Preexisting conditions: A primer

Thomas D. Snook, FSA, MAAA

Much of the discussion about the American Health Care Act (AHCA) has focused on people with "preexisting conditions"—how to cover them and how to pay for that coverage.

Previously, changing the way these people were covered and funded was a key focal point of market reforms introduced by the Patient Protection and Affordable Care Act (ACA). The purpose of this article is to discuss why the coverage of preexisting conditions is a key issue in health insurance, particularly with respect to affordability and sustainability, and to outline varying approaches to addressing it.

What is a preexisting condition?

In the context of health insurance in the United States, a preexisting condition is a medical condition for which treatment was received within a specified time before a person's health insurance went into effect.[1] Preexisting conditions that can be reasonably expected to require ongoing medical treatment (and, hence, incur ongoing medical expense) are of particular relevance in this discussion. A prior disease or medical condition that may have been "cured" may still be considered a preexisting condition if there is a probability that some patients may require ongoing treatment from future relapses or other complications.

Why is this important?

There is an old adage in the insurance industry—"You can't insure a burning barn." Farmer John can't call his local insurance agent and buy fire coverage the moment the rooster weather vane on his old wooden granary is struck by lightning. By that time, the risk that the insurance would be intended to protect against has already occurred. A fire insurance scheme in which it was permissible to buy coverage after the fire had already started would not be sustainable—people could just wait and buy a policy when their sheds were already ablaze. Premiums could not possibly be enough to cover costs, and the scheme would fail.

While this may seem like common sense, applying this thinking to health insurance has problematic repercussions. First, people are not corn silos. Fire insurance exists to provide money to cover the financial losses associated with the fire—it does nothing to actually put the fire out. Health insurance, in contrast, is the financial mechanism Americans use to pay for needed healthcare. Healthcare in the United States is quite expensive, and few Americans can afford to pay out-of-pocket for even moderate courses of treatment. Without a means to pay for healthcare, most people would need to seek charity[2] or simply forgo care altogether. The consequences of not having health insurance are far greater than just the financial. Health and well-being, and life itself, are at stake.

A second difference is the scale of time involved. Most barns would burn to the ground in just a couple hours. After the barn has burned down, there's no barn left to insure. In contrast, treatable medical conditions can last years, decades, or even a lifetime. Because of the way health insurance is provided in the United States, the type or source of that health insurance will change depending on an individual's life circumstances. And over a long period of time, circumstances in a person's life will change greatly. People graduate from high school and college, get married, get jobs, change jobs (or perhaps even lose jobs), have children, and grow old. As they do, the source of their health insurance coverage will also change as they, say, move to Medicare at 65, or move on or off Medicaid based on income level. As a result, most Americans will find themselves at some point in their lives needing health insurance but already having a preexisting medical condition.

1 Knapp, Darrell D. "Medical Benefits in the United States." In *Group Insurance, Fourth Edition*, edited by William F. Bluhm, 95-118. Winsted, CT: ACTEX Publications, 2003.

2 The Emergency Medical Treatment and Labor Act requires hospitals to stabilize patients who request treatment for an emergency medical condition, for example.

Is health insurance really insurance?

The fire insurance analogy raises a philosophical question that is often a source of policy disagreement: Is health insurance really insurance, or is it something else?

Certainly health insurance acts like other forms of insurance in some ways. It provides financial protection for the consequences of unknown or unforeseen risks. Getting in an accident or having a stroke are roughly analogous (in the sense described here) to Farmer John's burning barn, and health insurance serves a similar purpose as fire insurance.

But health insurance does other things, too, that aren't really like insurance. It pays for routine expenses like checkups and mammograms, and it can pay for small things that aren't financially devastating for most people, such as wart removal.[3] Health insurance also acts as a sort of discount club—in private health insurance, health plans negotiate significant discounts off doctor and hospital bills, while government programs legislate provider payment rates that are generally even lower.

