

Ed Doherty,
Compliance Consultant,
Health and Welfare,
Cammack LaRhette
Consulting

Group health plans and Medicare: Demystifying the Medicare secondary payer rules

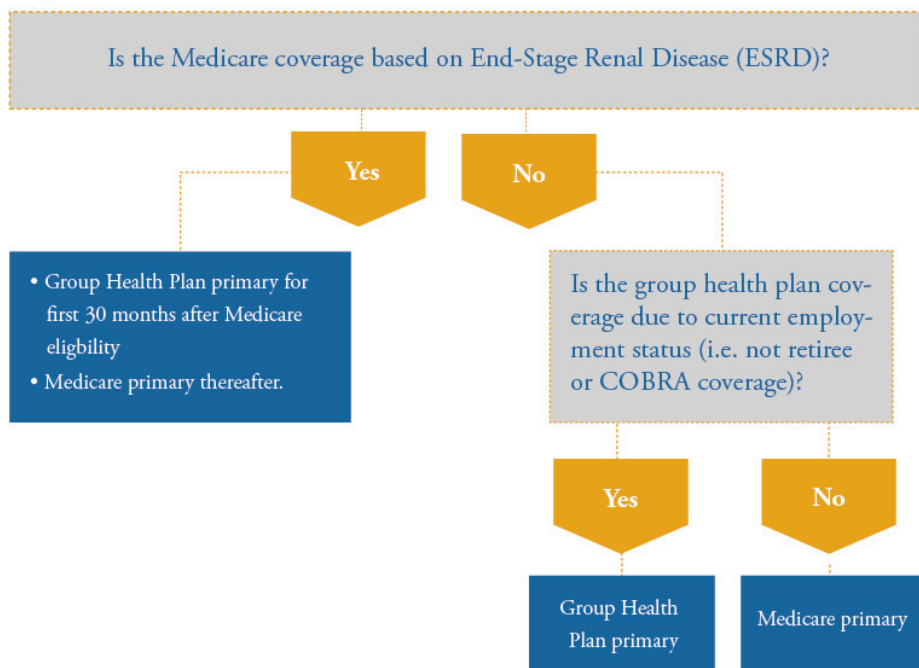
Despite being decades old, the Medicare Secondary Payer rules still cause consternation among group health plan administrators. When does Medicare pay for services, and when does a group health plan foot the bill? The answer depends on two key factors: the size of the group health plan, and why the individual is eligible for Medicare. This article seeks to lay out the Medicare Secondary Payer rules so that group health plan administrators clearly understand when their plans cover services.

Before beginning, it is important to understand the difference between Medicare eligibility and entitlement. A person is eligible for Medicare upon reaching a certain age or having certain health conditions. A person is entitled to Medicare when they are both eligible for Medicare and enrolled in Medicare.

Group health plans with 100+ employees

For group health plans with 100 or more employees, the following two-question chart explains whether Medicare or the group health plan is primarily liable for payment:

Figure 1



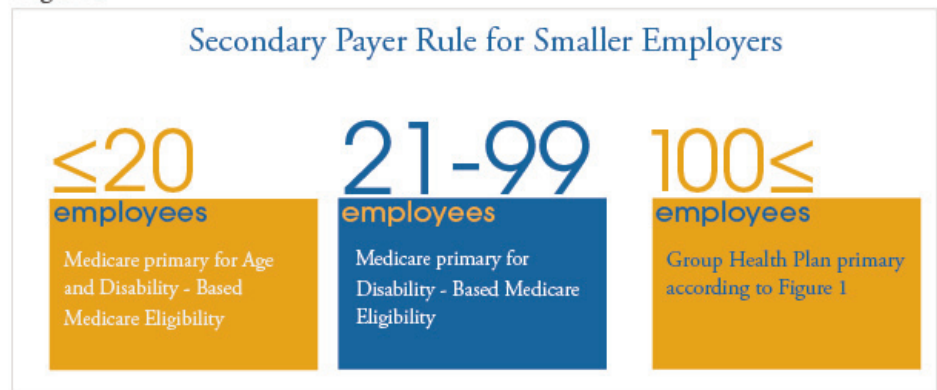
Group health coverage due to current employment status means that the employee is actively working or has a continuing business relationship with an individual, and that group health plan covers the employee and dependents due to that relationship.

Current employment status encompasses many types of paid or unpaid leave. These include FMLA leaves, USERRA leaves, unpaid leaves with an expectation of return, and when the employee is out on disability for the first six months of such leave. Participants do not have coverage due to current employment status when they are covered by retiree plans or through COBRA or severance coverage. Under the rules, spouses and dependents who are covered by group health plans are considered to have coverage due to the current employment status of the employed family member.

Group health plans with fewer than 100 employees

Whether Medicare pays first for smaller groups depends on the size of the group and on the reason for the participant's Medicare eligibility. The following chart explains how Medicare primary coverage depends on employer size:

Figure 2



Medicare Entitlement and Determining Group Health Plan Eligibility

Medicare secondary payer rules prohibit group health plans from “tak[ing] into account” that an individual is entitled to Medicare. This means group health plans cannot base eligibility or benefits on whether the participant is entitled to Medicare; they also cannot charge different premiums or contributions from participants entitled to Medicare.

These rules apply to group health plans that are usually exempted from ERISA's rules, such as church and governmental plans. Health Flexible Spending Accounts and Health Savings Accounts are not subject to Medicare Secondary Payer rules, but Health Reimbursement Arrangements must conform as a group health plan.

Understanding the Medicare Secondary Payer rules need not be a daunting task. Basically, most plans cannot discriminate in any way against a participant on the basis of the participant's Medicare entitlement. These rules were put in place so that plans would not take advantage Medicare by pushing all entitled people and their medical expenses onto the public system.

Cammack LaRhette provides full service consulting in healthcare, HR, employee benefits, retirement, actuarial and communications services. We build long-term relationships, offering high touch client service that has earned us a 98% retention rate.

For more information on our healthcare practice or any of our other services please contact Frank Lonardo, Practice Leader at 1-212-227-7770 or flonardo@clcinc.com.



Confidential Information

© 2011 All Rights Reserved.