WISCONSIN LEGISLATIVE COUNCIL
INFORMATION MEMORANDUM

Comparison of Approaches to Preexisting Conditions

This Information Memorandum compares three approaches to providing health insurance coverage for preexisting conditions. These include the approach that is provided in the Affordable Care Act (ACA), the preempted approach in current state law, and the approach proposed in Assembly Substitute Amendment 1 to 2017 Assembly Bill 365. Each approach provides some protections to individuals who have a preexisting condition, though the applicability of each approach varies in certain aspects.

BACKGROUND

Regulation of health insurance coverage for individuals with preexisting conditions can take a number of forms, each involving one or more different aspects of coverage. For example, the different aspects can include the concept of "guaranteed issue," under which a person cannot be denied enrollment in a plan, the concept of a "preexisting condition exclusion" that may limit or exclude coverage of a specific condition while a person is enrolled in a plan, and monetary aspects such as premium amounts and cost sharing in deductibles, copayments, and coinsurance.

Insurance coverage itself can come from different sources. For example, coverage could be provided by an employer under a group health plan, or be purchased by an individual directly from an insurer. Also, rather than providing an insurance policy, an employer could choose to provide coverage through a self-insured plan. Under these multiple options, regulations can vary, depending on the entity that is providing the coverage.[1]

Under current law, the source of the regulations is generally the federal ACA and the Employee Retirement Income Security Act (ERISA). In particular, the ACA supersedes state laws relating to health insurance coverage unless there is no conflict in enforcing both, and ERISA supersedes "any and all" state laws relating to a private self-insured plan. [29 U.S.C. s. 1144 (a) and 42 U.S.C. s. 18041 (d).]

[1] Additional methods of arranging health care coverage are not addressed in this memorandum, such as individual short-term policies, group association health plans, and individual policies that are not comprehensive.

AFFORDABLE CARE ACT

Under the ACA, as amended, a health insurance policy cannot refuse coverage, limit coverage, or charge a higher premium based on a preexisting condition. These provisions, relating to eligibility, benefits, and premiums, are sometimes referred to collectively as the coverage provisions for a preexisting condition. [42 U.S.C. ss. 300gg-3 and 300gg-4.]

The ACA coverage provisions for a preexisting condition apply to a group health plan and to an individual health insurance policy. For a group health plan, although not true of all aspects of the ACA, the coverage provisions for a preexisting condition apply to both an insured and a self-insured group health plan. The coverage provisions are also among the ACA requirements that apply to a grandfathered group health plan. However, the provisions do not apply to a grandfathered individual health insurance policy that was purchased before the ACA was enacted. [42 U.S.C. ss. 300gg-91 (a) (1) and 18011 (a) (4) (B) (i), and 29 U.S.C. s. 1002 (1).]

The following table summarizes the ACA provisions relating to coverage for a preexisting condition:

On the Basis of a Preexisting Condition, an Issuer May:	**Refuse Coverage**	**Limit Coverage**	**Charge Higher Amounts**
In a group health plan	No	No	No
In a self-insured plan	No	No	No
In an individual plan	No, unless grandfathered	No, unless grandfathered	No, unless grandfathered

CURRENT STATE LAW

Although the ACA preempts state law provisions relating to coverage of a preexisting condition, Wisconsin has laws in place that would address coverage if the federal provisions were to be repealed or overturned.

Regarding eligibility and premium amounts, under current state law, a group health insurance policy cannot limit eligibility or charge a higher premium based on an individual's medical condition or other identified health status-related factors. [s. 632.748 (1) and (2), Stats.]

However, current state law authorizes an issuer of a group health insurance policy to limit coverage through a preexisting condition exclusion, if the person received the diagnosis or any recommendations for care or treatment within the last six months before enrollment. A preexisting condition exclusion may restrict coverage for a specific condition while a person is enrolled and receiving other benefits of coverage. [s. 632.746 (1) (a), Stats.]

The law specifies certain time limits on the application of a preexisting condition exclusion in a group policy. In particular, a preexisting condition exclusion period cannot extend for more than 12 months after enrollment (or 18 months, for a late enrollment). Also, if a person is only moving

to a new policy and provides a certificate of insurance showing that the person had continuous coverage, the length of time in the exclusion period must be reduced by the amount of "creditable" previous coverage. [s. 632.746 (1) to (3), Stats.]

