Preexisting Exclusion Provisions for Children and Dependent Coverage under the Patient Protection and Affordable Care Act (PPACA)

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January 24, 2011
Summary

Under the Patient Protection and Affordable Care Act (P.L. 111-148, PPACA, as amended), a number of provisions directly affect access to health insurance coverage. Hereafter, “PPACA” will refer to PPACA, as amended. This report provides a description of two of the provisions in PPACA that are targeted toward younger individuals, for plan years beginning on or after six months from the date of enactment (i.e., the plan year beginning on or after September 23, 2010). PPACA prohibits coverage exclusions for children with preexisting health conditions who are under age 19, and the law also requires plans to continue to make dependent coverage available to children under age 26.
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Under the Patient Protection and Affordable Care Act (P.L. 111-148, PPACA, as amended), a number of provisions directly affect access to health insurance coverage. Hereafter, “PPACA” will refer to PPACA, as amended. Most of the insurance reforms in PPACA amend Title XXVII of the Public Health Service Act (PHSA, 42 U.S.C. 300gg et seq.). Title XXVII includes requirements on health insurance coverage for both the group and nongroup (individual) markets, enforcement applicable to such requirements, relevant definitions, and other provisions.

This report provides a description of two of the provisions in PPACA that are targeted toward younger individuals, for plan years beginning on or after six months from the date of enactment (i.e., the plan year beginning on or after September 23, 2010). PPACA prohibits coverage exclusions for children with preexisting health conditions who are under age 19, and the law also requires plans to continue to make dependent coverage available to children under age 26.

This report includes a description of the law and relevant information about the implementation of these two provisions.

No Preexisting Condition Exclusions for Children under Age 19

Summary of Provision

PPACA prohibits coverage exclusions for children with preexisting health conditions who are under age 19, effective for plan years beginning on or after September 23, 2010. In other words, health plans may not exclude benefits based on health conditions for qualifying children. This provision applies to all grandfathered and new group plans (including self-insured plans) and all new individual plans.

A strict interpretation of the statutory language appears to separate the guarantee for the issuance of a health insurance policy from the prohibition against coverage exclusions for preexisting conditions.
conditions once a policy has been issued. Such an interpretation would mean that children could be denied the offer of coverage altogether until 2014, but that if they are offered coverage, they would have access to all covered benefits to treat their health conditions for plan years beginning on or after September 23, 2010.

However, the law gives the Secretary of Health and Human Services (“Secretary”) wide latitude with respect to implementation of the insurance reforms and other provisions. In multiple instances, the law specifies that the Secretary will promulgate regulations to implement various provisions affecting private health coverage. In addition, the inclusion of the insurance reforms under Title XXVII of PHSA indicates the intent for the Secretary to exercise broad rulemaking and enforcement authority.

On March 29, 2010, Secretary Sebelius stated in a letter to the President of America’s Health Insurance Plans that she planned to issue regulations to confirm that beginning in September, 2010:

- Children with pre-existing conditions may not be denied access to their parents’ health insurance plan;
- Insurance companies will no longer be allowed to insure a child, but exclude treatments for that child’s pre-existing condition.

Then, on June 28, 2010, the Departments of Health and Human Services, Labor, and Treasury (“Departments”) issued joint interim final rules in the Federal Register, which include rules for coverage for preexisting conditions. In the preamble of the regulation, the Departments state that this provision “protects individuals under age 19 with a preexisting condition from being denied coverage under a plan or health insurance coverage (through denial of enrollment or denial of specific benefits) based on the preexisting condition.” The regulation defines preexisting conditions exclusion as “a limitation or exclusion of benefits (including a denial of coverage) based on the fact that the condition was present before the effective date of coverage (or if coverage is denied, the date of the denial).” In other words, the Departments have broadly defined preexisting condition exclusions to include the outright denial of coverage.

