CMS Center for Medicare: NAIC Q&A AND FOLLOW-UPS

1. **What criteria does CMS use to determine whether a network change is "significant" after receiving notification from a plan of a network change?**

   CMS has a rigorous internal review process that evaluates the totality of the unique circumstances around each termination to carefully determine whether that termination is "significant" and requires a special enrollment period (SEP). We evaluate every situation carefully so that we reach a determination as expeditiously as possible so that beneficiaries are informed of their rights, and may receive information on changing plans and their Medigap rights quickly

2. **Are employer-sponsored plans held to the same standard as other Medicare Advantage (MA) plans when there is a network change?**

   Provider terminations that occur within an employer-sponsored MA plan, are subject to the same CMS requirements and processes for determining whether an SEP is applicable. Employer-sponsored MA plans are also subject to the same SEP and Medigap guaranteed issue (GI) provisions.

   If CMS determines that a provider termination represents a "significant" change in the plan's provider network for purposes of the special enrollment period provided at 42 CFR 422.62(b)(23), CMS will communicate that determination to the plan. In that situation, the plan is required to notify impacted enrollees of their eligibility for an SEP. Plans are also required to notify affected enrollees of a termination of a contracted provider, regardless of whether they are eligible for an SEP. We have various resources available to plans so that they can contact us directly with any questions about these processes.

   A provider may not be aware that an enrollee's insurance coverage is provided through an employer-sponsored plan. Enrollees in employer-sponsored plans should check with their employer to determine whether there are additional coverage options available to the enrollee and the impact of any decision on their employer-sponsored coverage should the enrollee choose to disenroll from their employer-sponsored plan.

3. **How long does it take to make the determination that a network change is "significant"?**

   We thoroughly review each case and work quickly so that affected enrollees are notified as fast as possible about their rights. There is not a set timeframe in regulation and the timeframe for CMS determinations of a "significant" network change varies depending on different circumstances. We thoroughly review each case and work quickly so that affected enrollees are notified as fast as possible about their rights.

4. **How are plans notified of the need to send communications to enrollees after a provider network change?**

   If CMS determines a provider termination represents a "significant" change in the plan's provider network for purposes of the special enrollment period provided at 42 CFR 422.62(b)(23), the CMS Regional Office Account Manager for the MA plans communicates the requirement for an SEP notification letter to be sent by the MA plans to their impacted enrollees. MA plans are also required to notify affected enrollees of a termination of a contracted provider, regardless of whether they are eligible for an SEP. We have various resources available to plans so that they can contact us directly with any questions about these processes.

5. **Can CMS provide a link to the model notices MA plans must follow?**

   Please see the link for Marketing models, standards documents and educational materials. This link is updated periodically. MA plans are encouraged to use the latest versions. (https://www.cms.gov/medicare/health-drug-plans/managed-care-marketing/models-standard-documents-educational-materials).

6. **Some Medigap plans are providing $0 commissions for guaranteed issue Medigap plans. This appears to be an attempt to discourage the sale of plans to consumers the plans believe to be worse risk, is this allowed?**

   This is not something that is addressed under federal law or regulations. Medigap commissions are subject to state laws and regulations, as well as the terms and conditions of any contract between the Medigap carrier and the agent or broker. Consistent with the framework established under section 1882(a)(2)(A) of the Social Security Act (Act), states with regulatory programs that provide for the applicable of standards that are at least as stringent as those contained in the NAIC Medigap Model Regulation[1] and requirements equal to or more stringent than those set forth in section 1882 of the Act are the primary enforcers of Medigap coverage. Since establishment of this framework, all states have taken action to align state requirements with federal law changes and the accompanying updates to the

[1] These minimum standards (NAIC Model Standards) are found in the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Act* (NAIC Model Regulation), initially adopted by the NAIC on June 6, 1979, and revised periodically to reflect subsequent Federal legislative changes. *See, e.g.,* the Fall 2022 draft of the NAIC Model Regulation, available at: https://content.naic.org/sites/default/files/model-law-651.pdf.

