

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

OFFICE OF INSURANCE PROGRAMS

Date: December 28, 2010

To: Federal High Risk Pool Contractors

From: Richard Popper, Deputy Director, Office of Insurance Programs

Subject: Portability of Coverage, Enrollee Notices, and Third Party Payments under the Pre-Existing Condition Insurance Plan Program (Policy Letter #3)

The purpose of this memorandum is to provide your organization with information about the eligibility of individuals who permanently move out of the service area of a Pre-Existing Condition Insurance Plan (PCIP) in which they are enrolled. This memorandum also establishes requirements for notifying former enrollees, and other PCIPs, of prior periods of PCIP coverage. In addition, it answers questions about third-party payment of premiums for PCIP. We request that your organization establish procedures to implement this guidance as soon as practicable and submit information to your HHS account manager about how and when your organization will comply with this guidance. Please contact your designated HHS account manager if you have any questions.

Background

Section 152.15(b)(3)(i) of the regulations governing the PCIP program require a PCIP to disenroll an individual who no longer resides in its PCIP service area, which is defined as the geographic area encompassing an entire State in which the PCIP furnishes benefits. However, section 152.14(b) of the regulations specifies that the six-month period without creditable coverage that such an individual experienced prior to enrolling in the PCIP from which he or she is being disenrolled satisfies this condition of eligibility with respect to eligibility for enrollment in the PCIP covering the area where the individual now resides. This is the case regardless of whether the individual moves from a State served by the Federally-administered PCIP to an area served by a State-administered PCIP, from the area served by one State-administered PCIP to that served by another State-administered PCIP, or from a State served by a State-administered PCIP to a State served by the Federally-administered PCIP.

To the extent that an individual moves from one State served by the Federally-administered PCIP to another State served by the Federally-administered PCIP, he or she is not subject to disenrollment since such individual still resides in the service area of the Federally-administered PCIP.

What must a PCIP do if an enrollee must be disenrolled as a result of leaving the service area of the PCIP?

Section 152.15(b)(1) requires that a PCIP establish a disenrollment process that is approved by HHS. As part of this process, a PCIP must notify enrollees who are disenrolled because they no longer reside in the PCIP service area that:

- The Pre-Existing Condition Insurance Plan is available in every State and the District of Columbia.
- If they move out of the service area of a Pre-Existing Condition Insurance Plan, they don't have to be uninsured for another six months to be eligible to enroll in another Pre-Existing Condition Insurance Plan. They may apply to enroll in a Pre-Existing Condition Insurance Plan in their new area.
- They should contact the Pre-Existing Condition Insurance Plan in their new area to find out how to apply.
- Information about applying for the Pre-Existing Condition Insurance Plan in every State and the District of Columbia is available at www.HealthCare.gov or 1-866-717-5826 (TTY: 1-866-561-1604) Monday - Friday, 8 a.m. to 11 p.m., Eastern Time.

In addition, we encourage PCIPs to communicate this information via other mechanisms such as member handbooks, as determined appropriate by the PCIP.

Upon request by an individual, and except as noted below, a PCIP must promptly provide a written certificate that includes:

- The date the certificate was issued;
- The name of the PCIP that provided coverage including a clear indication that the coverage was provided by a PCIP (and not by a state high risk pool);
- The name of the individual with respect to whom the certificate applies;
- The name, address, and telephone number of the PCIP administrator or issuer, and a telephone number to call for further information; and
- The period of time in which the individual had PCIP coverage, e.g. coverage start date and coverage end date, in the case of a former enrollee.

Individuals may request that the certificate be sent directly to them or the PCIP in which they are applying to enroll, or the PCIP that would otherwise receive the certificate may agree to accept the information from the certifying PCIP through means other than a written certificate (such as by telephone).

How does this change eligibility determinations made by a PCIP?

Applicants who were disenrolled because they no longer resided in the PCIP service area are acknowledged to have previously satisfied the six-month without creditable coverage requirement in connection with their prior PCIP enrollment, and thus are considered to have satisfied this requirement for purposes of PCIP enrollment in a new State. Applicants must certify that they have not had other non-PCIP creditable coverage since the termination of their prior PCIP coverage. The new PCIP's eligibility and enrollment process will also establish whether an applicant is eligible on the basis of residence within the service area, citizenship and immigration status, and evidence of a pre-existing condition (subject to the exceptions discussed in the following question).

