



September 23 Health Care Reforms: Making Insurance Work for Children and Families

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Introduction

September 23, 2010 marks the six-month anniversary of the passage of the Patient Protection and Affordable Care Act (ACA). It also ushers in a new set of insurance reforms that will enable more children and families to obtain and keep their health care coverage. They include:

- Prohibiting most insurers from limiting benefits or denying coverage for children who have a pre-existing condition (such as asthma, diabetes, or autism).
- Requiring plans offering dependent coverage to allow young adults up to age 26 to enroll in their parents' plans.
- Providing well-child visits and other preventive screenings with no cost sharing to children (and preventive services to adults) signing up for new plans.
- Eliminating dollar caps on benefits that an individual or family can receive through their health plan over a lifetime and, ultimately, annually.
- Establishing a set of consumer reforms to make it easier for families to use their health coverage.

Together these improvements are estimated to affect millions of individuals with or without health coverage today. They also serve as a precursor to the broader set of reforms, set to take place in 2014, which will offer new coverage pathways to 32 million individuals.¹ The aim of these most immediate reforms is to help some of those most in need to better access care (i.e., children with special health care needs and uninsured young adults), in addition to shifting to a health care system that emphasizes prevention and wellness. Since the changes rely on health plans and

insurers to change the way they do business, however, there are a number of policy considerations for state officials and state-based advocates to consider, as described in this brief. Strategies to ensure that these policies work most effectively for children and families include:

- Encouraging states to enact more protective standards than the federal law.
- Collaborating with state insurance commissioners to improve monitoring and enforcement.
- Educating constituents and the public about the new protections and encouraging them to take advantage of them.

September 23 Health Reforms

The following child-focused reforms begin for new plan or policy years on or after September 23, 2010. As a result, some people will see the benefits when they renew their insurance, others when they sign up for a new health plan.

Additionally, what plans are affected varies. Some of the provisions apply to all group plans (i.e., plans offered through an employer, including those that are self-funded)² and plans offered on the individual market, whether a person is buying new coverage or already is enrolled. Other provisions do not apply to so-called "grandfathered" plans. Grandfathered plans are those in effect on the date of the ACA's passage, March 23, 2010, which have not made any significant changes to benefits, cost sharing, or employer contribution.³ Understanding the differences is critical to helping families navigate the changes. (See chart on page 2 and box 1 on page 3).

(continued on page 3)

Health Care Reforms in Effect for Plan Years Beginning On or After September 23, 2010
(apply to all new plans and some grandfathered plans, as listed)

Provision	Federal Requirement	Apply to Grandfathered Group Plans? (employer plans, including self-funded plans)	Apply to Grandfathered Individual Plans?
Guaranteed coverage for kids	Prohibits health plans from denying coverage or benefits for children under 19 due to a pre-existing condition. Insurers can charge more for premiums. Child-only plans on the individual market can establish open enrollment periods.	Yes	No
Extension of dependent coverage	Requires plans that provide dependent coverage to extend coverage to all adult dependents up to age 26. Plans must notify current subscribers, provide for an enrollment opportunity, and cannot charge more or offer different benefits for the older dependents than those applied to other dependents. Plans can implement across the board family premium increases and establish premium tiers (e.g., self only, self plus one, family coverage).	Yes. Until 2014 does not apply to young adults with an offer of job-based coverage.	Yes
Preventive care without cost sharing	Requires new health plans to cover and impose no cost sharing for recommended list of preventive items and services obtained in-network. For children, this includes preventive care recommended by Bright Futures. Cost and benefit levels for treatment needed following a preventive service are not guaranteed. Insurers can impose cost sharing for an office visit separate from the preventive service under certain circumstances.	No	No
No lifetime benefit limits	Prohibits health plans from imposing lifetime dollar limits on essential benefits. Plans must make “good faith” efforts to define essential benefits consistent with health reform bill. Plans can impose non-monetary limits (such as number of doctor visits).	Yes	Yes
Restricted annual benefit limits	Imposes new restricted annual limits on essential benefits before 2014. Starting in September 2010, plans cannot impose an annual limit less than \$750,000; in 2011, less than \$1.25 million; and in 2012 and 2013, less than \$2 million. In 2014, plans cannot impose any annual limit. Plans can impose non-monetary limits and apply for a waiver for “limited benefit plans.”	Yes	No
Choice of provider or pediatrician; access to OB/GYN	Requires plans to allow enrollees to choose which participating doctor or pediatrician they want as their or their child’s primary care provider, respectively. Allows a woman to go directly to her OB/GYN without a referral.	No	No
No prior authorization for emergency care services	Eliminates prior authorization requirements for plans that cover emergency services, even when someone goes out-of-network. Cost sharing for out-of-network emergency services cannot cost more than that charged in-network.	No	No
Right to internal and external appeals	Requires plans to establish a mandatory first level internal appeals procedure in addition to a second level, external appeals procedure administered by an independent third party.	No	No
Prohibition of unfair rescissions	Prohibits health plans from rescinding a health insurance policy unless the enrollee has committed fraud or made an “intentional misrepresentation of material fact.”	Yes	Yes

