August 27, 2010

Hon. Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services
Hon. Hilda Solis, Secretary, U.S. Department of Labor
Hon. Timothy Geithner, Secretary, U.S. Department of Treasury

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9994-IFC
P.O. Box 8016
Baltimore, MD 21244-1850

Submitted via the Federal Regulations Web Portal, http://www.regulations.gov

Re: Comments on Interim Final Rule on Annual and Lifetime Limits, and Rescissions, and Patient Protections Relating to Emergency Services

Dear Secretaries Sebelius, Solis, and Geithner:

We are writing on behalf of the American Benefits Council (the "Council") and the HR Policy Association ("HR Policy") to provide comments to the Departments of Health and Human Services, Labor, and Treasury (the "Departments") regarding the Interim Final Rule (the "IFR" or the "Regulation") on the Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections as issued in the Federal Register on June 28, 2010 (75 Fed. Reg. 37188).

The Council is a public policy organization representing principally Fortune 500 companies and other organizations that assist employers of all sizes in providing benefits to employees. Collectively, the Council's members either sponsor directly or provide services to retirement and health plans that cover more than 100 million Americans.

HR Policy represents the chief human resource officers of over 300 of the largest employers doing business in the United States. Representing every major industrial sector, HR Policy's members employ more than 18 million people worldwide and collectively spend more than $75 billion annually providing health insurance to millions of American employees, their dependents and retirees.

We are filing these comments in response to the Departments' request for comments on the Regulation. Our comments include specific recommendations regarding suggested changes to the Regulation, as well as requests for clarification on particular areas of the Regulation.

At the outset, we note that clarifying guidance regarding the items discussed below is needed urgently. Many employers and issuers are in the process of making final decisions with respect to their plans for the upcoming plan year. This is because, for those who sponsor and/or administer calendar year plans, they must begin printing the necessary materials for annual open enrollment, which frequently occurs in October preceding the start of the plan year. Furthermore, changes will need to be made to certain systems to ensure that claims for services incurred on or after January 1, 2011 are processed properly and that explanations of benefits ("EOBs") are accurate. Accordingly, we request that any clarifying guidance be issued as soon as possible to allow those employers and issuers that have not already finalized their plan terms for the upcoming plan year, to utilize the guidance for purposes of the upcoming plan year.

I. ANNUAL AND LIFETIME LIMITS

A. Application of Annual Limits to Day and Treatment Limits

Section 2711 of the Public Health Service Act ("PHSA"), as added by PPACA, and the IFR prohibit group health plans and health insurance issuers offering coverage to individual or group health plans from imposing annual or lifetime limits on the dollar value of essential health benefits.[1] The PHSA and the IFR also provide that a group health plan or issuer may impose annual or lifetime dollar limits on specific covered benefits that are not essential health benefits.[2] The IFR also expressly states that an exclusion of all benefits for a condition is not considered an annual or lifetime limit for a group health plan or issuer offering group health insurance.[3] Finally, the IFR provides guidance on certain "restricted" annual limits that are permitted for plan or policy years beginning before 2014.[4]

As noted above, plans and issuers are prohibited from imposing annual or lifetime limits on the *dollar* value of essential health benefits. The IFR does not provide that annual or lifetime limits apply to specific treatment limits, including day, visit, or

[1] 75 Fed. Reg. at 37190; 45 CFR § 147.126.
[2] PHSA § 2711(b); 75 Fed. Reg. at 37191; 45 CRF § 147.126(b).
[3] 45 CFR § 147.126(b)(2).
[4] 45 CFR § 147.126(a)(2) and (d).

per-procedure or device dollar limits, and thus, it appears that the restrictions on annual and lifetime dollar limits are not extended to such treatment limits.

Treatment limits such as day or visit limits are a common and effective medical management tool. For example, a health plan may limit skilled nursing care to 20 days per year. Per-procedure or device dollar limits may be applied to benefits, such as durable medical equipment, with a plan providing a set dollar limit such as $500 per device, but no limit on the number of devices available.

