

HOUSE No. 839

The Commonwealth of Massachusetts

PRESENTED BY:

Ruth B. Balsler and Daniel A. Wolf

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act to facilitate access to individual health insurance.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
<i>Ruth B. Balsler</i>	<i>12th Middlesex</i>
<i>Daniel A. Wolf</i>	<i>Cape and Islands</i>
<i>Kay Khan</i>	<i>11th Middlesex</i>
<i>Denise Andrews</i>	<i>2nd Franklin</i>
<i>Carl M. Sciortino, Jr.</i>	<i>34th Middlesex</i>
<i>Michael D. Brady</i>	<i>9th Plymouth</i>
<i>Michael J. Barrett</i>	<i>Third Middlesex</i>
<i>Thomas M. Stanley</i>	<i>9th Middlesex</i>
<i>Benjamin Swan</i>	<i>11th Hampden</i>
<i>Jonathan Hecht</i>	<i>29th Middlesex</i>
<i>Denise Provost</i>	<i>27th Middlesex</i>
<i>Walter F. Timilty</i>	<i>7th Norfolk</i>
<i>Gailanne M. Cariddi</i>	<i>1st Berkshire</i>

HOUSE No. 839

By Representative Balser of Newton and Senator Wolf, a joint petition (accompanied by bill, House, No. 839) of Ruth B. Balser, Daniel A. Wolf and others for legislation to facilitate access to individual health insurance. Financial Services.

The Commonwealth of Massachusetts

In the Year Two Thousand Thirteen

An Act to facilitate access to individual health insurance.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

1 SECTION 1. The definition of “Creditable coverage” in section 1 of chapter 176J of the
2 General Laws is hereby amended by striking out the words, “with no lapse of coverage of more
3 than 63 days”.

4 SECTION 2. Section 1 of chapter 176J of the General Laws is hereby amended by
5 striking out the definition of “Eligible individual” and inserting in place thereof the following
6 definition:-

7 “Eligible individual”, (a) an individual who is a resident of the commonwealth and who
8 is not eligible for an employment-based health plan that meets the following conditions:

9 (1) the employment-based health plan must be affordable to the individual according to
10 the affordability schedule determined by the commonwealth health insurance connector authority
11 pursuant to section 3 of chapter 176Q;

12 (2) the employment-based health plan must meet a minimum actuarial value of at least 60
13 per cent as determined by the commonwealth health insurance connector authority; and

14 (3) the plan must meet all requirements of minimum creditable coverage pursuant to
15 section 3 of chapter 176Q.

16 (b) Notwithstanding the provisions of paragraph (a),

17 (1) any person enrolled in an individual health benefit plan before September 30, 2010
18 shall be considered an eligible individual so long as such person continues to be a resident of the
19 commonwealth and maintains enrollment in an individual health benefit plan; and

20 (2) unless specifically stated otherwise, persons eligible to buy child-only plans and
21 catastrophic plans shall be considered eligible individuals for the purposes of this chapter.

22 SECTION 3. Section 1 of chapter 176J of the General Laws is hereby amended by
23 inserting after the definition of “Resident” the following definition:-

24 “Short-year health plan”, a health benefit plan that is less than 12 months in duration.

25 SECTION 4. Subsection (a) of section 4 of chapter 176J of the General Laws is hereby
26 amended by striking out paragraphs (2) through (4), inclusive, and inserting in place thereof the
27 following paragraphs:-

28 (2) A carrier shall enroll eligible individuals and eligible dependents into a health plan if
29 such individuals request coverage within 63 days of termination of any prior creditable coverage,
30 as defined in section 2741 of the Health Insurance Portability and Accountability Act of 1996, 42
31 U.S.C. section 300gg-41(b); provided, that an eligible individual or eligible dependent shall not
32 be required to have such coverage in effect for 18 or more months without a break in coverage
33 greater than 63 days in order to enroll in the health plan. Coverage shall become effective on the
34 first day of the month following the carrier’s receipt of a completed application, subject to
35 reasonable verification of eligibility.

36 (3) A carrier shall enroll an eligible individual who does not meet the requirements of
37 paragraph (2) into a health benefit plan during the mandatory annual open enrollment period for
38 eligible individuals and their dependents. In calendar year 2014 and in each subsequent year, the
39 open enrollment period shall begin on October 15 and end on December 17, and coverage shall
40 become effective on January 1 of the following year. A carrier shall only enroll an eligible
41 individual who does not meet the requirements of paragraph (2) into a health benefit plan during
42 the open enrollment period. The commissioner shall promulgate regulations for the open
43 enrollment period permissible under this section. With respect to Trade Act/Health Coverage
44 Tax Credit Eligible Persons, a carrier may impose a pre-existing condition exclusion or waiting
45 period of no more that 6 months following the individual's effective date of coverage if the Trade
46 Act/Health Coverage Tax Credit Eligible Person has had less than 3 months of continuous health
47 coverage before becoming eligible for the health care tax credit; or a break in coverage of over
48 62 days immediately before the date of application for enrollment into the qualified health plan.

