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Title: Medigap Bulletin Series – INFORMATION

Subject: Medigap Guaranteed Issue Requirements in Situations Involving Termination of Group Health Plan Coverage Because the Employee Retires

Market: Medigap

I. PURPOSE

This bulletin explains why a Medicare beneficiary is entitled to a Medigap guaranteed issue right under the following circumstances:

- The beneficiary has coverage under a group health plan through the beneficiary's own current employment, or the current employment of a spouse
- The plan pays secondary to Medicare
- The plan does not provide retiree coverage
- The beneficiary's coverage under the plan terminates when the beneficiary, or the beneficiary's working spouse, retires.

If the group health plan only covers current workers and not retirees, then the beneficiary loses coverage by operation of the terms of the plan when the working beneficiary or working spouse retires. In other words, the beneficiary does not choose to give up the group health plan coverage. Rather, loss of the group health plan coverage is the consequence of retirement. This bulletin clarifies that, for purposes of having a Medigap guaranteed issue right due to loss of group health plan coverage under the above circumstances, it is irrelevant that the beneficiary's retirement was voluntary. The bulletin also provides an example that illustrates why it is particularly important that this issue be clarified.

II. BACKGROUND

A. Medigap Guaranteed Issue Right Upon Loss of Group Health Plan Coverage

Section 1882(s)(3) of the Social Security Act (the Act) specifies circumstances under which certain Medicare beneficiaries are entitled to purchase a Medigap policy on a guaranteed issue basis.¹ Under section 1882(s)(3)(B)(i), one of these circumstances is when an individual is enrolled under an employee welfare benefit plan "that provides health benefits that supplement the benefits under [Medicare], and the plan terminates **or** ceases to provide all such supplemental health benefits to the individual." (Emphasis added.)ⁱⁱ Accordingly, there are two criteria for Medigap protections under

this provision. First, the group health plan coverage must be supplemental (or secondary) to Medicare, and second, the plan must “cease to provide” the coverage to the individual.

B. Determining Whether the Group Health Plan Coverage Is Supplemental: The Medicare Secondary Payer Rules

Whether the group health plan coverage is supplemental to Medicare is determined by the statutory “Medicare Secondary Payer” (MSP) requirements that may apply when a beneficiary is covered under a group health plan.ⁱⁱⁱ Most group health plan coverage that is provided to Medicare beneficiaries under employee welfare benefit plans is retiree coverage, because most Medicare beneficiaries are no longer currently employed, and relatively few are covered as dependents under the plan of a working spouse. Retiree coverage is almost always secondary, or supplemental, to Medicare.^{iv} Thus the Medigap guaranteed issue right set forth in section 1882(s)(3)(B)(i) of the Act would most frequently apply to a person who has previously retired and later loses retiree coverage that supplements Medicare.

Some beneficiaries, however, choose to continue working after they become entitled to Medicare at age 65; and some, while not themselves working, are covered as dependents under the group health plan of a working spouse of any age. If the worker’s employer has 20 or more employees, section 1862(b) of the Act requires the plan to pay primary to Medicare. However, if the employer has fewer than 20 employees, and is therefore too small to be subject to the MSP rules, Medicare is primary and the group health plan supplements Medicare.^v

When the group health plan is primary and Medicare is secondary, the federal Medigap guaranteed issue right that is the subject of this bulletin is not triggered by loss of the group health coverage. However, the federal Medigap guaranteed issue right does apply when the beneficiary loses coverage as a current worker or as the dependent of a current worker if the employer has fewer than 20 employees, because in that case the group health plan coverage supplements Medicare.

III. ISSUES

It has come to our attention that some Medigap issuers have taken the position that they do not have to offer a guaranteed issue right to beneficiaries whose supplemental group health plan coverage terminates because the beneficiary (or the beneficiary’s spouse upon whose employment the group health plan coverage is based) decides to retire. They argue that the beneficiary is voluntarily leaving the group health plan and that this voluntary action does not meet the statutory requirements for having a Medigap guaranteed issue right. They argue that voluntary retirement is analogous to nonpayment of premium.

In addition, these issuers have noted that several states have enacted laws that expand upon the federal protections, and require issuers to provide a guaranteed issue right when the lost coverage was *primary* to Medicare.^{vi} The issuers point out that many of these state laws specifically provide a guaranteed issue right when the plan ceases to provide benefits because “the individual leaves the plan.”^{vii} They argue that this language clearly protects individuals who “leave the plan” by retiring. These issuers then conclude that because the federal law provision does not include language that specifically protects individuals who “leave the plan,” the federal law cannot be read to require the issuers to guarantee issue policies in the retirement situations that are the subject of this bulletin.

