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September 15, 2010

Hon. Douglas Shulman
Commissioner
Internal Revenue Service
1111 Constitution Avenue, N.W.
Washington, DC 20224

Re: Comments on Regulations Regarding Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections under the Patient Protection and Affordable Care Act

Dear Commissioner Shulman:

Enclosed are comments on regulations regarding preexisting condition exclusions, lifetime and annual limits, rescissions, and patient protections under the Patient Protection and Affordable Care Act. These comments represent the views of the American Bar Association Section of Taxation. They have not been approved by the Board of Governors or the House of Delegates of the American Bar Association, and should not be construed as representing the policy of the American Bar Association.

Sincerely,

Charles H. Egerton
Chair, Section of Taxation

Enclosure

cc: Michael F. Mundaca, Assistant Secretary (Tax Policy), Department of the Treasury
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**ABA SECTION OF TAXATION
COMMENTS ON REGULATIONS REGARDING
PREEXISTING CONDITION EXCLUSIONS, LIFETIME AND
ANNUAL LIMITS, RESCISSIONS, AND PATIENT PROTECTIONS
UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE
ACT**

These comments (“Comments”) are submitted on behalf of the American Bar Association Section of Taxation and have not been approved by the House of Delegates or Board of Governors of the American Bar Association. Accordingly, they should not be construed as representing the position of the American Bar Association.

Principal responsibility for preparing these comments was exercised by Linda R. Mendel, Vice Chair of the Welfare Plan Design subcommittee of the Employee Benefits Committee of the Section of Taxation. Substantive contributions were made by Debbie Blackwell, Jennifer B. Dunsizer, Matthew J. Eickman, Norbert F. Kugele, and Patricia Moran. The Comments were reviewed by Robert A. Miller, a Committee Vice Chair, and John L. Utz, Committee Chair. The Comments were further reviewed by Roberta Casper Watson and James R. Raborn of the Section’s Committee on Government Submissions and by Thomas R. Hoecker, Council Director for the Employee Benefits Committee.

Although the members of the Section of Taxation who participated in preparing these Comments have clients who might be affected by the federal income tax principles addressed by these Comments, no such member or the firm or organization to which such member belongs has been engaged by a client to make a government submission with respect to, or otherwise to influence the development or outcome of, the specific subject matter of these Comments.

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Date: September 15, 2010

EXECUTIVE SUMMARY

These Comments pertain to the interim final regulations issued June 28, 2010, by the U.S. Department of the Treasury, the Internal Revenue Service, the U.S. Department of Labor, and the U.S. Department of Health and Human Services (the “Departments”)¹ and the proposed regulations issued June 28, 2010, by the U.S. Department of the Treasury and the Internal Revenue Service² (collectively, the “Regulation”), regarding certain provisions of the Patient Protection and Affordable Care Act of 2010³ and the Health Care and Education Reconciliation Act of 2010⁴ (collectively, the “Affordable Care Act” or “ACA”).

- I. We recommend that the Departments revise the provisions in the Regulations prohibiting lifetime and annual limits to:
 - A. Clarify that health savings accounts (“HSAs”), medical savings accounts (“MSAs”), and retiree-only health reimbursement arrangements (“HRAs”) are exempt from the prohibition on annual dollar limits in section 2711 of the Public Health Service Act (the “PHS Act”)⁵ and that a retiree-only HRA is exempt from the PHS Act amendments as long as active employees are not eligible to participate in the retiree-only HRA, even if the retiree-only HRA is a component of a broader plan that provides other benefit packages to active employees.
 - B. Permit a health plan to impose a lifetime limit, an annual limit, or both on the out-of-network dollar amount of individuals’ essential benefits provided that the health plan does not impose a lifetime or annual limit on the in-network dollar amount of individuals’ essential benefits.
 - C. Add an example illustrating that the Regulation does not prohibit day and visit limits.
 - D. Clarify the application of PHS Act section 2711 to dollar limits on specific essential benefits.

¹ 75 Fed. Reg. 37,188 (2010).

² 75 Fed. Reg. 37,242 (2010).

³ Pub. L. No. 111-148, 124 Stat. 119.

⁴ Pub. L. No. 111-152, 124 Stat. 1029.