Guaranteed Coverage for Kids

Prior to health care reform, children whose parents had an insurance plan through their employer could not be denied coverage entirely, but they could be denied payment for treatment for a pre-existing condition under certain circumstances.⁴ Families who sought coverage in the individual market had even less protection – those insurers could deny children a policy for almost anything, including minor conditions like acne and seasonal allergies.⁵

The ACA prohibits health plans from excluding children under age 19 from being covered because they have a pre-existing condition.⁶ This prohibition includes both benefit limits (i.e., an insurance company cannot refuse to pay for chemotherapy for a child with cancer because the child had the cancer before obtaining insurance) and outright coverage denials (i.e., an insurance company cannot refuse to issue a policy to the child because of the child's cancer). The Obama Administration estimates that up to 162,000 children could receive coverage due to this reform.⁷

Plans Affected: The rule applies to all group plans and new plans on the individual market. It does not pertain to grandfathered individual plans. As a result, children who currently have a pre-existing exclusion in their individual insurance plan (i.e., the plan does not pay for benefits related to a certain condition) must enroll in a new plan to take advantage of the reform. Beginning January 1, 2014, when broader insurance reforms go into effect, this provision also will apply to adults.

Policy Considerations: While most health plans will no longer be allowed to deny coverage or benefits to children with pre-existing conditions, they may use other tools to discourage these children from enrollment. For example, until 2014 federal law does not preclude them from charging significantly higher premiums to families because of the child's health status. States could address this potential loophole by barring plans from imposing excessive premium surcharges on families that have children with pre-existing conditions. In addition, insurers may look to impose general plan waiting periods to dissuade enrollment. States could strengthen the law by prohibiting insurers from imposing excessive waiting periods (i.e., greater than 90 days) for coverage, so that children do not face any delays in accessing necessary treatment.

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Box 1. What are Grandfather Plans?

Group or individual health plans that existed on March 23, 2010 have been afforded grandfather status, and are not required to adopt all of the provisions in the health reform bill. Plans will lose their grandfather status if they:

- Eliminate or substantially reduce benefits related to a particular health condition.
- Increase copayments by more than \$5 or the cost of medical inflation plus 15 percentage points, whichever is greater. Deductibles also cannot be raised by amounts in excess of medical inflation plus 15 percent.
- Decrease the employer contribution by more than five percentage points, increase co-insurance charges (a fixed percentage of the medical charge paid by the patient), apply new annual limit restrictions or tighten limits already in place, or switch insurance companies.

New employees and their families may be enrolled in a grandfathered group health plan. Federal officials estimate that by 2013 about half of employer-sponsored plans will not have grandfather status because employers will elect to make significant changes to the scope and cost of their coverage. And most individual policies are expected to move to plans without grandfather status by 2013 as policyholders seek better, more affordable coverage.

In regulatory guidance, the Department of Health and Human Services (HHS) indicated that insurers in the individual market could allow open enrollment periods in which families could only enroll their children in such plans during specific time periods.⁸ This could severely limit the ability of families to access these plans when they most need it. Unless further federal guidance is provided, states may want to consider putting stronger protections in place during the first year to allow families with a child with a pre-existing condition sufficient opportunity to take advantage of the provision as intended. This could include limiting plans from establishing open enrollments or allowing appropriate exemptions to any open enrollment periods, since it will take time for many families to learn about their new rights to coverage and seek enrollment. Beyond the first year, states may want to provide some parameters under which the open enrollment periods operate, including restricting insurers' ability to underwrite outside of the open enrollment period, expanding when open enrollments must occur and how long they should last, and providing for special enrollment periods for families facing changing circumstances (i.e., a divorce or job change).

Young adults can obtain coverage whether or not they live in their parents' home or are a student, and even if they are married or are no longer claimed as a dependent on their parents' tax return.

