



**THE AFFORDABLE CARE ACT'S PRE-EXISTING CONDITION INSURANCE
PLAN PROGRAM: A CRITICAL BRIDGE TO 2014, BUT NOT A LONG-TERM
SOLUTION FOR UNIVERSAL COVERAGE**

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A Critical Bridge to 2014, But Not a Long-Term Solution for Universal Coverage**

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EXECUTIVE SUMMARY

Thank you, Mr. Chairman, for this invitation to testify on the Patient Protection and Affordable Care Act's Pre-Existing Condition Insurance Plan (PCIP) Program. The major coverage provisions of the Affordable Care Act go into effect in January 2014, providing new insurance options for people without health insurance and sweeping new insurance market reforms to protect people who must buy health plans on their own. The Congressional Budget Office projects that the combination of new federal subsidies for insurance and consumer protections will newly insure at least 14 million people in 2014, and 27 million by 2021.

The PCIP program was one of several provisions of the law that went into effect in 2010 aimed at providing a bridge to 2014 for people who have been particularly at risk of being uninsured or poorly protected by their health insurance. Millions of adults and children with chronic health problems and young adults have benefited from these provisions, which included bans on lifetime benefit limits and preexisting condition exclusions for children. About 135,000 previously uninsured people with health problems who were not able to gain coverage in the individual insurance market because of their health have enrolled in the PCIP program since August 2010.

The PCIP program has succeeded in offering transitional support for thousands of people who would otherwise have been uninsurable in the individual insurance market. The 50-state program provided more affordable coverage than people could gain through the individual insurance market and most existing state high-risk pools, which operate in only 35 states. And, unlike most state high-risk pools, the PCIP program offered immediate coverage of preexisting conditions for people with serious health problems. The program has been a critical bridge to 2014, but its limitations demonstrate why high-risk pools are an inadequate substitute for the comprehensive insurance market reforms and expanded health insurance options to go into effect under the Affordable Care Act next January.

The PCIP Program Has Experienced Lower-than-Expected Enrollment

The program's low enrollment relative to the millions of uninsured Americans with serious chronic health problems reflects the program's lack of premium subsidies. This means that its potential benefits are out of reach for the vast majority of this population. An analysis of 2007 federal data found that 79 percent of the estimated 6.9 million people with a high-cost health problem who had been uninsured for at least six months had annual incomes of less than 400 percent of the federal poverty level; half had incomes of less than 200 percent of poverty.

In the Texas PCIP program, for example, the premium for a plan with a \$2,500 deductible was \$318 per month in 2012, or \$3,816 for 12 months. For a person in Texas with an income of \$11,500, or about 100 percent of poverty, the premium would comprise one-third of his income and the deductible, 22 percent of his income. Thus, even prior to out-of-pocket spending on coinsurance above the deductible, he would spend more than half of his annual income on premiums and out-of-pocket costs under the program.

The PCIP Program Has Experienced Higher-than-Expected Per-Enrollee Claims Costs

Like the existing state high-risk pools, premiums in the PCIP program have run well short of claims costs. Jean Hall and Janice Moore of the University of Kansas found that medical claims relative to premiums (medical loss ratios) in both state high-risk pools and the PCIP program exceed 100 percent, but that the PCIP medical loss ratios are as much as seven times that of high-risk pools in some states.

This difference in medical spending between the two risk pool programs is most likely driven by the fact that the PCIP program provides immediate coverage of people with health problems. Combined with the fact that people must be uninsured for six months, this likely has led to an overrepresentation of people in the PCIP program with serious health problems that have gone untreated for a long period. CMS's analysis of the federal PCIP program found that the top four diagnoses or treatments included cancers, ischemic heart disease, degenerative bone diseases, and follow-up medical care required after major surgery or cancer treatments. These four diagnoses comprised more than one-third (36%) of claims costs in the federal program in 2012. An analysis of one-year program claims found that costs were concentrated in a small number of enrollees: just 4.4 percent of PCIP enrollees accounted for more than half of claims paid. Hall and Moore also find evidence of a higher disease burden among PCIP enrollees

compared with people enrolled in state high-risk pools. Costs per member per month in the PCIP program are nearly nine times those in the state high-risk pools.

High-Risk Pools Are Not a Long-Term Solution for Expanding Health Insurance Coverage

The experiences of both the PCIP program and the state high-risk pools demonstrate the profound inefficiency of segmenting insurance risk pools. Without the benefit of a broad and diverse group of insured people, both programs operate at a considerable loss and depend on federal and state financing to fund the enormous gap between premiums and claims costs. Still, because of the high premium costs, particularly relative to the modest incomes of the target population of uninsured people with chronic health problems, both programs suffer from low enrollment.

Older Adults with Health Problems with Low and Moderate Incomes Will Face Far Lower Premiums in 2014 for Plans Offered Through the Marketplaces Compared with the PCIP Program

The Affordable Care Act's sweeping insurance market reforms take effect next year, making it possible for people with health problems or who are older to purchase a health plan with a comprehensive benefit package. These reforms include: requiring insurers to offer all applicants an essential health benefit package similar to that offered by employers; banning insurers from charging people higher premiums based on health or gender; limiting what older people may be charged relative to younger people by a factor of 3:1; banning carriers from limiting or denying benefits because of preexisting health conditions; and requiring broad pooling of risk in state insurance markets to further reduce the ability of carriers to maintain higher rates on older or sicker enrollees.

Expanded eligibility for Medicaid and premium tax credits for private plans sold through the new insurance marketplaces will help level the playing field between employer coverage and insurance that people must buy on their own for those with incomes under 400 percent of poverty. People with low and moderate incomes with health problems will face far lower premiums than they do now in the PCIP program. For example, a 50-year-old man with an income of \$23,011 would contribute 6.3 percent of his income, or \$1,450 annually, for a private plan offered through the state insurance marketplaces next year. In contrast, annual premiums for 50-year-olds at this

income level in the PCIP program exceed this contribution by nearly two times in Virginia, which has the lowest PCIP premiums, to more than 10 times in Alaska.

Conclusion and Policy Implications

Federal and state policymakers can address the PCIP program's shortcomings in enrollment and costs by allowing its enrollees to transition to the new state insurance marketplaces and the expanded Medicaid program in January 2014, as Congress intended. State high-risk pools are also likely to end operation in January. Enrollees from both programs will join an estimated 7 million new enrollees in the new state insurance marketplaces next year, with a diverse age and health profile, which will help spread the costs of care across a much broader risk pool. Twenty-seven million people are expected to gain coverage through the marketplaces by 2018.

