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House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING

Topic: House Bill 2552

Leigh County Government Center – Allentown, PA

July 25, 2018

AGENDA

10:00 a.m. Welcome and Opening Remarks

10:10 a.m. Allison Beam
Chief of Staff
Pennsylvania Insurance Department

10:40 a.m. Ken Bertka, MD, CPHIMS, FAAFP
Family Physician and Vice President of Clinical Integration
St. Luke's Care Network

11:00 a.m. Doug Furness
Senior Director of Government and Regulatory Affairs
Capital Blue Cross

11:20 a.m. Alvaro Castillo
Community Engagement Specialist
Pennsylvania Health Access Network

11:40 a.m. Closing Remarks

pennsylvania
INSURANCE DEPARTMENT

Testimony on HB 2552

Alison Beam
Chief of Staff
Pennsylvania Insurance Department

House Democratic Policy Committee

July 25, 2018

pennsylvania
INSURANCE DEPARTMENT

Good morning Chairmen Sturla and DeLuca, Representative Schweyer and members of the House Democratic Policy Committee. My name is Alison Beam and I serve as Chief of Staff at the Pennsylvania Insurance Department. On behalf of Commissioner Altman, thank you for the opportunity to be here today to speak about HB 2552, which would prohibit health insurers from using an individual's pre-existing medical condition to deny or exclude coverage under a health insurance policy. We applaud Representative Schweyer's efforts to shed light on such an important topic.

Before we start the conversation on HB 2552, we should take a moment to recognize the impact that the Affordable Care Act (ACA) has had on Pennsylvanians; that begins with remembering what our health care system looked like prior to the ACA's enactment. Before the ACA, sick people couldn't get health insurance due to a pre-existing condition, or if they were able to pay the expensive cost for the coverage, often their pre-existing condition would not be covered under the policy. Individuals with chronic medical issues or anyone who underwent a costly procedure, like a transplant, could face annual or lifetime limits leaving them in financially devastating circumstances. Women would often see higher coverage costs than men and perhaps not have had access to contraception or maternity care coverage. Finding coverage for other critical services like mental health and substance use disorder treatment services and prescription drugs was often difficult, if not impossible. Most importantly, more than 10 percent of Pennsylvanians went uninsured.

Since the ACA's enactment, Pennsylvania's uninsured rate has dropped to 5.6 percent – the lowest rate in our state's history. Over 1.1 million Pennsylvanians have access to coverage only available because of the ACA, and the current coverage is much more comprehensive than before because of protections required by the ACA. 5.4 million Pennsylvanians cannot be denied health insurance coverage due to their pre-existing conditions, 4.5 million Pennsylvanians can access coverage so that they no longer have

to worry about large bills due to annual or lifetime limits on benefits, and 6.1 million Pennsylvanians benefit from access to free preventive care services. Additionally, more than 175,000 Pennsylvanians have been able to access substance use disorder treatment services through the marketplace and Medicaid expansion coverage. This is critical as our Commonwealth strives to combat the overwhelming impact of the opioid crisis.

We recognize that the ACA is not perfect, and has not solved all of the health care coverage issues nationally or in Pennsylvania. To that end, we should be talking about how to further stabilize our health insurance market, how to make sure the market in Pennsylvania works better for consumers, and how we can ensure that this is a market that insurers want to continue to offer products in for the long-term. Unfortunately, that is not the conversation that is currently happening in Washington as reflected in many of the decisions that have been made.

The Trump Administration and Congress have made several decisions that have caused instability in insurance markets across the nation and are slowly and gradually undermining the ACA. Those decisions include, but are not limited to:

- Changing association health plan and short term limited duration plan rules, and messaging them as an alternative while not highlighting the short-comings of these options.
- Shortening the open enrollment period, giving Pennsylvanians less time to shop for and make informed decisions about their health insurance needs.
- Repealing the individual mandate, a key provision that requires most individuals to purchase health insurance coverage or pay a penalty, which helps to stabilize the market by broadening the pool of those covered.

- Reducing funding for the navigator program, a program that helps consumers and small businesses understand their new coverage options and find affordable coverage that meets their health care needs.
- Attempting numerous times to repeal and replace the ACA with proposals that do not seem to preserve protections for individuals with pre-existing conditions.

The combined effect of the above-mentioned decisions could lead to an environment that is similar to what existed before the ACA, where insurers may once again use an individual's pre-existing medical condition to deny or exclude coverage under a health insurance policy.

A Kaiser Family Foundation analysis[1] about a year and half ago found that 52 million adults under 65 – or 27 percent of that population — had pre-existing health conditions that would likely make them uninsurable if they applied for health coverage under medical underwriting practices that existed in most states before insurance regulation changes made by the ACA.

In Pennsylvania, the analysis estimated that 27% of non-elderly adults have conditions that would likely result in coverage being declined if they were to seek coverage in the individual market under pre-ACA underwriting practices. This puts Pennsylvania in close company with eleven states in which at least three in ten non-elderly adults would have a declinable condition, according to the analysis: West Virginia (36%), Mississippi (34%), Kentucky (33%), Alabama (33%), Arkansas (32%), Tennessee (32%), Oklahoma (31%), Louisiana (30%), Missouri (30%), Indiana (30%) and Kansas (30%).

What are these conditions that could prompt an insurer to deny coverage? Just to name a few, prior to the enactment of the ACA, insurers called the following health issues "pre-

[1] https://www.kff.org/health-reform/press-release/an-estimated-52-million-adults-have-pre-existing-conditions-that-would-make-them-uninsurable-pre-obamacare/

existing conditions": asthma, Alzheimer's, ALS or Lou Gehrig's disease (amyotrophic lateral sclerosis), cancer, diabetes, osteoarthritis or chronic joint pain, and pregnancy.

As the safeguards of the ACA are being chipped away, measures like HB 2552 are needed to help preserve protections for those with pre-existing conditions. As I mentioned at the beginning of this testimony, HB 2552 would amend the Insurance Company Law by adding a new section that would prohibit a health insurer from discriminating against a qualified individual or a qualified group based on a pre-existing medical condition. The bill defines a method of discrimination as any of the following:

- Refusing to sell, offer or issue a health insurance policy to a qualified individual or a qualified group due to a pre-existing medical condition;
- Selling, offering or issuing a health insurance policy to a qualified individual or a qualified group that excludes coverage for a preexisting medical condition;
- Considering a qualified individual's or qualified group's prior medical history in the medical underwriting process;
- Requiring or requesting a qualified individual or a qualified group to provide information regarding prior medical history as part of the health insurer's application or enrollment process; or
- Any other method or action of a health insurer that the Insurance Commissioner deems a limitation or exclusion of benefits based on the fact that a preexisting medical condition was present before the effective date of coverage, or, if coverage is denied, the date of the denial, under a qualified individual's or a qualified group's health insurance policy.

The department supports HB 2552 as currently written. No individual should be denied coverage because of their health status. Pre-existing conditions are not unusual. In one family, the mother could have a history of breast cancer, a child asthma, and the father high blood pressure. As modifications to existing insurance laws at the federal level are

considered, those with pre-existing conditions should continue to be protected here in Pennsylvania.

There are some technical and drafting issues that we believe should be addressed. For example, the bill is not clear as to what is a "qualified group" or what makes a group "qualified" for this protection, nor does it appear to address whether a pre-existing condition may factor into the rate that an individual or group would be charged. Other more technical edits may also be needed. We will be glad to work with the House Insurance Committee to submit our suggestions the at the appropriate time.

Again, thank you for allowing me to speak with you today on HB 2552. I would be happy to take any questions that you might have.

