

## States: Expanding Eligibility Requirements for Insured Plans

In recent months, state legislatures around the country have been busy working on a variety of proposals intended to reduce their numbers of uninsured. One particular approach has been the passage of insurance laws requiring the extension of coverage for dependent children. As of the date of this publication, more than twenty states have passed such laws or are considering such legislation.

Although most health insurance plans already provide dependent coverage up to age 19 (typically with an available three to five year eligibility extension for full-time students), these new laws are now beginning to require coverage for even older dependents. In some instances, the new laws mandate longer periods of coverage contingent upon the dependent's student status or financial dependency. Other state proposals have tied the extension to particular circumstances — such as taking a medical leave of absence from school or for full-time students whose studies are interrupted by National Guard or armed-forces reserve duty.

According to a recent study by the Kaiser Family Foundation, a health-care policy research group, young adults between the ages of 19 and 34 are the fastest growing segment of the uninsured population. Although adding expanded dependent eligibility requirements to group health policies will almost certainly speed the cost escalation of premiums, legislators seem persuaded by the idea that even the higher group cost would remain significantly lower than the cost of someone in the target age group attempting to obtain individual health coverage. In theory, expanding health coverage availability will reduce the number of uninsured.

Of obvious concern to employers and business groups is the additional expense this kind of mandate will add to the price of insurance. According to the Kaiser Foundation, health care premiums grew an average of nine percent last year, and were up eleven percent in 2004. Unrelenting cost escalation will likely cause at least some employers to consider whether they should continue providing health coverage to their workers.

### *New Jersey*

Although several states have recently passed dependent coverage measures, New Jersey's law has attracted quite a bit of attention. Effective May 12, 2006, the law requires continued coverage for certain dependents until age 30. What makes this extension so noteworthy is that it is significantly longer than any other state currently requires or has proposed.

New Jersey's new law applies to a covered employee's over-age dependents that meet the following criteria:

- Under 30 years old,
- Unmarried,
- Without children,
- Are either residents of New Jersey or are full-time students, and
- Who are not provided coverage under any other health benefit plan.

As this is a state enacted insurance law, it does *not* apply to self-insured plans. Compliance with the New Jersey law is generally left to the insurance carrier. (See further discussion below.) The law applies only to health insurance policies and stand-alone prescription drug plans. It also only applies to policies that allow for dependent children, but limit such coverage to dependents at an age younger than 30 years old. The law also does not require that coverage be provided to dependents to age 30 if coverage is currently not provided to other dependent children.

When extended coverage is offered under the New Jersey statute, the coverage provided to dependent must be identical to what the dependent was receiving under the plan prior to "aging-out." Of course, if coverage is modified for similarly situated dependents prior to the termination of coverage at the plan's limiting age, the over-age dependent will receive the modified coverage. In addition, if the employee is currently enrolled in a plan that is different than the one in which the dependent aged-out (for example, the

employee has changed employer's, the employee has made an election change, etc.), the dependent's right to elect continuation coverage will be under the plan in which the employee is currently enrolled, assuming such coverage is subject to the law.

Dependents who aged-out of the group policy before May 12, 2006 will have until May 11, 2007 to enroll. Dependents who age-out of a policy that is currently in force on or after May 12, 2006 but before the policy's anniversary date, may make an election within the 30 day period prior to the policy's anniversary date. Otherwise, enrollment is as follows:

- Within 30 days prior to the termination of coverage at age specified in the policy;
- Within 30 days after meeting the requirements for dependent status under the continuation coverage law; or
- During an open enrollment period, as provided under the policy (assuming the eligibility requirements are met).

Rules regarding continuity of care, creditable coverage, pre-existing condition exclusions, and other general rules must be applied to dependent coverage to the same extent they are applied to other dependents. Eligibility for extended dependent coverage is also tied to the covered employee's eligibility. This means that if the covered employee's coverage terminates, so does the dependent's coverage. In addition, the right to continue coverage under this law is not limited to one election upon reaching the limiting age. Instead, the right to the extension continues until age 30 and, as the dependent's circumstances change, this may result in multiple opportunities to re-establish eligibility for coverage. (For example, a dependent that might originally be considered ineligible for the extension due to marriage, but then subsequently divorced before age 30 and satisfied all statutory eligibility requirements, must be given the right to obtain coverage once again.)

#### *Extraterritoriality — Application Outside New Jersey*

The law requires that the dependent have aged-out of a group health benefit plan issued in New Jersey. Application of the law is based on where the policy is issued and *not* on the work location or place of residence of covered employees. For example, this law would not apply to a policy issued in Pennsylvania even if it covers employees living or working in New Jersey. But, it applies to all policies issued in New Jersey, even if the employee or dependent lives outside New Jersey.

#### *Applicable Cost*

Upon the dependent's election of the continuation coverage, the carrier may charge up to 102 percent of the cost of the applicable portion of the premium previously charged for dependent coverage under the contract. According to the statute's language, premiums will be:

“...based upon the difference between the contract's rating tiers for adult and dependent coverage or family coverage, as appropriate, and single coverage, or based upon any other formula or dependent rating tier deemed appropriate by the commissioner which provides a substantially similar result.”

