Legislator Conference Call: The ABC's of Pre-Existing Conditions in the American Health Care Act (AHCA)

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Audio Transcript
(Lightly edited for clarity)

Christie Herrera: Good afternoon everyone. My name is Christie Herrera and I'm Vice President of State Affairs at the Foundation for Government Accountability. Thank you so much for joining us to discuss a topic that I think has been in the headlines pretty much every day all day recently. If you check your Facebook account or your Twitter feed, you will see a ton of posts and articles talking about how the recently passed American Healthcare Act handles pre-existing conditions. Unfortunately, many of these reports are simply wrong. They are misleading, or they lack basic context—and that is why we've decided to set up this call today.

For those of you who aren't familiar with FGA. The Foundation for Government Accountability is a think tank working in roughly 35 states and D.C. on health and welfare reform. We've been on the front lines working on the American Healthcare Act issue both at the state level and in D.C. We thought it would be helpful for us to share some of our experiences with you all so you can speak more knowledgeably about what Congress is doing, how it impacts your constituents, and so you can learn the best ways to talk about it.

We will have a few minutes for questions at the end of this call so, at any point during the call if you'd like to ask a question please press *6 and you'll be placed into the queue. With that I want to turn the call over to FGA's CEO Tarren Bragdon and FGA Senior Fellow Josh Archambault, both of whom have been up to their necks in this discussion for the last couple of months.

Tarren, I'll turn it over to you.

Tarren Bragdon: Great. Thank you Christie, and thank you everyone for joining the call. You know, years ago I was a state legislator in Maine and worked on healthcare reform issues. Maine was really to the left of the ACA, and back when the Republicans took over in Maine in 2011 we were looking at strategies to respond to this whole situation that Christie just outlined. How do you protect access for individuals with pre-existing conditions, but drive down premiums? Because just like what's happening now—premiums were high, enrollment in the individual market was down, and insurers were leaving the market.

What we worked on was passing a law that flipped that switch. One key component of that reform was a program that helped those with pre-existing conditions while at the same time dropping premiums for all age groups. The results of this policy strategy were almost instant. You had dramatically lower premiums because you identified this risk upfront, you had additional voluntary enrollment in the individual market with the lead insurer, and you had guaranteed coverage of those with pre-existing conditions without higher premiums.

I'd like to have Josh now explain how this policy and program worked in practice.

Josh Archambault: Sure, Tarren. Perhaps the easiest way to explain how the program worked is simply to use Tarren and I as examples. In Maine we both would've applied for insurance in the individual market—and let's pretend for the sake of this example that I have cancer, what most people call these days a pre-existing condition. When Tarren and I applied for insurance in the individual market, we would've filled out a health questionnaire.

I would have gotten—based on my answers of having cancer—designated for this program. We both would pay the same premiums and have access to the exact same insurance plan, and that's really it. Really that simple. Of course, as you can imagine, there were a number of things happening behind the scenes, and so first and foremost, the insurers knew the risks upfront. They knew they were going to get some assistance for those patients with cancer, for myself in this example.

The insurers would have to pay about $10,000 of the claims upfront, so they had skin in the game as well. But as a result of knowing those risks upfront, they could price premiums much more aggressively. Think about it this way. They were able to price premiums for insurance as if everyone was healthy, whereas right now under the ACA, they have to price everybody as if they are sick, because they simply don't know.

The second piece of it was that the program was funded in two ways. The first was 90 percent of my premium, as somebody who is designated for this program would go to help pay for it, and there was also a $4 per member per month assessment to help fund the program. One question that Tarren and I frequently get asked about the Maine program is how it is different from a traditional high-risk pool.

Really, the only similarity is that both are trying to help provide coverage for those with pre-existing conditions, but that's about it. The differences included some very, very important things. The first one is patients weren't segmented out of the market. They had far more plan and insurer options in Maine, and the individuals with pre-existing conditions paid the same, not the elevated premiums that they frequently do in high-risk pools.

Insurers also had incentives to improve care management for those in the Maine program, because they actually had that upfront skin in the game. And then finally, the Maine program had a track record of lowering premiums in a much more effective way. As an example and for contrast, New Hampshire—which is next to Maine—had a traditional high-risk pool at the same time. For a very similar plan in the two states, the healthiest individual in New Hampshire, a non-smoker, for instance, paid the same or more for that coverage in the individual market than all individuals did in Maine.

