HEALTH INSURANCE GUARANTEED ISSUE - BACKGROUND MEMORANDUM

INTRODUCTION

Section 17 of Senate Bill No. 2010 (2019) (appendix) directs a study of the feasibility and desirability of state guaranteed issue provisions for health insurance. The study must include consideration of protections for individuals with pre-existing conditions and consideration of whether to restructure the Comprehensive Health Association of North Dakota (CHAND).

HISTORY

Engrossed Senate Bill No. 2010 was amended by the House to create a new section to North Dakota Century Code Chapter 26.1-36, which would have provided:

Pre-existing conditions.

Notwithstanding any law to the contrary, an accident and health insurance policy issued under this chapter may not take into account any pre-existing condition of an insured or applicant, including waiting periods, refusal of coverage, and ratesetting.

This section was replaced in the Conference Committee amendments with language that provides for this study.

BACKGROUND

In the United States and other developed nations, population health care spending is highly concentrated. In any given year, the healthiest 50 percent of the population accounts for less than 3 percent of total health care expenditures, and the sickest 10 percent account for nearly 66 percent of population health spending. The risk nature of the private health insurance pool is that premiums paid by the majority of enrollees, who have low claims costs, help pay claims for the small share of enrollees with high claims costs.

The membership of who is included in the high-cost and low-cost groups changes from year to year. Most people are healthy most of the time; however, illness and injury can and do onset unexpectedly. Some high-cost conditions, such as hemophilia or HIV, persist and require treatment for extended periods, whereas, other high-cost conditions may improve or resolve, allowing a patient to return to low annual health care spending. Annually, among the 50 percent least expensive people, 73 percent will remain in that low-cost group for a 2nd year. Of the people in the most expensive 10 percent of the population in a year, only 45 percent will still be in that group the following year.

Medical Underwriting

Background

Guaranteed issue is a term used in health insurance to describe a situation in which a policy is offered to any eligible applicant without regard to health status. Before private insurance market rules under the federal Affordable Care Act (ACA), which became effective in 2014, health insurance sold in most states was medically underwritten. Medical underwriting is the process used by insurers to evaluate the health status, health history, and other risk factors of applicants to determine whether and under what terms to issue coverage. Medical underwriting can apply to an entire group or to an individual. Medical underwriting could result in an applicant being declined and could result in adverse underwriting practices.

Over the years, various state and federal regulations have been implemented to limit medical underwriting for major medical coverage in the individual and small group market. Under the ACA medical underwriting for new enrollees is no longer used for major medical coverage in the individual and small group market.

Before 2014, insurers in most states could consider an individual applicant's health status to determine whether the applicant was eligible for coverage and, if eligible, whether to include pre-existing condition exclusions or increased rates based on health status. Since 2014, an insurer may not consider the applicant's health status other than consideration of tobacco usage.

Before 2014, in the small group market, insurers in 38 states, including North Dakota, and the District of Columbia were allowed to base a small group's premiums on the overall health status of the group. Although individual employees could not be charged differing premiums based on health status or denied eligibility for coverage, employees who did not have continuous creditable coverage could have pre-existing condition exclusion periods. The Affordable Care Act discontinued pre-existing condition exclusion periods and the practice of basing a small group's total premiums on the health history of the group's members.

The rules for large groups are different, even with the implementation of the ACA. Most large groups and many medium-sized groups opt to self-insure rather than purchase coverage from an insurer. However, when a large group buys coverage from an insurer, premiums can be based on the group's overall claims history, which means less healthy groups can be charged higher total premiums than healthier groups. Individual employees within a group are covered on a guaranteed issues basis and are not charged different rates based on the individual's medical history.

Current Medical Underwriting Uses

Although medical underwriting no longer exists for new enrollees in the individual market and for new small group plans, the several types of coverage that use medical underwriting are called excepted benefits under the ACA. Excepted benefits include short-term health insurance and supplemental insurance products, such as dental plans, vision plans, accident supplements, critical illness plans, and fixed indemnity plans. Most excepted benefits are designed to supplement major medical coverage, rather than replace the coverage.

Most Medicare coverage does not include medical underwriting, but there are exceptions for Medigap plans if the applicant applies outside the open enrollment period and Medicare Advantage plans for people who have end-stage renal disease.

Declinable Pre-existing Conditions

The table below contains information from the Kaiser Family Foundation reporting the rates of declinable pre-existing conditions within the nonelderly population under pre-ACA practices.

Estimated Number and Percent of Nonelderly People with Declinable Pre-existing Conditions Under Pre-ACA Practices, 2015

State	Percent of Nonelderly Population	Number of Nonelderly 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
United States	**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.