⁵ Pub. L. No. 78-410, 58 Stat. 682 (1944). Section 2711 of the PHS Act, and the other sections of the PHS Act addressed by the Regulation, generally are to be codified in 42 U.S.C. section 300gg *et seq.*

- E. Provide further guidance and examples as to what benefits are not essential health benefits, at least for purposes of the regulatory prohibition against annual and lifetime limits, including: (1) a transitional safe harbor list of benefits that may be considered nonessential by group health plans until general regulations are developed concerning the definition of essential health benefits under ACA; and (2) clarification that benefits that are discretionary or supplemental in nature (such as limited scope dental and vision benefits that would be “excepted benefits” under section 9832(c)(1)⁶ if they were separately administered and subject to separate participant elections and contributions) are not essential health benefits.
- II. We recommend that the Departments revise the rules in the Regulations regarding rescissions to:
- A. Provide that an intentional misrepresentation of material fact is deemed to occur when: (1) an employee enrolls or re-enrolls an individual under a plan or policy on the basis that the individual has a particular family relationship to the employee (*e.g.*, is the employee’s spouse, child, step-child, or other dependent, and, if applicable, that the individual has not yet reached a certain age) when the individual does not have such a relationship with the employee (or has reached such age); or (2) after enrolling an individual under a plan or policy on the basis that the individual has a particular family relationship to the employee, the employee fails to disenroll the individual when required by the terms of the plan following the date that the relationship changed or ceased (*e.g.*, due to divorce).
 - B. Clarify (1) the interplay between prohibition on rescissions and the continuation of coverage requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”);⁷ and (2) that if an eligible COBRA qualified beneficiary does not timely elect COBRA, coverage may be cancelled, without further notice, as of the date of the qualifying event.
 - C. Provide that cancellation of coverage as of the date of a divorce or legal separation (or later date as provided in a plan) will be treated as a cancellation of coverage attributable to a failure to timely pay

⁶ References to a “section” are to a section of the Internal Revenue Code of 1986, as amended (the “Code”), unless otherwise indicated.

⁷ Pub. L. No. 99-272, 100 Stat. 82.

required premiums or contributions towards the cost of coverage if
(i) COBRA continuation coverage is not timely elected or
(ii) COBRA continuation coverage is timely elected, but the initial
COBRA premium is not timely paid.

D. State that a plan may simultaneously discontinue prospective coverage (subject to regularly applicable plan and legal requirements) and pursue rescission with respect to previously paid claims (subject to the 30-day notice requirement and the finding of fraud or intentional misrepresentation of material fact).

E. Provide that a cancellation or discontinuance of coverage only constitutes rescission to the extent it involves an attempt to recover any previously paid claims, so that a group health plan would be required to provide 30 days' advance notice to an affected participant before attempting to recover such amounts, but that a group health plan would be permitted to immediately suspend the payment of claims upon discovery of a suspected fraud or intentional misrepresentation and that the suspension would apply to both: (1) claims incurred after the date of the suspension; and (2) claims incurred but unpaid as of the date of the suspension.

III. We recommend that the Departments revise the patient protections provisions in the Regulations to clarify that the notices regarding patient protections may be provided as part of the summary plan description or other similar description of benefits offered under the plan.

COMMENTS

BACKGROUND

The subject of these Comments is the Regulation interpreting the following provisions of the Affordable Care Act:

- prohibition on preexisting condition limitations;⁸
- prohibition on lifetime and annual limits;⁹
- prohibition on rescission of coverage;¹⁰ and
- new patient protections.¹¹

These provisions are incorporated by reference into the Code by section 9815¹² and into the Employee Retirement Income Security Act (“ERISA”) by ERISA section 715.¹³

We commend the extraordinary efforts the Departments have made and continue to make to rapidly provide comprehensive, thoughtful, and integrated regulations regarding the provisions of ACA, including those that become effective this year. We hope that these Comments advance the Departments’ ongoing process of developing guidance that applies the myriad of new requirements applicable to group health plans in a manner that is as clear, fair, and practical as reasonably possible.

⁸ PHS Act § 2704, as added by ACA § 1201(2).

⁹ PHS Act § 2711, as added by ACA § 1001(5).

¹⁰ PHS Act § 2712, as added by ACA § 1001(5).

¹¹ PHS Act § 2719A, as added by ACA § 1001(5).

¹² I.R.C. § 9815.

¹³ 29 U.S.C. § 1185d. Section 9815 and ERISA section 715 were added by subsections (e) and (f), respectively, of ACA section 1563, entitled “CONFORMING AMENDMENTS.”

I. Temporary Regulation Section 54.9815-2711T - No Lifetime or Annual Limits

A. Exceptions for HSAs, MSAs, and Retiree-Only HRAs

1. Summary

The Regulation provides that health flexible spending arrangements (“FSAs”) are exempt from the prohibition against annual limits.¹⁴

2. Recommendation

We recommend that the final Regulation clarify that HSAs, MSAs, and retiree-only HRAs also are exempt from the prohibition on annual dollar limits in PHS Act section 2711. We also recommend that the final Regulation treat a retiree-only HRA as exempt from the PHS Act amendments as long as active employees are not eligible to participate in the retiree-only HRA, even if the retiree-only HRA is a component of a broader plan that provides other benefit packages to active employees.

