



Health Reform Guidance: Group Health Plans and Rescissions of Health Coverage

Client Bulletin Provided by HUB International

August 9, 2010

Overview

Health reform alters the rules on cancellation of coverage for all group health plans. Group health plan sponsors must change the way they approach coverage terminations.

The law limits a plan's ability to terminate coverage retroactively, keeps coverage in effect pending an appeal of any termination, and imposes a new 30-day advance notice requirement for certain coverage terminations. Congress wished to provide new rights to individuals who do their best to complete long, complex enrollment questionnaires, but make mistakes with overly broad, unfair consequences. The new law and regulations go beyond that intent, however, and affect group health plan sponsors directly, not just insurance carriers' policy cancellations.

Scope of Rescission Rules -- The new rules protect individuals covered through group health plans as well as individual policies. This Bulletin focuses on group plans. This rule applies to insured and self-funded plans, despite early indications only insured plans would be affected. These rules also apply despite any incontestability period under state law affecting insured contracts (uncommon in self-funded plans).

Effective Date -- On June 28, 2010, the Departments of Labor, Treasury (IRS), and Health and Human Services jointly released interim final regulations on coverage rescissions. The rescission standards become effective for the first plan year starting on or after October 1, 2010. These rules apply to all plans whether grandfathered or not.

Identifying a "Rescission"

Making the distinction between a "rescission" and other events is very important. The 30-day advance notice requirement, discussed later in this Client Bulletin, does not apply unless there is a "rescission."

A "rescission" covered by the law is a cancellation or discontinuance of health plan coverage that has retroactive effect. Plans cannot terminate coverage retroactively except in very limited situations of fraud and intentional misrepresentation.

Rescissions

- A cancellation that treats a policy as void from the time of the individual's or the group's enrollment is a rescission.
- A cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose.

Not Rescissions

- Coverage terminations for reasons other than fraud or intentional misrepresentation are not “rescissions.” Other coverage terminations – following a mistake or simple administrative error – simply cannot trigger “rescissions” under the new definition.
- A cancellation of an insurance policy, or a termination of coverage by a group health plan, is not a “rescission” if it has only prospective (future) effect.
- In addition, a carrier or group health plan insurer can terminate coverage retroactively for failure to pay required premiums or contributions – that is not a “rescission” either, per the regulations.

A plan sponsor or carrier may continue such practices (unless state law prohibits a carrier from doing so in the context of an insured plan).

When Can Plans Rescind – Terminate Coverage Retroactively?

Under current law, a plan can enforce plan terms and can legally terminate coverage retroactively if a person has made a material misrepresentation of fact – even if done without intention or knowledge – as well as for other reasons. However, under new federal health reform rules, a group health plan must not rescind coverage (end coverage retroactively) except in the case of an act, practice, or omission constituting fraud or an intentional misrepresentation of a material fact. Proving what a person intended is difficult, if not impossible, and disputes likely will lead to appeals. The regulations provide an example implying any inadvertent statement will not be fraudulent or an intentional misrepresentation:

Example 1. (i) **Facts.** Individual A seeks enrollment in an insured group health plan. The plan terms permit rescission of coverage with respect to an individual if the individual engages in fraud or makes an intentional misrepresentation of a material fact. The plan requires A to complete a questionnaire regarding A’s prior medical history, which affects setting the group rate by the health insurance issuer. The questionnaire complies with the other requirements of this part. The questionnaire includes the following question: “Is there anything else relevant to your health that we should know?” A inadvertently fails to list that A visited a psychologist on two occasions, six years previously. A is later diagnosed with breast cancer and seeks benefits under the plan. On or around the same time, the issuer receives information about A’s visits to the psychologist, which was not disclosed in the questionnaire.

(ii) **Conclusion.** In this Example 1, the plan cannot rescind A’s coverage because A’s failure to disclose the visits to the psychologist was inadvertent. Therefore, it was not fraudulent or an intentional misrepresentation of material fact.

While the employer usually may not cancel coverage except prospectively, the question arises: What about the carrier?

- A carrier for a fully-insured plan would be bound by the new rule not to terminate coverage retroactively – in the absence of fraud or intentional misrepresentation.
- If the plan is self-funded, the law does not apply to the stop loss / reinsurance coverage carrier. If an employer fails to terminate an ineligible person in a timely manner, a stop loss carrier still may investigate a high-dollar claim and (to the extent allowed by contract) deny coverage for any period during which the person should not have been covered.

