



VCU Medical Center

Office of Health Innovation

Interim Final Rule with Comment Period: Pre-Existing Condition Insurance Plan Program

Description: This interim final rule with comment period sets the payment rates for covered services furnished to individuals enrolled in the Pre-Existing Condition Insurance Plan (PCIP) program administered directly by HHS beginning with covered services furnished on June 15, 2013. This interim final rule also prohibits facilities and providers who, with respect to dates of service beginning on June 15, 2013, accept payment for most covered services furnished to an enrollee in the federally-administered PCIP from charging the enrollee an amount greater than the enrollee's out-of-pocket cost for the covered service as calculated by the plan.

Background

The PCIP program is intended to provide health insurance coverage to eligible uninsured individuals with pre-existing conditions until 2014. Beginning in 2014, most health insurance issuers will be required to offer coverage to all individuals, regardless of pre-existing conditions. Based on estimates, HHS believes it is prudent and necessary to make additional adjustments in the federally-administered PCIP with respect to payment rates for covered services in order to ensure that there is sufficient funding available to provide coverage to currently enrolled individuals until the program ends in 2014.

Major Provisions

Funding for the PCIP Program

With the exception of covered services furnished under the prescription drug, organ/tissue transplant, dialysis and durable medical equipment benefits, the payment rates for covered services in the federally-administered PCIP with dates of service beginning June 15, 2013 will be paid at

1. 100 percent of Medicare payment rates; or
2. Where Medicare payment rates cannot be implemented by the federally-administered PCIP, 50 percent of billed charges or a rate using relative value scale pricing methodology.

As the new payment rates will become the new plan allowances for the covered services, HHS notes that the Plan will be responsible for reimbursing the facility or a provider for a portion of these rates, and the enrollee will be responsible for reimbursing the facility or provider for the remainder, as calculated by the Plan using the current cost sharing rules described in the Plan brochure.

Premiums and Cost-Sharing

Beginning with June 15, 2013 dates of service, this new section requires all facilities and providers that accept payment from the federally-administered PCIP for furnishing a covered service to an enrollee (with the exception of covered services furnished under the prescription drug, organ/tissue transplant,

dialysis and durable medical equipment benefits) to accept as payment in full the plan allowance for the covered service, which includes the cost-sharing amount calculated by the Plan for the covered service.

With respect to these covered services, facilities or providers may not bill the enrollee for an amount greater than the amount determined by the Plan to be the enrollee's cost-sharing amount for the covered service.