

Medicare Secondary Payer



BlueCross BlueShield
of Oklahoma

The Centers for Medicare & Medicaid (CMS) has rules for determining when other types of insurance such as an employer's group health plan must pay primary to Medicare. The Medicare Secondary Payer (MSP) rules are complex and the following information is intended to provide a summary of the MSP guidelines. Groups are encouraged to consult with their own legal counsel for advice regarding any law or regulations that impact their group health plan, including the MSP rules.

When is Medicare a “secondary payer?”

In general, the group health plan is required to be the primary payer, and Medicare is the secondary payer, when the member meets all of the criteria in at least one of the following rules:

The Working Aged Rule

- The individual is age 65 or over and is covered under a group health plan;
- The individual has current employment status (or has a spouse of any age with current employment status); and
- The individual is working (or has a spouse who is working) for an employer that has 20 or more employees.

The Disability Rule

- The individual is under 65 and is covered under a group health plan;
- The individual has current employment status (or has a family member who has current employment status); and
- The individual is working (or has a family member who is working) for an employer with 100 or more employees.

The End-Stage Renal Disease Rule (ESRD)

- The individual has ESRD and is covered under a group health plan;
- The individual is still within 30 months of the date of Medicare eligibility; and
- The individual is still within the 30-month coordination period from the date Medicare coverage begins; and
- The individual is covered under a group health plan based on either current or former working status (with no employer size requirements).

Responsibilities of Beneficiaries Under MSP

- Respond to MSP claims development letters in a timely manner to ensure correct payment of your Medicare claims. Be aware that changes in employment, including retirement and changes in health insurance companies may affect your claims payment.
- When you receive health care services, tell your doctor and other providers and the Coordination of Benefits Contractor (COBC) about any changes in your health insurance due to you, your spouse, or a family member's current employment or coverage changes.
- Contact the COBC if you take legal action or an attorney takes legal action on your behalf for a medical claim.
- Contact the COBC if you are involved in an automobile accident.
- Contact the COBC if you are involved in a workers' compensation case.

Source:

www.cms.gov/MedicareSecondPayerandYou

This information is a high-level summary and for general informational purposes only. The information is not comprehensive and does not constitute legal, tax, compliance or other advice or guidance.



How should an employer calculate its total number of employees?

Total employee size, not group or enrollment size, is used to assist in the determination of whether Medicare is primary or secondary to group health plan coverage. The general guideline is that employer size equals the total of nationwide full- and part-time employees, including seasonal employees. It is the responsibility of the employer to notify Blue Cross and Blue Shield of Oklahoma on an annual basis of their employer size and update us if employee size changes above or below 20 employees or above or below 100 employees throughout the year by completing and returning the Employer Acknowledgement Form.

Employers should consult their own legal counsel to determine their precise size and reporting responsibilities for MSP purposes.

What does it mean to have “current employment status?”

In addition to employee size, whether or not an individual or the spouse of the individual has “current employment status” with the employer assists in the determination of whether Medicare or the group health plan coverage is primary. Generally, an individual has “current employment status” if the individual is actively working or associated with the employer in a business relationship. In addition, an individual can have “current employment status” if the individual is not actively working but is receiving short or long-term disability benefits from the employer for up to 6 months (FICA taxes are being paid on the disability benefits).

What if a covered member is entitled to Medicare due to ESRD as well as aged or disability?

Generally, GHPs are subject to a 30-month coordination period for any plan enrollee eligible for, or entitled to Medicare based on ESRD, regardless of whether that individual also is entitled to Medicare on the basis of age or disability. The dual entitlement rules are complex and exceptions apply.

Responsibilities of Employers Under MSP

- Assure that your plans identify those individuals to whom the MSP requirement applies.
- Assure that your plans provide for proper primary payments where by law Medicare is the secondary payer.
- Assure that your plans do not discriminate against employees and employees' spouses age 65 or over, people who suffer from permanent kidney failure, and disabled Medicare beneficiaries for whom Medicare is secondary payer.
- Accurately complete and submit Data Match reports timely on identified employees.

Source: www.cms.gov/MedicareSecondPayerandYou



How does BCBSOK and CMS exchange data and information to make sure that claims are paid properly?

BCBSOK is registered with CMS as a Responsible Reporting Entity (RRE). As an RRE, we submit group health plan arrangement data for Medicare beneficiaries to the CMS Coordination of Benefits Contractor (COBC) on a quarterly basis through the Section 111 reporting process. This process allows CMS to coordinate the order of benefits correctly and pay claims appropriately.

