



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

1000 Washington Street, Suite 810, Boston, MA 02118-6200  
(617) 521-7794 • Fax: (617) 521-7475  
<http://www.state.ma.us/doi>

DEVAL L. PATRICK  
GOVERNOR

GREGORY BIALECKI  
SECRETARY OF HOUSING AND  
ECONOMIC DEVELOPMENT

BARBARA ANTHONY  
UNDERSECRETARY

JOSEPH G. MURPHY  
COMMISSIONER OF INSURANCE

**BULLETIN 2014-11**

**To:** Commercial Health Insurers; Blue Cross 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:** November 25, 2014

**Re:** Open Enrollment for Insured Health Benefit Plans

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**BACKGROUND**

The Division of Insurance ("Division") issues Bulletin 2014-11 ("Bulletin") to set forth the 2014-2015 enrollment requirements in Massachusetts for insured health benefit plans. This Bulletin supersedes the Division's Bulletin 2011-19 ("Open Enrollment for Individuals"), Bulletin 2013-01 ("Open Enrollment Periods for Individuals in Insured Health Benefit Plans"), and Bulletin 2013-04 ("Changes to Enrollment Requirements for Individuals in Insured Health Benefit Plans"). This Bulletin provides guidance to carriers regarding health benefit plans offered outside of the Massachusetts Health Connector ("Health Connector"); different or additional requirements may apply for health benefit plans offered through the Health Connector.

**HEALTH PLANS FOR INDIVIDUALS**

**Eligible Individual**

Massachusetts General Laws Chapter ("Chapter") 176J, § 1 defines an "eligible individual" as an individual who is a resident of the Commonwealth.

### **Annual Open Enrollment Periods**

Carriers must provide an annual open enrollment period during which the carrier must offer for sale all health plans approved for sale in the merged market and must accept any Eligible Individual who applies for any of those health plans.

The open enrollment period for 2014-2015 will run from November 15, 2014 through February 15, 2015. Subsequent open enrollment periods will be established by the Commissioner of Insurance.

Carriers shall not automatically deny applications that are submitted less than five (5) business days prior to the start of an open enrollment period and, instead, must hold the applications for processing during the upcoming open enrollment period.

### **Special Enrollment Periods**

Outside of the annual open enrollment periods, carriers must provide special enrollment periods for certain qualifying (or triggering) events pursuant to Chapter 176J § 4; and the Affordable Care Act ("ACA"), as well as any rules, regulations and guidance applicable thereto, including 45 C.F.R. § 147.104(b).

Unless otherwise specified in this bulletin, the carrier must allow for a special enrollment period of 60 days after the qualifying event. Carriers must enroll the Eligible Individual who experiences the qualifying event, along with any family members who may be eligible for coverage under the terms of the selected plan. Furthermore, unless otherwise specified in this bulletin, during a special enrollment period coverage shall become effective:

- the first day of the following month for applications completed between the 1<sup>st</sup> and the 23<sup>rd</sup> days, inclusive, of any month, unless the carrier permits the Eligible Individual to elect a coverage effective date of the first day of the second following month. If a carrier permits the Eligible Individual to elect the coverage effective date, coverage shall be effective on such date as elected by the Eligible Individual.
- the first day of the second following month for applications completed after the 23<sup>rd</sup> day of any month.

Certain of these qualifying events include, but are not necessarily limited to the following circumstances:

- An Eligible Individual, or his or her dependent, loses creditable coverage, as defined in M.G.L. c. 176J § 1, or minimum essential coverage, as defined in Section 1501(b) of the ACA, as codified in 26 U.S.C. § 5000A, and any rules, regulations and guidance applicable thereto, as they are amended from time to time.

- Loss of creditable coverage includes loss of pregnancy-related coverage as well as loss of medically needy coverage described under Title XIX of the Social Security Act. Loss of creditable or minimum essential coverage does *not* include voluntary termination of coverage under a health benefit plan; failure to pay premiums on a timely basis, including failure to pay COBRA premiums prior to the expiration of COBRA coverage; or situations allowing for rescission pursuant to 45 C.F.R 147.128.
- In the case of loss of creditable or minimum essential coverage, the carrier must allow for a special enrollment period of 63 days<sup>1</sup> after the Eligible Individual's, or his or her dependent's, last day of coverage under his or her previous health benefit plan.
- An Eligible Individual gains or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement for foster care.
  - In the case of marriage, coverage shall become effective on the first day of the month following plan selection, unless the carrier permits the Eligible Individual to elect a coverage effective date of the first day of the second following month.
  - In the case of birth, adoption, placement for adoption, or placement for foster care, coverage shall become effective on the date of the birth, adoption, placement for adoption, or placement for foster care, unless the carrier permits the Eligible Individual to elect a coverage effective date of the first day of the month following said events.
  - In either case, if a carrier permits the Eligible Individual to elect the coverage effective date, coverage shall be effective on such date as elected by the Eligible Individual.
- An Eligible Individual's, or his or her dependent's, enrollment or non-enrollment in a Qualified Health Plan ("QHP") offered through the Health Connector is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Health Connector, or its instrumentalities as evaluated and determined by the Health Connector. The date of the qualifying event shall be the date of the Health Connector's determination of error.
- An Eligible Individual, or his or her dependent, demonstrates to the Health Connector that the QHP in which he or she is enrolled substantially violated a material provision of the contract in relation to him or her. The date of the qualifying event shall be the date of the Health Connector's determination of a violation of the contract.