Extension of Dependent Coverage

In most states, insurers can and do remove young adult children from their parents' policies when they turn 19, or if still a student, when they graduate from college.⁹ The ACA has changed that by requiring plans that provide dependent coverage to extend coverage to adult dependents up to age 26.¹⁰ Young adults can obtain coverage whether or not they live in their parents' home or are a student, and even if they are married or are no longer claimed as a dependent on their parents' tax return. But insurers do not need to cover their spouses, nor, if they have any, their children.

Insurers must notify current subscribers of this new change to ensure that families do not miss out on this important benefit. Eligible young adults must be allowed to enroll in coverage during an enrollment period of at least 30 days prior to the beginning of the plan or policy year. This includes dependents not eligible when the parent first became covered under the plan or who lost eligibility previously due to age (even if currently on COBRA).¹¹ The law also extends tax rules excluding employer-provided dependent medical coverage from taxable income to coverage for these adult children.

Plans Affected: All group and individual plans must follow this rule. However, before January 1, 2014, grandfathered group plans are only required to cover adult dependents if they are not otherwise eligible for coverage through a job.

Policy Considerations: Young adults are the least likely to be insured of any age group and therefore stand to benefit substantially from the ability to join their parents' insurance. The Administration estimates that up to 2.12 million young adults (1.64 million who are uninsured) could benefit from the provision in 2011.¹²

While the definition of a dependent is broad, the federal guidance leaves it up to plans and insurers to define "child." As a result, states may want to ensure that the basic definition for a child includes a biological child, a stepchild, and an adopted or foster child (including formal kinship care arrangements). Plans and employers also can determine what, if any, documentation will be required to verify that the dependent has no other coverage available through a job.

Families who currently do not cover their children under a plan will need to pay the additional premium (minus any employer contribution) for family coverage. In addition, families may see an increase across the board in annual group coverage premiums due to the addition of young adult coverage. This increase has been estimated to range from .5% to 1.2% in 2011.¹³ However, plans cannot charge more or offer different benefits for the older aged dependents than those applied to other dependents. For example, while a plan can charge different premiums for different tiers of coverage (e.g., self-only, self plus one or family coverage) they cannot charge different rates based on a child's age.

Preventive Care Without Cost Sharing

As part of the effort to move the health system toward a preventive care model, the health reform law requires new health plans to cover and impose no cost sharing for the following preventive items and services obtained in-network:¹⁴

- Those items that receive an "A" or a "B" recommendation from the United States Preventive Services Task Force (USPSTF).^{15,16}
- Immunizations recommended by the Center for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP); and
- Women's preventive care and screenings, to be identified in future Health Resources and Services Administration (HRSA) guidelines.¹⁷

For children, this includes preventive care recommended by Bright Futures, an initiative by the American Academy of Pediatrics and HRSA. This ensures that families joining new plans will no longer face cost sharing (e.g., co-payments or co-insurance) for well-child visits, vision and hearing tests, various health and behavioral assessments, and developmental screenings.¹⁸

Plans Affected: This provision only applies to new group or individual plans. Thus, plans that maintain their grandfather status are not be required to follow this new policy.

Policy Considerations: The impact of this policy will depend on the extent to which consumers are aware of and take advantage of the new recommended

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services being made available to them without cost sharing charges. Helping consumers and providers to understand the preventive care benefits available under plans will be essential to ensuring that the new benefits are used.

Additionally, it is important to note that this policy only applies to preventive services, not to treatment that may be needed following a preventive screen. For example, an insurer must cover a child's vision screening with no cost sharing, but it is up to the plan whether required eyeglasses are covered, and at what level. Insurers also can impose cost sharing for an office visit separate from the preventive service under certain circumstances (i.e., if the preventive service is billed separately from the office visit, or if not, if the preventive service is not the primary purpose of the office visit).¹⁹

No Lifetime Limits and Restricted Annual Limits

The ACA prohibits all health plans from imposing lifetime dollar limits on essential benefits. In addition, the statute eventually prohibits annual limits on the dollar value of benefits, but allows "restricted annual limits" before January 1, 2014.²⁰ HHS has defined "restricted annual limits" so that they are phased-in over three years. Starting in September 2010, plans cannot impose an annual limit of less than \$750,000. In 2011, the limit cannot be less than \$1.25 million, and in 2012 and 2013, it cannot be less than \$2 million.²¹ In 2014, plans cannot impose any annual limit at all.

