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Cassidy-Graham Would Unravel Protections for People With Pre-Existing Conditions

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The bill from Senators Bill Cassidy and Lindsey Graham to repeal the Affordable Care Act (ACA) would allow insurers in the individual market to once again significantly scale back coverage and charge significantly higher premiums based on people's health status and other characteristics. These changes would eliminate or unravel the ACA's protections for people with pre-existing medical conditions, leaving them exposed to large gaps in benefits and unaffordable premium costs.

Cassidy-Graham would give states broad authority to eliminate or weaken many ACA pre-existing condition protections across their entire individual markets. That's because states could roll back these protections for any insurer or individual subsidized by block grant funding. For example, a state that used a small portion of its block grant to provide even tiny subsidies to everyone enrolled in individual market plans could then waive these protections for *its entire individual market* beginning in 2020. Likewise, states that used block grant funding to offer or subsidize coverage for low-income people could offer plans with large gaps in benefits.

To eliminate or weaken protections, states would merely have to submit as part of their block grant funding application a "description" of how they will "maintain access to adequate and affordable health insurance for individuals with pre-existing conditions." There is no standard for what constitutes "adequate" or "affordable," and states wouldn't even have to prove that they would actually *maintain* access to coverage.

As the Congressional Budget Office (CBO) wrote in its preliminary analysis of the plan, the Cassidy-Graham proposal would put intense pressure on states to eliminate or weaken consumer protections. The plan would eliminate the ACA's individual mandate immediately and eliminate federal subsidies for individual market (also called non-group) coverage beginning in 2020, replacing them with an inadequate block grant. As a result, CBO found, "most states would lack the [market] stabilizing mechanisms that exist under current law," and so "most states would eventually modify various rules to help stabilize the nongroup market." In effect, states would accept unaffordable premiums and/or out-of-pocket costs for people with serious health needs as the price of keeping premiums manageable for healthy people, absent the ACA's mechanisms for maintaining a balanced risk pool.

This means millions of people would face:

- **Sharply higher premiums based on health status and characteristics.** While insurers would still have to offer coverage to people with pre-existing conditions, they very likely could require them to pay far higher, unaffordable premiums if they have illnesses such as diabetes, heart disease, or cancer. Even people with less severe illnesses, such as seasonal allergies, could face higher premiums. Insurers would only be prohibited from varying premium rates based on sex or genetic information. People purchasing coverage in the individual market could face higher premiums for a variety of other reasons, including being older, being overweight, or working in a risky job. In its preliminary analysis of the Cassidy-Graham bill, CBO noted that, "the higher the expected health costs, the higher premiums would be; for some people, premiums would be a very large share of their income." While some people would be able to obtain coverage through an employer, others would become uninsured as a result of the bill, CBO wrote.[1]
- **Large gaps in coverage of core benefits.** Insurers in many states would stop covering one or more categories of the "essential health benefits" (EHB) that the ACA now requires or could significantly narrow the coverage they provide within those categories. Plans could exclude coverage of entire categories, such as maternity care or mental health and substance use disorder treatment, or they could scale back coverage within the categories, for example by excluding certain types of prescription drugs. (Before the EHB requirement took effect, 75 percent of individual market plans didn't cover maternity care and 45 percent didn't cover substance use treatment.) Plans also would no longer have to cover preventive services at no cost to enrollees, a popular ACA requirement. Many people — especially those with pre-existing conditions — would lack access to needed health services or would have to pay far more out of pocket to purchase them on their own.
- **Loss of out-of-pocket cost protections.** The ACA's prohibition against annual and lifetime dollar limits on benefits applies *only to health services included under a state's EHB standard.* Thus, any services that insurers no longer had to cover but still provided could once again be subject to annual and lifetime limits. Moreover, Cassidy-Graham would entirely eliminate the ACA's limit on annual out-of-pocket costs (the maximum amount a person can pay in deductibles and other out-of-pocket charges per year) and the ACA's requirement that individual market plans have an actuarial value of at least 60 percent (meaning the plan covers at least 60 percent of enrollees' costs for covered services, on average). This means that insurers could charge unlimited deductibles, co-insurance, and co-payments.

Cassidy-Graham Would Prompt Widespread Weakening of Plan Protections

Allowing states to eliminate or weaken the EHB requirement and the prohibition against charging higher premiums based on health status may seem less damaging than repealing these federal protections outright. But states would likely face heavy pressure to loosen these protections, and many would do so.

