# COMMONWEALTH OF MASSACHUSETTS
## Office of Consumer Affairs and Business Regulation
## DIVISION OF INSURANCE

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LINDA RUTHARDT
COMMISSIONER OF INSURANCE


**Bulletin 00-09**

**To: Issuers Offering Medicare Supplemental Insurance**
**Health Maintenance Organizations (HMOs) Offering Medicare Managed Care Plans**

**From: Commissioner Linda Ruthardt**

**Re: Required Open Enrollment Period To Be Held Pursuant to M.G.L. c. 176K**

**Date: September 8, 2000**

The purpose of this bulletin is to inform all issuers offering Medicare Supplement insurance policies and HMOs offering Medicare managed care plans that are subject to the provisions of M.G.L. c. 176K of their obligation to participate in a required open enrollment period pursuant to M.G.L. c. 176K, sections 2(b) and 3(g), as well as 211 CMR 71.10(6). The Division is scheduling such an open enrollment period to be held between **October 1, 2000 and December 15, 2000.** The Division has been notified by the federal Health Care Financing Administration (HCFA) that its contracts with Fallon Community Health Plan, Inc. (Fallon), Harvard Pilgrim Health Care, Inc. (HPHC) and United Healthcare of New England, Inc. (UHCNE) in the locations identified below will no longer be in effect after December 31, 2000 for the purposes of individual/direct pay enrollment.

- Fallon's Medicare managed care plan marketed as *Senior Saver* - for the Essex and Suffolk County service areas, as well as the following cities/towns within the Middlesex County service area: Arlington, Belmont, Burlington, Cambridge, Everett, Lexington, Lincoln, Malden, Medford, Melrose, Newton, North Reading, Reading, Somerville, Stoneham, Wakefield, Waltham, Watertown, Weston, Wilmington, Winchester and Woburn.
- HPHC's Medicare managed care plan marketed as *First Seniority* - for the Barnstable, Bristol, Plymouth and Worcester County service areas.
- UHCNE's Medicare managed care plan marketed as *Medicare Complete* statewide.

Only those persons who are enrolled in these Medicare HMOs and who live in the affected locations will be eligible for the state guaranteed issue provisions of the special open enrollment period that is required under 211 CMR 71.10(6). This required open enrollment period will be for

carriers marketing Medicare Supplement plans and Medicare HMO products within the Medicare-approved service areas of these plans and is scheduled to take place between **October 1, 2000 and December 15, 2000.**

During this special open enrollment period, carriers must make available to all affected individuals all Medicare Supplement policies or Evidences of Coverage of Medicare managed care plans currently available from the carrier. Please note that according to the provisions of the federal Balanced Budget Refinement Act of 1999 (BBRA), carriers must ensure that applicants who apply during this special open enrollment period are given the opportunity to make their coverage effective before January 1, 2001 coincident with the date that the applicant has disenrolled from his or her Medicare HMO plan and returned to traditional Medicare coverage. Carriers should prepare their systems to ensure that there is a seamless transition to Medicare Supplement coverage regardless of when applications are processed. The attached documents from the federal Department of Health and Human Services describe issuer obligations under BBRA.

Carriers are reminded that mandatory participation in this special open enrollment period is in addition to compliance with all other required enrollment rights afforded to individuals pursuant to M.G.L. c. 176K, as well as the federal Balanced Budget Act of 1997 and BBRA. Any questions regarding this bulletin should be directed to Kevin Beagan, Director of the Health Unit of the State Rating Bureau at the Division of Insurance, at (617) 521-7347, or faxed to (617) 521-7773.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

7500 SECURITY BOULEVARD
BALTIMORE MD 21244-1850

July 31, 2000

Dear President/CEO:

The purpose of this letter is to call your attention the provisions of the Medicare statute (Title XVIII of the Social Security Act), as amended by the Balanced Budget Act of 1997 (BBA) and the Balanced Budget Refinement Act of 1999 (BBRA), that expand guaranteed issue rights for certain Medicare beneficiaries. These provisions require Medigap issuers to sell certain Medigap policies on a guaranteed issue basis to individuals who will lose coverage under Medicare managed care plans effective December 31, 2000. Attachment 1 summarizes the responsibilities of Medigap issuers to affected beneficiaries and explains the changes made in these requirements by the BBRA.

As you may know, health maintenance organizations (HMOs) and other managed care plans contract with Medicare to provide covered services to Medicare beneficiaries. Plans decide each year whether to continue serving beneficiaries in selected counties or entire service areas. For the next calendar year, 65 Medicare+Choice plans have decided not to renew their contracts and 53 are reducing their service areas, affecting a total of about 934,000 enrollees.

Medigap issuers may therefore experience an increased demand for Medigap policies between now and March 3, 2001, in the affected areas. Most beneficiaries who wish to purchase a Medigap policy are likely to apply for the policy from early October through early December. Beneficiaries who have other managed care plans to choose from will be having a Special Election Period from October 1 through December 31. Those who decide during this period to return to the Original Medicare Plan will likely be applying for Medigap policies during or shortly after this period.

