



Rescission Requirements Impact Group Health Plans

The following information is being sent as a courtesy to keep you informed on the status of the Health Care initiatives taking place in our government.

The federal health care reform law changed the way health plans and issuers approach rescissions in both the group and individual markets. Group health plans are affected whether they are fully-insured or self-insured.

What constitutes a rescission?

It's important to understand what constitutes a "rescission" for federal health care reform, as opposed to another type of coverage termination. A rescission is broadly defined as a retroactive termination of a member's coverage.

However, there are some important exceptions from this broad definition. For example, termination of coverage because of nonpayment of premium or contribution (either by the group or the member) is not a rescission. It is not considered a "rescission" when the member's coverage is retroactively canceled to the last paid-to date if the member pays no premiums or contribution for periods of time after termination of employment or eligibility. The member's coverage can be retroactively canceled to the last paid-to date.

Restrictions on rescission?

If a group health plan or issuer is faced with a "rescission," certain restrictions apply for plan years that start on or after September 23, 2010:

- The federal health care reform law does not allow the plan or issuer to rescind coverage, except in cases of fraud or intentional misrepresentation of material fact as prohibited by the plan or coverage. Examples of when a group may consider rescinding coverage include intentional misrepresentations of marital status or dependent eligibility.
- Although federal law may prohibit rescinding coverage because of a member's lack of intent, the plan and issuer may still cancel coverage prospectively.
- When a policy or coverage is rescinded due to intentional misrepresentation of material fact or fraud, the plan or issuer must:
 - ◆ Provide notice of the rescission 30 days in advance of taking the action
 - ◆ When providing notice, inform the member of the opportunity to appeal the determination to rescind (as outlined in regulations for the appeals provision)

For group health plans, group customers control communications of membership eligibility. Therefore, when a member is removed from coverage, the carrier may not be aware of the reason for the coverage termination. For this reason, **it is the employer group's responsibility to comply with this provision**. If the group notifies a carrier within a reasonable period of time that the member is no longer an employee and, therefore, no longer a member, it would be assumed that it is not a rescission because no payment was received from the member.

What coverage terminations qualify as rescissions? Is the exception to the statutory ban limited to fraudulent or intentional misrepresentations about prior medical history? What about retroactive terminations of coverage in the “normal course of business”?

A rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent attributable to a failure to pay timely premiums towards coverage.

The statutory prohibition related to rescissions is not limited to rescissions based on fraudulent or intentional misrepresentations about prior medical history. An example in the Departments' interim final regulations on rescissions clarifies that some plan errors (such as mistakenly covering a part-time employee and providing coverage upon which the employee relies for some time) may be cancelled prospectively once identified, but not retroactively rescinded unless there was some fraud or intentional misrepresentation by the employee.

On the other hand, some plans and issuers have commented that some employers' human resource departments may reconcile lists of eligible individuals with their plan or issuer via data feed only once per month. If a plan covers only active employees (subject to the COBRA continuation coverage provisions) and an employee pays no premiums for coverage after termination of employment, the Departments do not consider the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative record-keeping, to be a rescission.

Similarly, if a plan does not cover ex-spouses (subject to the COBRA continuation coverage provisions) and the plan is not notified of a divorce and the full COBRA premium is not paid by the employee or ex-spouse for coverage, the Departments do not consider a plan's termination of coverage retroactive to the divorce to be a rescission of coverage. (Of course, in such situations COBRA may require coverage to be offered for up to 36 months if the qualified beneficiary pays the COBRA applicable premium.)

As always, we will keep you posted of significant developments as they occur.

If you have any questions, please contact your HARDEN Employee Benefits Account Manager.

Sources:

Blue Cross Blue Shield of Georgia Communications. Health Care Reform Update. March 25, 2011.

Department of Labor website, <http://www.dol.gov/ebsa/faqs/faq-aca2.html>. FAQs About the Affordable Care Act Implementation Part II, Question 7.