ALERT

HEALTH CARE REFORM FOR EMPLOYERS: COVERING DEPENDENTS UNTIL THEY TURN 26

PART 3 OF A SERIES

August 2, 2010

Many of the requirements in the new health care reform law are complicated and hard to explain. But there is one requirement in the Patient Protection and Affordable Care Act ("PPACA") that sounds simple and straightforward: *If a group health plan provides coverage for the children of a participant, the plan must continue to make such coverage available until a participant's child turns 26.*

However, nothing in this new law is as simple as it seems. What Congress enacted as a one-sentence mandate has already given rise to 20 pages of regulations.

In a nutshell, here is what the new regulations say:

(1) Although coverage is still referred to as "dependent coverage," coverage can no longer be conditioned upon any type of "dependent" status. If a child is a child of a participant, the plan will have to make coverage available even if the child does not live with the participant and even if the child is not a dependent of the participant for tax purposes.

(2) This rule applies not just to "adult children," but to any child of any age. As a result, coverage for minor children can no longer be limited to children who reside in the same household as the participant or who are dependents of a participant for tax purposes.

(3) A group health plan will be required to give "adult children" who are not already enrolled in the plan an opportunity to enroll.

(4) A *written notice* of the opportunity to enroll *must be provided* no later than the first day of the first plan year beginning on or after September 23, 2010.

   (a) For calendar year plans, this means that the deadline for providing the notice is January 1, 2011. However, most employers with a calendar year plan will want to provide the notice no later than November 30, 2010.

   (b) This notice can be combined with annual enrollment materials, as long as the notice is "prominent."

Additionally, Congress has amended the Internal Revenue Code to provide that coverage of an adult child under a group health plan will not result in taxable income if the adult child is younger than age 27.

These requirements, and the plans they apply to, are explained in more detail in the accompanying Memorandum we have prepared.

If you have any questions regarding the impact of health care reform on employers, please feel free to call Eric Namee, Steven Smith, Ruhe Wadud Rutter, or Brad Schlozman at (316) 267-2000.

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COVERING DEPENDENTS UNTIL THEY TURN 26

August 2, 2010

The "age 26 mandate," as we refer to it, may be one of the more popular provisions in the new health care reform law and, unlike many of the other provisions in that law, it doesn't sound like something that would be difficult to implement. But our experience with health care reform, to this point, has been that nothing in the new legislation – formally known as the Patient Protection and Affordable Care Act ("PPACA") – is as simple as it might seem. The age 26 mandate is no exception.

This new regulation has already generated a lot of questions from our clients and we expect that, as clients start to focus on their health care plan changes, it will generate even more. In this Memorandum, we thought it might be helpful to address many of the questions we have been asked. We are using a "question and answer" format to make this Memorandum easy to read.

I. – WHAT PLANS ARE (OR ARE NOT) SUBJECT TO THE AGE 26 MANDATE?

Q-1.1 What plans are subject to the age 26 mandate?

A-1.1 The age 26 mandate applies to most, but not all, "group health plans."

Q-1.2 What is a group health plan?

A-1.2 A plan that is offered through an employer and that provides any of the following benefits will normally be considered to be a group health plan:

- Coverage for hospital stays, physician visits, and/or prescription drugs;
- Dental or vision coverage; and
- Reimbursement for out-of-pocket expenses for medical care, such as through a health flexible spending account ("health FSAs") or a health reimbursement account ("HRA").

Q-1.3 Does that mean that all of these types of group health plans have to comply with the age 26 mandate?

A-1.3 No. Although the age 26 mandate applies to most group health plans, it does not apply to the following types of plans:

- Retiree only plans – that is, plans that provide coverage only to retirees and their family members; and
- Plans that provide only "limited scope" dental or vision coverage. In order words, plans that provide dental or vision coverage if that coverage is not "bundled with" or otherwise combined with a plan that also provides coverage for hospital stays, physician visits, and/or prescription drugs. (The technical term for these plans is "HIPAA-excepted benefits," but we are trying to use plain English in this Memorandum.)

Q-1.4 Does the age 26 mandate apply to most health FSAs?

A-1.4 No. Although a health FSA is technically a group health plan, most health FSAs will not be subject to the age 26 mandate.

