HOUSE DOCKET, NO. 1318 FILED ON: 1/16/2013

HOUSE . . . . . No. 839

The Commonwealth of Massachusetts

PRESENTED BY:

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

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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:

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

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

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

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

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

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

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

(1) 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; and

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

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

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

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

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

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

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

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

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

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

(iii) the individual had creditable coverage 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;

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

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

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

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

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

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

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

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

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

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

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

(ii) birth of a child;

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

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

(v) upon court order;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) If the applicant is denied eligibility to enroll in a health benefit plan, the connector authority shall provide electronic or written notice of the denial to the applicant no later than two business days after receipt of an application that specifies: (i) the specific reason or reasons the connector authority has determined that the applicant is not considered to be exempt from being restricted to applying for coverage during the annual open enrollment period; (ii) the right of the applicant to enroll during the next specified open enrollment period; (iii) 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 pursuant to section 16 of chapter 6D; and (iv) the right of the applicant to obtain consumer advocate assistance for the waiver request.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) Effective dates to be determined