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Statewide Parent Advocacy Network, Inc.
Empowered Families: Educated, Engaged, Effective!

Family Voices-NJ Comments on Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act
Submitted July 30, 2010

Thank you for the opportunity to comment on the interim rules regarding dependent coverage up to age 26 under the Patient Protection and Affordable Care Act. Family Voices is a national network that advocates on behalf of children with special healthcare needs and works to "keep families at the center of children's healthcare;" our NJ Chapter is housed at the Statewide Parent Advocacy Network (SPAN), NJ's federally designated Parent Training and Information Center, Family-to-Family Health Information Center, and a chapter of the Federation of Families for Children's Mental Health.

Overall comments
I. Background

We strongly support that "the term 'group health plan' includes both insured and self-insured group health plans." This is extremely helpful as 50-75% of plans were previously exempt from state regulation due to ERISA (Employee Retirement Income Security Act). We also support that the requirements for the Affordable Care Act are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect". In our state for example, although we support dependent care coverage to age 26 nationally, in NJ we already have coverage until the 31st birthday (see http://www.state.nj.us/dobi/division_consumers/du31.html).

II. Overview of the Regulations
A. PHS Act Section 2714, Continued Eligibility of Children until Age 26

We strongly support the notion that continuing coverage until age 26 shouldn't be conditional based on "whether a child is a tax dependent or student, or resides with or receives financial support from the parent" due to the correlation of these matters and age. We agree that plans may not define eligibility except for the "relationship between the child and the participant (in the individual market, the primary subscriber)." Again, eligibility will not be based on financial, residency, student status, employment, or eligibility for other coverage. This is particularly important as children with special needs may become eligible at age 18 for Medicaid as the payer of last resort. We also

agree that coverage cannot vary based on the age of the child. We also agree that coverage should not be limited based on marital status (except not requiring spousal coverage.) We strongly agree that dependent care coverage must be available whether or not the plan is "grandfathered" (effective 3/23/10) under the Affordable Care Act with the exception if the child is eligible under an employer plan other than the parent's plan. We also agree that if the child is eligible for plans under both parents "neither plan may exclude the adult child from coverage."

Transitional Rule

We strongly support the new provision that plans cannot "exclude coverage for the child prior to age 26 irrespective of whether or when that child was enrolled." We also agree that the child of a primary subscriber in the individual market will have the "opportunity to enroll if the child previously lost coverage due to age". We agree that this opportunity should continue "for at least 30 days (including written notice…) regardless of when any open enrollment period might otherwise occur" for continuity of care. This period cannot be "later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010" which will allow most plans to utilize their typical open enrollment period. Once the child is enrolled, we agree that coverage cannot begin "later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010, even if the request for enrollment is made after the first day of the plan year" again for continuity of care. We agree that "notice may be provided to an employee on behalf of the employee's child (in the individual market, to a primary subscriber) on behalf of the primary subscriber's child." We are concerned however that for group plans "notice may be included with other enrollment materials…provided the statement is prominent". We feel that particularly in this first plan year, separate notice should be required so children do not miss the opportunity to enroll and then have to wait until the next open enrollment period in subsequent years. At minimum, full notices should be available in English and Spanish and brief notice of how full notices can be obtained in other languages must be included in the full range of languages spoken by any significant population in the covered area.

We agree that these children should be considered as a "special enrollee, as provided under the regulations interpreting the HIPAA…provisions". We want to ensure however that under HIPAA the explanation of benefits statements are addressed to the child, not the parent, dependent upon the state's regulations on minor consent for treatment as well as once the child reaches age 18, except in the cases of continued guardianship of a child with significant disabilities. We agree that the child should have the same benefit packages and cannot be required to pay more than "similarly situated individuals who did not lose coverage by reason of cessation of dependent status". We also agree that plans who offered coverage of adult children previously do not have to "provide the enrollment opportunity…to children who do not lose coverage." We also agree if the parent isn't enrolled and the child is eligible, both must be given the opportunity to enroll. If more than one benefit package is available, we agree with the opportunity of allowing the parent to switch options as well. We also agree that if a child is covered under COBRA, they must be given the opportunity to enroll.

