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BULLETIN 93-01

TO: All Health Insurers Offering Health Benefit Plans to Small Businesses

FROM: Kay Doughty, Commissioner of Insurance

RE: Questions and Answers Concerning the Small Group Health Insurance Statute and Regulation

Date: January 6, 1993

As you are aware, Section 42 of Chapter 495 of the Acts of 1992--the Small Group Health Insurance Statute--was enacted on December 31, 1991 to take effect on April 1, 1992. Section 42 of Chapter 495 is codified in Massachusetts General Laws chapter 176J ("Chapter 176J").

Chapter 176J establishes a new system of rules regarding the sale of health benefit plans to small businesses. The Division issued a regulation to implement, in part, the requirements of Chapter 176J. This regulation is 211 CMR 66.00: Small Group Health Insurance.

The purpose of this bulletin is to provide answers to common questions regarding the requirements of the small group health insurance statute and regulation. The questions are divided into thirty-three (33) sections, and a table of contents listing the sections is provided in the bulletin prior to the questions and answers. This bulletin is not intended to explain each of the new obligations and requirements under the statute and regulation. Therefore, please refer to the regulation and statute in conjunction with this bulletin.

Questions regarding this bulletin, as well as the small group health insurance statute and regulation, may be directed to Teresa Gallinaro, Health Policy Section, (617) 727-7189, ext. 542.

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TABLE OF CONTENTS

SECTION NUMBER AND TITLE		PAGE NUMBER
I.	GUARANTEE ISSUE TO NEW GROUPS	1
II.	GUARANTEE ISSUE FOR RENEWALS	4
III.	OPEN ENROLLMENT	6
IV.	MEDICAL UNDERWRITING OF GROUPS	8
V.	HMO GUARANTEE ISSUE AND MEDICAL UNDERWRITING	9
VI.	ELIGIBILITY REQUIREMENTS AND ELIGIBILITY WAITING PERIODS	11
VII.	PARTICIPATION REQUIREMENT AND PARTICIPATION RATE	12
VIII.	USE OF NON-GROUP/INDIVIDUAL POLICIES	14
IX.	DIFFERENT CLASSES OF EMPLOYEES WITHIN THE SAME GROUP	15
X.	PRE-EXISTING CONDITION POLICY PROVISIONS: GENERAL QUESTIONS	16
XI.	PRE-EXISTING CONDITIONS: NEW GROUPS	17
XII.	PRE-EXISTING CONDITIONS: EXISTING GROUPS	18
XIII.	WAITING PERIODS: GENERAL QUESTIONS	19
XIV.	WAITING PERIODS: NEW GROUPS	21
XV.	WAITING PERIODS: EXISTING GROUPS	22
XVI.	LATE ENROLLEES	23
XVII.	PRODUCT LINKAGE	24
XVIII.	INVOLUNTARY TERMINATIONS	25
XIX.	RATE ISSUES	26
XX.	RATE BASIS TYPE	26

TABLE OF CONTENTS continued

SECTION NUMBER AND TITLE		PAGE NUMBER
XXI.	THE TWO TO ONE PREMIUM BAND FOR GROUP BASE PREMIUM RATES	27
XXII.	BENEFIT LEVEL RATE ADJUSTMENT	28
XXIII.	AREA RATE ADJUSTMENT	29
XXIV.	TRANSITION AGE RATE ADJUSTMENT	29
XXV.	LIST BILLING	29
XXVI.	STEP-RATING	30
XXVII.	RATES CHARGED TO LATE ENTRANTS AND TO NEW EMPLOYEES WHO ARE ADDED ON A TIMELY BASIS	30
XXVIII.	RENEWAL RATES	31
XXIX.	MASSACHUSETTS SMALL EMPLOYER HEALTH REINSURANCE PLAN	32
XXX.	INTERMEDIARIES	33
XXXI.	MANDATED BENEFITS UNDER THE SMALL GROUP HEALTH INSURANCE REGULATION	36
XXXII.	DISCLOSURE	37
XXXIII.	FILING REQUIREMENTS	37

QUESTIONS AND ANSWERS CONCERNING
THE SMALL GROUP STATUTE AND REGULATION:
M.G.L. c. 176J and Regulation 211 CMR 66.00

I. GUARANTEE ISSUE TO NEW GROUPS

(NOTE: Throughout this bulletin, the terms "eligible small businesses" and "groups" are used interchangeably.)

Q: What are the guarantee issue requirements for new groups?

A: The basic requirement is that a carrier must offer every health benefit plan which it offers to any eligible small business to all eligible small businesses. Carriers are advised to read 211 CMR 66.08(1) through (4) carefully in order to acquaint themselves with the full scope of the guarantee issue requirements for new groups and eligible employees and dependents. (Renewals of existing groups are discussed in Section II of this bulletin: "Guarantee Issue for Renewals")

Q: Are there any exceptions to the guarantee issue rule?