The data in this table is conservative, as it does not account for some declinable conditions and does not account for declinable medications and declinable occupations. Additionally, the table does not account for conditions that could lead to other adverse underwriting practices.

Adverse Medical Underwriting

Medical underwriting may result in a policy with pre-existing condition exclusions or a premium that is higher than the standard rate. Medical history that results in adverse medical underwriting may include acne, allergies, anxiety, asthma, basal cell skin cancer, depression, ear infections, fractures, high cholesterol, hypertension, incontinence, joint injuries, kidney stones, menstrual irregularities, migraine headaches, being overweight based on a high body mass index, restless leg syndrome, tonsillitis, urinary tract infections, varicose veins, and vertigo.

Affordable Care Act Legislation

The case of *Texas v. Azar* 340 F.Supp.3d 579(N.D. Tex., 2018), was filed in federal court in February 2018 by Texas and 19 other states, including North Dakota. This lawsuit, which builds on the repeal of the ACA's individual mandate, which was part of the 2017 federal tax reform law, argued because the individual mandate was an essential part of the ACA, the entire ACA should be invalidated. On December 14, 2018, a federal district court judge in Texas issued a ruling holding the ACA in its entirety is unconstitutional. However, since the court did not issue an injunction, immediate compliance is not required. On July 8, 2019, the Fifth Circuit Court of Appeals held hearings on the constitutionality of the individual mandate in *Texas v. Azar*.

This case is not expected to make its way to the United States Supreme Court until 2020 at the earliest and the ACA remains in effect while this case makes its way through the court system. However, if the district court decision is upheld, the ACA's limitations on medical underwriting will cease to exist and absent new federal legislation, states will again rely on state law to regulate medical underwriting.

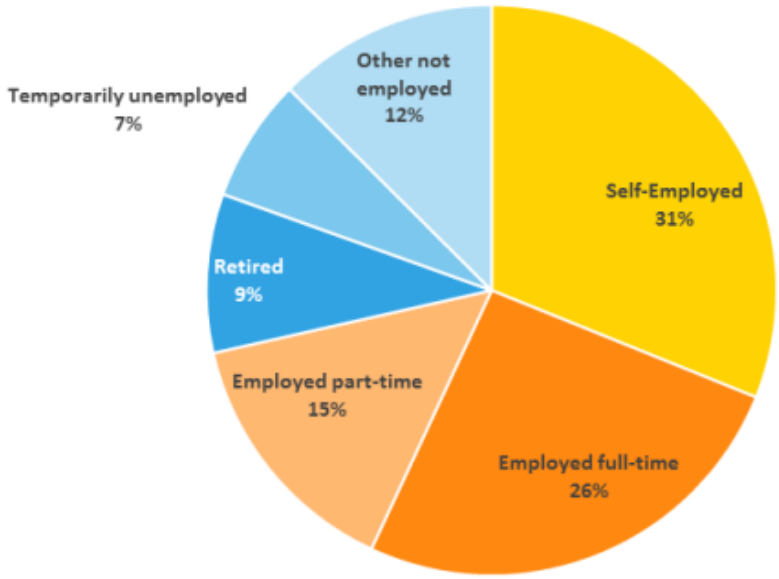
Individual Marketplace

At any given time, the vast majority of people with declinable pre-existing conditions in the United States have health coverage through an employer or through a public program, such as Medicaid. Typically, 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. In 2015, approximately 8 percent of the nonelderly population had individual market coverage; however, due to churn over a several year period, a much larger share may seek individual market coverage. For many people the need for individual market coverage is intermittent--for example, following a 26th birthday, job loss, or divorce--until those people again become eligible for group or public coverage. For other people, such as the self-employed, early retirees, and lower-wage workers in jobs that typically do not come with health benefits, the need for individual market coverage is ongoing.

The following chart from Kaiser Family Foundation shows the distribution of employment status among individual market enrollees:

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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High-Risk Pools

The Kaiser Family Foundation reports before 2014, medical underwriting was permitted in the individual insurance market in 45 states, including North Dakota, and in the District of Columbia. For more than 35 years, many states operated high-risk pool programs to offer nongroup health coverage to uninsurable residents. Under the ACA, the federal government also operated a temporary high-risk pool program to provide coverage to people with pre-existing conditions in advance of when broader insurance market changes took effect in 2014.

