Each member of the group shall provide the commissioner with the following:

\_\_\_\_\_ 1. An individual application, including a disclosure form describing the joint and several obligations of the members, a certification that the member has no outstanding workers' compensation obligations, and a description of the group's refund/assessment plan, signed by an officer or other responsible employee of the member, on a form prescribed or approved by the Commissioner;

\_\_\_\_\_ 2. A written explanation by any member with an experience modification greater than 1.25 describing the causes of its high experience modification and outlining remedial measures it has taken and will be taking in the future to lower its modification;

Every member of a group containing private employers shall also submit the following documents:

\_\_\_\_\_ 1. a certified or compiled financial statement, subject to the requirements of 211 CMR 67.06(1)(e);

\_\_\_\_\_ 2. a written agreement to pay the group not less than 25% of the member's estimated annual net premium not later than the initial day of coverage afforded by the group.

### **211 CMR 67.08: Financial standards and reporting requirements**

#### **Petition to Reduce Requirements**

After a group has been in operation for three years, so long as a group has continued to meet the requirements of 211 CMR 67.08(2), the Commissioner may grant, **upon petition of the group**, a reduction of the requirements applicable to the group that are set forth in 211 CMR 67.21 and 67.08(2)(d).

In reviewing a group's petition, the Commissioner may consider such financing alternatives or insurance mechanisms proposed by the group.

At the expense of the group, the Commissioner may engage such financial, insurance or other experts deemed necessary by the Commissioner to consider a petition submitted by a group in accordance with 211 CMR 67.08.

### **Security Required**

\_\_\_\_\_ For any group containing private employers, security shall be 10% of the group's standard premium, but in no case shall the security be less than \$100,000.

\_\_\_\_\_ The amount of the security deposit or bond shall be adjusted annually by the group based upon changes in the group's in-force premium, as determined from its annual statements; provided, however, that any time a group's in-force premium grows by more than 10%, it shall adjust its security in accordance with 211 CMR 67.11(7).

\_\_\_\_\_ Security shall be provided by either a surety bond or security deposit, or any combination thereof.

\_\_\_\_\_ Any surety bond provided shall be issued by a corporate surety company licensed to transact surety business in the commonwealth, and which is not affiliated with the group's administrator, other surety(ies) for the group, excess insurer(s) or reinsurer(s) for the group, or any member of the group.

\_\_\_\_\_ The bond shall be in a form prescribed or approved by the Commissioner.

\_\_\_\_\_ Any security deposit provided shall be in the form of bonds or other evidences of indebtedness issued, assumed, or guaranteed by the United States of America, or by an agency or instrumentality thereof, or certificates of deposit which meet the standards imposed by the NAIC, in a bank which is a member of the Federal Reserve System, or any bond or security issued by a state of the United States of America and backed by its full faith and credit. Any securities or certificates of deposit shall have a remaining maturity of one year or less from their time of purchase.

\_\_\_\_\_ The surety bond or security deposit, or both shall be for the benefit of the Commonwealth solely to pay claims and associated expenses and payable on the failure of the group to pay the workers' compensation benefits that it is legally obligated to pay.

### **Financial Reporting Required**

The following financial reports shall be filed with the Commissioner:

\_\_\_\_\_ Annual and quarterly statements on the forms prescribed by the National Association of Insurance Commissioners (NAIC) for property/casualty insurers, in accordance with the Commissioner's annual statement instructions and all applicable laws and regulations.