3. Explanation

The preamble to the Regulation includes the following explanations:

- FSAs are not subject to PHS Act section 2711 because contribution amounts are specifically limited by the Affordable Care Act to \$2,500 effective for taxable years beginning after December 31, 2012.
- HSAs and MSAs are not treated as group health plans because: (a) the amounts available under the accounts are available for both medical and non-medical expenses; and (b) HSAs and MSAs are subject to specific statutory provisions that require the contributions be limited.
- HRAs that are integrated with other coverage as part of a group health plan do not violate PHS Act section 2711 if the other coverage meets the requirements of PHS Act section 2711.

¹⁴ Temp. Reg. § 54.9815-2711T(a)(2)(iii). For convenience, these Comments generally cite to the sections of the Regulation that were issued by the Department of Treasury and the Internal Revenue Service as interim final regulations (including, without limitation, Temp. Reg. §§ 54.9815-2704T, -2711T, -2712T, -2719AT). Such citations are intended to include, and these Comments are also intended to apply to, the corollary sections of the Regulation issued by the Department of Labor (including, without limitation, 29 C.F.R. §§ 2590.715-2704, -2711, -2712, -2719A) and Department of Health and Human Services (including, without limitation, 42 C.F.R. §§ 146.108, 147.126, 147.128, 147.138), as well as the proposed regulations issued by the Department of Treasury and Internal Revenue Service (including, without limitation, Prop. Reg. §§ 54.9815-2704, -2711, -2712, -2719A).

- Stand-alone HRAs that are limited to retirees generally are not subject to the PHS Act section 2711 annual limit prohibition because these HRAs typically would be plans with fewer than two current employees and thus would be exempt from the requirements of ERISA and the Code relating to ACA.¹⁵

These are important clarifications for group health plans, and yet only the clarification relating to FSAs appears in the body of the Regulation.¹⁶ The remaining clarifications regarding HSAs, MSAs, and HRAs are only mentioned in the preamble. The preamble, however, may not have the same effect as a regulation. The purpose of the preamble is merely to “inform the reader, who is not an expert in the subject area, of the basis and purpose for the rule or proposal.”¹⁷ Leaving these important clarifications in the preamble means that group health plan sponsors and insurers may be uncertain as to whether they may rely upon them when making decisions on how to structure their plans to comply with the Regulation. In addition, plan fiduciaries and advisors using a commercially published version of the Regulation may not even be aware of the additional information in the preamble because preambles typically are not included in such publications (or are included only in separate volumes that many people referring to the Regulation may not think to consult). Moreover, these determinations are particularly significant, because they relate to the scope of the Affordable Care Act, generally, with respect to HSAs, MSAs, and stand-alone HRAs that are limited to retirees. Thus, we believe it is appropriate for these points to be addressed in the body of the Regulation, rather than merely in the preamble. We believe that the Regulation was intended to provide certainty and ready accessibility to those operating plans, and therefore should be revised to include these important clarifications.

It also would be helpful to clarify the definition of a stand-alone retiree HRA so that group health plan sponsors with retiree HRAs will know whether their HRAs will be considered exempt from the Affordable Care Act’s amendments to the PHS Act. We recommend that the final Regulation treat a retiree-only HRA as exempt from the PHS Act amendments as long as active employees are not eligible to participate in the retiree-only HRA (*i.e.*, they are not eligible to receive payment from the HRA of medical expenses incurred while they are active employees), even if the retiree-only HRA is a component of a broader plan that provides other benefit packages to active employees. This would be consistent with the Departments’ application of Affordable Care Act requirements separately to each benefit package available to participants, rather than on the basis of the plan as a whole as identified in Form 5500, Annual Return/Report of Employee Benefit Plan.¹⁸

¹⁵ 75 Fed. Reg. 37,188, 37,190-91 (2010).

¹⁶ Temp. Reg. § 54.9815-2711T(a)(2)(iii).

¹⁷ 1 C.F.R. § 18.12(a).

¹⁸ *See, e.g.*, Temp. Reg. § 54.9815-1251T(a)(1)(i) (applying the rules for grandfathered health plan coverage separately to each benefit package available under a group health plan).

B. Application of prohibition on lifetime and annual dollar limits to out-of-network benefits

1. Summary

The Regulation prohibits lifetime and annual limits on the dollar amount of essential benefits for any individual.¹⁹

2. Recommendation

We recommend that a health plan be permitted to impose a lifetime limit, an annual limit, or both on the out-of-network dollar amount of individuals' essential benefits provided that the health plan does not impose a lifetime or annual limit on the in-network dollar amount of individuals' essential benefits.