The "is it insurance?" question is more than academic, and in part is a driver of differences in health policy opinion between the different ends of the political spectrum. Conservative advocates believe that moving health insurance back to more coverage of catastrophic risk, and funding routine care through other means such as health savings accounts (HSAs), would improve affordability and hence be key to fixing the healthcare problem in the United States. The ACA took a different approach, and, for example, mandated expanded coverage of routine preventive care (with no cost sharing for the insured), under the rationale that such coverage increases the use of preventive care and thereby reduces the likelihood of a catastrophic event and ultimately overall costs. Resolution of this dispute—and how it in turn affects paying for care associated with preexisting medical conditions—will be an important determinant of the ultimate direction of healthcare reform.

Why is this an issue in healthcare reform?

For most of the U.S. population, health insurance is optional. To stretch the fire analogy to its snapping point, Farmer John can choose not to buy fire insurance on his barn and just deal with the financial consequences of replacing it and its contents if it burns down. Likewise, until very recently, most Americans could choose not to buy health insurance without incurring a penalty. In fact, the health insurance mandate imposed by the ACA is one of its most controversial provisions.

It is this optional nature of health insurance that makes the preexisting conditions issue so important in healthcare reform discussions today. Patients with preexisting conditions may know they need care and sign up only when they know they will incur higher costs.

The decision that an individual makes when deciding whether to purchase health insurance typically represents an exercise of consumer self-interest. Rational economic behavior requires an evaluation of anticipated personal or family needs along with other factors such as health plan reputation, provider network, and price. "Adverse selection" is the natural process of individuals making this purchasing decision based on their own personal circumstances, needs, and priorities. Such decisions are generally informed ones—an individual usually knows if he or she has a significant medical condition[4]—which means he or she will make a choice that maximizes the value of the trade-off in the purchasing decision. Healthy people go through a similar decision process as they weigh their likelihood of needing costly healthcare services (i.e., true insurance needs) against what their premiums would be. The decision that minimizes cost for maximal return for the individual has a mirror-image impact for a health insurance system—higher claim costs relative to the premium charged.[5]

For a health insurance system to be stable and sustainable, the effects of adverse selection must be mitigated. As in the fire insurance example, adverse selection will make it difficult or impossible for health insurance premiums to be adequate to cover costs. If the insurance pool only covers people with significant medical needs, the coverage will be quite expensive relative to an

3 *Insurance Journal* (September 11, 2009). Health insurance isn't really insurance, researcher says. Retrieved May 23, 2017, from **http://www.insurancejournal.com/news/national/2009/09/11/103684.htm**.

4 Reality is not this simple, of course. Preexisting conditions can be unknown to the individual, in which case they would not influence a purchasing decision. Or a person could have a family history, make poor lifestyle choices, or have undergone genetic testing revealing an underlying condition, for example. A thorough discussion of this topic is beyond the scope of this paper.

5 Snook, T.D. & Harris, R.G. (October 2009). Adverse Selection and the Individual Mandate. Milliman Health Reform Briefing Paper. Retrieved May 23, 2017, from **http://www.milliman.com/uploadedFiles/insight/research/health-rr/adverse-selection-individual-mandate.pdf**.

insurance program that includes an appropriate mix of healthy individuals.[6] The American Academy of Actuaries has stated: "Providing insurance protections to individuals with pre-existing conditions by prohibiting coverage denials, exclusions, or higher premiums based on health status requires that insurers enroll enough healthy individuals to spread the costs of the less healthy."[7]

Consequently, any discussion of the coverage of preexisting conditions in health insurance necessarily includes a discussion of limiting (or eliminating) the effects of adverse selection in the health insurance system.

Preexisting conditions in different health insurance programs

It may be instructive to examine the major sources[8] of health insurance in the United States and how they each manage the coverage of preexisting conditions.

