

THE LOW ENROLLMENT INTO THE AFFORDABLE CARE ACT'S PRE-EXISTING CONDITION INSURANCE PLAN

Preet K. Bassi, JD

MPH Candidate

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Jefferson School of Population Health

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Thank You!

The Pre-Existing Problem

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- Before the Patient Protection and Affordable Care Act of 2010 (ACA),
 - individuals attempting to purchase coverage in the *private individual market* could be
 - denied coverage;
 - offered coverage at higher-than-average premium; or
 - offered with a rider that excludes coverage of a pre-existing condition
- As a result, millions of individuals are uninsured, not getting access to adequate healthcare, and resort to less beneficial and more expensive forms of healthcare, such as emergency rooms.

What is a Pre-Existing Condition?

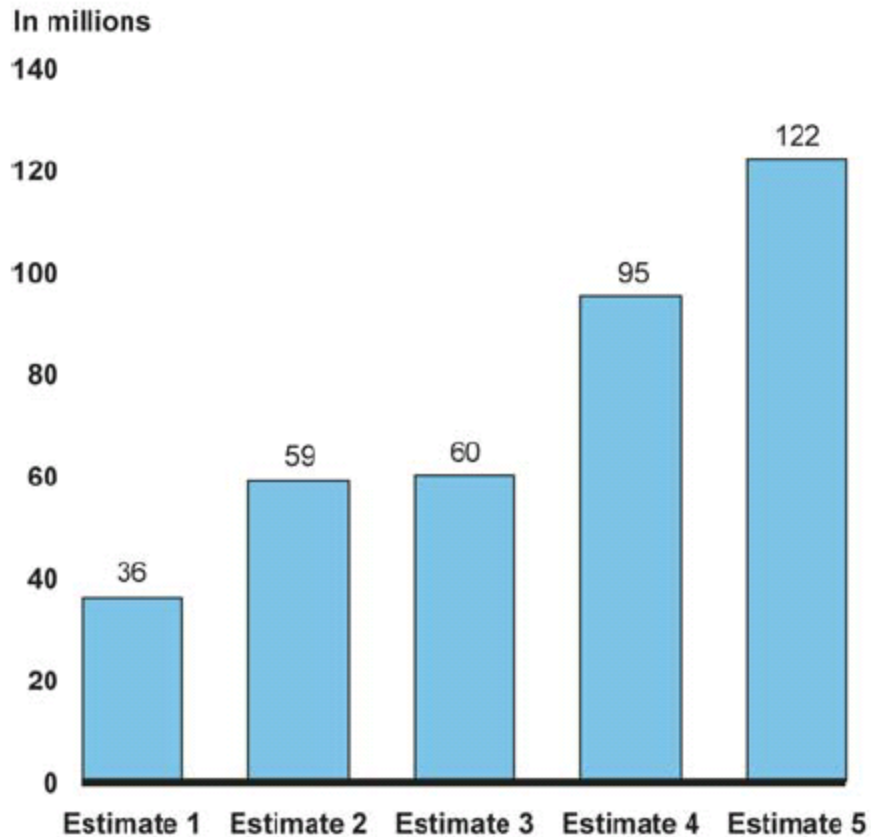
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- A pre-existing condition is a health condition that exists *before* someone applies for or enrolls in a new health insurance policy.
- There is *no standard definition* or list of qualifying conditions.
- Each insurer develops its own list of pre-existing conditions which influences to whom and under what terms it offers coverage.
- Pre-existing conditions can be conditions that
 - ▣ an individual is currently being treated for (such as heart disease, acne); or
 - ▣ past health problems (such as cancer in remission or depression).
- It does not matter if an individual sought or received medical advice, diagnosis, care, or treatment.
- While some States limit how far back an insurer can look for a pre-existing condition, some States have no limit.

