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STATE OF THE STATES

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Chapter 4: First Hurdle: Pre-Existing Condition Insurance Plans

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) includes a provision that creates a temporary high-risk pool to provide coverage to people who have been unable to obtain health coverage because of a pre-existing condition. The plans offered through the new high-risk pool are called Pre-Existing Condition Insurance Plans (PCIPs) and can be administered by either a state or the Department of Health and Human Services (HHS). The pools will operate until 2014, when most of the broader coverage reforms of the legislation take effect.

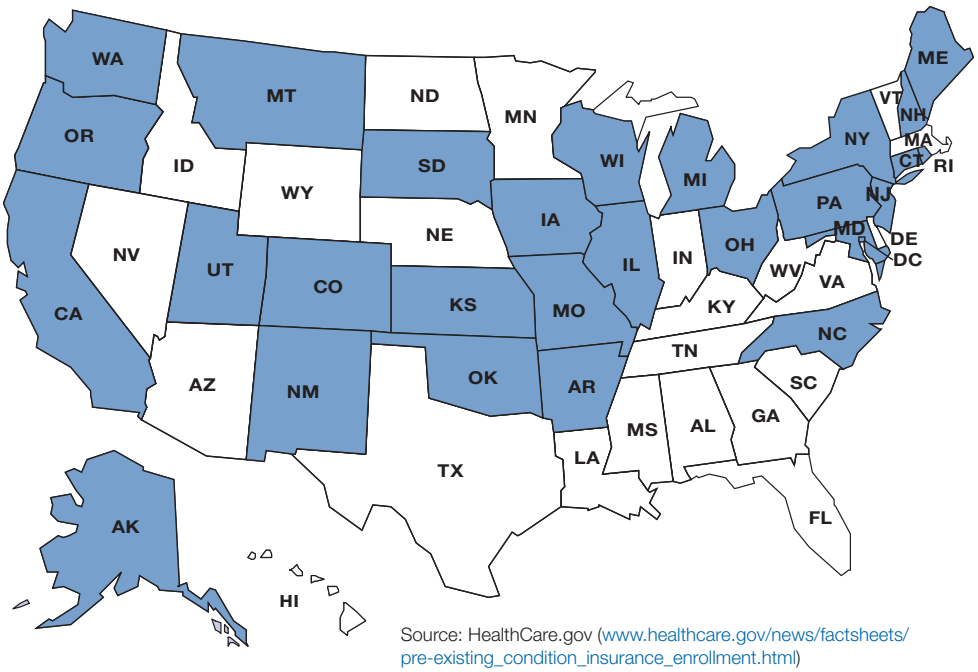
The PCIPs were required to be operational 90 days after the Affordable Care Act passed, so they became the first test of the ability of the federal government to work effectively with states to get a new program up and running. While there were understandable difficulties along the way, the whole process did proceed with unusual haste and the majority of states began taking applications in July or August. As of October 25, all PCIPs were operational. Twenty-three states and the District of Columbia (D.C.) chose to let the federal government run their PCIP and 27 states decided to govern their state-based PCIP (**See Figure 1**). Thirty-five states[1] operated state high-risk pools prior to the implementation of the Affordable Care Act. More than one-third (nine) of the states that opted out of running their own did not have an existing state high risk pool.

OVERVIEW OF PCIPS

States had the option to work with the federal program to design a state PCIP that generally met PCIP guidelines. The program rules of the new PCIPs include:

- In order to qualify for the program, individuals must have been uninsured for six months. In addition, they must meet one of two other requirements: have proof of being denied coverage by a health plan for a pre-existing condition; or have a condition that is on the state's official qualifying condition list. These requirements are waived (and replaced with proxy eligibility requirements) in a small number of states that already had guaranteed issue.
- Premiums must be set at or below standard market rates; they cannot vary by more than 4-to-1 based on age and insurers cannot use gender as a rating factor. These requirements generated lower premiums than were available in previous state-run high risk pools for which premium rates ranged from 125 percent to 250 percent of standard rates.
- The minimum actuarial value of a plan is 65 percent of medical costs. As a result, in 2010, for an individual, the deductible in all states with a federally-run PCIP is $2,500 and the out-of pocket maximum is $5,950. (Note: Deductibles and out-of-pocket maximums can vary and be lower in state-run PCIPs.)
- PCIPs may not impose a waiting period for coverage of pre-existing conditions.
- Eligibility for PCIP coverage is transferable between states.
- The programs will operate until December 31, 2013, or until the transition to exchange-based coverage (with subsidies and the guaranteed issue across the market) takes effect.

