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Bulletin No. 97-07

To: **Commercial Insurers, Blue Cross and Blue Shield of Massachusetts, and HMOs**

From: **Ralph A. Iannaco, First Deputy Commissioner and Chief of Staff acting for Commissioner Linda Ruthardt**

Re: **Implementation of the Massachusetts Nongroup Health Insurance Law**

Date: **June 9, 1997**

Carriers that offer or renew individual health insurance, offer health benefit plans to qualified small businesses, or offer or renew conversion coverage, are advised to carefully review the contents of this bulletin.

On June 6, 1997, the Division of Insurance (Division) approved the recommendations of the Nongroup Health Insurance Advisory Board regarding the benefits and cost-sharing requirements of the standard guaranteed issue health plans that will be offered in Massachusetts in accordance with the Nongroup Health Insurance Law, M.G.L. c. 176M. This approval triggers a series of statutorily required steps toward the full implementation of that law.

This bulletin addresses the following topics:

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- The Massachusetts Nongroup Health Insurance Law
- Guaranteed Issue Health Plans
- Enrollment Times for Guaranteed Issue Health Plans
- Establishment of Distinct Regions for Purpose of Area Rate Adjustments
- Filings of Rates and Forms and Division Review
- Upcoming Implementation Steps by the Division

Questions regarding this bulletin should be directed to Kevin Beagan, Director of the Health Unit of the Division's State Rating Bureau at (617) 521-7347 or may be sent to him at the Division of Insurance, 470 Atlantic Avenue, Boston, MA 02210-2223 (faxes may be sent to (617) 521-7771).

- **Introduction**

The Nongroup Health Insurance Law, M.G.L. c. 176M (Chapter 176M) (created by St. 1996, c. 297, § 29) became effective on August 15, 1996. Chapter 467 of the Acts of 1996, enacted on January 9, 1997, amended certain provisions of Chapter 176M. The purpose of this bulletin is to provide carriers with updated information regarding the implementation of Chapter 176M.

The Division has been working toward the orderly implementation of Chapter 176M since its enactment. The Division has issued two bulletins addressing Chapter 176M: Bulletin Nos. 96-12 and 96-13. On April 1, 1997, the Commonwealth of Massachusetts provided the federal Health Care Financing Administration (HCFA) with information regarding the Commonwealth's intent to implement an alternative mechanism in the Massachusetts nongroup market under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Additionally, the standard guaranteed issue health plans were approved on June 6, 1997, in accordance with the process outlined in Chapter 176M, § 2. This approval triggers the next statutorily required steps in the process of making guaranteed issue health plans available in the nongroup market. The initial open enrollment period for guaranteed issue health plans is therefore being postponed from the June 1, 1997 starting date and is scheduled to commence on October 1, 1997, as discussed in more detail below.

This bulletin provides information regarding HIPAA and an overview of Chapter 176M, as well as specific information regarding guaranteed issue health plans, enrollment times for guaranteed issue health plans, the establishment of distinct areas for the purpose of the area rate adjustments, requirements for carrier filings to the Division, Division review of filings, and upcoming implementation steps by the Division. This bulletin contains only a summary of certain Chapter 176M provisions. Carriers should refer to Chapter 176M, as well as HIPAA, for all specific statutory provisions.

- **The Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

As noted above, the Commonwealth has informed HCFA of its intent to implement an alternative mechanism by January 1, 1998 in accordance with the provisions of HIPAA and provided information regarding the mechanism to that agency. A copy of the Commonwealth's alternative mechanism submission to HCFA may be obtained at a cost of $25.00 per copy (.20 per page) by contacting the Health Unit of the State Rating Bureau at the Division at (617) 521-7349.

Please note that the Commonwealth has proposed certain changes to Chapter 176M within the submission to HCFA in order to comply with the HIPAA requirements for an

alternative mechanism. This bulletin highlights some areas where changes have been proposed. The Division is also currently reviewing how other HIPAA requirements will affect Chapter 176M. Chapter 176M may require amendments to meet the alternative mechanism requirements in addition to those already proposed by the Commonwealth or to meet other HIPAA requirements not related to the alternative mechanism.

To date, the Commonwealth has received no response from HCFA regarding the Massachusetts alternative mechanism. If the Commonwealth receives no response from HCFA by the end of the 90-day HCFA review period, it may be presumed that the Commonwealth's alternative mechanism is acceptable as outlined by the Commonwealth in its April 1, 1997 submission. However, HCFA may request additional information or initiate discussions with the Commonwealth before the 90-day review period is completed, in which case that review period may be suspended by HCFA. As outlined in HIPAA, if HCFA makes a final determination that the Commonwealth does not have an acceptable alternative mechanism or is not implementing an acceptable alternative mechanism, then the federal default provisions regarding guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage will apply as of the date specified by HCFA, in addition to Chapter 176M.

The Division intends to provide additional bulletins as all issues related to HIPAA are clarified.

- **The Massachusetts Nongroup Health Insurance Law**

The Massachusetts Nongroup Health Insurance Law, Chapter 176M, creates new nongroup health insurance products referred to as "guaranteed issue health plans." There are three types of guaranteed issue health plans: the guaranteed issue medical plan, the guaranteed issue managed care plan and the guaranteed issue preferred provider plan. Please note that the term "guaranteed issue health plan" in Chapter 176M refers to both standard guaranteed issue health plans and enhanced guaranteed issue health plans, which may be sold by carriers in accordance with Chapter 176M. Guaranteed issue health plans are discussed in more detail below.

As discussed in Bulletin No. 96-12, as of the first day of the first open enrollment period for the guaranteed issue health plans, carriers in the nongroup health insurance market in Massachusetts will offer a guaranteed issue health plan in accordance with the provisions of Chapter 176M. As of that day, no types of nongroup health plans, as defined in Chapter 176M, may be sold except the guaranteed issue health plans. All other nongroup plans in effect on that day will be considered to be closed plans, as defined by Chapter 176M.

Please note that the current definition for "health plan" in Chapter 176M, which is incorporated into the definition for "nongroup health plan," appears to need amendment to conform with HIPAA requirements, and the Commonwealth has proposed changes in that regard in the Commonwealth's alternative mechanism submission to HCFA. Please also note that on

June 6, 1997, the Governor signed into law House Bill 4384. Section 115 of that bill amends the definition of "health plan" in Chapter 176M to make clear that "disability income insurance" is excluded from that term, as was the case in the original definition of "health plan" in Chapter 176M.

Conversion nongroup health plans, as defined in Chapter 176M, are subject to the requirements of Chapter 176M, except that the offer, sale, renewal or delivery of a conversion nongroup health plan does not, in and of itself, obligate the carrier to otherwise offer, sell, issue, renew or deliver a nongroup health plan, including a guaranteed issue health plan, to any person to whom the carrier does not have such an obligation pursuant to a group policy, contract or agreement with an employer or through a trust or association.

