

ALERT: HEALTH CARE REFORM BILL

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ADULT CHILDREN HEALTH COVERAGE EXTENSION: REGULATIONS PUBLISHED

Recently enacted health care reform legislation* brings dramatic and swift changes for employers. Perhaps foremost among these changes is a provision requiring employer-sponsored group health plans that provide coverage for employees' children to make that coverage available until the child reaches age 26, regardless of that child's marital or student status. (For details of this mandate, [click here](#) to see the Willis Human Capital Practice Alert Vol. 3, No. 3, "First Things First: Health Care Reform in 2010 and 2011.")

* *Please note: In this Alert we refer to the health care reform law as the Patient Protection and Affordable Care Act (PPACA). However, the final enacted version of the law incorporates three component pieces: 1) The PPACA, 2) a PPACA "manager's amendment" and 3) the "fixer" measure passed through the budget reconciliation process (HR 4872), the Health Care and Education Affordability Reconciliation Act of 2010 (HCEARA). For purposes of simplicity, though, we will refer the entire package of law as the PPACA, or health care reform.*

SUMMARY

For employers struggling to implement a slew of new health coverage requirements, the clarity of these new rules is extremely welcome. The new regulations provide detailed guidance about who must be offered coverage. The rules also set forth important requirements governing required notices and special enrollment rights for adult children under age 26. The rules also make clear that coverage is not required for grandchildren (e.g., the child of a covered child). (Nothing in the law specifically precludes providing coverage for grandchildren but doing so is more than the PPACA requires. In addition, depending on local facts and circumstances, receipt of coverage for a grandchild might represent additional taxable compensation to an employee.)

Plans are also prohibited from charging an additional premium for adult children, or otherwise limiting plan coverage options. Plans are specifically allowed to charge more for the number of individuals added to the group health plan (e.g., tiers of coverage, employee only, employee + 1, employee + 2, etc.) as long as the charge is applied on a consistent and uniform basis and not shown to vary based on the age of the child.

In addition, plans cannot condition plan eligibility on anything except the "relationship" between the participant and the child. Although IRS Notice 2010-38 generally defines child as a "son, daughter, step-child, adopted child, or foster child," the new regulations do not offer a specific definition. Presumably many employers will apply plan definitions that correspond with the IRS Notice. The regulations include the following examples of factors that *cannot* be used for defining dependent for purposes of eligibility (or continued eligibility):

- Financial dependency on the participant
- Residency with the participant
- Student status
- Employment
- Eligibility for other coverage
- Any combination of these factors

EFFECTIVE DATE

On May 10, 2010, the Departments of Labor, Health and Human Services and Treasury jointly issued regulations implementing the PPACA by expanding coverage for adult children up to age 26. These rules are slated to go into effect for plan years beginning on or after September 23, 2010. For calendar year plans that will mean the provisions will become effective beginning January 1, 2011.

BACKGROUND

The health care reform law requires any group health plans that cover dependent children to provide health coverage for such children until they reach age 26 (i.e., the law does not mandate coverage for dependent children, but if dependent coverage is available, then eligibility must be extended until a child turns 26).

The expansion of health coverage eligibility for adult children applies to group health plans regardless of whether the coverage is insured or self-funded. This means that under PPACA, major medical plans, health reimbursement accounts, mini-medical plans and other similar arrangements that deliver coverage to dependents are covered by the mandate for providing conforming health coverage to adult children. (Essentially the only plans not subject to this requirement would be HIPAA-exceptions programs such as health FSAs, certain stand alone vision or dental plans, etc. Details explaining these HIPAA exceptions are addressed in the recent Willis Human Capital Practice *Alert*, available by [clicking here.](#))

On the Department of Labor’s website, Assistant Secretary of the Employee Benefits Security Administration Phyllis Borzi published the following statement regarding the importance of extending coverage for dependent children:

“The Affordable Care Act lets young adults stay on their parents’ health care plan until age 26. Before the President signed this landmark Act into law, many health plans and issuers could and did in fact remove young adults from their parents’ policies because of their age, leaving many college graduates and others with no coverage. Young adults are uninsured at the highest rate of any age group and have the lowest rate of access to employer-based coverage. The Affordable Care Act requires employee benefit plans and issuers that offer dependent coverage to children to make the coverage available until the adult child reaches the age of 26.”

