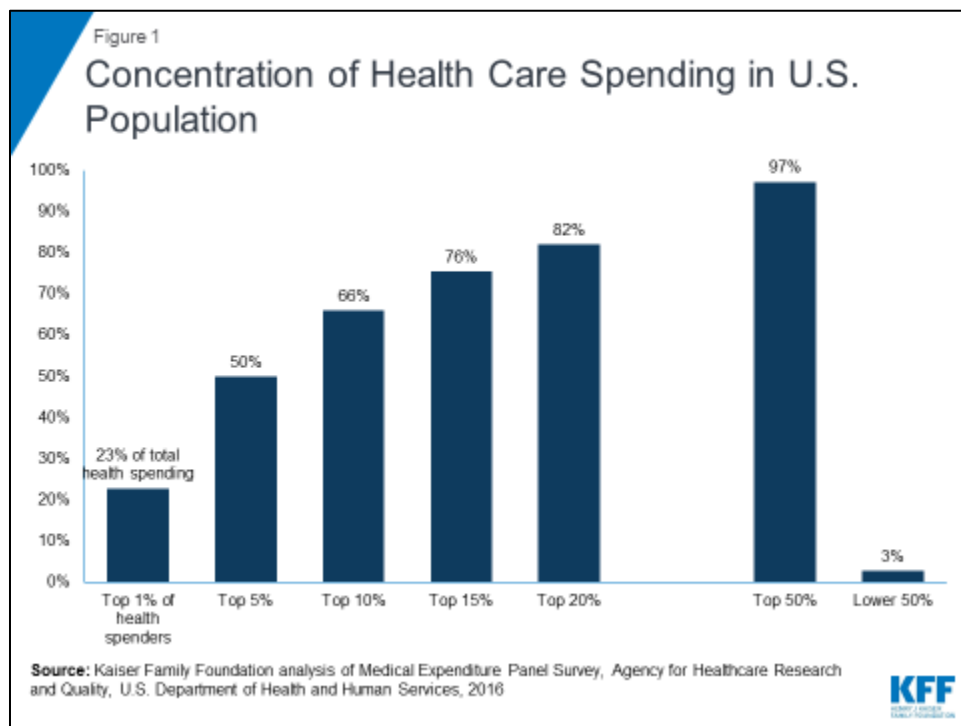


Good morning, Chairman Neal, Ranking Member Brady, and Members of the Committee.

Thank you for inviting me to testify about health insurance for people with pre-existing conditions. I am Karen Pollitz, a Senior Fellow at the Kaiser Family Foundation. We are a non-profit organization, serving as a non-partisan source of health policy analysis and journalism for policymakers, the media, the health policy community and the public. We not associated with Kaiser Permanente or Kaiser Industries.

### **Pre-existing Conditions and Health Insurance**

In the most basic sense, a pre-existing condition is a health condition that a person has. Most people are healthy most of the time, but when a serious condition strikes, health care can be costly. In any given year, the sickest 1% of people account for nearly one-quarter of total population health spending, while the healthiest 50% account for just 3% of health spending. (Figure 1)



Kaiser Family Foundation has estimated that [52 million](#) non-elderly adults (27%) have so-called “declinable” pre-existing conditions in a year.<sup>1</sup> These conditions – such as cancer, HIV/AIDS, diabetes, and pregnancy – are among the most costly conditions and those on which private insurers in the non-group market in most states routinely based decisions to deny applications for health insurance prior to the ACA. Using a broader definition – that includes less costly conditions such as high blood pressure, high cholesterol, and asthma – the US Department of Health and Human Services estimated [133 million](#) non-elderly Americans have pre-existing conditions in any given year.<sup>2</sup>

Very few people could self-finance care for expensive conditions such as cancer, heart disease, or even a routine pregnancy. Instead, most non-elderly Americans rely on private health insurance to collectively finance care.