Pre-Existing Conditions are Common

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Figure 1: Estimates of Adults (Age 19-64) with Pre-Existing Medical Conditions, 2009



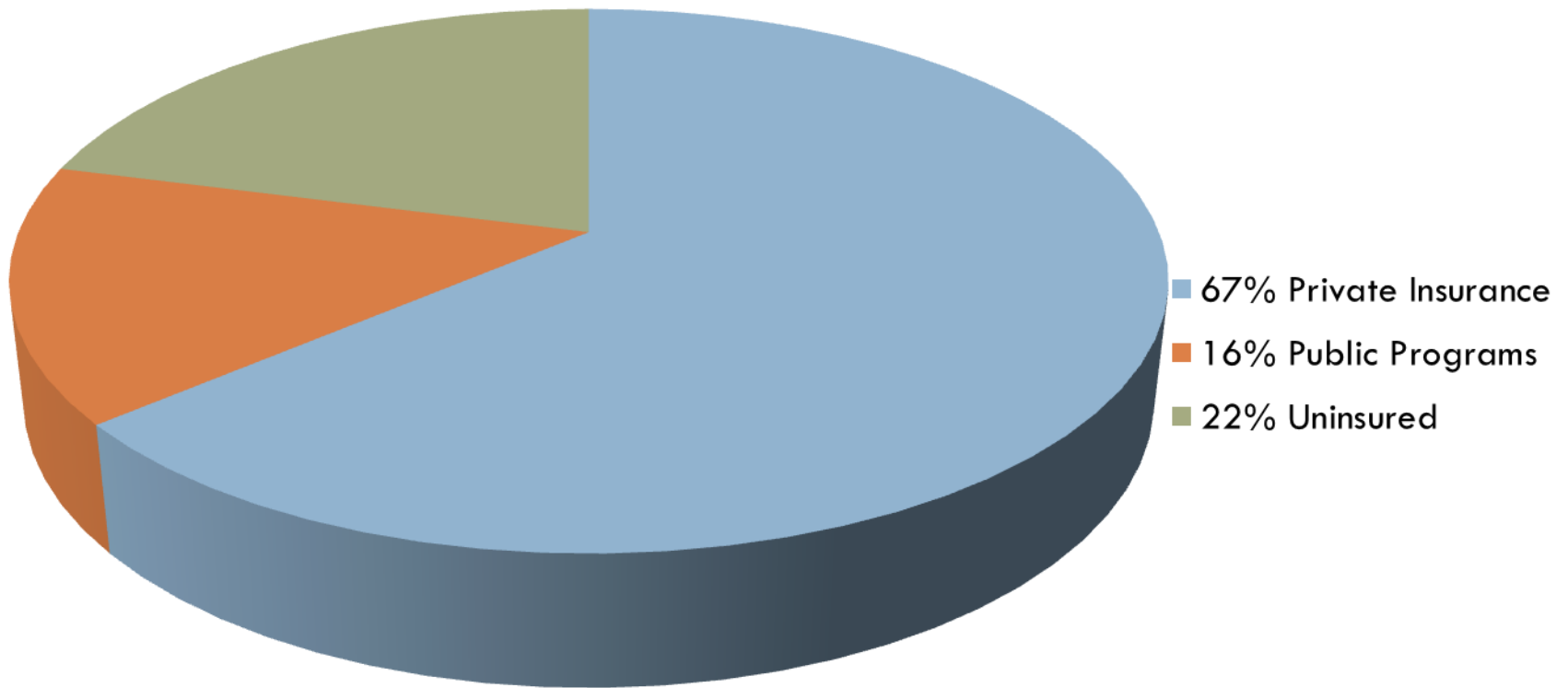
- Between 36 to 122 million non-elderly Americans have a condition that could qualify as a type of pre-existing health conditions.
- This represents about 20 to 66 percent of our adult population.

Source: GAO analysis of 2009 Medical Expenditure Panel Survey (MEPS).

The Pre-Existing System

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Sources of Health Insurance in 2010



Private Insurance Markets

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Three Basic Private Insurance Markets

Group-Insurance

- ❑ Employer assumes the financial risk
- ❑ Regulated by ERISA
- ❑ No. Pre-existing condition discrimination.
- ❑ Large risk pools, thus, cost spreading
- ❑ Community rating
- ❑ Usually have the lowest premiums, deductibles and copayments.

