Insight

Fact versus Fear: The AHCA and Pre-Existing Conditions

TARA O'NEILL HAYES | MAY 10, 2017

On May 4, 2017, the House of Representatives passed the American Health Care Act (AHCA), a bill to repeal and replace many provisions of the Affordable Care Act (ACA). Immediately following the vote, misinformation about the bill began spreading like wildfire, stoking fears and outrage. The issue which seems to be getting the most attention is the potential impact this legislation could have on people with pre-existing conditions. However, as the legislation now moves to the Senate for further consideration and amendment, it is important that all stakeholders be well informed, and understand what the legislation actually says and who may realistically be impacted by any possible changes to current law.

- The number of people in the U.S. with a condition that would likely qualify as pre-existing is not easily known, primarily because there is not a specific, pre-determined list of conditions. Estimates vary depending on how one defines "pre-existing."
- Even the range included in a recent report from the Department of Health and Human Services varied by a margin of more than 2:1, from between 61 million to 133 million people.[1] That said, it is likely that approximately as many as a quarter of Americans, and possibly more, have a pre-existing health condition, making it understandable why some are concerned.
- As the AHCA is currently written, the only people who could be charged a premium based on their health status are those with a pre-existing condition who are not enrolled in a large group health plan, are also living in a state that obtains a waiver, and have let their insurance lapse in the past year for 63 days or more. In this case, the increased premium would only be allowed for one year. Further, no one may be denied insurance because of a pre-existing condition.

Background

Before passage of the ACA, most laws pertaining to the regulation of the individual health insurance market were passed at the state level and could vary widely from one state to another. The McCarran-Ferguson Act of 1945 provided states primary responsibility for regulating the business of insurance.

The Employee Retirement Income Security Act of 1974 (ERISA) imposed federal standards on certain types and with respect to certain provisions of large group (employer-sponsored) health plans, some of which supersede state law.[2] Among the provisions included in ERISA is a requirement that plans be offered on a guaranteed-issue basis, meaning that insurers are prohibited from denying coverage to the group based on medical claims history; though, the policy may be medically underwritten, meaning the premiums are based on the insured's health status.

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) was passed and imposed additional federal health insurance standards across the individual, small group, and large group markets. In response to concerns of "job-lock"—the fear that leaving a job could result in the inability to regain health insurance if an individual had a pre-existing condition—HIPAA required all states to guarantee renewability of health

insurance coverage to anyone who had creditable coverage for the past 18 months, with no more than a 63-day gap in coverage during that time.[3] However, while insurers were required to renew an individual's policy from one year to the next, they were still not prohibited from medically underwriting individuals. Thus, some individuals found that while a plan was still technically available to them, the premium may have effectively priced them out of the market. Even those without a pre-existing condition may have found the cost of insurance to be significantly higher without the added employer contribution and tax advantage that such plans receive, which could make maintaining coverage, and HIPAA eligibility, more difficult.

Very few states previously had guarantee issue or renewability requirements or other protections for individuals not covered by HIPAA.[4] Most states permitted insurers to impose pre-existing condition exclusions, in which a pre-existing condition could be used to deny coverage altogether, or would not be covered by an individual's new insurance policy for at least a certain amount of time, if not indefinitely. Varying "look-back" periods were also prevalent, which regulated the amount of time during which the insurer may check an individual's claims history to make such a determination.

Current Law

The ACA attempted to mitigate these issues by imposing federal guaranteed issue requirements paired with community rating, which prohibits medical underwriting, across all health insurance markets. For many, these protections became the most important provisions of the ACA. However, there are economic consequences associated with such protections; primarily, higher average premiums in the individual market and increased spending by federal taxpayers. Multiple risk mitigation programs were included in order to help subsidize the cost of insuring high-risk, high-cost individuals, but the funding has not been sufficient. Insurers continue to lose money in the individual market, despite tens of billions of dollars in federal payments each year. In fact, many insurers have found the markets to be so unprofitable due to the many enhanced regulations, that they have decided they can no longer participate in the individual market in many states.[5]

The AHCA

The AHCA, passed by the House of Representatives on May 4, would repeal and replace many provisions of the ACA. One of the ACA's most well-known provisions, the individual mandate which requires everyone to obtain health insurance, would be repealed (practically speaking, though not technically) and replaced with a continuous coverage provision.[6] These two policies are similar. The individual mandate imposes an annual penalty for not being insured equal to the greater of $695 per adult or 2.5 percent of household income.[7] The continuous coverage provision in this legislation would, instead of federally mandating that everyone buy insurance, incentivize individuals to remain insured by allowing for the imposition of a 30 percent premium surcharge for one year on individuals who signed up for coverage if they were uninsured for more than two months in the previous year.[8] After paying the surcharge for one year, individuals would return to paying regular community-rated premiums.