\_\_\_\_\_ The annual statement shall be accompanied by an opinion on loss reserves certified by a qualified actuary and shall demonstrate the group's compliance with the minimum financial requirements set forth in 211 CMR

### **Financial Reporting Schedule**

Reports shall be submitted on the following schedule:

1. **Annual Statement:** due on or before the first day of the third month following the end of the group's fund year.
2. **Quarterly Statements:** due on or before the 45th day following the end of the group's first, second, and third fiscal quarters.
3. On or before the last day of the sixth month following the end of the group's fund year, a statement of financial condition audited by an independent Certified Public Accountant, including, but not limited to, actuarially fully funded reserves, for known claims and claim adjustment expenses, unearned premiums, including both direct and reinsurance, and bad debts.
4. The Commissioner may prescribe the form and frequency of other reports which may include, but not be limited to, payroll audit reports, summary loss reports and other financial statements.
5. In the event that the annual reserve report, required under 211 CMR 67.08(3)(a), shows that a group has not satisfied the minimum financial requirements prescribed in 211 CMR 67.08(2), the group shall submit a written plan to the Commissioner, at the same time as it submits the annual reserve report, describing what steps the group intends to take to bring the group into compliance promptly.

**211 CMR 67.09 Uniform classification system; premium contributions; application to make own rates; audits**

**Scope of Compliance Required**

Every group shall comply with the uniform classification system, uniform experience rating plan, including the All Risk Adjustment Program (ARAP), other experience rating plans the Commissioner may approve, and manual rules filed with the Commissioner by an advisory organization designated by the Commissioner.

Experience modifications for members shall be calculated, at the expense of the group, by an organization designated by the Commissioner, and shall be used by all groups. Members changing from one group to another, or returning to the insured workers' compensation market shall carry their experience modifications with them.

**Application to Make Own Rates**

\_\_\_\_\_ A group may apply to the Commissioner for authority to make its own rates. Such rates shall be filed with the Commissioner and shall be based upon at least two fund years, consisting of not less than 24 months, of the group's experience, to the extent actuarially credible.

\_\_\_\_\_ A public employer safety group in operation for at least two consecutive years before it applies for approval to operate as a public employer group, may apply to the Commissioner to make its own rates immediately.

### **Premium Contributions**

In no event shall a group determine members' premium contributions by any method other than that prescribed herein without the prior written approval of the Commissioner.

### **Dividend**

In no event shall a group make a distribution to its members, other than dividends, without the prior written approval of the Commissioner.

### **211 CMR 67.10: Reinsurance; security bond or deposit; fidelity bond; changes**

To maintain its certificate of approval, a group shall comply with the requirements of MGL c. 152, 211 CMR 67.00, and any other applicable laws or regulations, and the following:

\_\_\_\_\_ (1) Each group containing private employers shall maintain a combined provable net worth as prescribed in 211 CMR 67.08(2)(c), but not less than \$1,000,000;

\_\_\_\_\_ (2) Each group containing private employers shall maintain a security bond or deposit in an amount and form as prescribed in 211 CMR 67.08(2)(d), but not less than \$100,000.

\_\_\_\_\_ (3) Each group shall maintain specific and aggregate excess insurance or reinsurance in an amount and form as prescribed in 211 CMR 67.21.

\_\_\_\_\_ (4) Each group's administrator shall maintain a fidelity bond in a form and amount as prescribed by 211 CMR 67.06(2)(b)9.

\_\_\_\_\_ (5) Each group shall notify the Commissioner of any change in the manner of its compliance with 211 CMR 67.10(1), (2), (3) and (4) no later than 20 days after such change, including, but not limited to, cancellation, nonrenewal or change in amount and terms of coverage of any excess insurance, security bond or deposit or fidelity bond.

### **211 CMR 67.21: Reinsurance and excess insurance contract provisions**

#### **Minimum Requirements**

\_\_\_\_\_ 1. Specific Excess Coverage Limit for each group shall be at least \$5,000,000 per occurrence (per claim for disease). Groups composed of businesses with a high risk of multiple injury from a single occurrence may be required to maintain higher limits.

\_\_\_\_\_ 2. The retention allowed for a group's specific excess policy shall be actuarially sound and shall be not more than 30% of the net premium of the group up to a maximum of \$500,000. The maximum retention may be revisited after groups have been in operation for three years.

