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Agencies Issue Interim Final Regulations Regarding New Extended Adult Child Coverage Requirement

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Today, the Treasury Department, in conjunction with Health and Human Services and the Department of Labor, issued interim final rules regarding the dependent coverage extension for children under age 26, as required by the Patient Protection and Affordable Care Act, Pub. L. No. 111-149 (“PPACA”) (“Interim Final Regulations”). Today’s guidance follows on the heels of IRS Notice 2010-38, which was issued on April 27th and addresses the tax treatment of employer-paid health coverage for qualifying adult children. The Interim Final Regulations are generally effective for plan years beginning on or after September 23, 2010. Comments are requested with 90 days from the date of publication in the Federal Register.

Background Regarding PPACA and New Mandated Adult Child Coverage

The PPACA, which was enacted on March 23, 2010, added a new section 2714 to the Public Health Service Act (“PHSA”). Section 2714 generally provides that a plan or issuer that makes available coverage for dependent children must also make such coverage available for children until they turn age 26 (hereinafter referred to as an “Adult Child”). The provision is generally effective for plan years beginning on or after September 23, 2010 (i.e., the 2011 plan year for calendar year plans) and includes a special transition rule for “grandfathered” plans, as discussed below.

The PPACA, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (“HCERA”), also made a corresponding change to the Internal Revenue Code (“IRC”). Specifically, it amended IRC § 105(b), to make excludable from an employee’s income any employer-paid health coverage attributable to the employee’s child to the extent such child does not turn age 27 during the taxable year at issue.

On April 27, 2010, the Internal Revenue Service issued Notice 2010-38, which addresses the tax treatment of employer-provided health coverage attributable to Adult Children. In general, the Notice states that employer-provided coverage for a qualifying Adult Child is excludable from an employee’s income for federal income and payroll tax purposes. The Notice states that a qualifying Adult Child for purposes of tax-free coverage, is any individual who (i) is the legal child, foster child, or step child of the employee, and (ii) will not attain age 27 during the taxable year at issue.

Today’s Interim Final Regulations were issued in response to express language in new PHSA section 2714, which requires that regulations be issued defining “the dependents to which coverage shall be made available” under this new coverage rule.

As discussed below, the Interim Final Regulations define a qualifying adult child for purposes of the mandated coverage based solely on child status (i.e., whether the individual is indeed the child of the employee) and age (i.e., whether the child is under age 26). This is similar to the approach adopted by the IRS in Notice 2010-38. The regulations expressly prohibit plans and health insurance issuers from establishing eligibility rules for coverage based on any other

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criteria, including: shared residency; financial dependency; and student or employment status. The Interim Final Regulations also make clear that a plan or issuer may not vary the “terms” of coverage based on a child’s age, nor may a plan or issuer charge a premium surcharge based on a child’s age. The guidance requires plans to provide a special enrollment opportunity for children who either (i) “aged out” of coverage, or (ii) were denied or otherwise ineligible for coverage. In connection with this special enrollment opportunity, employers are required to provide qualifying written notice to all eligible children.

Highlights of the Interim Final Regulations

➤ ***Mandates extension of dependent coverage to all qualifying children until age 26.*** The Interim Final Regulations require all group health plans and issuers that currently provide dependent child coverage, to “make such coverage available for children until attainment of 26 years of age.” Notably, the term “child” is not defined in the regulations or the preamble thereto. IRS Notice 2010-38 incorporates a definition of child based on IRC section 152(f)(1) (which is generally limited to the taxpayer’s child, step-child, or foster child). It is unclear whether a similar definition applies for purposes of the extended coverage required under the Interim Final Regulations.

The regulations do appear to answer one frequently asked question regarding the new extended coverage requirement – specifically, whether a plan can limit coverage to only those adult children who were previously covered either as minor-age children or full-time students under the age of 24. Put differently, many had wondered whether a plan or issuer was only “on the hook” for providing coverage to Adult Children who “age out” of coverage. The preamble to the Interim Final Regulations appears to answer this question in the negative. Specifically, it states that, once the provisions of PHSa section 2714 become effective (i.e., beginning with the 2011 plan year for calendar year plans), “a plan or issuer can no longer exclude coverage for the child prior to age 26 irrespective of whether or when that child was enrolled in the plan (or coverage).”

Comments: Under prior law, plan sponsors had very little reason to focus on whether their plans constituted a single plan or many plans (and had great flexibility under the law to characterize their plan(s) as they saw fit). This is due, in part, to the fact that, at least with respect to self-insured plans governed by the Employee Retirement Income Security Act of 1974 (“ERISA”), such plans were generally excepted from state law mandates and, prior to the PPACA, there were very few federal law mandates. For purposes of administrative ease, many sponsors chose to bundle multiple health plans under one “umbrella plan” document in order to file a single annual Form 5500 with the Department of Labor. Some plan sponsors may now find themselves trying to recharacterize bundled plans as separate and distinct plans to avoid having to provide adult child coverage under one or more of their plans.

