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29 CFR Part 2590

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45 CFR Parts 144, 146, and 147

Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 54 and 602

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DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

[OCIIO–4150–IFC]

45 CFR Parts 144, 146, and 147

RIN 0991–AB66

Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Department of Health and Human Services.

ACTION: Interim final rules with request for comments.

SUMMARY: This document contains interim final regulations implementing the requirements for group health plans and health insurance issuers in the group and individual markets under provisions of the Patient Protection and Affordable Care Act regarding dependent coverage of children who have not attained age 26.

DATES: *Effective date.* These interim final regulations are effective on July 12, 2010.

Comment date. Comments are due on or before August 11, 2010.

Applicability date. These interim final regulations generally apply to group health plans and group health insurance issuers for plan years beginning on or after September 23, 2010. These interim final regulations generally apply to individual health insurance issuers for policy years beginning on or after September 23, 2010.

ADDRESSES: Written comments may be submitted to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments. Please do not submit duplicates.

All comments will be made available to the public. *Warning:* Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments are posted on the Internet exactly as received, and can be retrieved by most Internet search engines. No deletions, modifications, or redactions will be made to the comments received, as they are public records. Comments may be submitted anonymously.

Department of Labor. Comments to the Department of Labor, identified by RIN 1210–AB41, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *E-mail: E-OHPSCA.EBSA@dol.gov.*
- *Mail or Hand Delivery:* Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N–5653, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210, *Attention:* RIN 1210–AB41.

Comments received by the Department of Labor will be posted without change to *http://www.regulations.gov* and *http://www.dol.gov/ebsa,* and available for public inspection at the Public Disclosure Room, N–1513, Employee Benefits Security Administration, 200 Constitution Avenue, NW., Washington, DC 20210.

Department of Health and Human Services. In commenting, please refer to file code OCIIO–4150–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions under the "More Search Options" tab.

2. *By regular mail.* You may mail written comments to the following address only: Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, Attention: OCIIO–4150–IFC, P.O. Box 8016, Baltimore, MD 21244–1850.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address only: Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, Attention: OCIIO–4150–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—

Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201 (Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the OCIIO drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.).

b. For delivery in Baltimore, MD—

Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call (410) 786–7195 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security

Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. EST. To schedule an appointment to view public comments, phone 1–800–743–3951.

Internal Revenue Service. Comments to the IRS, identified by REG–114494–10, by one of the following methods:

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* CC:PA:LPD:PR (REG–114494–10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.
- *Hand or courier delivery:* Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG–114494–10), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW., Washington DC 20224.

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW., Washington, DC from 9 a.m. to 4 p.m.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 622–6080; Jim Mayhew, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, at (410) 786–1565.

Customer Service Information: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the Department of Labor's Web site (*http://www.dol.gov/ebsa*). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) Web site (*http://www.cms.hhs.gov/HealthInsReformforConsume/01_Overview.asp*).

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act (the Affordable Care Act), Public Law 111–148, was enacted on March 23, 2010; the Health Care and Education Reconciliation Act (the Reconciliation Act), Public Law 111–152, was enacted on March 30, 2010. The Affordable Care Act and the Reconciliation Act reorganize, amend, and add to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans.[1] The Affordable Care Act adds section 715 to the Employee Retirement Income Security Act (ERISA) and section 9815 to the Internal Revenue Code (the Code) to make the provisions of part A of title XXVII of the PHS Act applicable under ERISA and the Code to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if those provisions of the PHS Act were included in ERISA and the Code. The PHS Act sections incorporated by this reference are sections 2701 through 2728. PHS Act sections 2701 through 2719A are substantially new, though they incorporate some provisions of prior law. PHS Act sections 2722 through 2728 are sections of prior law renumbered with some, mostly minor, changes. Section 1251 of the Affordable Care Act, as modified by section 10103 of the Affordable Care Act and section 2301 of the Reconciliation Act, specifies that certain plans or coverage existing as of the date of enactment (*i.e.,* grandfathered health plans) are subject to only certain provisions.

Subtitles A and C of title I of the Affordable Care Act amend the requirements of title XXVII of the PHS Act (changes to which are incorporated into ERISA section 715). The preemption provisions of ERISA section 731 and PHS Act section 2724[2] (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the requirements of the Affordable Care Act are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group or individual health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of the Affordable Care Act. Accordingly, State laws that impose on health insurance issuers stricter requirements than those imposed by the Affordable Care Act will not be superseded by the Affordable Care Act.

The Departments of Health and Human Services, Labor, and the Treasury (the Departments) expect to issue regulations implementing the revised PHS Act sections 2701 through 2719A in several phases. The first publication in this series was a Request for Information relating to the medical loss ratio provisions of PHS Act section 2718, published in the **Federal Register** on April 14, 2010 (75 FR 19297). These interim final regulations are being published to implement PHS Act section 2714 (requiring dependent coverage of children to age 26). PHS Act section 2714 generally is effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010, which is six months after the March 23, 2010 date of enactment of the Affordable Care Act.[3] The implementation of other provisions of PHS Act sections 2701 through 2719A and section 1251 of the Affordable Care Act will be addressed in future regulations.

Because subtitles A and C of title I of the Affordable Care Act contain requirements that are applicable to both the group and individual health insurance markets, it would be duplicative to insert the requirements into both the existing 45 CFR part 146 (Requirements for the Group Health Insurance Market) and 45 CFR part 148 (Requirements for the Individual Health Insurance Market). Accordingly, these interim final regulations create a new part 147 in subchapter B of 45 CFR to implement the provisions of the Affordable Care Act. The provisions of the Affordable Care Act, to the extent that they apply to group health plans and group health insurance coverage, are also implemented under new regulations added to 29 CFR part 2590 and 26 CFR part 54.

II. Overview of the Regulations

A. PHS Act Section 2714, Continued Eligibility of Children Until Age 26 (26 CFR 54.9815–2714, 29 CFR 2590.715–2714, 45 CFR 147.120)

Section 2714 of the PHS Act, as added by the Affordable Care Act (and amended by the Reconciliation Act), and these interim final regulations provide that a plan or issuer that makes available dependent coverage[4] of children must make such coverage available for children until attainment

[1] The term "group health plan" is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term "health plan", as used in other provisions of title I of the Affordable Care Act. The term "health plan" does not include self-insured group health plans.

[2] Code section 9815 incorporates the preemption provisions of PHS Act section 2724. Prior to the Affordable Care Act, there were no express preemption provisions in chapter 100 of the Code.

[3] *See* section 1004 of the Affordable Care Act.

[4] For purposes of these interim final regulations, dependent coverage means coverage of any individual under the terms of a group health plan, or group or individual health insurance coverage, because of the relationship to a participant (in the individual market, primary subscriber).

of 26 years of age. The statute also requires the issuance of regulations to "define the dependents to which coverage shall be made available" under this rule.

Many group health plans that provide dependent coverage limit the coverage to health coverage excludible from employees' gross income for income tax purposes. Thus, dependent coverage is limited to employees' spouses and employees' children that qualify as dependents for income tax purposes. Consequently, these plans often condition dependent coverage, in addition to the age of the child, on student status, residency, and financial support or other factors indicating dependent status. However, with the expansion of dependent coverage required by the Affordable Care Act to children until age 26, conditioning coverage on whether a child is a tax dependent or a student, or resides with or receives financial support from the parent, is no longer appropriate in light of the correlation between age and these factors. Therefore, these interim final regulations do not allow plans or coverage to use these requirements to deny dependent coverage to children. Because the statute does not distinguish between coverage for minor children and coverage for adult children under age 26, these factors also may not be used to determine eligibility for dependent coverage for minor children.

Accordingly, these interim final regulations clarify that, with respect to children who have not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of the relationship between the child and the participant (in the individual market, the primary subscriber). Examples of factors that cannot be used for defining dependent for purposes of eligibility (or continued eligibility) include financial dependency on the participant or primary subscriber (or any other person), residency with the participant or primary subscriber (or any other person), student status, employment, eligibility for other coverage, or any combination of these. These interim final regulations also provide that the terms of the plan or policy for dependent coverage cannot vary 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. The Affordable Care Act, as originally enacted, required plans and issuers to make dependent coverage available only to a child "who is not married." This language was struck by section 2301(b) of the Reconciliation Act. Accordingly, under these interim final regulations, plans and issuers may not limit dependent coverage based on whether a child is married. (However, a plan or issuer is not required under these interim final regulations to cover the spouse of an eligible child).

The statute and these interim final regulations provide that nothing in PHS Act section 2714 requires a plan or issuer to make available coverage for a child of a child receiving dependent coverage.

Under section 1004(d) of the Reconciliation Act and IRS Notice 2010–38 (released to the public on April 27, 2010 and scheduled to be published in 2010–20 Internal Revenue Bulletin, May 17, 2010), employers may exclude from the employee's income the value of any employer-provided health coverage for an employee's child for the entire taxable year the child turns 26 if the coverage continues until the end of that taxable year. This means that if a child turns 26 in March, but stays on the plan past December 31st (the end of most people's taxable year), the health benefits up to December 31st can be excluded for tax purposes.

Application to grandfathered health plans. Under the statute and these interim final regulations, the requirement to make available dependent coverage for children who have not attained age 26 generally applies to all group health plans and health insurance issuers offering group or individual health insurance coverage whether or not the plan or health insurance coverage qualifies as a grandfathered health plan [5] under section 1251 of the Affordable Care Act, for plan years (in the individual market, policy years) beginning on or after September 23, 2010. However, in accordance with section 2301(a) of the Reconciliation Act, for plan years beginning before January 1, 2014, these interim final regulations provide that a grandfathered health plan that is a group health plan that makes available dependent coverage of children may exclude an adult child who has not attained age 26 from coverage only if the child is eligible to enroll in an employer-sponsored health plan (as defined in section 5000A(f)(2) of the Code) other than a group health plan of a parent. In the case of an adult child who is eligible for coverage under the plans of the employers of both parents, neither plan may exclude the adult child from coverage based on the fact that the adult child is eligible to enroll in the plan of the other parent's employer.

Regulations relating to grandfathered health plans under section 1251 of the Affordable Care Act are expected to be published in the very near future. The Departments anticipate that the regulations will make clear that changes to plan or policy terms to comply with PHS Act section 2714 and these interim final regulations, including voluntary compliance before plan years (in the individual market, policy years) beginning on or after September 23, 2010, will not cause a plan or health insurance coverage to lose grandfathered health plan status for any purpose under the Affordable Care Act, as amended.