A: Yes, there are seven major exceptions to the guarantee issue rule:

1. A carrier must refuse to accept a new group if the carrier is not conducting an open enrollment for small groups (211 CMR 66.08 (1)(c)1. and 2.).

2. A carrier may refuse to accept a new group between April 1, 1992 and December 31, 1993, inclusive, if the group was covered by a health benefit plan on December 31, 1991 ("the 12/31/91 exception"). This exception to the guarantee issue rule does not apply to groups that were insured on December 31, 1991 but whose coverage was <u>involuntarily terminated</u>. (211 CMR 66.08(1)(c)3.) As of January 1, 1994, this exception will no longer exist. Coverage by a <u>nongroup</u> plan as of December 31, 1991 is not considered to be coverage by a health benefit plan for purposes of this section.

3. HMOs are not required to issue every health benefit plan they offer to eligible small businesses on a guarantee issue basis. HMOs are required to offer only a prototype plan on a guarantee issue basis. (211 CMR 66.08(3))

Q: Under the 12/31/91 exception to guarantee issue, may a carrier exclude a particular individual within a group rather than the entire group?

A: No. Under the 12/31/91 exception, a carrier can only choose to accept the whole group or refuse the whole group. A carrier cannot refuse certain individuals within a group under this exception. Furthermore, if a carrier accepts the whole group, the policy is subject to all of the provisions of 211 CMR 66.00.

Q: If a new group was covered by a health benefit plan on 12/31/91 and was not involuntarily terminated, may a carrier reject the entire group under the 12/31/91 rule for reasons other than medical underwriting?

A: Yes. If the new group was covered by a health benefit plan on 12/31/91 and was not involuntarily terminated, the carrier may reject the small group for any reason which does not otherwise violate state or federal law.

Q: If a carrier prior to April 1, 1992 offered one of its product lines (such as an HMO or PPA) or health benefit plans only to small groups with some minimum number of members greater than one, is that carrier now required to offer the particular product line or health benefit plan to new eligible small businesses with one to twenty-five members?

A: Yes. 211 CMR 66.08(1) requires carriers to make available to every eligible small business every health benefit plan which they currently make available to any eligible small business. Carriers should refer to the definition of eligible small business in the regulation. For example, if a carrier, prior to April 1, 1992, offered a particular product only to small groups with at least ten eligible employees, it must now offer that product to new small groups from one to twenty-five eligible employees (or discontinue the product in accordance with 211 CMR 66.08(4)).

Q: Which definition should a carrier use to determine the first renewal date on or after April 1, 1992 when implementing the regulation: the policy anniversary date or the first rate renewal date (i.e., the first change in premium rates) falling on or after April 1, 1992?

A: A carrier may choose either the policy anniversary date or the first rate renewal date falling on or after April 1, 1992. However, regardless of the definition chosen, every small group health benefit plan and every eligible small group must be brought into compliance with 211 CMR 66.00 by April 1, 1993. Furthermore, once a carrier has chosen which definition it wants to use, it must apply that definition consistently to all small groups and to all its classes of business. The definition of renewal date may not vary by health benefit plan or by small group.

Example: A policy is issued on March 1, 1992. The carrier chooses the first rate renewal date on or after April 1, 1992 as the date of renewal for all of its small groups, but the carrier does not plan to issue a rate increase for this small group until June 1, 1993. Despite the carrier's intentions, the carrier must bring the group into compliance with the law no later than April 1, 1993.

Q: A carrier renews a policy on or after April 1, 1992 which had been originally issued prior to April 1, 1992. Individuals within the group have been completely excluded from coverage on the basis of medical underwriting prior to April 1, 1992. Is the carrier required to include those individuals within the group on or after April 1, 1992?

A: Yes. Upon the first renewal of the group on or after April 1, 1992, a carrier is required to take any individuals it had previously excluded from coverage through the group. For health benefit plans renewed on or after April 1, 1992 to eligible small businesses, a carrier may not permanently exclude a particular eligible employee or eligible dependent "on the basis of an actual or expected health condition of such person." (211 CMR 66.10(1)) Nothing in 211 CMR 66.00 prohibits the carrier from accepting the employee prior to the group's next renewal date, and carriers are encouraged to do so on a consistent basis throughout their book of business. (Please see Sections X through XII on "Pre-existing Condition Policy Provisions" and Sections XIII through XV on "Waiting Periods" for discussions of any temporary limitations which may be placed on coverage for previously excluded individuals.)

Q: May carriers enroll new groups other than during an open enrollment period?

