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## Healthcare Reform FAQ: Prohibition on Rescinding an Individual's Group Coverage

November 17, 2010

### General Information

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#### Rescission Defined

Rescission of coverage means a cancellation or discontinuance of coverage that has a retroactive effect. Under the federal Affordable Care Act, regulations prohibit a rescission of coverage except in the case of fraud or an intentional misrepresentation of material fact. Inadvertent misstatements of fact do not give rise to a permissible rescission. This provision became effective for all group medical plans as they renew on or after September 23, 2010, including both fully-funded and self-funded plans, regardless of grandfathered status. It does not apply to dental-only plans.

The prohibition does not apply to the cancellation or discontinuance of coverage that:

- has a prospective effect (effects coverage going forward); or
- is attributable to a failure to timely pay the required premium or contributions toward the cost of coverage.

#### 30-day Advance Notice Requirement

In the case of a permissible rescission by the plan sponsor/employer or insurer, the plan sponsor/employer or insurer must provide a 30-day advance notice to each person who would be affected. The advance notice is intended to provide the individual(s) an opportunity to explore their rights to contest the rescission, or look for alternative coverage, as appropriate.

### Information for Employers

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The following FAQ is not intended to give legal advice but only to provide guidelines. These guidelines are based on the limited regulatory guidance currently available. Keep in mind that the law does not prohibit prospective termination of coverage.

**Q1: What if we did not inform PacificSource of a termination of employment until a month or two after the employee's coverage would normally end? Could the employee's coverage be retroactively terminated to the last day of eligibility?**

A1: A delay in your process for notifying PacificSource of an employee's termination should not give rise to a prohibited rescission as long as the employee has no expectation that you intend to continue their coverage beyond termination of employment.

**Q2: What if we did not terminate an employee's coverage when the employee's hours were reduced below the hourly requirement for coverage? Can we correct that oversight by retroactively terminating the employee's coverage to the last day of eligibility?**

A2: Federal guidance includes this case scenario as a specific example of a prohibited rescission. Unless the employee did not pay his or her portion of the premium, termination of coverage may only be done on a prospective basis.

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**Q3: What if we did not find out that an employee gave us the wrong birth date for a dependent child until after the dependent should have aged-off the plan? Can we retroactively terminate the child's coverage to the last date of eligibility based on the child's true birth date?**

A3: If the employee inadvertently (unintentionally) provides the incorrect birth date, you cannot retroactively terminate the child's coverage. If the employee intentional misrepresented the child's birth day to extend the child's coverage beyond the normal eligibility period and the misrepresentation was material (e.g., employer contributed to the premium for an ineligible child), the child's coverage could be retroactively terminated with a 30-day notice to the child (or parent if under age 18). Establishing intent could be tricky in such cases. Read about potential COBRA continuation considerations below in Q5/A5.

**Q4: What if a COBRA beneficiary's premium payment check bounced and we did not know about it until after the period for which the premium was intended? Can we retroactively terminate the COBRA beneficiary's coverage to the last day for which premium was paid?**

A4: Yes. Retroactive termination of coverage for failure to pay timely premium is not a prohibited rescission.

**Q5: What if we continue coverage for a divorced spouse because we were not informed of the divorce? Can we retroactively terminate the divorced spouse's coverage to the last date of the spouse's eligibility?**

A5: Guidance is not clear on how COBRA or state continuation laws will affect such a situation. If the employer is not contributing to the dependent premium, we recommend that the coverage provided after eligibility be deducted from the continuation of coverage period that would have been applicable. Provide a COBRA or state continuation notice, as applicable, with the reduced period. If extended coverage exceeded the continuation coverage period, terminate coverage prospectively.

If the employer is contributing to dependent coverage, then you may want to consider following a similar approach as provided for an ineligible child in A3 above.

**Q6: What are PacificSource's responsibilities for retroactive termination of an individual's coverage?**

A6: In the event you retroactively terminate an individual from your health plan, PacificSource must assume the termination is being done in compliance with the new law. The group policy provision allowing for a refund of two months' premium less claims will continue to apply.

In the event that PacificSource retroactively terminates an ineligible individual, we will follow the rules for permissible rescissions and will provide 30-days advance notice to the affected individual and the plan administrator. The group policy provision for the termination of coverage for fraud or intentional misrepresentation by the policyholder, by a member, or by the policyholder's or member's representative will still apply.

**Q7: Does this provision apply to self-insured plans?**

A7: Yes. Both full-insured and self-insured group plans must follow this provision of healthcare reform, including the rule regarding notification of employees.

**Q9: Where can I find the actual language from the healthcare reform law?**

A9: At Healthcare.gov you can access links to the entire reform bill (800+ pages) and the interim final rules (50+ pages). For your convenience, we have excerpted the relevant sections below.

**Regulatory citations for the prohibition on rescissions enacted by the Patient Protection and Affordable Care Act, as amended (PPACA).**

Section 1001 of PPACA adds the following section to the Public Health Service Act (PHSA):

**“PHSA – SEC. 2712. (42 U.S.C. § 300gg-12) PROHIBITION ON RESCISSIONS.**

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).”

45 CFR § 147.128 from the Interim Final Rules published on June 28, 2010 regarding patient protections under PPACA:

**45 CFR § 147.128 Rules regarding rescissions.**

(a) *Prohibition on rescissions*—(1) A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide at least 30 days advance written notice to each participant (in the individual market, primary subscriber) who would be affected before coverage may be rescinded under this paragraph (a)(1), regardless of, in the case of group coverage, whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. (The rules of this paragraph (a)(1) apply regardless of any contestability period that may otherwise apply.)

(2) For purposes of this section, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual’s or group’s enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if—

(i) The cancellation or discontinuance of coverage has only a prospective effect; or

(ii) 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.

(3) The rules of this paragraph (a) are illustrated by the following examples:

*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 and

part 146. 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.

*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 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 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.

(b) *Compliance with other requirements*. Other requirements of Federal or State law may apply in connection with a rescission of coverage.

(c) *Applicability date*. The provisions of this section apply for plan years (in the individual market, for policy years) beginning on or after September 23, 2010. See § 147.140 of this part for determining the application of this section to grandfathered health plans (providing that the rules regarding rescissions and advance notice apply to all grandfathered health plans).