St Luke's Care Network

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Testimony of Ken Bertka, MD on House Bill 2552

July 25, 2018

Good morning. My name is Ken Bertka. I am a family physician and Vice President of Clinical Integration for St. Luke's Care Network. I am board certified in family medicine and in clinical informatics. I teach medical students and residents and see patients in our Family Medicine Residency Program in Bethlehem. My leadership role at St. Luke's is focused on the future practice of medicine. St. Luke's Care Network is our clinically integrated network composed of St. Luke's facilities, St. Luke's Physician Group, over 120 independent physician practices, and other community health care facilities working together to deliver value-based care across the health care continuum.

Thank you for allowing me to testify before members of the House Democratic Policy Committee on HB2552. This bill aims to protect people with pre-existing medical conditions by prohibiting health insurers from denying or excluding coverage based upon a pre-existing condition. Introduction of the bill was prompted by ongoing concern of repeal or invalidation of the pre-existing condition protection currently provided by the Affordable Care Act.

My testimony today has four objectives:

1. Offer support as a family physician and as a St. Luke's leader for access to health insurance coverage for people with pre-existing conditions
2. Provide an overview of those citizens of the Commonwealth of Pennsylvania who would be at most risk for lack of health care coverage if declinable conditions were a factor in the access to coverage
3. Emphasize that without a financial risk mitigation plan, prohibition on consideration of pre-existing conditions for health insurance coverage will likely lead to very high premiums and/or non-participation by health plans in the individual health insurance market
4. Suggest that in today's world of integrated and value-based care there is a role for the collection of prior medical history in the insurance enrollment process to allow proactive outreach and provision of care

Before, during and since the passage of the Affordable Care Act there has been bipartisan support for access to health insurance by people with pre-existing conditions. This is a benefit of the Affordable Care Act for which there is broad-based support to maintain. Speaking as a family physician and as a St. Luke's leader, access to essential, comprehensive medical care is critical for the health and well-being of our community. Health insurance coverage is an important part of access. We should not go backwards!

In December 2016, the Kaiser Family Foundation released an issue brief on pre-existing conditions and medical underwriting in the individual insurance market prior to the Affordable Care Act (https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/). Kaiser is a non-profit, non-partisan organization focusing on national health issues. The Kaiser brief on pre-existing conditions has data at both the national and state level that is pertinent for our discussion today. Nationally, and in Pennsylvania, Kaiser Family Foundation estimates that 27% of adults, ages 19-65 years, have health conditions that would prevent them from purchasing health insurance under pre-ACA underwriting practices when pre-existing condition exclusions were common. A larger proportion of these would be women (30%) than men (24%). Part, but not all of the difference between women and men is related to pregnancy. In the Commonwealth of Pennsylvania, 27% of the population ages 18-65 years amounts to over 2 million people. The following table from the Kaiser Family Foundation brief lists examples of common conditions for which people were declined individual insurance coverage prior to passage of the Affordable Care Act.

Table 2: Examples of Declinable Conditions In the Medically Underwritten Individual Market, Before the Affordable Care Act

Condition	Condition
AIDS/HIV	Lupus
Alcohol abuse/ Drug abuse with recent treatment	Mental disorders (severe, e.g. bipolar, eating disorder)
Alzheimer's/dementia	Multiple sclerosis
Arthritis (rheumatoid), fibromyalgia, other inflammatory joint disease	Muscular dystrophy
Cancer within some period of time (e.g. 10 years, often other than basal skin cancer)	Obesity, severe
Cerebral palsy	Organ transplant
Congestive heart failure	Paraplegia
Coronary artery/heart disease, bypass surgery	Paralysis
Crohn's disease/ ulcerative colitis	Parkinson's disease
Chronic obstructive pulmonary disease (COPD)/emphysema	Pending surgery or hospitalization
Diabetes mellitus	Pneumocystic pneumonia
Epilepsy	Pregnancy or expectant parent
Hemophilia	Sleep apnea
Hepatitis (Hep C)	Stroke
Kidney disease, renal failure	Transsexualism

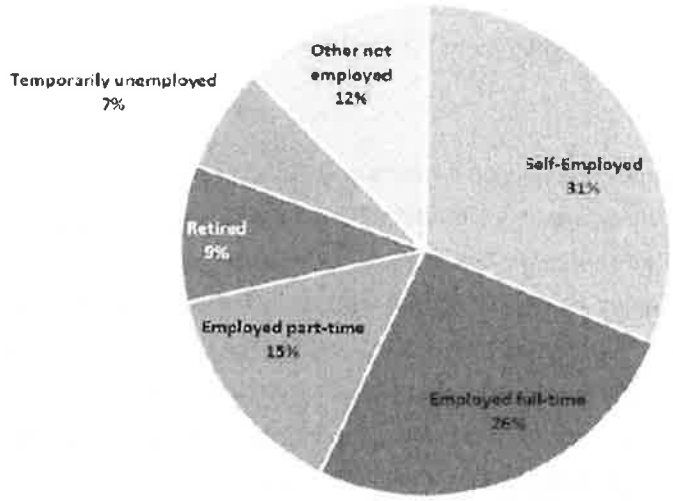
Source: Kaiser Family Foundation review of field underwriting guidelines from Aetna (GA, PA, and TX), Anthem BCBS (IN, KY, and OH), Assurant, CIGNA, Coventry, Dean Health, Golden Rule, Health Care Services Corporation (BCBS in IL, TX) HealthNet, Humana, United HealthCare, Wisconsin Physician Service. Conditions in this table appeared on declinable conditions list in half or more of guides reviewed. Note: Many additional, less-common disorders also appearing on most of the declinable conditions lists were omitted from this table.

The good news is that most individuals, with potentially declinable pre-existing conditions, have or would have coverage through an employer (group coverage) or a public program like Medicaid. Approximately 8% of the non-elderly adult population has individual market insurance. In Pennsylvania, this 8% is over 606,000 people. This is the group at highest risk of being declined coverage if pre-existing condition denials were allowed again. Although at any one point in time, 8% of the population has coverage in the individual insurance market, the composition of this group is not static. The individual insurance market is characterized by "churn." People move in and out of the individual insurance market depending upon their life situations. For

example, a student coming off his/her parents' insurance at age 27 might move into the individual insurance market pending group coverage from a new job. A person with a newly finalized divorce might lose eligibility for a group insurance plan. Nationally, the employment status of these individuals is depicted in the following figure.

Figure 1

Employment Status of Non-Group Enrollees, 2016



Source: Kaiser Family Foundation Survey of Non-Group Health Insurance Enrollees, Wave 3 (conducted Feb. 9 – Mar. 26, 2016)
Note: Employed full-time and employed part-time refers to work for someone else (not self-employed). Other not employed includes students, homemakers, and disabled.

HB2552 would prohibit the denial of insurance coverage by an insurer on the basis of a pre-existing condition or a review of prior medical history. I support this. St. Luke's University Health Network supports this. Major medical associations, such as the American Academy of Family Physicians, the American Medical Association and the Pennsylvania Academy of Family Physicians support insurance coverage for patients with pre-existing conditions.

With that support, I think it is important to explore the challenges that HB2552 will likely face. Insurers will push back that without access to prior medical history information they will not be able to adequately assess their risk exposure. Therefore, they will assume a high risk and set premiums accordingly. The premiums may be too high for many people in the individual insurance market to afford. Hence, eligibility may no longer be an insurmountable problem but cost could be. The Affordable Care Act attempted to mitigate this scenario in two ways. The first was to mandate that all adults have insurance either through a group plan (typically

through their employer) or an individual plan. Financially speaking, this mandate was designed to bring healthier people into the individual market with lower expected costs of care and, hence, lower risk. Their premium payments would offset care of higher risk patients. Second, the ACA established risk-adjustment funds collected from insurers and used to redistribute funds to plans with higher risk and costlier members. Without some form of risk abatement under HB2552, premiums for an individual insurance market plan will likely be high and/or insurance plan participation will be low. Both of these scenarios have been a challenge under the ACA which has been plagued with increasing premiums and insurers dropping out of the individual product market (known as the Exchange or Marketplace).