Without going into too much detail, a health FSA will not be subject to this mandate if two conditions are met:

- The health FSA is not the only group health plan being provided to the employer's employees; and
- The employer is:
  - not contributing any money to the health FSA that is over and above the amount of the pre-tax salary contributions being made by the participants themselves; or
  - the amount being contributed by the employer is not more than $500.

These exceptions cover the vast majority of health FSAs in our experience. There are other health FSAs that will also qualify for an exception to the age 26 mandate, but they are less common and we are trying to keep this Memorandum as simple as possible. If you have questions about the applicability of the age 26 mandate to your health FSA, please feel free to contact us.

Q-1.5 Are there plans that pay benefits when someone experiences a medical condition that are not group health plans (and thus are not subject to the age 26 mandate)?

A-1.5 Although most plans that pay benefits when an individual has experienced some type of medical problem are likely to fall within the definition of a group health plan, some plans will not. In particular, plans that offer the following types of benefits will not, as a general rule, fall within the definition of a group health plan:

- Cancer insurance, hospital insurance, and other similar policies if the policy pays a fixed amount per day without regard to other coverage or the expenses actually incurred by the insured; and
- Short-term and long-term disability benefits.

Most of these plans are not group health plans and, as a result, will not be affected by the age 26 mandate.

Q-1.6 Do "grandfathered" group health plans have to comply with the age 26 mandate?

A-1.6 "Grandfathered" group health plans are required to comply with the age 26 mandate. There is a special transition rule that allows a grandfathered plan to exclude an adult child if that adult child is eligible for coverage under another employer-sponsored group health plan (not including the plan of the other parent), but otherwise the mandate itself applies to grandfathered plans. This transition rule only applies for plan years that begin before January 1, 2014. For plan years that begin on or after January 1, 2014, the age 26 mandate will apply to grandfathered plans in the same way that it applies to any other group health plan.

Q-1.7 Does it matter for purposes of the age 26 mandate if a group health plan is self-insured or fully-insured?

A-1.7 No. The age 26 mandate applies equally to self-insured group health plans and fully-insured group health plans.

II. – WHAT COVERAGE WILL PLANS NEED TO PROVIDE TO COMPLY WITH THE AGE 26 MANDATE?

Q-2.1 What does the age 26 mandate require?

A-2.1 The age 26 mandate basically says this: If a group health plan provides coverage for a participant's children, then the plan must continue to make that coverage available until a participant's child turns 26.

Q-2.2 How is this different from what most plans are doing now?

A-2.2 The biggest change is that the age 26 mandate will require coverage to be made available even if a child is no longer a tax dependent of the parent and even if the child is no longer living with the parent. This is a bigger change than it might appear.

For many years, the most common plan design, at least among our clients, provided coverage for a participant's children, but only if the child:

(1) Resided in the participant's home in a normal parent-child relationship; or

(2) Could be claimed by the participant as a dependent for purposes of federal income tax.

As a result of the relatively recent enactment of Michelle's Law, many plans had moved away from requiring children over a certain age to be "full time students" as a condition of receiving coverage. But few, if any, plans provided coverage for children who were older than age 22.

In our experience, most plans also limited coverage to children who were not married.

All of that will change when the age 26 mandate takes effect.

Q-2.3 Do these changes apply to younger children as well?

A-2.3 Yes. Under regulations that were jointly issued by the Departments of Labor, Treasury, and Health & Human Services, the new rules established by the age 26 mandate apply not just to "adult children," but to any child of any age.

As a result, *coverage for minor children can no longer be conditioned upon their being a dependent of a participant and/or living in the same household as a participant.*

Q-2.4 Is this a big change?

A-2.4 From our point of view, this will be a major change for most group health plans. We suspect that it is also a change that has not attracted a lot of attention to this point.

Because this is a change from what almost every group health plan has done in the past, *group health plans will need to review and revise their definition of an "eligible dependent child."* This will affect not only plan documents, but also enrollment materials, benefit explanations, forms, and summary plan descriptions (and quite possibly a number of other things as well).

Q-2.5 Does the age 26 mandate require a group health plan to provide coverage to a child of a participant if that child is married and has children of his/her own?

A-2.5 Yes. If the child is under age 26, the plan must make coverage available to that child, even if the child is married. The plan is not, however, required to provide coverage for the child's spouse or to the child's children.

