ABA Sections of Business Law, Labor Law, Real Property, Probate and Trust Law, Taxation, and Tort and Insurance Practice

ABA Joint Committee on Employee Benefits

Meetings with Agencies
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HCFA Questions and Answers

1. With respect to the definition of "current employment status" in 42 C.F.R. §411.104, how soon after an individual, who is covered by the working aged provisions of MSP, ceases to be actively working due to disability can the employer take the position that such individual is no longer covered by the MSP rules?

The regulations provide that an individual will have current employment status even if he or she is not actively working, if the individual:

(1) is receiving disability benefits from an employer for **up to six months**, or

(2) (a) retains employment rights in the industry,

(b) has not had his employment terminated by the employer, if the employer provides the coverage,

(c) has not had his or her membership in the employee organization terminated, if the employee organization provides the coverage,

(d) is not receiving disability benefits from an employer for **more than six months**,

(e) is not receiving Social Security disability benefits, and

(f) has group health plan coverage that is not COBRA continuation coverage.

The dual use of a 6 month requirement with slightly different terminology ("up to" vs. "more than") presents some confusion. Perhaps an example will help flesh out this confusion.

Suppose an individual is eligible to receive disability benefits for 18 months. At the end of 6 months he is still entitled to "receive disability benefits from an employer for **MORE THAN** 6 months." Thus, one possible reading of the rules is that a switch to Medicare primary is not allowed until the individual has less than 6 months of coverage, or in this example, shortly after 12 months coverage. This reading is premised on a literal reading of the rule; namely that an individual who was initially entitled to 7 months of coverage would be switched to Medicare primary shortly after 1 month of coverage because at that time he would not be entitled to receive disability benefits for "up to" or "more than" 6 months.

Another possible reading is that if an individual is initially receiving disability benefits from an employer for **"up to" or "more than"** 6 months, he cannot be switched until he is no longer receiving disability benefits from an employer. Thus, an individual who is initially eligible for 18 months worth of benefits (even after the initial 6 months and even after 17 months) may be restructured since such individual was initially entitled to "receive benefits for up to or more than 6 months."

A third possible reading of the regulation is that a switch to Medicare Primary can be made after 6 months. This reading of the rule would result in the individual in the example having "current employment status" only for the first six months.

Proposed Answer: The purpose of defining "current employment status" was supposedly to stop requiring employers to cover as primary those individuals who are clearly not able to contribute to the employer's bottom line. The idea that such individuals are still MSP protected for their entire disability period simply because the employer was generous enough to provide substantial disability benefits seems at odds with the purpose of the statute. On the other hand, treating someone on disability leave as still an employee for the first 6 months only, would seem to strike some kind of desirable balance between the competing objectives. Therefore, my interpretation of the regulations is that the individual should be treated as an employee for the first 6 months only. (However, I would appreciate some clarification of the use of dual six month rules and the rationale behind the use of "up to" and "more than" rather than a uniform phrase.)

JCEB Summary of HCFA's Answer: During the first 6 months of disability, he will be paying FICA and this will be deemed by HCFA to have "current employment status." For someone who is NOT paying FICA taxes, they would have to NOT meet any of the other tests. The employer's bottom line has nothing to do with it.

HCFA's Comments:

2. What information constitutes adequate notification to individuals under the HCFA Reg. Section 411.108 requirement that a group health plan inform an individual, who rejects the employer plan's coverage, th the plan will not be permitted to provide or p secondary benefits?

The preamble addresses a question proposed by a commentator who suggested that the rules should include a provision that a statement in the Summary Plan Description ("SPD") satisfies the notification requirement. Section 411.108, however, states that a plan would be taking into account Medicare entitlement if it gave individuals information on their right to accept or reject the employer plan but failed to inform them of the consequences of rejection. Unfortunately, neither the regulation, nor the preamble provides any guidance on what information would meet the requirement.