IV. DISCUSSION

Nonpayment of premiums and a decision to retire are not analogous because nonpayment of premiums is a violation of the terms of the plan for which the individual would otherwise remain eligible. A beneficiary's (or spouse's) retirement makes the beneficiary ineligible for coverage under the plan terms even if he or she is still willing to pay premiums.^{viii}

With respect to the issuers' second argument, the wording of state laws is irrelevant to the interpretation of federal law. CMS is charged with the interpretation and administration of the Medigap guaranteed issue provisions, and this bulletin sets forth our interpretation. The federal law provides a Medigap guaranteed issue right when a group health plan ceases to provide supplemental health benefits to the individual. Reading this provision in the context of section 1882(s) as a whole, we interpret it to apply where an individual takes an action that does not violate any plan provision, but which results in loss of coverage (such as moving out of an HMO's service area). If the individual loses coverage after violating a plan provision (such as by failing to pay premiums, or providing fraudulent information), the Medigap right would not apply.

Example

Proper interpretation of the Medigap guaranteed issue provision addressed in this bulletin is of particular importance because the beneficiaries who benefit from it are ones who in many cases have forfeited their Medigap 6-month open enrollment period.^{ix} The open enrollment period starts automatically when the individual is both age 65 or older, and enrolled in Part B. The law permits beneficiaries who continue to work past age 65 to defer enrollment in Part B without penalty. However, we believe that a significant portion of beneficiaries who work for small employers (those with fewer than 20 employees) past age 65 may have been effectively compelled by their employer to enroll in Medicare Part B immediately upon turning 65. This causes them to trigger their Medigap open enrollment period at a time when they are less likely to need, or be able to justify paying for, a Medigap policy because they are still getting supplemental benefits under the group health plan.^x Then, at the time they retire, they have no Medigap open enrollment period (and no COBRA continuation coverage). Their only protection at that point is the guaranteed issue right to Medigap plans A, B, C, and F.

Even though enrollment in Medicare Part B is voluntary and the special enrollment period (SEP) protects an aged worker (or the spouse of a worker of any age) from late enrollment penalties,^{xi} many individuals enroll in Part B because they believe that they might miss their SEP or because the employer persuades them to do so. The group health plan may make enrollment in Part B a prerequisite to maintaining coverage under the plan while they are still working, or may tell them that if they do not take Part B, they will have to pay out-of-pocket for any services Part B would have covered.^{xii} We have been asked many times whether a group health plan that pays secondary to Medicare may legally require individuals to elect either Part A or Part B (or both) in order for the individual to continue receiving benefits under the plan. There is no federal law that prohibits them from doing this. Group health plans argue that the plan should not pay for benefits that could have been covered by Medicare if the individual had taken the relevant part(s) of Medicare for which he or she is eligible. Whether such "phantom coordination" (i.e., coordination against benefits that do not exist, but could have existed) is permitted depends on state law governing coordination of benefits provisions.^{xiii}

V. CONCLUSION

It is CMS's position that if a Medicare beneficiary shows that he or she was receiving supplemental benefits through an employee welfare benefit plan, and the plan has ceased to provide all such benefits to the individual because the individual (or the individual's spouse) is no longer eligible for benefits under the plan because he or she is no longer an employee, a Medigap issuer must provide guaranteed issue rights to the individual pursuant to section 1882(s)(3)(B)(i).

Where to get more information:

If you have any questions regarding this bulletin, contact the Private Health Insurance Group within the Centers for Medicare & Medicaid Services, via e-mail at phigmedigap@cms.hhs.gov or by telephone toll-free at 1-877-267-2323, Ext. 6-1565.

You may obtain an electronic copy of this bulletin and other technical Medigap regulatory resources at <http://www.cms.hhs.gov/medigap>. Consumer-oriented Medigap materials can be obtained at www.medicare.gov.

ⁱ Section 1882(s)(3) requires that, with respect to certain eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medigap policy (generally plans, A, B, C, or F) that is offered and is available for issuance to new enrollees by the issuer; shall not discriminate in the pricing of such a Medigap policy because of health status, claims experience, receipt of health care, or medical condition; and shall not impose an exclusion of benefits based on a preexisting condition under such a Medigap policy if the eligible individual seeks to enroll under the policy during the specified guaranteed issue period (generally 63 days from the loss of coverage or notice of loss) and submits evidence of the date of termination or disenrollment along with the application for such Medigap policy.

ⁱⁱ Section 607(1) of the Employee Retirement Income Security Act (ERISA) defines the term "group health plan," as "an employee welfare benefit plan providing medical care (as defined in section 213(d) of the Code) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise." The Medigap guaranteed issue right is triggered by loss of all supplemental coverage under an "employee welfare benefit plan." That term is not defined in section 1882 of the Act, but for COBRA purposes it is defined in section 3(1) of ERISA. Accordingly, for purposes of applying section 1882(s)(3)(B)(i) of the Act, we are interpreting the term "employee welfare benefit plan that provides health benefits" as used in section 1882(s) to be synonymous with a "group health plan" as used in the section 607(1) of ERISA.

