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Realizing Health Reform's Potential

The Affordable Care Act's Pre-Existing Condition Insurance Plan: Enrollment, Costs, and Lessons for Reform

Jean P. Hall and Janice M. Moore
University of Kansas

Abstract: The Pre-Existing Condition Insurance Plan (PCIP) is the temporary, federal high-risk pool created under the Affordable Care Act to provide coverage to uninsured individuals with preexisting conditions until 2014, when exchange coverage becomes available to them. Nearly 78,000 people have enrolled since the program was implemented two years ago. This issue brief compares the PCIP with state-based high-risk pools that existed prior to the Affordable Care Act and considers programmatic differences that may have resulted in lower-than-anticipated enrollment and higher-than-anticipated costs for the PCIP. PCIP coverage, like state high-risk pool coverage, likely remains unaffordable to most lower-income individuals with preexisting conditions, but provides much needed access to care for those able to afford it. Operational costs of these programs are also quite high, making them less than optimal as a means of broader coverage expansion.

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OVERVIEW

The Pre-Existing Condition Insurance Plan (PCIP) program is a national, temporary high-risk health insurance pool implemented as part of the Affordable Care Act. Its purpose is to provide a source of health insurance coverage for uninsured individuals with preexisting conditions until the exchanges are implemented in 2014 and individuals can no longer be denied coverage on the basis of their health history. The PCIP programs were implemented in each state between July and October 2010. To date, nearly 78,000 people have enrolled (Exhibits 1 and 2). Enrollment has been lower than initially projected while per member per month (PMPM) costs have been greater, suggesting that enrollees have more medical need than originally anticipated.[1,2,3]

To better understand the PCIP experience, this issue brief compares the PCIP with state-based high-risk pools that existed prior to the Affordable Care Act and considers programmatic differences that may have resulted in lower-than-anticipated enrollment and higher-than-anticipated costs for the PCIP.

PCIP coverage is generally more affordable to individuals than state high-risk pool coverage and purposefully does not impose a waiting period for coverage

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For more information about this study, please contact:

Jean P. Hall, Ph.D.
Associate Research Professor
University of Kansas
jhall@ku.edu

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of preexisting conditions—as most state high-risk pools do—so that more people with serious conditions can immediately access coverage. These PCIP features that have increased access to coverage also are likely to have led to higher per-person program costs. Because of these programmatic differences, implementation of the PCIPs has provided a natural experiment to test the feasibility of an expanded and affordable high-risk pool program as a permanent vehicle for coverage expansion. As this issue brief illustrates, using high-risk pools as an alternative to the provisions in the Affordable Care Act to cover the substantial remaining uninsured population with preexisting conditions would be extremely expensive and likely unsustainable. Under the law, in 2014, risk will be broadly pooled in the expanded Medicaid program for individuals with incomes below 133 percent of the federal poverty level ($30,657 for a family of four) and in the state insurance exchanges that will include people with and without health problems. In addition, premium and cost-sharing subsidies will make health insurance sold through the state exchanges more affordable for people with incomes below 400 percent of poverty ($92,200 for a family of four).

