

## **PCIP FEDERAL REGULATIONS**

### **SUMMARY**

#### **Pre-Existing Condition Insurance Plan Program (PCIP)**

Department of Health and Human Services  
Office of Consumer Information and Insurance Oversight  
Interim Final Rule with Comment Period  
Effective June 30, 2010

Full Text of the Regulations can be found at:

<http://www.hhs.gov/ociio/regulations/preexisting/preexisting.html>

#### **Overview**

The regulations implement Section 1101 of the Affordable Care Act (ACA) which requires the Secretary of the Department of Health and Human Services (DHHS) to establish, either directly or through contracts with states or nonprofit entities, a temporary high-risk health insurance program to provide access to coverage for uninsured Americans with pre-existing health conditions.

#### **General Provisions**

- 1) Adopts the definition of a pre-existing condition exclusion as currently defined for purposes of the Health Insurance Portability and Accountability Act (HIPAA), as a benefit exclusion or limitation based on a health condition present before the date of enrollment or denial of enrollment, whether or not any medical diagnosis, care, or treatment was recommended or received before that date.
- 2) Authorizes transfer of a state PCIP to DHHS administration or from DHHS to state administration if approved by the Secretary as in the best interests of PCIP enrollees.
- 3) Outlines the process for state proposal submission to administer the PCIP as the state level.
- 4) Prohibits pre-existing condition exclusions or any waiting periods after enrollment.
- 5) Establishes program end date as January 1, 2014.

#### **Eligibility**

Consistent with the ACA, eligibility for PCIP is for individuals who are: (1) a citizen or national of the United States, or lawfully present, as defined; (2) has not had creditable coverage for the previous six months; and (3) has a pre-existing condition. Specifically, the regulations provide for the following:

- 1) Citizenship -- Establishes detailed requirements for the verification of immigration status, authorizing states to verify status through the Social Security Administration or the Department of Homeland Security through existing electronic means used for other federal programs such as Medicaid and Children's Health Insurance Program, or submission of documentation by applicants as outlined.
- 2) Creditable Coverage -- Incorporates the definition of creditable coverage from the Public Health Service Act and specifies the types of coverage that qualify. Creditable coverage includes,

among other types, group and individual health insurance coverage, TRICARE, Medicare, Medicaid and CHIP and any existing high risk pool coverage.

- 3) Pre-existing Condition -- States must determine that an individual has a pre-existing condition based on one of the following: a) Documented evidence of a denial or indication of a potential denial from a health insurer; b) Evidence of an offer of coverage with a rider; c) Evidence of a medical condition as specified by the PCIP; or d) other criteria approved by the Secretary of DHHS.

### **Enrollment and Disenrollment**

- 1) Establishes the eligibility for enrollment as above.
- 2) Permits disenrollment for failure to pay premiums timely with a reasonable grace period not to exceed 61 days. Requires disenrollment if the individual is no longer in the program service area, the individual obtains other coverage, or death of the individual.
- 3) Requires coverage to be effective by the 1st day of the following month if completed request is received by the 15th day of the month.
- 4) Requires states to comply with funding limitations of the program and authorizes the establishment of a waiting list or other measures such as phased-in enrollment.

### **Benefits**

Required benefits in PCIP:

- 1) Hospital inpatient services;
- 2) Hospital outpatient services;
- 3) Mental health and substance abuse services;
- 4) Professional services for the diagnosis or treatment of injury, illness, or condition;
- 5) Non-custodial skilled nursing services;
- 6) Home health services;
- 7) Durable medical equipment and supplies;
- 8) Diagnostic x-rays and laboratory tests;
- 9) Physical therapy services (occupational therapy, physical therapy, speech therapy);
- 10) Hospice;
- 11) Emergency services, as defined, and ambulance services;
- 12) Prescription drugs;
- 13) Preventive care; and
- 14) Maternity care.

Excluded benefits in PCIP:

- 1) Cosmetic surgery or other treatment for cosmetic purposes except to restore bodily function or correct deformity resulting from disease;
- 2) Custodial care except for hospice care associated with the palliation of terminal illness;
- 3) In vitro fertilization, artificial insemination or any other artificial means used to cause pregnancy;
- 4) 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; and,

- 5) Experimental care except as part of an FDA-approved clinical trial.

### **Premiums and Cost-Sharing**

- 1) Limits premiums to no more than 100% of the applicable standard risk rate in the state and requires rates to be established using reasonable actuarial techniques approved by DHHS.
- 2) Limits age variations to no greater than 4 to 1.
- 3) Requires PCIP to cover 65% of the health service costs.
- 4) Limits annual out-of-pocket costs and deductibles to the amounts set by the Internal Revenue Code for Health Savings Accounts (\$5,950 out-of-pocket limit in 2010 for an individual).

### **Access to Care**

Authorizes states to use limited networks and demonstrate a sufficient number and range of providers to ensure services are reasonably available and accessible.

### **Appeals**

Requires procedures to appeal eligibility and coverage determinations, and requires a redetermination for determinations of coverage or the amount paid for a service by an entity independent of the PCIP.

### **Fraud, waste and abuse**

Requires development and implementation of procedures to prevent, detect and recover, and report to DHHS instances of waste, fraud and abuse. Requires state PCIP officials to cooperate with federal investigators.

### **Insurer Dumping**

Establishes procedures and criteria to identify and report to DHHS instances of dumping, where insurance issuers discourage high-risk persons from remaining in existing coverage to secure eligibility for PCIP.

### **Funding**

- 1) Limits administrative costs to no more than 10% over the life of the PCIP.
- 2) Sets the initial funding level at \$5 billion distributed to states by specified formula and authorizes DHHS to reallocate funds a state will not make use of to other states.
- 3) Requires reporting by states if funds are insufficient and implementation of adjustments to eliminate deficits, as well as authorizes DHHS to make adjustments necessary.
- 4) Requires states to maintain funding levels for the existing state high-risk pools.

### **Transition**

Provides for transition of PCIP enrollees to the Exchanges established in 2014 pursuant to ACA procedures developed by DHHS.

