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# COMING OF AGE: EXTENDED HEALTH COVERAGE FOR CHILDREN TO AGE 26

The Patient Protection and Affordable Care Act, as amended ("PPACA"), requires group health plans that offer health coverage to employees' or subscribers' children to make such coverage available until the child's 26th birthday.[1] PPACA's extended coverage mandate for children applies to insured and self-insured group health plans and to insurance issuers in both the individual and group markets.

On May 10, 2010, the Departments of Labor, Health and Human Services, and Treasury issued regulations, effective May 12, 2010, implementing the dependent coverage mandate under PPACA. The regulations require group health plans and issuers to offer a special enrollment opportunity for children who are newly eligible for dependent coverage under the plan as a result of this mandatory expansion of coverage on the terms described below.

## RESTRICTIONS IN DEFINING "ELIGIBLE CHILD"

Group health plans and issuers are prohibited from defining an eligible child based on any factors other than the relationship between the child and the participant. For purposes of eligibility for coverage, plans may no longer require a child to meet a financial dependency, student status, employment, residency, or marital status test (or any combination of those tests). Plans may have eligibility rules based on the relationship between the child and the participant. In addition, the regulations do not require a plan to cover grandchildren or the spouse of a covered child (even though plans are now required to cover married children). As was the case before PPACA,

1 The PPACA changes also apply to health insurance policies issued by insurance companies. Except as expressly noted, the discussion in this *Commentary* about group health plans and the effect of the adult dependent regulations on those plans applies equally to health insurance policies. Of course, an employer's group health plan may provide coverage through a health insurance policy.

plans subject to ERISA are required to provide coverage to adopted children (and children placed for adoption) on the same basis that such plans provide coverage to natural children. The regulations do not otherwise define the term "child" and do not make it clear whether the definition is coextensive with the definition of "child" in Code Section 152(f)(1) used for the purposes of the income tax exclusion for employer-provided health coverage (*i.e.*, the son, daughter, stepson, or stepdaughter (all whether natural, adopted, or placed for adoption), or the foster child of the employee or the employee's spouse).

Further, a plan may not deny coverage of a child under age 26 based on eligibility for other coverage. A limited exception is available to "grandfathered plans" for plan years beginning before January 1, 2014. A grandfathered plan may exclude a child under age 26 from coverage if the child is eligible to enroll in another employer-sponsored group health plan or employer-sponsored coverage other than a plan or coverage available to that child's parent. If coverage is available to the child through both parents, neither parent's plan may exclude the child from coverage based on eligibility to enroll in the other parent's plan.

The agencies have indicated that regulations regarding the grandfathered plan protection are expected to be issued in the near future. The dependent coverage regulations state that amending a grandfathered plan for compliance with the PPACA would not jeopardize the grandfathered plan status, including an early adoption of this PPACA mandate.

## UNIFORMITY OF COVERAGE

The terms of the plan may not vary coverage based on the age of a child (except for children age 26 or older). Accordingly, a plan may not limit coverage options available for children (*e.g.*, by offering only an HMO option for children above age 18) or impose a premium surcharge for covering children who have not attained age 26. Premiums may vary, however, based on the number of persons covered (*e.g.*, self plus one, self plus two, self plus three, etc.).

## NEW ENROLLMENT OPPORTUNITY FOR CURRENTLY INELIGIBLE CHILDREN

**Opportunity to Enroll**. For children whose coverage ended, was denied, or not made available due to the loss of or failure to satisfy dependent status and who have not attained age 26 as of the first day of the first plan year beginning on or after September 23, 2010, a group health plan must offer an opportunity to enroll in the plan. Because the new enrollment opportunity for most plans and coverages will coincide with open enrollment periods, this requirement generally may be handled through the open enrollment process with the addition of a prominent notice explaining the opportunity included with open enrollment materials.

**Period of Opportunity**. The enrollment opportunity must be offered not later than the first day of the first plan year beginning on or after September 23, 2010, and must continue for at least 30 days. Plans may satisfy this requirement using their open enrollment period for such plan year (as long as they provide 30 days to enroll). Coverage so elected must become effective not later than the first day of the first plan year beginning on or after September 23, 2010, even if the election is made after such date, as long as the election is made during the applicable election period.

**Notice**. A plan must provide written notice of this new enrollment opportunity to affected children. The notice requirement can be satisfied, however, by providing the notice to the employee on behalf of the child. In addition, the notice may be provided with other open enrollment materials as long as the statement is prominent. To avoid the burden of identifying employees with such children, employers may provide the notice to all employees.

## TREATMENT AS SPECIAL ENROLLEES

A child who is eligible for enrollment under the new enrollment opportunity must be treated as if the child were a special enrollee under the Health Insurance Portability and Accountability Act ("HIPAA"). Accordingly, a child must be offered all benefit packages available to similarly situated individuals who did not lose coverage due to cessation of

dependent status. For these purposes, any difference in cost-sharing arrangements constitutes a different benefit package. In addition, if a plan requires an employee to be enrolled in order for dependent children to be covered and a child becomes eligible for enrollment under the new enrollment opportunity, the employee must also be offered such new enrollment opportunity. A child who elected COBRA coverage upon losing his dependent status under the plan and who has not attained age 26 must be offered an opportunity to elect non-COBRA coverage. A child who subsequently ages out of plan coverage (*i.e.*, upon reaching age 26) will again be eligible for COBRA coverage for up to 36 months from the loss of eligibility that relates to attaining age 26.