Transitional Rule. Prior to the applicability date of PHS Act section 2714, a child who was covered under a group health plan or health insurance coverage as a dependent may have lost eligibility under the plan (or coverage) due to age prior to age 26. Moreover, if, when a parent first became eligible for coverage, a child was under age 26 but older than the age at which the plan (or coverage) stopped covering children, the child would not have become eligible for the plan (or coverage). When the provisions of section 2714 become applicable, 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). Also, a child of a primary subscriber with family coverage in the individual market may be entitled to an opportunity to enroll if the child previously lost coverage due to age while other family members retained the coverage.[6]

Accordingly, these interim final regulations provide transitional relief for a child whose coverage ended, or who was denied coverage (or was not

[5] Section 1251 of the Affordable Care Act, as modified by section 10103 of the Affordable Care Act and section 2301 of the Reconciliation Act, specifies that certain plans or coverage existing as of the March 23, 2010 date of enactment (*i.e.,* grandfathered health plans) are subject to only certain provisions.

[6] In the group market, section 9802(a) of the Code, section 702(a) of ERISA, and section 2705 of the PHS Act provide that a plan or issuer cannot impose any rule for eligibility for benefits (including any rule excluding coverage) based on a health factor, including a preexisting condition. These rules were added by HIPAA and generally became applicable for group health plans for plan years beginning on or after July 1, 1997. Similar guidance regarding re-enrollment rights for individuals previously denied coverage due to a health factor was issued by the Departments of the Treasury, Labor, and HHS on December 29, 1997, at 62 FR 67689 and on January 8, 2001 at 66 FR 1378, 1403, 1410, 1418.

eligible for coverage) under a group health plan or health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26.

These interim final regulations require a plan or issuer to give such a child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll), regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity (including the written notice) must be provided not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010. Thus, many plans can use their existing annual enrollment periods (which commonly begin and end before the start of the plan year) to satisfy the enrollment opportunity requirement. If the child is enrolled, coverage must begin not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010, even if the request for enrollment is made after the first day of the plan year. In subsequent years, dependent coverage may be elected for an eligible child in connection with normal enrollment opportunities under the plan or coverage.

Under these interim final regulations, the notice may be provided to an employee on behalf of the employee's child (in the individual market, to a primary subscriber on behalf of the primary subscriber's child). In addition, for a group health plan or group health insurance coverage, the notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. For a group health plan or group health insurance coverage, if a notice satisfying these requirements is provided to an employee whose child is entitled to an enrollment opportunity, the obligation to provide the notice of enrollment opportunity with respect to that child is satisfied for both the plan and the issuer.

Any child enrolling in group health plan coverage pursuant to this enrollment right must be treated as a special enrollee, as provided under the regulations interpreting the HIPAA portability provisions.[7] Accordingly, the child must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. The child also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

The Departments have been informed that many health insurance issuers have announced that they will allow continued coverage of adult children before such coverage is required by the Affordable Care Act. A plan or issuer that allows continued coverage of adult children before being required to do so by the Affordable Care Act is not required to provide the enrollment opportunity with respect to children who do not lose coverage.

Examples in these interim final regulations illustrate the application of these transitional rules. One example illustrates that, if a child qualifies for an enrollment opportunity under this section and the parent is not enrolled but is otherwise eligible for enrollment, the plan must provide an opportunity to enroll the parent, in addition to the child. Similarly, another example illustrates that, if a plan has more than one benefit package option, a child qualifies for enrollment under this section, and the parent is enrolled in one benefit package option, the plan must provide an opportunity to enroll the child in any benefit package option for which the child is otherwise eligible (thus allowing the parent to switch benefit package options). Another example illustrates that a child who qualifies for an enrollment opportunity under this section and who is covered under a COBRA continuation provision must be given the opportunity to enroll as a dependent of an active employee (*i.e.,* other than as a COBRA-qualified beneficiary). In this situation, if the child loses eligibility for coverage due to a qualifying event (including aging out of coverage at age 26), the child has another opportunity to elect COBRA continuation coverage. (If the qualifying event is aging out, the COBRA continuation coverage could last 36 months from the loss of eligibility that relates to turning age 26.) The final example in this section illustrates that an employee who joined a plan prior to the applicability date of PHS Act section 2714, and has a child who never enrolled because the child was too old under the terms of the plan but has not yet turned 26, must be provided an opportunity to enroll the child under this section even though the child was not previously covered under the plan. If the parent is no longer eligible for coverage under the plan (for example, if the parent has ceased employment with the plan sponsor) as of the first date on which the enrollment opportunity would be required to be given, the plan would not be required to enroll the child.

B. Conforming Changes Under the PHS Act

1. References to the Public Health Service Act

Conforming changes to references to sections of title XXVII of the PHS Act are made throughout parts 144 and 146 of title 45 of the Code of Federal Regulations to reflect the renumbering of certain sections by the Affordable Care Act.

2. Definitions (45 CFR 144.103)

These interim final regulations define "policy year" as the 12-month period that is designated in the policy documents of individual health insurance coverage. If the policy document does not designate a policy year (or no such document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year. The Affordable Care Act uses the term "plan year" in referring to the period of coverage in both the individual and group health insurance markets. The term "plan year", however, is generally used in the group health insurance market. Accordingly, these interim final regulations substitute the term "policy year" for "plan year" in defining the period of coverage in the individual health insurance market.

III. Interim Final Regulations and Request for Comments

Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act authorize the Secretaries of the Treasury, Labor, and HHS (collectively, the Secretaries) to promulgate any interim final rules that they determine are appropriate to carry out the provisions of chapter 100 of the Code, part 7 of subtitle B of title I of ERISA, and part A of title XXVII of the PHS Act, which include PHS Act sections 2701 through 2728 and the incorporation of those sections into ERISA section 715 and Code section 9815.

In addition, under Section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 551 *et seq.*) a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. The

[7] HIPAA is the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191). Regulations regarding the treatment of HIPAA special enrollees are included at 26 CFR 54.9801–6(d), 29 CFR 2590.701–6(d), and 45 CFR 146.117(d).

provisions of the APA that ordinarily require a notice of proposed rulemaking do not apply here because of the specific authority granted by section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act. However, even if the APA was applicable, the Secretaries have determined that it would be impracticable and contrary to the public interest to delay putting the provisions in these interim final regulations in place until a full public notice and comment process is completed. The statutory requirement implemented in these interim final regulations was enacted on March 23, 2010, and applies for plan years (in the individual market, policy years) beginning on or after September 23, 2010. Having a binding rule in effect is critical to ensuring that individuals entitled to the new protections being implemented have these protections uniformly applied.

Moreover, the provisions in these interim final regulations require lead time for implementation. These interim final regulations require that an enrollment period be provided no later than the first day the obligation to allow dependent children to enroll until attainment of age 26 takes effect. Preparations presumably would have to be made to put such an enrollment process in place. Group health plans and health insurance issuers also would have to take the cost associated with this new obligation into account in establishing their premiums, and in making other changes to the designs of plan or policy benefits, and any such premiums and changes would have to receive necessary approvals in advance of the plan or policy year in question.

For the foregoing reasons, the Departments have determined that it is essential to provide certainty about what will be required of group health plans and health insurance issuers under the statutory requirements implemented in binding regulations as far in advance of September 23, 2010 as possible. This makes it impracticable to engage in full notice and comment rulemaking before putting regulations into effect, and in the public interest to do so through interim final regulations under which the public will have an opportunity for comment, but that opportunity will not delay putting rules in effect (a delay that could possibly last past September 23, 2010).

Issuance of proposed regulations would not be sufficient because the proposed regulations would not be binding, and different group health plans or health insurance issuers could interpret the statutory language in different ways. Had the Departments published a notice of proposed rulemaking, provided for a 60-day comment period, and only then prepared final regulations, which would be subject to a 60-day delay in effective date, it is unlikely that it would have been possible to have final regulations in effect before late September, when these requirements could be in effect for some plans or policies. It therefore is in the public interest that these interim final regulations be in effect and apply when the statutory protections being implemented apply.

IV. Economic Impact and Paperwork Burden

A. Summary—Department of Labor and Department of Health and Human Services

As stated earlier in this preamble, these interim final regulations implement PHS Act section 2714, which requires plans or issuers that make dependent coverage available for children to continue to make such coverage available for an adult child until the attainment of age 26. The regulation also provides an enrollment opportunity to individuals who lost or were not eligible for dependent coverage before age 26.[8] This provision generally is effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010, which is six months after the March 23, 2010 date of enactment of the Affordable Care Act.

The Departments have crafted these interim final regulations to secure the protections intended by Congress in the most economically efficient manner possible. The Departments have quantified costs where possible and provided a qualitative discussion of the economic benefits and some of the transfers and costs that may stem from these interim final regulations.

B. Executive Order 12866—Department of Labor and Department of Health and Human Services

Under Executive Order 12866 (58 FR 51735), this regulatory action has been determined "significant" and therefore subject to review by the Office of Management and Budget (OMB). Section 3(f) of the Executive Order defines a "significant regulatory action" as an action that is likely to result in a rule (1) having an annual effect on the economy of $100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as "economically significant"); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. OMB has determined that this regulation is economically significant within the meaning of section 3(f)(1) of the Executive Order, because it is likely to have an annual effect on the economy of $100 million in any one year. Accordingly, OMB has reviewed these rules pursuant to the Executive Order. The Departments provide an assessment of the potential costs, benefits, and transfers associated with the regulatory provision below. The Departments invite comments on this assessment and its conclusions.

1. *Need for Regulatory Action*

PHS Act section 2714, as added by the Affordable Care Act and amended by the Reconciliation Act requires group health plans and health insurance issuers offering group or individual health insurance coverage that make dependent coverage available for children to continue to make coverage available to such children until the attainment of age 26. With respect to a child receiving dependent coverage, coverage does not have to be extended to a child or children of the child or a spouse of the child. In addition, as provided by the Reconciliation Act, grandfathered group health plans are not required to offer dependent coverage to a child under 26 who is otherwise eligible for employer-sponsored insurance other than a group health plan of a parent for plan years beginning before January 1, 2014. PHS Act section 2714 generally is effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010. Thus, these interim final regulations are necessary to amend the Departments' existing regulations to

[8] The Affordable Care Act adds section 715 and Code section to make the provisions of part A of title XXVII of the PHS Act applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, under ERISA and the Code as if those provisions of the PHS Act were included in ERISA and the Code. The PHS Act sections incorporated by this reference are sections 2701 through 2728. Section 1251 of the Affordable Care Act provides rules for grandfathered health plans, and these rules are further clarified in section 10103 of the Affordable Care Act and section 2301 of the Reconciliation Act.

implement these statutorily mandated changes.