Proposed Answer: Since the SPD is intended to be the primary source of supplying information regarding the plan document, and plan administrators must provide the SPD to each plan participant and each beneficiary receiving benefits under the plan, I think that the SPD constitutes adequate notification regarding the consequences of rejecting group health plan coverage. Under the rules, however, the answer is unclear, and I would appreciate more specific guidance as to the nature and the extent of the information that would preclude a finding of failure to inform.

JCEB Summary of HCFA's Answer: HCFA staff indicated that whenever an employer communicates with an employee concerning the employee's election to continue in the employer's health plan, or to choose to be covered by Medicare as the primary payor, the employer has the obligation to inform the employee of the potential negative consequences of rejecting the employer plan coverage. Providing such information is a requirement (and will not be viewed as a prohibited incentive to accept or reject the employer's plan coverage).

HCFA staff indicated that the consequences of rejecting the employer's coverage and electing Medicare as the primary payor, must be included in the SPD, but this is not necessarily sufficient. Every time an employee inquiries about the election or receives notification from the employer about the election, he or she must be told about the consequences of rejecting the employer's coverage.

HCFA staff seemed to indicate that if the SPD contains information which is considered to be sufficient notification concerning the consequences of rejecting employer plan coverage, that information will be deemed to be sufficient if there are no further communications with the employee concerning the election to continue under the employer's plan or to elect Medicare as the primary payor. This latter scenario, however, would be most unusual because it is unlikely that there will not be any further communications about plan participation when an employee attains age 65.

HCFA staff warned that it would not be prudent for an employer to accept disenrollment from the employer's plan over the telephone. The employer will be held accountable for the information communicated to its employees and, as a result, the best course of action would be to confirm the disenrollment by letter and, in that case, the letter should state the consequences of the disenrollment.

By way of example, HCFA staff indicated that a letter to an employee when he or she turns age 65 which says that the employee should "check off Medicare or check off continuation in the employer plan," would not be sufficient disclosure even if a full description of the consequences of not selecting the employer's plan is provided in the SPD.

A further question was raised about a situation in which an employee rejects coverage on his or her own without any communication with the employer. The information concerning the consequences of disenrolling from the employer plan is clearly set forth in the SPD. HCFA staff indicated that they have not formulated a view as to whether the employer has an affirmative duty to advise the employee concerning the consequences of the disenrollment in this situation; however, there likely is an ERISA fiduciary duty to advise the employee in these circumstances about the potentially negative consequences of opting out of the employer's plan.

HCFA's Comments:

3. A working-aged individual's only employer health coverage is provided by an HMO. The HMO refuses to pay a non-emergency out-of-network claim because services are not provided by a physician employed by the HMO. Is the employer responsible to pay the claim, before Medicare, out of the employer's general assets (i.e., not pursuant to any benefit plan) under the Medicare secondary rules? Does it matter if the HMO "mandated" the employer?

Proposed Answer: The HMO is only required to cover for MSP-protected individuals the expenses it covers for other members. The employer is not required to make up for benefits that the plan might have provided if it had other terms.

[Part of last year's reported answer — that Medicare would pay one or two out-of-network claims and then no more — is not supported by the statute or regulations. Consider the case of an over-age 65-active employee with an over-age-65 dependent spouse, both with Medicare. The fact that the active employee chose HMO coverage for himself and his spouse should not prevent the spouse from seeking treatment from a physician the HMO will not pay for because the physician is not employed by the HMO. Medicare should pay primary where the HMO does not cover an out-of-network claim. This would be true even if the spouse chose the non-HMO physician as a matter of personal preference and could have obtained similar service from an HMO affiliated physician.]

JCEB Summary of HCFA's Answer: HCFA staff agreed that the employer is not required to pay because the services rendered are not covered services. Moreover, Medicare also will refuse to pay for the out-of-network services because the individual "rejected" employer-provided health coverage. However, if the individual did not know that the services were not covered by Medicare when he or she submitted the claim, Medicare will notify the individual that the claim submitted was for an ineligible expense and that it will not pay future claims. In contrast, if the expense is for a service not covered under the employer plan, e.g. chiropractic services, Medicare will reimburse. Further, if the employer plan provides for out-of-network and in-network cost differentials for covered services and the individual chooses to go out-of-network for the service, Medicare will coordinate based on plan payments, up to the Medicare allowable amount, regardless of the fact that the individual could have chosen less costly services in-network.

