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Realizing Health Reform's Potential

Pre-Existing Condition Insurance Plans Created by the Affordable Care Act of 2010

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Abstract: The Patient Protection and Affordable Care Act includes a provision for the establishment of a temporary high-risk pool, also called the Pre-Existing Condition Insurance Plan (PCIP), to quickly make health insurance available to uninsured individuals with preexisting conditions, many of whom previously had been denied coverage. Twenty-seven states elected to administer the PCIPs for their citizens, while the remaining states and the District of Columbia chose to let their PCIPs be federally administered. This issue brief examines eligibility, benefits, premiums, cost-sharing, and oversight of the PCIP programs, as well as variation of the plans from state to state. The PCIPs will run through December 31, 2013, at which time participants will be transitioned to exchange coverage.

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OVERVIEW

State high-risk pools currently operate in 35 states. They provide coverage of last resort for individuals who cannot access group insurance and are denied individual market coverage because of preexisting conditions. Nationally, about 200,000 people are enrolled in these state high-risk pools. Although each pool is unique, most charge premiums ranging from 125 percent to 200 percent of standard market rates and require considerable cost-sharing by participants. In fact, in a recent study of state high-risk pools, the Government Accountability Office (GAO) found that premiums and deductibles are considerably higher, coverage is less generous, and annual and lifetime caps on coverage are much more common than in typical employer-based plans.[1] These high costs and limits on coverage are two very important reasons state high-risk pools currently enroll fewer than 5 percent of the potentially eligible population.

Most state high-risk pools do not collect many data on their participants' characteristics. The GAO found that, in the five states collecting those data, the average age of an enrollee was 49 and the average household income was $41,000. According to trade literature, the average state risk-pool enrollee is between 44 and 55 years old, has four to six chronic conditions, and visits six to eight physicians on a regular basis.[2]

The Patient Protection and Affordable Care Act (ACA) includes a provision for the establishment of a temporary national high-risk pool, also called the Pre-Existing Condition Insurance Plan (PCIP). Though participation in the PCIPs may follow different trends based on costs and other features that differ from state-based pools, it is likely that many PCIP enrollees will be similar to those in high-risk pools—older and experiencing multiple chronic conditions.

PCIPs are described by the U.S. Department of Health and Human Services (HHS) as being "an important first step in ensuring Americans have access to affordable, quality health care." As with other immediate changes under the ACA—such as coverage for adult children up to age 26, no longer excluding children under 19 for preexisting conditions, and eliminating rescissions except in cases of fraud—the PCIP addresses a small but significant subset of the population that has difficulty obtaining or maintaining insurance. The legislation clearly never intended to cover a large proportion of the uninsured population with this provision, which uses state high-risk pools as a model. Instead, the PCIP provision offers an important source of immediate coverage for a relatively small group of people with preexisting conditions who could not otherwise access insurance until 2014. Specifically, the PCIPs allow people who previously had been excluded from the individual market to purchase coverage that is comparable to other coverage in that market and at comparable premiums. Unlike the exchanges, which will be implemented in 2014, the PCIP does not index premiums to income and therefore will likely be unaffordable to those who cannot pay standard market rates. Federal funding for the PCIPs will be used to offset pool costs, making the premiums comparable to those in the individual market rather than those in the high-risk pools.

The PCIPs do, however, differ from most state-based high-risk pools in several important ways that may make them somewhat more accessible and affordable. These differences include:

- No waiting periods. Most state pools impose a three- to 12-month waiting period for coverage of preexisting conditions.
- Premiums set at standard market rates. Given the higher premium rates for state pools, this makes PCIP coverage relatively more affordable.
- Out-of-pocket costs in the PCIPs are capped at $5,950 for an individual. Some state pools have deductibles up to $15,000 and no caps on out-of-pocket liability.
- Eligibility for PCIP coverage is transferrable among states. Initial eligibility for PCIP coverage requires that a person be uninsured for at least six months prior to enrollment; this requirement remains satisfied when the person moves to another state and enrolls in its PCIP. Reciprocity between state pools is more limited and varies from state to state.

PCIPs, however, are not open to recently uninsured individuals with preexisting conditions, known as HIPAA-eligibles. These individuals are guaranteed transition to other coverage with no exclusions through provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[3]

