60.2 – Retroactive Disenrollment

(Rev. 38, 10-31-03)

In general, CMS does not accept retroactive disenrollments. As discussed in §50.1.1 of this chapter, voluntary disenrollment must be effective no later than the first day of the month following receipt of the member's written request for disenrollment, unless the beneficiary requests a later date. If the beneficiary requests a later date, it can be no later than the third month after the month in which CMS receives an acceptable disenrollment request from the cost plan.

However, CMS may approve retroactive disenrollments for certain situations on a case-by-case basis. The plan should submit retroactive disenrollment requests, including supporting evidence justifying the late disenrollment, to CMS. If CMS approves the cost plan's request for retroactive disenrollment, the plan must reimburse the member for any premium paid for any month for which CMS processes a retroactive disenrollment.

The following are examples of situations where retroactive disenrollment may be permissible. This list contains examples; it is not meant to be all-inclusive, nor does it imply that retroactive disenrollment is assured for any circumstance:

- **Systems Problems** - If the beneficiary submits a proper disenrollment request, but as a result of systems problems the disenrollment is not shown on a timely basis in the cost plan's and/or CMS' records.

- **Organizational Error -** When the organization has not properly processed or acted upon the member's properly made disenrollment request. A disenrollment request will be considered not properly processed or acted upon if the effective date is a date other than as required in §50.1.1 of this chapter.

- **Lack of Intent to Enroll** - The cost plan must submit a retroactive disenrollment request to CMS if there is evidence that the beneficiary did not intend to enroll in the plan (e.g., the beneficiary did not realize he or she ever enrolled in a cost plan).

  Evidence that the beneficiary did not intend to enroll may include:

  - Continuing supplemental (Medigap) insurance coverage after the effective date of cost plan enrollment;

  - Purchasing supplemental insurance immediately after enrolling in the plan; or

  - Making an inquiry to CMS questioning cost plan enrollment.

  Payment of the plan's premium does not necessarily indicate an informed decision to enroll. The beneficiary may believe that he or she was purchasing a supplemental health insurance policy. In addition, use of a plan doctor does not necessarily indicate an understanding of the cost plan's rules if the doctor also treats non-cost plan members.

60.2.1 – Failure of Employer Group to Notify Plan of Requested Disenrollment

(Rev. 38, 10-31-03)

The cost plan must submit a retroactive disenrollment request to CMS if an employer group fails to provide timely notification of a Medicare beneficiary's requested disenrollment. The CMS may process disenrollments up to 90 days retroactively. The employer group's notification is untimely if it does not result in a disenrollment effective for the month following the month the request is received, or for the requested effective date (if later).

Evidence must demonstrate that the beneficiary acted to disenroll in a timely fashion (i.e. prospectively), but the employer group was late in providing the information to the cost plan. Such evidence may include an election or application form signed by the beneficiary and given to the employer group during an open enrollment season. **NOTE:**

The application form could be the employer group’s generic form used during its open enrollment season for all employees and retirees.