The purchasers of the guaranteed issue health plans are eligible individuals and eligible dependents, also, as defined in Chapter 176M. Please note that the Commonwealth has proposed amendments to the definition for "eligible individual" in order to conform with HIPAA requirements for an alternative mechanism. Provisions in Chapter 176M regarding when an application can be made for coverage under a guaranteed issue health plan are discussed in more detail below.

In accordance with Chapter 176M, § 3(a), no carrier may "exclude any eligible individual or eligible dependent on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage, or medical condition of such person, nor impose any pre-existing condition provision or waiting period in any guaranteed issue health plan." Again, please note that the Commonwealth has proposed amendments to that provision in order to conform with HIPAA requirements for an alternative mechanism. However, it should be noted that carriers may not, at any time that a guaranteed issue health plan is offered or sold, medically underwrite to determine eligibility for a guaranteed issue health or impose any pre-existing condition exclusion or waiting period on a guaranteed issue health plan, in accordance with the provisions of Chapter 176M.

Section 4 of Chapter 176M addresses premium rates charged for guaranteed issue health plans. Under Chapter 176M, § 4(a), each carrier must establish a base premium rate for each rate basis type within each guaranteed issue health plan. The premium charged for each guaranteed issue health plan is limited to the base premium rate multiplied by an age rate adjustment and/or an area rate adjustment, if elected by the carrier. The Division will also permit actuarially sound adjustments based upon premium payment mode. A carrier may not, at any time, adjust the base premium rate charged for a guaranteed issue health plan based on any other factor, including the health status of an individual who is purchasing a guaranteed issue health plan. The distinct regions for the purpose of the area rate adjustments are established separately below.

Section 5 of Chapter 176M addresses rate filings and the rate review process. These provisions are discussed in more detail below.

Please note that § 3(d) of Chapter 176M contains provisions regarding rates for closed plans that reference §§ 4 and 5. In particular, § 3(d) states the following:

> A carrier shall file its rates for a closed plan in accordance with subsection (a) of section 5. A closed plan shall not otherwise be subject to the requirements of section 5. A closed plan shall not be subject to the requirements of section 4. No carrier shall, during the allowable renewal period for a closed plan, add any new rating factor to the rating methodology which was applicable to its closed plan as of August fifteenth, nineteen hundred and ninety-six.

Therefore, a carrier with closed plans will be required to provide nongroup rate filings for its closed plans within seventy-five days of the approval of the standard guaranteed issue health plans, as discussed in more detail below.

Chapter 176M, § 6 establishes a nonprofit entity to be known as the Massachusetts Nongroup Health Reinsurance Plan subject to the agreement to participate by five or more carriers. To date, the Division is not aware of any such agreement to participate by five or more carriers.

As the Division noted in Bulletin No. 96-12, small group carriers are affected by Chapter 176M. Under § 2(b)(1) of Chapter 176M, as a condition of doing business in Massachusetts, a carrier that offers health benefit plans to qualified small businesses (as defined by the Small Group Health Insurance Law, M.G.L. c. 176J) must participate in the nongroup health insurance market. This requirement is fulfilled by the carrier's offering of a guaranteed issue health plan to eligible individuals in accordance with the provisions of Chapter 176M. A carrier is exempt from the requirement to participate in the nongroup market "if, as of the close of the preceding calendar year, the combined total of eligible employees and eligible dependents, as defined by [the Small Group Health Insurance Law], enrolled in health benefit plans offered by [the carrier] to qualified small businesses does not exceed 5000 individuals." The definition for the term "carrier" in the Nongroup Law states that "carriers that are affiliated companies shall be treated as one carrier; provided, however, that a carrier shall offer a guaranteed issue health plan in every geographic area served by one or more of its affiliates." The Division is individually contacting those carriers that appear to be required to participate in the nongroup market under Chapter 176M.

Finally, carriers (especially those that are not currently selling in the nongroup market) do not need to establish or keep the administration of the guaranteed issue health plans totally within their own organizations in order to comply with Chapter 176M. Carriers may rely upon a "private label/front" mechanism administered by another licensed insurer and/or a third party administrator (referred to generally as administrator below) under the following circumstances. First, the carrier responsible for compliance with Chapter 176M must certify in its rate filing that it will take full responsibility for compliance including, but not limited to, market conduct. Please note that any "private label/front" mechanism must be implemented in a manner so as to not discourage consumers from buying and/or using guaranteed issue health plans. Also, the

carrier responsible for complying with Chapter 176M may contract with the administrator for indemnification of the carrier by the administrator *if* the consumer will not have to rely on the indemnification but has recourse against the carrier regardless of whether any indemnification agreement is honored by the carrier's administrator. Second, the carrier responsible for complying with Chapter 176M must also certify in its rate filing that risk of loss on the guaranteed issue health plan business will not be transferred to the administrator; this would not preclude the carrier from arranging to reinsure its guaranteed issue health plan business.

- **Guaranteed Issue Health Plans**

As noted above, under Chapter 176M, there are three types of guaranteed issue health plans: the guaranteed issue medical plan, the guaranteed issue preferred provider plan and the guaranteed issue managed care plan. Chapter 176M, § 2 specifies which type of carrier may sell which type of plan, and specifies that some types of carriers are allowed to offer both a guaranteed issue medical plan and a guaranteed issue preferred provider plan.

Guaranteed issue health plans may either have the benefit and cost-sharing components of the standard guaranteed issue health plans or may be enhanced guaranteed issue health benefit plans. Enhanced guaranteed issue health plans have additional benefits or lower cost-sharing requirements than the standard plans. Therefore, if the statutory requirements are met, a carrier may offer an enhanced guaranteed issue health plan in lieu of a standard guaranteed issue health plan.

Under Chapter 176M, § 2, the Nongroup Health Insurance Advisory Board (Board) is given the responsibility to develop the benefit and cost-sharing requirements of the standard guaranteed issue health plans. These recommendations must be approved by the Commissioner. The Board first met in February 1997. Recommendations regarding the standard guaranteed issue health plans were submitted by the Board to the Division on May 7, 1997. The Division held informational hearings across the state regarding the recommendations during the week of May 12, 1997. Following the hearings, the Board's recommendations were disapproved as outlined in a letter to the Board dated May 20, 1997. The Board submitted amendments to its original recommendations on May 22, 1997. The amended recommendations were disapproved as outlined in a letter to the Board dated June 2, 1997. On June 6, 1997, the Board submitted a new version of its recommendations, and these new recommendations have been approved. The approval letter and the approved recommendations (including the standard benefits) are attached to this bulletin. Please note that the approved recommendations address usual and customary charges in the guaranteed issue medical plan and the guaranteed issue preferred provider plan.