These types of limits do not appear to be the types of annual or lifetime dollar limits that are prohibited by the IFR because either they are not annual/lifetime limits and/or they do not involve dollars. However, if these types of treatment limits were considered as annual or lifetime dollar limits, we understand that many employers in order to effectively manage health care costs and promote value based insurance design would not be able to continue to cover these benefits if such limits were impermissible. The elimination of these benefits, which are used and valued by employees, would leave many employees without access to a number of health benefits, and a restriction on imposing these types of limits appears beyond the scope of the IFR.

We recommend that the final Regulation clarify that treatment limits, including day, visit, or per-procedure or device dollar limits, are not the type of limits considered to be annual or lifetime limits on the dollar value of essential benefits.

B. Application of Annual Limits to Specific Benefits

As mentioned above, certain "restricted" annual limits are permitted for plan or policy years beginning before 2014. Utilizing a phased approach to the annual limits, the IFR provides that plans or policies may impose "restricted" annual limits on the dollar value of essential health benefits for plan or policy years beginning before 2014, provided the limits are at least:

- $750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011;
- $1.25 million for plan years beginning on or after September 23, 2011, but before September 23, 2012; and
- $2 million for plan years beginning on or after September 23, 2012, but before January 1, 2014.[5]

This phased approach recognizes that the elimination of annual limits on essential health benefits likely will have a financial effect on plans. Plans are permitted

[5] 45 CFR § 147.126(a)(2) and (d).

to impose restricted annual limits on essential health benefits during the transition period while increasing the amount of the annual limit incrementally over a number of years. The incremental elimination of the annual limit affords plans time to prepare and budget for the total elimination of annual limits.

The IFR does not specify, however, whether a plan is permitted to apply benefit-specific annual limits on essential health benefits (for example, $200,000 annual limit on rehabilitative or habilitative services and devices, or $10,000 annual limit on prescription drugs), totaling the annual maximum allowed (for example, $750,000 for plan years beginning on or after September 23, 2010, but before September 23, 2011), or if plans are only permitted to have one overall annual limit on essential health benefits.

Employers may use annual limits on specific benefits to effectively manage the high and rising costs of health coverage. For employers with self-funded plans, it is not uncommon to have annual dollar limits on specific benefits, for example, a $250,000 annual limit on inpatient hospital services, but no overall annual limits. This approach – annual limits on specific benefits with no overall annual limit – strikes a balance between managing high healthcare costs associated with specific benefits or services and ensuring that employees have access to comprehensive health coverage that does not have an unreasonable overall limit on all benefits.

Requiring employers to eliminate annual benefits on specific essential health benefits during the restricted annual limits period would create a hardship for many employers, and may result in the elimination of certain benefits that otherwise would have been provided had the employer been permitted to continue to apply benefit-specific annual limits on certain essential health benefits. Permitting employers to retain such benefit-specific annual limits would be consistent with the phased-approach to annual limits that the Departments adopted in the IFR and still protect plan participants in that the total annual limit for essential health benefits cannot be less than the maximum annual limit allowed for the plan year ($750,000 for the 2011 plan year). Permitting these limits for this transition period would assist employers in managing costs during the transition period while allowing them the time necessary to plan and budget for the total elimination of annual limits on essential health benefits.

We recommend that the final Regulation specify that plans may apply benefit-specific annual limits on essential health benefits, provided that the benefit-specific limits total no less than the maximum annual limit allowed for the plan year.

