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Questions and Answers on Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions

Updated: October 13, 2010

On June 28, 2010, the Administration published the interim final regulations prohibiting new group health plans and health insurance issuers in both the group and individual markets from imposing pre-existing condition exclusions on children under 19 for the first plan year (in the individual market, policy year) beginning on or after September 23, 2010. These regulations apply to grandfathered group health plans and group health insurance coverage but do not apply to grandfathered individual health insurance coverage that was in existence on March 23, 2010.

Accordingly, for non-grandfathered individual health insurance policies, children under 19 cannot be denied coverage because of a pre-existing condition for policy years beginning on or after September 23, 2010. These questions and answers will assist issuers with implementation of this requirement.

Question #1: Will children in child-only individual market health plans today be affected by the new access to these plans for children with pre-existing conditions?

A: Child-only insurance plans that existed on or prior to March 23, 2010, and that do not significantly change their benefits, cost sharing, and other features, will be "grandfathered" or exempt from these regulations. As such, children enrolled in grandfathered child-only plans today are unlikely to be affected by the new policies.

Question #2: Do these interim final rules require issuers in the individual health insurance market to offer children under 19 non-grandfathered family and individual coverage at all times during the year?

A: No. To address concerns over adverse selection, 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. This is not precluded by the new regulations.

For example, an insurance company could set the start of its policy year for January 1 and allow an annual open enrollment period from December 1 to December 31 each year. A different company could allow quarterly open enrollment periods. Both situations assume that there are no State laws that set the timing and duration of open enrollment periods.

Question #3: How often must an issuer in the individual market provide an open enrollment period for children under 19?

A: Unless State laws provide such guidance, issuers in the individual market may determine the number and length of open enrollment periods for children under 19 (as well as those for families and adults). The Administration, in partnership with States, will monitor the implementation of the pre-existing condition exclusion policy for children and issue further guidance on open enrollment periods if it appears that their use is limiting the access intended under the law.

Question #4: How do these rules affect existing enrollment requirements in States that already require guaranteed issue of coverage for children under 19 in the individual market?

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A: If a State requires continuous open enrollment or requires issuers to maintain an open enrollment period of a particular length or open enrollment periods of a particular frequency, then the State requirement will apply. The State law is not preempted by any current federal requirements.

Question #5: “Premium assistance” programs allow States to provide payments to help people eligible for Medicaid and Children’s Health Insurance Programs (CHIP) enroll in private coverage. Won’t the policy to ban pre-existing condition exclusions in new plans for children lead cash-strapped States to steer high-cost children into individual market policies for children as a way to limit their own liability?

A: Federal law prohibits Medicaid and CHIP from denying children coverage based on their health status. Moreover, it limits the extent to which these programs can provide payment to support coverage in individual market policies. “Premium assistance” programs in CHIP allow States to provide payment to private policies to cover children if doing so both protects children and is cost effective to the Federal and State governments. Premium assistance is not designed as a strategy to transfer vulnerable children to individual market coverage. The Administration will enforce its current policies on premium assistance and consider new ones if evidence emerges that children with pre-existing conditions are being diverted inappropriately from Medicaid or CHIP to private insurance plans that newly offer guaranteed issue to children regardless of their health status.

HHS will not enforce these rules against issuers of stand-alone retiree-only plans in the private health insurance market.

Question #6: Some issuers have expressed concerns about adverse selection from newly offering child-only health insurance on a guarantee issue basis, and have asked for clarifications of what they could do, consistent with the current regulations, to mitigate this concern?

A: A number of actions have been suggested by insurance commissioners and insurers to address adverse selection in child-only policies. The following actions are not precluded by existing regulations:

- Adjusting rates for health status only as permitted by State law (note: the Affordable Care Act prohibits health status rating for all new insurance plans starting in 2014);
- Permitting child-only rates to be different from rates for dependent children, consistent with State law;
- Imposing a surcharge for dropping coverage and subsequently reapplying if permitted by State law;
- Instituting rules to help prevent dumping by employers to the extent permitted by State law;
- Closing the block of business for current child-only policies if permitted by State law; and
- Selling child-only policies that are self-sustaining and separate from closed child-only books of business if permitted by State law.

In addition, some States are considering legislation that would require individual-market issuers that offer family coverage to also offer child-only policies. This approach could increase the options for families with healthy as well as sick children, and would lower the risk of adverse selection. The Administration would welcome this and other State actions that ensure access to health plans by families with children and prevent adverse selection in the market.

