Coordination of Benefits with Medicare

Guide For Brokers Submitting Employer Information

Independence

Summary

Coordination of Benefits (COB) with Medicare is the determination of whether a member has alternate insurance with primary payment responsibility.

Initial Coordination of Benefits (COB) occurs as enrollment applications are processed and members are asked to provide information about other potential insurance coverage. The COB provisions of the policy or plan determine which plan is primary. The plan's benefits are applied to the claim first, and the unpaid balance is usually paid by the secondary plan to the limit of its responsibility. Therefore, benefits are "coordinated" among health plans so payments do not exceed 100% of the charges for the covered services.

This Guide is intended to help clarify the proper steps and processes for submitting data to Independence properly to ensure correct primacy determinations.

Please note: Independence does not provide legal advice. Groups should consult with their own legal counsel regarding their obligations under MSP rules/regulations.

Group Size

Medicare Secondary Payer (MSP) requirements for the Working Aged and Disabled require information on employer size to determine the correct primary payer. For example, for the Working Aged (employees who are eligible for Medicare because they are age 65 or over and who still actively working (and their dependents)), for companies with 19 or fewer full- and part-time employees, Medicare is almost always primary. If a company is larger, other rules apply to determine whether your group plan is the primary or secondary payer.

For purposes of determining whether the Group Health Plan (GHP) or Medicare is the primary payer for individuals who Medicare eligible because of age or a disability, MSP laws and regulations contain specific guidelines for determining group size, which is based on the number of full- and part-time employees. Employer size is based on the number of employees, not the number of individuals covered under the GHP.

Note: The MSP requirements for End-Stage Renal Disease (ESRD) are not based on any employer size. GHPs are the primary payer for members 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."

Employer Size Criteria

20 or more

An employer is considered to employ 20 or more employees if the employer has 20 or more employees for each working day in each of the 20 or more calendar weeks in the current calendar year or preceding calendar year.

100 or more

An employer is considered to have 100 or more employees if it has employed at least 100 full- or part-time employees on 50% or more of its regular business days during the previous calendar year.

There are two significant size thresholds that impact the determination of primacy:

a. **Working Aged**: Medicare is the <u>secondary</u> payer to GHP's for the "working aged" (individuals aged 65 or older) where:

   i. A single employer of 20 or more full and/or part time employees is the sponsor of the GHP or the contributor to the GHP; or

   ii. Two or more employers are sponsors or contributors to a multi-employer/multiple employer plan, and at least one of them has 20 or more full- and/or part-time employees.

b. **Disabled**: Medicare is the secondary payer for people under 65 who have Medicare because of a disability and who are covered under a GHP based on the individual's (or family member's) current employment status where either:

   i. The employer has 100 or more full- and/or part-time employees; or

   ii. For multi-employer/multiple employer GHPs, one or more of the employers in the GHP has 100 or more full- and/or part-time employees.

In determining whether the size threshold has been met in any given case, the statute and regulations must be consulted. In certain cases, application of the statute depends not only on the size of the employer but on whether the coverage is provided under the GHP based on "current employment status."

Under CMS regulations, an individual has "current employment status" if he or she is:

1. "actively working as an employee, [is] the employer...or [is] associated with the employer in a business relationship";
2. "not actively working" but is "receiving disability benefits from an employer for up to six months"; or
3. "not actively working" but "retains employment rights in the industry" and other specific requirements are met.

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

Who Pays First?

Member Type	Who Pays First
Working Aged (65 or older and still working) and has health coverage through an employer with 20 or more employees	**Independence pays first**
Working Aged (65 or older and still working) and has health coverage through an employer with less than 20 employees	**Medicare pays first**
Under 65 and disabled, with current employment status and has health coverage through an employer with 100 or more employees	**Independence pays first**
Under 65 and disabled, and has health coverage through an employer with less than 100 employees	**Medicare pays first**

CMS Employer Size Training

CMS offers training on how employer size relates to the MSP requirements for Working Age, Disability, and ESRD. It provides:

a. Examples of how to correctly determine employer size.

b. Definition of a multi-employer/multiple employer plan

c. Explanation of when a single employer falls under the multi-employer/multiple employer rules for MSP.

d. High-level overview on the Small Employer Exception.