Fig. 1. **Distribution of Federally and State-Administered PCIPs**
(Note: Shaded states are state administered)



Source: HealthCare.gov (www.healthcare.gov/news/factsheets/pre-existing_condition_insurance_enrollment.html)

Most of the states that opted not to run their state's PCIP cited concerns that the $5 billion allocated to the program would not be sufficient, which could leave them to shoulder the cost of the program (or at least the moral responsibility to help those who had been receiving subsidies) if the funding ran out before 2014. Other states may have faced operational challenges getting a new program established in such a short timeframe. For example, some states felt that they needed legislative approval to start a PCIP and were not able to implement one by the deadline (because of the timing of their legislative session or other considerations). However, the ACA does not preclude a state that chose to allow the federal government to run the PCIP from establishing its own PCIP at a later date.

HHS intends to reallocate allotments[2] after a period of not more than two years, based on an assessment of state actual enrollment and expenditure experiences. The reallocation aims to ensure that federal dollars are distributed to states based on the initial formula as well as the actual use of services. On November 5, 2010, HHS announced the first premium and benefit level adjustment of the new program. The details are outlined below.

STATE IMPLEMENTATION OF PCIPS: CHALLENGES AND OPPORTUNITIES

States with Guaranteed Issue and Other Existing Market Reforms

States with the highest levels of insurance regulation already in place have experienced the greatest challenges in securing a portion of the $5 billion of federal funding for PCIPs. For example, five states—Maine, Massachusetts, New Jersey, New York, and Vermont—have a "guaranteed issue" requirement, barring insurers from denying coverage to people due to a health condition. In addition, all five states have some form of community rating, which also bars insurers from charging unreasonable rates based on gender, health, and other factors. These provisions make high-risk pools unnecessary, as high-risk individuals are pooled with the rest of the insurance market.

HHS worked with the five states to find a way to help them use the funding to expand coverage in a manner that is consistent with the goals of the PCIP program. In all of these states, the federal government worked with the state to find other eligibility criteria besides a denied application. These included: being offered coverage that is at least twice the standard rate (Vermont and Massachusetts); having a health condition that comports with a state-developed list (Maine and New York); and being offered a plan with a pre-existing condition exclusion (New Jersey). Three states elected to use the federal dollars to support a state-run plan (Maine, New Jersey, and New York), while the others (Massachusetts and Vermont) decided to let the federal government run the PCIP program.[3] In states with guaranteed issue, the federal government allowed other rate-setting mechanisms besides one based on standard rates.

Maine elected to sign an agreement with the federal government to use the federal funding to make its existing plan covering eligible small employers and individuals—DirigoChoice—more affordable to those who satisfy the ACA's PCIP requirements.

Premiums in New York also became more affordable as a result of the federal funding. According to Governor David Paterson,[4] the new enhanced plan—NY Bridge—will cost $362 per month in upstate New York counties and $421 per month in downstate counties, compared to the current guaranteed-issue product premiums which tend to cost around $1,000 per month.

While New Jersey's individual market insurance regulation does not allow insurers to deny coverage to people with pre-existing conditions, it does allow them to not cover those pre-existing conditions during the first 12 months after enrollment. Under the new PCIP called NJ Protect,[5] coverage for new enrollees with pre-existing conditions begins immediately after enrollment. Monthly premiums range between $212 and $768 per month, depending on a person's age and the plan selected. This is lower than the premiums of many of the plans available in the state's individual health insurance market. According to Ed Rogan, spokesman for the state Department of Banking and Insurance, the state expects to use $141 million in federal

Fig. 2. **Comparison of the State High-Risk Pool and PCIP in California and Wisconsin**

State		Premium	Deductible	Out-of-Pocket Limit In-network	Annual and Lifetime Benefit Limits
California[a]	High-Risk Pool (Major Risk Medical Insurance Program (MRMIP)[c]	125-137% of the standard market rate	$500	$2,500	$75,000 Maximum Annual Benfits $750,000 Maximum Lifetime Benefits
	PCIP	100% of the standard market rate	$1,500	$2,500	None
Wisconsin[b]	High-Risk Pool[d] (Premiums vary by gender)	Male/Female $781/$843 $408/$421 $258/$266 HSAs* $361/$374 $328/ $340	 $1,000 $2,500 $5,000 HSAs* $2,500 $3,500	 $2,000 $3,500 $6,000 HSAs*(medical and pharmacy) $4,600 $5,600	$2 million combined medical and pharmacy
	PCIP (Premiums are not allowed to vary by gender)	$559 $458 $330 $277	$500 $1,000 $2,500 $3,500	$1,500 $2,000 $3,500 $4,500	$2 million combined medical and pharmacy