B. Conforming Changes under the PHS Act

2. Definitions

We agree that if the policy document doesn't define policy year (individual and group), it means "the deductible or limit year used under the coverage." If these limits are not annual, the policy year will be defined as the calendar year.

IV. Economic Impact and Paperwork Burden

B. Executive Order 12866-Department of Labor and Department of Health and Human Services

1. Need for Regulatory Action

We agree that coverage does not have to be extended to the children of the dependent child or their spouse.

3. Estimated Number of Affected Individuals

Current estimates show that this will affect 3.44 uninsured or 2.42 million who have individual coverage. We agree that grandfathered plans would not have to cover young adults who have employer-sponsored insurance (ESI) either on their own or through their parent. However of these 5.86 million, 2.61 million may not switch because the parent's plan allows coverage but they've chosen not to enroll, they have their own ESI, and lastly .4 million who have non-group coverage as well as their parents so there's no financial benefit to switch. So approximately 2.37 million (8%) of the 29.5 million young adults in this age group nationally may be affected. Besides Medicaid expansions and employee take-up rates (77-90%), we disagree that other factors could be the uninsured as less likely to enroll "because young adults who have purchased non-group insurance have shown a strong preference for coverage". It's not preference, but basic economics that many uninsured young adults can't afford coverage, particularly for traditionally underserved populations. Research indicates that the uninsured are diagnosed on average 2 years later than their insured counterparts. Insurance coverage is not only cost effective, but more importantly results in decreased morbidity and mortality by improving health outcomes. We do agree that many will save money by switching to their parent's policy. We do agree that health status (e.g. those in "fair of poor health" more likely to enroll) is a factor. We also agree that residency (e.g. living with parents more likely to enroll) is also a factor. Based on these factors, the Department has issued high take-up estimates (95% living at home 85% not), mid range (90% uninsured fair/poor health, 50% healthy), and low take-up (80% and 10% of the high take-up ratio respectively).

4. Costs and Transfers Associated with the Rule

We understand but do not agree that the incremental costs would be lowest for the high take-up group in excellent health and conversely the low take-up would have higher

incremental costs based on health status. We have been involved in the development of high risk pools in our state. For those under their parent's ESI the premiums for the mid-range are expected to be $3,380 in 2011, $3,500 in 2012, and $3,690 in 2013. Across all family ESI plans premium increases are expected to rise by .7% in 2011, 1% in 2012, and 1% in 2013. This document also gives figures for the mid-range which are lower because parents will be purchasing the policy to add their child, in another scenario could be higher (similar to ESI percentages above) if costs were distributed over the entire individual market. If workers have higher premiums or lower wages, cost transfer will be from workers who do not have newly covered dependents to those who do. However, if increased premiums result in lower profits or higher product prices for the employer, this "will result in a transfer either from stockholders or consumers". We do not agree with any of these calculations as we have seen double digit increases in premiums prior to enactment from corporations because "healthcare reform *might* happen" in backlash. We've also witnessed increased premiums, lower wages, no raises or bonuses, etc. in anticipation but no cost transfer to stockholders, only higher prices for consumers. We are hoping for monitoring and enforcement, including sanctions, for unreasonable premium increases as stated in the Act. We do agree that there will be decreases in uncompensated care, including Medicaid.

H. Federalism Statement-Department of Labor and Department of Health and Human Services

We strongly support that the requirements cannot be "construed to supersede any provision of State law…" and that "States may continue to apply State law" which is important under HIPAA, minor consent, and currently existing dependent care coverage.

As the Family to Family Health Information Center (F2F HIC) in New Jersey, we work with both families and professionals to help them collaborate to improve health care access and quality for children and youth with the full range of special healthcare needs. Thank you again for the opportunity to comment on dependent coverage to age 26.

Sincerely,

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