## INTERPLAY WITH INCOME EXCLUSION

The regulations closely follow on the heels of IRS Notice 2010-38, regarding the expansion of the gross income exclusion for employer-provided health coverage for children under age 27. Under this expansion, as reiterated in the new regulations, the value of coverage and the amount of medical expense reimbursements for a child during the year the child attains age 26 will receive favorable tax treatment.

For more information on the income exclusion for employer-provided child coverage, refer to *Jones Day Commentary*, "Time for Immediate Decisions: Income Tax Exclusion for Coverage of Adult Children" (May 2010), *available at* www.jonesday.com/time_for_immediate_decisions.

## ERISA PREEMPTION

PPACA amended the Code and ERISA by adding Sections 9815 and 715, respectively, to incorporate the provisions of part A of title XXVII of the PHSA by reference and make group health plans subject to these provisions as if they had been included in the Code and ERISA (with very limited exceptions for self-insured plans and grandfathered plans).

The recently issued guidance states that ERISA preemption applies to the provisions of PPACA. Such provisions, however, do not preempt state laws that contain any standard or requirement *solely relating to health insurance issuers* in connection with group or individual health insurance coverage unless such standard or requirement prevents the application of a requirement of PPACA. Thus, PPACA does not preempt state laws that impose stricter requirements on insurance issuers than those imposed by PPACA.

## ACTION ITEMS FOR EMPLOYERS

As a preliminary matter, employers sponsoring group health plans that offer coverage to children of employees need to decide whether to implement the extended coverage mandate early or wait until the coverage is required. This decision will determine the timing of employee notices, enrollment periods, and the effective date of coverage.

Whether or not the early compliance option is chosen, certain actions will be necessary. Employers must prepare (or work with providers to prepare) notices of the new enrollment opportunity for children who are newly eligible for coverage (including those on COBRA). Employers must also ensure that employees and children who are eligible for the new enrollment opportunity have at least 30 days to enroll in the plan (whether or not this period coincides with open enrollment).

Employers will want to review and update plan documents to comply with these new requirements. Because plans will no longer include such limitations on eligibility as financial dependence and residency, it is especially important that the definition of who constitutes an eligible child is clearly stated in the plan. For example, employers may want to specifically define "stepchild" as the natural or adopted child of the spouse of an employee, rather than leaving it open to potential unintended interpretations.

Employers may also want to consider cost-saving measures to offset any increased cost associated with the expanded coverage. For example, employers might consider expanding the enrollment tiers offered under the plan by further varying the employee portion of the premium based on the number of persons covered. As mentioned above, plans are not permitted to impose a premium surcharge for children who have not attained age 26.

In expanding dependent eligibility under the group health plan as mandated, employers may also want to consider whether to expand dependent eligibility for other benefits. While benefits such as stand-alone dental or vision coverage are not subject to the mandatory expansion of coverage described in this *Commentary*, expanded coverage will be subject to the same favorable tax rules that apply to group health plans as described under the heading "Interplay with Income Exclusion" above. The prohibition on imposing a premium surcharge does not apply with respect to benefits other than the health plan. Therefore, higher cost sharing could apply with respect to coverage for adult children in other benefit plans such as dental, vision, and dependent life.

Employers who implement the coverage mandate early may have special challenges. For example, logistical issues would arise with respect to children who are not currently enrolled but would become eligible for the extended coverage or children who are currently enrolled as qualified beneficiaries under COBRA (*e.g.*, whether coverage should apply retroactively or prospectively). In the event that coverage becomes effective retroactively, employers may need to determine how to cover claims submitted during the election period and how to respond to inquiries from providers regarding the availability of coverage. In the event that coverage becomes effective prospectively, employers may have preexisting condition exclusions that would apply to some newly eligible children. Employers who offer both active and retiree health coverage may need to decide whether an early implementation date would apply to both types of coverage. In addition, as with all plan eligibility changes, employers should check to be certain that any applicable stop-loss coverage will apply to the new participants.

## CONCLUSION

Employers have many decisions to make in a short period of time in order to comply with the expanded coverage mandate. The analysis will involve balancing compliance with cost, while at the same time keeping in mind the company's underlying objectives in providing dependent coverage as a benefit to its employees. Jones Day lawyers stand ready to assist with design changes, ensuring legal compliance, and preparing proper documentation in connection with the expanded coverage mandate.

This is one in a series of *Commentaries* Jones Day is providing to our clients and friends on the provisions of PPACA. In the weeks ahead, we will be providing additional guidance on how PPACA, and the developing regulatory framework, affect employer-sponsored health plans and their sponsoring employers.

## LAWYER CONTACTS

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