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HEALTH REFORM ISSUE BRIEF

Insurance Access for Preexisting Conditions – Now and Later

**Overview**

This issue brief will focus on insurance access and coverage for individuals with preexisting conditions, including individuals living with HIV/AIDS. This includes both state-run high risk pools and Preexisting Condition Insurance Pools (PCIPs) that the Affordable Care Act (ACA) created. This brief will also examine the transition from these pools to ACA-created insurance marketplaces, called exchanges, and ACA-related Medicaid expansion. Prior to the ACA, many states created special insurance programs, referred to as high risk pools, to provide insurance coverage for people with pre-existing conditions who were unable to purchase private insurance plans or ineligible for Medicare or Medicaid.[[1]](#endnote-1) The ACA created temporary PCIPs (to expire on Jan. 1, 2014) as an intermediate step while states prepared to establish exchanges.[[2]](#endnote-2) Because plans offered by the new state exchanges may not deny coverage due to preexisting conditions, many states are deciding whether to discontinue or modify their high risk pools. Additionally, under the ACA, states can expand Medicaid to help cover more low-income individuals with preexisting conditions.[[3]](#endnote-3) As the pools also cover many individuals with HIV/AIDS,[[4]](#endnote-4) HIV/AIDS departments may wish to provide input on the implications of various options for state high risk pools particularly if their state chooses to discontinue its program. Many HIV/AIDS patients are also enrolled in PCIPs, including some clients under the AIDS Drug Assistance Program (ADAP). Some ADAP programs provide clients with financial support to enroll in PCIPs or high risk pools, rather than directly providing or paying for medications.[[5]](#endnote-5) In order to ensure that coverage (and possibly treatment) is not disrupted for HIV/AIDS clients, it is important for ADAP coordinators and other HIV/AIDS program leadership to understand how transitions may work; especially to prepare enrolling clients in either the new state health exchanges or Medicaid. In the case of ADAP patients who receive premium support to enroll in discontinued plans and who are unable to qualify for other coverage, this may involve fully paying for services and treatment under ADAP. For questions about how these changes will impact coverage in your state, please contact Amy Killelea.

**Health Insurance for People with Preexisting Conditions.**

There are several insurance programs available to individuals with preexisting conditions. Currently, they can seek to obtain coverage through a state high risk pool or a PCIP.

*Now: State High Risk Pools*

States created high risk pools as a means to provide health insurance for otherwise “uninsurable” individuals. State law determines eligibility, premiums (usually as a percentage of the average premium), benefits and any cost sharing (like deductibles or co-pays), and these factors vary among states.[[6]](#endnote-6) High risk pools are typically directed at ensuring availability rather than affordability, and are therefore more expensive than insurance for an individual without a preexisting condition – usually 125-200% of an average premium.[[7]](#endnote-7) Despite these higher premiums, every state high risk pool reports that annual expenses exceed revenues from enrollees, necessitating subsidies from the state government to continue operations.[[8]](#endnote-8) Additionally, many high risk pools have an exclusionary period during which preexisting conditions are not covered.[[9]](#endnote-9)

**Facts on State High Risk Pools**:

* Prior to the ACA, thirty-five states had already created high risk pools.[[10]](#endnote-10)
* As of 2012, these pools covered approximately 226,000 people.[[11]](#endnote-11)
* Seventeen states of these states permit ADAP to enroll clients in the high risk pool.[[12]](#endnote-12)
* Currently, about 7,000 ADAP clients have been enrolled at an average cost of $8,000 per person.[[13]](#endnote-13)

Although many state high risk pools have expressed an intention to close once the ACA is fully implemented, high risk pools have the option to remain open, either temporarily to ease the ACA transition or permanently by offering the plan through an exchange or as a reinsurance program. Reinsurance is a program in which a third party (in this case, the state) agrees to indemnify an insurer for costs that exceed a certain amount – essentially, insurance for insurance plans.[[14]](#endnote-14)

*Now: Preexisting Condition Insurance Pools*

PCIPs were established by Section 1101 of the ACA.[[15]](#endnote-15) Like existing state high risk pools, PCIPs are intended to provide health insurance for people who cannot purchase insurance in the private market. States were offered the choice of running a PCIP themselves, or allowing the federal government to administer a PCIP instead.