HCFA's Comments:

4. The Medicare Secondary Payor ("MSP") rules provide that Medicare must be the secondary source of medical coverage (i.e., secondary to the employer's group health plan coverage) for "working aged" individuals (i.e., those age 65 or older) who are employed by an employer with 20 or more employees. Thus, employers with fewer than 20 employees are exempt from this rule, and may make Medicare coverage primary to their group health plan coverage. There is an additional special exemption from the MSP rules for employers with less than 20 employees that participate in a multiple employer group health plan which covers at least one employer with 20 or more employees. In this case, it appears that the small employer may still qualify for the exemption from the MSP rules if the plan makes an appropriate election to have the MSP exception apply to the small participating employer (See 42 C.F.R. § 411.172(b), as recently amended at 60 Reg. 53877 (Oct. 18, 1995)).

Moreover, the special exemption indicates that the plan must identify the individual participants for whom the exemption is being requested. With regard to this special exception, is it only the plan that may make the election on behalf of the small participating employer, or may the employer make the election? In addition, how should the election be made and what form should it take? (e.g. should the election take the form of a letter to the local Medicare office? What information must it contain?)

Proposed Answer: Although the MSP rules indicate that the plan must make the above-referenced election on behalf of the small employer within the multiple employer group health plan, it is likely that the employer will be more acutely aware of whether there are employees who would be affected by the MSP exception and the identity of those employees. In addition, the administrative expense and complication of making the election for each affected employer should fall on the individual employer rather than the plan. Accordingly, either the plan or employer may make the election to be exempt from the MSP rules. If the employer makes the election, it should be made by sending a letter stating that it has made the appropriate election and identifying the individuals for whom the election is made to the Medicare office nearest the employer.

JCEB Summary of HCFA's Answer: Contrary to the proposed answer, HCFA staff noted that the statute only permits a multiple employer plan to make an election to treat an individual employer as a "small employer" for the Medicare Secondary payer ("MSP") rules. Thereafter, HCFA noted that "individual employers" should not make any elections.

In connection with an election by a multiple employer plan, HCFA noted that no established procedures exist to make the election, but it is optimistic that such procedures will be established in the next year. In the interim, the best advice available to employers is the following:

- If an employer wishes to be treated as a small employer, it should take the initiative to advise the plan of this desire, and to encourage the plan to take all necessary actions. The plan is the appropriate party to act, since any improper payments will be directed to the plan, and not the underlying employer.

- The multiple employer plan should file a "Statement" with the appropriate Medicare Regional Office. This action would appear to be appropriate, since many plans have employees in multiple states.

- HCFA implied that an election on behalf of a plan would apply to all small employers in the plan.

- Upon the filing of a Statement, no further action need be taken, since no "approval process" exists. The election will become effective after notice to HCFA, and, according to HCFA, may not be retroactive in scope.

- All employees of the "small employer" should be identified to help HCFA update its "common working file."

- The Statement should identify the total number of employees working for the employer claiming the exemption. An employee certification may be appropriate and may be required in the future.

- Employees should be informed of the election, to advise them that Medicare will provide primary benefits, and that the multiple employer plan will provide secondary coverage under the MSP rules.

- The plan should apprise HCFA when the total number of employees of an electing employer equals or exceeds 20.

Although not directly related to the specific multiple employer question, HCFA noted that similar procedures need to be established for small employers, to require employers to notify HCFA when 20 or more employees exist. HCFA acknowledged that it is diffi-

cult to monitor these rules and that many employers hover around the 20 employees level creating difficulties. Nevertheless, in order to ensure proper payments, some procedures will be required in the future. Otherwise, an employer may be treated as a small employer for a considerable period of time, may ultimately exceed 20 employees, and HCFA may thereafter seek reimbursements for periods during which it paid for coverage on a primary basis, and should have been secondary. Determining the 20 employee threshold is exacerbated by the fact that some employers have multiple EINs for various related companies nationwide, and other administrative procedures often create difficulties for HCFA to determine employee numbers.

