PROGRAM MEMORANDUM
INSURANCE COMMISSIONERS
INSURANCE ISSUERS

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Transmittal No. 01-03 **Date** December 2001

Title: Medigap Bulletin Series - INFORMATION

Subject: CMS Guidance on a Beneficiary's Right to Suspend a Medigap Policy while Entitled to Medicaid

Markets: Medigap

I. Purpose

This Bulletin provides states and issuers with guidance on the provision of the Social Security Act that allows a Medicare beneficiary to suspend (and later reinstitute) coverage under a Medigap policy if he or she becomes eligible for Medicaid.[i]

II. Discussion

Suspending Medigap Policy while Eligible for Medicaid

Section 1882(q)(5)(A) of the Social Security Act (the Act) allows a Medicare beneficiary who has a Medigap policy that was sold on or after November 5, 1990, and who later becomes eligible for Medicaid, to request that the Medigap policy be suspended for a period not to exceed 24 months. However, the beneficiary is only entitled to this suspension if he or she notifies the issuer of the Medigap policy within the specific time period described below.

If the beneficiary becomes ineligible for Medicaid benefits during the 24-month suspension period, the Medigap policy is automatically reinstituted effective as of the date of the termination of the Medicaid entitlement, under terms at least as favorable as before the policy was suspended, so long as the beneficiary gives proper notice and begins paying premiums again.

The Purpose of Suspending Medigap Policies

The right to suspend a Medigap policy for up to 24 months during Medicaid eligibility exists to benefit Medicaid recipients who cannot afford the premiums on their Medigap policies and would otherwise be forced to let their policies lapse. If a policy lapses, and if the individual subsequently loses Medicaid eligibility, he or she could be subject to medical underwriting when applying for a new policy from the old issuer or any other issuers. This could mean that many

issuers would not be willing to sell a policy to him or her. Alternatively, any issuer willing to offer a policy could charge him or her a very high premium as a high risk. Even if not a high risk, the individual could also be charged a higher premium than he or she would otherwise have paid had the old policy not lapsed, based on his or her age at entry into the new policy.

In addition, the individual could be subject to pre-existing condition restrictions under a new policy for up to 6 months, even if he or she could find an affordable policy, since the replacement rule that limits the application of pre-existing condition restrictions would not apply.

Suspension of Medigap Policy is at the Beneficiary's Election

It is the beneficiary's right to request a suspension of the Medigap policy. However, the beneficiary is not required to request the suspension and the law does not require a suspension if it is not requested.

<u>It is Not Always Advisable for a Beneficiary to Request Suspension During Medicaid Eligibility</u>

Generally, it is expected that a person eligible for Medicaid could not afford the premiums on a Medigap policy and would request suspension. However, suspension may not be advisable in some cases. Sometimes, payment of a constant monthly premium enables an individual to qualify for Medicaid on a spend-down basis. Because Medicaid eligibility is determined on a monthly basis, maintaining the policy keeps the individual from going on and off Medicaid if the individual experiences wide periodic fluctuations in his or her medical costs. Other times, a relative or some other source (other than a health care practitioner, provider or supplier) may be available to help meet the premiums.

Maintaining a Medigap policy under these circumstances may permit the individual to continue a relationship with a physician or other provider who may not accept Medicaid rates. Maintaining the policy may also allow him or her to have better access to physician services in general.

There is no Limitation on How Often a Suspension May be Requested

The Medigap suspension right may be invoked whenever a beneficiary newly qualifies for Medicaid, assuming that the Medigap policy has not been allowed to lapse. A policy could have lapsed because of nonpayment of premiums, because a suspension period has expired without the beneficiary notifying the issuer, or because of failure to comply with any other requirements for suspension and reinstitution.

When and How a Beneficiary May Request a Suspension

In order to understand a beneficiary's suspension rights, it is important to understand the relevant timeframes for determining Medicaid eligibility. After an individual **applies** for Medicaid, the

state's Medicaid agency makes an **eligibility determination,** usually within 45 days after the application date. The agency then mails a notice of the eligibility determination to the individual. If the person is eligible, the actual effective date of the eligibility is frequently retroactive – it can be as much as 3 months **before the application date**.[ii]

Pursuant to § 1882(q)(5) of the Act, in order to be eligible for suspension of a Medigap policy, an individual must request suspension from the issuer within 90 days "after the date the individual becomes entitled to such assistance." We interpret this date to be the date of the determination rather than the effective date, because in many cases the individual will not even be notified that he or she is eligible until more than 90 days after the effective date.

The suspension period is counted from the date the Medicaid recipient requests suspension to prevent altering an eligibility decision, which was based on the inclusion of Medigap premiums. The suspension period can last for up to 24 months from the date of request, regardless of the actual effective date of the individual's Medicaid eligibility, which may be retroactive.

Conditions for Reinstitution of a Suspended Medigap Policy

If an individual loses Medicaid eligibility any time during the 24-month suspension period, the issuer must reinstitute coverage under the Medigap policy, under underwriting and rating terms that are at least as favorable as those that applied prior to suspension, if the individual requests reinstitution within 90 days after the loss of eligibility. Naturally, the policyholder must also resume payment of premiums on the policy as of the effective date of coverage. The reinstitution must be effective as of the loss of eligibility, not as of the date of the request for reinstitution of coverage.

Reinstitution Requirements for Issuers of Medigap Policies

Under § 1882(q)(5)(A) of the Act, if the issuer receives timely notice that a policyholder has lost eligibility for Medicaid, the issuer must automatically reinstitute the policyholder's coverage under Medigap pursuant to these requirements.

1) Issuers may not apply any waiting periods with respect to pre-existing conditions.

2) Issuers must provide coverage which is substantially equivalent to coverage in effect before suspension. CMS would consider this requirement to be satisfied if the issuer provides coverage at least for the same plan the beneficiary had prior to the suspension.

3) Issuers must provide a classification of premiums on terms that are at least as favorable to the policyholder as the premium classification terms that would have applied to the policyholder had the coverage never been suspended. CMS would consider this requirement to be met if an issuer prices the policy at the time of

reinstitution as if he or she had never suspended coverage. However, we believe it would be reasonable for issuers to raise the premium of the reinstituted policy to account for medical inflation, increases in volume, increased intensity of services, and increase in age of beneficiary (if the policy is attained-age rated). Also, issuers may collect premiums for retroactively instituted coverage to the date of loss of Medicaid, under generally applicable insurance principles.

Effect of Suspension for More Than 24 Months

If more than 24 months have passed since the suspension went into effect, an individual who loses Medicaid eligibility may be treated by issuers as a new applicant or lapsed policyholder. That is, the individual can be subject to medical underwriting which might result in denial of coverage or classification as a high risk for premium-setting purposes. The individual may also be subject to pre-existing condition restrictions for up to 6 months and be charged a higher premium than he or she would otherwise have been charged because of his or her age at entry into the new policy.

Where to get more information:

If you have any questions regarding this Bulletin, contact the Private Health Insurance Group, the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration via e-mail at phigmedigap@cms.hhs.gov or by phone at (410) 786-1565.

You may obtain an electronic copy of this bulletin and other technical Medigap regulatory resources at *www.hcfa.gov/medicaid/medigap*. Consumer-oriented Medigap materials can be obtained at *www.medicare.gov*.

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[i] Section 4354(b) of the Omnibus Budget Reconciliation Act of 1990 (OBRA), Pub. Law 101-508, amended § 1882 of the Act by adding § 1882(q).

[ii] 42 CFR 435.911.