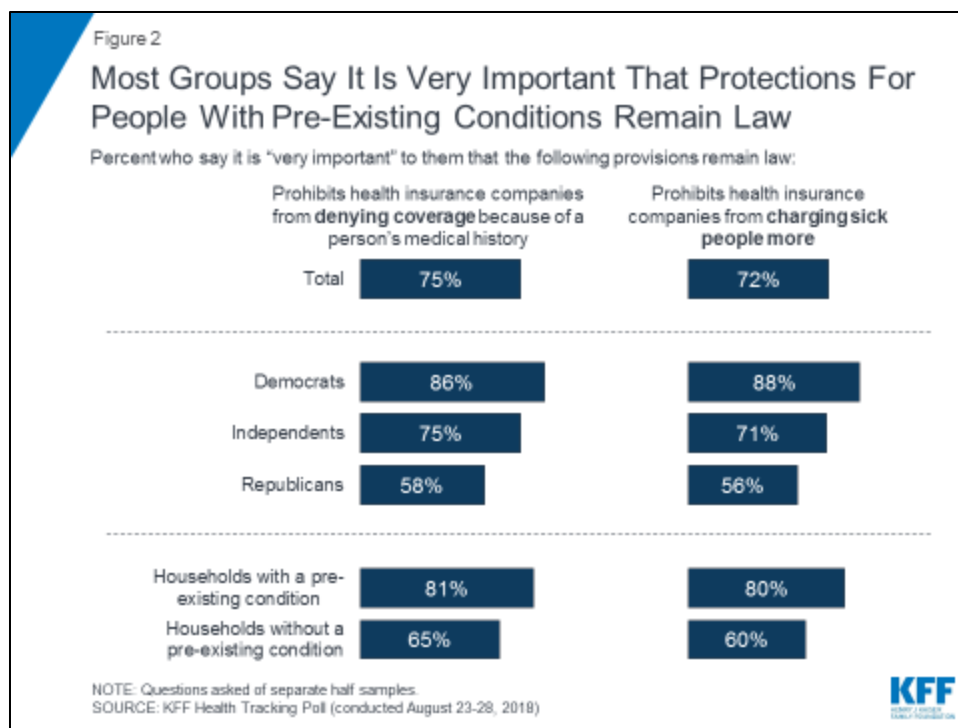
A number of provisions were included in the Affordable Care Act (ACA) to ensure that private coverage will be available and affordable, including to people when they have pre-existing conditions.

### **Prohibition of Medical Underwriting in the ACA**

Before the ACA, insurer medical underwriting practices created barriers to getting and keeping coverage for people with pre-existing conditions, especially in the non-group insurance market. A KFF [survey](#) of private insurers prior to the ACA found that even people with mild health conditions such as hay fever could have their application denied, or their premiums surcharged, or they could be offered a policy that permanently excluded coverage for their health condition or the affected body part or system (e.g., in the case of hay fever, respiratory system.)<sup>3</sup> By contrast, under federal law today,

- Group and individual health insurance policies must be sold on a guaranteed issue basis and must be guaranteed renewable. People cannot be turned down or have coverage cancelled based on health status.
- No private group plans or individual health insurance policies can impose pre-existing condition exclusion periods.
- Premiums for policies sold in the individual and small group market use modified community rating. Policy premiums can vary based only on four factors: family size, geography, age (up to 3:1 ratio) and tobacco use (up to 1.5:1). Premiums cannot vary based on a consumer’s health status or other factors. Insurers also must set rates based on a single risk pool.<sup>4</sup>

Our tracking polls find strong, bipartisan support for these provisions. (Figure 2)

