McGraw Wentworth

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In This Issue

In this ninth issue of the McGraw Wentworth Benefit Advisor for 2009, we discuss the Medicare Secondary Payer (MSP) rules. The MSP rules have not changed recently, but they are not rules that employers use every day.

With the mandatory reporting requirements recently implemented by Medicare, CMS certainly will be more diligent in managing the MSP rules. It is important to make sure you understand these rules to ensure you are not inadvertently violating their provisions.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGraw Wentworth web site at www.mcgrawwentworth.com.

"Medicare Secondary Payer Rules"

Medicare is a federally funded, government-administered health insurance program that covers the aged and disabled. When group health plans coordinate with Medicare, they must follow Medicare secondary payer rules. If your plan participant is covered by or eligible for Medicare, you need to be familiar with these rules.

For information on Medicare coverage and eligibility, please read our September 2008 *Benefit Advisor* at http://mcgrawwentworth.com/resources_benefitsadvisor.html.

This *Advisor* describes the following aspects of the Medicare secondary payer rules:

- Overview of the Medicare Secondary Payer (MSP) Rules
- Exceptions to the Rules
- Special Rules Apply to End Stage Renal Disease
- Employer Prohibited Actions
- Mandatory Reporting Requirements
- Data Match Program
- Recovery of Payments from Group Health Plans

New mandatory reporting rules enable the government to better monitor the secondary coverage of all Medicare beneficiaries and help the government process claims more efficiently. These rules apply to health plans, workers' compensation carriers and other liability carriers.

Employers need to understand how to pay claims when Medicare is involved. If your organization pays a claim improperly, the Centers for Medicare and Medicaid Services (CMS) may send you a letter demanding that you correct the error.

Overview of the Medicare Secondary Payer (MSP) Rules

The Medicare secondary payer rules determine when your group health plan must pay primary and when it can pay secondary to Medicare. These rules apply to private group health plans, federal government plans, and state government plans as well. Unfortunately, the rules are not particularly straightforward. In many cases, payment order depends on employer size or the reason for Medicare entitlement.

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For many years, Medicare simply paid primary whenever other coverage existed. However, as Medicare costs began increasing dramatically, the government, just like employers, began to shift the cost to other coverage available to the Medicare beneficiary. In the mid-nineties, the government issued regulations allowing Medicare to pay secondary to other group health plans in specific instances.

Medicare secondary payer rules define a group health plan as "*a plan (including self-funded plans) of, or contributed to by an employer, (including a self-employed person) or an employee organization to provide health care (directly or otherwise) to employees, former employees, others associated or formerly associated with the employer in a business relationship*." This section discusses the rules for group health plans sponsored by employers with 100 or more employees. The next section discusses the rules for small employers.

The MSP rules generally, with the exceptions noted in the next section, apply to individuals who have group health plan coverage by virtue of current employment status. Current employment status means an individual is actively working as an employee of the employer or is associated with employer in a business relationship. These current status rules also apply to the employee's spouse or dependents.

Employees covered by the plan but not actively working may still be considered to have current employment status if:

- The employee is receiving disability benefits from the employer for up to six months.
- The employee retains employment rights in the industry, that is, the employer has not terminated employment, the employee is not receiving disability benefits from an employer or from social security for more than six months, and the employee has group health plan coverage other than COBRA (regardless of whether the employee is on the payroll).

Employees covered by Medicare and a group health plan but not actively at work are rare. Most employers focus on actively employed Medicare-eligible employees and dependents covered by the group health plan.

In general, the group health plan pays primary in situations where employees or their dependent are Medicare-eligible and covered under the group health plan by reason of current employment status. Special rules apply for Medicare-eligible participants with end stage renal disease.

Medicare will become the primary payer when beneficiaries lose their jobs and lose coverage by virtue of current employment status. If a Medicare beneficiary chooses COBRA, Medicare pays primary and the COBRA coverage pays secondary. Make sure to direct Medicare-eligible individuals to the Medicare website if they are considering COBRA. The beneficiary will have to elect Medicare Part B or risk having to pay a late enrollment penalty. Typically, a Medicare beneficiary can combine a Medicare supplement plan with a Medicare Part D plan or replace Medicare with a Medicare Advantage plan. Both of these approaches are usually less expensive than the combined premiums for COBRA and Medicare Part B.