- **Enrollment Times for Guaranteed Issue Health Plans**

Chapter 176M, § 3(b) generally provides for four types of enrollment times for guaranteed issue health plans: the initial open enrollment period, subsequent annual open

enrollment periods, required enrollment outside of open enrollment periods, and permissive enrollment outside of open enrollment periods.

Chapter 176M, § 3(b) provides for an initial two-month open enrollment period for the guaranteed issue health plans commencing on June 1, 1997 and ending July 31, 1997 with coverage to be effective September 1, 1997. That section also gives the Commissioner the authority to postpone that initial open enrollment period and effective date of coverage "should a substantial number of carriers, due to substantial administrative delay, be unable to enroll eligible individuals into" the guaranteed issue health plans at that time. Due to delays in implementation, the initial open enrollment period will be postponed and is scheduled to commence on **October 1, 1997 and extend through November 30, 1997 with coverage to become effective January 1, 1998**. However, if a substantial number of carriers, due to substantial administrative delay, will be unable to enroll eligible individuals into the guaranteed issue health plans starting on October 1, the initial open enrollment period may be rescheduled to a date beyond October 1. Carriers will be notified of any such rescheduling.

Please note that Chapter 176M, § 3(b) provides that any small group carrier that is required to participate in the nongroup market and is unable to enroll eligible individuals into a guaranteed issue health plan during the initial open enrollment period "may be subject to a fine of one thousand dollars for every day in which it is unable to enroll" and any other penalties available under Chapter 176M or other applicable law.

In subsequent years, the annual open enrollment periods will be held between the dates of September 1 and October 31 with coverage to become effective on the following December 1, as required in Chapter 176M, § 3(b).

Chapter 176M, § 3(b)(1) provides other circumstances under which a carrier must enroll eligible individuals and eligible dependents outside of the initial and annual open enrollment periods. Again, please note that it appears that amendments to this provision may be required to conform with HIPAA requirements, and the Commonwealth has made proposed amendments in its alternative mechanism submission to HCFA.

Chapter 176M, § 3(b)(2) states that a carrier may enroll eligible individuals and eligible dependents outside of an open enrollment period, "provided however, that the terms and conditions that apply outside of the open enrollment period are identical to the terms and conditions that apply during the open enrollment period." Therefore, if a carrier chooses to offer guaranteed issue health plans outside of the enrollment times described above, all the provisions of Chapter 176M apply to that coverage, including but not limited to a prohibition on medical underwriting in determining eligibility, the prohibition on preexisting condition exclusions, the prohibition on waiting periods, and the premium rate requirements of §§ 4 and 5.

Finally, Chapter 176M, § 3(d) states that a carrier must permit "a subscriber of a closed plan to enroll in a guaranteed issue health plan at any time during the allowable three year

renewal period" described in that section. Please note that a carrier must accept a subscriber of any carrier's closed plans, not just that carrier's closed plans, if any.

- **Establishment of Distinct Regions for Purpose of the Area Rate Adjustments**

Chapter 176M, § 4(3) states that the Commissioner "shall annually establish not fewer than five distinct regions of the state for the purpose of area rate adjustments." The following distinct regions of Massachusetts are hereby established for the purpose of the area rate adjustments:

> The permissible regions are based on the following zip code groupings which refer to the first three digits of the zip code for each eligible individual or eligible dependent:
>
> a. 010 through 013
> b. 014 through 016
> c. 017 and 020
> d. 018 through 019
> e. 021 through 022
> f. 023 through 024 and 027
> g. 025 through 026
>
> except that a carrier may combine the zip code groupings outlined in c. and d. into one region or combine the zip code groupings outlined in c., d. and e. into one region for all of its guaranteed issue health plans subject to Chapter 176M or use regions based on groupings for counties that roughly approximate the zip code groupings.

Please note that these regions are the same as those found in the Small Group Health Insurance regulation at 211 CMR 66.08(2)(b).

- **Filings of Rates and Forms and Division Review**

In order to fulfill the filing requirements under Chapter 176M, § 5(a), a carrier offering a guaranteed issue health plan or a carrier with a closed plan must submit the following to the Health Unit of the State Rating Bureau, 470 Atlantic Avenue, Boston, MA 02210-2223:

- Three copies of each plan's policy or certificate of coverage, specifying coverage for all the benefits and meeting all other provisions found in applicable statutes and regulations (benefits in guaranteed issue health plans must be consistent with the provisions of Chapter 176M and carriers offering those plans should include any other provision which is required under the carrier's licensing statute and which is not inconsistent with Chapter 176M).

- Eleven copies of each nongroup rate filing and one copy on a 3.5" floppy disk readable in IBM format, ASCII only.
- Applicable form and rate filing fees.

This submission will meet the requirement that carriers provide a copy of their nongroup rate filings to the Nongroup Health Insurance Advisory Board. The Division will forward the necessary copies to the Board, which is within the Executive Office for Administration and Finance.

Nongroup rate filings must contain at least the following information required by Chapter 176M, § 5(a)(2). **Unless otherwise specified, the items below apply to both guaranteed issue health plans and closed plans.**

1. A list and definition of each *rate basis type*[a] which the carrier has established for each plan.
2. The *base premium rate*[b] to be charged for each rate basis type for each plan.
3. The adjustments to be applied to each rate basis type's base premium rate for each plan based upon age, geographic area or payment mode. For each plan, the filing shall contain:

   a) a list and definition of each age band for which adjustments will be made for each rate basis type;
   b) a list of each geographic area on which adjustments shall be based for each rate basis type; and
   c) a list and description of each payment mode for which adjustments will be made for each rate basis type.

   For each closed plan, the filing shall also contain a list and definition of any other underwriting adjustments to be charged within each rate basis type.
4. A complete set of proposed rate schedules for each plan, showing proposed rates applicable to each potential insured based upon age band, geographic area and payment mode. For each closed plan, the rate schedules shall also include proposed rates applicable to each insured based upon any other underwriting adjustments.
5. The *composite rate*[c] for each guaranteed issue health plan, including a specific explanation and all calculations, of the method by which the composite rate was determined, including all

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[a] A "rate basis type" is defined in Chapter 176M as each category of individual or family composition for which separate rates are charged for a guaranteed issue health plan as determined by the carrier.

[b] The "base premium rate" is defined in Chapter 176M as the midpoint rate within a "modified community rate" band for each rate basis type of each guaranteed issue health plan of a carrier. A "modified community rate" is defined as a rate resulting from a rating methodology in which the premium for all persons within the same rate basis type who are covered under a guaranteed issue health plan is the same without regard to health status; provided, however, that premiums may vary due to age or geographic area for each rate basis type as permitted by Chapter 176M.

[c] The "composite rate" is defined in Chapter 176M as the average per member per month premium rate for each type of guaranteed issue plan.

figures used for the actual or estimated distribution among age, geographic area and payment mode for each rate basis type.

