The Many Elements Of Protection For Pre-Existing Conditions

By Catherine Livingston and Elena Kaplan

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The recent midterm elections and the U.S. District Court for the Northern District of Texas' decision in Texas v. United States[1] invalidating the entire Patient Protection and Affordable Care Act have focused attention on the protection given to individuals with pre-existing conditions under federal law. Protection for pre-existing conditions is a convenient shorthand that refers to multiple provisions of federal statutory law affecting different aspects of whether and how health coverage is offered and priced.

Catherine Livingston

Together, these provisions ensure that individuals who have a disease or a medical condition are not denied access to affordable coverage to pay for their health care, including treatment for the disease or condition, simply because they had the disease or condition prior to the date they enrolled in the coverage.

Elena Kaplan

Protection for pre-existing conditions under health coverage is important to individuals for obvious reasons — it ensures that care is available to them when they need it, regardless of their health history. It also affects the employers and health insurers who bear the direct costs of health care for those they cover and the indirect costs the health care delivery system shifts onto them for the care of people who cannot get coverage.

If protection for pre-existing conditions is tied to employment-based coverage, it affects the recruitment and retention of employees and also the risks involved in leaving a job to become an entrepreneur. It is not surprising that protection for pre-existing conditions is one of the most popular aspects of the ACA. As discussion and debate about health coverage continues, it is useful to appreciate that what may be referenced in the singular as protection for pre-existing conditions is in fact a collection of multiple provisions working in concert.

The initial federal statutory provisions securing coverage for pre-existing conditions were enacted as part of the Health Insurance Portability and Accountability Act of 1996. HIPAA protections for pre-existing conditions applied to group health plans and to individuals who had group health plan coverage but lost it. Group health plans cover approximately half of the people in the United States.

The ACA enhanced group health plan protections for pre-existing conditions and extended those protections to coverage in the individual market. While a much smaller fraction of the United States population receives coverage through individual health insurance policies than through employer-sponsored coverage, the individual market remains critical because it may be the only source of coverage for independent contractors; employees working in small businesses; part-time workers; individuals who are between jobs or want to retire before they are eligible for age-based Medicare; and individuals who are too sick to work consistently but not sick enough to qualify for disability-based Medicare.

The protection that individuals have under federal law as a result of HIPAA and the ACA goes beyond requiring that employer-sponsored health plans and health insurance companies offer coverage to people who have pre-existing conditions. It has multiple components that combine to eliminate potential loopholes to the protection.

Federal law defines the term pre-existing condition exclusion for purposes of health coverage to mean “a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before such date.”[2]

Note that under this definition, a pre-existing condition is not only a medical condition that has been diagnosed by a medical professional, but any condition the individual has at the time the individual’s coverage takes effect, whether or not the individual has sought care or treatment for it or is even aware of the condition. Federal law currently protects an individual with a pre-existing condition by setting requirements for all forms of what a consumer would recognize as major medical coverage, including employer-sponsored self-funded group health plans, fully-insured coverage as part of an employer-sponsored group health plan, and individual health insurance coverage.[3]

Group health plans and health insurance issuers offering fully insured group health plan coverage or individual health insurance coverage are required to protect an individual with a pre-existing medical condition in three ways:

1. Allow the person to enroll in the group health plan or health insurance coverage.[4] Neither the group health plan nor the health insurance issuer may bar the person from enrolling based on her health condition. This protection covers not only the employee who enrolls in the group health plan but also spouses, children and other dependents if they are otherwise eligible for coverage. The protection also extends to renewal of health insurance in subsequent years.[5] Renewal of an individual's coverage, whether in the individual or group market, cannot be denied for another year because the person has a health condition.

