

# Medicare Primary/Secondary Guide

## Introduction

Medicare primary/secondary rules are discussed in four parts:

- General Commentary
- Definitions
- Medicare Primary/Secondary Priority
- Plan Document and Booklet Language

## General Commentary

1. Virtually all of the tough issues have been settled.
  - a. Being a plan supervisor (either as a TPA or as an insurer under an ASO arrangement) does not connote financial responsibility (i.e., obligation to pay the claim).
  - b. Medicare has subrogation recovery rights where there is a tortfeasor liability.
  - c. COBRA need not be provided to a person with a Medicare card even if such medical care was during the first 30 months of ESRD.
  - d. Medicare's right to recovery does not abrogate the clear terms of the plan document such as time limits for the reporting of claims.
  - e. Statute and clarifying regulations are well publicized and deal with the following issues:
    - i. Defining employer group health plan and large employer group health plan
    - ii. Defining employee
    - iii. Defining disabled
    - iv. ESRD dual-entitlement.

2. Two ongoing problems deserve attention:
  - a. End stage renal disease – See Par. 3
  - b. Three-Plan situation in general – See Par. 4

3. End Stage Renal Disease

*What We Know.* Medicare will be secondary when any group health care plan provides coverage to a beneficiary judged as having ESRD for the first 30 months of such disease. Thereafter, Medicare will be primary. When ESRD begins is, or should be, Medicare-determined. The dual-qualification determination is simplified by these HCFA-promulgated rules:

- a. If a person is already on Medicare because of age or disability, acquiring ESRD does not trigger such 30-month-period.
- b. If a person is on the 30-month-period because of ESRD, gaining Medicare eligibility because of age or disability does not waive the remainder of any such 30-month-period.

*What May Be a Further Question?* The D.C. Circuit Court, which held for the Medicare position, involved a dialysis firm requesting that Medicare be secondary during the first 30 months in situation (a) above.

4. Three-Plan Situation in General

*What We Know.* If a covered person is double-covered by both Plan ABC and

Plan LMN and also has a Medicare Card (due either to age or disability) these rules may be followed:

- a. Medicare is Primary to Plan ABC and also Primary to Plan LMN.  
Medicare is primary; Plan ABC and Plan LMN are secondary and/or tertiary (or vice versa) by their terms.
- b. Medicare is Secondary to Plan ABC and also Secondary to Plan LMN  
Plan ABC and Plan LMN are primary and/or secondary (or vice versa) by their terms. Medicare is tertiary.
- c. Medicare is Secondary to Plan ABC and Primary to Plan LMN or Vice Versa.  
Plan ABC and Plan LMN are primary/and or secondary (or vice versa) by their terms. Medicare is tertiary.

*Recent Decisions.* Several recent decisions from the Sixth Circuit, one of which the Supreme Court declined to review, held that in case (c) above, Medicare had *no dog in the fight* which really meant that Medicare become tertiary.

## Definitions

Active means retaining current employment status either by being actively-at work or meeting certain employment-related tests:

Test 1. Retention of employment rights in an industry (for Taft-Hartley plans)

Test 2. Employment status not been terminated by employer

Test 3. In first 6 months of an employer-provided disability benefit

Test 4. Not receiving Social Security benefits

Test 5. Not on COBRA

*Beneficiary* means an employee, disabled employee or retired former employee or the covered spouse thereof. Rare circumstance of a dependent child having a Medicare Card is ignored.

*Disabled* applies to an employee, under age 65, who has a Medicare Card due to Social Security – determined disability. The term includes (a) those who are actively working despite their disability (such as disabled Medicare beneficiaries engaged in a trial work period), (b) those who are not actively working but who the employer treats as employees and (c) those who are under age 65 and not actively working and whom the employer treats as retired (inactive). Medicare decides whether or not a person is an active employee in accordance with regulations and instructions. Such determination is generally based upon whether or not the employer treats such disabled person as an active or retired employee.

Employee means an individual who works for an employer, whether on a full or part-time basis, and receives remuneration.