Click GHP Training Material to view the training information.

If the group has any questions regarding the calculation of group size for MSP purposes, they should consult with their legal counsel.

Compliance

If a GHP fails to comply with the requirements of MSP rules/regulation, it may subject to penalties.

B - ENFORCEMENT:

"(i) IN GENERAL- An entity, a plan administrator, or a fiduciary described in subparagraph (A) that fails to comply with the requirements under such subparagraph shall be **subject to a civil money penalty of $1,000 for each day of noncompliance for each individual for which the information under such subparagraph should have been submitted.** The provisions of subsections (e) and (k) of section 1128A shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). A civil money penalty under this clause shall be in addition to any other penalties prescribed by law and in addition to any MSP claim under this title with respect to an individual."

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 "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.

Independence does not provide legal advice. The group should consult with its own legal counsel regarding its obligations under MSP rules/regulations.

Primary vs. Secondary Payer Responsibility: Common Examples

Set forth below are examples of common situations when Medicare and other health insurance or coverage may be present, and which entity will be the primary or secondary payer..

I. Working Aged (Medicare beneficiaries age 65 or older) and Employer Group Health Plan (GHP):

a. *Individual is age 65 or older*, is covered by a GHP through current employment or spouse's current employment AND *the employer has less than 20 employees:*
Medicare pays Primary, GHP pays secondary

b. *Individual is age 65 or older*, is covered by a GHP through current employment or spouse's current employment AND *the employer has 20 or more employees (or at least one employer is a multi-employer group that employs 20 or more individuals):*
GHP pays Primary, Medicare pays secondary

c. *Individual is age 65 or older*, is *self-employed* and covered by a GHP through current employment or spouse's current employment AND *the employer has 20 or more employees (or at least one employer is a multi-employer group that employs 20 or more individuals):*
GHP pays Primary, Medicare pays secondary

II. Disability and Employer GHP:

a. *Individual is disabled*, is covered by a GHP through his or her own current employment (or through a family member's current employment) AND the employer has 100 or more employees (or at least one employer is a multi-employer group that employs 100 or more individuals)
GHP pays Primary, Medicare pays secondary

III. End-Stage Renal Disease (ESRD):

a. Individual has ESRD, is covered by a GHP and is in the first 30 months of eligibility or entitlement to Medicare
GHP pays Primary, Medicare pays secondary during 30-month coordination period for ESRD

b. Individual has ESRD, is covered by a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA plan) and is in the first 30 months of eligibility or entitlement to Medicare
COBRA pays Primary, Medicare pays secondary during 30-month coordination period for ESRD

IV. Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA): the law that provides continuing coverage of group health benefits to employees and their families upon the occurrence of certain qualifying events where such coverage would otherwise be terminated.

a. Individual has ESRD, has COBRA continuation coverage and is in the first 30 months of eligibility or entitlement to Medicare COBRA coverage pays Primary, **Medicare pays secondary during 30-month coordination period for ESRD**

b. Individual is age 65 years or older and covered by Medicare and has COBRA continuation coverage: **Medicare pays Primary, COBRA pays secondary**

c. Individual is disabled and covered by Medicare and has COBRA continuation coverage:
Medicare pays Primary, COBRA pays secondary

V. Retiree Health Plans:

a. *Individual is age 65 or older* and has an employer retirement plan: **Medicare pays** Primary, Retiree coverage pays secondary

Employer Responsibilities under MSP

Please be sure that your group customers:

I. Identify those individuals to whom the MSP requirement applies;

II. Plans provide for proper primary payments where by law Medicare is the secondary payer.

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.