2. Cover the care for a given condition on the same basis for those who have the condition prior to the start of coverage and those who do not. [6]

3. Charge the individual a price for the health coverage that does not vary based on her health condition (or the health condition of her spouse or dependents if they are also covered).[7]

To illustrate, consider Ms. Smith, an adult who is self-employed and has been diagnosed with cancer. She is too young to have Medicare coverage, and her income is too high to allow her to qualify for Medicaid coverage. She is also not eligible for veterans health care coverage or other government-sponsored health care coverage. She wants to purchase a health insurance policy from a health insurance company in the individual market during the annual open enrollment period.

Under current federal law, regardless of the state in which Smith lives, the insurance company cannot refuse to sell Smith a policy because of the cancer diagnosis. The policy must cover the treatment and care Smith needs for her cancer in the same way it would cover another individual purchasing a policy under the same plan who has not been diagnosed with cancer at the time the policy is purchased. Moreover, under the Affordable Care Act, because Smith is seeking coverage in the individual market, the price of Smith's policy must be the same price charged to someone else of the same age and may not be more than three times the price charged to any other adult who lives in the same county or other rating area in the state and who matches Smith in either being or not being a tobacco

user.[8]

The combination of all of the provisions, the guaranteed issue and renewal, the bar on pre-existing condition preclusions, and the bar on setting premiums by reference to health status, work together to give Smith meaningful protection. For example, if the insurance company were required to issue a policy to her but were permitted to exclude coverage for the cost of treating her pre-existing condition, the coverage would pay for a flu shot or care for a broken arm, but would not help her pay the costs for her cancer treatment. If the insurance company were required to issue her a policy that covered care for her cancer, but were allowed to set the premium based on health factors, she might not be able to afford the coverage even though it would be offered to her. Elimination of any of the three provisions could effectively eliminate protection for Smith's pre-existing condition.

The district court in Texas v. United States has ruled that the individual mandate is invalid and cannot be severed from the rest of the ACA, and, therefore, all of the other provisions of the ACA, including the pre-existing condition protections described above are invalid.[9]

When the U.S. Department of Justice took the position in Texas v. United States to decline to defend the constitutionality of the individual mandate once the penalty for a violation is reduced to $0, then-Attorney General Jeff Sessions wrote to House Speaker Paul Ryan, R-Wis., conveying the DOJ's position as to which provisions in the Affordable Care Act are or are not severable from the individual mandate and thus which provisions (the nonseverable ones) would be invalidated if the individual mandate were held to be unconstitutional.[10] Sessions wrote that the DOJ concurs with the position taken by the prior administration in their briefs in National Federation of Independent Business v. Sebelius as to the provisions identified as not being severable from the individual mandate. Those provisions include:

- The requirement that health insurance issuers issue coverage to every individual and every employer. (42 U.S.C. 300gg-1.)

- The prohibition against imposing pre-existing condition exclusions, which applies to group health plans and health insurance issuers offering group or individual health insurance coverage. (42 U.S.C. 300gg-3.)

- The prohibition against setting rules for eligibility based on health status, medical condition, claims experience or any other health status-related factor, which applies to

group health plans and health insurance issuers offering group or individual health insurance coverage. (42 U.S.C. 300gg-4(a).)

- The prohibition against setting employee contributions or premiums by reference to health status-related factors, which applies to group health plans and health insurance issuer offering group or individual health insurance coverage. (42 U.S.C. 300gg-4(b).)

- The requirement that health insurance issuers offering individual or small group health insurance coverage set premiums based on only three factors: age, where the individual resides and tobacco use. With respect to age, the premium for the oldest adult may be no greater than three times the premium for the youngest adult (i.e., age 18). (42 U.S.C. 300gg(a)(1).)

If all of these provisions were struck down, federal law would no longer require health insurers in the individual market to issue policies to individuals with pre-existing conditions, let alone cover the cost of treatment for those conditions, nor would it limit the ability of insurers to set premiums based on health status factors. State law in some states would still provide some level of protection for pre-existing conditions in the individual market, but only four states (Colorado, Massachusetts, New York and Virginia) have adopted protections that guarantee issuance of insurance, prohibit pre-existing condition preclusions and require community rating for setting premiums.