HCFA's Comments:

5. Who is the proper primary payer in the following situations: Medicare or the employer group health plan ("EGHP")?

a. An insured/employee of an employer with 20 or more employees turns 65, continues to work, and develops End State Renal Disease ("ESRD") at age 66. Who is primary? Does the 18 month coordination period come into play?

Proposed Answer: None given.

JCEB Summary of HCFA's Answer: Under the MSP provisions, once an individual who is entitled to Medicare on the basis of age or disability also becomes eligible for Medicare on the basis of ESRD, the MSP-ESRD rules apply to the exclusion of the working aged or disabled provisions for as long as the person has ESRD. In this example, when the insured/employee turns 65, the EGHP is primary under the working aged provisions. When the insured/employee develops ESRD, the MSP-ESRD rules apply and the EGHP will be primary for the next 18 months ("the coordination period"). Once the coordination period is over, Medicare will become primary regardless whether the insured/employee continues working.

HCFA's Comments:

b. An insured/employee of an employer with 20 or more employees turns 65 after developing ESRD. Who is primary? Does the 18 month coordination period come into play?

Proposed Answer: None given.

JCEB Summary of HCFA's Answer: The EGHP is primary for the first 18 months of Medicare eligibility on the basis of ESRD, after which Medicare becomes the primary payer. Medicare remains the primary payer even after the insured/employee turns 65 because the MSP-ESRD rules continue apply to the exclusion of the working aged rules as long as the insured/employee has ESRD.

HCFA's Comments:

c. Who is primary for the disabled dependent spouse of an employee of an employer with more than 20 but less than 100 employees when the disabled spouse turns 65?

Proposed Answer: None given.

JCEB Summary of HCFA's Answer: Under MSP, once an individual who is entitled to Medicare on the basis of disability turns 65, the working-aged MSP rules apply to the exclusion of the disabled provisions. In our example, Medicare is primary for the disabled dependent spouse under age 65 because the employer has less than 100 employees (the threshold under the MSP-disability provisions). Once the spouse reaches age 65, the EGHP is primary because the working aged rules apply and the employer comes within the size requirements of the working aged provisions.

HCFA's Comments:

6. What is the status of the HIAA/BCBSA litigation?

Proposed Answer: None given.

JCEB Summary of HCFA's Answer: This case was sent back to the United States District Court for the District of Columbia for entry of a final order in light of the Circuit Court's 1994 decision. The District Court has yet to issue its order.

HCFA's Comments:

HCFA Replies to Questions Submitted by American Bar Association

Question 1

With respect to the definition of "current employment Status" in 42 CFR §411.104, how soon after an individual, who is covered by the working aged provisions of MSP, ceases to be actively working due to disability can the employer take the position that such individual is no longer covered by the MSP rules?

The regulations provide that an individual will have current employment status even if he or she is not actively working if the individual:

(1) is receiving disability benefits from an employer for up to 6 months, or

(2) (a) retains employment rights in the industry,

(b) has not had his employment terminated by the employer if the employer provides the coverage,

(c) has not had his membership in the employee organization terminated, if the employee organization provides the coverage,

(d) is not receiving disability benefits from an employer for more than 6 months

(e) is not receiving social security disability benefits, and

(f) has group health coverage that is not COBRA continuation coverage.

The dual use of a 6-month requirement with slightly different terminology ("up to" vs. "more than") presents some confusion.

Answer:

This question incorrectly states the criteria in 42 CFR §411.104 for determining that a person who is not working has current employment status. Rules 2(a) (b) and (c) should be deleted and the following should be substituted:

2(a). Retains employment rights in the industry and has not had his employment terminated by the employer if the employer provides the coverage, (or has not had his membership in the employee organization terminated, if the employee organization provides the coverage).

Rules 2 (d) (e) and (f) should be renumbered as 2 (b) (c) and (d).

