~~211 CMR 63.00: YOUNG ADULT HEALTH BENEFIT PLANS~~

~~Section~~

~~63.01: Purpose~~

~~The purpose of 211 CMR 63.00 is to define coverage for young adult health benefit plans.~~

~~63.02: Applicability~~

~~211 CMR 63.00 applies to all young adult health benefit plans offered, made effective, issued, delivered, or renewed through the Connector for delivery to any eligible young adult under M.G.L. c. 176J.~~

~~63.03: Authority~~

~~211 CMR 63.00 is issued under authority of M.G.L. c. 176J, § 10.~~

~~63.04: Definitions~~

~~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.~~

~~Commissioner: the commissioner of insurance.~~

~~Connector: the Commonwealth Health Insurance Connector created under M.G.L. c. 176Q.~~

~~Creditable Coverage: Coverage of an individual under any of the following health plans with no lapse of coverage of more than 63 days for purposes of portability under 211 CMR 63.00 in relation to any pre-existing condition provision or waiting period:~~

~~(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 section 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, section 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) coverage for young adults as offered under M.G.L. c. 176J, § 10; or~~
~~(l) any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, or by regulations promulgated under that act.~~

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211 CMR 63.04: Creditable Coverage applies to creditable coverage for portability as used in 211 CMR 63.00 in relation to any pre-existing condition provision or waiting period. It is not intended to define minimum creditable coverage as defined by the Connector Board for purposes of determining individual responsibility for maintaining health coverage.

Date of Enrollment: with respect to an individual covered under a health benefit plan, the date of enrollment of the individual in the plan or coverage or, if earlier, the first day of the waiting period for such enrollment.

Eligible Young Adult: a Massachusetts resident from his/her nineteenth birthday up until the day before his/her 27th birthday who does not otherwise have access to health insurance coverage subsidized by the young adult's employer. For the purpose of identifying whether there is access to subsidized health coverage from the young adult's employer, a young adult will be considered to have access to such subsidized coverage, if the young adult's employer subsidizes at least 33% of the cost of the young adult's health insurance coverage.

Health Benefit Plan: any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under M.G.L. c. 175; an individual or a group hospital service plan issued by a non-profit hospital corporation under M.G.L. c. 176A; an individual or a group medical service plan issued by a non-profit medical corporation under M.G.L. c. 176B; an individual or a group health maintenance contract issued by an HMO under M.G.L. c. 176G; a young adults health benefit plan under M.G.L. c. 176J, § 10.

Health benefit plans shall not include those plans whose benefits are for:

(a) accident only;

(b) credit only;

(c) limited scope vision or dental benefits if offered separately;

(d) hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of 211 CMR 63.00 shall mean policies issued under M.G.L. c. 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in M.G.L. c. 152, § 1, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent;

(e) disability income insurance;

(f) coverage issued as a supplement to liability insurance;

(g) specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set;

(h) insurance arising out of a workers' compensation law or similar law;

(i) automobile medical payment insurance;

(j) insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance;

(k) long-term care if offered separately;

(l) coverage supplemental to the coverage provided under 10 U.S.C. 55 if offered as a separate insurance policy;

(m) any policy subject to M.G.L. c. 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans; or

(n) 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 shall not be considered a health plan for the purposes of 211 CMR 63.00 and shall be governed by M.G.L. c. 15A.

Minimum Creditable Coverage: Creditable Coverage determined to be sufficient to fulfill the individual health coverage mandate as defined by the Connector pursuant to M.G.L. c. 111M.

Pre-existing Conditions Provision: with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for the coverage, regardless of whether any medical advice, diagnosis, care or treatment was recommended or received before the date. Genetic information shall not be treated as a condition in the absence of a diagnosis of the condition related to that information. Pregnancy shall not be a pre-existing condition.

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Procedural Fee Schedule: a fixed dollar amount to be paid for a specific service or episode of care.

