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Report to the Ranking Member, Committee on Health, Education, Labor, & Pensions, U.S. Senate

July 2011

PRE-EXISTING CONDITION INSURANCE PLANS

Program Features, Early Enrollment and Spending Trends, and Federal Oversight Activities

GAO-11-662

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Highlights

Highlights of GAO-11-662, a report to the Ranking Member, Committee on Health, Education, Labor, & Pensions, U.S. Senate

Why GAO Did This Study

Individuals applying for health insurance are often denied coverage due to a pre-existing condition. The Patient Protection and Affordable Care Act appropriated $5 billion to create a temporary pool—known as the Pre-Existing Condition Insurance Plan (PCIP) program—to provide access to insurance for such individuals until new protections take effect in 2014. Twenty-seven states opted to run their own PCIPs, while 23 states and the District of Columbia opted to let the Department of Health and Human Services (HHS) run the PCIPs for their residents. Initial projections of total enrollment varied from 200,000 to 375,000, and questions have been raised about funding, implementation, and oversight of this new program.

GAO examined (1) PCIP features, premiums, and criteria for demonstrating a pre-existing condition, (2) trends in PCIP enrollment and spending, including administrative costs, and (3) federal oversight activities. GAO reviewed PCIP benefits and rates; interviewed officials from selected state PCIPs, HHS, and the Office of Personnel Management (OPM), which assists HHS in administering aspects of the federally run PCIP; analyzed data provided by HHS and OPM; and examined contracts and interagency agreements.

In its comments, HHS emphasized its recent efforts to increase enrollment and provided technical comments, which GAO incorporated as appropriate.

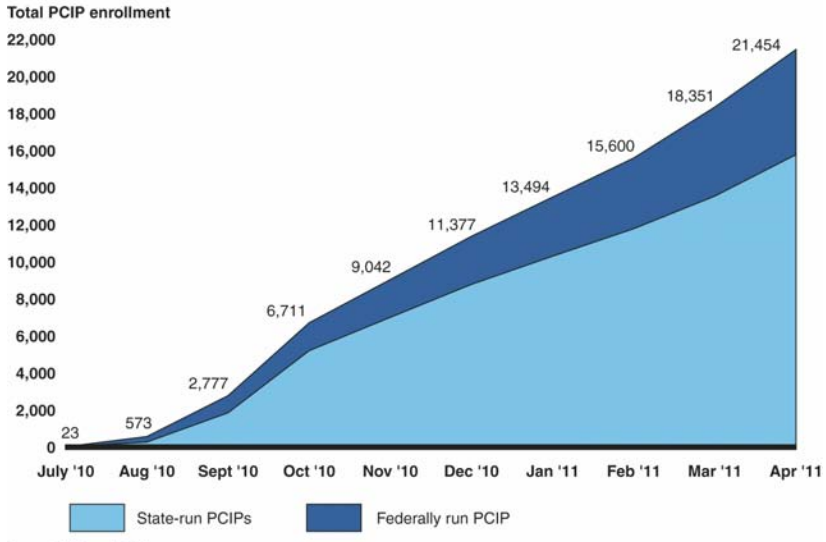
View GAO-11-662 or key components. For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

What GAO Found

State- and federally run PCIPs generally had similar cost sharing arrangements, although other features varied. Most states had annual deductibles falling within $1,000 to $2,999, with out-of-pocket limits at or near $5,950. Coverage limits were common but varied, both in terms of the benefits affected and the extent of the limits. Monthly premiums ranged considerably—from $240 in Utah to $1,048 in Alaska for a 50-year-old enrollee—and were generally lower in the federally run PCIP. Additionally, applicants in the federally run PCIP generally had fewer options to demonstrate a pre-existing condition—a criteria of program eligibility—than did those in the state-run PCIPs.

Enrollment and spending for state- and federally run PCIPs have been significantly lower than initial projections. As of April 30, 2011, enrollment had exceeded 21,000, ranging from 0 in one state to nearly 3,200 in another state. Factors contributing to low enrollment include the statutory requirement that enrollees be uninsured for 6 months prior to applying; premiums that may be unaffordable to many; and a lack of PCIP awareness. In response, HHS reduced premiums in the federally run PCIP states and increased its outreach efforts in 2011. Spending was also lower than projected—about 2 percent of total program funding had been spent, or about $78 million by state-run PCIPs and $26 million for the federally run PCIP.

Monthly Enrollment in State- and Federally Run PCIPs Remained Lower Than Initial Projections, Despite Increases



Source: HHS and OPM.

To provide for program oversight, HHS established contracts with states and the carrier selected to provide benefits for the federally run PCIP, which include numerous provisions to ensure program requirements are met. For example, the contracts require regular reporting of expense and enrollment data, and annual completion of independently audited financial reports. Also, HHS and OPM are engaged in ongoing oversight activities, such as reconciling the reported data, and HHS intends to conduct performance audits in the future.

Contents

Figures

Abbreviations

CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
GEHA	Government Employees Health Association, Inc.
HHS	Department of Health and Human Services
HRP	high-risk pool
HSA	health savings account
NFC	National Finance Center
OIG	Office of Inspector General
OPM	Office of Personnel Management
PCIP	Pre-Existing Condition Insurance Plan
PPACA	Patient Protection and Affordable Care Act

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Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

July 27, 2011

The Honorable Michael B. Enzi
Ranking Member
Committee on Health, Education, Labor, & Pensions
United States Senate

Dear Senator Enzi:

Those applying for health insurance in the individual markets of most states are often denied coverage or may be charged significantly higher premiums if they have a pre-existing medical condition.[1] The Patient Protection and Affordable Care Act (PPACA), which became law in March 2010, appropriated $5 billion toward the creation of a temporary federal high-risk pool, known as the Pre-Existing Condition Insurance Plan (PCIP) program. The PCIP program provides access to insurance for individuals unable to acquire affordable coverage due to a pre-existing condition.[2] States were given the option to run their own PCIP with federal funding, or to allow the Department of Health and Human Services (HHS) to administer the PCIP in their state. Twenty-seven states elected to administer a PCIP for their residents, while 23 states and the District of Columbia opted to allow HHS to administer their PCIPs. In order to implement various provisions of PPACA, including the PCIP program, HHS created the Center for Consumer Information and Insurance Oversight (CCIIO) in April 2010.[3] PCIP enrollment began as early as July 2010, and all PCIPs will run until December 31, 2013, after

[1]We previously reported that 19 percent of applicants in the individual market were denied enrollment and a quarter of insurers had denial rates of 40 percent or higher, based on data collected by HHS for the first quarter of 2010. See GAO, *Private Health Insurance: Data on Application and Coverage Denials*, GAO-11-268 (Washington, D.C.: Mar 16, 2011).

[2]Pub. L. No. 111-148, §1101(g), 124 Stat. 119, 143. The funds are available without fiscal year limitation.

[3]CCIIO was initially located within HHS and was known as the Office of Consumer Information and Insurance Oversight. Its name was changed to CCIIO in January 2011 when it was transferred to the Centers for Medicare & Medicaid Services.

which, the enrollees will be able to transition to a plan under their state's new health insurance Exchange.[4]

Early estimates of the number of people the PCIP program could cover varied. Before the program was implemented, the Congressional Budget Office estimated the program could cover an average of 200,000 individuals each year with the $5 billion appropriation.[5] The Office of the Actuary within the Centers for Medicare & Medicaid Services (CMS) projected enrollment of 375,000 by the end of 2010 and that funding would be exhausted by 2011 or 2012.[6] Concerns were raised that the number of individuals potentially eligible for this program may be significantly more than its capacity to serve them.[7] Also, given the new and unique nature of this federal program, there was uncertainty about whether there would be differences in the implementation or administration of the state- and federally run PCIPs, and an interest in ensuring appropriate oversight of the PCIPs.

Because of these questions, you asked us to examine several aspects of the PCIP program. In this report, we describe:

1. PCIP features, premiums, and criteria for demonstrating a pre-existing condition;

2. trends in enrollment and spending, including administrative costs, for state- and federally run PCIPs; and

3. federal oversight of the PCIP program.

[4]PPACA establishes new options for individuals to obtain health insurance coverage through the Exchanges starting in 2014, when insurers cannot deny such coverage for individuals with pre-existing conditions. *See* Pub. L. No. 111-148, Title I, Subtitle D, 124 Stat. 162 et seq., as amended by § 10104, 124 Stat. 896, et seq. Accordingly, PPACA requires HHS to develop procedures to transition PCIP enrollees to the Exchanges in 2014. Pub. L. No. 111-148, §1101(g)(3)(B), 124 Stat. 143.

[5]CBO subsequently estimated in June 2010 that if funding were not limited to $5 billion, enrollment could reach 700,000 by the end of 2013 at a cost of up to $15 billion.

[6]While HHS did not produce its own estimate of total enrollment, the agency indicated in its rule establishing PCIP requirements that between 200,000 and 400,000 individuals would likely enroll in the program.

[7]For example, The Commonwealth Fund estimated that about 6 million individuals were potentially eligible to enroll in a PCIP. See Jean Hall and Janice Moore, "Realizing Health Reform's Potential: Pre-existing Condition Insurance Plans Created by the Affordable Care Act of 2010," *The Commonwealth Fund*, vol. 100, pub. 1445 (2010).

To describe the PCIP benefits, cost sharing features, premiums, and criteria for demonstrating a pre-existing condition, we obtained 2011 PCIP benefit summaries and premium rate tables through the federal PCIP web sites and individual state PCIP web sites. In addition, we interviewed officials from HHS and the Office of Personnel Management (OPM), which is assisting CCIIO in the administration of the federally run PCIP. We also interviewed PCIP officials from eight states. We selected states with varying levels of enrollment based on data available in November 2010. We also included states that did and did not have an existing state high-risk pool (HRP).[8] (See table 1.)

Table 1: States Selected for Interviews, 2011

Lower enrollment		Higher enrollment	
Existing state high-risk pool	**No state high-risk pool**	**Existing state high-risk pool**	**No state high-risk pool**
Alaska	Maine	Illinois	Ohio
Connecticut	Michigan	North Carolina	Pennsylvania

Source: GAO.

