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LINDA RUTHARDT
Commissioner of Insurance

Bulletin No. 00-11

To: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts (BCBSMA), Health Maintenance Organizations

From: Linda Ruthardt, Commissioner of Insurance

Re: Changes in Nongroup Health Insurance Law

Date: September 8, 2000

This bulletin is to inform carriers of the enactment of Chapter 140 of the Acts of 2000, which was signed into law on July 21, 2000. Chapter 140 amends M.G.L. c. 176M (the nongroup law) and directs other changes regarding nongroup health insurance in Massachusetts. Chapter 140 modifies the nongroup statute in the following ways:

- changes the treatment of closed nongroup health insurance plans;
- modifies certain definitions to be consistent with the federal Health Insurance Accountability and Portability Act of 1997 (HIPAA);
- redefines "eligible individual" for the purposes of the guaranteed issue purchase of nongroup health insurance;
- requires continuous open enrollment for nongroup products;
- requires that rates be offered for specific family types;
- permits products other than the standard plans currently offered; and
- establishes a Nongroup Health Insurance Reinsurance Plan.

Although this bulletin summarizes the changes, carriers are advised to refer to Chapter 140 for specific requirements, the effective dates of the various provisions and further details.

- **Treatment of Closed Nongroup Health Insurance Plans**

The Division of Insurance has already advised those carriers with members currently enrolled in closed plans that Chapter 140 changed the requirements relative to closed plans, and requires such plans to remain in effect at least until subscriber membership falls below 25 percent of 1999 enrollment. *See* Bulletin No. 00-07.

- **Definitions Changed to be Consistent with HIPAA**

On March 31, 1997, Massachusetts filed materials with the federal Health Care Financing Administration (HCFA) for an alternative mechanism in accordance with the provisions of the Public Health Service Act, Title XXVII, Part B, section 2744. Chapter 140 modified certain provisions of M.G.L. c. 176M, including the definitions for "adjusted composite rate," "average adjusted composite rate," "creditable coverage," "group health plan," "guaranteed issue managed care plan," "guaranteed issue medical plan," "guaranteed issue preferred provider plan," "health plan" and "pre-existing condition exclusion", so that the provisions are consistent with the alternative mechanism as filed with HCFA.

- **New Definition of Eligible Individual**

Effective November 1, 2001, the definition of "eligible individual" is changed to include any natural person who is a resident of Massachusetts and is not enrolled for coverage under Part A or Part B of Medicare or under Medicaid. Please note that carriers may no longer deny enrollment to individuals who are eligible for or enrolled in any group product, including those offered under M.G.L. c. 176J (governing small group health insurance).

- **Continuous Open Enrollment Period**

Effective November 1, 2001, carriers must offer continuous open enrollment for nongroup guaranteed issue products. Under certain circumstances, carriers may impose up to a six-month pre-existing condition exclusion or waiting period. In determining whether a pre-existing condition exclusion or a waiting period applies, carriers must credit the time enrollees were covered under prior creditable coverage if the previous coverage was reasonably actuarially equivalent to the new coverage and continuous to a date not more than 63 days prior to the date of the request for new coverage. The Division will promulgate regulations relative to pre-existing condition exclusions and waiting periods.

- **Changes to Allowable Rate Basis Types and Termination Provisions**

For rate filings due on May 1, 2001 for rates to be effective as of December 1, 2001, one rate basis type must be for a single parent with dependents. The Division will promulgate regulations to specify the minimum four rate basis types that carriers will be required to offer on and after November 1, 2001.

Effective April 30, 2001, a carrier that intends to terminate coverage for all eligible individuals enrolled in a specific guaranteed issue health plan must notify the Commissioner of Insurance no later than 180 days prior to terminating coverage.

- **Alternative Guaranteed Issue Health Plans**

Effective November 1, 2001, a carrier may offer one alternative guaranteed issue health plan in addition to the standard benefits guaranteed issue plan that it offers. The alternative benefits plan may have benefits and cost-sharing requirements, including deductibles, that differ from those in the standard benefits plan. Carriers must file alternative plans with the Division for approval. The Division will promulgate regulations relative to the requirements for alternative health plans.

For rate filings due on May 1, 2001, (*i.e.*, for rates to be effective on December 1, 2001), carriers may establish a benefit level rate adjustment for each type of approved alternative guaranteed issue health plan. The benefit level rate adjustment must be expressed as a number and represent the actuarial value of the benefit level of the alternative guaranteed issue health plan, assuming no difference in the expected cost and utilization from those in the standard plans. Carriers must calculate rates for guaranteed issue products by establishing a base premium rate for each rate basis type, then multiplying that base premium rate by any age rate adjustment, multiplied by the area rate adjustment, multiplied by the benefit level rate adjustment (for alternative plans only). There is no benefit level rate adjustment for standard guaranteed issue plans.

- **Plans Exempt from Guaranteed Issue Statute**

Effective November 1, 2001, specified disease insurance is exempted from the definition of health plans that must comply with chapter 176M. Specified disease insurance that is purchased as a supplement and not as a substitute for a health plan which otherwise meets the requirements of 211 CMR 42.00 and any other applicable regulations may be sold in Massachusetts on and after that date. Also, the definition of hospital indemnity insurance is changed to permit the sale of policies with benefits up to $500 per day.

- **Nongroup Health Insurance Reinsurance Plan**

Effective July 21, 2000, Chapter 140 establishes a nonprofit entity to be known as the Massachusetts Nongroup Health Insurance Reinsurance Plan. Any carrier issuing or renewing a guaranteed issue nongroup health plan under c. 176M must be a member of the plan. Members of the plan may reinsure the coverage of an eligible individual or the eligible dependents of such an individual who enrolls in a guaranteed issue nongroup health plan on and after November 1, 2001.

Please refer to Chapter 140 for the full text of all changes and their effective dates. The Division expects to amend 211 CMR 41.00, the regulation governing nongroup health insurance, and will issue additional bulletins as necessary. Questions about this bulletin should be directed to the Health Unit at the Division of Insurance, (617) 521-7349, or faxed to (617) 521-7773.