Indicative of *employee* status:

- Receives from an employer payments that are subject to taxes under the Federal Insurance Contributions Act (FICA) or would be subject to such taxes, except for the fact that the employment or the payments are exempt from those taxes under the Internal Revenue Code.
- Is termed an employee under a federal or state law or in accordance with a court decision.
- Is designated as an employee in the employer's records; that is, has not had employee status terminated. Medicare does not consider termination from payroll to be, in and of itself, termination from employee status.

Suggestive of *employee* status:

- Accrual of vacation time or receipt of vacation pay
- Accrual of sick leave
- A legally enforceable right to return to work if the disabling condition improves
- Payment by the employer, on the individual's behalf, of the same taxes that are paid on behalf of actively working employees
- Participation in any benefit plan that is available only to employees.

End Stage Renal Disease means permanent kidney failure with the prognosis being dialysis, transplant surgery or death. The precise date of the onset of ESRD should be determined by Medicare.

Entitlement means having a Medicare Card either due to (a) being age 65 or over (b) being disabled, under age 65, and not connected with the employer as an employee.

Group Health Care Plan means any plan of, or contributed to by, an employer (including a self-funded plan) to provide health care directly or otherwise) to the employer's employees, or the families of such employees or former employees. This includes plans where the employee pays all costs; e.g., through payroll deductions.

Inactive means a status other than active; includes both a retiree and disabled status.

Large Employer means one with 100 or more employees on 50% or more of the business days during the prior calendar year.

Other Employer means one which is not either a very small or large employer.

Very Small Employer means one with 20 or fewer employees on each working day of 20 calendar weeks of either the prior or the current calendar year.

## Medicare Primary/Secondary Priority

1. Why does patient (beneficiary, covered person, patient) have Medicare Card?

- a. Age 65 Entitlement. Go to 2.
- b. Under age 65, disabled (not ESRD). Go to 3.
- c. Any age, ESRD. Go to 4.

Definitions useful to these priorities should be read carefully. Also, useful designations are as follows:

- Patient B is a person with a Medicare Card.
- B may be a participant in plan of Employer ABC; or a dependent spouse with the plan of Employer LMN (Spouse’s plan).
- S denotes spouse of B.
- Either B or S may be an employee.

2. B, over 65, Has Medicare Card (Select 2 (a) or 2 (b))

a. B is Covered in Only One Employer Plan (Select 2(a)(i) or 2(a)(ii))

i. B Is Covered Only as a Participant in Plan ABC

<u>Size of ABC</u>	<u>Work Status of B</u>	<u>Medicare</u>	<u>Priority Comments</u>
Very Small	Active	Primary	2-1
Very Small	Inactive	Primary	2-3
Other	Active	Secondary	2-3
Other	Inactive	Primary	2-4

ii. B Is Covered Only as a Spouse of S in Plan LMN

<u>Size of LMN</u>	<u>Work Status of S</u>	<u>Medicare</u>	<u>Priority Comments</u>
Very Small	Active	Primary	2-5
Very Small	Inactive	Primary	2-6
Other	Active	Secondary	2-7
Other	Inactive	Primary	2-8

\* Age of spouse is not significant

b. B is Covered Both As a Participant in Plan ABC and As a Dependent in Plan LMN.

If Medicare is secondary to either ABC or LMN, it is tertiary to both with ABC and LMN being secondary or primary by their terms. If Medicare is primary to both, ABC and LMN will be secondary and tertiary by their terms.

### Priority Comments

<u>Number</u>	<u>Comment</u>
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- |     |  |
|-----|--|
| 2-1 | Medicare is primary to ABC because ABC is a very small employer.   |
| 2-2 | Medicare is primary to ABC also because B is inactive.   |
| 2-3 | Medicare is always secondary to the working aged where there is an employer group health plan which does not meet the 20 employee lives rules.                           |
| 2-4 | Medicare is primary to ABC because B is inactive.  |
| 2-5 | Medicare is primary to LMN because LMN is a very small employer plan.  |
| 2-6 | Medicare is also primary to LMN because B is inactive.   |
| 2-7 | Medicare is always secondary to the working aged (or their covered spouses) where there is an employer group health plan which does not meet the 20 employee lives rule. |
| 2-8 | Medicare is primary to LMN because S is inactive.  |

3. For an individual under age 65, with a Medicare Card due to disability and not ESRD, Medicare will always be secondary when both of these conditions are met:
- Plan is a large plan (employer has over 100 employees).
  - Covered person is active.
- See Paragraph 2(b) for the logic to be followed when dealing with Medicare as secondary or tertiary.