Some beneficiaries will have additional rights to purchase Medigap policies, with different time limits. As explained in the attachment, certain beneficiaries who have been in Medicare managed care for less than 12 months may have the right to purchase a Medigap policy they held prior to enrolling in managed care, or, if they enrolled in a managed care plan when they became eligible for Medicare Part A at age 65, they may have the right to choose any Medigap policy. Other beneficiaries may still be within the six-month Medigap open enrollment period that begins when they turn 65 and are covered by Part B. None of these rights is exclusive—a beneficiary might meet the criteria for more than one type of protection. Attachment 2 contains a chart indicating the areas in the country where the heaviest demands for Medigap policies are likely to occur.

DIVISION OF INSURANCE
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OFFICE OF THE COMMISSIONER

Under BBA, beneficiaries had to apply for Medigap policies no later than 63 days after loss of managed care coverage. As explained more fully in Attachment 1, the BBRA changes give beneficiaries an additional option. If they wish to terminate their managed care coverage and begin coverage under the Original Medicare Plan with a Medigap policy before December 31, they can choose to have their guaranteed issue rights apply during the 63-day period that begins with the date of the "final notification letter" they receive from their managed care plans. Also, this year, in most States, individuals who are enrolled for the first time ever in a managed care plan, and are in their first 12 months of enrollment in that plan, are being sent separate interim notices by their plans advising them that they may have additional rights. These individuals may exercise these rights at any time between now and the end of December, as long as they are still within the initial 12 month period. These special interim notices will have the beneficiary's name and address on them so that they can be used as proof that these individuals may have additional rights.

The BBA statutory provisions cited in Attachment 1 are implemented by sections 11 and 12 of the NAIC Model Regulation for Medicare Supplement Policies, as amended by the NAIC on April 29, 1998. All States were required to have adopted standards that are at least as stringent as those contained in the April 29, 1998 version of the NAIC Model Regulation by no later than April 29, 1999. The BBRA provisions apply to issuers as of the effective date in the statute, which is the date of enactment (November 29, 1999).

The NAIC is in the process of further amending sections 11 and 12 of the Model Regulation to conform to the amendments added by BBRA. The NAIC is expected to formally adopt these changes to the Model Regulation in September 2000. However, we wish to emphasize that the statutory provisions are in effect, and do not depend on NAIC action. We are urging States to implement these revisions as quickly as possible by emergency regulation or other means, in order to comply with the statute and have these provisions in place before the bulk of Medicare beneficiaries affected by this year's managed care nonrenewals start to exercise their rights.

We appreciate your cooperation in serving Medicare beneficiaries in a timely manner. If you have questions, please contact Julie Walton or Marcia Marshall of my staff at 410-786-4622 or 410-786-6674 respectively. You may also obtain additional information about the nonrenewal process by checking HCFA's <www.medicare.gov> website (containing information for Medicare beneficiaries) and <www.hcfa.gov> website (containing information for providers, partners, and others). HCFA's Partner website <www.nmep.org> may be of particular interest to you, containing the following information:

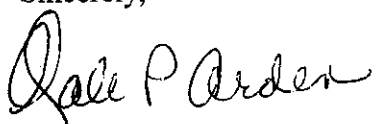
- A packet of training materials prepared for the Regional Education about Choices in Health (REACH) Campaign, which may be useful to you for agent or customer service representative training;

- A Medigap factsheet and a series of beneficiary Qs and As on Medigap issues; and

- The model beneficiary notices that Medicare contracting managed care plans are required to use to notify beneficiaries of their choices.

According to the Standard Operating Procedure (SOP) that HCFA has developed for the managed care plan nonrenewal process, the final beneficiary notices should be mailed to beneficiaries by September 27 and dated October 2 (to comply with the statutory 90-day notice requirement). The letters direct beneficiaries to contact their local State Health Insurance Assistance Program (SHIP) or the State Insurance Commissioner's Office if they encounter problems or need assistance in locating a Medigap policy.

Sincerely,



Gale P. Arden
Director
Private Health Insurance Group
Center for Medicaid and State Operations

Attachment 1: Medigap issuers' responsibilities
Attachment 2: Chart showing geographic areas and number of beneficiaries impacted

cc:
State Insurance Commissioners
State Insurance Dept. Medigap contacts
National Association of Insurance Commissioners
Associate Regional Administrators
Regional Office Medigap Coordinators
All Managed Care Nonrenewal coordinators
Health Insurance Association of America
Blue Cross Blue Shield Association of America
American Association of Health Plans
National Association of Health Underwriters
American Association of Retired Persons
State Health Insurance Assistance Programs
State Health Insurance Assistance Program Regional Coordinators

## Attachment 1

# Issuer Obligations under Federal Law With Respect to Medicare Beneficiaries who Lose Coverage when Medicare Managed Care Plans Withdraw from the Medicare Program or Reduce their Service Areas

Section 1882(s)(3)(A) of the Social Security Act (the Act) (42 U.S.C. 1395ss(s)(3)(A)) provides that Medigap issuers may not --

- Deny or condition the issuance or effectiveness of a policy to which an individual has a guaranteed issue right;
- Discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition; and
- Impose any preexisting condition exclusion period under such policy.

