



# Medicare Secondary Payer Overview

Version 1.0, 1/13/2014

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Welcome to the Medicare Secondary Payer (MSP) Overview course.

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## Course Overview

- Definition
- MSP vs. State law
- GHP MSP
- NGHP MSP
- Coordination of Benefits



The MSP Overview course begins with a definition of Medicare Secondary Payer. This course also explores the relationship of the provisions of Medicare Secondary Payer with State law. Next, it provides information on the two broad categories of MSP, Group Health Plan (GHP) and Non-Group Health Plan (NGHP), and for a final topic, addresses Coordination of Benefits.

## Medicare Secondary Payer

- A term used when Medicare is not responsible to pay first on healthcare claim
  - Comparable to private insurance industry using the term “coordination of benefits”

Medicare Secondary Payer (MSP) is a term used when Medicare is not responsible for paying first on a healthcare claim. The decision as to who is responsible for paying first on a claim and who pays second is known in the insurance industry as “coordination of benefits.”

## Medicare Supplement (i.e., Medigap)

- Private health insurance policy to fill “gaps” in Medicare’s coverage when Medicare is primary
- Typically pay for expenses that Medicare does not pay for, such as
  - Deductibles
  - Coinsurance
  - Other limits
- Private Medigap insurance and MSP law and regulations are not the same
- Medigap policy is not a Medicare program benefit

The term Medicare supplement (i.e., Medigap) should not be confused with Medicare Secondary Payer. Medicare supplemental is a private health insurance policy designed specifically to fill some of the “gaps” in Medicare’s coverage when Medicare is the primary payer. Medigap policies typically pay for expenses that Medicare does not pay for, such as deductible or coinsurance amounts or other limits under the Medicare program. Private “Medigap” insurance and Medicare secondary payer law and regulations are not the same. A “Medigap” policy is not a Medicare program benefit.

## GHP and NGHP

- Medicare Secondary Payer includes two broad Categories:
  - Group Health Plan (GHP)
  - Non-Group Health Plan (NGHP)

Medicare Secondary Payer provisions apply to two broad categories of insurance: Group Health Plan (GHP), and Non-Group Health Plan (NGHP).

## What is a Group Health Plan?

- Health coverage sponsored by an employer or employee organization (such as a union) for a group of employees, and possibly for dependents and retirees as well
- Includes:
  - Self-insured plans
  - Government plans (Federal, State and local)
  - Employee organization plans
  - Union plans
  - Employee health and welfare funds



A Group Health Plan is health coverage sponsored by an employer or employee organization (such as a union) for a group of employees, and possibly for dependents and retirees as well. The term GHP includes self-insured plans, plans of government entities (Federal, State, and local), and employee organization plans such as union plans, employee health and welfare funds, or other employee organization plans. The term also includes “employee-pay-all” plans which receive no financial contributions from the employer. The term does not include self-employed persons.

## Group Health Plans

**As the primary payer, they must provide the same coverage to Medicare beneficiaries as they do all other individuals**

**Medicare may pay secondary for Medicare-covered services up to Medicare approved amount**

**If GHP denies payment for services they don't cover, Medicare may pay for services covered by Medicare**

As the primary payer, the GHP must provide the same coverage to Medicare beneficiaries as they do to all other individuals. GHPs such as Blue Cross and Blue Shield plans are required to process and make primary payment on the claim in accordance with the coverage provisions of their contract. If the GHP does not pay in full for the services, Medicare may make a secondary payment for Medicare-covered services up to the Medicare approved amount. If a GHP denies payment for services because those services are not covered by the plan, Medicare may pay for those services if those services are covered by Medicare.

## Who does GHP MSP Affect?

- Working Aged
- Disabled individuals
- Individuals with ESRD



When certain conditions are met, Medicare is the secondary payer to Group Health Plans for services provided to the following groups of Medicare beneficiaries: the Working Aged, Disabled individuals, and individuals with End-Stage Renal Disease (ESRD). For more information on these MSP provisions, please view the following CBT's: Working Aged MSP, Disability MSP, and End Stage Renal Disease MSP.