\_\_\_\_\_ 3. Aggregate Excess Insurance shall attach at 105% of standard premium, and groups may choose their aggregate limit from the following two options:

\_\_\_\_\_ **Option A:** An amount not less than 50% of the group's in-force premium of which the first \$1,000,000 of this aggregate reinsurance coverage must be total reimbursement reinsurance and the remainder may be total reimbursement reinsurance or financial reinsurance.

\_\_\_\_\_ **Option B:** An amount of not less than ten times the specific retention, all of which shall be total reimbursement insurance. Groups with in-force premium in excess of \$15,000,000, shall obtain additional reinsurance, which may be financial reinsurance, in the amount of 50% of the in-force premium in excess of \$15,000,000.

The aggregate excess insurance or reinsurance requirements may be revisited after groups have been in operation for three years.

### **Who May Be Covered**

\_\_\_\_\_ No more than one group shall be covered by any contract or policy of excess insurance or reinsurance and the named insured shall be the group or its statutory successor in interest.

### **Criteria For Reinsurers / Excess Insurers**

Except as otherwise provided herein, reinsurers and excess insurers shall be subject to the Commissioner's approval, and shall meet all of the following criteria:

\_\_\_\_\_ (a) They shall be licensed, admitted or otherwise authorized to transact insurance or reinsurance business in the Commonwealth; and,

\_\_\_\_\_ (b) They shall be classed, according to the following table, in either the top two categories by one of the rating agencies, or receive at least the minimum acceptable rating from two of the rating agencies shown below:

	<u>Top Two Categories</u>		<u>Minimum Acceptable Rating</u>
A. M. Best & Company	A++,	A+	A-
Duff & Phelps	AAA,	AA+	AA
Moody's Investors Services	AAA,	AAI	AA2
Standard & Poor Corporation	AAA,	AA	A

(c) The NLC Mutual Insurance Company, an affiliate of the National League of Cities, and the Underwriters at Lloyd's of London are specifically approved for reinsurance, provided their policies comply with 211 CMR 67.21(7).

### **Required Policy Language**

No contract or policy of specific or aggregate excess insurance or reinsurance shall be recognized by the Commissioner in considering the ability of the group to fulfill its financial obligations unless such contract or policy shall contain the following statement:

"This policy [contract] is in compliance with all the provisions of 211 CMR 67.21(7). Provisions at variance with 211 CMR 67.21(7) will be automatically amended to comply with that regulation."

### **Mandatory Provisions**

The policy or contract shall also be subject to the following provisions, whether included or not:

\_\_\_\_\_ (a) Cancellation: the policy or contract shall not be cancelable except upon at least 60 days written notice by registered or certified mail to the other party to the policy or contract and to the Commissioner;

\_\_\_\_\_ (b) Renewal: the policy or contract is automatically renewable at the expiration of the contract or policy period unless written notice of intent not to renew is given at least 60 days prior to such expiration by the party desiring to cancel or non-renew the policy or contract by registered or certified mail to the other party to the policy or contract and to the Commissioner;

\_\_\_\_\_ (c) Claim Handling: the excess carrier or reinsurer agrees to be subject to the claims handling standards of MGL chapters 152 and 176D and any rules or regulations promulgated thereunder.

\_\_\_\_\_ (d) Insolvency Clause: the bankruptcy or insolvency of the group will not relieve the excess insurer(s) or reinsurer(s) of their duties and liabilities under the policy.

\_\_\_\_\_ (e) Default by the Group: the excess carrier or reinsurer will, in the event of the default of the group, continue to provide information and services with respect to its obligations under the contract or policy to any service agent appointed by a receiver.

\_\_\_\_\_ (f) Intermediary Clause: if the reinsurance contract is negotiated through an intermediary all payments by the group to the intermediary shall be deemed to be payments to the reinsurer; provided, however, that all payments by the reinsurer to the intermediary shall be deemed to be payments to the group only to the extent that they are actually received by the group.

