

Medicare Secondary Payer

A guide to the rules and requirements



Medicare Secondary Payer (MSP) requirements determine when Medicare is the primary insurance payer. If your company has 19 or fewer full- and part-time employees, Medicare is almost always primary. If your company is larger, various rules apply to determine whether your group plan is the primary or secondary payer. MSP requirements also apply for Medicare-eligible employees who are disabled or have end-stage renal disease.

The following information provides a summary of the MSP requirements. This information may help you to correctly target benefits for your Medicare-eligible participants and avoid potentially costly penalties and litigation. You should, of course, also refer to the actual laws and regulations with the assistance of your own legal counsel.

More information is available from the Centers for Medicare & Medicaid Services (CMS) at www.cms.gov/home/medicare.asp.

You may also contact your IBC account executive, consultant, or broker with any questions regarding MSP requirements.

Information regarding the MSP statute

Employers, group health plans (GHPs), and entities that sponsor or contribute to GHPs, as well as insurers, have certain obligations under the MSP provisions of the Social Security Act, commonly known as the "MSP statute."¹ As an employer² or administrator of a GHP, you need to know the requirements of the statute so that you can avoid potentially costly penalties and litigation.

This guide is designed to provide you with a general overview regarding operation of the MSP statute and the enrollment and membership information system that has been developed to determine instances when the MSP statute applies.

¹ The MSP provisions are set forth at 42 U.S.C. 81395(b). The regulations the Centers for Medicare and Medicaid has issued implementing the statute are located at 42 C.F.R. Part 411. It is important that you and your counsel review the statute and regulations periodically to ensure compliance with your statutory obligations. This content is provided for informational purposes, and is not offered or intended as legal advice.

² In this section, the term "employer" includes a plan sponsor or entity that contributes to a GHP.

The MSP law

A coordination of benefits approach: During the first 15 years of the Medicare program, Medicare was the primary payer of all services provided to Medicare beneficiaries, with the sole exception of services covered under a workers' compensation policy or program. As a result, where a Medicare beneficiary had dual health care coverage, Medicare paid first, and the employer, GHP, or insurer paid all or a portion of the remainder of the bill for the health care item or service at issue, depending on the terms of the relevant plan or contract.

In an effort to save scarce Medicare resources, Congress enacted a series of amendments to the Social Security Act, beginning in 1981, which made GHPs responsible in certain instances for making primary payment in connection with medical items or services provided to specific Medicare beneficiaries with dual health care coverage.

The MSP statute is essentially a coordination of benefits statute. It requires, in discrete instances, that a GHP make primary payment where dual coverage exists for a particular health care item or service. Employers are constrained in the benefits they can offer employees and other individuals covered under the plan. The statute specifically prohibits employers and GHPs from differentiating between benefits offered to certain Medicare beneficiaries and their counterparts not enrolled in Medicare. The anti-discrimination provisions of the statute are explained more fully below.

Scope of the statute: The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and GHP coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

- GHPs that cover participants with end-stage renal disease (ESRD) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees or whether the individual has "current employment status."
- In the case of a covered participant or his or her covered spouse age 65 or over, a GHP of an employer with 20 or more employees, if that participant has "current employment status." If the GHP is a multi-employer or multiple employer plan that has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
- In the case of a covered participant or his or her covered family member who is disabled and under age 65, GHPs of employers with 100 or more employees, if participant has "current employment status." If the GHP is a multi-employer or multiple employer plan that has at least one participating employer with 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees. (There is no small employer exception under the statute.)

In determining whether the size threshold has been met in any given case, the statute and regulations must be consulted.

Application of the statute depends not only on the size of the employer but also, in certain cases, on whether the coverage is provided under the GHP based on "current employment status." Thus, generally the age-based and disability-based MSP provisions apply when the GHP participant (not necessarily the covered person with Medicare) has "current employment status." (By contrast, the MSP provisions relating to individuals who have ESRD apply regardless of whether the beneficiary has GHP coverage as a result of "current employment status" and regardless of the number of employees.)

Under Centers for Medicare and Medicaid (CMS) regulations, an individual has "current employment status" if the individual: (1) is "actively working as an employee, [is] the employer...or [is] associated with the employer in a business relationship"; (2) is "not actively working" but is "receiving disability benefits from an employer for up to six months"; or (3) is "not actively working" but "retains employment rights in the industry" and other specific requirements are met. For additional information, we again direct your attention to the statute and regulations.