Q-2.6 What about stepchildren?

A-2.6 In the past, many plans addressed coverage for a participant's stepchildren in the same way that they addressed coverage for a participant's children. If a child lived with the participant or was considered to be a tax dependent of the participant, coverage would be made available.

How stepchildren should be treated when the age 26 mandate takes effect is not directly addressed in the regulations and is not entirely clear.

On the one hand, we know that coverage for the children of a participant can no longer be based on the child's status as a tax dependent or on whether the child still resides with the participant. On the other hand, the age 26 mandate, as enacted by Congress, applies only to a child of a participant and, by definition, a stepchild is not the same as a child.

One possibility is that plans could choose to treat stepchildren the same as children. This is not required, but it is permissible. Another possibility is that plans could exclude any coverage for stepchildren. This is probably permissible, but many employers may not want to do this and it may not be a good step to take until further regulatory guidance has been provided regarding the proper treatment of stepchildren.

A middle ground may be possible. It may be possible for plans to provide coverage for a participant's children until they turn 26 without imposing any conditions, while only providing coverage for a participant's stepchildren if the stepchildren either live with the participant or are tax dependents of the participant. Without further regulatory guidance, it is very difficult to say whether this approach will be acceptable.

III. – WHAT STEPS WILL PLANS NEED TO TAKE TO COMPLY WITH THE AGE 26 MANDATE AND WHAT DEADLINES APPLY?

Q-3.1 When will the age 26 mandate take effect?

A-3.1 For group health plans, the age 26 mandate will take effect as of the first plan year beginning on or after September 23, 2010. This date was chosen by Congress because it represents the date that is six months after the date PPACA was enacted. By making the mandate effective as of the first day of a plan year, Congress has made it easier for plans to comply by avoiding the need to make changes in the middle of a plan year.

For a calendar year plan – and, in our experience, most (but not all) group health plans operate on a calendar year basis – this means that the *age 26 mandate will take effect on January 1, 2011*.

Q-3.2 What will a group health plan need to do before the age 26 mandate takes effect?

A-3.2 As we discussed above, an employer will need to do the following:

(a) Review the existing definition of an "eligible dependent child" (or whatever comparable definition your plan uses) in your plan document to determine if the definition needs to be changed. *It is our expectation that almost every group health plan will find that its definition needs to be updated.*

(b) Review and update your summary plan description to reflect the updated definition of "eligible dependent child" (along with other PPACA changes taking effect in 2010).

(c) Review and update any benefit summaries and other communications that will be provided to participants prior to the plan's annual enrollment period.

(d) Review and update your plan's enrollment materials and forms.

(e) Include in the plan's enrollment materials the notice that is required by the regulations (see Q-3.4 below).

Q-3.3 What should an employer do about dependent children who had already "aged out" of its group health plan before the age 26 mandate took effect?

A-3.3 Under the regulations that have been issued, children who had already "aged out" of coverage before the age 26 mandate took effect must be given an opportunity to re-enroll if (a) they will be under age 26 when the age 26 mandate takes effect, and (b) their parent is still eligible to participate in the plan. This requirement applies *both* to children who were actually enrolled at one time but who lost coverage *and also* to children who had never previously been covered under the plan.

Q-3.4 How is a plan supposed to provide this opportunity to these adult children?

A-3.4 The regulations establish the following requirements for group health plans:

(a) A written notice of the opportunity to enroll must be provided no later than the first day of the first plan year beginning on or after September 23, 2010. For group health plans, this notice can be provided to the employee. This notice can be combined with annual enrollment materials as long as the statement is "prominent."

(b) After the notice is provided, the plan must provide an enrollment window that is at least 30 days long.

(c) Coverage must begin as of the first day of the plan year, even if the request for enrollment is not made until a later date.

(i) As a result, although the legal deadline for providing the notice is the first day of the plan year – January 1, 2011, for a calendar year plan – *most plans will want to provide the required noticed more than 30 days in advance of the first day of the next plan year*.

(ii) This means that *most calendar year plans will want to provide the required notice no later than the end of November 2010.*

(d) If it is necessary for a parent to be enrolled in order for a child to receive coverage and the parent is eligible for coverage but is not enrolled, the plan must give the parent the opportunity to enroll.

