Health Insurance Coverage for Adult Children

pennsylvania
INSURANCE DEPARTMENT

Act 4 of 2009 (Senate Bill 189), which was signed into law by Governor Edward G. Rendell on June 10, 2009, expands health insurance coverage for children of insured parents. It allows adults up to age 30, under certain conditions, to remain covered by their parents' health insurance.

Those eligible children are

- unmarried
- have no dependents
- are residents of the commonwealth or enrolled as a full-time student at an institution of higher education and
- are not provided private insurance coverage or enrolled in, or eligible for, government benefits.

The coverage expansion occurs at the discretion of the employer and does not preclude an increase in premiums related to covering children for these additional years.

Still have questions? Call the Pennsylvania Insurance Department

Toll-free, Automated Consumer Hotline
877.881.6388

Regional Offices:
Harrisburg - 717.787.2317
TTY/TDD - 717.783.3898

Philadelphia -
215.560.2630
TTY/TDD - 215.560.2471

Pittsburgh - 412.565.5020
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www.insurance.state.pa.us
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The law applies to new health contracts and renewals occurring 180 days (six months) after June 10, 2009, and then on a rolling basis as contracts are made or renewed.

So, for example, since the bill was signed in June of 2009, if a policy is issued or renewed in January 2010, the provision will kick in with that January 2010 issuance or renewal.

Policies that are issued or renewed less than six months after signing will wait until next year. For example, if a policy is issued or renewed in July 2009, the provision will not kick in until the renewal of that policy in July 2010.

This timing provision gives insurers time to revise their policies to be consistent with this new requirement.

Prior to this law, insurance companies were only required to cover children on their parents' insurance until the age of 19, if the employer offered dependent coverage. At the current time, almost 40 percent of those who are uninsured in Pennsylvania are between the ages of 19 to 29.

Michelle's Law: New Mandate on Dependent Student Eligibility

Milliman

Donald Sims
Penny Plante, CEBS

On Oct. 9, 2008, a new federal law (P.L.110-381) was enacted that provides for a continuation of dependent coverage for college students who would otherwise lose eligibility because of a reduction in their full-time class status or a medically necessary leave of absence from school itself. The law, named Michelle's Law in memory of Michelle Morse, applies to almost all insured and self-insured group health plans that cover dependents and use student status to determine eligibility. Examples of covered plans are private employers, church groups, and government entities (unless certain opt-out provisions are available).

HISTORY AND BACKGROUND

Michelle Morse was a college student in New Hampshire who was diagnosed with colon cancer. In light of the strenuous treatment schedule, she was advised by her doctors to take time off from school. However, when her parents were advised that COBRA would cost $550 a month, an amount they could not afford, she continued to take a full-time course load in an effort to maintain her health insurance coverage. She passed away on Nov. 10, 2005.

Her mother, AnnMarie, took her daughter's case to the New Hampshire state legislature. With the assistance of some legislators and several medical groups, NH House Bill 37 was signed into state law on June 22, 2006, by Governor John Lynch. The federal law, patterned after the New Hampshire law, was introduced into the U.S. House of Representatives by New Hampshire Rep. Paul Hode on June 25, 2007.

WHAT IS THE IMPACT TO EMPLOYER HEALTH PLANS?

For plan years starting on or after Oct. 9, 2009, the new law prohibits a group health plan from terminating a college student's health coverage on the basis of the child taking a medically necessary leave of absence from school or changing to a part-time status. For plans on a calendar-year basis, this law becomes effective on Jan. 1, 2010.

The leave of absence or reduction in hours must be medically necessary and must commence while the eligible student is suffering from a serious illness or injury and would otherwise lose coverage under the plan.

Other requirements exist in order for this provision to apply. The student must have been enrolled in the group health plan before the first day of the leave. There must also be a written certification by the student's physician indicating that the student is indeed suffering from a serious illness or injury that necessitates the leave or change in enrollment status.

The coverage under Michelle's Law must be extended for at least one year; however, coverage may end earlier for certain reasons, such as the student aging out of the plan (e.g., exceeding the plan's normal dependent-eligibility age).

Note that certain states are considering extending the mandatory age of dependent eligibility for students. If the age when a student would no longer be covered is increased, Michelle's Law would continue to apply for that minimum one year in those states.

There are also a number of states that have passed similar laws. One example is California. Effective Jan. 1, 2009, California's version of Michelle's law became effective for fully insured plans. Its provisions are not quite the same as the federal law in that it imposes timelines for providing documentation; the federal law leaves this requirement unstated.

Another aspect of the law is that group health plans must provide notice of the requirements of the law along with any notice regarding a requirement for certifying student status for coverage under the plan.

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The law does raise certain questions that as of today do not have answers. First, the law does not specifically indicate who is responsible for paying the cost of coverage extended via Michelle's Law. The legislation does not specifically indicate that the employer

is required to absorb additional costs (i.e., for premiums) because of the extension of coverage. Because there has been a limited push for employers to absorb the cost of coverage extended through other mandates (post-mastectomy benefits, for example), who will ultimately be required to shoulder the costs related to Michelle's Law remains unknown.