As an alternative to imposing a preexisting condition exclusion period, a health maintenance organization (HMO) could instead choose to uniformly impose an "affiliation" or waiting period for full coverage for up to two months (or three months, for a late enrollment). [s. 632.746 (8), Stats.]

The above provisions under current state law apply to a group health insurance policy, and do not apply to an individual plan or to a private or governmental self-insured plan.

For an individual health insurance policy, state law specifies that coverage more than 12 months after a policy was issued may be reduced or denied only if the preexisting condition was individually excluded by name or specific description in the original policy. An individual policy may also define a "preexisting" condition only as a condition for which the person received the diagnosis or any recommendations for care or treatment within the last 12 months before enrollment. [s. 632.76 (2) (ac) 1. and 2., Stats.]

The following table summarizes the current state law provisions relating to coverage for a preexisting condition:

On the Basis of a Preexisting Condition, an Issuer May:	**Refuse Coverage**	**Limit Coverage**	**Charge Higher Amounts**
In a group health plan	No	Yes, for up to 12 months, but must credit previous coverage	No
In a self-insured plan	Yes*	Yes*	Yes*
In an individual plan	Yes	Yes, and may extend beyond 12 months after the policy was issued if condition is specifically named in the policy	Yes

*State law cannot regulate a private self-insured plan, due to ERISA preemption.

ASSEMBLY SUBSTITUTE AMENDMENT 1 TO 2017 ASSEMBLY BILL 365

In the 2017 legislative session, a proposal to revise the state law regarding coverage of a preexisting condition passed the Assembly, but did not receive concurrence in the Senate. [Assembly Substitute Amendment 1 to 2017 Assembly Bill 365.]

Under that bill, as amended by the Assembly, state law would have been revised to specify that a health insurance policy or governmental self-insured plan cannot impose a preexisting condition exclusion.

However, if a person did not have continuous coverage, a preexisting condition could be considered for the purpose of setting a premium or setting any deductibles, copayments, or coinsurance. In this context, "continuous" coverage means coverage for the 12 months before the date of enrollment with no breaks in coverage for any period longer than 63 continuous days.

The amended bill did not affect, and accordingly retains, the provision in current law that prohibits basing eligibility for a group health plan on a medical condition or other health status-related factor.

The bill, as amended, additionally authorized the Office of the Commissioner of Insurance to propose a plan to assist in purchasing coverage for individuals who have a preexisting condition, and who have not had continuous coverage. If the office were to propose a plan, the plan must address certain aspects, including expanded choices of insurance coverage, more affordable options for an individual to purchase coverage, and greater flexibility in portability of coverage. The plan could supersede the statutory provisions included in the substitute amendment and any other statutory insurance provision, but must be submitted to the Joint Committee on Finance before the plan may be implemented.[2]

The provisions under the amended bill would have applied to both a group and individual health insurance policy, and to a governmental self-insured plan, but not to a private self-insured plan.[3]

The following table summarizes the bill's provisions relating to coverage for a preexisting condition:

On the Basis of a Preexisting Condition, an Issuer May:	**Refuse Coverage**	**Limit Coverage**	**Charge Higher Amounts**
In a group health plan	No	No	No, unless no continuous coverage

[2] The plan could potentially be modeled on other plans, such as the risk-sharing plans identified in state law for specific lines of insurance, in which private insurers participate in the pool, or the former health insurance risk-sharing plan (HIRSP), in which coverage was provided by the independent HIRSP Authority. [s. 619.01, Stats., and ch. 149, 2011 Stats.; see also Legislative Fiscal Bureau, *Health Insurance Risk-Sharing Plan (HIRSP)*, Informational Paper 53 (Jan. 2013), http://docs.legis.wisconsin.gov/misc/lfb/informational_papers/january_2013.]

[3] As noted earlier, ERISA preempts state law related to a private self-insured plan. However, ERISA does not apply to a "governmental plan" that is established or maintained by a state government, or by a political subdivision of the state, for its employees. Accordingly, state insurance regulations do apply to a governmental self-insured plan when explicitly made applicable. [29 U.S.C. ss. 1002 (1), (3), and (32) and 1003 (b) (1).]