A person who is not working and who meets either the condition in (1) or who meets all of the conditions in (2) (a) through (d) is considered to have current employment status.

Medicare would be primary payer for a disabled person who is not working if the individual does not meet the condition in (1) and also does not meet any of the conditions in (2).

A further explanation of these rules follows:

Rule (1):

This is the so called "6-month requirement." In accordance with the Internal Revenue Code, the IRS treats the first 6 months of disability benefits paid by an employer as wages; i.e., such benefits are subject to FICA (social security) taxes. In other words, an individual who is receiving disability benefits from an employer for 6 months or less is considered to be an employee and the payments are considered "sick pay" (which is subject to FICA taxes) despite the fact that the employer may refer to the payments as "disability benefits." Also see Rule 2(b)

Since the first 6 months of employer paid disability benefits are taxed under FICA, HCFA also treats such benefits as wages for purpose of MSP. Thus, a person who is receiving disability benefits from an employer

for 6 months or less is considered to be employed; i.e., to have "current employment" status.

Rule (2)(a):

Under this rule, Medicare is secondary for individuals who are not working and who have group health coverage, provided the individual is either: (1) still carried on the employer's employment rolls, and is available for employment in the same industry as the employer, or (2) in the case of members of employee organization plans such as "Taft Hartley" union plans, available for assignment by the organization to another job. If coverage continues for a member of such a plan who is not actively working but who is available for work in that industry, the coverage is by virtue of current employment status. Thus, for example, members of trade unions and screen actors who move from one job to another and whose group coverage continues between jobs, have that coverage "by virtue of current employment status".

Rule (2)(b):

This is the converse of Rule (1). Since, under Rule (1), a person is considered to have current employment status if he or she is receiving disability benefits from an employer for up to 6 months, it follows that a person who is receiving disability benefits from an employer for more than 6 months is not considered to have current employment status.

Rule (2)(c):

An individual who has been determined to be disabled by the Social Security Administration becomes entitled to disability benefits beginning with the 6th month of disability, i.e., there is a 5-month waiting period before entitlement to disability benefits begins. Since disability is defined for social security purposes, as "inability to engage in any substantial gainful activity...", HCFA considers an individual who has been found disabled under social security not to have current employment status after the first 6 months of disability. The 6 months correspond to the 6-month period during which an individual who is receiving disability benefits from an employer is considered to have current employment status under Rule (1).

Rule (2)(d):

Under the law, Medicare is secondary to group health coverage only if the coverage is by virtue of current employment status. The COBRA continuation of benefits law requires employers to continue health coverage for employees and dependents of employees who no longer work sufficient hours to qualify for the employer's health plan. Where the employer is required to provide such coverage, the coverage is considered to be "by virtue" of the COBRA law, rather than by virtue of "current employment status," Therefore, Medicare is primary to such coverage.

Question 2

"What information constitutes adequate notification to individuals under the HCFA Reg. Section 411.108 requirement that a group health plan inform an individual, who rejects the employer plan's coverage, that the plan will not be permitted to provide or pay secondary benefits?

Answer

The requirement that plans notify individuals of the consequences of rejecting the employer's plan applies only when the employer informs an individual of the availability of the group health plan (GHP). Each time an employer informs a Medicare beneficiary for whom Medicare is secondary that a GHP is available he or she must also inform the individual of the effect of rejecting the plan i.e., that Medicare is primary and that the employer cannot sponsor or contribute to a Medicare supplement.

Informing beneficiaries about their rejection right without also informing them that the employer cannot offer them a Medicare supplement may mislead beneficiaries into thinking that the only results of rejection are that (1) Medicare becomes the primary payer; and (2) they and/or the employer are relieved of the cost

of primary coverage. Beneficiaries who receive such incomplete information are more likely to reject the plan than they would had they received full disclosure regarding the rejection. An employer who misleads beneficiaries in this manner is violating the prohibitions against (1) taking Medicare into account, and (2) inducing a beneficiary for whom Medicare is secondary to drop the employer plan coverage. Also, the employer may not influence the member's selection of primary payer but must provide sufficient information about coverage and costs to help the member to make an informed decision.