The nondiscrimination provisions – age and disability: The MSP statute prohibits GHPs from "take[ing] into account" that an individual covered by virtue of "current employment status" is entitled to receive Medicare benefits as a result of age or disability. The statute expressly requires GHPs to furnish to Medicare beneficiaries the same benefits, under the same conditions, that they furnish to employees and spouses not entitled to Medicare.

Thus, GHPs may not offer coverage that is secondary to Medicare under a provision that "carves out" Medicare coverage (commonly known as a "carve-out" policy), or that supplements the available Medicare coverage (commonly known as "Medicare supplemental" or "Medigap" policies), to individuals covered by the provisions of the MSP statute relating to the working aged and the disabled. By contrast, Medigap and secondary health care coverage may appropriately be offered to retirees in this context because the GHP coverage is not based on "current employment status."

End-stage renal disease (ESRD): The MSP statute also prohibits a GHP from taking into account that an individual is entitled to Medicare benefits as a result of ESRD during a coordination period specified in the statute. This coordination period begins with the first month the individual becomes eligible for or entitled to Medicare based on ESRD and ends 30 months later. During this period, the GHP generally must pay primary for all covered health care items or services, while Medicare serves as the secondary payer.

GHPs are prohibited from offering secondary (i.e., "carve-out") and Medigap coverage in this context. After the coordination period has expired, however, the GHP is free to offer carve-out and Medigap coverage to ESRD Medicare beneficiaries, but may not otherwise differentiate between the benefits provided to these individuals and all others on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. (Important note: Special rules apply to persons eligible for or entitled to Medicare based on ESRD and one or more other reasons.)

Special rules apply regarding retired individuals and members of their families who receive Medicare benefits on the basis of age or disability immediately before the onset of ESRD. Where immediately prior to contracting the disease, the GHP was lawfully providing only Medigap coverage, or was otherwise a secondary payer for that individual, the GHP may continue to offer such coverage and is not required to pay primary during the 30-month coordination period.

Employer obligations: It is your obligation to ensure that beneficiaries who are covered by the MSP statute are not improperly enrolled in carve-out or Medigap coverage under your plan. If an individual is improperly enrolled in a supplemental or secondary policy or contract when the individual should be enrolled in a plan that makes the GHP the primary payer, it is Medicare's position that Medicare pays secondary and the plan is required to pay primary regardless of contrary language contained in the plan or contract. These individuals may choose to purchase and pay for Medigap insurance on their own, but neither the employer nor the GHP may sponsor, contribute to, or finance such coverage.

Prohibition of financial or other incentives not to enroll in a GHP: An employee or family member of an employee who is entitled to Medicare is free to refuse the health plan offered by an employer or GHP, in which case Medicare will be the primary payer. It is unlawful, however, for an employer to offer any financial (or other) incentive for a Medicare beneficiary not to enroll, or to terminate enrollment, in a GHP that would be primary to Medicare if the individual enrolled in the GHP. Any entity violating this prohibition is subject to a civil monetary penalty under the MSP statute of up to \$5,000 for each violation.

When an employee or spouse of an employee chooses to reject the employer-sponsored health plan, the employer and GHP are prohibited from offering or sponsoring that individual's health coverage or contributing to the premium for that coverage.

Other consequences of noncompliance: Noncompliance with the statute can result in serious consequences. Thus, a significant excise tax in the amount of 25 percent of the employer's or employee organization's GHP expenses for the relevant year may be assessed under the Internal Revenue Code against a private employer or employee organization contributing to a "nonconforming" group health plan.

Under CMS Regulations, a nonconforming group health plan is a plan that, for example: (1) improperly takes into account that an individual is entitled to Medicare; (2) fails to provide the same benefits under the same conditions to employees (and spouses) age 65 or over as it provides to younger employees and spouses; (3) improperly differentiates between individuals with ESRD and others; or (4) fails to refund to CMS conditional Medicare payments mistakenly made by the agency.

It is Medicare's position that, in addition to the possible imposition of an excise tax, failure to reimburse CMS for mistaken primary payments may result in ultimate liability double the amount at issue. The law also establishes a private cause of action to collect double damages from any GHP that fails to make primary payments in accordance with the MSP provisions.