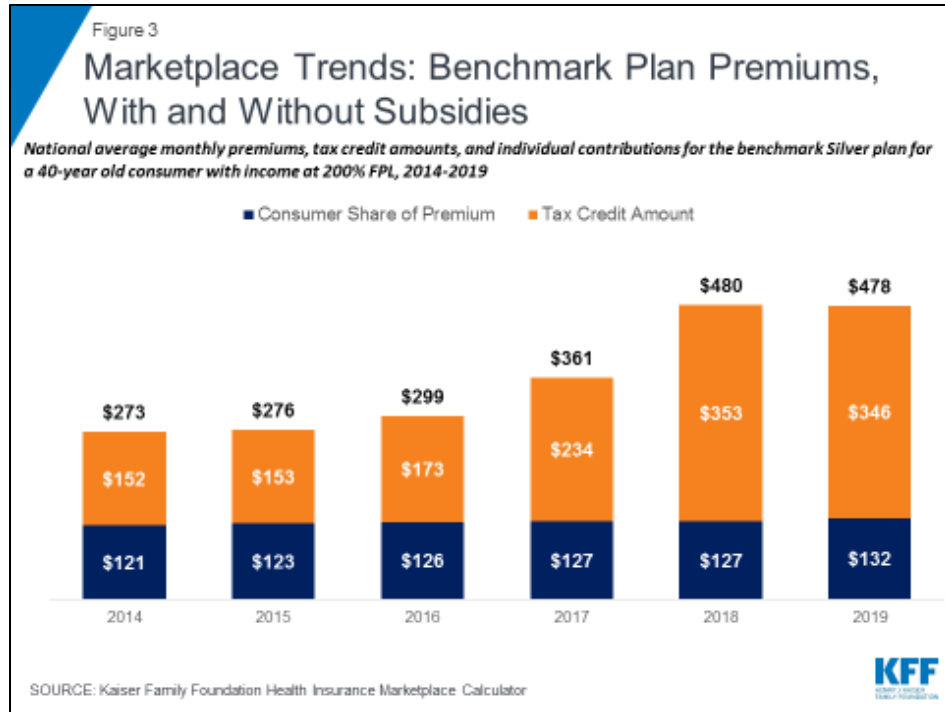


Providing more accessible and comprehensive coverage to people with pre-existing conditions costs money, and the result has been higher average premiums in the non-group market, compared to premiums for non-group plans prior to the ACA.

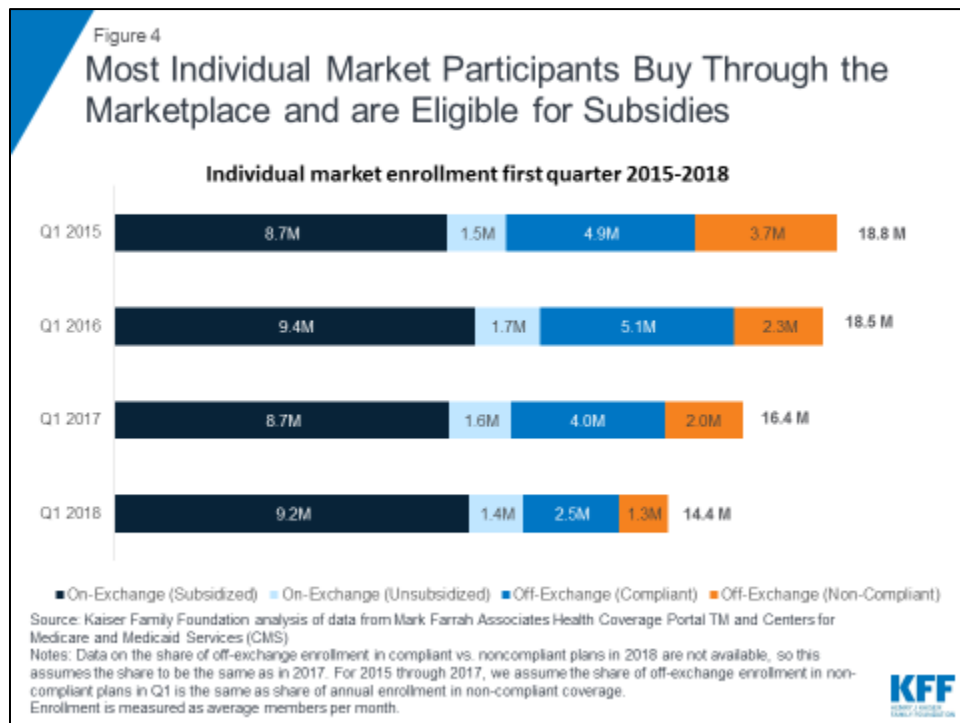
**Other ACA provisions Help Stabilize the Insurance Risk Pool**

In addition to the ACA market rules, other key provisions under the law also serve to encourage people to participate in coverage and to curb adverse selection.

Premium subsidies – As of June 2018, 9.2 million, or 87% of individuals enrolled in non-group policies in the marketplace received premium tax credits to make the monthly cost of coverage more affordable. Subsidies are key to stabilizing the risk pool. That is because consumers will tend to compare the cost of coverage to their expected health care costs as they make their enrollment decisions. Subsidies generally allow more people to buy health insurance, and they lower this ratio of premium costs to expected health costs for healthier individuals. Year to year, premium subsidies also shield eligible consumers from premium increases. Since the marketplaces opened, the national average premium for the benchmark silver plan has increased by about 75%, though premium tax credits absorbed this increase for subsidy-eligible individuals. (Figure 3)



This, in turn, has helped stabilize enrollment in the marketplace. The number of subsidized marketplace enrollees has held relatively steady, even while premiums have increased. However, consumers not receiving subsidies have felt the full brunt of these premium increases, and enrollment in this group has dropped significantly. (Figure 4)



Minimum coverage standards - ACA-compliant policies in the individual and small group market must cover 10 categories of essential health benefits (EHB), such as hospitalization, physician care, maternity care, mental health and substance abuse treatment, and prescription drugs. In addition, the ACA limits annual cost sharing (copays, deductibles, etc.) for essential health benefits provided in-network. These coverage standards had an important definitional effect – essentially they defined ACA-compliant policies as providing major medical coverage. Prior to the ACA, federal law had defined health insurance as any policy sold by health insurance companies, with some exceptions. Policies in the non-group market before 2014 [routinely excluded or limited](#) coverage for maternity care, mental health and substance abuse care, and prescription drugs.<sup>5</sup> Since the ACA, people with serious health conditions can buy non-group policies that cover the care they need, though premiums are also higher as a result.