To describe the enrollment and spending trends among the state- and federally run PCIPs, we obtained enrollment data as of April 2011 from HHS's web site, states' unaudited monthly reports from July 2010 through March 2011, and PCIP financial information from CCIIO. We also obtained enrollment and financial data from OPM for the federally run program covering the same period. To assess the reliability of the enrollment and spending data, we discussed with agency officials the steps taken by CCIIO and OPM to ensure data accuracy and completeness, and conducted our own logic testing, such as verifying internal agreement within a data source. We determined that the enrollment and spending data were sufficiently reliable for our purposes. We also discussed the enrollment and spending trends with officials from HHS, OPM, and the eight selected states. Because of the unaudited nature of the data, and because the data represent less than 1 year of a

[8]Thirty-five states operate high-risk pools that are separate from, and predate, the federal PCIP program. These risk pools similarly provide coverage for individuals without access to coverage due to a pre-existing medical condition, but differ from the PCIP program in certain ways. The existing HRPs collectively covered about 208,000 people as of December 2009. See "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis," Twenty-fourth edition, *National Association of State Comprehensive Health Insurance Plans,* 2010/2011.

newly established program, we do not make conclusions about long-term program enrollment and spending trends.

To describe the federal oversight of the PCIP program, we reviewed key documents from CCIIO, OPM, and state-run PCIPs. These documents included state- and federally run PCIP proposals and contracts; interagency agreement documents between HHS, OPM, and the National Finance Center (NFC);[9] the HHS request for proposal for selecting an insurance carrier for the federally run PCIP; and the PCIP regulations as promulgated by HHS. In addition, we discussed planned and actual oversight activities with officials from HHS, OPM, and the eight selected states. We conducted this performance audit from November 2010 through June 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

PPACA required HHS to establish the PCIP program within 90 days of enactment and set forth requirements for eligibility, coverage, and premiums. For example, PPACA limited PCIP enrollment to those who have a pre-existing condition and have been without creditable coverage[10] for at least 6 months prior to application. This requirement effectively prevents enrollment by those who were already insured, thus limiting the program to those who have likely been unable to access insurance because of their pre-existing health condition.[11] PCIP programs may not impose waiting periods for coverage based on the enrollee's pre-existing condition, and plan benefits must cover at least 65 percent of the cost of coverage without exceeding a statutory out-of-pocket spending

[9]NFC is a federal agency within the U.S. Department of Agriculture, which is assisting the federally run PCIP with processing applications and premium collection.

[10]Pub. L. No. 111-148, § 1101(a)-(d), 124 Stat. 141-142. Creditable coverage is defined for this purpose by §2701(c)(1) of the Public Health Service Act as coverage for an individual under: a group health plan, health insurance, Medicare Part A or B, Medicaid, the Indian Health Service, a state health benefits high-risk pool, the Federal Employees Health Benefits Program, the Peace Corps health benefit plan, or a public health plan as defined in regulations.

[11]Eligible PCIP applicants must also be a citizen, national, or lawfully present in the United States, as well as a resident of a state that falls within the PCIP service area.

limit, which was $5,950 for an individual in 2010 and 2011. PPACA required PCIP premiums to be set at 100 percent of the standard rate for a standard population in each state or market, and the premiums may vary only on the basis of age—by no more than a 4 to 1 ratio—geography, and smoking status.

The PCIP program was generally modeled after existing HRPs, but with some important distinctions. For example, unlike PCIPs, state HRPs do not require that individuals be without coverage for 6 months to be eligible. Once enrolled, however, many HRPs impose waiting periods of 6 to 12 months for coverage of the pre-existing condition, while PCIPs have no waiting periods.[12] Also, there is no federal limit on out-of-pocket expenses in existing HRPs. Finally, whereas PCIP premiums are limited to the standard rate in each state, existing HRPs typically offer premiums ranging from 125 to 200 percent of the standard rates available in their states.

To begin implementing the PCIP program, CCIIO determined states' funding allocations and issued regulations. In April 2010, CCIIO determined a state-by-state allocation of the total $5 billion PCIP appropriation, and asked states to indicate their interest in administering their own PCIP by April 30. The initial allocations were based on a formula similar to that used for the Children's Health Insurance Program with factors that reflected each state's population, number of uninsured individuals under age 65, and a geographic health care cost factor.[13,14] CCIIO issued an interim final rule on July 30, 2010 to provide further guidance on PCIP program requirements, although it allowed state-run

[12]Some individuals without pre-existing conditions may also be eligible for their states' HRPs. For example, about 28 percent of those enrolled in state HRPs in 2008 were individuals who were eligible because their state used its HRP as a mechanism to implement the group to individual market portability provision of the Health Insurance Portability and Accountability Act of 1996. See GAO, *Health Insurance: Enrollment, Benefits, Funding, and Other Characteristics of State High-Risk Health Insurance Pools*, GAO-09-730R (Washington, D.C.: July 22, 2009).

[13]The Children's Health Insurance Program is a joint state and federal program for uninsured children in families whose incomes are too high for Medicaid, but too low to afford private coverage.

[14]PCIP allocations ranged from $8 million for North Dakota, Vermont, and Wyoming to $761 million for California. CCIIO reserves the right to reallocate unused funds to states in future years from initial allocations and make adjustments as necessary to eliminate any potential deficit due to projected expenses exceeding a state's allocation.

PCIPs some flexibility in how they operated their programs.[15] For example, CCIIO identified options PCIPs may allow for applicants to demonstrate their pre-existing conditions, such as documentation of coverage denial by another carrier, an offer of coverage with a rider excluding a pre-existing condition, or a diagnosed medical condition or health condition approved by the state. The rule also prescribed that eligible individuals who submitted their complete applications before the fifteenth day of the month must be covered on the first day of the following month. All PCIPs were required to cover certain categories of services, such as physician and hospital services, mental health and substance abuse services, skilled nursing and home health care, preventive and maternity care, and prescription drugs.[16]

For the 27 states that chose to administer their own PCIPs, HHS directly contracted with states or their designated nonprofit entities, and obligated funds for calendar years 2010 and 2011. The contracts established that HHS would reimburse states or their designated entities for claims and administrative costs incurred in excess of the premiums they collected. HHS also established a limit on administrative costs of no more than 10 percent of each state's total spending over the lifetime of the program. The contracting process for states could also involve the selection of subcontractors to provide services, such as claims processing, pharmacy benefits management, or disease management. Two state-run PCIPs began coverage in July 2010, 9 states began coverage in August 2010, 12 states in September 2010, and the remaining 4 states in October 2010.

To implement the federally run PCIP for the 24 states that opted not to administer their own PCIP, HHS coordinated with other federal agencies and selected the Government Employees Health Association, Inc.

[15]75 Fed. Reg. 45014 (Jul. 30, 2010)(to be codified at 45 C.F.R. Part 152).

[16]75 Fed. Reg. 45030-45031 (to be codified at 45 C.F.R. §§ 152.14(c), 152.15(c), and 152.19(a)). The interim final rule also required all PCIPs to exclude certain services, including benefits for cosmetic surgery except to restore bodily function or correct a deformity; custodial care except for hospice care associated with the palliation of terminal illness; *in vitro* fertilization; abortion except when the life of the woman would be endangered or when a pregnancy resulted from an act of rape or incest; and experimental care except for clinical trials approved by the Food and Drug Administration. 75 Fed. Reg. 45031 (to be codified at 45 C.F.R. § 152.19(b)).

(GEHA) to administer the coverage benefits in these states.[17,18] In 2011, HHS offered three plans through GEHA—the Standard, Extended, and Health Savings Account (HSA) plans.[19] To assist with the administration of the federally run PCIP, CCIIO established interagency agreements with two federal agencies—OPM and NFC—that had experience administering the Federal Employees Health Benefits Program.[20] Under these agreements, OPM manages the daily operations with GEHA and NFC, and NFC performs administrative functions pertaining to eligibility determination and premium collection. GEHA was awarded a cost-plus-award fee contract, which established that HHS would reimburse GEHA for claims and administrative costs in addition to granting fixed and performance-based award fees.[21] Moreover, the agreements with OPM and NFC established that HHS would reimburse the administrative costs incurred by the two agencies. HHS began taking applications in July 2010, and coverage began in August 2010 in 21 states, in September 2010 in 2 states, and in October 2010 in 1 state.[22] (See fig. 1.)

[17]In this report, we will refer to the 23 states and the District of Columbia included in the federally run PCIP as "24 states."

[18]GEHA was selected from among 14 interested entities, several of which did not meet the statutory requirement of being nonprofit.

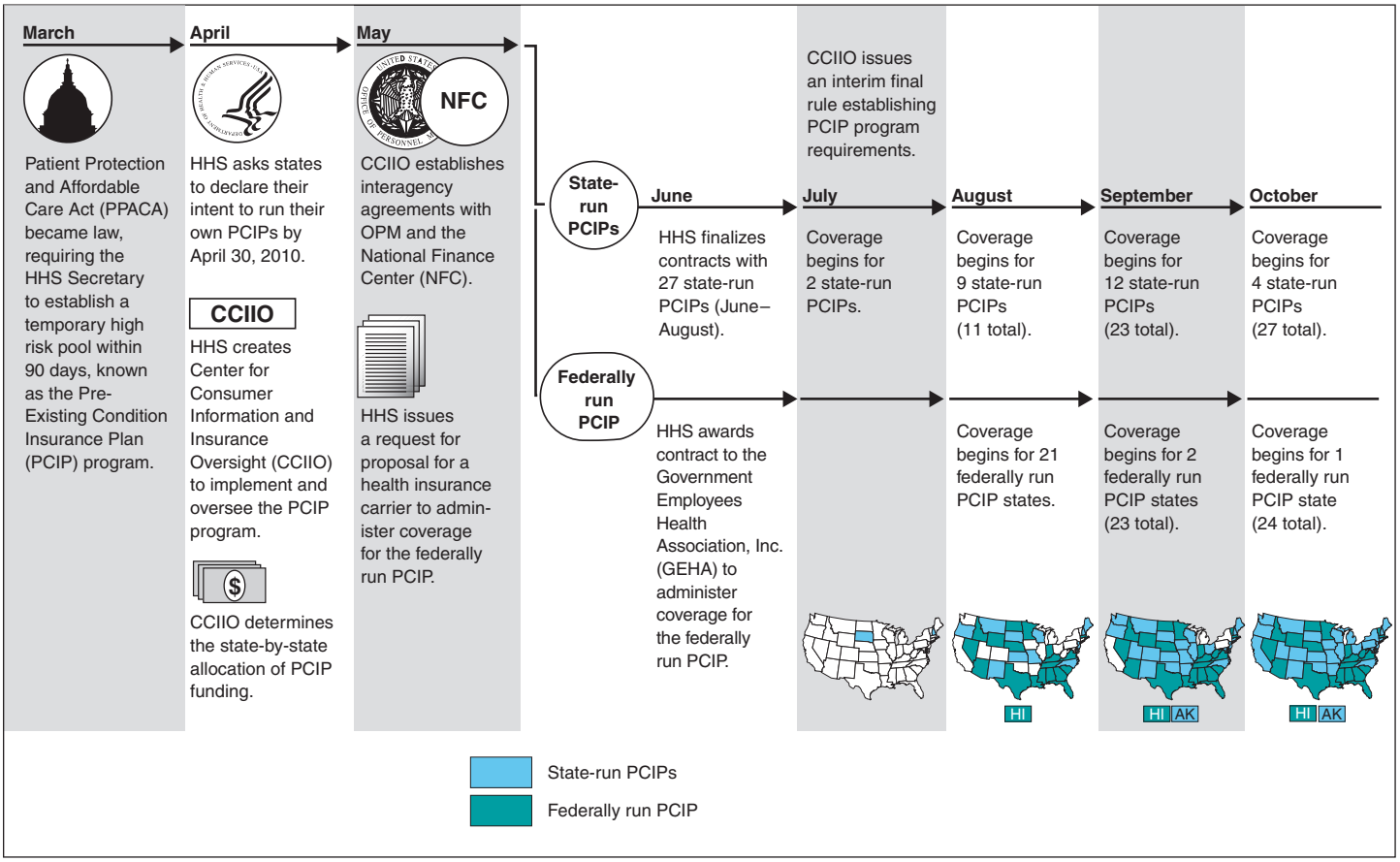
[19]These plan options each had different annual deductibles and premiums. An HSA is a type of consumer-directed health plan that combines a high-deductible health plan with a tax-advantaged savings account that enrollees use to pay for a portion of their health expenses.