C. "Good Faith" Determinations of Essential Health Benefits

Under section 2711 of the PHSA and the IFR, group health plans and issuers are prohibited from imposing annual or lifetime limits on the dollar value of "essential

health benefits." Neither the PHSA nor the IFR defines "essential health benefit" beyond the following categories that are listed in PPACA, which are:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

Until further guidance is issued more fully defining these categories, the Preamble to the IFR provides that the Departments will take into account "good faith efforts" to comply with a "reasonable interpretation" of the term "essential health benefits."[6] The Preamble further states that plans must apply the definition of "essential health benefits" on a consistent basis for purposes of applying the lifetime and annual limit restrictions. These standards – good faith efforts to comply with reasonable interpretations and consistent application – should be retained, and we recommend that the final Regulation include them explicitly.

Our members have indicated particular concern about a number of services that typically are not as "mainstream" as more traditional benefits, but that arguably could fall under the essential health benefits categories if the categories are broadly read. These services include, for example, benefits such as fertility treatments and orthodontic services for children. Plans often cover these services as an added value to complement the more traditional services under the plan, but usually with some type of limit, since these can be expensive and are not seen as "medically necessary" as more traditional benefits. If these types of benefits were considered essential so that no annual or lifetime limits were allowed, we believe that many employers could no longer offer coverage for these less traditional benefits because they would be unaffordable to continue.

[6] 75 Fed. Reg. at 37191.

D. Limit Annual/Lifetime Maximum Restrictions to In-Network Providers Only, Similar to Preventive Care Rule

The IFR does not address whether employers may differentiate in the delivery of essential health benefits between in-network and non-network coverage. The Interim Final Rule for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act[7] acknowledges the important role of value-based insurance designs by allowing cost-sharing for preventive care services delivered by an out-of-network provider and prohibiting cost-sharing for preventive care services delivered by an in-network provider. The same rationale for allowing value-based designs under the preventive care rule also would apply here – that is, providing an incentive for employees to utilize higher value in-network providers, which likely would result in the plan being better able to control rising health costs. Allowing a plan to differentiate between in-network and out-of-network providers still offers protection to plan participants, who would have no (or restricted, as applicable) annual or lifetime limits for essential health benefits received in-network.

We recommend that the final Regulation adopt the same value-based plan designs found in the preventive care rule. Specifically, we recommend that the final Regulation limit the restrictions on annual and lifetime maximums to services provided in-network and allow employers to design plans that are able to apply annual or lifetime limits on services provided by out-of-network providers.

E. Application of Annual Limits to Stand Alone Health Reimbursement Arrangements

As discussed above, section 2711 of the PHSA and the IFR prohibit group health plans and issuers from imposing annual or lifetime limits on the dollar value of essential health benefits.[8] The IFR provides, however, that the annual limits apply differently to certain account-based plans, and do not apply at all to health flexible spending arrangements.[9] The Preamble clarifies that the rules also are not applicable to medical savings accounts or health savings accounts.

The Preamble to the IFR provides that the annual and lifetime limits are not applicable to a health reimbursement arrangement ("HRA") that is "integrated with other coverage," where the other coverage alone would comply with the limit requirements.[10] The Preamble goes on to state that the fact that benefits under an HRA are limited does not violate the rule because the combined benefit satisfies the annual

[7] 75 Fed. Reg. 41726 (July 19, 2010).
[8] 75 Fed. Reg. at 37190; 45 CFR § 147.126.
[9] 75 Fed. Reg. at 37190; 45 CFR § 147.126(a)((2)(ii).
[10] 75 Fed. Reg. at 37190.

and lifetime limit requirements. Retiree-only HRAs also are expressly excluded from the requirements of the annual and lifetime limits rule due to the "retiree-only" exception discussed in the Preamble to the Interim Final Rule for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act,[11] which relates to the small employer exception in ERISA § 732(a) and the Internal Revenue Code § 9831(a)(2). The Departments requested comments as to whether the annual and lifetime limits rule should apply to stand-alone non-retiree HRAs.

The Departments should except all HRAs — stand-alone or integrated — from the annual and lifetime limit rules. As a practical matter, this type of rule simply does not apply in the HRA context. While account balances may vary in an HRA (by employers and/or employees), most HRAs do not limit how much may be paid out of the account in a given year or over the life of the account. So, it is counterintuitive to apply an annual or lifetime maximum rule to this type of benefit. If such a rule were applied, employers would no longer be able to offer HRAs.