Medicaid: Preexisting conditions are generally covered without exception, and in fact coverage may be extended retroactively for some individuals. The issue of adverse selection is managed through outreach enrollment efforts. For those eligible for Medicaid coverage, there is generally no premium and little or no out-of-pocket expense. The barrier to enrollment is (broadly speaking) limited to the hassle[9] associated with enrolling or individuals not realizing they are eligible for coverage. Adverse selection is an issue—it is common for individuals to become enrolled in Medicaid when they present at hospital emergency rooms for care, for example—but it is relatively small compared with other markets.

Medicare: Preexisting conditions are covered under Medicare. However, Medicare-eligible individuals are financially incentivized to enroll immediately upon becoming eligible rather than waiting to obtain coverage. For Part B coverage (which requires payment of a premium to the government), the late enrollment penalty is 10% of the premium for every year an individual has delayed in signing up for coverage; the penalty is paid for the entire duration the individual has Part B coverage. There is a similar penalty for late enrollment in Part D. These late enrollment penalties are generally considered significant enough to mitigate most of the effects of adverse selection in the Medicare program.[10]

Employer-sponsored coverage: Preexisting conditions are generally required to be covered by employer plans under the terms of the ACA. (An employer can still impose a three-month waiting period on eligibility for coverage, however). Prior to adoption of the ACA, it was not uncommon for plans to exclude coverage of preexisting conditions for as long as a year following the start of coverage, if certain requirements weren't met.[11] Adverse selection is generally less of an issue for large employers compared with the individual health insurance market because the cost of health insurance is usually greatly subsidized by employers, and as a result most employees elect coverage. For smaller employers, the adverse selection issue is more material and much more complex. Generally speaking, the smaller the employer, the more closely the health insurance purchasing decision resembles that seen in the individual markets. The ACA treats small employer coverage similarly to individual as well.

Individual health insurance: Historically, many preexisting conditions were not covered under individual health insurance, or higher premiums were charged, as the risk of adverse selection was considered too great. Subsequent reforms have addressed this issue with mixed results. We address this in depth in the next section.

6 Categorizing individuals as "healthy" and "sick" is of course an oversimplification of a broad spectrum of individual healthcare needs. The point is valid nonetheless.

7 From a letter written by Karen Bender and Michael E. Nordstrom to the Hon. Paul Ryan and the Hon. Nancy Pelosi, March 22, 2017. See the full letter at **http://www.actuary.org/files/publications/AHCA_comment_letter_032217.pdf**.

8 There are more than these, but for the sake of simplicity, we limit discussion to just those listed here. Issues related to Veterans Affairs (VA) healthcare, correctional healthcare, and other sources of healthcare are beyond the scope of this paper.

9 The enrollment process includes determining eligibility through documentation of income, age, disability status, and family status.

10 For example, about 93% of those on Medicare Part A also enroll in Part B. **https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/2013/Downloads/MDCR_ENROLL_AB/CPS_MDCR_ENROLL_AB_3.pdf**.

11 The Health Insurance Portability and Accountability Act of 1996 (HIPAA) significantly restricted a health plan's ability to exclude preexisting conditions from coverage, allowing prior "creditable coverage" to count against the preexisting condition exclusion period. State laws also typically restricted the definition of a preexisting condition.

Preexisting conditions in the individual health insurance market

The individual health insurance market is particularly susceptible to adverse selection and hence the coverage of preexisting conditions is a thorny issue.

PRE-ACA: MEDICAL UNDERWRITING

Prior to adoption of the ACA, health insurers in the individual market were generally free[12] to decline to issue coverage for individuals with preexisting conditions as they saw fit. Careful selection of the individuals being insured was viewed by health insurers as crucial to successful operation in the individual market.

The pre-ACA practice of medical underwriting—the careful evaluation of the medical conditions of individuals applying for health insurance, and limiting or refusing to issue coverage to those who do not meet certain standards consistent with the underlying risk pool—has been viewed with contempt by many in the public square. And indeed the high number of uninsured individuals prior to the full implementation of the ACA has been viewed as a societal ill in need of correction and was an impetus for the market reforms included in Title I of the ACA. However, it is important to understand the rationale for this behavior, if only to understand the factors that led to it so as to avoid them in the future.