[20]The Federal Employees Health Benefits Program covered nearly 8 million federal employees, dependents, and retirees in 2009.

[21]*See* 48 C.F.R. § 16.405-2 (2010)(Federal Acquisition Regulation §16.405-2). The fixed award fee was set at 5 percent of annual projected administrative costs. The incentive award fee was based on performance measures such as claims processing timeliness and accuracy, care management, and cost containment.

[22]According to HHS, PCIP coverage was delayed in the three states which began in September and October 2010 because they had initially told HHS they would operate their own state-run PCIP.

Figure 1: Implementation Timeline of the PCIP Program, 2010



Source: GAO.

The interim final rule set forth additional requirements for both state- and federally run PCIPs providing CCIIO the means to oversee the program and to promote its efficient and fair operation. For example, the rule requires PCIPs to establish procedures to identify and report instances of fraud, waste, and abuse, as well as cases of "insurer dumping"—that is, insurance carriers or employers discouraging high-risk individuals from remaining enrolled in their coverage so that they may instead enroll in a PCIP program.[23] In addition, state-run PCIPs operating in states that had

[23]75 Fed. Reg. 45032 (to be codified at 45 C.F.R. §§ 152.27 and 152.28).

an existing HRP were subject to a maintenance of effort provision, which required these states to maintain funding for the existing pool. Provisions relating to maintenance of effort and other requirements were included in contracts signed with states and nonprofit entities administering the PCIPs.[24]

PCIPs Generally Had Similar Cost Sharing, but Varied in Coverage Limits, Premiums, and Criteria for Demonstrating Pre-Existing Conditions

Health insurance plans offered by state- and federally run PCIPs generally had similar cost sharing features. Other PCIP features varied across states, such as coverage limits, premiums, and the criteria for demonstrating that an applicant had a pre-existing condition.

PCIPs Generally Had Similar Cost Sharing Features

Health insurance plans offered by state- and federally run PCIPs had similar cost sharing, including annual deductibles and out-of-pocket maximums. For example, the most popular plans available in most states had annual deductibles ranging from $1,000 to $2,999, out-of-pocket maximums at or near the legal maximum of $5,950, and coinsurance of 20 percent.[25] (See table 2.) In 2011, the 27 state-run PCIPs collectively offered 49 plans—15 out of the 27 states offered a single plan, 5 states offered 2 plans, and 7 states offered more than 2 plans. HHS offered 3 plans in the 24 federally run PCIP states—known as the Standard, Extended, and HSA plans.[26] See appendix I for PCIP cost sharing features by state.

[24]75 Fed. Reg. 45033 (to be codified at 45 C.F.R. §152.39).

[25]We define the most popular plans as those with the highest enrollment in each state.

[26]In 2011 the Standard and Extended plans offered separate deductibles for medical ($2,000 and $1,000, respectively) and prescription expenses ($500 and $250, respectively) whereas the HSA plan offered a combined medical and prescription deductible ($2,500). In 2010, HHS only offered the HSA plan; however, individuals who were enrolled in this plan were given the option to select one of the three plans in 2011. For enrollees who did not make a selection, CCIIO automatically transferred them into the 2011 Standard plan.

Table 2: Cost Sharing Features for the Most Popular PCIPs across All States, 2011

	Number of states		
Annual cost sharing features	**State-run PCIPs**	**Federally run PCIP**	**Total states**
Medical deductible			
Less than $1,000	4		**4**
$1,000-$1,999	11		**11**
$2,000-$2,999	9	24	**33**
$3,000 or more	3		**3**
Prescription deductible			
No deductible	22		**22**
$100-$499	2		**2**
$500	3	24	**27**
Out-of-pocket maximum			
$1,000-$2,999	4		**4**
$3,000-$4,999	4		**4**
$5,000-$5,950	19	24	**43**
Coinsurance			
Less than 20%	5		**5**
20%	18	24	**42**
More than 20%	4		**4**

Source: State- and federally run PCIP web sites.

Notes: In cases where a state-run PCIP offers more than one plan, we show the cost sharing features of the most popular plan in that state as of March 31, 2011. For the federally run PCIP, we show the cost sharing features of the Standard plan, the most popular of the three plan options.

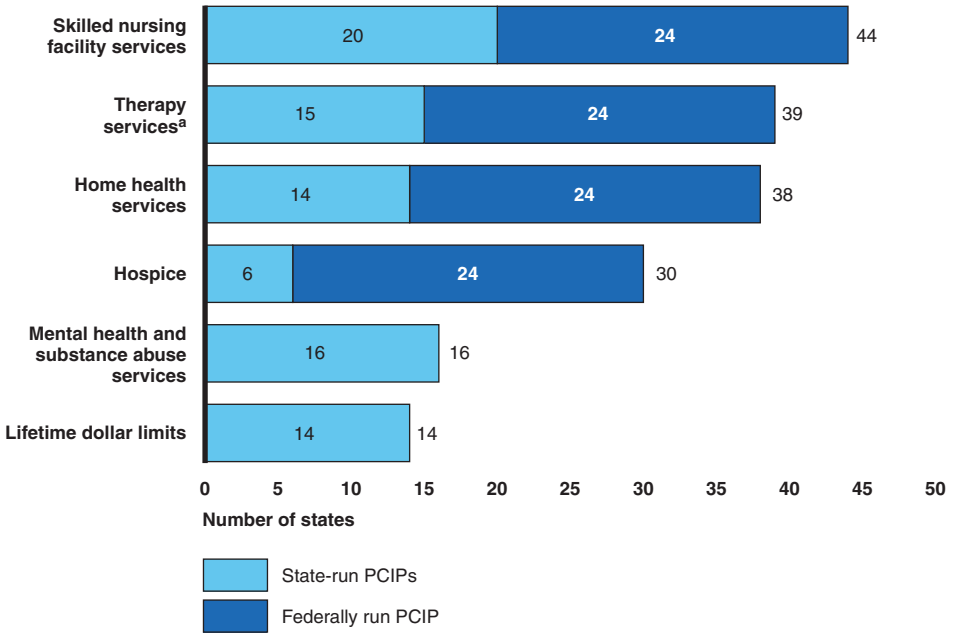
Coverage Limits, Premiums, and Criteria for Demonstrating Pre-Existing Conditions Varied across States

In 2011, almost all state- and federally run PCIPs had coverage limits for some benefits; however, the selected benefits and the extent of coverage limits varied.[27] (See fig. 2.) Most PCIPs imposed limits on skilled nursing, home health, and therapy services. For example, coverage limits for skilled nursing services in the state-run PCIPs ranged from 30 days to 180 days per year in Utah and Oklahoma, respectively. The federally run PCIP limited skilled nursing charges to $700 per day for up to 14 days

[27]Where state-run PCIPs offered more than one plan option, the coverage limits were generally the same across all plans, except for one state for which we present the limits for the most popular plan. Similarly, coverage limits were the same for each of the three plans offered by the federally run PCIP.

following an acute inpatient discharge. Limits on home health services ranged from 25 visits per year in the federally run PCIP states to 270 visits per year in Alaska's, Arkansas', and Illinois' state-run PCIPs. Most state-run PCIPs (17 out of 27) imposed coverage limits for mental health and substance abuse services, whereas the federally run PCIP did not have any limits for these services. For example, in California's state-run PCIP, adult enrollees were limited to 10 inpatient days and 15 outpatient visits per year for mental health disorders, and up to 20 visits per year for outpatient alcohol and drug treatment. Additionally, the federally run PCIP and 13 state-run PCIPs did not impose any lifetime dollar limits, whereas 14 state-run PCIPs had lifetime limits ranging from $1 million to $5 million. In addition to these common coverage limits, some state-run PCIPs also imposed limits on professional services, durable medical equipment, and hospital inpatient services.

Figure 2: Most Common PCIP Coverage Limits across All States, 2011



Source: State- and federally run PCIP web sites.

Note: Where state-run PCIPs offered more than one plan option, the coverage limits were generally the same across all plans, except for one state for which we present the limits for the most popular plan. Similarly, coverage limits were the same for each of the three plans offered by the federally run PCIP.

[a]Therapy services include physical, occupational, and speech therapy.