On July 27, 2010, HHS posted Q&As to provide further clarification about implementation of this provision. HHS stated that “issuers in the individual market may restrict enrollment of children under 19, whether in family or individual coverage, to specific open enrollment periods if allowed under State law.” Issuers have discretion regarding the number and duration of open enrollment periods, but must allow children under age 19 to enroll in their parents’ plans without any restrictions based on their preexisting conditions.

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8 For plan years beginning on or after January 1, 2014, PPACA will require insurance carriers that offer new health insurance policies in the group or individual market to accept any applicant for coverage who is willing to accept the terms of such coverage (“guaranteed issue”). Guaranteed issue generally does not define what benefits must be covered under the offered insurance policy, nor does it specify the premium charged; such issues are addressed in other PPACA provisions, also effective beginning in 2014.

9 This will apply in cases when a child receives dependent coverage on a parent’s policy, or when a child is covered under her own policy in the individual market.


12 Ibid. pp. 37222-37223.

13 Office of Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services, (continued...)

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periods, unless such conditions are specified under state law. If a state imposes open enrollment requirements on issuers in the individual market, such requirements are not preempted by federal statute or regulations.14

**Estimated Effect**

The interim final rules for coverage of preexisting health conditions include analysis of the potential impact of such rules on children with preexisting conditions.

Using data from an existing health insurance survey, the Departments estimated that over 19 million children potentially had a preexisting condition in 2010. Most of these children had coverage through the private market (mainly provided through a parent’s employer) or had public coverage. The Departments estimated that 540,000 children with preexisting health conditions were left uninsured.

Assuming that a parent’s insurance status would be a fundamental factor in the likelihood that an uninsured child with preexisting conditions would gain coverage as a result of the regulation, the Departments analyzed the number of such children (540,000) by the parents’ insurance status: has employer-provided coverage, was offered employer-provided coverage, has coverage through the individual health insurance market, does not have private insurance, or there is no parent. Half of uninsured children with preexisting conditions (270,000) had a parent who did not have private coverage. Of the remaining half, most had a parent that were offered or had employer-provided coverage (see Table 1).

<table>
<thead>
<tr>
<th>Parent’s Insurance Status</th>
<th>Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has employer-provided coverage</td>
<td>190,000</td>
</tr>
<tr>
<td>Was offered employer-provided coverage</td>
<td>60,000</td>
</tr>
<tr>
<td>Has coverage through the individual health insurance market</td>
<td>10,000</td>
</tr>
<tr>
<td>Does not have private insurance</td>
<td>270,000</td>
</tr>
<tr>
<td>There is no parent</td>
<td>20,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>540,000</strong></td>
</tr>
</tbody>
</table>

*Source: Federal Register, Vol. 75, No. 123, June 28, 2010.*

(...continued)


14 This clarification regarding open enrollment periods is, in part, in response to issuer concerns regarding adverse selection. Issuers argue that requiring coverage to be guaranteed issue prior to implementation of the requirement on individuals to have health insurance (“individual mandate”) will give people the incentive to wait until children have an illness or injury to buy insurance, then drop the policy when the insurance is no longer needed. Such conditions make managing insurance risk very difficult. Given this uncertainty, there were anecdotes prior to the Q&A posting that some insurance carriers have decided to no longer offer child-only policies.
Preexisting Exclusion Provisions for Children and Dependent Coverage under PPACA

The Departments researched the literature on take-up rates (i.e., the share of individuals with access to health insurance who end up obtaining coverage) to develop estimates on the number of children with preexisting conditions who could gain coverage under the regulation. In developing these estimates, the Departments acknowledged “substantial uncertainty,” but, nonetheless, assumed that

50 percent of uninsured children whose parents have individual coverage will be newly insured, 15 percent of uninsured children whose parents are uninsured will be newly insured, and that very few children whose parents have ESI [employer-sponsored insurance], are offered ESI, or who do not live with a parent will become covered as a result of these interim final regulations.15

These take-up rates formed the mid-range estimates of the number of uninsured children with preexisting conditions who will gain coverage. As shown in Table 2, of the 51,000 children who could gain coverage under the mid-range estimates, most would be enrolled in the individual health insurance market (45,000). Given the uncertainty regarding take-up rates, the Departments also developed high-end and low-end estimates.