In the pre-reform individual health insurance market, the potential for adverse selection was severe. Unlike Medicare, Medicaid, and most employer-sponsored insurance, the cost/benefit analysis on an individual's part about whether to purchase coverage was weighted quite heavily toward the "cost" side. With no government or employer subsidy, the individual bore the full cost of insurance premiums (and, unlike employer coverage, the cost was not tax-deductible). The economic incentive to go without health insurance was quite strong, and thus the potential for an individual to wait to purchase coverage until a medical need arose was very real.

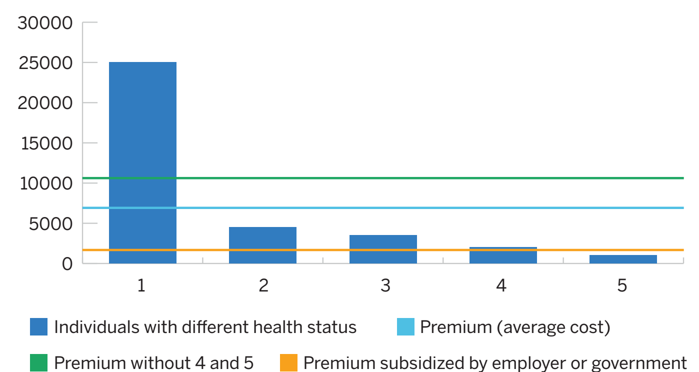
In this environment, then, the rational course of action[13] for a health insurer was to either (1) not issue individual health insurance at all or (2) participate in the market but be careful in evaluating the risks of those they agreed to cover. One effect of careful risk selection was that many individuals who sought to purchase coverage were unable to do so. While some individuals were able to buy individual health insurance, many others were turned away, charged a higher premium ("rating up"), or had the cost of treatment related to certain conditions carved out of their policy coverage ("exclusionary riders").

Most states regulated, but did not entirely forbid, how insurers considered preexisting conditions in their policy coverage. Common provisions included limiting the definition of a preexisting condition (typically, a condition had to be one for which the applicant sought treatment in the months preceding the application) or how long an exclusionary rider could be in effect. A number of states, however, attempted to address this issue by simply making medical underwriting illegal. In such "guaranteed issue" states, the number of carriers participating in the individual market reduced substantially and, in many cases, no coverage was available at all. In other guaranteed issue states, premium rates rose dramatically.[14]

ACA: GUARANTEED ISSUE, SUBSIDIES, AND THE INDIVIDUAL MANDATE

Under the ACA, the rules for coverage of preexisting conditions in the individual health insurance market were completely overhauled. Carriers are required to issue coverage to any applicant, regardless of health status, who applies and pays a premium; thus unbridled coverage for preexisting conditions is available.[15] To address adverse selection, the law requires individuals to purchase coverage (the "mandate") or face a tax penalty. The law also makes considerable funds available to subsidize out-of-pocket costs for lower-income individuals—thus directly addressing the "cost" side of the cost/benefit trade-off analysis that occurs when a purchasing decision is made. The idea is that by making health insurance less expensive and imposing non-participation penalties (carrots and sticks), healthy individuals will be more inclined to purchase coverage, thereby mitigating the effects of adverse selection and bringing healthier risks into the risk pool.

PURCHASING DECISION BY HEALTH STATUS



12 One notable exception was provided by HIPAA. Individuals who lost their group insurance coverage and met certain other criteria had to be issued individual coverage when they applied for it. For individuals who were not applying for an individual policy because they'd lost their employer coverage, however, no such exception was available.

13 American Academy of Actuaries (February 1999). Risk Classification in Individually Purchased Voluntary Medical Expense Insurance. Issue Paper. Retrieved May 23, 2017, from http://www.actuary.org/pdf/health/risk.pdf.