While stand-alone HRAs are not as widely used by employers as traditional health plans and health FSAs, they are nevertheless an important and valuable benefit for the employees who are covered by them. HRAs have unique and desirable features, including that they are not subject to the "use it or lose it" rule (so carry-over to the next year is allowed), HRA accounts may be credited with earnings, and HRAs are funded with employer dollars, not employee salary reductions. Eliminating stand-alone HRAs likely would result in the loss of employer-sponsored health coverage for some employees.

We recommend that the Departments provide that all HRAs, including stand-alone non-retiree HRAs, are not subject to the annual and lifetime limits requirements in the final Regulation.

F. Recommendations for Waiver Process for Limited Benefit Plans ("Mini-Med" Plans)

Under the IFR, certain "restricted" annual limits are permitted for plan or policy years beginning before 2014.[12] The IFR provides for the Secretary of Health and Human Services to establish a program to waive annual limits for a plan or coverage that has annual dollar limits below the restricted annual limit amounts if compliance with the new limits "would result in a significant decrease in access to benefits under the plan or health insurance coverage or would significantly increase premiums for the plan or health insurance coverage."[13] The Preamble indicates that guidance on the application

[11] 75 Fed. Reg. 34538 (June 17, 2010).
[12] 45 CFR § 147.126(a)(2) and (d).
[13] 75 Fed. Reg. at 37191; 45 CRF § 147.126(d)(3).

process for a waiver is expected to be issued in the "near future." According to the Preamble, the waiver program would be established so that individuals with certain coverage, including coverage under limited benefit or so-called "mini-med" plans, would not be denied access to needed services or experience more than a minimal impact on premiums.

There are approximately 1.4 million workers nationwide that have group healthcare coverage under limited benefit plans that cover accident- and sickness-related medical expenses, and these plans typically have an annual dollar cap on overall benefits and/or an annual dollar cap on specific services. The individuals covered by such plans typically work for employers on a part-time, seasonal, or temporary basis and are ineligible for coverage under the employer's regular group health plan, or are in an eligibility waiting period for an employer's regular health plan. Many of our members provide limited benefit plans to their employees who otherwise have few options for finding affordable health coverage. There is a strong desire among our members to continue to be able to offer limited benefit plans to employees.

Our members are particularly concerned about how to apply for a waiver in what is a very short period of time (before September 23, 2010). We recommend that, under the waiver process, waivers be granted to insurers (and self-funded plans, as appropriate) on a product basis so that the waiver is granted to the limited benefit plan or policy rather than to the employer purchasing the plan or policy. A group waiver – based on a product rather than the employer providing the plan – would be consistent with the approach used by the Treasury Department for prototype retirement plans (and other prototype products such as IRAs) where a prototype plan is made available by a prototype sponsor (e.g., a financial institution or bank) and the prototype plan is adopted by employers. The prototype sponsor, not the adopting employer, is responsible for applying to the Internal Revenue Service for approval of the prototype product and for various other filings. A prototype process maximizes efficiency for the government and for employers because the plan or product is approved one time (when it is submitted by the prototype sponsor) rather than many times over, which would happen if it were submitted by each adopting employer. Adopting a similar process for the waivers for limited benefit plans would ease the burden on the government of having to review the same limited benefit plans several times and facilitate an efficient approval process in what will be a very short time period.

We also recommend that granted waivers remain in effect until 2014, without the need to reapply for waivers on an annual or other periodic basis. This would also ease the administrative burden on the government, insurers, and plan sponsors (particularly since the process is temporary through 2014).