Prior to the ACA, states were free to adopt ACA-like protections for people with health conditions in the individual market, *but few did.* Robust protections for people with pre-existing conditions weren't sustainable for states without the other key elements of the ACA structure: an

[1] "Preliminary Analysis of Legislation That Would Replace Subsidies for Health Care With Block Grants," Congressional Budget Office, September 25, 2017, https://www.cbo.gov/publication/53126.

individual mandate that people obtain health coverage or pay a penalty, and robust subsidies that keep individual market premiums, deductibles, and other out-of-pocket costs affordable.

Cassidy-Graham would immediately eliminate the individual mandate, a change that has been estimated to increase premiums by about 20 percent. And starting in 2020, it would replace the ACA's marketplace subsidies and Medicaid expansion with an inadequate block grant. The block grant funding would be well below current-law federal funding for coverage, would not adjust based on need, would disappear altogether after 2026, and wouldn't even have to be used for health coverage. As noted above, CBO concluded that the lack of a mandate and sharp funding reduction would put considerable pressure on states to allow individual market insurers to reinstitute harmful practices from the past in order to lower premiums and attract more healthy people. If states did not make such changes, their markets would grow increasingly unstable over time, and "coverage could become unavailable or more expensive for many more people than it would be under current law."[2]

Higher Premiums Based on Health Status, Age, and Other Factors

Cassidy-Graham would still require insurers to offer a plan to applicants with health conditions, and it would bar insurers from excluding a person's pre-existing conditions from coverage. But people with medical conditions could very likely be charged premium rates so high that coverage would be effectively out of reach, as the bill would allow states to diverge from federal community-rating requirements. It would only bar insurers from charging higher premiums based on sex and genetic information, not any other factors.[3]

Beginning in 2014, the ACA barred insurers in the individual market from charging people higher premiums because of their health status or health conditions. Insurers can only adjust an individual's premium by specific factors: age (within limits), geographic area, and tobacco use (also within limits).

Before the ACA, people in the individual market frequently paid much higher premiums if they had pre-existing conditions. Often, a "standard" premium rate would be established for a particular insurance product, and people could be charged a higher premium ("rated up") if they had health conditions or get a reduced premium ("rated down") if they were healthy.

To understand an applicant's health status, insurers generally required people to go through "medical underwriting," where they filled out lengthy forms, answered a variety of questions about past medical treatments, and gave the insurer permission to examine their medical records. After this process, many people were offered premium rates considerably higher than the standard rate. A

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[2] CBO, *op cit.*

[3] Section 204 of the latest version of Cassidy-Graham allows states to permit insurers "to vary premium rates for such coverage, except that in no case may an issuer vary premium rates on the basis of sex or on the basis of genetic information;" this language clearly implies that health status *would* be a permissible rating factor. This provision also instructs states that want to vary premium rates to describe the degree to which an insurer could require a person to pay a greater premium compared to other similar enrollees. The same section, however, contains some contradictory language that seems to permit premium variation only due to age and geographic variation. See "Summary of Graham-Cassidy-Heller-Johnson Amendment, September 13, 2017, as amended September 25, 2017," Kaiser Family Foundation, http://files.kff.org/attachment/Summary-of-Graham-Cassidy-Heller-Johnson-Amendment.

2009 industry survey of individual-market insurers found that 34 percent of coverage offers were at higher-than-standard rates.[4]

Also before the ACA, insurers could *deny* coverage to people with health issues in most states, which happened to 18 percent of applicants in 2013, federal data show.[5] Insurers could also exclude people's pre-existing conditions from coverage. Cassidy-Graham does not allow denials or exclusions, but it does allow states unlimited amounts of premium rate-ups based on health status (as well as other characteristics including age and industry, as described below), so it would likely lead to even greater disparities in premiums between healthier people and people with health problems than occurred in 2009.

An estimated 27 percent of adults under age 65 have health conditions — such as cancer, diabetes, obesity, pregnancy, or others — that would likely render them "uninsurable" if they had to apply for individual market coverage under pre-ACA rules, according to the Kaiser Family Foundation.[6] Less severe health issues could also be a barrier to getting affordable coverage. A 2001 study examined the experience of a sample of people with various types of health conditions when they applied for insurance in several states' individual insurance markets:[7] Emily, a 56-year-old diagnosed with depression taking an anti-depressant medication, was rejected 23 percent of the time. Bob, a 36-year-old with prior knee surgery, was rejected 12 percent of the time.

The extra cost for someone with a serious health condition could be eye-popping, and rate-ups for people with more common conditions such as depression or pregnancy could also be large. If insurers charged people the full expected cost of their conditions, a 40-year-old with metastatic cancer would pay an additional $142,650 per year in premiums, according to an analysis by the Center for American Progress. Having a baby, even without any complications, would mean $17,320 more in premiums, and having rheumatoid arthritis would mean an additional $26,580. Even relatively common health conditions would cost thousands of dollars more in premiums per year: $5,600 for diabetes without complications, $8,490 for major depressive disorders, and $4,340 for asthma.8

As CBO concluded about a similar provision in the House-passed bill: "less healthy individuals (including those with preexisting or newly acquired medical conditions) would be unable to purchase comprehensive coverage with premiums close to those under current law *and might not be able to purchase coverage at all* [emphasis added]."

