

Health Reform

Dependent Child Mandate and COBRA

Dependent Child Mandate

According to the Patient Protection and Affordable Care Act (PPACA), for plan years beginning on or after Sept. 23, 2010, if a group health plan provides coverage for the children of a participant, the plan generally must continue to make such coverage available until a participant's child turns age 26. This summary provides answers to many of the frequently asked questions regarding the dependent child mandate. This information is from the Department of Labor (DOL) interim final regulations on the mandate as well as other DOL publications, which are referenced below.

Frequently Asked Questions

Is the applicable age of dependent coverage up to the age of 26 or through the age of 26?

In general, coverage must be allowed to continue until the child reaches the age of 26. And, the regulations provide that the obligation to make dependent coverage available to children ends the day before the child's 26th birthday. Plan sponsors have the option to elect more generous plan benefit designs, if available to them, such as covering dependents until the end of the month in which the child reaches age 26 or the end of year in which the child attains the age of 26.

What is the definition of "dependent" for purposes of the dependent child mandate?

In sub regulatory guidance provided in the form of an FAQ jointly released by the Department of Health and Human Services, the DOL, and the Internal Revenue Service on Sept. 20, 2010, the agencies clarify that, for purposes of the mandate, a plan must provide coverage up to age 26 for adult dependents who meet the definition of "child" found in Code §152(f)(1). This definition includes biological sons and daughters, stepchildren and adopted children (including children placed for adoption, and eligible foster children). A plan may, however, be more generous in plan design by extending dependent coverage to those outside of the definition found in Code §152(f)(1), such as a grandchild, niece or nephew. In addition, as provided in more detail below, state law may require more expansive coverage.

May a group health plan take into account factors such as residency or student status?

No. With respect to the eligibility of a child under age 26, the interim final regulations prohibit plans from defining "dependent" using any terms other than the relationship between a child and the participant. For purposes of the mandate, a plan may no longer take into account factors such as residency, tax dependence, marital status, financial dependence or student status. A plan also may no longer take into account the dependent's eligibility for health coverage under his or her employer or a spouse's employer, unless the plan is considered grandfathered and then only until 2014.

The jointly-released FAQ specifically addresses whether a plan will fail to satisfy the mandate by conditioning health coverage on support, residency, or other dependency factors for individuals under age 26 who do not fall within the definition of "child" found in Code § 152(f)(1). The agencies' guidance provides that a plan will satisfy the mandate by imposing such limits on an individual who is not a Code § 152(f)(1) child, such as a grandchild or niece, provided the limits are not imposed on children who meet the definition of "child" in Code § 152(f)(1). In other words, plans may impose additional conditions on eligibility for additional dependents outside the definition in Code § 152(f)(1).

May a group health plan charge a surcharge or extra premium for covering children under age 26?

No. The regulations clarify that group health plans are not allowed to charge a surcharge or extra premium for covering dependent children under age 26. The regulations make it clear that any age-based surcharges for children under age 26 are not allowed. The regulations also provide that the terms of the plan or policy for dependent coverage may not change based on the age of a child, except for children age 26 or older. Examples illustrate that surcharges for coverage of children under age 26 are not allowed except where the surcharges apply regardless of the age of the child (up to age 26) and that, for children under age 26, the plan cannot vary benefits based on the age of the child.

Example 1: A group health plan offers a choice of self-only or family health coverage. Dependent coverage is provided under family health coverage for children of participants who have not attained age 26. The plan imposes an additional premium surcharge for children who are older than age 18. In this example, the plan violates the law because the plan varies the terms for dependent coverage of children based on age.

Example 2: A group health plan offers a choice among the following tiers of health coverage: self-only, self-plus-one, self-plus-two, and self-plus-three-or-more. The cost of coverage increases based on the number of covered individuals. The plan provides dependent coverage of children who have not attained age 26. In this example, the plan does not violate the requirement that the terms of dependent coverage for children not vary based on age. Although the cost of coverage increases for tiers with more covered individuals, the increase applies without regard to the age of any child.

Does the dependent child mandate apply to grandfathered health plans?

