

Pre-existing Condition? Now, a Health Policy May Not Be Impossible

By **WALECIA KONRAD**

SIX years ago, Jerry Garner, 45, a real estate agent in Gowen, Mich., underwent a [kidney transplant](#). He recovered nicely, and thanks to diligent adherence to his drug regimen and frequent checkups, he has been healthy ever since — “a miracle,” said his wife, Stephanie.

But last year, the Garners were starting to believe that their good fortune had run out.

Mr. Garner’s insurer asked that he fill out a survey, but somehow this piece of mail slipped through the cracks at the Garner household. As a result, he lost his [health insurance](#). (Ms. Garner, 44, and three of the children — their oldest child is grown — were covered under a different policy.) But because of his pre-existing condition, Mr. Garner proved impossible to insure.

Transplant recipients must take expensive immunosuppressant medications. Without them, the new kidney will not survive. The couple paid Mr. Garner’s \$2,000 monthly drug bill out of pocket and prayed nothing went wrong. Some months they had to choose between the medication and the [mortgage](#).

Finally, after weeks of searching the Internet, making phone calls and praying, Ms. Garner saw a television ad for Michigan’s new pre-existing condition [insurance plan](#). P.C.I.P.’s, as they are known, are state and federal programs for people previously deemed uninsurable because of pre-existing conditions. They offer a bridge to 2014, when the new health insurance exchanges, which must accept all comers, are to open.

Mr. Garner applied to Michigan’s plan and was accepted. Now he pays less in premiums than he did under his previous plan, and he receives more comprehensive coverage.

“It was definitely an answered prayer,” said Ms. Garner. “Two thousand dollars when you’re already struggling is just impossible.”

Plenty of people with pre-existing conditions like Mr. Garner are struggling to find affordable insurance. These plans offer a real alternative, but consumers are only now becoming aware of them. Plus, there are some tough restrictions. Here is what you need to know:

FINDING A PLAN

Pre-existing condition insurance plans, required by the new health care law, opened for business in July. The new plans come in two flavors: 27 states run their own plans with federal money, while the rest rely on the federal [Department of Health and Human Services](#) to administer the plans within their borders.

The new plans did not replace state high-risk pools, which have long offered insurance to people with pre-existing conditions. But the premiums in the new plans are generally much lower. That is why experts had worried that the new plans could be overwhelmed by a deluge of desperate applicants.

In fact, the P.C.I.P.'s got off to a slow start, and many consumers still have no idea they exist. In January, premiums in the federally run plans were reduced nearly 20 percent. Since then, enrollment in all of the new plans has increased 50 percent to 12,000 members.

To find a plan in your state, start with the federal government's Web site, PCIP.gov, which offers lots of application information and details about each of the state plans the department administers. An interactive map at www.pcip.gov/StatePlans.html links to each federal- and state-run plan.

Next, you will need to compare the plan offerings in your state. Federally run P.C.I.P.'s offer three options: standard coverage; extended coverage, with a lower deductible and higher premiums; and an option that combines a high deductible with a health savings account. For a side-by-side comparison of the three choices, click on bit.ly/gS3z9i. Premiums for all three options are also listed online.

State plans that are not administered by the federal government may also offer more than one option. The details can be found at the interactive state map mentioned above.

People without access to the Internet can call the Department of Health and Human Services at 866-717-5826 to find out which plans are available in their states.

ELIGIBILITY RESTRICTIONS

The plans were not intended to solve the health insurance mess. They were intended as a temporary Band-aid, and they have some frustrating limitations.

You must be uninsured for at least six months to be eligible for a plan. That means people already enrolled in state high-risk pools or private insurance cannot apply, even if the new plans would be far less expensive. Unemployed people who are on Cobra or whose benefits have only recently expired are also not eligible.

Plans run by the federal government and those administered by individual states have slightly different application procedures.

To qualify for a federally run plan, you will need proof that you have applied for individual insurance and that a carrier denied you coverage because of a pre-existing condition, or proof that a carrier approved coverage but with a rider that excluded payment for your pre-existing condition. (Do not buy a policy with such a rider, as you will no longer be eligible for a P.C.I.P.)

An uninsured patient may have to apply for insurance simply to get proof of denial to enroll in a plan. Proof may take the form of a denial letter.

State-run plans may have less stringent eligibility requirements. Some require proof of denial, but in others people with certain pre-existing conditions, like [diabetes](#) or [asthma](#), qualify for coverage more or less automatically. Those people need only obtain a letter from their doctors or other health care providers confirming that they have one of the conditions recognized by the plan.

Patients who live in Vermont and Massachusetts can qualify for those state plans if they can show proof that the premiums they have been offered by a private insurer in the individual market are at least twice as high as the P.C.I.P. premium. But they cannot be enrolled in those plans.

If you are newly uninsured, have a pre-existing condition and are shopping for private insurance in the individual market, keep a record of any denials you may receive. If you do not find insurance on your own and you live in a state that requires denial confirmation, you will have the documentation you need.

THE RIGHT COVERAGE The federal government set aside \$5 billion to subsidize the new plans. Even with the subsidies, an individual premium in the federally run standard plan for a 50-year-old can range from \$320 to \$570.

State-run plans determine their own premiums based on what the private insurance market charges insurable members. In Connecticut, for example, monthly premiums for the plan can be as much as \$890.

Review your coverage options carefully. In the plans sponsored by the federal government, all three options cover 100 percent of preventive care, like annual physicals and screenings. All charge a 20 percent co-pay (40 percent for out-of-network providers) for other care, with a \$5,950 out-of-pocket annual maximum for in-network care (\$7,000 for out of network).

The difference is in the deductible. The standard plan has a \$2,000 deductible for in-network care (\$3,000 for out of network), compared to the extended plan's \$1,000 and \$1,500 deductibles.

In Massachusetts, for example, standard plan premiums for people ages 35 to 44 are \$324 a month, compared to \$438 a month for the extended plan. If you can afford the higher out-of-pocket costs, it may make sense to opt for lower premiums.