Waiting Period: a period immediately subsequent to the effective date of an insured's coverage under a health benefit plan during which the plan does not pay for some or all hospital or medical expenses, but in all cases pays for emergency services.

63.05: Minimum Coverage Standards

(1) (a) All young adult health benefit plans are to be offered only through the Connector and must have been granted the Connector's seal of approval. Only carriers which, as of the close of any preceding calendar year, have a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to eligible small businesses or eligible individuals may offer young adult health benefit plans through the Connector. Enrollees in young adult health benefit plans shall not be counted toward the requirement that there be a total of 5,000 or more covered persons as of the end of a preceding calendar year.

(b) For the period July 1, 2007 through June 30, 2009 the following shall apply:

1. A carrier, together with any wholly owned and/or wholly controlled subsidiary of that carrier, that together had a combined total of 5,000 or more members (individuals, employees, and dependents) enrolled in health plans sold, issued, delivered, made effective or renewed to eligible small businesses or eligible individuals at the close of any preceding calendar year, may also offer young adult health benefit plans through the Connector.

2. In such a case, a carrier or wholly owned subsidiary or wholly controlled subsidiary that meets the 5,000 member requirement in combination with its wholly-owned or wholly-controlled subsidiary, but that by itself has less than 5,000 members, shall develop rates for young adult health benefit plans that are:

a. consistent with the requirements of 211 CMR 63.07; and

b. developed in combination with the rates that are developed for eligible small businesses and eligible individuals by the entity(s) with which it meets the requirement for a combined total of 5,000 members.

(2) Benefits:

(a) Young adult health benefit plans must adhere to the following requirements:

1. The young adult health benefit plans that include deductible(s) or coinsurance must include an annual out-of-pocket maximum for in-network covered services not to exceed $5,000 in total; provided, however, that this requirement shall not apply to a health benefit plan that includes coinsurance for only a limited number of non-core benefits that are not required to be part of a young adult health benefit plan, including, but not limited to, outpatient prescription drug coverage or durable medical equipment.

a. The calculation of the out-of-pocket maximum must include the following payments made by the young adult for in-network covered services:

i. copayments over $100,

ii. coinsurance, and

iii. payments applied to deductibles.

b. Carriers may, but are not required to, exclude the following payments the young adult may make when calculating the out-of-pocket maximum:

i. payments for non-covered services;

ii. payments for services from out-of-network providers, such as payments applied to deductibles, copayments or coinsurance payments;

iii. payments for services provided in emergency departments, such as payments applied to deductibles, copayments or coinsurance payments, unless the member is admitted to a hospital inpatient bed; and

iv. in-network copayments under $100.

c. Carriers may, but are not required to, exclude amounts paid by the young adult for outpatient prescription drugs, whether as payments applied to deductibles, coinsurance or copayments, when calculating the out-of-pocket maximum.

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2. Notwithstanding the annual out-of-pocket maximum for covered services, the young adult health benefit plan may include a limitation on covered medical services that is no less than either $50,000 per illness, injury, or condition within a contract year or $50,000 per calendar year for in-network and out-of-network services combined.

3. If included in a young adult health benefit plan, the annual deductible for all covered medical services in total must not exceed $2,000 for in-network benefits.

4. The young adult health benefit plan may not include a procedural fee schedule of benefits.

(b) Such plans are to provide coverage of inpatient and outpatient hospital services, physician services for physical and mental illness, emergency services, and all other services mandated to be covered under Massachusetts law.

(c) Young adult health benefit plans may include reasonable copayment, coinsurance and deductible levels, subject to 211 CMR 63.05(2)(a), as approved by the Connector.

(d) Young adult health benefit plans may use cost control techniques commonly used in the health insurance industry, including tiered provider networks and selective provider contracting, as approved by the Connector.

(e) Any carrier offering young adult health benefit plans must offer at least one young adult health benefit plan that includes coverage for outpatient prescription drugs.