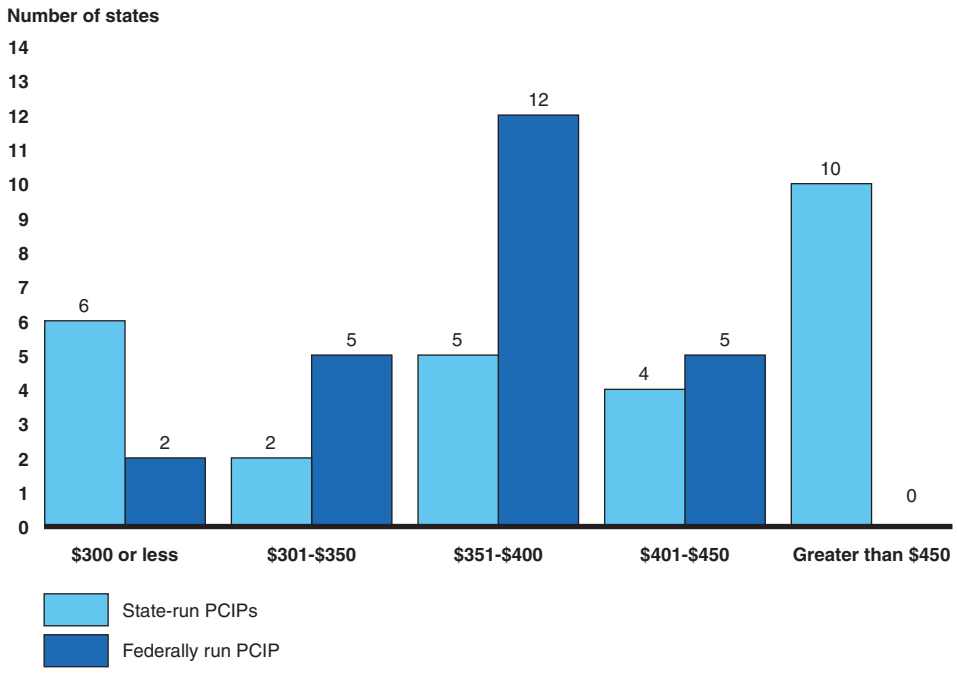
Premiums among PCIPs varied by age, state, and plan type, and premiums were on average higher among state-run PCIPs compared with the federally run PCIP. (See fig. 3.) As of June 2011, the average monthly premium for a 50-year-old person was $407 across all states, ranging from $240 in Utah to $1,048 in Alaska.[28,29] Monthly premiums among state-run PCIPs were 19 percent higher, on average, than the average premium for the same enrollee in the federally run PCIP Standard plan—$440 per month for a 50-year-old person compared to $370, respectively.[30] In 2010, however, average premiums among state-run PCIPs were 5 percent lower compared to the federally run PCIP—$431 per month versus $455.

[28]Premiums were based on rates available as of June 1, 2011. On May 31, 2011, HHS announced it would reduce PCIP premiums in 18 federally run PCIP states, beginning July 1, in order to more closely align premiums with each state's individual health insurance market. Premium reductions would range from 2 percent in one state to 40 percent in six states. See "HHS to Reduce Premiums, Make it Easier for American with Pre-Existing Conditions to Get Health Insurance," HHS news release (May 31, 2011), accessed June 1, 2011, www.hhs.gov/news/press/2011pres/05/20110531b.html.

[29]For state-run PCIPs that offered multiple plan options or varied premiums by geographic region, we calculated the average premium for a 50-year-old person across all regions for the most popular plan. If the state varied premiums by smoking status, we used premiums for nonsmokers. For the federally run PCIP states, we only included premiums for the Standard plan, which was the most popular plan in 2011. To average premiums across multiple states, we did not weight the premiums based on enrollment. Because the program is new and many states currently have limited enrollment, a weighted average would not accurately reflect the range of premiums enrollees face across all states.

[30]Comparable average monthly premiums for a 50-year-old in the HSA and Extended plans offered by the federally run PCIP were $385 and $498 in 2011, respectively.

Figure 3: Distribution of Average Monthly PCIP Premiums for 50-year-old Persons across All States, June 2011



Source: State- and federally run PCIP web sites.

Notes: For state-run PCIPs that offered multiple plan options or varied premiums by geographic region, we calculated the average across all regions for the most popular plan for a 50-year-old person. If the state varied premiums by smoking status, we used premiums for nonsmokers. For the federally run PCIP, we used the premiums for the Standard plan for this analysis because it was the most popular plan option.

On May 31, 2011, HHS announced in a news release that it would reduce premiums in 18 federally run PCIP states beginning July 1, 2011, in order to more closely align premiums with each state's individual health insurance market.

Eleven state-run PCIPs charged higher premiums for smokers, and seven state-run PCIPs varied premiums by geographic regions within the state. Conversely, the federally run PCIP did not vary premiums by smoking status or geographic regions within states. Furthermore, in developing their standard rates, state-run PCIPs typically based their rates on a survey of top insurance carriers in their states, whereas HHS and OPM calculated the rates for the federally run PCIP states based on premiums

charged by existing state HRPs.[31] See appendix II for the premium rates for the most popular PCIPs by state.

Until July 1, 2011, applicants for the federally run PCIP generally had fewer options available to demonstrate their eligibility based on a pre-existing condition than did those in the state-run PCIPs. In the federally run PCIP, applicants could demonstrate the criteria by providing documented evidence in one of two ways: (1) a denial letter indicating refusal of coverage by an insurance carrier; or (2) an offer of insurance with a rider that excluded coverage for a pre-existing condition.[32] Additionally, within the federally run PCIP, all children under age 19 had the option to provide documented evidence of an offered plan with premium rates at least twice that of the PCIP Standard plan premium rates offered in their respective states.[33] On May 31, 2011, HHS announced in a news release that beginning July 1, 2011, applicants could demonstrate their pre-existing condition by providing a letter from a health care provider dated within the previous 12 months documenting a current or past diagnosed medical condition.[34]

[31]Officials from the states that we interviewed generally described their methodologies for determining the standard rates as follows: (1) survey top insurance carriers in the state for the rates of benefit plans comparable to the PCIP plans; (2) make actuarial adjustments to account for differences in factors such as benefits, age bands, and regions; and (3) take an average—straight or weighted—of the adjusted rates. In contrast, the standard rates for the federally run PCIP were based on premiums charged by 24 existing HRPs—specifically, by calculating a median of each state's standard rate, adjusted for differences in plan benefits and to be age and gender neutral. The premiums were then divided into four age bands and adjusted to account for geographic cost differences across states. Finally, an estimate of per member per month administrative costs was added to the premium amounts.

[32]The denial letter can also be from an insurance agent or broker indicating that the applicant is ineligible due to a medical condition. Effective with applications received on or after January 11, 2011, the letter or offer must be dated within 12 months prior to the date of application.

[33]Applicants in Massachusetts and Vermont were eligible if they could provide proof of an offered plan within the 12 month period prior to their PCIP application that charged premiums at least two times the PCIP premiums in their states. This option was available to enrollees in Massachusetts and Vermont specifically because these states have guaranteed issue laws that prohibit health insurance denials based on health status or medical condition.

[34]Accessed June 1, 2011, www.hhs.gov/news/press/2011pres/05/20110531b.html. This option became available for children under age 19 in February 2011.

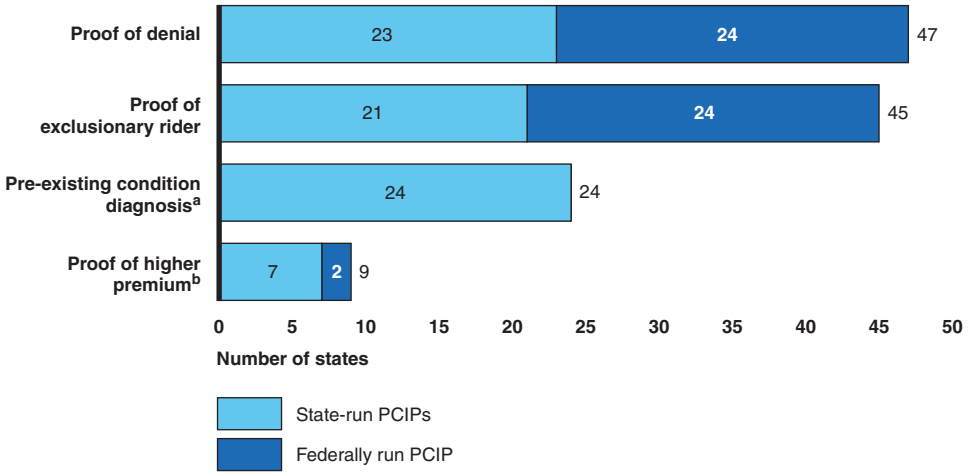
In contrast, most state-run PCIPs have allowed three options to demonstrate a pre-existing condition since their inception. Similar to the federally run PCIP, most state-run PCIPs allowed applicants to document their pre-existing condition by submitting a notice of denial or an offer of coverage with a rider excluding the condition.[35] In addition, 24 state-run PCIPs allowed applicants to provide documentation from a health care provider of a medical condition on the state's pre-existing condition list.[36] Additionally, seven states accepted evidence of an offered health plan with premiums higher than the PCIP premiums available to the same applicant in those states.[37] Considering the four options above, 20 states accepted at least three options, including 5 states that accepted all four options for demonstrating a pre-existing condition. (See fig. 4.) See appendix III for the criteria allowed for demonstrating a pre-existing condition in each state.

[35]The number of required denial letters varied from state to state.

[36]In these states, applicants were required to provide a letter from a health care provider to qualify their condition based on a presumptive list of pre-existing conditions. Some states allowed applicants to submit letters from providers that documented a medical condition not on the state's condition list, for which the state would review the condition on a case-by-case basis. Some states, however, did not have a condition list, in which case, the state considered a provider's letter documenting a diagnosed condition.

[37]States determined how much higher the premium must be compared to those offered by the state's PCIP. For instance, New Mexico accepted proof of offered coverage with premiums that are at least 25 percent higher than the state's standard rate for similar deductible options.

Figure 4: Criteria for Demonstrating Pre-existing Conditions Across All States, June 2011



Source: State- and federally run PCIP web sites.

Note: On May 31, 2011, HHS announced in a news release that beginning July 1, 2011, applicants living in the 24 federally run PCIP states would be able to demonstrate their pre-existing condition by submitting a letter from a doctor, physician assistant, or nurse practitioner stating that they have or, at any time in the past, had a medical condition, disability, or illness.

[a]Most states required documentation of a diagnosed medical condition that is included on the state's list of presumptive conditions, although some considered documentation of conditions not on the list on a case-by-case basis. States that did not have a list of presumptive conditions, however, considered a provider's letter documenting of a diagnosed medical condition.

[b]States determined how much higher the premium must be compared to those offered by the state's PCIP. For instance, New Mexico accepted proof of offered coverage with premiums that are at least 25 percent higher than the state's standard rate for similar deductible options. Individuals in two federally run PCIP states—Massachusetts and Vermont—who were offered plans with premiums that were at least twice as high as the premiums for the federally run PCIP Standard plan in each state would meet the criteria for demonstrating a pre-existing condition.

