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Amendment to House ACA Repeal Bill Guts Protections for People with Pre-Existing Conditions

Amendment Fixes None of House Bill's Underlying Problems

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Representative Mark Meadows, head of the House Freedom Caucus, and Representative Tom MacArthur, co-chair of the House Tuesday Group, have reportedly reached agreement on an amendment to the House Republicans' Affordable Care Act (ACA) repeal bill, the American Health Care Act (AHCA).[1] Freedom Caucus members rejected earlier versions of the AHCA because they retained many of the ACA's insurance market reforms, most notably its protections for people with pre-existing health conditions. Meanwhile, other House Republicans rejected the bill because it would have caused 24 million people to lose health insurance and made coverage weaker or less affordable for millions more. Many of these opponents of the bill also promised to maintain the ACA's pre-existing conditions protections — as did President Trump and other Republican leaders.

The Meadows-MacArthur amendment is not a compromise between these views. It does nothing to mitigate the AHCA's coverage losses, $839 billion in Medicaid cuts, or large increases in premiums and out-of-pocket costs for moderate-income and older individual-market consumers. But it does give the Freedom Caucus what it has demanded from the beginning: elimination of key ACA protections for people with pre-existing health conditions. Under the amendment, states could waive both the ACA's standards for what health benefits insurance plans must offer and its prohibition on charging people more based on their medical history. Supposedly, the latter waiver would only affect people who do not maintain continuous health coverage. But in practice, as explained below, it would mean higher — and often unaffordable — premiums for people with pre-existing conditions, even if they had no break in coverage.

The Meadows-MacArthur amendment would largely restore pre-ACA rules for people with pre-existing conditions. Just like before the ACA, insurers could discriminate based on medical history, eliminate coverage for key health services, and impose annual and lifetime limits on benefits, except in states that chose to prohibit these practices — which few chose to do before the ACA. For congressional Republicans who have promised to maintain the ACA's pre-existing conditions protections, it should be clear that this amendment violates that commitment.

[1] This analysis has been updated based on the text of the MacArthur-Meadows amendment, which became publicly available on April 25: http://www.politico.com/f/?id=0000015b-a790-d120-addb-f7dc0ec90000.

Amendment Restores Key Elements of Pre-ACA Status Quo

The Meadows-MacArthur amendment would allow states to request waivers of key pre-existing conditions protections for both the individual and small-group markets. States would receive automatic approval for waivers within 60 days as long as they attested that the waiver would lower premiums, increase coverage levels, stabilize the market, stabilize premiums for people with pre-existing conditions, or increase the choice of health plans in the state. There would be no federal review to determine whether such a waiver would actually achieve any of those goals. "Essentially, any state that wanted a waiver would get one," Washington and Lee University School of Law professor Tim Jost concludes.[2]

Waivers of Community Rating Requirements

The amendment would allow states to waive the ACA's "community rating" requirements.[3] "Community rating" refers to the ACA's prohibition against charging people higher premiums for coverage based on their health, a practice referred to as "medical underwriting."

Waiving community rating means insurers could once again discriminate against people based on their medical history. Insurers could increase premiums by unlimited amounts for people with a history of cancer, hypertension, asthma, depression, or other conditions. If insurers charged people the full expected cost of their conditions, that would mean premiums exceeding $100,000 per year for people with metastatic cancer, premiums in the tens of thousands per year for people who are pregnant or need treatment for substance use disorders, and large premium increases for people with common pre-existing conditions like asthma, depression, or diabetes.[4]

Under the amendment, waivers of community rating are technically limited in two respects — but neither limitation would have much practical impact: all states could get waivers, and waivers would affect all people with pre-existing conditions.

First, states could only waive community rating if they had a program in place for people with pre-existing conditions. But states could meet that requirement just by participating in the House bill's modestly funded "Federal Invisible Risk Sharing Program" or by using *any* of the funding in the bill's Patient and State Stability Fund for anything that they argue assists high-risk individuals or stabilizes premiums. Presumably, that would include high-risk pools, reinsurance, or any other program states claim will help reduce premiums or help those with pre-existing conditions — irrespective of the program's funding levels, benefits, or overall effectiveness in terms of affordability, access, and coverage. This is an exceedingly low bar.