Additionally, the ACA allows insurers in the individual and small group markets to vary rates based upon age (limited to a ratio of 3 to 1 for adults) and tobacco use (limited to a ratio of 1.5 to 1 for adults). This provision also helps to mitigate risk to the insurer.

I would like to raise a specific concern with a section from House Bill 2552 found on page 2, lines 12-15, about prohibiting insurers from "requiring or requesting a qualified individual or a qualified group to provide information regarding prior medical history as part of the health insurer's application or enrollment process".. The intent of this part of the bill is connected to the prohibition on declining coverage to a person or group with pre-existing conditions. However, it may have an unintended consequence of preventing proactive outreach and population health management of beneficiaries. For example, St. Luke's Care Network routinely partners with payers and uses enrollment medical history information to proactively reach out to patients with chronic conditions or care gaps to engage them to receive needed care and to close care gaps before they require more expensive care or have complications. Perhaps the wording on page 2, lines 12-15 can be modified to prohibit the collection of medical history for the purposes of denying or limiting coverage while allowing collection of such information during enrollment to be used to do population health management and to proactively reach out to enrollees to close care gaps.

Thank you for your commitment to maintaining access to insurance coverage for individuals with pre-existing medical conditions. I appreciate the opportunity to comment on HB2552 and I am open to any questions that you may have.

Respectfully submitted,

Ken Bertka m.d.

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Kenneth R. Bertka, MD, FAAFP, CPHIMS

Ken Bertka is a family physician, clinical informaticist and physician executive focussed on clinical integration, value-based care, population health and healthcare transformation. He is Vice President of Clinical Integration of St. Luke's Care Network in eastern Pennsylvania – a clinically integrated network (CIN) consisting of 10 hospitals, 300 practices, 1600 physicians/providers and several post-acute facilities. Previously, he was Chief Medical Officer of Integrated Health Network of Wisconsin, a statewide CIN. Bertka held positions with Mercy Health in Ohio including CMO of Mercy Health Physicians and Mercy's CIN in northwest Ohio, and Chief Medical Information Officer for the Northern Division of Catholic Health Partners. Bertka spent 20 years in a five-physician family medicine practice which he founded. In 2004, he was the physician lead for the first multi-hospital implementation of computerized physician order entry within Catholic Health Partners. Bertka was elected to a three-year term on the American Academy of Family Physicians (AAFP) board of directors in 2007. He served six years as co-editor of *The Core Content Review of Family Medicine*. He led Mercy Health's patient-centered medical home (PCMH) initiative and chaired Mercy's Primary Care Clinical Institute. He represented the Ohio Academy of Family Physicians (OAFP) on the Ohio PCMH Education Advisory Group which developed a PCMH model for medical student and residency education. He served on the PCMH design team and episode payment steering committee of the State of Ohio's Office of Health Transformation. Bertka's career path affirms his decision to commit the remainder of his professional career to re-engineering the health care system for patients and our communities.

A member of the AAFP since 1979, Bertka has served on numerous committees and commissions. He chaired the AAFP Commission on Membership and Member Services and the AAFP Chapter Affairs Committee. He served as Board liaison to the Quality, Science, and Governmental Affairs committees. Additionally, Bertka has served in various capacities on AAFP projects relating to electronic health records, medically-related computer classes and office computerization. In his AAFP board role, he was actively involved in the transformation of the U.S. health care system through promotion of the patient-centered medical home and advocacy for primary care as the foundation of meaningful health care reform. He chaired the AAFP Task Force on Accountable Care Organizations. Presently, Bertka is President-Elect of the Council of Medical Specialty Societies. He is an accomplished speaker and author on health care transformation topics. His clinical work includes precepting residents and medical students at one of St. Luke's Family Medicine residency programs.

Bertka and his wife, Vicki (also a family physician and hospice/palliative care physician), have been recognized for their substantial contributions to their Catholic parishes, Boy Scouts of America, and family medicine. The couple was honored as AAFP Philanthropists of the Year in 2002 and OAFP Philanthropists of the Year in 2000. Bertka volunteered as a Homeland Security Ohio Citizens Corps physician, Douglas Foundation Board member and as a presenter for Tar Wars, the AAFP's tobacco-free education program.

Raised in Toledo, Ohio, Bertka attended the University of Toledo where he graduated summa cum laude with a degree in biology. He earned his medical degree at the University of Cincinnati. Bertka completed his family medicine residency at the Medical College of Ohio/St. Vincent Medical Center where he served as chief resident. He also completed a Family Medicine Faculty Development Fellowship at Michigan State University. Bertka is board certified by the American Board of Family Medicine. Bertka was in the inaugural cohort of physicians to be Board Certified in Clinical Informatics in 2013. In 2015, he was recognized as a Healthcare Hero for Lifetime Achievement by the Northwest Ohio Hospital Council.

The Bertkas have two sons. Their older son, Brian, is a US Air Force pilot and their younger son, Kevin, works in marketing. Ken enjoys model trains, computers, fishing, and cycling.

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December 2016 | Issue Brief

Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA

Gary Claxton, Cynthia Cox, Anthony Damico, Larry Levitt, Karen Pollitz

Before private insurance market rules in the Affordable Care Act (ACA) took effect in 2014, health insurance sold in the individual market in most states was medically underwritten.[1] That means insurers evaluated the health status, health history, and other risk factors of applicants to determine whether and under what terms to issue coverage. To what extent people with pre-existing health conditions are protected is likely to be a central issue in the debate over repealing and replacing the ACA.

This brief reviews medical underwriting practices by private insurers in the individual health insurance market prior to 2014, and estimates how many American adults could face difficulty obtaining private individual market insurance if the ACA were repealed or amended and such practices resumed. We examine data from two large government surveys: The National Health Interview Survey (NHIS) and the Behavioral Risk Factor Surveillance System (BRFSS), both of which can be used to estimate rates of various health conditions (NHIS at the national level and BRFSS at the state level). We consulted field underwriting manuals used in the individual market prior to passage of the ACA as a reference for commonly declinable conditions.

Estimates of the Share of Adults with Pre-Existing Conditions

We estimate that 27% of adult Americans under the age of 65 have health conditions that would likely leave them uninsurable if they applied for individual market coverage under pre-ACA underwriting practices that existed in nearly all states. While a large share of this group has coverage through an employer or public coverage where they do not face medical underwriting, these estimates quantify how many people could be ineligible for individual market insurance under pre-ACA practices if they were to ever lose this coverage. This is a conservative estimate as these surveys do not include sufficient detail on several conditions that would have been declinable before the ACA (such as HIV/AIDS, or hepatitis C). Additionally, millions more have other conditions that could be either declinable by some insurers based on their pre-ACA underwriting guidelines or grounds for higher premiums, exclusions, or limitations under pre-ACA underwriting practices. In a separate Kaiser Family Foundation poll, most people (53%) report that they or someone in their household has a pre-existing condition.

A larger share of nonelderly women (30%) than men (24%) have declinable preexisting conditions. We estimate that 22.8 million nonelderly men have a preexisting condition that would have left them uninsurable in the individual market pre-ACA, compared to 29.4 million women. Pregnancy explains part, but not all of the difference.