6. A list and description of each enhanced benefit included in each enhanced guaranteed issue health plan.

7. The *adjusted composite rate*[d] for each guaranteed issue health plan, and documentation reasonably necessary to substantiate the adjustments made, including:

   a) a specific explanation and all calculations of the method by which the adjusted composite rate was determined;

   b) a list of all adjustments based upon age, geographic area, payment mode, and enhanced benefit;

   c) explanation of the actuarial value and actuarial basis for adjustments made for each age band, geographic area, payment mode, and enhanced benefit; and

   d) an explanation of any different treatment of adjustments for age, geographic area or payment mode in determining the composite rate and the adjusted composite rate.

8. For carriers that base payments on usual and customary charges for noncontracting providers for guaranteed issue medical plans and the out-of-network portion of guaranteed issue preferred provider plans, a specific explanation of the method for developing any "usual and customary" (U&C) charges and a memorandum signed by an actuary certifying that the methodology results in usual and customary charges that are, in the aggregate, at least comparable to, and not lower than, the 80th percentile of charges based on Health Insurance Association of America (HIAA) data that are no older than eighteen months.

9. A memorandum signed by an actuary certifying that the rates for each guaranteed issue health plan have been developed in accordance with Chapter 176M, § 4, including the rate bands and multipliers specified therein and that the proposed rates are reasonable in relation to the benefits provided, including a explanation of the basis for the actuarial opinion, with consideration of the actuarial basis for each age, area, payment mode and benefit level adjustment in light of the value of benefits and the effects on utilization.

10. A memorandum signed by an actuary certifying that the rates for each closed plan have been developed in accordance with Chapter 176M, § 3(d) in that no new rating factor has been added to the rating methodology which was applicable to the closed plan as of August 15, 1996.

11. For each plan, the actual loss ratio for the previous year and the projected loss ratios for the present year and the year for which the rate is being filed. Loss ratio is defined as the ratio of the incurred costs of hospital, medical, or health care services for the relevant period to the premium earned for that same period.

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[d] The "adjusted composite rate" is defined in Chapter 176M as the composite rate for each guaranteed issue health plan issued by a carrier adjusted in a consistent manner to be prescribed by the Commissioner by regulation to account for differences in premiums between carriers that are the result of (i) geographic differences in the cost of health care, (ii) the average age of eligible individuals enrolled in a carrier's guaranteed issue health plan, and (iii) differences in benefit levels as permitted by Chapter 176M.

12. A comparison of current and proposed rates for each guaranteed issue health plan which shows premium cost components, including but not limited to expenses, hospital inpatient costs, outpatient costs, the cost of prescription drugs administered on an outpatient basis, and the cost of other medical services, each stated as a percentage of premium.
13. A copy of the carrier's most recent annual report.
14. **For the filing in calendar year 1997 only**, the total number of insureds, the total number of policies issued, the total number of policies issued within each rate basis type, and the rates charged for each closed plan offered by the carrier as of August 15, 1996.
15. For carriers that are relying on a "private label/front" mechanism for guaranteed issue health plans, a certification by an officer of the carrier that (1) the carrier takes full responsibility for compliance with Chapter 176M, including but not limited to, market conduct and (2) the carrier is not transferring the risk to the administrator of the "private label/front" mechanism.

Nongroup rate filings for closed plans must comply with items 1, 2, 3, 4, 10, 11, 13 and 14 above. Additionally, these rate filings must be consistent with the provisions of the rate and filing requirements of the carrier's licensing statutes which are not inconsistent with Chapter 176M.

In accordance with Chapter 176M, § 5(a), carriers are required to provide to the Division policy forms and rate filings for all guaranteed issue health plans and all closed plans no later than August 20, 1997 (75 days after the Commissioner's approval of the standard guaranteed issue health plans). Failure to provide the Division with the required nongroup rate filings by that date may subject a carrier to the fines and penalties allowed under M.G.L. c. 176D (entitled Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance) and any other applicable law.

Review of the nongroup rate filings for guaranteed issue health plans by the Division will proceed in accordance with the following schedule established by Chapter 176M. In accordance with the provisions of Chapter 176M, § 5(c), no later than October 4, 1997 (45 days after the carrier form and rate filing deadline of August 20, 1997), the Commissioner is required to notify any carrier if its filing is subject to further review. A carrier's filing will be subject to further review if the Commissioner, after determining the average adjusted composite rate for each type of guaranteed issue health plan, determines that the adjusted composite rate filed by that carrier exceeds the average adjusted composite rate for that type of guaranteed issue health plan by more than two standard deviations. However, the Division intends to provide this notice to carriers by September 19, 1997 if carriers meet the filing deadline of August 20 so that the Commissioner is able to proceed to determine the average adjusted composite rate for each type of guaranteed issue health plan. If a carrier does not receive a notice that the carrier's filing is subject to further review by September 19, 1997, it may implement the filed rates beginning October 1, 1997, unless the carrier is otherwise notified that the Commissioner will not be able to make a determination by September 19 and/or the initial open enrollment period is rescheduled to start later than October 1, as discussed earlier in the bulletin.

Review of the nongroup filings for closed plans by the Division will proceed in accordance with the applicable provisions of the carrier's licensing statutes.

Please note that Chapter 176M, § 5(a)(1) states that after the initial process in 1997, filings must be made "no later than May first of each year thereafter...." Therefore, the next time that a rate filing is required for carriers in the nongroup market, including those with closed plans, will be May 1, 1998.

- **Upcoming Implementation Steps By the Division**

The Division will promulgate an emergency regulation regarding the contents and review of nongroup filings in the next few weeks. The Division will also update carriers regarding HCFA's review of the Massachusetts alternative mechanism and clarification of HIPAA related issues as appropriate, as well as any other issues that arise regarding the implementation of Chapter 176M. The Division also intends to develop, with the advice of the Nongroup Health Insurance Advisory Board, a guide for consumers explaining more about the new guaranteed issue health plans and Chapter 176M.

Questions regarding this bulletin should be directed to Kevin Beagan, Director of the Health Unit of the Division's State Rating Bureau at (617) 521-7347 or may be sent to him at the Division of Insurance, 470 Atlantic Avenue, Boston, MA 02210-2223 (faxes may be sent to (617) 521-7771).

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LIEUTENANT GOVERNOR

LINDA RUTHARDT
COMMISSIONER

June 6, 1997

Nongroup Health Insurance Advisory Board
within the Executive Office for Administration and Finance

Dear Members of the Board:

As you know, the Nongroup Health Insurance Advisory Board (Board) provided its recommendations to me by letter dated May 6, 1997 "relative to the benefits to be provided by, and the cost sharing requirements of, the standard guaranteed issue health plans" in accordance with the provisions of the Nongroup Health Insurance Law, M.G.L. c. 176M (Chapter 176M). Public informational hearings were held regarding these recommendations on May 12, 13, 15 and 16 in Boston, Springfield, Worcester and New Bedford, respectively. By letter dated May 20, 1997, I disapproved the Board's recommendations and asked the Board to carefully consider and study the issues outlined in that letter with the contractors hired to assist the Board in making its recommendations.