The Congressional Budget Office estimates that the influx of young and healthy people into the marketplaces will lower premiums by 7 percent to 10 percent below what they are today in the individual market for an equivalent benefit package. Economies of scale and lower administrative costs from bans on underwriting will lower premium costs by an additional 7 percent to 10 percent. A nationwide reinsurance program that will go into effect next year will protect state insurance marketplaces that experience a disproportionately large influx of high-cost enrollees.

One of the central goals of the Affordable Care Act is to pool risk in insurance markets far more broadly than is the case today in the United States. Extensive segmentation of risk in insurance markets has fueled growth in the number of uninsured Americans over the past several decades and has made the U.S. the industrialized world's unequivocal leader in the cost of insurance administration. The experience of both the PCIP program and the state high-risk pools over their 40-year history underscores why a shared responsibility for health care costs across the population and the life cycle is essential for an equitable and efficiently run health insurance system.

Thank you.

The Affordable Care Act's Pre-Existing Condition Insurance Plan Program: A Critical Bridge to 2014, But Not a Long-Term Solution for Universal Coverage

Introduction

Thank you, Mr. Chairman, for this invitation to testify on the Patient Protection and Affordable Care Act's Pre-Existing Condition Insurance Plan (PCIP) Program. The major coverage provisions of the Affordable Care Act go into effect in January 2014, providing new insurance options for people without health insurance and sweeping new insurance market reforms to protect people who must buy health plans on their own. The Congressional Budget Office projects that the combination of new federal subsidies for insurance and consumer protections will newly insure at least 14 million people in 2014, and 27 million by 2021.

The PCIP program was one of several provisions of the law that went into effect in 2010 aimed at providing a bridge to 2014 for people who have been particularly at risk of being uninsured or poorly protected by their health insurance. Millions of adults and children with chronic health problems and young adults have benefited from these provisions. In particular:

- 135,000 previously uninsured people with health problems who were not able to gain coverage in the individual insurance market because of their health have enrolled in the PCIP program since August 2010.¹
- Health plans are banned from imposing preexisting condition exclusions for children: an estimated 17.6 million children have benefited.²
- Insurers can no longer place limits on what health plans will pay over a lifetime: 105 million people with such limits have benefited.³ This particularly benefits people with chronic health problems or who become seriously ill.
- 18 million people who faced annual limits on what their health plans would pay are experiencing a gradual phase-out of those limits through 2013. This also particularly benefits people with health problems.⁴

¹ Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, *Covering People with Preexisting Conditions: Report on the Implementation and Operation of the Pre-Existing Condition Insurance Plan Program*, Jan. 31, 2013.

² <http://www.whitehouse.gov/sites/default/files/uploads/careact.pdf>.

³ Assistant Secretary for Planning and Evaluation, Under the Affordable Care Act, 105 Million Americans No Longer Face Lifetime Limits, available at <http://aspe.hhs.gov>.

⁴ S. B. Larson, *Obamacare: Why the Need for Waivers? (Annual Limits Bridge Program)*, Testimony before the U. S. House Committee on Oversight and Government Reform Subcommittee on Health Care,

- Carriers cannot cancel policies retroactively: 10,700 people had policies rescinded each year prior to law's passage.⁵
- Health plans must cover recommended preventive care without cost-sharing, including a new set of preventive services for women: an estimated 71 million Americans in private health insurance plans received coverage for at least one free preventive health care service in 2011 and 2012 because of this new requirement.⁶
- An estimated 6.6 million young adults ages 19–25 stayed on or joined their parents' health plans, who likely would not have been able to do so prior to the passage of the law.⁷

The law's major coverage provisions will build on this critical set of transitional reforms providing new, affordable health insurance options and protections to all Americans who have to buy coverage on their own, with particular safeguards for people with health problems and who are older. While the PCIP program has benefited thousands of people over the past three years who otherwise would have been without health insurance, the program's limitations demonstrate why high-risk pools are an inadequate substitute for the comprehensive insurance market reforms and expanded health insurance options to go into effect under the Affordable Care Act next January.

This testimony examines the problems people with health problems currently face gaining coverage in the individual insurance market and how states have responded with high-risk pools. It discusses the experiences of the high-risk pools and the PCIP program in insuring people with health problems and looks ahead to the benefits for this population when the major coverage provisions go into effect next year.

District of Columbia, Census, and The National Archives, U.S. House of Representatives (March 15, 2011), available at <http://www.hhs.gov/asl/testify/2011/03/t20110315a.html>.

⁵ Department of Treasury, Department of Labor and Department of Health and Human Services, Patient Protection and Affordable Care Act: Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule (*Federal Register*, June 28, 2010), available at <http://www.gpo.gov/fdsys/pkg/FR-2010-06-28/pdf/2010-15278.pdf>.

⁶ http://aspe.hhs.gov/health/reports/2013/PreventiveServices/ib_prevention.cfm.

⁷ S. R. Collins, R. Robertson, T. Garber, and M. M. Doty, *Young, Uninsured, and in Debt: Why Young Adults Lack Health Insurance and How the Affordable Care Act Is Helping* (New York: The Commonwealth Fund, June 2012).

The Individual Insurance Market is Not an Affordable or Accessible Option for People with Health Problems

People who do not have access to employer health benefits and are ineligible for Medicaid are largely limited to purchasing coverage in the individual insurance market. But the individual market for most Americans is neither affordable nor easy to navigate. People buying coverage in the individual market must pay the full premium and, under current laws in most states, are rated on the basis of their health, gender, and age. They can also be denied coverage because of a preexisting condition or have their condition excluded from their health plan.⁸ The Commonwealth Fund Biennial Health Insurance Survey of 2010 found that of an estimated 26 million adults who said that they tried to buy a health plan in the individual market between 2007 and 2010, 43 percent found it very difficult or impossible to find plan that fit their needs and 60 percent found it very difficult or impossible to find a plan they could afford (Exhibit 1).⁹ More than one-third (35%), or 9 million people, were turned down by an insurance carrier because of a health problem, charged a higher price because of a health problem, or had a specific health problem excluded from their coverage.

⁸ M. M. Doty, S. R. Collins, J. L. Nicholson, and S. D. Rustgi, [*Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*](#) (New York: The Commonwealth Fund, July 2009); K. Swartz, *Reinsuring Health: Why More Middle Class People Are Uninsured and What Government Can Do* (New York: Russell Sage Foundation, 2006); S. R. Collins, C. Schoen, K. Davis, A. Gauthier, and S. Schoenbaum, [*A Roadmap to Health Insurance for All: Principles for Reform*](#) (New York: The Commonwealth Fund, Oct. 2007); and N. C. Turnbull and N. M. Kane, [*Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market—Findings from a Study of Seven States*](#) (New York: The Commonwealth Fund, Feb. 2005).