2. *Summary of Impacts*

In this section, the Departments estimate the number of individuals affected by these interim final regulations, and the impact of the regulations on health insurance premiums in the group and individual markets. Beginning with the population of individuals age 19–25, the number of individuals potentially affected is estimated by applying several criteria including whether their parents have existing employer-sponsored insurance (ESI) or an individual market policy; and whether the individuals are themselves uninsured, have ESI, individual market policies or other forms of coverage. A range of assumptions concerning the percentage of the potentially affected individuals that will accept the offer of new dependent coverage—"take-up" rates—is then applied to estimate the number of newly covered individuals. The premium impact is calculated by using an estimated incremental insurance cost per newly-covered individual as a percent of average family premiums.

In accordance, with OMB Circular A–4,[9] Table 1 below depicts an accounting statement showing the Departments' assessment of the benefits, costs, and transfers associated with this regulatory action.

TABLE 1—ACCOUNTING TABLE

Benefits:	
Annualized Quantified: low estimate	0.19 million previously uninsured individuals gain coverage in 2011.
mid-range estimate	0.65 million previously uninsured individuals gain coverage in 2011.
high estimate	1.64 million previously uninsured individuals gain coverage in 2011.
Qualitative: Expanding coverage options of the 19–25 population should decrease the number uninsured, which in turn should decrease the cost-shifting of uncompensated care onto those with insurance, increase the receipt of preventive health care and provide more timely access to high quality care, resulting in a healthier population. Allowing extended dependent coverage will also permit greater job mobility for this population as their insurance coverage will no longer be tied to their own jobs or student status. Dependents aged 19–25 that have chronic or other serious health conditions would still be able to continue their current coverage through a parent's plan. To the extent there is an increase in beneficial utilization of healthcare, health could improve.	

Costs[10]	Low estimate	Mid-range estimate	High estimate	Year dollar	Discount rate percent	Period covered[11]
Annualized Monetized ($millions/year)	11.2	11.2	11.2	2010	7	2011–2013
	10.4	10.4	10.4	2010	3	2011–2013
A one-time notice of right to enroll must be sent to those affected.						
Qualitative: To the extent additional coverage increases utilization of health care services, there will be additional costs incurred to achieve the health benefits.						
Transfer:[12]						
Annualized Monetized ($millions/year)	3,459.3	5,250.2	6,893.9	2010	7	2011–2013
	3,482.5	5,274.5	6,895.4	2010	3	2011–2013
Qualitative: If the rule causes family health insurance premiums to increase, there will be a transfer from individuals with family health insurance coverage who do not have dependents aged 19–25 to those individuals with family health insurance coverage that have dependents aged 19–25. To the extent that these higher premiums result in lower profits or higher prices for the employer's product, then the higher premiums will result in a transfer either from stockholders or consumers.						

[10] The cost estimates are annualize across the years 2011–2013, and reflects a single point estimate of the cost to send out a notice in the first year only.

[11] The Departments limited the period covered by the RIA to 2011–2013, because it only has reliable data to make projections over this period due to the fact that in 2014, things will change drastically when the subsidies and tax credits to offset premium increases and the exchanges are in effect.

[12] The estimates in this table reflect the annualized discounted value in 2010 of the additional premium costs for family policies calculated as the product of the newly covered dependents in each year from 2011–2013 (see below) and an incremental cost per newly-covered person in those years (see below).

3. *Estimated Number of Affected Individuals*

The Departments' estimates in this section are based on the 2004–2006 Medical Expenditure Panel Survey Household Component (MEPS–HC) which was projected and calibrated to 2010 to be consistent with the National Health Accounts projections. The Departments estimate that in 2010, there are approximately 29.5 million individuals aged 19–25 (young adults) in the United States. Of those individuals, 9.3 million young adults (of whom 3.1 million are uninsured) do not have a parent who has either ESI or non-group insurance, and thus they have no access to dependent coverage. As shown in Table 2, among the remaining 20.2 million young adults whose parents are covered either by ESI or by non-group insurance:

- 3.44 million are currently uninsured,
- 2.42 million are covered by their own non-group insurance,
- 5.55 million are covered by their own ESI,
- 5.73 million are already on their parent's or spouse's ESI, and
- 3.01 million have some other form of coverage such as Medicaid or TRICARE.

[9] Available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf.*

TABLE 2—YOUNG ADULTS AGED 19–25 BY INSURANCE STATUS

	Uninsured*	Non-group	Own ESI	ESI as a dependent	Other	Total
Total U.S. Population Aged 19–25	**6.59**	**2.69**	6.98	5.75	7.5	29.5
All Young Adults in U.S. with a Parent with a Policy by Young Adult Insurance Status						
Parents have ESI	**3.28**	**2.03**	5.32	5.73	2.91	19.27
Parents have non-group	**0.16**	**0.40**	0.23	.....	0.10	0.88
Subtotal A	**3.44**	**2.42**	5.55	5.73	3.01	20.15

*The **bolded** numbers are potentially affected by the regulation.

Source: MEPS 2004–2006 HC Surveys, controlled to 2010 consistent with the National Health Accounts. Note: Total number of young adults, age 19–25 is 29.5 million; the 20.15 million in this Table are the subset whose parents have either ESI or non-group coverage.

Initially, the subset of this group of young adults that will be affected by these interim final regulations are those who are either uninsured (3.44 million) or covered by individual coverage (2.42 million). The statute does not require grandfathered group health plans to offer coverage to young adults who currently have their own ESI or an offer of an ESI. For the purposes of this analysis, it is assumed that all plans begin 2011 with grandfathered status. These impacts could change if plans lose their Grandfathered status.

Of these 5.86 million young adults, as shown in Table 3, 3.49 million are also unlikely to switch to their parents' coverage because:

• They are already allowed to enroll in extended dependent coverage for young adults through their State's existing laws, but have chosen not to (2.61 million). Thirty-seven states already have requirements concerning dependent coverage in the group market, although most of these are substantially more restrictive than those contained in this regulation.[13] Using information about State laws obtained from the Kaiser Family Foundation,[14] a State by State profile of State required coverage based on a person's State of residence, age, student status, and living situation was developed. This profile was then overlaid on MEPS data to obtain an estimate of the number of individuals that would newly become eligible for coverage due to these interim final regulations.

• They have an offer of ESI and have parents who are covered by ESI (0.48 million). For the purposes of this regulatory impact statement, the Departments assume that the parents of these young adults will be in grandfathered group health plans, and thus that these young adults will not be affected by the provisions of these interim final regulations. To the extent that some of the coverage in which these parents are enrolled is not grandfathered, the effect of these interim final regulations will be larger than the estimates provided here.

• Finally, there are 0.40 million young adults who have non-group coverage and whose parents have non-group coverage. Because the parents' non-group coverage is underwritten, there is not likely to be any financial benefit to the family in moving the young adult onto the parents' coverage, and the Departments assume that these young adults will not be affected by the regulation.

TABLE 3—"UNINSURED" AND "NON-GROUP" YOUNG ADULTS UNLIKELY TO BE AFFECTED BY EXTENDING DEPENDENT COVERAGE TO AGE 26

	Uninsured	Non-Group coverage	Total
(1) Young adults potentially covered by parent ESI due to state law	1.30	1.31	2.61
(2) Young adults with an offer of ESI whose parents have ESI	0.31	0.17	0.48
(3) Young adults with non-group coverage whose parents have non-group coverage	.....	0.40	0.40
Subtotal B	1.61	1.88	3.49

As shown in Table 4, this leaves approximately 2.37 million young adults who might be affected by this provision, or approximately eight percent of the 29.5 million young adults in the age group. Among the approximately 2.37 million young adults who are estimated to be potentially affected by this provision, approximately 1.83 million are currently uninsured, and 0.55 million are currently covered by their own non-group coverage.

TABLE 4—YOUNG ADULTS POTENTIALLY AFFECTED BY EXTENDING DEPENDENT COVERAGE TO AGE 26

	Uninsured	Non-group coverage	Total
Parents have ESI	1.67	0.55	2.21
Parents have non-group	0.16	.....	0.16

[13] Restrictions include requirements for financial dependency, student status, and age limits.

[14] As described in Kaiser Family Foundation, *Definition of Dependency by Age, 2010,* KFF State Health Facts, *at http://www.statehealthfacts.org/comparetable.jsp?ind=601&cat=7.*

TABLE 4—YOUNG ADULTS POTENTIALLY AFFECTED BY EXTENDING DEPENDENT COVERAGE TO AGE 26—Continued

	Uninsured	Non-group coverage	Total
Total (Subtotal A–Subtotal B)*	1.83	0.55	2.37

Source: MEPS 2004–2006 HC Surveys, controlled to 2010 consistent with projections of the National Health Accounts.
*Subtotal A is in Table 2 and Subtotal B is in Table 3.

It is difficult to estimate precisely what fraction of the 2.37 million young adults who might potentially be affected by the provision will actually enroll on their parents' coverage. A study by Monheit and Cantor of the early experience in States that have extended coverage to dependents suggests that few uninsured children in these States shift to their parents' policy.[15] However, data and methodological difficulties inevitably lead to substantial uncertainty about the finding.

The Departments considered two other points of reference to estimate take-up rates. One is the work that has analyzed take-up rates among people made newly eligible for public coverage by Medicaid expansions. These studies suggest take-up rates in the range of 10–34 percent.[16] However, the populations eligible for these expansions have different socio-demographic compositions than those eligible for the dependent coverage provisions covered under these interim final regulations, and the decision to take-up Medicaid is clearly different than the decision to cover a child on a parent's private insurance policy. A second point of reference are estimates from the Kaiser/HRET Employer Health benefits Survey[17] which suggest that, depending on the size of the worker contribution, between 77 percent and 90 percent of employees accept offers of family policies. Again, these estimates would be based on a group that differs in characteristics from those eligible for new dependent coverage. These concerns notwithstanding, the analyses of Medicaid expansions and employee take-up of employer sponsored coverage provide useful points of reference.