3. Explanation

The preamble to the Regulation states:

When HRAs are integrated with other coverage as part of a group health plan and the other coverage alone would comply with the requirements of PHS Act section 2711, the fact that benefits under the HRA by itself are limited does not violate PHS Act section 2711 because the combined benefit satisfies the requirements.²⁰

The same principle may be applied to in-network benefits and out-of-network benefits. When out-of-network benefits are provided subject to lifetime dollar limits, annual dollar limits, or both along with in-network benefits, and the in-network benefits alone would comply with the requirements of PHS Act section 2711, we do not believe the fact that the out-of-network benefits are subject to lifetime dollar limits, annual dollar limits, or both should be treated as violating PHS Act section 2711 because we believe the combined benefits satisfy the requirements. The regulations on preventive care under the Affordable Care Act adopt the same principle.²¹ Preventive care services that must be provided without cost sharing in-network may be subject to cost sharing or excluded out-of-network.²² Moreover, plan design that encourages the use of in-network providers is a key cost containment tool that furthers the goal of keeping coverage affordable. As noted in the preamble to the regulations on preventive care under the Affordable Care Act, “[p]lans and issuers negotiate allowed charges with in-network providers as a way to

¹⁹ Temp. Reg. § 54.9815-2711T(a)(1), -2711T(a)(2).

²⁰ 75 Fed. Reg. 37,188, 37,190-91 (2010).

²¹ 75 Fed. Reg. 41,726 (2010).

²² Temp. Reg. § 54.9815-2713T(a)(3).

promote effective, efficient health care, and allowing differences in cost sharing in- and out-of-network enables plans to encourage use of in-network providers.”²³

C. Day and visit limits

1. Summary

The Regulation prohibits lifetime and annual limits on the dollar amount of benefits for any individual.²⁴

2. Recommendation

We recommend the addition of an example illustrating that the Regulation does not prohibit day and visit limits.

3. Explanation

PHS Act section 2711 prohibits lifetime and annual limits on the “dollar value” of essential benefits for a participant. Consistent with the statutory language, the Regulation prohibits lifetime and annual limits on the “dollar amount” of essential benefits for an individual. It appears from both PHS Act section 2711 and the Regulation that the prohibition on lifetime and annual dollar limits only applies to limits stated in dollar terms and not to other types of limitations. Consequently, we believe limits on the number of days of care or visits to health care providers that will be covered under a plan or policy during a stated period or for treating a specific condition should be permissible. We recommend the addition of an example illustrating that the Regulation does not prohibit day and visit limits, to avoid any uncertainty on this point.

D. Lifetime and annual limits on specific essential benefits

1. Summary

The Regulation prohibits aggregate annual and lifetime dollar limits on essential benefits but does not address dollar limits on individual essential benefits.²⁵

2. Recommendation

We recommend the issuance of additional guidance clarifying the application of PHS Act section 2711 to dollar limits on specific essential benefits.

²³ 75 Fed. Reg. 41,726, 41,738 (2010).

²⁴ Temp. Reg. § 54.9815-2711T(a)(1), -2711T(a)(2).

²⁵ Temp. Reg. § 54.9815-2711T.

3. Explanation

Without further guidance, the prohibition on lifetime and certain annual dollar limits could be interpreted as only prohibiting dollar limitations on aggregate essential benefits and as not prohibiting dollar limitations on specific essential benefits. The Regulation permits the imposition of lifetime and annual dollar limits on specific benefits that are not essential health benefits.²⁶ The implication of the explicit permission to impose lifetime and annual dollar limits on nonessential benefits may be that the imposition of lifetime and annual dollar limits on specific essential benefits is prohibited but that prohibition is not stated. To provide certainty on this point, we recommend that the Regulation be modified to include a statement on the permissibility of lifetime and annual dollar limits on specific essential benefits.

E. Transitional definition of nonessential benefits

1. Summary

In connection with the application of the rules on lifetime and annual dollar limits to specific health benefits that are or are not essential, the Regulation refers to the statutory definition of essential health benefits set forth in ACA section 1302(b).²⁷ ACA section 1302(b) will not apply for any other plan design purposes until January 1, 2014, at which time it will be relevant to the purpose of establishing a plan's "qualified health plan" status for an exchange. In the interim, the preamble to the Regulation provides that prior to issuance of regulations defining essential health benefits, the Departments will take into account a good faith effort to comply with a reasonable interpretation of the term.²⁸

2. Recommendation

We recommend that the Departments provide further guidance and examples as to what benefits are not essential health benefits, at least for purposes of the regulatory prohibition against annual and lifetime limits. We recommend that such guidance include a transitional safe harbor list of benefits that may be considered nonessential by group health plans until general regulations are developed concerning the definition of essential health benefits under ACA. We further recommend that such nonessential benefits include benefits that are discretionary or supplemental in nature, such as limited scope dental and vision benefits that would be "excepted benefits" under section 9832(c)(1) if they were separately administered and subject to separate participant elections and contributions.

²⁶ Temp. Reg. § 54.9815-2711T(b)(1); *see also* PHS Act § 2711(b), as added by ACA § 1001(5).

²⁷ Temp. Reg. § 54.9815-2711T.

²⁸ 75 Fed. Reg. 37,188, 37,191 (2010).