Yes, but, a special transition period is provided. Until 2014, grandfathered plans may deny eligibility for dependent coverage to a child under age 26 who is eligible to enroll in another employer-sponsored group health plan—other than a group health plan of a parent.

Does a fully-insured group health plan have to comply with a state law that has a more favorable eligibility entitlement beyond the dependent child mandate?

Yes. Some state laws require coverage beyond what the federal health care reform laws require. For example, some states mandate coverage beyond age 26 or they require that grandchildren be covered. For those states, the benefits beyond the federal health care reform laws must be provided for fully-insured group plans.

Does the dependent child mandate apply to group health plans that are excepted benefits?

No. The mandate does not apply to plans that provide only HIPAA-excepted benefits, such as stand-alone dental or vision policies. The mandate does apply to group health plans and insurers (as defined by applicable provisions of PPACA, ERISA, and the Internal Revenue Code), such as a major medical group health plan covering at least two current employees (regardless of whether the plan is self-funded or fully insured).

Will dependents be given a special chance to enroll after Sept. 23, 2010?

Yes. For plan or policy years beginning on or after Sept. 23, 2010, plans and issuers must give children who qualify an opportunity to enroll that continues for at least 30 days regardless of whether the plan or coverage offers an open enrollment period. This enrollment opportunity and a written notice must be provided not later than the first day of the first plan or policy year beginning on or after Sept. 23, 2010. The DOL has provided a model notice for this purpose that is provided below. Some plans may provide the opportunity before Sept. 23, 2010, as long as the enrollment opportunity is at least 30 days and written notice is provided. A plan that provided the opportunity prior to Sept. 23, 2010, but did not satisfy the criteria, would need to offer another enrollment opportunity in order to comply. Any dependent child enrolling in group health plan coverage must also be treated as a special enrollee under HIPAA. Accordingly, the dependent child must be offered all the benefit packages available to similarly situated individuals who did not lose coverage (or were denied coverage) based on cessation of dependent status.

COBRA Implications of the Dependent Child Mandate

An important consideration for group health plans is the extent to which the dependent child mandate has COBRA implications. This summary provides answers to many of the frequently asked questions regarding health care reform and COBRA as well as the COBRA implications of the dependent child mandate. The information is from the DOL interim final regulations as well as the publications referenced below.

Frequently Asked Questions

Did the health reform legislation eliminate COBRA?

No. PPACA did not eliminate COBRA or change the COBRA rules.

Did the health care reform legislation extend the COBRA continuation coverage time period?

No. PPACA did not extend the maximum time periods of continuation coverage provided by COBRA. COBRA establishes required periods of coverage for continuation health benefits. COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, including a dependent child ceasing to be a dependent under the plan, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. A plan, however, may provide longer periods of coverage beyond those required by COBRA, and state law may provide for an additional period of coverage.

What will happen when dependent children lose coverage at age 26?

When a dependent ages out of coverage at age 26, that event will be considered a COBRA- triggering event. In order for COBRA to be offered, the dependent will have to experience both the triggering event and a loss of coverage. Thus, following the triggering event, COBRA will be offered at the time the loss of coverage occurs. The date of the loss of coverage will depend on the plan document. Generally, the loss of coverage will either occur on the date the dependent attains age 26 or the end of the month in which age 26 is attained. Some plans will permit the loss of coverage to occur even later. At the time the loss of coverage occurs, the dependent will have the option to elect up to 36 months of COBRA continuation coverage.

What are the implications of the COBRA multiple qualifying event rule and the dependent child mandate?

The COBRA multiple qualifying event rule applies only when a 36-month qualifying event follows a qualifying event that is a termination of employment or a reduction of hours, the dependent child has elected COBRA in connection with the first qualifying event, and the dependent is receiving COBRA coverage in connection with the first event at the time of the second event. The implications of the dependent child mandate and the multiple qualifying event rule are demonstrated by the following examples:

Example 1: Tom has terminated employment and is entitled to COBRA coverage for up to 18 months from the group health plan of his former employer. Tom has a dependent child who is age 22. Prior to PPACA, the group health plan otherwise terminates dependent child coverage at age 23. Under the COBRA rules, if Tom's dependent child ceases to meet the requirements for dependent coverage under the plan terms during Tom's 18-month COBRA period that would constitute a multiple qualifying event. The 18-month COBRA coverage period on account of Tom's termination of employment would be extended for the dependent child to up to 36 months from Tom's date of employment termination.