PCIP Enrollment and Spending Remain Significantly Lower Than Initial Projections, Though Enrollment Has Increased Steadily

As of April 2011, enrollment in state- and federally run PCIPs was significantly lower than projected, though it has increased steadily. To increase awareness of the program, HHS and states have undertaken a variety of outreach efforts. Consistent with the low enrollment, spending has also been lower than projected.

PCIP Enrollment Remains Lower Than Projected but Has Increased Steadily

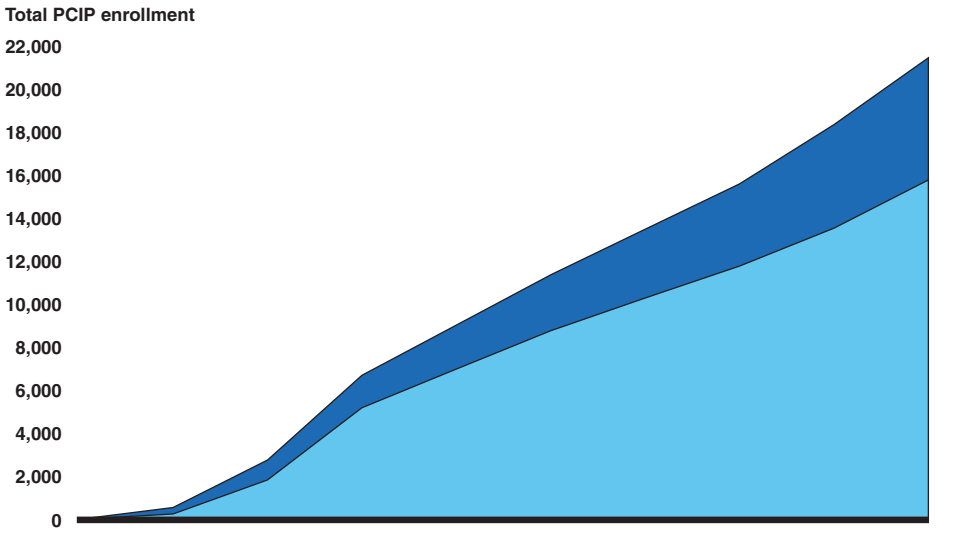
Early PCIP enrollment has been significantly lower than initially projected. By November 2010, after about 4 months of coverage, total PCIP enrollment was about 9,000, and increased to nearly 21,500 by April 2011, ranging from 0 in Vermont to nearly 3,200 in Pennsylvania. Initial projections of average monthly enrollment made in 2010 were about 71,500 for state-run PCIPs and about 78,000 for the federally run PCIP.[38] As of April 30, 2011, actual enrollment totaled about 15,800 in the state-run PCIPs and about 5,700 in the federally run PCIP. (See fig. 5.) This represents 5.6 people per 10,000 uninsured living in the 27 state-run PCIP states and 2.5 per 10,000 uninsured living in the 24 federally run PCIP states.[39] Enrollment in PCIPs was evenly split between males and females and the majority of enrollees were age 45 or older.[40] See appendix IV for additional information on state-level PCIP enrollment.

[38]State PCIP enrollment estimates were provided for the calendar year ending December 31, 2010, while estimates for the federally run PCIP were based on the fiscal year ending September 30—39,000 average monthly enrollment in fiscal year 2010 and 78,000 for fiscal year 2011.

[39]Estimates of the uninsured populations were based the U.S. Census Bureau's Current Population Survey, 2010 Annual Social and Economic Supplement.

[40]Based on the state-run PCIPs that had accurate demographic data, about 53 percent were female and 59 percent were age 45 or older, as of March 2011. Similarly, in the federally run PCIP, 52 percent of enrollees were female, and 67 percent were age 45 or over.

Figure 5: Monthly Enrollment in State- and Federally Run PCIPs, July 2010 through April 2011



	July '10	Aug '10	Sept '10	Oct '10	Nov '10	Dec '10	Jan '11	Feb '11	Mar '11	Apr '11
State-run PCIPs	23	274	1,853	5,205	7,002	8,781	10,300	11,784	13,543	15,781
Federally run PCIP	0	299	924	1,506	2,040	2,596	3,194	3,816	4,808	5,673
Total	**23**	**573**	**2,777**	**6,711**	**9,042**	**11,377**	**13,494**	**15,600**	**18,351**	**21,454**

Source: HHS and OPM.

We found that lower than expected enrollment may be attributed to five factors: (1) the statutory requirement that applicants be uninsured for 6 months prior to applying, (2) affordability concerns, (3) a lack of awareness about the program, (4) the processes used for determining eligibility, and (5) existing state laws or state-supported health insurance programs.

1. *Statutory requirement that applicants be uninsured for 6 months*: Officials from several state-run PCIPs told us they considered this requirement to be a barrier to eligibility. Based on applications data received from CCIIO, 45 percent of denials for state-run PCIPs and 69 percent of denials for the federally run PCIP were due to the applicant having creditable health coverage within the previous 6 months. Other individuals likely did not apply because they had creditable coverage within the prior 6 months and knew they were not eligible.

2. *Affordability concerns*: CCIIO and state PCIP officials told us they considered the cost of premiums—which were required to be set at 100 percent of the standard market rate, and averaged $407 per month in June 2011—to be unaffordable for many. In its May 31, 2011 news release, HHS announced it would reduce PCIP premiums in 18 states with a federally run PCIP beginning July 1, which may improve the affordability in those states.

3. *Lack of awareness of the PCIP program*: PCIP officials cited several possible reasons for why awareness about the program has been low. First, PCIP officials explained that the quick roll-out of the program allowed little time to focus on marketing and outreach, and that the agency intentionally limited initial marketing activities in an effort to avoid enrolling more individuals than the plan could support. Further, PCIP officials also said that, compared to other populations targeted by federal programs (such as low-income children), the segment of the uninsured population with pre-existing conditions has been difficult to identify and target. Additionally, hospitals and providers are generally less familiar with the individual insurance market and where to refer uninsured individuals.

4. *Processes used for determining eligibility*: Lower enrollment in the federally run PCIP states may be due, in part, to the fact that applicants only had two options to demonstrate their pre-existing condition through June 2011, whereas most state-run PCIPs allowed three or more options. Most notably, the federally run PCIP did not use a pre-existing condition list, and required applicants to provide proof of denial or an offer of coverage with an exclusionary rider from another insurance carrier, which could have imposed additional burden. We found that over half of new enrollees in state-run PCIPs demonstrated their pre-existing condition by providing evidence of a diagnosed condition on their state's list. In its May 31, 2011 news release, HHS announced that beginning July 1, 2011, applicants living in the
24 states in the federally run PCIP would be able to demonstrate their pre-existing condition by submitting a letter from a provider documenting a current or past diagnosed medical condition.

5. *Existing state laws or state-supported health insurance programs without pre-existing condition limitations*: PCIP enrollment has likely been affected by state health insurance laws. For example, five states—Maine, Massachusetts, New Jersey, New York, and Vermont—have guaranteed issue laws that prohibit health insurance denials based on health status or medical condition, which may have

contributed to low PCIP enrollment in these states. PCIP enrollment may also be lower in states that offer other state-funded health insurance programs that do not impose pre-existing condition limitations. For example, PCIP officials from Connecticut and Maine told us that they attribute low PCIP enrollment, in part, to the availability of alternative health insurance programs in their states that provide lower cost coverage for individuals without imposing any restrictions for those with pre-existing conditions. Similarly, controlling for differences in state populations of uninsured individuals, enrollment was lower among the states with an existing HRP compared to the states that did not have an existing pool—3.7 per 10,000 uninsured compared to 5.5, respectively.[41]

In efforts to improve the affordability of PCIP coverage and to increase awareness of the program, CCIIO lowered PCIP premiums and undertook additional marketing and outreach efforts beginning in 2011. Compared to 2010 premiums, CCIIO lowered 2011 premiums for adults in the federally run PCIP Standard plan by about 19 percent, and intends to further lower premiums, ranging from 2 percent to 40 percent, in 18 states beginning July 1, 2011. HHS also added rates for children under 19 beginning in 2011, which allowed these enrollees to pay lower premiums than they would have paid in 2010.[42] CCIIO's outreach efforts included educating various referral sources about the PCIP program—that is, those who most often interact with potential PCIP applicants, such as disease advocacy groups, provider groups, and state officials. In addition, CCIIO conducted several nationwide webinars, distributed posters and brochures, and coordinated with the Social Security Administration to contact individuals applying for disability insurance.[43] Since integrating as part of CMS in 2011, CCIIO and CMS have coordinated to conduct PCIP outreach at over 100 events and conferences. In addition, HHS

[41]Existing high-risk pools collectively covered about 208,000 people in 2009.

[42]Premiums for a 50-year-old in the 2011 Standard and HSA plans were 19 and 15 percent lower, respectively, than the single plan offered in 2010, while premiums for the Extended plan were 10 percent higher. The new child-only premiums were 46 and 44 percent lower for the Standard and HSA plans, respectively, and 27 percent lower for the Extended plan in 2011, compared to what they would have paid in 2010.

[43]The Social Security Administration has included a paragraph about the PCIP program in its mailings to all applicants for Social Security Disability Income and Supplemental Security Income. It received over 3.2 million disability applications in fiscal year 2010. Most individuals entitled to disability income must wait 2 years before qualifying for Medicare, during which time they could be eligible for a PCIP.

announced in February 2011 that several large carriers had volunteered to include PCIP information in all insurance denial letters,[44] and the agency announced in its new release on May 31, 2011 that beginning in fall 2011, HHS will begin paying health insurance agents and brokers a referral fee for successfully enrolling individuals in a PCIP. Further, PCIP officials told us they were actively procuring media and grassroots outreach contracts.

In contrast to federal outreach efforts, many state-run PCIPs undertook multiple marketing and outreach efforts early on. Officials we interviewed from all eight states told us they conducted outreach to referral sources, such as advocacy and provider groups. Officials from six states told us they leveraged free media outlets, such as news articles or local television coverage, through the use of press announcements or media events; five used paid radio, television, or print advertisements; and four paid agent referral bonuses. The amount of money states have spent on marketing varies, with one state spending as much as $1.1 million and others spending nothing. Any spending on marketing is limited by the 10 percent cap on administrative expenditures.