TAX IMPLICATIONS

Extending health coverage raises significant tax issues. The IRS recently addressed and resolved many of these issues in IRS Notice 2010-38. For a detailed consideration of this tax guidance, please see the Willis document available by [clicking here.](#)

OVERVIEW

The new regulations underscore the point that a group health plan is *not* obliged to provide any dependent coverage. However, any plan that chooses to make dependent coverage of children available must do so in a manner that conforms to federal law and now has a specific obligation to ensure that such coverage is available for children until attainment of 26 years of age.

The regulations also make the observation that historically, plans regularly imposed conditions on available dependent coverage. For example, in addition to the age of the child, plans might condition eligibility on student status, residency and financial support or other factors indicating dependent status. The new regulations unequivocally state that conditioning coverage is no longer appropriate. Specifically, new regulatory rules will not allow plans or coverage to use these requirements to deny dependent coverage to children. Moreover, because the health care reform law never distinguishes between coverage for minor children and coverage for adult children under age 26 – plan design coverage distinctions are similarly precluded. We take this to mean that group health plans must extend full “parity” in the treatment of all covered dependent children. In other words, any plan rule governing the participation of younger dependent children would automatically apply to control plan participation of older age children as well.

The regulations specifically note that with respect to children who have not attained age 26, a plan may not define “eligible dependent” except in terms of the relationship between the child and the participant.

VARYING COVERAGE COST BASED ON AGE: PRECLUDED

The regulations also provide that the group health plan rules governing dependent coverage *cannot* vary based on the age of a child – except for children age 26 or older, presuming such a plan chose to offer health coverage to adult children beyond age 26.

Numerous examples contained in the regulations illustrate that surcharges for coverage of children under age 26 are not allowed except where the surcharges apply regardless of the age of the child (up to age 26) and that, for children under age 26, the plan cannot vary benefits based on the age of the child.

Group health plans are also specifically precluded from conditioning dependent coverage based on whether a child is married. Happily, the regulations note that, if a child is married, there is no legal obligation to also provide coverage to the spouse of the eligible child.*

**An interesting related issue stems from COBRA. Under applicable COBRA rules, qualified beneficiaries are empowered to add dependents to coverage in the same manner as any “similarly situated active” individual. The similarly situated active rule directs that a dependent adult child who “ages out” of coverage at 26 and then elects COBRA would have the capacity to add a spouse to his or her continuation coverage at the next open enrollment opportunity. Some commentators have suggested that it might even be appropriate to do so at the moment of the dependent’s qualifying event. Although such an individual would not hold the status of a qualified beneficiary, he or she would still be entitled to draw coverage through the COBRA user.*

GRANDFATHERED PLANS

Group health plans that were already in existence on March 23, 2010 (the date the PPACA was signed) are deemed “grandfathered plans.” All grandfathered plans have the option of limiting dependent health coverage eligibility under certain circumstances. Specifically, until January 1, 2014, grandfathered plans may exclude from coverage an adult child who is eligible to enroll in his or her own employment-based plan.

Under the new regulations a grandfathered plan may not exclude a child merely because the child is eligible to enroll in each parent’s employer-sponsored plan. In other words the regulations are designed to prevent an adult child from being “frozen” out of coverage on the basis of dual eligibility in each parent’s plan. This rule seems to clarify that “grandfathered” plans likely will only be able to exclude adult children from coverage (under the pre-2014 available exclusion) where that individual is employed and is eligible for employer sponsored group health coverage through the adult child’s own employer.

The newly published regulations also note that separate guidance relating to grandfathered health plans are anticipated to be released in the very near future. Those forthcoming regulations are expected to specify that plan changes to implement plan coverage for adult children will not in any way jeopardize a group health plan’s grandfather status. In fact, a plan that chooses to make changes, such as to move towards immediate voluntary compliance before plan years beginning on or after September 23, 2010, will not cause a plan or health insurance coverage to lose grandfathered health plan status for any purpose under the health care reform law. The regulations do not state whether a plan that chooses to eliminate dependent coverage altogether risks its grandfather status, but any employer considering the elimination of dependent coverage should probably exercise caution and defer a decision until after publication of the grandfather regulations before implementing such a change.

TRANSITIONAL RULE AND SPECIAL ENROLLMENT

The regulations require a special enrollment opportunity for children who are not yet 26 and who were either:

- “Dis-enrolled” from the group health plan by reason of “aging out” of coverage, or
- Ineligible or otherwise denied coverage because they were too old under governing plan rules.