Independence does not provide legal advice. The group should consult with its own legal counsel regarding its obligations under MSP rules/regulations.

Broker Responsibilities to provide information to Independence under MSP

The ability of Independence 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 each GHP. We depend on you to provide us with this information. It is very important that you respond promptly and accurately to our requests for information.

Moreover, to ensure the continuing accuracy of our files, it is required that we are notified promptly of any changes in the size of a work force or the status of 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 a workforce that place them in or out of the scope of the MSP statute.

We use the information you provide us to update our files, and also forward that information to CMS on a quarterly basis reflect relevant changes in primary/secondary status.

Medicare Secondary Payer (MSP) Demand Process

MSP Demand Notices

MSP Demand Notices are issued by CMS when it is seeking reimbursement of payment made as the primary insurer. MSP Demand Notices are issued when Medicare believes that it:

1. paid one or more specific claims in error for a particular member for a particular period of time as primary; and
2. Independence Blue Cross should have made the payment instead.

The MSP Demand Notice presents what is referred to as a "Demand Case". The MSP Demand Notice includes a letter from the CMS – for which the vendor is currently Benefit Coordination Recovery Center (BCRC). Please note that a Demand Case can involve multiple claims. A listing of claims and an MSP Summary Data sheet are typically received as part of the Demand case.