Fourteen states have partially adopted the pre-existing condition protections currently in federal law. For example, Delaware law requires insurers to issue policies to consumers regardless of health status, but insurers would be permitted to impose pre-existing condition exclusions if the bar on pre-existing condition preclusions in federal law (42 U.S.C. § 300gg-3) were struck down. Nine states and Washington, D.C., adopted one or more aspect of the pre-existing condition protection under federal law, but the law in each of these jurisdictions includes provisions that render the state law protection void in the event the corresponding federal provisions are repealed or invalidated.[11]

The impact is somewhat different for group health plans. If the current pre-existing condition protections in federal law were invalidated, the pre-existing conditions provisions that applied to group health plans under federal law prior to the enactment of the ACA, that is the pre-existing condition protections that were enacted with HIPAA, would seem to go back into effect.[12] If the pre-existing condition protections of HIPAA went back into effect, group

health plans would be constrained in their ability to impose pre-existing condition exclusions, but group health plans would once again be able to delay coverage for pre-existing conditions for new enrollees who had gaps in coverage prior to enrolling in the group health plan.

In Texas v. United States, the government has not yet addressed the question of whether the pre-ACA HIPAA provisions would go back into effect in the event the ACA's pre-existing condition protections are struck down.

Protecting coverage for pre-existing conditions remains very popular. It is likely that policymakers will want to offer proposals to preserve that protection in the event that the pending litigation invalidates the protections enacted in the ACA. Individuals and employers evaluating these proposals will want to review the details carefully to determine whether all of the dimensions of pre-existing condition protection are included.

Employers will also want to seek clarification as to whether a proposal would leave them once again subject to the requirements with respect to pre-existing conditions and portability that existed under HIPAA, such as the requirement to provide departing enrollees with certificates of creditable coverage, or would supersede HIPAA in these respects as the ACA did.

Catherine E. Livingston and Elena Kaplan are partners at Jones Day.

[1] 340 F. Supp. 3d 579 (N.D. Tex. 2018).

[2] 42 U.S.C. § 300gg-3(b)(1)(A) (2018).

[3] Short-term limited duration insurance, though it may provide a wide scope of benefits, is not considered individual health insurance coverage, and therefore is not subject to the protections for pre-existing conditions. Id. § 300gg-91(a)(5).

[4] Id. § 300gg-1(a).

[5] Id. § 300gg-2.

[6] Id. § 300gg-3(a).

[7] Id. § 300gg-4(b).

[8] Id. § 300gg(1)(1)(A).

[9] See generally Complaint, Texas v. United States, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (No. 4:18-cv-00167-O).

[10] Letter from Jefferson B. Sessions III, Attorney Gen., to Paul Ryan, Speaker, U.S. House of Representatives (June 7, 2018), https://www.justice.gov/file/1069806/download.

[11] See Sabrina Corlette, Maanasa Kona, & Justin Giovannelli, Lawsuit Threatens Affordable Care Act Preexisting Condition Protections But Impact Will Depend on Where You Live, Commonwealth Fund: To The Point (Aug. 29, 2018), https://www.commonwealthfund.org/blog/2018/lawsuit-ACA-preexisting-condition-protections-where-you-live.

[12] The government's brief on the question of severability in NFIB v. Sebelius filed in 2013 took the position that if the individual mandate were ruled invalid and the provisions providing for guaranteed issue and community rating were invalidated with it on the grounds that they were not severable, the statute as it existed prior to the Affordable Care Act would return to its form prior to the enactment of the ACA. For this position, the Government cited Frost v. Corp. Commission of Oklahoma, 278 U.S. 515, 526–27 (1921). Brief for Respondents (Severability) at 54–55 n.23, NFIB v. Sebelius, 567 U.S. 519 (2012) (Nos. 11–393 & 11–400).