

§ 411.161 Prohibition against taking into account Medicare eligibility or entitlement or differentiating benefits.

(a) *Taking into account*—(1) *Basic rule.* A GHP may not take into account that an individual is eligible for or entitled to Medicare benefits on the basis of ESRD during the coordination period specified in § 411.162 (b) and (c). Examples of actions that constitute taking into account Medicare entitlement are listed in § 411.108(a).

(2) *Applicability.* This prohibition applies for ESRD-based Medicare eligibility to the same extent as for ESRD-based Medicare entitlement. An individual who has ESRD but who has not filed an application for entitlement to Medicare on that basis is eligible for Medicare based on ESRD for purposes of paragraphs (b)(2) and (c)(2) through (c)(4) of § 411.162 if the individual meets the other requirements of § 406.13 of this chapter.

(3) *Relation to COBRA continuation coverage.* This rule does not prohibit the termination of GHP coverage under title X of COBRA when termination of that coverage is expressly permitted, upon entitlement to Medicare, under 26 U.S.C. 4980B(f)(2)(B)(iv); 29 U.S.C. 1162.(2)(D); or 42 U.S.C. 300bb–2.(2)(D).² (Situations in which Medicare is secondary to COBRA continuation coverage are set forth in § 411.162(a)(3).)

(b) *Nondifferentiation.*—(1) A GHP may not differentiate in the benefits it provides between individuals who have ESRD and others enrolled in the plan, on the basis of the existence of ESRD, or the need for renal dialysis, or in any other manner.

(2) GHP actions that constitute differentiation in plan benefits (and that may also constitute “taking into account” Medicare eligibility or entitlement) include, but are not limited to the following:

(i) Terminating coverage of individuals with ESRD, when there is no basis for such termination unrelated to ESRD (such as failure to pay plan premiums) that would result in

termination for individuals who do not have ESRD.

(ii) Imposing on persons who have ESRD, but not on others enrolled in the plan, benefit limitations such as less comprehensive health plan coverage, reductions in benefits, exclusions of benefits, a higher deductible or coinsurance, a longer waiting period, a lower annual or lifetime benefit limit, or more restrictive preexisting illness limitations.

(iii) Charging individuals with ESRD higher premiums.

(iv) Paying providers and suppliers less for services furnished to individuals who have ESRD than for the same services furnished to those who do not have ESRD, such as paying 80 percent of the Medicare rate for renal dialysis on behalf of a plan enrollee who has ESRD and the usual, reasonable and customary charge for renal dialysis on behalf of an enrollee who does not have ESRD.

(v) Failure to cover routine maintenance dialysis or kidney transplants, when a plan covers other dialysis services or other organ transplants.

(c) *Uniform Limitations on particular services permissible.* A plan is not prohibited from limiting covered utilization of a particular service as long as the limitation applies uniformly to all plan enrollees. For instance, if a plan limits its coverage of renal dialysis sessions to 30 per year for all plan enrollees, the plan would not be differentiating in the benefits it provides between plan enrollees who have ESRD and those who do not.

(d) *Benefits secondary to Medicare.* (1) The prohibition against differentiation of benefits does not preclude a plan from paying benefits secondary to Medicare after the expiration of the coordination period described in § 411.162 (b) and (c), but a plan may not otherwise differentiate, as described in paragraph (b) of this section, in the benefits it provides.

(2) Example—

Mr. Smith works for employer A, and he and his wife are covered through employer A's GHP (Plan A). Neither is eligible for Medicare nor has ESRD. Mrs. Smith works for employer B, and is also covered by employer B's plan (Plan B). Plan A is more comprehensive than Plan B and covers certain items and services which Plan B does not cover, such as prescription drugs. If Mrs. Smith obtains a medical service, Plan B pays primary and Plan A pays secondary. That is, Plan A covers Plan B copayment amounts and items and services that Plan A covers but that Plan B does not.

Mr. Jones also works for employer A, and he and his wife are covered by Plan A. Mrs. Jones does not have other GHP coverage. Mrs.

Jones develops ESRD and becomes entitled to Medicare on that basis. Plan A pays primary to Medicare during the first 18 months of Medicare entitlement based on ESRD. When Medicare becomes the primary payer, the plan converts Mrs. Jones' coverage to a Medicare supplement policy. That policy pays Medicare deductible and coinsurance amounts but does not pay for items and services not covered by Medicare, which plan A would have covered. That conversion is impermissible because the plan is providing a lower level of coverage for Mrs. Jones, who has ESRD, than it provides for Mrs. Smith, who does not. In other words, if Plan A pays secondary to primary payers other than Medicare, it must provide the same level of secondary benefits when Medicare is primary in order to comply with the nondifferentiation provision.

§ 411.162 [Amended]

3. In newly designated § 411.162, the following changes are made:

a. The section heading and paragraph (a) are revised to read as set forth below.

b. In the following paragraphs, “solely” is removed:

Paragraphs (b)(2)(i), (b)(2)(ii), (c)(2)(iii), (c)(2)(iv), (c)(3)(i), (c)(3)(ii), (c)(4)(i), (c)(4)(ii), and (f).

c. In the following paragraphs, “employer plan” and “employer group health plan” are revised to read “group health plan”: The section heading and paragraphs (a)(1), (a)(2)(i)(A), (a)(2)(i)(B), (a)(2)(i)(C), (a)(2)(ii), (d)(7), (d)(8), and (d)(9).

d. In paragraphs (c)(2)(iii) and (c)(2)(iv), “January 1995” is revised to read “September 1997”.

e. In paragraphs (c)(3)(i) and (c)(3)(ii), “July 1994” is revised to read “April 1997”.

f. In paragraph (c)(4), introductory text, “January 1, 1996” is revised to read “September 30, 1998”.

g. In paragraphs (c)(4)(i) and (c)(4)(ii), “August 1994 through January 1, 1995” is revised to read “May 1997 through September 1997”.

h. In paragraph (d)(9), “January 1, 1995” is revised to read “December 1, 1997”; “January 1, 1995 through January 1, 1996, a period of 12 months plus 1 day.” is revised to read “December 1, 1997 through November 30, 1998, a period of 12 months.”; “January 2, 1996” is revised to read “December 1, 1998” and “on or before January 1, 1996” is revised to read “before October 1, 1998”.

i. In paragraph (d)(10), “September 1, 1995” is revised to read “August 1, 1997”; “September 1, 1995 through August 31, 1996” is revised to read “August 1, 1997 through September 30, 1998”; “September 1, 1996” is revised to read October 1, 1998”; and “12 months” is revised to read “14 months”.

j. Paragraph (e) is removed and reserved.

²COBRA requires that certain group health plans offer continuation of plan coverage for 18 to 36 months after the occurrence of certain “qualifying events,” including loss of employment or reduction of employment hours. Those are events that otherwise would result in loss of group health plan coverage unless the individual is given the opportunity to elect, and does so elect, to continue plan coverage at his or her own expense. With one exception, the COBRA amendments expressly permit termination of continuation coverage upon entitlement to Medicare. The exception is that the plan may not terminate continuation coverage of an individual (and his or her qualified dependents) if the individual retires on or before the date the employer substantially eliminates regular plan coverage by filing for Chapter 11 bankruptcy (26 U.S.C. 4980B(g)(1)(D) and 29 U.S.C. 1167.(3)(C)).