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[2] Timothy Jost, "The MacArthur Amendment Language, Race in the Federal Exchange, and Risk Adjustment Coefficients," *Health Affairs* blog, April 25, 2017, http://healthaffairs.org/blog/2017/04/25/the-macarthur-amendment-language-race-in-the-federal-exchange-and-risk-adjustment-coefficients/.

[3] Waivers would be available starting in 2019 (2018 for people enrolling through special enrollment periods).

[4] Sam Berger and Emily Gee, "Latest ACA Repeal Plan Would Explode Premiums for People with Pre-existing Conditions," Center for American Progress, April 20, 2017, https://www.americanprogress.org/issues/healthcare/news/2017/04/20/430858/latest-aca-repeal-plan-explode-premiums-people-pre-existing-conditions/.

Second, while the amendment says that insurers in states with waivers could base premiums on medical history only for people who fail to show they have maintained continuous health coverage, this would not protect people with pre-existing conditions. Even if that limitation were binding — which it almost certainly would not be in practice, as explained below — it would leave out many people with pre-existing conditions: nearly one-third of people with pre-existing conditions experience a gap in coverage over a two-year period due to job changes, other life transitions, or periods of financial difficulty.[5]

Moreover, in practice, the limitation almost certainly wouldn't bind: people with pre-existing conditions who maintained continuous coverage would still end up being charged more, often far more, as a result of the waiver — because they would end up being pooled primarily with sick people rather than with a mix of sick and healthy people, as at present.

Here's why this would occur. The current rules require "community rating," which means that insurers can't set premiums based on an applicant's health status. Instead, insurers must pool healthy and sick people together and charge them the same rates. But under the Meadows-MacArthur amendment, in states obtaining a waiver, community rating would be limited to people who demonstrate continuous coverage (that they had coverage for all but 63 days of the prior 12 months). Anyone *not* doing so would be medically "underwritten" — that is, their premium would be based on their health status.

The key point here is that *for people who are healthy and low cost, medical underwriting would result in lower premiums than if they were part of a "community rated" pool that also includes sicker, higher-cost individuals*. As a result, most healthy people who were continuously insured would choose (and be advised by insurers and brokers) *not* to submit proof of continuous coverage, so that they could obtain lower premiums by being medically underwritten. (Exacerbating this problem, some healthier-than-average people who have been enrolled in individual market plans could decide to leave the market entirely, as they would no longer be subject to the individual mandate to pay a penalty if they are uninsured.)

The result is that the people choosing to provide proof of continuous coverage would largely be those who are sicker than average. And to avoid losing money, insurers would have to raise their premiums substantially for these people. The bottom line is that coverage would become much less affordable for people who have pre-existing conditions and are in poor health, whether or not they maintained continuous coverage, because community rating would essentially exist in name only: sick people would mostly be pooled with other sick people.[6]

Moreover, this problem could grow worse over time. Once community-rated plans were priced for a sicker-than-average pool of enrollees, new applicants with moderately expensive conditions like hypertension often would find that they could obtain lower premiums by undergoing medical

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[5] Assistant Secretary for Planning and Evaluation, "Health Insurance Coverage for Americans with Pre-existing Conditions," Department of Health and Human Services, January 5, 2017, https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

[6] See also Matthew Fielder, "New amendment to GOP health bill effectively allow full elimination of community rating, exposing sick to higher premiums," *Brookings Upfront*, April 27, 2017, 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/.

underwriting than by being pooled with people with much costlier conditions like cancer. As a result, over time more and more individual-market consumers would be charged premiums that effectively were based on their health status, either because they chose to undergo medical underwriting (because they were healthier than the people in the "community rated" pool) or because they were part of a "community rated" risk pool that consisted largely of sick people and for which premiums were set accordingly.

