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From: Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services

Title: Examples for Issuers of QHPs in the Exchanges of Elements Demonstrating an Appropriate Rescission

Stakeholders have asked for examples of what information the Federally-facilitated Exchanges (FFEs) would consider in determining whether it is appropriate for an issuer to rescind coverage under a Qualified Health Plan (QHP) offered through the FFE. The examples below can serve the purpose of demonstrating to the FFE under 45 C.F.R. § 155.430(b)(2)(iii) indicia of fraud or intentional misrepresentation of material facts. However, comprehensive review of all relevant facts and circumstances will be necessary. Note that these examples do not automatically meet the criteria necessary to permit a rescission, and an issuer will need to provide evidence to substantiate compliance with applicable rules regarding rescissions. The examples below are not exhaustive and are not a substitute for any regulations or other interpretive guidance.

Bases for a Rescission

Issuers of individual health insurance coverage[1], including Qualified Health Plans (QHPs) offered through an Exchange, may only rescind such coverage when the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of a material fact, as prohibited by the terms of the plan or coverage.

45 C.F.R. § 155.430(b)(2)(iii) requires that QHP issuers demonstrate, to the reasonable satisfaction of the Exchange, if required by the Exchange, that the basis for a rescission is appropriate. Although the FFEs are unable to give an exact formula for an approved rescission, the elements listed below are meant to be a guide to QHP issuers in gathering evidence to be submitted to the FFE to support the appropriateness of any rescission request.

Demonstrating fraud or intentional misrepresentation of a material fact generally requires demonstrating that the information was false, and intent by the individual (or a person seeking coverage on behalf of the individual) to use false information to obtain coverage.

1. Falsity of Information

The issuer must demonstrate that the enrollee (or a person seeking coverage on behalf of the enrollee) intentionally provided information that was false. The following are examples of information that could be presented to demonstrate the falsity of information presented to the issuer. One of these examples of

[1] The prohibition on rescissions also applies to group health plans, health insurance issuers offering group health insurance coverage, and health insurance issuers offering individual market coverage outside the Exchanges. See 45 CFR 147.128. However, this document is addressed to individual market QHPs offered through an FFE about what the FFEs may rely on to determine whether a rescission is appropriate.

false information alone may not be sufficient to show intentional wrongdoing, but multiple examples of false information may indicate an intention to defraud:

a. False residency address: Evidence that an enrollee's residency address in the service area may not be valid or may not comply with FFE residency rules could include:

- An address at which the enrollee could not have lived.
- A single address listed for an unreasonable number of enrollees.
- An address associated with known fraud in the past.
- Enrollment pursuant to a "permanent move" Special Enrollment Period where the residency address is that of the facility at which the enrollee is receiving treatment on a temporary basis.
- A written statement from the property owner or resident that the enrollee is unknown to the owner or resident and has not lived at that address during the benefit year.
- A record, made in the normal course of business, which documents the property owner's or resident's claim that the enrollee is unknown to the owner or resident and has not lived at that address during the benefit year.
- A statement from the enrollee that he or she has not lived at the address during the benefit year.

b. False enrollment: Evidence that an enrollment could have been submitted without the enrollee's knowledge or consent could include:

- Suspicious patterns of enrollment involving licensed or unlicensed brokers.
- Suspicious third party-premium payments, such as:

  i. Payments from an agent/broker.

  ii. Payments for an unreasonable number of enrollees from a source unrelated to the enrollees.

  iii. Payments that are made with gift cards.

- Deceased enrollee - The QHP issuer can demonstrate that the enrollee was deceased at the time of enrollment by matching the member name and SSN against the SSA Death Master File (to prevent improper cancelation for enrollees with mistyped SSNs and surviving family members who have inherited the deceased's SSN during a Change in Circumstance, aka "subscriber inheritance") and that the enrollment was not effectuated retroactively after the enrollee's death.

c. False billing: Evidence that an enrollee's claims may be false could include:

- The enrollee is receiving or has received treatment that corresponds to a known pattern of fraud. Since evidence of a specific type of treatment, by itself, seldom (if ever) would be evidence of fraud, an issuer would need to provide evidence (to the satisfaction of the FFE) that the enrollee was not receiving the billed treatment. An example is sober-home schemes.

2. Intent

The issuer must demonstrate that the enrollee (or a person seeking coverage on behalf of the enrollee) intended to provide information that was false. The following are examples that could be presented to demonstrate the intention of the enrollee (or someone acting on the enrollee's behalf) to enroll using false

information. One of these examples alone may not be sufficient to show intentional wrongdoing, but multiple examples may indicate an intention to defraud. Examples include:

a. Enrollee corroboration. The issuer communicates with the enrollee in person, by phone or by mail and the enrollee:

    - Corroborates enough indicia of fraud to prove, to the satisfaction of the FFE, that a rescission would be appropriate; or
    - States that a third party entered into the enrollment without the enrollee's knowledge and the enrollee does not want the coverage the issuer is seeking to rescind.

b. Inability to contact enrollee: The QHP issuer has made a good faith, but unsuccessful, effort to communicate with the enrollee and:

    - The unsuccessful efforts to communicate with the enrollee are documented; and
    - The QHP issuer attempts to communicate with the enrollee using every method of contact (mail, e-mail, phone number) on file for the enrollee.

Note on #2.b – If, within the 30 day notice period prior to the rescission becoming effective, the enrollee states to the QHP issuer that he or she wants the coverage that would be rescinded, and demonstrates to the issuer or attests to the FFE the validity of the information that supposedly was false, forming the basis of the rescission, the QHP issuer must not rescind the coverage.