

August 16, 2010

MEMORANDUM TO CLIENTS

RE: Pre-Existing Condition Insurance Plan Program- Interim Final Rule

The Department of Health and Human Services ("HHS") has issued an interim final rule relating to the Pre-Existing Condition Insurance Plan program (the "Rule"). 45 CFR 45014 (July 30, 2010). The Rule implements a temporary program to provide health insurance coverage to uninsured individuals with pre-existing conditions. Created by the Patient Protection and Affordable Care Act ("PPACA"), this Pre-Existing Condition Insurance Plan program, known as "PCIP," will be run through contracts with States or eligible non-profit entities. The Rule addresses how the PCIP will be administered, eligibility requirements, premiums, appeals, and oversight. Significantly, the Rule prohibits health insurance issuers from encouraging high-risk individuals to disenroll from existing coverage and seek coverage through the PCIP. The Rule is effective immediately, and comments are due by September 28, 2010. The PCIP will terminate on January 1, 2014, and PCIP enrollees will transition to coverage within the insurance exchanges.

I. Background

Congress established the PCIP to provide health insurance coverage to individuals with preexisting medical conditions who currently lack coverage. PPACA Section 1101 requires that HHS establish a process for creating and overseeing the PCIP, which will be administered either through the States or nonprofit private entities, at the discretion of the Secretary of HHS. The Rule describes the PCIP proposal process, as well as the eligibility and enrollment requirements for individuals. Among other things, the Rule provides that PCIP coverage is available for those individuals who have not been covered for six months prior to their application for PCIP coverage, and who have a preexisting condition. Congress was concerned that creation of the PCIP could induce insurers or group health plans to incentivize participants to discontinue their existing coverage or to decline enrollment in coverage that is otherwise available. Accordingly, PPACA required HHS to issue guidance designed to prevent this practice, known as "dumping."

II. Insurer Dumping: Rules and Consequences

While the Rule describes many aspects of the PCIP program in detail, the Rule contains only a short section aimed at discouraging risk dumping. Specifically, the Rule requires each PCIP to develop, implement, and execute operational procedures to detect, recover, and promptly report – to HHS – incidents of waste, fraud, and abuse. As part of such procedures, each PCIP must establish procedures to identify and report to HHS instances in which health insurance issuers or employer-based group health plans are discouraging high risk individuals from enrolling in, or remaining enrolled in, coverage offered by the issuer or the group health plan. At a minimum, each PCIP is required (either through the PCIP enrollment application or another vehicle) to establish methods to identify the following:

- a. Situations where a PCIP enrollee or potential enrollee had prior coverage obtained from a health insurance issuer or a group health plan, and the individual was provided financial consideration or another reward for disenrolling from such coverage, or disincentives for remaining enrolled in such coverage; or
- b. Situations where a PCIP enrollee or potential enrollee had prior coverage obtained directly from a health insurance issuer or a group health plan, and *either* of the following occurred:
 1. The premium for the prior coverage was increased to an amount that exceeded the premium required by the PCIP (adjusted based on the age factors applied to prior coverage), and the increase was not otherwise explained; or
 2. The issuer, group health plan, or employer provided the individual with money or other financial consideration to disenroll from coverage, or provided a disincentive to remain enrolled in such coverage. Such consideration includes the issuer, plan, or employer's payment of the PCIP premium on behalf of an enrollee or a potential enrollee.

If HHS determines that the insurance issuer or the group health plan has engaged in dumping, the issuer or plan will be billed for the medical expenses incurred by the PCIP with respect to the individual, and referred to the appropriate Federal and State authorities for additional enforcement action.

III. Remaining Issues

A number of questions remain regarding the scope of the anti-dumping provisions of PPACA. Among other things, it is unclear whether an insurer may be liable for actions taken by an employer that may violate the anti-dumping rule. For instance, an employer may offer new employees financial consideration to decline insurance coverage that the employer otherwise offers, or may terminate or modify insurance coverage, creating an incentive for an employee to enroll in the PCIP. The Rule's language may indicate that the insurer could be billed for expenses resulting from an employer's decision. Additionally, the Rule does not elaborate on the process that the Secretary of HHS will use to make a determination of dumping; nor does it describe an appeals process for insurers or group health plans who are accused of violating the Rule's anti-dumping provision. Finally, the term "financial consideration" is not defined in the Rule. At its broadest, this term might include consideration provided to similarly situated individuals without regard to eligibility under the risk pool or health status.

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If you have any questions, please contact your regular Groom contact or any of the attorneys listed below:

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