Question #7: In some States with guarantee issue, to limit adverse selection, open enrollment periods are set for a particular time of the year, required to be used by all issuers, and, in some cases, are the only time when issuers can sell policies. Would the Administration consider adopting such a policy?

A: As clarified earlier, issuers and States can already choose to use open enrollment periods consistent with existing regulations. To require a uniform open enrollment period for child-only policies would require a change in the existing regulations. The Administration would consider making such a change if it would result in issuers continuing to sell child-only plans.

Question #8: May carriers cancel or non-renew children currently insured under child-only coverage due to a pre-existing condition, while continuing to renew coverage only for healthy children?

A. No. Under federal and state laws – pre-dating the Affordable Care Act – all policies in the individual health insurance market are guaranteed renewable. In addition, the Affordable Care Act (by adding section 2712 of the Public Health Service Act) expressly prohibits carriers from rescinding coverage except in cases of fraud or intentional misrepresentation of material fact. Children under age 19 with pre-existing conditions who have child-only coverage may therefore maintain their coverage so long as that coverage is offered.

Question #9: May either a state or HHS establish a uniform open enrollment period during which all insurers would be required to accept a child who applies, regardless of any pre-existing condition?

A. HHS does not have the authority to establish a uniform open enrollment period without adopting a regulation that would expressly establish such a period. The Administration would consider making such a regulatory change if it would result in issuers selling new child-only plans, as explained in Q7 posted on September 24, 2010. States typically have the authority to promulgate bulletins or emergency regulations establishing uniform open enrollment periods relatively quickly. Some states, including California, Colorado, Ohio, Oregon, South Dakota, and Washington, have already established such periods, and others are considering doing so. HHS welcomes the state-based establishment of such periods to the extent that they expand options for families. If HHS were to establish a uniform open enrollment period in the future, it would anticipate accommodating states that have enacted their own uniform open enrollment periods.

Question #10: In states that have established uniform open enrollment periods, under what, if any, circumstances may families purchase child-only coverage for their children during the remainder of the year?

A. If a child has had at least 18 months of prior creditable coverage (or has had continuous creditable coverage since a date within 30 days of birth) and loses group health coverage, he/she is a HIPAA-eligible individual and is guaranteed access to individual coverage without regard to a pre-existing health condition. The child must be allowed to apply for HIPAA-mandated coverage within 63 days after losing coverage. In many states, this coverage would be provided by a state high risk pool. Additional circumstances like the birth of a child or adoption may also be circumstances in which families may purchase child-only coverage for their children outside of open enrollment periods, depending on state law. These policies pre-date the Affordable Care Act.

Question #11: May an issuer that has an open enrollment period during which it enrolls children under age 19 with pre-existing conditions, medically underwrite during the rest of the year and decline to enroll children under age 19 with pre-existing conditions outside of the open enrollment period?

A: No. Issuers that have an open enrollment period may not decline to enroll children under age 19 with pre-existing conditions outside of the open enrollment period while enrolling children under age 19 without such conditions. Depending on state policies regarding open enrollment periods, issuers must either (i) enroll all children under age 19, regardless of pre-existing conditions, at all times, including outside the open enrollment period; or (ii) enroll all children under age 19, regardless of pre-existing conditions, during the open enrollment period, but decline to enroll all children under age 19 outside the open enrollment period, with exceptions described in Q10. Even for children who qualify for exceptions to enrollment during open enrollment periods, issuers may not decline enrollment due to a pre-existing condition. States may set one or more open enrollment periods for coverage for children under age 19, but cannot allow insurers to selectively deny enrollment for children with a pre-existing condition while accepting enrollment from other children outside of the open enrollment period(s).

Question #12: Does the pre-existing condition policy for children under age 19, and the clarifications in these “frequently asked questions,” apply to the family policies as well as child-only policies?

A: Yes.

[Letter from Secretary Sebelius to Jane L. Cline Regarding Child-Only Policies \(Oct. 13, 2010\)](#)

[Letter from Secretary Sebelius to America’s Health Insurance Plans Regarding Children’s Access to Health Insurance \(Sept. 24, 2010\)](#)

[Letter from Secretary Sebelius to Blue Cross and Blue Shield Association Regarding Children’s Access to Health Insurance \(Sept. 24, 2010\)](#)