Put it this way. The healthiest individual in New Hampshire paid the same or more than the sickest did in Maine. As many of you know, 35 states had traditional high-risk pools pre-ObamaCare, pre-ACA, and they had a mixed track record. Some worked well and others didn't. But we believed the Maine program does provide a proven and highly effective option, which brings us back to the federal level in the American Health Care Act. Tarren, could you walk us through exactly what Congress passed?

Tarren Bragdon: Sure. What happened with the AHCA is the House about a month ago added an amendment to their bill that really pulls from this Maine experience, and the amendment was called the Federal Invisible Risk Sharing Program. It was sponsored by Congressman Palmer and Congressman Schweikert, but really a far better description of the strategy is that they created a Pre-Existing Condition Protection Fund, if you will.

At FGA, we wanted to really understand what would be the impact of this policy reform at the national level because we're building on the state experience. We contracted with the international and renowned actuarial firm Milliman to do an independent study of what would be the impact across the country of this policy reform. They looked at real claims data from across the country, and here's what they found.

Number one, if this approach were used nationally, premiums would drop in the individual market. Again, these are people buying insurance on their own outside their employer and outside the exchange. Premiums dropped by up to 50 percent, averaging around 30 percent, reversing some of the key skyrocketing premiums that we saw as a result of the ACA.

Number two, it could help people for all ages. Milliman showed that premiums were dropped for individuals, whether you're talking about folks in their 20s or folks in their 60s buying insurance on their own.

Number three, because premiums would drop you'd have fewer uninsured. Milliman projected that up to two million uninsured would voluntarily buy coverage now, because it was more affordable to them.

Number four, which is critically important, you would still have guaranteed coverage for those with pre-existing conditions. All these outcomes would help to stabilize the markets that have been on this roller coaster under the ACA. The amendment started by setting up a federal version of this program to deliver this premium relief as quickly as possible, while still providing protection and guaranteed access for those with pre-existing conditions.

But the amendment also envisions that states—all of you—would play a more active role in the future. While for a lot of procedural reasons, the House amendment did lack some of the specifics of the things that were analyzed in the Milliman's study, they set up the exact same kind of structure that Josh just outlined, and the Senate is looking at adding those policy amendments to really guarantee that this Pre-Existing Condition Protection Fund approach would get the results that were projected by Milliman, and built off the great case example we have in Maine.

Remember this whole process is taking place within this very convoluted, very complex, budget reconciliation process, which has a number of rules associated with it. It restricts what the House can do, what the Senate can do. It's complicated, but we're on the path to achieve the kind of results that we saw in Maine, and that Milliman projects nationally. Josh, why don't we talk about what's coming up next.

Josh Archambault: We wanted to spend a minute to just put this in context. So what population are we actually talking about that would be impacted by this sort of program? Given some of the rhetoric lately, perhaps we all think everyone would be impacted, but it's simply not true. Regardless of what the media has been reporting, the House bill retains the guaranteed issue rule that requires insurers to offer policies to all applicants.

There's been a lot of misinformation around that in the media. It also retains the ACA's community rating rules, which mean that insurers can vary premiums by zip code and by age, but not by health condition. Really, as Tarren mentioned, the only place where pre-existing conditions become a real issue is in the individual market. For those that are working in a large company or even in a small business—which is where over 90 percent of us who have private coverage, get our coverage—pre-existing conditions is largely a non-issue when it comes to insurance.

We're talking about this single-digit individual market. We asked Milliman to estimate how many people would be part of this program that's in the House bill, the Pre-Existing Conditions Protection Fund. They estimate just under two percent of the entire privately insured market. It's just under three million people. We want to unpack that just a tiny bit more for you.

All those individuals, just over a million people, would be participating because they have a pre-existing condition—but that number also includes their family members who are on the same insurance policy. The remainder of individuals that Milliman estimated—just under two million—are those that insurers could designate to the program because they believe they're going to have high costs, but not necessarily because they have a pre-existing condition. This is a design feature of the program. It was included in the Maine program as well.

Really what we're talking about is a sliver of a sliver of a sliver of the privately-insured population. The House bill guarantees access to coverage for all Americans regardless of health status. We want to be very clear about that, given the misinformation that's been out there. This Pre-Existing Conditions Protection Fund, like the Maine program, does that. We're helping to reduce premiums, which is really great. But yet, Tarren, we know the media in the last few days have been in freak-out mode, so what has caused this confusion?

Tarren Bragdon: Most of the recent media coverage and confusion about the House bill has been focused on another amendment that was added right before the House passed the bill. That was amendment authored by Representative Tom MacArthur of New Jersey. He is a moderate. He also has a very personal experience with pre-existing conditions with his daughter who has since passed away. His goal was to try to provide states with even more flexibility.