Small-Group Market & Individual Market

- ❑ Insurer bears financial risk
- ❑ Regulated by States
- ❑ Yes. Pre-existing condition discrimination
- ❑ Smaller risk pools
- ❑ Experience Rating
- ❑ Usually have higher premiums, deductibles and copayments, especially if you have a pre-existing condition

The Pre-Existing System

- *Group health plans* or employer-based health insurers offering group coverage may not condition eligibility based on an individual's health status.

- These protections generally do not exist for individuals attempting to purchase coverage directly through the *private individual market*, which accounted for about 14.6 million adults aged 18-64 years old in 2010.

- Individuals are at risk of losing the protections of employer-based group coverage if they
 - become unemployed;
 - change jobs or job status (full-time to part time);
 - change in relationship status (divorce);
 - move to a different state;
 - retire before eligibility for Medicare begins at age 65; and

The Pre-Existing System - HIPAA

- The **Health Insurance Portability and Accountability Act of 1996** (HIPAA) provides limited protections for individuals going from **group-market coverage** into the **individual market**.

- HIPAA prohibits health insurers from **denying coverage** to or imposing **any pre-existing condition exclusion** on individuals who meet the following eligibility criteria:
 - have had at least 12 months of prior creditable coverage with no break of more than 63 days;
 - have exhausted any available continuation coverage;
 - i.e. COBRA
 - are uninsured and are not eligible for other group coverage; and
 - i.e. Medicare or Medicaid);
 - did not lose group coverage due to nonpayment of premiums or fraud.

The Pre-Existing System

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- Individuals who do not meet the HIPAA eligibility criteria can be denied insurance coverage in the individual market due to a pre-existing condition, unless the prohibited by state law.

- How did people with pre-existing conditions get insurance?

- Pre-ACA alternatives:
 - Insurers of last resort;
 - Guarantee-issue laws;
 - Traditional state high-risk pools;

Beginning 2014

With the enactment of the ACA in March 2010, enrollment in private health insurance could expand significantly, particularly for individuals and families that do not have access to group coverage through their employer due to the

- Medicaid Expansion to 133%; and
- Health Insurance Exchanges
 - income-based subsidies to make coverage more affordable for certain individuals;
 - penalties for individuals not obtaining coverage; and
 - new insurance requirements to increase access to coverage, particularly for individuals with pre-existing conditions.

Beginning 2014

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- Health insurers in the individual market will be prohibited from
 - denying coverage;
 - increasing premiums; or
 - restricting benefits due to a pre-existing condition.

- Thus, make guaranteed issue and adjusted community rating national requirements.

Until 2014, the ACA creates PCIP

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- Until 2014, Section 1101 of the ACA requires that HHS establish a “temporary high risk health insurance pool program.”
- The PCIP program was established in July 2010.
- Provides coverage for individuals with pre-existing conditions until January 1, 2014, when:
 - Health Insurance Exchanges are established
 - Private insurers may not decline or surcharge people based on health status
- Congress appropriated \$5 billion for life of the program
- The Statute allows *direct* or *indirect* establishment—States may run their own PCIP program in their state with federal funding, or allow the federal government to administer the PCIP program in their state.

Eligibility Criteria for PCIP

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1. Must be a U.S. citizen or legally residing in the U.S.
2. Must have been uninsured for last 6 months
3. Below 400% of the Federal Poverty Level
 - \$43,560 for an individual
 - \$89,400 for a family of four in 2011
4. Proof of a pre-existing condition
 - Denial letter from insurer;
 - Letter excluding coverage from insurer; or
 - Evidence that have a medical condition categorically covered by PCIP

PCIP Premiums & Deductible

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- **Premium:**

- Premiums are capped at market rate (100%) but can be lower
- PCIP premiums may vary based on age, tobacco use, geographic area, and deductible

- **Deductible:**

- Can be no higher than \$5,000; the most common amount \$2,500
- Fifteen states offer plans with deductibles at or below \$1,000

PCIP Cost-Sharing & OOP Costs

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□ Co-Insurance:

- Can be no more than 20%
- Most states use 20% co-insurance; 3 states use 30%; 1 uses 25% and 1 uses 15%

□ Annual Out-of-Pocket:

- Maximum for 2011 was \$6,050
- Washington & Maryland have the lowest in-network Out-of-Pocket limit at \$1,500

PCIP Provides Comprehensive Coverage

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- Benefits include:
 - Prescription drugs
 - Care in medical offices for treatment of illness or injury
 - Emergency services
 - Inpatient & outpatient hospital services
 - Inpatient & outpatient mental health and substance abuse services
 - Home health care & hospice services
 - Outpatient laboratory & diagnostic services
 - In- and out-of-network benefits
 - First-dollar coverage for preventive care
 - No lifetime maximum on the amount the plan pays for enrollee's care
 - Benefits are available immediately

- No waiting period

High Enrollment Expectations

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- **The Congressional Budget Office (CBO)** had estimated that over **200,000** people would enroll into this program **“each year.”**
- **Centers for Medicare and Medicaid Services (CMS)** had predicted an enrollment of **375,000** individuals by the **“end of 2010.”**
- CMS also expected the **\$5 billion** in **funding to be exhausted** by 2011 or 2012.

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Low Enrollment Rate & Numbers

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- **CBO** expected enrollment: **200,000 per year**
 - ▣ Actual – July 30, 2012 = 30,395

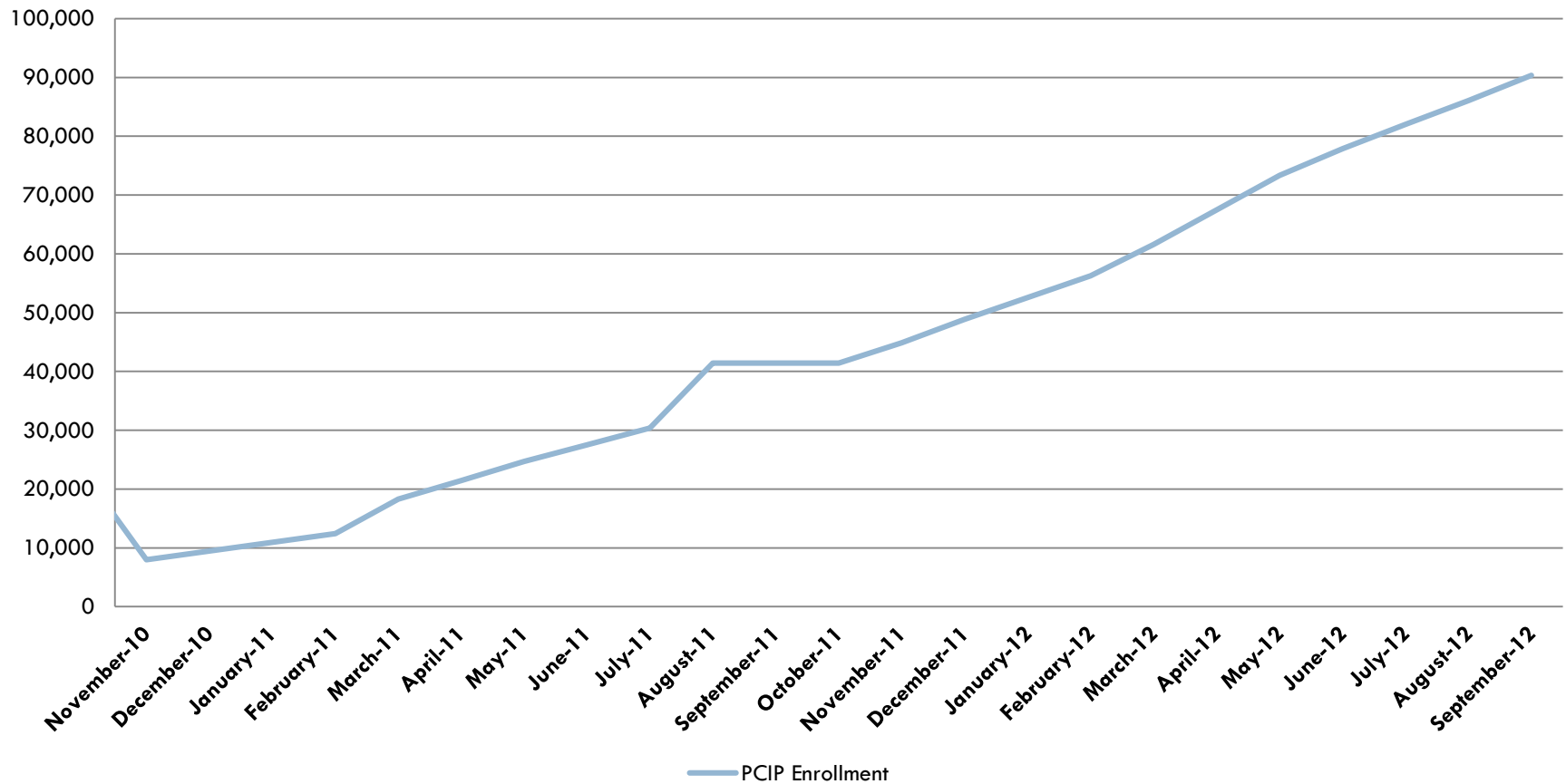
- **CMS** expected enrollment: **375,000 by the end of 2010**
 - ▣ Actual – November 1, 2010 = 7,986
 - ▣ Actual – February 1, 2011 = 12,437

