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

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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 six months after date of enactment* (i.e., the plan year beginning after September 23, 2010). PPACA does not allow preexisting condition exclusions for children under age 19, and the law also requires plans to continue to make dependent coverage available up to 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. Most of the insurance reforms in PPACA amend Title XXVII of the Public Health Service Act (PHSA, 42 U.S.C. 300gg et seq.).[1] Title XXVII includes requirements on health insurance coverage for both the group and nongroup 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 six months after date of enactment* (i.e., the plan year beginning after September 23, 2010).[2] PPACA does not allow preexisting condition exclusions for children under age 19, and the law also requires plans to continue to make dependent coverage available under age 26.

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

No Preexisting Exclusion for Children under Age 19

Summary of Provision

PPACA will prohibit preexisting health condition exclusions for children under 19, effective for plan years beginning after September 23, 2010.[3] This provision applies to all grandfathered[4] and new group plans (including self-insured plans)[5] and all new individual plans.[6] In other words, such plans may not exclude benefits based on health conditions for qualifying children.[7]

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* once a policy has been issued.[8] Such an interpretation would mean that children could

[1] PPACA also includes conforming amendments to the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1986 (§1563(e) and (f)).

[2] As an example, if a plan year begins on January 1 of each year, as many plans do, these provisions would take effect on January 1, 2011.

[3] §1201 of P.L. 111-148 (new PHSA §2704), as amended by §2301 of P.L. 111-152.

[4] Grandfathered plans are defined as those individual and group plans that an individual or family was enrolled in on the date of enactment. A plan that provides group coverage on the date of enactment may provide for the enrolling of new employees (and their families) in such plan. For additional information about grandfathered plans, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)*, by Bernadette Fernandez.

[5] The definitions for group health plans and health insurance coverage refer to definitions in the Public Health Service Act (PHSA). Under PHSA, group health plans include self-insured plans. For additional information about self-insured plans, see CRS Report R41069, *Self-Insured Health Insurance Coverage*, by Bernadette Fernandez.

[6] Prior to PPACA, preexisting coverage exclusions were limited in the group market and prohibited in the nongroup market for individuals who met criteria specified under federal law.

[7] Beginning January 1, 2014, the provision would be expanded to include those individuals aged 19 and older.

[8] For plan years beginning 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 (continued...)

be denied the offer of coverage altogether until 2014, but that if they are offered coverage,[9] they would have access to all covered benefits to treat their health conditions for plan years beginning 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.[10]

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 proposed 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."[11] 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)."[12] Thus it appears that the Secretaries have exercised their authority to broadly define preexisting condition exclusions to include denial of coverage.

Moreover, 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."[13] Issuers have discretion regarding the number

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(...continued)

provisions, also effective beginning 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.

[10] Kathleen Sebelius, Secretary of Health and Human Services, letter to Ms. Karen Ignagni, March 29, 2010, p. 1.

[11] *Federal Register*, vol. 75, no. 123, June 28, 2010, p. 37190, available at http://frwebgate2.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=K6MoCp/0/2/0&WAISaction=retrieve.

[12] Ibid, pp. 37222-37223.

[13] Office of Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services, "Questions and Answers on Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions," available at http://www.hhs.gov/ociio/regulations/children19/factsheet.html.

and duration of open enrollment 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

Analysis of existing surveys of the individual market may provide rough estimates of the size of the population that may be affected by this provision.[15] According to one ongoing survey of the individual market,[16] almost 13% of medically underwritten applications for health insurance were denied in 2008, representing over 220,000 applicants. Of those applications for children (under age 18), nearly 5% were denied that year, equivalent to more than 20,000 applicants.

Moreover, of those individuals offered insurance, some applicants were offered policies that excluded coverage for certain conditions ("condition waiver"), and other applicants were offered policies with both a condition waiver and higher premium (see **Table 1**). Note that this data do not include individuals who chose to not apply for health insurance because they assumed they would be rejected based on their medical history.

Table 1. Medically Underwritten Policies in the Individual Market, 2008

Offered Policies, Condition Waivers, and Higher Premiums

Applicants by Age Range	Medically Underwritten Policies Offered	Policies Offered with Condition Waiver	Policies Offered with Condition Waiver and Higher Premium
All non-elderly (under 65 years of age)			
Number of applicants	1,540,127	92,914	23,569
Percentage	100%	6.0%	1.5%
Under 18 years of age			
Number of applicants	408,990	10,948	7,408
Percentage	100%	2.7%	1.8%

Source: America's Health Insurance Plans, "Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits," October 2009.

[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.

[15] Precise estimates of the population that potentially could be affected by this provision are difficult to calculate given limitations of existing, publicly available data sources.

[16] America's Health Insurance Plans (AHIP) conducted its latest survey of member companies offering insurance products in the individual market during the summer of 2009.

Dependent Coverage

Summary of Provision

The requirement relating to coverage of adult children will also take effect for the plan years beginning after September 23, 2010.[17] 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 until age 26.[18]

- 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 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.
- With one exception, these provisions apply to grandfathered plans. Prior to 2014, for grandfathered group health plans, dependent coverage is *not* available to those adult children who can enroll in an eligible employer-sponsored health plan based on their employment.

The statutes *do not require plans to offer coverage*, so that if a plan chooses not to provide dependent 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 will age 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 have already chosen to "bridge the gap between now and the fall when the law becomes effective."[19] The Office of Personnel Management (OPM) has stated it cannot 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 *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

[17] §1001 of P.L. 111-148 (new PHSA §2714), as amended by §2301 of P.L. 111-152.

[18] 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.

[19] See http://www.hhs.gov/news/press/2010pres/04/20100419a.html.

[20] See information on OPM's website, http://www.opm.gov/insure/health/reform/index.asp.

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 *Federal Register* on dependent coverage under PPACA. The rule clarifies 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 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 through the age of 26.

Estimated Effect

For 2008, about 30.7 %, or 8.8 million, young adults aged 19 to 25 (i.e., up to their 26th birthday) had no health insurance.[24] Another 6.2% or 1.8 million, young adults in that cohort had private nongroup coverage. So while the potential "pool," at least in 2008, was 10.6 million individuals, it is difficult to estimate how this number might translate into covered lives as a result of the dependent coverage provision in PPACA. The potential effect is difficult to estimate because (1) some of these individuals may have had an offer of coverage through their employer that they did not accept, which would disqualify them from enrolling in their parent's policy, and (2) the parents of these individuals may not have had an offer of dependent coverage through their employer, or may be uninsured themselves.

[21] For more information on COBRA, see CRS Report R40142, *Health Insurance Continuation Coverage Under COBRA*, by Janet Kinzer and Meredith Peterson. For individuals covered by the FEHBP, the Temporary Continuation of Coverage (TCC) program provides coverage similar to COBRA.

[22] The Departments issued "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under PPACA" on May 13, 2010, p 27136, available at http://frwebgate3.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=FvOwFx/0/2/0&WAISaction=retrieve.

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

[24] For more information, see CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured in 2008*, by Chris L. Peterson.

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