US preexisting conditions health plan closed for enrollment

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With the Obama administration's halting of enrollment in the Pre-Existing Condition Insurance Plan (PCIP), thousands of people are in danger of losing health coverage. PCIP was set up as a stopgap measure in the transition to full implementation of the Patient Protection and Affordable Care Act (PPACA) in January 2014, when insurance companies will be required to cover so-called uninsurables—people with serious preexisting medical conditions.

In mid-February, the Department of Health and Human Services (HHS) announced it was suspending new enrollment in the program because the allocated funding was running out. The states are being asked to pick up some of the cost overruns. The Obama administration has requested no additional funding for PCIP in its budget proposal. A Republican bid to tap other funds in the PPACA to pay for the program—a measure President Obama had threatened to veto—failed to win support in the House in late April.

The health care legislation capped spending on PCIP at $5 billion. About 100,000 signed up for the program, demonstrating the critical need for such coverage. Four thousand people on average have been signing up each month for the plan, which means that an estimated 40,000 people needing coverage will be turned away by the end of the year.

People with the most serious health conditions, such as cancer and advanced heart disease, have accounted for the bulk of the costs associated with PCIP, which have varied widely. While the average cost per enrollee in 2012 was $32,108, costs have varied widely from state to state, from as low as $4,276 to as high as $171,909. According to The Commonwealth Fund, just 4.4 percent of enrollees account for half the claims paid, with some individual claims running as high as $225,000.

Coverage will continue for people already enrolled in the plan, but they face increased costs for coverage. The maximum out-of-pocket spending limit has already been raised from $4,000 to $6,250, and prescription refills must be ordered by mail. The plan has always included the requirement that participants be uninsured for six months before they are eligible. Some provider fees have also been reduced.

Susan Zurface of Hillsboro, Ohio, is among those who have been turned away from the program. She was uninsured when she was diagnosed with chronic lympocytic leukemia and incurred $60,000 in medical bills almost immediately. Ms. Zurface testified in April on behalf of the Leukemia & Lymphoma Society before the congressional Health Energy and Commerce Subcommittee on Health.

"Without the benefit of coverage," she said, "I will be willfully incurring expenses that I know I have no means to pay, in which case, I will have to consider bankruptcy to discharge whatever medical expenses I have incurred from providers who treated me in good faith, but whom I cannot pay for their services."

State officials in Pennsylvania, where 6,845 are enrolled in the plan, had expected to sign up about 2,000 more people by the end of this year. These individuals will now have to seek out coverage in the very expensive private market, incur huge medical bills, or go without care.

The Obama administration is proposing to shift the risk for cost overruns to the states. HHS has given state officials until this Wednesday to respond to proposed contract terms for the remaining months of the program. In a letter to HHS Secretary Kathleen Sebelius last week, state officials said they were "blindsided" and "very disappointed" with the federal proposal to hold states accountable for the increased

costs.

The HHS contract stipulates that states will be reimbursed “up to a ceiling.” In an interview quoted by AP, Michael Keough, chairman of the National Association of State Comprehensive Health Insurance Plans, commented, “The ‘ceiling’ part is the issue for us. They are shifting the risk from the federal government, for a program that has experienced huge costs overruns on a per-member basis, to states. That’s a tall order.”

The funding crisis surrounding the Pre-Existing Condition Insurance Plan is a predictor of issues that will arise with full implementation of the Obama-backed health care legislation. The law’s requirement that people with preexisting conditions be covered on the insurance “exchanges” set up under the bill will inevitably lead to private insurers hiking their premiums, as people with serious medical conditions become more represented in the pool of insured.

Private insurers across the US are already hiking rates for many customers, in some cases seeking and receiving double-digit increases in premiums from state regulators. The Affordable Care Act provides no meaningful oversight on what private insurance companies can charge for their coverage.

Another likely outcome is that higher insurance costs will lead many younger, healthier people to forgo coverage, opting to pay a financial penalty rather than purchase high-priced premiums. Others will simply not be able to afford it. Potentially, large numbers of the people—those the health care legislation was supposed to bring into the insurance market—will be left uninsured and without access to medical care.