Exhibit 1. Pre-Existing Condition Insurance Plan (PCIP) Enrollments by State

State	Date coverage for enrollees began in 2010	Reported enrollment 11/1/2010	Reported enrollment 3/31/2011	Reported enrollment 6/30/2011	Reported enrollment 9/30/2011	Reported enrollment 12/31/2011	Reported enrollment 3/31/2012	Reported enrollment 6/30/2012	State high-risk pool enrollment 12/31/2011
Alabama	1-Aug	33	77	118	230	340	429	559	2,133
Alaska	1-Sep	12	32	38	45	44	42	45	525
Arizona	1-Aug	112	374	639	1,178	1,783	2,448	3,282	NA
Arkansas	1-Sep	127	198	254	310	404	554	648	2,801
California	25-Oct	513	1,543	2,659	3,745	5,599	7,634	10,402	6,334
Colorado	1-Sep	368	617	807	964	1,054	1,171	1,333	13,859
Connecticut	1-Sep	12	51	57	73	163	265	440	1,603
Delaware	1-Aug	13	41	73	107	153	200	231	NA
District of Columbia	1-Oct	0	15	30	37	38	48	57	NA
Florida	1-Aug	293	770	1,201	2,381	3,736	5,232	7,114	208
Georgia	1-Aug	161	515	822	1,177	1,476	1,883	2,386	NA
Hawaii	1-Aug	11	24	45	63	78	101	122	NA
Idaho	1-Aug	19	43	79	145	316	514	707	1,658
Illinois	1-Sep	664	1,150	1,491	1,784	1,962	2,231	2,717	19,998
Indiana	1-Aug	63	177	273	471	678	968	1,316	7,502
Iowa	1-Sep	56	129	161	200	238	279	310	3,268
Kansas	1-Aug	81	161	216	268	301	356	430	1,528
Kentucky	1-Aug	23	77	140	264	435	641	867	4,798
Louisiana	1-Aug	31	121	166	267	377	676	979	1,728
Maine	1-Aug	13	13	18	31	30	36	43	NA
Maryland	1-Sep	62	298	430	607	741	876	999	20,646
Massachusetts	1-Aug	0	0	1	1	5	14	19	NA
Michigan	1-Oct	36	184	339	527	789	1,100	1,567	NA
Minnesota	1-Aug	15	37	66	137	244	370	522	26,859
Mississippi	1-Aug	19	71	105	137	163	215	289	3,328
Missouri	15-Aug	101	289	433	683	1,031	1,254	1,563	4,009
Montana	1-Aug	149	198	236	262	280	306	331	2,878
Nebraska	1-Aug	12	49	79	117	174	230	314	4,021

THE PRE-EXISTING CONDITION INSURANCE PLAN AND STATE-BASED HIGH-RISK POOLS

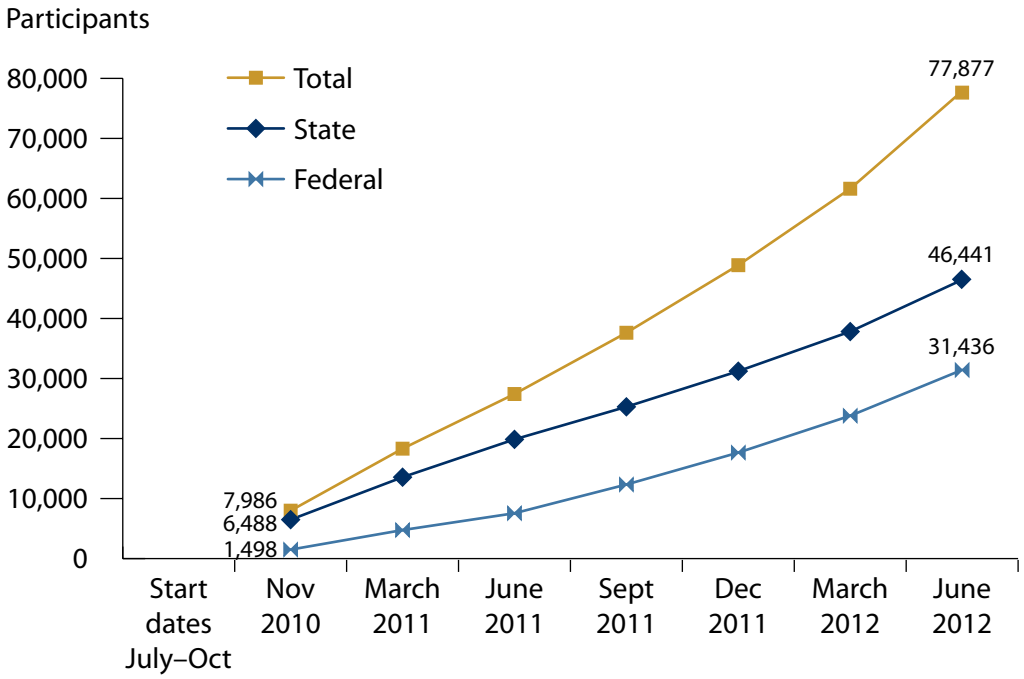
By statute, the PCIP cannot impose a waiting period for coverage of preexisting conditions; any person with a preexisting condition who has been uninsured for at least six months is potentially eligible for coverage. In addition, premiums for coverage must be no higher than the rate a healthy individual in the same age range would pay for coverage in the individual insurance market for the area in which the PCIP operates. No individual premium subsidy is provided, and federal funding under the law is used to offset losses resulting from claims that exceed premium income. Finally, enrollment is open to qualifying individuals throughout the year. Congress established these rules to provide immediate and more affordable coverage to the intended population of uninsured individuals who had previously been excluded from the individual insurance market because of their preexisting conditions. However, PCIPs are not intended to replace existing coverage nor are they intended to extend coverage to those unable to afford to pay market-based rates—which would require expenditures far in excess of the