⁹ S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, [*Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010*](#) (New York: The Commonwealth Fund, March 2011).

Exhibit 1. The Individual Insurance Market Is Not an Affordable Option for Many People, Particularly Those with Health Problems

Adults ages 19–64 with individual coverage* or who tried to buy it in past three years who:	Total 26 million	Health problem**	No health problem	<200% FPL	200%+ FPL
Found it very difficult or impossible to find coverage they needed	43% 11 million	53%	31%	49%	35%
Found it very difficult or impossible to find affordable coverage	60% 16 million	70	46	64	54
Were turned down, charged a higher price, or had condition excluded because of a preexisting condition	35% 9 million	46	20	38	34
Any of the above	71% 19 million	83	56	77	64

Note: FPL refers to federal poverty level.

* Bought in the past three years.

** Respondent rated their health status as fair or poor, has a disability or chronic disease that keeps them from working full time or limits housework/other daily activities, or has any of the following chronic conditions: hypertension or high blood pressure; heart disease, including heart attack; diabetes; asthma, emphysema, or lung disease; high cholesterol.

Source: S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, *Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010*, The Commonwealth Fund, March 2011.



People with health problems found it particularly difficult to find an individual insurance plan. More than half (53%) of those with health problems who tried to buy coverage in the individual market found it very difficult or impossible to find a plan with the coverage they needed, compared with 31 percent of those without a health problem (Exhibit 1).¹⁰ Similarly, 70 percent of survey respondents with health problems said they found it very difficult or impossible to find an affordable plan, compared with 46 percent of those in better health. And 46 percent were denied coverage by an insurance carrier because of a health problem, charged a higher price, or had a specific health problem excluded from their coverage. This was more than two times the rate (20%) reported by adults who did not have health problems.

State High-Risk Pools

Beginning in the 1970s, many states created high-risk pools to provide a means for people to gain health insurance when they were turned down or charged exorbitant

¹⁰ People with health problems are defined as those reporting fair or poor health status, any one of five chronic conditions, or a disability or condition that prevents them from working.

prices in the individual market. By 2011, 35 states were operating such pools, but total enrollment was just 226,000 people nationwide, or only 0.6 percent of the total uninsured population in those states.¹¹ Enrollment varies widely by state, ranging from just 208 people in Florida to 27,000 people in Minnesota. Following voluntary guidelines established by the National Association of Insurance Commissioners, most states make premiums more affordable by imposing premium caps for their high-risk pools, ranging from 125 percent of average individual market rates in Minnesota and Oregon to as high as 250 percent in Florida. Most states also vary premiums on the basis of age and gender. In addition, all states (with the exception of Alabama) impose waiting periods for coverage of preexisting conditions, ranging from three to 12 months.¹² During this period, coverage of a condition that existed prior to enrollment is not covered unless someone transitions directly from other coverage, including COBRA when benefits are exhausted. Several states provide discounts or premium support for lower-income enrollees, but the generosity of the support varies widely.¹³

There is tremendous variation in what the high-risk pool plans cover, the size of deductibles, and whether they impose maximum annual and lifetime benefit limits. For example, the Alaska high-risk pool plan with the most enrollees has a \$10,000 deductible, the highest among the states, compared with a \$200 deductible for the most popular plan in Maryland. In nine states, the plans with the highest enrollment have \$5,000 deductibles. Thirty states have maximum lifetime benefit limits, ranging from \$750,000 in California to \$5 million in Florida and Minnesota, and six states including have annual benefit limits as well.

Even though premiums in high-risk pools are higher than those in the individual market, they have not been sufficient to finance the expensive claims made in these pools. In 2011, premiums on average provided only half (53%) of the funding for high-risk pools, ranging from 22 percent in New Mexico to 91 percent in South Carolina.¹⁴ Claims expenses across the 35 risk pools averaged 181 percent of premiums collected. New Mexico's ratio was more than 400 percent.

¹¹ National Association of State Comprehensive Health Insurance Plans, 2011, available at http://naschip.org/portal/index.php?option=com_content&view=article&id=230.

¹² J. P. Hall and J. M. Moore, *Realizing Health Reform's Potential: The Affordable Care Act's Pre-Existing Condition Insurance Plan: Enrollment, Costs, and Lessons for Reform* (New York: The Commonwealth Fund, Sept. 2012).

¹³ L. Achman and D. Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (New York: The Commonwealth Fund, Aug. 2001).

¹⁴ National Association of State Comprehensive Health Insurance Plans, 2011, available at http://naschip.org/portal/index.php?option=com_content&view=article&id=230;

States have struggled to make up the difference between claims and premiums using a combination of approaches, including assessments on insurance carriers (29 states) and state revenue funds such as general revenues and tobacco taxes (five states). Many states also receive federal grants directed toward specific initiatives, such as premium subsidies. But states also have tried to reduce their costs by: limiting enrollment through waiting periods for preexisting conditions; closing the pools to new enrollment (Florida's pool has just 208 members and has been closed to new enrollment since 1991); limiting the amount of time someone can be in the pool; imposing lifetime and annual benefit limits on coverage; negotiating more favorable provider payment rates; and increasing premiums, deductibles, and copayments.

The PCIP Program

To provide a transitional coverage option for people who are uninsured and who cannot gain coverage in the individual insurance market, the Affordable Care Act sought to build on the model of state high-risk pools but with more affordable premiums and consumer protections. The law allocated HHS \$5 billion to subsidize the gap between premiums collected for the PCIPs and claims costs between 2010 and 2013. As Jean Hall and Janice Moore of the University of Kansas point out, Congress intended the program to provide an immediate coverage source for people who were uninsured; it was not intended to extend coverage to those already insured.¹⁵ Available in all 50 states and the District of Columbia, PCIPs were open to people who have been uninsured for at least six months and who have a health problem that has made it difficult for them to gain health insurance.¹⁶ PCIPs cover a broad range of health benefits, including primary and specialty care, hospital care, and prescription drugs. Premiums are set for a standard population in the individual insurance market and cannot vary by more than a factor of four, based on age (i.e., 4:1 age bands). The PCIPs are required to cover, on average, no less than 65 percent of medical costs and to limit out-of-pocket spending to \$6,250 in 2013. They also cannot impose preexisting condition exclusions or, unlike state high-risk pools, waiting periods.

The federal government invited states to submit applications to form their own PCIPs, supported by federal subsidies to cover the difference between premiums and

¹⁵ J. P. Hall and J. M. Moore, *Realizing Health Reform's Potential: Enrollment, Costs*, 2012.