By letter dated May 22, 1997 from the Chairperson of the Board, Nancy Turnbull, acting on behalf of the Board, the Division received amendments to the Board's recommendations of May 6. In her letter, Ms. Turnbull asked that Division staff amend Tables 1 through 5, which were part of the May 6 recommendations, so that the tables would be consistent with her letter.

The following day, Kevin Beagan, Director of the Health Unit of the State Rating Bureau, made revisions to Tables 1 through 5 in accordance with Ms. Turnbull's letter, as well as a small number of additional amendments to clarify the tables. By letter dated May 23, 1997, Mr. Beagan requested that each Board member review the revisions to the tables. In particular, each Board member was to provide his or her signature if he or she affirmatively agreed that:

1. Ms. Turnbull's letter of May 22, 1997 reflected the actions and votes taken by the Board on May 22, 1997 regarding the Board's revised recommendations; and
2. the revised Tables 1 through 5 enclosed with Mr. Beagan's letter conformed to the action and votes taken by the Board on May 22, 1997, as well as on May 6, 1997 (with the exception of the Chiropractic Services benefit and the other changes outlined in Mr. Beagan's letter, in which case a signature by the Board member indicated an affirmative approval by the Board member of the "Chiropractor Services" benefit as outlined in the revised Table 1, as well as an affirmative approval of the other changes which Mr. Beagan made to the revised tables as outlined in his letter).

As of June 2, 1997, the Division had not received any written response to Mr. Beagan's letter from any official Board member who participated in the voting regarding the original recommendations or revised recommendations. However, certain Board members had informally told Mr. Beagan that they did not agree that Ms. Turnbull's letter reflected the Board's decision regarding cost sharing for blood glucose monitoring material, and one Board member suggested additional changes to the tables for other benefits.

Additionally, in its original May 6 recommendations, the Board provided recommendations regarding the practice of basing payment for covered services on "usual and customary" (U & C) or "usual, customary and reasonable" charges. In particular, the Board recommended that the Division "require nongroup carriers to use the same methodology for developing U & C charges for their nongroup and small group lines of business" and that the Division "require carriers to provide information on the specific methodology they use to develop U & C charges in their nongroup rate filings with the Division, so that the Division and the Board can assess whether any additional action is needed." The May 20 disapproval letter requested that the Board review whether it had "any recommendations regarding carriers which are not operating in the small group market but are offering" a guaranteed issue health plan and "whether there are any ranges of U & C standards which the Board finds should not be used by plans." Ms. Turnbull's May 22 letter stated that the Board was not able "at the present time to make a recommendation" regarding "any ranges of U & C standards that should be used by plans, and believes that such a recommendation is not required for [the Commissioner] to approve the benefits and cost-sharing requirements."

By letter dated June 2, 1997, I disapproved the Board's recommendations as provided in the Board's May 6 letter and amended by Ms. Turnbull's May 22 letter. The June 2 disapproval letter requested the Board to review the benefit and cost sharing recommendations contained in the tables and finalize them for my review and develop new recommendations regarding the U & C issues.

Today, by letter dated June 6, 1997, the Board provided to me a new set of recommendations that incorporates all of its recommendations regarding the standard guaranteed issue health plans. Pursuant to the authority granted to me in Chapter 176M, section 2(c)(2), I hereby approve the Board's recommendations as submitted on June 6, 1997.

I would like to take this opportunity to thank each of you for all the work you have done on this difficult project. The Division is issuing a bulletin, which will be provided to the Board. to inform carriers about this approval and to provide information regarding the filing of policy forms and rate filings for guaranteed issue health plans for review by the Division. If you have any questions or would like to discuss the bulletin in more detail, please contact Kevin Beagan. Director of the Health Unit, State Rating Bureau, here at the Division at (617) 521-7347.

Very truly yours,

Linda Ruthardt
Commissioner

cc: Secretary Charles Baker, EOAF
Director Michael Duffy, OCA&BR
Joint Committee on Insurance

Nongroup Health Insurance Advisory Board
June 6, 1997

Linda Ruthardt
Commissioner
Division of Insurance
470 Atlantic Avenue
Boston, MA 02210-2223

Dear Commissioner Ruthardt:

The Nongroup Health Insurance Advisory Board ("the Board") is pleased to submit its revised recommendations for the benefits and cost-sharing requirements for guaranteed issue nongroup health plans, as required by M.G.L. c. 176M, s. 2 (c) (1) and 2 (c) (2). The revisions respond to the issues identified by the Division in the Board's previous recommendations. Table 1 provides a list of the benefits that the Board recommends be provided in the guaranteed issue medical, preferred provider and managed care plans . Tables 2-4 provide the recommended cost-sharing requirements for each of the three guaranteed issue plans. Table 5 gives the Board's recommendations for the specific benefit and cost sharing requirement issues raised by the Division in Kevin Beagan's April 23, 1997 letter.

As required by the nongroup statute, the recommendations have been approved by a majority of the members of the Board. The Board's consultant, Coopers & Lybrand, has reviewed the revised recommendations and provided a certification that each of the standard guaranteed issue plans is reasonably actuarially equivalent to the others. This certification is included as an attachment.

As you know, you have required as a condition for the approval of the benefits and cost-sharing requirements that the Board develop a recommendation regarding the methodology that carriers shall use to establish usual and customary charges for the medical and preferred plans. This recommendation is also attached.

We look forward to the Division's prompt approval of the recommendations.

Sincerely,

Phyllis Baron
Blue Cross Blue Shield of Massachusetts

Louis Bertonazzi
Executive Office of Health and Human Services

Carolyn Boyiard
National Federation of Independent Business

Shannon Kelly Linde
Massachusetts Business Association

Robert Restuccia
Health Care for All

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Coopers &Lybrand

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To the Nongroup Insurance Advisory Board
(formed according to Section 31 of Chapter 297 of the Acts of 1996)

I, Peter Matson, am a member of the American Academy of Actuaries and meet its qualification standards for providing actuarial opinions related to health care programs. I have reviewed the benefits provided and the cost-sharing requirements of the updated accompanying standard guaranteed issue managed care plan, guaranteed issue medical plan and guaranteed issue preferred provider plan as they relate to their actuarial equivalence and requirements as specified in Chapter 176M of the Acts of 1996.

