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BULLETIN 2011-19

TO: Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts, Inc. and Health Maintenance Organizations Offering or Renewing Insured Health Products in the Merged Market in Massachusetts

FROM: Joseph G. Murphy, Commissioner of Insurance

DATE: December 28, 2011

RE: Open Enrollment for Individuals in Insured Health Benefit Plans

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Background

The Division of Insurance ("Division") issues this Bulletin to replace Bulletin 2010-13 ("Open Enrollment for Individuals") and Bulletin 2011-03 ("Additional Qualifying Event for Enrollment of Individuals in Merged Market") and to highlight recent amendments to Division Regulation 211 CMR 66.00 and Massachusetts General Laws Chapter 176J. M.G.L. c. 176J and 211 CMR 66.00 set forth the requirements for open enrollment in the merged market in Massachusetts.

Eligible individuals generally will be able to apply for and purchase merged market coverage only during annual open enrollment, from July 1 – August 15 each year.

Eligible Individual

M.G.L. c. 176J, § 1 defines an eligible individual as:

> a Massachusetts resident who is not seeking individual coverage to replace an employment-based health plan for which the individual or the individual's dependent is eligible, which provides coverage that is at least actuarially equivalent to minimum creditable coverage; provided, however, that any person enrolled in an

> individual health benefit plan before September 30, 2010 shall be considered an eligible individual so long as such person continues to be a resident of the commonwealth and maintains enrollment in an individual health benefit plan.[1]

A person who has access to, or has waived access to, an employment-based health plan is not an eligible individual, unless that person was enrolled in an individual health benefit plan before September 30, 2010 in accordance with M.G.L. c. 176J, § 1.

Continuation coverage under M.G.L. c. 176J, § 9 ("mini-COBRA") or under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") shall not be considered an employment-based health plan.

Verifying Eligibility

Carriers may require that an applicant provide reasonable documentation to establish eligibility, including documents that verify residency or certify that the individual is not covered under an employment-based health plan. Where necessary, carriers may require the applicant to submit reasonable proof of prior coverage, such as a letter of creditable coverage from the prior health plan or a notice regarding COBRA eligibility. Carriers shall exercise flexibility in their requests for documentation and shall request only such information as is necessary to establish eligibility.

Carriers shall provide notice to applicants and renewing members at the outset of the application or renewal process that social security numbers are not required to obtain individual coverage. Carriers shall use reasonable efforts to implement the notice requirements on relevant written and website materials. Carriers shall not refuse to issue or renew coverage to an applicant or a member solely because an applicant or member chooses not to provide a social security number.

Open enrollment rules under M.G.L. c. 176J and 211 CMR 66.00 do not apply to eligible small businesses or groups (groups of 1-50) which will continue to have the right to apply for coverage throughout the year. For the requirements for verification of the eligibility of a small group, see Division Bulletin 1998-08.

Individuals Exempt from Enrollment Restricted to Open Enrollment Periods

HIPAA-Eligible Individuals

Under M.G.L. c. 176J, § 4, carriers must enroll an individual who is eligible under section 2741 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. Section 300gg-41(b) ("HIPAA"), within 30 days of that individual's submission of a completed application.

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[1] The definition of "eligible individual" was modified effective October 27, 2011 by Chapter 142 of the Acts of 2011 and supersedes the definition currently appearing in 211 CMR 66.00.

This includes an individual:

- who had a prior health plan that was terminated no more than 63 days before the date of submission of the application; and
- whose prior health plan was a
    - group health plan (including COBRA or mini-COBRA),
    - government health plan (including Commonwealth Care),
    - church plan, or
    - health insurance plan offered in connection with any such plan; and
- whose prior coverage was "creditable coverage" as defined in HIPAA that was in effect for 18 or more months as of the date of submission of the application; so long as:
    - that individual, at the time of submission of the application, is not eligible for coverage under
        - A group health plan,
        - Medicare Part A or B,
        - Title XIX (including Medicaid or Commonwealth Care), and
    - was not terminated from the prior coverage due to fraud or non-payment of premium.

Other Qualifying Events

Carriers must enroll an eligible dependent (spouse and/or child(ren)) of an enrolled individual into an individual health plan within 30 days of the following qualifying events:

- marriage (and establishment of domestic partnership, if available under the terms of the policy);
- birth of a child*;
- adoption of a child or placement of that child for adoption*;
- the dependent's loss of creditable coverage from another group or government plan; or
- upon court order.

* Carriers shall enroll a child directly into an individual health plan if the child is an eligible individual and coverage is sought within 30 days of the qualifying event.

Carriers must enroll an eligible individual in a health plan within 30 days of the date that the individual submits an application to the carrier, so long as the application is made within 63 days of the date of termination of the prior coverage, if the individual:

- was dis-enrolled from individual creditable coverage as defined in HIPAA due to loss of status as a dependent on another individual's health plan;
- was dis-enrolled from individual creditable coverage as defined in HIPAA due to the carrier's termination of the plan;
- had creditable coverage as defined in HIPAA in an individual health plan with coverage available only in a limited service area and this coverage is terminated because the individual has moved to a location in Massachusetts that is outside the original plan's service area;
- loses eligibility for a qualified student health insurance plan; or
- cancels mini-COBRA or COBRA coverage.

Individuals Limited to Enrollment During Open Enrollment Periods

Carriers must enroll an eligible individual limited to enrollment during an open enrollment period only during open enrollment.

Carriers must make coverage effective the first of the month following submission of a complete application.

- Carriers must accept applications until the last date of the open enrollment period, and will consider that a postmark date, or online filing date, of August 15 (of any year) satisfies the requirement that an application is submitted within the open enrollment period, even in the event that the application is not "complete" on the date of submission. See Division Bulletin 1997-10 for further information.
- Carriers shall not automatically deny applications that are submitted less than five (5) business days prior to an open enrollment period and instead must hold the applications for processing during the next open enrollment period.
- Carriers may establish a reasonable cut-off period for the purpose of determining the effective date.

Carriers shall consider a person who was enrolled in an individual health benefit plan before September 30, 2010 to be an eligible individual for the purposes of enrollment or renewal during open enrollment so long as such person continues to be a resident of the commonwealth and maintains enrollment in an individual health benefit plan.

New Enrollees Outside of Open Enrollment

Carriers must enroll a new eligible individual (i.e., not renewing) who qualifies to purchase coverage outside of open enrollment at any time only for a short year through the next open enrollment period and must either allow the individual to renew the existing coverage or to enroll in different coverage during the next open enrollment period.

2012 Renewals Outside of Open Enrollment

Carriers must allow:

- a renewing eligible individual whose coverage was issued during the January 1-February 15, 2011 open enrollment period only to renew his or her existing coverage for a short year through July 31, 2012.

- an eligible individual only to renew his or her existing coverage for a short year through July 31, 2012.

Individuals Who Are Denied Enrollment

In the event that an applicant is denied the opportunity to enroll in a carrier's health plan, the carrier must provide electronic or written notice of the denial to the applicant no later than five (5) days after receipt of an application that specifies:

- the specific reason(s) the applicant's enrollment was denied, including:
    - the reasons the health plan has determined that the applicant is not considered to have met the standard as an eligible individual; or
    - the reasons the health plan has determined that the applicant is not considered to be exempt from being restricted to applying for coverage during required open enrollment periods;

- the right of the applicant to enroll during the specified open enrollment period, if any; and

- the right of certain applicants who do not qualify to enroll outside open enrollment periods to pursue a waiver process available from the Office of Patient Protection.