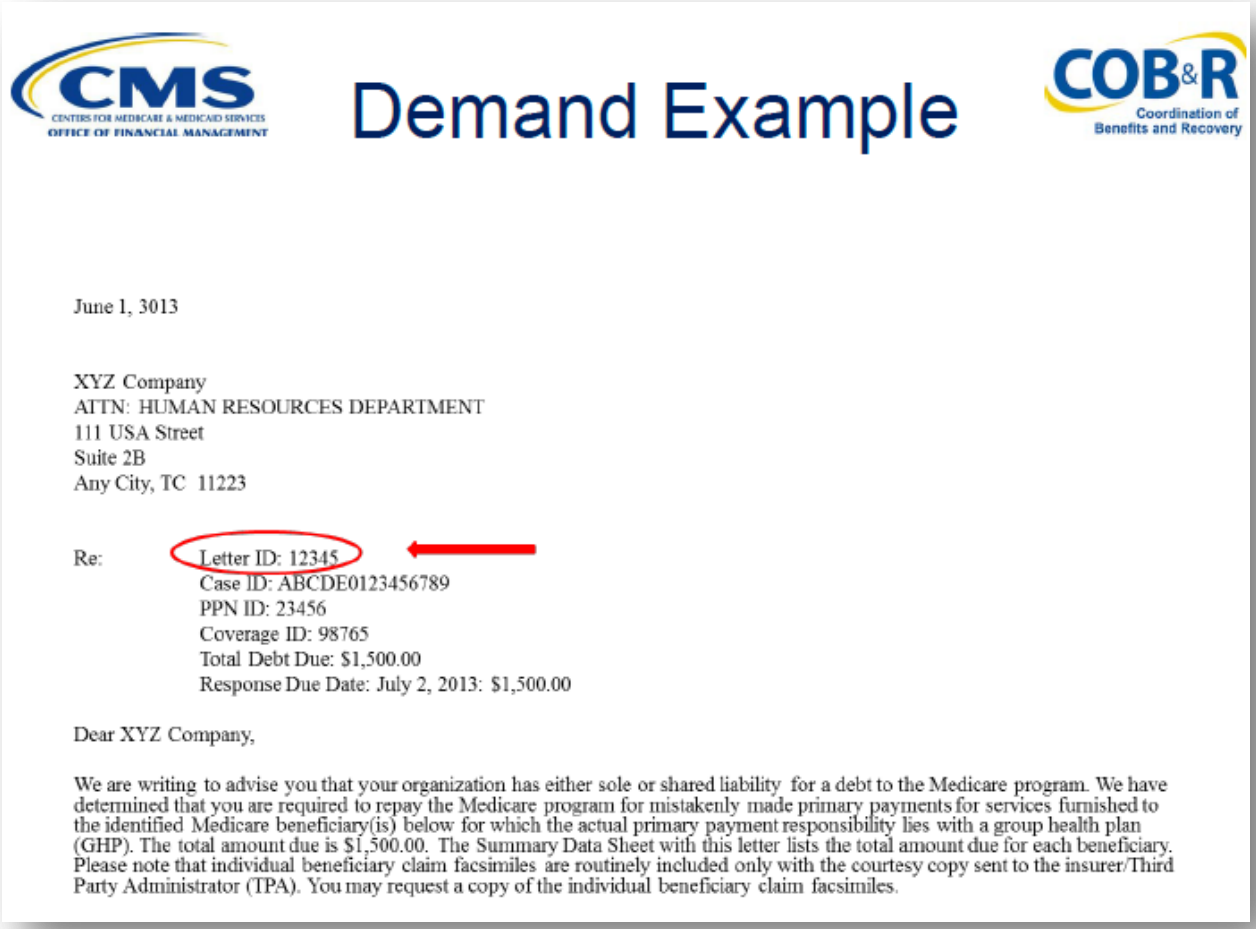
The Demand Package

The Demand Package will contain the following information:

- An explanation of the medical/hospital debt along with the rules/regulations associated with repayment
- The beneficiary name
- The subscriber name
- The employer name and address
- The Patient Policy Identification number
- Reason for entitlement
- Health Insurance Claim Number (HICN)
- Total number of claims in question
- Total repayment amount due
- The address to which payment should be sent

Overview of the Recovery Process

Example: MSP Demand



CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

Demand Example

COB&R
Coordination of Benefits and Recovery

June 1, 3013

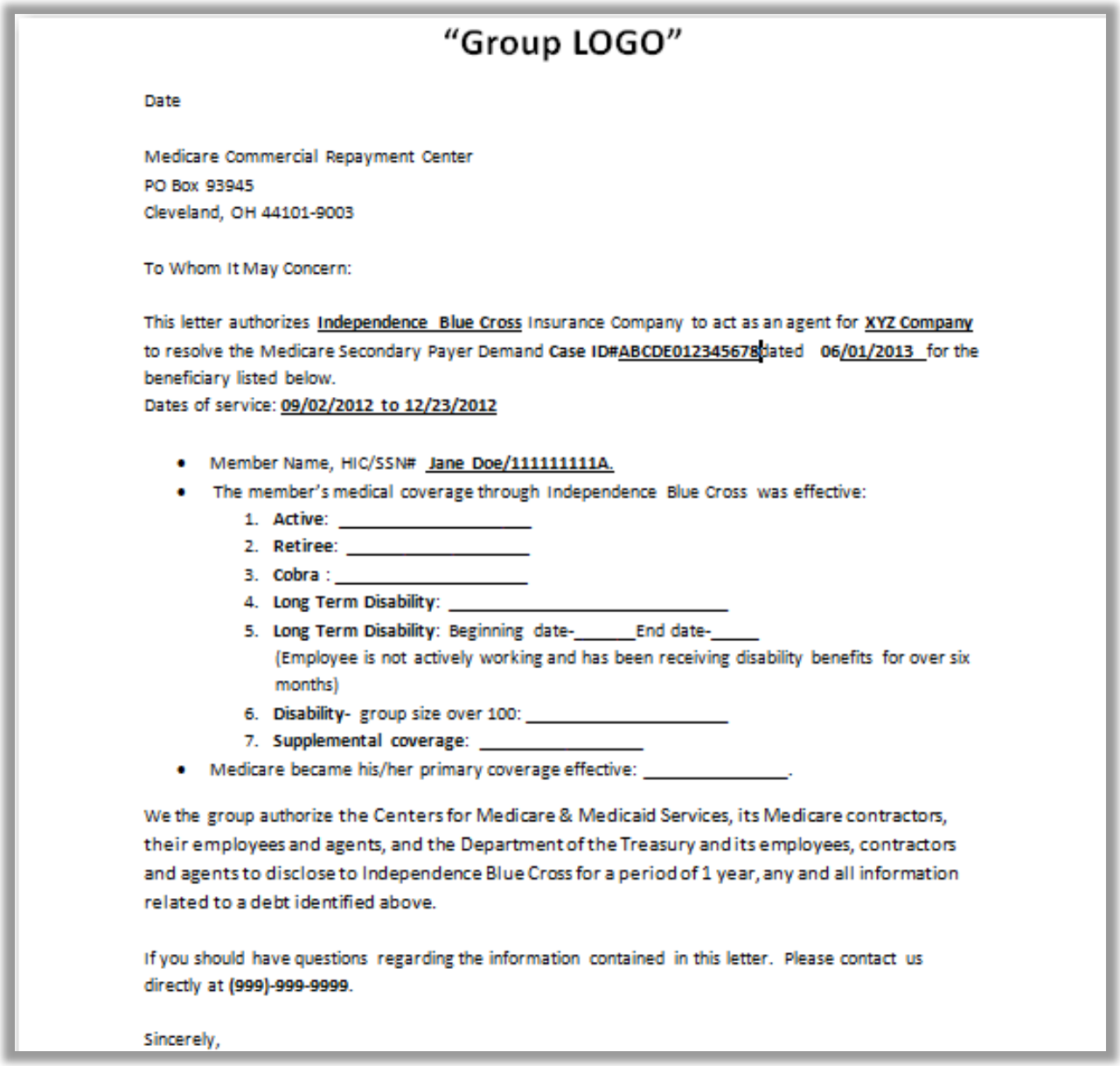
XYZ Company
ATTN: HUMAN RESOURCES DEPARTMENT
111 USA Street
Suite 2B
Any City, TC 11223