## Non-Group Health Plan (NGHP) MSP

- Includes Liability insurance (including self-insurance), No-Fault insurance, and Workers' Compensation
- Liability insurance example
  - Medicare beneficiary injured in an auto accident
  - Beneficiary files a claim against the alleged responsible party and receives payment
  - Medicare is secondary to the Liability insurance payment

Non-Group Health Plan MSP encompasses three different types of insurance: Liability, No-Fault, and Workers' Compensation. By statute, Medicare is always a secondary payer to Liability insurance (including Self-insurance). An example of Liability insurance is where a Medicare beneficiary is injured in an auto accident. The beneficiary files a claim against the alleged responsible party and receives payment. Medicare is the secondary payer to the Liability insurance payment.

## Non-Group Health Plan (NGHP) MSP

- No-Fault insurance is always primary to Medicare
- Example of No-Fault insurance
  - Driver has an accident
  - Driver has \$5,000 medical payments coverage on policy
  - \$5,000 is considered No-Fault insurance and is primary to Medicare

No-Fault insurance is always primary to Medicare. An example of No-Fault insurance is where a driver has had an accident. The driver has \$5,000 of medical payments coverage on his/her automobile insurance policy. This \$5,000 of medical payments coverage is considered No-Fault insurance and is primary to Medicare.

## Non-Group Health Plan (NGHP) MSP

- Workers' Compensation is primary to Medicare
- Example of Workers' Compensation
  - Warehouse worker suffers a back injury while on the job
  - All related medical bills are the primary payment responsibility of the Workers' Compensation insurer

Note: Liability insurance (including Self-insurance), No-Fault insurance, and Workers' Compensation known as Non-Group Health Plan, or NGHP

Workers' Compensation insurance is primary to Medicare. For example, a warehouse worker who suffers a back injury while on the job would have all related medical bills paid for by the Workers' Compensation insurer.

Collectively, Liability insurance (including Self-insurance), No-Fault insurance, and Workers' Compensation are known as Non-Group Health Plan, or NGHP.

## State Law and Policy Provisions

Medicare, including MSP, is governed under Federal law

Most NGHP insurance policies are governed by State law

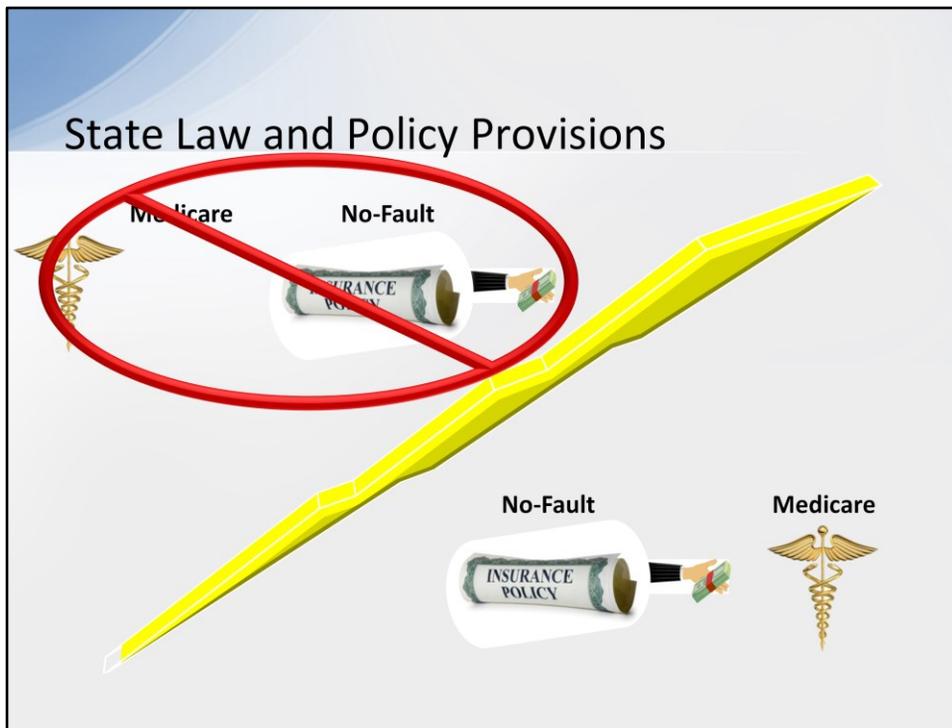
Most GHP insurance policies are governed by State law or ERISA

The Federal ERISA law requires GHP's to comply with MSP laws

Federal law takes precedence over State law or any conflicting policy provision

In the Introduction to Medicare CBT, you learned that Medicare is a health insurance system created under Federal law. MSP is also governed by Federal law. Most Non-Group Health Plan policies, i.e., Liability, No-Fault, and Workers Compensation are governed by State law. Most Group Health Plan policies are governed by State law or the Employee Retirement and Income Security Act, ERISA. The Federal ERISA law requires Group Health Plans to comply with Medicare Secondary Payer laws.

