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Office of Consumer Information
and Insurance Oversight,
Department of Health and Human Services
Attention: OCIO-9994-IFC

United States Department of Labor
Employee Benefits Security Administration
RIN 1210-AB43

Internal Revenue Service
REG-120399-10

Re: *The Interim Final Regulations Published June 28, 2010, Interpreting
Selected Patient Protection and Affordable Care Act ("PPACA")
Provisions; Commenting on the Rescission Provisions*

Dear Rulemakers:

I am providing these comments to the interim final regulations published June 28, 2010 (75 Fed. Reg. 37188, *et seq.*) (the "June 28th Interim Rules") which interpret a series of changes made to the Public Health Service Act ("PHSA"), as added by PPACA §1001. While the June 28th Interim Rules are set to take effect August 27, 2010, for plan years commencing on or after September 23, 2010, the agencies involved – the Department of Health and Human Services ("DHHS"), the Employee Benefits Security Administration of the U.S. Department of Labor ("EBSA") and the Internal Revenue Service of the U.S. Treasury Department ("IRS"; jointly with the others, the "Agencies") – have invited the public to comment on them.

My comments are directed at the interpretation given by the June 28th Interim Rules to new PHSA §2712 (the "Rescission Rule"), which appears in identical form in

three separate regulations.¹ My objective is to bring to your attention a number of practical issues which need to be addressed – either by modifying the Rescission Rule, or by issuing additional related guidance – in order to make the Rescission Rule workable for all of the affected stakeholders.

Perspective

As an employee benefits attorney with more than 25 years of experience, I have worked with both public sector and private sector employers to facilitate the delivery of health, accident and sickness benefits to employees, former and retired employees, and their respective eligible dependents, under employment-based plans. I have found that the methods and means those employers use to provide such benefits varies widely, and is heavily influenced by the size of the employer's employee population and by the regulatory environment within which the employer (and its employment-based plan) functions.

It is axiomatic that small employers purchase insured group coverage (in one form or another) to deliver the benefits promised under their employment-based plans, that large employers invariably self-insure (subject to engaging in some form of risk-sharing arrangement with, e.g., a duly-licensed property and casualty or surplus lines insurer), and that those employers in-between choose between insurance and self-insurance (or, a variation) based on market conditions and relevant facts and circumstances (e.g., demographics, location of operations, finances, etc.). It likewise is plain that public sector employers' plan arrangements are subject to (and dictated by) relevant state and local law, but that most private sector employers' plan arrangements are subject to the procedural and remedial (and for welfare benefit plans, the increasingly substantive) provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").²

Despite the differing regulatory constructs, virtually all employer-sponsored plans have some common features. For example, virtually all employment-based coverages are now contributory (at least on some level), and virtually all employers rely on multiple parties to handle the day-to-day administrative chores (e.g., third party administrators, payroll vendors such as ADP, health insurance issuers, etc.). Among the Agencies involved, EBSA likely is the one most acutely aware of the problems this traditional reliance on multiple parties can potentially cause.³

¹ Treas. Reg. §54.9815-2712T; 29 C.F.R. §2590.715-2712; and 45 C.F.R. 147.128. For simplicity's sake, I will only refer to the IRS regulations (Treas. Reg. §54.9815-2712T, *et seq.*).

² As the Agencies doubtless are aware, there are private sector outliers, such as "employment-based" plans which cover only partners in partnership or sole proprietors, or employees covered by non-electing "church plans," where state law (rather than ERISA) controls.

³ E.g., *Solis v. Eanes*, Civ. No. 10-cv-0090 (N.D. Ill.; filed 1.13.10) (suit to recover employee contributions withheld after insurer had cancelled group policy for non-payment of premium).

**PHSA §2712: Initial
Guidance & Shortcomings**

The Statute

New PHSA §2712, merely two sentences long, has important implications for both the sponsors and fiduciaries of group health plans, as well as for any health insurance issuer that issues a group contract to any such plan:

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2702(c) or 2742(b).

PHSA §2712 (42 U.S.C. §300gg-11).

§2712's statutory language is comparatively straightforward. It generally prohibits a plan or an insurer from rescinding either the "plan" or the "coverage" "with respect to an enrollee once the enrollee is covered" under "such plan" or "[such] coverage." However, "a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage" is explicitly excepted from that general proscription.

