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.