Exceptions to the Rules

Generally, the group health plan is the primary payer; however, small group health plans are treated differently. In fact, the Medicare secondary payer rules have two categories of small employers and those categories are treated differently:

1. ***Employers with fewer than 20 employees***: To qualify under this category, companies must have had fewer than 20 employees for each working day in at least 20 weeks of the current or preceding calendar year. When an employer satisfies this test, Medicare pays primary and the group health plan pays secondary. The employer has to have had fewer than 20 employees when the patient receives the Medicare-covered service. Employers with around 20 workers must continuously monitor employee headcount whenever a participant becomes Medicare-eligible. The rules do not take into account the number of employees the health plan covers; they simply consider the number of employees on the payroll.

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2. ***Employers with at least 20 employees but fewer than 100 employees:*** To qualify under this category, the company must have had fewer than 100 workers, including full-time and part-time employees on at least 50% of its regular business days during the previous calendar year.

   In this case, if a plan participant is eligible for Medicare because of a disability, Medicare pays primary and the group health plan secondary. On the other hand, if a plan participant is eligible for Medicare simply because of age, the group health plan pays primary, Medicare secondary. Participants qualifying for Medicare because of end stage renal disease are treated differently; the next section explains that situation.

To count employees for these small group exceptions, you must:

- Include leased employees in your count if they would be counted under Code 414(n).
- Treat all employees of a member of an affiliated service group as defined by Code 414(m) as if they were employees of a single employer.
- Use IRS control group rules (as outlined in Section 52) to determine what organizations should be considered a single employer.

The Medicare secondary payer rules are much easier to manage when you have 100 or more employees. In that case, the group health plan pays primary for anyone eligible because of age or disability. A completely different set of rules apply when a person is Medicare-eligible because of end stage renal disease.

Special Rules Apply to End Stage Renal Disease

When a plan participant becomes eligible for Medicare because of end stage renal disease, the group health plan must pay primary for the first 30 months. There are no exceptions to this requirement and having coverage by virtue of current employment status does not apply. These special rules apply only when end stage renal disease is the initial reason a person qualifies for Medicare. They do not apply if a Medicare beneficiary is initially eligible because of age or some other disability and subsequently develops end stage renal disease.

In addition, a plan must not treat end stage renal disease patients differently from anyone else covered under the plan. The regulations give the following examples of actions that are not permitted:

- Terminating coverage of individuals with ERSD when there is no basis for the termination unrelated to the ESRD (such as a failure to pay plan premiums) that would not result in a termination for those that do not have ESRD.
- Limiting benefits for end stage renal disease patients when benefits for others enrolled in the plan are not limited; for example, requiring higher deductibles or coinsurance, lower annual or lifetime benefits, excluding certain benefits and so on, that would apply to ERSD treatment.
- Charging higher premiums for patients with end stage renal disease.
- Paying providers less for treating end stage renal disease.
- Failing to cover routine maintenance dialysis or a kidney transplant when a plan covers other dialysis services or other organ transplants.

While plans can certainly limit coverage for a particular service, those limits must apply uniformly to all plan participants. For example, a plan may limit its coverage for dialysis to 30 sessions a year for all plan enrollees. If it does not differentiate between participants receiving dialysis for end stage renal disease and participants receiving dialysis for other reasons, this limitation is acceptable.

Employer Prohibited Actions

Under the Medicare secondary payer rules, employers cannot offer Medicare entitled participants a financial or any other incentive to opt-out of the employer-sponsored group health plan and take Medicare instead. The plan must offer current employees or current employees' spouses age 65 or older the same benefits, under the same conditions and terms available to employees or spouses under age 65.

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CMS has informally confirmed that an opt-out bonus for everyone choosing other coverage is not considered a financial incentive to elect Medicare instead of the group health plan. However, employers cannot offer to pay for any Medicare supplemental policies, premiums, or a Medicare Advantage plan in order to encourage current employees or their spouses to opt for Medicare rather than employer coverage.

Group health plans cannot take Medicare entitlement into account (either age-based or disability-based) for current employees. Unless an exception was already noted, the following actions are not permitted:

- Failing to pay primary benefits.
- Only offering coverage that pays secondary to Medicare.
- Terminating coverage because an individual has become eligible for Medicare, except as permitted under COBRA.
- Denying or terminating coverage if an employee qualifies for Medicare because of a disability when the plan covers other disabled employees.
- Limiting benefits for Medicare-entitled individuals and not for others enrolled in the plan, such as providing less comprehensive health coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, providing lower annual or lifetime benefit limitations, and so on.
- Charging Medicare-entitled employees higher premiums.
- Requiring Medicare-eligible employees to wait longer for health care coverage to begin.
- Paying providers or suppliers less for services furnished to a Medicare beneficiary than the amounts paid for the same services for a non-Medicare beneficiary.