Additionally, on a quarterly basis, BCBSOK sends a HIPAA Eligibility Wrapper Query File (HEW) to CMS to query certain members that could potentially have Medicare entitlement. If Medicare entitlement exists for a member, the COBC will return a response file notifying us of the member's Medicare status and reason for entitlement.

Do you need a Social Security Number on file for every member?

CMS requires Medicare Health Insurance Claims Numbers (HICNs) or Social Security Numbers (SSNs) for anyone who is Medicare eligible or any individuals who are age 45 or older. As the RRE, we must be able to demonstrate that we have tried to obtain HISCNs or SSNs for this target group.

The annual HISCN/SSN letter request serves as HCSC's due diligence to solicit this sensitive information from our members.

What should an employer do if they receive a demand letter from Medicare?

A demand letter is a debt collection tool sent by a Medicare contractor to group health plans for any of the following reasons:

- To request a payment
- To address a late charge to a debt (interest, penalties and administrative costs)
- To report delinquent debts to credit bureaus
- To refer debts that are 180 days delinquent
- To bar delinquent debtors from receiving loans or loan guarantees

It is imperative for the group to send the demand letter immediately to:

HCSC Blue Cross Blue Shield
ATTN: MSP Demand Case Enclosed
300 East Randolph
Chicago, IL 60601-5099
MSP_Inquiries@bcbsok.com

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How Medicare Secondary Payer (MSP) Rules Apply to Medicare Beneficiaries Covered by Group Health Plans

AGE ENTITLED - Member is Medicare-entitled due to age of 65 or greater.

Total employer size (Please refer to footnotes referenced)	Subscriber's employment status (employee or former employee)	Primary payer for member with BCBS(Plan) and Medicare
Fewer than 20 employees ✖	Current or former employee	Medicare
20 or more employees *	Current employee	BCBS(Plan) +
	Former employee	Medicare

DISABILITY ENTITLED - Member is Medicare-entitled due to Social Security Administration determination of disability.

Total employer size	Subscriber's employment status (employee or former employee)	Primary payer for member with BCBS(Plan) and Medicare
Fewer than 100 employees ✖	Current or former employee	Medicare
100 or more employees ✓	Current employee	BCBS(Plan)
	Former employee	Medicare

END-STAGE RENAL DISEASE - Member is Medicare-entitled due to end-stage renal disease (ESRD)

30-month (^) ESRD Coordination Period	Subscriber's employment status (employee or former employee)	Plan paying primary at time of ESRD Entitlement	Primary payer for member with BCBS(Plan) and Medicare
Coordination Period Not completed	Current or former employee	BCBS(P) or other Group Health Plan	BCBS(Plan)
		Other (not a Group Health Plan)	Medicare
Coordination Period completed	Current or former employee	N/A	Medicare

DUAL ENTITLEMENT - Member is Medicare-entitled due to ESRD as well as age or disability

Order of entitlements	Total Employer Size	Subscriber's employment status at time of ESRD entitlement ➤	30-month (^) ESRD Coordination Period	Primary payer for member with BCBS(Plan) and Medicare
Age First then ESRD	Fewer than 20 employees ✖	Current or former employee	N/A	Medicare ➤
			20 or more employees *	Current employee
	Former employee	Completed		Medicare ➤
		N/A	Medicare	
Disability first then ESRD	Fewer than 100 employees ✖	Current or former employee	N/A	Medicare ➤
			100 or more employees ✓	Current employee
	Former employee	Completed		Medicare ➤
		N/A	Medicare ➤	
ESRD first, then Age or Disability	N/A	Current or former employee	Not completed	BCBS(Plan) ** ➤
			Completed	Medicare ➤

Notes Applying to All Above Tables

- * Employer had 20 or more total employees for each working day in each of 20 or more weeks in the current or preceding calendar year.
- ** If the individual was not covered by a group health plan prior to joining BCBS(P) and Medicare was primary, Medicare remains primary
- ✓ Employer had 100 or more total employees on 50 percent or more business days during the preceding calendar year.
- ✖ If the employer is a member of a 'multi-employer group health plan' and any one employer in the plan meets the working-aged (*) or disability (✓) thresholds, the threshold(s) applies to all employers in the multi-employer group health plan.
- For ESRD, the accountability during the coordination period depends on the assignment at the time the member becomes ESRD entitled. Whatever the primary payer is at the time of ESRD entitlement is maintained through the coordination period.
- + If the member is the employee's domestic partner and is also Medicare-entitled due to age, Medicare is the primary payer
- ^ Some individuals with ESRD wait up to three months after the month dialysis begins before becoming Medicare-entitled and the 30-month coordination period begins. Also, Medicare entitlement due to ESRD may end before the 30-month coordination period ends. Go to www.Medicare.gov or call Medicare at 1-(800) 633-4227 for authoritative information.