Affordable Care Act

Enacted in 2010, the ACA contains various provisions with various effective dates. Title 1 of Subtitle B of Section 1101 of the ACA created the temporary high-risk pool program, which was named the Pre-existing Condition Insurance Plan. The goal of the Pre-existing Condition Insurance Plan was to make health insurance quickly available to uninsured people who had pre-existing conditions. This federal high-risk pool provision became effective June 21, 2010, with individual policies offered for sale in all states by September 2010. This program remained in effect until January 1, 2014, at which time it was replaced by policies sold through the health benefit exchanges, as market changes resulted in pre-existing conditions no longer preventing people from qualifying for private health insurance coverage.

Under the ACA, each state had the choice of running its own high-risk pool that complied with the ACA requirements or deferring to the federal government and allowing the federal government to run the new program. Twenty-seven states chose to run state programs, and 23 states and the District of Columbia had the federal government run the program. North Dakota chose to have the federal government run the state's ACA high-risk pool, while CHAND continued to operate separately.

Comprehensive Health Association of North Dakota

North Dakota is one of 35 states that before 2010 implemented a high-risk health insurance pool. The National Conference of State Legislatures reports as of 2010, more than 200,000 people were served by these state high-risk health insurance pools.

During the 1979-80 interim, the Legislative Management's interim Health Care Committee recommended House Bill No. 1058 (1981), codified as Chapter 26.1-08, which provides for CHAND--the state's high-risk health insurance pool. During the 1981-82 interim, the Legislative Management's interim Social Services Committee recommended House Bill No. 1068 (1983), which, along with House Bill No. 1054 (1983), amended Chapter 26.1-08, to address premiums received by participating insurance companies not covering the cost of required care and premiums being too expensive for those individuals who required insurance. The legislative history indicates the purpose for CHAND was to provide comprehensive major medical insurance to individuals who were otherwise uninsurable.

Program

The Comprehensive Health Association of North Dakota offers health insurance to North Dakota residents who are unable to find adequate health insurance coverage in the private market due to medical conditions or who have lost their employer-sponsored group health insurance. An insurance carrier licensed to do business in North Dakota must inform individuals denied health insurance coverage by the company about CHAND.

Subject to benefit plan limitations and exclusions, CHAND covers major medical and prescription drug expenses. An individual is eligible to receive up to $1 million in benefits from CHAND during that individual's lifetime. An individual who has received $1 million in CHAND benefits from enrollment in any combination of benefit plans is not eligible to obtain new coverage through CHAND.

Under CHAND, traditionally the premiums have funded approximately one-half to two-thirds of the program, not to exceed 135 percent of premiums charged in the state of North Dakota for similar coverage, with most of the balance covered by assessments to companies that write at least $100,000 in annual premiums on behalf of residents of the state. Historically, federal grants also have accounted for a portion of CHAND funding.

The Comprehensive Health Association of North Dakota is overseen by a board of directors that consists of the Insurance Commissioner; the state health officer; the director of the Office of Management and Budget; one senator appointed by the Majority Leader of the Senate; one representative appointed by the Speaker of the House of Representatives; and one individual from each of the three participating member insurance companies of CHAND with the highest annual premium volumes of health insurance coverage as provided by the Insurance Commissioner, verified by the lead carrier, and approved by the CHAND Board of Directors. Blue Cross Blue Shield of North Dakota is the insurance company the CHAND Board of Directors has selected to be the lead carrier to administer the CHAND benefit plans.

Under Section 26.1-08-12(5), the four ways an applicant can qualify for CHAND are:

1. Traditional applicant (waiting period);
2. Health Insurance Portability and Accountability Act of 1996 (HIPAA) applicant (no waiting period);
3. Federal Trade Adjustment Assistance Reform Act of 2002 (TAARA) applicant (no waiting period); and
4. Age 65 and older applicant or disabled supplement applicant (waiting period).

According to the CHAND website, an eligible traditional, HIPAA, or TAARA applicant has the option of choosing from the following coverage options:

	Deductible Amount Per Benefit Period	Coinsurance Maximum Per Benefit Period	Out-of-Pocket Maximum Per Benefit Period
Option 1	$1,000	$2,000	$3,000
Option 2	$500	$2,500	$3,000

These applicants are subject to a CHAND lifetime maximum of $1 million. An eligible supplement applicant has the option of choosing basic supplement coverage or standard supplement coverage. Detailed information regarding eligibility and coverage is available at the CHAND website--*www.chand.org*.

STUDY APPROACH

In conducting this study, the committee may wish to consult with:

- The Insurance Department and North Dakota health insurance carriers to receive updates on the ACA and ACA litigation;
- The Insurance Department and Blue Cross Blue Shield on the status of CHAND, including current enrollment figures and enrollment trends; and

- Insureds, North Dakota health insurance carriers, health care providers, the Insurance Department, and the Department of Human Services regarding the effect medical underwriting has on medical care and the business of insurance.

ATTACH:1