This information needs to be communicated in any dialogue between the employer and the beneficiary and in any written materials disseminated to the beneficiaries about the option of rejecting the employer plan. It would also be helpful if the employer included information regarding the possible need to enroll in Part B Medicare and that the beneficiary should contact his or her local Social Security office for information on Part B enrollment.

Question 3

A working age individual's only employer health coverage is provided by an HMO. The HMO refuses to pay a non-emergency out-of network claim because services are not provided by a physician employed by the HMO. Is the employer responsible to pay the claim, before Medicare, out to the employer's general assets (i.e., not pursuant to any benefit plan) under the Medicare secondary rules?

Consider the case of an over-age 65 active employee with an over-age 65 dependent spouse, both with Medicare. The fact that the active employee chose HMO coverage for himself and his spouse should not prevent the spouse from seeking treatment from a physician the HMO will not pay for because the physician is not employed by the HMO. Medicare should pay primary where the HMO does not cover an out-of-network claim. This would be true even if the spouse chose the non-HMO physician as a matter of personal preference and could have obtained similar services from an HMO affiliated physician.

Answer:

An employer that has contracted with an HMO so that the HMO is responsible to furnish certain medical services, is not obligated to pay for any services that were performed outside of the scope of the contract. This includes out of network services that would have been paid for by the HMO if they had been provided within the network.

The Medicare secondary payer law (sec. 1862(b)(2)(A)(I) and regulations (42 CFR 411.20(a)), provide that when Medicare is the secondary payer, Medicare payment cannot be made to the extent that payment has been made, or can reasonably be expected to be made, under a group health plan. When a person is enrolled in a prepaid employer group health plan (e.g., HMO, Competitive Medical Plan, Health Care Prepayment Plan) the employer makes a capitation payment to the plan regardless whether the employee/dependent has availed himself or herself of the services paid for by the employer. In other words, all services covered by the plan have been paid for in advance by the employer. Therefore Medicare will not pay for services obtained from a source outside the prepaid employer health plan if the same type of services could have been obtained as covered services through the plan.

However, since many individuals affected by this rule may not have been informed of it, Medicare will make a one time payment for services not covered by the HMO. When making that payment the Medicare contractor notes on the Explanation of Medicare Benefits that the services obtained outside the HMO are not covered under Medicare. However, since the individual was not previously notified of this in writing, a one time payment is being made, but that in the future, payment will not be made for non HMO services which could have been obtained from, or through, the HMO.

Question 4

The Medicare Secondary Payor ("MSP") rules provide that Medicare must be the secondary source of

medical coverage (i.e., those age 65 or older) who are employed by an employer with 20 or more employees. Thus, employers with fewer than 20 employees are exempt from this rule, and may make Medicare coverage primary to their group health plan coverage. There is an additional special exemption from the MSP rules for employers with less than 20 employees that participate in a multiple employer group health plan which covers at least one employer with 20 or more employees. In this case, it appears that the small employer may still qualify for the exemption from the MSP rules if the plan makes an appropriate election to have the MSP exception apply to the small participating employer (See 42 C.F.R. § 411.172(b), as recently amended at 60 Reg. 53877 (Oct. 18, 1995)). Moreover, the special exemption indicates that the plan must identify the individual participants for whom the exemption is being requested. With regard to this special exception, is it only the plan that may make the election on behalf of the small participating employer, or may the employer make the election? In addition, how should the election be made and what form should it take? (e.g., should the election take the form of a letter to the local Medicare office? What information must it contain?)

Answer

Section 1862(b)(1)(A)(iii) of the law specifies that the plan may elect to exempt from the MSP provision for the working aged, employees of small employers that participate in a multiple employer or multi-employer group health plan. While the plan must obtain information from the employer about the total number of employees and the identity of those affected by the election, the plan is in a better position to make the actual election. The plan is more familiar with the applicable laws and regulations concerning the manner in which employees are to be counted for purpose of the election, determining the effective date of the election, and the rules for documenting the factual situation and notifying the parties. Also, the plan is required to coordinate its election with the Medicare contractors so that Medicare can properly begin paying primary benefits as soon as the election is effective.