One provision that would not be repealed is the federal guaranteed issue requirement; insurers in every state would still be prohibited from denying insurance coverage to anyone on the basis of a pre-existing condition. In no circumstance would this protection be denied, though it seems much confusion surrounding this protection has stemmed from the adoption of several amendments to the underlying legislation.

The first relevant amendment is one that was negotiated by Rep. Mark Meadows (R-NC), on behalf of the Freedom Caucus. This amendment includes a provision pertaining to the "essential health benefits" established

by the ACA—ten categories of care which are now required to be covered under every health insurance plan. The amendment would permit states, rather than the federal government, to define the EHB standards for themselves beginning in 2018.[9] However, this provision was ultimately struck.

A second amendment was offered by Rep. Tom MacArthur (R-NJ) to address concerns that states would drastically reduce benefit requirements. The MacArthur amendment reinstates the federal EHB standards, but would allow states to apply for waivers to a number of provisions, under certain conditions. Waivers would be permitted for the following: beginning in 2018, a change in age-rating restrictions (which determine how much more an insurer may charge an older person relative to a younger person); beginning in 2019, changes to the community rating provisions, which prohibit insurers from medically underwriting individuals; and, beginning in 2020, changes to the federal EHB standards, permitting states to set their own.

Any state seeking to obtain a community rating waiver must first have in place a program to help high-risk individuals enroll in coverage or a program providing incentives to insurers to enter the market and stabilize premiums, or an invisible risk-sharing program, as defined by the Schweikert/Palmer amendment.[10] All of these programs would be at least partially funded by the $138 billion provided over the next ten years by the Patient and State Stability Fund created by AHCA. The state must also specify how the waiver it is requesting would assist in: reducing average premiums in the state, increasing the number insured, stabilizing the health insurance market, stabilizing premiums for people with pre-existing conditions, or increasing plan choice in the state. If a state demonstrates it has met these conditions and obtains such a waiver, then it may permit insurers to waive the community rating protections, though only for individuals who have not maintained continuous coverage (save for the 63-day allowance) seeking to enroll in coverage in the individual and small group markets. In other words, individuals who would otherwise face a 30 percent surcharge as a result of not maintaining continuous coverage, would instead be medically underwritten for one year. However, under no circumstance may the gender rating protections be waived; insurers would continue to be prohibited from charging different rates based on whether an individual is a male or female.

Thus, the only people who could be charged a premium based on their health status are those with a pre-existing condition, not enrolled in a large group health plan, living in a state that obtains a waiver, who have let their insurance lapse in the past year for 63 days or more, and then only for one year. All others would continue to be protected by the community rating provisions currently in place under the ACA. Further, no one could be denied coverage because of the existence of a pre-existing condition, or even face a lock-out period.

Conclusion

The AHCA would not provide for the return to the status quo prior to the ACA. It is unlikely that many Americans will be impacted by the provisions of the MacArthur amendment. Finally, the AHCA must still be passed by the Senate and is likely to undergo significant reforms before it does, in which case, the legislation would again have to be passed by the House.

[1] https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf

[2] https://www.nahu.org/consumer/GroupInsurance.cfm

[3] There are some exceptions to the guaranteed renewability requirements.

[4] http://www.ncsl.org/research/health/individual-health-insurance-in-the-states.aspx

[5] http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/

[6] Technically, the mandate would not be repealed because legislative rules prohibit such a change through the reconciliation process, but the applicable penalty would be set to $0, rendering the mandate moot.

[7] https://www.healthcare.gov/fees/fee-for-not-being-covered/

[8] The continuous coverage provisions which match the 63-day rule of the HIPAA requirements.

[9] https://rules.house.gov/sites/republicans.rules.house.gov/files/115/policymngr-amdt.pdf

[10] https://rules.house.gov/sites/republicans.rules.house.gov/files/115/AHCA/Palmer-Schweikert%20Amendment.pdf