The guaranteed issue health benefit plans are based upon the HMO prototype for small group plans under Chapter 176J modified to provide for a co-payment for outpatient benefits that is no greater than three-fifths of the co-payment applicable to the small group prototype. The standard plans also include at least the following medically necessary services: reasonably comprehensive physician services, inpatient and outpatient hospital services, emergency health services, the full range of effective clinical preventative care, and prescription drugs administered on an outpatient basis. For each thirty day supply of generic prescription drugs, the guaranteed issue health plans require a twenty dollar co-payment. For each thirty day supply of brand name prescription drugs, the guaranteed issue health plans require a twenty-five dollar co-payment. Any insured individual who incurs fifty co-payments for prescription drugs in a calendar year is not required to make any additional co-payments for prescription drugs in that calendar year.

My review for determination of actuarial equivalence between the respective plans utilized available and appropriate Massachusetts 1995 HMO cost and utilization data to establish base costs by benefit category. Statewide cost and utilization differences for HMO versus medical versus PPO benefits were based on an analysis of national employer data appropriately adjusted for Massachusetts differences based on Coopers & Lybrand's experience and our best judgment.

In my opinion, the updated accompanying standard guaranteed issue managed care plan, guaranteed issue medical plan, and guaranteed issue preferred provider plan provide for benefits and cost-sharing requirements which in all respects conform to meet the requirements of reasonable actuarial equivalence as specified in Chapter 176M of the Acts of 1996.

Peter G. Matson, F.S.A., M.A.A.A.

June 6, 1997
Date

lmh/cldata/smipro/docs/peter/nngrpad.sam

NONGROUP HEALTH INSURANCE ADVISORY BOARD

Table 1

Recommended Covered Benefits for Guaranteed Issue Medical Plan, Preferred Provider Plan and Managed Care Plan

Covered Services	Limitations
Inpatient admissions • General hospital • Rehabilitation hospital • Skilled nursing facility • Mental health • Substance abuse treatment facility Services including but not limited to: • Room and board (semi-private unless private room is medically necessary) • Physician services • Special care units • Anesthesia • Surgery • Lab tests, x-rays and other special/ancillary services • Inpatient drugs, medications and medical supplies	• Unlimited days • 60 days per calendar year • 100 days per calendar year • Unlimited days in general hospital 60 days in mental hospital • 30 days per calendar year (including detoxification and rehabilitation)
Ambulance services	When medically necessary
Ambulatory surgery	
Bone marrow transplants	In accordance with state mandate for women with metastatic breast cancer; coverage for other conditions subject to medical necessity
Cardiac rehabilitation	Same coverage as state mandated benefit
*Chiropractor services	-Medical and preferred provider plans: benefit as required by M.G.L. c. 175, §108D -Managed care plan: not required
Dental care	Hospital costs (not dental costs) must be covered as any other inpatient stay if hospitalization is medically necessary because of complicating medical condition
Diabetic testing materials	-Same coverage for blood glucose monitoring material as state mandated benefit -Glucometers covered as DME -Covered for insulin-dependent diabetics
Dialysis services (inpatient, outpatient and home dialysis)	
Durable medical equipment (including orthotics)	$1,500 per calendar year (but unlimited when provided as part of home health benefit)
Early intervention services	Same coverage as state mandated benefit: • $3,200 per calendar year • $9,600 per lifetime
Emergency room care	Cost-sharing waived if admitted
Home health care	Same coverage as state mandated benefit
Hospice services	Same coverage as state mandated benefit
Infertility services	Same coverage as state mandated benefit
Lab tests, x-rays and other tests	

*These benefits are different for different types of guaranteed issue health plans.

NONGROUP HEALTH INSURANCE ADVISORY BOARD

Table 1

Recommended Covered Benefits for Guaranteed Issue Medical Plan, Preferred Provider Plan and Managed Care Plan

Covered Services	Benefit Limits
Maternity care	-Same coverage as state mandated benefit -Includes prenatal and postnatal care and tests and routine nursery care -Maternity incentive programs permitted in accordance with state law
Medical care visits	
Medical formulas	Same coverage as state mandated benefits for: • Low protein food products • Nonprescription enteral formulas • Phenyl free foods/formulas per DPH
*Mental health/substance abuse visits	• Medical and preferred provider plans: -$500 per calendar year for mental health conditions and an additional $500 for alcoholism treatment • Managed care plan: -20 visits per year; differential copayments permitted
Oral surgery	May be limited to surgery for: reduction or dislocation or fracture of the jaw or facial bone; excision of tumor of the jaw; extraction of fully impacted wisdom teeth; extraction of fully or partially impacted third molars; orthognathic surgery needed to correct a significant functional impairment that cannot be adequately corrected with orthodontic services
Oxygen and respiration therapy	Includes coverage of equipment needed to administer oxygen
Podiatric care	Routine foot care not covered
Prescription drugs	Must also include off-label drugs used for cancer and HIV/AIDS in accordance with state mandated benefits
Preventive care • Pediatric and routine well child care (including related tests and immunizations) • Periodic adult exams (including related tests and immunizations) • Family planning • Routine gynecological exams • Routine mammograms • Routine blood tests to screen for lead poisoning • Routine hearing exams and tests • Routine vision exam	• Includes all state mandated benefits, and at least one exam per year for children over age six. • Once per calendar year • Same coverage as state mandated benefit • Same coverage as state mandated benefit • One exam every 24 months • One exam every 24 months
Prosthetic devices	$1,500 per calendar year
Radiation therapy and chemotherapy	

*These benefits are different for different types of guaranteed issue health plans.

Table 1

Recommended Covered Benefits for Guaranteed Issue Medical Plan, Preferred Provider Plan and Managed Care Plan

Covered Services	Benefit Limits
Rehabilitation therapy • Physical therapy • Speech/language therapy • Occupational therapy	Up to 60 visits for each unrelated illness or injury; plan may require significant improvement within 60 days of first visit. (In accordance with state mandate, benefit is unlimited when provided as part of home health benefit.)
Second and third surgical opinions	
Surgery (includes related anesthesia)	

*These benefits are different for different types of guaranteed issue health plans.

NONGROUP HEALTH INSURANCE ADVISORY BOARD

Table 2

Recommended Cost-Sharing for Guaranteed Issue Medical Plan

Benefit Features	Medical Plan
Deductible per calendar year	$700 per member $1,400 per family membership
Coinsurance Maximum per calendar year	$1,800 per member $3,600 per family membership
Lifetime Maximum	$1,000,000 per member
Covered Services	**Cost-sharing for insured**
Admissions for Inpatient Care:	
• General, Chronic Disease or Rehabilitation Hospital	20% coinsurance after deductible
• Skilled Nursing Facility	20% coinsurance after deductible
• Mental Hospital or Other Covered Substance Abuse Treatment Facility	20% coinsurance after deductible
Ambulance Services	20% coinsurance after deductible
Ambulatory Surgery	20% coinsurance after deductible
Cardiac Rehabilitation	20% coinsurance after deductible
Chiropractor Services	20% coinsurance after deductible
Dialysis Services	20% coinsurance after deductible
Durable Medical Equipment	20% coinsurance after deductible
Early Intervention Services	20% coinsurance after deductible
Emergency Care	20% coinsurance after deductible
Home Health Care	20% coinsurance after deductible
Hospice Services	20% coinsurance after deductible
Infertility Services	20% coinsurance after deductible
Lab Tests and X-Rays	20% coinsurance after deductible
Maternity Care	20% coinsurance after deductible
Medical Care	20% coinsurance after deductible
Medical Formulas	20% coinsurance after deductible
Mental Health and Substance Abuse Treatment	20% coinsurance after deductible
Oxygen (includes equipment for its administration)	20% coinsurance after deductible
Podiatric Care	20% coinsurance after deductible