Exhibit 1. Pre-Existing Condition Insurance Plan (PCIP) Enrollments by State (continued)

State	Date coverage for enrollees began in 2010	Reported enrollment 11/1/2010	Reported enrollment 3/31/2011	Reported enrollment 6/30/2011	Reported enrollment 9/30/2011	Reported enrollment 12/31/2011	Reported enrollment 3/31/2012	Reported enrollment 6/30/2012	State high-risk pool enrollment 12/31/2011
Nevada	1-Aug	56	147	222	386	579	747	976	NA
New Hampshire	1-Jul	43	123	183	233	306	424	510	2,586
New Jersey	15-Aug	108	416	670	702	794	892	1,055	NA
New Mexico	1-Aug	133	322	498	645	805	963	1,155	8,442
New York	1-Oct	201	847	1,638	2,176	2,632	3,122	3,764	NA
North Carolina	1-Aug	513	1,106	1,671	2,341	2,889	3,566	4,383	8,160
North Dakota	1-Aug	1	6	13	23	32	49	72	1,446
Ohio	1-Sep	634	1,024	1,398	1,771	2,137	2,480	2,819	NA
Oklahoma	1-Sep	148	262	380	471	576	689	788	2,422
Oregon	1-Aug	340	734	919	1,102	1,187	1,261	1,556	12,152
Pennsylvania	1-Oct	1,657	2,684	3,617	4,101	4,567	5,111	5,839	NA
Rhode Island	15-Sep	78	102	125	134	136	160	161	NA
South Carolina	1-Aug	104	309	504	743	948	1,209	1,457	1,799
South Dakota	15-Jul	43	94	105	133	153	170	190	645
Tennessee	1-Aug	43	255	419	655	878	1,102	1,385	3,265
Texas	1-Aug	393	1,298	2,020	2,967	4,029	5,092	6,623	24,792
Utah	1-Sep	73	223	395	568	696	860	1,005	3,946
Vermont	1-Sep	0	0	0	0	0	2	1	NA
Virginia	1-Aug	75	268	424	693	982	1,343	1,796	NA
Washington	1-Sep	75	304	446	586	708	765	842	3,862
West Virginia	1-Sep	4	18	30	48	76	108	132	1,152
Wisconsin	1-Aug	248	456	676	822	1,000	1,256	1,546	21,317
Wyoming	1-Aug	17	61	87	113	137	175	230	945
Total		7,986	18,313	27,416	37,624	48,879	61,619	77,877	226,615
State		6,488	13,560	19,860	25,284	31,222	37,823	46,441	
Federal		1,498	4,753	7,556	12,340	17,657	23,796	31,436	
Percent federal		19%	26%	28%	33%	36%	39%	40%	

Notes: Shaded states have a federally administered PCIP. NA denotes states (n=15) that do not have a state high-risk pool.
Source: U.S. Department of Health and Human Services, "State by State Enrollment in the Pre-Existing Condition Insurance Plan, as of June 30, 2012," available at http://www.healthcare.gov/news/factsheets/2012/08/pcip08102012a.html.

Exhibit 2. PCIP Enrollment over Time



$5 billion set aside for this program. Rather, they are a short-term solution for individuals who could otherwise afford nongroup coverage were it not for their preexisting conditions.

