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Requirements for Group Health Plans and Health Insurance Issuers under the Patient Protection and Affordable Care Act

Comment On: IRS-2010-0015-0002

Patient Protection and Affordable Care Act: Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections

Document: IRS-2010-0015-0014

Comment on FR Doc # 2010-15278

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General Comment

See attached file(s)

Attachments**IRS-2010-0015-0014.1:** Comment on FR Doc # 2010-15278

August 25, 2010

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Attention: RIN 1210-AB43

Submitted via eRulemaking Portal at <http://www.regulations.gov>

Dear Sir/Madam:

Thank you for the opportunity to comment.

“Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers Under Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule” were published in the Federal Register on June 28, 2010. Of specific concern today are the provisions under “Section 54.9815-2712T Rules Regarding Rescissions (Temporary)”, as well as Section 2590.715-2712 and Section 147.128 published on behalf of the IRS and DHHS, respectively, and contain the same provisions.

While the preamble makes it clear the coverage rescission regulations are directed at eliminating certain insurance industry practices, the regulations are written so broadly that they create unmanageable situations for a significant number of employers, and as pointed out by a colleague of mine, are inconsistent with COBRA regulations

The provisions of Section 54.9815-2712T (a)(2) define coverage rescission “as a cancellation or discontinuance of coverage that has retroactive effect.” As written, the regulations provide no exceptions and do not distinguish between insurance company practices that are the stated target of these rules and employer practices which are the unintended victim of these rules.

To illustrate, if an employer’s plan stops coverage at the end of the day on which an employee separates from employment, and a covered employee tenders a resignation effective immediately (i.e. “quits”), under 54.9815-2712T(a)(2) the employer must discontinue the coverage immediately. Waiting until the next day to cancel the coverage as of the end of the prior day renders the coverage cancellation a “rescission” under the rules, as written.

There are a number of reasons that the coverage cancellation will not likely happen on the date of separation in this example. First, the employer’s staff needs time to communicate the coverage cancellation to the area responsible for managing coverage enrollment. The separation was probably given to the employee’s supervisor or manager, not someone in benefits administration. Therefore, the employer needs time to communicate the employee’s status change to those handling the benefits enrollment, and for the benefits administration staff to process the coverage termination. Second, the cancellation must be communicated from the employer to the insurance

carrier/TPA. In some cases this is a paper communication, sometimes it is a fax, and sometimes it is an e-mail communication. In still other situations, it is a secure electronic file transfer that is automated and run periodically. Here again, time needs to be allowed for the employer processes to be completed. Third the carriers/TPA's need time to complete their processing. It is not uncommon for a carrier/TPA system to have a 24 hour cycle time for updates and changes to be made effective. Fourth, not all employer or carrier/TPA systems permit pre-dating of coverage change events. Some systems require changes be entered on or after the date of change. According to Section 54.9815-2712T (a)(2), termination of coverage in this manner is a retroactive termination and not permitted.

The problem exists in similar form for plans that terminate coverage at the end of the month in which a separation occurs. While more it is expected that more information about employment separations would be available prior to a month end, there are still situations when the employment separation occurs too close to the coverage end date to permit employers to process the coverage termination through normal processes and still meet the standard established by Section 54.9815-2712T (a)(2).

And, because nothing in the example rises the level of fraud or misrepresentation, many employers will find compliance with Section 54.9815-2712T (a)(2) to be problematic in such situations since they have no ability to process coverage terminations in advance. This is an unintended consequence of the regulations, and should be rectified by adding language that allows employers to complete coverage terminations in their normal course of business but not more than 30 days after coverage should have been terminated under the provisions of the employers' medical plans.

A second problems with Section 54.9815-2717T(a)(2) involves COBRA. Under COBRA regulations Section 2590.606-3(c), employees are permitted 60 days following the event to report divorces and losses of dependent status to employers. Thus, employees have the ability to delay reporting of events which would result in the loss of coverage, and employers are prohibited from cancelling the coverage retrospectively. Clearly if COBRA regulations allow 60 days to report such events, it is inconceivable that reporting a divorce or loss of dependent status any time up to day 61 would constitute fraud or misrepresentation of a material fact under Section 54-9815-2717T(a)(1). As written, Section 54.9815-2717T(a)(2) would only permit an employer's retroactive cancellation of the ex-spouse's coverage IF the employee reported the divorce more than 60 days after the event. Not only is this problematic for employers, but it provides an incentive to report such changes later rather than sooner. Again, this is not consistent with the intent described in the preamble to the regulations, and Section 54.9815-2717T(a)(2) should be modified to make it consistent with the 60 day COBRA reporting time frame.

A third problem exists with respect to the content of Sections 54.9815-2712T(a)(1) and (2) and the 2 examples appearing in 54.9815-2717T(a)(3). I believe the examples are completely insufficient to address employer issues arising from the paragraphs they are intended to clarify. Section 54.9815-2712T (a) (1) requires "an act, practice or omission" to rise to the level of "fraud" or "intentional misrepresentation of material fact" in order for a rescission to be permitted. There are no examples given of any such situations from an employer perspective. The only example given, Example 1, involves a commercial application where 2 psychology visits from 6 years prior were not reported, and in the conclusion, that omission is described as

“inadvertent”. The example is rarely, if ever, applicable to employers providing coverage to employees.

Next, it is extremely unfortunate that Example 1 justifies the conclusion that the coverage cannot be rescinded because the omission was “inadvertent”, rather than reaching the conclusion because of the immateriality of 6 year old psychology visits to a current cancer case. Instead of focusing on the thresholds established in paragraph (a)(1), the example creates a third standard, “inadvertency”. Employees intent on escaping the consequences of their own actions will flock to this “inadvertency” standard since it requires only feigning a lack of attentiveness rather than showing they had no knowledge or could not reasonably have had knowledge, or there no intent to defraud or misrepresent. Not only are there no examples to guide employers with respect to Section 54.9815-2712T (a), if the rationale for the conclusion in Example 1 is not changed, the standard for compliance will become the employee’s claimed level of inattentiveness. Such a standard places an undue burden on employers who already put a great deal of effort into communicating benefit packages, eligibility, and so forth. Please add examples that deal with real life employer situations to clarify Sections 54.9815-2712T (a) (1) and (2), and please write the examples so that the conclusions are based on the standards appearing in Sections 54.9815-2712T (a)(1) and (2) rather than using examples to add standards.

Thank you for considering these comments. I look forward to seeing revisions to Section 54.9815-2712T.

Sincerely,
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