Source: [a] California Managed Risk Medical Insurance Board: Facts about California's High Risk Pool and the Federal High Risk Pool (www.mrmib.ca.gov/MRMIB/Facts_About_California_HR_Pool.pdf).
[b] Wisconsin Health Insurance Risk-Sharing Plan (HIRSP): HIRSP State and Federal Plan Comparison (www.hirsp.org/pdfs/HIRSPvsHIRSP-Federal-Plan-Comparison.pdf).
[c] The MRMIP has an enrollment cap which limits the number of individuals that can be enrolled.
[d] In Wisconsin, individuals with incomes below $33,000 per year qualify for a subsidy.
* Health Savings Account Plans

money to cover an estimated 21,000 residents for three years.[6]

Funding and Enrollment Issues

One of the biggest concerns state officials have voiced is that, due to limited funding, they would not be able to enroll all the people who could qualify for enrollment in the PCIP. This apprehension was based on estimates by the Congressional Budget Office projecting that the costs for the program between inception and January 1, 2014, would range between $10 billion and $15 billion.[7] The amount that was appropriated is $5 billion. However, so far, most states have enrolled fewer than expected beneficiaries. According to statistics released by the Department of Health and Human Services, only 8,011 people had enrolled by November 1, 2010.[8] This was well below 10 percent of the capacity of these programs.

According to Amie Goldman, chair of the National Association of State Comprehensive Health Insurance Plans and CEO of the Wisconsin Health Insurance Risk-Sharing Plan (HIRSP), Wisconsin has received just over 450 applications[9] so far. They have capacity for more than 8,500 people in the program and the Government Accountability Office estimated that 63,504 people are potentially eligible.[10] As of October 18, California's Managed Risk Medical Insurance Board—the administrative entity responsible for the state's PCIP and other health care expansion efforts—mailed 6,300 enrollment forms, but received back only 768 (12 percent) applications.[11]

Several possible reasons may account for the current low enrollment in the PCIPs:

- Eligibility requirements that prevent people from applying. For instance, people who are HIPAA-eligible[12] are guaranteed immediate eligibility for coverage in the individual market or an existing state-based high risk pool. These individuals would likely not choose to go without coverage for six months in order to enroll in a PCIP when they can apply to the state high-risk pool and obtain immediate coverage.
- Premiums that—while lower than those in many state high risk pools—remain unaffordable for many potential applicants;
- Benefit levels and/or cost-sharing requirements that make the program unattractive; and
- Limited awareness of the program among health providers, community groups, and the general public.

As noted above, to qualify for a PCIP in the majority of states, people must have been denied coverage by a private insurer due to a pre-existing condition and must have been uninsured for at least six months.[13] If a person is not denied coverage, but the coverage is unaffordable either because the premium or other out-of-pocket expenses are too high—that person does not qualify for the PCIP in many states. For example, having a $411 per month premium coupled with a $25,000 deductible prevented a 64-year-old Virginia resident from obtaining PCIP coverage.[14] On the other hand, eligibility

criteria are less stringent in some of the states with already existing state-based high-risk pools. For example, in Wisconsin, people could qualify for enrollment in the state high-risk pool—Wisconsin HIRSP—if they have been rejected by one or more private insurers *or* if they satisfy other criteria such as showing that their plan was cancelled, reduced coverage or that they received at least one insurance offer with premiums at least 50 percent higher than a standard individual policy. In addition, families with incomes less than $33,000[15] qualify for a subsidy if they receive coverage in the state's risk pool. As a result, in September 2010, 674 people applied for the Wisconsin HIRSP as compared with 101 people for Wisconsin's PCIP.[16]

Another barrier to enrolling in a PCIP is related to the overall cost of a policy, which may surpass that of a policy under an already existing state high-risk pool. While premiums are generally higher in state risk pools than those in the PCIP, deductibles and out-of-pocket costs can be higher in the PCIP. The actuarial value of the PCIPs is set at a minimum of 65 percent. For example, in 2008, premiums in California's previously existing high-risk pool were approximately 125 percent of the standard market rates—25 percent higher than premiums in the PCIP plans, which are set at standard market rates. However the deductible in the California state high-risk plan is $500 while that in the PCIP is $1,500. The out-of-pocket limit is the same—$2,500 (see **Figure 2**). While not every state's high-risk pool has more generous benefits than the PCIP (and some have benefit levels that are more limited), the point remains that when premiums and cost-sharing are added together, these plans can be prohibitively expensive for many.