#### *Notice Requirements*

The law imposes some notice obligations upon employers. The employer must provide notice to the insured (the parent-employee) about the dependent coverage extension prior to:

- Any open enrollment period,
- On or before the date the dependent ages-out of coverage, and
- At the time the dependent loses the extended coverage due to ineligibility caused by marriage, leaving New Jersey, losing full-time student status, or because the dependent is covered under another group health plan.

In addition, employers must provide notice immediately following the effective date of this law to let the insured know about the over-age dependent's right (for 12 months following the May 12th effective date), to make a written election to reinstate coverage. Coverage would then be reinstated immediately. The New Jersey Department of Banking and Insurance has drafted a sample notice, entitled *Continuation of Dependents – More Choices*, that can be used to meet the notice requirements. A copy of the sample notice can be found at [http://www.state.nj.us/dobi/bulletins/blt06\\_14.pdf](http://www.state.nj.us/dobi/bulletins/blt06_14.pdf).

The New Jersey law's imposition of notice obligations on employers raises significant concerns for those plans governed by the Employee Retirement Income Security Act (ERISA). The general rule is that ERISA preempts (supersedes) state laws that relate to employee benefits programs that are subject to ERISA. ERISA will not override laws that directly regulate insurance insofar as they are applied to insurers — but the application of such laws to employers and their employee benefit plans, as done by the New Jersey law, would appear to fall within

the preemption rule. As such, the New Jersey insurance regulatory authorities would be unable to enforce this requirement against employers whose plans are governed by ERISA. Nevertheless, rather than recognizing the ERISA protection available to plan sponsors, employers can expect insurance carriers to incorporate the notice requirement into group health policies issued in New Jersey. Employers who do not want that additional burden, and who do not want to risk possible confrontation with the New Jersey department of insurance, should seek written assurance that the insurance carrier will accept and fulfill the notice requirement, on behalf of the employer. (Insurance carriers offering such services would likely impose additional fees for the notice distribution.)

#### *Interplay with Continuation Coverage Laws*

New Jersey regulators have indicated that the new state law represents a coverage continuation opportunity that arises independently from those rights provided under COBRA. They have informally indicated that a loss of coverage continued pursuant to the New Jersey law is not a qualifying event for purposes of COBRA. Consequently, although state insurance regulators are currently seeking specific guidance from federal authorities, it is their belief that the over-age dependent's right to make a COBRA election because of a loss of eligibility due to age occurs at the time he or she reaches the limiting age under the terms of the group health plan. (No official guidance to corroborate this point has yet been published.) Therefore, as of the publication date of this document, our best answer is that COBRA rights would *not* arise when the dependent exhausts his or her rights under the New Jersey law. (At the time the person aged out of the group health plan, the person would have the right to elect either continuation coverage through COBRA, or elect coverage under the New Jersey state law.)

#### *Integrated Option*

New Jersey regulatory authorities have provided carriers with two options for administering this coverage for claims and billing purposes. The first option is the Integrated Option. With this option, charges incurred by the dependent covered under this law are combined with charges incurred by other family members covered under the policy for purposes of meeting the family deductible, maximum out-of-pocket expenses, and other cost-sharing requirements or limitations. The premium is included in the group premium billed to the employer, the employer collects the premium for the dependent coverage with the group premium for employees and dependents and remits the premium to

the carrier, and the employer retains, or the carrier provides the employer credit for, the two percent administrative component of the dependent's premium.

#### *Stand Alone Option*

The second option is the Stand Alone Option. With this option, charges incurred by the dependent covered under this law are separated from those charges incurred by other members of the family covered by the policy. The dependent's covered charges do not apply towards meeting the family deduction, maximum out-of-pocket expenses or other cost-sharing requirements or limitations applicable to other family members. Instead, the dependent's covered charges are applied towards meeting a deductible, maximum out-of-pocket expenses or other cost-sharing requirements and limitations as if the dependent had single coverage under the group contract. In addition, the carrier bills the dependent premium directly to the dependent; the carrier retains the two percent administrative component of the dependent's premium and issues the dependent his or her own ID card.

#### *Self-Funded Plans*

When Congress first enacted ERISA it added a special "preemption rule" that reserves regulatory and legislative power over employee benefit plans to the federal government. This "preemption" power, however, contains a special exception which continues to allow states to regulate insurance laws. Because the state laws discussed in this article are considered insurance mandates, we believe that the laws will apply to employers who choose to buy insurance policies. On the other hand, self-funded plans (since they are not considered insured) are generally unaffected due to ERISA's preemption power. Employers sponsoring self-funded plans are therefore free to continue defining a "dependent" for purposes of benefit eligibility.

As the New Jersey law is an insurance requirement and compliance ultimately rests with the insurance carrier, employer concerns about how the carrier intends to comply should be directed to the carriers. Additional information about the New Jersey law can be found on the New Jersey Department of Banking and Insurance website at <http://www.state.nj.us/dobi/>.

Whether these measures actually reduce the number of uninsured, and at what cost to employers offering fully-insured benefits, remains to be seen. Meanwhile, employers and benefit professionals around the country will be closely monitoring developments related to New Jersey's law as there is an undeniable possibility that other states will seek to enact similar requirements.

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