Recognizing the uncertainty in the area, the Departments produced a range of assumptions concerning take-up rates. In developing the range of take-up rates, the Departments assume that these rates will vary by the following factors: (1) The young adult's current health coverage status (uninsured young adults are less likely to take advantage of the dependent coverage option than young adults already covered by non-group insurance, because young adults who have purchased non-group insurance have shown a strong preference for coverage, and can almost always save money and get better coverage by switching to their parents' policy); (2) the young adult's health status (young adults in fair or poor health are more likely to take advantage of the option than those in excellent, very good or good health), and (3) the young adult's living situation (those living with their parents are more likely to take up the option than those not living with their parents).

The almost fully covered or "high" take-up rate scenario assumes that regardless of health or insurance status, 95 percent of young adults living at home and 85 percent of those not living at home would move to dependent coverage. For the mid-range scenario, the Departments assume that relative to the high take-up rate scenario, 90 percent of the uninsured whose health status was fair or poor health and 50 percent of those in good to excellent health would move to dependent coverage. In the low take-up rate scenario, the Departments adjusted the percentages to 80 percent and 10 percent of the high take-up rate scenario. In all three scenarios, the same assumptions apply to individuals with non-group policies whose parents have ESI—95 percent of those living at home and 85 percent of those living elsewhere would move to dependent coverage.

In the low take-up rate scenario, the assumptions lead to the result that approximately 30 percent of eligibles will enroll in dependent coverage. In the mid-range scenario, they result in an approximate 50 percent take-up rate, and in the high take-up scenario, they result in an approximate 90 percent take-up rate. The Departments are uncertain regarding which of these scenarios is most likely but are confident that they bracket the expected outcome.

TABLE 5—NUMBER OF INDIVIDUALS WITH NEW DEPENDENT COVERAGE AND IMPACT ON GROUP INSURANCE PREMIUMS, 2011–2013

	Low estimate			Mid-range estimate			High estimate		
	2011	2012	2013	2011	2012	2013	2011	2012	2013
Individuals with New Dependent Coverage (millions)	0.68	0.97	1.08	1.24	1.60	1.65	2.12	2.07	1.98
From Uninsured (millions)	0.19	0.29	0.33	0.65	0.94	0.91	1.64	1.42	1.21
Incremental Premium Cost Per Individual Coverage	$3,670	$3,800	$4,000	$3,380	$3,500	$3,690	$3,220	$3,340	$3,510
Impact on Group Insurance Premiums (%)	0.5	0.7	0.7	0.7	1.0	1.0	1.2	1.2	1.1

[15] Monheit, A., J. Cantor, *et al,* "State Policies Expanding Dependent Coverage to Young Adults in Private Health Insurance Plans," presented at the Academy Health State Health Research and Policy Interest Group Meeting, Chicago IL, June 27, 2009.

[16] Bansak, Cynthia and Steven Raphael. "The Effects of State Policy Design Features on Take-Up and Crowd-out Rates fro the State Children's Health Insurance Program." Journal of Policy Analysis and Management, Vol. 26, No. 1, 149–175. 2006. Find that for the time period 1998–2002 take-up rates for SCHIP were about 10 percent.

Currie, Janet and Jonathan Gruber. "Saving babies: The Efficacy and Cost of Recent Changes in Medicaid Eligibility of Pregnant Women." The Journal of Political Economy, Vol. 104, No. 6, Dec. 1996, pp. 1263–1296. Find for Medicaid expansions during the 1979–1992 period the take-up rate for eligible pregnant women was 34 percent.

Cutler, David and Jonathan Gruber. "Does Public Insurance Crowd Out Private Insurance?" The Quarterly Journal of Economics, Vol. 111, No. 2, May 1996, pp. 391–430. Find that for the Medicaid expansions from 1987–1992 the take-up rate for the uninsured is close to 30 percent, while for pregnant women it was seven percent.

Gruber, Jonathan and Kosali Simon. "Crowd-Out Ten years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" NBER Working Paper 12858. January 2007. Find that for the Medicaid expansions during 1996–2002 the take-up rate was 7 percent across all children, but nearly one-third for uninsured children.

[17] Found at *http://www.kff.org/insurance/snapshot/chcm020707oth.cfm.*

These take-up rate assumptions are then applied to the number of potentially affected individuals displayed in Table 3. The resulting number of individuals with new dependent coverage is summarized in Table 5. Under the mid-range take-up rate assumption, the Departments estimate that in 2011, 1.24 million young adults will newly be covered by their parents' ESI or non-group market policies, of whom 0.65 million were previously uninsured, and 0.6 million were previously covered by non-group coverage. The number of individuals newly covered by their parents' plans would be 0.7 and 2.12 million under the high and low take-up rate assumptions respectively, with 0.2 and 1.64 million of these individuals being previously uninsured. Relative to the individuals covered under the high take-up rate assumption, higher proportions of the low- and mid-range assumption groups are accounted for by people who previously had non-group coverage (72 percent and 48 percent respectively in contrast to 23 percent for the high take-up rate group). This difference is a result of the Departments' assumption for the low- and mid-range take-up rates that people with non-group coverage will be more likely than healthy people who were uninsured to take advantage of the dependent coverage option.

Under the mid-range take-up rate assumptions, the estimated number of young adults covered by their parents' plans in 2012 increases somewhat over the 2011 estimate to 1.6 million in total, of whom approximately 0.9 million would have been uninsured. The increase in the estimate for 2012 results from the assumption that as children reach the age that would have caused them to be excluded from their parents' policy before the implementation of these interim final regulations, a large fraction of them now will remain on their parents' policy. Similarly, the estimated number of young adults enrolling in their parents' non-group policy increases from just under 75,000 in 2011 to approximately 100,000 in 2012, and 120,000 in 2013.

4. Benefits

The benefits of these interim final regulations are expected to outweigh the costs to the regulated community. In the mid-range take-up rate assumption, the Departments estimate that in 2011, 0.65 million previously uninsured individuals will now be covered on their parent's policies due to these interim final regulations and 1.24 million individuals total will now be covered on their parent's coverage. Expanding coverage options for the 19–25 population should decrease the number uninsured, which in turn should decrease the cost-shifting of uncompensated care onto those with coverage, increase the receipt of preventive health care and provide more timely access to high quality care, resulting in a healthier population. In particular, children with chronic conditions or other serious health issues will be able to continue coverage through a parent's plan until age 26. Allowing extended dependent coverage also will permit greater job mobility for this population as their health coverage will no longer be tied to their own jobs or student status.

5. Costs and Transfers Associated With the Rule

Estimates for the incremental annual premium costs for the newly covered individuals are developed based on expenditure data from MEPS and vary based on the take-up rate assumptions. These incremental costs are lowest for the high take-up rate assumption since the newly covered group would contain a relatively high percentage of individuals whose health status was good to excellent. Conversely, the low take-up rate assumption results in the highest incremental costs because a higher percentage of the newly covered individuals would be those whose health status was fair to poor. For those enrolling in their parents' ESI, the expected annual premium cost under the mid-range take-up rate assumption would be $3,380 in 2011, $3,500 in 2012 and $3,690 in 2013. If these costs were distributed among all family ESI plans, family premiums would be expected to rise by 0.7 percent in 2011, 1.0 percent in 2012, and 1.0 percent in 2013 due to these interim final regulations.[18] The comparable incremental costs and premium effects for the low and high take-up rate assumptions are summarized in Table 5. To the extent that these increases are passed on to workers in the form of higher premiums for all workers purchasing family policies or in the form of lower wages for all workers, there will be a transfer from workers who do not have newly covered dependents to those who do. To the extent that these higher premiums result in lower profits or higher prices for the employer's product, the higher premiums will result in a transfer either from stockholders or consumers.

In addition, to the extent that these interim final regulations result in a decrease in the number of uninsured, the Departments expect a reduction in uncompensated care, and a reduction in liability for those who fund uncompensated care, including public programs (primarily Medicaid and State and local general revenue support for public hospitals), as well as the portion of uncompensated care that is paid for by the cost shift from private premium payers. Such effects would lead to lower premiums for the insured population, both with or without newly covered children.

For the small number of children (75,000 in 2011) enrolling in their parents' non-group insurance policy under the mid-range take-up assumption, the Departments expect estimated annual premium cost to be $2,360 in 2011, $2,400 in 2012 and $2,480 in 2013. To a large extent, premiums in the non-group market are individually underwritten, and the Departments expect that most of the premium cost will be borne by the parents who are purchasing the policy to which their child is added. If, instead, these costs were distributed over the entire individual market (as would be the case in a pure community-rated market), then individual premiums would be expected to rise 0.7 percent in 2011, 1.0 percent in 2012, and 1.2 percent in 2013 due to these interim final regulations. However, the Departments expect the actual increase across the entire individual market, if any, will be much smaller than these estimates, because they expect that the costs largely will be borne by the subscribers who are directly affected rather than distributed across the entire individual market.

6. Enrollment Opportunity

These interim final regulations provide an enrollment opportunity for children excluded from coverage because of age before the effective date of the rule. The Departments estimate that this information collection request will result in approximately 105,000,000 notices being distributed with an hour burden of approximately 1,100,000 hours and cost burden of approximately $2,010,500. For a discussion of this enrollment opportunity, see the Paperwork Reduction Act section later in this preamble.

7. Regulatory Alternatives

Section 6(a)(3)(C)(iii) of Executive Order 12866 requires an economically significant regulation to include an assessment of the costs and benefits of potentially effective and reasonable alternatives to the planned regulation, and an explanation of why the planned

[18] For purposes of this regulatory impact analysis, the Departments assume that there would be no effect on premiums for employee-only policies.

regulatory action is preferable to the potential alternatives. The Departments carefully considered limiting the flexibility of plans and policies to define who is a child. However, the Departments concluded, as they have in other regulatory contexts, that plan sponsors and issuers should be free to determine whether to cover children or which children should be covered by their plans and policies (although they must comply with other applicable Federal or State law mandating coverage, such as ERISA section 609). Therefore, these interim final regulations have not limited a plan's or policy's flexibility to define who is a child for purposes of the determination of children to whom coverage must be made available.

C. Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the APA (5 U.S.C. 551 *et seq.*) and that are likely to have a significant economic impact on a substantial number of small entities. Under Section 553(b) of the APA, a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. These interim final regulations are exempt from APA, because the Departments made a good cause finding that a general notice of proposed rulemaking is not necessary earlier in this preamble. Therefore, the RFA does not apply and the Departments are not required to either certify that the regulations would not have a significant economic impact on a substantial number of small entities or conduct a regulatory flexibility analysis.

Nevertheless, the Departments carefully considered the likely impact of the regulations on small entities in connection with their assessment under Executive Order 12866. Consistent with the policy of the RFA, the Departments encourage the public to submit comments that suggest alternative rules that accomplish the stated purpose of PHS Act section 2714 and minimize the impact on small entities.

D. Special Analyses—Department of the Treasury

Notwithstanding the determinations of the Department of Labor and Department of Health and Human Services, for purposes of the Department of the Treasury, it has been determined that this Treasury decision is not a significant regulatory action for purposes of Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the APA (5 U.S.C. chapter 5) does not apply to these interim final regulations. For the applicability of the RFA, refer to the Special Analyses section in the preamble to the cross-referencing notice of proposed rulemaking published elsewhere in this issue of the **Federal Register.** Pursuant to section 7805(f) of the Code, these temporary regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small businesses.

E. Paperwork Reduction Act

1. Department of Labor and Department of the Treasury: Affordable Care Act Enrollment Opportunity Notice Relating to Extended Dependent Coverage

As part of their continuing efforts to reduce paperwork and respondent burden, the Departments conduct a preclearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3506(c)(2)(A)). This helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed.

As discussed earlier in this preamble, prior to the applicability date of PHS Act section 2714, a child who was covered under a group health plan (or group health insurance coverage) may have lost eligibility for coverage under the plan due to age before age 26. Moreover, if a child was under age 26 when a parent first became eligible for coverage, but older than the age at which the plan stopped covering children, the child would not have become eligible for coverage. When the provisions of PHS Act section 2714 become applicable to the plan (or coverage), the plan or coverage can no longer exclude coverage for the individual until age 26.

Accordingly, these interim final regulations require plans to provide a notice of an enrollment opportunity to individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage) under a group health plan or health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26. The enrollment opportunity must continue for at least 30 days, regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity must be presented not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010 (which is the applicability date of PHS Act section 2714). Coverage must begin not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010.[19]

The Affordable Care Act dependent coverage enrollment opportunity notice is an information collection request (ICR) subject to the PRA. Currently, the Departments are soliciting public comments for 60 days concerning these disclosures. The Departments have submitted a copy of these interim final regulations to OMB in accordance with 44 U.S.C. 3507(d) for review of the information collections. The Departments and OMB are particularly interested in comments that:

- Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, for example, by permitting electronic submission of responses.

Comments should be sent to the Office of Information and Regulatory Affairs, Attention: Desk Officer for the Employee Benefits Security

[19] Any individual enrolling in coverage pursuant to this enrollment right must be treated as a special enrollee, as provided under HIPAA portability rules. Accordingly, the individual must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. The individual also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

Administration either by fax to (202) 395–7285 or by e-mail to *oira_submission@omb.eop.gov.* A copy of the ICR may be obtained by contacting the PRA addressee: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW., Room N–5718, Washington, DC 20210. Telephone: (202) 693–8410; Fax: (202) 219–4745. These are not toll-free numbers. E-mail: *ebsa.opr@dol.gov*. ICRs submitted to OMB also are available at reginfo.gov (*http://www.reginfo.gov/public/do/PRAMain*).

The Departments assume that 2,800,000 ERISA covered plans will send the enrollment opportunity notice to all 79,573,000 employees eligible for group health insurance coverage. The Departments estimate that preparing the enrollment notice will require 30 minutes of legal professional time at a labor rate of $119 per hour [20] and one minute of clerical time at $26 per hour per paper notice to distribute the notices.[21] This results in an hour burden of nearly 822,000 hours and an associated equivalent cost of nearly $21,513,000.

The Departments estimate that the cost burden associated with distributing the approximately 79,573,000 notices will be approximately $2,467,000 based on one minute of clerical time, and $.05 per page for material and printing costs. The Departments assumed that 38 percent of the notices would be sent electronically.[22] In addition, plans can send these notices with other plan documents, such as open enrollment materials. Therefore, the Departments have not included postage costs in this estimate. The Departments note that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a valid OMB control number.[23]

These paperwork burden estimates are summarized as follows:

Type of Review: New collection.

Agencies: Employee Benefits Security Administration, Department of Labor; Internal Revenue Service, U.S. Department of the Treasury.

Title: Affordable Care Act Enrollment Opportunity Notice Relating to Extended Dependent Coverage.

OMB Number: 1210–0139; 1545–2172.

Affected Public: Business or other for-profit; not-for-profit institutions.

Total Respondents: 2,800,000.

Total Responses: 79,573,000.

Frequency of Response: One-time.

Estimated Total Annual Burden Hours: 411,000 hours (Employee Benefits Security Administration); 411,000 hours (Internal Revenue Service).

Estimated Total Annual Burden Cost: $1,233,500 (Employee Benefits Security Administration); $1,233,500 (Internal Revenue Service).

2. Department of Health and Human Services: Affordable Care Act Enrollment Opportunity Notice Relating to Extended Dependent Coverage

We are soliciting public comment on the following sections of this document that contain information collection requirements (ICR) regarding the Affordable Care Act—ICR Relating to Enrollment Opportunity Notice—Dependent Coverage. As discussed earlier in this preamble, the Affordable Care Act and these interim final regulations require issuers in the individual market and group health plans sponsored by State and local governments to notify participants regarding an enrollment opportunity related to the extension of dependent coverage. Prior to the applicability date of PHS Act section 2714, a child who was covered under a group health plan (or group health insurance coverage) as a dependent may have lost eligibility for coverage under the plan due to age before age 26. Moreover, if, when a parent first became eligible for coverage, a child was under age 26 but older than the age at which the plan stopped covering children, the child would not have become eligible for coverage. When the provisions of PHS Act section 2714 become applicable to the plan (or coverage), the plan or coverage can no longer exclude coverage for the individual until age 26.

Accordingly, these interim final regulations require issuers in the individual insurance market and group health plans sponsored by State and local governments to provide a notice of an enrollment opportunity to individuals whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or group health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26. The enrollment opportunity must continue for at least 30 days, regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity must be presented not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010 (which is the applicability date of PHS Act section 2714). Coverage must begin not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010.[24]

The Department estimates that 126,000 State and local governmental plans would have to send 19,627,000 notices to eligible employees and 490 insurers in the individual market would have to send approximately 5,444,000 notices to individuals with policies covering dependents.[25] For purposes of this estimate, the Department assumes that it will take a legal professional, on average, 30 minutes to prepare the notice at a labor rate of $119 per hour,[26] and one minute, on average, of a clerical professional's time at $26 per hour to copy and mail the notice.[27] While plans could prepare their own notice, the

[20] Hourly wage estimates are based on data from the Bureau of Labor Statistics Occupational Employment Survey (May 2008) and the Bureau of Labor Statistics Employment Cost Index (June 2009). All hourly wage rates include wages and benefits. Clerical wage and benefits estimates are based on metropolitan wage rates for executive secretaries and administrative assistants. Legal professional wage and benefits estimates are based on metropolitan wage rates for lawyers.

[21] While plans could prepare their own notice, the Departments assume that the notices will be prepared by service providers. The Departments have previously estimated that there are 630 health insurers (460 providing coverage in the group market, and 490 providing coverage in the individual market.). These estimates are from NAIC 2007 financial statements data and the California Department of Managed Healthcare (2009), *at http://wpso.dmhc.ca.gov/hpsearch/viewall.aspx.* Because the hour and cost burden is shared between the Departments of Labor/Treasury and the Department of Health and Human Services, the burden to prepare the notices is calculated using half the number of insurers (315).

[22] For purposes of this burden estimate, the Departments assume that 38 percent of the disclosures will be provided through electronic means in accordance with the Department of Labor's standards for electronic communication of required information provided under 29 CFR 2520.104b–1(c).

[23] 5 CFR 1320.1 through 1320.18.

[24] Any individual enrolling in coverage pursuant to this enrollment right must be treated as a special enrollee, as provided under HIPAA portability rules. Accordingly, the individual must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. The individual also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

[25] The number of individual insurance notices was based on the number of individual policy holders with dependents on that policy according to the 2009 March Current Population Survey (CPS).

[26] Estimates of labor rates include wages, other benefits, and overhead based on the National Occupational Employment Survey (May 2008, Bureau of Labor Statistics) and the Employment Cost Index June 2009, Bureau of Labor Statistics).

Department assumes that the notices will be prepared by service providers. The Department has previously estimated that there are 630 health insurers [28] (460 providing coverage in the group market, and 490 providing coverage in the individual market). Because the hour and cost burden is shared among the Departments of Labor/Treasury and the Department of Health and Human Services, the burden to prepare the notices is calculated using half the number of insurers (315). The Department assumes that 38 percent of the notices would be sent electronically.[29] Notices that are sent electronically do not require any of the clerical worker's time to mail the notice. This results in an hour burden of approximately 259,000 hours and an associated equivalent cost of about $6,791,000 to prepare and distribute 25,071,000 notices. The Department estimates that the cost burden associated with distributing the notices will be approximately $777,000.[30] The Department assumes that 38 percent of the notices would be sent electronically.[31] In addition, plans and issuers can send these notices with other plan documents (for example, during open enrollment for the government plans, or other communication at reenrollment in the individual market). Therefore, the Department did not include postage costs in this estimate. The Department notes that persons are not required to respond to, and generally are not subject to any penalty for failing to comply with, an ICR unless the ICR has a valid OMB control number.[32]

These paperwork burden estimates are summarized as follows:

Type of Review: New collection.

Agency: Department of Health and Human Services.

Title: Notice of Special Enrollment Opportunity under the Affordable Care Act Relating to Dependent Coverage.

*OMB Numbe*r: 0938–1089.

Affected Public: Business; State, Local, or Tribal Governments.

Respondents: 126,000.

Responses: 25,071,000.

Frequency of Response: One-time.

Estimated Total Annual Burden Hours: 259,000 hours.

Estimated Total Annual Burden Cost: $777,000.

If you comment on this information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, 4140–IFC

Fax: (202) 395–6974; or

E-mail: *OIRA_submission@omb.eop.gov*

F. Congressional Review Act

These interim final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and have been transmitted to Congress and the Comptroller General for review.