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[4] "Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits," America's Health Insurance Plans, October 2009.

[5] Larry Levitt *et al.,* "How Buying Insurance Will Change under Obamacare," Kaiser Family Foundation, September 24, 2013. This doesn't account for people who didn't apply at all because they had a pre-existing health condition.

[6] Gary Claxton *et al.,* "Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA," Kaiser Family Foundation, December 12, 2016. This estimate is conservative because the data it relies on don't account for several costly conditions, such as HIV, that would cause someone to be considered uninsurable.

[7] Karen Pollitz, Richard Sorian, and Kathy Thomas, "How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?" prepared for the Henry J. Kaiser Family Foundation, June 2001.

[8] 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/.

Cassidy-Graham also would allow insurers in the individual market to raise premiums for individual enrollees based on their health status and other factors when they renew their policy. Current federal law bars this practice: everyone who wants to renew a plan is charged the same rate, regardless of their how their health status may have changed. But under Cassidy-Graham, insurers could once again sharply raise rates on people based on the health services they received during the prior year.

Cassidy-Graham would also explicitly allow insurers to diverge from the federal age-rating standard, meaning that in states that permit it, older people could pay premiums that are five or six times, or even more, than younger people. And it would allow states to weaken or eliminate the ACA's "single risk pool" requirement, under which each insurer in the individual market must consider all of its enrollees in all of its plans (within each respective insurance market) when setting premiums. This could allow states or insurers to set up multiple risk pools, perhaps based on enrollees' health status, how long they have had their plans, or how comprehensive their coverage is, and charge higher premiums based on which risk pool an individual is part of. The bill also would allow insurers to give discounted rates to healthier people or those with other characteristics they find desirable. Such changes would lead to markets in many states that are segmented between the healthy and the sick, with people who have pre-existing medical conditions likely bearing much higher, or even unaffordable, costs.

Many States Would Weaken or Eliminate EHB Standard

All individual and small-group health plans must cover ten EHBs: emergency services; hospitalizations; outpatient care; maternity and newborn care; mental health and substance use disorder treatment; prescription drugs; rehabilitation services; laboratory services; preventive services and chronic disease management; and pediatric care. Most people purchasing health insurance probably assume that it always covers these basic services. But before the ACA, it frequently didn't. In 2013, among plans in the individual market:

- 75 percent didn't cover maternity care;
- 45 percent didn't cover substance use treatment;
- 38 percent didn't cover mental health services; and
- 13 percent didn't cover specialty prescription drugs.[9]

Under Cassidy-Graham, insurers in the individual market would no longer have to cover the ten essential health benefits. States could decide to establish new benefit standards much weaker than what's in place today, or they could have no benefit standards at all.

CBO's analysis of an earlier Senate repeal bill noted that if states modify EHBs to target services with high costs but relatively few users, "coverage for maternity care, mental health care, rehabilitate and habilitative treatment, and certain very expensive drugs could be at risk."[10] Similarly, in

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[9] Gary Claxton *et al.,* "Would States Eliminate Key Benefits If AHCA Waivers Are Enacted?" Kaiser Family Foundation, June 14, 2017, http://files.kff.org/attachment/Issue-Brief-Would-States-Eliminate-Key-Benefits-if-AHCA-Waivers-are-Enacted.

[10] Congressional Budget Office, "H.R. 1628: Better Care Reconciliation Act of 2017," June 26, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf.

analyzing the House-passed repeal bill, CBO stated that "services or benefits likely to be excluded … include maternity care, mental health and substance abuse benefits, rehabilitative and habilitative services, and pediatric dental benefits." People needing these services "would face increases in their out-of-pocket costs. Some people would have increases of thousands of dollars in a year."[11]

If given the ability, individual market plans in many places would likely revert to benefit packages much like what they offered before the ACA. Insurers would likely stop covering services that were no longer required as a way to discourage enrollment by sicker, costlier enrollees. Or, if plans did cover such costly treatments, they would charge exorbitant premiums because only those with pre-existing conditions would enroll in them.

For example, if insurers weren't required to cover maternity benefits as an essential benefit, they would likely strip them out. They might then offer a "rider" so that someone could add the missing benefit. As CBO noted in its analysis of the House-passed health care bill, a maternity coverage rider could cost more than $1,000 per month, since insurers would price it with the expectation that people buying the benefit would use it.