Before we go into that, I just want to step back and acknowledge the needle we're trying to thread here. Here's what we're trying to do. How do we guarantee coverage for all Americans, while not rewarding those who wait to purchase insurance in the individual market until they're sick? We're trying to give folks access while not encouraging bad behavior. The analogy's been used before—that it would be unsustainable if homeowners could wait until their house is on fire before purchasing homeowner's insurance.

I think that it's clear that everyone on the phone—and all Americans—want to help those with pre-existing conditions. But yet, there's some hard policy decisions that must be made to ensure that the market is affordable and sustainable. This is clearly not the case in the individual market right now in most of your states under Obamacare, and given what's going on in the exchange.

Here's some context of how this tricky policy issue has been dealt with in the past— Medicare Part D. There was bipartisan agreement in Medicare Part D, the prescription drug program, if somebody didn't sign up right away, if they waited until they actually needed a lot of prescriptions, they would pay a surcharge or a higher cost for their Part D coverage, for the rest of their lives. That's how they threaded the needle of personal responsibility and access.

The AHCA before the MacArthur amendment added a one-year, 30 percent surcharge—but if you had a gap in coverage with a pre-existing condition and then went to get coverage, you paid 30 percent more for a year. What the MacArthur amendment granted to states was more flexibility in how they could handle this decision. This is again, just for people who have a gap in continuous coverage for a significant period of time. States could set their standard, and states could decide if they wanted to allow premiums to be higher for individuals with pre-existing conditions who had gaps and coverage and waited to sign up. A state would also have to participate in some kind of high-risk pool to provide coverage for those with a pre-existing condition.

What the MacArthur amendment also provided for states was flexibility to set their own benefit mandate standards. ObamaCare required 10 Essential Health Benefits. The amendment would allow states to go back to what they used to have—nationally, about 2,100 provider and benefit mandates existed in the marketplace for individual insurance prior to ObamaCare. Most states are somewhere between 13 and 70. The MacArthur amendment would allow states to go back to making those decisions locally within their states, rather than having them made at the national level.

Let's also not forget that the ACA locks you out if you have not had coverage for a significant period of time. Right now, under ObamaCare, you have to wait until the next open enrollment period. You can't buy insurance whenever you want, if you have a pre-existing condition and have had a gap in coverage. At a high level, the rhetoric has been about as Josh mentioned, the sliver of a sliver of a sliver of the privately-insured population. Then one more sliver of that population has this long gap in coverage and only for those states who decide to take advantage of one of these MacArthur waivers.

The speculation and the over-the-top rhetoric has been about what states may or may not try to do down the road for this very small portion of the population. My goal is not to downplay any of the legitimate questions about how someone with a pre-existing condition would experience insurance going forward, but I think you can see that we're talking about a small universe, and we're talking about what states may do going forward. That has gotten really a disproportionate amount of attention and some really over-the-top rhetoric within the media.

Josh, what are some considerations that states should have?

Josh Archambault: Going forward, there are a couple of really important things to start to think about at the state level, and we thought it would be helpful just to spend one minute putting a couple of those on the table. The first one is revolving around this pre-existing condition protection fund that is in the House Bill—and if the Senate puts in a much clearer off-ramp to devolve this program to the states, which has been some of the conversation, you need to start to think through how would you administer something like that.

How would you tailor a program to do that? How would you specifically name the pre-existing conditions that are driving up premiums in your state, and tailor such a program to help drive down premiums as much as possible? Another policy question to think about is how much skin in the game would you want the insurer to have upfront under these sorts of programs? Then finally how are you going to fund it? How are you going to get the state share of this? Are you going to do it similar to how Maine did it, with an insurer assessment? Or are you going to look at general funds to help stabilize the market?

Now related to this funding conversation, we should mention the House bill did have $100 billion of federal funds that does require states to start spending money in 2020 to draw down from these federal funds. Now the funds can be used for financially helping high-risk people in the individual market; providing incentives to entities to help stabilize premiums in the individual market; reducing the cost of providing health care to high-cost users in the individual and small group market; providing payments directly or indirectly to providers for services; or providing assistance to reduce out-of-pocket costs for people enrolled in health insurance.

Quite broad, but really, in theory a state could look at this money to help set up a traditional high-risk pool or to help set up or do one of these Pre-Existing Condition Protection Funds as we've described like in Maine.