Administrative mistakes by an employer will not justify a carrier's retroactive termination in the context of an insured plan.

*“Example 2. (i) **Facts.** An employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Individual B has coverage under the plan as a full-time employee. The employer reassigns B to a part-time position. Under the terms of the plan, B is no longer eligible for coverage. The plan mistakenly continues to provide health coverage, collecting premiums from B and paying claims submitted by B. After a routine audit, the plan discovers that B no longer works at least 30 hours per week. The plan [i.e., the insurance carrier] rescinds B's coverage effective as of the date that B changed from a full-time employee to a part-time employee.*

*(ii) **Conclusion.** In this Example 2, the plan [i.e., the insurance carrier] cannot rescind B's coverage because there was no fraud or an intentional misrepresentation of material fact. The plan may cancel coverage for B prospectively, subject to other applicable Federal and State laws.”*

Rescissions Involving More Than One Person

A group health plan or an insurance carrier may attempt to cancel group health plan coverage of an entire family or a group of employees. The new rule provides additional protections in this context. For example, an individual (usually the employee) makes representations regarding other family members (such as ages and relationships). An employer seeking coverage for an entire group of employees often makes representations on issues such as the prior claims experience of the group. Mistakes that are not fraudulent or are unintentional will prevent a carrier (and employer) from retroactively terminating coverage.

Effect on State Law and Federal Court Precedents

State laws indirectly regulate insured plans by regulating carriers and plan terms. State laws are inapplicable to most self-funded group health plans (with the exception of church and governmental plans). The new health reform rule overrides most state insurance laws as to insured plans as well as prior federal common law (generally federal court standards, precedents, and interpretations). However, all state insurance or federal laws that do not conflict with the new rules and that are more protective of individuals will still apply.

Example -- A state insurance statute limits rescissions to cancellations of coverage for fraud within a 3-month limited contestability period. That state law could still apply; the state law provides greater protections to plan participants.

Effect on Appeals

Under new health reform rules, coverage generally must be kept in effect pending an appeal. A rescission of coverage in the context of an ERISA plan triggers this new standard, as well as traditional ERISA appeal rights. (Federal health reform has changed appeal rules in other ways. A separate Hub Client Bulletin will provide additional guidance on those changes.)

Notice of Rescission

A group health plan must provide at least 30 calendar days advance notice to an individual before coverage can be rescinded. The 30-day notice is designed to give individuals and plan sponsors an opportunity to explore their rights to contest the rescission or look for alternative coverage, as appropriate. But a carrier or plan is only required to provide the notice in very limited situations. The 30-day advance notice requirement does not apply unless there has been a “rescission.” So, the notice only applies when coverage is ended retroactively in the limited circumstances allowed by law – for fraud and intentional misrepresentation. As noted earlier, making the distinction among various coverage termination events is very important:

- When retroactive termination is allowed – for fraud or misrepresentations – the termination is a rescission, and it triggers the 30-day advance notice.
- When termination is not retroactive, the termination is not a rescission, and it does not trigger the 30-day advance notice.

(An individual can appeal either decision.)

The regulations provide more detail on the advance notice rule. Making the distinction between different coverage termination events is crucial, as illustrated by the following examples:

Example: A group health plan sponsor learns an employee has covered his step-son for 8 months beyond the limiting age in the plan. Upon inquiry, the employee asserts he accidentally misstated the child’s birth year, not being the biological father. The plan fiduciary considers whether the plan can terminate coverage retroactively. Taking into account the father’s assertions, the plan decides the misrepresentation is inadvertent. Under the new federal law, the plan cannot terminate the child’s coverage retroactively, so the termination cannot be a “rescission.” The plan is not required to send a 30-day advance notification of termination. Instead, the plan mails a letter, with certificate of mailing, indicating coverage terminates as of the date the letter was mailed.

Example: Same facts as above, but the child is the employee’s biological son, and an examination of past enrollment materials indicates he changed the child’s birth year on the form for the year in which coverage would otherwise have ended. The plan fiduciary considers whether the plan can terminate coverage retroactively. The situation involves a knowing misrepresentation or fraud, so the plan can terminate the child’s coverage retroactively. As a result, the termination is a “rescission.” The employer mails a notice of coverage termination, and must provide this deceitful employee a 30-day advance notice of termination.

The DOL is aware of this anomalous situation. They cite the statute as setting the rule on when the 30-day notice can apply and when it is inapplicable. The “bad” person benefits from the 30-day notice, while an innocent mistake does not warrant the same advance notice.