14 Wachenheim, L. & Leida, H. (March 2012). The Impact of Guaranteed Issue and Community Rating Reforms on States' Individual Insurance Markets. America's Health Insurance Plans (AHIP). Retrieved May 23, 2017, from http://www.statecoverage.org/files/Updated-Milliman-Report_GI_and_Comm_Rating_March_2012.pdf.

15 As of this writing, "repeal and replace" has not occurred and the ACA remains the law of the land—thus the use of the present tense.

The ACA also limits the time period during which an individual can buy coverage without restriction. Returning to the fire insurance analogy, Farmer John would have to wait until the next open enrollment period before he could insure his barn. The idea is that this creates a further incentive for Farmer John not to wait to purchase coverage. Similarly, individuals are, in theory at least, restricted to enrolling in a plan to certain open enrollment periods under the ACA. Special enrollment periods are available to individuals with "qualifying life events" – the rules for which have not always been strictly enforced, and hence have led to adverse selection, according to many in the health insurance industry.

In practice, this approach to managing adverse selection has not gone as well as its framers would have hoped. It appears thus far that adverse selection remains a significant issue, resulting in higher-than-expected claims costs and substantial losses incurred by participating health plans.[16] As noted in the American Academy of Actuaries letter, "In general, enrollment in the individual market has been lower than initially expected and enrollees have been less healthy than expected. Insurer participation and plan choice have been declining."[17]

Generally, the ACA's individual mandate—perhaps its most controversial provision—is seen as being ineffective at mitigating adverse selection. The Academy letter reads: "The current individual mandate is relatively weak because its financial penalty is usually low as a share of premiums, many individuals are exempt, and enforcement is weak."[18] In addition, the open enrollment provision and subsidies have not been adequate to diminish the effects of adverse selection.

AHCA: GUARANTEED ISSUE, CONTINUOUS COVERAGE, AND STATE WAIVERS

As currently positioned,[19] the AHCA would generally retain the guaranteed issue provision of the ACA, but replaces the controversial individual mandate with a continuous coverage requirement. This is a key philosophical difference from the ACA's mandate approach.[20] Premium subsidies would also be retained, although significantly changed in the way they are calculated.

The AHCA in a nutshell

For states that do not apply for or are not granted a waiver: For those individuals who maintained continuous coverage, (i.e., did not have a lapse of coverage lasting 63 days or more), guaranteed issue applies with no additional premium. Carriers can charge an additional premium of 30% for the plan year for individuals who had a 63-day lapse of coverage in the preceding 12 months. (Note that this additional premium only applies for the first plan year in contrast to the late enrollment penalties for Medicare.)

For states that are granted a waiver: Guaranteed issue at standard rates also applies for individuals who meet the continuous coverage requirement. Carriers can vary premiums consistent with the terms of the state waiver based on an individual's health status for the plan year for individuals with a 63-day lapse of coverage in the preceding 12 months. This premium variation based on health status would nominally be based on a carrier's determination of relative costs associated with an applicant's preexisting conditions, and would be in lieu of the 30% penalty for non-waiver states.

For all states: Federal funding is available for the states to use to stabilize the individual health insurance market with a variety of allowable uses.[21]

Waivers are granted if a state can demonstrate it would reduce premiums, increase coverage, stabilize the market, stabilize premiums for those with preexisting conditions, or be in the public interest.[22] States seeking waivers for health status rating would also be required to have a reinsurance pool or a high risk pool, though the default state option under the PSSF and the FIRSP each would meet this requirement.

16 See, for example, "Health insurers under pressure to improve margins on health plans" in the Wall Street Journal, February 10, 2016, at **https://www.wsj.com/articles/insurers-under-pressure-to-improve-margins-on-health-plans-1455154838**.