The rates of declinable pre-existing conditions vary from state to state. On the low end, in Colorado and Minnesota, at least 22% of non-elderly adults have conditions that would likely be declinable if they were to seek coverage in the individual market under pre-ACA underwriting practices. Rates are higher in other states – particularly in the South – such as Tennessee (32%), Arkansas (32%), Alabama (33%), Kentucky (33%), Mississippi (34%), and West Virginia (36%), where at least a third of the non-elderly population would have declinable conditions.

At any given time, the vast majority of these approximately 52 million people with declinable pre-existing conditions have coverage through an employer or through public programs like Medicaid. The individual market is where people seek health insurance during times in their lives when they lack eligibility for job-based coverage or for public programs such as Medicare and Medicaid. In 2015, about 8% of the non-elderly population had individual market insurance. Over a several-year period, however, a much larger share may seek individual market coverage.[2] This market is characterized by churn, as new enrollees join and others leave (often for other forms of coverage). For many people, the need for individual market coverage is intermittent, for example, following a 26th birthday, job loss, or divorce that ends eligibility for group plan coverage, until they again become eligible for group or public coverage. For others – the self-employed, early retirees, and lower-wage workers in jobs that typically don't come with health benefits – the need for individual market coverage is ongoing. (Figure 1 shows the distribution of employment status among current individual market enrollees.)

Prior to the ACA's coverage expansions, we estimated that 18% of individual market applications were denied. This is an underestimate of the impact of medical underwriting because many people with

Table 1: Estimated Number and Percent of Non- Elderly People with Declinable Pre- existing Conditions Under Pre- ACA Practices, 2015

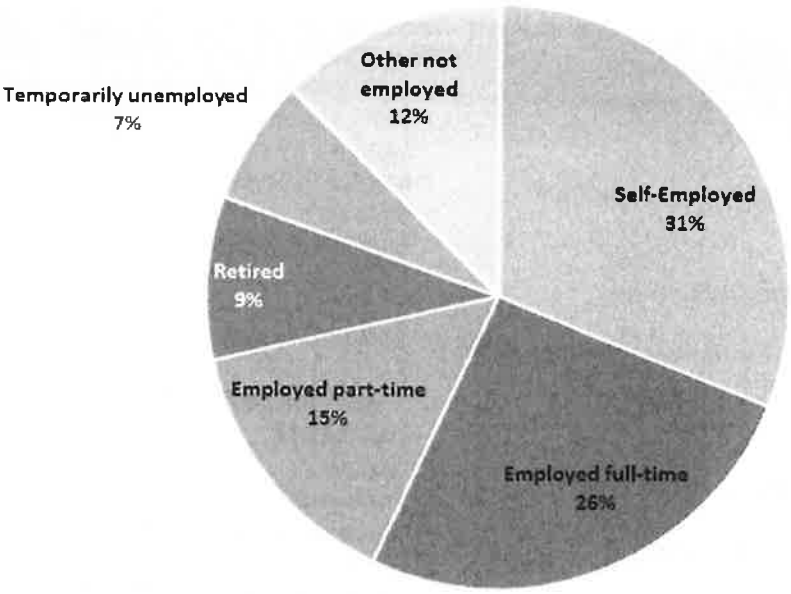
State	Percent of Non-Elderly Population	Number of Non-Elderly Adults
Alabama	33%	942,000
Alaska	23%	107,000
Arizona	26%	1,043,000
Arkansas	32%	556,000
California	24%	5,865,000
Colorado	22%	753,000
Connecticut	24%	522,000
Delaware	29%	163,000
District of Columbia	23%	106,000
Florida	26%	3,116,000
Georgia	29%	1,791,000
Hawaii	24%	209,000
Idaho	25%	238,000
Illinois	26%	2,038,000
Indiana	30%	1,175,000
Iowa	24%	448,000
Kansas	30%	504,000
Kentucky	33%	881,000
Louisiana	30%	849,000
Maine	29%	229,000
Maryland	26%	975,000
Massachusetts	24%	999,000
Michigan	28%	1,687,000
Minnesota	22%	744,000
Mississippi	34%	595,000
Missouri	30%	1,090,000
Montana	25%	152,000
Nebraska	25%	275,000
Nevada	25%	439,000
New Hampshire	24%	201,000
New Jersey	23%	1,234,000
New Mexico	27%	332,000
New York	25%	3,031,000
North Carolina	27%	1,658,000
North Dakota	24%	111,000
Ohio	28%	1,919,000
Oklahoma	31%	706,000
Oregon	27%	654,000
Pennsylvania	27%	2,045,000
Rhode Island	25%	164,000
South Carolina	28%	822,000
South Dakota	25%	126,000
Tennessee	32%	1,265,000
Texas	27%	4,536,000
Utah	23%	391,000
Vermont	25%	96,000
Virginia	26%	1,344,000
Washington	25%	1,095,000
West Virginia	36%	392,000
Wisconsin	25%	852,000
Wyoming	27%	94,000
US	**27%**	**52,240,000**

Source: Kaiser Family Foundation analysis of data from National Health Interview Survey and the Behavioral Risk Factor Surveillance System.
Note: Five states (MA, ME, NJ, NY, VT) had broadly applicable guaranteed access to insurance before the ACA. What protections might exist in these or other states under a repeal and replace scenario is unclear.

health conditions did not apply because they knew or were informed by an agent that they would not be accepted. Denial rates ranged from 0% in a handful of states with guaranteed issue to 33% in Kentucky, North Carolina, and Ohio. According to 2008 data from America's Health Insurance Plans, denial rates ranged from about 5% for children to 29% for adults age 60-64 (again, not accounting for those who did not apply).

Figure 1

Employment Status of Non-Group Enrollees, 2016



Source: Kaiser Family Foundation Survey of Non-Group Health Insurance Enrollees, Wave 3 (conducted Feb. 9 – Mar. 26, 2016)
Note: Employed full-time and employed part-time refers to work for someone else (not self-employed). Other not employed includes students, homemakers, and disabled.

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Medical Underwriting in the Individual Market Pre-ACA

Prior to 2014 medical underwriting was permitted in the individual insurance market in 45 states and DC. Applications for individual market policies typically included lengthy questionnaires about the health and risk status of the applicant and all family members to be covered. Typically, applicants were asked to disclose whether they were pregnant or contemplating pregnancy or adoption, and information about all physician visits, prescription medications, lab results, and other medical care received in the past year. In addition, applications asked about personal history of a series of health conditions, ranging from HIV, cancer, and heart disease to hemorrhoids, ear infections and tonsillitis. Finally, all applications included authorization for the insurer to obtain and review all medical records, pharmacy database information, and related information.

Once the completed application was submitted, the medical underwriting process varied somewhat across insurers, but usually involved identification of declinable medical conditions and evaluation of other conditions or risk factors that warranted other adverse underwriting actions. Once enrolled, a person's health and risk status was sometimes reconsidered in a process called post-claims underwriting. Although our analysis focuses on declinable medication conditions, each of these other actions is described in more detail below.

Declinable Medical Conditions

Before the ACA, individual market insurers in all but five states maintained lists of so-called declinable medical conditions. People with a current or past diagnosis of one or more listed conditions were automatically denied. Insurer lists varied somewhat from company to company, though with substantial overlap. Some of the commonly listed conditions are shown in Table 2.