NONGROUP HEALTH INSURANCE ADVISORY BOARD

Table 2

Recommended Cost-Sharing for Guaranteed Issue Medical Plan

Covered Services	Cost-sharing for insured
Prescription drugs (includes insulin and syringes and blood glucose monitoring materials) • Retail pharmacy up to a 30-day supply	Up to 50 copayments per insured per calendar year; then no further copayments $20 copayment per generic supply $25 copayment per brand name supply
Preventive Health Services	20% coinsurance after deductible
Prosthetic Devices	20% coinsurance after deductible
Radiation Therapy and Chemotherapy	20% coinsurance after deductible
Rehabilitation Therapy	20% coinsurance after deductible
Second and Third Surgical Opinions	20% coinsurance after deductible
Surgery (includes related anesthesia)	20% coinsurance after deductible

NONGROUP HEALTH INSURANCE ADVISORY BOARD

Table 3

Recommended Cost Sharing for Guaranteed Issue Managed Care Plan

Covered Services	Cost-sharing for insured**
Admissions for Inpatient Care:	
• General Hospital	$500 per admission*
• Chronic Disease or Rehabilitation Hospital or Skilled Nursing Facility	Nothing
• Mental Hospital or Other Covered Substance Abuse Treatment Facility	$500 per admission*
Ambulance Services	$15 per trip
Ambulatory Surgery	$300 per admission for outpatient day surgery*
Cardiac Rehabilitation	$15 per visit
Dialysis Services	Nothing
Durable Medical Equipment	Nothing
Early Intervention Services	$15 per visit
Emergency Care	$50 per visit; waived if admitted (any applicable inpatient copayment still applies)
Home Health Care	Nothing
Hospice Services	$15 per visit
Infertility Services	$300 per admission for outpatient day surgery* $15 per visit
Lab Tests and X-Rays	Nothing
Maternity Care	Nothing
Medical Care	$15 per office visit
Medical Formulas	Nothing
Mental Health and Substance Abuse Treatment	$15 per visit: Visits 1-10 $25 per visit: Visits 11-20
Oxygen (includes equipment for its administration)	Nothing
Prescription Drugs (Including insulin and syringes and blood glucose monitoring material)	Up to 50 copayments per member per calendar year; then no further copayments
• Retail Pharmacy up to a 30-day supply	$20 copayment per generic supply $25 copayment per brand name supply
Preventive Health Services	$15 per visit

*Copayment for inpatient admission followed by outpatient day surgery or additional inpatient care (or for outpatient day surgery followed by inpatient care) within 30 days for the same or related illness will not total more than $500.

**Out-of-pocket maximum of $2,000 per member and $4,000 per family per calendar year applies only to copayments for: inpatient admissions, emergency room care and day surgery.

NONGROUP HEALTH INSURANCE ADVISORY BOARD

Table 3

Recommended Cost Sharing for Guaranteed Issue Managed Care Plan

Covered Services	Cost-sharing for insured**
Prosthetic Devices	Nothing
Radiation Therapy and Chemotherapy	$15 per visit
Rehabilitation Therapy	$15 per visit
Second and Third Surgical Opinions	$15 per visit
Surgery (includes related anesthesia)	$300 per admission for outpatient day surgery* $15 per visit

*Copayment for inpatient admission followed by outpatient day surgery or additional inpatient care (or for outpatient day surgery followed by inpatient care) within 30 days for the same or related illness will not total more than $500.

**Out-of-pocket maximum of $2,000 per member and $4,000 per family per calendar year applies only to copayments for: inpatient admissions, emergency room care and day surgery.

NONGROUP HEALTH INSURANCE ADVISORY BOARD

Table 4

Recommended Cost Sharing for Guaranteed Issue Preferred Provider Plan

Benefit Features	In-Network Benefits	Out-of-Network Benefits
Deductible per calendar year for In-Network Benefits and Out-of-Network Benefits combined	$250 per member $500 per family membership	
Coinsurance Maximum per calendar year	$2,250 per member $4,500 family membership	$4,500 per member $9,000 per family membership
Lifetime Maximum	$1,000,000 per member	$1,000,000 per member
Covered Services	**In-Network Cost sharing***	**Out-of-network Cost sharing***
Admissions in a:		
• General Hospital	10% coinsurance after deductible	30% coinsurance after deductible
• Rehabilitation Hospital	10% coinsurance after deductible	30% coinsurance after deductible
• Chronic Disease Hospital	10% coinsurance after deductible	30% coinsurance after deductible
• Skilled Nursing Facility	10% coinsurance after deductible	30% coinsurance after deductible
• Mental Hospital or Other Covered Substance Abuse Treatment Facility	10% coinsurance after deductible	30% coinsurance after deductible
Ambulance Services	10% coinsurance after deductible	30% coinsurance after deductible
Ambulatory Surgery	10% coinsurance after deductible	30% coinsurance after deductible
Cardiac Rehabilitation	10% coinsurance after deductible	30% coinsurance after deductible
Chiropractor Services		
• First accident treatment within 3 calendar days*	10% coinsurance	10% coinsurance
• Lab tests and x-rays	10% coinsurance after deductible	30% coinsurance after deductible
• Medical care services	10% coinsurance after deductible	30% coinsurance after deductible
Dialysis Services	10% coinsurance after deductible	30% coinsurance after deductible
Durable Medical Equipment	10% coinsurance after deductible	30% coinsurance after deductible
Early Intervention Services	10% coinsurance after deductible	30% coinsurance after deductible
Emergency Care*	10% coinsurance (deductible does not apply)	10% coinsurance (deductible does not apply)
Home Health Care	10% coinsurance after deductible	30% coinsurance after deductible
Hospice Services	10% coinsurance after deductible	30% coinsurance after deductible
Infertility Treatment	10% coinsurance after deductible	30% coinsurance after deductible
Lab Tests, X-Rays and Other Tests	10% coinsurance after deductible	30% coinsurance after deductible
Maternity Care	10% coinsurance after deductible	30% coinsurance after deductible
Medical Care Outpatient Visits (includes clinic, office and home visits)	10% coinsurance after deductible	30% coinsurance after deductible
Covered Services	**In-Network Benefits Cost-sharing for insured ***	**Out-of-Network Benefits Cost-sharing for insured ***
Medical Formulas	10% coinsurance after deductible	30% coinsurance after deductible
Mental Health and Substance Abuse Outpatient Treatment	10% coinsurance after deductible	30% coinsurance after deductible

*Emergency services required to be covered at same level in-network and out-of-network, in accordance with G.L. c. 176I.