General PCIP Provisions

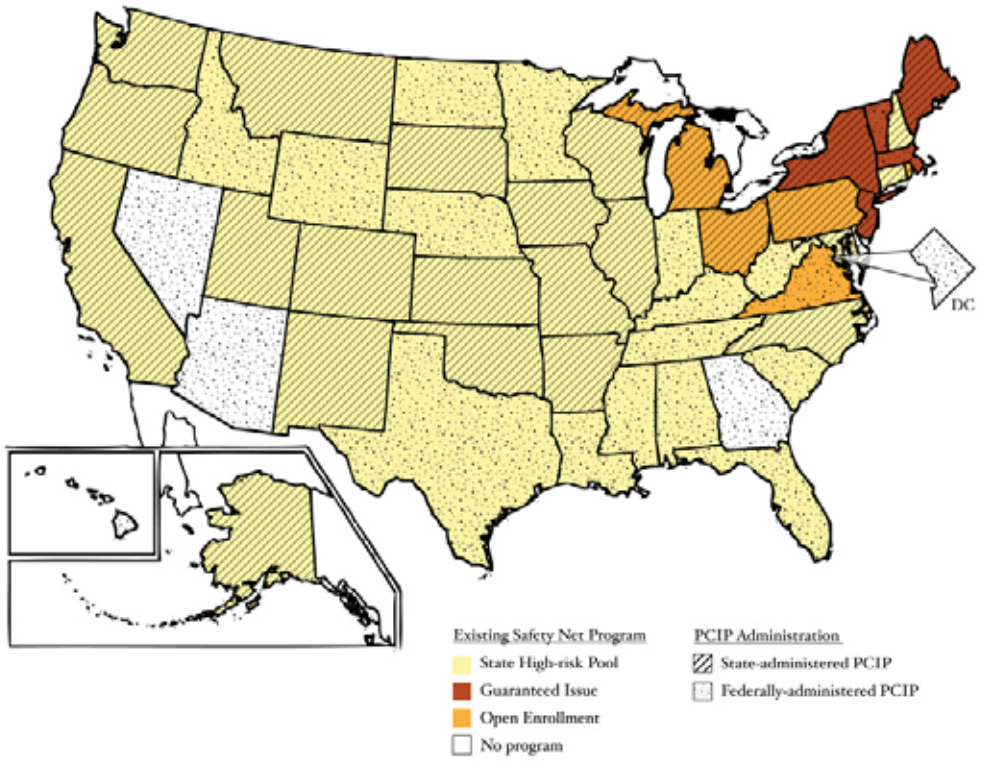
Funding

The total congressional allocation included in the ACA legislation for operation of the PCIP program is $5 billion. The legislation indicates that the secretary of HHS shall have the option to operate the PCIPs directly or through contracts with states or nonprofit entities. The legislative language also indicates that, in the case of insufficient funds to operate the PCIPs, the secretary shall make such adjustments as are necessary to eliminate the deficit.

Administration

Using a formula similar to the one used to allocate Children's Health Insurance Program (CHIP) funding to states, HHS determined an approximate state-by-state allocation of the federal PCIP funding.[4] The secretary then invited states to indicate their interest in administering the PCIP for their citizens. Currently, 27 states have chosen to administer the PCIP, while 23 states and the District of Columbia have opted

Exhibit 1. States with State High-Risk Pools or Other Safety-Net Coverage, and Distribution of State and Federally Administered PCIPs.



Note: Florida high-risk pool has been closed to new enrollment since 1991.
Sources: National Association of State Comprehensive Health Insurance Plans, Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis, 23rd edition (Denver, Colo.: NASCHIP, 2009); National Conference of State Legislatures, "Coverage of Uninsurable Preexisting Conditions: State and Federal High-Risk Pools," July 20, 2010, with additions Aug. 27, 2010, available at http://www.ncsl.org/?tabid=14329.

to let HHS or its contractor operate the programs. HHS solicited applications from states that indicated an intention to administer their own PCIPs. For the other states, HHS issued a request for proposals (RFP) for a nonprofit third-party administrator to operate the program. The Government Employees Health Association, which administers plans under the Federal Employees Health Benefits Program, was awarded the contract to administer the PCIP in the nonparticipating states. (See Figure 1 for a map of existing state high-risk pools and administration of the PCIPs).

Duration

The ACA states that the PCIP program would be in place no later than 90 days after the legislation passed, which was March 23, 2010. Some programs began accepting applications from potential enrollees as early as July 1. All will be operational by late summer or early fall 2010 and are intended to operate through December 31, 2013. PCIP administrators will assist enrollees in the transition to exchange-based coverage that will begin on January 1, 2014.

Coverage

States were given considerable latitude in the design of their PCIP programs, within the requirements of the legislation, which include a minimum 65 percent actuarial value for coverage, a maximum annual out-of-pocket expense of $5,950 for individuals, and premiums at the standard rate for the state or its subdivisions that cannot exceed a ratio of 4:1 for age-based tiers. The RFP for third-party administrators included a model coverage template and the same requirements regarding actuarial value, out-of-pocket expenses, and premiums. These requirements were minimum standards; states were allowed to design plans with higher actuarial values and lower out-of-pocket costs and premium ratios.

Whom PCIP Affects

The PCIPs are intended for individuals who have had no creditable health insurance coverage for the six-month period prior to applying for PCIP coverage and who have a preexisting condition. As Exhibit 2 shows, the population of individuals who have preexisting conditions and are uninsured for at least some time is quite large. These figures include those uninsured for any time period, so the number who would meet the six-month PCIP minimum is probably somewhat smaller. Historically, only a small proportion of this population has enrolled in state high-risk pools in the 35 states where they operate, at least in part because of the high cost. In the 15 states without high-risk pools, coverage provided through other mechanisms (open enrollment, guaranteed issue, or conversion policies) also can be prohibitively expensive, or, in some states, not even available. Even with premiums set at standard rates, most PCIP coverage remains relatively expensive and may not be affordable to many who otherwise might enroll. Unlike the exchange coverage available starting in 2014, the PCIP program does not specifically include a low-income subsidy. With premium rates lower than in state high-risk pools, the PCIPs will likely attract more applicants, including a higher proportion of younger people, than the state pools. However, the lower prevalence of preexisting conditions in younger people suggests that the PCIPs will still primarily serve older enrollees.

The Interim Rules for PCIPs

Interim final rules for the PCIPs were published on July 30, 2010, and became effective immediately. The rules consistently indicate that HHS is allowing broad flexibility in how state-administered plans are structured and operated, with many specific requirements included in state contracts rather than in the overall regulations.

Eligibility

To be eligible for coverage in a PCIP, a person must:

- be a U.S. citizen or national or lawfully present;
- have been uninsured for at least six months (waived if the person moves from PCIP coverage in one state to PCIP coverage in another state);
- have a preexisting condition; and
- reside in an area served by a PCIP.