Table 2: Examples of Declinable Conditions In the Medically Underwritten Individual Market, Before the Affordable Care Act

Condition	Condition
AIDS/HIV	Lupus
Alcohol abuse/ Drug abuse with recent treatment	Mental disorders (severe, e.g. bipolar, eating disorder)
Alzheimer's/dementia	Multiple sclerosis
Arthritis (rheumatoid), fibromyalgia, other inflammatory joint disease	Muscular dystrophy
Cancer within some period of time (e.g. 10 years, often other than basal skin cancer)	Obesity, severe
Cerebral palsy	Organ transplant
Congestive heart failure	Paraplegia
Coronary artery/heart disease, bypass surgery	Paralysis
Crohn's disease/ ulcerative colitis	Parkinson's disease
Chronic obstructive pulmonary disease (COPD)/emphysema	Pending surgery or hospitalization
Diabetes mellitus	Pneumocystic pneumonia
Epilepsy	Pregnancy or expectant parent
Hemophilia	Sleep apnea
Hepatitis (Hep C)	Stroke
Kidney disease, renal failure	Transsexualism

Source: Kaiser Family Foundation review of field underwriting guidelines from Aetna (GA, PA, and TX), Anthem BCBS (IN, KY, and OH), Assurant, CIGNA, Coventry, Dean Health, Golden Rule, Health Care Services Corporation (BCBS in IL, TX) HealthNet, Humana, United HealthCare, Wisconsin Physician Service. Conditions in this table appeared on declinable conditions list in half or more of guides reviewed. Note: Many additional, less-common disorders also appearing on most of the declinable conditions lists were omitted from this table.

Our analysis of rates of pre-existing conditions in this brief focuses on those conditions that would likely be declinable, based on our review of pre-ACA underwriting documents. Our analysis is limited – and our results are conservative – because NHIS and BRFSS questionnaires do not address some of the conditions that were declinable, and in some cases the questions that do relate to declinable conditions were too broad for inclusion. See the methodology section for a list of conditions included in the analysis.

In addition to declinable conditions, many insurers also maintained a list of declinable medications. Current use of any of these medications by an applicant would warrant denial of coverage. Table 3 provides an examp

of medications that were declinable in one insurer prior to the ACA. Our analysis does not attempt to account for use of declinable medications.

Table 3: Declinable Medications

Anti- Arthritic Medications
- Adalimumab/Humira
- Cyclosporine/Sandimmune
- Methotrexate/Trexall
- Ustekinumab/Stelara
- others

Anti- Cancer Medications
- Anastrozole/Arimidex
- Nolvadex/Tamoxifen
- Femara
- others

Anti- Coagulant/Anti-Thrombotic Medications
- Clopidogrel/Plavix
- Coumadin/Warfarin
- Heparin
- others

Anti- Diabetic Medications
- Avandia/Rosiglitazone
- Glucagon
- Humalog/Insulin products
- Metformin HCL
- others

Anti- Psychotics, Autism, Other Central Nervous System Medications
- Abilify/Ariprazole
- Aricept/Donepezil
- Clozapine/Clozaril
- Haldol/Haldoperidol
- Lithium
- Requip/Ropinerole
- Risperdal/Risperidone
- Zyprexa
- others

Medications for HIV/AIDS or Hepatitis
- Abacavir/Ziagen
- Efavirenz/Atripla
- Interferon
- Lamivudine/Epivir
- Ribavirin
- Zidovudine/Retrovir
- others

Miscellaneous Medications
- Anginine (angina)
- Clomid (fertility)
- Epoetin/Epogen (anemia)
- Genotropin (growth hormone)
- Remicade (arthritis, ulcerative colitis)
- Xyrem (narcolepsy)
- others

Source: Blue Cross Blue Shield of Illinois, Product Guide for Agents

Some individual market insurers also developed lists of ineligible occupations. These were jobs considered sufficiently high risk that people so employed would be automatically denied. In addition, some would automatically deny applicants who engaged in certain leisure activities and sports. Table 4 provides an example of declinable occupations from one insurer prior to the ACA. Our analysis does not attempt to account for declinable occupations.

Table 4: Ineligible Occupations, Activities

Active military personnel	Iron workers	Professional athletes
Air traffic controller	Law enforcement/detectives	Sawmill operators
Aviation and air transportation	Loggers	Scuba divers
Blasters or explosive handlers	Meat packers/processors	Security guards
Bodyguards	Mining	Steel metal workers
Crop dusters	Nuclear industry workers	Steeplejacks
Firefighters/EMTs	Offshore drillers/workers	Strong man competitors
Hang gliding	Oil and gas exploration and drilling	Taxi cab drivers
Hazardous material handlers	Pilots	Window washers

Source: Preferred One Insurance Company Individual and Family Insurance Application Form

Other Adverse Underwriting Actions

Beyond the declinable conditions, medications and occupations, underwriters also examined individual applications and medical records for other conditions that could generate significant "losses" (claims expenses.) Among such conditions were acne, allergies, anxiety, asthma, basal cell skin cancer, depression, ear infections, fractures, high cholesterol, hypertension, incontinence, joint injuries, kidney stones, menstrual irregularities, migraine headaches, overweight, restless leg syndrome, tonsillitis, urinary tract infections, varicose veins, and vertigo. One or more adverse medical underwriting actions could result for applicants with such conditions, including:

- **Rate-up** – The applicant might be offered a policy with a surcharged premium (e.g. 150 percent of the standard rate premium that would be offered to someone in perfect health)
- **Exclusion rider** – Coverage for treatment of the specified condition might be excluded under the policy; alternatively, the body part or system affected by the specified condition could be excluded under the policy. Exclusion riders might be temporary (for a period of years) or permanent
- **Increased deductible** – The applicant might be offered a policy with a higher deductible than the one originally sought; the higher deductible might apply to all covered benefits or a condition-specific deductible might be applied
- **Modified benefits** – The applicant might be offered a policy with certain benefits limited or excluded, for example, a policy that does not include prescription drug coverage.

In some cases, individuals with these conditions might also be declined depending on their health history and the insurer's general underwriting approach. For example, field underwriting guides indicated different underwriting approaches for an applicant whose child had chronic ear infections:

- One large, national insurer would issue standard coverage if the child had fewer than five infections in the past year or ear tubes, but apply a 50% rate up if there had been more than 4 infections in the prior year;
- Another insurer, which used a 12-tier rate system, would issue coverage at the second most favorable rate tier if the child had just one infection in the prior year or ear tubes, at the fifth rate tier if there had been 2-3 infections during the prior year, and at the seventh tier if there had been 4 or more infections; for some conditions, this company's rating might depend on the plan deductible – applicants with history of ear infections would be offered the second rating tier for policies with a deductible of $5,000 or higher;
- Another insurer would issue standard coverage if the child had just one infection in the prior year or if ear tubes had been inserted more than one-year prior, apply a rate up if there were two infections in the prior year, and decline the application if there were three or more infections;
- Another insurer would issue standard coverage if the child had fewer than 3 infections in the past year, but issue coverage with a condition specific deductible of $5,000 if there had been 3 or more infections or if ear tubes had been inserted.

In a 2000 Kaiser Family Foundation study of medical underwriting practices, insurers were asked to underwrite hypothetical applicants with varying health conditions, from seasonal allergies to situational

depression to HIV. Results varied significantly for less serious conditions. For example, the applicant with seasonal allergies who made 60 applications for coverage was offered standard coverage 3 times, declined 5 times, offered policies with exclusion riders or other benefit limits 46 times (including 3 offers that excluded coverage for her upper respiratory system), and policies with premium rate ups (averaging 25%) 6 times.