Should there be a conflict between Federal and State law, Federal law takes precedence. If an insurance policy or plan has a provision that conflicts with Federal law, Federal law must be followed.



For example, a No-Fault insurance policy has a provision that states its benefits are only payable after the claimant has exhausted all other health insurance benefits. In this case, it appears that Medicare should pay before the No-Fault policy. However, the MSP provisions that require the No-Fault policy to pay first are part of Federal law. Therefore, the MSP provisions take precedence over the No-Fault insurance policy provisions and Medicare does not pay before the No-Fault policy.

## MSP Review

Medicare is always secondary payer to NGHP

Medicare is secondary payer to GHP when certain conditions are met

When Medicare is not aware of other primary insurance, Medicare may mistakenly pay as primary

We just addressed the fact that Medicare is always the secondary payer of benefits to Non-Group Health Plan insurance, and when certain conditions are met, the secondary payer to Group Health Plan insurance. If Medicare is not aware of other primary insurance, Medicare may mistakenly pay as primary.

## Coordination of Benefits

- Health Plans and Drug Plan Sponsors have a responsibility to help ensure Medicare payments are made in the proper order by participating in Coordination of Benefits processes
- Purpose of Coordination of Benefits:
  - Identification of other insurance benefits
  - Coordination of the payment process

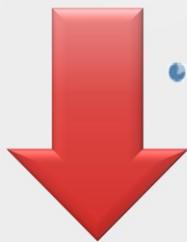
Responsible Reporting Entities (RREs) help ensure Medicare payments are made in the proper order by being knowledgeable of and participating in Coordination of Benefits processes.

The purpose of Coordination of Benefits is to identify the other insurance benefits available to a Medicare beneficiary, and to coordinate the payment process to prevent mistaken payment of Medicare benefits.

## Benefits Coordination & Recovery Center



- The BCRC
  - Consolidates activities that support the identification, collection, management and reporting of other primary insurance
  - Supplies information on supplemental drug coverage
  - Updates Medicare systems with other insurance information



- The BCRC does not
  - Process claims
  - Answer claim inquiries

The Benefits Coordination & Recovery Center (BCRC) consolidates the activities that support the identification, collection, management, and reporting of other primary insurance coverage for Medicare beneficiaries. They also collect and supply information on supplemental prescription drug coverage. The BCRC updates the Medicare systems with other insurance information.

The BCRC does not process claims or answer claim-specific inquiries.

## Data Collection Activities

- Initial Enrollment Questionnaire (IEQ)
- Secondary Claims Investigation
- IRS/SSA/CMS Data Match
- Data Sharing Agreements
- Self-Reports
- Mandatory Insurer Reporting (MMSEA Section 111)

The BCRC uses multiple data collection activities to detect and identify other insurance coverage such as the Initial Enrollment Questionnaire (IEQ), Secondary Claims Investigation, IRS/SSA/CMS Data Match, Data Sharing Agreements, Self-Reports, and Mandatory Insurer Reporting (MMSEA Section 111). The following slides will briefly address each activity.

## Data Collection Activities



### IEQ

- IEQ letter is typically sent to individuals 3 months before they become entitled to Medicare
- Provides details on how to complete the IEQ online
- Used to determine if other primary insurance exists
- New MSP Occurrences are discovered and added to Medicare's records

An Initial Enrollment Questionnaire (IEQ) letter is typically sent to individuals approximately ~~two to~~ three months before they become entitled to Medicare. This letter provides details about how to complete the IEQ online at MyMedicare.gov. The IEQ itself includes a series of questions that solicit information about other insurance the person may have that is primary to Medicare. The BCRC uses the answers on the IEQ to help set up the beneficiary's file and to add any new MSP Occurrences to Medicare's records.

