



- Issue:** PRE-EXISTING CONDITION INSURANCE PLAN
- Citation:** Title I, Subtitle B, Section 1101 of the Patient Protection and Affordable Care Act.
- Statutory Directive:** Directs the Department of Health and Human Services (HHS) to establish a temporary high risk health insurance pool program within 90 days of enactment, June 21, 2010, to provide health Insurance coverage to eligible individuals through grants.
- Program Duration:** July 1, 2010 through January 1, 2014
- Funding:** Appropriates \$5 Billion to support the new program.
- Requirements:**
1. Prohibits the use of preexisting condition exclusions,
 2. The out-of-pocket limit must not be greater than the maximum amounts applicable to high deductible health plans, \$5,950 for single coverage and \$11,900 for a family.
 3. Premium rates may vary on the basis of age by a factor of not greater than four-to-one, and be established at a standard rate for a standard population.
 4. **Eligible individuals include:**
 - Citizens or nationals of the United States,
 - Individuals who have been uninsured for the last six month or greater period,
 - An individual with a preexisting condition.
 5. **MAINTENANCE OF EFFORT** — Participating states must agree to maintain funding levels at FY 2009 levels for existing high risk pools.

Existing state high-risk pools: 35 states had high risk health insurance pools in FY 2009

Alabama	Connecticut	Iowa	Minnesota	New Hampshire	Oregon	Utah
Alaska	Florida	Kansas	Mississippi	New Mexico	South Carolina	Washington
Arkansas	Idaho	Kentucky	Missouri	North Carolina	South Dakota	West Virginia
California	Illinois	Louisiana	Montana	North Dakota	Tennessee	Wisconsin
Colorado	Indiana	Maryland	Nebraska	Oklahoma	Texas	Wyoming

States choosing to operate their own high-risk Pool:

Alaska	Connecticut	Kansas	Missouri	New Mexico	Oklahoma	Utah
Arkansas	District of Columbia	Maine	Montana	New York	Oregon	Vermont
California	Illinois	Maryland	New Hampshire	North Carolina	Pennsylvania	Washington
Colorado	Iowa	Michigan	New Jersey	Ohio	Rhode Island	West Virginia
					South Dakota	Wisconsin

States electing to have HHS run their high-risk pool program:

Alabama	Florida	Idaho	Louisiana	Mississippi	North Dakota	Texas
Arizona	Georgia	Indiana	Massachusetts	Nebraska	South Carolina	Virginia
Delaware	Hawaii	Kentucky	Minnesota	Nevada	Tennessee	Wyoming

Source: <http://www.hhs.gov/news/press/2010pres/07/20100701a.html>

Updated August 2010

Regulatory Requirements:

Action:

Interim Final Rule Published July 30, 2010

Comment Period:

Comments must be received not later than 5 p.m. September 28, 2010

Summary:

Implements requirements in section 1101 of the Affordable Care Act (ACA) requiring the HHS Secretary to establish a temporary high risk health insurance program to provide access to coverage for uninsured Americans with pre-existing conditions, **the Pre-Existing Condition Insurance Plan (PCIP) to avoid confusion with existing high-risk pools.**

Program Administration:

HHS may “carry out” the temporary high risk health insurance pool program either directly or through contracts with eligible entities, which are states and non-profit entities.

Eligibility for a PCIP Program:

- An individual is eligible if he or she:
 1. Is a citizen or national of the United States (U.S.) or is lawfully present in the U. S.,
 2. Has not been covered under creditable coverage as of the date of enactment, during the six-month period prior to the date of application for coverage through the PCIP, and
 3. Has a pre-existing condition based on the presentation of documentation that the individual has been refused coverage on the grounds related to their health; has been offered coverage but only with a rider that excludes certain benefits associated with their condition; documented medical evidence of the condition; and other information as pertinent.
- Administrating authorities must verify that an individual is a U.S. citizen or national, or lawfully present in the U.S. with the following sources:
 1. The Social Security Administration, or
 2. The Department of Homeland Security.

Covered Benefits:

- Benefits parallel those offered by the Federal Employees Health Benefits Plans, and
- Prohibits PCIPs from imposing any type of coverage waiting period upon eligible individuals.

Premiums and Cost-Sharing

- Requires that premium rates charged for coverage be established at “a standard rate for a standard population”, which the National Association of Insurance Commissioners (NAIC) suggests be determined by considering the premium rates charged by other insurers offering health insurance coverage to individuals”.
- A PCIP may not offer enrollees premiums at a rate that exceeds 100 percent of the standard individual market rate in the PCIP service area.
- A specific formula for calculating the standard rate is not mandated by the rule.
- In that provisions defining permissible age bands for rating purposes do not go into effect until January 1, 2014, specific age band rating will be established through the PCIP contracting process.
- Sets the threshold for the issuer’s share of the total cost of benefits at no less than 65 percent.

Appeals Procedures

- The ACA requires that PCIP programs establish an appeals process for reconsideration of adverse benefit determination. The interim final rule is interpreting these provisions to include determinations with respect to an individual's eligibility for the program, including whether an individual is a citizen or national of the U.S., or lawfully present in the U.S.
- The interim final rule establishes minimum requirements that all PCIPS must meet including:
 1. Providing a timely redetermination of an eligibility or coverage determination.
 2. Coverage determinations must include both whether an item or services covered and the amount paid by the PCHIP.
 3. Enrollees must have a right to a second-level, or "reconsideration" by an independent entity.
- States may satisfy the requirements for independent review s through a variety of arrangements including:
 1. An existing appeals mechanism provided for under state law.
 2. In the case of a state administered PCIP, a review process created by the state.
 3. An independent contractor, such as the independent review entities contracted by HHS for Medicare program reviews.

Funding

- All funds awarded under the program must be used exclusively to pay allowable claims and administrative costs of a PCIP.
- Funds are not available to pay expenses to defray premiums of existing state high risk pools.
- The rule permits PCIPs to spend no more than 10 percent of its total allotted funds towards administrative expenses.
- Administrative costs and expenses may include:
 1. Start-up and program implementation activities,
 2. The production and distribution of information and outreach materials,
 3. Eligibility determinations and enrollment processing,
 4. Claims processing,
 5. Costs associated with prevention and detection of fraud, waste, and abuse, and
 6. Other ancillary services such as operation of a customer service call center, account maintenance, and appeals.
- Initial allotment ceilings for PCIPs in each state are based on a blended formula based on the state population, number of uninsured individuals under 65, and geographic health care costs.
- HHS has been given explicit authority to reallocate funds among states if they determine a given state will not make use of the total estimated funding originally allotted to them.
- HHS also has been given the authority to adjust premiums, alter required benefits, limit PCIP applications or take other measures to eliminate a projected deficit.

Maintenance of Effort Requirement

- States are required to maintain their budgeted funding amounts or per capita amount for the operation of an existing high risk pool, the formula for providing funding, or establishing an altered formula that has been approved by the secretary and will not reduce the total funds expended for the high risk pool.

Effective Date: July 30, 2010 and to remain in effect until the exchanges are established, January 1, 2014.