In addition to verifying U.S. residency status, many states are also requiring proof of state residency in the form of tax returns, utility bills, or driver's licenses. The regulations permit PCIPs to exercise flexibility in how they determine whether a person has a preexisting condition and PCIPs are employing a variety of methods. Many state-administered PCIPs are using condition lists and the applicant provides proof from a physician of a particular condition on the list. The federally administered PCIPs require documentation of an insurer's refusal to cover, intent to refuse coverage, or intent to impose a rider excluding the preexisting condition. Media stories and comments from advocacy groups indicate that this documentation requirement has been difficult for some potential applicants to meet.[5,6] HHS is working to address the issue.[7]

Benefits

The HHS regulations imposed minimum standards for the PCIPs, but also allowed a great deal of flexibility in the benefit package. For all PCIPs, there will be no waiting periods or exclusions for preexisting conditions, and no coverage for cosmetic surgery (except to restore bodily function), custodial care, most forms of assisted reproductive technology, abortion services (except in cases of rape or incest, or to preserve the life of the mother), or experimental treatments.

PCIPs are required to cover: hospital inpatient and outpatient services; mental health and substance abuse; professional services for the diagnosis or treatment of injury, illness, or condition; noncustodial skilled nursing services; home health services; durable medical equipment and supplies; diagnostic X-rays and laboratory tests; therapy services, including occupational therapy, physical therapy, and speech therapy;

Exhibit 2. State High-Risk Pool Enrollment, Federal Funding for PCIPs, Estimate of Potentially Eligible Individudals, and Number Uninsured, by State

State	Total high-risk pool enrollees, as of Dec. 31, 2009	Federal funding for PCIPs (in dollars)	Estimated number of individuals potentially eligible for PCIPs[a]	Number uninsured
Alabama	2,416	$69,000,000	79,758	633,000
Alaska	524	13,000,000	15,876	126,000
Arizona	—	129,000,000	155,862	1,237,000
Arkansas	3,055	46,000,000	63,126	501,000
California	6,830	761,000,000	872,802	6,927,000
Colorado	10,439	90,000,000	98,406	781,000
Connecticut	2,177	50,000,000	45,612	362,000
Delaware	—	13,000,000	12,978	103,000
District of Columbia	—	9,000,000	7,938	63,000
Florida	265	351,000,000	478,170	3,795,000
Georgia	—	177,000,000	224,658	1,783,000
Hawaii	—	16,000,000	12,474	99,000
Idaho	1,424	24,000,000	28,476	226,000
Illinois	16,085	196,000,000	219,618	1,743,000
Indiana	6,715	93,000,000	100,422	797,000
Iowa	2,991	35,000,000	37,800	300,000
Kansas	1,754	36,000,000	43,722	347,000
Kentucky	4,535	63,000,000	81,774	649,000
Louisiana	1,322	71,000,000	99,036	786,000
Maine	—	17,000,000	16,128	128,000
Maryland	17,658	85,000,000	93,366	741,000
Massachusetts	—	77,000,000	41,454	329,000
Michigan	—	141,000,000	153,342	1,217,000
Minnesota	27,187	68,000,000	55,944	444,000
Mississippi	3,446	47,000,000	65,772	522,000
Missouri	3,613	81,000,000	100,044	794,000
Montana	2,926	16,000,000	19,026	151,000
Nebraska	5,081	23,000,000	27,216	216,000
Nevada	—	61,000,000	61,992	492,000
New Hampshire	1,275	20,000,000	17,136	136,000
New Jersey	—	141,000,000	164,682	1,307,000
New Mexico	7,684	37,000,000	56,070	445,000
New York	—	297,000,000	339,192	2,692,000
North Carolina	2,365	145,000,000	193,914	1,539,000
North Dakota	1,422	8,000,000	8,568	68,000
Ohio	—	152,000,000	179,424	1,424,000
Oklahoma	1,896	60,000,000	75,096	596,000
Oregon	14,517	66,000,000	81,144	644,000
Pennsylvania	—	160,000,000	159,390	1,265,000

State	Total high-risk pool enrollees, as of Dec. 31, 2009	Federal funding for PCIPs (in dollars)	Estimated number of individuals potentially eligible for PCIPs[a]	Number uninsured
Rhode Island	—	13,000,000	15,246	121,000
South Carolina	2,255	74,000,000	92,106	731,000
South Dakota	653	11,000,000	12,096	96,000
Tennessee	3,785	97,000,000	116,676	926,000
Texas	26,556	493,000,000	776,160	6,160,000
Utah	3,924	40,000,000	46,998	373,000
Vermont	—	8,000,000	7,812	62,000
Virginia	—	113,000,000	130,662	1,037,000
Washington	3,618	102,000,000	101,430	805,000
West Virginia	734	27,000,000	32,634	259,000
Wisconsin	16,458	73,000,000	63,504	504,000
Wyoming	732	8,000,000	9,576	76,000
United States	*208,317*	*5,000,000,000*	*5,992,182*	*47,557,000*

[a] Estimate of potentially eligible individuals based on Government Accountability Office estimates of the percentage of uninsured individuals with at least one chronic condition that was diagnosed or treated in 2006, using 2006 Medical Expenditure Panel Survey data. This percentage (12.6%) was applied to U.S. Census Current Population Survey estimates of the number of uninsured by state on the three-year average (2007–2009).
— indicates no existing high-risk pool in that state.
Sources: U.S. Government Accountability Office Report, *GAO–09–730R Health Insurance: Enrollment, Benefits, Funding and Other Characteristics of State High-Risk Health Insurance Pools,* July 22, 2009; R. DiRosa and L. Brogan, GAO, personal communication on Sept. 21, 2010; U.S. Census Bureau, Current Population Survey, 2007 to 2010 Annual Social and Economic Supplements, Number and Percentage of People Without Health Insurance Coverage by State Using 2- and 3-Year Averages: 2006–2007 and 2008–2009.

hospice; ambulance and emergency services; prescription drugs; and preventive and maternity care. The nature and level of coverage for these services, however, varies from state to state and will be addressed later in this issue brief. Additionally, the PCIP interim regulations specifically indicate that ACA prohibitions on lifetime and annual benefit limits do not apply to the PCIPs because they do not meet the legislation's definition of a group health plan or a health insurance issuer. Indeed, many state-administered PCIPs have elected to incorporate such limits into their coverage.

