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Title: Medigap Bulletin Series — INFORMATION

Subject: CMS Guidance on TWWIIA Provisions Affecting Medigap Policies

Markets: Medigap

I. Purpose

This Bulletin provides states and issuers with guidance on the provisions of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) which allow disabled beneficiaries to suspend and later to resume coverage under a Medigap policy if they obtain coverage under a group health plan. [i]

II. Discussion

Extension of Medicare Benefits

Under the Social Security Act (the Act), individuals with disabilities under the age of 65 who meet certain criteria are eligible both for cash assistance and for premium-free Part A Medicare benefits. Prior to TWWIIA, if a disabled beneficiary returned to work, the individual was entitled to Medicare for an additional 4 years. TWWIIA extended this Medicare entitlement for most beneficiaries to at least 8 ½ years. While Federal law does not guarantee beneficiaries under 65 a right to buy a Medigap policy, many are able to obtain a policy if state law requires it, or if issuers sell the policies voluntarily. In order to purchase a policy, the individual would in most cases have to enroll in and pay for Medicare Part B as well. Because of the extension of Medicare benefits under TWWIIA, an issuer may experience increased interest from beneficiaries regarding Medigap suspension.

Suspending Medigap and Participating in a Group Health Plan

A beneficiary who returns to work (or is a dependent of an employed spouse or parent) may have the option of getting additional health coverage through an employer-sponsored group health plan. [ii] If an individual has coverage through Medicare and an employer group plan, one generally pays as the primary issuer and the other acts as the supplemental issuer. [iii] A Medigap policy is generally unnecessary.

Section 1882(q)(6) as added by section 205 of TWWIIA allows disabled beneficiaries who become covered under an employer group health plan, [iv] the ability to suspend their Medigap policy without fear of losing access to Medigap coverage. These new provisions under

TWWIIA allow policyholders entitled to Medicare Part A to request a suspension of Medigap coverage and premiums while covered under the employer plan.

Since no statutory deadline is established for requesting a suspension under section 1882(q)(6), it is the position of the Center for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, that an individual with a disability who is entitled to benefits under Medicare and is covered under a group health plan may request the suspension described in TWWIIA at any time the individual is covered under the plan and is still classified as a disabled Medicare beneficiary.

Reinstituting Medigap Coverage due to Loss of Coverage under a Plan

The Act as amended by TWWIIA guarantees automatic reinstitution of the Medigap policy as of the date of the loss of coverage under the group health plan.[v] If the policyholder provides notice to the Medigap issuer after the loss of coverage under a group health plan in a timely manner (no later than 90 days after the loss of coverage under the group health plan), the issuer must reinstitute the policyholder's Medigap coverage. Issuers must provide such coverage to such a policyholder *automatically*. Therefore, the issuer is prohibited from requiring the policyholder to reapply for coverage, undergo additional underwriting based on health factors, or be subject to a waiting period before coverage begins.

Losing coverage under a group health plan includes the loss of coverage due to a voluntary termination initiated by an individual. If a beneficiary chooses not to continue enrollment in a plan, he or she would accrue the reinstitution rights under section 1882(q)(6) as added by TWWIIA. Since the suspension right is voluntary, the individual can revoke the suspension at any time while continuing to be covered under the group health plan.[vi] So, if an individual's benefits deteriorate under a plan, he or she may drop coverage under that plan and request reinstitution under the Medigap policy.

Issuers' Reinstitution Requirements

Under section 1882(q)(6), if the issuer receives timely notice that a policyholder had group coverage under a qualifying employee health plan, the issuer must automatically reinstitute the policyholder's coverage under Medigap pursuant to these requirements.[vii]

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

2) Issuers must provide coverage that 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 no higher a premium than 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

reinstituted coverage to the date of loss of coverage under the group health plan, under generally applicable insurance principles.

Period of Allowable Suspension

The provisions of section 1882(q)(6) do not specify a limit to the period of time for which a Medigap policy may be suspended. CMS interprets this to indicate that the guarantee for Medigap policy reinstitution runs indefinitely and cannot be conditioned on a given time period of suspension (e.g., within 10 years of the suspension request).

Group Health Coverage

In order to trigger the reinstitution rights of section 1882(q)(6), the beneficiary must have health coverage through a *group health plan* and must request reinstitution of the Medigap policy no later than 90 days after losing group health coverage.[viii] If a beneficiary were to get coverage through a group health plan, purchase an individual policy upon loss of coverage under the plan, allow greater than 90 days to elapse from losing group coverage, and then request reinstitution after loss of coverage under the individual policy, the beneficiary would not be entitled to reinstitution of a Medigap policy under this provision.