Not having enough information about the new PCIP program has also contributed to fewer than expected new enrollees. According to Richard Popper, deputy director for insurance programs at the Office of Consumer Information and Insurance Oversight at HHS, states that have more active outreach and referral mechanisms in place for their existing state-based high risk pools have seen stronger PCIP enrollment compared to those without an existing state high-risk pool.[17] This difference indicates that the number of people applying for coverage in the PCIP could substantially increase as more people become aware of the program.

State Variation

The federal government allowed a certain level of flexibility to states that agreed to manage their own PCIPs (**see Figure 3**). As a result, states have a variety of tools to make their PCIP more appealing and easier to access. These include:

- Offering enrollees choices of plans—Each plan design involves a trade-off between premium level and cost-sharing levels. States like New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Oregon, Utah, Washington, and Wisconsin have allowed enrollees to choose the plan design most appealing to them.
- Subsidies—A few states created a PCIP through an existing state-subsidized program (Maine and New Mexico) and enabled lower-income individuals to receive extra financial assistance. Wisconsin and Maryland have income-related subsidies for their state-sponsored pools, but not their PCIPs.
- Deductibles—In general, state-run PCIPs have lower deductibles than those found in the federally run pools. In the federally run plans, individuals have to meet their deductible ($2,500) before any prescription drug coverage is available, but many states offered first-dollar coverage for drugs that could include a tiered co-payment structure.
- Benefit Design—States could adapt the benefit design to be more accommodating to people with chronic conditions. Rhode Island, for example, required that enrollees choose a primary care physician and have a physical examination within six months of joining the plan. They also covered diabetic supplies and insulin, smoking cessation drugs, and generic drugs at no cost.

States vary in how they deal with co-insurance, prescription drug coverage, lifetime and annual limits, age bands, geographical variation in rates, and whether they have included a non-smoking differential in premiums, to name a few.

New Plan Options for Federally Administered PCIPS in 2011

On November 5, 2010, HHS announced[18] new plan choices for people enrolling in a PCIP in 2011. Beginning January 1, 2011, those who enroll in a federally administered PCIP will have the following three plan options. These plan changes are likely to make the program more affordable and attractive for potential enrollees.

- The Standard Plan—A plan with almost 20 percent lower premiums than the premiums of the plans offered in 2010, but with a $2,000 medical deductible and a separate $500 prescription drug deductible for in-network services.
- The Extended Plan—A plan with premiums slightly higher than the premiums of the plans offered in 2010, but with a $1,000 deductible for medical expenses and a separate $250 deductible for prescription drugs.
- A Health Savings Account—A plan with premiums that are 16 percent less than the premiums offered in 2010 and with a combined annual deductible of $2,500 for both medical and prescription drug coverage.

In addition, a lower child-only premium will be available for all of these plans starting in 2011 for children between 0-18 years of age.

CONCLUSION

While PCIPs have been slow to ramp up and they certainly are not for everyone, they have provided important health coverage for some of the individuals who need it most. The program has reflected an effective partnership between states and the federal government.

It has also shown the ways states can build on existing policy work to be advocates for their residents and bring stronger products to the market than what would otherwise have been available. Future success of the program will depend on the willingness of states and the federal government to continue to refine the program to make it more attractive and on the communication and outreach efforts that are undertaken.

ENDNOTES

1 The National Association of State Comprehensive Health Insurance Plans (NASCHIP). States that have High-risk Pools. Retrieved November 10, 2010, from www.naschip.org/states_pools.htm.

2 U.S. Department of Health & Human Services. Fact Sheet – Temporary High Risk Pool Program. Retrieved November 10, 2010, from www.hhs.gov/ociio/initiative/hi_risk_pool_facts.html.

3 Hall, J., & Moore, J. (2010, October). *Realizing Health Reform's Potential: Pre-Existing Condition Insurance Plans Created by the Affordable Care Act of 2010.* The Commonwealth Fund. Retrieved November 10, 2010, from www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Oct/1445_Hall_PCIPs_and_the_ACA_ib_FINAL.pdf.

4 Governor David A. Paterson press release. Governor Paterson Announces State Pre-Existing Condition Insurance Plan is Ready to Accept Applications. Retrieved November 10, 2010, from www.ny.gov/governor/press/082310Insurance.html.