(3) A carrier is not required to issue a young adult health benefit plan to an eligible young adult if the carrier can demonstrate to the satisfaction of the commissioner that within the prior 12 months the eligible young adult has:

(a) made at least three or more late payments; or

(b) committed fraud, misrepresented the eligibility of a person as an eligible young adult or misrepresented information necessary to determine the health benefit plan premium rate; or

(c) failed to comply in a material manner with a health benefit plan provision; or

(d) voluntarily ceased coverage under that carrier's health benefit plan before the contract renewal date, provided that a carrier shall be required to credit the time such person was covered under prior creditable coverage provided by a carrier if the previous coverage was continuous to a date not more than 63 days prior to the date of the request for the new coverage.

(4) A carrier may request information from other carriers regarding the items listed in 211 CMR 63.05(3)(a) through (d) provided that the request does not violate any applicable state or federal law. The carrier receiving such a request from another carrier may provide the information consistent with state or federal law.

(5) A carrier is not required to issue a young adult health benefit plan to an eligible young adult if the young adult fails to comply with reasonable requests by the carrier for information relevant to the young adult's application for coverage, including but not limited to the information listed in 211 CMR 63.05(3)(a) through (d) and information regarding the young adult's access to health insurance coverage subsidized by the young adult's employer.

(6) A carrier is not required to issue a young adult health benefit plan to an eligible young adult if acceptance of an application would create for the carrier a condition of financial impairment. The carrier must file with the commissioner, at least 30 days in advance of any such denial or as soon as its financial position becomes known to the carrier, a certified statement by the Chief Financial Officer attesting to the carrier's overall financial impairment and accompanied by supporting documentation. Any carrier found to be financially impaired by the commissioner must immediately cease issuing policies on an initial basis to eligible young adults in accordance with the provisions of 211 CMR 63.05(9).

(7) A carrier is not required to issue a young adult health benefit plan, in the case of a carrier offering benefits through a network plan as part of an HMO (approved under M.G.L. c. 176G and 211 CMR 43.00) or insured preferred provider plan (approved under M.G.L. c. 176I and 211 CMR 51.00), if the young adult does not meet the carrier's requirements regarding residence within the carrier's network's approved service area;

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(8) Any carrier who denies coverage under a young adult health benefit plan to an eligible young adult under the provisions of 211 CMR 63.05 must:

(a) provide to the young adult, in writing, the specific reason(s) for the denial of coverage; and

(b) make available to the commissioner and the Connector, upon request, the documentation for the denial.

(9) Discontinuance Provisions.

(a) Filing Requirements. Notwithstanding any other provision in 211 CMR 63.05, a carrier may deny a young adult enrollment in a young adult health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that young adult health benefit plan to new eligible young adults.

(b) Material to Be Submitted. A carrier that intends to discontinue selling a young adult health benefit plan to new eligible young adults must, at least 30 days in advance of discontinuing the sale of the health plan, submit to the commissioner and the Connector a statement certified by an officer of the carrier that specifies:

1. The date by which it will discontinue selling the young adult health benefit plan to all new young adults;

2. The reason(s) for the discontinuance of the young adult health benefit plan;

3. A list of any other health benefit plans it intends to continue selling in Massachusetts;

4. The number of young adults covered by the discontinued young adult health benefit plan, both in Massachusetts and in its total book of business; and

5. An acknowledgment that the carrier is prohibited from selling the particular young adult health benefit plan again in Massachusetts to new young adults for a period of not less than three years.

(c) Notwithstanding any other provision in 211 CMR 63.05, carriers are required to renew coverage, as described in 211 CMR 63.06, under an otherwise discontinued young adult health benefit plan for young adults currently enrolled in such plan.

(d) The commissioner, in consultation with the executive director of the Connector, may disapprove, within 21 days of receiving notice under 211 CMR 63.05(9)(b), a carrier's election to discontinue the sale of a young adult health benefit plan if the carrier fails to comply with 211 CMR 63.05(9)(b) or is in violation of 211 CMR 63.05(10).