The June 28th Interim Rules

The June 28th Interim Rules interpret §2712's rescission rule to apply to any "cancellation or discontinuance of coverage that has retroactive effect." Treas. Reg. §54.9815-2712T(a)(2). However, the Interim Rules do not provide practical guidance (such as an example) as to what is meant by a coverage termination which "has a 'retroactive effect.'"

The June 28th Interim Rules also recognize that the scope of §2712 is not unlimited, and that not every coverage cancellation constitutes a rescission; they do so by providing that a "rescission" does not occur in the following circumstances:

- (i) where the cancellation or discontinuance of coverage has only a prospective effect; or
- (ii) where the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Treas. Reg. §§54.9815-2712T(a)(2)(i), (ii).⁴ It goes without saying that it will be critically important for plans and issuers to understand and apply these two exceptions accurately and properly because they do not require a plan or issuer to follow any of the procedural and substantive protections that must be observed in order for an actual rescission of coverage to occur, such as (1) the need to provide proper notice, see PHSA §2712; also, Treas. Reg. §54.9815-2712T(a) (providing for thirty (30) days advance notice, independent of any contestability period that otherwise might apply under relevant state law), and (2) for non-grandfathered plans and coverages, the need to also undergo an entire cycle of claims and appeals where the rescission can be administratively contested.⁵

It is equally vital that the “fraud” and “misrepresentation” exceptions found in the statute, which actually permit coverage to be rescinded, be clearly understood and be capable of being practically applied both by plans and by issuers, because once an individual’s coverage has become effective, that coverage can be rescinded only after first providing notice to the enrollee and observing whatever other rules might apply under relevant state law.⁶ The June 28th Interim Rules incorporate these important exceptions in the following fashion:

- Where the individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud, as permitted by the terms of the plan or coverage; or
- Where the individual makes an intentional misrepresentation of material fact, as permitted by the terms of the plan or coverage.

Treas. Reg. §54.9815-2712T(a)(1).

Finally, the June 28th Interim Rules offer two examples to help illustrate how the Rescission Rule is intended to function, but neither example provides the sort of guidance that plan fiduciaries and sponsors and issuers need to have when they encounter individuals and employer groups that seem intent upon taking unfair advantage. The first example describes a remote (and medically unconnected) failure to disclose, made in response to an oblique question (“Anything else [] we should

⁴ I particularly welcome the decision to recognize that a coverage cancellation due to a nonpayment of premium exception falls outside the scope of a “rescission.” Indeed, had the June 28th Interim Rules characterized as a “rescission” any cancellation of coverage that results from a failure to timely pay premium (or, make a required contribution), it would only have prompted plans and health insurance issuers to eliminate grace periods altogether (to the extent permitted by relevant and applicable state law) and more rigorously police (and cancel) existing coverage(s).

⁵ See PHSA §2719, as interpreted by Treas. Reg. §§54.9815-2719T(a)(2)(i) and (b)(2)(ii)(A); 29 C.F.R. §§2590.715-2719(a)(2)(i) and (b)(2)(ii)(A); and 45 C.F.R. §§147.136(a)(2)(i) and (b)(2)(ii)(A).

⁶ At least in some circumstances (e.g., self-insured group health plans subject to ERISA, etc.) state law would be pre-empted, leaving only the federal rule.

know?"); the second example considers a mistake made not by the covered individual, but by the plan (presumably, by one of the plan's fiduciaries). Treas. Reg. §54.9815-2712T(a)(3).

Practical Suggestions

I appreciate the Agencies' efforts at interpreting the Rescission Rule and providing plans, plan sponsors and health insurance issuers with guidance in the form of the June 28th Interim Rules. I nonetheless submit that additional guidance is needed – preferably in the form of additional regulations – to make the Rescission Rule clearer and more predictable. Here are some suggestions and recommendations:

1. Clarify the Scope of the "Representative" Rule In Treas. Reg. §54.9815-2712T(a)(1). As noted above, the June 28th Interim Rules permit a plan, or an issuer, to rescind coverage with respect to an individual if the individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud, as permitted by the terms of the plan or coverage.