A: No. Carriers may enroll new groups only during open enrollment periods and enrollment must be on a guarantee issue basis. If a carrier is not conducting an open enrollment period, it may not enroll a new group either on a guarantee issue basis or on an underwritten basis. (However, please see Section XXX on "Intermediaries" regarding enrollment of new groups who seek coverage through an intermediary.)

Q: May carriers have open enrollments other than the three open enrollment periods of ninety days each between April 1, 1992 and December 31, 1994 or the continuous open enrollment?

A: Yes. Carriers must comply with the minimum requirement of three open enrollment periods of at least ninety days each between April 1, 1992 and December 31, 1994 inclusive. However, carriers may choose to have more frequent limited open enrollment periods between April 1, 1992 and December 31, 1994. They may also choose to lengthen the duration of the required three open enrollment periods, or to have continuous open enrollment.

Q: What notification of open enrollment periods must a carrier provide to the Division of Insurance?

A: Carriers are required to file with the Division the dates for the consecutive ninety-day open enrollment periods in accordance with 211 CMR 66.08(1)(c)1.. If a carrier chooses to have additional open enrollment periods in a twelve-month period it may do so without notification to the Division, but the guarantee issue requirements still apply.

Q: If a carrier did not hold its first required ninety-day open enrollment period during the first three months following April 1, 1992, must it postpone all enrollment of new groups until it holds its ninety-day enrollment?

A: Not necessarily. Carriers had until August 1, 1992 to inform the Division of the beginning date of their first ninety-day open enrollment period. A carrier may have the ninety-day open enrollment at one point during the period April 1, 1992 to April 1, 1993, but still have an additional open enrollment at some other time.

Q: Does 211 CMR 66.00 impose specific underwriting criteria which carriers must follow in underwriting small groups?

A: No. The regulation does not impose specific underwriting criteria in those limited situations where underwriting is allowed. Carriers that medically underwrite must, however, be consistent in their medical underwriting of all similarly situated groups. In addition, carriers may not attempt to discourage eligible small businesses from applying for coverage by creating an unduly burdensome or unreasonable underwriting process.

Q: May a carrier require or request an individual to sign a waiver of coverage as a condition for granting coverage to the group as a whole?

A: No. Carriers may not require or request individuals in a small group to sign waivers of coverage for any reason. This prohibition applies to all small groups, including those that were insured on 12/31/91. A carrier may choose not to accept a group which was insured on 12/31/91 until December 31, 1993. However, if the carrier accepts the group, all members must be taken, and it is impermissible to place riders on the coverage of any group member.

Q: May a carrier use medical underwriting to decide whether it will directly write a group with five or fewer employees or tell that group to enroll through an intermediary?

A: No. Carriers must implement the rules regarding enrollment of groups with five or fewer employees consistently and treat all similarly situated groups in a similar manner (211 CMR 66.08(1)(b)4.). Therefore, carriers must decide which, if any, organizations they will work with as intermediaries. A carrier must also decide whether it will (1) give businesses with five or fewer employees the choice to decide whether to enroll directly with the carrier or through an intermediary or (2) require all businesses of that size to enroll through the intermediary if the regulation allows the carrier to do so. Once this decision is made, the policy must be applied consistently to all groups.

V. HMO GUARANTEE ISSUE AND MEDICAL UNDERWRITING

Q: What are the guarantee issue requirements for HMOs?

A: HMOs are required to offer coverage or accept applications on a guarantee issue basis only for a prototype plan that meets the requirements of 211 CMR 66.14. See 211 CMR 66.08(3) for further requirements for HMO product offerings.

VI. ELIGIBILITY REQUIREMENTS AND ELIGIBILITY WAITING PERIODS

Q: May an employer impose its own rules regarding how long an employee must work at the company before the employee becomes eligible to be covered under the group's policy?

A: Yes. To the extent otherwise permissible under applicable law, an employer may impose its own rules regarding how long a particular employee must work in order to be eligible to be covered under that business' group policy. This waiting period is often referred to as an "eligibility waiting period." For example, many employers require that an employee work for two months before the employee is eligible for health insurance benefits through the employer's group health insurance program.

Q: May a carrier require that an employee work for a certain amount of time in order to qualify as an "eligible employee"?

A: The definition of "eligible employee" in 211 CMR 66.04 refers to an employee who "is hired to work" for a time period of "not less than five months." A carrier cannot require that an employee work for an unreasonable length of time in order to qualify as an eligible employee; five months is deemed to be an unreasonable length of time. Carriers should develop reasonable rules to determine if an employee is an "eligible employee" and apply those rules consistently. A permissible way to implement this determination would be for the carrier to request that an employer certify to the carrier that it is the employer's intent to hire a particular employee for at least five months. The purpose of such a request would be to exclude employees whom the employer intends to hire for less than a five month period.

Q: May a carrier require an employee to be actively at work on the day the group coverage commences in order for the employee to be covered on the commencement date of the group coverage?

