November 29, 2022

Kevin Beagan, Deputy Commissioner
Rebecca Butler, Counsel to the Commissioner
Massachusetts Division of Insurance
1000 Washington Street #810
Boston, MA 02118

By email to kevin.beagan@mass.gov and rebecca.butler@mass.gov

Re: Comments Regarding Chapter 177 of the Acts of 2022 – Continued Coverage

Dear Deputy Commissioner Beagan and General Counsel Butler:

On behalf of Health Law Advocates (HLA), the Massachusetts Association for Mental Health (MAMH), and Health Care For All (HCFA), thank you for holding listening sessions and written comment opportunities on various provisions of Chapter 177 of the Acts of 2022, *An Act addressing barriers to care for mental health.*

Please find below responses to questions the Division of Insurance ("Division") has asked stakeholders on the requirement for fully insured health insurance carriers to provide continued coverage of dependents over age 26 with disabilities.

Please do not hesitate to contact us with any questions or to discuss our comments further.

Sincerely,

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1. Is it clear what should be considered "as a member of a family group" or does the term require additional clarification? How can carriers request information to demonstrate that a person is a "member of a family group"? what types of information should be considered appropriate and sufficient to demonstrate this?

We recommend that this statutory definition be interpreted to include not just biological children, adoptive children, foster children, and step-children living in the parent's household, but also a disabled adult who has a legal guardian who wishes to furnish health insurance coverage through the guardian's own health plan. Many disabled adults with significant disabilities require legal guardians who furnish the person with much or all of their significant support in the home or community.

2. Is it clear what is meant by the phrase "is mentally or physically incapable of earning their own living due to disability" or does the term require additional clarification? How can carriers request information to demonstrate that a person is a "member of a family group." What types of information should be considered appropriate and sufficient to demonstrate this?

The clear purpose of these statutory changes was to allow adults with disabilities to access health insurance through their parents' plans. We recommend that this standard of being "mentally or physically incapable of earning their own living due to disability" be established as a fundamentally medical determination, based upon a treating clinician's medical judgment of the extent of a person's disability, their understanding of the trajectories of various conditions and their patient's particular capabilities at a specific time.

Furthermore, we commend the carriers' current practices discussed in the listening session of allowing a family to satisfy any relevant eligibility criteria for this coverage simply by having a medical professional, such as a physician, complete and sign a form attesting that, in their medical opinion, their patient has a disability which makes the patient medically unable to earn their own living and live independently. This approach significantly reduces the possible burden upon families to document their compliance with this requirement.

Considering this eligibility criterion to be a medical criterion also will allow persons with disabilities greater latitude to work part-time or to even attempt to return to full-time work. In some cases, the period of disability may not be permanent and all parties – persons with disabilities, employers and carriers – have strong incentives to encourage persons with disabilities to return to full-time work when possible. In light of this concern, we recommend that the legal standard "incapable of earning their own living due to disability" under Division guidance accommodate those circumstances in which a person with disabilities attempts to resume full-time employment after a period of disability, without the risk of having their coverage retroactively revoked or suddenly terminated in a manner that could cause an otherwise avoidable gap in coverage. Alternatively, other disabilities based upon chronic conditions would reasonably be expected to continue for years or indefinitely. In order to reduce the administrative burden upon families and individuals with disabilities, any required attestations should be no more frequent than once every year, and they should allow for longer intervals for certain disabilities based on chronic conditions.

Finally, during the process to renew any attestation in support of this coverage, carriers should be required to furnish adequate advance notice of any requirement that a person or their family must meet to gain or renew coverage, such as any attestation that must be obtained from a medical provider. Carriers also should have flexible deadlines in the case that a disabled person's complex medical

concerns or inadequate access to treating provider(s) due to long wait lists, for example, delays access to an appropriate provider who can furnish the attestation. Dependents should not risk termination of benefits during the pending redetermination.

3. Will carriers need to establish new systems to allow these eligible persons to be on plans? Will new types of information need to be collected from employers in order to enroll dependents?