NAIC Medigap Model Regulation.[2,3] As such, primary oversight and enforcement of Medigap coverage, including sales and commissions, are under the purview of the States.

7. **Some MA plans are providing $0 commissions for new MA sales. Is this allowed? Does this violate the new Federal rules on MA agent/broker compensation?**

   This question implicates aspects of the new agent and broker compensation regulation that CMS finalized in its April 2024 final rule. Certain provisions of that regulation are the subject of pending litigation. On July 3, 2024, the U.S. District Court for the Northern District of Texas issued nationwide preliminary injunctions in Americans for Beneficiary Choice v. HHS, No. 4:24– cv–00439, and Council for Medicare Choice v. HHS, No. 4:24–cv–00446, which enjoined the implementation of the changes to 42 CFR §§422.2274(a), (c), (d), and (e) and 423.2274(a), (c), (d), (e). Therefore, the regulatory language within 42 CFR § 422.2274(a), (c), (d), (e) and § 423.2274(a), (c), (d), (e) that was effective prior to the issuance of the Contract Year 2025 Final Rule will be in effect for Contract Year 2025 while the stay is ordered.

   We note that the language in CMS's regulations that are currently in effect at §§ 422.2274 (d)(1)(ii) and 423.2274 (d)(1)(ii) provides that MA organizations and Part D sponsors "may determine, through their contracts, the amount of compensation to be paid, provided it does not exceed limitations outlined in this section." CMS only determines what the maximum fair market value (FMV) is for initial and renewal enrollments, and MA organizations and Part D sponsors determine payment schedules through their contracts, provided they stay at or below FMV. So, a plan may set a range (for example, $0 to max FMV) and they may adjust their compensation within that range, including $0.

8. **When an MA enrollee's provider(s) no longer contracts with the MA Plan, can the enrollee switch back to traditional Medicare and enroll in Medigap on a guaranteed issue (GI) basis so that they can retain their provider(s)?**

   If CMS determines that a provider termination represents a "significant" change in the plan's provider network for purposes of the special enrollment period provided at 42 CFR

---

[2] This framework was established as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) amendments to section 1882 of the Act, and it was generally effective as of July 30, 1992.

[3] *See, e.g., "The Impact of OBRA 1990 on State Regulation of Medigap Insurance,"* available at: https://oig.hhs.gov/oei/reports/oei-09-93-00230.pdf (noting the Health Care Financing Administrative (HCFA) review and approval of State regulatory programs for Medigap following enactment of OBRA 1990). More recently, CMS worked with the NAIC and States to implement the most recent federal law changes and updates to the NAIC Model Regulation to align with Section 401 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which prohibits the sale of Medigap policies that cover the Medicare Part B deductible to "newly eligible" Medicare beneficiaries. *See* section 1882(z) of the Act and supra note 2. As of January 1, 2020, all states took action to align state requirements with these MACRA changes and therefore retained primary enforcement authority for Medigap.

422.62(b)(23), CMS will communicate that determination to the plan. In that situation, the plan is required to notify impacted enrollees of their eligibility for an SEP. Plans are also required to notify affected enrollees of a termination of a contracted provider, regardless of whether they are eligible for an SEP. We have various resources available to plans so that they can contact us directly with any questions about these processes.

Case by case SEP eligibility determinations can be made as well. Enrollees can call 1-800-MEDICARE to see if they might be eligible.

Section 1882(s)(3)(B)(ii) of the Act outlines certain Medigap GI rights provided to MA enrollees under certain situations, including in circumstances that permit discontinuance of the individual's election of the MA plan under the first sentence of section 1851(e)(4) of the Act. In turn, Section 1851(e)(4) outlines the authority of the HHS Secretary to establish MA special election periods. The MA SEPs are codified within CMS's MA regulations at 42 CFR § 422.62(b). Depending on the specific facts of the situation, there may be other Medigap GI rights under federal or state law to support the MA enrollee's transition back to traditional Medicare and Medigap.