4. B has a Medicare Card Due to ESRD (Select (a) or (b))
- B Has Had ESRD for More Than 30 Months  
Medicare will be secondary to any group health plan.
  - B Has Had ESRD for Less Than 30 Months (Select (b)(i) or (b)(ii))
    - ESRD Began Prior to other Medicare Entitlement  
Medicare will be secondary to any group health care plan
    - ESRD Began After Other Medicare Entitlement  
Medicare will continue to be primary to an group health care plan

These priorities reflect the current published positions of CMS and the decision of the D.C. Circuit. Any group health care plan includes employers with fewer than 20 employees (very small plans). Preferred practice of claims administrators should be to have ESRD commencement date be determined by Medicare.

## Plan Document Language

### Coordination with Certain Government-Sponsored Plans

Except in certain circumstances with Medicare, this Plan will generally be primary to an federal or State-federal plan. To the extent that the Plan's rules are at variance with those of the government, the rules of government will prevail.

#### Medicare

Each covered person eligible for Medicare is a Medicare Person and is subject to this provision. The provision is intended to comply with the Medicare secondary payer rules which are intended to make this Plan the primary of benefits for covered persons eligible for Medicare benefits except for certain exceptions.

1. Coverage Requirement for the Working Aged Under Group Health Plans. For purposes of paying benefits, this Plan shall not take into account that the Participant (or the Participant's spouse), who is covered under the Plan by virtue of the Participant's current employment status with the Employer is entitled to Medicare benefits. Any Participant, age 65 or over, (and the Participant's spouse age 65 or older) who is covered under the plan by virtue of the Participant's current employment status with the Employer shall be entitled to the same benefits under the Plan under the same conditions as any such Participant (or spouse) under age 65.
  - Exclusion For Group Health Plan of a Small Employer. The coverage requirement stated above shall not apply to this Plan unless the Plan is a plan of, or contributed to by, an employer that has 20 or more employees in current employment status for each working day in each 20 or more calendar weeks in the current calendar year or the preceding calendar year.
  - Exception for Participants with End Stage Renal Disease. Notwithstanding any other rules to the contrary, this Plan will always be secondary to Medicare for any covered person who has been deemed by Medicare to have had end stage renal disease for over 30 months.
2. Disabled Participants in Large Group Health Plans. If this Plan is a large group health plan, this Plan shall not take into account that a Participant (or member of the Participant's family)

who is covered under this Plan by virtue of the Participant's current employment status with the Employer is entitled to disability benefits under Medicare. For the purposes of this provision, this Plan will be a *large group health plan*, if the Plan covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

3. *Current Employment Status Defined.* A Participant has current employment status with the Employer if the Participant is an employee, (which includes a self-employed person) or is associated with the Employer in a business relationship.

## **Medicaid**

The fact that a covered person is eligible for, or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act (i.e., a state Medicaid plan) shall not be taken into account for purposes of determining eligibility in this Plan or providing benefits hereunder. Benefits shall be paid in accordance with any assignment of rights made by or on behalf of a covered person as required by Medicaid. To the extent that payment has been made under Medicaid, benefits payable under this Plan shall be paid in accordance with any state law that provides that the state has acquired the rights with respect to a covered person to payment for benefits payable under this Plan. The provisions of the paragraph shall be applied in good faith, based upon a reasonable interpretation of applicable federal law and regulations.

## **Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)**

CHAMPUS will always be secondary to any employer-sponsored health care plan.

## **Veterans Administration Health Care**

The Veteran's Administration will look to the Veteran's health care plan as the primary payer of any medical care provided by a VA facility.

## **Plan Booklet Language**

Your spouse's plan generally will be primary and Medicare secondary when you are covered as an active-worker participant (and not as a retiree or permanently disabled participant). When you are an active-worker participant and your covered spouse has a Medicare care, your plan will be primary to such Medicare. Special rules involve active-worker participants who have a Medicare card and are in small plans (employers with fewer than 100 employees). Additionally, special rules apply to participants who are disabled or who have with end stage renal disease. Call the Plan Supervisor for details.