I read the term "person" in the parenthesis broadly, to include any individual or entity authorized to seek coverage on behalf of the individual whose coverage potentially could be rescinded. Thus, for example, this provision could be triggered by a fraud committed by an employer acting for and on behalf of its employees and their dependents, just as it could be triggered by a fraud committed by an enrolled parent acting for a dependent child or a dependent spouse. For unexplained reasons, the parenthesis does not appear in the second prong of the exception, which permits rescission for intentional misrepresentations of material fact, even though the same objectives are being served and even though the Preamble does not distinguish between the two types of conduct. *See Preamble at Part II.C (Overview; 75 Fed. Reg. 37192)* ("Under the new standard for rescissions set forth in PHSA Section 2712 and these interim final regulations, plans and issuers cannot rescind coverage unless an individual was involved in fraud or made an intentional misrepresentation of material fact. This standard applies to all rescissions . . .").

To avoid forcing plan sponsors and fiduciaries, and issuers, to discern whether a fraud or an intentional misrepresentation has been committed for purposes of determining whose coverage can be rescinded (which could have substantial implications if administered incorrectly), I strongly suggest that the parenthesis appear in both clauses. It also would help to clarify that an employer that seeks coverage on behalf of an entire group from an issuer will qualify as a "person" for purposes of applying this provision.

2. Specify By Example the Type of Language Needed to Satisfy the “As Prohibited By The Terms of the Plan or Coverage” Condition. (Treas. Reg. §54.9815-2712T(a)(1)) Both the statute and the June 28th Interim Rules make plain that a rescission is only possible if the plan (or where relevant, the coverage) clearly prohibit the conduct (i.e., the fraud or the material misrepresentation). It is important for all to know whether a general statement, or detailed language which describes specific acts, must be used in the plan to permit a plan (or an issuer) to rescind coverage. Leaving the issue to chance will only produce inconsistent results; this would undermine one of the salutary purposes of having the rule: to eliminate the problems caused by having varying standards (which the Interim Rules recognize as a current problem). See *Preamble at Part IV.4.a* (Economic Impact; 75 Fed. Reg. 37208 (“According to the Committee, the current regulatory framework governing the individual insurance market in this area is a haphazard collection of inconsistent State and Federal laws.”)).

3. Establish by Definition Standards for “Fraud” and “Intentional Misrepresentation of Material Fact.” (Treas. Reg. §54.9815-2712T(a)(1)) Neither the statute nor the June 28th Interim Rules spell out what type(s) of conduct will rise to the level of “fraud” or “intentional misrepresentation” for purposes of applying the rule. This is problematic, since there are several different types of fraud (e.g., fraud in the inducement, fraud in fact, constructive fraud, etc.) and the elements for each type of fraud can differ. Similar concerns plague the concept of “intentional misrepresentation as to a material fact” (e.g., how to distinguish between intentional conduct and mere “knowing” conduct, what constitutes a material fact, etc.). The lack of common, clearly-understood standards not only increases the likelihood of uneven results, but it also increases the risk that plans, issuers, and courts will adopt state law-based standards – which also can produce uneven results depending on where one lives or where a plan is being administered. I strongly encourage the Agencies to define those terms so a single set of national standards is established.

4. Clarify What “Retroactive Effect” Means in Practical Terms. (Treas. Reg. §54.9815-2712T(a)(2)) The phrase “retroactive effect” is potentially elusive – although not in extreme circumstances, such as eliminating coverage retroactive to the date individual or plan-based coverage initially was extended to a covered individual. Rather, “retroactive effect” creates problems where logistics or the need for proper documentation gives rise to a delay, such as a termination of coverage upon a termination of employment where the process used to alert the plan’s administrator or health insurance issuer and effect the coverage cut-off takes place days (or even weeks) after the date the actual termination of coverage occurs. This problem is particularly vexatious in employer plan and group coverage situations, where a health insurance issuer may not immediately be informed that an individual has lost or relinquished coverage due to an employment termination or some other event (e.g., divorce, death of the covered employee, etc.).

What matters is that the covered individual (or the party responsible for securing the individual's coverage, such as a child's parent or an employee's employer) be clearly and unequivocally notified that coverage has ended, even if it takes time to update and revise the relevant electronic and other records. As such, I strongly recommend that the Interim Rules be clarified to provide that a cancellation or discontinuance of coverage will not be considered to have "retroactive effect" (emphasis mine) if the covered individual (or the person or individual responsible for securing the coverage) is notified of the cancellation or discontinuance of the coverage prospectively and in writing – no matter when the actual records and other arrangements are updated to reflect the change. Since the June 28th Interim Rules contain both a definition of rescission (Treas. Reg. §54.9815-2712T(a)(2)), and a description of what does not constitute a rescission (Treas. Reg. §54.9815-2712T(a)(2)(i)), the clarification could be added to either provision.