Currently, 27 states administer the PCIP program for their residents while 23 states and the District of Columbia allow the federal government to administer their PCIPs.[4,5] Twenty of the 27 states that administer a PCIP program also administer a state-based high-risk pool in parallel with the PCIP, providing the opportunity to compare experiences between the two risk-pool programs.[6]

Overall, 35 states operate state-based high-risk pools, which have existed in some states since the 1970s, with a total national enrollment of about 226,000 (Exhibit 1). In contrast to the PCIP, these state-based pools have premiums that range from 100 percent to 200 percent of rates paid in the local nongroup market, though some states provide low-income subsidies. All states, with the exception of Alabama, impose a waiting period for coverage of the preexisting condition of three to 12 months. During the waiting period, conditions not existing prior to enrollment are covered. The waiting period is waived for individuals transitioning directly from other coverage, including people who have exhausted COBRA eligibility.[7] The PCIP program, in contrast, does not allow people to transition directly from other coverage because of the six-month uninsurance requirement. No exception is made for those exhausting COBRA benefits.

Given these eligibility and operational differences between the PCIP and state high-risk pools, it is not surprising that pronounced differences in characteristics between enrollees in the two programs have become apparent since the PCIPs have been operating. These differences in enrollee characteristics and the associated costs are timely and relevant to understanding the importance of certain plan design features in coverage for people with preexisting conditions.

By definition, both the PCIP program and the state high-risk pools operate at a loss. Income from premiums is insufficient to cover claims incurred by enrollees—who often have multiple chronic and costly conditions—meaning that medical loss ratios (MLRs), or the ratios of paid medical claims to premium revenue, for state high-risk pools and PCIPs always exceed 100 percent.[8,9] The Affordable Care Act requires that private insurers have minimum MLRs of 80 percent

to 85 percent, with the remaining 15 percent to 20 percent allowed for administrative costs and profits. An MLR exceeding 100 percent, however, means that the insurer is collecting less in premiums than the cost of claims and requires a substantial direct subsidy to maintain program viability. State high-risk pool premiums, which are well above the standard premium in the individual market for a healthy person, cover only 53 percent of the cost of claims, on average.[10] State high-risk pools therefore depend on external sources to break even, including assessments charged to health carriers and hospitals and, in a few cases, state general tax funds. In addition, the Centers for Medicare and Medicaid Services (CMS) has provided limited grant funding to states to offset their high-risk pool losses. For the PCIP program, the $5 billion one-time allocation included in the health reform legislation covers the difference between premium income and claims costs until exchanges become available in 2014. Although some state-administered PCIP programs with particularly high costs have had to request additional funds from the $5 billion allocation, the overall current level of spending is not on track to exceed the allocation.[11]

Despite the fact that both PCIPs and state high-risk pools enroll people with preexisting conditions, PCIPs appear to be attracting individuals with more high-cost conditions. Exhibit 3 compares annual MLRs for the PCIP program and state high-risk pools in 20 states. The MLRs for the PCIP programs are substantially greater than those for state pools, by as much as a factor of eight. Even after correcting for the somewhat higher premiums paid by state high-risk pool members (adjusted MLRs, Exhibit 3, column 4), the MLRs for the PCIPs are up to seven times higher. Similarly, per member per month costs (i.e., average monthly costs for enrollees) are nearly nine times higher in the PCIP programs than in the corresponding state high-risk pools, confirming the greater disease burden of PCIP enrollees (Exhibit 4). Although no studies have compared the prevalence of health problems among PCIP and state pool enrollees, initial health care utilization by PCIP enrollees suggests they have more, and more expensive, conditions than their state pool counterparts. An early analysis of a sample of PCIP claims, for example, showed high rates of costly conditions such as cancer (see Appendix).

A key eligibility requirement for the PCIP program is that individuals have been uninsured for at least six months, which is not the case for state high-risk pool eligibility. This six-month uninsurance provision is generally recognized as necessary to prevent "crowd-out" from private insurance—that is, people dropping their existing coverage to enroll in the PCIP. As enacted, the provision prevents people with current or recent coverage from transitioning immediately to the PCIP, including those enrolled in state pools, who may be paying substantially higher premiums or facing higher deductibles, and those who have exhausted COBRA benefits. The requirement also serves to prioritize coverage availability to people who did not have it, which is a stated intention of the health reform legislation.