G. Unfunded Mandates Reform Act

The Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) requires agencies to prepare several analytic statements before proposing any rules that may result in annual expenditures of $100 million (as adjusted for inflation) by State, local and tribal governments or the private sector. These interim final regulations are not subject to the Unfunded Mandates Reform Act, because they are being issued as an interim final regulation. However, consistent with the policy embodied in the Unfunded Mandates Reform Act, these interim final regulations have been designed to be the least burdensome alternative for State, local and tribal governments, and the private sector, while achieving the objectives of the Affordable Care Act.

H. Federalism Statement—Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by Federal agencies in the process of their formulation and implementation of policies that have "substantial direct effects" on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments' view, these interim final regulations have federalism implications, because they have direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government. However, in the Departments' view, the federalism implications of these interim final regulations are substantially mitigated because, with respect to health insurance issuers, the Departments expect that the majority of States will enact laws or take other appropriate action resulting in their meeting or exceeding the Federal standard.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of ERISA section 731 and PHS Act section 2724 (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of the Affordable Care Act) are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of a federal standard. The conference report accompanying HIPAA indicates that this is intended to be the "narrowest" preemption of State laws. (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.) States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. State insurance laws that are more stringent than the Federal requirements are unlikely to "prevent the application of" the Affordable Care Act, and be preempted. Accordingly, States have significant latitude to impose requirements on health

[28] These estimates are from NAIC 2007 financial statements data and the California Department of Managed Healthcare (2009), *at http://wpso.dmhc.ca.gov/hpsearch/viewall.aspx.*

[29] For purposes of this burden estimate, the Department assumes that 38 percent of the disclosures will be provided through electronic means.

[30] This estimate is based on an average document size of one page and $.05 cents per page for material and printing costs.

[31] For purposes of this burden estimate, the Department assumes that 38 percent of the disclosures will be provided through electronic means.

[32] 5 CFR 1320.1 through 1320.18.

insurance issuers that are more restrictive than the Federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Departments have engaged in efforts to consult with and work cooperatively with affected State and local officials, including attending conferences of the National Association of Insurance Commissioners and consulting with State insurance officials on an individual basis. It is expected that the Departments will act in a similar fashion in enforcing the Affordable Care Act requirements. Throughout the process of developing these interim final regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to the Affordable Care Act, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to these regulations, the Departments certify that the Employee Benefits Security Administration and the Office of Consumer Information and Insurance Oversight have complied with the requirements of Executive Order 13132 for the attached regulation in a meaningful and timely manner.

V. Statutory Authority

The Department of the Treasury temporary regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor interim final regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Secretary of Labor's Order 6–2009, 74 FR 21524 (May 7, 2009).

The Department of Health and Human Services interim final regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 USC 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

26 CFR Part 602

Reporting and recordkeeping requirements.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Parts 144, 146, and 147

Health care, Health insurance, Reporting and recordkeeping requirements, and State regulation of health insurance.

Steven T. Miller,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved: May 7, 2010.

Michael F. Mundaca,

Assistant Secretary of the Treasury (Tax Policy).

Signed this 6th day of May 2010.

Phyllis C. Borzi,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Approved: May 4, 2010.

Jay Angoff,

Director, Office of Consumer Information and Insurance Oversight.

Approved: May 7, 2010.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

Internal Revenue Service

26 CFR Chapter 1

■ Accordingly, 26 CFR Parts 54 and 602 are amended as follows:

PART 54—PENSION EXCISE TAXES

■ **Paragraph 1.** The authority citation for part 54 continues to read in part as follows:

Authority: 26 U.S.C. 7805. * * *

■ **Par. 2.** Section 54.9815–2714T is added to read as follows:

§ 54.9815–2714T Eligibility of children until at least age 26 (temporary).

(a) *In general*—(1) A group health plan, or a health insurance issuer offering group health insurance coverage, that makes available dependent coverage of children must make such coverage available for children until attainment of 26 years of age.

(2) The rule of this paragraph (a) is illustrated by the following example:

Example. (i) *Facts.* For the plan year beginning January 1, 2011, a group health plan provides health coverage for employees, employees' spouses, and employees' children until the child turns 26. On the birthday of a child of an employee, July 17, 2011, the child turns 26. The last day the plan covers the child is July 16, 2011.

(ii) *Conclusion.* In this *Example,* the plan satisfies the requirement of this paragraph (a) with respect to the child.

(b) *Restrictions on plan definition of dependent.* With respect to a child who has not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of a relationship between a child and the participant. Thus, for example, a plan or issuer may not deny or restrict coverage for a child who has not attained age 26 based on the presence or absence of the child's financial dependency (upon the participant or any other person), residency with the participant or with any other person, student status, employment, or any combination of those factors. In addition, a plan or issuer may not deny or restrict coverage of a child based on eligibility for other coverage, except that paragraph (g) of this section provides a special rule for plan years beginning before January 1, 2014 for grandfathered health plans that are group health plans. (Other requirements of Federal or State law, including section 609 of ERISA or section 1908 of the Social Security Act, may mandate coverage of certain children.)

(c) *Coverage of grandchildren not required.* Nothing in this section requires a plan or issuer to make coverage available for the child of a child receiving dependent coverage.

(d) *Uniformity irrespective of age.* The terms of the plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older).

(e) *Examples.* The rules of paragraph (d) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* 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.

(ii) *Conclusion.* In this *Example 1,* the plan violates the requirement of paragraph (d) of this section because the plan varies the terms

for dependent coverage of children based on age.

Example 2. (i) *Facts.* 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.

(ii) *Conclusion.* In this *Example 2,* the plan does not violate the requirement of paragraph (d) of this section 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.

Example 3. (i) *Facts.* A group health plan offers two benefit packages—an HMO option and an indemnity option. Dependent coverage is provided for children of participants who have not attained age 26. The plan limits children who are older than age 18 to the HMO option.

(ii) *Conclusion.* In this *Example 3,* the plan violates the requirement of paragraph (d) of this section because the plan, by limiting children who are older than age 18 to the HMO option, varies the terms for dependent coverage of children based on age.

(f) *Transitional rules for individuals whose coverage ended by reason of reaching a dependent eligibility threshold*—(1) *In general.* The relief provided in the transitional rules of this paragraph (f) applies with respect to any child—

(i) Whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or group health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26 (which, under this section, is no longer permissible); and

(ii) Who becomes eligible (or is required to become eligible) for coverage under a group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010 by reason of the application of this section.

(2) *Opportunity to enroll required.* (i) If a group health plan, or group health insurance coverage, in which a child described in paragraph (f)(1) of this section is eligible to enroll (or is required to become eligible to enroll) is the plan or coverage in which the child's coverage ended (or did not begin) for the reasons described in paragraph (f)(1)(i) of this section, and if the plan, or the issuer of such coverage, is subject to the requirements of this section, the plan and the issuer are required to give the child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). This opportunity (including the written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010.

(ii) The written notice must include a statement that children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the plan or coverage. The notice may be provided to an employee on behalf of the employee's child. In addition, the notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. If a notice satisfying the requirements of this paragraph (f)(2) is provided to an employee whose child is entitled to an enrollment opportunity under this paragraph (f), the obligation to provide the notice of enrollment opportunity under this paragraph (f)(2) with respect to that child is satisfied for both the plan and the issuer.

(3) *Effective date of coverage.* In the case of an individual who enrolls under paragraph (f)(2) of this section, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

(4) *Treatment of enrollees in a group health plan.* Any child enrolling in a group health plan pursuant to paragraph (f)(2) of this section must be treated as if the child were a special enrollee, as provided under the rules of § 54.9801–6(d). Accordingly, the child (and, if the child would not be a participant once enrolled in the plan, the participant through whom the child is otherwise eligible for coverage under the plan) must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package. The child also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(5) *Examples.* The rules of this paragraph (f) are illustrated by the following examples:

Example 1. (i) *Facts.* Employer Y maintains a group health plan with a calendar year plan year. The plan has a single benefit package. For the 2010 plan year, the plan allows children of employees to be covered under the plan until age 19, or until age 23 for children who are full-time students. Individual B, an employee of Y, and Individual C, B's child and a full-time student, were enrolled in Y's group health plan at the beginning of the 2010 plan year. On June 10, 2010, C turns 23 years old and loses dependent coverage under Y's plan. On or before January 1, 2011, Y's group health plan gives B written notice that individuals who lost coverage by reason of ceasing to be a dependent before attainment of age 26 are eligible to enroll in the plan, and that individuals may request enrollment for such children through February 14, 2011 with enrollment effective retroactively to January 1, 2011.

(ii) *Conclusion.* In this *Example 1,* the plan has complied with the requirements of this paragraph (f) by providing an enrollment opportunity to C that lasts at least 30 days.

Example 2. (i) *Facts.* Employer Z maintains a group health plan with a plan year beginning October 1 and ending September 30. Prior to October 1, 2010, the group health plan allows children of employees to be covered under the plan until age 22. Individual D, an employee of Z, and Individual E, D's child, are enrolled in family coverage under Z's group health plan for the plan year beginning on October 1, 2008. On May 1, 2009, E turns 22 years old and ceases to be eligible as a dependent under Z's plan and loses coverage. D drops coverage but remains an employee of Z.

(ii) *Conclusion.* In this *Example 2,* not later than October 1, 2010, the plan must provide D and E an opportunity to enroll (including written notice of an opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example 3. (i) *Facts.* Same facts as *Example 2,* except that D did not drop coverage. Instead, D switched to a lower-cost benefit package option.

(ii) *Conclusion.* In this *Example 3,* not later than October 1, 2010, the plan must provide D and E an opportunity to enroll in any benefit package available to similarly situated individuals who enroll when first eligible.

Example 4. (i) *Facts.* Same facts as *Example 2,* except that E elected COBRA continuation coverage.

(ii) *Conclusion.* In this *Example 4,* not later than October 1, 2010, the plan must provide D and E an opportunity to enroll other than as a COBRA qualified beneficiary (and must provide, by that date, written notice of the opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example 5. (i) *Facts.* Employer X maintains a group health plan with a calendar year plan year. Prior to 2011, the plan allows children of employees to be covered under the plan until the child attains age 22. During the 2009 plan year, an individual with a 22-year old child joins the plan; the child is denied coverage because the child is 22.