## Medicare As Primary Or Secondary

### In General

Medicare provides primary coverage under three circumstances:

- To the over 65 beneficiary who is not covered, either as a participant in dependent of an employer-sponsored health plan. Employees below 20 employees are excluded.
- To the under-65 beneficiary who is covered, either as a participant or dependent, under such plan as above where the employer has 100 or more employees.
- To the under-65 beneficiary, classed as end staff renal for more than over 30 months regardless of employer size. Where the beneficiary looks to the employer plan as primary and is in the 30 month tolling period, such tolling period continues even if eligibility for Medicare as secondary might occur (as, e.g., reaching age 65).

In all other circumstances, Medicare will be secondary.

Before a Medicare claim may be processed, the provider must develop certain items of information to properly administer the CMS secondary payor program. These items are shown in the questions which the provider is expected to have answered by the Medicare beneficiary. See following sections.

In noting what information is needed, the reader will be able to better understand the secondary payor program.

The introduction of the provider letter to the Medicare beneficiary reads as follows: “We have received a Medicare claim on your behalf. Federal law specifies instances in which other insurance is required to pay before Medicare. Since our files do not show whether you have other insurance, we are asking that you supply this information. We will use the information to determine whether another insurer must pay before Medicare. It is very important that you supply the requested information as quickly and accurately as possible. The correct payment of your future Medicare claims depends on it. Please complete, sign, and return the enclosed questionnaire immediately so we may update your Medicare records with the correct insurance information.”

### Medicare Beneficiaries Over Age 65

These are the qualifying questions of the Medicare Beneficiaries:

1. Are you currently working full or part-time?
2. Are you married, and is your spouse currently working full or part-time?
3. If yes, how many employees does your employer or your spouse’s employer have?
4. Are you covered under an employer group health plan based on your current employment, or the current employment of your spouse?
5. If yes, please provide the following:
  - Name of insured, relationship to patient (self, spouse)

- Name and address of employer
  - Name and address of insurer, underwriter, third party administrator, HMO, etc.
  - Group identification number
  - Policy identification number.
6. Are you entitled to Black Lung medical benefits?
  7. Was this service for treatment of a work-related injury or illness?
  8. If yes, provide the name and address of the workers' compensation agency, the workers' compensation carrier and your employer.
  9. Was this service for the treatment of an illness or injury which resulted from an automobile or other accident?
  10. If yes, provide the name, address and policy number of the automobile or non-automobile liability or no-fault accident?
  11. Are the services to be paid by a government program such as a research grant?

## **Medicare Beneficiaries Under Age 65**

Medicare beneficiaries under age 65 may gain entitlement because they are either disabled or because of an end stage renal disease. Therefore, one must determine the reason for the beneficiary's entitlement by asking the following questions:

1. Have you received a kidney transplant. If yes, date:
2. Have you received maintenance dialysis treatments? If yes, date dialysis began:

## **End-Stage Renal Disease**

### **Medicare Coverage**

Medicare covers certain individuals, even though they have not reached age 65, who are suffering from *end-stage renal disease*. These are persons (1) who are fully insured for old-age and survivors insurance benefits, (2) who are entitled to monthly social security benefits, or (3) who are spouses or dependent children of individuals described in clause.

Coverage for dialyzing patients begins with the third month after the month in which a course of renal dialysis is initiated, except that this entire three-month waiting period will be waived in the case of an individual who participates in a self-care training program (in the expectation of completing the training and entering self-dialysis) before the beginning of the third month after the one in which he initiates a regular course of dialysis. In the case of a transplant candidate, coverage can begin as early as the month in which the patient is hospitalized for transplantation, provided the surgery takes place in that month or in the following two months.

In the case of an individual who receives a kidney transplant, coverage ends with the 36th month after the month of the transplant. In the case of an individual who has not received a transplant, coverage ends with the 18th month after the one in which a regular course of dialysis was ended.

