SOLUTIONS LAW PRESS

HEALTH CARE UPDATE

New Affordable Care Act Mandated High Risk Pre-Existing Condition Insurance Pool Program Regulations Set Program Rules, Prohibit Plan Dumping of High Risk Members

July 31, 2010

Interim final rules (Regulations) implementing the implementation of the "Pre-Existing Condition Insurance Plan" (PCIP) program required by the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) became effective immediately upon their publication by the Department of Human Services on Friday, July 30, 2010. The Regulations published by HHS on July 30, 2010 define eligible individuals and detail the rules governing the establishment, implementation and administration of the PCIP program. The Regulations also send a clear message that insurers and group health plans risk stiff penalties for engaging in activities that HHS considers inappropriate dumping from coverage of individuals with pre-existing conditions.

Who May Qualify For Enrollment In PCIP Program

Section 1101 of the Affordable Care Act requires HHS to set up the PCIP program to ensure that a temporary high risk health insurance pool program exists to provide affordable health insurance coverage to uninsured individuals with pre-existing conditions until January 1, 2014, when Exchanges established under sections 1311 and 1321 of the Affordable Care Act take effect.

The Regulations provide an individual will be eligible to enroll in a PCIP if he or she:

- Is a citizen or national of the United States or lawfully present in the United States;
- Has not been covered under creditable coverage for a continuous 6-month period of time prior to the date on which such individual is applying for PCIP;
- Has a pre-existing condition within the meaning of the Affordable Care Act;
- Is a current resident of one of the 50 States or the District of Columbia which constitutes or is within the service area of the PCIP; and
- Meets other criteria established by the PCIP with HHS approval.
- PCIP Plans will be required to cover eligible individuals without any pre-existing condition limitation or waiting period.

Requirements For States, Non-Profits To Operate PCIP Program

The Regulations outline the process that a State or nonprofit private entity to pursue and enter into a contract with HHS to set up and run a PCIP program. The PCIP program generally anticipates that each State will contract with HHS to maintain a qualifying PCIP program directly or by subcontracting with another party. If a State elects not to or fails to maintain a PCIP program, however, the Regulation states HHS will contract with a nonprofit private entity to offer a PCIP program in that State.

PCIP program operates must have enrollment and disenrollment rules and processes that meet the applicable standards in the Regulations. The Regulations dictate that as part of this process, a PCIP verify that an individual is a United States citizen or national or lawfully present in the

United States in accordance with the Regulations. The Regulations also allow PCIPS to employ certain strategies to manage enrollment over the course of the program that may include enrollment capacity limits, phased-in (delayed) enrollment, and other measures, as defined by the PCIP and approved by HHS to manage the PCIP program's compliance with funding and other allowable requirements.

PCIP Plan Benefits

The Regulations specify that each benefit plan offered by a PCIP cover at least the following categories and the items and services:

- Hospital inpatient services
- Hospital outpatient services
- Mental health and substance abuse services
- Professional services for the diagnosis or treatment of injury, illness, or condition
- Non-custodial skilled nursing services
- Home health services
- Durable medical equipment and supplies
- Diagnostic x-rays and laboratory tests
- Physical therapy services (occupational therapy, physical therapy, speech therapy)
- Hospice
- Emergency services and ambulance services
- Prescription drugs
- Preventive care
- Maternity care

The Regulations also prohibit PCIP Plans from offering certain benefits. Benefit plans offered by a PCIP cannot cover the following services:

- Cosmetic surgery or other treatment for cosmetic purposes except to restore bodily function or correct deformity resulting from disease.
- Custodial care except for hospice care associated with the palliation of terminal illness.
- In vitro fertilization, artificial insemination or any other artificial means used to cause pregnancy.
- Abortion services except when the life of the woman would be endangered or when the pregnancy is the result of an act of rape or incest.
- Experimental care except as part of an FDA-approved clinical trial.

The Regulations regulate the premiums and cost sharing that PCIP programs can use. The Regulations limit the premium a PCIP may charge to 100 percent of the premium for the applicable standard risk rate that would apply to the coverage offered in the State determined in accordance with the Regulations using HHS-approved reasonable actuarial techniques. Premiums charged to enrollees in the PCIP may vary on the basis of age by a factor not greater than 4 to 1. Also, the PCIP program's average share of the total allowed costs of the PCIP benefits must be at least 65 percent of such costs. Furthermore, the out-of-pocket limit of coverage for cost-sharing for covered services under the PCIP cannot exceed the Internal Revenue Code § 223(c)(2) limit. If the plan uses a network of providers, this limit may be applied only for in-network providers, consistent with the terms of PCIP benefit package.

The Regulations allow a PCIP program to require that covered persons use network providers for non-emergency services if that the PCIP has sufficient providers to ensure that all covered

services are reasonably available and accessible to its enrollees. Out-of-network coverage for emergency services will be required under certain conditions. The Regulations also will require PCIPst o process and administer claims and appeals in compliance with the Regulations.

The Regulations also require PCIPs to develop and apply operating procedures to prevent, detect, report to HHS and law enforcement and recover (when applicable or allowable) incidences of waste, fraud, and abuse and to cooperate with Federal law enforcement and oversight authorities in cases involving waste, fraud and abuse.