Finally, there's going to be quite a few state decisions that need to be made around the Medicaid program, like implementing a work requirement for able-bodied adults, which is an option in the House bill. There are likely to be additional options added in the Senate. States will need to think through—do they want to apply for a block grant from Medicaid? What other eligibility changes would they like to make under a per-capita cap, however that program is structured in a final bill?

Tarren, one of the questions we get asked most frequently is how do we talk about pre-existing conditions? Could you wrap up our time by just giving us a few suggestions on ways to talk about this?

Tarren Bragdon: I think that's a really important thing because as a former state legislator, I know that we often get tripped up when we're talking about such an important issue, but also such an emotional issue. Here are just four strategies that I think are really important when talking to the media, your colleagues, or constituents about it. Number one is make it personal or tell a story. My wife and I, one of our sons has epilepsy, that's a pre-existing condition, so for me this is a really personal issue.

There's some over-the-top rhetoric in the media about would rape be a pre-existing condition. I find that offensive. I have had a family member who's been raped and struggled with recovery from that, so make it personal. Tell a story.

Number two, assume that most people are compassionate and want to help, but at the same time they just want to understand. Again, assume good intentions and that people want to help.

Number three, I think it's really important to highlight the failures in the status quo or what's happening right now under ObamaCare in the insurance market.

Number four, highlight a proven state program. This isn't something that hasn't been tried before. Point to the proven program in Maine, and it was also in Idaho before that. How it lowers premiums and yet helps out everyone including those with pre-existing conditions. I care about—along with, I think, most Americans—individuals who have a pre-existing condition and want to make sure that they get access in the individual market.

As I mentioned, this is an issue that's really personal to me, like it is to almost everybody on the phone. Right now, the ACA locks those people out, if they have gaps in coverage, by only allowing them to sign up certain times during the year. ObamaCare has certainly harmed individuals by canceling their plans, driving up premiums that they're buying outside the exchange, offering fewer and fewer options, and fewer doctors, and forcing people into high-cost insurance that Washington D.C. has designed.

The goal should be not to force you to buy what government tells you and is expensive, but to get a lot more options, so that people can find something that fits their budget. Repeal and replace needs to focus on lowering premiums and expanding choice. As a result of that, people can afford coverage without a massive taxpayer subsidy or without forcing people to be trapped on government-run coverage like Medicaid. In that future world, this issue that we're talking about today with pre-existing conditions, largely goes away, if people can afford to buy and keep their coverage, and nobody will be denied coverage under this proposal.

If you have coverage through your employer, nothing changes for somebody with a pre-existing condition. Again, we're talking about less than two percent of the private market, but if you or I were one of those two percent, or one of our family members, we would want to be sure that there were options, affordable options for coverage. The problem with those with pre-existing conditions is it's almost exclusively in the individual market, which is why this whole Pre-Existing Conditions Protection Fund concept must be part of any repeal and replace bill, as it helps those with high-cost care and is similar to the programs that have been proven to draw premiums for everybody.

That's really a win-win for everyone. I want to thank you for joining the call today, and we have time now for a few minutes of questions. Christie, I'll have you lead the Q&A.

Christie Herrera: Sure, thanks so much Tarren. As he said, we do have a couple of minutes for questions? If you want to enter the question queue please, press *6.

We've just started Q&A. While we wait for folks to jump on, I did have a couple of questions. One of them is something that's been popping up on my social media feed. I have heard that sexual assault and rape would be a pre-existing condition. A lot of my female friends have been talking about that, and I wanted to know if that's true or not true.

Josh Archambault: This is Josh. There is no list of pre-existing conditions that is out there. In fact, the program that we've been talking about—this Pre-Existing Conditions Protection Fund—would have the Secretary of HHS determine which conditions are driving premiums the most for people with pre-existing conditions. If that program were to devolve to the states, it would be up to the states. The bill is explicit that you cannot be denied for a pre-existing condition, but there is no magical secret list of pre-existing conditions that's out there. Unfortunately, social media has fueled that even though it's not true.

Tarren Bragdon: Christie, I just want to jump in here. I'm all for having spirited debate about public policy issues, even really emotional ones. But I think those kinds of charges, like how rape is a pre-existing condition—and using such a traumatic and violent event and suggesting that individuals who have gone through that would be in any way impacted by this legislation—is really the height of fear mongering and horrible behavior.

It's not true. It's a complete lie. I think it just shows how some people—and this happens on both sides—some people can use really over-the-top rhetoric to scare people rather than inform. Our goal is to inform folks of the facts, but also to let them know that we do need to solve a problem that was made worse by ObamaCare. Reform needs to protect access for those with pre-existing conditions, but do it in a way that drives down the cost of premiums for people who get insurance on their own.