Premiums and cost-sharing

The regulations also established parameters for premiums, cost-sharing, and actuarial value of the PCIP coverage:

- premiums are to be set no higher than the "standard rate" for the state or geographic region; other premium-setting methods are allowed in states with guaranteed issue or community rating;
- premiums cannot vary by a ratio of more than 4:1 on the basis of age and cannot vary on the basis of gender;
- out-of-pocket costs are limited to $5,950 for an individual, indexed to the limit for high-deductible health plans associated with a tax-favored health savings account; and
- PCIP plans must have an actuarial value of at least 65 percent (i.e., on average, they must pay 65 percent of participants' medical costs).

Although premiums are set to standard rates, premium costs may still be prohibitive for some individuals with lower incomes. Some states have chosen to provide low-income subsidies or to charge a flat premium for all ages, which are discussed later in this issue brief. In addition, even though out-of-pocket costs are capped at $5,950, plans may impose higher limits for services used out of network. Many states have also opted to have lower caps for out-of-pocket costs.

The Preexisting Dilemma for States with Guaranteed Issue

Maine, Massachusetts, New Jersey, New York, and Vermont all have laws that guarantee issue of health insurance and prohibit insurers from denying a person coverage on the basis of a preexisting condition. Residents of these states will therefore not have letters of denial or riders from insurers to use in the PCIP eligibility process. Vermont and Massachusetts elected not to administer their PCIPs; they have federally administered programs. For these two states, the federal proof-of-denial requirements were modified to accept documentation that shows the individual was offered coverage in the last six months at a premium at least twice as much as the PCIP premium in the state. In Maine, eligibility for the state-administered PCIP is restricted to individuals with health conditions that are included in a list of 30 selected conditions. New York also restricts eligibility to people with conditions on an approved list, but the list is much more extensive and the state allows individuals with other conditions to apply with approval subject to medical review. Finally, in New Jersey, insurers cannot deny coverage because of a preexisting condition, but can impose an exclusion period for treatment of the preexisting condition. A person is eligible for the New Jersey PCIP if he or she has a condition that a carrier would have temporarily excluded from coverage.

Most states that administer their own PCIPs allow applicants to use one of the following to satisfy the preexisting condition requirement: 1) a letter or letters documenting a denial of coverage or rider on coverage—sometimes within a predefined period of time; or 2) documentation of a preexisting condition—usually limited to a list prepared by the state.

Access to services

PCIPs may designate a provider network, but must demonstrate to HHS that the number and range of providers is sufficient. In addition, emergency room services must be covered. Virtually all of the PCIPs have established either a preferred provider network or managed care network.

Oversight

The regulations establish the following rules addressing PCIP oversight:

- PCIPs must have timely processes in place for redetermination of an eligibility or coverage determination;
- PCIPs must have measures in place to detect fraud, waste, and abuse, including "dumping" from employer-based coverage;
- federal funds are to be used only for allowable claims and administrative costs of the PCIPs; they may not be used to defray costs of existing state pools;
- states may expend not more than 10 percent of federally allotted funds on administrative costs;
- initial funding ceilings are based on a modified Children's Health Insurance Program (CHIP) formula, but funds may be reallocated based on actual experience;
- states and third-party administrators must submit monthly reports on costs and enrollment; and
- subject to HHS approval, PCIPs may adjust premiums, alter benefits, limit applications, or take other measures to eliminate a projected deficit; HHS reserves the right to make adjustments as necessary.

While the regulations specifically prohibit an employer from attempting to "dump" a high-cost employee into PCIP coverage from employer-based coverage, they do not seem to specifically prohibit other types of third-party payment of premiums for individuals. For example, some state high-risk pool administrators suggested that providers of high-cost services (e.g., hospitals, dialysis centers, cancer treatment centers) might pay PCIP premiums for their uninsured patients.

Relationship to existing laws and programs
The following rules concern the relationship of the PCIPs to existing health care laws and programs:

- Insurance reforms in the ACA, such as prohibitions on lifetime limits or requirements to cover preventive services at no cost, do not apply to the PCIPs (or state high-risk pools) because they do not meet the definition of a group health plan or a health insurance issuer, pursuant to the Public Health Service Act.
- Maintenance of effort is required for state high-risk pools in those states electing to administer their PCIP, so that state high-risk enrollees will not be negatively affected by PCIP implementation.
- PCIPs are not subject to state standards, except for licensing and solvency.
- HHS will develop procedures to transition PCIP enrollees to exchanges in 2014.

The intent of the maintenance of effort requirement is to prevent shifting of state high-risk pool costs to the PCIPs. States with existing high-risk pools that also chose to operate PCIPs may encounter less difficulty with funding issues than with equity issues. Balancing the benefits available to participants in the state pool with those available to new enrollees in the PCIP may be challenging. In most cases, these states seem to have designed their PCIP coverage to be similar to one or more of their existing state high-risk pool plans.