¹⁶ Department of Health and Human Services, "Pre-Existing Condition Insurance Plan Program," Interim Final Rule with Comment Period, July 29, 2010.

the cost of claims. Twenty-seven states elected to run their own plans.¹⁷ States have flexibility in setting the size of the deductible, the level of coinsurance or copayments, and the scope of benefits, so there is variation in PCIPs from state to state. Most states offer a choice of plans with deductibles ranging from \$0 in New York and New Jersey to a \$5,000 in-network deductible plan option in Illinois and Missouri.¹⁸ And many states also have separate deductibles for prescription drugs. Some states, such as Washington and Maryland, have also offered plans with out-of-pocket maximums at \$1,500, well below the federal standard.¹⁹ Monthly premiums vary according to deductibles and by state, ranging from a low of \$195 per month for Illinois' \$5,000 deductible plan to a high of \$1,215 for Alaska's only plan option, which comes with a \$1,500 deductible.²⁰

The federal government is operating PCIPs in the remaining 23 states and the District of Columbia.²¹ Through 2012, the federal PCIP offered three different plan options: \$1,000 deductible for in-network medical services and \$250 deductible for formulary prescription drugs; \$2,000 in-network deductible and \$500 prescription drug deductible; and a plan with a \$2,500 in-network deductible. Monthly premiums ranged from a low of \$214 in Virginia for the \$2,000/\$500 deductible option to a high of about \$450 in Georgia, Mississippi, and Vermont for the lowest-deductible option. The lowest-deductible option in Massachusetts has a monthly premium of \$559, but because the state has universal coverage with premium subsidies and insurance market reforms including bans on preexisting condition exclusions and health and gender rating, only 12 people are enrolled in the program.

To reduce program costs and ensure funding availability for current enrollees through the end of 2013, the Centers for Medicare and Medicaid Services' (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) which directs the PCIP program, announced in February 2013 that it was suspending enrollment in the

¹⁷ These are: Alaska, Arkansas, California, Colorado, Connecticut, Illinois, Iowa, Kansas, Maine, Maryland, Michigan, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, and Wisconsin. See <http://www.pcip.gov/StatePlans.html> for more information on state-run PCIPs.

¹⁸ J. P. Hall and J. M. Moore, *Realizing Health Reform's Potential: Enrollment, Costs*, 2012.

¹⁹ J. P. Hall and J. M. Moore, *Realizing Health Reform's Potential: Pre-Existing Condition Insurance Plans Created by the Affordable Care Act of 2010* (New York: The Commonwealth Fund, Oct. 2010).

²⁰ J. P. Hall and J. M. Moore, *Realizing Health Reform's Potential: Enrollment, Costs*, 2012.

²¹ These are: Alabama, Arizona, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, Nebraska, Nevada, North Dakota, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. See <http://www.pcip.gov/StatePlans.html> for more information about the federal PCIP.

program.²² In addition, CMS consolidated the number of plan options into one through the end of 2013, i.e., the remainder of the program's life. The plan includes a \$2,000 deductible for in-network medical services and a \$500 deductible for formulary prescription drugs. The agency also reduced the amount the plan will pay after an enrollee reaches the deductible from 80 percent of allowable charges to 70 percent and increased coinsurance to 30 percent from 20 percent. The maximum out-of-pocket limit for in-network services is \$6,250 for in-network services and \$10,000 for out-of-network services. CMS is also urging, though not requiring, states to determine the feasibility of changing their current PCIP benefits to the federal standard, in order to ensure the viability of the program through the end of the year.

Why the PCIP Program Experienced Lower-than-Expected Enrollment and High Costs

The PCIP program was expected to cover between 175,000 and 400,000 people over its three-and-a-half years of operation.²³ Based on an analysis of the Medicaid Expenditure Panel Survey (MEPS), the CMS Office of the Actuary in April 2010 estimated that the program would cover 375,000 people and exhaust its \$5 billion in funding by 2012.²⁴ Instead, the program has provided coverage to about 135,000 people over its lifetime, though enrollment has grown steadily over time. Applications for enrollment climbed by an average of 10,000 per month over the period July 2012 to October 2012, an increase of 30 percent from the same period a year earlier.²⁵ By January 2013, average monthly enrollment in the PCIP program nationwide exceeded 100,000.

Driven by high per-enrollee claims costs, monthly program costs also have climbed: between May 2012 and October 2012, combined federal and state expenditures averaged \$160 million per month.²⁶ The average claims cost per enrollee was \$32,108 in 2012, but an analysis of program claims over a one-year period found

²² Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, "Announcement of PCIP Program Enrollment Suspension and Benefit Adjustment Analysis," Letter from Richard Popper, Director, Insurance Programs Group, to Pre-Existing Insurance Plan Contractors, Feb. 15, 2013.

²³ Hall and Moore, *Realizing Health Reform's Potential: Created by the Affordable Care Act, 2010*; Department of Health and Human Services, "Pre-existing Condition Insurance Plan Program," Interim Final Rule, July 30, 2010, available at <http://edocket.access.gpo.gov/2010/pdf/2010-18691.pdf>; and Congressional Budget Office, Letter to the Honorable Michael B. Enzi, June 21, 2010.

²⁴ R. S. Foster, "Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended," Centers for Medicare and Medicaid Services, Office of the Actuary, April 22, 2010.

²⁵ Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, *Covering People with Preexisting Conditions: Report on the Implementation and Operation of the Pre-Existing Condition Insurance Plan Program*, Jan. 31, 2013.

²⁶ Ibid.

that claims have been concentrated in a small number of enrollees: just 4.4 percent of PCIP enrollees accounted for more than half of claims paid. There are several features of the PCIP program that have contributed to both low enrollment and high per-enrollee claims costs.

Low Enrollment in the PCIP Program

The intended purpose of the PCIP program was to provide coverage to people who were uninsured and unable to gain coverage because of a preexisting health condition. An analysis of the MEPS by Mark Merlis found that in 2007 there were an estimated 6.9 million people in the United States who had been uninsured for six months and who had a high-cost health condition.²⁷ Merlis defined a high-cost health condition as one that would result in claims costs greater than 50 percent of the average for their age group, and which would likely make it nearly impossible for someone to gain coverage for their condition in most state individual insurance markets.

With such a large population of people potentially eligible for the PCIP program, why has enrollment been so low? The primary reason, as Hall and Moore have pointed out in their work, are unaffordable premiums. The Merlis analysis shows that of the 6.9 million people who had been uninsured for six months with a high-cost health condition, 79 percent were in households with incomes under 400 percent of the federal poverty level, or about \$46,000 for a single person in 2013. A full one-quarter had incomes under poverty (\$11,490 for a single person), an additional quarter had incomes between 100 percent and 200 percent of poverty (\$22,980 for a single person), and 29 percent had incomes between 200 percent and 400 percent of poverty.