9. **If CMS does determine a "significant" event has occurred, where the consumer would qualify for a special enrollment period with Medigap GI rights, how are the Medigap GI rights communicated to the insurer and the consumer?**

   When CMS notifies an MA plan that the change to their network has been determined to be "significant", the plan must notify its enrollees of their eligibility for this SEP, including Medigap GI rights, and how to use the SEP. CMS provides model language regarding the SEP and Medigap GI rights for the MA organization to use in its notice to affected enrollees.

10. **The consumer is notified that the MA plan they had in 2024 will no longer be available in 2025 and the consumer has been cross-walked to another MA plan offered by the carrier. If the new plan has a tighter network and the consumer does not want that plan, can they switch back to traditional Medicare and enroll in Medigap on a GI basis?**

    Yes, this is considered a plan nonrenewal. Cross-walked beneficiaries whose plan or contract is non-renewed (i.e., termination or service area reduction) effective January 1st are eligible for an SEP and may switch to another MA plan OR switch to traditional Medicare and enroll in Medigap on a GI basis. The SEP is available from December 8th through the end of February of the following year.

11. **The consumer is notified that the MA plan is leaving their service area and they must switch to another MA plan. The alternative MA plan options have a different network or the consumer simply does not like the other plans. Can they switch back to traditional Medicare and enroll in Medigap on a GI basis?**

    Yes, this is considered a plan nonrenewal and the consumer whose plan or contract is non-renewed (i.e., termination or service area reduction) effective January 1st is eligible for an SEP where they may switch to another MA plan OR switch to traditional Medicare and enroll in Medigap on a GI basis. The SEP is available from December 8th through the end of February of the following year.

    ***Follow-Up Q*: What if a person switches to another MA plan to ensure coverage begins January 1, but finds they don't like the new MA plan, can they switch to traditional Medicare and enroll in Medigap on a GI basis if they do so by the end of February?**

    Yes, the person can purchase Medigap with GI rights if still within the SEP duration, which goes through the end of February, for individuals whose plan or contract is terminated or non-renewed, including service area reductions.

12. **A consumer was switched to an MA plan through fraud. Can they switch back to traditional Medicare and enroll in Medigap on a GI basis?**

    Yes, if a consumer is enrolled in an MA plan by fraud or misleading marketing by a producer or agent/broker they have an SEP under section 1851(e)(4)(C) of the Act and may return to traditional Medicare. If they elect to return to traditional Medicare, the consumer would also have the opportunity to enroll in Medigap coverage on a GI basis.

    Follow-Up Qs:

    A. **Can CMS provide the specific language which outlines when the "fraud" SEP would apply?**

       Yes. Section 1851(e)(4)(C) states that the individual demonstrates (in accordance with guidelines established by the Secretary) that—

       (i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

       (ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan

to the individual;.... ”

The MA special election period related to material misrepresentation of plan provisions is cited at 42 CFR § 422.62(b)(3)(ii).

Section 1882(s)(3)(B)(ii), in turn, outlines certain Medigap GI rights provided to MA enrollees under certain situations, including in circumstances that permit discontinuance of the individual’s election of the MA plan under the first sentence of section 1851(e)(4). Depending on the specific facts of the situation, there may be other Medigap GI rights under federal or state law to support the MA enrollee’s transition back to traditional Medicare and Medigap.

B. If a person who has been in traditional Medicare for a number of years without a Medicare Supplement (Medigap) plan is enrolled into an MA plan without their knowledge, will they be granted GI rights?

Yes, if a consumer is enrolled in an MA plan by fraud or misleading marketing by a producer or agent/broker they would be eligible for an SEP to switch back to traditional Medicare and enroll in Medigap on a GI basis. The Medigap GI right under section 1882(s)(3)(B)(ii) resulting from use of an SEP under 1851(e)(4) to disenroll from an MA plan is not dependent upon past participation in MA or traditional Medicare. Section 1882(s)(3)(B)(ii) outlines certain Medigap GI rights provided to MA enrollees under certain situations, including in circumstances that permit discontinuance of the individual’s election of the MA plan under the first sentence of section 1851(e)(4). In turn, Section 1851(e)(4)(D) outlines the authority of the HHS Secretary to establish MA special election periods. The MA special election periods are cited at 42 CFR § 422.62(b). Depending on the specific facts of the situation, there may be other Medigap GI rights under federal or state law to support the MA enrollee’s transition back to traditional Medicare and Medigap, some of which may be dependent upon past participation in MA or traditional Medicare.