3. Explanation

Many group health plans include a variety of annual and lifetime dollar limits on benefits that are appropriately intended to be limited in scope due to the discretionary or supplemental nature of the benefits and expenses involved. Many of these types of supplemental or limited scope benefits may be offered under a separate plan or insurance policy, such as limited scope dental and vision benefits, without being subject to the prohibition against annual and lifetime dollar limits. Other examples of supplemental or limited scope benefits include supplemental accident and hearing benefits. However, if these benefits are treated as “essential benefits,” then a plan sponsor that offers a generous program including these benefits in the primary group health plan at no additional cost would now have to: (a) shift these benefits into a separate plan (to the extent they could qualify for the exemption for stand-alone limited scope dental and vision benefits);²⁹ (b) eliminate the benefits entirely; or (c) eliminate an important cost containment tool for these supplemental benefits.

In addition, certain types of benefits provided by group health plans are often subject to annual or lifetime dollar limits due to the potential for significant discretionary usage by participants, beyond the need to address basic health care requirements. Examples of benefits that frequently are limited due to discretionary usage concerns include eyeglasses and contact lenses, dental and orthodontic care, wigs (for cancer patients), temporomandibular joint (TMJ) treatments, and chiropractic or spinal manipulation care. While medical necessity determinations could be applied in a preauthorization process for these treatments, the lower dollar amounts involved may make such administration too costly relative to the appropriate need for restriction.

We believe that these and potentially other similar common group health plan benefits that are limited or supplemental in nature, or appropriately restricted due to the potential for cosmetic or other unnecessary discretionary usage, should be considered for inclusion in a safe harbor list of nonessential health benefits until the Departments give further deliberate consideration to the definition of essential health benefits. We believe that such a safe harbor list would allow many plans to avoid substantial changes or elimination of desired and helpful benefits due to uncertainty concerning the scope of essential health benefits.

One of the general categories to be included in the definition of essential health benefits is “[p]ediatric services, including oral and vision care.”³⁰ Because of the uncertainty as to which pediatric oral and vision care services might be essential health benefits, we believe that a safe harbor is particularly appropriate for limited-scope dental and vision benefits that are integral to a medical plan. We do not believe that an employer should have to provide separate participant elections and impose separate participant contributions to continue to offer otherwise-permissible limited-scope dental

²⁹ Reg. § 54.9831-1(c)(3).

³⁰ ACA § 1302(b)(1)(J).

benefits, vision benefits, or both subject to annual and lifetime dollar limits during the period prior to guidance concerning the definition of essential health benefits.

II. Temporary Regulation Section 54.9815-2712T Rules Regarding Rescissions

A. Employees' failure to provide accurate and timely identification of family members

1. Summary

PHS Act section 2712 prohibits rescission except when an individual was involved in fraud or made an intentional misrepresentation of material fact. The preamble to the Regulation notes that if the Departments become aware of attempts in the marketplace to subvert the rules regarding rescissions (*e.g.*, long, complex enrollment questionnaires), the Departments may issue additional regulations or administrative guidance to ensure individuals do not lose health coverage unjustly or without appropriate process.³¹

2. Recommendation

We recommend that the final Regulation provide that an intentional misrepresentation of material fact be deemed to occur when:

- an employee enrolls or re-enrolls an individual under a plan or policy on the basis that the individual has a particular family relationship to the employee (*e.g.*, is the employee's spouse, child, step-child, or other dependent, and, if applicable, that the individual has a certain age) when the individual does not have such a relationship with the employee; or
- after enrolling an individual under a plan or policy on the basis that the individual has a particular family relationship to the employee, the employee fails to disenroll the individual at the time required by the plan following the date that the relationship changed or ceased (*e.g.*, due to divorce).

3. Explanation

When determining whether an individual is eligible for plan participation as the employee's spouse, child, or other dependent, plan sponsors and administrators typically rely on the representations made by the employee at the time of open or special enrollment regarding the individual's relationship with the employee. This reliance is necessary, because plan sponsors and administrators often will not have direct knowledge regarding the employee's family relationships. Moreover, knowledge about one's family relationships, such as whether one is married and has children, or the ages of the family

³¹ 75 Fed. Reg. 37,188, 37,193 (2010).

members, is sufficiently basic that it is fair to assume that an employee has accurate knowledge regarding such matters. Consequently, if an employee misstates such information on an enrollment form, we believe it would be appropriate to deem the incorrect information to constitute an “intentional misstatement of a material fact” for purposes of PHS Act section 2712 (assuming that eligibility under the plan depends upon the misstated information), so that coverage could be rescinded upon 30 days notice, rather than requiring the employer to produce additional evidence of the employee’s intent.

If the above cases are *not* deemed to constitute “intentional misrepresentations of material fact,” the adverse effect on plans and other employees might be significant. If plan sponsors and administrators continue to rely on the representations of employees regarding their family members, it is likely that a number of ineligible persons will be enrolled in the plan. The plan sponsor and administrator may not find out that such individuals are ineligible until after they incur numerous or large medical claims. If rescission is not readily available in such cases (as could occur if the plan sponsor was required to produce additional evidence that the misstatement was knowing), then the claims involved would result in increased premiums that could be passed on to other participants.