(10) In no event may a carrier deny a young adult enrollment in a young adult health benefit plan as part of an effort to circumvent the intent of M.G.L. c. 176J.

63.06: Renewability

(1) Every young adult health benefit plan must be renewable with respect to all eligible young adults at the option of the eligible young adult through the day before the young adult's 27th birthday except as provided in 211 CMR 63.06(2). A carrier shall continue coverage beyond the young adult's 27th birthday but only until the anniversary date of the young adult's enrollment in the young adult health plan.

(2) A carrier is not required to renew the young adult health benefit plan of an eligible young adult if the young adult by the renewal date:

(a) has not paid the required premiums; or

(b) has committed fraud, misrepresented whether a person is an eligible young adult, or misrepresented any information relevant to enrolling the young adult in the plan; or

(c) failed to comply in a material manner with health benefit plan provisions including but not limited to the relocation of the young adult or dependent outside the service area of the carrier; or

(d) fails to comply with reasonable requests to verify the information described in 211 CMR 63.05(3).

(3) A carrier must file with the commissioner any material changes in the criteria it uses under 211 CMR 63.06(2) to determine the nonrenewability of a young adult health benefit plan for an eligible young adult as part of the annual filing it makes with the Connector as required by 211 CMR 63.09.

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(4) A carrier must provide at least 60 days prior notice to an eligible young adult of the carrier's intention not to renew the health benefit plan and the specific reason(s) for the nonrenewal in accordance with the carrier's filed criteria.

(5) A carrier that elects to nonrenew all of its young adult health benefit plans delivered or issued for delivery to eligible young adults in Massachusetts:

(a) must submit to the commissioner and Connector, 30 days in advance of providing notice required under 211 CMR 63.06(5)(c) a statement certified by an officer of the carrier that specifies:

1. The date by which it will nonrenew all of its young adult health benefit plans to all young adults;
2. The reason(s) for the nonrenewal of all young adult health benefit plans;
3. The number of young adults covered by the nonrenewed health benefit plans, both in Massachusetts and in its total book of business; and
4. An acknowledgment that the carrier is prohibited from writing new business in the young adult market in Massachusetts for a period of five years from the date of notice to the commissioner.

(b) The commissioner, in consultation with the executive director of the Connector, may disapprove, within 21 days of receiving notice under 211 CMR 63.06(5)(a), a carrier's election to nonrenew if the carrier fails to comply with 211 CMR 63.06(5)(a) or is in violation of 211 CMR 63.06(6).

(c) A carrier must provide notice of the decision not to renew coverage to all affected eligible young adults at least 180 days prior to the nonrenewal of any health benefit plan by the carrier in the event the commissioner has not disapproved the carrier's election to nonrenew; and

(d) after the 180 day notification period, must nonrenew coverage to eligible young adults only on the date of renewal.

(6) Nothing in 211 CMR 63.06 prohibits a carrier from canceling during the term of the policy a health benefit plan issued to an eligible young adult for the reasons outlined in 211 CMR 63.06(2)(a), (b), or (c), provided that if the carrier cancels the health benefit plan for the reason found in 211 CMR 63.06(3)(a) during the policy term, a carrier must provide the eligible young adult with any grace period as provided in the health benefit plan, including any prior notification requirements.

(7) In no event may a carrier deny a young adult enrollment in or renewal of a young adult health benefit plan as part of an effort to circumvent the intent of M.G.L. c. 176J.

63.07: Rating of Young Adult Health Plans

Premiums charged to every eligible young adult for young adult health plans issued or renewed through the Connector must satisfy the rating requirements for small group health insurance plans, as defined in 211 CMR 66.08 and carriers are required, when completing the actuarial filing required under 211 CMR 66.09, to certify that all rates offered to eligible small groups and eligible individuals, including those offered to eligible young adults through young adult health benefit plans, are in compliance with the relevant requirements of M.G.L. c. 176J.