Also, the new law does not specifically describe how it will integrate with COBRA coverage. It is yet to be determined conclusively if Michelle's Law continuation coverage can be credited toward COBRA coverage.

Taking both questions into account can result in complex and difficult scenarios. For example, if the employer is to maintain the proportional cost of benefits for students who have their coverage extended under Michelle's Law, and the parents have a COBRA event, then would the student coverage be continued under a) a single employee where the employer and former employee are charged the relative contributions or b) under a family election where the employer subsidizes the cost of COBRA premiums by the amount it would have contributed under an active single employee? Would COBRA even be offered for the student until such time as the Michelle's Law extension would terminate?

Combining the two questions can produce certain scenarios that we suspect will have to be determined by legal counsel until federal guidelines are established.

SUGGESTED ACTION ITEMS

- review eligibility terms as illustrated in plan documents
- prepare notification language for release to employees
- prepare eligibility-requirement-criteria language for release to employees
- in light of little federal guidance (and potential establishment of precedents), have preliminary conversations regarding decisions with your health-plan advisors and legal counsel

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For more information, contact Donald Sims (donald.sims@milliman.com, 813.282.9262), Penny Plante (penny.plante@milliman.com, 206.504.5592), or your local Milliman consultant.

Mental Health Parity

The Mental Health Parity Act ("MHPA") was originally passed in late 1996. It amended ERISA and the Public Health Service Act ("PHSA") to prohibit a group health plan from offering benefits that contain annual and/or lifetime dollar maximums for mental health benefits that are more restrictive than limitations imposed on benefits for physical illness. The Mental Health Parity and Addiction Equity Act of 2008 (the "Act") was enacted on October 3, 2008 and extends the MHPA parity requirements in ERISA and the PHSA to substance use disorder benefits and requires any such offered benefits to be similar to those for physical illness.

When are mental health parity laws effective?
The MHPA was first effective for plan years beginning on or after January 1, 1998. It contained a sunset date which was extended a number of times. The Act, which amends ERISA and the PHSA to remove the sunset date, is applicable to plan years beginning after October 3, 2009 (for calendar year plans, that is **January 1, 2010**) and to group health plans under a collective bargaining agreement at the later of (1) plan years starting on or after Jan. 1, 2010, or (2) the termination date of the last collective bargaining agreement relating to the plan.

Who must comply?
The following group health plans must comply with the MHPA and the Act:

- Fully insured group health plans,
- Self-funded group health plans,
- Church plans, and
- Non-federal governmental plans.

Employers with fewer than 50 employees during the preceding calendar year are not required to comply with the MHPA and the Act. For purposes of determining group size, both part-time and full-time employees are included. Plans offering only HIPAA excepted benefits are not required to comply (e.g., dental, vision only).

Non-federal governmental plans that are self-funded may choose not to comply. In order to opt out, the plan must file an election with the Center for Medicare and Medicaid Services prior to the beginning of each plan year and notify the plan participants of its choice to opt out.

Does the law require that mental health or substance use disorder benefits be provided?
No. Neither the MHPA nor the Act requires that group health plans provide mental health or substance use disorder benefits. However, fully-insured group health plans located in a state where mental health and substance use disorder benefits are mandated must comply with both state law, the MHPA and the Act.

What coverage is required?
The MHPA and the Act require that any annual and/or lifetime dollar maximums imposed on mental health or substance use disorder benefits be no less than those applicable to coverage for physical illness and that offered benefits be comparable.

Does the Act govern benefits for treatment of alcohol and drug abuse?
Yes. The Act now specifically includes substance use disorder benefits.

May a plan apply cost sharing to mental health or substance use disorder benefits under the Act?
The Act does not prohibit the application of cost sharing tools such as copayments/coinsurance and deductibles to mental health or substance use disorder benefits, so long as the cost sharing tools apply equally to physical health benefits.

May a plan apply day or visit limits to mental health or substance use disorder benefits under the Act?
The Act does not prohibit application of day or visit limits to mental health or substance use disorder benefits, so long as the limits apply equally to physical health benefits.

Does the law have an exemption when compliance is overly burdensome?
Yes. Until the Act becomes effective, the MHPA exemption provisions must be followed. The MHPA provisions provide that the MHPA does not apply to plans where compliance would result in a 1% increase in cost to the plan. In order for a group health plan to be exempt from the MHPA, it must:

- Comply with the MHPA for a period of at least six months,*
- Determine that the cost of compliance is at least 1% by comparing retroactive claim data,
- Notify plan participants that the plan will be amended and that they may request at no charge a summary of information on which the exemption was based, and
- Notify the appropriate federal agency.

**In no event can the six-month period begin prior to the date the Act applied to the group health plan.*

The exemption is effective 30 days from the date notice is provided to plan participants and the appropriate federal agency.

Once the Act becomes effective, its provisions must be followed and are similar to the MHPA in the treatment of exemption criteria. However, the Act amends the applicable increased cost percentage to 2% in the case of the first plan year that the new requirement applies and 1% in the case of each subsequent plan year.

Please contact your [b_officialname] representative if you have any questions or would like to discuss modifying coverage for mental health or substance use disorder benefits.