On the other hand, if plan sponsors become more aggressive with requests for enrollment information, such as by demanding extensive documentation regarding family members and family relationships, or requiring employees to certify enrollment information several times a year, other concerns arise. Such steps would not only be costly, but also could create tension in the employer/employee relationship. At any rate, these tools may ultimately be unavailable to plan sponsors, as the Departments have indicated potential disapproval (in the preamble to the Regulation) of tools such as “long, complex enrollment questionnaires.”³²

We recommend that misstatements of family relationships be deemed to be intentional misrepresentations for purposes of PHS Act section 2712. If the Departments believe it is inappropriate to adopt such a rule on an unqualified basis, we suggest that the Departments adopt it subject to qualifications, such as:

- The plan’s enrollment guidelines must be clearly set forth in writing and distributed at the time of open enrollment; and
- The plan’s enrollment guidelines must designate a person, entity, or department to which the employee must give notice of changes in family relationships, along with an explanation of the form, content, and timing of the notice.

³² 75 Fed. Reg. 37,188, 37,193 (2010).

B. General coordination with COBRA

1. Summary

The Regulation requires that 30 days' advance written notice be provided to each plan participant who will be affected by a rescission.³³ The Regulation further indicates that a cancellation or discontinuance of coverage is not a rescission if it is effective retroactively, to the extent the cancellation or discontinuance of coverage is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.³⁴

2. Recommendation

We recommend that the Departments clarify the interplay between this new rescission rule and COBRA. Specifically, we recommend that the Departments clarify that if an eligible COBRA qualified beneficiary does not timely elect COBRA, coverage may be cancelled, without further notice, as of the date of the qualifying event.

3. Explanation

A COBRA election period must last at least 60 days from a qualifying event.³⁵ So long as a qualified beneficiary elects COBRA within that 60-day period and then pays for all premiums then owed within 45 days of election,³⁶ coverage will be retroactive to the date of a qualifying event. During the election period and before the qualified beneficiary has made an election, coverage may be provided on a provisional basis.³⁷

If a plan continues to provide medical coverage to a qualified beneficiary from the date of the qualifying event through the date of COBRA election and the qualified beneficiary does not timely elect COBRA, coverage is terminated as of the date of the qualifying event, and the qualified beneficiary is responsible for any medical expenses incurred since the qualifying event.³⁸ For example, in the event of a termination of employment, the employee must be given 60 days to elect COBRA from the date the employee is provided a COBRA election notice. During that 60-day period, coverage may be provided on a provisional basis.³⁹ If the employee never elects COBRA (or

³³ Temp. Reg. § 54.9815-2712T(a)(1).

³⁴ Temp. Reg. § 54.9815-2719AT(a)(2)(ii).

³⁵ The notice period runs from the later of: (a) the date the COBRA election notice is provided; or (b) the date coverage is lost on account of the COBRA qualifying event. Reg. § 54.4980B-6, Q&A 1.

³⁶ Reg. § 54.4980B-8, Q&A 5(b).

³⁷ Reg. § 54.4980B-6, Q&A 3.

³⁸ *Id.*

³⁹ Reg. § 54.4980B-6, Q&A 3.

elects COBRA but does not make the initial payment within 45 days of election), coverage is terminated effective on the date of termination of employment, and the employee is responsible for all claims incurred since the qualifying event.

We recommend that the Departments clarify that a rescission does not occur when coverage is cancelled retroactively because a COBRA qualified beneficiary does not make a timely COBRA election.

C. Obligation to pay COBRA premiums after a divorce or legal separation

1. Summary

A retroactive cancellation or discontinuance of coverage is not a rescission if it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.⁴⁰

Divorce and legal separation are COBRA qualifying events if, in the absence of COBRA continuation coverage, the divorce or legal separation would result in the spouse's loss of coverage.⁴¹ An employer is permitted to charge a COBRA premium of 102% of the cost of coverage to continue health coverage after a qualifying event.⁴²

2. Recommendation

We recommend that cancellation of coverage as of the date of a divorce or legal separation (or later date as provided in a plan) be treated as a cancellation of coverage attributable to a failure to timely pay required premiums or contributions towards the cost of coverage if (i) COBRA continuation coverage is not timely elected or, (ii) COBRA continuation coverage is timely elected, but the initial COBRA premium is not timely paid.

3. Explanation

Typically, an employee's spouse ceases to be eligible for group health coverage as of the date an employee and spouse divorce or become legally separated.⁴³ It is not unreasonable to expect that an employee and spouse will know when their marital status changes, but the plan administrator would not have this information in the absence of notice from the employee or spouse. In recognition of this situation, the employee or spouse is responsible for notifying the plan administrator within 60 days of a divorce or

⁴⁰ Temp. Reg. § 54.9815-2712T(a)(2)(ii).