**Facts on PCIPs:**

* Currently, twenty-seven states administer their own PCIPs.
* The federal government administers the remaining twenty-three (plus the District of Columbia).[[16]](#endnote-16)
* More than 107,000 people are currently enrolled in the PCIP program.[[17]](#endnote-17)
* Twenty-three states have permitted ADAP to enroll patients in PCIPs, totaling approximately 4,700 clients at an average cost of $6,188 each.[[18]](#endnote-18)

Unlike state high risk pools, the PCIP program was created with a specified amount of funding ($5 billion) and an expiration date (January 1st, 2014).[[19]](#endnote-19) Also unlike state high risk pools, PCIPs may not have exclusion or waiting periods, and beneficiaries may not pay more than $6,250 out-of-pocket annually.[[20]](#endnote-20) Although PCIPs are cheaper than high risk pools for ADAP clients, it should be noted that the average cost for all PCIP enrollees is significantly higher than those for high risk pools (about nine times higher per member per month).[[21]](#endnote-21) Because the expiration date is set by federal law, PCIPs must close on January 1, 2014. The Department of Health and Human Services closed enrollment on February 16, 2013 for federally operated PCIPs and March 2, 2013 for state operated PCIPs, in order to preserve existing funding.[[22]](#endnote-22)

*Later – 2014 and Beyond: Health Insurance Exchanges*

After 2014, the prohibition on preexisting condition exclusions will allow some patients to enroll in an insurance plan offered by the newly-created insurance exchanges. Health insurance exchanges are special marketplaces where individuals and insurance companies will be able to purchase health insurance. States may choose whether to administer the state exchange themselves, enter into a state-federal exchange partnership, or to allow the federal government to run the exchange.

**Facts on Exchanges as of April 2013:**

* Seventeen states and the District of Columbia intend to run their own exchanges.
* Seven states have entered into partnerships.
* Twenty-six states have defaulted to a federally-run exchange.
* Open enrollment for all states will begin in October 2013, and coverage will start on January 1, 2014.[[23]](#endnote-23)

Insurance plans meeting the requirements to be offered on the exchange must include Essential Health Benefits (EHBs) specified by the federal government and will have annual cost-sharing limits based on the limits for health savings accounts (currently about $6,000 for individuals and $12,000 for families).[[24]](#endnote-24) Additionally, insurers may not charge increased premiums based on health status (except for age). People with income greater than 100%, but less than 400%, of the FPL will qualify to receive government subsidies for purchasing an exchange plan.[[25]](#endnote-25)

*Later – 2014 and Beyond: Medicaid*

Beginning in January 2014, states will the option to expand their Medicaid coverage to all individuals under 138% of the federal poverty level (FPL).[[26]](#endnote-26)

**Facts on Medicaid Expansion as of April 2013:**

* Twenty-five states and the District of Columbia intend to participate in Medicaid expansion.
* Fifteen states have declined.
* The remaining ten states are currently undecided.[[27]](#endnote-27)

Because Medicaid is aimed at affordability, cost sharing is typically minimal, and there are no premiums for individuals with incomes less than 150% of FPL.[[28]](#endnote-28) As of 2013 at least 7,376 ADAP clients were enrolled in Medicaid,[[29]](#endnote-29) and this number is likely to increase once Medicaid expansion begins.

**Preexisting Condition Coverage Case Studies**

The following case studies illustrate how individuals with preexisting conditions are currently covered and how they would be affected the 2014 transition.