Interpreting the Medicare Secondary Payer (MSP) Matrix

To determine an individual's Medicare secondary payer (MSP) status, first identify why the individual is entitled to Medicare—age 65 or older; due to a determination of **disability** by the Social Security Administration; due to end-stage-renal disease (**ESRD**); or because the individual is entitled to Medicare due to age or disability, as well as ESRD, which is called **dual entitlement**. Then go to the appropriate table on the reverse side.

Medicare Secondary Payer Rules

For Medicare beneficiaries, three basic rules determine when Medicare is the secondary payer and the employer's Group Health Plan (GHP) must be the primary payer. The GHP member must meet *all* criteria in at least one of the following rules for MSP to be applicable:

- The **Working Aged Rule** applies to individuals who
 - are age 65 and over and are covered under a Group Health Plan;
 - have current employment status (or have a spouse of any age with current employment status); **and**
 - are working (or have a spouse who is working) for an employer that has/ has had 20 or more employees for each working day in each of 20 or more weeks in the current or preceding calendar year.

The Working Aged Rule also applies to aged spouses who are not working, but are covered by working individuals.

- The **Disability Rule** applies to disabled individuals who
 - are under age 65 and are covered under a Group Health Plan;
 - have current employment status (or have a family member with current employment status); **and**
 - are working (or have a family member who is working) for an employer that had 100 or more full- and part-time employees, including seasonal employees, during the preceding calendar year.
- The **End-Stage Renal Disease Rule (ESRD)** applies to individuals (with a current or former employer of any size) who
 - have ESRD and are covered under a Group Health Plan;
 - are still within the 30-month coordination period from the date of Medicare entitlement (due to ESRD); **and**
 - are covered under a Group Health Plan based on either current or former working status.

Dual Entitlement Rules

When a covered member is entitled to Medicare due to ESRD as well as aged or disability (dual entitlement), the rules become more complicated. General guidelines are as follows:

- the first entitlement establishes the primary or secondary accountability until the ESRD coordination period has been met.
- once the ESRD coordination period has been met, Medicare pays primary.

Employer Size Impacts MSP Status for Age and Disability

Total employee size, not group or enrollment size, is used to determine primary or secondary payer status for individuals who are Medicare-entitled due to age or disability. The rules for calculating employer size are complicated and can vary depending on many factors. The general guideline is that employer size equals the total of nationwide full- and part-time employees, including seasonal employees, where applicable.

If the employer is a member of a "multi-employer group health plan", the MSP status of the employer with the largest number of employees becomes the MSP status for all employers in the multi-employer group health plan. However, employers may ask the Centers for Medicare and Medicaid Services (CMS) for a 'small employer exception.' This exception allows the employer's group health plan to remain the secondary payer for individuals entitled due to age. For additional information, see the Centers for Medicare and Medicaid Service's *Medicare Secondary Payer Manual*, Chapter 2, Section 10.4, at www.cms.hhs.gov/Manuals/IOM/list.asp.

The Employee's "Current Employment Status" Always Impacts MSP Status

An employee does not necessarily have to be actively-at-work to have current employment status, such as an employee on short-term disability. If the employee is receiving compensation that is subject to employment tax, such as FICA, current employment status usually applies. Consult the statute and regulations for details.

The ESRD 'Coordination Period' Impacts MSP Status

Individuals who are Medicare-entitled due to end-stage renal disease (ESRD) must meet a 30-month coordination period immediately following their initial ESRD entitlement. If the coordination period has not been completed, the general rule is the entity paying primary at the time the individual became ESRD-entitled remains the primary payer during the coordination period. If the coordination period is completed, Medicare is the primary payer.

This flier contains general information and should not be construed as either legal advice or opinion on any specific facts or circumstances, and is not intended to replace independent legal counsel. Readers are urged to consult a lawyer concerning their own situation or any specific legal questions they may have.

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