As the American Academy of Actuaries concluded in analyzing a similar proposal, "healthy individuals, even those who had continuous coverage, would have an incentive to undergo underwriting. As a result, healthy individuals would be charged lower premiums and less healthy individuals would face higher premiums and potentially less generous or no coverage options."[7]

Waivers of Essential Health Benefits

The amendment also allows states to waive the ACA's "Essential Health Benefits" standards starting in 2020. Under the ACA, health plans in the individual and small-group markets must cover key services, such as inpatient and outpatient care, prescription drugs, mental health treatment, substance use disorder treatment, and maternity care.[8] In contrast, before the ACA, states set their own benefits standards, with the result that 62 percent of individual-market consumers had plans that didn't cover maternity care, 18 percent had plans that didn't cover mental health treatment, 34 percent had plans that didn't cover substance use treatment, and 9 percent had plans that didn't cover prescription drugs.[9]

Even without changes to community rating, waiving Essential Health Benefits would itself effectively end pre-existing conditions protections. That's because it would drive a race to the bottom, creating strong incentives for insurers to drop coverage for expensive services such as cancer treatment, high-cost drugs, or mental health treatment in order to discourage sicker, high-cost people from enrolling. As a result, people with pre-existing conditions, who need these and other costly services, often would not be able to find an individual-market plan covering the services they need at any price, much less an affordable one.

In addition, allowing states to waive Essential Health Benefits would effectively let them waive other provisions not explicitly waivable under the Meadows-MacArthur amendment. These include:

- **Prohibitions on annual and lifetime limits on coverage — including for people with coverage through their jobs.** The ACA prohibited plans from imposing annual or lifetime limits on coverage, but *only on coverage of Essential Health Benefits*. Plans can still impose coverage limits on services not classified as Essential Health Benefits (for example, adult dental

[7] American Academy of Actuaries, "An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes," January 2017, https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

[8] For an explanation of Essential Health Benefits, see CBPP, "Essential Health Benefits Under Threat," http://www.cbpp.org/essential-health-benefits-under-threat. See also Sarah Lueck, "If 'Essential Health Benefits' Standards Are Repealed, Health Plans Would Cover Little," CBPP, March 23, 2017, http://www.cbpp.org/blog/if-essential-health-benefits-standards-are-repealed-health-plans-would-cover-little.

[9] Assistant Secretary for Planning and Evaluation, "Essential Health Benefits: Individual Market Coverage," Department of Health and Human Services, December 16, 2011, https://aspe.hhs.gov/basic-report/essential-health-benefits-individual-market-coverage#_edn2.

coverage). This means that in states that eliminated or greatly weakened Essential Health Benefits standards, plans could once again impose coverage limits on anything from emergency services to inpatient care to prescription drugs.[10]

Before the ACA, 105 million people with private health insurance — the large majority of whom had employer plans — had policies that imposed lifetime limits on coverage.[11]

- **Requirements that plans limit out-of-pocket costs — including for people with coverage through their jobs.** Similarly, plans would also no longer have to cap consumers' out-of-pocket costs, since that ACA requirement also applies only to out-of-pocket costs for Essential Health Benefits.

  Before the ACA, nearly one-fifth of people with employer plans had policies with no limit on total out-of-pocket costs.[12] That means that millions of people *with health coverage* were one major illness away from medical bankruptcy.

- **Prohibitions on charging women more than men.** Eliminating Essential Health Benefit requirements means that women would once again have to pay more for plans that included maternity coverage.

Republican Claims About These Changes Don't Hold Up

Republicans have claimed that their amendment maintains some protections for people with pre-existing conditions. In fact, Rep. MacArthur has claimed that his amendment would "make coverage of pre-existing conditions sacrosanct for all Americans."[13] Such claims ignore the amendment's actual impacts.

- **People with pre-existing conditions would be charged more, even if they had continuous coverage.** Supporters of the amendment may claim that it protects people with pre-existing conditions as long as they maintain continuous coverage. Even if that were true, the amendment would leave millions of people without access to affordable health insurance: as noted, almost one third of people with pre-existing conditions experience a gap in coverage over a two-year period, due to job changes, other life transitions, or periods of financial difficulty.

  But in practice, as explained above, even people who maintain continuous coverage would end up getting charged more. Healthier people would prefer to be charged lower premiums

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[10] Matthew Fiedler, "New Changes to Essential Health Benefits in GOP Health Bill Could Jeopardize Protections Against Out-of-Pocket Costs, Even for People with Job-Based Coverage," Brookings, March 24, 2017, https://www.brookings.edu/blog/up-front/2017/03/24/new-changes-to-essential-benefits-in-gop-health-bill-could-jeopardize-protections-against-catastrophic-costs-even-for-people-with-job-based-coverage/.

