



# **Preexisting Condition Exclusion Provisions for Children and Dependent Coverage under the Patient Protection and Affordable Care Act (ACA)**

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## Summary

Under the Patient Protection and Affordable Care Act (P.L. 111-148, ACA, as amended), a number of provisions directly affect access to health insurance coverage. This report provides a description of two of the provisions in ACA 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). ACA 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, ACA, as amended), a number of provisions directly affect access to health insurance coverage. Hereafter, “ACA” will refer to ACA, as amended. Most of the insurance reforms in ACA amend Title XXVII of the Public Health Service Act (PHSA, 42 U.S.C. 300gg et seq.).<sup>1</sup> 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 ACA 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).<sup>2</sup> ACA 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 Coverage Exclusions for Children under Age 19**

### **Summary of Provision**

ACA 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.<sup>3</sup> In other words, health plans may not exclude benefits based on health conditions for qualifying children.<sup>4</sup> This provision applies to all grandfathered<sup>5</sup> and new group plans (including self-insured plans<sup>6</sup>) and all new individual plans.<sup>7</sup>

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.<sup>8</sup> Such an interpretation would mean that children could

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<sup>1</sup> ACA also includes conforming amendments to the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code of 1986 (§1563(e) and (f)).

<sup>2</sup> As an example, if a plan year begins on January 1 of each year, as many plans do, these provisions first took effect on January 1, 2011.

<sup>3</sup> §1201 of P.L. 111-148 (new PHSA §2704), as amended by §2301 of P.L. 111-152.

<sup>4</sup> For plan years beginning on or after January 1, 2014, this provision would be expanded to apply to all individuals, regardless of age.

<sup>5</sup> A grandfathered plan is defined as an individual or group plan that has had enrollment since the date of enactment (March 23, 2010), and has not undergone coverage changes that would cause it to lose grandfathered status. For additional information about grandfathered plans, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)*.

<sup>6</sup> The definitions for group health plans and health insurance coverage refer to definitions in the Public Health Service Act (PHSA). Under the PHSA, group health plans include self-insured plans. For additional information about self-insured plans, see CRS Report R41069, *Self-Insured Health Insurance Coverage*.

<sup>7</sup> Prior to ACA, preexisting coverage exclusions were limited in the group market and prohibited in the individual (nongroup) market for individuals who met criteria specified under federal law.

<sup>8</sup> For plan years beginning on or after January 1, 2014, ACA will require insurance carriers that offer new health (continued...)

be denied the offer of coverage altogether until 2014, but that if they are offered coverage,<sup>9</sup> 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.<sup>10</sup>

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.”<sup>11</sup> 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).”<sup>12</sup> 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.”<sup>13</sup> Issuers have discretion regarding the number and duration of open enrollment

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(...continued)

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 ACA provisions, also effective beginning in 2014.

<sup>9</sup> 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.

<sup>10</sup> Kathleen Sebelius, Secretary of Health and Human Services, letter to Ms. Karen Ignagni, March 29, 2010, p. 1.

<sup>11</sup> *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>.

<sup>12</sup> *Ibid.*, pp. 37222-37223.

<sup>13</sup> 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 (continued...)”

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.<sup>14</sup>

## 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 who was offered or had employer-provided coverage (see **Table 1**).

**Table 1. Uninsured Children with Preexisting Health Conditions Under Age 19, by Parent’s Insurance Status, 2010**

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

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

(...continued)

Condition Exclusions,” available at <http://www.hhs.gov/ociio/regulations/children19/factsheet.html>.

<sup>14</sup> 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.

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.<sup>15</sup>

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 2. Estimate of Uninsured Children with Preexisting Health Conditions Under Age 19 who Gain Coverage**

	Gains employer-provided coverage	Gains coverage in individual health insurance market	Total
<b>High-end estimates</b>	10,000	62,000	72,000
<b>Mid-range estimates</b>	6,000	45,000	51,000
<b>Low-end estimates</b>	2,000	29,000	31,000

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

## Dependent Coverage for Children Under Age 26

### Summary of Provision

The requirement relating to coverage of children under age 26 will also take effect for the plan years beginning on or after September 23, 2010.<sup>16</sup> The statute requires that if a plan provides for dependent coverage of children, the plan must make such coverage available for a child under age 26.<sup>17</sup>

- 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

<sup>15</sup> *Federal Register*, Vol. 75, No. 123, June 28, 2010, pp. 37199-37200.

<sup>16</sup> §1001 of P.L. 111-148 (new PHS A §2714), as amended by §2301 of P.L. 111-152.

<sup>17</sup> In general, an employer’s contributions toward premiums for health insurance are excluded from an employee’s taxable income. Prior to ACA, 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 that offer dependent coverage must make it available for both married and unmarried children under age 26, but not for the children's children.
- The requirement affects individuals enrolled in group and individual health plans, including self-insured plans.<sup>18</sup>
- With one exception, these provisions apply to grandfathered plans. Prior to 2014, grandfathered group health plans are *not required* to make dependent coverage available to adult children who can enroll in an eligible employer-sponsored health plan based on their own employment. (However, a plan *may* make dependent coverage available to such adult children if it wishes.)

The statute does *not require* plans to offer dependent coverage in the first place, 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.

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 ACA. 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.”<sup>19</sup>

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.<sup>20</sup> 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.

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<sup>18</sup> 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 ACA 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 ACA, so individual states may decide to enforce ACA requirements on retiree-only plans. For additional information about these issues, see the Appendix in CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)*.

<sup>19</sup> 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://fwebgate3.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=FvOwFx/0/2/0&WAIAction=retrieve>.

<sup>20</sup> For a complete description of state law applying to dependent coverage, see <http://www.ncsl.org/default.aspx?tabid=14497>.



## 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.<sup>21</sup> 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 2010<sup>22</sup> 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.

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 uncertainty in the estimates of take-up rates, the Departments produced a range of assumptions, shown in **Table 3**.

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<sup>21</sup> *Federal Register*, Vol. 75, No. 92, May 13, 2010.

<sup>22</sup> The estimates are based on Medical Expenditure Panel Survey Household Component (MEPS-HC) data from 2004-2006, calibrated to 2010, using the National Health Accounts Projection.

**Table 3. Estimate of the Number of Individuals with New Dependent Coverage, 2011**  
(in millions)

	Low Estimate	Mid-range Estimate	High Estimate
Individuals with New Dependent Coverage	.68	1.24	2.12

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

## Attributed Impact

The most current national data on the uninsured from the Census Bureau showed a decline in the uninsured rate for young adults. For 19- to 25-year-olds, the rate of uninsurance declined from 31.4% in 2009 to 29.7% in 2010. Not only was this a statistically significant change from one year to the next, but young adults were the only adult age group that experienced a decline in their uninsured rate. All other adult age groups experienced slight increases in their uninsured rates.<sup>23</sup> Another national data source also found a decrease in the uninsured rate for young adults, from 2010 to the first half of 2011.<sup>24</sup> Some observers have attributed the uninsured rate decline to ACA's coverage provisions, specifically the dependent coverage requirements.

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<sup>23</sup> See Table 8. "People Without Health Insurance Coverage by Selected Characteristics: 2009 and 2010," U.S. Census Bureau, <http://www.census.gov/hhes/www/hlthins/data/incpovhlth/2010/table8.pdf>.

<sup>24</sup> See M. Martinez and R. Cohen, "Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–June 2011," CDC/NCHS, <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201112.pdf>.