New Rules Under PPACA Governing the Rescission of Health Care Coverage

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Thousands of Americans lose health care coverage each year due to rescissions. According to the House Energy and Commerce Committee, some health insurance companies wait until expensive claims are submitted and then investigate enrollment materials to try to locate some discrepancy or omission in those materials that could justify a rescission of coverage and denial of the expensive claims, even if the discrepancy or omission was unintentional and unrelated to the medical condition for which the patient sought care.

To end this practice, the Patient Protection and Affordable Care Act ("PPACA") included language to ensure that individuals would no longer unjustly lose health coverage by rescission. Effective for the first plan year beginning on or after September 23, 2010, a group health plan or health insurance issuer cannot rescind coverage with respect to an individual once the individual is covered under a plan or policy unless the individual performs an act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. A group health plan or health insurance issuer must provide at least 30 days advance written notice to each participant who would be affected before coverage can be rescinded, regardless of whether the coverage is self-funded or fully-insured. These regulations apply to both grandfathered and non-grandfathered health plans.

The regulations define a rescission as a cancellation or discontinuance of coverage that has a 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. A cancellation is not a rescission if: (1) the cancellation has only a prospective effect, or (2) the cancellation is effective retroactively to the extent that it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.
The regulations contain the following example: An employer sponsors a group health plan that provides coverage for full-time employees. Judy has coverage under the plan because she is a full-time employee. Judy is later transferred to part-time position. The plan mistakenly continues to provide health coverage to Judy, and collects premiums from her and pays claims that she submitted. The plan soon discovers that Judy is not eligible for benefits because she is not a full-time employee and would like to rescind her coverage effective as of the date that Judy changed from a full-time employee to a part-time employee. However, under the new regulations, the plan cannot rescind Judy’s coverage because there was no fraud or intentional misrepresentation of material fact. The plan may cancel Judy’s coverage prospectively only. This example demonstrates that employers must be vigilant in their plan administrative activities (including immediately informing the insurer) and in terminating coverage immediately when an employee loses eligibility, for example, when the employee separates from service. A retroactive termination for administrative reasons will no longer be permitted, absent some fraud or intentional misrepresentation of material fact.

In addition, a rescission is permitted because of fraud or intentional misrepresentation of material fact only if the plan or policy actually prohibits fraud or intentional misrepresentation of material fact. We therefore recommend that employers determine whether their plan documents or insurance policies contain this important language.