

Health Care Reform Update

Dependent Children Coverage to Age 26

As previously communicated, the *Patient Protection and Affordable Care Act* (PPACA, the Act)¹ requires group health plans that offer dependent children coverage to provide such coverage to children up to age 26. The Departments of Labor, the Treasury and Health & Human Services (the Departments) issued joint interim regulations on this new requirement, providing much needed clarification. The Departments are requesting comments on this interim rule by August 11, 2010.

The following summarizes key points from the regulations in a question and answer format.

WHEN MUST I COMPLY WITH THE REQUIREMENT TO PROVIDE COVERAGE TO CHILDREN UP TO AGE 26?

If your group health plan provides coverage to dependent children, the plan generally must extend coverage to children up to age 26 (i.e. before the child's 26th birthday) effective with the first plan year that begins on or after September 23, 2010 (January 1, 2011 for calendar-year plans).

Example

An employer-sponsored group health plan has a plan year that begins January 1, 2011. The employer plan provides health plan coverage for employees, employees' spouses and employees' children until age 26. An employee's child turns 26 on July 17, 2011.

The last day the plan covers the child is July 16, 2011. This plan satisfies the extended eligibility requirements under the PPACA.

There is a limited exception for "grandfathered plans".² For plan years that begin before January 1, 2014, a grandfathered group health plan providing dependent children coverage may exclude an adult child under age 26 only if the adult child is eligible to enroll in another eligible employer-sponsored health plan. However, the other eligible employer-sponsored group health plan cannot be the group health plan of a parent. In other words, if an adult child is eligible for coverage under the employer-sponsored plans of both parents, neither plan may exclude the adult child from coverage based on the fact that the adult child is eligible to enroll on the plan of the other parent's employer.

Grandfathered plans will need to offer health plan coverage to adult children up to age 26, regardless of other employer-provided coverage for plan years that begin on or after January 1, 2014.

¹ As amended by the *Health Care and Education Affordability Reconciliation Act of 2010*, enacted March 30, 2010.

² A health plan in effect on March 23, 2010 is considered "grandfathered coverage." It retains this status until plan changes are made; merely enrolling new hires or adding/dropping dependents will not cause a plan to lose its grandfathered status.

WHO IS A CHILD FOR PURPOSES OF THIS REQUIREMENT?

The regulations do not provide a clear definition of a child. Rather, the regulations indicate that a group health plan may not define eligibility for dependent children in terms other than the relationship between the child and the plan participant (e.g. eligibility is extended to the child of the employee).

Thus, a plan may not deny or restrict coverage for a child who has not attained age 26 based on:

- The presence or absence of the child's financial dependency (upon the employee or any other person);
- Eligibility for other coverage except as permitted under the special rule for grandfathered group health plans;
- Residency with the employee or any other person;
- Marriage status;
- Student status;
- Employment; or
- Any combination of these factors.

The regulations make it clear that a group health plan is not required to provide coverage to grandchildren or to a spouse of an eligible child.

CAN I CHARGE THESE "NEWLY ELIGIBLE" CHILDREN MORE FOR COVERAGE UNDER THE GROUP HEALTH PLAN? CAN I ONLY OFFER THEM ONLY OUR LOWER COST PLAN?

No. The regulations prohibit a group health plan from varying the terms of the plan (including contributions, premiums and benefit offerings) based on age. Thus a plan cannot impose an increased premium or reduced benefit offering for children under age 26. Plans may still vary the cost of coverage based on tiers (e.g. self-only; self-plus-one; self-plus-two; self-plus-three-or-more) without violating this rule, provided the increases are not tied to the child's age.

Example

A group health plan offers a choice of self-only or family health coverage. Dependent coverage is provided under family health coverage for children of participants who have not attained age 26. The plan imposes an additional premium surcharge for children who are older than age 18.

This plan **violates** the requirement because the plan varies the terms for dependent coverage of children based on age.

Example

A group health plan offers a choice among the following tiers of health coverage: self-only, self-plus-one, self-plus-two, and self-plus-three-or-more. The cost of coverage increases based on the number of covered individuals. The plan provides dependent coverage of children who have not attained age 26.

The plan **does not violate** the requirement as the cost of coverage increases for tiers with more covered individuals regardless of the age of the children covered by the plan.

The regulations do not prohibit variances with respect to children who are age 26 or older; however, other laws (e.g. state insurance mandates) may prohibit different treatment.

ARE THERE ENROLLMENT REQUIREMENTS?

Yes.

Transition Rule

A special transition rule exists for children who were covered by a group health plan but lost coverage as a result of aging out of the plan prior to turning age 26, and for children who were not eligible for coverage as they exceeded the age limitations of the plan (but are age 25 or younger).