May a PCIP choose to enroll a new applicant who has recently moved without obtaining proof of a pre-existing condition or proof of citizenship or lawful presence?

Yes. The Federally-administered PCIP will deem individuals who have moved from a State-administered PCIP service area to a Federally-administered PCIP service area to have met the pre-existing condition, and citizenship and lawful presence requirements. Subject to HHS approval, a State-administered PCIP may adopt a policy that deems applicants to have satisfied these two requirements on the basis of having previously established eligibility under another PCIP. HHS strongly encourages State-administered PCIPs to recognize that an individual who was formerly enrolled in a PCIP, and is newly applying for another PCIP due to a change in residence, is deemed to have met the pre-existing condition requirement. In addition, it is unnecessary to require an applicant to reprove his or her citizenship and lawful presence, since the individual had previously done so with another PCIP. Such a policy would prevent undue burden on the enrollee and prevent unnecessary delays in enrollment as a result of having to resubmit proof of a pre-existing condition and citizenship or immigration status.

Once an enrollee moves out of his or her current PCIP service area, how soon must that individual apply to enroll in the new PCIP in order to be deemed to have satisfied the six-month without creditable coverage requirement?

A PCIP shall establish a six-month period during which any individual who was formerly enrolled in a PCIP and is newly applying for another PCIP due to a change in residence is deemed to have met the requirement of going six months without creditable coverage. This six-month period subsequent to an individual's disenrollment from another PCIP is established because, after that point, having previously satisfied such a six-month period would no longer be relevant. This timeframe allows ample time for an individual to learn about the state's program and apply for coverage.

How does a PCIP establish whether an applicant who has left another PCIP service area is deemed to have satisfied the six-month without creditable coverage requirement?

A PCIP is required to establish a process for verifying and documenting whether an individual is deemed to have satisfied the six-month without creditable coverage requirement either by relying on the certificate provided by the applicant or another PCIP or by accepting the information from another PCIP through means other than a written certificate (such as by telephone). In addition, a PCIP is required to inform applicants as part of the enrollment application process (such as by including a statement in the enrollment application) that they meet the six-month requirement, subject to the six-month period of time restriction discussed in the previous question, if they have left another PCIP service area.

What happens if the PCIP program where the individual is applying has a waiting list?

Pursuant to section C.5 of the contract, to the extent that a PCIP experiences a funding limitation, a PCIP is required to report such insufficiency to HHS and identify and implement necessary adjustments, which are subject to HHS approval. At the PCIP's request, we will address any limitations on enrollment, including the administration of a waiting list, at such time. If the

individual applies for coverage within a reasonable period of time, the individual's prior six-month period without creditable coverage would continue to apply for the duration of the individual's time on any waiting list, provided that the individual does not have non-PCIP creditable coverage while on the waiting list.

Can third-party payers pay the premium for PCIP enrollees?

HHS has received a number of comments and questions since the publication of the interim final rule (45 C.F.R. pt. 152) asking for clarification as to whether, and under what circumstances, a PCIP may accept premium payments for individual enrollees or groups of enrollees from third parties.

We are aware that some employers, employer-based group health plans, and health insurance issuers may attempt to encourage high-risk individuals to enroll in the PCIP program rather than to participate in their plans. Such action could violate the anti-dumping provisions found in section 1101 of the Affordable Care Act and in section 152.28(b)(1) of the PCIP regulations, which prohibit employer-based group health plans and health insurance issuers from discouraging individuals from remaining enrolled in their prior employer-based coverage. Such enrollment could also implicate the closely related fraud, waste, and abuse provision set forth in section 152.27(a) of the PCIP regulation, which addresses situations in which employers discourage individuals with access to group health coverage from enrolling in such coverage.

A conflict of interest may also arise when medical providers, such as hospitals or clinics, seek to pay premiums on behalf of uninsured patients. Specifically, payment made by healthcare providers on behalf of their patients can increase the risk of provider-induced demand for services, and thus the risk of increased costs caused by providers attempting to recoup the amounts they have expended on premium subsidies through additional billings. Premium payments by drug manufacturers, or organizations funded by such manufacturers, can also present a conflict of interest.