⁴¹ I.R.C. § 4980B(f)(3)(C).

⁴² I.R.C. § 4890B(f)(2)(C).

⁴³ As permitted by section 4980B(f)(8), some plans continue a spouse's eligibility for a period to time (such as to the last day of the month) after a divorce or legal separation.

legal separation (or, if later, within 60 days of the date that the spouse would lose coverage due to the divorce or legal separation).⁴⁴ The plan administrator is required to notify both the employee and the spouse of this responsibility when the spouse first becomes covered under the plan.⁴⁵ If the employee and spouse fail to provide notice of the divorce or legal separation within the 60-day period, the spouse loses eligibility for COBRA continuation coverage.⁴⁶ If the employee or spouse provides timely notice of the divorce or legal separation, the plan administrator has 14 days to send a COBRA election notice to the spouse. The spouse then has 60 days to elect COBRA continuation coverage⁴⁷ and up to an additional 45 days to pay the first COBRA premium.⁴⁸ If a plan administrator fulfills its notice responsibilities and the spouse fails to elect and pay for COBRA continuation coverage within the specified timeframes, the group health plan is permitted to “terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the plan with respect to that qualified beneficiary.”⁴⁹

The obligation to pay COBRA premiums starts on the date that a spouse becomes ineligible for coverage. If COBRA continuation coverage is not elected and the initial COBRA premium paid within the timeframes specified by COBRA, we do not believe the retroactive termination of coverage to the date that the spouse became ineligible for coverage should be treated as a rescission. Rather, we believe it should be treated as a retroactive cancellation of coverage attributable to the failure to timely pay required premiums or contributions towards the cost of coverage.

D. Simultaneous cancellation of prospective coverage and rescission of past coverage

1. Summary

A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect.⁵⁰

⁴⁴ Reg. § 54.4980B-6, Q&A 2.

⁴⁵ 29 C.F.R. § 2590.606-1(b).

⁴⁶ *Id.*

⁴⁷ The notice period runs from the later of: (1) the date the COBRA election notice is provided; or (2) the date coverage is lost on account of the COBRA qualifying event. Reg. § 54.4980B-6, Q&A 1.

⁴⁸ Reg. § 54.4980B-8, Q&A 5(b).

⁴⁹ Reg. § 54.4980B-8, Q&A 1.

⁵⁰ Temp. Reg. § 54.9815-2712T(a)(2)(i).

2. Recommendation

We recommend that the Regulation be modified to state that a plan may simultaneously discontinue prospective coverage (subject to regularly applicable plan and legal requirements) and pursue rescission with respect to previously paid claims (subject to the 30-day notice requirement and the finding of fraud or intentional misrepresentation of material fact).

3. Explanation

The rule adopted in the Regulation could be interpreted to prohibit a plan administrator from simultaneously: (a) canceling coverage prospectively (without the 30-day advance notice and a finding of fraud or intentional misrepresentation of a material fact); and (b) separately pursuing rescission of the previously provided coverage. If so construed, a plan administrator unsure of whether it is possible to prove that a misstatement was intentional could be placed in a precarious situation. For example, suppose that a misstatement relates to an eligibility requirement (such as whether an individual is the participant's child). In such a situation, the plan administrator would have to choose whether to: (i) attempt to rescind the prior coverage, in which case, if the plan were unsuccessful, it would not only have to pay the prior claims, but also continue to cover the ineligible individual until the 30-day period for notice of cancellation expires (and potentially during an appeal); or (ii) forgo attempting to rescind coverage and only discontinue coverage of the ineligible individual on a prospective basis (in which case, the cancellation could be implemented without providing a 30-day notice). Construing PHS Act section 2712 to require such a choice could force plans to pay numerous or large claims for otherwise ineligible individuals. In addition, depending upon the type of plan involved, the existence of such situations may put the plan administrator at risk of a fiduciary violation for failing to take actions needed to avoid losses to the plan.⁵¹

As a result, it would be helpful if the Regulation were modified to clearly indicate that a plan may simultaneously discontinue prospective coverage (subject to regularly applicable plan and legal requirements) and pursue rescission with respect to previously paid claims (subject to the 30-day notice requirement and the finding of fraud or intentional misrepresentation of material fact). This could be accomplished by defining a cancellation or discontinuance of coverage to constitute a rescission only to the extent that it has a retroactive effect.

