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REFORM Update

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On May 13th, the Departments of Labor, Treasury, and HHS released interim final rules about the new requirement for health plans to cover dependent children to the age of 26. The implications for plan sponsors appear much broader than a simple coverage extension as the rules re-define dependent child and make it clear that all dependent children must be treated in a uniform manner (whether age 5 or age 25).

Reform Update Issue 5 reviewed the legislative language and IRS regulations clarifying the tax status of coverage for adult children. In this *Reform Update,* we will discuss the May 13th interim final rules for extending health care coverage to dependent children to age 26 including:

- Definition of dependent
- Enrollment requirements
- Examples provided in regulations
- Action steps for employers

The interim final rules become effective July 12, 2010, but that does not change the timeframe for compliance with the age 26 rule – it remains the first day of the first plan year following September 23, 2010. Though not final, these interim rules will help employers that opted to implement age 26 rules early and provide the best information to help employers plan for implementation later this year.

Definition of Dependent

The interim rules state "a plan that makes coverage available to any dependent child(ren), must extend that coverage until the attainment of age 26". The rules clarify that stricter state insurance laws are not to be superseded by the new rules, and they reiterate that coverage for adult children will be tax favored.

From there, the interim rules make a number of important clarifications about dependent status:

- Plans cannot distinguish between minor children and adult children up to age 26 – all must be treated in the same manner
  - Surcharges or additional contributions for adult children are not allowed **unless** surcharge applies regardless of age
  - Plan can not vary benefit based on age

- Plan can NOT define dependent eligibility or continued eligibility on:
  - Financial dependency on the participant or primary subscriber
  - Residency with the participant or primary subscriber
  - Student status
  - Marital status
  - Employment
  - Eligibility for other coverage
  - Or any combination of the above
- A *grandfathered* plan may exclude coverage for an adult dependent child that is eligible for coverage under that child's employer's group health plan until 2014
- A plan cannot exclude coverage on a dependent child because the child is married. This provision applies regardless of age. The law **does not** require a plan to cover the spouse of a child or any dependent children of the child.
- **These rules apply to both minor children and adult children!!**

After 30 years of developing rules that gave employers a wide range of choices about how to define a dependent child, what coverage to provide, and what to charge for coverage, these interim final rules simply mandate that any dependent child will now qualify as a dependent. Employers will be allowed to make uniform changes such as dropping all dependent coverage, altering all benefit levels, or charging a "per dependent" premium. However, all dependent children (at any age) must be covered in a uniform manner.

For most plan sponsors, these changes will significantly increase the number of dependents that will be eligible to enroll for coverage. Employers with high benefit levels and low employee premiums may want to be particularly aware of this change and the potential cost implications – cost estimates vary, but many estimates place the annual cost of coverage per dependent child at $3,000 per year.

Interestingly, the interim final rules do not actually define the word "child". The IRS guidance on tax deductibility did specify a child as a son, daughter, stepchild, adopted child or eligible foster child, but those are tax rules and may or may not be considered binding on a health plan. Until further clarification is provided, employers may have some flexibility on how their health plan defines a child – we will need to watch for additional guidance in this area.

Enrollment Requirements

The interim final rules include an enrollment transition rule to address employers' questions regarding the enrollment process after changes are made to the dependent definition. Key points include:

- Employers are required to provide written notice to employees about coverage expansion for children and ability for potentially new dependents to enroll in health plan:
  - Can be provided with typical open enrollment materials, but must be prominent

- The enrollment period must be provided, *at the latest*, as of the **first date the extended dependent coverage is offered** and run for a minimum of 30 days:
  - If plan runs open enrollment during this timeframe and it begins and ends before beginning of plan year, this satisfies enrollment period requirement, but employer must still provide notice about expanded dependent coverage
- If a dependent child lost coverage or initially was not eligible due to age, after the plan changes definition of dependent, the child must be given the opportunity to enroll:
  - Employer must provide minimum 30-day window to enroll
  - As many plans will make change at beginning of the plan year, this will correspond with the plan's normal open enrollment period
  - If employer plan year occurs before open enrollment period, plan must allow newly eligible children a 30-day window to enroll at beginning of the plan year
- Any child enrolling in a group health plan pursuant to this enrollment right will be treated as a special enrollee as defined by HIPAA, as such:
  - Child must be offered all coverage options available to similarly situated dependents who did not lose coverage due to cessation of dependent status
  - Child cannot be required to pay more for coverage than similarly situated dependents who did not lose coverage due to cessation of dependent status
  - An employee not currently enrolled that wants to enroll so that they can enroll a dependent child, must be allowed to enroll
  - Employer must allow employees to switch benefit plan options in addition to enrolling newly eligible dependent children
- If a child lost coverage due to age and elected COBRA, the plan must allow an under age 26 child to enroll as a dependent again:
  - If child ages out again at 26, COBRA eligibility kicks in again for an additional 3 years

Many employers will need to modify enrollment materials to include the notification of the dependent coverage extension. The interim final rules do not indicate that a model notice will be released (though one may be released), but the list of information expected in the notice includes:

- Statement that children whose coverage ended, were denied coverage, or were not eligible for coverage because availability of coverage ended before age 26 are now eligible to enroll
- Coverage effective date if a newly eligible child chooses to enroll - date cannot be later than first day of the first plan year following September 26, 2010
- Cost of coverage should the child elect to enroll
- Coverage options for the child to enroll must be explained including an option for employee to enroll in order to enroll a dependent child
- Timeframe for enrollment to be submitted and consequences for not submitting an enrollment form within the required timeframe

- For example, if you fail to enroll a child by January 1, the child will have limited ability to enroll midyear and may need to wait until next year's open enrollment
- *Remember:* You must provide an enrollment window of at least 30 days after notice. If your normal open enrollment timeframe is less than 30 days, it does not appear that you need extend that timeframe. However, if an employee requests to add a dependent once open enrollment is closed, but within the 30 day window, your plan should allow that addition.