Additionally, a government program that pays for a defined, limited set of benefits for individuals with a specified disease may seek to save costs by opting to instead pay the PCIP premium on behalf of such individuals. This however can lead to cost-shifts from one group of government programs to the PCIP program. This could have the effect over time of accelerating the depletion of the fixed amount of funding allocated to the PCIP program thereby, limiting its ability to serve as a bridge for uninsured people with pre-existing conditions to the new choices available in 2014.

HHS is aware of the potential concerns posed by third-party payments of the premiums for PCIP enrollees given the potential for dumping, fraud, waste, and abuse. Given the fixed funding of the program, HHS also understands that excessive cost-shifting could prevent PCIPs from enrolling uninsured people with pre-existing conditions not eligible to receive healthcare benefits through other government programs. Thus, HHS will be closely monitoring enrollment trends and tracking the extent to which PCIP enrollment results from third-party payments. To the extent that HHS finds that these payments present conflicts of interest or contribute to greater

than projected spending, HHS anticipates that it will issue further guidance that restricts or even prohibits third-party payments for premiums.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, DC 20201

December 28, 2010

Dear Ryan White HIV/AIDS Program Grantees:

The Affordable Care Act provides people living with HIV/AIDS additional options for health care coverage, now and in the future. Starting in 2014, Americans can no longer be denied coverage or charged more based on their health status when they enroll in a health plan. New "Health Insurance Exchanges" will be established to help individuals and small businesses shop for coverage and easily compare plan options based on price, benefits and services, and quality. Coverage will include essential health benefits, limit annual out-of-pocket expenditures, and provide the health security that all Americans, including those living with HIV/AIDS, need.

In the meantime, the Affordable Care Act provides assistance to people needing health care, including temporary coverage for eligible people without insurance who have a pre-existing condition. This program is known as the "Pre-Existing Condition Insurance Plan" or the PCIP program. Because people living with HIV and AIDS may be eligible for enrollment in the PCIP program, the Health Resources and Services Administration's HIV/AIDS Bureau and the Office of Consumer Information and Insurance Oversight (OCIO), both within the U.S. Department of Health and Human Services (HHS), are providing the following information to help Grantees and other interested stakeholders understand how this new program affects Ryan White program beneficiaries.

Section 1101 of the Affordable Care Act establishes the PCIP program, which is a "temporary high risk health insurance pool program" to provide health insurance coverage to certain currently uninsured individuals who have a pre-existing health condition. The PCIP program is a transitional program that makes health coverage available to those with a pre-existing condition who have gone without coverage for at least six months, at premiums that are adjusted based on age but are not based on an individual's health status. The cost of coverage for people living with HIV/AIDS is often out of reach for most Americans who buy their own insurance. The PCIP program covers a broad range of health benefits, with no waiting period or exclusions for pre-existing conditions, and is designed as a temporary bridge to 2014 for people with pre-existing conditions who cannot obtain health insurance coverage in today's private insurance market.

Ryan White HIV/AIDS Program Grantees have raised questions regarding the PCIP program and its impact on people living with HIV/AIDS and Ryan White HIV/AIDS Program-related issues. The following are responses to frequently asked questions and additional information regarding the important role Ryan White HIV/AIDS Program Grantees have with regard to implementation of the Affordable Care Act.

Q: Does the PCIP program place limits on Ryan White HIV/AIDS Program grantees' ability to pay for deductibles or cost sharing for eligible enrollees in the PCIP program?

No. Program Grantees may subsidize out-of-pocket benefit costs of Ryan White program beneficiaries who are enrolled in the PCIP program. Out-of-pocket benefit costs can include annual deductibles, coinsurance requirements, and copayments. In addition, Grantees will continue to serve an important role assisting beneficiaries navigate the health care system and helping to enroll eligible beneficiaries in the PCIP program if the beneficiary is not enrolled in other sources of creditable coverage. We encourage Grantees to assist clients to ensure they receive the health care services they need. Because the rules differ among State-administered PCIP programs, we encourage you to visit HHS's new consumer website, www.HealthCare.gov, for State-specific information.