Case 1:

* John is a 40 year-old man living with HIV and is a New Mexico resident. John recently lost his employer-based health insurance, but has found another job that pays 250% of federal poverty level (about $28,725 a year).
* Because he has had health insurance within the last 6 months, he is not eligible for PCIP enrollment, but is eligible for the state high risk pool.
* If John enrolls in the $2000 deductible plan, his premiums in the state high risk pools will be $1,887 annually.
* If New Mexico decides to close its high risk pool in 2014, John would need to enroll in the state health exchange.
* Assuming John enrolls in a “silver” plan (which would have roughly the same level of cost sharing as the PCIP), his premiums would increase to $2,315 annually after the subsidy is taken into account.
* If John were instead 50 years old, his premiums in the exchange would remain the same, but his premiums in the state health pool would be $2,565.

Case 2:

* Joanne is a thirty year-old living in North Carolina who has never had health insurance. She has a preexisting condition, and makes 100% of the FPL ($11,490), but is not disabled and does not currently qualify for Medicaid.
* As a result, she was eligible for the PCIP program before enrollment closed. Her PCIP premiums under the “standard” plan range from $69 to $658 per year depending on where in North Carolina she resides.[[30]](#endnote-30)
* In 2014, the PCIP program will no longer provide coverage and Joanne will need a different type of health insurance.
* Joanne would qualify for Medicaid under the expansion, but North Carolina has indicated it will not expand Medicaid eligibility. Therefore she would need to purchase health insurance through the exchange, which for her age and income, would cost about $230 annually.[[31]](#endnote-31)
* If she stopped working, however, she would no longer qualify for the exchange subsidy, because her income would be below the 100% level where subsidies begin. Unable to afford the insurance premium, Joanne would be left without any insurance coverage.

**Potential Implications of PCIP and State High Risk Pool Transition**

As full ACA implementation approaches, HIV/AIDS departments face several challenges for individuals with pre-existing conditions. The first is how best to ensure continuous coverage for those individuals currently enrolled in PCIPs and (in certain states) high risk pools. At minimum, clients should be informed of the change in their coverage status. It is also likely that at least some patients will need assistance in enrolling in state health exchanges or Medicaid. Additionally, certain categories of patients may have difficulty affording health insurance through the exchange, even with premium subsidies. In these cases, ADAPs may wish to provide premium support as permitted by the Ryan White Program.

Additionally, many state-run high risk pools are still in flux. Due to the guaranteed issue provisions of the ACA, patients currently enrolled in high risk pools will no longer be prevented from purchasing private insurance. However, state high risk pools still have other potential roles, such as covering gaps in affordability and reducing the number of high cost patients immediately enrolling in health exchange plans. Although the specifics of the transition will vary based on existing state programs and finances, the following are possible questions departments may have as they prepare for health reform implementation:

***Are PCIPs permitted to continue any operations after 2014?***

Yes, to a limited extent. Although PCIP insurance *coverage* must end January 1st, PCIPs may continue to operate for a “run off” period to process claims from services provided prior to 2014, and to close out existing contracts.[[32]](#endnote-32)

***What options are available for states with high risk pools?***

Several options have been identified. Of the thirty-five states operating high risk pools, the current status is as follows:

* Eight states intend to close operations and transition all members to health exchanges on January of 2014.
* An additional two states are likely to close operations.
* Three states intend to cease enrollment in high risk pools on January 1, 2014 but will continue providing coverage temporarily to ease the transition to state health exchanges.
* Three states are planning to continue operating at least some populations for the foreseeable future.
* Two states are considering operating as a reinsurance program.
* Seven states intend to utilize a mix of options such as continuing operations temporarily and considering operating as a reinsurance program. For example, Mississippi plans to cease new enrollment on January 1 (with an undefined transition period) but is also considering using its high risk pool as a reinsurance program.[[33]](#endnote-33)
* Ten states have no specific indication of their future plans on their high risk pools.