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<sup>1</sup> The ACA provides for a 60-day special enrollment period in the event that an individual, or his or her dependent, loses "minimum essential coverage." The Division has determined that the federal definition of "minimum essential coverage" is sufficiently similar to the state definition of "creditable coverage" such that the State's more protective standard allowing for a 63-day special enrollment period in the case of loss of creditable coverage applies to both loss of creditable coverage and loss of minimum essential coverage.

- An Eligible Individual who is enrolled in a QHP, or his or her dependent who is enrolled in a QHP (*e.g.*, a dependent who is in a different tax household), is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions. The date of the qualifying event shall be the date of the eligibility (or change in eligibility) determination.
- An Eligible Individual, or his or her dependent, who is enrolled in an eligible employer-sponsored plan, as defined in 45 C.F.R. 155.20, becomes newly eligible for advance payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible employer-sponsored plan in accordance with 26 C.F.R. 1.36B-2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage.
  - The carrier must allow for a special enrollment period of up to 60 days *before* and 60 days after loss of eligibility for qualifying coverage in an eligible employer-sponsored plan.<sup>2</sup>
- The Health Connector determines that an Eligible Individual, or his or her dependent, was not enrolled in QHP coverage, was not enrolled in the QHP selected by the Eligible Individual, or is eligible for but is not receiving advanced payments of premium tax credit or cost-sharing reductions as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities. The date of the qualifying event shall be the date of the Health Connector's determination of misconduct.
- New coverage becomes available to an Eligible Individual, or his or her dependent, as a result of a permanent move, including a move from another service area, from another state, or from another country.

### **New Enrollees Outside of Annual Open Enrollment**

Carriers must enroll an Eligible Individual who newly qualifies to purchase (*i.e.*, not renewing) coverage outside of an annual open enrollment period for a short year through December 31<sup>st</sup> of that year. During the next annual open enrollment period, carriers must either allow the individual to renew the existing coverage or to enroll in different coverage.

If an individual has coverage with a calendar-year deductible or calendar-year out-of-pocket limitation, the coverage shall be issued without any policy endorsement to pro-rate the

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<sup>2</sup> State law allowing for a special enrollment period of 63 days after loss of creditable coverage does not apply here if the individual who is losing eligibility for qualifying coverage in an eligible employer-sponsored plan has continuing eligibility for an employer-sponsored plan that is not qualifying coverage under 26 CFR 1.36B-2(c)(3); in such situations, the individual has a special enrollment period of 60 days before and after loss of eligibility for the qualifying coverage.

deductible or limitation, and the calendar-year deductible or calendar-year limitation will apply through the policy period.

Disclosures shall be provided to prospective insureds that will explain the following:

- Coverage will only be in effect through December 31<sup>st</sup> of that year;
- Any calendar-year deductible or calendar-year out-of-pocket limitations within the health benefit plan will *not* be pro-rated; and
- Eligible Individuals may switch to other coverage during the next annual open enrollment period.

### **Enrollment Process**

Carriers must accept applications submitted during an enrollment period, whether open or special, up until the last day of the enrollment period. Carriers must treat the postmark date or online filing date as the date of submission for purposes of determining if the application is submitted within the enrollment period. Carriers must consider an application to be submitted within the enrollment period even if the application is not “complete” on the date of submission.

### **Verifying Eligibility**

Carriers may require that an applicant provide reasonable documentation to establish eligibility, including documents that verify residency. Where necessary, carriers may require the applicant to submit reasonable proof of prior coverage, such as a notice regarding COBRA status. Carriers shall exercise flexibility in their requests for documentation and shall request only such information as is necessary to establish eligibility.

At the outset of the application or renewal process, carriers may request that an applicant or renewing subscriber provide the Social Security number of each individual to be covered under the health plan for purposes of reporting minimum essential coverage.<sup>3</sup> However, carriers shall provide notice to applicants and renewing subscribers 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 subscriber chooses not to provide a Social Security number.

### **Individuals Who Are Denied Enrollment**

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

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<sup>3</sup> Note that any carrier that provides minimum essential coverage to an individual during a calendar year must make reasonable efforts to obtain the covered individual’s Taxpayer Identification Number for purposes of filing the information return with the Internal Revenue Service pursuant to 26 U.S.C. §6055. See TD 9660, 26 CFR Part 1, Final Regulations, dated March 10, 2014.

- the specific reason(s) the applicant's enrollment was denied, including, but not limited to:
  - the reason(s) the applicant is not considered an Eligible Individual; or
  - the reason(s) the applicant is restricted to applying for coverage during the required annual open enrollment period;
- the right of the applicant to enroll during the next annual open enrollment period; and
- the right of an applicant who is an Eligible Individual seeking coverage outside of the annual open enrollment period but who cannot demonstrate a qualifying event for a special enrollment period to pursue a waiver process available from the Office of Patient Protection.

### **HEALTH PLANS FOR SMALL GROUPS**

Eligible small businesses or groups continue to have the right to apply for coverage anytime during the year. In cases where a small business or group cannot comply with a carrier's employer contribution or group participation rules, a carrier may restrict the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each calendar year. For the requirements for verification of a small business or group, *see* Division Bulletin 1998-08.

Please direct any questions to Nancy Schwartz, Director of the Bureau of Managed Care, Division of Insurance at 617-521-7347 or [nancy.schwartz@state.ma.us](mailto:nancy.schwartz@state.ma.us).