NONGROUP HEALTH INSURANCE ADVISORY BOARD

Table 4

Recommended Cost Sharing for Guaranteed Issue Preferred Provider Plan

Oxygen (includes equipment for its administration)	10% coinsurance after deductible	30% coinsurance after deductible
Podiatirc Care	10% coinsurance after deductible	30% coinsurance after deductible
Prescription Drugs (includes insulin and syringes and blood glucose monitoring materials)	Up to 50 copayments per member per calendar year; then no further copayments	
• Retail Pharmacy up to 30- day supply	$20 copayment per generic supply $25 copayment per brand name supply	$20 copayment per generic supply $25 copayment per brand name supply
Preventive Health Services	10% coinsurance after deductible	30% coinsurance after deductible
Prosthetic Devices	10% coinsurance after deductible	30% coinsurance after deductible
Radiation Therapy and Chemotherapy	10% coinsurance after deductible	30% coinsurance after deductible
Rehabilitation Therapy	10% coinsurance after deductible	30% coinsuranee after deductible
Second and Third Surgical Opinions	10% coinsurance after deductible	30% coinsurance after deductible
Surgery (includes related anesthesia)	10% coinsurance after deductible	30% coinsurance after deductible

*Emergency services required to be covered at same level in-network and out-of-network, in accordance with G.L. c. 176I.

Nongroup Health Insurance Advisory Board

TABLE 5

Recommendations in Response to Specific Benefit Questions Raised in Division of Insurance Letter Dated April 22, 1997

Service	Advisory Board Recommendation
Air ambulance	Required if medically necessary
Ambulance in non-emergency	Ambulance covered when medically necessary
Acupuncture	Not required
Holistic treatments	Not required
Alternative medicine	Not required
Experimental treatments	Coverage subject to medical necessity, except as otherwise provided by state law (e.g., bone marrow transplants for metastatic breast cancer and for off-label use of drugs for cancer and HIV/AIDS)
Tempomandibular Joint Disorders	Not required
Routine Podiatric Care	Not required
Chiropractic care	Required when otherwise mandated for carrier
Treatments by family members	Not required
Dental care	Not required except as outlined in Table 1.
Inpatient stays due to dental condition	If medically necessary because of complicating medical condition; dental services are not required to be covered
Vision care	See Table 1 for required benefit.
Alcoholism rehabilitation treatment	Yes--see Table 1.
Substance abuse treatment	Yes--see Table 1.
Ambulatory surgery	Yes--see Table 1.
Lithotripsy	Yes, when medically appropriate
Dialysis treatments	Yes--see Table 1.
Radiation treatments, including MRIs, CT scans and fluoroscopes	Yes, when medically appropriate
Human organ transplants	Yes, when medically necessary, unless otherwise required by state mandated benefit laws; experimental transplants only when required by state mandated benefit laws
Cosmetic surgery	Only for restorative or reconstructive surgery to restore bodily function or correct a functional physical impairment following an accidental injury, prior surgical procedure (e.g., mastectomy), or a congenital/birth defect.
Gender reassignment operations and treatments	Not required
Circumcisions	Required
Speech therapy	Yes--see Table 1.
Physical therapy	Yes--see Table 1.
Occupational therapy	Yes--see Table 1.
Respiratory therapy	Yes--see Table 1.
Skilled nursing facility care	Yes--see Table 1.
Custodial care, at home or in a facility setting	Not required
Social work for non-mental health care	Not required
Home health care	Yes, same coverage as state mandated benefit-- see Table 1.
Rehabilitation hospital	Yes--See Table 1.
Audiology exams	Yes--See Table 1.
Pastoral counseling	Not required

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TABLE 5
Recommendations in Response to Specific Benefit Questions Raised in Division of Insurance Letter Dated April 22, 1997

Service	Advisory Board Recommendation
Weight control programs	Not required
Smoking cessation programs	Not required (except patches covered as prescription drugs)
Physical education programs, including health club memberships	Not required
Obsessive compulsive disorder counseling	Required to extent meets requirements of coverage under mental health benefits
Bone densitometry for treatment of osteoporosis	Yes, based on medical necessity
Community health center care	Based on carrier delivery system for network-based plans
Norplant implantations	Not required
Depo-provera injections	Not required
Home deliveries	Not required; may be covered at discretion of medical policy of carrier
Non-mandated infertility treatments	Not required
Birth control counseling	Required
Sterilizations	Required
Reversals of voluntary sterilizations	Not required
Services associated with hiring requirements	Not required
Second or third provider opinions	Yes--see Table 1.
Home visits	Required
Travel time and non-hospital costs for the insured and those traveling with the insured	Not required
Inoculations associated with foreign travel	Required
Care received outside the United States	Required for emergency and urgent conditions. Not required for routine care or care that could have been reasonably foreseeable before the insured left the U.S.
Inpatient private duty nursing	Only when medically necessary
Provider charges for shipping/copying medical records	Not required
Private hospital rooms	Only when medically necessary
Provider charges for failing to keep appointment	Not required
Christian Science practitioner and sanitarium stays	Not required
Durable medical equipment	Yes--see Table 1.
Motorized wheelchairs	Covered to extent of DME benefit
Prosthetics	Yes--see Table 1. Specific types of prostheses based on medical necessity
Orthotics	Covered as part of DME benefit
Vision aids, such as glasses or contact lenses	Not required
Specialty clothing appropriate to specific medical conditions	Not required
Glucometers	Required
Glucose strips when not mandated by law	Not required (i.e., blood glucose monitoring strips required for insulin-dependent diabetics only)
Hearing aids	Not required
Charges for convenience as opposed to medical necessity	Not required

Nongroup Health Insurance Advisory Board

TABLE 5

Recommendations in Response to Specific Benefit Questions Raised in Division of Insurance Letter Dated April 22, 1997

Service	Advisory Board Recommendation
Medical supplies necessary for administration of covered outpatient prescription drugs	Required
Over-the-counter drugs	Not required
Office visits associated with covered services (e.g., office visit for immunizations)	Required

Recommendation regarding usual and customary charges:

For carriers that base payments on usual and customary charges for noncontracting providers for a guaranteed issue medical plan or the out-of-network benefits for a guaranteed issue preferred provider plan, a carrier shall determine its usual and customary charges using a methodology that results in usual and customary charges that are, in the aggregate, at least comparable to, and not lower than, the 80th percentile of charges based on Health Insurance Association of America (HIAA) data that are no older than eighteen months.