DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
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OFFICE OF INSURANCE PROGRAMS

Date: May 31, 2011

To: Pre-Existing Condition Insurance Plan (PCIP) Contractors

Subject: PCIP Premium and Benefit Revisions (Policy Letter #6)

From: Richard Popper, Director of Insurance Programs

The purpose of this policy letter is to inform state-based contractors of the opportunity to modify their current Pre-Existing Condition Insurance Plan (PCIP) premiums and benefits and provide information about the ways a PCIP may make such modifications.

In accordance with the Affordable Care Act, premium rates charged in the PCIP program shall "be established at a standard rate for a standard population." The PCIP interim final regulation at 45 C.F.R. § 152.21(a)(1) further specifies that premiums should be calculated by considering the individual market rates charged for similar benefits in the state. In their proposals, PCIP contractors were required to submit rates that complied with this requirement. While PCIPs can revise their current rates, any changes must continue to be based on individual market rates in the state where the PCIP operates. This letter addresses specific inquiries regarding how a PCIP may revise current premiums and benefits. Please contact your designated CMS account manager if you have further questions about this letter and/or wish to modify other aspects of your PCIP program, including eligibility standards.

What are some ways that a PCIP could adjust premiums rates?
A PCIP could adjust its original methodology for calculating its standard risk rate (SRR). This change could be executed by incorporating new individual market data or revising the methodology for calculating the SRR. For example, instead of considering the rates offered by all individual market carriers in the state, a PCIP could develop the SRR by looking at base rates offered by the carriers or a single carrier with the largest share of the individual market in the state where the PCIP operates. CMS revised premiums in the federally-administered PCIP by examining rates offered by the largest carriers where the federally-administered PCIP operates. CMS staff is available to discuss alternative methods for calculating SRR that a PCIP may be considering prior to the submission of a revision.

Could a PCIP change the premium variation by age?
Yes. The Affordable Care Act and PCIP regulation require that premiums charged to enrollees in a PCIP may vary on the basis of age by a factor not greater than 4 to 1. However, this does not prevent a PCIP from varying premiums by age by a factor which is less than 4 to 1, thereby

decreasing rates for enrollees in the higher age bands relative to what they would be if rates varied by a ratio of 4 to 1.

Could a PCIP make changes to the benefit structure?
Yes. All plans still must meet the minimum coverage requirements and limitations on out-of-pocket costs, however, a PCIP could still modify existing plan offerings within these parameters. For example, in 2011 a number of PCIPs added plan options with lower premiums and higher deductibles in order to provide applicants additional benefit options. In addition, a PCIP may consider reducing deductibles or other out-of-pocket costs for its existing plans, although this could indirectly affect the premium if the value of the benefit package increases and results in a higher benchmark SRR.

Can PCIPs offer subsidized premiums for low-income individuals?
While the premium itself may not vary based on income, states may provide subsidies based on income to individuals who are otherwise eligible for the PCIP program in order to improve affordability. However, a PCIP cannot use its federal allotment for this purpose. Currently, two state-administered PCIPs provide these types of income-based premium subsidies.

What type of premium changes would not be permissible?
All revisions must continue to take into account the rates offered in the State's individual market. A PCIP cannot decrease premiums without linking the modification to the current individual market. CMS will not accept new approaches for calculating the SRR that attempt to account for differences between the public and private sector in administrative overhead or claims payment levels. For example, a PCIP cannot adjust premiums to account for differences between the provider rates paid by the PCIP and provider rates typically paid by individual market issuers. Nor may a PCIP adjust premiums to account for differences between the PCIP administrative costs and those of individual market issuers.

Can a PCIP increase premiums if the standard risk rate increases?
Yes. A PCIP may revise rates based on any projected changes in SRR in 2011. This would include any increase or decrease to the SRR that result from changes in the individual market rates.

What information should a PCIP submit if it wishes to revise premiums or benefits in 2011?
A PCIP wishing to adjust its premiums or benefits should submit the following information to its assigned CMS account manager:

1. A description of any premium and/or benefit changes, compared with current levels. Any proposed rates should be submitted via Microsoft Excel.

2. For a PCIP that is proposing a change to its original methodology for calculating the SRR, a written description from its actuary explaining the underlying differences between the old and new methodology and rationale for the modification.

3. The anticipated effective date of the proposed benefit and/or premium changes.

4. A written description from its actuary explaining how the revised premiums and benefits will impact total costs and enrollment over the life of the program. This should be accompanied by a new Table 2 that includes revised enrollment, claims, premium revenue projections, and incorporates actual enrollment numbers, claims costs, and premium revenue to date. A PCIP should also submit a revised Table 1 if there are any changes in its administrative costs.

5. PCIPs that are proposing a rate revision of more than 10 percent and currently have at least 100 enrollees, information pertaining to cohorts of enrollees by quarter (e.g., 3Q10, 4Q10, 1Q11). This should include:
    a. Number of enrollees in each cohort;
    b. Paid claims by month for each cohort;
    c. Top 20 primary diagnoses with amount paid (enrollment-to-date) and number of members with this diagnosis.

6. A description of any changes in outreach initiatives that will accompany the premium or benefit revisions, including the timing of these outreach activities relative to the effective date of the change.

7. A list of any organizations subsidizing PCIP premiums not previously reported to CMS, as well as an estimate of current and predicted numbers of enrollees who will have their premiums subsidized by a third party.

When should a PCIP submit these revisions?
PCIPs wishing to implement premium and benefit changes in the summer of 2011 are encouraged to submit any proposed revisions to their CMS account managers no later than July 1, 2011. Please allow approximately 4 weeks from the time the complete revision is submitted for a final decision from CMS.