The regulations now provide a special transition rule to help address these situations by creating a special enrollment opportunity and notice requirement that will impact open enrollment as plans become subject to the health care reform law (e.g., with the plan year beginning on or after September 23, 2010).

A child under age 26 whose coverage ended, or who was denied coverage because the plan’s dependent coverage ended before the child attained the age of 26, must be allowed at least 30 days to enroll in the plan. Group

health plans must provide accurate notice and the special enrollment period must begin no later than the first day of the first plan year after the plan becomes subject to the health care reform law. (Generally January 1, 2011 for calendar year plans.)

WRITTEN NOTICE

Group health plans must provide written notice explaining the special enrollment opportunity, including details outlining the minimum 30-day window of enrollment. The notice may be delivered to the parent employee on behalf of the child. The regulations indicate that the notice can be included with regular plan enrollment materials – but it must be “prominently” worded. Although the regulations do not define the term “prominent,” we know that in the context of other laws the usage of the word “prominent” typically suggests using a larger size font, all capital lettering, colored text, shaded or otherwise highlighted text boxes.

Is an employer going to be able to easily identify all individuals who should be notified? In most situations, it would be unlikely that an employer maintained such detailed records. To help simplify plan administration we believe most employers will seek to incorporate special enrollment notification to targeted individuals as part of its general open enrollment materials package.

WHO RECEIVES NOTICE?

This special enrollment opportunity must be extended to adult children under age 26 who, due to age or lack of tax dependent status, lost coverage, are on COBRA, or were never enrolled in the plan. If the parent of such a child is not currently enrolled, this special enrollment opportunity may be used to elect coverage for the parent. The regulations further state that all benefit packages offered to minor children must be available to adult children.

The 30-day special enrollment requirement might authorize some retroactive election of coverage. For example, for calendar-year plans becoming subject to health care reform law on January 1, 2011, the 30-day notice rule would give the adult child coverage an election opportunity which stretches to January 30, 2010. When timely elected, the adult child’s coverage would still be effective as of January 1, 2010. Other compliance options exist, however, that satisfy compliance while avoiding retroactive coverage. Plan sponsors should be able to avoid the retroactive coverage possibility by providing the required notice in advance as described in the example below.

EXAMPLE ABC Company operates a calendar-year plan that is becoming subject to PPACA duties on January 1, 2011. ABC’s annual open enrollment season for plan year 2011 starts on November 1, 2010. Nothing in the regulations would prevent ABC Company from providing the adult child a special enrollment notice early (e.g., on November 1) and then extending a 30-day open enrollment period for all participants, with regular plan coverage commencing for adult dependent children on January 1, 2011. This approach would offer the administrative advantage of not having to operate one adult child enrollment period and then a second for other participants and beneficiaries. Even more importantly, with advance notice about enrollment, ABC Company also avoids the possible obligation of having to retroactively cover a participant if the 30-day notice was not delivered until the first day that the plan officially became subject to PPACA.

The regulations specifically state that, once the adult child has been afforded the “special enrollment” opportunity, then in subsequent years, dependent coverage may be elected for an eligible child in connection with normal plan enrollment season opportunities.



WHAT COVERAGE IS TO BE AVAILABLE?

Many benefit professionals will remember that when HIPAA was enacted back in 1996, individuals who were permanently locked out of group health plan coverage due to a pre-existing condition exclusion were also afforded a special enrollment opportunity. The regulations governing the extension of coverage to adult children now harkens back to those old HIPAA-era rules. In fact the new rules state that “For a group health plan or group health guidance regarding re-enrollment rights for individuals previously denied coverage due to a health factor was issued by the Departments of the Treasury, Labor, and HHS on December 29, 1997... if a notice satisfying these requirements is provided to an employee whose child is entitled to an enrollment opportunity, the obligation to provide the notice of enrollment opportunity with respect to that child is satisfied.”

In order to satisfy the cited HIPAA portability regulations, the child must be offered *all* the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. The child also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of dependent status loss. In addition, if a child qualifies for an enrollment opportunity and the parent is not enrolled but is otherwise eligible for enrollment, the plan must provide an opportunity to enroll the parent, in addition to the child. Also, if a plan has more than one benefit package option, and the parent is enrolled in one benefit package option, the plan must provide an opportunity to enroll the child in any benefit package option for which the child is otherwise eligible – thereby enabling the parent to switch benefit package options as well.

WHAT SHOULD EMPLOYERS DO NEXT?