- Most Recent Enrollment - September 30, 2012 = **90,347**

- Funding remains

Enrollment Rates

PCIP Enrollment- November 1, 2010 to September 30, 2012



Research Question & Specific Aims

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- **Research Question:** To study the PPACA's PCIP program, which has had an unexpected low-enrollment into the program, in effort to strengthen the PCIP and the PPACA.

- **Aim 1:** Identify reasons for the below expected enrollment into the State and Federal PCIP programs between July 1, 2010 and July 1, 2012.

- **Aim 2:** Based on the reasons identified in Aim 1, formulate recommendations to boost enrollment in the State and Federal run PCIP programs for August 1, 2012 and January 1, 2014.

- **Aim 3:** Based on the analysis of PICP's enrollment patterns, determine whether we are likely to see a similar trend in 2014 by the pre-existing condition population.

- **Aim 4:** Formulate recommendations to boost purchase of private health insurance in the exchanges by the pre-existing condition population after 2014.

Research Methods

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- This policy research study is *qualitative study* based on *interviews* with key informants and *literature review*.
- Key informants were contacted by phone or email and requested to partake in a 30-minute phone interview.
- Out of the 20 people contacted, 7 interviews were conducted.
- Before the start of the interview, the key informant for asked for their consent to audio record, use the contents of the interview, their affiliation for purposes of this study.

Key Informants

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□ **Lynn R. Gruber, J.D.**

- Former President & CEO of Minnesota's high risk pools for over 20 years
- Chair of Communications Committee at National Association of State Comprehensive Health Insurance Plans (NASCHIP)
- Now works as a healthcare consultant

□ **Amanda Cassidy**

- Robert Wood Johnson
- Meitheal Health Policy, LLC
- Previously worked for the CMS, in the Office of Legislation and the Center for Medicare Management

□ **Joanne Kenen**

- POLITICO Pro's deputy health care editor.
- Has written and published on areas of health policy and health politics since 1994

Key Informants

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- **Jean P. Hall, Ph.D.**
 - The Commonwealth Fund
 - Associate Professor at the University of Kansas
 - Published articles on PCIP, insurance and other related subjects.

- **Karen Larson**
 - Executive Director
 - Washington State Health Insurance Pool (WSHIP)

- **Pete Cutler J.D.**
 - Office of Washington State Insurance Commissioner, Mike Kreidler

- **Richard Onizuka, Ph.D.**
 - CEO of Washington Health Benefit Exchange
 - Previously served as Health Care Authority's assistant director for health policy

Interview Topics & Analysis

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- The interviews followed a pre-determined script of questions on the below listed topic areas
 - 1) Reasons for low enrollment;
 - 2) How enrollment may be increased into PCIP;
 - 3) If similar enrollment trends are to be expected with the exchanges 2014; and
 - 4) Recommendations for 2014.