The PCIP program has made premiums more affordable than they otherwise would be for people compared with purchasing coverage in the individual market, or enrolling in most state high-risk pools. Rates are set to the average of a healthy person in the individual market as opposed to 100 percent–250 percent of that rate in state high-risk pools. Still, because the vast majority of the target population has low or moderate incomes, even these premiums can account for a substantial share of someone's income. For example, in the Texas PCIP program, the premium for a plan with a \$2,500 deductible was \$318 per month in 2012, or \$3,816 for 12 months. For a person in Texas with an income of \$11,500, or about 100 percent of poverty, the

²⁷ M. Merlis, *Health Coverage for the High-Risk Uninsured: Policy Options for Design of the Temporary High-Risk Pool* (Washington, D.C.: National Institute for Health Care Reform, May 2010), available at <http://www.nihcr.org/High-RiskPools#Table2>.

premium would comprise one-third of his income and the deductible, 22 percent of his income. Thus, even prior to out-of-pocket spending on coinsurance above the deductible, he would spend more than half of his annual income on premiums and out-of-pocket costs under the program.

In addition to high costs relative to income, the program's requirement that someone be uninsured for six months also likely contributed to lower enrollment. People may have moved from high-cost, low-benefit coverage in both the individual market and the state high-risk pools in the absence of the restriction. In addition, people transitioning from exhausted benefits under COBRA following a long period of unemployment may have enrolled in the PCIP program if not for this restriction.

High Costs in the PCIP Program

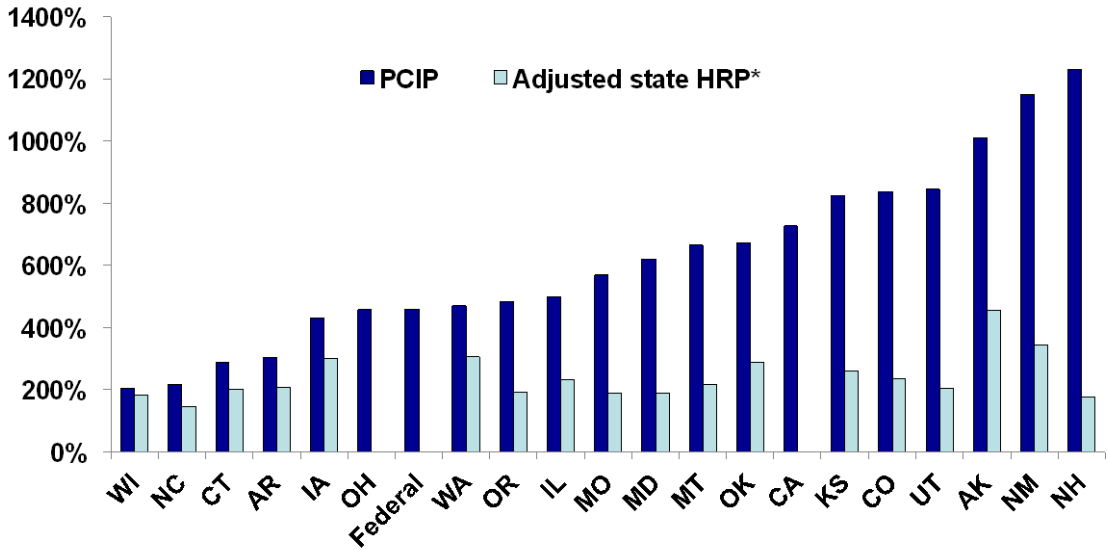
Like the existing state high-risk pools, premiums in the PCIP program have run well short of claims costs. Indeed, the purpose of the program was to provide a temporary source of funding, \$5 billion, to fill the gap between premiums and claims costs for people with uninsurable health problems through the end of 2013. As discussed above, state high-risk pools also rely on alternative sources of funding, including assessments on insurance carriers, state general revenues, and federal grants. But as Hall and Moore demonstrate, claims costs in the PCIP program have been even higher than those in the state high-risk pools relative to premium revenues.²⁸

Medical loss ratios (MLRs) are a measure of claims costs to overall premium revenues. Under the Affordable Care Act, insurance carriers are now required to spend at least 80 percent and 85 percent of their premiums on medical costs and quality improvement, as opposed to nonmedical expenses including administrative costs and profits. But insurance plans are unsustainable if medical costs exceed premiums. Hall and Moore find that MLRs in both state high-risk pools and the PCIP program exceed 100 percent, but that those of the PCIPs are as much as seven times those of high-risk pools in some states, even after adjusting for the higher premiums paid by people enrolled in the high-risk pools (Exhibit 2).

²⁸ Hall and Moore, *Realizing Health Reform's Potential: Enrollment, Costs*, 2012.

Exhibit 2. Medical Loss Ratios (MLRs) of State PCIP and High-Risk Pool (HRP) Programs

Medical loss ratios (MLRs) of PCIP and state high-risk pool (HRP) programs



* Most state HRP premiums are higher than standard risk rates, therefore MLR is adjusted to reflect premiums priced at standard risk rate.

Notes: Ohio does not have a state high-risk pool. The federal bar shows the MLR for all of the PCIP programs that were federally administered in 23 states and D.C. California does not use a standard risk rate.

Source: J. P. Hall and J. M. Moore, *Realizing Health Reform's Potential—The Affordable Care Act's Pre-Existing Condition Insurance Plan: Enrollment, Costs, and Lessons for Reform*, The Commonwealth Fund, Sept. 2012.



Why have claims costs run so far ahead of those in state high-risk pools? First, as Hall and Moore point out, unlike nearly all state high-risk pools, the PCIP program imposed no waiting periods for coverage of preexisting health conditions for people who became eligible for program enrollment. This requirement combined with the fact that people must be uninsured for six months likely has led to an overrepresentation of people in the PCIP program with serious health problems that have gone untreated for a long period of time.

CMS's analysis of the federal PCIP program found that the top four diagnoses or treatments included cancers, ischemic heart disease, degenerative bone diseases, and follow-up medical care required after major surgery or cancer treatments.²⁹ These four diagnoses comprised more than one-third (36%) of claims costs in the federal program in 2012. Nearly 5,000 enrollees had ischemic heart disease, among the most costly conditions to treat, and nearly 700 of those patients had heart failure. Also in that year, 2,200 enrollees had cancer, and nearly 1,000 of those were women with a diagnosis of

²⁹ Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, Jan. 2013.

breast cancer. CMS points out that all of these conditions involved care in hospitals and other facilities. Indeed in 2012, 57 percent of claims paid in the federally administered program were for care provided in a hospital or other facility on an inpatient or outpatient basis.