Pre- existing Condition Exclusion Provisions

In addition to medical screening of applicants before coverage was issued, most individual market policies also included more general pre-existing condition exclusion provisions which limited the policy's liability for claims (typically within the first year) related to medical conditions that could be determined to exist prior to the coverage taking effect.[3]

The nature of pre-existing condition exclusion clauses varied depending on state law. In 19 states, a health condition could only be considered pre-existing if the individual had actually received treatment or medical advice for the condition during a "lookback" period prior to the coverage effective date (from 6 months to 5 years). In most states, a pre-existing condition could also include one that had not been diagnosed but that produced signs or symptoms that would prompt an "ordinarily prudent person" to seek medical advice, diagnosis or treatment. In 8 states and DC, conditions that existed prior to the coverage effective date – including those that were undiagnosed and asymptomatic – could be considered pre-existing and so excluded from coverage under an individual market policy. For example, a congenital condition in a newborn could be considered pre-existing to the coverage effective date (the baby's birth date) and excluded from coverage. About half of the states required individual market insurers to reduce pre-existing condition exclusion periods by the number of months of an enrollee's prior coverage.

Example of pre-existing condition exclusion

Jean, an Arizona teacher whose employer provided group health benefits but did not contribute to the cost for family members, gave birth to her daughter, Alex, in 2004 and soon after applied for an individual policy to cover the baby. Due to time involved in the medical underwriting process, the baby was uninsured for about 2 weeks. A few months later, Jean noticed swelling around the baby's face and eyes. A specialist diagnosed Alex with a rare congenital disorder that prematurely fused the bones of her skull. Surgery was needed immediately to avoid permanent brain damage. When Jean sought prior-authorization for the $90,000 procedure, the insurer said it would not be covered. Under Arizona law, any condition, including congenital conditions, that existed prior to the coverage effective date, could be considered a pre-existing condition under individual market policies. Alex's policy excluded coverage for pre-existing conditions for one year. Jean appealed to the state insurance regulator who upheld the insurer's exclusion as consistent with state law.

Source: Wall Street Journal, May 31, 2005

Unlike exclusion riders that limited coverage for a specified condition of a specific enrollee, pre-existing condition clauses were general in nature and could affect coverage for any applicable condition of any enrollee. Pre-existing condition exclusions were typically invoked following a process called post-claims underwriting. If a policyholder would submit a claim for an expensive service or condition during the first year of coverage, the individual market insurer would conduct an investigation to determine whether the condition could be classified as pre-existing.

In some cases, post-claims underwriting might also result in coverage being cancelled. The investigations would also examine patient records for evidence that a pre-existing condition was known to the patient and should have been disclosed on the application. In such cases, instead of invoking the pre-existing condition clause, an issuer might act to rescind the policy, arguing it would have not issued coverage in the first place had the pre-existing condition been disclosed.

Example of policy rescission

Jennifer, a Colorado preschool teacher, was seriously injured in 2005 when her car was hit by a drug dealer fleeing the police. She required months of inpatient hospitalization and rehab, and her bills reached $185,000. Jennifer was covered by a non-group policy which she had purchased five months prior to the accident. Shortly after her claims were submitted, the insurer re-reviewed Jennifer's application and medical history. Following its investigation, the insurer notified Jennifer they found records of medical care she had not disclosed in her application, including medical advice sought for discomfort from a prolapsed uterus and an ER visit for shortness of breath. The insurer rescinded the policy citing Jennifer's failure to disclose this history. Jennifer sued the insurer for bad faith; four years later a jury ordered the insurer to reinstate the policy and pay $37 million in damages.

Source: Westworld, February 11, 2010.

Discussion

The Affordable Care Act guarantees access to health insurance in the individual market and ends other underwriting practices that left many people with pre-existing conditions uninsured or with limited coverage before the law. As discussions get underway to repeal and replace the ACA, this analysis quantifies the number of adults who would be at risk of being denied if they were to seek coverage in the individual market under pre-ACA rules. What types of protections are preserved for people with pre-existing conditions will be a key element in the debate over repealing and replacing the ACA.

We estimate that at least 52 million non-elderly adult Americans (27% of those under the age of 65) have a health condition that would leave them uninsurable under medical underwriting practices used in the vast majority of state individual markets prior to the ACA. Results vary from state-to-state, with rates ranging around 22 - 23% in some Northern and Western states to 33% or more in some southern states. Our estimates are conservative and do not account for a number of conditions that were often declinable (but for which data are not available), nor do our estimates account for declinable medications, declinable occupations, and conditions that could lead to other adverse underwriting practices (such as higher premiums or exclusions).

While most people with pre-existing conditions have employer or public coverage at any given time, many people seek individual market coverage at some point in their lives, such as when they are between jobs, retired, or self-employed.

There is bipartisan desire to protect people with pre-existing conditions, but the details of replacement plans have yet to be ironed out, and those details will shape how accessible insurance is for people when they have health conditions.

Gary Claxton, Cynthia Cox, Larry Levitt, and Karen Pollitz are with the Kaiser Family Foundation. Anthony Damico is an independent consultant to the Kaiser Family Foundation.

Methods

To calculate nationwide prevalence rates of declinable health conditions, we reviewed the survey responses of nonelderly adults for all question items shown in Methods Table 1 using the CDC's 2015 National Health Interview Survey (NHIS). Approximately 27% of 18-64 year olds, or 52 million nonelderly adults, reported having at least one of these declinable conditions in response to the 2015 survey. The CDC's National Center for Health Statistics (NCHS) relies on the medical condition modules of the annual NHIS for many of its core publications on the topic; therefore, we consider this survey to be the most accurate means to estimate both the nationwide rate and weighted population.

Since the NHIS does not include state identifiers nor sufficient sample size for most state-based estimates, we constructed a regression model for the CDC's 2015 Behavioral Risk Factor Surveillance System (BRFSS) to estimate the prevalence of any of the declinable conditions shown in Methods Table 1 at the state level. This model relied on three highly significant predictors: (a) respondent age; (b) self-reported fair or poor health

status; (c) self-report of any of the overlapping variables shown in the left-hand column of Methods Table 1. Across the two data sets, the prevalence rate calculated using the analogous questions (i.e. the left-hand column of Methods Table 1) lined up closely, with 20% of 18-64 year old survey respondents reporting at least one of those declinable conditions in the 2015 NHIS and 21% of 18-64 year olds in the 2015 BRFSS. Applying this prediction model directly to the 2015 BRFSS microdata yielded a nationwide prevalence of any declinable condition of 28%, a near match to the NHIS nationwide estimate of 27%.

Methods Table 1: Declinable Medical Conditions Available in Survey Microdata

Declinable Condition Questions Available in both the 2015 National Health Interview Survey and also the 2015 Behavioral Risk Factor Surveillance System	Declinable Condition Questions Available in only the 2015 National Health Interview Survey
Ever had CHD	Melanoma Skin Cancer
Ever had Angina	Any Other Heart Condition
Ever had Heart Attack	Crohn's Disease or Ulcerative Colitis
Ever had Stroke	Epilepsy
Ever had COPD	Difficulty Due to Mental Retardation
Ever had Emphysema	Difficulty Due to Cerebral Palsy
Chronic Bronchitis in past 12 months	Difficulty Due to Senility
Ever had Non-Skin Cancer	Difficulty Due to Depression
Ever had Diabetes	Difficulty Due to Endocrine Problem
Weak or Failing Kidneys	Difficulty Due to Blood Forming Organ Problem
BMI > 40	Difficulty Due to Drug / Alcohol / Substance Abuse
Pregnant	Difficulty Due to Schizophrenia, ADD, or Bipolar Disorder

In order to align BRFSS to NHIS overall statistics, we then applied a Generalized Regression Estimator (GREG) to scale down the BRFSS microdata's prevalence rate and population estimate to the equivalent estimates from NHIS, 27% and 52 million. Since the regression described in the previous paragraph already predicted the prevalence rate of declinable conditions in BRFSS by using survey variables shared across the two datasets, this secondary calibration solely served to produce a more conservative estimate of declinable conditions by calibrating BRFSS estimates to the NHIS. After applying this calibration, we calculated state-specific prevalence rates and population estimates off of this post-stratified BRFSS sample.

