DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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MAY 2 8 2002

Ms. Roberta Casper Watson
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101 East Kennedy Boulevard
Tampa, Florida 33601-1102

Dear Ms. Watson:

As indicated at the May 8, 2002 Joint Committee on Employee Benefits (JCEB) meeting, we are responding to the questions you submitted in writing the previous year. While we addressed the majority of these questions in our meetings, several remained outstanding. We are therefore providing our written responses to the issues which deal with Medicare as a secondary payer. The additional questions submitted for this year's discussion were answered adequately at the meeting. We have stated the questions we addressed for ease of reference.

1. MSP Rules under Geissal case.

a. When the COBRA qualifying event is termination of employment can we assume that Medicare will be primary where the employee and/or the dependents have elected COBRA?

Answer: For individuals who are entitled to Medicare on the basis of age or disability Medicare is the secondary payer due to the individual's "current employment status." COBRA benefits are provided where the individual would otherwise lose coverage under the employer's group health plan (GHP) because of certain "qualifying events." These include termination of employment (other than for gross misconduct) and reduction of hours of employment. Since COBRA coverage is provided pursuant to the COBRA statute, rather than "by virtue of current employment status" Medicare is the primary payer for the working aged and disabled who are enrolled in the GHP as a result of COBRA coverage.

However, in the case of individuals entitled to Medicare on the basis of ESRD, there is no requirement that the GHP coverage be by virtue of the individual's employment status. Medicare is secondary to any GHP coverage including COBRA coverage during the 30-month coordination period without regard to the individual's employment status.

b. We have had difficulty in getting HMOs to provide COBRA on a Medicare primary basis. Does CMS know of any reason why it would be impermissible under the laws regulating HMOs for them to provide COBRA coverage in a manner consistent with the MSP requirements?

Answer: We are not aware of any provision in the Medicare HMO/CMP regulations that would preclude a managed care organization from providing COBRA coverage. We do, however, expect group health plans that happen to be HMOs to properly coordinate benefits when Medicare is primary as well as when Medicare is secondary.

c. In a situation where Medicare is based on age or disability and the COBRA qualifying event is divorce, you ask if it is correct that Medicare is the primary payer.

Answer: You are correct, Medicare is the primary payer. As the response to question 1.a. indicates, COBRA benefits are provided because of certain "qualifying events." Qualifying events, in addition to termination of employment and reduction of hours of employment, include divorce. The loss of employer group health plan coverage because of divorce can entitle that individual to COBRA continuation coverage. While we agree that the covered employee on whom an ex-spouse's coverage is based is currently working and thus has "current employment status," for the Medicare secondary payer rules to apply, the group health plan coverage must be provided "by virtue of" current employment status. Since COBRA coverage is not in effect by virtue of current employment status (rather it is provided under the COBRA law because of divorce) Medicare is the primary payer when the beneficiary is an aged or disabled ex-spouse whose GHP coverage is a result of COBRA.

d. In the case of ESRD, is the 30-month coordination period only applied once to an individual and could the 30-month coordination period occur partially before and partially after the COBRA effective date?

Answer: As you know, Medicare is the secondary payer to group health plans for individuals entitled to Medicare based on ESRD for a 30-month coordination period. The 30-month coordination period is fixed in time--it begins with the first month of Medicare Part A eligibility or entitlement based on ESRD and ends 30 months later. If an individual has more than one period of Medicare enrollment based on kidney disease, there is a separate coordination period for each period of Medicare enrollment. For instance, if an individual receives a kidney transplant which is successful for at least 36 months, Medicare coverage based on ESRD ends. If after that 36 months, an individual again becomes enrolled in Medicare because they resume renal dialysis or receive another transplant, Medicare coverage will begin without a waiting period, and a new 30-month coordination period will begin.

As previously stated, the 30-month coordination period is fixed in time. At the point in time an individual becomes enrolled in COBRA continuation coverage, Medicare is secondary and the COBRA coverage primary. For example, --an individual becomes entitled to Medicare based on ESRD in January 2001. In June 2001, the individual obtains COBRA coverage. The 30-month coordination period begins January 2001

(before COBRA) and continues for 30 months. At the point the individual obtains COBRA (in this case, June 2001), the COBRA coverage would be responsible to pay as a primary payer for the remainder of the coordination period. Medicare then becomes the primary payer at the end of the 30-month coordination period.

2. MSP and Short Term Disability Benefits

Our understanding of this issue surrounding COBRA is that an employer can continue health plan coverage after a qualifying event and then start COBRA coverage in order to give an individual a longer period of health insurance coverage. This issue was discussed at the meeting and we suggested that additional information be supplied before a response could be developed. To date, we have not received any such additional information.