Opportunity to Enroll and Written Notice

When the expanded age requirements come into effect for a group health plan (first plan year on or after September 23, 2010), the plan will be required to provide an enrollment opportunity that lasts for at least 30 days (including the provision of a written notice of the opportunity to enroll). The enrollment opportunity, including a written notice, must be provided no later than the first day of the first plan year beginning on or after September 23, 2010 (no later than January 1, 2011 for a calendar-year plan).

The plan will need to provide a written notice that contains a statement that children whose coverage ended or who were denied coverage (or were not eligible for coverage) because the availability of group health plan coverage ended before attainment of age 26 are eligible to enroll in the plan or coverage. See *Model Notice of Opportunity to Enroll in Connection with Extension of Dependent Coverage to Age 26*, available at <http://www.dol.gov/ebsa/dependentsmodelnotice.doc>.

Notice can be provided to the employee on behalf of the employee's child. The notice may be included with other open enrollment materials that the plan distributes to employees provided the statement is prominent.

The Departments expect many plans will use their existing annual enrollment periods (which may begin and end before the start of the plan year) to satisfy this notice and enrollment opportunity.

Enrollment

Should a child elect coverage, the coverage must begin no later than the first day of the first plan year beginning on or after September 23, 2010, even if the request for enrollment is made after the first day of the plan year.

The newly enrolled child is treated as a HIPAA special enrollee. Accordingly, the child (and the participant through whom the child is eligible for coverage under the plan) must be offered all the benefit packages available to similarly situated individuals. This means that the child cannot be required to pay more for coverage than other similarly situated individuals and that any difference in benefits or cost-sharing requirements will constitute a different benefit package.

These requirements are illustrated in the following examples.

Example

ZYX Company maintains a group health plan with a plan year beginning October 1 and ending September 30. Prior to October 1, 2010, the group health plan allows children of employees to be covered under the plan until age 22. Employee David and his son Eric are enrolled in family coverage under the employer-provided group health plan for the plan year beginning on October 1, 2008. On May 1, 2009, Eric turns 22 years old and ceases to be eligible as a dependent under ZYX Company's plan and loses coverage. David drops coverage but remains an employee of ZYX Company.

In this Example, not later than October 1, 2010, the plan must provide David and Eric an opportunity to enroll (including written notice of an opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example

Widget Corp. maintains a group health plan with a calendar year plan year (Jan. 1-Dec. 31). Prior to 2011, the plan allows children of employees to be covered under the plan until the child attains age 22. During the 2009 plan year, an individual with a 22-year old child joins the plan; the child is denied coverage because the child is 22.

In this Example, notwithstanding that the child was not previously covered under the plan, the plan must provide the child, not later than January 1, 2011, an opportunity to enroll (including written notice to the employee of an opportunity to enroll the child) that continues for at least 30 days, with enrollment effective not later than January 1, 2011.

IF A CHILD AGES OUT OF OUR PLAN AND IS ON COBRA, WILL HE OR SHE BE OFFERED A NEW OPPORTUNITY TO ENROLL? WHAT HAPPENS IF THEY AGE OUT AGAIN?

An example in the regulations makes it clear that a child who has COBRA coverage because he or she aged out of the group health plan will be provided a new enrollment opportunity as a dependent of the employee effective with the first plan year on or after September 23, 2010, assuming the child is age 25 or younger.

If the child has a future qualifying event (including aging out of coverage at age 26), the child has another opportunity to elect COBRA continuation of coverage. If the child is COBRA eligible as a result of aging out of the plan (i.e. turning 26), he or she may receive up to 36 months of COBRA coverage.

WILL EXPANDING THE DEPENDENT ELIGIBILITY PROVISIONS UNDER OUR GROUP HEALTH PLAN CAUSE US TO LOSE “GRANDFATHERED STATUS”?

Likely no, but additional guidance is needed. Informally, the Departments say they anticipate regulations relating to grandfathered plans will make it clear that changes in a group health plan to comply with this requirement will not cause a plan to lose grandfathered status. Further, the Departments expect that plans who voluntarily expand their dependent age provisions before the effective date will not lose grandfathered status.³ While this is encouraging news, further guidance is needed. The Departments state that regulations related to grandfathered plans are expected “in the very near future.” Stay tuned.

WHERE CAN I GET MORE INFORMATION?

For more information, including how to comment on the regulations, visit the following websites.

- For the regulations (including how to provide comments), visit: <http://www.dol.gov/ebsa/pdf/dependentcoverage.pdf>
- For a fact sheet, visit: <http://www.dol.gov/ebsa/newsroom/fsdependentcoverage.html>
- For FAQs, visit: <http://www.dol.gov/ebsa/faqs/faq-dependentcoverage.html>
- For model notice, visit: <http://www.dol.gov/ebsa/dependentsmodelnotice.doc>
- For more information on the tax treatment of children up to age 27, see IRS Notice 2010-38: <http://www.irs.gov/pub/irs-drop/n-10-38.pdf>

³ “Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule”, *75 Federal Register* 92 (May 13, 2010) 27122, 27124.



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