(ii) *Conclusion.* In this *Example 5,* notwithstanding that the child was not previously covered under the plan, the plan must provide the child, not later than January 1, 2011, an opportunity to enroll (including written notice to the employee of an opportunity to enroll the child) that continues for at least 30 days, with enrollment effective not later than January 1, 2011.

(g) *Special rule for grandfathered group health plans*—(1) For plan years

beginning before January 1, 2014, a group health plan that qualifies as a grandfathered health plan under section 1251 of the Patient Protection and Affordable Care Act and that makes available dependent coverage of children may exclude an adult child who has not attained age 26 from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2)) other than a group health plan of a parent.

(2) For plan years beginning on or after January 1, 2014, a group health plan that qualifies as a grandfathered health plan under section 1251 of the Patient Protection and Affordable Care Act must comply with the requirements of paragraphs (a) through (f) of this section.

(h) *Applicability date.* The provisions of this section apply for plan years beginning on or after September 23, 2010.

(i) *Expiration date.* This section expires on or before May 13, 2013.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

■ **Par. 5.** The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

■ **Par. 6.** In § 602.101, paragraph (b) is amended by adding the following entry in numerical order to the table:

§ 602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where identified and described	Current OMB control No.
* * * * *	
54.9815–2714T	1545–2172
* * * * *	

Employee Benefits Security Administration

29 CFR Chapter XXV

■ 29 CFR Part 2590 is amended as follows:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 1. The authority citation for Part 2590 is revised to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L.104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Secretary of Labor's Order 6–2009, 74 FR 21524 (May 7, 2009).

■ 2. Section 2590.715–2714 is added to Subpart C to read as follows:

§ 2590.715–2714 Eligibility of children until at least age 26.

(a) *In general*—(1) A group health plan, or a health insurance issuer offering group health insurance coverage, that makes available dependent coverage of children must make such coverage available for children until attainment of 26 years of age.

(2) The rule of this paragraph (a) is illustrated by the following example:

Example. (i) *Facts.* For the plan year beginning January 1, 2011, a group health plan provides health coverage for employees, employees' spouses, and employees' children until the child turns 26. On the birthday of a child of an employee, July 17, 2011, the child turns 26. The last day the plan covers the child is July 16, 2011.

(ii) *Conclusion.* In this *Example,* the plan satisfies the requirement of this paragraph (a) with respect to the child.

(b) *Restrictions on plan definition of dependent.* With respect to a child who has not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of a relationship between a child and the participant. Thus, for example, a plan or issuer may not deny or restrict coverage for a child who has not attained age 26 based on the presence or absence of the child's financial dependency (upon the participant or any other person), residency with the participant or with any other person, student status, employment, or any combination of those factors. In addition, a plan or issuer may not deny or restrict coverage of a child based on eligibility for other coverage, except that paragraph (g) of this section provides a special rule for plan years beginning before January 1, 2014 for grandfathered health plans that are group health plans. (Other requirements of Federal or State law, including section 609 of ERISA or section 1908 of the Social Security Act, may mandate coverage of certain children.)

(c) *Coverage of grandchildren not required.* Nothing in this section requires a plan or issuer to make coverage available for the child of a child receiving dependent coverage.

(d) *Uniformity irrespective of age.* The terms of the plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older).

(e) *Examples.* The rules of paragraph (d) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* 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.

(ii) *Conclusion.* In this *Example 1,* the plan violates the requirement of paragraph (d) of this section because the plan varies the terms for dependent coverage of children based on age.

Example 2. (i) *Facts.* 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.

(ii) *Conclusion.* In this *Example 2,* the plan does not violate the requirement of paragraph (d) of this section 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.

Example 3. (i) *Facts.* A group health plan offers two benefit packages—an HMO option and an indemnity option. Dependent coverage is provided for children of participants who have not attained age 26. The plan limits children who are older than age 18 to the HMO option.

(ii) *Conclusion.* In this *Example 3,* the plan violates the requirement of paragraph (d) of this section because the plan, by limiting children who are older than age 18 to the HMO option, varies the terms for dependent coverage of children based on age.

(f) *Transitional rules for individuals whose coverage ended by reason of reaching a dependent eligibility threshold*—(1) *In general.* The relief provided in the transitional rules of this paragraph (f) applies with respect to any child—

(i) Whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or group health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26 (which, under this section, is no longer permissible); and

(ii) Who becomes eligible (or is required to become eligible) for coverage under a group health plan or group health insurance coverage on the first day of the first plan year beginning on or after September 23, 2010 by reason of the application of this section.

(2) *Opportunity to enroll required*—(i) If a group health plan, or group health

insurance coverage, in which a child described in paragraph (f)(1) of this section is eligible to enroll (or is required to become eligible to enroll) is the plan or coverage in which the child's coverage ended (or did not begin) for the reasons described in paragraph (f)(1)(i) of this section, and if the plan, or the issuer of such coverage, is subject to the requirements of this section, the plan and the issuer are required to give the child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). This opportunity (including the written notice) must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010.

(ii) The written notice must include a statement that children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the plan or coverage. The notice may be provided to an employee on behalf of the employee's child. In addition, the notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. If a notice satisfying the requirements of this paragraph (f)(2) is provided to an employee whose child is entitled to an enrollment opportunity under this paragraph (f), the obligation to provide the notice of enrollment opportunity under this paragraph (f)(2) with respect to that child is satisfied for both the plan and the issuer.

(3) *Effective date of coverage.* In the case of an individual who enrolls under paragraph (f)(2) of this section, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

(4) *Treatment of enrollees in a group health plan.* Any child enrolling in a group health plan pursuant to paragraph (f)(2) of this section must be treated as if the child were a special enrollee, as provided under the rules of § 2590.701–6(d) of this Part. Accordingly, the child (and, if the child would not be a participant once enrolled in the plan, the participant through whom the child is otherwise eligible for coverage under the plan) must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package. The child also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(5) *Examples.* The rules of this paragraph (f) are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *Y* maintains a group health plan with a calendar year plan year. The plan has a single benefit package. For the 2010 plan year, the plan allows children of employees to be covered under the plan until age 19, or until age 23 for children who are full-time students. Individual *B,* an employee of *Y,* and Individual *C, B*'s child and a full-time student, were enrolled in *Y*'s group health plan at the beginning of the 2010 plan year. On June 10, 2010, *C* turns 23 years old and loses dependent coverage under *Y*'s plan. On or before January 1, 2011, *Y*'s group health plan gives *B* written notice that individuals who lost coverage by reason of ceasing to be a dependent before attainment of age 26 are eligible to enroll in the plan, and that individuals may request enrollment for such children through February 14, 2011 with enrollment effective retroactively to January 1, 2011.

(ii) *Conclusion.* In this *Example 1,* the plan has complied with the requirements of this paragraph (f) by providing an enrollment opportunity to *C* that lasts at least 30 days.

Example 2. (i) *Facts.* Employer *Z* maintains a group health plan with a plan year beginning October 1 and ending September 30. Prior to October 1, 2010, the group health plan allows children of employees to be covered under the plan until age 22. Individual *D,* an employee of *Z,* and Individual *E, D*'s child, are enrolled in family coverage under *Z*'s group health plan for the plan year beginning on October 1, 2008. On May 1, 2009, *E* turns 22 years old and ceases to be eligible as a dependent under *Z*'s plan and loses coverage. *D* drops coverage but remains an employee of *Z.*

(ii) *Conclusion.* In this *Example 2,* not later than October 1, 2010, the plan must provide *D* and *E* an opportunity to enroll (including written notice of an opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example 3. (i) *Facts.* Same facts as *Example 2,* except that *D* did not drop coverage. Instead, *D* switched to a lower-cost benefit package option.

(ii) *Conclusion.* In this *Example 3,* not later than October 1, 2010, the plan must provide *D* and *E* an opportunity to enroll in any benefit package available to similarly situated individuals who enroll when first eligible.

Example 4. (i) *Facts.* Same facts as *Example 2,* except that *E* elected COBRA continuation coverage.

(ii) *Conclusion.* In this *Example 4,* not later than October 1, 2010, the plan must provide *D* and *E* an opportunity to enroll other than as a COBRA qualified beneficiary (and must provide, by that date, written notice of the opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example 5. (i) *Facts.* Employer *X* maintains a group health plan with a calendar year plan year. Prior to 2011, the plan allows children of employees to be covered under the plan until the child attains age 22. During the 2009 plan year, an individual with a 22-year old child joins the plan; the child is denied coverage because the child is 22.

(ii) *Conclusion.* In this *Example 5,* notwithstanding that the child was not previously covered under the plan, the plan must provide the child, not later than January 1, 2011, an opportunity to enroll (including written notice to the employee of an opportunity to enroll the child) that continues for at least 30 days, with enrollment effective not later than January 1, 2011.

(g) *Special rule for grandfathered group health plans*—(1) For plan years beginning before January 1, 2014, a group health plan that qualifies as a grandfathered health plan under section 1251 of the Patient Protection and Affordable Care Act and that makes available dependent coverage of children may exclude an adult child who has not attained age 26 from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2) of the Internal Revenue Code) other than a group health plan of a parent.

(2) For plan years beginning on or after January 1, 2014, a group health plan that qualifies as a grandfathered health plan under section 1251 of the Patient Protection and Affordable Care Act must comply with the requirements of paragraphs (a) through (f) of this section.

(h) *Applicability date.* The provisions of this section apply for plan years beginning on or after September 23, 2010.

Department of Health and Human Services

45 CFR Subtitle A

■ For reasons set forth in the preamble, the Department of Health and Human Services is amending 45 CFR Subtitle A, Subchapter B as follows:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

Subpart A—General Provisions

■ 1. Section 144.101 is amended by-
■ A. Revising paragraph (a).
■ B. Redesignating paragraphs (b), (c) and (d) as paragraphs (c), (d) and (e), respectively.
■ C. Adding a new paragraph (b).
■ D. Revising the first sentence of newly redesignated paragraph (c).
■ E. Amending newly redesignated paragraph (d) by removing "2722" and adding in its place "2723".

The revisions and additions read as follows:

§ 144.101 Basis and purpose.

(a) Part 146 of this subchapter implements requirements of Title XXVII of the Public Health Service Act (PHS Act, 42 U.S.C. 300gg, *et seq.*) that apply to group health plans and group health insurance issuers.

(b) Part 147 of this subchapter implements the provisions of the Patient Protection and Affordable Care Act that apply to both group health plans and health insurance issuers in the Group and Individual Markets.