Most if not all of the carriers who participated in the Division's listening session reported current practices to allow adult dependents with disabilities to retain coverage under their parent's plan after attaining the age of 26. However, a spokesperson for some carriers noted a restriction that has been in place: a requirement that the dependent needed to have been previously and continuously covered by the plan before turning 26 in order to continue their coverage under the plan. Restricting eligibility for coverage after age 26 in this way may have been permissible when this coverage was furnished at the option of the carriers. However, under the statutes amended by §§ 52, 53, 57, 60 and 62 of Chapter 177, eligibility for coverage after age 26 is not contingent upon any prior or any continuous coverage before age 26.[1]

It is possible, and in some cases likely, that an adult dependent could suffer disabling symptoms after the age of 26 from either a physical or behavioral health condition that render that person newly unable to maintain their employment and any associated health insurance coverage. In these situations, their disabilities would reasonably force them to leave their prior insurance plan and enroll under their parent's plan.

We recommend that the Division issue guidance clarifying that the expanded coverage for persons with disabilities under these sections in Chapter 177 is intended to apply without regard to whether the person with disabilities was previously covered by the parent's plan or whether the disabled person was continuously covered by the parent's plan prior to the age of 26.

Because these reforms apply to fully-insured plans, but not self-funded plans, we further recommend that the Division instruct carriers to issue updated membership cards that clearly indicate whether the plan is fully insured and subject to the insurance laws of Massachusetts. Carrier customer service staff also should be trained as to whether particular plans are subject to this requirement (and several other new Massachusetts state law requirements) so that they can answer questions and offer accurate information in an easy to understand manner without having to seek that answer in a consumer handbook.

4. The legal changes apply to insured coverage that is issued or renewed in MA. Is this clear or would it be helpful to do a Q & A w/ examples of what this means? The law also applies to insured health plans. Would it be helpful to do a Q & A with examples of what this means? How will covered persons and providers know whether or not the law applies to them?

[1] For instance, M.G.L. c. 176J, § 4t states that "A health maintenance contract [ ] shall provide [ ] coverage to eligible dependents under 26 years of age or without regard to age, so long as the dependent, who is covered under the membership of the dependent's parent as a member of a family group, is mentally or physically incapable of earning their own living due to disability."

Yes, it will be important to develop a Q & A with examples, as well as other educational materials. It will also be important to provide outreach to various organizations in the disability community. Many people are unaware of the availability of coverage of dependent adults.

Moreover, carrier customer service representatives do not always provide accurate information regarding such coverage. Therefore, we recommend that the Division issue guidance for carriers briefly summarizing these new rights and instruct carriers to train their customer services staff with respect to these new rights for their covered members enrolled in fully-insured plans.

In addition to any consumer-facing guidance documents that the Division might issue, it would also be helpful if Division guidance could clarify the process by which carriers can communicate to their existing plan members who are 25 years old about how such members might be eligible for continued coverage after age 26 if they meet the requirements of M.G.L. c. 176G, § 4T et seq. One carrier noted their internal system to automatically notify some members of this right using a written notice sent 30 days before a dependent's 26th birthday. We like the idea of carriers issuing an automatic notice with an application included via email and regular mail, as well as in the patient portal. We also agree with the suggestion made in the listening session that such a notice should be provided earlier, perhaps at 90 days prior to the 26th birthday to better allow families to plan and prepare.

5. What types of provider and member education may be helpful to educate providers and members about the availability of these services?

In addition to recommendations or requirements that carriers fully train their customer service staff about these rights and the Division developing Q & A documents, carriers also could place this information on their websites and member portals. Carriers could send specific notices to plan members with enrolled dependents who are age 24 or older, including a notice to plan members who have had adult dependents who have disenrolled in the last two or three years due to the adult dependent attaining the age of 26.

With respect to providers, carriers should establish administratively simple, efficient, and secure systems that providers can use to obtain information about the scope of covered benefits for their patients. Providers report that long wait times on the phone with carriers present difficulty accessing even basic information about a patient's coverage.

6. Are there any barriers or privacy concerns that should be considered?

With respect to privacy concerns, provision of continued coverage of dependents with disabilities should follow all established privacy protections currently required under law, regulation, and/or as required by codes of ethics and practice requirements for providers and professionals, as well as health insurance carriers. These protections should be shared with consumers, including minors, when appropriate. Consistent with such privacy protections, we also would suggest that the Division collect data from carriers that would allow inquiry regarding who is or is not accessing the continued coverage benefit. It is important to ensure that this benefit is described clearly in benefit handbooks, other plan documents and any consumer-facing notices, so that it is easily understood and accessible to people of diverse backgrounds.