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6 Fleisher, L. (2010, August 2). N.J. starts U.S.-funded health insurance for patients with pre-existing conditions. NJ.com. Retrieved November 10, 2010, from www.nj.com/news/index.ssf/2010/08/nj_opens_federally_funded_heal.html.

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8 Healthcare.gov. (2010, November 5). *State by State Enrollment in the Pre-Existing Condition Insurance Plan, as of November 1, 2010* [Fact Sheet]. Retrieved November 10, 2010, from www.healthcare.gov/news/factsheets/pre-existing_condition_insurance_enrollment.html.

9 Ibid.

10 Hall, J., & Moore, J. (2010, October). *Realizing Health Reform's Potential: Pre-Existing Condition Insurance Plans Created by the Affordable Care Act of 2010.* The Commonwealth Fund. Retrieved November 10, 2010, from www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Oct/1445_Hall_PCIPs_and_the_ACA_ib_FINAL.pdf.

11 Rizo, C. (2010, November 1). California: PPACA High-Risk Pools Opens With Lackluster Pre-Enrollment. BNA's Health Care Policy Report (Subscription only). Retrieved November 10, 2010, from http://news.bna.com/hcln/HCLNWB/split_display.adp?fedfid=18354973&vname=hcpnotallissues&fcn=12&wsn=496270500&fn=18354973&split=0.

12 The Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title I). Retrieved November 30, 2010, from www.cms.gov/HealthInsReformforConsume/Downloads/HIPAA_Eligibility_Criteria.pdf.

13 A few states negotiated exceptions to the federal requirement that all people be denied coverage due to a health condition. Several states had existing condition lists that made people eligible for coverage under the state high risk pool, and these lists were applied to the PCIPs in a few cases. In addition, the five states listed above with guarantee issue also did not require a coverage denial.

14 Andrews, M. (2010, Oct 26). High Risk Pools For People With Medical Issues Start Slowly. *Kaiser Health News.* Retrieved November 10, 2010, from www.kaiserhealthnews.org/Features/Insuring-Your-Health/high-risk-pools-response.aspx?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed:+NewFromKaiserHealthNews+(New+From+Kaiser+Health+News)

15 Wisconsin's Health Insurance Risk Sharing Plan Authority. Retrieved November 10, 2010, from www.hirsp.org/pdfs/HIRSPvsHIRSP-Federal-Plan-Comparison.pdf.

16 Hansard, S. (2010, October 18). States Face "Equity Dilemma" Between Pre-Existing Condition Plans, High-Risk Pools. BNA's Health Care Policy Report (Subscription only). Retrieved November 10, 2010, from http://news.bna.com/hcln/HCLNWB/split_display.adp?fedfid=18008424&vname=hcpnotallissues&fcn=22&wsn=496360500&fn=18008424&split=0.

17 Ibid.

18 Healthcare.gov. (2010, November 5). *New Plan Options for Federally Administered Pre-Existing Condition Insurance Plan in 2011.* [Fact Sheet]. Retrieved November 30, 2010, from www.healthcare.gov/news/factsheets/new_plan_options_2011.html

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Figure 3. **PCIP Costs and Benefit Designs for All States**
(Note: Shaded states are federally administered)

State	Monthly Premium for a 50-year old	Deductible	Co-insurance In-network	Out-of-Pocket Limit In-network	Services Exempted from Deductible	
					Prescriptions	Office Visits
Federally Administered States	100% standard market rate	$2,500	20%	$5,950	No	No
Alabama	$518	$2,500	20%	$5,950	No	No
Alaska	$1,006	$1,500	20%, most services; 50% mental health	$3,000	No	No
Arizona	$495	$2,500	20%	$5,950	No	No
Arkansas	$395	$1,000	20%, most services; 50% mental health/drug dependency	$2,000	$10/$30/$70 copay	No
California	$445-494	$1,500	15%	$2,500	$5 copay, generic Rx before deductible; $500 separate deductible for brand-name drugs	$25 copay, physician visits
Colorado	$374-425	$2,500	20%	$5,950	$10 copay, generic Rx before deductible; $500 separate deductible for brand-name drugs	$30 copay, primary care; $45 copay, specialist
Connecticut	$507	$1,250	20%	$4,250	Separate $250 deductible	Prenatal office visits fully covered
Delaware	$513	$2,500	20%	$5,950	No	No
District of Columbia	$466	$2,500	20%	$5,950	No	No
Florida	$556	$2,500	20%	$5,950	No	No
Georgia	$495	$2,500	20%	$5,950	No	No
Hawaii	$330	$2,500	20%	$5,950	No	No
Idaho	$377	$2,500	20%	$5,950	No	No
Illinois	$253-338	$2,000	20%	$5,950	Yes	No
Indiana	$476	$2,500	20%	$5,950	No	No
Iowa	$385	$1,000	20%	$3,500	Yes	Yes, for in-network only
Kansas	$318-380	$2,500	30%	$5,950	No	No
Kentucky	$466	$2,500	20%	$5,950	No	No
Louisiana	$485	$2,500	20%	$5,950	No	No
Maine*	$609-657 $609-658	$1,750 $2,500	30%	$5,600	Yes	$25 copay
Maryland	$274	$1,500	0% for high-deductible plan	$1,500	No	No
Massachusetts	$513	$2,500	20%	$5,950	No	No
Michigan	$447	$1,000	20%	$5,950	Yes	No
Minnesota	$419	$2,500	20%	$5,950	No	No
Mississippi	$424	$2,500	20%	$5,950	No	No
Missouri	$680	$1,000	20%	$5,950	Separate $100 Rx deductible	No
Montana	$392	$2,500	30%	$5,950	Yes	No