63.08: Pre-existing Conditions and Waiting Periods

(1) No carrier may exclude any eligible young adult from a young adult health benefit plan on the basis of an actual or expected health condition, duration of coverage, or medical condition.

(2) No carrier may modify the coverage of an eligible young adult through riders or endorsements, or otherwise restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the young adult health benefit plan except as otherwise permitted in 211 CMR 63.00.

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(3) No policy may include pre-existing condition provisions that exclude coverage for a period beyond six months following the young adult's date of enrollment or waiting periods that exclude coverage for a period beyond four months following the young adult's date of enrollment. The pre-existing condition provision shall only relate to a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage and for which any medical advice, diagnosis, care or treatment was recommended or received during the six months before the young adult's date of enrollment. Pregnancy shall not be a pre-existing condition. Notwithstanding 211 CMR 63.08(3), no waiting period may be imposed if an eligible young adult lacked creditable coverage for 18 months or more immediately prior to the date of enrollment.

(4) When a young adult changes from one health benefit plan to another, whether such plan is with the same carrier or a different carrier, the carrier may impose a new waiting period of not more than four months on the young adult and for only those services covered under the new plan that were not covered under the old plan.

(5) In determining whether a pre-existing condition provision or waiting period applies to an eligible young adult, all young adult health benefit plans must credit the time the person was covered under prior creditable coverage if the prior creditable coverage was continuous to a date not more than 63 days prior to request for the new coverage, exclusive of any applicable services during the waiting period under the new coverage, provided that the prior creditable coverage was reasonably actuarially equivalent to the new coverage. For the purpose of 211 CMR 63.08(5), "reasonably actuarially equivalent" means the following:

(a) the Benefit Level Rate Adjustment factor for the new health benefit plan is no more than ten percentage points greater than the Benefit Level Rate Adjustment factor of the previous health benefit plan; provided, however, that if the Benefit Level Rate Adjustment factor for the new health benefit plan is more than ten percentage points greater than the Benefit Level Rate Adjustment factor of the previous health benefit plan, the eligible young adult must receive at least the benefits of the previous health benefit plan during the term of the pre-existing condition period or waiting period; or

(b) if the previous coverage is under Medicare or Medicaid, the previous coverage is presumed to be reasonably actuarially equivalent to the new health benefit plan.

(6) If a policy includes a waiting period, emergency services must be covered during the waiting period.

(7) A carrier may only impose either a pre-existing condition limitation or a waiting period.

63.09: Filing and Reporting Requirements

(1) Carriers must file all young adult health plans offered under 211 CMR 63.00 with the Division of Insurance and the Connector in accordance with 211 CMR 66.13.

(2) Carrier Reporting Requirements. On or before March 31st of each year, every carrier offering young adult health benefit plans under 211 CMR 63.00 must file electronically with the commissioner and the Connector two copies of a report verified by at least two principal officers of the carrier and covering its preceding calendar year; provided that, if the commissioner determines that a threat of financial impairment exists to the carrier, he or she may require submission of the report before March 31st. The report must contain at least the following information in a format specified by the commissioner:

(a) Number of young adult health benefit plans offered in Massachusetts during the preceding calendar year;

(b) Number of eligible young adults, as of the close of the preceding calendar year, who purchased a young adult health benefit plan from the carrier; and

(c) A copy of the criteria used to determine the nonrenewability of a young adult health benefit plan for an eligible young adult as described in 211 CMR 63.06(2).

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~~63.10: Severability~~

~~If any section or portion of a section of 211 CMR 63.00, or the applicability thereof to any person or circumstance is held invalid by any court of competent jurisdiction, the remainder of 211 CMR 63.00, or the applicability thereof to other persons or circumstances, shall not be affected thereby.~~

~~REGULATORY AUTHORITY~~

~~211 CMR 63.00: M.G.L. c. 176J, § 10.~~

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