

HealthAffairs

Robert Wood Johnson Foundation



Health Policy Brief

AUGUST 10, 2010

Pre-Existing Condition Insurance Plan. A new program will provide coverage to people with costly preexisting health conditions. But the program faces challenges—starting with the funding.

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 Patient Protection and 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. The \$5 billion that Congress appropriated for the program is generally recognized as insufficient to cover all those who may be eligible until the broader reforms take effect. Although Congress specified a number

of requirements for the program, 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 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

\$5
billion

Federal funding

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

“The temporary pools are intended to cover U.S. nationals—citizens or permanent and temporary legal residents—who are unable to find coverage elsewhere.”

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 (HIPAA) 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 those 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 those estimated to 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 with 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 whom the pools serve 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.

OTHER MEANS OF 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.

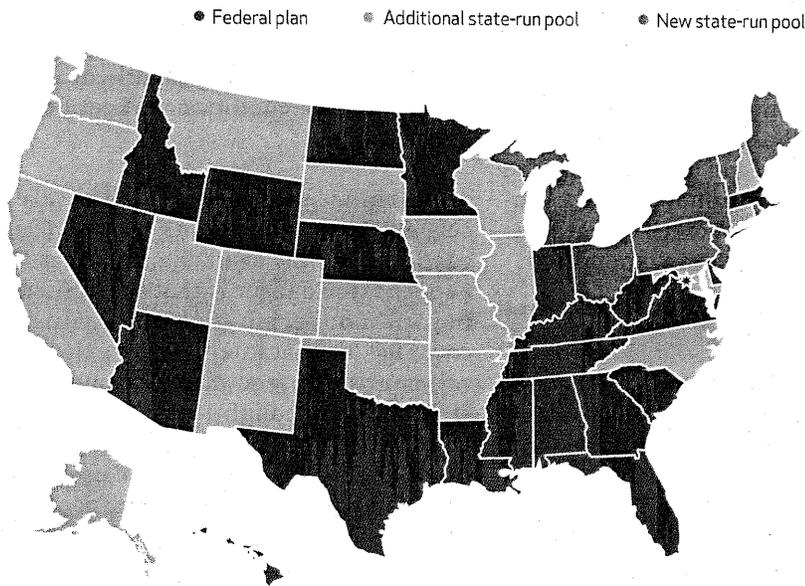
Five states—New York, New Jersey, Massachusetts, Maine, and Vermont—have what are called “guaranteed issue” requirements that restrict the ability of insurers to deny coverage based on health status. These guaranteed-issue states also require some form of “community rating,” under which premiums aren’t 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.

NEW PREEXISTING CONDITION PROGRAM: 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 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-two states that have chosen the federal option.

The remaining twenty-eight states and the District of Columbia 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.

Exhibit 1 shows which states are running their own plans and which have plans run by HHS. On July 30, HHS published an interim final rule open to public comment that describes the program and its requirements. The comment period closes September 28, 2010,

EXHIBIT 1**Temporary Federal High-Risk Pools Administered By The States Or The Federal Government**

SOURCE U.S. Department of Health and Human Services. **NOTES** Twenty-two states (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. Eight states and the District of Columbia (blue) will create a new pool.

and HHS will issue a final version sometime after that, possibly before the end of the year.

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. Monthly premiums will range from \$115 to \$1,735, depending on the enrollee's age and state of residence, with most being between \$140 and \$900.

Most state-administered plans also 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 cannot exceed \$5,950 per year for individuals and \$11,900 for families. All plans are required to have a so-called actuarial value of at least 65 percent; this means they must pay for at least 65 percent of the total costs that a typical group of people would normally incur for covered health services. The plans obviously cannot limit care for preexisting conditions, or impose annual or lifetime limits on coverage. In addition, they cannot spend more than

10 percent of the funds they receive on administrative costs (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 U.S. 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 due to 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 ninety days to implement the temporary pools. In fact, coverage will not begin in some states until September 2010, two months behind schedule.

INADEQUATE FUNDING: Congress appropriated \$5 billion to fund the new program through 2013. Approximately five to seven million Americans are estimated to lack health insurance and have a preexisting condition. But as with the existing state high-risk pools, only a fraction of those who need coverage are expected to enroll in the program. There is a range of estimates about how large that fraction will be. The Congressional Budget Office (CBO), for example, expects the program to have an average enrollment of 200,000 per year. Meanwhile, the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary has estimated that as many as 375,000 Americans could gain coverage under the new program in 2010.

High premiums are expected to be the main factor limiting enrollment of eligible adults. Even though premiums for the new program are likely to be less than those offered in the private market and in existing state-operated

"Critics are concerned that expectations for the program vastly exceed the available resources."

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.

plans, they may still be unaffordable for some potential enrollees.

Some estimates are that the \$5 billion in funding could run out as early as 2011 if as many as 375,000 people enroll this year. 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.

WHAT'S THE DEBATE?

