

July 8, 2010

Amy Turner

Beth Baum

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

Via Email to: E-OHPSCA.EBSA@dol.gov

Attention: RIN 1210-AB41

Dear Ms. Turner and Ms. Baum:

Families USA appreciates the opportunity to submit these comments on the 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. Families USA is a national, nonprofit, nonpartisan organization for health care consumers. Our mission is to ensure that all Americans have access to high-quality, affordable health care. Families USA strongly supports comprehensive, affordable health insurance for all residents of this nation.

We applaud the agencies for issuing rules that are straightforward and clearly state that reaching age 26 will be the only way a dependent child can be aged out of family coverage. It is appropriate that the rules do not require the young adult to reside in the same location nor to be financially dependent in order to receive these protections. Further, we applaud the agencies for providing a special enrollment period for young adults who may have lost coverage prior to the effective date. However, we do recommend that the agencies provide additional guidance on three areas of the transitional rules.

- 1) 26 CFR 54.9815-2714T(f); 29 CFR 2590.715-2714(f); and 45 CFR 147.120(f): Transitional rules for individuals whose coverage ended by reason of reaching a dependent eligibility threshold.

The 30-day enrollment opportunity for a dependent child to enroll begins no later than the first day of the first plan year beginning after September 23, 2010. Notice must be provided at the same time and the effective date of coverage is also the first day of the first plan year beginning after September 23, 2010. The agencies should consider drafting model language for the required notice that could be posted on the agencies' websites. The agencies should also consider posting a FAQ that provides an example of notice and retroactive coverage to the first day of the plan year.

- 2) 26 CFR 54.9815-2714T(g); 29 CFR 2590.715-2714(g); and 45 CFR 147.120(g): Further clarity about definition of "eligible employer-sponsored group health plan."
 - a) Add an additional reference to other plans outside this definition.

Under this temporary rule, dependent children who are eligible to enroll in an “eligible employer-sponsored health plan” need not be given an opportunity to enroll in their parent’s grandfathered group health plans. The regulations fail to describe the characteristics of an “eligible employer-sponsored health plan.” The statute defines eligible employer sponsored plan in IRC 5000A (f) (2) as “ a group health plan or group health insurance coverage offered by an employer to the employee which is (A) a governmental plan, or (B) another plan or coverage offered in the small or large group market within a State. Such term shall include a grandfathered plan described in plan....” It would be helpful to also reference regulations in 45 CFR 146.145, for example, that explain that plans which only offer excepted benefits or that cover only accidents or disability are not eligible employer-sponsored health plans. If it is possible under the statute, we would also recommend allowing dependent children to enroll in a grandfathered group plan if they only have an offer of a limited benefit policy (mini-med) through their own jobs.

b) Do not consider temporary coverage policies as “eligible employer-sponsored group health plans.”

We are also concerned about offerings of temporary coverage policies through a job. These policies are sometimes offered to young adults who are short-term interns (temporary employees), for example, but they are not guaranteed renewable and do not provide portability protections. They should not be considered eligible employer-sponsored plans that would prevent otherwise eligible young adults from staying on their parents’ coverage. Young adults would be much better protected by staying on their parent’s plan than by accepting a temporary policy.

3) The agencies should remind states that state and federal protections regarding pre-existing condition exclusions for young adults are unchanged by PACCA until 2014, and that stronger state protections will not be pre-empted.

We understand that the statute did not make any changes in this area until 2014, but this could be easily misunderstood by consumers, regulators, and state legislators. We therefore suggest that you send a letter to state insurance commissioners reminding them of the protections that young adults have against pre-existing condition exclusions in group plans under federal law, and that states still have authority to set more protective standards in the group market and to set standards in the individual market. For example, the letter could remind states that adults over the age of 19 can be subject to pre-existing condition exclusions, but if they are rejoining a group plan, pre-existing condition exclusion periods are limited to 12 months and would be offset by the months of prior creditable coverage. If states enact stronger protections in the group market (lessening exclusionary periods for all consumers, for example, or prohibiting pre-existing condition exclusions for young adults rejoining a parent’s plan), these state rules would not be pre-empted. Similarly, if states wanted to extend protections to the individual market, those state rules would not be pre-empted.

Thank you for the opportunity to submit these comments. If you have any questions, please do not hesitate to contact us at 202-628-3030.

Sincerely,

Cheryl Fish-Parcham
Deputy Director of Health Policy