DPC
DIALYSIS PATIENT CITIZENS

Improving Life Through Empowerment

February 1, 2018

Ms. Crisanta Johnson, Director
Employee Benefits Security Administration
Los Angeles Regional Office
1055 East Colorado Blvd., Suite 200
Pasadena, CA 91106-2357

Dear Ms. Johnson:

I am writing on behalf of Gloria Palos of Ewa Beach, Hawaii. Ms. Palos received the attached letter from Hawaii Medical Services Association ("HMSA") on January 12, 2018 notifying her that her HMSA COBRA coverage would terminate on January 31, 2018, even though HMSA had already received payment of her premium for February and March of 2018. Based on her limited income, Ms. Palos qualifies for charitable assistance from the American Kidney Fund ("AKF"), a non-profit organization that HHS advises low-income people to contact for financial assistance. Because of Ms. Palos's financial status, the AKF has been paying her COBRA premiums for several months. HMSA's letter notifies Ms. Palos that it will terminate her coverage if the AKF continues to pay her premium, and that it will also terminate her if she pays her premium herself with funds "that originate from" the AKF. Because HMSA's announced termination of Ms. Palos would violate multiple provisions of both the COBRA statute and the COBRA regulations, we are asking for assistance from a Benefits Advisor. In particular, we ask that a Benefits Advisor contact HMSA and inform it that the attached letter violates COBRA, and that COBRA requires that HMSA maintain Ms. Palos's COBRA coverage during the statutory 18-month coverage period as long as the premiums for Ms. Palos's HMSA policy are paid timely, as they always have been and continue to be.

I. The COBRA statute

HMSA's termination letter violates the COBRA statute because 29 U.S.C. § 1161(a) unambiguously provides that any “qualified beneficiary” is “entitled” to elect continuation coverage. Notably, HMSA does not argue in its letter that Ms. Palos is not a “qualified beneficiary,” nor does it argue that she is not “entitled” to such coverage.

Moreover, the COBRA statute indicates that payment need not be made by the insured but rather may be made by third parties, and none of those provisions limit the types of third parties that may make payment, as HMSA seeks to do. For example, 29 U.S.C. § 1162(2)(c) refers to the “failure to make timely payment of any premium required under the plan with respect to the qualified beneficiary.” The provision does not refer to payment “by” the qualified

beneficiary, but rather payment "with respect to" the beneficiary. Such language contemplates third-party payment, without limitation.

In addition, 29 U.S.C. § 1162(4), entitled "No requirement of insurability," provides that COBA coverage "may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability." On its face, by notifying dialysis patients like Ms. Palos that it is terminating their coverage unless they pay the premiums with money that does not "originate from" AKF, HMSA discriminates on the basis of the insured's payment source. As applied, however, the only patients HMSA seeks to terminate under its new policy are low-income dialysis patients, since no other patients have a need for AKF funding. HMSA's articulated discrimination based on payment source is therefore in fact discrimination based on lack of evidence of insurability.

II. The COBRA regulations

26 CFR § 54.4980B-7 A-1(b) compels the conclusion that a beneficiary may not be terminated based on the source of her premium payment. That is because it provides that a qualified beneficiary may be terminated for cause only "on the same basis that the plan terminates for cause the coverage of similarly situated nonCOBRA beneficiaries." Because a plan providing nonCOBRA coverage necessarily, by definition, pays for that coverage; terminating COBRA coverage due to the source of the insured's payment can never be "on the same basis that the plan terminates for cause the coverage of similarly situated nonCOBRA beneficiaries." Terminating COBRA beneficiaries based on the source of their payment therefore cannot possibly be a termination for cause within the meaning of § 54.4980B-7.

In addition, several provisions of the COBRA regulations indicate that the insured satisfies her legal duties under the policy when the plan receives timely payment, and that the source of the payment is irrelevant. For example:

* Section 54.4980B-1 A-1(a) provides that a group health plan "must offer each qualified beneficiary . . . an opportunity to elect . . . continuation coverage under the plan." The Answer contains no suggestion that a plan may be excused from offering such coverage depending on the source of the payment.

* Section 54.4980B-3 A-1(a)(1)(i) defines a qualified beneficiary as "any individual who, on the day before a qualifying event, is covered under a group health plan…." There is no suggestion that a beneficiary may become disqualified due to the source of his or her payment.

