INFORMATION REGARDING THE MEDICARE AS SECONDARY PAYER STATUTE

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Employers, group health plans (GHPs), and entities that sponsor or contribute to GHPs, as well as insurers, have certain obligations under the Medicare Secondary Payer (MSP) provisions of the Social Security Act, commonly known as the "MSP statute"[1]. The MSP provisions of the Social Security Act are similar to the coordination of benefits clauses in GHPs. As an employer[2] or administrator of a GHP, you need to know the requirements of the statute to remain in compliance and to avoid potentially costly penalties and litigation. To assist in this endeavor, Health Care Service Corporation (HCSC) provides this basic information regarding operation of the MSP statute and the enrollment and membership information system that is used to obtain necessary data to detect instances in which the MSP statute applies and to ensure the proper processing of claims consistent with the law.

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 employers and GHPs, as well as their insurers, responsible in certain instances for making primary payment in connection with medical items or services provided to specified Medicare beneficiaries with dual health care coverage.

The MSP statute is essentially a coordination of benefits statute. It does not dictate the benefits an employer or GHP must offer, but instead simply requires 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, however, in one important respect: 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:

1. GHPs that cover individuals 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 employed by the employer or whether the individual has "current employment status".

2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status". If the GHP is a multi-employer or multiple employer plan, which 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).

3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employment status". If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 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.)

1 The MSP provisions are set forth at 42 U.S.C. §1395y(b), as amended. The regulations the Center for Medicare and Medicaid Services (CMS) has issued regulations implementing the statute which are located at 42 C.F.R. §411.20-.37, 411.100-.130, 411.160-.175 and 411.200-.206. It is important that you and your counsel review the statute and regulations periodically to ensure compliance with your statutory obligations. This document is provided for information purposes and is not offered or intended as legal advice.

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

The information in these instructions should not be construed as legal advice or as a legal opinion on any specific facts or circumstances, and is not intended to replace advice of independent legal counsel.

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The rules for calculating the size of the employer are complicated, and vary depending on numerous factors. In determining whether the size threshold has been met in any given case, the statute and regulations must be consulted.

As noted, application of the statute depends not only on the size of the employer but also, in certain cases, on whether the coverage provided under the GHP is based on "current employment status". Thus, the MSP provisions apply to the aged only if the age 65 or over Medicare beneficiary or the beneficiary's spouse has "current employment status" and to the disabled only if the disabled Medicare beneficiary, or a member of his family, has "current employment status" with the employer. (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 which an employer employs.) Under the regulations issued by the Centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration or HCFA), 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 6 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 Non-Discrimination Provisions: Age and Disability

The MSP statute prohibits GHPs from "taking 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 aged employees and spouses the same benefits, under the same conditions, that they furnish to employees and spouses under age 65. 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 which 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", and thus the MSP provisions do not apply.

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 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.

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 due to a "carve-out" provision, the GHP may continue to offer such coverage and is not required to pay primary during the 30 month coordination period. By contrast, where a GHP was providing primary benefits immediately before the onset of the disease, the GHP is responsible to continue providing primary benefits for that individual for 30 more months. This is because a change from primary to secondary or supplemental coverage would improperly "take into account" Medicare eligibility based on ESRD.

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. 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 spouse of an employee 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 (or any one else for that matter) to offer any financial or other incentive for a Medicare beneficiary not to enroll, or to terminate enrollment, in a GHP which would be primary to Medicare if the individual enrolled in the GHP. This is so even if the incentive is offered universally to all individuals who are eligible for coverage under 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. **Where 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 Non-compliance

Non-compliance 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 "non-conforming" group health plan. Under CMS Regulations, a non-conforming group health plan is a plan that: (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 provide required information, fails to pay correctly, or 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 right of individuals to collect double damages from any GHP that fails to make primary payments in accordance with the MSP provisions.

THE INFORMATION SYSTEM

Information Gathering

In an effort to facilitate the processing of claims consistent with the requirements of the MSP statute and to assist this organization and its accounts in meeting their statutory obligations, we (HCSC) have been and continue to participate in a data exchange enrollment and membership system that was developed to electronically exchange health insurance benefit entitlement information related to the MSP statute. The system is aimed at obtaining, in a timely and current fashion, information necessary for us to identify dual coverage situations which fall within the MSP statute and to determine whether primary or secondary payment should be made for a particular claim. Section 111 of the Medicare, Medicaid and SCHIP Expansion Act of 2007 (MMSEA) (P.L. 110-173), added new mandatory reporting requirements for GHP arrangements, liability insurance (including self-insurance), no-fault insurance and workers' compensation. Responsible Reporting Entities (RREs) are now **required** by Mandate S111 from CMS to report information necessary for us to identify dual coverage situations which fall within the MSP statute. The MSP Statute requires that HCSC as Plan Administrator and/or Health Insurer act as the RRE. The sharing of data through this system helps us and our customers to meet the statutory obligations by identifying instances in which an individual participating in your GHP is or may be improperly enrolled in a program providing secondary or supplemental coverage.

CMS has, in the past, reported that it has made hundreds of millions of dollars in mistaken Medicare payments annually as a result of paying primary when under the MSP statute only secondary payment was required. Historically, many of these mistaken payments resulted from the fact that providers often filed claims which failed to identify sources of health care coverage other than Medicare and CMS lacked information in its own files regarding the existence of duplicate coverage for Medicare beneficiaries. **The information void was greatest with regard to the spouses of working-aged individuals covered by the statute and the greatest number of undetected dual coverage cases accordingly occurred in this context.**

To help remedy this problem, and as a RRE, we are continuing to provide basic information to CMS about individuals enrolled in GHPs who are also covered by Medicare so that

CMS can supplement its files to better detect dual coverage situations. The information we require from you and provide to CMS is relatively discrete and includes the following:

Information on Employers

- Employer Identification Number (EIN)

Information on Medicare Beneficiaries

- Beneficiary Name
- Date of Birth
- Gender
- Social Security Number
- Health Insurance Claim Number (e.g., Medicare Number)
- Relationship to Policyholder (e.g., policyholder, spouse of policyholder, child of policyholder, other)
- Reason for Medicare Entitlement (e.g., beneficiary insured under Medicare due to age, disability, or ESRD)
- Medicare Effective Date
- Medicare Termination Date

Information on Certificate Holder/Policyholder and Covered Dependents

- Policyholder Name
- Social Security Number
- Individual Policy Number of Policyholder
- Current Employment/Retirement/COBRA/State Continuation Status
- Coverage Effective Date
- Coverage Termination Date
- Group Plan Number
- Benefits Provided (e.g., Hospital only, medical benefits only, drug with major medical, etc.)
- Coverage (e.g., self, family, self/spouse, etc.)

Our goal is to obtain the identified information with as little inconvenience and burden to you and your employees as possible. We will gather this information through application forms and group-size questionnaires with detailed instructions on how to complete each form.

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 work force 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 in meeting your statutory obligations by providing general information about the statute and gathering information that will detect potential problems in enrollment, it is ultimately your responsibility to ensure your company's compliance with the MSP statute.