

As adopted by the Health Insurance and Managed Care (B) Committee, Nov. 22, 2010.

MODEL LANGUAGE FOR DEPENDENT COVERAGE FOR INDIVIDUALS TO AGE OF 26

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Section 1. Definitions.

- A. “Group health insurance coverage” means, in connection with a group health plan, health insurance coverage offered in connection with such plan.
- B. “Group health plan” means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA) to the extent that the plan provides medical care, as defined in subsection H, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.
- C. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
(2) “Health benefit plan” includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.
(3) “Health benefit plan” does not include:
 - (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers’ compensation or similar insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; and
 - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (4) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
 - (a) Limited scope dental or vision benefits;

- (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- (5) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
 - (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.
- (6) “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance:
 - (a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.
- D. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.
- E. “Health maintenance organization” means a person that undertakes to provide or arrange for the delivery of basic health care services to covered persons on a prepaid basis, except for the covered person’s responsibility for copayments, coinsurance or deductibles.
- F.
 - (1) “Individual health insurance coverage” means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association or other discretionary group that is not an employer plan, but does not include short-term limited duration insurance.
 - (2) For purposes of this subsection, a health carrier offering health insurance coverage in connection with a group health plan shall not be deemed to be a health carrier offering individual health insurance coverage solely because the carrier offers a conversion policy.
- G. “Individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.
- H. “Medical care” means amounts paid for:
 - (1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
 - (2) Transportation primarily for and essential to medical care referred to in paragraph (1); and
 - (3) Insurance covering medical care referred to in paragraphs (1) and (2).

- I. “Participant” has the meaning given for such term under section 3(7) of ERISA.
- J. “Subscriber” means, in the case of individual health insurance contract, the person in whose name the contract is issued.

Drafting Note: There is no definition of “dependent” in this section. Section 152(f)(1) of the Internal Revenue Code defines “child” as including only sons, daughters, stepchildren, adopted children, including children placed for adoption and foster children. Some states have defined “dependent” similarly, while others have not. In defining “dependent,” States should keep in mind that the intent of the Patient Protection and Affordable Care Act (Affordable Care Act) is to require the availability of dependent coverage of children until the child reaches age 26 and that coverage cannot be conditioned based on certain dependency factors, such support, residency, student status or marital status.

Section 2. Applicability and Scope.

- A. Except as provided in subsection B, these sections apply to any health carrier providing coverage under an individual or group health benefit plan.
- B. (1) Subject to section 6, these sections apply to grandfathered plan coverage for individual health insurance coverage and group health insurance coverage.
(2) For purposes of this subsection, “grandfathered plan coverage” means coverage provided by a health carrier in which an individual was enrolled on March 23, 2010 for as long as it maintains that status in accordance with federal regulations.

Section 3. Eligibility for Dependent Coverage to Age 26; Definition of Dependent; Uniformity of Plan Terms

- A. A health carrier that makes available dependent coverage of children shall make that coverage available for children until attainment of twenty-six (26) years of age.
- B. (1) With respect to a child who has not attained twenty-six (26) years of age, a health carrier shall not define dependent for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the plan participant, and, in the individual market, primary subscriber.
(2) (a) A health carrier shall not deny or restrict coverage for a child who has not attained twenty-six (26) years of age based on the presence or absence of the child’s financial dependency upon the participant, primary subscriber or any other person, residency with the participant and in the individual market the primary subscriber, or with any other person, marital status, student status, employment or any combination of those factors.
(b) In addition to subparagraph (a) of this paragraph, a health carrier shall not deny or restrict coverage of a child based on eligibility for other coverage, except as provided in section 6.
- C. Nothing in this section shall be construed to require a health carrier to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the legal guardian or adoptive parent of that grandchild.
- D. The terms of coverage in a health benefit plan offered by a health carrier providing dependent coverage of children cannot vary based on age except for children who are twenty-six (26) years of age or older.