Multiple employer or multi-employer group health plans that wish to exempt a small employer should notify the employer of the statutory and regulatory provisions for determining the number of employees, request the employer to furnish a statement of the number of employees that it employs and how it determined that number, e.g., whether it counted part-time employees and self-employed persons such as contractors. If the plan determines that the employer qualifies for the exemption based on the information furnished by the employer, the plan should notify the employer of its decision. If the decision is to exempt the employer, the plan should: (1) request the employer to furnish a list of the names and health insurance numbers of the Medicare beneficiaries which it employs, (2) notify each plan enrollee to whom the exception would apply, informing them that since the individual is enrolled in a group health plan through a small employer, the plan has elected to make Medicare primary payer for them and the effective date; and (3) submit to the HCFA regional office, the names and health insurance numbers of those beneficiaries for whom Medicare is primary payer, the effective date of the change and a copy of the letter from the employer regarding the number of employees that the employer employs.

An election to exempt a small employer from the MSP provision for the working aged can only be effective prospectively.

It is the responsibility of the employer to notify the plan, and the plan's responsibility to notify the HCFA regional office, whenever the number of employees employed by the employer equals or exceeds twenty.

The plan should maintain sufficient records to document that the beneficiaries affected by the election are enrolled in the plan through employment with an employer that has fewer than 20 employees.

Question 5

Who is the proper primary payer in the following situations: Medicare or the employer health plan ("GHP")?

a. An insured/employee of an employer with 20 or more employees turns 65, continues to work, and develops End-Stage Renal Disease (ESRD) at age 66. Who is primary? Doesn't the 18-month coordination period come into play?

Answer:

Medicare is secondary payer for individuals age 65 or over who have current employment status. If a working aged individual for whom Medicare was secondary subsequently develops ESRD, Medicare would continue to be the secondary payer throughout the 18 month ESRD coordination period. The coordination period begins when the individual becomes eligible for or entitled to Medicare on the basis of ESRD, which is generally three months after he begins dialysis.

b. An insured/employee of an employer with 20 or more employees turns age 65 after developing ESRD. Who is primary? Does the 18-month coordination period come into play?

Answer:

If the individual who has ESRD has completed the 18-month coordination period and then turns age 65, Medicare is already legally primary and remains primary once the coordination period is over, regardless of the individual's age. Even though the individual is dually entitled on the basis of age and ESRD, once the coordination period is completed Medicare becomes and remains primary. This rule applies, even if the individual is currently employed and Medicare would otherwise be secondary under the working aged provisions. Once a plan has paid primary for an ESRD individual for 18 months, the plan is relieved of liability to pay primary (unless a new period of Medicare entitlement and a new coordination period begins). That is, where Medicare is legally the primary payer, it remains the primary payer. Conversely, if the individual is within the 18 month coordination period, the plan is legally primary and must continue to pay primary until the end of the coordination period.

c. Who is primary for the disabled dependent spouse of an employee of an employer with more than 20 but less than 100 employees when the disabled individual turns 65?

Answer:

The MSP provision for the working aged applies to plans of employers in which at least one employer of 20 or more employees participates. The MSP provision for the disabled applies to plans of employers in which at least one employer of 100 or more employees participates. If the individual has GHP coverage by virtue of current employment status when the individual reaches age 65, the GHP is primary; Medicare is secondary since the plan is your example has 20 or more employees. (The 100 or more employee requirement applies only to disabled individuals under age 65). Before the individual reached age 65, Medicare is primary; the GHP is secondary since the plan in your example had between 20 and 99 employees (fewer than 100 employees).

Question 6

What is the status of the HIAA/BCBSA litigation?

Answer:

On May 13, 1994, the United States Circuit Court of Appeals for the District of Columbia remanded this case to the United States District Court for the District of Columbia. The District of Columbia has not yet issued a final ruling.