<table>
<thead>
<tr>
<th>Gains employer-provided coverage</th>
<th>Gains coverage in individual health insurance market</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High-end estimates</strong></td>
<td>10,000</td>
<td>62,000</td>
</tr>
<tr>
<td><strong>Mid-range estimates</strong></td>
<td>6,000</td>
<td>45,000</td>
</tr>
<tr>
<td><strong>Low-end estimates</strong></td>
<td>2,000</td>
<td>29,000</td>
</tr>
</tbody>
</table>


Dependent Coverage for Children Under Age 26

Summary of Provision

The requirement relating to coverage of adult children will also take effect for the plan years beginning on or after September 23, 2010.16 The statute requires that if a plan provides for dependent coverage of children, the plan must continue to make such coverage available for an adult child under age 26.17

- Plans that offer dependent coverage must continue to make that offer available until the adult child turns 26 years of age. As an example, an adult

16 §1001 of P.L. 111-148 (new PHSA §2714), as amended by §2301 of P.L. 111-152.
17 In general, an employer’s contributions toward premiums for health insurance were excluded from an employee’s taxable income. Prior to PPACA, the exclusion was only allowed for dependent coverage up to age 23. §1004(d) of P.L. 111-152 extends the age limit on the exclusion to conform with this new dependent coverage.
child who is 26 years and 1 month old would no longer be required to be covered.

- Plans must make coverage available for both married and unmarried adult children under age 26, but not for the adult child’s children.
- The requirement affects individuals enrolled in all group and individual health plans, including self-insured plans.\(^{18}\)
- With one exception, these provisions apply to grandfathered plans. Prior to 2014, grandfathered group health plans are \textit{not required} to make dependent coverage available to adult children who can enroll in an eligible employer-sponsored health plan based on their employment. (However, a plan \textit{may} make dependent coverage available to such adult children if it wishes.)

The statute \textit{does not require plans to offer dependent coverage}, so that if a plan chooses not to provide such coverage, nothing in this statute would require them to do so. The age requirement affects only plans that choose to offer dependent coverage.

Because the statute takes effect for plan years beginning six months after the date of enactment, there may be some adult children who were covered when PPACA was enacted, but who aged out of their parent’s plan before the required effective date. However, several insurers have already indicated that they will continue to provide dependent coverage for these individuals even before such coverage is required. In addition, Secretary Sebelius issued a statement on April 19, 2010, recognizing those insurers who had already chosen to “bridge the gap between now and the fall when the law becomes effective.”\(^{19}\) The Office of Personnel Management (OPM) stated it could not provide this gap coverage for enrollees of the Federal Employees Health Benefits program (FEHBP), because the current law governing FEHBP specifically prohibits OPM from doing so.\(^{20}\)

For those individuals who \textit{do} lose coverage before the requirements are in place, the health insurance options for an adult child who ages out of a parent’s policy remain unchanged from those available prior to the passage of PPACA. Children who age out of their parent’s policy may be able to purchase health insurance through COBRA,\(^{21}\) which provides temporary access to health insurance for qualified individuals who lose coverage for certain conditions. One of the qualifying conditions for COBRA coverage is the end of dependent coverage. The child could also buy health insurance through the individual market.