C. How does CMS determine that an individual is eligible for an SEP based on allegations of fraud, contract violation, or misleading marketing? Can states input these allegations in the Complaint Tracking Module (CTM)?

Individuals who think that they may be eligible for an SEP based on a violation of their plan’s contract with CMS or misleading marketing activity by a plan or an agent/broker should call 1-800-MEDICARE and speak to a customer service representative to demonstrate their eligibility by explaining the circumstances of the alleged plan contract violation or marketing misrepresentation. These issues are evaluated on a case-by-case basis, looking at the individual circumstances and claims made by the beneficiary. State Health Insurance Assistance Programs (SHIPs) can also enter these cases in CTM.

13. **For individuals eligible for a special enrollment period with Medigap GI rights, which Medigap plans are available?**

    Enrollees eligible for an SEP who use the SEP under section 1851(e)(4) to disenroll from an MA plan and are exercising the Medigap GI right under section 1882(s)(3)(B)(ii) would have access on a GI basis into Plans A, B, C, D, G, F, K, and L if available in their state unless they are new to Medicare on or after January 1, 2020, and are prohibited from purchasing Plans C and F. Additionally, beneficiaries who do not meet the MACRA "Newly Eligible Medicare Beneficiary" definition who are exercising GI rights under section 1882(s)(3)(B)(ii) may not be able to enroll in Medigap Plans D or G.

    Follow-Up Q: **Would an individual have GI rights into Plan N?**

    The federal Medigap GI right under section 1882(s)(3)(B)(ii) does not provide access on a GI basis to Plan N.

14. **Can states be notified when a MA plan changes their network? Can states be notified (maybe a database that can be sorted by state and county) of which plans are deemed to have a "significant" provider network change and which enrollees have an SEP? This would help the states answer questions and know how their Medigap markets may be impacted.**

    CMS' enrollment group will notify NAIC when an SEP has been made available to individuals affected by a "significant" provider network change.

15. **Is this information included on the Medicare Open Enrollment website and in other consumer outreach?**

    CMS summarized Medigap information on our webpages and publications listed below:
    - https://www.cms.gov/medicare/health-drug-plans/medigap
    - www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf
    - https://www.medicare.gov/health-drug-plans/medigap/basics/coverage

16. **Some consumers are having their MA premiums taken out of their Social Security checks well after they have switched from that plan. How can this be corrected?**

    This has occurred due to a systems change. It will be fixed and refunds will be issued.

    Follow-Up Q: **Can CMS provide a statement for states to give to consumers?**

    The beneficiary can call 1-800-MEDICARE to request that premiums erroneously deducted from their Social Security check be refunded. 1-800-MEDICARE customer

service representatives should be able to direct the complaint to the plan for resolution.

17. What is the difference between a plan terminating, which provides a special enrollment period and GI rights vs. a change in the network that doesn't provide a special enrollment period and GI rights?

If an individual is enrolled in an MA plan and the plan is leaving Medicare or the service area (or the beneficiary moves out of the plan's service area), the beneficiary will have an SEP and will also have Medigap GI rights.

When CMS determines a change in an MA plan's provider network to be "significant", affected enrollees are eligible for an SEP and can switch to traditional Medicare and enroll in Medigap on a GI basis. For example, the Medigap GI right under section 1882(s)(3)(B)(ii) results from use of an SEP under 1851(e)(4) to disenroll from an MA plan. Depending on the specific facts of the situation, there may be other Medigap GI rights under federal or state law to support the MA enrollee's transition back to traditional Medicare and Medigap.

