CHILDREN'S HOSPITAL ASSOCIATION
Champions for Children's Health

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Insurance Market Protections under the Affordable Care Act

Key protections affecting children's coverage by plan type

	Exchange plans	Non-Exchange individual/small group market	Large group fully-funded plans	Self-funded ERISA plans	Assoc. Health Plans (AHPs)[1]	Short-term plans, health ministries, etc.
Must cover essential health benefits (EHBs)	Yes	Yes	No	No	No	No
Annual/lifetime dollar limits on cost of EHB coverage prohibited[2]	Yes	Yes	Yes – for benefits that are EHBs	Yes – for benefits that are EHBs	Yes – for benefits that are EHBs	No
Maximum out-of-pocket limits on cost-sharing[3]	Yes	Yes	Yes – for benefits that are EHBs	Yes – for benefits that are EHBs	Yes – for benefits that are EHBs	No
Pre-existing condition exclusions prohibited	Yes	Yes	Yes	Yes	Yes	No
Use of a health status application to determine child's coverage eligibility is prohibited[4]	Yes	Yes	Yes	Yes	Yes	No
Use of a child's health status to set premiums is prohibited	Yes	Yes	Yes	Yes	No	No
Guaranteed availability[5]	Yes	Yes	Yes	Yes	No	No
Coverage of dependent child up to age 26	Yes	Yes	Yes	Yes	Yes	No
Preventive services w/no cost-sharing	Yes	Yes	Yes	Yes	Yes	No
Must comply with mental health parity[6]	Yes	Yes, but not for self-funded plans	Yes	Yes, but not for small group plans	Yes	No
Must provide Summary of Benefits & Coverage and Glossary of Terms	Yes	Yes	Yes	Yes	Yes	No

[1] Consumer protections under AHPs depend, in part, on the structure and type of association offering the plan. In general, AHPs are subject to the standards indicated in this column.
[2] Applies only to benefits that are considered EHBs, provided in or out-of-network. Annual limits are allowed on the # of visits for individual services.
[3] Iincludes deductibles, coinsurance and copayments for qualified medical expenses for in-network svcs, including in-network emergency (ED) svcs. Does not include premiums or spending for non-covered services. Plans may implement a maximum limit for out-of-network services. Cost-sharing for out-of-network ED svcs. cannot be greater than those for in-network ED svcs.
[4] Insurers use medical underwriting to review a health status application to determine whether an individual will be issued coverage.
[5] Insurers must offer plan to any applicant regardless of age, gender, geography, health status, disability and other factors.
[6] As part of the "No Surprises Act," signed into law in December 2020, the Secretaries of HHS, Labor and Treasury must finalize mental health parity guidance that details how insurers must conduct required comparative analyses of nonquantitative treatment limits (e.g., prior authorization requirements) to demonstrate compliance with the Mental Health Parity and Addiction Equity Act. They must also request comparative analyses from at least 20 plans a year to identify instances of noncompliance and submit a summary annually to Congress.

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