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Health Policy Brief

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Pre-Existing Condition Insurance Plan.

A new program provides coverage to people with costly preexisting health conditions. To boost enrollment, the government has already made changes.

WHAT'S THE ISSUE?

People with illnesses or disabilities may be unable to obtain private health insurance or may find that the coverage offered them is so costly that they cannot afford it. In the Affordable Care Act, Congress provided relief for these people that will roll out in two phases.

First, as of 2010, insurers can no longer deny or restrict coverage for children who have been diagnosed with an illness (that is, a pre-existing condition). Also, from 2010 to 2014, a new, temporary Pre-Existing Condition Insurance Plan program will offer uninsured adults with preexisting conditions coverage in special state-based “pools.” In a second phase, from 2014 on, all health plans will be prohibited from restricting coverage of preexisting conditions or charging higher premiums to individuals with health problems.

This brief focuses on issues surrounding the Pre-Existing Condition Insurance Plan program, which will be operated by some of the states themselves and, in other states that have chosen not to take on this role, by the federal government.

One issue is that initial enrollment in the program, at only 8,000 people as of November 1, 2010, has been significantly lower than anticipated. This fact prompted the government

to reduce premiums and create additional plan options that will start in 2011. A second issue is that the \$5 billion that Congress appropriated for the program is generally recognized as insufficient to cover all those who may be eligible until 2014, when broader reforms take effect. As a result, depending on future enrollment, difficult decisions may still have to be made about who is eligible and what health care services will be covered in order for the plans to stay within the spending constraints.

WHAT'S THE BACKGROUND?

People buy insurance to obtain help with future costs. Unless restricted by regulation, insurers generally charge higher health insurance premiums to individuals who are more likely to incur higher health care expenses. An individual with a preexisting condition is generally considered “high risk” because that condition may make him or her more likely to need high-cost health care services. Such a person may face higher premiums than a person who is not known to have a preexisting condition simply because the insurer knows more about the former’s probable future health care costs.

DRIVING UP COSTS: Because they expect to incur medical costs, people who know they have a health problem may be more likely to seek health insurance than those who either

\$5
billion

Federal funding

The amount Congress appropriated to fund the new program through 2013.

don't have a health problem or don't know that they do. Insurers call this behavior "adverse selection." An insurer that enrolls more than the expected number of sick people may have difficulty selling policies that are properly priced to cover the higher-than-average expenses of its sicker enrollees. One way that insurers guard against enrolling an unusual number of sick people is to restrict coverage of preexisting conditions. That generally excludes from coverage any treatment for conditions that people have when they apply for insurance.

The Health Insurance Portability and Accountability Act of 1996 said these restrictions could apply for only a year for people who got health coverage through their employers. However, millions of Americans who buy their own coverage may still be subject to a permanent exclusion of coverage for preexisting conditions until 2014, when the terms of the Affordable Care Act take full effect.

EXISTING STATE POOLS: To help people with preexisting conditions, thirty-four states have set up high-risk pools that offer coverage to an estimated 200,000 Americans. However, that's only a small fraction of the estimated total number of people who need such coverage. Enrollment in current state pools is low: Although coverage is less expensive than that offered by private insurers because it is at least partially subsidized by the state, it may still be unaffordable for some potential enrollees or not meet their health care needs.

For instance, existing state high-risk pools often have high deductibles and premiums that can be twice those that are typical for individual insurance policies. And almost all state pools have a lifetime limit on the benefits available. Six states also have annual limits on benefits. Finally, since high-risk pools are also vulnerable to adverse selection, all but two states have a waiting period during which treatment for preexisting conditions is excluded.

Offering coverage through a high-risk pool is expensive. By definition, the people served by the pools have high costs that exceed even the high premiums charged by the pools. States have had to raise premiums or limit enrollment to keep the cost of their subsidies to the pools affordable. Florida actually closed enrollment in its state pool in 1991. Many states have long waiting lists for people to obtain coverage.

States without high-risk pools use other mechanisms to improve access to coverage for individuals with preexisting conditions. These include requiring that a specific plan be offered to certain individuals who cannot obtain coverage in the private market. In some cases, states designate a specific insurer to offer such coverage; this company is called the "insurer of last resort." In other cases, states put limits on insurers' ability to charge higher premiums based on an applicant's health status.

Five states—New York, New Jersey, Massachusetts, Maine, and Vermont—have what are called "guaranteed issue" requirements that restrict the ability of insurers to deny coverage based on health status. These guaranteed issue states also require some form of "community rating," under which premiums aren't allowed to vary based on individuals' health status. The combination of guaranteed-issue and community-rating requirements increases the likelihood that individuals with preexisting conditions will be offered coverage and that such coverage will be affordable.

