

Health Care Reform Alert Extended Coverage For Young Adult Dependents

Health Plans Must Cover Young Adult Children Until Age 26

The Affordable Care Act, the new health care reform law¹, requires group health plans and health insurance issuers that provide dependent coverage of children to continue to make such coverage available until the child turns 26 years of age. On May 13, 2010 the three federal agencies primarily responsible for administering the Affordable Care Act (the Departments of Health and Human Services, Labor and the Treasury) issued interim final regulations on the new dependent coverage law. The law and regulations impose significant new obligations on group health plan sponsors and insurers that go into effect as early as October 1, 2010, including a requirement that health plans offer young adult children (and in some cases, their parents) a special enrollment opportunity effective as of the first plan year beginning on or after September 23, 2010.

Overview of New Dependent Coverage Rules

The Affordable Care Act requires group health plans and health insurance issuers² that provide dependent child coverage to make that coverage available until the child reaches age 26. This requirement applies to all group health plans otherwise subject to the Affordable Care Act, including insured and self-insured plans, excluding only certain plans (such as stand-alone dental or vision plans and some flexible spending accounts) that are currently exempt from HIPAA "portability" requirements.³

The health care reform law also amended the Internal Revenue Code to provide that an employee will not be taxed on the reimbursements received under an employer group health plan for a tax year of the employee (usually, the calendar year) with respect to a child who will not reach age 27 by the end of such year. The new regulations state that employees will similarly not be taxed on the value of employer-provided health coverage of the employee's child for a tax year if the child will not attain age 27 by the end of such year.

Effective Date

In general, the new dependent coverage rules apply to group health plans as of the first day of the first plan year that begins on or after September 23, 2010 (so for calendar year plans the effective date is January 1, 2011). However, certain grandfathered group health plans (i.e., plans in existence on March 23, 2010), may exclude an adult child until the first plan year beginning on or

¹ We refer to the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152, as the "Affordable Care Act" or the "health care reform law".

² The requirements apply to health insurance issuers in both the group and individual markets. This Alert focuses on group health plans and group health insurance coverage.

³ HIPAA portability requirements are set forth in Sections 9801 and 9802 of the Internal Revenue Code, Sections 701 and 702 of the Employee Retirement Income Security Act (ERISA) and Sections 2702-2706 of the Public Health Service Act (PHSA).

after January 1, 2014 if such child is eligible to enroll in an employer-sponsored health plan, other than a plan of either parent. In addition, the Affordable Care Act provides for a delayed effective date for collectively bargained health plans.

Defining Eligible Dependents

The health care reform law and the new regulations will significantly impact the manner in which group health plans determine eligibility for dependent coverage. For a participant's child under age 26 - whether a minor or adult child - a group health plan may no longer condition eligibility for dependent coverage on

- whether the child is financially dependent on the participant, or a dependent of the participant for income tax purposes,
- whether the child resides with the participant,
- the child's marital status, student status or employment status, or
- any combination of these factors.

For a child under age 26, eligibility for dependent coverage can now be defined only by reference to the precise nature of the parent-child relationship. The new regulations do not define the term "child" for purposes of the required extension of coverage to age 26. Presumably, a plan could limit eligible dependents to natural and adopted children⁴, and exclude, for example, step-children and foster children. In addition, a group health plan that covers children age 26 and older presumably could still condition eligibility on financial dependency or any of the other factors listed above which can no longer be used for children under age 26.

Under the Internal Revenue Code, a group health plan can provide tax-free coverage to the natural children, adopted children, step-children and eligible foster children of participants. A plan that provides dependent coverage to other individuals – such as grandchildren or children of domestic partners – could provide such coverage on a tax-free basis only if the dependent qualified under the rules in effect before the Affordable Care Act.⁵

Group health plan sponsors should review the eligibility rules for dependent coverage under their plans in light of these new rules and make appropriate changes, no later than the first plan year that begins on or after September 23, 2010.

⁴ Note that an existing law – Section 609(c) of ERISA – already requires that a group health plan that provides coverage for dependent children must cover a participant's adopted children, and children placed for adoption with a participant, on the same terms and conditions as natural children.

⁵ In other words, the child would have to meet the requirements for treatment as a "qualifying child" or a "qualifying relative" under Section 152 of the Internal Revenue Code.

Premiums and Other Plan Terms Cannot Vary Based on Age

The new regulations state that a plan's terms and conditions for dependent coverage cannot vary based on age, except for children who are age 26 or older. For example, a plan cannot charge a higher premium for children older than 18 (and younger than 26) than for children age 18 and younger. Nor could a plan limit children older than 18 (and younger than 26) to a specific coverage option (an HMO option as opposed to an indemnity option, for example), if the other options are available to participants and younger dependent children.

Special Enrollment Opportunity

The regulations take the position that as soon as a group health plan become subject to the new dependent coverage mandate, a child under age 26 may not be excluded, regardless of whether or when a child was enrolled in the plan previously. Accordingly, the regulations provide transitional relief for a child whose prior dependent coverage ended, or who was not previously covered, because the plan terminated eligibility for dependent coverage before age 26.

