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INSIGHT

Consumer Protections in Private Health Insurance for Individuals with Preexisting Health Conditions

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Individuals with preexisting health conditions may have concerns about practices in the private health insurance market in which insurers use medical underwriting to assess their risk of offering health insurance to applicants. Before full implementation of the Affordable Care Act's (ACA's; P.L. 111-148, as amended) insurance reforms, subject to certain exceptions, insurers generally were permitted to consider health factors in determining the offer of insurance, its price, and covered health services. Although references to individuals with preexisting conditions commonly focus on the possibility of denial of insurance, they also pertain to the offer of insurance that is more expensive on the basis of health factors and to insurance that excludes health services to treat preexisting conditions.

Current Law

Current federal law prohibits those insurer practices from most (but not all) private health plans. *Guaranteed issue*, *adjusted community rating*, and *coverage of preexisting health conditions* provide consumer protections related to the offer, price, and scope of insurance, respectively. These provisions are included in the ACA, but their applicability varies across different types of health plans, such as individual vs. group, small group vs. large group, and so on. (The ACA also requires the coverage of *essential health benefits* in the individual and small-group markets, and the range of covered benefits may be a factor in an individual's decision to purchase insurance. However, this discussion focuses on the key consumer protections that prohibit differentiating individuals with preexisting health conditions from otherwise healthy insurance applicants.) For more information about these and other federal requirements applicable to private plans, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

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Consumer Protections Established Prior to the ACA

A number of federal health insurance requirements established prior to the ACA provided protections to individuals with preexisting conditions. Almost all pre-ACA consumer protections applicable to private health insurance were established under the Health Insurance Portability and Accountability Act (HIPAA; P.L. 104-191). (ACA revisions to HIPAA-established provisions took many forms; HIPAA language was struck and replaced, renumbered, expanded, or left alone.) Specifically, HIPAA's preexisting condition protections applied to the individual health insurance market under limited circumstances and to a greater degree in the group market (see **Table 1**).

Table 1. Selected HIPAA Provisions Applicable to Individual and Group Health Plans

HIPPA Provision	Individual Health Plans	Group Health Plans
Guaranteed Issue	HIPAA eligibles only[a]	All small groups
Prohibit Health Discrimination in Eligibility	n/a	All groups—across similarly situated individuals[b]
Prohibit Health Discrimination in Premiums	n/a	All groups—across similarly situated individuals
Coverage of Preexisting Health Conditions	HIPAA eligibles only—prohibit coverage exclusions	All groups—allow coverage exclusions for a limited duration

Source: CRS Report RL31634, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions*.

a. *HIPAA eligibles* refers to individuals who meet certain requirements to be eligible for HIPAA protections.

b. *Similarly-situated* individuals are employees who are part of the same "bona fide employment-based classification"; such classifications include part-time vs. full-time status, different workplace locations, length of employment, and so on. See 29 C.F.R. §2590.702(d).

In addition to federal protections, states enacted preexisting condition protections prior to ACA enactment, particularly targeting the individual and small-group markets. These protections varied across states. For example, in 2008, 7 states prohibited the use of health factors in determining premiums in the individual health insurance market, another 11 states allowed health factors to be used in premium development but limited the effects of such factors, and the remaining 32 states and the District of Columbia (DC) allowed health factors to be used to develop premiums with no specified limitations. In the small-group market, in 2009, 12 states prohibited the use of health factors, 35 states allowed limited use of health factors, and 3 states and DC allowed unlimited use of health factors. Likewise, guaranteed issue and preexisting condition coverage provisions varied by state prior to the ACA. Since enactment of the ACA, some states have enacted provisions to partially or completely align with the federal requirements, but such state action has not been uniform. Therefore, current state health insurance requirements are a mix of pre- and post-ACA enacted provisions.

Recent Developments

Policy and legal developments this past year have refocused attention on preexisting conditions in the press and in policy circles. For example, the Trump Administration has taken actions to support health plans that are largely exempt from federal law, such as promulgation of a final rule regarding short-term, limited-duration insurance. Although such insurance is "primarily designed to fill temporary gaps in coverage," which may benefit individuals transitioning from one health plan to another, extension of the duration of such plans has raised questions about their value to individuals with preexisting (or newly developed) health conditions.

Plaintiffs in a current federal lawsuit argue that Congress lacks the authority to impose an "individual mandate" to purchase health insurance and seek invalidation of the entire ACA. Further, the Department of Justice (DOJ) submitted a brief in which DOJ maintains that "the individual mandate is not severable from the ACA's guaranteed-issue and community-rating requirements" but is severable from the rest of the ACA; DOJ seeks to strike down provisions related only to those three requirements.

Future administrative and judicial developments may raise questions about the applicability and enforcement of consumer protections for individuals with preexisting health conditions. A decision in the federal lawsuit is anticipated following oral arguments heard on September 5, 2018. Congress and states may undertake legislative activity to address preexisting condition protections. In the meantime, uncertainty in the regulatory environment may affect the process (currently under way) for reviewing and approving exchange health plans, which subsequently may affect the types of and prices for plans offered in 2019.