Preventing Insurer Dumping

The Regulations also contain provisions to deter and punish insurers and group health plans from "dumping" coverage of individuals with pre-existing conditions. A health insurance issuer or group health plan found to have illegally discouraged an individual from remaining enrolled in its coverage based on the individual's health status will be responsible for any medical expenses incurred by the PCIP to provide coverage for a dumped individual who subsequently enrolls in the PCIP plan. Additionally, HHS also may refer the insurer or the plan to Federal and State authorities for other enforcement actions that may be warranted based on the behavior at issue.

For More Information or Assistance

If you need assistance evaluating or responding to the Health Care Reform Law or health care compliance, risk management, transactional, operational, reimbursement, or public policy concerns, please contact the author of this update, Cynthia Marcotte Stamer, at (469) 767-8872 or via e-mail **here**.

Vice President of the North Texas Health Care Compliance Professionals Association, Past Chair of the ABA Health Law Section Managed Care & Insurance Section and the former Board Compliance Chair of the National Kidney Foundation of North Texas, Ms. Stamer has more than 23 years experience advising health care providers, health care payers and other health industry clients about these and other matters. A popular lecturer and widely published author on health industry and human resources matters, Ms. Stamer continuously advises these and other clients about health industry and other related concerns. Ms. Stamer also publishes and speaks extensively on health and managed care industry regulatory, staffing and human resources, compensation and benefits, technology, public policy, insurance and reimbursement and other operations and risk management concerns. Her insights on these and other related matters appear in the Health Care Compliance Association, Atlantic Information Service, Bureau of National Affairs, World At Work, The Wall Street Journal, Business Insurance, the Dallas Morning News, Modern Health Care, Managed Healthcare, Health Leaders, and a many other national and local publications. For additional information about Ms. Stamer, her experience, involvements, programs or publications, see **here**. If you need assistance with these or other compliance concerns, wish to inquire about arranging to engage Ms. Stamer for advice, compliance audit or training, or need legal representation on other matters please contact Ms. Stamer at (469) 767-8872 or via e-mail **here**.

Other Recent Developments

If you found this information of interest, you also may be interested in reviewing some of the following recent Updates available online by clicking on the article title:

- **Register Now For 8/24 2010 Health Plan Update Briefing**
- **2010 Health Plan Update: Learn What You Must Do Now To Meet Key 2010/2011 Affordable Care Act & Other Federal Health Plan Deadlines**

- **New Affordable Care Act Health Plan Appeals Regulations Require Health Plan Updates**
- **Blockbuster & Health Delivery Disability Discrimination Settlements Highlight Need For Tightened Disability Discrimination Risk Management**
- **Agencies Release Regulations Implementing Affordable Care Act Health Plan Preventative Care Mandates**
- **Office of Civil Rights Proposes Changes To HIPAA Privacy, Security & Civil Sanctions Rules**
- **Key Affordable Care Act Health Plan Coverage Mandates Guidance Issued June 28; Apply ASAP For Early Retirement Reinsurance Program**
- **CMS Proposes Rules To Implement Affordable Care Act Required Expansion Of Medicare Preventive Services And Other 2011 Reimbursement Changes**
- **New Law Clarifies Medicare 3-Day Payment Window Rule**
- **HHS Invites Comments On Health Center Program Federal Tort Claims Policy Manual**
- **NCPDP SCRIPT 10.6 Approved As Medicare Part D/Advantage E-Prescribing Option**
- **President Directs Quick HHS Action To Implement Physician Medicare Payment Restoration**
- **Proposed Medicare Rules Will Require Hospitals Honor Patient Visitation Preferences**
- **IRS Invites Input On Application of New Tax Exemption Requirements For Hospital Organizations Added By Affordable Care Act**
- **OIG Touts Expanding Health Care Fraud Enforcement Success & Launches New Health Care Fraud Hotline**
- **HHS Invites Input on Proposed Strategic Framework on Multiple Chronic Conditions**
- **New CBO Analysis Hikes Projected Affordable Health Care Act Cost by $115 Billion**
- **Pennsylvania Nurses Vote For Union In NLRB Election Highlights Rising Union Organizing Activity In Health Care Industry**
- **WellPoint To Ban Coverage Rescissions Before Affordable Care Act Fall 2010 Deadline**
- **DEA/DOJ Release Interim Final E-Prescribing Rules**
- **Joint Commission Revises Medical Staff Bylaw Standard**
- **IRS To Allow Medical Resident FICA Refund Claims**
- **Rising Enforcement and Changing Rules Require Prompt Review & Update of Health Plan Privacy & Data Security Policies & Procedures**
- **Pfizer To Pay $2.3 Billion For Fraudulent Marketing In Largest DOJ Health Care Fraud Settlement**
- **Maximum Penalty For Patient Protection Act Confidentiality Breaches To Rise To $11,000**

For More Information

We hope that this information is useful to you. If you or someone else you know would like to receive future updates about developments on these and other concerns, please be sure that we have your current contact information – including your preferred e-mail – by creating or updating your profile **here.**