States and HHS Spent about 2 Percent of Total Program Funding by March 2011

As of March 31, 2011, federal expenditures for the PCIP program totaled about $106 million, significantly lower than projections. Specifically, state-run PCIPs collectively expended about $78 million as of March 31, 2011, and HHS expended almost $26 million for the federally run PCIP and about $1.6 million for its own administrative expenses, which together represented about 2 percent of the total $5 billion appropriation. (See table 3.) Related to lower-than-expected enrollment, expenditures have been significantly lower than projections. State-run PCIPs had initially projected that they would collectively spend about $123 million in calendar year 2010 and over $644 million in 2011. Initial spending projections for the federally run PCIP were nearly $71 million in fiscal year 2010 and over $555 million in fiscal year 2011. While spending varied across states, according to CCIIO officials, it is too soon to predict whether they will need to reallocate funds. See appendix IV for additional information on state-level PCIP expenditures.

[44]See “Uninsured Americans with Pre-existing Conditions Continue to Gain Coverage through Affordable Care Act,” HHS news release, issued February 10, 2011, accessed February 11, 2011, http://www.hhs.gov/news/press/2011pres/02/20110210a.html.

Table 3: Expenditures for State- and Federally Run PCIPs, through March 31, 2011

PCIP type	Paid claims	Paid administrative expenses[a]	Total expenses (paid claims and administrative expenses)	Premium revenue	Expenditures net of premium revenue
State-run	$81,338,650	$19,620,486	$100,959,136	$22,622,210	$78,336,926
Federally run	27,360,116	5,267,351	32,627,467	6,824,441	25,803,026

Source: HHS.

[a]Administrative expenses for state-run PCIPs include fees for claims processing, eligibility screening, and personnel and marketing costs, among other expenses. Administrative expenses for the federally run PCIP include GEHA's administrative expenses and payments to OPM. HHS does not track administrative expenses by state in the federally run program.

On average, state-run PCIPs spent about 19 percent of their total expenditures on administrative expenses as of March 31, 2011. In sum, state-run PCIPs spent the most on marketing, eligibility screening, claims processing, personnel costs, and "other" costs, which included such expenses as case and utilization management, consultant services, audit fees, and pharmacy benefits management. According to state PCIP officials we spoke to, it is expected that administrative expenditures as a percentage of program spending will drop to below 10 percent of total expenditures over the lifetime of the program that was established in the interim final rule.

Administrative expenditures by the federally run PCIP were incurred by federal agencies and GEHA, and represented about 16 percent of its total spending as of March 31, 2011. Specifically, OPM received interagency payments totaling $2.2 million to manage the daily operations with GEHA and NFC, though according to CCIIO officials, OPM had only expended a portion of the funds and will return any unused funds to HHS. NFC is authorized to receive up to $63.7 million through fiscal year 2011 to conduct eligibility screening and premium collection, though as of March 31, 2011, the agency had not withdrawn any funds from HHS. Administrative expenses also included payments to GEHA to reimburse its incurred costs for such items as claims processing, customer service, and member materials.[45] In addition, GEHA received $865,000 in payment for its contractual fixed award fee, which was set at 5 percent of projected administrative costs.[46] Due to lower than expected enrollment,

[45]The terms of the federal contract prohibit GEHA from paying for advertising.

[46]Award payments were based on projected, rather than actual, costs in order to deter fraudulent over-runs by the contractor.

actual administrative costs were only 13 percent of projections in 2010, and thus projections were revised significantly downward for 2011 to about $6 million with a fixed award fee of $296,400.[47]

Federal Oversight Activities Intended to Ensure Compliance with PCIP Program Requirements Are in Place or Being Planned

Contained in the contracts CCIIO established with states and GEHA are provisions intended to help CCIIO assure program requirements are met. Three federal agencies—CCIIO, OPM, and HHS Office of Inspector General (OIG)—are currently engaged in or planning oversight activities.

CCIIO Established Contracts Intended to Ensure Key Program Requirements Are Met

The contracts HHS signed with states and GEHA to provide PCIP coverage are a primary means to ensure that the state- and federally run PCIPs are implemented efficiently and as intended.

State-run PCIP contracts

For state-run PCIPs, CCIIO developed a model contract requiring states, or their non-profit designees implementing the PCIP on their behalf, to conduct key activities consistent across all states.[48] The contracts formalized and operationalized the federal requirements established in PPACA and the interim final rule. For example, state-run PCIPs are contractually required to:

- verify that the enrollee meets all PCIP eligibility criteria;

[47]In addition to the fixed award fee, GEHA was also authorized to receive an incentive award fee based on plan performance. According to the original contract, GEHA could earn up to an additional 5 percent of annual projected administrative costs ($791,000 in 2010), based upon 21 performance measures, such as claims processing timeliness and accuracy, care management, and cost containment. However, given the lower than expected enrollment and incurred administrative expenses, the terms of the contract were renegotiated, and GEHA was paid an incentive award of $79,100 for 2010. According to OPM officials, the difference was placed into a "bonus pool" that GEHA may receive in future years based on performance.

[48]In addition, each state's approved PCIP proposal was incorporated into the contracts by reference.

- implement disease and utilization management procedures to ensure enrollees receive necessary but cost-effective care;
- establish a detailed claims database that tracks each covered service;
- develop operating procedures to detect and report to CCIIO incidences of fraud, waste, abuse, and insurer dumping;
- notify CCIIO if enrollment reaches 75 percent of projected levels or if the state expects its expenses to exceed its allotted funding, and develop a mitigation strategy to control costs, which may include raising premiums, reducing benefits, or capping enrollment, as approved by CCIIO;
- submit monthly cost reports—certified as being accurate and complete—with information on administrative expenses, paid claims, premiums collected, and withdrawals from HHS;
- provide CCIIO with an independently audited financial report detailing all PCIP finances by June 30 of each year, 2011 through 2013, in accordance with the state's standard accounting practices or generally accepted accounting principles.

Additionally, states with existing high-risk pools were required to segregate PCIP funding from expenditures associated with the operation of the existing pool, and to comply with the maintenance of effort requirement that they maintain funding for their existing high-risk pools. CCIIO required that states include in their proposals a description of how they would comply with the maintenance of effort requirement and stipulated in the signed contracts that any state-run PCIP shall notify the agency of any changes in the state's funding levels or methods of the existing pool.[49]

[49]CCIIO gave states latitude in determining how they could satisfy the maintenance of effort provision. For example, a state could maintain its total or per capita funding of the existing HRP, or maintain the mechanism by which it collects funds from insurance carriers in the state. The state must attain approval from the Secretary of HHS to alter the funding mechanism.

Federally run PCIP contract

For the federally run PCIP, GEHA was generally subject to contractual requirements similar to those applied to state-run PCIPs, such as implementing disease and utilization management, reporting cases of fraud or insurer dumping, and submitting regular cost reports. As do the state-run PCIPs, GEHA is also required to submit independently audited financial statements each year. Notable differences from the state PCIP contracts included provisions related to periodic data reporting and reporting of fraud, waste, and abuse. Rather than the monthly cost reports required of state-run PCIPs, GEHA is required to report similar information biweekly, including claims and administrative expenses and a reconciliation of expenditures to withdrawals from HHS. Regarding fraud, waste and abuse, HHS stipulated additional requirements for GEHA—specifically that it would annually (by March 31) report detailed information on the disposition and dollar amounts associated with any identified cases. In the first such report required, GEHA identified one active case.

Three Federal Agencies Are Engaged in or Planning Future Oversight Activities

CCIIO is engaged in or planning a range of PCIP oversight activities. While ultimately responsible for the entire program, CCIIO also relies on OPM in its capacity as administrator of the contract with GEHA to perform oversight. Additionally, the OIG is considering its role.

CCIIO, in its role directly overseeing state-run PCIPs, relies on several mechanisms to monitor their compliance and performance. For example, according to CCIIO officials, the agency uses the data provided by state-run PCIPs in their monthly reports to conduct comparisons between projected and actual costs, and reported withdrawals of federal funds. According to CCIIO officials, the agency also conducts a more formal annual reconciliation in March of each year to compare state-reported claims and state-reported withdrawals with records of actual withdrawals from HHS's Payment Management System. CCIIO notifies any state with identified discrepancies, asking them to correct or clarify the difference. For example, as part of its first reconciliation, CCIIO identified a small number of states for which reported withdrawals did not match records from HHS's Payment Management System in a given month. In addition, CCIIO officials said they will examine the independently audited financial statements each state-run PCIP is required to provide by June 30th of each year. In addition to financial audits, CCIIO officials stated that they are developing a performance audit strategy, which will include oversight of enrollment, disenrollment, spending as a percentage of allocated funds, and other performance metrics. To identify which states to review, CCIIO officials told us they will conduct a risk assessment of state-run

PCIPs based on such factors as enrollment, premium revenue, claims expenditures, and applicability of the maintenance of effort provision.

OPM, as the agency overseeing GEHA's day-to-day operation of the federally run PCIP, reviews GEHA's compliance with contractual requirements and its financial reports. According to OPM officials, they monitor GEHA's daily reimbursements from HHS and request detailed information when needed to explain any unusually high claims. OPM also plans to review the annual independently audited financial report to compare claims and administrative expenses to the withdrawal of federal funds. OPM is also responsible for reviewing GEHA's reported performance measures and determining the amount of its incentive award fee. While GEHA's performance is self-reported, the systems it relies on to calculate performance will be evaluated by an independent auditor as part of its annual financial audit, according to OPM officials.

Finally, the OIG has authority to initiate reviews of state or federal PCIPs at its discretion, per the signed contracts with state PCIPs and GEHA. Although still in the planning phase, OIG included in its fiscal year 2011 work plan an evaluation of the methods used across the PCIP program (state and federal) to prevent and identify fraudulent health care claims. An OIG official told us in May 2011 that it is reconsidering whether to conduct the audit given lower than expected enrollment in the program.

Agency Comments

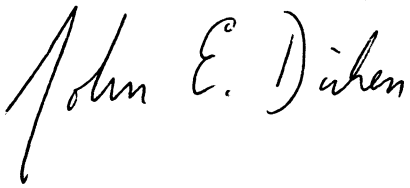
We provided a draft of this report to HHS for comment, and received a written response, which is included in this report as appendix V. In commenting on the draft, HHS emphasized our findings addressing its recent and planned efforts to increase enrollment by expanding outreach activities, providing additional ways for applicants to demonstrate eligibility, and reducing premiums. Regarding our finding that administrative costs incurred by the federally run and some state-run programs have exceeded 10 percent of total expenditures during the first year, HHS said that it anticipates administrative costs will average 10 percent or less of total expenditures over the life of the program as required by the interim final rule, and will continue to monitor those costs closely.[50] HHS also provided technical comments, which we incorporated as appropriate.