Plans Affected: The elimination of lifetime limits applies to all group and individual plans. The new, transitional restrictions on annual limits applies to all group plans, but not to grandfathered individual plans.

Policy Considerations: While the law bans monetary lifetime limits and restricts annual limits, health plans could still impose non-monetary limits, such as limits on physician visits, days in the hospital, and prescription drug refills. For children with high cost conditions, these restrictions could continue to limit access to treatment. States could take additional steps to restrict or prohibit these alternative kinds of limits.

The law also allows HHS to issue a "waiver" to a health plan, if the health plan claims that complying with the annual limit restrictions would result in a significant decrease in access to benefits or a significant

Box 2. Coverage Available Now for Millions of Children

The implementation of the September 23 reforms will bring into focus some of the issues families face when obtaining health insurance for their children. This creates an important opportunity to raise awareness among eligible families that their children could secure coverage through Medicaid or CHIP. New data from the Urban Institute reveals that of the 7.2 million uninsured children in the U.S., 4.7 million are eligible for Medicaid or CHIP. Of these uninsured children, the vast majority (90%) had family incomes below 200 percent of the federal poverty level (FPL). See: G.M. Kenney, et al., "Who and Where are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program," *Health Affairs*, 29(10) (October 2010).

Additionally, families with special health care needs may be eligible for the new pre-existing condition insurance plan, now available in all states. See "New Pre-Existing Condition Insurance Plan," <http://www.healthcare.gov/law/provisions/preexisting/index.html>

increase in premiums. HHS has issued guidance that would allow so-called "limited benefit plans" to receive such waivers.²² Limited benefit plans, also called "mini-med" plans, do not provide comprehensive medical insurance and often have annual limits well below the restricted limits allowed in the regulations. States could help inform consumers and employers about these limited benefit plans through prominent warnings on what benefits are not covered or limited, as well as information on where to find more comprehensive coverage.

The lifetime and annual limit requirements apply to the benefits covered in the minimum essential benefits package, which will be defined in future regulations.²³ However, some plans, such as self-funded employer plans and grandfathered plans, do not need to provide the essential benefits package. HHS has stated that plans and employers must make "good faith" efforts to define essential benefits, consistent with the categories provided for in the law.²⁴ States can help ensure that plans are complying with the ACA by establishing appropriate, robust standards for what constitutes a "good faith" effort and closely monitoring health plans' implementation of the new requirements.

Once these reforms become effective, insurance will start working better for many families and children.

Patient Protections

A set of additional reforms will go into effect for plan or policy years on or after September 23, 2010 that will make it easier for families to use their health insurance coverage.

Choice of Provider and Pediatrician.²⁵ Under the ACA, non-grandfathered plans requiring a primary care provider designation must allow enrollees to designate which participating doctor or pediatrician they want as their or their child's primary care provider, respectively. This is an important provision for children as regular pediatric care has been proven to improve child health outcomes, avert preventable health care costs, and limit delays in care. The law also allows a woman to see her OB/GYN without a referral.

No Prior Authorization for Emergency Service.²⁶ The ACA requires non-grandfathered plans providing emergency services to eliminate the need for prior authorizations, even when the services are provided out-of-network. In addition, cost sharing for out-of-network emergency services cannot cost more than that charged in-network.

Right to Internal and External Appeals.²⁷ The ACA provides health insurance enrollees, except for those in grandfathered plans, with a new national standard for appealing an unfavorable decision by a health plan. The standard establishes a mandatory first level internal appeals procedure, administered by the health plan, and a second level, external appeals procedure administered by an independent third party.

Prohibition of Unfair Rescissions.²⁸ The ACA prohibits health plans from rescinding a health insurance policy once an enrollee is covered, unless the enrollee has committed fraud or made an "intentional misrepresentation of material fact" in his/her application. The ACA also requires plans, if they do rescind a policy, to provide a minimum 30 days notice to the enrollee.

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Georgetown Center for Children and Families (CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. CCF is based at Georgetown University's Health Policy Institute.