The uninsurance requirement may also be a factor in the higher cost of PCIP enrollees. People who have been uninsured often have pent-up, high-cost health care needs. In addition, these individuals may not have a regular source of care and may not initially use coverage in optimal or cost-effective ways.[12,13,14,15]

Regulations also prohibit PCIP programs from having limited open enrollment periods and from imposing any waiting period for coverage of a preexisting condition. These provisions have undoubtedly been life-saving for many individuals who enrolled in the program to address a health crisis. Indeed, in an effort to reach those most in need of the coverage, PCIP administrators conducted outreach to disease-specific organizations to inform their members of the availability of coverage and actively enrolled uninsured individuals already in the hospital. In this respect, the PCIPs have truly played their intended role of providing coverage to people with acute need and no other coverage options. On the other hand, these individuals had immediate and often high-cost needs that have resulted in higher per member per month costs relative to the state high-risk pools.

Exhibit 3. Medical Loss Ratios (MLRs) of PCIP and State High-Risk Pool (HRP) Programs

State	PCIP	State HRP	State HRP Adjusted to Standard Risk Rate (SRR)[a]
Alaska	1,010%	350%	455%
Arkansas	303%	138%[b]	207%
California	726%	133%	—[c]
Colorado	836%	181%	237%
Connecticut	289%	135%	202%
Illinois	500%	177%	232%
Iowa	430%	200%	300%
Kansas	824%	203%	262%
Maryland	620%	189%	189%
Missouri	570%	145%	189%
Montana	665%	161%	216%
New Hampshire	1,230%	140%	175%
New Mexico	1,151%	442%	345%[d]
North Carolina	217%	105%	147%
Ohio	458%	NA	NA
Oklahoma	673%[e]	191%	287%
Oregon	484%	163%	191%
Utah	844%	149%	204%
Washington	470%	270%	305%
Wisconsin	206%[e]	175%	182%
All Federally Administered PCIPs (average)	460%	NA[f]	NA[f]

[a] Because most state HRP premiums are higher than standard risk rates, MLR is adjusted in the last column to reflect premiums priced at SRR.

[b] Arkansas's MLR data are from 2010.

[c] California does not use an SRR.

[d] With low income subsidies, New Mexico's HRP premiums are 78% of SRR, thus inflating their MLR; if premiums are adjusted to SRR, the loss ratio would decrease.

[e] In Oklahoma and Wisconsin, reimbursement rates are lower for PCIP than for state HRP.

[f] Most states that have federally administered PCIPs do not have state high-risk pools. See Exhibit 1, shaded area, for a list of federally administered PCIPs.

Exhibit 4. Per Member Per Month (PMPM) Costs of Pre-Existing Condition Insurance Plan (PCIP) and State High-Risk Pool (HRP) Enrollees

State	PCIP PMPM	State HRP PMPM
Alaska	$7,457	$2,151
Arkansas	$1,001	$760[a]
California	$2,398	$752
Colorado	$3,036	$744
Connecticut	$2,981	$1,236
Illinois	$1,652	$910
Iowa	$1,883	$1,017
Kansas	$3,476	$1,410
Maryland	$1,588	$783
Missouri	$2,146	$1,006
Montana	$2,554	$797
New Hampshire	$6,178	$694
New Mexico	$2,757	$1,169
North Carolina	$679[b]	$520[b]
Ohio	$1,661	NA[c]
Oklahoma	$2,339[d]	$891[d]
Oregon	$2,326	$783
Utah	$2,870	$722
Washington	$3,279	$2,033
Wisconsin	$646[d]	$722[d]
All Federally Administered PCIPs (average)	$2,632	NA[e]
Arizona	$1,983	NA[e]
Florida	$2,216	NA[e]
Georgia	$2,486	NA[e]
Texas	$3,738	$1,009[f]
Virginia	$2,049	NA[e]

[a] Arkansas's MLR data are from 2010.

[b] In North Carolina, both pools are reimbursed at Medicare rates.