[50] *See* 75 Fed. Reg. 45032 (to be codified at 45 C.F.R. § 152.32).

As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days after its issuance date. At that time, we will send copies of this report to the Secretary of Health and Human Services, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. In addition, the report will be available at no charge on the GAO web site at http://www.gao.gov.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VI.

Sincerely yours,



John E. Dicken
Director, Health Care

Appendix I: Pre-Existing Condition Insurance Plan (PCIP) Cost Sharing Features by State, 2011

State	Date PCIP first became effective	In-network medical deductible	In-network prescription deductible	In-network coinsurance	In-network out-of-pocket limit	Lifetime limit
			State-run PCIPs			
Alaska	9/1/2010	$1,500	N/A	20%	$3,000	$3 Million
Arkansas	9/1/2010	1,000	N/A	20%	2,000	1 Million
California	10/25/2010	1,500	$500[a]	15%	2,500	Unlimited
Colorado	9/1/2010	2,500	500[a]	20%	5,950	1 Million
Connecticut	9/1/2010	1,250	250	20%	4,250	1.5 Million
Illinois	9/1/2010	1,000	N/A	20%	5,950[c]	5 Million
(2 plans)		2,000[b]	N/A	20%	5,950[c]	5 Million
Iowa	9/1/2010	1,000	N/A	20%	2,500	3 Million
Kansas	8/1/2010	2,500	N/A	30%	5,950	Unlimited
Maine	8/1/2010	1,750	N/A	30%	5,600	Unlimited
(2 plans)		2,500[b]	N/A	30%	3,500	Unlimited
Maryland	9/1/2010	500	100	20%	5,000	2 Million
(2 plans)		1,500	N/A	0%	1,500	2 Million
Michigan	10/1/2010	1,000	N/A	20%	5,950	Unlimited
(3 plans)		2,500	N/A	20%	5,950	Unlimited
		3,500	N/A	20%	5,950	Unlimited
Missouri	8/15/2010	1,000[b]	100	20%	5,950	1 Million
(3 plans)		2,500	100	20%	5,950	1 Million
		5,000	100	20%	5,950	1 Million
Montana	8/1/2010	2,500	N/A	30%	5,950	2 Million
New Hampshire	7/1/2010	2,000	500	20%	5,000	Unlimited
(3 plans)		1,000	500	20%	3,500	Unlimited
		2,500[b]	500	20%	5,000	Unlimited
New Jersey	8/15/2010	2,500	N/A	20%[d]	5,000	Unlimited
(3 plans)		0[b]	N/A	0%[d]	5,000	Unlimited
		2,500	N/A	10%[d]	5,000	Unlimited
New Mexico	8/1/2010	500[b]	N/A	20%	5,950[c]	Unlimited
(3 plans)		1,000	N/A	20%	5,950[c]	Unlimited
		2,000	N/A	20%	5,950[c]	Unlimited
New York	10/1/2010	0	N/A	0%	5,950	Unlimited

State	Date PCIP first became effective	In-network medical deductible	In-network prescription deductible	In-network coinsurance	In-network out-of-pocket limit	Lifetime limit
North Carolina	8/1/2010	1,000	N/A	20%	5,950	1 Million
(4 plans)		2,500	N/A	20%	5,950	1 Million
		3,500[b]	N/A	20%	5,950	1 Million
		4,500	N/A	0%	4,500	1 Million
Ohio	9/1/2010	1,500[b]	N/A	20%	5,950[c]	Unlimited
(2 plans)		2,500	150[a]	20%	5,950[c]	Unlimited
Oklahoma	9/1/2010	2,000	200	20%	5,950[c]	1 Million
Oregon	8/1/2010	500[b]	N/A	20%	5,950[c]	2 Million
(2 plans)		750	N/A	20%	5,950[c]	2 Million
Pennsylvania	10/1/2010	1,000	N/A	20%	5,000	Unlimited
Rhode Island	9/15/2010	1,000	N/A	20%	3,000	Unlimited
South Dakota	7/15/2010	2,000	N/A	25%	5,750[c]	Unlimited
Utah	9/1/2010	500	150	20%	5,950[c]	1.5 Million
(4 plans)		1,000	250	20%	5,950[c]	1.5 Million
		2,500	500	20%	5,950[c]	1.5 Million
		5,000[b]	N/A	0%	5,000	1.5 Million
Washington	9/1/2010	500	N/A	20%	1,500[c]	Unlimited
(2 plans)		2,500[b]	N/A	20%	5,950[c]	Unlimited
Wisconsin	8/1/2010	500	N/A	20%	3,500[c]	2 Million
(4 plans)		1,000	N/A	20%	4,000[c]	2 Million
		2,500	N/A	20%	5,500[c]	2 Million
		3,500[b]	N/A	20%	5,950[c]	2 Million
Federally run PCIP						
24 States[e]	8/1/2010[f]	$2,000[b]	$500	20%	$5,950	Unlimited
(3 plans in each state)[g]		1,000	250	20%	5,950	Unlimited
		2,500	N/A	20%	5,950	Unlimited

Source: State- and federally run PCIP web sites.

Legend: N/A = Not applicable

[a]This deductible only applies to brand name drugs.

[b]This was the most popular plan as of March 31, 2011.

[c]Includes separate out-of-pocket maximums for medical and prescription drugs.

[d]Coinsurance for prescription drugs is 50 percent.

[e]The 24 states in the federally run PCIP 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.

[f]Coverage for the federally run PCIP began in August 2010 in 21 states, in September 2010 in 2 states, and in October 2010 in 1 state.

[g]The three plan options are the Standard, Extended, and Health Savings Account options, which have annual medical deductibles of $2,000, $1,000, and $2,500, respectively.

Appendix II: Premiums for the Most Popular Pre-Existing Condition Insurance Plans (PCIP) by State, June 2011

State	Average monthly premium for a 50 year-old[a]	Overall monthly premium range	Number of age bands
State-run PCIPs			
Alaska	$1,048	$452-$1,806	47
Arkansas	395[b]	140-624	9
California	477[c]	127-652	12
Colorado	406[b,c]	116-594	11
Connecticut	507	243-893	10
Illinois	289[b,c]	99-526	28
Iowa	398[b]	156-622	49
Kansas	375[b,c]	133-646	48
Maine	647[c,d]	439-658	8
Maryland	274	141-354	9
Michigan	447	172-687	10
Missouri	544	195-780	8
Montana	434	171-681	48
New Hampshire	396[b]	152-605	47
New Jersey	531	311-836	10
New Mexico	465[d]	140-596	48
New York	392[c]	362-421	1
North Carolina	285[b]	97-388	51
Ohio	349[b,c]	101-475	62
Oklahoma	327[b]	121-524	28
Oregon	649	263-783	12
Pennsylvania	283	283	1
Rhode Island	439	200-897	11
South Dakota	456[b]	141-626	11
Utah	240	127-382	10
Washington	514[b]	183-715	11
Wisconsin	277	100-398	10
Federally run PCIP			
Alabama	$419	$183-$583	5
Arizona	400	174-557	5
Delaware	416	181-578	5
District of Columbia	396	173-551	5
Florida	450	196-626	5

State	Average monthly premium for a 50 year-old[a]	Overall monthly premium range	Number of age bands
Georgia	400	174-557	5
Hawaii	267	116-371	5
Idaho	305	133-424	5
Indiana	385	168-536	5
Kentucky	377	164-525	5
Louisiana	393	171-546	5
Massachusetts	416	181-578	5
Minnesota	358	156-498	5
Mississippi	343	149-477	5
Nebraska	381	166-530	5
Nevada	416	181-578	5
North Dakota	305	133-424	5
South Carolina	374	163-520	5
Tennessee	374	163-520	5
Texas	400	174-557	5
Vermont	339	148-472	5
Virginia	358	156-498	5
West Virginia	324	141-451	5
Wyoming	290	126-403	5

Source: State- and federally run PCIP web sites.

Note: On May 31, 2011, HHS announced in a news release that it would reduce PCIP premiums in 18 states with a federally run PCIP beginning July 1, in order to more closely align premiums with each state's individual health insurance market.

[a]For states with multiple PCIP plans, the premium of the most popular plan is shown; for states that varied premiums by region, the average premium was calculated across all regions.

[b]Premiums varied by smoking status in this state and we show the premium for a nonsmoker.

[c]Premiums varied by region in this state.

[d]Individuals in New Mexico with incomes below 400 percent of the federal poverty level could receive premium discounts ranging from 25 to 75 percent using state funds. Individuals in Maine with incomes below 300 percent of the federal poverty level were also eligible for state-funded premium subsidies.

Appendix III: Criteria for Demonstrating a Pre-Existing Condition by State, June 2011

State	Criteria for Demonstrating a Pre-Existing Condition				Total number of criteria options
	Pre-existing condition diagnosis[a]	Proof of denial	Proof of exclusionary rider	Proof of higher premium[b]	
State-run Pre-Existing Condition Insurance Plans (PCIP)					
Alaska	x	x	x	[c]	3
Arkansas	[d]	x	x	[c]	2
California		x		x	2
Colorado	x	x	x		3
Connecticut	x	x	x		3
Illinois	x	x	x	x	4
Iowa	x	x	x	[c]	3
Kansas	x	x	x	[c]	3
Maine	x				1
Maryland	x	x	x	x	4
Michigan	x	x	x		3
Missouri	x[e]	x	x	x	4
Montana	x	x	x		3
New Hampshire	x	x	x		3
New Jersey	x[e]				1
New Mexico	x	x	x	x	4
New York	x				1
North Carolina	x	x	x		3
Ohio	x	x	x		3
Oklahoma	x	x	x	[f]	3
Oregon	x	x	x		3
Pennsylvania	x	x	x	x	4
Rhode Island	x				1
South Dakota	x	x	x		3
Utah	x	x			2
Washington	x	x	x		3
Wisconsin	[g]	x	x	x	3

State	Criteria for Demonstrating a Pre-Existing Condition				
	Pre-existing condition diagnosis[a]	Proof of denial	Proof of exclusionary rider	Proof of higher premium[b]	Total number of criteria options
Federally run PCIP					
24 states[h]	[i]	x	x	[j]	2
Total number of states that allowed each criterion	**24**	**47**	**45**	**9**	

Source: State- and federally run PCIP web sites.