3. Cafeteria Plans

a. An employer with a cafeteria plan under Section 125 of the Internal Revenue Code allows employees to choose between health insurance and cash amounts equivalent to what the insurance would cost the employer under the employer GHP. The same choices would be offered to everybody regardless of age or Medicare status.

i. In the case of participants who are eligible for or entitled to Medicare, would the cash payments be viewed as an improper incentive for those individuals to select Medicare as their primary payer?

Answer: As long as any cash payment to an employee is made based on the employee's election as a benefit offered under the employer's cafeteria plan, i.e., one which meets the requirements of section 125 of the IRC, it would not be a violation of the Medicare law, which prohibits an employer from offering an individual entitled to Medicare any financial or other benefits as an incentive not to enroll in, or to terminate enrollment in, a GHP which would be, or is primary to Medicare.

ii. Suppose the cafeteria plan requires the participant to demonstrate other coverage before he or she could elect cash. Would the answer to i. be different?

Answer: If the plan treats all employees the same in that those without Medicare entitlement must also show that they have other health insurance coverage before they could elect a cash payment then such cafeteria plan would not be illegally taking Medicare into account in having such a requirement.

iii. What if the cafeteria plan's choice of non-taxable benefits is not covered by section 125?

Answer: The benefit must be covered under Section 125 as previously stated.

a. Cafeteria plans often allow employees to contribute amounts out of what would otherwise be their pay to a "health flexible spending account." These accounts are separate from the employer's main GHP and are designed to cover deductibles, copayments, and other medical expenses not fully covered by the main plan (glasses, psychotherapy, orthodontia, etc.). Since the employee can also keep the money in cash, there would usually be no reason to elect to make a contribution if the employee's money in the account will have to be applied to health expenses not paid by the main plan before those expenses can be submitted to Medicare.

Answer: As previously stated "if a beneficiary for whom Medicare would be secondary payer elects a benefit offered under the employer's cafeteria plan, i.e., one which meets the requirements of 125 of the IRC…" then the employer would not be in violation of the MSP provisions. Based on the additional input you and your colleagues provided in our meetings, we understand that these accounts are composed of the employee's own pretax salary or employee contributions and are not contributed to by the employer. The flexible spending account must be for certain specified services and amounts and, therefore, it depends what these services and amounts are in order to determine whether Medicare is the primary or the secondary payer. The flexible spending account is primary and Medicare is secondary if the account is to be used for Medicare-covered services such as hospital, physician or laboratory services. The flexible spending account is primary as the only payer if the account is to be used for noncovered services under Medicare, such as for prescription drugs, eyeglasses or orthodontia, etc. Medicare is primary to the flexible spending account amounts designated for Medicare deductibles and copayments for which the employee would otherwise pay out-of-pocket. (The basis for the Medicare deductible and copayment flexible spending plan rule (i.e., Medicare is primary) is analogous to a choice by the employee of a cash payment from a cafeteria plan, which would not be used to pay primary to Medicare.)

7. MSP Data Match Program Electronic Information Exchange Alternative. Last year you told us of a new program under which employers (and hopefully insurers) could avoid having to answer periodic data match questionnaires by entering into an electronic information exchange program. This new program was designed to get updates to CMS faster on things such as people who are no longer covered by the plan, and also to allow employers to determine quickly which individuals are covered by Medicare. Is this program proving successful?

Answer: Yes. We currently have voluntary data match agreements with AT&T, Lucent Technologies and GE, and are in negotiations with several more large companies including the Ford Motor Company and Wells Fargo & Co. We are also in negotiations with the Blue Cross and Blue Shield Association to extend and expand the terms of a negotiated Medicare Secondary Program settlement agreement so that it mirrors the current employer voluntary data match agreement process. Our Coordination of Benefits Contractor markets the employer voluntary data match agreement as an alternative to the IRS/SSA/HCFA Data Match.

The benefits of an employer voluntary data match agreement accrue to both CMS and the employer; interest in the employer and insurer community is building. Rather than waiting the two-plus years it takes to get employer coverage information via the IRS/SSA/HCFA Data Match, CMS benefits in that it receives employee and spousal coverage information on a current quarterly basis. CMS is able to update its internal records and immediately avoid making mistaken primary payments. In addition to these cost avoided savings, CMS saves in that it does not have to spend resources recovering as many mistaken payments that occur because of the lag time associated with gathering this coverage information via the IRS/SSA/HCFA Data Match.

Employers benefit from the voluntary agreements several ways. First, in exchange for the employee and spousal coverage information they furnish, CMS provides the employer with Medicare eligibility information on employees who are no longer working. These are situations where Medicare is usually the primary payer. Second, because the voluntary process is a regular, quarterly process, the employer can more efficiently budget for the expense of doing the match. Third, because the voluntary process is relatively automated, the voluntary process can be more efficient, over the long run compared to answering the annual IRS/SSA/HCFA data match questionnaires. Fourth, as with CMS, the employer's costs associated with dispute resolution related to resolving mistaken payments are reduced. Lastly, we believe it is in the best interests of our mutual customers to pay beneficiary claims correctly.