A: No. A carrier may not require an employee to be actively at work on the day the group coverage commences in order for that employee to be immediately covered through the group policy. For instance, carriers may not exclude persons covered through the group as a result of COBRA from eligibility or coverage even though the COBRA group members are not actively at work.

Example: Carrier X has a 100% participation requirement for a health benefit plan when it is the only offering, and a 50% participation requirement for the same plan when it is part of a multiple offering. A small group chooses to offer two different health benefit plans from two different carriers to its employees. One carrier is Carrier X which has the 50% participation requirement for multiple offerings; the second carrier has a 75% participation requirement. Carrier X may not change its 50% participation requirement to fit this situation unless it changes the multiple offering participation rate for that health benefit plan for all small groups with that plan.

Q. Are carriers required to lower their participation rates if a small group wants to offer two or more different health benefit plans from two different carriers to its employees?

A. No. Carriers are not required by Chapter 176J or by 211 CMR 66.00 to lower their participation rates in order to accommodate a small employer that wants to offer more than one health benefit plan to its employees.

Q: In calculating the participation rate, may carriers include eligible dependents as well as eligible employees?

A: Yes. In determining the participation rate, a carrier may choose to use either the percentage of eligible employees electing to participate in a health benefit plan, or the percentage of the sum of eligible employees and eligible dependents electing to participate in a health benefit plan. (211 CMR 66.04: "Participation Rate")

Q: Is there a typographical error in 211 CMR 66.08(1)(d), which discusses the proper implementation of participation requirements, as well as employer contribution requirements?

A: Yes, there is a typographical error. The second sentence of that paragraph should read: "Carriers shall not increase participation or employer contribution requirements at any time after an eligible small business has been accepted for coverage [except] where the size of the group has changed." It should also be noted that 211 CMR 66.08(1)(d) states that carriers must apply participation requirements "in a uniform manner to all groups of the same size."

IX. DIFFERENT CLASSES OF EMPLOYEES WITHIN THE SAME GROUP

Q: May an employer create different classes of employees for the purpose of eligibility for group health benefits? For example, could an employer divide his/her employees into union and non-union employees and offer group coverage only to the non-union employees?

A: The small group insurance statute and regulation do not preempt an employer's prerogative to establish its own rules regarding the eligibility of employees for health benefits (provided the rules are otherwise consistent with applicable state and federal laws). A carrier may, however, choose not to offer a plan if an employer's rules for eligibility do not meet the carrier's rules, provided the carrier's criteria are consistent with Massachusetts General Law chapter 176J, Regulation 211 CMR 66.00, and any other applicable law. For example, a carrier may not offer coverage to an employer who divides its employees into one class of eligible healthy people and one class of non-eligible sick people because the carrier may not use health status as the basis for providing coverage under Chapter 176J.

Q: Can an employer provide different levels of benefits or different health benefit plans to different classes of employees?

A: The small group insurance statute does not prohibit an employer from asking a carrier to provide different health benefit plans or levels of benefits to its different classes of employees (provided the request is otherwise consistent with applicable state and federal laws). It is the carrier's decision, limited only by any applicable provisions of 211 CMR 66.00, or other applicable state and federal laws, whether the carrier will accede to the employer's request. However, carriers are required to comply with the provisions of Chapter 176J and 211 CMR 66.00 concerning participation requirements and participation rates in this type of situation.

Q: May carriers provide different health benefit plans or benefit levels to employers who have established classes of employees based on employee health status?

A: No. Classes established on the basis of health status are not permitted. The intent of the small group statute and regulations is to eliminate the medical underwriting of groups and individuals within those groups except in defined situations.

XI. PRE-EXISTING CONDITIONS: NEW GROUPS

Q: If a policy is originally issued on or after April 1, 1992 to a new eligible small business and has a six month pre-existing condition provision, how does the carrier determine which employees and dependents who are enrolled in the plan on its effective date (original enrollees) are subject to the pre-existing clause, and for how long?

A: The carrier should refer to 211 CMR 66.10(4) to determine which individuals in the group are eligible for a time credit towards the six month pre-existing condition period. As stated in the regulation, the carrier should look to each individual's prior coverage to determine how long the individual was covered by a reasonably actuarially equivalent qualifying health plan and if that previous coverage was continuous to a date not more than 30 days prior to the effective date of the new coverage, exclusive of any applicable benefit waiting period under such new coverage. 211 CMR 66.10(4) also defines "reasonably actuarially equivalent."

For example, if (1) an individual's previous coverage was under a reasonably actuarially equivalent health benefit plan, (2) the coverage did not end more than thirty days from the date the individual is enrolled in the new coverage, exclusive of any waiting period, and (3) the individual had that coverage for six months or longer, the carrier may not impose any pre-existing condition provision on that individual for any length of time. However, if an individual met requirements (1) and (2) above but was only insured for a total of two months, the new carrier could impose a four month pre-existing condition provision period. If an individual did not meet either condition (1) or (2), the carrier could impose a pre-existing condition period of up to six months.