[11] Thomas D. Musco and Benjamin D. Sommers, "Under the Affordable Care Act, 105 Million Americans No Longer Face Lifetime Limits on Health Benefits," Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, March 2012, https://aspe.hhs.gov/basic-report/under-affordable-care-act-105-million-americans-no-longer-face-lifetime-limits-health-benefits.

[12] Loren Adler and Paul B. Ginsburg, "Health Insurance as Assurance: the Importance of Keeping the ACA's Limits on Enrollee Health Costs," Brookings, January 17, 2017, https://www.brookings.edu/blog/up-front/2017/01/17/health-insurance-as-assurance-the-importance-of-keeping-the-acas-limits-on-enrollee-health-costs/.

[13] See https://www.facebook.com/CongressmanTomMacArthur/posts/1982611475303157.

based on their medical history, and so would decline to provide proof of continuous coverage. Ultimately, the only people not opting for premiums based on health status would be those with costly pre-existing conditions, and insurers would set their "community rated" premiums accordingly, at very high levels.

- **Exorbitant premiums and coverage exclusions are, in practice, no different than coverage denials.** Rep. MacArthur has stressed that, under the amendment, insurers couldn't deny coverage altogether to people with pre-existing conditions. But an insurer that wanted to deny someone coverage could simply offer her a plan with a premium of tens of thousands of dollars per month and without coverage for hospitalizations, prescription drugs, or various other basic health services. For a consumer, such an "offer" is no different than a denial.
- **Leaving protections for pre-existing conditions up to the states means a return to the pre-ACA status quo, when most people were unprotected.** Republicans may argue that states can keep protections in place if they choose. However, states always had the option before the ACA to regulate their health insurance markets to protect people with pre-existing conditions and very few chose to do so — in part because they would have been criticized for increasing premiums for healthy people.[14]

  The ACA took on this challenge through a combination of pre-existing conditions protections, premium tax credits to help pay for coverage, and the individual mandate, which together enable both sick and healthy people to get affordable coverage. But the AHCA would eliminate the individual mandate and slash subsidies, so premiums and out-of-pocket costs for individual-market consumers would increase substantially.[15] As a result, states would be under substantial pressure to seek waivers to eliminate the ACA's pre-existing conditions protections, even though doing so would only lower premiums for healthy people at the expense of those with more serious health needs.

AHCA's Underlying Flaws Remain

The reported amendment makes no changes to the underlying AHCA. Under the underlying bill:[16]

- 24 million more people would be uninsured by 2026 — meaning 1 of every 10 non-elderly Americans who have health insurance coverage under current law would lose it under the AHCA. This would eliminate all of the coverage gains made under the ACA.
- Medicaid would be cut by $839 billion over ten years. The bill would effectively end the ACA's Medicaid expansion and radically restructure the entire Medicaid program by

[14] For an overview of states' pre-ACA policies, see National Conference of State Legislatures, "Individual Health Insurance and States: Chronologies of Change," http://www.ncsl.org/research/health/individual-health-insurance-in-the-states.aspx.

[15] Aviva Aron-Dine and Tara Straw, "House GOP Bill Still Cuts Tax Credits, Raises Costs by Thousands of Dollars for Millions of People," CBPP, March 22, 2017, http://www.cbpp.org/research/health/house-gop-health-bill-still-cuts-tax-credits-raises-costs-by-thousands-of-dollars.

[16] Robert Greenstein, "House ACA Repeal Bill Would Be Largest Robin-Hood-in-Reverse Transfer in Modern U.S. History," CBPP, April 4, 2017, http://www.cbpp.org/blog/house-aca-repeal-bill-would-be-largest-robin-hood-in-reverse-transfer-in-modern-us-history.

converting it to a per capita cap or block grant. Under the House bill, 14 million fewer people would be enrolled in Medicaid by 2026.

- People who currently purchase coverage through the ACA marketplaces would see large increases in their premiums, deductibles, and other out-of-pocket costs. Total out-of-pocket costs (premiums, deductibles, copays, and coinsurance) would increase by an average of $3,600 for current HealthCare.gov marketplace consumers, with larger increases for older and lower-income consumers and consumers in high-cost states.
- High-income people would receive billions of dollars in tax cuts, averaging over $50,000 per year for people with incomes exceeding $1 million.