Hall and Moore's analysis of the state and federal PCIP program also finds evidence of a higher disease burden among PCIP enrollees compared with people enrolled in state high-risk pools. Per member per month costs in the PCIP program are nearly nine times those in the state high-risk pools. In an earlier analysis of claims in 10 state programs, Hall and Moore found higher-than-average enrollment among young adults with serious health problems including epilepsy, cancer, lupus, rheumatoid arthritis, and hemophilia, as well as young women with high-risk pregnancies.³⁰ They also found above average enrollment among older adults ages 58–62 and a concentration of diagnoses similar to that of the CMS analysis: cancer, ischemic heart disease, degenerative bone disease, and diabetes.

CMS has pursued a number of strategies to control costs in the PCIP program.³¹ They include:

- Changing provider networks used in the federal program and decreasing both its negotiated and out-of-network provider payment rates.
- Negotiating additional discounts for reimbursement rates for hospitals that serve large numbers of PCIP enrollees.
- Requiring covered specialty drugs to be dispensed only by the lowest-cost pharmacies and providers.
- Consolidating health plan options into one, with higher cost-sharing by enrollees, as described above.
- Conducting clinical and nonclinical audits of all federal and state programs. To be completed by the end of 2014, the audits are focusing on program enrollment and disenrollment, premium billing, eligibility and benefit coverage, appeals, finances of the risk pool, and medical and pharmaceutical claims payments and payment safeguards.

³⁰ J. P. Hall and J. Moore, [*Realizing Health Reform's Potential—Early Implementation of Pre-Existing Condition Insurance Plans: Providing an Interim Safety Net for the Uninsurable*](#) (New York: The Commonwealth Fund, June 2011).

³¹ Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, Jan. 2013.

High-Risk Pools Are Not a Long-Term Solution for Expanding Health Insurance Coverage

The experiences of both the PCIP program and the state high-risk pools demonstrate the profound inefficiency of segmenting insurance risk pools. Without the benefit of a broad and diverse group of insured people, both programs operate at a considerable loss and depend on federal and state financing to fund the enormous gap between premiums and claims costs. Still, because of the high premium costs, particularly relative to the modest incomes of the target population of uninsured people with chronic health problems, both programs suffer from low enrollment. The PCIP program is covering only about 2 percent of the likely eligible population of people with a high-cost condition who had been uninsured for six months.

The experience of both programs also underscores why high-risk pools are not long-term solutions for expanding health insurance. Indeed, analyses of proposals to achieve near-universal coverage that have included high-risk pools as a central feature have found that they would cover few people at exorbitant cost. In 2008, Senator John McCain proposed as a presidential candidate a plan for universal coverage that would have ended the personal income tax exemption for employer-provided health benefits and replaced it with tax credits for purchasing insurance in the individual market. The proposal did not change insurance market rules, allowing carriers to continue to rate premiums on the basis of health and gender and deny coverage or exclude benefits based on preexisting conditions. Indeed, Sen. McCain's proposal would likely have undermined state efforts to ban such practices by allowing the sale of health insurance across state lines. People with preexisting health conditions who were not able to find coverage in the individual insurance market would have been able to gain coverage through high-risk pools. States could join with other states to enlarge existing high-risk pools. The pools would have received federal financial support and people with low incomes would have been eligible for premium assistance.

The Urban Institute and Brookings Institution Tax Policy Center estimated that over the 10-year period 2009 to 2018, the total federal cost of McCain's plan could reach \$1.3 trillion, but only reduce the number of uninsured people by up to 4.6 million.³² But the Center's estimates for the McCain proposal did not include the effects of his proposed high-risk pools, which would cover people who cannot find coverage in the individual market. Two features of the McCain proposal increased the likelihood

³² L. Burman, S. Khitatrakun, G. Leiserson et al., *An Updated Analysis of the 2008 Presidential Candidates' Tax Plans* (Washington, D.C.: Urban Institute and Brookings Institution, Sept. 12, 2008).

that millions of people would likely seek coverage through the high-risk pools. Allowing people to buy coverage across state lines would have weakened existing consumer protections in the states that require guaranteed issue and community rating, leaving many people who currently have coverage through those markets to go to the high-risk pools. The Center and Buchmueller et al. also estimated that as many as 20 million people might lose employer coverage as a result of the elimination of the employer benefit tax exemption, leading many with health problems to seek coverage in high-risk pools.³³ The Center estimated that Sen. McCain's high-risk pools, if they were financed adequately and coverage was made affordable as he proposed, might have added an additional \$1 trillion to the cost of his plan over 10 years.

The Affordable Care Act Is a Long-Term Solution to Achieving Near-Universal Coverage

The enactment of the Affordable Care Act three years ago placed the United States on a path to near-universal health insurance coverage. More than 100,000 people who were uninsurable in most state individual insurance markets because of a preexisting health problem gained coverage through the PCIP program. Millions of young adults have gained or maintained insurance through their parents' plans. And the law's early insurance regulations that banned carriers from placing limits on what they will pay and from retroactively cancelling health policies when someone becomes ill, have already improved the reliability of health insurance for millions of Americans who must buy coverage on their own.

But the limitations of these early reforms in reaching near-universal coverage underscore the imperative for federal and state policymakers to complete the rollout of the law's central coverage provisions, scheduled to go into effect in January of next year. These provisions include an expansion in income eligibility for Medicaid for people in families with incomes up to 133 percent of poverty (\$15,282 for an individual and \$31,322 for a family of four). Comprehensive insurance plans will be available through new health insurance marketplaces in every state with tax credits available to people with incomes up to 400 percent of poverty (\$45,960 for an individual and \$94,200 for a family of four) to help pay for premiums (Exhibit 3). Carriers selling plans in the new marketplaces, as well as in the individual and small-group markets, are required to provide an "essential health benefit" package, similar to plans provided by employers. Insurers must offer these benefits at four tiers of cost coverage: bronze plans (covering

³³ T. C. Buchmueller, S. A. Glied, A. Royalty et al., "Cost and Coverage: Implications of the McCain Plan to Restructure Health Insurance," *Health Affairs* Web Exclusive (Sept. 16, 2008):w472-w481.

on average 60% of someone’s annual medical costs), silver (70% of costs), gold (80% of costs), or platinum (90% of costs). For people with low incomes, the average costs covered by the silver plan are increased to 94 percent (for those with incomes up to 149% of poverty), 87 percent (150% to 199% of poverty), and 73 percent (200% to 249% of poverty). Out-of-pocket spending limits will also be lower for people with incomes under 400 percent of poverty.