Weakened EHB Definition Means Effective Return of Annual and Lifetime Limits

Before the ACA, millions of people had health insurance that wouldn't actually cover them if they got sick. Many plans had annual and lifetime dollar limits on coverage. The ACA fixed this by prohibiting annual and lifetime limits. While Cassidy-Graham wouldn't eliminate this prohibition outright, it would allow states to eliminate or weaken EHB standards in the individual market (as discussed below), which would make these rules meaningless for people purchasing coverage on their own. That's because the prohibition on annual and lifetime limits applies *only to EHBs,* so if certain services are no longer considered EHBs, costs related to those services are not subject to the prohibition.

Thus, Cassidy-Graham would allow insurers to once again cap payments for certain services needed by a consumer with a high-cost or long-term health need, such as cancer treatment. Just like before the ACA, people *with health insurance* would often be surprised, discovering too late that their health plan wouldn't cover treatments they need, leaving them with staggering out-of-pocket costs — or forcing them into medical bankruptcy.

Insurers Could Raise Enrollees' Deductibles and Other Costs

Under Cassidy-Graham, insurers could also pare down their plans by raising enrollees' out-of-pocket costs. If states chose to allow it, plans in the individual market could once again:

- **Raise or remove the ACA's cap on annual out-of-pocket costs**. Insurers could once again charge people exorbitant deductibles and other cost-sharing for the benefits that remained. Today, each individual is protected from paying more than about $7,000 each year in deductibles, co-payments, and other out-of-pocket costs for in-network care under their plan. Under Cassidy-Graham, states could eliminate this requirement or raise the cap far

[11] Congressional Budget Office, "H.R. 1628, American Health Care Act of 2017," May 24, 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.

higher than it would otherwise be, shifting significant costs to people with costly illnesses. Moreover, even if the state retained the out-of-pocket cap, it wouldn't apply to items and services that were no longer part of a state's weakened EHB definition. In other words, an insurer could impose a $20,000 annual out-of-pocket limit and subject many costly non-EHB services to unlimited deductibles and co-payments on top of that. In 2013, before the ACA's major coverage provisions took effect, *more than one-third* of plans offered in the individual market lacked out-of-pocket caps that would have satisfied the ACA standard.[12]

- **Eliminate the minimum standards for how comprehensive plans must be.** Today, insurers can't offer coverage in the individual or small-group market that's less generous than "bronze" plans, which generally have deductibles of about $6,000 or more. Bronze plans (as with the other "metal" level requirements that plans must satisfy under current law) are defined based on actuarial value: an estimate of how much of a standard population's costs for covered health care services a given plan will cover. Bronze plans cover about 60 percent of the cost of providing the EHBs, with enrollees covering the remaining 40 percent through deductibles, co-payments, and other costs. Under Cassidy-Graham, plans' actuarial values could fall far below 60 percent. In other words, there would be no limit on how meager coverage would be. In 2010, more than half of individual market plans fell short of 60 percent actuarial value; many policies were in the 35 to 50 percent range.[13]
- **Not offer lower-deductible, more comprehensive plans.** The ACA requires insurers that offer coverage through the marketplace to offer at least one "gold" plan with an 80 percent actuarial value and one "silver" plan with a 70 percent actuarial value. Otherwise, many insurers would likely stop offering these more comprehensive plans. Or, if such plans were available, they would likely have unaffordable premiums because only people with greater health care needs would likely purchase them. People who have health conditions — especially chronic conditions that require ongoing checkups, regular medications, and periodic interventions — could end up spending large amounts out of pocket if they had individual or small-group coverage, assuming insurers still offer those plans at all.

Conclusion

Many Senate Republicans have expressed public support for maintaining the ACA's protections for people with pre-existing conditions, such as the ban on denying coverage outright or excluding coverage of a medical condition. Cassidy-Graham would undermine these protections by allowing states to vitiate other ACA protections, such as the prohibition against charging higher premiums based on health status and requirement that insurers cover essential health benefits. Cassidy-Graham would thereby leave people with pre-existing conditions either facing premiums they can't afford or coverage that doesn't address their health needs.

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[12] Julie Appleby, "Study: One-Third of Individual Plans Exceed Law's Out-of-Pocket Cap," Kaiser Health News, February 11, 2013, http://khn.org/news/study-one-third-of-individual-plans-exceed-laws-out-of-pocket-cap/. At that time, the out-of-pocket limit was about $6,300 per year.

[13] Jon R. Gabel *et al.*, "More Than Half of Individual Health Plans Offer Coverage That Falls Short of What Can Be Sold Through Exchanges As Of 2014," *Health Affairs*, May 23, 2012.