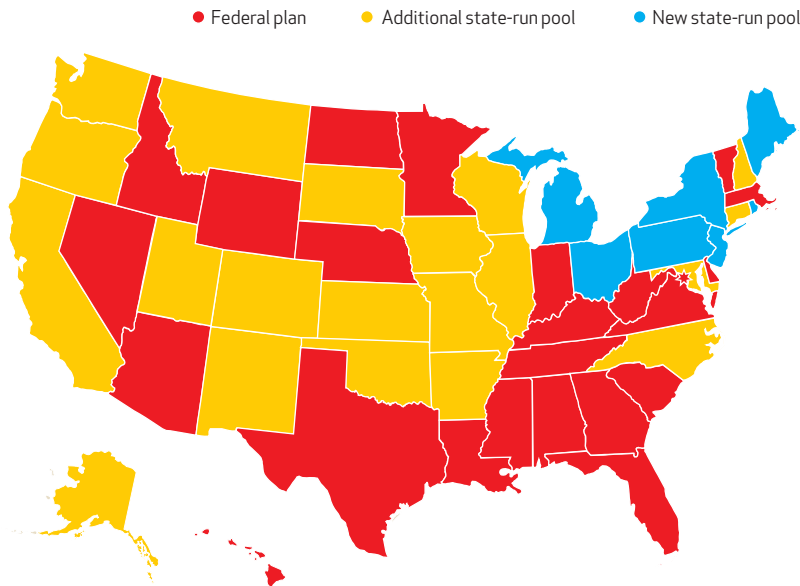
WHAT'S IN THE LAW?

Since 2003, the federal government has offered the states grants to develop and support high-risk pools. The Affordable Care Act builds on this support by creating temporary, federally funded pools in addition to the existing state pools. The temporary pools will operate until 2014, when enrollees will be able to transition to insurance plans that are forbidden to have preexisting condition exclusions.

Under the program, which took effect July 1, 2010, a new pool is established in each state. States can choose whether to operate their own pool or allow the US Department of Health and Human Services (HHS) to do so. HHS has selected the Government Employees Health Association Inc., a nonprofit association that offers health insurance to federal employees and their families, to administer plans in the twenty-three states and the District of Columbia that have chosen the federal option.

The remaining twenty-seven states have chosen to administer their own plans. They can set up a new high-risk pool if they did not previously have one; create an additional high-risk pool alongside an existing one; contract with a nonprofit entity to operate a new pool on the state's behalf; or build on other existing state programs to help cover high-risk individuals.

"The temporary pools are intended to cover US nationals—citizens or permanent and temporary legal residents—who are unable to find coverage elsewhere."

EXHIBIT 1**Temporary Federal High-Risk Pools Administered by the States or the Federal Government**

SOURCE US Department of Health and Human Services. **NOTES** Twenty-three states and the District of Columbia (red) have requested that HHS run the program for them. Twenty states (yellow) will set up a new high-risk pool alongside an already existing pool. Seven states (blue) will create a new pool for the first time.

Exhibit 1 shows which states are running their own plans and which have plans run by HHS. On July 30, 2010, HHS published an interim final rule open to public comment that describes the program and its requirements. The comment period closed September 28, 2010, and HHS will issue a final version, possibly before the end of the year.

2010 COSTS AND BENEFITS: State-operated plans have discretion over how they calculate the premiums that they will charge, subject to approval by HHS. But in general, the cost will not exceed the premium that would be charged in the state's individual insurance market for coverage providing the same benefits. For 2010, monthly premiums range from \$115 to \$1,735, depending on the enrollee's age and state of residence; most fall between \$140 and \$900.

Almost all of the preexisting condition insurance plans include deductibles and other enrollee cost sharing. By law, the total out-of-pocket costs that anyone enrolled in the plans will have to pay for in-network care cannot exceed \$5,950 per year for individuals and \$11,900 for families. All plans must pay at least 65 percent of the total costs that a typical insured population would normally incur

for the plan's covered health care services. The plans cannot limit care for preexisting conditions and cannot spend more than 10 percent of the funds they receive on administrative costs. However, they may impose annual and lifetime limits on coverage (Exhibit 2).

The benefits offered by the plans are based on the "essential health benefits" defined in the Affordable Care Act. They include hospital care, mental health and substance abuse services, noncustodial skilled nursing services, prescription drugs, preventive care, and maternity care. Cosmetic surgery, custodial care, in vitro fertilization, elective abortion, and experimental care are not covered under the program.

ELIGIBILITY REQUIREMENTS: The temporary pools are intended to cover US nationals—citizens or permanent and temporary legal residents—who are unable to find coverage elsewhere. To be eligible to participate in the new pools, an individual must have been uninsured for at least the previous six months and must have proof that he or she has been denied coverage because of a preexisting condition. Current participants in state pools are ineligible to participate in the new plans unless they go without coverage for six months.

The timeline for establishing this new program was extremely short. Following the enactment of health reform legislation in March 2010, HHS and the states had only 90 days to implement the temporary pools. In fact, coverage did not begin in some states until September 2010, two months behind schedule.