G. Clarify HIPAA Excepted Benefits Provisions to Address Additional Types of Supplemental/Limited Plans

The Preamble to the Interim Final Rule addressing grandfathered group health plans notes that HIPAA excepted benefits are not subject to the insurance market reforms of PPACA (which would include the annual and lifetime limit rules).[14] HIPAA excepted benefit plans include those that are: (1) limited in scope, such as certain dental and vision benefits; (2) noncoordinated with group health plan coverage; and (3) supplemental to group health plan coverage. Each of these exceptions has its own requirements.

Many of our employer members provide limited or supplemental-type coverage, usually in addition to comprehensive health coverage. These benefit plans may range from additional coverage for a specific group, such as disabled children, to providing a prescription-only policy or a wellness program that is intended to complement the underlying medical coverage. The HIPAA excepted benefits statute was adopted in 1996 and the regulations last updated in 2004, so a variety of new types of benefits have emerged, which appear to be the type intended to be excepted under HIPAA, but which are not clearly addressed. As such, employers are uncertain as to how these ancillary benefits should be treated and, in many cases, the requirements of the HIPAA portability rules or the new insurance market reforms under PPACA would not be appropriate for these types of benefits. Employers are considering whether to continue these benefits, which provide additional benefits to employees, for fear of violating the new rules.

We recommend that the Departments address the following types of benefits, about which we have routinely been receiving questions:

- Limited Scope Benefits – HIPAA provides an exception for "limited" benefits that are offered separately and says the exception will apply to limited scope dental and vision benefits, long-term care coverage, and "such other similar, limited benefits as are specified in regulations."[15] The HIPAA portability regulations, to date, have not specified any additional types of limited benefits that would fall under this category, even though employers are offering a number of limited benefits outside of just vision and dental. We recommend that the Department create a catch-all category that will allow employers to be flexible in the benefits they offer to complement their medical coverage, so that employers are not forced to stop offering these benefits.

  In addition, one requirement under the limited scope benefit exception is that benefits be provided under a separate policy, certificate, or contract of insurance, or not otherwise be an integral part of the plan.[16] The HIPAA portability

[14] 75 Fed. Reg. at 34539.
[15] ERISA § 733(c)(2).
[16] ERISA § 732(c)(1).

regulations provide that a benefit is "not an integral part of the plan" if participants may elect not to receive the coverage and if they do elect to receive, must pay an additional premium.[17] However, many employers offer these "add-on" benefits either automatically (so no separate election is required) or as an employer pay-all benefit. For example, employee assistance programs and wellness programs typically are available to all employees or plan participants without an affirmative election required and at no cost to employees. Similarly, employers, particularly those participating in multi-employer plans, often provide dental and vision benefits at no cost without a separate election required (since coverage is provided automatically). We recommend that the regulation be revised to allow employer-pay-all benefits also to be considered "not an integral part of the plan" where offered separately.

- Self-Funded Non-Coordinated or Supplemental Benefits – Non-coordinated benefits generally provide coverage for a specific disease or illness and are not intended to coordinate with a particular plan maintained by the same plan sponsor. For example, a cancer-only policy may augment comprehensive medical coverage. Supplemental benefits are designed to fill specific gaps in primary coverage, such as Medicare Supplement coverage. One requirement for both of these exceptions is that the coverage be provided under a separate policy, certificate, or contract of insurance. While these types of benefits typically may have been insured when HIPAA was drafted, many employers today offer these types of benefits on a self-funded basis. For example, an employer may offer an additional benefit plan for children with physical or developmental disabilities that augments the child's underlying coverage, or the employer may contribute to a supplemental plan that assists employees in paying their deductible or other cost-sharing. Where these are self-funded, it is not clear whether they would meet the exception requirement of being provided under a separate policy, certificate, of contract of insurance – specifically, whether they must be insured. The limited scope benefit exception (described above) specifies that benefits either be provided under a separate insurance policy or otherwise not be an integral part of the plan. We do not see a policy reason why non-coordinated or supplemental plans should be treated differently. We recommend that the Departments clarify that these exceptions may apply to insured or self-funded coverage that is offered separately (whether under a separate insurance policy or otherwise not an integral part of the plan), as long as the other regulatory requirements are met.