49 (4) (a) A carrier shall enroll an eligible individual into a health plan on the first day of the
50 month following the carrier’s receipt of a completed application if such individual makes an
51 application for coverage within 63 days of experiencing a qualifying event. A carrier shall enroll
52 persons eligible to buy child-only plans into a health plan if coverage is sought for the eligible

53 individual within 180 days of a qualifying event. Qualifying events shall include, but not be
54 limited to, the following:

55 (i) the individual was dis-enrolled from individual creditable coverage due to loss of
56 status as a dependent on another individual's health plan;

57 (ii) the individual was dis-enrolled from individual creditable coverage due to the
58 carrier's termination of the plan;

59 (iii) the individual had creditable coverage in an individual health plan with coverage
60 available only in a limited service area and this coverage is terminated because the individual has
61 moved to a location in Massachusetts that is outside the original plan's service area;

62 (iv) the individual loses eligibility for a qualified student health insurance plan;

63 (v) the individual cancels mini-COBRA or COBRA coverage;

64 (vi) the individual has a change in eligibility for cost-sharing reductions or for advanced
65 payments of the premium tax credit pursuant to the Affordable Care Act;

66 (vii) the individual's existing coverage through an employment-based health plan or
67 existing individual coverage becomes unaffordable due to changes in income, family size, or
68 other factors according to the affordability schedule determined by the commonwealth health
69 insurance connector authority pursuant to section 3 of chapter 176Q;

70 (viii) the individual's existing coverage through an employer-sponsored plan will no
71 longer provide actuarial value of at least 60 percent for the upcoming plan year;

72 (ix) the individual was denied eligibility for a subsidized health insurance plan, including
73 MassHealth, Commonwealth Care, Medical Security Program or other similar programs;

74 (x) for an individual eligible to buy a child-only plan, the birth or adoption of the eligible
75 individual child shall be considered a qualifying event;

76 (xi) the individual meets other exceptional circumstances as the commissioner may
77 provide; or

78 (xii) any other event as may be designated by the commissioner.

79 (b) A carrier shall enroll the eligible dependent of an eligible individual into a health plan
80 if coverage is sought for the eligible dependent within 63 days of a qualifying event. A carrier
81 shall enroll the eligible dependent under age 19 of an eligible individual into a health plan if
82 coverage is sought for the eligible dependent within 180 days of a qualifying event. Qualifying
83 events for an eligible dependent shall include, but not be limited to, the following:

84 (i) marriage or establishment of domestic partnership, if available under the terms of the
85 policy;

86 (ii) birth of a child;

87 (iii) adoption of a child or placement of that child for adoption;

88 (iv) the dependent's loss of creditable coverage from another group or government plan;

89 (v) upon court order;

90 (vi) the individual has a change in eligibility for cost-sharing reductions or for advanced
91 payments of the premium tax credit;

92 (vii) the dependent's existing coverage through an employment-based health plan will no
93 longer be affordable according to the affordability schedule determined annually by the
94 commonwealth health insurance connector authority pursuant to section 3 of chapter 176Q;

95 (viii) the dependent's existing coverage through an employer-sponsored plan will no
96 longer provide minimum actuarial value of 60 percent for the upcoming plan year;

97 (ix) the dependent was denied eligibility for a subsidized health insurance plan;

98 (x) the dependent meets other exceptional circumstances as the commissioner may
99 provide; or

100 (xi) any other event as may be designated by the commissioner.

101 (c) An eligible individual or eligible dependent may transfer health plans outside of the
102 annual open enrollment period if the eligible individual, eligible dependent, or parent or other
103 designated guardian of the eligible dependent demonstrates the following:

104 (i) (1) continued enrollment in the individual's existing health plan will result in a lack of
105 continuity of care for a particular medical condition, and (2) the health plan has not provided the
106 individual with access to health care providers that meet the individual's health care needs over
107 time;

108 (ii) the individual's primary care provider is no longer a contracted provider with the
109 individual's existing health plan; or

110 (iii) the individual's health care access has been adversely affected by a significant
111 change in the health plan's group of providers, including but not limited to the health plan's loss
112 of a contract with a hospital, health center, physician group or specialty provider group.

113 (5)(a) To apply to enroll in a health benefit plan as an eligible individual, an individual
114 shall apply to the commonwealth health insurance connector authority for certification that the
115 individual satisfies the definition of eligible individual.

116 (b) To apply to enroll in a health benefit plan as an eligible dependent, a dependent shall
117 apply to the commonwealth health insurance connector authority for certification that the
118 dependent satisfies the definition of eligible dependent.

119 (c) If an applicant is denied certification as an eligible individual or eligible dependent,
120 the connector authority shall provide electronic or written notice of the denial to the applicant no
121 later than two business days after receipt of an application. The notice shall specify the reasons
122 the connector authority has determined that the applicant is not considered to have met the
123 standard as an eligible individual or eligible dependent. The notice shall also specify the right to
124 pursue a waiver process available from the office of patient protection pursuant to section 16 of
125 chapter 6D and the right of the applicant to obtain consumer advocate assistance for the waiver
126 request.