[c] Ohio does not have a state high-risk pool.

[d] In Wisconsin and Oklahoma, reimbursement rates are lower for PCIP than for state HRP.

[e] Most states that have federally-administered PCIPs do not have state high risk pools. The five federally administered PCIPs listed above represent a random sample for comparison with state-administered plans. See Exhibit 1, shaded area, for a complete list of federally administered PCIPs.

[f] Texas's MLR data are from 2010.

Clearly, PCIPs have enabled more people with preexisting conditions to obtain health insurance and mitigated their need for uncompensated care. Early enrollment data from a sample of PCIP programs showed higher rates of enrollment among young adults, ages 26 to 28, and also among older adults, ages 58 to 62.[16] Younger individuals in the PCIP experience a variety of high-cost conditions including epilepsy, cancer, lupus, rheumatoid arthritis, and hemophilia. Even though the prevalence of such conditions is low (see Appendix), they account for a high proportion of expenditures. Because they no longer are eligible for coverage under a parent's plan at age 26, and because many work in jobs that do not provide health insurance, these individuals would likely have been unable to obtain coverage without the PCIP. Young women experiencing high-risk pregnancies—considered a preexisting condition—have also enrolled in PCIPs. Without these plans, these women might have been covered only via Medicaid or not at all.

Similarly, higher enrollment of older adults ages 58 to 62 indicates that the PCIP is an important source of coverage for individuals who need a source of coverage until they qualify for Medicare.[17] Because prevalence of chronic conditions also increases with age, this segment of the population is at greater risk of being uninsurable in the individual market. Indeed, 70 percent of the uninsured population with any chronic condition is between the ages of 50 and 64.[18]

DISCUSSION

The PCIP program provides important information for better understanding the limitations of using high-risk pools to expand coverage and segment risk. By making coverage more affordable via premiums that reflect local market rates for healthy people and more accessible by having no waiting period, the PCIP program has allowed previously uninsurable individuals to afford health insurance. These plan features were essential to making immediate coverage available to those most in need. Perhaps because of these plan features, in combination with the fact that enrollees are uninsured for at least six months, PCIP enrollees have proven to have higher medical costs than people enrolled in state-based high-risk pools.

Current proposals that call for repealing and replacing the Affordable Care Act would continue to rely on expanding high-risk pools as a solution to covering people with preexisting conditions.[19,20] To make high-risk pool coverage affordable and accessible to the remaining and much larger pool of lower-income, uninsured individuals with chronic conditions, policymakers would need to include a mechanism to subsidize premiums and cost-sharing to at least the levels proposed for exchange plans. (See Exhibit 5 for premiums and deductibles for PCIP programs by state.) And, if PCIPs or state high-risk pools were the mechanism for expansion, their benefits would also need to be broadened to meet the essential benefits package mandated for exchange plans, and programs would need to eliminate current lifetime limits on coverage. Further, the remaining uninsured individuals may experience high levels of pent-up need that initially will make their coverage costly. Using data from the federal Medical Expenditure Panel Survey (MEPS), Merlis determined that a total of 19.1 million uninsured Americans have chronic conditions; among these, 5.5 million were individuals with incomes less than 400 percent of the federal poverty level and high-cost chronic conditions (i.e., at least 1.5 times higher than the standard costs for a given age group).[21] Another, more recent estimate of the number of individuals with preexisting conditions was based on lists of conditions commonly used to determine eligibility for state high-risk pools. The authors found that one of four individuals across all social and economic strata have preexisting conditions that would likely result in coverage denial.[22] The authors estimate that at least 11.6 million uninsured individuals meet high-risk pool admission criteria.