Most group health plans currently provide a dependent coverage benefit and therefore will become subject to the requirement that coverage must be delivered to adult children until age 26. Plan sponsors should therefore begin planning now to comply with the new adult child coverage requirement. Plan documents (e.g., group health plan document, cafeteria plan, health reimbursement accounts, etc.) and summary plan descriptions must be amended to provide for coverage of children up to age 26 regardless of any factors other than age and relationship to the participant. Compliant notices will need to be prepared and distributed as plans become subject to the new health care reform law. Strategies for addressing the required special enrollment opportunity to individuals who will be eligible for protection under this rule, but currently ineligible for plan coverage should be considered. Specifically, will the plan provide a separate special enrollment for those individuals, or is it preferable to integrate such notice as part of the annual open enrollment season?

The HHS and DOL have published statements encouraging plans to comply earlier than the law requires. If an employer plans to comply early, then plan document and notification work would need to be addressed sooner than otherwise required.

TOOLS

The interim final regulations described in this article can be found by [clicking here](#).

For more information about implementation of the Affordable Care Act visit the [EBSA webpage](#). See also the helpful [DOL FAQ](#).

KEY CONTACTS

US BENEFITS OFFICE LOCATIONS

NEW ENGLAND

Auburn, ME
207 783 2211

Bangor, ME
207 942 4671

Boston, MA
617 437 6900

Hartford, CT
860 756 7365

Manchester, NH
603 627 9583

Portland, ME
207 553 2131

Shelton, CT
203 924 2994

NORTHEAST

Buffalo, NY
716 856 1100

Cranford, NJ
908 931 3005

Florham Park, NJ
973 410 4622

Morristown, NJ
973 829 6374
973 829 6465

New York, NY
212 915 8802

Norwalk, CT
203 523 0501

Radnor, PA
610 254 7289

Wilmington, DE
302 397 0171

ATLANTIC

Baltimore, MD
410 584 7528

Bethesda, MD
301 581 4261

Knoxville, TN
865 588 8101

Memphis, TN
901 248 3103

Nashville, TN
615 872 3716

Norfolk, VA
757 628 2303

Reston, VA
703 435 7078

Richmond, VA
804 527 2343

Rockville, MD
301 692 3025

SOUTHEAST

Atlanta, GA
404 224 5000

Birmingham, AL
205 871 3300

Charlotte, NC
704 344 4856

Gainesville, FL
352 378 2511

Greenville, SC
704 344 4856

Jacksonville, FL
904 355 4600

Marietta, GA
770 425 6700

Miami, FL
305 421 6208

Mobile, AL
251 544 0212

Orlando, FL
352 378 2511

Raleigh, NC
704 344 4856

Savannah, GA
912 239 9047

Tallahassee, FL
850 385 3636

Tampa, FL
813 490 6808
813 289 7996

Vero Beach, FL
772 469 2842

MIDWEST

Appleton, WI
414 259 8837

Chicago, IL
312 288 7700
312 621 4843
312 348 7678

Cleveland, OH
216 357 5921

Columbus, OH
614 326 4788

East Lansing, MI
517 349 3226

Grand Rapids, MI
248 735 7249

Green Bay, WI

414 259 8837

Milwaukee, WI

414 203 5248

414 259 8837

Minneapolis, MN

763 302 7131

763 302 7209

Moline, IL

309 764 9666

Pittsburgh, PA

412 645 8537

412 586 3524

Schaumburg, IL

847 517 3469

SOUTH CENTRAL**Amarillo, TX**

806 376 4761

Austin, TX

512 651 1660

Dallas, TX

972 715 2194

972 715 6272

Denver, CO

303 765 1564

303 773 1373

Houston, TX

713 625 1017

713 625 1082

McAllen, TX

956 682 9423

Mills, WY

307 266 6568

New Orleans, LA

504 581 6151

Oklahoma City, OK

405 232 0651

Overland Park, KS

913 339 0800

San Antonio, TX

210 979 7470

Wichita, KS

316 263 3211

WESTERN**Fresno, CA**

559 256 6212

Irvine, CA

949 885 1200

Las Vegas, NV

602 787 6235

602 787 6078

Los Angeles, CA

213 607 6300

Novato, CA

415 493 5210

Phoenix, AZ

602 787 6235

602 787 6078

Portland, OR

503 274 6224

Rancho/Irvine, CA

562 435 2259

San Diego, CA

858 535 1800

858 678 2130

San Francisco, CA

415 291 1567

San Jose, CA

408 436 7000

Seattle, WA

800 456 1415

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