Also, importantly, the ACA coverage standards limit adverse selection based on benefit design. Without this standard, consumers might self-select into plans offering coverage for only the services they expect to use (e.g., only people planning to have a baby would select policies covering maternity care; only people with HIV or high medication needs would select policies covering prescription drugs), resulting in sicker people paying higher premiums than healthier people.

Individual mandate – The ACA required most Americans to have health coverage or pay a tax penalty. Congress repealed the tax penalty effective for January 1, 2019. Although the [individual mandate](#) was never a leading reason why people sought health insurance, it did create a reinforcing incentive for healthy individuals to be covered.<sup>6</sup> As discussed below, with repeal of the mandate penalty, at least some healthy individuals are more likely to forego coverage, causing upward pressure on premiums.

### **Relaxing ACA Requirements Involves Tradeoffs**

A significant number of people who buy ACA-compliant non-group health insurance – 3.9 million last year – do not receive subsidies. For them, rising premiums present serious affordability concerns. Two recent actions present these and other consumers with new options, but also have the demonstrated effect of increasing premiums for ACA-compliant plans.

Reducing the individual mandate tax penalty to zero - As part of the 2017 tax reform legislation, and following months of debate over repeal and replacement of the ACA, Congress reduced the individual mandate penalty to \$0 effective in 2019. It is likely this year that at least some individuals will forego health insurance as a result. Those most likely to do so would be individuals who struggle to pay health insurance premiums, particularly those who are not eligible for subsidies, and those who are younger and in good health, for whom doing without coverage feels less risky.

Promoting availability of short-term health insurance – Last year, the Trump administration issued regulations to allow more loosely regulated plans – short-term limited duration insurance (STLDI) – to expand and compete with ACA-compliant non-group coverage.<sup>7</sup> These more loosely regulated plans offer lower premiums for some people who are not eligible for premium tax credits.

With respect to STLDI, prior regulations governing these policies had required that they could provide only short-term coverage, defined as a term of less than 3 months. The new regulations re-define short-term policies as providing coverage for a term of less than 365 days, and, with renewals – at the option of the insurer – up to 36 months. This change could make short-term policies appear to consumers to be a more comparable alternative to ACA-compliant non-group policies, even though the protection STLDI policies offer is not the same.

ACA market rules for other individual health insurance policies do not apply to STLDI, and as a result, short-term policies raise multiple barriers to coverage for people with health conditions. First, issuers of short-term policies can and will deny applicants with pre-existing conditions. Second, STLDI policies typically exclude or severely limit coverage for some ACA essential health benefits, including prescription drugs, maternity care, and mental health and substance use treatment.<sup>8</sup> Third, STLDI policies exclude coverage of all benefits related to pre-existing conditions. Healthy applicants who develop health conditions once covered risk having claims denied if the insurer can establish the condition existed (even undiagnosed) prior to enrollment. Finally, because STLDI policies are not guaranteed renewable, policyholders who get sick will likely find coverage terminates without the option to renew at the end of the policy term.

These differences mean short-term policies can be offered at much lower premiums. We estimate that, on average, STLDI policy premiums are 54% lower than premiums for ACA-compliant plans.<sup>9</sup> Importantly, this lower cost option is not available to people with pre-existing conditions. They can continue to rely on ACA-compliant plans, but will have to pay even higher premiums if they are not subsidy-eligible due to a worsening of the risk pool as a result of STLDI plans pulling healthier than average people out of the ACA-compliant market.