Regulatory impact analysis
The PCIP Interim Rule also contains a Regulatory Impact Analysis, which primarily addresses the estimated number of enrollees and the benefits of the program. Some legislators have suggested that enrollment in the PCIPs will far surpass what the available funding can cover, forcing the program to close enrollment. In discussing the potential number of enrollees in the PCIPs, the regulations point out that estimates based on existing enrollment in state high-risk pools is problematic because of the differences between the state pools and the PCIPs. For example, the PCIPs do not impose a waiting period for coverage and have premiums set at standard rates. The Interim Rule cites estimates of potential enrollment that range from 175,000 to 400,000 individuals. It concludes by reiterating that "efficient program implementation, effective cost control, targeted benefit design, and enrollment patterns different from projections will mitigate the need for enrollment constraints."[8]

The benefits of the program are discussed in terms of reductions in mortality, morbidity, and medical expenditure risk; and increases in worker productivity through reductions in absenteeism and low productivity due to illness, and elimination of "job-lock," wherein individuals are stuck in inappropriate jobs because of their health insurance situations. In addition, the rule posits that the PCIPs will reduce cost-shifting for uncompensated care, thereby potentially reducing premiums and other costs for all consumers of health care. Finally in this section, the rule suggests that induced utilization (i.e., using services previously not covered by insurance) among enrollees in the PCIPs will be relatively low because the population has greater need for health care and therefore less ability to reduce utilization when uninsured. Recent research on participants in one state high-risk pool suggest that induced utilization may be more common than predicted.[9,10]

PCIP Plan Features

Because HHS allowed states great flexibility in designing their PCIPs, state-administered plans vary enormously. Great variation also exists between the plans administered by states and those administered by the federal government. Affordability of the plans hinges on their premiums and cost-sharing requirements. Based on enrollment in the state high-risk pools, PCIP enrollees will likely be older adults, for whom the premiums will be higher. Additionally, for the people with chronic conditions who will be enrolling in the PCIPs, out-of-pocket costs, covered benefits, and plan limits are especially important features.

Premiums

PCIP premiums may vary according to age by a ratio of 4:1 between the highest and lowest rates, meaning

that older individuals will pay premiums up to four times higher than younger individuals. The ratio allowed for PCIPs is higher than the 3:1 ratio that will eventually be allowed for exchange plans. Most of the state-administered PCIPs structured their premium tiers close to the 4:1 limit, while all of the federally administered plans vary rates by only 2.1:1. Two state-administered plans chose to implement flat premiums: Pennsylvania, which has a flat monthly rate of $283 for all enrollees, and New York, which charges $362 for upstate residents and $421 for downstate residents.

Age-rating bands are also highly variable. The federally administered plans have only four age bands (34 and under, 35 to 44, 45 to 54, and 55 and over), while many states have an individual rate for each age. HHS also allowed states to establish separate rates for tobacco users. Some states did so, but federally administered plans did not. Some states have also chosen to use the option to vary premiums by geographic subdivisions. In Kansas, for example, premiums in rural areas are higher than those in more urban areas.

Gender rating is illegal for all plans under the ACA, including PCIPs. Almost all states offer only individual coverage. Other family members may be covered at individual rates but only if they meet all eligibility rules, including having a qualifying health condition.

The ACA does not provide funding for low-income subsidies for enrollees in PCIPs. A handful of states have covered PCIP enrollees through subsidy programs already in place and funded outside ACA. For instance, Maine includes PCIP enrollees in its Dirigo program subsidy, which covers individuals with incomes of up to 300 percent of the federal poverty level and assets of less than $60,000. New Mexico includes its PCIP in its state high-risk pool subsidy program, which covers people with incomes up to 400 percent of the poverty level. Wisconsin and Maryland do not subsidize their PCIPs. However, individuals in Wisconsin with family incomes below $33,000, or those in Maryland with family incomes below 200 percent of the poverty level, may qualify for a subsidy for their state's high-risk pool, potentially making the state risk pool less expensive than the PCIP.

Because of the variation in factors that influence premiums, including actuarial value, the number of age bands, cost-sharing and regional variations in medical costs, premium comparisons among states are difficult. However, monthly rates for a nonsmoking 50-year-old range from $240 for a $5,000 deductible plan in Utah to $1,006 for a $1,500 deductible plan in Alaska. The federally administered plan, which has the same actuarial value, $2,500 deductible, age rating, and cost-sharing structure in all covered states charges a range of premiums, tied to local market rates. Premiums for a 50-year-old range from $330 in Hawaii to $556 in Florida, with an average of $455 (Exhibit 3).

Cost-Sharing

PCIPs resemble individual insurance plans in terms of their cost-sharing structure and high out-of-pocket costs (Exhibit 4). Only seven states have at least one plan with a deductible lower than $1,000. Most fall in the $1,000 to $2,500 range, although three states have deductibles of $3,500 to $5,000. The most common coinsurance percentage is 20 percent, although three states—Kansas, Maine, and Montana—have coinsurance of 30 percent. In South Dakota, it is 25 percent, and in California, it is 15 percent. Copayment structures are commonly used for prescription drugs and less commonly used for office visits. New York appears to have the most generous of all plans, with no deductible or coinsurance and only small copayments for services.

Although the ACA limits the maximum out-of-pocket cost for any plan to $5,950, some states have opted to set lower limits. In Washington, it is possible to purchase a plan with a $1,000 medical and $500 prescription out-of-pocket maximum. Oregon offers a plan with a $1,000 medical out-of-pocket, but an accompanying prescription out-of-pocket maximum of $4,450. The state has another plan with a $2,000 medical out-of-pocket limit and a $2,200 prescription out-of-pocket limit. This illustrates the complexity of attempting to evaluate the true cost of a plan, with multiple factors determining actual out-of-pocket costs. An out-of-pocket limit of $1,000 may seem low, but with prescription costs, it could go as high as $5,450.