[17] *See* 29 CFR 2590.732(c)(3)(ii).

H. Notice Related to Lifetime Limits

Under the IFR, individuals who reached a lifetime limit under a plan or health insurance coverage prior to the applicability date of the IFR and are otherwise eligible under the plan or health insurance coverage must be provided with a notice that the lifetime limit no longer applies. If such individuals are no longer enrolled in the plan or health insurance coverage, the IFR also provides an enrollment opportunity for such individuals.

It is unclear under the IFR how far back a plan must look to identify individuals for which it must provide notice. An open-ended "look back" period would be administratively burdensome and costly, particularly for plans that may have changed service providers over many years and may not have data readily available, if at all.

We recommend that the Departments clarify that that plans may use a "look back" period of two years or an otherwise reasonable period of time for purposes of providing notices to individuals who reached a lifetime limit under the plan.

II. RESCISSIONS

A. Retroactive Terminations in "Normal Course of Business" Should Not Be Considered Rescissions

PHSA § 2712, as added by PPACA, and the IFR provide that a group health plan or health insurance issuer offering coverage to individual or group health plans shall not rescind coverage with respect to an enrollee except where the individual has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact, as prohibited by the terms of the plan or coverage.[18] The PHSA and the IFR also provide that a plan may cancel coverage only with prior notice to the enrollee and only as permitted under certain exceptions to the HIPAA guaranteed renewability rules (nonpayment of premium, fraud, violation of participation or contribution rules, termination of plan, movement outside service area, and association membership ceasing). The IFR defines a rescission as a cancellation or discontinuance of coverage that has a retroactive effect.[19] The IFR states that a rescission would include a cancellation that treats a policy as void from the time of the individual's or group's enrollment or that voids benefits up to a year before cancellation. The IFR clarifies that a cancellation will not be considered a rescission if it is prospective or only is effective retroactively to the extent attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

[18] 75 Fed. Reg. at 37192; 45 CFR § 147.128(a).
[19] 75 Fed. Reg. 37192; 45 CFR § 147.128(a)(2).

Generally, when an employee terminates employment or a dependent no longer is eligible for coverage (for example, a dependent attains age 26 or divorces), employee or dependent health coverage terminates immediately or at the end of the month in which the employee terminates his or her employment or the dependent no longer is eligible (unless an employee or dependent elects COBRA continuation coverage). Typically, the employee or employer (as applicable, depending on the particular fact situation) notify the human resources department, who notifies the plan's eligibility vendor, who sends a data feed with a list of eligible individuals to the appropriate service providers (third party administrators or insurers). The data feed generally consists of identifying information on the participants (and, if applicable, dependents) in question, a code indicating the reason for cancellation, and coverage information including the date as of which coverage is to be canceled. This entire process usually is not instantaneous, but may take anywhere from a few days to a couple of weeks. However, coverage is still considered terminated as of the date employment is terminated or eligibility is lost, as generally described in the plan documents.

> Example. Employee A terminates her employment on June 15. On June 28, in its next regular data transmission to its group health plan's third-party administrator ("TPA"), A's employer includes data indicating that A's coverage should be terminated, the reason for the termination, and the effective date, June 15. The TPA processes this data and transmits it in its next regular transmission to the insurance carrier, on July 5. On July 8 the insurance carrier processes the data file and terminates A's coverage, retroactive to June 15.

We are concerned that these types of "retroactive" terminations, which occur in the normal course of business (and often occur because the employee may not have notified human resources in a timely manner), will somehow be construed as rescissions. We do not think this type of routine termination is what PPACA intended to address under the rescission rule and arguably, this would be a termination based on failure to pay a premium since employees likely no longer are experiencing payroll deduction.