Section 1882(s)(3)(B) of the Act created guaranteed issue rights for six categories of beneficiaries. Three of these categories (referred to here as "classes," and identified by the subparagraph of section 1882(s)(3)(B) that pertains to them), will be potentially affected by managed care contract terminations and service area reductions. These classes are:

- Individuals who will be involuntarily disenrolled by a plan with a Medicare contract under Part C of the Act (a "Medicare+Choice" plan), because the plan is not renewing its contract, or is reducing its service area, as of December 31, 2000. (See section 1882(3)(B)(ii) -- this category is called "class ii.");
- Individuals who had a Medigap policy which they terminated when they enrolled for the first time in a Medicare managed care plan (Medicare+Choice, a cost contract under section 1876 of the Act, or any similar organization operating under a demonstration project authority), or under any Medicare SELECT policy, and who terminate their enrollment in the Medicare managed care plan or Medicare SELECT policy during the first 12 months after enrolling. (See section 1882(3)(B)(v) ("class v")); and
- Individuals, who, upon first becoming eligible for Medicare Part A at age 65, enrolled in a Medicare+Choice plan and then disenroll from their plan by no later than 12 months after the effective date of their enrollment (section 1882(3)(B)(vi) ("class vi")).

Each of these classes has different rights. Under section 1882(s)(3)(C), individuals in class (ii) (regardless of whether they qualify for Medicare by reason of age, disability or End Stage Renal Disease), have the right to buy any Medigap plan available in the State that is designated "A", "B", "C", or "F." (The only exception is that for beneficiaries under age 65, issuers are only

required to guarantee issue those policies that are already filed and approved to sell to the under 65 population.) In all cases, the issuer may not discriminate in the pricing of the policy and must offer the policy at its best rate.). Individuals in class (v) may return to their old Medigap policies from their previous insurers, if the policies are still available. If they are not available, the beneficiaries have the choice of policies "A," "B," "C" or "F." Individuals in class (vi) have the right to buy any Medigap plan, designated "A" through "J".

As a result of changes made by the Balanced Budget Refinement Act of 1999, beneficiaries in class (ii) who are being disenrolled by their Medicare+Choice (M+C) plans have been given an additional time period during which they can choose to exercise their rights.

- If they voluntarily disenroll from their M+C plan before the plan's contract terminates, and if they apply no later than 63 days after they receive a final notice from their plan that the contract is terminating, they are entitled to guaranteed issue of plans "A," "B," "C" or "F." (Since the final notices are required to be dated October 2, 2000, this 63-day period will last until December 4, 2000.

- If they stay in their M+C plan until it terminates, they are entitled to guaranteed issue rights as long as they apply no later than 63 days after the date their coverage terminates under the M+C plan on December 31, 2000. (This 63-day period will last until March 3, 2001.)

Because voluntary disenrollment from a Medicare+Choice plan is effective the beginning of the following month, beneficiaries who the earlier 63-day window, who return to the Original Medicare Program, and who wish to ensure seamless coverage under a Medigap policy, will likely want to arrange to have their Medigap policy start on November 1 if they request to disenroll from their M+C plans during October, or on December 1 if they request to disenroll during November. Similarly, beneficiaries who are being disenrolled effective December 31, 2000 and who choose Original Medicare will likely want to arrange ahead of time for Medigap coverage to start on January 1, 2001. However, they may apply as late as March 3, 2001 and still have a right to buy plans "A", "B", "C", or "F" on a guaranteed issue basis.

Some beneficiaries may qualify under more than one of these protected classes. Those who are also in one of the two classes of beneficiaries who are in Medicare managed care for the first time (classes v and vi) and are still within their initial 12-month period must disenroll and apply for the Medigap policy of their choice before their initial 12-month period expires, in order to obtain the broader choice of Medigap plans that are available to individuals in those two categories. Please note also, that some beneficiaries may still be in their 6-month Medigap open enrollment period, if they have been in a managed care plan less than 6 months, and they are entitled to the full protection of open enrollment, even if they may also be entitled to the BBA/BBRA guaranteed issue rights.

Medicare+Choice plans were required to notify HCFA of their decisions to withdraw from the program or reduce their service areas by July 1, 2000. Because HMOs with cost contracts under section 1876 of the Act do not need to notify HCFA of their decisions regarding participation for

calendar year 2001 until October 2 (90-day notice before the end of the contract year), there may still be more areas affected by plan withdrawals, but the number and size of these contracts is much smaller than for Medicare+Choice. Any beneficiaries affected by cost plan nonrenewal or service area reductions would be protected by section 1882(s)(3)(B)(iii) and have the same rights as those in class (ii) to purchase plans "A", "B", "C", or "F" on a guaranteed issue basis with one exception. Because of the later date for notifying HCFA of the plan's intent to withdraw, beneficiaries do not have time for, and therefore are not given, a choice of when to take their 63-day Medigap guaranteed issue period. The guaranteed issue period runs for 63 days from the date coverage ends under the cost plan.