Q: When a carrier reviews an individual's prior coverage to determine the time credit for pre-existing condition exclusions, the carrier is told to "credit the time such person was covered under a previous qualifying health plan." (211 CMR 66.10(4)) Does the term "previous qualifying health plan" refer to group and non-group (i.e., individual) policies or only to group policies?

A: The term "previous qualifying health plan" in that section of the regulation refers to both group and non-group or individual policies. The non-group or individual policies would include policies which have no relation to an employment situation, as well as those policies which are related to an insured's employment. A frequent example of non-group policies related to an insured's employment is the situation where a carrier may go to a group and offer non-group policies only to employees who meet the carrier's underwriting guidelines. (See 211 CMR 66.04 for definition of "Qualifying Health Plan".)

Q: How should a carrier treat an eligible employee or dependent who is being added onto the group policy on a timely basis on or after April 1, 1992 where the policy was originally issued or most recently renewed prior to April 1, 1992?

A: For policies issued or most recently renewed prior to April 1, 1992, carriers may accept timely add-ons with pre-existing exclusions which are longer or more restrictive than those allowed under 211 CMR 66.00 only until the first renewal after April 1, 1992 but no later than April 1, 1993. At the group's next renewal date, the carrier must reassess the status of each timely add-on to determine if the individual has satisfied the pre-existing condition provision. If the individual has served six or more months, then the provision must be completely eliminated, regardless of the length of the timely add-on's pre-existing condition provision. If the individual has satisfied less than six months of the pre-existing condition period at the time of the group's renewal, the carrier may require the individual to satisfy the difference between six months and the time satisfied prior to the renewal (See 211 CMR 66.10(4) for the other requirements for crediting time). In all cases, the carrier should anticipate the transition that will occur at the renewal date and inform the group of the anticipated change in the pre-existing condition when the renewal date occurs.

XIII. WAITING PERIODS: GENERAL QUESTIONS

Q: What is meant by the term "Waiting Period" as defined in 211 CMR 66.04?

A: As discussed in Section VI. Eligibility Requirements and Eligibility Waiting Periods, "waiting period" refers to a <u>benefit</u> waiting period which occurs <u>after</u> an individual is enrolled in the group's coverage. The benefit waiting period is distinct from the eligibility waiting period which employers may establish and which precedes the individual's enrollment in the group's coverage. 211 CMR 66.10(5)(6) and (7) describe the limitations on waiting periods. Although the limitations on waiting periods are similar to those for pre-existing condition provisions, there are certain differences, as discussed below.

XIV. WAITING PERIODS: NEW GROUPS

Q: If a policy is originally issued on or after April 1, 1992 to a new eligible small business and has a six month waiting period provision, how does the carrier determine which employees and dependents (individuals) who are original enrollees are subject to the waiting period provision, and for how long?

A: The carrier should refer to 211 CMR 66.10(5) and (6) to determine whether each individual should be given a time credit towards the six month waiting period. As discussed in the regulation, the carrier must look at each individual's prior coverage to determine how long the individual was covered by a reasonably actuarially equivalent health benefit plan and if that previous coverage was continuous to a date not more than 30 days prior to the effective date of the new coverage. 211 CMR 66.10(5)(d) also defines "reasonably actuarially equivalent."

For example, if (1) an individual's previous coverage was under a reasonably actuarially equivalent health benefit plan, (2) the coverage did not end more than thirty days from the date the individual is enrolled in the new coverage, and (3) the individual had that coverage for six months or longer, the carrier may not impose a waiting period on that individual. However, if an individual met requirements (1) and (2) above but was only insured for a total of two months, the maximum waiting period the new carrier could impose would be four months. If an individual did not meet either condition (1) or (2), the carrier could impose a six month waiting period.

Q: When a carrier reviews an individual's prior coverage to determine the time credit for waiting period exclusions, the carrier is told to "credit the time such person was covered under a previous qualifying health plan." (211 CMR 66.10(5)(d)) Does the term "previous qualifying health plan" refer to group and non-group (i.e., individual) policies or only to group policies?

A: The term "previous qualifying health plan" in that section of the regulation refers to both group and non-group or individual policies. The non-group or individual policies would include policies which have no relation to an employment situation, as well as those policies which are related to an insured's employment. A frequent example of non-group policies related to an insured's employment is the situation where a carrier may go to a group and offer non-group policies only to employees who meet the carrier's underwriting guidelines. (See 211 CMR 66.04 for definition for "Qualifying Health Plan.")