Drafting Note: The provisions of this section are consistent with the provisions of section 2714 of the Affordable Care Act and the interim final regulations on dependent coverage to age 26 published in the *Federal Register* May 13, 2010. However, states that have or are considering more stringent, consumer protection requirements, such as extending dependent coverage beyond age 26. The Affordable Care Act’s preemption standards would permit States to impose such a requirement.

Section 4. Individuals Whose Coverage Ended by Reason of Cessation of Dependent Status—Applicability; Opportunity to Enroll; Written Notice; Effective Date.

- A. This section applies to any child:

- (1) Whose coverage ended, or who was denied coverage, or was not eligible for group health insurance coverage or individual health insurance coverage under a health benefit plan because, under the terms of coverage, the availability of dependent coverage of a child ended before the attainment of twenty-six (26) years of age; and
 - (2) Who becomes eligible, or is required to become eligible, for coverage on the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010 by reason of the provisions of this section.
- B. (1) If group health insurance coverage or individual health insurance coverage, in which a child described in subsection A is eligible to enroll, or is required to become eligible to enroll, in the coverage in which the child's coverage ended or did not begin for the reasons described in subsection A, and if the health carrier is subject to the requirements of this section the health carrier shall give the child an opportunity to enroll that continues for at least [thirty (30)] days, including the written notice of the opportunity to enroll as described subsection C.

Drafting Note: States should be aware that they may require carriers to provide individuals a longer length of time to enroll for coverage than the 30 days provided in paragraph (1) above. The 30 days provided in the interim final regulations published in the *Federal Register* May 13, 2010, is the minimum time frame.

- (2) The health carrier shall provide the opportunity to enroll, including the written notice beginning not later than the first day of the first plan year and in the individual market the first day of the first policy year, beginning on or after September 23, 2010.
- C. (1) The written notice of opportunity to enroll shall include a statement that children whose coverage ended, or who were denied coverage, or were not eligible for coverage, because the availability of dependent coverage of children ended before the attainment of twenty-six (26) years of age are eligible to enroll in the coverage.
- (2) (a) The notice may be provided to an employee on behalf of the employee's child and, in the individual market, to the primary subscriber on behalf of the primary subscriber's child.
 - (b) For group health insurance coverage:
 - (i) The notice may be included with other enrollment materials that the health carrier distributes to employees, provided the statement is prominent; and
 - (ii) If a notice satisfying the requirements of this section is provided to an employee whose child is entitled to an enrollment opportunity under subsection B, the obligation to provide the notice of enrollment opportunity under subsection B with respect to that child is satisfied for both the plan and health carrier.
 - (3) The written notice shall be provided beginning not later than the first day of the first plan year and in the individual market the first day of the first policy year, beginning on or after September 23, 2010.
- D. For an individual who enrolls under subsection B, the coverage shall take effect not later than the first day of the first plan year and, in the individual market, the first day of the first policy year, beginning on or after September 23, 2010.

Section 5. Individuals Whose Coverage Ended by Reason of Cessation of Dependent Status—Group Health Plan Special Enrollee

- A. A child enrolling in group health insurance coverage pursuant to section 4 shall be treated as if the child were a special enrollee, as provided under 45 CFR §146.117(d).
- B. (1) The child and, if the child would not be a participant once enrolled, the participant through whom the child is otherwise eligible for coverage under the plan, shall be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

- (2) For purposes of this subsection, any difference in benefits or cost-sharing requirements constitutes a different benefit package.
- C. The child shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

Section 6. Grandfathered Group Health Plans—Applicability

- A. For plan years beginning before January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered plan and makes available dependent coverage of children may exclude an adult child who has not attained twenty-six (26) years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than the group health plan of a parent.
- B. For plan years, beginning on or after January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered plan shall comply with the requirements of sections 3 through 5.

Section 7. Applicability Date

The provisions of these sections apply for plan years, in the individual market, policy years, beginning on or after September 23, 2010.

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