Exhibit 3. PCIP Premiums and Deductibles

State[a]	Deductible, in-network[b] ($)	Premium (50-year-old) ($)[c]	Overall premium range, non-smoker ($)	Number of age bands
Alabama	2,500	518	338–721	4
Alaska	1,500	1,006	434–1,735	46
Arizona	2,500	495	323–688	4
Arkansas	1,000	395	156–624	8
California	1,500	445–494	127–1,003[c]	12
Colorado	2,500	374–425	115–601[c]	10
Connecticut	1,250	507	243–893	10
Delaware	2,500	513	335–714	4
District of Columbia	2,500	466	304–649	4
Florida	2,500	556	363–773	4
Georgia	2,500	495	323–688	4
Hawaii	2,500	330	215–459	4
Idaho	2,500	377	246–524	4
Illinois	2,000	253–338	111–526[c]	27
Indiana	2,500	476	310–662	4
Iowa	1,000	385	178–601	47
Kansas	2,500	318–380	121–591[c]	48
Kentucky	2,500	466	304–649	4
Louisiana	2,500	485	317–675	4
Maine	1,750 2,500	609–657 609–658	438–657[c] 439–658[c]	8
Maryland	1,500	274	141–354	9
Massachusetts	2,500	513	335–714	4
Michigan	1,000	447	147–687	10
Minnesota	2,500	419	274–583	4
Mississippi	2,500	424	277–590	4
Missouri	1,000	680	243–972	8
Montana	2,500	392	190–615	48
Nebraska	2,500	471	307–655	4
Nevada	2,500	513	335–714	4
New Hampshire	1,000 1,750[d] 2,500	569 738[d] 462	218–868 283–1,127 177–706	46 46 46
New Jersey	0 2,500	488 363	286–768 213–572	10

State[a]	Deductible, in-network[b] ($)	Premium (50-year-old) ($)[c]	Overall premium range, non-smoker ($)	Number of age bands
	500	423	127–542	48
New Mexico	1,000	379	113–485	48
	2,000	340	102–435	48
New York	0	362–421	362–421[c]	1
North Carolina	1,000	469	150–729	51
	2,500	346	113–592	51
	3,500	316	107–531	51
	4,500	261	77–382	51
North Dakota	2,500	377	246–524	4
Ohio	1,500	323–378	101–597[c]	62
	2,500	294–344	92–542[c]	62
Oklahoma	2,000	327	137–524	27
Oregon	500	593	240–714	12
	750	544	221–656	12
Pennsylvania	1,000	283	283	1
Rhode Island	1,000	430	206–994	10
South Carolina	2,500	462	301–642	4
South Dakota	2,000	456	141–626	11
Tennessee	2,500	438	286–609	4
Texas	2,500	495	323–688	4
Utah	500	508	261–744	10
	1,000	431	228–631	10
	2,500	331	175–486	10
	5,000	240	127–382	10
Vermont	2,500	419	274–583	4
Virginia	2,500	443	289–616	4
Washington	500	986	324–1,355	11
	2,500	476	161–655	11
West Virginia	2,500	401	261-557	4
Wisconsin	500	559	214–802	9
	1,000	458	176–658	9
	2,500	330	127–474	9
	3,500	277	106–398	9
Wyoming	2,500	358	234–498	4

[a] Shaded states are federally administered.
[b] Some states offer multiple plans as shown, and some states have deductibles for out-of-network services and prescriptions that are not shown.
[c] Premiums vary by region.
[d] Indemnity plan rather than PPO.
Sources: PCIP Web sites and personal communication with PCIP program staff.

Alternatively, an individual with high prescription costs may prefer a plan with a higher medical out-of-pocket limit if he or she does not anticipate heavy use of medical benefits.

It is important to note that the ACA out-of-pocket limit applies only to in-network costs. Virtually all states use some form of managed care, most commonly a preferred provider organization, and allow for higher out-of-pocket costs for out-of-network care. Some states have no coverage for out-of-network care except for emergencies, while others pay only in-network rates (leaving the insured to pay the balance), reduce coinsurance to 50 percent, or have separate out-of-network deductibles and out-of-pocket limits. Wisconsin enrollees do not have a PPO network but are limited to Medicaid-certified providers. In addition, virtually all states cap some services. Thus, it may be possible to incur very large out-of-pocket costs, despite ACA and PCIP limits.

Although many plans have deductibles large enough to meet IRS standards for designation as a high-deductible plan, only the federally administered plans and state plans in Maryland, North Carolina, and Utah offer a high-deductible designated health plan (HDHP). In Maryland, the HDHP is the only PCIP plan and has a deductible of $1,500, while in North Carolina and Utah the deductibles are $4,500 and $5,000, and there are other plans from which to choose. High-deductible designated plans differ from other plans with a high deductible because no benefits, other than preventive services, may be provided until the deductible is met. HDHP plan administrators must report to the IRS the names and social security numbers of enrollees so that eligibility for a health savings account or other tax-sheltered reimbursement arrangement may be verified. Thus, a state would not be able to provide first-dollar coverage or exempt services from the deductible under a high-deductible designated plan.

First-Dollar Coverage and Services Outside Deductibles

An important feature of the PCIPs is whether or not they cover any services before the deductible is met (Exhibit 5). Providing so called "first-dollar" services or, at minimum, waiving the medical deductible, allows enrollees to immediately utilize some services or medications, likely increasing access to those services.

Preventive services

While the ACA requires that health plans provide preventive services without deductibles or coinsurance, PCIPs are exempt from this requirement because they do not meet the definition of a health plan or health insurance issuer. Nevertheless, many PCIPs, including those administered by the federal government, chose to follow the ACA rule to some degree. In most cases, preventive care must be provided within network. The scope of coverage varies greatly. Some states cover services up to a specific dollar limit while others cover preventive services comprehensively, including office visits, laboratory and x-ray testing, and age-appropriate colorectal cancer screenings, up to and including a full colonoscopy. Eventually, a federal definition of preventive care services will be set by the Preventive Services Task Force, but in the interim, HHS has left these coverage decisions to PCIP administrators.