Q: How should a carrier treat an eligible employee or dependent who is being added to the group on a timely basis on or after April 1, 1992 where the policy was originally issued or most recently renewed prior to April 1, 1992?

A: For policies issued or most recently renewed prior to April 1, 1992, carriers may accept timely add-ons with waiting period exclusions which are longer or more restrictive than those allowed under 211 CMR 66.00 only until the first renewal after April 1, 1992 but no later than April 1, 1993. At the group's next renewal date, the carrier must reassess the status of each timely add-on to determine if the individual satisfied the waiting period provision under the regulation. If the individual has served six or more months, then the provision must be completely eliminated, regardless of the length of the timely add-on's waiting period provision. If the individual has satisfied less than six months of the waiting period at the time of the group's renewal, the carrier may require the individual to satisfy the difference between six months and the time satisfied prior to the renewal (See 211 CMR 66.10(5) for the other requirements for crediting time). In all cases, the carrier should anticipate the transition that will occur at the renewal date and inform the group of the anticipated change in the waiting period when the renewal date occurs.

XVI. LATE ENROLLEES

Q: What is a late enrollee?

A: A late enrollee is "an eligible employee or dependent who requests enrollment in an eligible small business' health insurance plan...after the group's initial enrollment period, his or her initial eligibility date provided under the terms of the plan... or the group's annual open enrollment period." (211 CMR 66.04: "Late Enrollee") For the purposes of this definition, the term "group's annual open enrollment period" should be interpreted to mean either the group's policy anniversary date or the group's policy rate renewal date, as elected by the carrier for all of its small groups. 211 CMR 66.08(2) provides further clarification regarding how a carrier determines if a person is a late enrollee and, once that determination is made, how a carrier must deal with eligible employees or dependents who are late enrollees.

However, a carrier may not require the purchase of life insurance in a manner that thwarts or undermines the intent of 211 CMR 66.00.

For example, a carrier may not price the life insurance product at such a high premium, or require groups to purchase such large amounts of life coverage, so that groups or individuals are effectively discouraged from seeking health insurance from that carrier. In addition, a carrier may not treat similarly situated small groups differently. For example, for two similarly situated small groups, a carrier may not require the first group to purchase both life and health insurance, but require the second group to purchase only health insurance.

XVIII. INVOLUNTARY TERMINATIONS

Q: May a carrier choose not to accept a new group which was covered by a health benefit plan on December 31, 1991 if that group's health benefit plan was involuntarily terminated?

A: No. A carrier must accept a new group which was covered by a health benefit plan on December 31, 1991 if that group's health benefit plan was involuntarily terminated, except if the involuntary termination was due to the reasons listed in 211 CMR 66.08(1)(c)4, as explained in the following question and answer. (211 CMR 66.08(1)(c)3.)

Q: Under what circumstances are carriers not required to issue a health benefit plan to a new group which had a health benefit plan on December 31, 1991 that was involuntarily terminated?

A. Carriers are not required to issue a health benefit plan to a new group which had coverage as of December 31, 1991 if the carrier can demonstrate to the satisfaction of the commissioner that the group was involuntarily terminated for the following reasons:

1. The eligible small business made at least three or more late payments in the prior twelve month period. (211 CMR 66.08(1)(c)4.a.)

2. The eligible small business committed fraud, misrepresented the eligibility of an employee, or misrepresented information necessary to determine group size, group participation rate, or the group premium rate within the prior twelve month period. (211 CMR 66.08(1)(c)4.b.)

3. The eligible small business failed to comply in a material manner with a health benefit plan provision, including carrier requirements for employer group premium contributions within the prior twelve month period. (211 CMR 66.08(1)(c)4.c.)

Q: May a carrier have rate basis types that are different from those outlined in the regulation?

A: Yes. As long as the resulting rate basis types are actuarially equivalent to those in the regulation, a carrier may have up to four differently described categories. The carrier's rate basis types must be used consistently for the carrier's entire small group book of business.

Q: May a carrier have more than four rate basis types?

A: No, a carrier may use a maximum of four rate basis types.

Q: Do the rules for rate basis types apply only to policies issued or renewed after April 1, 1992?

A: Yes, the rate basis types in 211 CMR 66.04 apply only to policies issued or renewed on or after April 1, 1992. Carriers should refer to Section II of the bulletin to determine at what point policies issued prior to April 1, 1992 must be in compliance with the rate basis types in 211 CMR 66.00.

XXI. THE TWO TO ONE PREMIUM BAND FOR GROUP BASE PREMIUM RATES

Q: May a carrier have a different two to one premium band for each type of health benefit plan that it offers to eligible small businesses?

A: According to 211 CMR 66.11(2), only the benefit level rate adjustment may be used to distinguish one health benefit plan from another. The benefit level rate adjustment is outside the two to one premium band for group base premium rates.