Notably, this clarification would not require Example 2, found at Treas. Reg. §54.9815-2712T(a)(3), to be recast, since in that circumstance the covered individual is unaware of the loss of eligibility due to plan mistake.

5. Clarify the "Failure to Timely Pay" Exception in the Context of Grace Periods and Representative Payments. (Treas. Reg. §54.9815-2712T(a)(2)(ii)) In an era where virtually all coverage (and all plan participation) is contributory, the "failure to timely pay" exception is perhaps the most important exception found in the June 28th Interim Rules. It therefore is vital that this exception be well understood and capable of being followed. There are two practical circumstances where the exception comes into play, where the June 28th Interim Rules need to clearly spell out how the exception applies: first, when a grace period permits contributions or premiums to be paid late (which avoids having to cancel, and then possibly reinstate, the coverage); and second, when a "person acting on behalf of the covered individual" fails to timely make a required payment – and places that individual's coverage in a position to be cancelled.

Grace Periods

Grace periods are not uncommon. There are countless instances where a covered individual (or, a person acting on behalf of the covered individual) can fail to make a required contribution or premium payment by its due date without causing that coverage to be immediately cut off; most persons and individuals who pay late are provided with a short period of time in which to cure the non-payment problem. Several group health plan-related statutes, such as the "COBRA" continuation coverage statutes, have such a grace period. The use of a grace period also is not uncommon in group accident and sickness insurance policy situations, where delayed payment of group premium by small and medium-sized employers is not an infrequent occurrence.

The June 28th Interim Rules should spell out how the “timely pay” exception applies when a grace period is available, preferably by making plain that (1) the phrase “attributable to a failure to timely pay required premiums or contributions” includes any grace period that customarily is provided, and (2) coverage can be cut off as of the original due date, if the person responsible for making the payment still has not paid by the time the grace period expires.⁷

Representative Situations

While grace periods are not uncommon, representative situations are virtually commonplace. Two types of representative situations predominate: where a covered employee (alternatively known as either the “enrollee” or as the “participant”; see Comment 6, below) is paying premiums or making contributions on behalf of one or more dependents; and where a plan sponsor is paying premiums on behalf of an entire group of individuals (comprised of both covered employees and covered dependents) to a health insurance issuer to keep a group policy in force. The June 28th Interim Rules need to address directly how the “timely pay” exception applies in both circumstances – optimally, by providing practical examples. As between the two situations, the two-tiered payment situation (i.e., where covered individuals are required to contribute towards the cost of coverage under a plan (tier 1) and the plan sponsor pays monthly premiums to a health insurance issuer under a group accident and sickness policy to keep it in force (tier 2)) is the situation where it is most important to provide practical guidance.

The June 28th Interim Rules should make plain that the “timely pay” exception applies at both levels (tier 1 and tier 2), in part for practical reasons. Subject to a few isolated exceptions,⁸ a health insurance issuer knows only whether the plan sponsor (in the context of the Interim Rules, the “person acting on behalf of [every] covered individual”) has timely paid the group premium, while a plan sponsor is in the unique position of knowing not only if the group premium has been timely paid but also whether each covered individual has timely made the necessary contributions.⁹

⁷ In the absence of clear guidance, it is possible to interpret the “timely pay” exception in a number of ways. For instance, it is quite common for plans (and insurers) to treat a late payment that has been made within a “grace period” as though it has been made “timely.” As such, it is possible to read the exception to only permit a plan or issuer to prospectively terminate coverage after the grace period has expired. Such an interpretation (if widely embraced) would only lead to the elimination of many grace periods (to the extent plans and insurers could otherwise do so under other relevant law).

⁸ There are, of course, instances where individuals covered by or through a group policy will pay the health insurance issuer directly. The most typical circumstances involve federal and state coverage continuation laws (e.g., COBRA, COBRA-like state laws, etc.), where an issuer either has state-based insurance responsibilities or has agreed by contract to handle the COBRA administrative responsibilities normally borne by the “plan administrator” of an employer’s underlying group health plan.

⁹ There also will be representative situations occurring at the covered employee level, where individual employees not only are making contributions for their own benefit but also as a “person acting on behalf of” the various eligible dependents they have elected to cover.