Prescriptions, physician services, and other services

Access to medications is especially important in managing many chronic health conditions. Many states either exempt prescriptions from the medical deductible or impose a smaller, separate prescription deductible. Most use a tiered cost-sharing structure, with graduated copays reflecting the relative cost of the prescription. To help control costs, plans generally contract with pharmacy benefit managers. Less commonly, plans waive deductibles for professional services, such as office visits, mental health outpatient visits, urgent and emergency room care, and therapies, substituting small copays for coinsurance. Other low- or no-cost services in some states include diabetic education and supplies, obesity management, and smoking cessation. Depending on the plan, copays may or may not count toward the out-of-pocket maximum.

Lifetime and Annual Maximums

Because PCIPs do not meet the legal definition of a group plan or health insurance issuer, they are also

Exhibit 4. PCIP Coinsurance Levels and Out-of-Pocket Limits

State	Coinsurance, in-network	Coinsurance, out-of-network	Out-of-pocket limit, in-network	Out-of-pocket limit, out-of-network
Federally administered states	20%	40%, most services; 100%, home health and durable medical equipment	$5,950	$7,000
Alaska	20%, most services; 50%, mental health	40%, most services; 50%, mental health or drug dependency	$3,000	No separate limit
Arkansas	20%, most services; 50%, mental health or drug dependency	40%, most services; 50%, mental health or drug dependency	$2,000	Unlimited
California	15%	50%	$2,500	Unlimited
Colorado	20%	No coverage except for emergencies or if a network provider is not available and care is preauthorized	$5,950	Unlimited
Connecticut	20%	40% most services 25% home health	$4,250	$15,000
Illinois	20%	40%	$5,950	$6,500
Iowa	20%	40%	$3,500	$6,000
Kansas	30%	50%	$5,950	No separate limit
Maine	30%	50%	$5,600	No separate limit
Maryland	0% for high-deductible plan	0% for high-deductible plan	$1,500	No separate limit
Michigan	20%	No coverage except with prior approval	$5,950	Unlimited
Missouri	20%	50%, most services; 20%, emergency services	$5,950	No separate limit
Montana	30%	50%	$5,950	No separate limit
New Hampshire	20%	20%, indemnity plan; 40%, PPO plans	$3,500–$5,000	$4,750–$8,500

State	Coinsurance, in-network	Coinsurance, out-of-network	Out-of-pocket limit, in-network	Out-of-pocket limit, out-of-network
New Jersey	0% or 20%	30% both plans	$5,000	$10,000 or $22,500
New Mexico	20%	Balance billing[a]	$5,450–$5,950	No separate limit
New York	0%	100%	$5,950	Unlimited
North Carolina	20%, PPO plans; 0%, high-deductible plan	50%, PPO plans; 0%, high-deductible plan	$5,950, PPO plans; $4,500, high-deductible plan	$7,000, PPO plans; $4,500, high-deductible plan
Ohio	20%	50%	$5,950	$9,000–$9,950
Oklahoma	20%	40%	$5,950	No separate limit
Oregon	20%	40%	$5,200–$5,450	$6,450–$8,200
Pennsylvania	20%	50%	$5,000	$20,000
Rhode Island	20%	No coverage except emergencies	$3,000	Unlimited
South Dakota	25%	50%	$5,750	Unlimited
Utah	20%	No coverage except emergencies	$5,000–$5,950; $5,000, high-deductible plan	Unlimited
Washington	20%	40%	$1,500–$5,950	$2,000–$7,400
Wisconsin	20%	Balance billing, if provider is not Medicaid certified[a]	$3,500–$5,950	Unlimited

[a] Balance billing is difference between billed amount and in-network reimbursement.
Sources: PCIP Web sites and personal communication with PCIP program staff.

Exhibit 5. Services Exempt from Medical Deductible or Covered in Full[a]

State	Preventive care	Prescriptions	Office visits	Other
Federally administered states	Yes	No	No	No
Alaska	$1,000 maximum	No	No	No
Arkansas	$25 copay	$10/$30/$70 copay	No	No
California	Yes	$5 copay, generic Rx before deductible; $500 separate deductible for brand-name drugs	$25 copay, physician visits	No
Colorado	$30 copay, primary care physician; $45 copay, specialist	$10 copay, generic Rx before deductible; $500 separate deductible, brand-name drugs	$30 copay, primary care physician; $45 copay, specialist	$30, copay mental health outpatient; $75 copay, urgent after-hours care; $150 copay, emergency room[b]
Connecticut	Well-child only	Separate $250 deductible	Prenatal office visits fully covered	No
Illinois	No	Yes	No	No
Iowa	Yes, but subject to coinsurance	Yes	Yes, in-network only	$75 copay, urgent care facility; diabetes education[b]
Kansas	Yes	No	No	No
Maine	Yes	Yes	$25 copay	$25 copay, hospice,[b] smoking cessation program[c]
Maryland	$10 copay	No	No	$75 copay, emergency room[b]
Michigan	Yes	Yes	No	No
Missouri	Yes, but subject to coinsurance	Separate $100 Rx deductible	No	No
Montana	$300 max	Yes	No	Durable medical equipment, prosthetics, rehabilitation therapy, well-child care, newborn initial care, and lifesaving;[b] hospice, diabetic education[c]
New Hampshire	No	Separate $300 Rx deductible	No	No
New Jersey	$500 maximum $750 newborns	Yes	$30 copay, primary care physician; $50 copay, specialist	Therapies (speech, occupational, rehabilitation and therapeutic manipulations);[b] Durable medical equipment, laboratory[d]
New Mexico	$500 maximum, deductible and coinsurance thereafter	Yes	No	Diabetic education, diabetic supplies and equipment; hospice;[b] outpatient preadmission testing[c]