Importantly, a health insurance carrier's decision to extend coverage for adult dependents in advance of the effective date does not require employers to make an early change.

Review of Examples

The regulations provide examples and statements that may help employers understand how the requirements work in practice, including:

- If child turns 26 on July 17, 2011, health plan can cancel coverage on July 16, 2011 (coverage only required "up to" age 26)
- If health plan offers choice between self and family coverage and charges a premium surcharge for children over age 18 - not permitted (cannot vary based on age of child)
- If health plan contribution structure is employee only, employee plus one dependent, employee plus two and employee plus three or more - permitted (uniform application at any age)
- If choice between PPO and HMO is offered to employees, but children over 18 limited to HMO option – not permitted
- Numerous examples address ability for adult dependents to enroll or re-enroll in plan once age limit moved to 26 and clarifications that employees must be able to change coverage election when adding an adult dependent child

The examples may help clarify a number of real issues that will challenge employers trying to determine how the dependent child extension will impact their organization.

Employer Action Steps

All employers will need to revisit their dependent coverage definitions and take action to comply with this portion of health care reform. Employers may want to consider a number of steps:

Step One: Determine when extension of dependent coverage is required. For ERISA plans, the term "plan year" is defined in plan documents and 5500 filings. For non-ERISA plans, policy year may be the best guide. Once plan year is determined, it will be important to consider whether your open enrollment corresponds with your plan year and, if not, how your organization will allow a midyear special enrollment for individuals affected by the coverage expansion.

Step Two: Will dental and vision be included? While the regulations do not speak directly to dental and vision coverage, the extension will apply unless they are considered *excepted benefits* by HIPAA. Dental and vision are excepted when they are stand-alone ERISA plans or for non-ERISA organizations, they will defer to policies. Are the policies stand alone policies or are they incorporated with the medical plan? Even if your organization is not required to extend coverage to adult children due to the dental and vision plan set up, you may choose to allow the extension simply for administrative ease. It may get confusing administering separate definitions of dependents across different lines of coverage.

Step Three: Contact your vendors to find out what definitions they plan to use. Without a formal definition of child, this may be helpful to know. In addition, you may want to find out if they can accommodate the grandfathered provision of excluding coverage on dependents that have coverage available through their employers.

Step Four: Keep an eye out for guidance on grandfathering. It is expected soon and if your plan can reserve grandfathered status, you will at least be able to limit covering adult children to those that don't have coverage available through their employers.

Step Five: Evaluate potential cost - a tricky proposition. Many employers will see an increased number of dependents eligible, but determining how many will enroll will not be simple. It does seem likely that employers with higher benefit levels and low employee premiums will be the most affected, but this oversimplifies the situation. Your insurance carrier, if your plan is insured, may have some cost factors and may be changing how they calculate rates. Self-funded organizations may want to change rate development methodology. It may be difficult to wrap your arms around financial impact in the first year, but it seems safe to assume that it will not be free and many projections range between 1% to 3% increased health plan cost.

Step Six: Review how you charge employees to participate in the health plan. If employee premiums vary based on dependents' age or student status this will not be permitted. Your organization will be very limited in how they structure contributions. The interim final rules do include an example that allows employee premiums based on employee plus one, employee plus two, employee plus three, employee plus four or more – a structure that provides some financial incentive for adult dependent children to consider other coverage (instead of "free" coverage through the parents). It may make sense to charge for each dependent rather than a single premium for "family" that costs the same amount whether covering two dependents or eight. You should also look at your payroll system to see if they have any constraints that may limit your contribution structure.

Step Seven: Create an implementation plan. All of your documents will need to be amended for the new dependent coverage extension - SPDs, open enrollment newsletter, benefit websites, PowerPoint enrollment presentations, and new hire communications. Educate your employees about the changes, how it may affect open enrollment timeframes. Let them know if the changes will affect your cost. Also if your ERISA plan year is separate from your Section 125 plan year, you will need to plan a special enrollment when you amend your plan to extend dependent coverage.

The dependent eligibility extension will likely affect all employers. With this new guidance, employers can now start to plan how they will make the necessary changes to comply with this law. However, employers may choose to plan for the change, but may want to see if the government formally defines a child.

This latest round of guidance illustrates how expansive the government can be in interpreting the health reform statutes. Employers will have few options in managing dependent eligibility to keep cost in check once this coverage expansion is effective. Employers will need to look at other areas of the plan to help offset cost increases associated with trend and health care reform.

Our next *Update* will cover a number of additional health reform requirements such as small employer cafeteria plan requirements, Federal rate reviews and minimum loss ratios, health plan summary communication requirements and coverage for clinical trials.