Exhibit 3. Premium Tax Credits and Cost-Sharing Protections Under the Affordable Care Act

Federal poverty level	Income	Premium contribution as a share of income	Out-of-pocket limits	Actuarial value: Silver plan
<133%	S: <\$15,282 F: <\$31,322	2% (or Medicaid)	S: \$1,983 F: \$3,967	94%
133%–149%	S: \$15,282 – <17,235 F: \$31,322 – <35,325	3.0%–4.0%		94%
150%–199%	S: \$17,235 – <22,980 F: \$35,325 – <47,100	4.0%–6.3%		87%
200%–249%	S: \$22,980 – <28,725 F: \$47,100 – <58,875	6.3%–8.05%	S: \$2,975 F: \$5,950	73%
250%–299%	S: \$28,725 – <34,470 F: \$58,875 – <70,650	8.05%–9.5%		70%
300%–399%	S: \$34,470 – <45,960 F: \$70,650 – <94,200	9.5%	S: \$3,967 F: \$7,933	70%
400%+	S: \$45,960+ F: \$94,200+	—	S: \$5,950 F: \$11,900	—

Four levels of cost-sharing: 1st tier (Bronze) actuarial value: 60%
 2nd tier (Silver) actuarial value: 70%
 3rd tier (Gold) actuarial value: 80%
 4th tier (Platinum) actuarial value: 90%

Catastrophic policy with essential benefits package available to young adults and people whose premiums are 8%+ of income

Notes: Actuarial values are the average percent of medical costs covered by a health plan. Premium and cost-sharing credits are for silver plan.

Source: Federal poverty levels are for 2013; Commonwealth Fund Health Reform Resource Center: What’s in the Affordable Care Act? (PL 111-148 and 111-152), <http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx>.



These new subsidized insurance options are complemented by a set of sweeping new insurance market reforms. The reforms include: requiring insurers to offer an essential health benefit package similar that offered in employer plans; banning insurers from charging people higher premiums based on health or gender; limiting what older people may be charged relative to younger people by a factor of 3:1; banning carriers from limiting or denying benefits because of preexisting health conditions; and requiring broad pooling of risk in state insurance markets to further reduce the ability of carriers to maintain higher rates on older or sicker enrollees.

Older Adults with Health Problems with Low and Moderate Incomes Will Face Far Lower Premiums in 2014 for Plans Offered Through the Marketplaces Compared with the PCIP Program

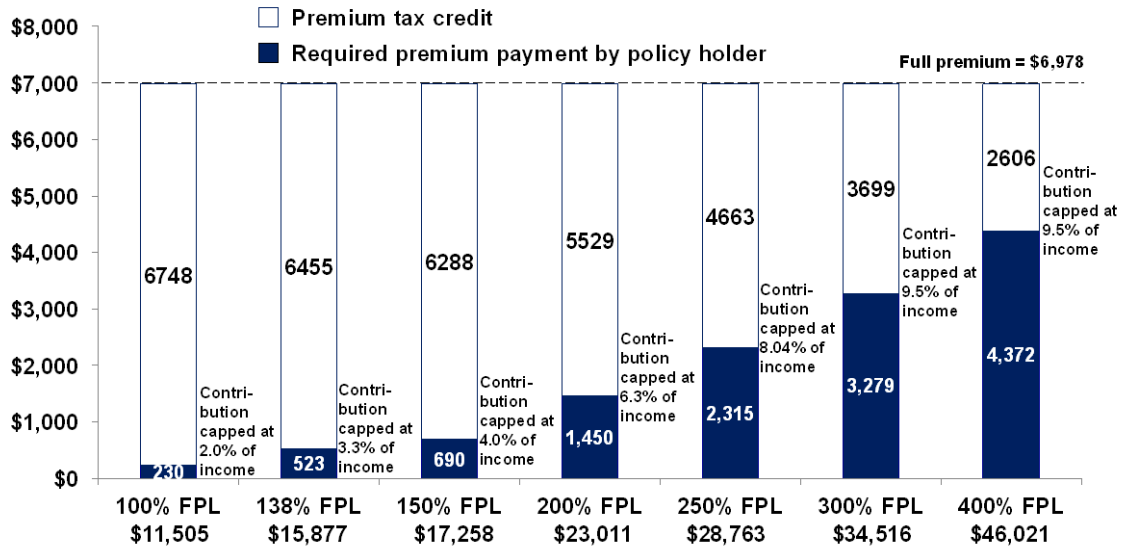
While the Affordable Care Act's insurance market reforms will finally make it possible for people with even minor health problems or who are older to purchase a health plan with a comprehensive benefit package at the same premium rate as a healthier person, the considerable subsidies will, also for the first time, level the playing field between the individual market and employer coverage for people with incomes under 400 percent of poverty. Under the reform law, taxpayers with incomes between 100 percent and 400 percent of poverty who do not have an affordable offer of health insurance through their jobs and are not eligible for Medicaid, will be eligible for insurance premium tax credits for private plans sold through the marketplaces. Over that income range, people eligible for the tax credits would contribute no more than 2 percent to 9.5 percent of their income toward their premium. The amount of the credit will be equal to the difference between someone's required premium contribution and the premium of the benchmark health plan—the second-lowest-cost “silver plan” offered through the marketplaces.³⁴ This means that someone may choose a plan that is not the benchmark plan, but the amount of the tax credit will be determined based on the premium for the benchmark plan, not the plan they enroll in, which could be less or more than the benchmark. In addition, the tax credit amount cannot exceed the amount of the full premium.

To illustrate, a 50-year-old man with an income of \$23,011 would be at 200 percent of the poverty level in 2014 (Exhibit 4). His required premium contribution would be 6.3 percent of his income, or \$1,450. The Kaiser Family Foundation estimates that his premium for a benchmark plan in a medium-cost area of the country would be about \$6,978. The man's tax credit would thus be equal to the benchmark premium minus his required contribution, or \$5,529. If he were 60, he would be charged a higher premium in the marketplaces. But the tax credit would also be higher, since his premium contribution is a fixed share of his income. At 200 percent of poverty, the 50-year-old man would also have an out-of-pocket limit of \$2,975. His plan, which would include the essential health benefit package, would cover on average 73 percent of his medical costs during the year (Exhibit 3).

³⁴ S. R. Collins, [“Proposed Rule on Premium Tax Credits: Who's Eligible and How Much Will They Help?”](#) *The Commonwealth Fund Blog*, Aug 2011.