EARLY EXPERIENCE, FUTURE CHANGES: The first few months' experience with the program has shown enrollment to be significantly lower than anticipated. As of November 1, 2010, the Pre-Existing Condition Insurance Plan had about 8,000 enrollees across the country, with more than 20 percent of those in one state, Pennsylvania. Twenty-two states have fewer than 50 enrollees. Observers identify the high premium and lack of program awareness as potential causes for the low enrollment to date. As a result, HHS took steps to reduce premiums and create additional plan options that will begin in 2011. It is hoped that these changes will make the program more attractive and will boost enrollment.

FUNDING: A major question now is whether the program will have adequate funding. Congress appropriated \$5 billion to fund the new program through 2013. Approximately five

200,000

Enrollees per year

The average predicted enrollment in high-risk pools per year, according to the Congressional Budget Office.

65%

Actuarial value

The new high-risk pools must cover at least 65 percent of what a typical group of people would normally incur for covered health services.

to seven million Americans are estimated to lack health insurance and have a preexisting condition. Some early estimates were that the \$5 billion in funding could run out by 2011 if as many as 375,000 people had enrolled this year. However, as of November 1, 2010, enrollment stood at only 8,000, suggesting that any funding problems are far from imminent.

Should funding difficulties arise in the future, the federal government has broad authority to make adjustments to the program to stave off any deficits. For example, HHS can simply stop taking applications for enrollment. If the costs of the program do end up exceeding the available funding, HHS may have to make other difficult decisions about how the program is structured, including increasing premiums. But as with the existing state high-risk pools, only a fraction of those who need coverage are expected to enroll in the program.

PROS AND CONS: Supporters of the plan emphasize that even with its funding limitation, it is an improvement over the options that are currently available. They say it will help hundreds of thousands of people who are uninsured. HHS, for example, expects the program to provide numerous benefits—including improved health for enrollees, improved worker productivity through fewer absences from work, and a reduced financial burden for both enrollees and health care providers, who will have to provide less uncompensated care.

Critics remain concerned that expectations for the program will vastly exceed the available resources, despite the relatively low enrollment to date. If that happens, the danger is

that the limited funding will not permit high-quality insurance coverage, or that it will require limiting enrollment sharply to meet the budgetary restrictions.

In addition, anti-abortion groups believe that the new plans offered by some states will pay for elective abortions, leading the groups to oppose the plans. In response, HHS has reiterated that both the federally administered and state-run plans will comply with existing federal law. This means that the plans will cover abortions only in the case of a pregnancy resulting from rape or incest, or where the life of the woman would be endangered if a pregnancy were continued.

WHAT'S NEXT?

HHS has created additional plan options for the federally run plans in 2011. Two options will include separate medical and drug deductibles. The standard plan option will have a \$2,000 medical deductible, a \$500 drug deductible, and a premium that is roughly 20 percent less than the 2010 premium. The extended plan will have lower medical and drug deductibles and premiums slightly higher than 2010 levels. The third option has the same deductible and similar coinsurance as the 2010 plan but with a premium that is 16 percent less than the 2010 premium.

Like the 2010 plan, this third option qualifies as a high-deductible health plan and enrollees who also have a health savings account may qualify for favorable tax treatment. In 2011, HHS also further refines the premium rates for age by creating a category for children younger than 19 (in 2010, the lowest age bracket was 34 years and younger).

EXHIBIT 2

Provisions Of Temporary Preexisting Condition Insurance Plans

Eligibility	Preexisting medical condition No "creditable" coverage for past six months, including coverage in a state-run pool Proof of insurance company denial, limitation, or exclusion of benefits US citizen, resident, or lawfully present in United States
Benefits	Primary and specialty care, hospital care, prescription drugs No abortion services (except for rape, incest, or mother's health) Pay at least 65 percent of average individual health expenses (actuarial value) May impose annual or lifetime limits
Premiums and cost sharing	Premiums can vary by age, but not by more than by four times Premiums vary by geographic area and family composition, but will generally range from \$140 to \$900 per month Deductibles can range from \$500 to \$3,000 Out-of-pocket costs (in network) limited to \$5,950 for individuals, \$11,900 for families (in 2010)

HHS has asked state-run plans to consider whether they may want to make changes to their individual programs, including lowering premiums. In addition, HHS is exploring

options for increasing public awareness of the program. Several state plans are reportedly considering marketing campaigns to increase enrollment. ■

About Health Policy Briefs

Written by

Amanda Cassidy

Principal

Meitheal Health Policy

(Cassidy previously worked for the Centers for Medicare and Medicaid Services, in the Office of Legislation and the Center for Medicare Management.)

Editorial review by

Deborah J. Chollet

Senior Fellow

Mathematica Policy Research

Len M. Nichols

Director

Center for Health Policy Research

and Ethics

George Mason University

Ted Agres

Senior Editor for Special Content

Health Affairs

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Health Affairs

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ERRATUM

The original version of this brief published August 10, 2010, incorrectly stated that preexisting condition insurance plans cannot impose annual or lifetime limits on coverage. Under HHS regulations, they are allowed to do so. The text and Exhibit 2

have been corrected in this version. In addition, information has been added about new plan options and reduced deductibles, and the number of federally run programs has been updated in the text and in Exhibit 1.