When the provider termination is not considered "significant" and an individual contacts 1-800-MEDICARE to request an SEP due to exceptional circumstances, such as situations where access to services is compromised and adverse health consequences would result including maintaining continuity of care for a chronic condition and to prevent interruptions in treatment, CMS will review the supporting details and documentation. CMS will determine eligibility for the SEP on a case-by-case basis. If a beneficiary is determined eligible for an SEP under section 1851(e)(4), the individual would have the option to either switch to traditional Medicare and enroll in Medigap on a GI basis or the individual could elect to join another MA plan. For example, the Medigap GI right under section 1882(s)(3)(B)(ii) results from use of an SEP under 1851(e)(4) to disenroll from an MA plan. Depending on the specific facts of the situation, there may be other Medigap GI rights under federal or state law to support the MA enrollee's transition back to traditional Medicare and Medigap.

When CMS determines an individual to be eligible for an SEP under 1851(e)(4) and the individual requests disenrollment from the MA plan, CMS notifies the MA plan of the disenrollment. The MA plan will subsequently send a notification letter to the beneficiary, which the beneficiary can provide to the Medigap plan as evidence of their right to enroll into Medigap on a GI basis.

18. Have there been GI rights available when using an MA SEP in the past?

Yes, the MA SEP with GI rights have been available in the past. When an individual is eligible for an MA SEP under Section 1851(e)(4)(D) of the Social Security Act (the Act), Medigap GI rights are triggered under section 1882(s)(3)(B)(ii) of the Act, which outlines certain Medigap GI rights provided to MA enrollees under certain situations, including circumstances that permit discontinuance of the individual's election of the MA plan under

the first sentence of section 1851(e)(4). Depending on the specific facts of the situation, there may be other Medigap GI rights under federal or state law to support the MA enrollee's transition back to traditional Medicare and Medigap.

CMS has provided model language for plans to use to inform beneficiaries of their SEP rights, including Medigap GI rights. If this was not clearly communicated to an individual in the past who may have been eligible, they should contact 1-800-MEDICARE and see if they would be eligible for an exceptional circumstance SEP under Section 1851(e)(4), which would trigger certain federal Medigap GI rights.

19. When determining whether a provider termination is "significant", does it matter to CMS whether the MA plan terminated the provider from their network or if the provider terminates their contract with the MA plan?

With regard to CMS' determination as to whether the network change is "significant", it does not matter if it was the plan or the provider that initiated the termination. If CMS determines the network change is "significant", affected enrollees are eligible for an SEP under section 1851(e)(4) of the Social Security Act (Act), which in turn triggers federal Medigap GI rights under section 1882(s)(3)(B)(ii) of the Act.

20. What are the deductible amounts for Parts A & B in 2025?

Please see https://www.cms.gov/newsroom/fact-sheets/2025-medicare-parts-b-premiums-and-deductibles.

21. Who can states contact to ask questions?

Questions can be sent to our Enrollment and Eligibility LMI mailbox: https://enrollment.lmi.org/deepmailbox

22. Are plans required to conduct outbound enrollment verification calls?

Pursuant to regulations at 42 CFR §§ 422.2272(b) and 423.2272(b), MA organizations and Part D sponsors are required to establish and maintain a system for confirming that enrolled beneficiaries have, in fact, enrolled in the relevant plan, and understand the rules applicable under the plan.

Consistent with that requirement, CMS has outlined in the Medicare Communications and Marketing Guidelines (MCMG, https://www.cms.gov/files/document/medicare-communications-and-marketing-guidelines-3-16-2022.pdf) that for all agent/broker assisted enrollments, plans should conduct an outbound enrollment verification within 15 calendar days following the receipt of the enrollment request. The outreach may be completed via phone call (including during welcome call) or via email, if email is requested by an enrollee.

A written communication should be sent if the plan fails to speak with the individual within 15 calendar days of an enrollment request.

23. Does the guidance pertaining to the SEPs for Significant Change in Provider Network extend to cost plans?

Yes, cost plans are treated the same. Section 1882(s)(3)(B)(iii) of the Act outlines the Medigap GI rights to individuals in a cost plan. These GI rights are the same as those for individuals in an MA organization under exceptional circumstance SEPs under section1851(e)(4).