However, a qualified beneficiary changing employers (and thus changing group health plans) would not forfeit his or her right to Medigap policy reinstitution. As long as the beneficiary has suspended a Medigap policy, continues to be covered under a group health plan, and requests reinstitution no later than 90 days after the loss of group coverage, he or she maintains the rights accruing to any qualified disabled beneficiary under the provisions of TWWIIA. In this instance, the beneficiary would be entitled to reinstitution at the time of loss of coverage under the first health plan and then again at the time of loss of coverage under subsequent group health plans.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

An individual qualified to have Medigap coverage reinstated under the provisions of TWWIIA may lose his or her group health plan coverage and be eligible for continuation of coverage under COBRA.[ix] At this point, such individuals may choose either continuation coverage through the health plan pursuant to the provisions of COBRA or the reinstitution of coverage under their Medigap policy pursuant to section 1882(q)(6) of the Act. For the purposes of section 1882(q)(6) of the Act, COBRA continuation coverage would constitute coverage under a group health plan.[x] If an individual chooses COBRA, he or she does not forfeit his or her right to a reinstituted Medigap policy under TWWIIA. A Medigap issuer must reinstitute a policy or plan as specified in section 1882(q)(6) of the Act when a qualified individual loses coverage under COBRA and requests reinstitution under the terms specified above under issuers' reinstitution responsibilities.

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.* For additional information on the health care provisions of TWWIIA, visit *http://www.hcfa.gov/medicaid/twwiia/twwiiahp.htm.*

ENDNOTES

[i] The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), Pub. Law 106-170, amended section 1882(q) of the Social Security Act (the Act) by adding section 1882(q)(6).

[ii] Under the provisions of TWWIIA, beneficiaries are neither granted a suspension right nor guaranteed reinstitution of the Medigap policy following a termination of coverage under a policy purchased in the *individual* market (i.e., coverage not sold in connection with a group health plan).

[iii] Medicare generally acts as the primary payer. Medicare is also the primary payer for beneficiaries with disability who purchase Medicare Part A. Medicare is the primary payer for beneficiaries with retiree group health coverage.

However, for certain Medicare beneficiaries who have coverage through a group health plan, Medicare is the secondary payer. These beneficiaries must have coverage under the plan due to status as an active employee (either because they are actively working or because their spouse is actively working and the individual is covered under the spouse's plan). Medicare pays secondary for aged beneficiaries whose health plan covers at least one employer with more than 20 employees, disabled beneficiaries with premium-free Medicare Part A whose health plan covers at least one employer with more than 100 employees, and for End Stage Renal Disease (ESRD) beneficiaries regardless of employer size during a 30-month coordination period.

[iv] Pursuant to section 1862(b)(1)(A)(v) of the Act a group health plan has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code (the Code) of 1986 without regard to section 5000(d) of such Code. Therefore, a group health plan is a plan of, or contributed to by, an employer or employee organization to provide health care to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. For purposes of the provisions of TWWIIA, a group health plan includes those health plans provided through a governmental entity, or religious organization such as a church, synagogue or mosque, to its employees, former employees, and family members. The definition of group health plan is not limited to a plan with 20 or more employees.

[v] Section 205 of TWWIIA added 1882(q)(6) of the Act specifying that if such a "suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, such policy shall be automatically reinstituted (effective as of the date of such loss of coverage) under terms described in subsection (n)(6)(A)(ii) of the loss of such coverage if the policyholder provides notice of loss of such coverage within 90 days after the date of such loss."

[vi] It is not illegal, under the anti-duplication provisions in section 1882(d)(3) of the Act, for an issuer to issue or sell (or in this case, reinstitute) a Medigap policy with knowledge that the individual has coverage under a group health plan.

[vii] Pursuant to the terms described in section 1882(n)(6)(A)(ii) of the Act.

[viii] See endnote ii regarding the individual market.

[ix] COBRA provisions, sections 601 to 608 of Title I of ERISA, and the related portions of section 4980B of the Code establish the requirement that any group health plan maintained by an employer that employs 20 or more employees must offer qualified beneficiaries the opportunity to elect continuation coverage under the plan following certain qualifying events that would otherwise result in the loss of coverage. Under COBRA, employees or family members are allowed to continue their group health coverage at their own expense at group rates if the employer will no longer fund coverage because of a loss of employment, reduction in hours, divorce, death of the supporting spouse, or other designated events.

[x] Section 4980B of the Code.