Each carrier's two to one premium band for group base premium rates may be different only for each rate basis type within the carrier's class or classes of business. For example, for a carrier's indemnity business, if the carrier used the four rate basis types outlined in the regulation, the carrier would have four different two to one premium rate bands. If a carrier had four rate basis types and two classes of businesses, the carrier could have eight different two to one premium rate bands. (211 CMR 66.11(1)(a))

XXIII. AREA RATE ADJUSTMENT

Q. May carriers use geographic areas for rate purposes which are different from those outlined in 211 CMR 66.11(2)(b)?

A. Yes. The regulation allows the carrier some flexibility in determining what geographic areas a carrier will use for its entire small group book of business. However, any geographic areas used by a carrier must roughly approximate the permissible regions listed in 211 CMR 66.11(2)(b)2. The carrier may not have more than seven geographic areas.

Q: May a carrier have fewer geographic areas than those listed in 211 CMR 66.11(2)(b)2.?

A: Yes. A carrier may use fewer than seven geographic areas.

XXIV. TRANSITION AGE RATE ADJUSTMENT

Q: May carriers use any actuarially sound method to determine how to apply the transition age rate adjustments as discussed in 211 CMR 66.11(3)(b)?

A: Yes. A carrier may use any actuarially sound method it desires to determine how it will apply the transition age rate adjustments. For example, a carrier could develop a schedule of different age rate adjustments for different aged groups. The carrier could then calculate a composite/average age rate for each business and apply the appropriate adjustment. However, the adjustments must be within the range provided in the regulation.

XXV. LIST BILLING

Q: May a carrier use list billing (e.g., charge different rates to people within a single small business based on their ages and/or gender)?

A: A carrier may, but is not required to, charge different rates to people within a single small business based on age and/or gender, as long as the carrier remains within the appropriate two to one premium band for that group.

For example, if a small business has among its employees two single people, one who is twenty-five and one who is fifty-five, these two people could be charged different individual rates based on their age. However, in charging different rates based on age and/or gender, carriers are always constrained by the requirement that the average rate for the group fall within the two to one premium band.

Q: What rate may a carrier charge to an employee or dependent who is added onto a group plan which was issued or most recently renewed prior to April 1, 1992 if that employee or dependent is added on a timely basis or as a late enrollee?

A: If the policy was issued or most recently renewed prior to April 1, 1992, the carrier may charge the timely add-on or late enrollee the same premium as called for under the terms of the policy. However, the carrier must come into compliance with the rating provisions of 211 CMR 66.00 for all members of the group at the group's next renewal on or after April 1, 1992 but no later than April 1, 1993.

XXVIII. RENEWAL RATES

Q: In 211 CMR 66.11(5)(a) the phrase "trend within that class of business for that carrier" is used. May a carrier use different trends for differently sized groups or different trends based on other variables (e.g. different health benefit plans or different deductibles)?

A: No. A carrier may only have different trends for different classes of business. The term "class of business" is defined in 211 CMR 66.04. According to the definition, there are only three classes of business: (1) Health Maintenance Organizations (HMOs) operating under Massachusetts General Law chapter 176G, (2) Preferred Provider Arrangements (PPAs) operating under Massachusetts General Law chapter 176I and (3) indemnity plans operating under Massachusetts General Laws chapters 175, 176A and 176B. A carrier which has only one class of business in the small business group market may have only one trend factor for the purposes of 211 CMR 66.11(5). A carrier which has two classes of business, (e.g., a PPA and an indemnity plan), may have two different trend factors, one for its PPA and one for its indemnity plan. But the carrier may use benefit level rate adjustments in accordance with 211 CMR 66.11(2)(a)1.

Q: May a carrier use a representative group census to determine the trend for the carrier's class(es) of business?

A: A carrier may use a representative group census to determine the trend for the carrier's class(es) of business as long as the census is truly representative of the carrier's entire book of business in Massachusetts and is calculated in accordance with sound actuarial standards.

Q: Will the reinsurance prototypes be the same as the HMO prototypes? Who will develop the reinsurance prototypes?

A: The Massachusetts Small Employer Health Reinsurance Plan will develop the prototype plans for reinsurance purposes. The reinsurance prototype plans are completely unrelated to the HMO prototype plans. The HMO prototypes are filed with the Commissioner of Insurance for her approval. Neither HMOs nor Blue Cross/Blue Shield, will be participating in the Reinsurance Plan.

XXX. INTERMEDIARIES

Q: Must a carrier provide coverage to any organization seeking to act as an intermediary that wants to do business with the carrier?

A: A carrier is not required to contract with any organization that wants to act as an intermediary for that carrier. However, a carrier may not under any circumstance medically underwrite, or collect medical information on, an organization's members for the purpose of deciding whether it will accept an organization as an intermediary for the purposes of 211 CMR 66.00.