Christie Herrera: Thanks. We did have one pre-submitted question from a legislator in Virginia, who wanted to know—we've heard that the House bill will probably not remain in its current form once it gets over into the Senate, so do you have any expectation of what changes will happen in the Senate moving forward?

Tarren Bragdon: We've certainly been engaged in this conversation heavily in the House and now on the Senate side. I think that what's clear, and this has been in the media report, is the Senate is not starting from a blank sheet of paper. The Senate is starting from the House bill and looking at addressing some of the real challenges in the

House bill or some political pain points. What happens to folks on the exchange? How can we provide more flexibility to states in the Medicaid program? How do we make sure this Pre-Existing Condition Protection Fund works in the best way possible?

Those are the kinds of changes or improvements to the bill we've heard talked about on the Senate side. I think that you haven't heard talked about getting rid of whole swaths of the House bill and replacing it with something brand new and different. It's really a refinement of the House proposal.

Christie Herrera: Josh, do you have anything to add?

Josh Archambault: Well, just to add for context. Remember, because this is through the budget reconciliation process, there are rules and guardrails that the Senate needs to stay in. They are locked into the same budget saving numbers, so there's not a lot that can change from a financial standpoint, and it's just something for us to keep in mind as we're watching the Senate debate going forward.

Christie Herrera: Fantastic. It looks like we have a question from Georgia. Erik, can you unmute that line?

Jason Spencer: Yes, this is Jason Spencer from Georgia.

Christie Herrera: Hey, how are you? Go ahead with your question.

Jason Spencer: Hey, I'm a state legislator in the State of Georgia, and I have sort of a two-part question. When we're talking about the pre-existing pool, risk fund, whatever we're naming this thing, where do the funds come from to fund such a pool? That's number one. Number two, is it also considered that if it's coming from taxpayer sources, is it considered sort of a bailout for the insurance industry who's actually offering a product in the pool? Aren't they just sort of being subsidized in the market with the taxpayers essentially subsidizing this pool? How does one reconcile the fact that this is not really a bailout for the insurance companies? Two questions there.

Tarren Bragdon: Sure, I think that's a great question, Representative Spencer. I think that these are taxpayer funds raised from general revenue—federal aid that's put into this Pre-Existing Conditions Protection Fund proposal, and then devolved to the states over time. That's how it also operated with a lot of high-risk pools that were subsidized

out of either an assessment on those with private insurance, or out of general fund revenue pre-ACA.

The concept here though, you're guaranteeing access for people with pre-existing conditions who are getting insurance on their own, including individuals who had insurance all along. They just happen to have a pre-existing condition and they're buying insurance outside their employer. If you're going to make that policy choice, you want to do it in a way that doesn't drive up cost for everybody else. How you do that is you target subsidies just to those individuals.

What ObamaCare did is it took buckets and buckets of taxpayer money and provided them to insurance companies, in a really broad way to try to bailout the negative impacts of a bunch of the insurance regulations that were part of the law. What this proposal seeks to do and is proven to do, both with the Maine experience and with the Milliman study is to say if you're going to make this policy choice—how do you do it in a way that provides lower premiums for folks with pre-existing conditions and everybody else.

You can do that in a cost-effective, very targeted way.

Josh Archambault: I would just add for a little bit of context, too, of the moving parts in this House bill. We have to remember that they repealed roughly a trillion dollars in ObamaCare spending. As a result, you do have some funds that you can utilize as you're making these policy choices. I think the vision here though is that you want to tag the known risks for those individuals so that you can guarantee them coverage, but also drive down premiums and have it be as effective as possible going forward. Insurers have some skin in the game as well, and don't profit off anyone designated for such a program.

Under the ACA debate there were other payments that people called bailouts. This doesn't necessarily fit in that same context, because it's really trying to stabilize the market and drive premiums down for everybody. It's not just an open-ended checkbook to these individual insurers.

Christie Herrera: Okay. It looks like we're a little bit over time, so we'll go ahead and wrap this up. I want to thank FGA CEO Tarren Bragdon and FGA Senior Fellow Josh Archambault for all of their insight and comments about the bill moving through Congress. If you want to learn more about some of the work that FGA is doing at the federal level, go to our website thefga.org, click on the "Our Solutions" tab, and you'll see a host of one-pagers and explanations to make what's going on in Washington a little more understandable for those of us who are not healthcare policy wonks.

With that I want to thank you for your time. Please reach out to us if you have any questions. Have a great day.