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Implications for Children and Families

When these reforms become effective, insurance will start working better for many families and children. It is a good first step prior to the full implementation in 2014, offering families protections they have not seen before. However, as with anything new, there is the need for state-based groups and state officials to work together to ensure the provisions work as intended for children and families. Strategies that can be employed include:

- **Encouraging states to enact more protective standards than the federal law.** As noted throughout this brief, states can take further action to strengthen the new reforms. The ACA provides the general parameters of the new provisions, but states retain their flexibility to refine and enhance it in ways that meet the needs of their citizens. For example, in legislation that implements the federal probation on denying coverage to children with pre-existing conditions and limits, the California Legislature went one step further by restricting the amount that insurers can charge to cover those children.²⁹
- **Collaborating with state insurance commissioners to improve monitoring and enforcement.** State insurance commissioners are on the front lines of implementing these reforms and ensuring health plan compliance. Building relationships and working partnerships with state insurance commissioners are vital to successful implementation. Community-based organizations can also play a monitoring role to alert insurance commissioners, and other state officials, about abuses or other issues raised by the reforms.
- **Educating constituents and the public about the new protections and encouraging them to take advantage of them.** Families need help understanding what options are available to them under the new reforms. Providing simple, easy-to-understand materials, in addition to hands-on consumer assistance, are important tools for state officials and community-based organizations to provide. Additionally, families need to know who to contact with complaints and/or concerns about their health insurance plans.

Endnotes

1. Congressional Budget Office, "Cost Estimate of H.R. 4872, Reconciliation Act of 2010" (March 20, 2010).
2. Many children and families receive coverage through self-funded plans. Self-funded plans are sponsored by employers that have elected to pay claims under the plan out of the employer's own funds. Under a federal law called "ERISA", only the federal government has jurisdiction to regulate employer-sponsored health plans.
3. "Group Health Plan and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan," Federal Register, 75: 34538-34570 (June 17, 2010).
4. Public Health Service Act (PHSA) §1204, 42 U.S.C. §300gg(a). Note that state law may offer more generous protections.
5. D. Hilzenrath, "Acne, Pregnancy Among Disqualifying Conditions," Washington Post (September 19, 2009), available at <http://www.washingtonpost.com/wp-dyn/content/article/2009/09/18/AR2009091803501.html>.
6. Patient Protection and Affordable Care Act (ACA) § 1201, adding new PHSA § 2704; and § 1255.
7. "Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections," Federal Register, 75: 37187-37200 (Jun. 28, 2010).
8. US 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," Jul. 27, 2010, available at <http://www.hhs.gov/ociio/regulations/children19/factsheet.html>.
9. The Kaiser Family Foundation, "Dependent Coverage," statehealthfacts.org, (January 2010).
10. ACA § 1001, adding PHSA § 2714.
11. Note that many insurers have publicly pledged to comply before the September 23, 2010 effective date so that new college graduates do not experience a gap in coverage.
12. "Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26," Federal Register 75: 27120-27140 (May 13, 2010).
13. Ibid.
14. ACA § 1001, adding PHSA § 2713.
15. The USPSTF is convened by the Public Health Service to evaluate clinical research in order to assess the merits of preventive measures, including screening tests, counseling, immunizations, and preventive medications. An "A" recommendation signifies that the net benefit of the item or service is "substantial," and a "B" recommendation signifies a "moderate to substantial" net benefit.
16. The ACA specifically rejects the USPSTF's recommendations on breast cancer screening, prevention, and mammography issued in November 2009 as the standard for coverage and cost sharing. Instead, the Task Force's pre-November 2009 recommendations set the standard. § 1001, adding PHSA § 2713(a)(5).
17. Ibid.
18. "Group Health Plan and Health Insurance Coverage Relating to Coverage of Preventive Services," Federal Register, 75: 41726-41760 (June 19, 2010).
19. Ibid.
20. ACA § 1001, adding new PHSA § 2711.
21. op. cit. (7).
22. "OCIIO Sub-Regulatory Guidance (OCIIO-2010-1): Process for Obtaining Waivers of the Annual Limits Requirements of PHS Act Section 2711", HHS Office of Consumer Information and Insurance Oversight (September 3, 2010), available at http://www.hhs.gov/ociio/regulations/patient/ociio_2010-1_20100903_508.pdf.
23. The essential benefits package must, at a minimum, include the following categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness and chronic disease management services; and pediatric services, including oral and vision care. ACA § 1302(b).
24. op. cit. (7).
25. ACA § 1001, adding new PHSA § 2719A.
26. ACA § 1001, adding new PHSA § 2719A(b).
27. ACA § 1001, adding PHSA § 2719.
28. ACA §1001, adding new PHSA § 2712.
29. A.B. 2244, 2009-10 Regular Session (California, 2010). The legislation is awaiting Governor Schwarzenegger's signature.