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New Rules for Insurers: Recent Federal Law Mandates Dependent Coverage for Young Adults, Among other Requirements

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Among the provisions of the Patient Protection and Affordable Care Act that are to have the most immediate impact for health care consumers are the Act's new rules for insurers, many of which are to go into effect by this September or sooner. Especially affected by these new rules are young adults, who will, effective September 23, 2010, be allowed to stay on their parent's health insurance policy up to their 26th birthday. Until 2014, grandfathered group plans (defined as an existing group health plan in which a person was enrolled on the date of enactment) will only be required to extend such dependent coverage if the young adult is not eligible for employment-based health benefits. However, for new plans, young adults will be eligible for dependent coverage regardless of eligibility for employment-based benefits. Likewise, beginning in 2014, grandfathered plans will have to comply with the extended dependent coverage requirements regardless of a child's eligibility for employment-based benefits.

At least 25 states already have laws that require dependent coverage be extended to some young adults. Such state laws vary on the age cap and may impose other conditions in order for a young adult to be entitled to dependent coverage. In Georgia, group policies must allow a dependent child of the insured to be covered through age 25 so long as the child remains a dependent of the insured and is a full-time student (or would be a full-time student but for an illness or injury). In contrast, the new

federal law's guarantee of coverage for young adults is fairly broad, allowing such persons to remain on their parent's policy regardless of student status, financial dependency, or marital status. In addition, while state insurance laws do not apply to self-funded plans, which cover approximately 57 percent of U.S. employees[1], the provisions of the Act are generally intended to apply to both self-funded and fully-insured health insurance plans.[2]

The federal law will apply to all Americans, regardless of their state of residence. However, individual states can offer more extensive guarantees of dependent coverage if they so choose. For example, New Jersey law requires insurers to allow young adults to remain on their parent's policy until age 30; this dependent age will still apply to New Jersey residents under the new federal law.

On May 10th, the Departments of Health and Human Services, Labor, and Treasury issued regulations related to this requirement. These regulations, which went into effect on July 10, 2010, prohibit group plans from denying or restricting coverage for a child under 26 based on the child's financial dependency, residency with the insured, student status, employment status, marital status, or any combination of these factors. Group plans are also prohibited from defining dependent coverage in any way other than as a relationship between a child and parent or from varying the terms of coverage to the dependent based on age, except for ages 26 and older. For example, young adults covered by virtue of this law cannot be excluded from benefits that other dependent children receive, nor can they be charged a special surcharge, unless dependent children of all ages are subject to the same surcharge. Additionally, the regulations clarify that, while married young adults will have the right to remain on their parent's policy, plans are not required to cover a dependent child's own children or spouse.

Other Rules for Insurers

The new federal law also imposes numerous other requirements on health insurers, banning several practices that are widespread throughout the insurance industry. On June 22nd, the Obama Administration released new regulations to implement several of these provisions, calling these new rules a "Patient's Bill of Rights." Prominent among these rules is a ban on denying coverage based on pre-existing conditions. For plans beginning on or after September 23rd (six months after enactment), health insurers are prohibited from denying coverage to children under the age of 19 based on a pre-existing condition. In 2014, this prohibition will apply to all persons.

Other major insurance - related provisions of the Patient Affordability and Affordable Care Act ("Act") include the following:

Lifetime Caps - Effective September 23rd, health insurance companies will be prohibited from placing lifetime caps on coverage.

Revocation of Coverage - Effective September 23rd, insurers will be barred from rescinding coverage except for cases of fraud. This provision is intended to prevent patients from losing coverage due to an unintentional error when applying for coverage.

Annual Caps - Effective September 23rd, the Act calls for the Secretary of Health and Human Services to adopt rules restricting new insurance plans' use of annual limits so that such limits do not prevent access to needed care. In 2014, the use of annual limits will be prohibited.

Preventive Services - New insurance plans are required to cover, with no out-of-pocket cost to the patient: preventative services rated A or B by the United States Preventative Services Task Force; recommended immunizations; preventative care for infants, children, and adolescents; and additional preventive care for women, effective September 23rd. In 2018, this requirement will apply to all plans.

Appeals Process - Consumers in new plans must have access to an internal and external appeals process to appeal decisions by their health insurance plan, effective September 23rd.

Medical Loss Ratio (Value for Premium Payments) - The Act requires health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs. Plans in the individual and small group market must spend 80 percent of premium dollars on medical services; for plans in the large group ratio, the required amount is 85 percent. Insurers that do not meet these thresholds must provide rebates to policy holders, beginning in 2011.

Discrimination in Favor of Higher Wage Employees - Effective September 23rd, new group health plans are barred from establishing any eligibility rules for coverage that have the effect of discriminating in favor of higher wage employees.

Benefit Tiers - Beginning in 2014, all new policies (except stand-alone dental, vision, and long-term care insurance) must comply with one of the four benefit categories, regardless of whether they are offered inside or outside of an exchange. Existing individual and employer-sponsored plans are exempt from this requirement.

Limits on Deductibles - Beginning in 2014, deductibles for health plans in the small group market are limited to $2,000 for individuals and $4,000 for families.

Waiting Periods for Coverage - Beginning in 2014, the Act limits any waiting period for coverage to 90 days.

Reinsurance Program - The Act establishes a temporary reinsurance program to collect payments from insurers in the individual and group markets, so as to provide payments to plans in the individual market that cover high-risk individuals. The reinsurance program will be financed through mandatory contributions by insurers totaling $25 billion over three years and will be in effect from January 1, 2014 through December 31, 2016.

Proponents of these measures hope that they will ensure greater access to affordable health care coverage for Americans. At the same time, some critics have noted that the effect these new regulations will have on premiums is very uncertain. The Act does not give the federal government any authority to limit the amount insurance companies may charge in premiums. However, it does establish a process for reviewing increases in health plan premiums and requires plans to justify any increases. States are to report on trends in premium increases, and if appropriate, to report on whether a plan should be excluded from the Exchange based on unjustified premium increases. The Act also provides grants to states to support the review of premium increases. These premium review provisions will take effect this year.

Information for this brief was obtained from the National Conference of State Legislatures, the Kaiser Family Foundation, and HealthReform.gov.

[1] As reported in the Kaiser Family Foundation and Health Research & Educational Trust: *2009 Kaiser/HRET Employer Health Benefits Survey.*

[2] Self-funded plans are plans in which the employer pays the health care claims of its employees and their dependents themselves (thereby paying only the actual costs of these health claims) and contracts with an insurer to handle claims administration. With a fully-funded plan, an employer pays an insurer a premium, and the insurer in turn pays all claims and handles claims administration. Self-funded plans are governed by the federal Employee Retirement Income Security Act of 1974 (ERISA) and thus not subject to state law.