The programming code, written using the statistical computing package R v.3.3.2, is available upon request for people interested in replicating this approach for their own analysis.

Endnotes

[1] In 2013, five states – Maine, Massachusetts, New Jersey, New York, and Vermont – required all non-group health insurance policies to be offered on a guaranteed issue basis (meaning applicants could not be denied based on health status) with community rating (meaning premiums could not vary based on health status).

[2] See, for example, L Duchon, "Security Matters: How Instability in Health Insurance Puts US Workers at Risk," The Commonwealth Fund, 2001. There has also been a long-term decline in employer offer rates. See Kaiser Family Foundation "Diminishing Offer and Coverage Rates Among Private Sector Employees" available at http://kff.org/private-insurance/issue-brief/diminishing-offer-and-coverage-rates-among-private-sector-employees/

[3] Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), eligible individuals who had at least 18 months of continuous prior coverage, who were leaving group health plan coverage, and who met other requirements, had to be offered non-group policies on a guaranteed issue basis with no pre-existing condition exclusions. HIPAA gave insurers flexibility to limit the number of guaranteed issue policies to two. In addition, HIPAA gave states flexibility to offer eligible individuals an alternative source of individual market coverage, such as high-risk pool coverage, which most states elected to do. See Kaiser Family Foundation State Health Facts.

Capital BLUE

Public Testimony
House Democrat Policy Committee
House Bill 2552

Wednesday, July 25, 2018

Douglas Furness
Senior Director of Government & Regulatory Affairs

Good Morning Chairman Sturla and other members of the Committee. Thank you for the opportunity to offer comments on House Bill 2552. Also, thank you to Rep. Schweyer for bringing this issue to the attention of the Legislature.

First, I would like to give a little background on Capital Blue Cross (CBC). CBC has been providing quality health insurance to its customers in South Central Pennsylvania and the Lehigh Valley for 80 years. We are fortunate to provide coverage for approximately 800,000 Pennsylvanians in one of the most competitive health insurance markets in the country.

House Bill 2552 – as written - would prohibit health insurers from using an individual's pre-existing medical condition to deny or exclude coverage under a health insurance policy. CBC traditionally has not made it a practice to refuse insurance to a customer because of a pre-existing condition, and currently, the Patient Protection and Affordable Care Act (ACA) prohibits this activity. It is important to recognize that the pre-existing condition exclusion was included in the ACA so those with chronic illnesses could receive the care they need at a much lower cost than if they had to pay for it on their own.

We understand House Bill 2552 is meant as a safeguard should the ACA's pre-existing condition exclusion be repealed through legislation or litigation. However, it is unclear at best whether any Congressional action of this type will occur.

That said, should the ACA be repealed by Congress or the federal courts rule against the pre-existing condition exclusion, reforms of this type should not be made in a vacuum. The pre-existing condition exclusion is only one part of the ACA. Simply prohibiting insurers from using it post ACA, while not examining other stabilization measures, could impact pricing and further destabilize an already unpredictable health insurance market.

Eliminating a pre-existing condition exclusion only works if some of the other basic tenants of the ACA are also included. Examining a strong individual mandate and clearly defined open enrollment periods appear essential to avoid the inevitability of adverse selection and the possibility that individuals would only buy insurance as necessary.

Other changes would also be needed to add predictability and affordability to the market. They include examining a reinsurance program to help pay for the cost of caring for those with significant medical needs, and also providing funding for cost-sharing reductions that reduce out-of-pocket costs for customers.

It is also important to note that while the reforms included in the ACA have been beneficial to consumers, more insurance risks are moving into the self-insured market as a result. What we are seeing is a two-tier health care system with different rules in each system.

Once again, thank you for inviting me here today. CBC appreciates the opportunity to engage in discussions on House Bill 2552. We will continue to follow the fate of the ACA at the federal level and anticipate working with the legislature to ensure adequate health insurance coverage for all Pennsylvanians in the event the pre-existing condition provision is eliminated.

Testimony on the Need for Pre-Existing Condition Protections in Pennsylvania
Alvaro Castillo, Community Engagement Specialist
Pennsylvania Health Access Network
House Democratic Policy Committee
July 25, 2018

My name is Alvaro Castillo and I am a Community Engagement Specialist with the Pennsylvania Health Access Network (PHAN). PHAN is Pennsylvania's only statewide consumer advocacy organization working to expand and protect access to high-quality, equitable, affordable healthcare for all Pennsylvanians. We work to ensure that the voices of people who would be directly impacted by healthcare policy are heard. We also operate a statewide helpline connecting individuals and their families to health coverage through the Marketplace, Medicaid, and CHIP. Over the past four years, we have connected over 8,500 individuals to coverage in 51 of 67 counties. Each year, we answer over 8,000 calls to our helpline. We help consumers from every walk of life. We help folks from both rural and urban communities, small business owners and hourly employees.

The establishment of pre-existing condition protections is one of the Affordable Care Act's signature accomplishments. Before these protections were established, insurance companies were allowed to charge people with pre-existing conditions more or deny them coverage altogether based on their medical history and regularly did. Pre-existing conditions included anything from cancer to diabetes to high blood pressure to asthma. Approximately 133 million non-elderly Americans have pre-existing conditions.[1] This includes 5.3 million Pennsylvanians.[2] Thanks to the Affordable Care Act, people with a pre-existing condition can now access affordable healthcare coverage.

Meet Ali Shapiro from Pittsburgh, PA:

Ali was diagnosed with cancer at the age of 13. Research confirmed that her Hodgkin's lymphoma was in part caused by pesticide exposure on a neighbor's lawn. In other words, she was unlucky. Thankfully, she recovered from her cancer and is now healthier than most 39-year-olds. She is on no medications and has healed from all the accompanying health issues that came as a result of chemotherapy and cancer. Being a cancer survivor, however, made it difficult – if not impossible -- to get health insurance before pre-existing condition protections were established. As an entrepreneur who runs a successful health coaching business full-time for the last ten years, Ali is contributing to her community with her work and the risks she has taken. The Affordable Care Act's ban on discrimination against those with pre-existing conditions combined with access to affordable plans has made it possible for her to remain an entrepreneur and get an affordable health insurance plan. Without these protections, ten years of work could go up in smoke.

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[1] https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf
[2] https://www.americanprogress.org/issues/healthcare/news/2017/04/05/430059/number-americans-pre-existing-conditions-congressional-district/

Pre-existing condition protections are currently in danger in multiple ways.

A lawsuit, *Texas v. HHS,* argues that the elimination of the coverage requirement under the recently passed tax law warrants the elimination of the Affordable Care Act's pre-existing condition protections. As part of this litigation, the Justice Department has told a federal court that it is opting to not defend the existing law and regulations under the Affordable Care Act, including protections for those with pre-existing conditions. If the challenge to pre-existing conditions under *Texas v. HHS* prevails, Pennsylvanians may lose access to pre-existing condition protections.

In another attempt to undermine pre-existing condition protections, the Trump administration is pushing states to allow increased usage of plans that do not cover all the essential health benefits or provide protections for pre-existing conditions. These plans – including short-term, limited duration plans and association health plans — were prohibited by the Affordable Care Act because they left many without adequate coverage.

Short-term plans are currently allowed as a *short-term* solution for people with gaps in coverage. The Affordable Care Act allows this for up to three months, but it requires that individuals have full coverage for the majority of the year. The Trump Administration, however, wants to lengthen the amount of time that people can be covered by these plans, possibly extending them beyond a year.