(e) If there are multiple benefit options available under the plan, the child must be permitted to enroll in any benefit package option for which the child is otherwise eligible, even if this means that the parent must switch to a different benefit package option.

Note: For plans that provide the required notice during their annual enrollment period, the last two requirements are not likely to present any particular issues since eligible employees are generally able to enroll during open enrollment and to select new benefit options. But the last two requirements could present issues if an employer is late in sending out the required notice since the employer might end up having to allow employees with adult children to enroll in the middle of a plan year.

Q-3.5 Who should an employer provide the required notice to?

A-3.5 Although the regulations permit employers to send the required notice to the affected children themselves, the regulations also allow the notice to be sent to the employee on behalf of the child who is eligible for coverage as a result of the age 26 mandate. Because most employers won't know the identity or the address of all affected children, and because it is the employee who ultimately will be enrolling the child in the plan, the safest course for an employer may be to simply provide notice to the employee.

As far as which employees must be notified, the regulations only require that the notice be provided in cases where a child's "coverage ended" or a child "was denied coverage (or was not eligible for coverage)" because the child was too old to be covered under the plan.

As a practical matter, however, *we think that an employer should provide the notice that is required under the age 26 mandate regulations to every employee who is eligible for coverage* (regardless of whether that employee has ever been enrolled in the employer's group health plan).

If an employer does not send the required notice to every employee, it is likely that some child who was required to receive notice under the regulations will be inadvertently omitted. As noted, the notice has to be sent not just to adult children under age 26 (or their parents) who were actually enrolled in the plan at one time and later aged out, but also to adult children under age 26 (or their parents) who were "not eligible for coverage" before the age 26 mandate took effect. Some employers might know if their employees have children who fall into this category, but most employers probably will not know. Consequently, *it seems to us that the only way of being certain that the notice is provided to everyone who needs to receive it is to provide the notice to everyone.*

And, when we say "everyone," we mean not just every employee who has actually chosen to enroll in a group health plan, but every *employee who is eligible to enroll*, whether or not they actually enrolled in the plan.

Some employers may already be providing enrollment materials to all eligible employees, but it is possible that other employers are not doing this.

If an employer chooses to comply with the notice requirement by including the required notice in the enrollment materials for its group health plan, the employer needs to make sure that those

enrollment materials are distributed to every employee who is eligible to enroll in its group health plan.

Q-3.6 Is there a model age 26 notice?

A-3.6 Yes. The Department of Labor has provided a model notice on its website at the following address: http://www.dol.gov/ebsa/healthreform/. However, employers should be cautious about using this model notice. Although the Department of Labor's model notice is helpful in some respects, it is not necessarily complete and may not contain provisions that most employers will want to include. We will be providing the age 26 mandate's required notice to our clients when we prepare this year's amendments to their plan documents.

IV. – WHAT ARE THE TAX ASPECTS OF THE AGE 26 MANDATE?

Q-4.1 Will employer-provided coverage for adult children under the age 26 mandate result in taxable income for either the child or the parent?

A-4.1 In the past, many employer-sponsored group health plans have tried to limit dependent coverage to individuals who are the participant's dependents for federal income tax purposes because providing coverage to someone who was not a tax dependent could result in taxable income to the employee.

However, when Congress enacted the age 26 mandate, it also amended the Internal Revenue Code so that coverage provided to an adult child under the age of 27 will no longer result in taxable income. This means that the value of the coverage will not be taxable and that any benefits paid under the plan to, or on behalf of, the adult child will not be taxable merely because the child is no longer a tax dependent of the employee.

V. – CONCLUSION

The age 26 mandate is more complicated and more far-reaching than it might seem. To comply with this mandate, almost every employer with a group health plan will need to make changes to its plan document and its enrollment materials (among other things). By late November, most employers with calendar year plans will need to send out the notice that is required by the age 26 mandate regulations. And employers with non-calendar year plans (whose next plan year begins on or after September 23, 2010) will need to send out the required notice even earlier. Given this, employers will want to start thinking about what they will need to do in order to comply with the age 26 mandate. Prompt planning will help avert major headaches down the road.

If you have any questions regarding the impact of health care reform on employers, please feel free, as always, to call Eric Namee, Steven Smith, Ruhe Wadud Rutter, or Brad Schlozman at (316) 267-2000.