Reporting requirements

In 2007 the Medicare, Medicaid and SCHIP Extension Act of 2007 (the "Act") was signed into law. The Act included modifications to the MSP laws and imposed significant new obligations on insurers, third-party administrators ("TPAs") and plan administrators of group health plans that both self-insured and self-administered ("Plan Administrators"). Specifically, it requires that these entities ("Responsible Reporting Entities or RREs") (1) secure certain information from group health plan sponsors and plan participants, and (2) share such information with the Secretary of the U.S. Department of Health and Human Services (HHS) to CMS to assist in determining who should be the primary payer for claims, i.e., IBC or Medicare.

TPAs and Plan Administrators are required to collection certain information from Plan Sponsors and participants and provide it to HHS in order to identify situations where the group health plan is or has been a primary plan to the Medicare program.

The penalties for failure to comply with these data collection and reporting requirements are potentially severe. Insurers, TPAs and Plan Administrators that fail to comply may be subject to civil monetary penalties of \$1,000 for each day of non-compliance for each individual for which the information should have been submitted.

RREs must provide the following information to CMS:

- Medicare health insurance claim numbers (HICNs) for members of a certain age and older. This allows CMS to determine if members of group health plans also have Medicare coverage. If the HICN is not available, the social security number (SSN) may be provided to determine if the individual is a Medicare beneficiary. IBC has elected to obtain HICNs/SSNs for all subscribers, dependents, and domestic partners (if applicable) regardless of age. Requiring HICNs/SSNs for all ages now will hopefully prevent future follow-up with you and our group customers.
- Group size. The MSP laws and regulations contain specific guidelines for determining group size (the number of full- and part-time employees) for the purposes of determining whether the group health plan or Medicare is the primary payer.
- The employer's tax identification numbers (TINs).

In order to determine whether Medicare is the primary or secondary payer, there are group size thresholds (number of employees measured over a period of time) that determine primacy. For example:

- For members and/or their spouses who are age 65 or older and employed by a company with fewer than 20 employees, Medicare is the primary payer.
- For members and/or their spouses who are age 65 or older and employed by a company with 20 or more employees, Medicare is the secondary payer. This includes multiple and multi-employer health plans.
- Medicare is the secondary payer for individuals under 65 who have Medicare because of a disability and who are covered under a group health plan based on the individual's (or a family member's) current employment status if the employer has 100 or more employees.

CMS has clarified that the term "multi-employer health plan" means any trust, plan, association, or any other arrangement made by one or more employees to contribute, sponsor, directly provide health benefits, facilitate directly or indirectly the acquisition of health insurance by an employer member. If such facilitation exists, the employer is considered to be a participant in a multi-employer group health plan even if it has a separate contract with the insurer.

Go to www.cms.hhs.gov/MandatoryInsRep/Downloads/EmployerSize.pdf for additional details on multi-employer health plans and exceptions.

Our goal is to obtain the identified information with as little inconvenience and burden to you and your employees as possible.

The need for your active participation

Our ability to make accurate primary/secondary determinations involving individuals enrolled in your GHP, and thus to assist CMS in processing MSP claims properly in the first instance, depends entirely on the breadth and accuracy of our files concerning individuals covered by your GHP. We depend on you to provide us with this information. Accordingly, it is important that you respond promptly and accurately to our requests for information.

Moreover, to ensure the continuing accuracy of our files, it is your responsibility to notify us promptly of any changes in the size of your work force or the status of your employees that might affect the order of payment under the MSP statute, such as information regarding working-aged persons who retire (and thus for whom Medicare makes primary payment) and changes in the size of your workforce that place you in, or take you out of, the scope of the MSP statute.

If we do not receive such information from you, we will assume that all relevant factors remain unchanged and will process claims accordingly.

We will be using the information you provide us to update our files, and will also forward this information to CMS on a quarterly basis so that CMS can revise its file to reflect relevant changes in primary/secondary status.

Amendments to the MSP statute and regulations

The MSP statute and regulations are frequently amended. As a result, it is important that you and your counsel continue to monitor changes in the law and assess the impact of such changes on your company. While we can assist you by providing general information about the statute, it is ultimately your responsibility to ensure your company's compliance with MSP statute.

Questions? Call
1-800-ASK-BLUE (1-800-275-2583)



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