Without any protections, the impact of short-term plans on Pennsylvania is significant, according to a report by the Urban Institute. Importantly, the effect is cumulative when combined with the repeal of the Affordable Care Act's individual mandate last fall as part of the tax package as both policies encourage younger, healthier individuals to leave the marketplace.

According to this report, 209,000 are expected to lose coverage in Pennsylvania as a result of the repeal of the individual mandate. Because of the resulting increase in premiums, expanding short-term plans would add an additional 87,000 – or 18.2% of those who currently have marketplace covered– to the uninsured. The 165,000 expected to be covered under short-term plans will be technically insured, but their coverage will be inadequate. Combining the effects of this exodus from the marketplace, we would expect to see a significant increase in individual marketplace plan premiums.

Under House Bill 2552, Pennsylvanians with pre-existing conditions would be protected from all of these challenges.

The 165,000 who enroll in short-term plans would, at a minimum, be certain that benefits under the plan would cover people with pre-existing conditions. Fewer people would likely become uninsured because the cost of short-term plans would need to increase to cover pre-

existing conditions, and they would therefore be less attractive to people. As a result, fewer people would enroll in them, and premiums on the individual marketplace would not rise as quickly.

We don't have these numbers for association health plans, but the same logic would be true: those who do go over to less desirable coverage options would at least have some protection, and fewer people would be uninsured because fewer people would enroll and premiums wouldn't rise so quickly.

If challenges to pre-existing condition protections in the courts – like *Texas v. HHS* – prevail, a state-based protection like the one proposed in HB 2552 would ensure that Pennsylvanians with pre-existing conditions can still get affordable coverage.

HB 2552 is necessary legislation that will provide critical protections and stabilize our health insurance marketplace, despite the instability and confusion coming out of Washington. If pre-existing condition protections are lost, 5.3 million lives are on the line.

While this law is a necessary first step, we believe Pennsylvania should also consider requiring plans to cover the 10 essential health benefits without lifetime or annual limits and with out-of-pocket maximums to subsequently reduce the number of individuals without minimum essential coverage, reduce the number of uninsured individuals, keep markets competitive, and keep premiums from rising.

Thank you for this opportunity to testify today.

House Co-Sponsorship Memoranda

House of Representatives
Session of 2017 - 2018 Regular Session

MEMORANDUM

Posted: June 19, 2018 03:50 PM
From: Representative Peter Schweyer
To: All House members
Subject: Prohibiting Health Insurers from Denying or Excluding Coverage Based on a Pre-Existing Condition (Companion to SB 958)

On February 26th of this year, 20 states filed a lawsuit against the federal government to challenge the constitutionality of the Patient Protection and Affordable Care Act (ACA). The lawsuit argues that, because Congress eliminated the individual mandate tax penalty of the ACA as part of tax reform legislation in December 2017, the entire ACA is invalid. As a representative of the United States government, the Department of Justice (DOJ) typically defends the laws of the land; however, on June 7, 2018, the DOJ announced that it will not defend several critical provisions of the ACA in court. One such provision includes the key patient protection that prohibits insurers from denying medical coverage for people with pre-existing medical conditions.

If the DOJ persists in refusing to defend this provision of the ACA, and the lawsuit against it is successful, millions of people across this nation and in Pennsylvania may be left without health insurance or face paying exorbitant premiums to keep coverage. However, by passing a state law, we can preserve the pre-existing condition protection in the instance that the entire ACA is invalidated by the courts.

It is for this reason that I plan to introduce a companion bill to Senate Bill 958, introduced by Senator Hughes, which would prohibit health insurers from using an individual's pre-existing medical condition to deny or exclude coverage under a health insurance policy. It is my hope that my colleagues join me in co-sponsoring this very important legislation in an effort to protect the health and wellbeing of all Pennsylvanians.

Introduced as HB2552

PRINTER'S NO. 3858

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 2552 Session of 2018

INTRODUCED BY SCHWEYER, DeLUCA, HARKINS, MURT, DEAN, SIMS, DONATUCCI, RABB, STURLA, CALTAGIRONE, A. DAVIS, KORTZ, SCHLOSSBERG, CHARLTON, DAVIS, J. McNEILL, BIZZARRO, GOODMAN, RAVENSTAHL, YOUNGBLOOD, TAI, D. MILLER, ROEBUCK, FREEMAN, DRISCOLL, DAVIDSON AND DALEY, JULY 10, 2018

REFERRED TO COMMITTEE ON INSURANCE, JULY 10, 2018

AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," in health and accident insurance, prohibiting exclusions for preexisting conditions.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended by adding a section to read:

Section 635.8. Exclusions For Preexisting Conditions.--(a) A health insurer shall be prohibited from discriminating against a qualified individual or a qualified group based on a preexisting medical condition.

(b) Methods of discriminating based on preexisting medical conditions shall include:

(1) refusing to sell, offer or issue a health insurance policy to a qualified individual or a qualified group due to a preexisting medical condition;

(2) selling, offering or issuing a health insurance policy to a qualified individual or a qualified group that excludes coverage for a preexisting medical condition;

(3) considering a qualified individual's or qualified group's prior medical history in the medical underwriting process;

(4) requiring or requesting a qualified individual or a qualified group to provide information regarding prior medical history as part of the health insurer's application or enrollment process; or

(5) any other method or action of a health insurer that the Insurance Commissioner deems a limitation or exclusion of benefits based on the fact that a preexisting medical condition was present before the effective date of coverage, or, if coverage is denied, the date of the denial, under a qualified individual's or a qualified group's health insurance policy.

(c) This section shall apply as follows:

(1) For health insurance policies for which either rates or forms are required to be filed with the Insurance Department or the Federal Government, this section shall apply to any policy for which a form or rate is first filed on or after the effective date of this section.

(2) For health insurance policies for which neither rates nor forms are required to be filed with the Insurance Department or the Federal Government, this section shall apply to any

policy issued or renewed on or after 180 days after the effective date of this section.

(d) As used in this section, the following words and phrases shall have the meanings given to them in this subsection unless the context clearly indicates otherwise:

"Government program." Any of the following:

(1) The Commonwealth's medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the "Human Services Code."

(2) A program under Article XXIII-A.

"Health insurance policy." Any individual or group health, sickness or accident policy, or subscriber contract or certificate offered, issued or renewed by a health insurer. The term does not include any of the following types of insurance:

(1) Accident only.

(2) Fixed indemnity.

(3) Limited benefit.

(4) Credit.

(5) Dental.

(6) Vision.

(7) Specified disease.

(8) Medicare supplement.

(9) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) supplement.

(10) Long-term care or disability income.

(11) Workers' compensation.

(12) Automobile medical payment.

"Health insurer." An entity that issues a health insurance policy and is subject to the following:

(1) this act, including, but not limited to, section 630 and

Article XXIV;

(2) the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act"; or

(3) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

"Preexisting medical condition." A physical or mental condition, including, but not limited to, a disease, an illness, an injury, pregnancy or a genetic defect for which medical advice, diagnosis, care or treatment has been recommended or received prior to the effective date of coverage.

"Qualified group." Any of the following:

(1) A group of qualified individuals covered or applying for coverage under the same health insurance policy.

(2) A group of individuals covered under an employer sponsored group health insurance policy.

"Qualified individual." Any of the following:

(1) An individual who is less than nineteen (19) years of age.

(2) An individual who:

(i) is covered or applying for coverage under a health insurance policy; and

(ii) has had health coverage under a health insurance policy or government program for at least nine months of the twelve consecutive month period immediately preceding the date of application or enrollment.

Section 2. This act shall take effect in 30 days.