Effective as of the first day of the first plan year beginning on or after September 23, 2010, group health plans are required to give these adult children - and, in some cases, their parents - a special one-time opportunity to enroll or re-enroll in the plan. Plans must provide written notice of this enrollment opportunity to each eligible child or parent no later than the first day of such plan year, and provide for an enrollment period of at least 30 days. A plan could provide this enrollment opportunity as part of its regular open enrollment, but the notice and enrollment opportunity must be furnished by the date just described regardless of when the plan's open enrollment period is scheduled to occur.

The special one-time enrollment opportunity must be provided to any young adult child who

- previously was not eligible to enroll, or was denied dependent coverage, because the child was older than the plan's upper age limit for dependent children, or
- whose dependent coverage ended in connection with the child reaching the maximum age for dependent coverage (upon graduating from college, for example).

If an eligible child takes advantage of the one-time enrollment opportunity, 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. In addition, the new regulations provide that such a child must be treated as a special enrollee under the pre-2010 HIPAA special enrollment rules.⁶ As a result, if the *participant* had previously dropped coverage in connection with his or her child's loss of dependent eligibility, the participant must also be given an opportunity to enroll in any available option under the plan.

Example: An employee and her son are enrolled in an employer group health plan (which has a calendar plan year) prior to 2010. In September 2009 the son turns 19 and stops being eligible for dependent coverage, and the employee drops her coverage as well. Not later than January 1, 2011 the plan must give both the employee and her son the opportunity, for at least 30 days, to re-enroll in the plan.

⁶ These rules can be found in Section 9801(f) of the Internal Revenue Code, Section 701(f) of ERISA and Section 2704(f) of the PHSA.

If the young adult child had elected COBRA when his regular dependent coverage expired, he still must be given the special enrollment opportunity. If he re-enrolls for regular coverage, he would again be entitled to COBRA – for another 36 months -- if he later “ages out” or otherwise loses dependent eligibility under the plan.

Relationship to New York Law “Age 29 Law”

The dependent coverage rules enacted by the Affordable Care Act are somewhat similar in purpose to the requirements under the New York “Age 29 law” passed in 2009. Under the New York law, effective for policies issued, renewed or amended in New York on or after September 1, 2009, group health insurance issuers must:

- if they offer group health policies with dependent coverage, offer sponsoring employers a coverage option under which the unmarried child of a participant would be covered through age 29, regardless of whether the child is financially dependent on the parent (the “make available option”), and
- separately, permit a dependent child to elect continued coverage under a parent's group health policy through age 29 (the “young adult option”).

Additional information on New York’s “Age 29 law” can be found here:

<http://www.jaekle.com/NYSHealthLawChanges>

In addition to the different ages of the young adult child (26 vs. 29) through which coverage is required, the differences between the new federal requirements and those under the New York “Age 29 law” include the following :

- The new federal requirements can be enforced against the employer-plan sponsor as well as against the insurer.
- The new federal requirements are mandatory for all group health plan sponsors and insurers, while the New York “make available option” applies only if the employer chooses to make it a part of its group health plan.
- The new federal requirements apply to self-insured plans as well as insured arrangements.
- The new federal requirements apply even if the young adult is married; the New York requirements do not.
- Except with respect to grandfathered group health plans for plan years beginning before January 1, 2014, the new federal requirements apply even if the young adult is eligible for other coverage; the New York requirements do not.

Relationship to Michelle’s Law

Michelle’s Law, passed in 2008 and first effective for plan years beginning on or after October 9, 2009,⁷ prohibits a group health plan and the plan’s insurer from terminating a college student’s health coverage due a medically necessary leave of absence. This law is much more limited in scope than the Affordable Care Act requirements for dependent coverage. Michelle’s Law only applies if the dependent child was covered immediately before the leave of absence began, and

⁷ Public Law 110-381, which added Section 9813 of the Internal Revenue Code, Section 714 of ERISA and Section 2707 (now Section 2728) of the PHSA.

only requires that coverage be continued for one year. There are other requirements as well, and Michelle's Law likely will have little or no impact on a group health plan once it becomes subject to the Affordable Care Act dependent coverage rules.

What Sponsors Should Do

The Affordable Care Act dependent rules take effect on the first day of the first plan year that begins on or after September 23, 2010. Before that date, group health plan sponsors should:

- determine the effective date of the new dependent coverage requirements, based on the plan's plan year⁸,
- work with the plan's insurer and/or third party administrator (or administrator and stop-loss insurer, for a self-insured plan) to implement the required changes,
- consider whether the dependent coverage changes should be out into effect *before* the mandatory effective date,
- prepare and distribute the required special enrollment notice, separately or, if permissible, as part of regular annual enrollment materials, and
- amend the plan documents, summary plan description and enrollment forms to reflect the new dependent coverage rules.

If you have any questions about the new dependent coverage rules or any other aspect of health care reform, please contact Robert W. Patterson at 716.843.3910 or rpatterson@jaeckle.com, or Michele O. Heffernan at 716.843.3850 or mheffernan@jaeckle.com.

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⁸ See "Immediate and Long Term Changes – 'Plan Year'" in our first Health Care Reform Alert, which can be found here: <http://www.jaeckle.com//EmployerHealthCareChallenges>