The federal funding allotted for the new program will clearly not be enough to help all affected individuals get coverage. To fully meet the demand, Congress would have to appropriate more money. The CBO estimates that \$5–\$10 billion is needed in addition to the \$5 billion already appropriated. Not surprisingly, given its cost, the new program has both supporters and critics.

SUPPORTING ARGUMENTS: Supporters emphasize that even with its funding limitation, the new program 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.

Administration officials plan to adapt the program as necessary to ensure that the original \$5 billion lasts through 2013. Therefore, many supporters say, it is unlikely that the administration will ask Congress to appropriate additional funds for the program before the new system of state health insurance exchanges, which will offer broad health coverage with no preexisting condition restrictions, takes effect in 2014.

OPPOSING ARGUMENTS: Critics are concerned that expectations for the program vastly exceed the available resources. 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. Although it is possible that the administration could request additional funds to fully meet the needs of uninsured individuals with preexisting conditions, getting congressional approval would be extremely difficult in this time of large federal budget deficits.

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.

EXHIBIT 2

Provisions Of Temporary Preexisting Condition Insurance Plans

Eligibility	Preexisting medical condition No "creditable" coverage for past 6 months, including coverage in a state-run pool Proof of insurance company denial, limitation, or exclusion of benefits U.S. citizen, resident, or lawfully present in U.S.
Benefits	Primary and specialty care, hospital care, prescription drugs No abortion services (except for rape, incest, or mother's health) Pay at least 65% of average individual health expenses (actuarial value) No annual or lifetime limits
Premiums and cost sharing	Premiums can vary by age, but not by more than by 4 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)

200,000

Enrollees per year

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

WHAT'S NEXT?

For HHS-operated plans, enrollment began July 1, and coverage became effective August 1. Some state-operated plans also began accepting applications on July 1, and most are expected to be operating by the end of August. Consumers can get the latest information about the program in their state on the Web site www.HealthCare.gov.

Once enrollment is under way, HHS will have the ability to move funds among states to better meet demand for coverage. Administration officials plan to make the original \$5 billion last through 2013 and thus do not expect to ask Congress for additional funding. As noted, the law gives HHS broad discretion to revise the program if spending exceeds the available funds. It requires only that the HHS secretary "shall make such adjustments as are necessary to eliminate such deficit."

UNCERTAIN PATH AHEAD: At this time, HHS has not indicated how it might exercise its authority to close a deficit in the program. But the interim final rule issued on July 30 would permit adjustments to premiums, changes in the benefits the plans would be required to offer, limits on new applications, and other measures to limit program costs. These steps would probably reduce the number of individuals receiving coverage under the program.

Some observers note that as people gain coverage under the plan, there may be additional political pressure to ensure that the program will survive without restricting benefits or increasing premiums. That could prompt Congress to appropriate more funds for the program. On the other hand, recent concerns in Congress about raising federal spending without making offsetting budget cuts or increasing tax revenues are likely to continue. All these pressures make it difficult to forecast the future of the program beyond 2011. ■

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

Susan Dentzer

Editor-in-Chief
Health Affairs

Ted Agres

Senior Editor
Health Affairs

Health Policy Briefs are produced under a partnership of *Health Affairs* and the Robert Wood Johnson Foundation.

Cite as:

"Pre-Existing Condition Insurance Plan," *Health Affairs*, August 10, 2010.

Sign up for free policy briefs at:
www.healthaffairs.org/healthpolicybriefs

RESOURCES

Centers for Medicare and Medicaid Services, "[Estimated Financial Effects of the 'Patient Protection and Affordable Care Act' as Amended.](#)" April 22, 2010.

Chollet, Deborah J., "[How Temporary Insurance for High-Risk Individuals May Play Out under Health Reform.](#)" *Health Affairs* 29, no. 6 (2010): 1164-67.

Congressional Budget Office, "[Letter to Sen. Michael B. Enzi](#), Ranking Member of the Committee on Health, Education, Labor, and Pensions, June 21, 2010.

Kaiser Family Foundation, "[Explaining Health Reform: Questions about the Temporary High-Risk Pool.](#)" July 2010.

Kaiser Family Foundation, "[Issues for Structuring Interim High-Risk Pools.](#)" January 2010.

Kaiser Family Foundation, "[Pre-Existing Condition Insurance Plan: Operation Decisions and Preliminary Funding Allocations.](#)" July 2010.

Nichols, Len M., "[Implementing Insurance Market Reforms under the Federal Health Reform Law.](#)" *Health Affairs* 29, no. 6 (2010): 1152-57.

U.S. Department of Health and Human Services, "[HHS Secretary Sebelius Announces New Pre-Existing Condition Insurance Plan.](#)" July 1, 2010.

U.S. Department of Health and Human Services, "[Pre-Existing Condition Insurance Plan Program.](#)" Interim Final Rule with Comment Period, July 30, 2010.

U.S. Government Accountability Office, "[Health Insurance: Enrollment, Benefits, Funding, and Other Characteristics of State High-Risk Health Insurance Pools.](#)" July 22, 2009.

