958 CMR 4.000: HEALTH INSURANCE OPEN ENROLLMENT WAIVERS

Section

4.001: Scope and Purpose

958 CMR 4.000 establishes the requirements for requests by consumers who wish to enroll in a nongroup health plan outside of the open enrollment periods established by M.G.L. c. 176J. 958 CMR 4.000 applies to all carriers subject to the requirements of M.G.L. c. 176J.

4.020: Definitions

As used in 958 CMR 4.000 the following words shall have the following meanings:

Carrier an insurer licensed or otherwise authorized to transact accident and health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a non-profit medical service corporation organized under M.G.L. c. 176B; or a health maintenance organization organized under M.G.L. c. 176G. For the purposes of 958 CMR 4.000, Carrier also means an agent of a carrier that reviews or processes enrollment applications, including but not limited to, the Connector.

Connector the Commonwealth Health Insurance Connector Authority established by M.G.L. c. 176Q, § 2(a).

Creditable Coverage coverage of an individual under any of the following health plans with no lapse of coverage of more than 63 days:

(a) a group health plan;
(b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under M.G.L. c. 15A, § 18 or a qualifying student health program of another state;
(c) Part A or Part B of Title XVIII of the Social Security Act;
(d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under § 1928;
(e) 10 U.S.C. 55;
(f) a medical care program of the Indian Health Service or of a tribal organization;
(g) a state health benefits risk pool;

(h) a health plan offered under 5 U.S.C. 89;
(i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, § 2701(c)(I)(I), as amended by Public Law 104-191;
(j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e);
(k) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as it is amended, or by regulations promulgated under that act; or
(l) any other minimum essential coverage as defined under the Patient Protection and Affordable Care Act, Public Law 111-148, and any rules, regulations or guidance issued thereunder.

Creditable Coverage is used as a criterion for eligibility for enrollment outside of the open enrollment period as defined in M.G.L. c. 176J and 211 CMR 66.00: *Small Group Health Insurance*. It is different from Minimum Creditable Coverage as defined by the Connector pursuant to 956 CMR 5.00: *Minimum Creditable Coverage*.

Eligible Individual an individual who is a resident of Massachusetts.

Enrollment Waiver permission granted to an eligible individual by the Office of Patient Protection to enable such individual to enroll in a nongroup health benefit plan outside of the open enrollment period.

Health Benefit Plan or Health Plan as defined at M.G.L. c. 176J, §1, a policy, contract, certificate or agreement entered into, offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Intentionally Forgo Enrollment an individual turned down the opportunity to enroll in or failed to apply for a health benefit plan or any plan offering creditable coverage when the individual was eligible for enrollment.

Minimum Creditable Coverage the lowest threshold health benefit plan as determined by the Connector pursuant to 956 CMR 5.00: *Minimum Creditable Coverage* that a resident must purchase in order to satisfy the legal requirement to avoid paying a penalty to the Department of Revenue pursuant to M.G.L. c. 111M, §2. Minimum Creditable Coverage is different from Creditable Coverage.

Nongroup Health Plan a health benefit plan offered pursuant to M.G.L. c. 176J to an eligible individual.

Office of Patient Protection the office within the Health Policy Commission established by M.G.L. c. 6D, §16.

Open Enrollment or Open Enrollment Period the mandatory period established by M.G.L. c. 176J, § 4(a)(3). For the purposes of 958 CMR 4.000, Open Enrollment also means the period of time prior to December 1, 2010 during which individuals could enroll in a nongroup health plan at any time.

Resident a natural person living in Massachusetts, but the confinement of person in a nursing home, hospital or other institution shall not by itself be sufficient to qualify a person as a resident.

4.030: Eligibility for Enrollment Waivers

(1) An eligible individual may apply for an enrollment waiver within 30 calendar days of receipt of notice by a carrier in accordance with regulatory guidance issued by the Division of Insurance that such individual is not eligible to enroll in a health benefit plan outside of open enrollment pursuant to 211 CMR 66.00: *Small Group Health Insurance,* or pursuant to applicable federal law including the Patient Protection and Affordable Care Act, Public Law 111-148, and any rules, regulations or guidance issued thereunder.