* Premiums vary by region

Figure 3. **PCIP Costs and Benefit Designs for All States** *(Continued)*

State	Monthly Premium for a 50-year old	Deductible	Co-insurance In-network	Out-of-Pocket Limit In-network	Services exempted from Deductible	
					Prescriptions	Office Visits
Nebraska	$471	$2,500	20%	$5,950	No	No
Nevada	$513	$2,500	20%	$5,950	No	No
New Hampshire	$569 $738 $462	$1,000 $1,750 $2,500	20%	$3,500- $5,000	Separate $300 Rx deductible	No
New Jersey	$488 $363	$0 $2,500	0% or 20%	$5,000	Yes	$30 copay, primary care; $50 copay, specialist
New Mexico	$423 $379 $340	$500 $1,000 $2,000	20%	$5,450 -$5,950	Yes	No
New York	$362-421	$0	0%	$5,950	Yes	$20 copay, primary care and specialist
North Carolina	$469 $346 $316 $261	$1,000 $2,500 $3,500 $4,500	20%, PPO plans; 0%, high-deductible plan	$5,950, PPO plans; $4,500, high-deductible plan	Yes	$20 copay, primary care; $40 copay, specialist
North Dakota	$377	$2,500	20%	$5,950	No	No
Ohio	$323-378 $294-344	$1,500 $2,500	20%	$5,950	$15/$40/$60 copay for both plans; separate $150 Rx deductible for $2,500 deductible plan only	$30 copay, primary care; $50 copay, specialist; $40 copay, urgent care
Oklahoma	$327	$2,000	20%	$5,950	Separate $200 Rx deductible	No
Oregon	$593 $544	$500 $750	20%	$5,200- $5,450	Yes; $0 copay for diabetic supplies, insulin, and some evidence-based generic maintenance medications	No
Pennsylvania	$283	$1,000	20%	$5,000	Yes	$25 copay, primary care; $30 copay, specialist
Rhode Island	$430	$1,000	20%	$3,000	Yes	$20 copay, primary care; $40 copay, specialist; $75 copay, urgent care
South Carolina	$462	$2,500	20%	$5,950	No	No
South Dakota	$456	$2,000	25%	$5,750	Yes	No
Tennessee	$438	$2,500	20%	$5,950	No	No
Texas	$495	$2,500	20%	$5,950	No	No
Utah	$508 $431 $331 $240	$500 $1,000 $2,500 $5,000	20%	$5,000- $5,950; $5,000, high-deductible plan	Separate $150-$500 Rx deductible	No
Vermont	$419	$2,500	20%	$5,950	No	No
Virginia	$443	$2,500	20%	$5,950	No	No
Washington	$986 $476	$500 $2,500	20%	$1,500- $5,950	Yes	No
West Virginia	$401	$2,500	20%	$5,950	No	No
Wisconsin	$559 $458 $330 $277	$500 $1,000 $2,500 $3,500	20%	$3,500- $5,950	Yes	No
Wyoming	$358	$2,500	20%	$5,950	No	No

Source: Realizing Health Reform's Potential: Pre-Existing Condition Insurance Plans Created by the Affordable Care Act of 2010 (www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Oct/1445_Hall_PCIPs_and_the_ACA_ib_FINAL.pdf)