Note: On May 31, 2011, HHS announced in a news release that beginning July 1, 2011, applicants living in the 24 states in the federally run PCIP would be able to demonstrate their pre-existing condition by submitting a letter from a doctor, physician assistant, or nurse practitioner stating that they have or, at any time in the past, had a medical condition, disability, or illness.

[a]Most states required documentation of a diagnosed medical condition that is included on the state's list of presumptive conditions, although some considered documentation of conditions not on the list on a case-by-case basis.

[b]States determined how much higher the premium must be compared to those offered by the state's PCIP. For instance, New Mexico accepted proof of offered coverage with premiums that are at least 25 percent higher than the state's standard rate for similar deductible options.

[c]Children under age 19 in Alaska, Arkansas, Iowa, and certain counties in Kansas could meet the criteria for demonstrating a pre-existing condition if they were offered plans with premiums at least twice as high as the state's current child-only PCIP premiums.

[d]Children under age 19 in Arkansas could demonstrate their pre-existing condition by submitting documentation stating that they have received medical advice or treatment from a physician or other licensed health care provider for a condition listed on the state's pre-existing conditions list.

[e]Missouri and New Jersey did not have a list of presumptive conditions, but did accept provider documentation of a medical condition.

[f]All children under age 19 in Oklahoma who were offered plans with premiums at least 125 percent, or more, higher than the state's current child-only PCIP premiums could meet the criteria for demonstrating a pre-existing condition.

[g]Wisconsin allowed proof of a diagnosed pre-existing condition only in the case of individuals who have tested positive for HIV.

[h]The 24 states in the federally run PCIP 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.

[i]Beginning in February 2011, all children under age 19 in the 24 federally run PCIP states could demonstrate their pre-existing condition by submitting a letter from a doctor, physician assistant, or nurse practitioner stating that they have or, at any time in the past, had a medical condition, disability, or illness.

[j]In addition to the 7 state-run PCIPs that allowed proof of higher premium, all individuals in two federally run PCIP states—Massachusetts and Vermont—and children under age 19 in all 24 federally run PCIP states who were offered plans with premiums that were at least twice as high as the premium for the Standard plan in their respective states would meet the criteria for demonstrating a pre-existing condition.

Appendix IV: Enrollment and Expenditures for State- and Federally Run Pre-Existing Condition Insurance Plans (PCIP)

State	Enrollment as of April 30, 2011	Federal allocation	Claims paid as of March 31, 2011	Administrative expenses paid[a] as of March 31, 2011	Expenditures net of premium revenue[a] as of March 31, 2011
State-run PCIPs					
Alaska[b]	34	$13,000,000	$757,824	$246,942	$894,812
Arkansas[b]	226	46,000,000	611,951	202,848	497,301
California[b]	1,858	761,000,000	8,348,162	4,784,092	11,103,972
Colorado[b]	699	90,000,000	6,496,467	929,205	6,136,869
Connecticut[b]	42	50,000,000	351,584	1,340,169	1,617,332
Illinois[b]	1,261	196,000,000	3,452,527	263,208	1,885,563
Iowa[b]	143	35,000,000	812,031	497,274	1,060,870
Kansas[b]	177	36,000,000	2,241,229	266,156	2,193,995
Maine	14	17,000,000	250,927	7,419	193,977
Maryland[b]	348	85,000,000	1,980,256	402,888	2,084,889
Michigan	225	141,000,000	1,441,211	861,769	2,080,058
Missouri[b]	322	81,000,000	731,508	262,450	474,288
Montana[b]	214	16,000,000	2,224,149	279,702	2,111,073
New Hampshire[b]	148	20,000,000	4,693,580	340,659	4,725,802
New Jersey	507	141,000,000	3,956,621	81,488	3,312,451
New Mexico[b]	354	37,000,000	2,404,543	280,784	2,244,603
New York	1,075	297,000,000	4,606,218	3,803,323	7,443,353
North Carolina[b]	1,302	145,000,000	2,675,089	1,011,409	2,197,524
Ohio	1,145	152,000,000	7,645,708	508,045	6,003,936
Oklahoma[b]	291	60,000,000	1,764,806	338,719	1,666,716
Oregon[b]	822	66,000,000	6,350,982	307,525	4,478,465
Pennsylvania	3,191	160,000,000	9,371,095	779,413	6,350,438
Rhode Island	115	13,000,000	802,808	133,722	714,754
South Dakota[b]	94	11,000,000	897,353	103,300	733,943
Utah[b]	286	40,000,000	1,652,769	133,573	1,466,687
Washington[b]	341	102,000,000	3,631,932	668,968	3,436,908
Wisconsin[b]	547	73,000,000	1,185,319	785,435	1,226,347
State-run PCIP totals	**15,781**	**$2,884,000,000**	**$81,338,650**	**$19,620,486**	**$78,336,926**

State	Enrollment as of April 30, 2011	Federal allocation	Claims paid as of March 31, 2011	Administrative expenses paid[a] as of March 31, 2011	Expenditures net of premium revenue[a] as of March 31, 2011
Federally run PCIP					
Alabama[b]	91	$69,000,000	$315,073	N/A	N/A
Arizona	457	129,000,000	1,825,039	N/A	N/A
Delaware	54	13,000,000	16,867	N/A	N/A
District of Columbia	21	9,000,000	15,662	N/A	N/A
Florida[b]	925	351,000,000	5,474,757	N/A	N/A
Georgia	608	177,000,000	1,795,661	N/A	N/A
Hawaii	27	16,000,000	585,987	N/A	N/A
Idaho[b]	47	24,000,000	432,367	N/A	N/A
Indiana[b]	201	93,000,000	974,410	N/A	N/A
Kentucky[b]	93	63,000,000	318,612	N/A	N/A
Louisiana[b]	137	71,000,000	426,817	N/A	N/A
Massachusetts	1	77,000,000	0	N/A	N/A
Minnesota[b]	49	68,000,000	437,350	N/A	N/A
Mississippi[b]	75	47,000,000	406,488	N/A	N/A
Nebraska[b]	61	23,000,000	599,177	N/A	N/A
Nevada	181	61,000,000	921,964	N/A	N/A
North Dakota[b]	9	8,000,000	54,777	N/A	N/A
South Carolina[b]	377	74,000,000	2,102,372	N/A	N/A
Tennessee[b]	314	97,000,000	632,263	N/A	N/A
Texas[b]	1,528	493,000,000	10,175,426	N/A	N/A
Vermont	0	8,000,000	0	N/A	N/A
Virginia	320	113,000,000	1,043,431	N/A	N/A
West Virginia[b]	24	27,000,000	118,947	N/A	N/A
Wyoming[b]	73	8,000,000	220,185	N/A	N/A
Federally run PCIP totals	**5,673**	**$2,119,000,000**	**$28,893,632**	**$5,267,351**	**$25,803,026**

Source: GAO analysis of HHS and OPM data.

Legend: N/A = Not applicable

[a]For the federally run PCIP states, administrative expenses and federal reimbursements were not available on a state-by-state basis.

[b]Indicates states with an existing high-risk pool.

Appendix V: Comments from the Department of Health & Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

John Dicken
Director , Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

JUL 13 2011

Dear Mr. Dicken:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft report entitled, "PRE-EXISTING CONDITION INSURANCE PLANS: Program Features, Early Enrollment and Spending Trends, and Federal Oversight Activities" (GAO 11-662).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "PRE-EXISTING CONDITION INSURANCE PLANS: PROGRAM FEATURES, EARLY ENROLLMENT AND SPENDING TRENDS, AND FEDERAL OVERSIGHT ACTIVITIES" (GAO-11-662)

The Department appreciates the opportunity to review and comment on this draft report.

The Affordable Care Act created the Pre-Existing Condition Insurance Plan (PCIP) to help uninsured people with a pre-existing condition get high quality care at market prices. PCIP serves as a bridge to 2014, when insurers will no longer be allowed to deny coverage to people with any pre-existing condition. In 27 States, PCIP coverage is run by State-based programs. In the other 23 States and the District of Columbia, HHS, with the help of the US Office of Personnel Management and the US Department of Agriculture's National Finance Center, runs the Pre-Existing Condition Insurance Plan. The Federal Government contracts with a national insurance plan to administer benefits in those States. For a program that has been in operation for only a year, PCIP has succeeded in providing vital insurance and life-saving care to tens of thousands of Americans who could not find coverage for their conditions.

In the past year, the Department has employed a number of strategies to reach out to eligible individuals and increase enrollment in the program. In January of 2011, we began a coordinated outreach effort to providers and consumer groups in order to provide information on PCIP to patients and other eligible consumers. HHS has built strong partnerships with States that have both a PCIP program and a State-run High Risk Pool in order to provide the best coverage at market-aligned prices to consumers. HHS is also partnering with CMS regional offices to expand the reach and number of outreach events. In the month of June alone, PCIP was featured at more than 140 events nationwide. Finally, HHS announced that beginning in fall 2011, the federally administered PCIP will begin paying agents and brokers for successfully connecting eligible people with the PCIP program. Enrollment continues to grow at a steady pace.

The Department has taken several steps to make PCIP more affordable and accessible. As of July 1, 2011, HHS has improved the affordability of the program by cutting premiums in Federal PCIP programs by as much as 40 percent in some States. We have also expanded the eligibility pathways into PCIP, also effective July 1, 2011, by permitting all applicants to demonstrate eligibility by providing a signed letter from a healthcare provider. This option was originally made available to children under age 19 in February 2011.

It is important to note that while this report shows that administrative costs in some States and in the federally-run program may have exceeded 10 percent in the first year of the program, PCIP programs incurred substantial start-up costs in this time. The PCIP interim final rule places a limit of 10 percent on administrative costs over the life of the program. We anticipate that our overall administrative costs will be at 10 percent or less by the end of the program and continue to monitor these costs closely.

HHS continues to build on program integrity best practices in order to detect any fraud, waste and abuse. By utilizing innovative strategies while working within the authority provided by the Affordable Care Act, HHS has helped the PCIP program grow from 23 enrolled individuals in June of 2010 into a program that provides comprehensive and affordable health coverage to over 21,000 Americans.

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

John E. Dicken, (202) 512-7114 or DickenJ@gao.gov

Staff Acknowledgments

In addition to the contact named above, Randy DiRosa, Assistant Director; Laura Brogan; Drew Long; Perry Parsons; Said Sariolghalam; and George Bogart made key contributions to this report.

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