If a transplant fails, and as a result the individual initiates or resumes a regular course of dialysis, entitlement begins again with the first day of the month in which the course is initiated or resumed. Similarly, in any case in which the regular course of dialysis is resumed subsequent to the termination of an earlier course, entitlement resumes with the first day of the month in which a regular course of dialysis is resumed.

## **Relationship to Private Plans**

Medicare benefits are secondary for a limited period of time (a period of up to 30 consecutive months in the case of individuals who are entitled to Medicare solely on the basis of end-stage renal disease and who are entitled to coverage under an employer group health plan.

This exclusion does not apply to beneficiaries entitled to Medicare because of age 65 or disability. During the period in which Medicare benefits are secondary, Medicare will pay primary benefits for Medicare covered services that are not covered by the employer plan and it will make secondary payments to supplement the amount paid by the employer plan if that plan pays only a portion of the charge for the service. This limitation on Medicare payments applies even if the employer policy or plan states that its benefits are secondary to Medicare's or otherwise excludes or limits its payments to Medicare beneficiaries.

There may be instances where there is more than one primary insurer (e.g., automobile medical insurer and the employer's group health plan). In such cases, the primary insurer will customarily coordinate benefits. Medicare is secondary to all primary insurers.

Under the Omnibus Budget Reconciliation Act of 1981, the Internal Revenue Code of 1954 § 162(i) was amended to deny business expense deductions for employer group health plans that contain discriminatory provisions that reduce or deny payment or benefits for renal patients.

The period of 30 consecutive months commences the earlier of (1) the month in which the individual initiates a regular course of renal dialysis, or (2) the month in which an individual who receives a kidney transplant could become entitled to Medicare.

When Medicare's liability is secondary to any employer group health plan, the provider, facility, physician, or supplier may bill either Medicare or the employer plan first. If Medicare is billed first, Medicare will pay conditional primary benefits and then attempt to recover the employer plan. The conditional payments are subject to recovery when the employer plan pays. If the employer plan does not pay, CMS may bring action against the employer plan, and the beneficiary is required to cooperate in HCFA's action. CMS is authorized to bring a subrogation action. CMS is authorized to waive recovery action if the probability of recovery or the amount involved does not warrant pursuit of the claim.

As noted above, if a provider, facility, physician, or supplier bills the employer plan first, and the employer does not pay for the services in full, Medicare will pay secondary benefits if the services are otherwise covered by Medicare.

## **Disabled Employees**

## **Medicare Coverage**

The earliest possible month for which individuals who are either social security (including Medicare-Qualified federal employee) beneficiaries or railroad retirement disability beneficiaries may become eligible for Medicare benefits is the 25th month in which the individual is entitled to monthly social security or railroad retirement benefits by reason of disability.

## **Relationship to Private Plans**

Medicare is the secondary payer for disability beneficiaries who are covered by a large group health plan (an employer with 100 or more employees) as a current employee (or as a family member of a current employee). Thus, when an employee (or a member of the employee's family) becomes disabled, the large employer's group health plan has a primary coverage responsibility and Medicare has secondary coverage responsibility.

The Internal Revenue Code provides for a tax on employers and employee organizations that deny health insurance coverage to an employee (or to a member of the employee's family) on the basis of his or her eligibility for disability Medicare coverage. The tax is 25% of the employer's or employee organizational's annual contributions to the nonconforming *large group health plan*.

## **Medicare Reporting Requirements of the Plan Supervisor**

CMS regulations of Medicare require certain that third party payers, for health services provided to Medicare beneficiaries, must furnish certain information to Medicare intermediaries and carriers when they learn that Medicare made primary payment for services for which the third party payer has made or should have made primary payment. The notice also informs third party payers that they should contact CMS if they wish to discuss arrangements for exchanging, on a voluntary basis.

The third party payers affected by this notice are workers' compensation plans and insurers; all liability and no-fault insurers, including automobile insurers; and group health plans under certain circumstances, including plans which are self-insured and/or self-administered. If the group health plan, or workers' compensation plan is self-funded and self-administered, the employer must provide the notice; otherwise the insurers, underwriter or third party administrator must give the notice. This description of information third party payers must furnish is intended to help ensure that, in accordance with the Medicare law, Medicare pays only secondary to primary coverage of third party payers.