Additionally, the Affordable Care Act changed what expenses count as true out-of-pocket (TrOOP) costs for the annual Medicare Part D Drug Plan Threshold. Beginning January 1, 2011, AIDS Drug Assistance Programs (ADAPs) will become what the Centers for Medicare & Medicaid Services (CMS) refers to as "TrOOP included entities." Medicare Part D Plan sponsors will be required to include ADAP expenditures for Part D drugs toward the TrOOP limit of Medicare Part D enrollees. Consequently, ADAP clients who are Medicare Part D enrollees will now be able to move through the coverage gap phase into the catastrophic coverage phase where Part D covered drugs will be available at a nominal cost. Prior to this change, it was difficult, if not impossible, for ADAP members to reach the catastrophic phase. This new policy will help Program Grantees to better meet the health care needs of people living with HIV/AIDS.

Q: Is it permissible to have the Ryan White HIV/AIDS Program Grant funds pay for the premiums?

The PCIP program is a unique, temporary program intended to provide coverage to eligible uninsured individuals who are unable to access coverage at a standard premium due to pre-existing conditions between now and 2014, when new affordable options become available to all Americans with pre-existing conditions. As such, as described in a federal bulletin published on December 28, 2010, HHS does not expressly prohibit but is closely monitoring potentially significant concerns about premium payments for enrollees in the PCIP program made by third-party sources (examples: government payers, charities, other non-governmental organizations, employers, medical providers, drug assistance programs, drug manufacturers, or organizations funded by such manufacturers). Among other things, HHS recognizes there may be an incentive for third-party payers to cost shift to the PCIP program. For example, a government program that pays for a defined, limited set of benefits for individuals with a specified disease may opt instead to pay the PCIP premium on behalf of such individuals, if the premium is below the cost of the set of benefits provided by the government program. This may result in an accelerated depletion of the fixed \$5 billion allocated to the PCIP program, limiting its ability to serve as a bridge for uninsured people with pre-existing conditions to the new choices available in 2014. As such, HHS is closely monitoring program enrollment and tracking the extent to which PCIP enrollment results from third-party payments. If these payments are found to result in an undue risk of greater than projected spending from the limited Federal funding appropriated by Congress for the PCIP program, HHS anticipates issuing further guidance that restricts or even prohibits third-party payments for premiums.

It is important to note that the PCIP program may accept premium payments from the individual enrolled in the program, a family member, a guardian or another authorized legal representative. Because the rules differ among State-administered PCIP programs, please check the rules in your State.

Q: Does the receipt of medical care services from a Ryan White HIV/AIDS Program funded clinic constitute creditable coverage under the PCIP program?

No. These are grant programs, not insurance programs. Receiving medical care services from a Ryan White HIV/AIDS Program funded clinic does not disqualify an individual from being eligible for the PCIP program.

Q: If a person was covered by health insurance paid for by Ryan White HIV/AIDS Program Grant funds prior to the creation of the PCIP program, could such creditable coverage disqualify the person from PCIP eligibility?

Yes. Individuals with creditable insurance coverage, irrespective of whether it is paid for with Ryan White HIV/AIDS Program Grant funds or another source, are ineligible for the PCIP program. Creditable coverage includes, but is not limited to: COBRA, job-based coverage, individual market coverage, State high risk pools, and most other public programs (e.g., Medicaid, Medicare). To be eligible for the PCIP program, an individual must lack creditable coverage for the six months prior to applying for the PCIP program.

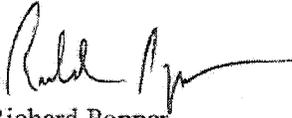
While all uninsured Americans with pre-existing conditions who meet the eligibility criteria can join the PCIP program, the specific rules for the PCIP program vary by State. In order to determine if a client is eligible for the PCIP program, please visit www.HealthCare.gov for State-specific information.

The Ryan White HIV/AIDS Program will always play a role in serving people living with HIV and AIDS. The role may change over time as implementation of the Affordable Care Act moves forward and we transition to an improved health care system. As questions arise, we will continue to work with Ryan White HIV/AIDS Program Grantees to provide technical assistance and ensure a seamless transition and continuous quality care for people living with HIV and AIDS. If you have additional questions or need more information, please discuss with your project officer.

Sincerely,



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