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Health and Human Services Issue Interim Final Regulations on Pre-Existing Condition Insurance Plan Program

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August 9, 2010

On July 29, 2010, the Office of Consumer Information and Insurance Oversight (OCIIO) and the Department of Health and Human Services (HHS) released interim final regulations establishing the Pre-Existing Condition Insurance Plan program ("PCIP") under the Patient Protection and Affordable Care Act and the subsequent Reconciliation Act (collectively, "PPACA").

In this *On Benefits*, we review the interim final regulations and explore how the new rules will help enforce the health care reform provisions.

Pursuant to PPACA, HHS is required, either directly or through contracts with States or nonprofit private entities (eligible entities), to establish a temporary high risk health insurance program to provide access to coverage for uninsured individuals with pre-existing conditions. The program (the PCIP) is supposed to remain in place until the exchanges established under PPACA go into effect on January 1, 2014. The interim final regulations of OCIIO and HHS establish the rules for the PCIP.

The regulations describe the eligibility requirements, covered benefits, and how premiums are established. It also details how an individual can appeal a PCIP decision, how Federal funding will be allocated, ways to prevent "dumping" of already-insured people into the program,

and strategies for preventing fraud.

Background. Historically, public policy has addressed the challenges of people with pre-existing conditions through either high risk pools or insurance reform. Most States that permit insurers to decline coverage for health reasons have established high risk pools as an alternative coverage option in their individual market. These current pools provide safety net coverage for people who have difficulty obtaining individual health insurance.

States and the Congress through PPACA have also elected to use insurance reforms to address the accessibility and availability of health insurance for high risk populations. PPACA applies a ban on pre-existing condition exclusions and rate-ups based on health status starting in 2014 and prohibits the use of pre-existing condition exclusions for children starting in plan or policy years that begin on or after September 23, 2010. The PCIP program provides coverage to uninsured individuals with pre-existing conditions until PPACA is fully implemented in 2014.

Eligible entities must submit a proposal to carry out a PCIP program in a time and manner, containing such information that HHS requires. The following sets forth the standards required by HHS.

Eligibility. An individual is eligible to

enroll in a PCIP if:

- he is a citizen of the United States;
- he has not been covered under creditable coverage for a continuous six-month period of time beginning prior to the date he is applying for PCIP;
- he has a pre-existing condition; and
- he is a resident of the fifty States (or the District of Columbia).

As it pertains to the first item above, eligibility in a PCIP is limited to citizens of the United States. A PCIP must verify that an individual is a United States citizen or lawfully present in the United States (either through the Department of Homeland Security's automated U.S. Citizenship and Immigration Service or through required documentation).

As it pertains to the second item above, for purposes of establishing a six-month period of time, creditable coverage is coverage as an individual under a group health plan. If an individual has already satisfied the requirement for a six-month period without creditable coverage, the individual will be considered to have satisfied the eligibility requirement for purposes of a PCIP in another State. Thus, an individual who becomes ineligible for a PCIP on the basis of no longer residing in the PCIP's service area is deemed to have satisfied the requirements of this item for purposes of applying to enroll in a PCIP in the new service area.

Comment. Most States currently have high risk pools as created in response to HIPAA but these programs have lower coverage and higher premium costs than the PCIP program. It will be difficult for States to transition their high risk pool into the PCIP program because of the six-month restriction.

As it pertains to the third item above, for purposes of establishing a process for deter-

mining eligibility, "pre-existing condition" generally means a denial of coverage, or limitation or exclusion of benefits, based on the fact that the individual denied coverage or benefits had a health condition that was present before the date of enrollment for the coverage. However, the regulations provide that a PCIP may elect to determine whether an individual has a "pre-existing condition" based on: (i) documented evidence that an insurer has refused, or a clear indication that the insurer would refuse, to issue coverage to an individual on grounds related to the individual's health; (ii) documented evidence that such individual has been offered coverage but only with a rider that excludes coverage of benefits associated with an individual's identified pre-existing condition; (iii) documented evidence of the existence or history of certain medical or health condition; or (iv) other criteria as approved by HHS.

Covered Benefits. The benefits required to be covered under a PCIP builds off of the "essential health benefits" under PPACA, as yet to be defined by HHS. However, the list will be consistent with the most commonly covered services offered in existing State high risk pools. The following benefits must be excluded under a PCIP: cosmetic surgery, custodial care, in vitro fertilization, artificial insemination, abortion services, and experimental care.

Premiums. The premium rates charged for coverage under a PCIP must be established at a standard rate for a standard population. Consideration must be given to the premium rates charged by other insurers offering health insurance coverage to individuals. The regulations do not mandate a specific formula; rather, they specify that a PCIP may calculate the standard rate using reasonable actuarial techniques, as approved by HHS.

Comment. Although the premiums in a

PCIP will generally be lower than a State high risk pool, they may well remain unaffordable for many lower income individuals. The regulations and PPACA however, fail to offer assistance to those that cannot afford coverage in a PCIP.

Appeals. PPACA requires the establishment of an appeals process to enable individuals to appeal determinations under a PCIP. The regulations clarify that this requirement applies both to determinations with respect to benefit coverage and determinations with respect to an individual's eligibility.

Fraud, Waste and Abuse. The regulations require the PCIP to develop, implement, and execute operating procedures to prevent, detect, recover payments, and promptly report to HHS incidences of waste, fraud and abuse. Such procedures must include identifying situations in which individuals are employed, and may have, or have had, access to other coverage such as group health coverage, but were discouraged from enrolling.

Preventing Insurer Dumping. There has long been an incentive for employers and issuers to single out high risk and thus high-cost individuals and offer incentives for them to disenroll from their coverage and obtain coverage under a State high risk pool. The regulations, to combat this historical practice, require PCIPs to establish procedures to identify and report to HHS instances where health insurance issuers or group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage, in instances where such individuals subsequently are eligible to enroll in the PCIP.

Also, in applying the requirement, the HHS may bill the issuer or group health plan for any medical expenses incurred by the PCIP for an individual dumped from coverage.

HHS is also tasked with referring such matters to appropriate Federal or State authorities for other enforcement action. The regulations indicate that additional guidance will be forthcoming to prevent dumping from public programs like Medicaid and CHIP.

Funding. The regulations further clarify that PPACA appropriates \$5 billion to pay the claims and administrative costs of the PCIP program. Historically, State high risk pools collected the funding costs (claims and administrative) through premiums. Likewise, the total costs of the PCIP program comprises the \$5 billion; however such costs may not be used to pay expenses or defray premiums of existing State high risk pools.

The regulations do contain a limitation; presumably, in order to prevent abuse in costs for administrative expenses. A ten percent limit applies to all PCIPs to cover administrative costs.

Comment. Whether the \$5 billion allocated to the PCIP program is sufficient remains to be seen. In June, the Congressional Budget Office estimated that \$10 to \$15 billion would be required to fund the program adequately through 2013.

Furthermore, it is unknown how many individuals will participate in a PCIP. There are approximately five to seven million Americans that are eligible, but only 375,000 are projected to participate. Regardless, several thousand individuals will be covered by the PCIP program. For many, coverage will mean the difference between life and death.

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