We do not believe that adopting such a rule would undercut the protections provided by PHS Act section 2712. In order for a cancellation to apply retroactively, the requirements for 30-day advance notice and a finding of fraud or intentional misrepresentation of material fact would still apply. Moreover, because the advance notice requirement does not apply to prospective cancellations, the purpose of the advance notice would seem to relate to permitting participants “the opportunity to explore

⁵¹ ERISA § 404(a)(1)(ii).

their right to contest the cancellation”⁵² or perhaps providing them time to notify and make alternative payment arrangements with their health care providers with respect to amounts previously paid by the plan, rather than providing them time to obtain different coverage for the future. Consequently, allowing a plan administrator to immediately discontinue future coverage (without advance notice), while simultaneously pursuing rescission with respect to prior payments (with advance notice), would appear to satisfy both the terms and underlying purpose of the statutory requirement.

E. 30-day advance notice of rescission

1. Summary

Under the Regulation, a group health plan must provide at least 30 days’ advance written notice to a participant who would be affected before coverage may be rescinded.⁵³

2. Recommendation

We recommend that a cancellation or discontinuance of coverage only constitute rescission to the extent it involves an attempt to recover any previously paid claims, so that a group health plan would be required to provide 30 days’ advance notice to an affected participant before attempting to recover such amounts, but that a group health plan would be permitted to immediately suspend the payment of claims upon discovery of a suspected fraud or intentional misrepresentation and that the suspension would apply to both: (a) claims incurred after the date of the suspension; and (b) claims incurred but unpaid as of the date of the suspension.

3. Explanation

As noted above, the Regulation generally provides that a cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect.⁵⁴ We agree with the Departments that a cancellation must have a retroactive effect to constitute a rescission, and that a prospective cancellation would not be a rescission and consequently should not trigger the application of the restrictions set forth in PHS Act section 2712. Therefore, we believe a prospective cancellation may be accomplished without 30 days’ advance notice or a determination of fraud or an intentional misrepresentation of material fact (the “fraud finding”). However, the meaning of a retroactive cancellation is not clear.

⁵² 75 Fed. Reg. 37,188, 37,193 (2010).

⁵³ Temp. Reg. § 54.9815-2712T(a)(1).

⁵⁴ Temp. Reg. § 54.9815-2712T(a)(2).

We recommend that the Regulation be clarified to indicate that a rescission is limited to cancellation of benefits previously paid, and that a prospective cancellation may involve suspension or elimination of any benefits not yet paid (even if previously incurred). It is often difficult or impossible for a group health plan to recover amounts paid to or on behalf of an ineligible individual. If a group health plan were required to continue to pay claims to or on behalf of an individual suspected of fraud or an intentional misrepresentation during a 30-day notice period, the plan is unlikely to recover such amounts. We believe this would create an automatic and potentially significant financial benefit to individuals engaging in intentional misconduct, and unfairly penalize plans and employers.

Claims procedures applicable to group health plans provide a sufficient mechanism for dealing with claims incurred but unpaid as of the date of a suspension. The claims administrator could request additional information needed to clarify the individual's eligibility for coverage and decide the claims when such information is provided.⁵⁵ Alternatively, the claims administrator could deny claims, subject to the individual's right to appeal. If the claims administrator were to ultimately conclude that the individual was eligible for the benefits, the suspended claims would be released for payment.⁵⁶

III. Temporary Regulation Section 54.9815-2719AT Patient Protections

A. Notices relating to patient protections

1. Summary

The Regulation states that a group health plan or health insurance issuer must provide a notice informing each participant of his or her rights to: (a) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (b) obtain obstetrical or gynecological care without prior authorization.⁵⁷

⁵⁵ 29 C.F.R. § 2560.503-1(f)(4) (applicable to group health plans other than those sponsored by churches or governmental entities). If the plan has approved an ongoing course of treatment to be provided over a period of time or a number of treatments, the treatment may not be terminated without advance notice and opportunity to appeal. Temp. Reg. § 54.9815-2719T(b)(2)(iii) (referencing 29 C.F.R. § 2560.503-1(f)(2)(ii)).

⁵⁶ This would be similar to the suspension and retroactive reinstatement of coverage that is permitted pending a COBRA election and premium payment. *See* Reg. § 54.4980B-6, Q&A-3(b).

⁵⁷ Temp. Reg. § 54.9815-2719T(a)(4).

2. Recommendation

We recommend that the Departments revise the Regulation to clarify that this notice may be provided as part of the summary plan description or other similar description of benefits offered under the plan.

3. Explanation

As drafted, the Regulation is unclear as to whether the patient protection notices must be separate documents or may be incorporated into the body of a summary plan description or other similar description of benefits. Although the preamble includes a discussion about the notices,⁵⁸ it also does not clarify whether the notices are meant to be separate documents.

To provide certainty and to ease the burden on group health plan sponsors and administrators, we recommend that the final Regulation clarify that the notices may be, but are not required to be included within the body of a summary plan description or other similar description of benefits. Permitting the notices to be provided in this manner also would be convenient for participants, because summary plan descriptions and similar documents are where they typically would look for information regarding their rights under a group health plan or policy.

⁵⁸ 75 Fed. Reg. 37,188, 37,194 (2010).