ⁱⁱⁱ These MSP requirements are contained in section 1862(b) of the Act and are implemented by regulations at 42 CFR § 411.100-411.206. For consumer information on these requirements, read the CMS publication *Medicare and Other Health Benefits: Your Guide to Who Pays First* that is available at <http://www.medicare.gov>.

^{iv} The one exception to this rule is when the individual has End Stage Renal Disease (ESRD) and is in the initial 30-month coordination period that applies under the statute.

^v If the worker's employer has 100 or more employees, section 1862(b) of the Act requires the plan to pay primary to Medicare in the case of a beneficiary who is under 65 and disabled (usually the spouse of the worker). However, if the employer has fewer than 100 employees, and is therefore too small to be subject to the MSP rules, Medicare is primary with respect to the disabled beneficiary and the group health plan similarly supplements Medicare.

^{vi} Approximately 21 states have enacted more generous guaranteed issue requirements that allow individuals losing group health plan coverage that is primary to Medicare to also have a guaranteed issue right.

^{vii} The following states have language that refers to the individual “leaving the plan” (or similar language that suggests voluntary disenrollment from the plan): Alaska, Colorado, Idaho, Illinois, Indiana, Kansas, Louisiana, Maine, Missouri, Montana, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Texas, Vermont, and Wisconsin.

^{viii} A beneficiary who loses eligibility under a plan due to retirement may still be entitled under the federal COBRA law to up to 18 months of continuation coverage under the plan. However, the federal COBRA law uses the same employer-size threshold as the MSP rules do for aged beneficiaries. Accordingly, employers with fewer than 20 employees, whose plans pay secondary to Medicare, are not required to offer COBRA continuation coverage. Thus, loss of eligibility under one of those plans triggers a cessation of all benefits that supplement the individual’s Medicare coverage. However, individuals who are offered and take COBRA (or any state mini-COBRA) continuation coverage would have a guaranteed issue right at the end of that coverage because they would again be losing eligibility under the group health plan, but this time the coverage being lost would be secondary.

^{ix} Section 1882(s)(2) of the Act requires an issuer to make available any Medigap policy it sells in a state, to any Medicare beneficiary, during the first six months the individual is both age 65 or older and is enrolled in Part B of Medicare. During the Medigap open enrollment period, an issuer may not deny or condition the issuance or effectiveness of a Medigap policy, or discriminate in the pricing of the policy because of health status, claims experience, receipt of health care, or medical condition. An individual uses his or her open enrollment protections by submitting an application for a Medigap policy “before or during the 6 month period beginning with the first month as of the first day of the month on which the individual is 65 years of age or older and is enrolled for benefits under part B.” (Subsection 1882(s)(2)(A) of the Act)

^x That is, with Medicare primary and the group health plan secondary, the individual likely has little or no need of a third form of coverage, a Medigap policy.

^{xi} Part A is premium-free for most individuals attaining age 65 because they or their spouse have earned at least 40 Social Security work credits. Therefore, they generally choose to enroll in Part A at age 65. Taking Part B is voluntary and requires the payment of a monthly premium. Individuals who do not take Part B at age 65 may only enroll during the general enrollment period (GEP). The GEP is held January 1 through March 31 of each year with Part B coverage beginning July 1. In addition, individuals are subject to the late enrollment premium surcharge of 10 percent for each year for which they could have been enrolled in Part B, but were not. However, beneficiaries covered by a group health plan that is based on current employment can delay enrolling in Part B at age 65 and subsequently enroll during the SEP. The SEP lasts throughout the time they are covered under the plan by virtue of current employment and ends eight months after the employment ends or the group health plan coverage ends, whichever occurs first. If they enroll in Part B during the SEP, they will not be subject to the late enrollment premium surcharge. If they fail to enroll in Part B during the SEP, they will have to wait until the next GEP to enroll. Individuals who miss the SEP may thus have to wait up to 15 months for Part B coverage to start.

^{xii} CMS hears most frequently of cases in which the supplemental group health plan either requires or induces beneficiaries to prematurely trigger their Medigap open enrollment rights. When the group health plan is primary to Medicare, we seldom hear of pressure from the employer upon the beneficiary to take Part B prematurely because the plan has nothing to gain by having the beneficiary enrolled in Part B. Nevertheless, many beneficiaries sign up for Part B while covered by a primary group health plan by virtue of current employment because Part B can serve as an inexpensive supplement to the group health plan.

^{xiii} At least with respect to fully insured plans since states have no control over self-insured plans.