Re: Letter ID: 12345
Case ID: ABCDE0123456789
PPN ID: 23456
Coverage ID: 98765
Total Debt Due: $1,500.00
Response Due Date: July 2, 2013: $1,500.00

Dear XYZ Company,

We are writing to advise you that your organization has either sole or shared liability for a debt to the Medicare program. We have determined that you are required to repay the Medicare program for mistakenly made primary payments for services furnished to the identified Medicare beneficiary(is) below for which the actual primary payment responsibility lies with a group health plan (GHP). The total amount due is $1,500.00. The Summary Data Sheet with this letter lists the total amount due for each beneficiary. Please note that individual beneficiary claim facsimiles are routinely included only with the courtesy copy sent to the insurer/Third Party Administrator (TPA). You may request a copy of the individual beneficiary claim facsimiles.

Sample Authorization Letter



"Group LOGO"

Date

Medicare Commercial Repayment Center
PO Box 93945
Cleveland, OH 44101-9003

To Whom It May Concern:

This letter authorizes **Independence Blue Cross** Insurance Company to act as an agent for **XYZ Company** to resolve the Medicare Secondary Payer Demand **Case ID#ABCDE012345678** dated **06/01/2013** for the beneficiary listed below.
Dates of service: **09/02/2012 to 12/23/2012**

- Member Name, HIC/SSN# **Jane Doe/111111111A.**
- The member's medical coverage through Independence Blue Cross was effective:
  1. **Active**: _____
  2. **Retiree**: _____
  3. **Cobra** : _____
  4. **Long Term Disability**: _____
  5. **Long Term Disability**: Beginning date-_____End date-_____
     (Employee is not actively working and has been receiving disability benefits for over six months)
  6. **Disability-** group size over 100: _____
  7. **Supplemental coverage**: _____
- Medicare became his/her primary coverage effective: _____.