Exhibit 4. Annual Premium Amount and Tax Credits for an Individual Plan Under the Affordable Care Act, 2014

Annual premium amount paid by policy holder and premium tax credit



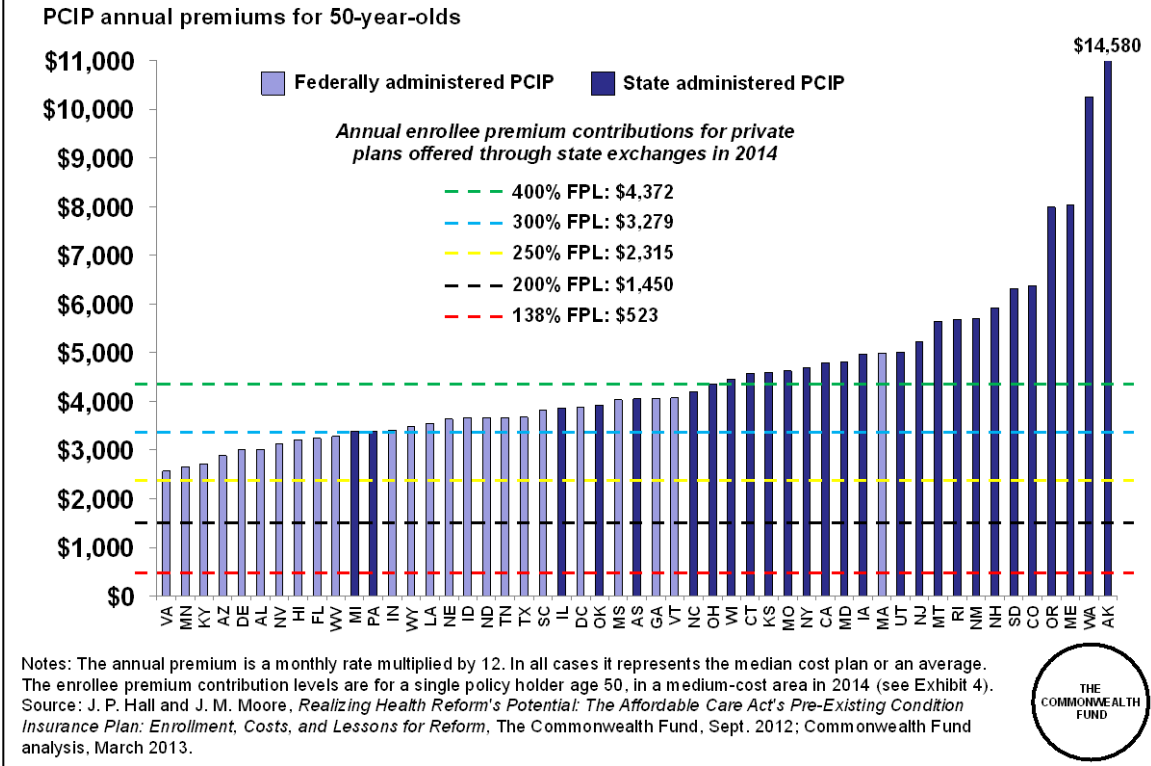
Notes: For single policy holder age 50, in a medium-cost area in 2014. Premium estimates are based on an actuarial value of 0.70. Actuarial value is the average percent of medical costs covered by a health plan. FPL refers to federal poverty level.

Source: Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator <http://healthreform.kff.org/Subsidycalculator.aspx>.



In contrast, annual premiums for 50-year-olds at this income level in the PCIP program are far higher in every state (Exhibit 5). Depending on the state that he lives in, the 50-year-old man in the example would face a premium for a PCIP plan that would exceed his contribution for a private plan offered through the marketplaces in 2014 by nearly two times in Virginia, which has the lowest PCIP premiums, to more than 10 times in Alaska, the state with the highest premiums.

Exhibit 5. PCIP Annual Premiums by State vs. National Average Premium Contributions for Plans Offered Through Exchanges



Conclusion and Policy Implications

The Pre-Existing Condition Insurance Plan Program has succeeded in offering transitional support for thousands of people who would otherwise be uninsurable in the individual insurance market. The 50-state program provided more affordable coverage than people could gain through most existing state high-risk pools, which operate in only 35 states. And it offered immediate coverage of preexisting conditions for people with serious health problems.

The program's low enrollment relative to the millions of uninsured Americans with serious chronic health problems reflects the program's lack of premium subsidies. This means that its potential benefits are out of reach for the vast majority of this population: 79 percent of the estimated 6.9 million people with a high-cost health problem who have been uninsured for at least six months have annual incomes of less than 400 percent of poverty; half have incomes of less than 200 percent of poverty.

The PCIP program's high costs relative to premiums reflect its intended purpose of providing immediate coverage of people with health problems. In this way, the program fulfilled its Congressional mandate and also made it a more costly program than even the existing state high-risk pools.

Federal and state policymakers can address the program's shortcomings in enrollment and costs by allowing its enrollees to transition to the new state insurance marketplaces and the expanded Medicaid program in January 2014, as Congress intended. All state high-risk pools are also likely to end operation in January. Enrollees from both programs will join an estimated 7 million new enrollees in the marketplaces next year, with a diverse age and health profile, which will help spread the costs of care across a much broader risk pool. Twenty-seven million people are expected to gain coverage through the marketplaces by 2018. The Congressional Budget Office estimates that the influx of younger and healthy people into the marketplaces and the individual market will lower premiums by 7 percent to 10 percent below what they are today in the individual market for an equivalent benefit package.³⁵ In addition, the CBO estimates that economies of scale and lower administrative costs from bans on underwriting will lower premium costs by an additional 7 percent to 10 percent under full implementation. A substantial nationwide reinsurance program that will go into effect next year will protect state marketplaces that experience a disproportionately large influx of high-cost enrollees.

One of the central goals of the Affordable Care Act is to pool risk in insurance markets far more broadly than is the case today in the United States. Extensive segmentation of risk in insurance markets has fueled growth in the number of uninsured Americans over the past several decades and has made the U.S. the industrialized world's unequivocal leader in the cost of insurance administration.³⁶ The experience of both the PCIP program and the state high-risk pools over their 40-year history underscores why a shared responsibility for health care costs across the population and the life cycle is essential for an equitable and efficiently run health insurance system.

Thank you.

³⁵ D. W. Elmendorf, Letter to the Honorable Evan Bayh (Washington, D.C.: Congressional Budget Office, Nov. 30, 2009).

³⁶ The Commonwealth Fund Commission on a High Performance Health System, [*Why Not the Best? Results from the National Scorecard on U.S. Health System Performance, 2011*](#) (New York: The Commonwealth Fund, Oct. 2011).