17 Bender and Nordstrom letter, ibid.

18 Bender and Nordstrom letter, ibid.

19 The version of the AHCA passed by the House on May 4, 2017.

20 For a detailed comparison of the individual mandate vs. a continuous coverage requirement, see the Milliman report, "Repeal, replace, or reform: Key policy discussions affecting the individual health insurance market" by Fritz Busch, Nick Krienke, and Scott Weltz at **http://www.milliman.com/uploadedFiles/insight/2017/repeal-replace-or-reform.pdf**.

21 For an overview of the uses of the PSSF, see the Milliman report, "The Patient and State Stability Fund: What Happens Now?" by Kathleen Ely, Thomas Murawski, and Paul Houchens, at **http://us.milliman.com/uploadedFiles/insight/2017/patient-state-stability-fund.pdf**.

22 For a complete overview of the provisions of the AHCA, see the Milliman report, "The American Health Care Act" by Jason Karcher at **http://www.milliman.com/insight/2017/The-American-Health-Care-Act/**.

The bill would also allow states to apply for waivers from some requirements, subject to the approval of the federal government. In particular, these waivers could allow carriers to factor in health status when determining premiums for individuals who did not meet the continuous coverage provision in lieu of the standard penalty as long as the state had a qualifying high risk pool or reinsurance pool. The bill also provides for additional funding via the Patient & State Stabilization Fund (PSSF) and the Federal Invisible Risk Sharing Pool (FIRSP).[23]

It is unclear how these provisions will play out in practice, and, in fact, there is considerable debate as to how the AHCA will affect coverage for individuals with preexisting conditions. Respected publications have so far reached very different conclusions.[24] The ultimate outcome will depend on the ideas contained in the state waivers and the criteria used to evaluate them.

It is also unclear how the repeal of the individual mandate and replacement with a continuous coverage provision will impact adverse selection in the individual health insurance market. Conceptually, the idea is to penalize individuals who delay seeking coverage—the Farmer Johns who want to buy insurance only when the barn is on fire—by requiring them to pay a higher premium once they do apply for insurance. But is the penalty high enough to materially affect consumer behavior? The Academy letter notes, "Delaying coverage would require payment of a penalty only upon enrollment and then only for a limited time period, as opposed to the current law penalty, which applies every year an individual is uninsured. Lower enrollment among healthy individuals would likely result, especially if they would have to pay the premium surcharge due to having prior gaps in coverage, putting upward pressure on premiums, all else equal."[25] States that use health status rating waivers have access to an additional pool of money to offset increased premium and cost sharing, which could limit the impact of these waivers on the purchase decision as well.

23 Karcher, ibid.

24 For a pro-AHCA perspective, see, for example, "What the AHCA really says about preexisting conditions" by Juliana Dorrow in the National Review, May 16, 2017, at http://www.nationalreview.com/ahca-preexisting-conditions-democrats-misleading-rhetoric. For an anti-AHCA perspective, see, for example, "New amendment to GOP health bill effectively allows full elimination of community rating, exposing sick to higher premiums" by Matthew Fiedler for the Brookings Institution, at https://www.brookings.edu/blog/up-front/2017/04/27/new-amendment-to-gop-health-bill-effectively-allows-full-elimination-of-community-rating-exposing-sick-to-higher-premiums/.

25 Bender and Nordstrom letter, ibid.

Conclusion: Solving the preexisting conditions issue is a significant hurdle in healthcare reform

Making health insurance available to individuals with preexisting conditions while ensuring affordability in a system in which health insurance is optional rather than mandatory has proven to be very challenging thus far, and may in fact be impossible. The effects of adverse selection are best thought of like a law of physics—and hope as one might, gravity always wins.

Consequently, Americans face a conundrum. Coverage for preexisting conditions under the ACA is very popular, while the mandate to purchase coverage has been unpopular and has not always been enforced. Reconciling these two views for the individual health insurance market in a sustainable way remains a challenge and is one of the biggest hurdles policymakers have to face when tackling healthcare reform.

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CONTACT

Thomas D. Snook
tom.snook@milliman.com

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