* Like § 1162(4) of the statute, § 54.4980B-5 A-1(a) provides that COBRA coverage "must not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability." Because the only patients terminated by HMSA under its new policy are low-income dialysis patients, the HMSA letter is *de facto* discrimination based on lack of evidence of insurability.

* Section 54.4980B-7 A-1(a) provides that “COBRA coverage "must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of” certain specified dates. There is no suggestion that such coverage may be terminated before those dates based on the source of the premium payment.

* Section 54.4980B-7 A-1(b) provides that for a beneficiary who is entitled to Medicare before she elects COBRA coverage--Ms. Palos is such a beneficiary--the beneficiary’s “entitlement to Medicare benefits cannot be a basis for terminating” the beneficiary’s COBRA coverage. The HMSA letter tells Ms. Palos that she "must take action before January 31,” and notes that “Returning to Original Medicare” is the only action she can take if she is ineligible for Medicaid other than paying her premium with her own money. HMSA's reliance on Ms. Palos's eligibility for Medicare is inconsistent with the language of § 54.4980B-7 A-1(b). It should also be noted here that the Medicare Act specifically provides ESRD patients the right to keep their employer-sponsored health insurance for up to 30 months (although, as a practical matter, most are only able to keep it for 18 months) even if they are entitled to Medicare. This rule ensures that employers retain a stake in the continued stable health of employees who have kidney disease.

* Section 54.4980B-8, in multiple places, makes clear that a plan may terminate a beneficiary’s COBRA coverage if it does not receive timely payment, but does not permit a plan to reject timely payment because it objects to the source of the payment. For example, subsection A-1(a) provides that a plan “can terminate” a qualified beneficiary if “timely payment is not made to the plan with respect to the qualified beneficiary.” The phrase “with respect to” indicates that the regulation contemplates payment by third parties, without limitation. Similarly, the phrase “payment of an amount”--without identifying the payer--is used throughout the section. *E.g.*, A-1(b), A-1(c). The phrase “payment that is made to the plan” is also used. A-5(a). In short, the section authorizes plans to terminate insureds if they do not receive timely payment. It does not authorize plans to terminate insureds if they do receive timely payment, as HMSA has with respect to Ms. Palos.

III. The rationale HMSA articulates for terminating Ms. Palos’s coverage does not apply to COBRA coverage.

Several insurers have argued that insurers should be permitted to reject third-party payment on behalf of dialysis patients for individual market coverage. They argue that the Affordable Care Act’s guarantee-issue requirement, which for the first time enabled dialysis patients to buy private coverage, unduly raises costs for individual market insureds in standard health.

COBRA coverage, on the other hand, has no effect on the individual market. Group health plans must internalize the cost of COBRA coverage, but unlike individual market carriers seeking to adjust to the new individual market guarantee-issue requirement, such plans have been living with COBRA for decades. In addition, because dialysis patients are far less likely to be

able to work than are people in standard health, there are very few dialysis patients who are or will be eligible for COBRA coverage.

In short, the policy arguments that insurers make with respect to individual market coverage do not apply with respect to COBRA coverage. Notably, to our knowledge HMSA is the only carrier in the nation that has attempted to make such an argument.

IV. The HMSA letter is too clever by half, and insulting

The HMSA letter, on page 1, recites that "This is not a cancellation notice," but in the very next sentence it says that it *is* a cancellation notice: it states that "if we don't receive your payment by January 31, your current HMSA plan will end that day." If the plan ends that day, then the plan is cancelled, HMSA's initial characterization to the contrary notwithstanding.

HMSA goes on to tell Ms. Palos, after telling her in the letter that she will be terminated but that the letter is not a cancellation notice, that "Your health and your peace of mind are always our first priorities," and that "Serving you is our privilege." Those statements have no legal effect, but their breathtaking hypocrisy strengthens Ms. Palos's commitment to obtain a satisfactory resolution of this matter.

We understand that at least one other COBRA enrollee in a plan administered by HMSA is affected by this situation. There is some urgency here both because of the deadlines HMSA has imposed and by the fact that COBRA rights are time limited; we believe Ms. Palos' term expires within the next few months. Thank you for your consideration, and we would be happy to provide additional information or to meet with you at any time.

Sincerely,

Jackson Williams
General Counsel