8. Medicare Secondary Payer

i. Is it true that CMS' policy is that a plan covering transplants must cover kidney transplants and that if there is a cap on transplant coverage, the kidney transplant can be no lower than the highest cap on any other type of transplant?

ii. If the cap is expressed as a dollar amount, may the plan set a cap at a lower dollar amount for a kidney transplant than for another more expensive transplant, as long as the dollar amounts set would each cover the same number of transplants (e.g., one)?

Answer: Regulations at 42 CFR 411.102(a)(ii) specify that a GHP of any size may not differentiate in the benefits it provides between individuals with ESRD and other individuals covered under the plan on the basis of the existence of ESRD and/or the need for dialysis or in any other manner. Similarly regulations at 42 CFR 411.162(b)(v) prohibit a GHP from failing to cover kidney transplants when it covers other organ transplants. It violates these provisions of regulations for a GHP to provide coverage of transplants other than renal transplants but not to provide coverage of renal transplants.

However, this is not to say that coverage of renal transplants cannot be limited, as long as limitations on particular services are uniform (see 411.162(c)). The following are examples of ways that a GHP could limit transplant coverage without violating the regulations:

--Cover the same fixed number of transplants of all covered types (i.e., cover one transplant of each covered type per lifetime);

--Cover the same fixed number of transplants of all covered types and also impose the same dollar limit on the coverage of each (e.g., cover one transplant of each covered type per lifetime, limited to no more than $100,000 each).

--Impose an overall lifetime cap on the amount of payment that would be made under the plan for all services (e.g., coverage could be limited to $1 million total payment per lifetime).

The employer GHP may not establish a transplant cap on kidney transplants that is lower than the cap for other covered transplants by assigning an arbitrary monetary value. The GHP could, however, set a monetary cap on kidney transplants that is lower than the cap for other covered transplants if it bases that monetary cap for kidney transplants upon a sound actuarial basis. To establish a monetary cap on kidney transplants, the GHP must provide its actuarial basis for establishing the monetary cap to CMS's Regional Office and explain how it arrived at its monetary cap value (i.e., demonstrate that the monetary cap for kidney transplants reflect reasonable and customary charges for kidney transplants in that geographical area).

11. Some of us have heard of HMOs that operate in the Choice Plus market offering special deals to employers to enroll their 65 and over population. Under the special deal, the employer would pay to the HMO what it would expect to pay under its other plans, and the employee would get increased benefits. This would clearly be permissible under MSP so long as CMS was told that the person was Medicare secondary, but we suspect that the HMO reports the person as Medicare primary and gets the full amount it would get from Medicare under the Choice Plus program as if

the person were a retiree. Is there any kind of experimental program going on that makes legal the integration of employer coverage and Medicare Choice Plus in such a fashion?

Answer: No, there are no "special rules" or "experimental programs" for M+C organizations for determining which entity is primary for certain items and services. An M+C organization is paid by CMS for furnishing directly, arranging for, and/or paying for health care services, which include all items and services (services) covered under Original Medicare (except Hospice services), for Medicare beneficiaries electing an M+C plan. Even though the services are covered under Original Medicare, CMS does not pay for services (to the extent a third party is required to pay) if Medicare is not the primary payer. (See Medicare 1862(b) and Part 411 of the regulations.)

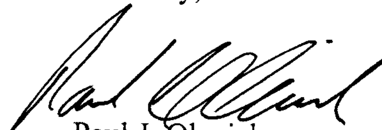
Except for the working aged category, payment rates used to pay M+C organizations have been adjusted to take into account those situations where Original Medicare would not have been the primary payer. Reporting to CMS by M+C organizations for these MSP situations is not necessary and the collection of any primary payer liability is up to the M+C organization.

For the working aged category, CMS established reduced payment rates for those Medicare beneficiaries for whom, under original Medicare, CMS would not have been the primary payer. M+C organizations report monthly which Medicare enrollees are considered working aged for proper payment. In addition, CMS uses other sources (e.g., provider reporting to CMS' intermediaries, data matches with IRS) to help identify which Medicare beneficiaries are considered working aged.

Beyond these rules, an M+C organization may negotiate with employer groups for other health benefits that supplement the benefit package approved by CMS. The coverage and payment for those services are a product of those negotiations and outside the purview of CMS.

I hope that this information adequately addresses the issues. If you have questions or need further assistance please contact Eve Fisher at 410-786-5641.

Sincerely,



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