(2) The following individuals are not eligible to apply for an enrollment waiver:

(a) A person who does not meet the definition of "eligible individual" set forth in 958 CMR 4.020.

(b) An individual who has not first applied to a carrier for enrollment in a health plan and been notified that he or she is not eligible to enroll outside of the open enrollment period.

(3) The Office of Patient Protection is not required to review any request for an enrollment waiver that is received within 30 days of the next open enrollment period.

4.040: Procedure for Submission of Request for Enrollment Waiver

(1) An eligible person shall submit a request for an enrollment waiver on a form specified by the Office of Patient Protection and shall include a copy of the notice from the carrier that denied enrollment to the eligible person.

(2) The Office of Patient Protection shall not charge a fee to any person who requests an enrollment waiver.

4.050: Review of Applications for Enrollment Waivers

(1) The review of enrollment waiver requests is not an adjudicatory proceeding. The Office of Patient Protection shall not be required to conduct a hearing or hold a face-to-face meeting with any applicant.

(2) The Office of Patient Protection may grant an enrollment waiver to an eligible individual who certifies, under penalty of perjury, that such individual did not intentionally forgo enrollment into coverage that is at least actuarially equivalent to minimum creditable coverage and for which the individual is or was eligible during a period of open enrollment.

(3) The Office of Patient Protection may use the following criteria in determining whether to grant an enrollment waiver to an eligible individual.

(a) Evidence of extenuating circumstances that prevented an individual from enrolling in a health benefit plan during the previous open enrollment period or during an applicable

special enrollment period, including but not limited to lack of accessibility to minimum creditable coverage;
(b) The similarity of the circumstances to the qualifying events set forth in regulations or guidance issued by the Division of Insurance, the Health Connector, or applicable federal law including the Patient Protection and Affordable Care Act, Public Law 111-148, and any rules, regulations or guidance issued thereunder, that permit an individual to enroll in a nongroup health benefit plan outside of the open enrollment period. The Office of Patient Protection may confer with the Division of Insurance, the Health Connector, or other state or federal agency in order to make such determination.
(c) The credibility of the evidence presented in the enrollment waiver request.

(4) The Office of Patient Protection may not use the applicant's current health status as grounds for approval or disapproval of an enrollment waiver request.

(5) The Office of Patient Protection shall notify an applicant of its decision in writing within 30 calendar days of receipt of the enrollment waiver request.

4.060: Effect of Decision on a Request for an Enrollment Waiver

(1) The applicant for the request for the enrollment waiver is responsible for notifying the carrier that issued the denial notice of an approval of an enrollment waiver request by the Office of Patient Protection within 30 calendar days of the receipt of the approval.

(2) The carrier shall enroll the eligible individual in accordance with regulations or guidance issued by the Division of Insurance.

(3) An applicant whose request for an enrollment waiver is denied must wait until the next open enrollment period to apply to a carrier for enrollment in a nongroup health benefit plan.

4.070: Reporting to Office of Patient Protection

Each carrier shall provide to the Office of Patient Protection no later than April 1st of each year, the following information to assist the Office of Patient Protection in resolving enrollment waiver requests.

(1) Each carrier shall provide the name, telephone number and e-mail address of the person or persons within its organization who will serve as the general contact for the Office of Patient Protection for enrollment waivers.

(2) Each carrier shall provide the name, telephone number and e-mail address of the person or persons who have the authority to approve enrollment applications.

(3) Each carrier shall provide the name, telephone number and e-mail address of the person or persons to whom the Office of Patient Protection can direct a specific caller with a particular enrollment problem. This information shall include the name and contact information for a specific individual or individuals and shall not be a general customer service number.

(4) If any of this contact information changes, the carrier shall provide the new information in writing to the Office of Patient Protection within ten business days following the change.

REGULATORY AUTHORITY

958 CMR 4.000: M.G.L. c. 6D § 16 and c. 176J.