State	Preventive care	Prescriptions	Office visits	Other
New York	$20 copay	Yes	$20 copay, primary care and specialists	Laboratory and x-ray, maternity pre- and post-natal care, preadmission testing, skilled nursing facility, home health, hospice, surgery professional fees, and durable medical equipment;[c] $20 copay, therapists; $500 copay, inpatient admission[b]
North Carolina	Yes	Yes	$20 copay, primary care; $40 copay, specialists	No
Ohio	Yes	$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	No
Oklahoma	Yes	Separate $200 Rx deductible	No	No
Oregon	Yes, but subject to coinsurance	Yes; $0 copay for diabetic supplies, insulin, and some evidence-based generic maintenance medications	No	No
Pennsylvania	Yes	Yes	$25 copay primary care physician; $30 copay, specialist	Obstetrical care, nutritional counseling for weight management;[c] $30 copay, therapists[b]
Rhode Island	Yes	Yes	$20 copay, primary care physician; $40 copay, specialist; $75 copay, urgent care	Laboratory and x-ray; [c] $200 copay, emergency room; $50 copay, ambulance[b]
South Dakota	Yes	Yes	No	No
Utah	Yes	Separate $150–$500 Rx deductible	No	No
Washington	$500 maximum	Yes	No	Diabetic education, tobacco cessation[c]
Wisconsin	$150 maximum	Yes	No	No

[a] Most states specify that covered services must be in-network to be exempted from deductible. Also, some states only cover some preventive services.
[b] No deductible or deductible is waived.
[c] No deductible, coinsurance, or copayment.
[d] No cost-sharing in Horizon Direct Access Plan C 100/70 only.
Sources: PCIP websites and personal communication with PCIP program staff.

exempt from the ACA requirement prohibiting annual and lifetime benefit maximums. In practice, the federally administered plans and about half of the state-administered plans chose not to impose these limits, although two states (New Mexico and Washington) without overall limits have separate lifetime limits for transplant surgeries. Of those with lifetime limits, most are in the $1 million to $2 million range (Exhibit 6). To date, Utah, which has a $1.5 million lifetime limit, is the only state with a flat annual limit ($400,000). Michigan and Maryland have $100,000 annual limits on prescriptions.

Service Caps

Virtually all PCIP plans limit coverage for at least some services. Mental health and substance abuse services, therapies (physical, occupational, speech, cardiac), and long-term care services (home health, skilled nursing, hospice) are among the categories usually restricted through dollar limits or caps on numbers of inpatient days or outpatient visits. Federally administered plans and 14 state plans (California, Colorado, Maine, Missouri, Montana, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Dakota, and Washington) have mental health parity or coverage of biologically based psychiatric conditions at the same levels as physical illnesses. Even in those states, except for federally administered plans, non-biologically based mental illnesses and chemical dependency typically have caps on outpatient and inpatient treatment. The federally administered plans limit hospice care to $15,000 per year, home health visits to 25 per year, physical and occupational therapy to 60 visits per year, and speech therapy to 30 visits per year. Medical necessity of these services must be precertified.

Special Benefits

Rhode Island requires that PCIP enrollees participate in either a care coordination program or a patient-centered medical home program; new enrollees are required to choose a primary care physician and have a physical within six months of joining the plan. Other innovative practices include providing no-cost generic drugs, diabetic supplies and insulin, and smoking cessation drugs. At least four states pay for hearing aids on a limited basis. New York provides an annual vision exam with a $20 copay for all enrollees, and Rhode Island provides no-cost vision and foot exams for diabetics. Some states have "roll-over deductibles" that allow beneficiaries who do not meet their deductible by the end of a plan year to apply fourth-quarter claims to the following year's deductible. This is not an exhaustive

Exhibit 6. Lifetime and Other Limits

State	Lifetime Limit
Federally administered states	None
Alaska	$3 million
Arkansas	$1 million
California	None
Colorado	$1 million
Connecticut	$1.5 million
Illinois	$5 million
Iowa	$3 million
Kansas	None
Maine	None
Maryland	$2 million
Michigan	None
Missouri	$1 million
Montana	$2 million
New Hampshire	$2.5 million
New Jersey	None
New Mexico	None
New York	None
North Carolina	$1 million
Ohio	None
Oklahoma	$1 million
Oregon	$2 million
Pennsylvania	None
Rhode Island	None
South Dakota	None
Utah	$1.5 million
Washington	None
Wisconsin	$2 million

Sources: PCIP Web sites and personal communication with PCIP program staff.

list; other states may cover these or other services but coverage is not specified in currently available plan documents.

CONCLUSION

The PCIPs provide an important early opportunity for perhaps hundreds of thousands of uninsured individuals with preexisting conditions to acquire health insurance coverage. Applicants cannot be excluded or charged higher premiums on the basis of their medical histories, in sharp contrast to their likely past experiences in the individual market. Though plans vary substantially from state to state, PCIP regulations are flexible enough to allow states to make modifications to their plans if needed. Because PCIPs are modeled on insurance coverage in the individual market, their coverage is less comprehensive and more expensive than employer-based insurance, potentially making them unaffordable to lower-income applicants. Starting in 2014, however, people with incomes below 133 percent of the federal poverty level will be eligible for Medicaid, and those with incomes up to 400 percent of the poverty level will be eligible for subsidized coverage through the exchanges. In the interim, PCIPs will provide protection against medical expenditure risk and adverse health outcomes for many previously uninsured people.

Notes

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