***If a state continues to offer a high risk pool, will it need to make changes?***

Possibly. Although state-operated high risk pools may be able to qualify for the “grandfathering” provisions under the ACA, they will still be required to comply with certain other provisions. All health insurance plans, including “grandfathered” plans must allow extension of a parent’s coverage to any adult children under the age of 26, and may *not* place lifetime limits on coverage, rescind coverage for unintentional mistakes on an insurance application, or have a waiting period of more than 90 days.[[34]](#endnote-34) Certain changes, such as the elimination of benefits or an increase in copayments, may cause a plan to lose its “grandfathered” status; at which point the plan would be required to fulfill all ACA requirements (such as required benefits and limits on cost sharing).

***Are there potential coverage or affordability gaps in the ACA system?***

Yes. Although exchange plans are subsidized for individuals with incomes between 100% and 400% of federal poverty level, some patients may still find exchange plans unaffordable, either because the subsidy is insufficient or because they do not qualify. Additionally, some individuals with incomes below 100% do not qualify for exchange subsidies, and may not be eligible for Medicaid coverage in states that do not choose to expand. State high risk pools may also be less costly for individuals in certain income and age brackets. Finally, undocumented immigrants are not eligible to participate in Medicaid or state exchanges (for more on immigrants, see the NASTAD issue brief).

***Can ADAP offer premium assistance for state exchange plans?***

Most likely, at least on the federal level. There has been no official regulation either allowing or disallowing ADAP from offering premium assistance for state exchange programs. ADAP is authorized by statute to provide premium assistance to its clients.[[35]](#endnote-35) Nonetheless, in considering whether to allow third-parties (including ADAP) to pay PCIP premiums, HHS expressed concern over the possibility of “dumping” of costly patients and stated that it would closely monitor third party payers.[[36]](#endnote-36) However, HHS did ultimately allow third parties (including ADAP) to provide premium assistance for PCIPs, and the structure of state health exchanges makes dumping less of a concern. Of course, individual states may still choose not to provide premium assistance (as many do not currently enroll ADAP clients in PCIPs, high risk pools, or Medicaid currently).

***What issues are addressed by allowing high risk pools to remain open?***

Some states have expressed concern that transitioning all patients currently enrolled in PCIPs and state high risk pools immediately could overwhelm the insurance exchanges.[[37]](#endnote-37) Because PCIP and high risk pool enrollees are more expensive than the average consumer, their entry into the market could force insurers to increase premiums across the board. By transitioning more slowly, the insurance exchange plans could have the chance to enroll more people without preexisting conditions, allowing any rate increases to be spread over more people, and occur more gradually. Alternatively, operating the state high risk pool as a reinsurance program could defray the cost of these patients. Additionally, the state high risk pool may be more affordable for people in certain age and income brackets, who might otherwise have difficulty affording health insurance. Furthermore, the high risk pool could provide insurance access to those individuals who would otherwise fall into a coverage gap.