"Retroactive" terminations also occur in the normal course of COBRA administration when plan administrators receive notices of qualifying events. In such circumstances, a qualified beneficiary often will notify the plan administrator of the qualifying event, for example, divorce, after the divorce has occurred. Following such notification, the divorced spouse's coverage is terminated retroactively to the date of the loss of coverage (generally either the date of the divorce or the last day of the month in which the divorced spouse was eligible for coverage). We do not think PPACA intended to extend the rescission rules to these COBRA-related routine terminations. Applying the rescission rules to such COBRA-related terminations could result in adverse selection since qualified beneficiaries have 60 days to provide notice of such qualifying events.

We recommend that the final Regulation clarify that retroactive cancellation in the normal course of business is not considered a rescission, as long as the time period involved is reasonable. Additionally, we recommend that the final Regulation clarify that retroactive cancellation made in the course of COBRA administration is not considered a rescission.

B. Clarification of Intentional Misrepresentation of Material Fact

As mentioned above, PHSA § 2712 and the IFR provide that a group health plan or health insurance issuer offering coverage to individual or group health plans shall not rescind coverage with respect to an enrollee except where the individual has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact, as prohibited by the terms of the plan or coverage.[20] The IFR is silent, however, on the meaning of "intentional misrepresentation of a material fact" except to state that the misrepresentation must be prohibited by the terms of the plan or coverage.

Plan sponsors are unsure of what might constitute a misrepresentation of a material fact that would permit rescission of coverage. Occasionally, employees enroll — accidentally or intentionally — themselves and their dependents in coverage for which they are not eligible, or an employee may fail to notify the plan administrator when a dependent who was previously eligible for coverage is no longer eligible for coverage. The second of these types of errors — an employee failing to remove someone from his or her coverage — is often discovered by plan sponsors during a dependent audit.[21] Plan sponsors often discover that divorced spouses who are ineligible for coverage under the plan because of the divorce (notwithstanding eligibility for COBRA coverage) are still covered under the plan and that the employee has failed to notify the plan administrator of the divorce. With divorce, employers are particularly dependent on employees to advise them of their change in marital status, a material fact for plan eligibility. Another common coverage error that is discovered in dependent audits is the coverage of individuals who are not, and have never been, the employee's legal spouse or domestic partner (as defined in the plan).

For most plan sponsors, there has been clear communication with employees regarding who is eligible for coverage under the plan. Such communications include, for example, the summary plan description, COBRA general notices, open enrollment materials, and enrollment forms. Enrollment forms may even include a statement wherein the employee certifies that any dependents the employee is enrolling for coverage are eligible for coverage.

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[20] 75 Fed. Reg. at 37192; 45 CFR § 147.128(a).

[21] Dependent audits are used by plan sponsors to verify that all individuals covered by the plan are in fact eligible for coverage under the plan.

We believe that the plan should be permitted to deem the incorrect enrollment (or continued enrollment) an intentional misrepresentation of a material fact, which would allow rescission. The intentional misrepresentation of a material fact being the representation that the employee and/or the dependent was eligible for coverage. This would allow employers to rectify mistakes that otherwise would require the plan to provide benefits to ineligible individuals, which is impermissible under the fiduciary duties imposed by ERISA § 404(a)(1)(A).[22]

We recommend that the final Regulation provide that incorrect enrollment may be deemed by a plan to be intentional misrepresentations of material fact that would permit a plan to rescind coverage.

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Thank you for the opportunity to comment on the IFR and for considering our suggested recommendations.

If we can be of further assistance, please contact Kathryn Wilber at 202-289-6700 or kwilber@abcstaff.org or Marisa Milton at 202-789-8671 or mmilton@hrpolicy.org.

Sincerely,

Kathryn Wilber
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American Benefits Council

Marisa Milton
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HR Policy Association

[22] ERISA § 404(a)(1)(A) provides that a plan fiduciary must "discharge his duties with respect to a plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits to participants and their beneficiaries."