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Office of Health Plan Standards and Compliance Assistance  
Employee Benefits Security Administration  
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RE: Technical Release 2012-02 (Guidance on 90-Day Waiting Period Limitation)

Cigna Corporation sponsors a group health plan for its thousands of employees and their dependents and will be directly impacted by the rules promulgated to implement section 2708 of the Public Health Service Act as amended by the Patient Protection and Affordable Care Act. In addition, the Cigna companies (including Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company and their HMO affiliates, collectively "CIGNA") are one of the nation's largest providers of health insurance and group health plan-related administrative services and works closely with plan sponsors whose plans are subject to the requirements of section 2708. Cigna offers the following comments on Technical Release 2012-02.

**Recommendation: To facilitate ease of administration and reduce administrative costs for employers, the rules should clarify that coverage may, in all cases, begin on the first day of the next payroll period or calendar month following the end of a 90 day waiting period.**

Currently, most employers sponsoring group health plans make coverage effective on the first day of the calendar month or pay period following satisfaction of all eligibility requirements. This practice has developed for a reason; aligning the coverage effective date with the employer's pay period or a calendar month makes it easier and less costly for employers to administer the employee payroll deductions or salary reductions. Requiring that coverage be made effective any earlier would have the unintended consequence of requiring employers to unnecessarily expend limited funds on system changes or on external vendor fees in order to comply with such a requirement. This would hit the smaller employers that can least afford such an expense particularly hard. Making coverage effective on the next payroll date or the beginning of the first calendar month following the end of a waiting period is clearly not intended to avoid compliance with any waiting period limitation. Accordingly, it is recommended that the rules and/or sub-regulatory guidance clarify that making coverage effective the first payroll period or first day of the calendar month following completion of a 90 day waiting period complies with PHSA section 2708.

**Recommendation: The rules or sub-regulatory guidance should recognize that a health insurance issuer may rely upon the eligibility determination made by the employer sponsoring an insured group health plan.**

In the case of an insured group health plan, both the health insurance issuer and the group health plan are required to comply with the requirement of PHSA section 2708. However, health insurance issuers typically have no insight into when individuals become eligible for coverage; the eligibility is administered by the employer sponsoring the insured group health plan. Accordingly, the health insurance issuer must rely entirely upon the eligibility information reported to it by the employer. Health insurance issuers do not, as a practical matter, therefore, have the ability to assure their compliance with section 2708. While the express wording of the statute makes section 2708 applicable to both the health insurance issuer and the group health plan in connection with insured group health plans, the rules and/or sub-regulatory guidance should take cognizance of the practical reality that health insurance issuers must rely entirely upon the eligibility reported to them by their group policyholders in administering the group health insurance policy. We recommend that the rules or regulatory sub-guidance clarify that a health insurance issuer may rely upon the eligibility information reported to it by or on behalf of its group policyholder where the group policyholder is responsible for administering eligibility for its group health plan.

We understand that the departments have expressed concern with whether the wording of the statute affords the flexibility to offer the regulatory relief requested. We would point out that the requirement to issue a summary of benefits and coverage (SBC) under PHSA section 2715 likewise falls upon both the insurer and the group health plan in the case of an insured group health plan. However, in the March 19, 2012 sub-regulatory guidance FAQ 5, the departments indicated that no enforcement action would be taken against an issuer or group health plan for non-compliance if either party enters into a “binding contractual arrangement” under which the other party has assumed compliance responsibility provided certain actions are taken. Compliance with PHSA section 2708 presents a similar situation, the difference being that where either the issuer or the group health plan could possibly assume responsibility for most of the obligations under section 2715, the health insurance issuer is never or rarely in a position to assume responsibility for administering eligibility and, therefore ensuring compliance with section 2708. We believe that similar regulatory flexibility to comport with reality should be exercised in this instance as well so that health insurance issuers that have no ability to assure compliance with section 2708 may rely upon the eligibility determinations made solely by employers sponsoring insured group health plans.

Thank you for your consideration of these comments.

Respectfully,



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