**Table 1: Comparison of Preexisting Condition Administration and ADAP Cooperation Between States**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| States | State-run High Risk Pool and ADAP Cooperation[[38]](#endnote-38) | High Risk Pool Post-2014[[39]](#endnote-39)  | PCIP Administration[[40]](#endnote-40) | PCIP and ADAP Cooperation[[41]](#endnote-41) | Medicaid Expansion[[42]](#endnote-42) | State Exchange Administration[[43]](#endnote-43) |
| Alabama | Pool, but no ADAP enrollment | Considering as reinsurance plan | Federal | No enrollment | Not Participating | Federal Exchange |
| Alaska | ADAP Enrollment | 1 | State | No enrollment | Undecided | Federal Exchange |
| Arizona | No Pool | No Pool | Federal | Allows Enrollment | Participating | Federal Exchange |
| Arkansas | Pool, but no ADAP enrollment | Close operation January 2014 | State | No enrollment | Participating | State-Federal Partnership |
| California | Pool, but no ADAP enrollment | Close operation January 2014 | State | Allows Enrollment | Participating | State-run exchange |
| Colorado | Pool, but no ADAP enrollment | Cease enrollment January 2014 | State | Allows Enrollment | Participating | State-run exchange |
| Connecticut | Pool, but no ADAP enrollment | Continue operating post-2014 | State | Allows Enrollment | Participating | State-run exchange |
| Delaware | No Pool | No Pool | Federal | No data reported | Participating | State-Federal Partnership |
| DC | No Pool | No Pool | Federal | No data reported | Participating | State-run exchange |
| Florida | Pool, but no ADAP enrollment | Unknown | Federal | Allows Enrollment | Participating | Federal Exchange |
| Georgia | No Pool | No Pool | Federal | Allows Enrollment | Not Participating | Federal Exchange |
| Hawaii | No Pool | No Pool | Federal | No enrollment | Participating | State-run exchange |
| Idaho | Pool, but no ADAP enrollment | Unknown | Federal | No enrollment | Not Participating | State-run exchange |
| Illinois | ADAP Enrollment | Unknown | State | Allows Enrollment | Participating | State-Federal Partnership |
| Indiana | ADAP Enrollment | Close operation January 2014 | Federal | No enrollment | Undecided | Federal Exchange |
| Iowa | Pool, but no ADAP enrollment | Unknown | State | No enrollment | Not Participating | State-Federal Partnership |
| Kansas | ADAP Enrollment | Unknown | State | Allows Enrollment | Undecided | Federal Exchange |
| Kentucky | Pool, but no ADAP enrollment | Cease enrollment January 2014 | Federal | Allows Enrollment | Undecided | State-run exchange |
| Louisiana | ADAP Enrollment | Close operation January 2014 | Federal | Allows Enrollment | Not Participating | Federal Exchange |
| Maine | No Pool | No Pool | State | No enrollment | Not Participating | Federal Exchange |
| Maryland | ADAP Enrollment | Considering as reinsurance plan | State | No enrollment | Participating | State-run exchange |
| Massachusetts | No Pool | No Pool | Federal | No enrollment | Participating | State-run exchange |
| Michigan | No Pool | No Pool | State | Allows Enrollment | Participating | State-Federal Partnership |
| Minnesota | ADAP Enrollment | Continue operating post-2014 | Federal | No enrollment | Participating | State-run exchange |
| Mississippi | Pool, but no ADAP enrollment | 2 | Federal | No enrollment | Not Participating | Federal Exchange |
| Missouri | Pool, but no ADAP enrollment | Unknown | State | No data reported | Participating | Federal Exchange |