In accordance with the dependent coverage mandate, the plan will now be required to extend coverage up to the child's attainment of age 26. This means that the child's attainment of age 23 during the original 18-month COBRA coverage period will no longer constitute a multiple qualifying event because the covered dependent will not have suffered a loss of group health coverage. As a result, under the new regulations, the dependent child's attainment of age 23 in this circumstance will not affect the duration of COBRA coverage, it will still end 18 months after Tom's termination of employment.

Example 2: Tom has terminated employment and is entitled to COBRA coverage for up to 18 months from his former employer's group health plan. Tom has a dependent child who is age 25. In accordance with the dependent child mandate, the group health plan otherwise terminated dependent child coverage at age 26.

In this circumstance, if Tom's dependent child ceases to meet the requirements for dependent coverage under the plan during Tom's 18-month COBRA period that will constitute a multiple qualifying event. The 18-month COBRA coverage period on account of Tom's termination of employment would be extended for the dependent child for up to 36 months from Tom's termination of employment. The expanded period would apply only to the dependent child and not to Tom.

Example 3: Same facts as Example 2, except Tom's dependent child did not elect COBRA in connection with Tom's termination of employment. In this example, the fact that the dependent did not elect COBRA continuation coverage means that the dependent will not be eligible to an extended coverage period.

This is because qualified beneficiaries whose COBRA coverage has ended, either because their maximum coverage has expired or for some other reason, lose their status as qualified beneficiaries. This means that, in order to get an extended coverage period due to a second qualifying event, a qualified beneficiary must (1) have elected COBRA in connection with the first qualifying event and (2) be receiving COBRA coverage in connection with the first event at the time of the second event.

Example 4: Same facts as Example 2, except Tom did not elect COBRA coverage in connection with his termination of employment. Assuming Tom's dependent child elected COBRA coverage, the fact that Tom did not elect COBRA coverage does not affect the application of the multiple qualifying event rule and the attainment of age 26 in this circumstance, and will result in the dependent child being offered 36 months of COBRA continuation coverage from the date of Tom's termination of employment.

If a dependent is already on COBRA and is under the age of 26 may the dependent enroll onto the parent's plan?

Yes. If a child who will become eligible for dependent coverage under the dependent child mandate is currently a COBRA qualified beneficiary, that child must be allowed to re-enroll into the plan's dependent coverage in accordance with the special enrollment rules. As a result, employers must include COBRA qualified beneficiaries in their dependent child special enrollment that must be offered before the beginning of their first plan year on or after Sept. 23, 2010. Further, if a child who was a COBRA qualified beneficiary re-enrolls as a dependent in the plan under the mandate, that child will be eligible for COBRA at the age of 26.

Example: Mary's calendar-year group plan provides dependent child coverage to age 19, or age 23 for full-time students. Mary's child was covered under the group plan until she dropped out of college at age 21. At that time, the child elected, and maintained, COBRA. The child, now 22, will be eligible for coverage under Mary's active group health plan as a dependent child on Jan. 1, 2011 (and the group must have provided, by that date, written notice of the opportunity to enroll that continues for at least 30 days, with enrollment effective not later than Jan. 1, 2011). The child, therefore, should be provided with a special enrollment effective January 1, 2011. If the child re-enrolls in the group plan, eligibility would continue until the child turns 26 (or later, if the plan so provides). At age 26, the child would be eligible for up to 36 months of COBRA.

Additional Resources:

- DOL Dependent Coverage Regulations: www.hhs.gov/ociio/regulations/dependent/index.html
- DOL Dependent Coverage Fact Sheet: www.dol.gov/ebsa/newsroom/fsdependentcoverage.html
- DOL COBRA FAQ: www.dol.gov/ebsa/faqs/faq-PPACA.html
- DOL Model Notice: www.dol.gov/ebsa/dependentsmodelnotice.doc
- Jointly Released FAQ: www.dol.gov/ebsa/faqs/faq-aca.html

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