Family Member Notices -- When an employee has family coverage, this rule appears to require a separate notice for each affected family member. (One person may lose coverage, or the loss may affect the entire family.)

Carrier Notices -- If a carrier initiates termination of a person's health coverage, the carrier is required to provide a notice to each person whose coverage is rescinded (again, retroactively terminated for fraud or intentional misrepresentation).

When No Notice is Required -- No 30-day advance notice is required prior to a termination for failure to pay premiums or when the termination is not retroactive -- regardless of why the plan coverage is being terminated. A carrier or plan sponsor may choose to end coverage only prospectively, to avoid the notice requirement.

Termination of Entire Group Policy -- A carrier may terminate an employer's group health insurance policy as a whole. Unfortunately, if a carrier terminates an employer's policy for a reason other than fraud or intentional misrepresentation, or if the carrier does not terminate the coverage retroactively, such that it is not a "rescission," the employer generally will not receive advance notice unless required by state law. That employer faces an undesirable position in the insurance market – the employer must either cease offering insurance coverage, purchase coverage on a rush basis, or allow coverage gaps during a due diligence process for a new insurance program. (Thankfully, federal and state laws will limit the circumstances in which carriers may terminate entire groups.)

By contrast, assume an employer has intentionally lied regarding their group health plan, and the carrier terminates the coverage retroactively back to the inception of the contract as allowed under the new federal law. That employer will enjoy advance notice of the termination, can appeal through any carrier or state law process, and has 30 days to shop for new coverage. (Carriers likely will ask probing questions at the time they release new group quotes off-anniversary, specifically on the issue of whether a coverage rescission notice has been sent.)

Enhanced Future Protections Possible

The federal agencies note they may require additional, different notices that may apply other than in the case of a rescission, as well as other protections to ensure individuals do not lose health coverage unjustly or without due process.

COBRA Issues

The new regulations do not address COBRA coverage, and whether persons should be offered continuation coverage in the event coverage ends retroactively. (When coverage is terminated prospectively, the person possibly has lost coverage due to a qualifying event. If so, he or she should receive a COBRA notice because coverage was in place on the day before that qualifying event.) The DOL discussed the following as their interpretation of COBRA implications:

- When coverage is terminated retroactively, the reason will be either due to
 1. Non-payment of premiums, or
 2. Fraud or intentional misrepresentation.

If a person has experienced a qualifying event in connection with event (1), a non-payment of premiums, presumably the person knows amounts for health coverage were owed but not paid. COBRA rights would apply to the extent the person experiences a qualifying event in connection with the non-payment of premiums, such as a

reduction in hours. (Other federal rules may provide protection, such as FMLA.)
The DOL assumes the termination is processed shortly after the failure to pay.

If a person has been terminated retroactively for fraud or intentional misrepresentation, event (2), COBRA rights should not be triggered. Fraud and misrepresentation rarely correspond with COBRA qualifying events. Fraud and misrepresentation also may be considered gross misconduct, another reason for denying continuation.

Decision Process for Employer Actions

After the new rules take effect, an employer should focus on whether their reason for the termination of a person's coverage is a protected event under the law, then must consider if the coverage may be terminated (rescinded) retroactively, triggering a notice of termination.

What if the termination is due to failure of the person to pay required contributions (for individual or family coverage)?

- If so, it is not a "rescission," and the termination may be effective retroactively.
- A 30-day advance notice is not required.
- COBRA coverage may be available depending on the situation.

Is the termination due to an act, practice, or omission that is fraudulent, or is it due to an intentional misrepresentation of material fact?

- If so, it is a "rescission" event, and coverage may be terminated retroactively.
- A 30-day advance notice is required.
- COBRA coverage generally is not available, but eligibility should be evaluated.

What if coverage is being terminated for a reason other than either nonpayment of employee contributions or fraud / intentional misrepresentation?

- The coverage may not be rescinded; coverage may only be terminated prospectively (for the future).
- A 30-day notice is not required.
- COBRA coverage may be available depending on the situation.

What if the termination is prospective (not retroactive) either because (1) the employer could do otherwise but chooses to cancel the coverage prospectively instead, or (2) the employer cannot cancel the coverage retroactively under the new health reform rules?

- If so, the new rules on an advance notice generally do not apply.
- COBRA coverage eligibility should be closely evaluated.

Be aware in the event of an appeal, coverage must remain in effect pending that appeal -- regardless of whether the coverage ends retroactively or prospectively.