| Montana | Pool, but no ADAP enrollment | Unknown | State | No enrollment | Participating | Federal Exchange |
| Nebraska | ADAP Enrollment | Unclear, but likely to close | Federal | Allows Enrollment | Undecided | Federal Exchange |
| Nevada | No Pool | No Pool | Federal | No enrollment | Participating | State-run exchange |
| New Hampshire | Pool, but no ADAP enrollment | 3 | State | Allows Enrollment | Participating | State-Federal Partnership |
| New Jersey | No Pool | No Pool | State | No enrollment | Participating | Federal Exchange |
| New Mexico | ADAP Enrollment | 2 | State | No enrollment | Participating | State-run exchange |
| New York | No Pool | No Pool | State | Allows Enrollment | Undecided | State-run exchange |
| North Carolina | Pool, but no ADAP enrollment | Close operation January 2014 | State | Allows Enrollment | Not Participating | Federal Exchange |
| North Dakota | ADAP Enrollment | Unknown | Federal | Allows Enrollment | Participating | Federal Exchange |
| Ohio | No Pool | No Pool | State | Allows Enrollment | Participating | Federal Exchange |
| Oklahoma | ADAP Enrollment | Close operation January 2014 | State | No enrollment | Not Participating | Federal Exchange |
| Oregon | ADAP Enrollment | Close operation January 2014 | State | Allows Enrollment | Participating | State-run exchange |
| Pennsylvania | No Pool | No Pool | State | No enrollment | Not Participating | Federal Exchange |
| Rhode Island | No Pool | No Pool | State | No data reported | Participating | State-run exchange |
| South Carolina | Pool, but no ADAP enrollment | Unknown | Federal | Allows Enrollment | Not Participating | Federal Exchange |
| South Dakota | ADAP Enrollment | Cease enrollment January 2014 | State | No enrollment | Not Participating | Federal Exchange |
| Tennessee | Pool, but no ADAP enrollment | Unknown | Federal | Allows Enrollment | Not Participating | Federal Exchange |
| Texas | Pool, but no ADAP enrollment | Unclear, but likely to close | Federal | No enrollment | Not Participating | Federal Exchange |
| Utah | ADAP Enrollment | 2 | State | Allows Enrollment | Undecided | State-run exchange |
| Vermont | No Pool | No Pool | Federal | No data reported | Participating | State-Federal Partnership |
| Virginia | No Pool | No Pool | Federal | No enrollment | Undecided | State-run exchange |
| Washington | ADAP Enrollment | 4 | State | Allows Enrollment | Participating | State-run exchange |
| West Virginia | Pool, but no ADAP enrollment | Close operation January 2014 | Federal | No enrollment | Undecided | State-Federal Partnership |
| Wisconsin | ADAP Enrollment | 2 | State | Allows Enrollment | Not Participating | State-run exchange |
| Wyoming | Pool, but no ADAP enrollment | Continue operating post-2014 | Federal | No enrollment | Undecided | State-run exchange |
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|  |  |  |  |  |  |  |
| 1: Alaska plans to plans to continue operating HRP, may also operate as reinsurance |  |  |  |  |
| 2: Mississippi, New Mexico, Utah and Wisconsin plan to keep pool open temporarily and operate as reinsurance plan. |  |  |  |  |
| 3: New Hampshire plans to stop taking new applications January 2013, but may operate as a reinsurance program and/or QHP. |  |  |
| 4: Washington's high risk pool may close enrollment, remain open temporarily, and/or operating as reinsurance.  |  |  |
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**Resources on State High Risk Pools and PCIPs**