We the group authorize the Centers for Medicare & Medicaid Services, its Medicare contractors, their employees and agents, and the Department of the Treasury and its employees, contractors and agents to disclose to Independence Blue Cross for a period of 1 year, any and all information related to a debt identified above.

If you should have questions regarding the information contained in this letter. Please contact us directly at **(999)-999-9999**.

Sincerely,

Social Security Number (SSN) Requirement

The MSP Act was amended in 2007 as part of the Medicare, Medicaid, and SCHIP Extension Act ("MMSEA"). Notably, Section 111 of the MMSEA imposed new data collection and mandatory reporting requirements on insurers in an effort to provide CMS with greater tools to enforce the MSP Act. It also provides civil monetary penalties for noncompliance with the mandated reporting requirements. One of the elements of data is a member's Social Security Number.

Independence currently has incorrect, missing, or duplicate SSNs in various systems and is now requiring them in order to meet Section 111 requirements and the Affordable Care Act. Accurate SSNs are required to validate data in the CMS database to determine if the member has Medicare and outreach to other commercial plans.

Government Language: Medicare Secondary Payer

The Medicare Secondary Payer (MSP) program is designed to reduce costs to the Medicare program by requiring other insurers of health care for beneficiaries to pay primary to Medicare. It applies in three situations: where there is liability insurance (e.g. for an accident); where there is workers compensation coverage (e.g. for a job related injury); and where there is an Employer's Large Group Health Plan (EGHP).

The MSP provisions apply to situations when Medicare is not the beneficiary's primary health insurance coverage. Medicare statute and regulations require that all entities that bill Medicare for items or services rendered to Medicare beneficiaries must determine whether Medicare is the primary payer for those items or services.

I. CMS requires that health insurers obtain certain information about their members to determine who should be the primary payer for claims (i.e. Independence or Medicare.) CMS has created a fact sheet, which may provide you with more information. You can find it online at: CMS Fact Sheet

II. To comply with CMS, Independence) is requesting your Health Insurance Claim Number (HICN) or Social Security number (SSN) if you do not have a HICN, for employees, spouses, and domestic partners regardless of age. Please update your employment records with your employer or contact Independence at number on the back of your card.

Please be assured that we are committed to protecting your privacy. Independence will provide your HICN or SSN to CMS only to be compliant with the new regulation.

Please advise groups to continue to monitor status

The MSP statute and regulations are frequently amended. As a result, it is important that the group and its 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 the group's responsibility to ensure the company complies with the MSP statute.

Frequently Asked Questions

Q: When a Retro Change to Employee Size is requested, is a letter from the Group necessary?

A: Yes, if the Group plans on updating the "Total Number of Employees" retro back greater than 60 days.

Q: How far back will we actually go to update MSP?

A: If a MSP Demand is involved, we may have to go back as far as 3 years.

Q: If we go back more than one year to update MSP, does it require a Marketing VP approval?

A: Yes, if a MSP Demand is not involved. Independence is required to pay "Interest" on all claims.

Q: Does the letter have to state the exact number of employees or greater/less than 20?

A: The letter "MUST" state the exact number of employees and the date they met the size.

Q: Once updated, how are past claims then reprocessed? Does it involve any additional steps from Marketing?

A: Once the size is changed either above or below the MSP Size regulation, a Primacy change report is generated to identify the impacted member or claim. The appropriate business team performs the claim adjustment.

Acronyms used in this guide

MSP	Medicare Secondary Payer
BCRC	Benefit Coordination Recovery Center
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
CMS	Centers for Medicare & Medicaid Services
DOBI	Department of Banking and Insurance
EGHP	Employer's Group Health Plan
ESRD	End-Stage Renal Disease
GHP	Group Health Plan
HICN	Health Insurance Claim Number
ICIS	Integrated Customer Information System
MMSEA	Medicare, Medicaid, and SCHIP Extension Act
NAIC	National Association of Insurance Commissioners
OPIS	Other Party Information System
OPL	Other Party Liability
PID	Pennsylvania Insurance Department

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