Georgetown University Health Policy Institute
Center for Children and Families

HPI
policy matters

Frequently Asked Questions: Enrollment in Child-Only Plans Under ACA Requirement Prohibiting Pre-Existing Condition Exclusions

The Patient Protection and Affordable Care Act (ACA) prohibits new group and individual health plans from imposing pre-existing condition exclusions on children under 19, a requirement that went into effect on September 23, 2010.[1] The prohibition extends to grandfathered group plans but does not apply to grandfathered individual market plans.

Recent news coverage has documented that a number of health insurance companies are responding to the requirement by discontinuing "child only" insurance products. The following questions and answers will help child advocates understand how children and families may be affected by such decisions, as well as policy options for effective implementation.

Q. Health plans that have offered "child-only" plans in my state are dropping out of the market, or threatening to drop out of the market as a result of the new rules. What are child-only plans and how many children could be impacted if they no longer offer coverage?

"Child only" policies are individual market policies that are sold to children under the age of 19. They do not include policies that are sold to adults with children as dependents. They are often sold to parents whose employers don't provide dependent coverage, or to grandparents on Medicare who are the primary caregivers for children not otherwise eligible for public programs. They represent a very small percentage of the individual insurance market – by some estimates only 8% of all individual policies.[2] Child-only plans that existed prior to March 23, 2010, are "grandfathered" unless they make material changes in their benefits or cost-sharing, and will not be affected by the new law.

The estimates of children "affected" if plans drop child-only coverage is difficult to determine. First, it is important to remember that many of the insurance companies that have threatened to "drop out" of the market are not leaving the market completely. Rather, they are saying they will no longer issue *new* policies. So children currently enrolled in these plans should not lose coverage as a result.

The Administration's upper estimate of the number of children affected by the overall ban on pre-existing condition exclusions is 162,000.[3] This number includes uninsured children with pre-existing

[1] For children in employer-sponsored group plans, the requirement may not go into effect until the new "plan year", which in many cases does not begin until January 1, 2011.
[2] AHIP Center for Policy Research, "Individual Health Insurance 2009," available at http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf.
[3] 75 Fed. Reg. 37187, 37200 (Jun. 28, 2010).

conditions who could gain coverage as dependents on their parents' policies (either through employer-sponsored plans or policies on the individual market). It also includes children who currently have individual market plans that exclude coverage or impose an exclusion period based on health status – who could potentially switch to new plans to take advantage of the new prohibition. We do not know how many of the 162,000 children are in child only plans, but it certainly is not a large number.

Q. I thought the health plans said they would follow the law. Now they're dropping out. Can anything be done to stop them?

Unfortunately if a health plan no longer wants to offer coverage, it is difficult for state and federal authorities to require them to do so. However, government officials have a handful of options to encourage plans to stay in the market:

- Require that plans who wish to offer any individual market policies in the state cover applicants who are children. In this scenario, the state insurance commissioner will likely need to issue an emergency rule informing plans that if they want to continue to market any individual plans in the state, they have to take all children.[4] Not all states have this kind of regulatory authority, so advocates should check with their state commissioner to see if this is an option. In some states, legislation may be required. For example, California recently passed legislation barring insurers from offering coverage in the individual market for 5 years if they discontinue child-only policies.[5]
- If insurers agree to stay in the market, allow plans to impose surcharges on families who drop coverage and subsequently reapply. Insurance companies are concerned that because the law requires "guaranteed issue" of policies to sick children, many families will wait until their child needs treatment before applying for insurance. Once treatment is completed, these plans say, the family will stop paying premiums and drop the policy. While this concern does not adequately reflect the strong desire of most parents to make sure their children have year-round access to quality health care, it can be addressed by allowing plans to impose a modest financial penalty on families that drop their coverage and then seek to re-enroll at a later date. The Department of Health and Human Services has issued guidance that would allow plans to do just that.[6]
- Allow plans to require "open enrollment" periods, so that families could only enroll in coverage at certain times during the year. HHS has issued guidance to health plans, expressly allowing them to limit enrollment of children to specific open enrollment periods, if those are allowed under State law.[7] Some states place restrictions on the duration and number of those open enrollment periods, as well as impose rules for "special enrollment" opportunities for families

[4] See, e.g., New Hampshire Insurance Department Bulletin, Sept. 23, 2010, available at: http://www.nh.gov/insurance/media/bulletins/2010/documents/ins_10_041_ab.pdf.
[5] AB 2244 (currently awaiting signature from the Governor), available at http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_2201-2250/ab_2244_cfa_20100825_190459_asm_floor.html.
[6] HHS, Questions and Answers on Enrollment of Children Under 19," available at http://www.hhs.gov/ociio/regulations/children19/factsheet.html.
[7] Ibid.

because of certain changes in circumstances (i.e., a divorce, loss of employment, etc.) Other states do not. Child advocates should talk to their state insurance commissioner to ensure that any open enrollment period does not unreasonably limit access to coverage. At a minimum, states should require an initial open enrollment period of 6-12 months so that families have time to learn about the coverage options available to them.

Q. What if child-only plans are still refusing to offer new policies? What options do families have?

Children who are currently enrolled in child-only plans should not be affected. Their policies are likely to continue as they have before, with few changes. Also, even though some child-only plans may stop marketing new policies, there may be others in your state or region that will continue to do so. But in all parts of the country, families who have been counting on this new law to access insurance coverage for their children need meaningful and affordable alternative options to do so.

It's also important to note that with two-thirds of uninsured children eligible for Medicaid or CHIP coverage, some of these children may be eligible for these programs in your state. Two other public coverage options to consider if not already available in the state are a CHIP buy-in for children in families with too much income to qualify for CHIP or Medicaid and/or the Family Opportunity Act option, which allows privately-insured children with special health care needs and income up to 300% of the FPL to buy supplemental Medicaid coverage.

For some families, enrolling their children in the state high risk pool (or the federal high risk pool if the state does not have one) could be an option. To date, the high risk pool programs created under the ACA are significantly under-subscribed and could be opened up to children who cannot access coverage from child-only plans. For this option to work, however, HHS and the states must ensure that pediatric benefits are covered under the plans and pediatric providers are available. In addition, some children may need a special waiver under the current rules for the high risk pools. Under the law, eligible applicants to the high risk pools must show that they have been uninsured for at least 6 months. Children who currently have insurance but their treatment costs are excluded because of a pre-existing condition rider will not be able to demonstrate this. However, they are effectively "uninsured" with respect to the treatment they need for their condition. Child advocates should argue forcefully that they should be eligible for the state high risk pools.