127 (6)(a) To apply to enroll in a health benefit plan outside of the annual open enrollment
128 period, an eligible individual or eligible dependent shall apply to the commonwealth health
129 insurance connector authority to determine eligibility based on a qualifying event pursuant to
130 paragraph 4.

131 (b) If the applicant is denied eligibility to enroll in a health benefit plan, the connector
132 authority shall provide electronic or written notice of the denial to the applicant no later than two
133 business days after receipt of an application that specifies: (i) the specific reason or reasons the
134 connector authority has determined that the applicant is not considered to be exempt from being
135 restricted to applying for coverage during the annual open enrollment period; (ii) the right of the
136 applicant to enroll during the next specified open enrollment period; (iii) the right of certain
137 applicants who do not qualify to enroll outside open enrollment periods to pursue a waiver
138 process available from the office of patient protection pursuant to section 16 of chapter 6D; and
139 (iv) the right of the applicant to obtain consumer advocate assistance for the waiver request.

140 (7) Carriers shall allow a new eligible individual who purchases coverage outside of open
141 enrollment at any time to enroll in a short-year health plan through the next open enrollment
142 period and shall either allow the individual to renew the existing coverage or to enroll in
143 different coverage during the next open enrollment period.

144 (8) For an eligible individual who enrolls in a short-year health plan with a policy-year
145 deductible, carriers shall prorate the annual deductible amount and out-of-pocket maximum
146 amount in proportion to length of time of the short-year health plan divided by twelve months.

147 (9) No policy may require any waiting period if the eligible individual has not had any
148 creditable coverage for the 18 months prior to the effective date of coverage. Notwithstanding

149 paragraph (3), an eligible individual who does not meet the requirements of paragraphs (2) and
150 (4) may seek an enrollment waiver to permit enrollment not during a mandatory open enrollment
151 period. Enrollment waivers shall be administered and granted by the office of patient protection
152 established by section 16 of chapter 6D.

153 SECTION 5. Subsection (a) of section 16 of chapter 6D of the General Laws is hereby
154 amended by striking out paragraph (7) and inserting in place thereof the following paragraph:-

155 (7) administer and grant enrollment waivers under paragraphs (5), (6) and (9) of
156 subsection (a) of section 4 of chapter 176J. The office of patient protection may grant a waiver
157 permitting a person to enroll in a health benefit plan during the annual open enrollment period if
158 the office determines that the person is an eligible individual, notwithstanding the determination
159 of the connector authority.

160 The office of patient protection may grant a waiver permitting a person to enroll in a
161 health benefit plan outside of the annual open enrollment period if the office determines that:

162 (2) (i) the person is an eligible individual, notwithstanding the determination of the
163 connector authority; and

164 (ii) the person experienced a qualifying event notwithstanding the determination of the
165 connector authority; or

166 (iii) the person experienced an event sufficiently similar to a qualifying event to warrant
167 granting a waiver; or

168 (iv) the person experienced a qualifying event or event sufficiently similar to a qualifying
169 event and applied after the expiration of the applicable time limit and the delay in application
170 was unintentional or by no fault of the person; or

171 (3) the person did not intentionally forego enrollment into other health coverage for
172 which the individual was eligible.

173 The office shall establish by regulation standards and procedures for enrollment waivers.

174 SECTION 6. (a) In calendar year 2013, there shall be two open enrollment periods
175 pursuant to section 4 of chapter 176J of the general laws. The first open enrollment period shall
176 begin on July 1, 2013 and end on August 15, 2013. The second open enrollment period shall
177 begin on October 1, 2013 and end on December 31, 2013. All coverage shall become effective
178 on the first day of the month following enrollment.

179 (b) In calendar year 2014, there shall be two open enrollment periods pursuant to section
180 4 of chapter 176J of the general laws. The first open enrollment period shall begin on January 1,
181 2014 and end on March 31, 2014. The second open enrollment period shall begin on October 15,

182 2014 and end on December 7, 2014. All coverage shall become effective on the first day of the
183 month following enrollment.

184 (c) For 2013, if an applicant is denied the opportunity to enroll in a carrier's health plan
185 based on a determination that the applicant: (1) is not considered to have met the standard as an
186 eligible individual; or (2) the applicant is not considered to be exempt from being restricted to
187 applying for coverage during required open enrollment periods, the carrier must provide
188 electronic or written notice of the denial to the applicant no later than 5 days after receipt of an
189 application that specifies: (a) the specific reason or reasons the applicant's enrollment was
190 denied; (b) the right of the applicant to enroll during the next specified open enrollment period;
191 (c) the right to pursue a waiver process available from the office of patient protection pursuant to
192 section 16 of chapter 6D; and (d) the right of the applicant to obtain consumer advocate
193 assistance for the waiver request.

194 (d) Effective dates to be determined