By law, STLDI policies are not considered “minimum essential coverage,” which is required to satisfy the ACA individual mandate. While the individual mandate penalty remained in effect, consumers considering short-term plans because of their lower premiums had to take into account the offsetting cost of the tax penalty. With the mandate tax penalty eliminated and under the new STLDI regulations, it is likely more people will buy short-term policies instead of ACA-compliant policies; and insurers have factored this change into their rates for ACA-compliant plans. Analysis by KFF of rate filings by non-group

market health insurers finds that 2019 premiums are, on average, 6% higher than they would otherwise be due to changes in the mandate penalty and expected expansion of short-term policies.<sup>10</sup>

### **Future Actions Could Affect Coverage for Pre-existing Conditions**

Recent Trump Administration [guidance on ACA Section 1332 waivers](#) raises the possibility that states could take further steps to promote the sale short-term health insurance policies and even shift federal subsidy dollars from marketplace policies into these less-regulated plans.<sup>11</sup> Under Section 1332, states can apply for waivers of certain ACA requirements in order to pursue other coverage strategies. Federal law includes so-called guardrails requiring that state waivers cover at least as many people at least as affordably and comprehensively as would be the case in the absence of a waiver.

The 2018 Administration guidance changes administrative standards for measuring compliance with 1332 guardrails and gives CMS broader discretion to determine whether a state waiver meets the law's requirements. In particular, the new guidance encourages greater reliance on short-term policies as a source of coverage. It makes clear that people enrolled in such plans would still be counted as "covered" in evaluating whether the waiver program results in at least as many residents having coverage. In addition, under the new waiver guidance, states could shift at least some federal subsidy resources out of the ACA marketplace to instead provide subsidies for the purchase of ACA non-compliant plans. Reducing marketplace subsidies would make the cost of ACA-compliant plans less affordable for people who rely on them. This could prompt more people to drop marketplace coverage, increasing instability in the market.

The new waiver guidance offers states a pathway to pursue changes under the ACA similar to those that Congress debated, but could not enact, during the ACA repeal-and-replace debate in 2017. How states might respond to the new waiver guidance, and how the Trump Administration might act on any new state waiver applications remains to be seen.

### **Summary**

In summary, the ACA substantially changed private health insurance so it would cover people with pre-existing conditions. Insurance that covers sick people and the care they need will cost more than coverage that does not. Subsidies make the cost of ACA-compliant plans more affordable, but not all consumers are eligible and, for them, affordability concerns are rising.

Relaxing ACA protections for pre-existing conditions can make cheaper coverage available to some, though at other costs. Coverage that is less expensive for people only while they are young and healthy, puts the same people at risk once they get sick. Strategies based on dividing the risk pool drive up the cost of plans that do cover people with pre-existing conditions. Our polling suggests that most Americans want health insurance to work for people when they get sick.

## End Notes

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<sup>1</sup> Kaiser Family Foundation, “Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA,” December 2016.

<sup>2</sup> US Department of Health and Human Services, “Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act,” January 5, 2017.

<sup>3</sup> Kaiser Family Foundation, “How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?” June 2001.

<sup>4</sup> The ACA requires insurers to determine premiums for compliant policies using a single risk pool that includes all such plans, both inside and outside of the marketplace, offered within a state. As a result, premiums for all compliant policies reflect the average expected costs of everyone in the single risk pool; this requirement spreads the cost of the most expensive individuals across the entire risk pool.

<sup>5</sup> Kaiser Family Foundation, “Would States Eliminate Key Benefits if AHCA Waivers are Enacted?” June 2017.

<sup>6</sup> Kaiser Family Foundation, “Poll: Survey of the Non-Group Market Finds Most Say the Individual Mandate Was Not a Major Reason They Got Coverage in 2018, And Most Plan to Continue Buying Insurance Despite Recent Repeal of the Mandate Penalty,” April 2018.

<sup>7</sup> In 2018, the Administration also published regulations permitting the sale of new association health plans (AHPs), which could be offered to self-employed individuals who otherwise buy coverage in the non-group market. AHPs would not be allowed to deny applicants or charge more based on health status, and would not be allowed to impose pre-existing condition exclusion periods. AHPs would be exempted from the requirement to cover 10 essential health benefits however. To the extent consumers could choose, based on their health status, between plans offering materially different benefits, adverse selection could result, and this could drive up premiums for ACA-compliant policies in the non-group market.

<sup>8</sup> Kaiser Family Foundation, “Understanding Short-Term Limited Duration Health Insurance,” April 2018.

<sup>9</sup> Kaiser Family Foundation, “Why Do Short-Term Health Insurance Plans Have Lower Premiums Than Plans That Comply with the ACA?” October 2018.

<sup>10</sup> Kaiser Family Foundation, “How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums,” October 2018.

<sup>11</sup> Kaiser Family Foundation, “New Rules for Section 1332 Waivers: Changes and Implications,” December 2018.