On the Basis of a Preexisting Condition, an Issuer May:	Refuse Coverage	Limit Coverage	Charge Higher Amounts
In a self-insured plan	Yes*	Yes, for a private self-insured plan* No, for a governmental self-insured plan	Yes, for a private self-insured plan* No, for a governmental self-insured plan, unless no continuous coverage
In an individual plan	Yes	No	No, unless no continuous coverage

*State law cannot regulate a private self-insured plan, due to ERISA preemption.

UNDERWRITING

Common to each of these approaches is the question of underwriting. Insurance itself is a device to transfer risk and uncertainty for individuals through pooling of resources. In this process, an insurance company generally examines all known risks and determines whether to accept a risk and at what classification to rate a risk. [National Association of Insurance Commissioners, *Glossary of Insurance Terms*, https://www.naic.org/consumer_glossary.htm.]

Accordingly, as a general principle, state law allows an insurance company to set rates in any "reasonable way" that is not "unfairly discriminatory."[4] A rating classification is permitted to modify rates for individual risks, in accordance with "reasonable standards" for measuring hazards and expenses. This is subject, however, to the limitation in current state law, noted above, which prohibits a group health insurance plan from determining eligibility or setting a premium on the basis of a medical condition or other health-status related factor. [ss. 625.11 (1) and (4), 625.12 (2), 628.34 (3), and 632.748 (1) and (2), Stats.]

The different approaches described in this memorandum attempt to mitigate the underwriting costs associated with providing coverage for a preexisting condition in different ways. For example, in very broad terms, the ACA attempts to spread the risk among a larger pool,[5] while

[4] State law specifies certain categories that can never be used to classify a risk. The prohibited categories are race, color, creed, or national origin. State administrative rules specify additional categories that generally cannot be used for setting rates unless certain conditions are met. [s. 625.12 (2), Stats.; and ss. Ins 6.54 and 6.55, Wis. Adm. Code.]

[5] Under a provision of the ACA that is commonly referred to as the "individual mandate," an individual must pay a fee in the person's federal income tax return for any month in which the person voluntarily fails to maintain health insurance coverage. The fee applies to coverage through 2018, and does not apply to coverage in 2019 or later. [26 U.S.C. s. 5000A, as amended by P.L. 115-97 SEC. 11081, eff. after Dec. 31, 2018.]

current state law allows a temporary intermediate level of coverage, and the Assembly proposal encourages continuous coverage over obtaining coverage only when known expenses arise.

SUMMARY

The following table summarizes the differing approaches that are described above relating to certain common aspects of coverage for a preexisting condition:

On the Basis of a Preexisting Condition, an Issuer May:	**Under the ACA**	**Under Current State Law**	**Under Assembly Substitute Amendment 1 to 2017 Assembly Bill 365**
Refuse Coverage			
In a group health plan	No	No	No
In a self-insured plan	No	Yes*	Yes*
In an individual plan	No, unless grandfathered	Yes	Yes
Limit Coverage			
In a group health plan	No	Yes, for up to 12 months, but must credit previous coverage	No
In a self-insured plan	No	Yes*	Yes, for a private self-insured plan* No, for a governmental self-insured plan
In an individual plan	No, unless grandfathered	Yes, and may extend beyond 12 months after policy was issued if condition is specifically named in the policy	No

On the Basis of a Preexisting Condition, an Issuer May:	Under the ACA	Under Current State Law	Under Assembly Substitute Amendment 1 to 2017 Assembly Bill 365
Charge Higher Amounts			
In a group health plan	No	No	No, unless no continuous coverage
In a self-insured plan	No	Yes*	Yes, for a private self-insured plan* No, for a governmental self-insured plan, unless no continuous coverage
In an individual plan	No, unless grandfathered	Yes	No, unless no continuous coverage

*State law cannot regulate a private self-insured plan, due to ERISA preemption.

This memorandum is not a policy statement of the Joint Legislative Council or its staff.

This memorandum was prepared by Margit S. Kelley and Brian Larson, Senior Staff Attorneys, on November 26, 2018.

WISCONSIN LEGISLATIVE COUNCIL
One East Main Street, Suite 401 • Madison, WI 53703-3382
Telephone: (608) 266-1304 • Fax: (608) 266-3830
Email: leg.council@legis.wisconsin.gov
http://www.legis.wisconsin.gov/lc