CMS manages the coordination of benefits process very diligently. It will investigate any situations that seem unusual, especially if an employer seems to be treating Medicare-entitled individuals differently from other employees.

Mandatory Reporting Requirements

Congress passed the Medicare, Medicaid and SCHIP Expansion Act at the end of 2007. This act established mandatory reporting requirements for group health plans as well as a host of liability plans. The health plan requirements became effective on January 1, 2009, and apply to health insurance issuers and third party administrators.

In general, insurers and third party administrators report specific information on Medicare-eligible plan participants to the CMS. The reporting helps CMS track group health plan coverage for Medicare beneficiaries and also to determine the primary and secondary payer.

In some cases, employers did not even realize these reporting requirements existed. What's more, some carriers and third party administrators did not have all the required information for the reports and needed employers' help. The reporting requirements took effect for liability carriers over the summer.

Failing to comply with these reporting requirements can result in significant fines; violators may be forced to pay $1,000 for each day of non-compliance for each individual whose information was not submitted. Employers should check with their group health plan vendors and their workers' compensation vendors to make sure they are submitting the required reports to CMS.

Data Match Program

CMS does monitor other coverage that Medicare beneficiaries may have in addition to Medicare. Using a data match program, it identifies Medicare participants covered under both a group health plan and Medicare by comparing data from the IRS and the Social Security Administration.

To determine whether a working Medicare beneficiary also has group health plan coverage, CMS sends employers a questionnaire asking about certain employees identified as having Medicare. The questionnaire asks for specific data on employment dates and their health plan coverage.

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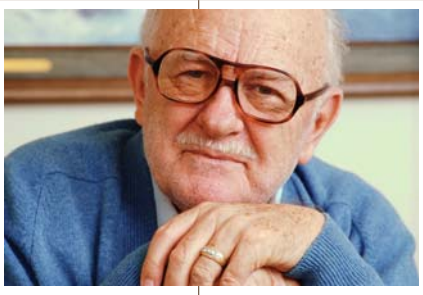
Employers must complete these questionnaires within 30 days unless the government approves an extension. Failure to comply within the requested time frame can result in:

- A fine of $1,000 for each person the employer does not list in the questionnaire and for each person the employer lists without including complete information.
- A government subpoena of business records.
- An investigation of the employer's group health plan to determine nonconformance. The employer may then be forced to pay excise taxes.



For now, employers must respond to these questionnaires. However, if the new mandatory reporting rules work effectively, CMS may eliminate them.

Recovery of Payments from Group Health Plans

Medicare meticulously reviews these questionnaires to determine whether a group health plan should have been the primary payer. When Medicare identifies a situation where they paid primary in error, the process of recovering the payment begins.

The Medicare secondary payer rules allow Medicare to make only "conditional payments." Therefore, if Medicare identifies another health plan that should have paid primary, it can recover payments it made in error. A group health plan must repay the amount Medicare paid in error or the amount that should have been paid by the group health plan, whichever is less. If CMS has to sue to recover the payment, it can collect double damages.

CMS sends demand letters to employers to collect primary payments made in error. Demand letters have deadlines, so employers need to review the letter as quickly as possible to determine whether they agree with Medicare's assessment. Some health insurance carriers and TPAs have areas that specialize in working with Medicare to make payments associated with demand letters. If at all possible, allow your health plan to determine how much it would have paid primary to make sure your plan is only repaying Medicare the amount required. Since CMS can assess fines on organizations that do not meet the repayment deadlines outlined in these letters, it is very important to respond to these requests immediately.

Hopefully, with the new mandatory reporting requirements, Medicare will be able to identify primary payer status before paying the claim. This system should reduce the number of demand letters your organization receives.

Concluding Thoughts

Medicare secondary payer rules are not necessarily on most organizations' minds every day. However, as organizations try to manage cost, they may be very tempted to encourage Medicare-eligible workers to use Medicare as their primary coverage. Employees can certainly choose Medicare over a group health plan, but your organization cannot provide any incentives, financial or otherwise, for employees to make that choice.

CMS actively monitors Medicare beneficiaries to determine whether they have health coverage through their employers. Your organization needs to understand these rules to make sure your plan pays properly for Medicare recipients.

If your organization has any questions regarding Medicare secondary payer rules, please contact your McGraw Wentworth Account Manager. MW

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