\_\_\_\_\_ (g) Offset Clause: the policy or contract may contain a provision permitting offset of any balances, whether on account, premiums, commissions, claims, losses, loss adjustment expenses, salvage, or any other amounts due from one party to the other under the agreement; provided, however, that in the event of liquidation or insolvency, the right of offset shall be limited to offset within the particular policy year or contract year.

\_\_\_\_\_ (h) Sunset Clauses are permitted only for approved financial reinsurance products referred to in 211 CMR 67.21(8). The excess policy or reinsurance contract shall be concurrent with the underlying workers' compensation certificates issued by the group. Clauses requiring the group to report all claims by a certain date and eliminating a reinsurer's or excess insurer's liability for claims not reported by that date, or clauses which force a commutation of losses as of a certain date are not permitted. All

reinsurance shall cover all claims arising during the term of the contract on an occurrence basis.

### **Limitations**

\_\_\_\_\_ Finite Risk or Financial Reinsurance is permitted only for that portion of the aggregate excess coverage specified in 211 CMR 67.21(3). Loss portfolio transfers, time and distance contracts and all other methods of transferring investment or timing risk alone are excluded.

### **211 CMR 67.11: New members; cancellation of members; insolvency or bankruptcy of members; changes in premium**

\_\_\_\_\_ Whenever, as the result of the addition of new members, including affiliates of existing members, the in-force premium of the group shall grow by more than ten percent, the board of trustees shall submit to the Commissioner a list of the new members or additional affiliates of existing members, along with payroll data, estimated annual premium, and an interim report of the total in-force premium of the entire group.

### **211 CMR 67.12: Merger of groups**

#### **General Requirements**

Subject to the prior written approval of the Commissioner, a group may merge with another group engaged in the same or similar type of business only if the resulting group assumes in full all obligations of the merging groups.

A public employer group may merge only with another public employer group.

The resulting group may be a continuing group under the name of one or more of the merged groups or a new group whose name shall be subject to the Commissioner's approval.

#### **Merger Agreement / Approval**

\_\_\_\_\_ Groups merging under 211 CMR 67.12 shall enter into a written agreement for such merger prescribing its terms and conditions. In all respects, the continuing group or the new group shall be subject to the provisions of 211 CMR 67.00.

Such agreement shall be:

\_\_\_\_\_ (a) assented to by a majority of the members and the Board of Trustees of each group;

\_\_\_\_\_ (b) executed in duplicate by a majority of the board of each group;

\_\_\_\_\_ (c) accompanied by copies of the resolutions authorizing the merger and the execution of the agreement attested by the recording officer of each group; and

\_\_\_\_\_ (d) submitted to the Commissioner, with the records of the companies pertaining thereto.

\_\_\_\_\_ (e) approved, in writing, by the Commissioner;

If it appears that the requirements of 211 CMR 67.12(1), and (2) have been complied with, the Commissioner may certify and approve the agreement by signing it.

**211 CMR 67.14: Provisions Regarding Deficiencies / Assessments**

Every group's Application and Indemnity Agreement shall contain provisions providing for the following:

\_\_\_\_\_ (a) in the event that a group incurs a fund deficit in any fund year, such deficit shall be made up immediately with surplus from a prior fund year or administrative funds, or the members of the group shall be subject to automatic assessment without further action by the group;

\_\_\_\_\_ (b) in the event a member fails to pay any premium, assessment, or other contribution to the group when due, the members of the group shall be subject to automatic assessment without further action by the group.

**211 CMR 67.16: Termination of certificate**

The certificate of approval issued by the Commissioner to a workers' compensation self-insurance group authorizes the group to provide workers' compensation coverage for members of the group. The certificate of approval remains in effect until terminated at the request of the group or revoked by the Commissioner pursuant to the provisions of 211 CMR 67.17.

The Commissioner shall grant the request of any group to terminate its certificate of approval provided the group has insured or reinsured all outstanding, both known and unknown, workers' compensation obligations with a licensed insurer under an agreement filed with and approved in writing by the Commissioner. Such obligations shall include both known and unknown claims and the expenses associated with the claim.