* [The National Association of State Comprehensive Health Insurance Plans (NASCHIP](http://naschip.org/portal/)) is the professional organization for administrators of state high risk pools. The NASCHIP website includes information on existing state high risk pools, as well as resources on options for state high risk pools during ACA implementation.

**NASTAD Resources on Health Reform**

* [NASTAD Health Reform Website](http://www.nastad.org/care_and_treatment/resources.aspx?category=health%20reform) houses NASTAD’s presentations, issue briefs, fact sheets, and other resources on health reform.
* [NASTAD Blog](http://blog.nastad.org/tag/health-reform/) provides timely updates and breaking news with regard to federal and state health reform implementation.
1. *About Pools,* National Association of State Comprehensive Insurance Plans, *available at* <http://naschip.org/portal/index.php?option=com_content&view=article&id=54:about-pools> (hereafter “About Pools”). [↑](#endnote-ref-1)
2. 42 USC § 18001(a). [↑](#endnote-ref-2)
3. 42 USC § 1396(a)(10)(A)(i)(VIII). [↑](#endnote-ref-3)
4. Amy Killelea and Britten Pund, *National ADAP Monitoring Project Annual Report: Module 2 April 2013*, *available at* <http://nastad.org/docs/NASTAD-National-ADAP-Monitoring-Project-Report-Module-2-2013.pdf> (hereafter “National ADAP Monitoring Project Annual Report”). [↑](#endnote-ref-4)
5. *Id.* at 9, 25 and 26 (Table 6). [↑](#endnote-ref-5)
6. *See About Pools, supra* note 1. Generally speaking, high risk pools allow enrollment for one or more of three groups: 1) people who had insurance previously through an employer (i.e., eligible for continuing coverage under the Health Insurance Portability and Accountability Act (HIPAA), HIPAA provides for continuing coverage of patients who had health insurance for individuals who lost insurance coverage for reasons other than fraud or non-payment of premiums; generally, the individual must have had insurance for at least 18 months with a gap of no more than 63 days. *See* Centers for Medicare and Medicaid Services, *HIPAA Eligibility Criteria for Individual Coverage*, *available at* <http://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/HIPAA_Eligibility_Criteria.pdf>); 2) people who qualify for the federal Health Care Tax Credit (HCTC) program, which provides premium support for certain groups of workers or are receiving payments from the federal government due to termination of a pension plan. *See HCTC: Eligibility Requirements and How to Receive the HCTC*, Internal Revenue Service, available at [http://www.irs.gov/Individuals/HCTC:-Eligibility-Requirements-and-How-to-Receive-the-HCTC-](http://www.irs.gov/Individuals/HCTC%3A-Eligibility-Requirements-and-How-to-Receive-the-HCTC-); 3) and/or people who can prove they are uninsurable in the individual market (either by showing they have been denied coverage or showing they have a condition that the state has deemed to make them presumptively uninsurable). *See* *About Pools, supra* note 1. [↑](#endnote-ref-6)
7. *About Pools, supra* note 1. [↑](#endnote-ref-7)
8. *Id.* [↑](#endnote-ref-8)
9. *Id.* [↑](#endnote-ref-9)
10. *Id.* [↑](#endnote-ref-10)
11. Jean Hall and Janice Moore, *Realizing Health Reform’s Potential: The Affordable Care Act’s Pre-existing Condition Insurance Plan: Enrollment, Costs, Lessons for Reform,* 4, *available at* <http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Sep/1627_Hall_PCIP_enrollment_costs_lessons_rb.pdf>. [↑](#endnote-ref-11)
12. *National ADAP Monitoring Project Annual Report*, *supra* note 4, at 9 and 25 (Table 6). [↑](#endnote-ref-12)
13. *Id.* [↑](#endnote-ref-13)
14. *The Transitional Reinsurance Program,* Center for Consumer Information and Insurance Oversight, *available at* <http://cciio.cms.gov/resources/files/hie-reinsurance-fact-sheet-handout.pdf>. [↑](#endnote-ref-14)
15. 42 USC § 18001(a) [↑](#endnote-ref-15)
16. *Covering People with Pre-existing Conditions: Report on the Implementation and Operation of the Pre-existing Condition Insurance Plan Program*, Center for Consumer Information and Insurance Oversight, 3, *available at* <http://cciio.cms.gov/resources/files/Files2/02242012/pcip-report.pdf> (hereafter “CCIIO Report”). *.*  [↑](#endnote-ref-16)
17. *Id.* [↑](#endnote-ref-17)