Comments: As noted in the first paragraph of the preamble to the Interim Final Regulations, the term “group health plan” is defined in the PHSA to encompass self-insured group health plans. Accordingly, both fully insured and self-insured health plans are subject to the coverage requirement, including health reimbursement arrangements (“HRAs”).

Although not addressed in the Interim Final Regulations, under the express statutory language of the PPACA, plans that qualify as “HIPAA-excepted” benefits generally are exempt from the new coverage requirement. These plans typically include, among others, the following:

- Stand-alone dental
- Stand-alone vision
- Long-term care (“LTC”)
- Specified disease or illness
- Fixed or hospital indemnity
- Medicare supplemental
- Disability
- Onsite medical

Health Savings Accounts (“HSAs”) are also not subject to the new coverage requirement (although an underlying high deductible health plan likely would be subject to the requirement).

➤ ***Excepts coverage of grandchildren.*** The Interim Final Regulations make clear that a plan or issuer is not required to make coverage available for the child of a child receiving dependent coverage.

Comments: Although the guidance excepts grandchildren from the extended coverage requirement, plan sponsors should keep in mind that nothing contained in the PPACA nor the Interim Final Regulations precludes a plan from extending coverage to an employee’s grandchildren (as is the case with respect to many existing plans). Moreover, to the extent an employee’s grandchild qualifies as the employee’s dependent for purposes of the federal tax provisions governing employer-provided coverage, coverage paid for by an employer with respect to the grandchild (whether paid for by a direct employer subsidy or through a cafeteria plan via salary reduction by the employee) would be eligible for tax-free treatment.

➤ ***Prohibits placing restrictions on eligibility based on child’s age.*** The Interim Final Regulations prohibit plans and issuers from placing restrictions on dependent child eligibility. Specifically, the Interim Final Regulations state that “[w]ith respect to a child who has not attained age 26, a plan or issuer may not define ... eligibility... other than in terms of a relationship between a child and the participant.” Prohibited restrictions include (but are not limited to) restrictions based on any of the following:



- The presence or absence of the child’s financial dependency;
- Residency with the participant or with any other person;
- Student status;
- Employment status;
- Eligibility for other coverage (except if the pre-2014 transition rule for “grandfathered” plans applies, as discussed below); and
- Any combination of the above.

Comments: Health plans that currently limit dependent coverage to an employee’s spouse and dependent child will in many instances no longer need to look at indicia of dependent status for purposes of plan eligibility. This is because such plans will now be required to make coverage available to all children under the age of 26 regardless of residency, financial support, etc. Plan sponsors likely will need to amend their plans to reflect these changes.

For plans that provide for additional categories of dependent coverage (such as with respect to an employee’s qualifying domestic partner or dependent grandchildren), such plans may continue to administer their plans in accordance with the status quo with respect to any non-child dependent, including with respect to the use of any eligibility and benefit restrictions.

➤ ***Prohibits making available coverage with different “terms” based on a child’s age.*** The Interim Final Regulations state that the “terms of the plan or health insurance coverage” cannot vary based on the age of a child (except for children over age 26). Based on examples included in the Interim Final regulations, the word “terms” should be construed broadly and appears to encompass not only specific benefits, but also levels of coverage (i.e., HMO versus indemnity) and premium pricing (see bullet below).

Comments: The Interim Final Regulations do not include an express definition of the phrase “terms of the plan or health insurance coverage”. This could lead to some uncertainty for plans and issuers as they work to comply with the requirement but maintain design flexibility and minimize actuarial risk.

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➤ ***Prohibits charging more for coverage based on child's age.*** The Interim Final Regulations prohibit a plan or issuer from charging a “premium surcharge” for coverage attributable to a child based on the child's age.

Comments: Prior to the issuance of the Interim Final Regulations, a frequently asked question was whether, and to what extent, a plan or issuer could charge an increased premium to employees for Adult Child coverage. Today's guidance appears to clearly preclude the establishment of increased premium rates for use in connection with Adult Child coverage. Significantly, the term “premium surcharge” is quite limited, presumably applying only to premium increases, and does not appear to encompass other financial aspects of coverage, such as copayments and deductibles. Notwithstanding, it would seem that imposing increased copayments and/or deductibles for Adult Children would seem to violate the requirement that all plan or coverage “terms” be uniform for children regardless of age.

For plans that provide for additional categories of dependent coverage (such as with respect to an employee's qualifying domestic partner or dependent grandchildren), such plans remain free to the extent of existing law to charge increased premiums with respect to any non-child dependents.

➤ ***Transition rule requires plans to provide an open enrollment opportunity and notice for Adult Children for plan years beginning on or after September 23, 2010 (i.e., for the 2011 plan year for calendar year plans).*** Under law in effect prior to the PPACA, a child may have lost coverage or, alternatively, been denied coverage under a group health plan or health insurance coverage because he or she was too old. The Interim Final Regulations require a plan or issuer to provide a 30-day open enrollment period to children who are not yet age 26 and who either (i) were dis-enrolled from the plan by reason of “aging out”, or (ii) were ineligible or otherwise denied for coverage because they were too old.