- Analysis:
 - ▣ Interviews were recorded and transcribed
 - ▣ Transcriptions and notes taken during the interview were used to identify themes and common responses
 - ▣ Themes and responses were compared and compiled with literature on this topic.

Aim 1: Reasons for Low Enrollment

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- Content analysis of responses elicited major four major themes:
 1. PCIP Premiums are still too High;
 2. The Six-month Uninsured Period Requirement is a major deterrent;
 3. Lack of Awareness of PCIP; and
 4. Lack of Funding.

PCIP Premiums are too High

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- “Unless people have a very pressing medical condition, they are not going to buy in because they were not going to pay about \$1,000, which is the average cost for a 50 year old, just to have back up care.”
- “If the PCIP had been made available with the same kind of tax subsidies that will be available in the exchange there would have been more people in the program.”
- “Subsidies are the real incentive for them to enroll. Plus it is not like they do not want insurance, rather they cannot afford it.”
- “The federal law provides a lot for the cost barriers and I think that will go a long way in making enrollment much more attractive.”

PCIP Premiums are too High

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□ PCIP

- Based on Standard Risk Rate (100%) of “individual market”, not group-market
- No Premium subsidies

□ Insurance Exchanges

- Individual mandate / tax penalty, thus, larger pools and group rates
- Premium subsidies for people below 400% FPL

Six-Month Uninsured

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□ PCIP

- “Even if you have an unsatisfactory insurance (one that has a heavy deductible or does not meet all your health needs) you are not going to go uninsured for six months in order to get into the PCIP.”
- “There are people out there that perhaps do not have very good insurance or have marginal coverage but have something. It is too much of a risk to go for six-months without coverage. Risk because what if something happens during the six months?”

□ Insurance Exchanges

- No such limit for Exchanges.

Lack of Awareness

- “There is a lot of data that people **do not understand** what is in the health law or what applies to them.”
- “The main reason that enrollment was so low is because **people just never knew about it**”
- “But it **appears as if the money is running out**. They are **not advertising** much and not getting the word out. That is the reason we have very few people that ever became aware of it.”
- “Once the **exchanges** are established the options will be much **easier to explain** because they will be much **more simplified compared to PCIP.**”

Lack of Awareness

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- PCIP
 - ▣ Less outreach due to funding restrictions

- Insurance Exchanges
 - ▣ PCIP enrollees will automatically be transitioned into the exchanges in 2014
 - ▣ Navigator programs
 - ▣ More general awareness

Lack of Awareness Recommendations

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- Denial letter refer to the Pool
- AARP mass mailing notifying of PCIP
- Education for insurance brokers
- Advocacy organization outreach
- Legislator and provider education
- News articles

Lack of Funding

- “The funding was recognized as an issue when the law passed...”
- “Part of the reason the enrollment was low is because of the funding. They wanted to design the program in a way that they would not create the situation where they would have to cut people off.”
- “They were trying not to increase the deficit of the whole package [ACA] and had a certain finite amount of money to address this problem.”
- “Plus, if they increased the money then this would make it difficult for the overall bill to pass.”

Lack of Funding

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- PCIP
 - ▣ \$5 Billions dollars

- Insurance Exchanges
 - ▣ Exchanges are a marketplace—not being subsidized by the Federal government

Conclusions

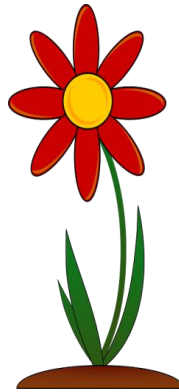
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- **“It’s a question of money! “**
 - High Premiums;
 - The Six-month Uninsured Period Requirement; and
 - Lack of Awareness of PCIP.

- **“PCIP has been a kind of a pilot program.** It provided us understanding of the economics of health insurance. It showed how the pre-existing population will behave when offered coverage at market prices without having those conditions previously covered.”
 - “Something we have seen is that there has been a **high amount of turnover.**”
 - **“People are sicker than we thought”**

- **“PCIP is a successful program** because in the end, it got tens of thousands of people who needed the health insurance some coverage, until they can get coverage on their own in the exchanges.”

Thank you for you attention.



Questions?



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