18. *National ADAP Monitoring Project Annual Report, supra* note 4, at 9 and 24 (Table 5). [↑](#endnote-ref-18)
19. CCIOO Report, *supra* note 16, at 15. [↑](#endnote-ref-19)
20. *Id.* at 11, 13. [↑](#endnote-ref-20)
21. *Realizing Health Reform’s Potential: The Affordable Care Act’s Pre-existing Condition Insurance Plan: Enrollment, Costs, Lessons for Reform,* 5, *available at* <http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Sep/1627_Hall_PCIP_enrollment_costs_lessons_rb.pdf> [↑](#endnote-ref-21)
22. *Pre-Existing Condition Insurance Plans* Department of Health and Human Services <http://www.healthcare.gov/law/features/choices/pre-existing-condition-insurance-plan/index.html>. [↑](#endnote-ref-22)
23. *Establishing Health Insurance Exchanges: an Overview of State Efforts,* Kaiser Family Fund, 1, *available at* <http://www.kff.org/healthreform/upload/8213-02.pdf>. [↑](#endnote-ref-23)
24. *Patient Cost Sharing under the Affordable Care Act,* Kaiser Family Foundation, 3, *available at* <http://www.kff.org/healthreform/upload/8303.pdf>. [↑](#endnote-ref-24)
25. For more information on how exchange subsidies are calculated, see the NASTAD *Premium Tax Credits and Cost Sharing Subsidies* Issue Brief at <http://www.nastad.org/docs/HCA-Affordability-Brief-FINAL-February-2013.pdf> [↑](#endnote-ref-25)
26. *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State by State Analysis*, Kaiser Family Foundation, 3, *available at* <http://www.kff.org/medicaid/upload/8384.pdf> [↑](#endnote-ref-26)
27. Center on Budget and Policy Priorities, *Health Reform’s Medicaid Expansion, available at* <http://www.cbpp.org/cms/index.cfm?fa=view&id=3819>. [↑](#endnote-ref-27)
28. 42 USC § 1396o(a)(3). [↑](#endnote-ref-28)
29. *National ADAP Monitoring Project Annual Report, supra* note 4, at 21 (Table 2). [↑](#endnote-ref-29)
30. Pre-existing Condition Insurance Plan: North Carolina, <http://www.healthcare.gov/law/features/choices/pre-existing-condition-insurance-plan/nc.html>. [↑](#endnote-ref-30)
31. *See* NASTAD *Premium Tax Credits and Cost Sharing Subsidies* Issue Brief, *available at* <http://www.nastad.org/docs/HCA-Affordability-Brief-FINAL-February-2013.pdf>. [↑](#endnote-ref-31)
32. Pre-Existing Condition Insurance Plan Program Interim Final Rule, 75 Fed. Reg. 45014, 45021 (July 30, 2010) (to be codified at 7. C.F.R. Part 152). [↑](#endnote-ref-32)
33. State of Illinois, Office of the Board of Directors, Comprehensive Health Insurance Plan, *Material Considered at the Sept. 19, 2012 Board Meeting, available at* <http://www.chip.state.il.us/Material%20considered%20at%20the%20October%202%202012%20Board%20meeting.pdf>. [↑](#endnote-ref-33)
34. 14 USC § 18011(4). [↑](#endnote-ref-34)
35. *Portability of Coverage, Enrollee Notices and Third Party Payments under the Pre-Existing Condition Insurance Plan Program (Policy Letter #3),* Office of Insurance Programs, 4-5, *available at* <http://cciio.cms.gov/resources/files/12-28-2010portability_of_coverage-ltr.pdf>. [↑](#endnote-ref-35)
36. *Id.* [↑](#endnote-ref-36)
37. Brett Norman, *States Rethink High-Risk-Pool Plans, available at* <http://www.politico.com/story/2013/01/states-rethink-high-risk-pools-exchanges-86831_Page2.html> [↑](#endnote-ref-37)
38. *See National ADAP Monitoring Project Annual Report: Module 2 April 2013.* [↑](#endnote-ref-38)
39. Each state’s website for its high risk pool was visited for transition information. *See* State of Illinois, Office of the Board of Directors, Comprehensive Health Insurance Plan, *supra* note 33. States may have modified plans since the issuance of this report. [↑](#endnote-ref-39)
40. *See Coverage of Uninsurable Pre-existing Conditions: State and Federal High-Risk Pool ,* National Conference of State Legislatures, *available at* <http://www.ncsl.org/issues-research/health/high-risk-pools-for-health-coverage.aspx> (hereafter “NCSL Coverage of Uninsurable Pre-existing Conditions.”) [↑](#endnote-ref-40)
41. *National ADAP Monitoring Project Annual Report, supra* note 4, at 24 (Table 5). [↑](#endnote-ref-41)
42. *Where Each State Stands on Medicaid Expansion,* The Advisory Board, *available a*t <http://www.advisory.com/Daily-Briefing/2012/11/09/MedicaidMap#lightbox/1/>. [↑](#endnote-ref-42)
43. *See NCSL Coverage of Uninsurable Pre-existing Conditions.* [↑](#endnote-ref-43)