On May 13, 2010, the Departments of Health and Human Services, Labor, and Treasury (“Departments”) issued joint interim final rules in the \textit{Federal Register} on dependent coverage

\(^{18}\) Retiree-only health plans may, or may not, be subject to the dependent coverage provision. Under regulations concerning grandfathered health plans, HHS stated that it will not enforce PPACA insurance reforms with respect to retiree-only coverage, in keeping with existing rules that have exempted retiree-only coverage from federal health insurance requirements since 1996. However, states continue to be the primary regulators of health insurance, even post PPACA, so individual states may decide to enforce PPACA requirements on retiree-only plans. For additional information about these issues, see the Appendix in CRS Report R41166, \textit{Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)}, by Bernadette Fernandez.


\(^{21}\) For more information on COBRA, see CRS Report R40142, \textit{Health Insurance Continuation Coverage Under COBRA}, by Janet Kinzer. For individuals covered by the FEHBP, the Temporary Continuation of Coverage (TCC) program provides coverage similar to COBRA.
under PPACA. The rules clarify that “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.22

The federal requirements are a floor. That is, they provide a minimum requirement. States that already impose requirements beyond attaining age 26 may continue to do so. For example, New Jersey requires dependent coverage to be available up to the age of 31, as long as the adult child is unmarried and has no dependents.23 To the extent that the state law is more restrictive than the federal law (e.g., New Jersey’s requires that the individual not be married), the federal statute would apply, therefore covering the married adult child under the age of 26.

**Estimated Effect**

As part of the interim final rules for dependent coverage of children under age 26, the Departments of the Treasury, Labor, and Health and Human Services estimated the impact of the regulation on the health insurance coverage for this group.24 In order to estimate the number of individuals potentially affected, they examined several criteria including whether or not the parents of these adult children had existing employer-sponsored insurance (ESI) or individual insurance, and whether the adult children themselves were insured. Using this information, they estimated the take-up rates, that is, the number of individuals who are likely to accept coverage if offered it.

The Departments estimated that in 201025 there were approximately 29.5 million individuals between the ages of 19 and 25. Of those, 9.3 million such individuals were estimated to have no access to dependent coverage, because their parents did not have ESI or non-group coverage. That left 20.2 million adult children whose parents were covered either by ESI or by non-group insurance. The 20.2 million are further broken down, as follows:

- 3.42 million were uninsured,
- 2.42 million were covered by their own non-group coverage,
- 5.55 million were covered by their own ESI,
- 5.73 million were already on their parent’s or spouse’s ESI, and
- 3.01 million had other coverage, such as Medicaid.

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23 For a complete description of state law applying to dependent coverage, see http://www.ncsl.org/default.aspx?tabid=14497.


25 The estimates are based on Medical Expenditure Panel Survey Household Component (MEPS-HC) data from 2004-12006, calibrated to 2010, using the National Health Accounts Projection.
The Departments assumed that the initial group of potential individuals for dependent coverage would only include those who were either uninsured or those who were covered by individual insurance (3.44 million + 2.42 million, for a total of 5.86 million).

Of the 5.86 million, the Departments estimated that 3.49 million would choose not to enroll in their parent’s plan, because (1) they are already allowed to enroll in their parent’s plan under their State’s existing laws, but have chosen not to do so; (2) they have their own offer of ESI and their parent’s plan will not extend coverage to them; or (3) their parent’s coverage in the nongroup market is underwritten (based on health status and other factors), so that there is no financial benefit for the adult child to enroll in the parent’s plan.

Subtracting out these 3.49 million individuals leaves a potential pool of 2.37 million. However, as they noted in the regulation, it is difficult to estimate how many of these 2.37 million individuals would likely take up the insurance. Recognizing the uncertainly in the estimates of take-up rates, the Departments produced a range of assumptions, shown in Table 3.

### Table 3. Number of Individuals with New Dependent Coverage, 2011

<table>
<thead>
<tr>
<th></th>
<th>Low Estimate</th>
<th>Mid-range Estimate</th>
<th>High Estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals with</td>
<td>.68</td>
<td>1.24</td>
<td>2.12</td>
</tr>
<tr>
<td>New Dependent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: Federal Register, Vol. 75, No. 92, May 13, 2010.*

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