Currently, the cost of health care for people without health insurance is financed by themselves and their families, with the remainder paid by providers and taxpayers, and by higher premiums among the insured. Many of these uninsured individuals are saddled with massive medical debt that can limit their employment

Exhibit 5. PCIP Premiums and Deductibles by State

State	Available deductibles (in-network)	Premium for 50-year-old
Alabama	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$338 $251 $262
Alaska	$1,500	$1,215
Arizona	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$324 $240 $250
Arkansas	$1,000	$338#
California	$1,500 medical $500 prescriptions	$370–$428*
Colorado	$2,500 medical $500 prescriptions (brand name)	$497–$565*#
Connecticut	$1,250 medical $250 prescriptions	$381 (all ages)
Delaware	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$335 $250 $259
District of Columbia	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$436 $324 $337
Florida	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$363 $270 $280
Georgia	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$455 $338 $351
Hawaii	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$359 $267 $277
Idaho	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$410 $305 $317
Illinois	$500 $1,000 $2,000 $5,000	$333–$446*# $292–$391*# $253–$338*# $195–$261*#
Indiana	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$382 $284 $295
Iowa	$1,000	$413#
Kansas	$2,500	$349–$417*#
Kentucky	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$305 $226 $235
Louisiana	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$397 $296 $307
Maine	$2,000 $2,750	$666 $674
Maryland	$500 $1,500	$538 $263
Massachusetts	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$559 $416 $432
Michigan	$1,000 $2,500 $3,500	$393 $283 $238
Minnesota	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$298 $221 $230
Mississippi	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$452 $336 $348
Missouri	$1,000 medical, $100 prescription $2,500 medical, $100 prescription $5,000 medical, $100 prescription	$419 $385 $383
Montana	$2,500	$471
Nebraska	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$408 $303 $315
Nevada	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$350 $260 $270
New Hampshire	$2,000 medical, $500 prescription (indemnity plan) $1,000, $500 prescription $2,500, $500 prescription	$670 $493 $396
New Jersey	$0 $2,500 $2,500	$661 $436 $456
New Mexico	$500 $1,000 $2,000	$545 $475 $397
New York	$0	$362* $421*
North Carolina	$1,000 $2,500 $3,500 $4,500	$516# $384# $314# $235#
North Dakota	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$410 $305 $317
Ohio	$1,500 $2,500	$362–$424*# $302–$353*#
Oklahoma	$2,000 medical, $200 prescription	$327#
Oregon	$500 $750	$685 $646
Pennsylvania	$1,000	$283 (all ages)
Rhode Island	$1,000	$474
South Carolina	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$429 $319 $331
South Dakota	$2,000	$526#
Tennessee	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$411 $305 $317
Texas	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$412 $306 $318
Utah	$500 medical, $150 prescription $1,000 medical, $250 prescription $2,500 $5,000	$552 $468 $367 $270
Vermont	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$457 $339 $352
Virginia	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$288 $214 $222
Washington	$500 $2,500	$1,131# $579#
West Virginia	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$367 $273 $284
Wisconsin	$500 $1,000 $2,500 $3,500	$526 $431 $310 $261
Wyoming	$1,000 medical, $250 prescription $2,000 medical, $500 prescription $2,500	$390 $290 $301

Note: All deductibles are for in-network services. Separate deductibles for out-of-network services apply in some cases.
* Rate varies by residence location.
# Non–tobacco-user rate.

opportunities and result in personal bankruptcy.[23,24] Estimated claims costs for a comprehensive high-risk pool are as high as $100 billion annually.[25] Although premiums would offset some of these costs, additional funding for subsidies that would make premiums and cost-sharing affordable would be substantial. Yet, preliminary proposals for high-risk pool expansion by those who oppose the Affordable Care Act do not address the need for additional revenue to offset these costs.[26,27] Both the PCIP and state high-risk pool cost experiences illustrate the inadvisability of extending this form of coverage to a large number of people.

The overarching strategy of the Affordable Care Act is to create an exchange pool large enough to absorb and offset these costs while providing comprehensive and affordable coverage to all enrollees. Numerous provisions of the law work toward this end. The individual requirement to have health insurance, in particular, is designed to ensure enrollment of healthier individuals and adequately spread risk, resulting in lower per member per month costs for all plans.[28] Subsidies will also be provided to make coverage more affordable for lower-income individuals, regardless of health status, again broadening the pool and lowering average costs for all. Finally, the law's ban on setting premiums on the basis of a person's health status will result in lower administrative costs for exchange plans, with potentially lower premiums for enrollees.[29]