Q: If a carrier decides that it will work with an intermediary, must the carrier offer all of its health benefit plans to the intermediary or may the carrier limit the number of health benefit plans from which the intermediary can choose?

A: A carrier must offer the intermediary every health benefit plan which it makes available to all eligible small businesses. In the case of HMOs, HMOs must offer both their prototypes and their non-prototype plans to intermediaries. However, HMOs are required to offer only the prototype plans to individual small groups on a guarantee issue basis. HMOs may medically underwrite individual small groups for the HMO non-prototype plans.

Q: Can an intermediary choose which health benefit plan or plans offered by a particular carrier it will make available to its members?

A: An intermediary is responsible for choosing which health benefit plan or plans made available by a carrier will be offered to its members. A carrier may limit the number of health benefit plans which each intermediary chooses to offer if such limits are reasonable and do not thwart the intent of the regulation. Intermediaries must always offer at least the HMO prototype plan from those plans offered by an HMO to the intermediary.

Q: If a carrier writes groups both directly and through intermediaries, must a carrier charge similarly situated businesses the same total premium regardless of whether the group is enrolled directly, through an association or through an intermediary?

A: 211 CMR 66.11(6) states that "[p]remiums charged to similarly situated eligible small businesses shall be calculated on the same basis regardless of whether the eligible small business is enrolled directly, through an association or through an intermediary." There are, however, two permissible adjustments to that rule. First, 211 CMR 66.11(2)(e) allows a carrier to factor in an intermediary discount and sets rules for the determination of a permissible discount. Second, 211 CMR 66.11(2)(d) allows intermediaries to charge a reasonable fee which will be outside the two to one premium band for group base premium rates if certain conditions are met.

Q: If an intermediary has groups that have 26 or more employees (large groups), as well as groups with one to twenty-five employees (small groups), must a carrier charge rates to the small groups according to 211 CMR 66.00 while charging different rates to large groups that are not in accordance with 211 CMR 66.00?

A: Yes. A carrier must charge rates to groups of one to twenty-five employees which are calculated in accordance with 211 CMR 66.00, even if rates for groups with twenty-six or more employees are calculated differently.

Q: How does a carrier determine whether an eligible small business has five or fewer employees for the purpose of determining whether the carrier can require the group to be enrolled through an intermediary in accordance with 211 CMR 66.08(1)(b)? For example, if a business has a total of eight eligible employees but three employees are covered by group plans as spouses, can a carrier require the group to enroll through an intermediary under 211 CMR 66.08(1)(b)?

A: Carriers must base the size of the group in accordance with the definitions of "Eligible Employee" <u>and</u> "Participation Rate" found in 211 CMR 66.04: Definitions. In the case given above, the three people who are enrolled in their spouses' plans would be excluded from the calculation of the participation rate. Therefore, in this circumstance, a carrier could treat this group as a group with five employees and require the group to enroll through an intermediary if all the requirements in 211 CMR 66.08(1)(b) are also met.

XXXII. DISCLOSURE

Q: What information must carriers disclose in their solicitation and sales material to eligible small businesses seeking coverage?

A: Carriers should refer to 211 CMR 66.15 regarding proper disclosure of certain aspects of the small group health insurance regulation. The listed items include reasonable disclosure regarding rates, benefits, participation rates, mandatory offer and renewal and the reinsurance surcharge. Failure to provide the information required in 211 CMR 66.15 may subject the carrier to penalties and fines as prescribed in applicable Massachusetts insurance law.

XXXIII. FILING REQUIREMENTS

211 CMR 66.00 has a number of different filing requirements. The following is a listing of each type of filing and a reference to the regulation.

Filings for Association Exemption Pursuant to 211 CMR 66.03(3):
211 CMR 66.05(1) through (3)

Filings for Associations Not Exempt Pursuant to 211 CMR 66.03(3):
211 CMR 66.05(4)

Filings for Limited Exemption from Mandatory Offer For Carriers Offering Coverage Only Through Association Group Policies Not Exempt Under 211 CMR 66.03(3):
211 CMR 66.06(1) through (3)

Intermediary Filings:
211 CMR 66.07(1) through (3)

Filings for Limited Open Enrollment:
211 CMR 66.08(1)(c)1. and 211 CMR 66.12(1)

Filing Regarding Financial Impairment:
211 CMR 66.08(1)(c)7.

Filing Regarding HMO Limited Service Area Capacity:
211 CMR 66.08(1)(f) and (g)

Filing Regarding Discontinuance of a Health Benefit Plan to New Eligible Small Businesses:
211 CMR 66.08(4)

Filing Regarding Carrier's Criteria for Determining Nonrenewability of a Health Benefit Plan:
211 CMR 66.09(3)