The special open enrollment opportunity must be provided “not later than the first day of the first plan year beginning on or after September 23, 2010,” (i.e., January 1, 2011 for calendar year plans). The preamble states that the open enrollment opportunity must be provided regardless of whether the plan or coverage offers an open enrollment period and regardless of whether any open enrollment period might otherwise occur. Based on language in the preamble, plans may choose to use their existing open enrollment periods (which typically occur prior to the start of the plan year) to satisfy this requirement, and that “[i]n subsequent years, dependent coverage may be elected for an eligible child in connection with normal enrollment opportunities under the plan or coverage.”

The Interim Final Regulations require plans and issuers to provide written notice of the special enrollment opportunity. The guidance states that the written notice must include a statement that children who “aged out” of dependent coverage or were denied dependent coverage

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because they were too old, are eligible to enroll in the plan or coverage (presumably so long as they will not be 26 by the first day of the plan year). The guidance states that the notice may be provided to an employee parent on behalf of a child and may be included with other enrollment materials provided to employees, so long as the statement is “prominent”.

If a child is enrolled in coverage, the Interim Final Regulations provide that such coverage must begin as of the first day of the next plan year (i.e., January 1, 2011 for calendar year plans). Lastly, the guidance states that any child enrolling in coverage via the special open enrollment opportunity must be offered all of the benefit packages available to “similarly situated individuals” who did not lose coverage by reason of cessation of dependent status. The regulations expressly state that “[f]or this purpose, any difference in *benefits or cost-sharing requirements* constitutes a different benefit package” (emphasis added). The guidance also states that a child cannot be required to pay more for coverage than similarly situated individuals.

Comments: With open enrollment for the 2011 plan year fast approaching, plans will likely need to work quickly if they want to try and satisfy the special open enrollment requirement for Adult Children as part of their regular annual open enrollment processes. To the extent that plans seek to satisfy the special enrollment requirement as part of regular open enrollment, plans will need to make sure that open enrollment for the 2011 plan year remains open for at least 30 days. Plans also will need to decide whether to provide such notice as part of their standard open enrollment materials.

As noted above, the Interim Final Regulations require plans to provide notice of the special enrollment opportunity to certain children, including those who were denied coverage or were otherwise ineligible for coverage because they were too old. Query whether plan sponsors and/or administrators will be able to determine the identities of all qualifying children who were denied coverage and/or who may have been ineligible for coverage but did not in fact apply for enrollment. Given the difficulties in identifying all such children, plans may be better off providing notice to all employees to ensure full compliance with the notice requirements.

The guidance provides that the notice may be provided with other enrollment materials so long as the statement is “prominent”. The guidance, however, does not explain what satisfies as “prominent” for this purpose. At a minimum it would seem to suggest that the notice language must be of at least the same or larger font size and perhaps be offset or otherwise highlighted in the general open enrollment materials.

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➤ **Clarifies that providing Adult Child coverage during transition period does not jeopardize “grandfathered” health plan status.** Existing plans that qualify as a “grandfathered” health plans under section 1251 of the PPACA are excepted from certain of the requirements of the PPACA, including, among others, certain new reporting requirements and the new nondiscrimination rules applicable to fully insured plans. The Interim Final Regulations clarify that plans will not jeopardize their status as “grandfathered” health plans under PPACA if they voluntarily choose to extend Adult Child coverage for the remainder of the 2010 plan year.

Comments: Many had wondered whether voluntarily extending Adult Child coverage for the remainder of the 2010 year could jeopardize a plan’s “grandfathered” status under the statute. Today’s guidance makes clear that extending coverage to Adult Children during this transition period will not adversely affect a plan’s “grandfathered” status.

With certain of the insurance reform provisions having an effective date as early as September 23, 2010, many have wondered how much flexibility plans will have generally to change coverage terms, etc., without jeopardizing “grandfathered” status. Thankfully, the preamble states that regulations regarding grandfathered health plans “are expected to be published in the very near future” (emphasis added).

➤ **Clarifies pre-2014 transition rule for “grandfathered” health plans.** The PPACA, as amended, provides that for plan years beginning prior to 2014, a “grandfathered” health plan may exclude an Adult Child “only if such adult child is not eligible to enroll in an eligible employer-sponsored health plan... other than such grandfathered health plan.” The preamble to the Final Interim Regulations clarifies that for purposes of this transition rule, a “grandfathered” plan may only exclude an Adult Child if he or she is eligible to enroll in an employer-sponsored health plan “*other than a group health plan of a parent*” (emphasis added).

Comments: Based on the design of most group health plans, it would seem that, “grandfathered” health plans likely can only exclude Adult Children from coverage under the pre-2014 transition rule where an Adult Child is employed and is eligible for employer-sponsored group health plan coverage through his or her worksite employer.

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