CONCLUSION

Despite the lower-than-anticipated enrollment and higher-than-anticipated costs, PCIPs appear to be performing their intended role as a bridge program, reducing costs of catastrophic medical liabilities for individuals and providers and improving access to care, including preventive and life-sustaining services. PCIP enrollment continues to grow steadily; however, because premiums are priced at the regular rates for nongroup coverage, enrollment is likely limited to people with relatively higher incomes. Given the general lack of affordability of high-risk pool coverage at the individual level and the high costs of plan operation, the potential of high-risk pools as a vehicle for coverage expansion remains quite limited. In short, the only way to make insurance affordable for everyone is to make sure that everyone has insurance.

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Appendix. Comorbidities of 10 States' PCIP Enrollees [a]

Condition (ICD-9 Codes)	N [b]	Percent of sample
Immune disorders (042, V08, 279, 695.4)	48	3.2
HIV (042, V08)	44	3.0
Cancers (140–65, 170–72, 174–76, 179–208, 209.0–209.3, 230–34, 237.7, 237.8, 511.81, 789.51, V58.0–.12, V66.1–.2)	197	13.3
Endocrine (245.2–.3, 250, 252.01, 253, 255, 275, 277.1–.6, 277.8–.9, 758.7, V45.85, V58.67)	249	16.8
Diabetes (250)	219	14.7
Blood disorders (281.0, 282–90)	142	9.6
Psychiatric disorders (290, 294–301, 309.81, 310–11, V11.0–.1)	218	14.7
Neurological disorders (326, 327.2, 330–37, 340–45, 350–359)	135	9.1
Sensory disorders (360–65, 369, 386–89)	59	4.0
Vision (360–65, 369)	37	2.5
Hearing (386–89)	22	1.5
Cardiovascular disorders (393–98, 402, 410–17, 420–29, 440–53, V43.2–.3, V45.0, V53.3)	228	15.4
Stroke and cerebrovascular disorders (430–38)	41	2.8
Respiratory disorders (491–96, 500–07, 518, V46.1–.2)	140	9.4
Digestive disorders (070, 555–56, 569.6–569.7, V44.1–44.4, V55.1–55.4, 570–73, 577)	117	7.9
Renal disorders (580–86, V44.5–.6, V45.1, V55.5, V56)	36	2.4
Arthropathies (274, 696.0, 710–19, 725)	277	18.7
Dorsopathies (720–24, 731, 737, 738.4–738.6, 741)	219	14.7
Cancer history (V10, 457.0)	49	3.3
Transplant history or need (V42, V49.83, 996.8)	9	0.6
High-risk pregnancy (641, 649, 651, 654.5, 655–57, V23, V91)	34	2.3

[a] Based on a sample of claims incurred between July 1 and December 31, 2010. The 10 states represented in this table are Alaska, California, Iowa, Montana, New Hampshire, North Carolina, Oklahoma, Oregon, Utah, and Wisconsin.

[b] n = 1,485 enrollees with at least two months enrollment and at least three medical claims.

Source: J. P. Hall and J. M. 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).

About the Authors

Jean P. Hall, Ph.D., is an associate research professor at the University of Kansas. She has an extensive background in the evaluation of health care programs, especially for people with disabilities or chronic illnesses. Her research has included private, state, and federal projects related to health care, education, and employment for people with disabilities or chronic illnesses in the educational, welfare to work, workforce center, Medicaid, and Medicare systems. In addition to her work with The Commonwealth Fund, Dr. Hall is currently evaluating the Kansas Medicaid buy-in program and directing a federal project to study the nexus of disability, health, and employment. She recently completed an evaluation of the Kansas Demonstration to Maintain Independence and Employment. Dr. Hall earned her Ph.D. in disability studies from the University of Kansas.

Janice M. Moore, M.A., M.S.W., M.B.A., is a project coordinator and data manager at the University of Kansas, where she contributes to research on disability, aging, and health reform. Prior to entering health services research, her experiences included teaching, health care administration, clinical social work, and corporate communications within the insurance industry, all of which have informed her work in health policy research. She earned master's degrees in English, business, and social work from the University of Kansas.

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