Only by doing so will the Interim Rules place the responsibility for non-payment (or lack of timely payment) where it properly belongs: on the party that failed to make timely payments. In those comparatively rare instances where unscrupulous or dishonest plan sponsors collect contributions from covered individuals yet fail to make timely premium payments, the courts already have demonstrated the ability and willingness to hold errant plan sponsors appropriately accountable.¹⁰

6. Clarify the 30-Day Notice Rule; Coordinate the Rule with the New "Adverse Benefit Determination" Claims and Appeals Rule. (Treas. Reg. §54.9815-2712T(a)(1) and Treas. Reg. §54.9815-2719T(a)(2)(i)) PHSA §2712 by its terms requires an "enrollee" to receive prior notice of any cancellation of plan or coverage which amounts to a rescission. The June 28th Interim Regulations use a different term to describe this requirement: they require a plan or issuer to provide at least thirty (30) days advance written notice to each "participant" who would be affected by the plan or coverage rescission – which may or may not be the same as an "enrollee."¹¹ Treas. Reg. §54.9815-2712T(a)(1). Nor does the Preamble bring clarity to this notice requirement; it indicates that the 30-day advance notice period is intended to provide *individuals and plan sponsors* with an opportunity to explore their right to contest the decision or seek alternative coverage (as appropriate). See *Preamble at Part II.C* (Overview; 75 Fed. Reg. 37193).

Since the advance notice requirement serves as an important condition precedent to any rescission of coverage, the notice process should be clear and easy to follow. As such the June 28th Interim Rules should be revised to spell out exactly which individuals – or, what persons (a term which would then include the plan sponsor, if group coverage were being rescinded) – are to receive the advance notice.

¹⁰ *E.g.*, *Cook v. Jones & Jordan Eng'g*, 2009 U.S. Dist. LEXIS 835 (SD WV; 1.7.09) (sponsor, fiduciaries held liable to plan-covered individual for collecting contributions but not paying premiums, resulting in cancellation of group coverage); also, *Munsey v. Tactical Armor Prods., Inc.*, 2008 U.S. Dist. LEXIS 73881 (ED TN; 9.25.08) (permitting plaintiff to amend complaint, make ERISA-based claims in factual circumstances similar to *Cook*).

¹¹ The term "participant" is of course a defined term in ERISA, which is defined to include any employee or former employee who is or may become eligible to receive a benefit from a plan. See ERISA §3(7) (29 U.S.C. §1002(7)). Of course, not all plans or coverages covered by the Rescission Rule constitute (or, are part of) an employee benefit plan subject to ERISA.

There also is a need to indicate how the 30-day advance notice, required to be given to comply with the Rescission Rule, is supposed to coordinate with the new claims and appeals rules (PHSA §2719) to which most plans and coverages (other than grandfathered plans and coverages) are subject. Our present expectation is that, for group health plans subject to both provisions, the 30-day advance written notice needed to satisfy Treas. Reg. §54.9815-2712T(a)(1) could double as the adverse benefit determination notice required by Treas. Reg. §54.9815-2719T(a)(2)(i) (so long as modified appropriately to comply with the information requirements imposed by the new claims and appeals rules¹²); that would permit the two periods to run concurrently. However, it would be beneficial for the Agencies to provide some form of guidance which indicates how those rules operate under different circumstances (e.g., where no claims are pending, in an urgent care setting, when claims are being subjected to external review, etc.)

Conclusion

The June 28th Interim Rules provide important and helpful guidance regarding the ability of plans and health insurance issuers to rescind coverage. However, given the importance of the issue to those affected by it – not only those individuals who find that their coverage has been rescinded, but also the plans and plan fiduciaries, and health insurance issuers, who feel compelled to take such an extraordinary step to prevent the unscrupulous and unethical from benefiting at everyone else's expense – it is extremely important for all to have clear and easy-to-follow rules. Accordingly, I hope the Agencies will take into account the above concerns, suggestions and recommendations, and provide additional clarity.

I appreciate the opportunity to provide these comments; in the event any of the Agencies involved have any questions regarding them, I invite those inquires and would be pleased to respond.

Respectfully submitted,



John J. McGowan, Jr.

¹² Naturally, plans and coverages subject to both provisions would have to provide the sort of explanations, and appeals rights, specified in Treas. Reg. §54.9815-2719T.