(c) Part 148 of this subchapter implements Individual Health Insurance Market requirements of the PHS Act.

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■ 2. Section 144.103 is amended by adding the definition of "Policy Year" to read as follows:

§ 144.103 Defintions.

* * * * *

Policy Year means in the individual health insurance market the 12-month period that is designated as the policy year in the policy documents of the individual health insurance coverage. If there is no designation of a policy year in the policy document (or no such policy document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year.

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PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

■ 3. Section 146.101 is amended by—

■ A. Revising the first sentence of paragraph (a).

■ B. Revising paragraph (b)(4).

The revisions read as follows:

§ 146.101 Basis and Scope.

(a) Statutory basis. This part implements the Group Market requirements of the PHS Act.* * *

(b) * * *

(4) *Subpart E.* Subpart E of this part implements requirements relating to group health plans and issuers in the Group Health Insurance Market.

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§ 146.115 [Amended]

■ 4. Section 146.115 is amended by removing "2721(b)" wherever it appears in paragraph (a)(6) and adding in its place "2722(a)".

§ 146.130 [Amended]

■ 5. Section 146.130 is amended by—

■ A. Removing "2704" wherever it appears in paragraphs (e) and (f), including the examples in paragraph (e)(4), and adding in its place "2725".

■ B. Removing "2723" wherever it appears in paragraph (e)(3), including the paragraph heading, and adding in its place "2724".

■ 6. A new Part 147 is added to read as follows:

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

Authority: Secs 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 USC 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

§ 147.100 Basis and scope.

Part 147 of this subchapter implements the requirements of the Patient Protection and Affordable Care Act that apply to group health plans and health insurance issuers in the Group and Individual markets.

§ 147.120 Eligibility of children until at least age 26.

(a) *In general*—(1) A group health plan, or a health insurance issuer offering group or individual health insurance coverage, that makes available dependent coverage of children must make such coverage available for children until attainment of 26 years of age.

(2) The rule of this paragraph (a) is illustrated by the following example:

Example. (i) *Facts.* For the plan year beginning January 1, 2011, a group health plan provides health coverage for employees, employees' spouses, and employees' children until the child turns 26. On the birthday of a child of an employee, July 17, 2011, the child turns 26. The last day the plan covers the child is July 16, 2011.

(ii) *Conclusion.* In this *Example,* the plan satisfies the requirement of this paragraph (a) with respect to the child.

(b) *Restrictions on plan definition of dependent.* With respect to a child who has not attained age 26, a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of a relationship between a child and the participant (in the individual market, the primary subscriber). Thus, for example, a plan or issuer may not deny or restrict coverage for a child who has not attained age 26 based on the presence or absence of the child's financial dependency (upon the participant or primary subscriber, or any other person), residency with the participant (in the individual market, the primary subscriber) or with any other person, student status, employment, or any combination of those factors. In addition, a plan or issuer may not deny or restrict coverage of a child based on eligibility for other coverage, except that paragraph (g) of this section provides a special rule for plan years beginning before January 1, 2014 for grandfathered health plans that are group health plans. (Other requirements of Federal or State law, including section 609 of ERISA or section 1908 of the Social Security Act, may mandate coverage of certain children.)

(c) *Coverage of grandchildren not required.* Nothing in this section requires a plan or issuer to make coverage available for the child of a child receiving dependent coverage.

(d) *Uniformity irrespective of age.* The terms of the plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older).

(e) *Examples.* The rules of paragraph (d) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* 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.

(ii) *Conclusion.* In this *Example 1,* the plan violates the requirement of paragraph (d) of this section because the plan varies the terms for dependent coverage of children based on age.

Example 2. (i) *Facts.* 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.

(ii) *Conclusion.* In this *Example 2,* the plan does not violate the requirement of paragraph (d) of this section 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.

Example 3. (i) *Facts.* A group health plan offers two benefit packages—an HMO option and an indemnity option. Dependent coverage is provided for children of participants who have not attained age 26. The plan limits children who are older than age 18 to the HMO option.

(ii) *Conclusion.* In this *Example 3,* the plan violates the requirement of paragraph (d) of this section because the plan, by limiting children who are older than age 18 to the HMO option, varies the terms for dependent coverage of children based on age.

(f) *Transitional rules for individuals whose coverage ended by reason of reaching a dependent eligibility*

threshold—(1) *In general.* The relief provided in the transitional rules of this paragraph (f) applies with respect to any child—

(i) Whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan or group or individual health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26 (which, under this section, is no longer permissible); and

(ii) Who becomes eligible (or is required to become eligible) for coverage under a group health plan or group or individual health insurance coverage on the first day of the first plan year (in the individual market, the first day of the first policy year) beginning on or after September 23, 2010 by reason of the application of this section.

(2) *Opportunity to enroll required*—(i) If a group health plan, or group or individual health insurance coverage, in which a child described in paragraph (f)(1) of this section is eligible to enroll (or is required to become eligible to enroll) is the plan or coverage in which the child's coverage ended (or did not begin) for the reasons described in paragraph (f)(1)(i) of this section, and if the plan, or the issuer of such coverage, is subject to the requirements of this section, the plan and the issuer are required to give the child an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). This opportunity (including the written notice) must be provided beginning not later than the first day of the first plan year (in the individual market, the first day of the first policy year) beginning on or after September 23, 2010.

(ii) The written notice must include a statement that children whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the plan or coverage. The notice may be provided to an employee on behalf of the employee's child (in the individual market, to the primary subscriber on behalf of the primary subscriber's child). In addition, for a group health plan or group health insurance coverage, the notice may be included with other enrollment materials that a plan distributes to employees, provided the statement is prominent. For a group health plan or group health insurance coverage, if a notice satisfying the requirements of this paragraph (f)(2) is provided to an employee whose child is entitled to an enrollment opportunity under this paragraph (f), the obligation to provide the notice of enrollment opportunity under this paragraph (f)(2) with respect to that child is satisfied for both the plan and the issuer.

(3) *Effective date of coverage.* In the case of an individual who enrolls under paragraph (f)(2) of this section, coverage must take effect not later than the first day of the first plan year (in the individual market, the first day of the first policy year) beginning on or after September 23, 2010.

(4) *Treatment of enrollees in a group health plan.* For purposes of this Part, any child enrolling in a group health plan pursuant to paragraph (f)(2) of this section must be treated as if the child were a special enrollee, as provided under the rules of 45 CFR 146.117(d). Accordingly, the child (and, if the child would not be a participant once enrolled in the plan, the participant through whom the child is otherwise eligible for coverage under the plan) must be offered all the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. For this purpose, any difference in benefits or cost-sharing requirements constitutes a different benefit package. The child also cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(5) *Examples.* The rules of this paragraph (f) are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *Y* maintains a group health plan with a calendar year plan year. The plan has a single benefit package. For the 2010 plan year, the plan allows children of employees to be covered under the plan until age 19, or until age 23 for children who are full-time students. Individual *B,* an employee of *Y,* and Individual *C, B*'s child and a full-time student, were enrolled in *Y*'s group health plan at the beginning of the 2010 plan year. On June 10, 2010, *C* turns 23 years old and loses dependent coverage under *Y*'s plan. On or before January 1, 2011, *Y*'s group health plan gives *B* written notice that individuals who lost coverage by reason of ceasing to be a dependent before attainment of age 26 are eligible to enroll in the plan, and that individuals may request enrollment for such children through February 14, 2011 with enrollment effective retroactively to January 1, 2011.

(ii) *Conclusion.* In this *Example 1,* the plan has complied with the requirements of this paragraph (f) by providing an enrollment opportunity to *C* that lasts at least 30 days.

Example 2. (i) *Facts.* Employer *Z* maintains a group health plan with a plan year beginning October 1 and ending September 30. Prior to October 1, 2010, the group health plan allows children of employees to be covered under the plan until age 22. Individual *D,* an employee of *Z,* and Individual *E, D*'s child, are enrolled in family coverage under *Z*'s group health plan for the plan year beginning on October 1, 2008. On May 1, 2009, *E* turns 22 years old and ceases to be eligible as a dependent under *Z*'s plan and loses coverage. *D* drops coverage but remains an employee of *Z.*

(ii) *Conclusion.* In this *Example 2,* not later than October 1, 2010, the plan must provide *D* and *E* an opportunity to enroll (including written notice of an opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example 3. (i) *Facts.* Same facts as *Example 2,* except that *D* did not drop coverage. Instead, *D* switched to a lower-cost benefit package option.

(ii) *Conclusion.* In this *Example 3,* not later than October 1, 2010, the plan must provide *D* and *E* an opportunity to enroll in any benefit package available to similarly situated individuals who enroll when first eligible.

Example 4. (i) *Facts.* Same facts as *Example 2,* except that *E* elected COBRA continuation coverage.

(ii) *Conclusion.* In this *Example 4,* not later than October 1, 2010, the plan must provide *D* and *E* an opportunity to enroll other than as a COBRA qualified beneficiary (and must provide, by that date, written notice of the opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example 5. (i) *Facts.* Employer *X* maintains a group health plan with a calendar year plan year. Prior to 2011, the plan allows children of employees to be covered under the plan until the child attains age 22. During the 2009 plan year, an individual with a 22-year old child joins the plan; the child is denied coverage because the child is 22.

(ii) *Conclusion.* In this *Example 5,* notwithstanding that the child was not previously covered under the plan, the plan must provide the child, not later than January 1, 2011, an opportunity to enroll (including written notice to the employee of an opportunity to enroll the child) that continues for at least 30 days, with enrollment effective not later than January 1, 2011.

(g) *Special rule for grandfathered group health plans*—(1) For plan years beginning before January 1, 2014, a group health plan that qualifies as a grandfathered health plan under section 1251 of the Patient Protection and Affordable Care Act and that makes available dependent coverage of children may exclude an adult child who has not attained age 26 from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health plan (as defined in section 5000A(f)(2) of the Internal Revenue Code) other than a group health plan of a parent.

(2) For plan years beginning on or after January 1, 2014, a group health plan that qualifies as a grandfathered

health plan under section 1251 of the Patient Protection and Affordable Care Act must comply with the requirements of paragraphs (a) through (f) of this section.

(h) *Applicability date.* The provisions of this section apply for plan years (in the individual market, policy years) beginning on or after September 23, 2010.

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