## Data Collection Activities

### Secondary Claim Investigation

- Provider of service bills and is paid by an insurer other than Medicare
- Provider submits claim to Medicare for consideration of any balance
- The BCRC will investigate the other insurance to confirm it is primary to Medicare

Providers of service may identify a payer they believe to be primary to Medicare. When this occurs, the provider will bill the other insurance. After the other insurance processes the claim, the provider submits the claim to Medicare for consideration of any balance. The BCRC is alerted to the existence of the other insurance and will investigate to confirm that it truly is primary to Medicare.

## Data Collection Activities



IRS/SSA/CMS

Data Match

- Electronic data match using IRS/SSA/CMS records
- Data match identifies beneficiaries and/or spouses who have had earning in a given tax year
- Earning signify employment so a questionnaire is sent to the employer
- Questionnaire inquires about other coverage primary to Medicare

An electronic data match is performed between the Internal Revenue Service (IRS), the Social Security Administration (SSA), and CMS. This data match identifies persons that have had earnings in a given tax year. If a Medicare beneficiary and/or the spouse of a beneficiary has had earnings, that signifies employment, which means it is possible they also had Group Health Plan insurance coverage. A questionnaire is then sent to the employer inquiring about possible coverage that is primary to Medicare. If coverage exists or existed, dates of coverage are obtained, as well as the name and address of the insurer. Records obtained through this process are generally very reliable.

## Data Collection Activities



### DSA

- Regular electronic additions, updates, and deletes transmitted by data sharing partners
- Records are either posted or rejected back to submitter

Some employers have entered into Data Sharing Agreements (DSAs) with CMS to provide information on employees that have insurance primary to Medicare. Employers transmit electronic files to the BCRC on a regular basis that contain MSP Occurrence adds, updates, and deletes. MSP Occurrences on the files are either posted to Medicare's records or rejected back to the submitter.

## Data Collection Activities



### Self Reports

#### New MSP situations are reported by:

- Employers
- Insurers
- Attorneys
- Beneficiaries

#### New MSP situations are received through:

- Telephone calls
- Written correspondence

Employers, insurers, attorneys, and beneficiaries will self-report Group Health Plan and Non-Group Health Plan occurrences through telephone calls or written correspondence to the BCRC. If an MSP Occurrence is self-reported by telephone, the BCRC representatives will review existing records and make any needed adds or changes based upon information received during the call. If written correspondence is received, but the information is incomplete or inconsistent with existing records, development letters are sent. Development letters are sent when there is a need to gather additional information about the matter being addressed.

## Data Collection Activities

- Mandatory Insurer Reporting
  - RREs required to report coverage status on certain persons they insure
  - RREs may not participate in the voluntary data sharing agreement program (VDSA)
  - Incoming files subjected to threshold errors
  - Records are either posted or rejected
    - Submitter required to correct and resubmit rejected records

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Mandatory Insurer Reporting) requires RREs, often the insurer, to report information about certain persons they insure to the BCRC. This has replaced the insurer voluntary data sharing agreement (VDSA) program for any entity who is an RRE for Section 111. RREs are no longer permitted to participate in the VDSA program. The BCRC will check to see if any of these persons also have Medicare coverage. If Medicare coverage exists, the employer insurance will be primary to Medicare and an MSP Occurrence will be created. Section 111 also requires RREs to report Medicare beneficiaries who may receive a settlement, judgment, award, or other payment from Liability insurance (including Self-insurance), No-Fault insurance, or Workers' Compensation.

Incoming Mandatory Insurer Reporting records are subjected to data quality edits and threshold testing to ensure the integrity of the files. Records are either posted to Medicare's files or rejected back to the submitter. If the record is rejected, the submitter is expected to research the record and submit a correction.

CMS believes this process will result in the most complete and accurate MSP information available.

## Benefits Coordination & Recovery Center

Management of other insurance information is an ongoing process

When circumstances change, updates must be made to the existing insurance occurrences

Changes must be updated on Medicare's systems and reported to Health Plans/Drug Plan Sponsors

The BCRC ensures appropriate updates are made

Management of other insurance information is an ongoing process. Other insurance information for Medicare beneficiaries constantly changes. For example, Working Aged Medicare beneficiaries or their spouses retire, pending Liability cases get resolved, No-Fault insurance benefits become exhausted, and supplemental prescription drug coverage is dropped. All of these circumstances require updates to existing other insurance occurrences. All of the changes that occur must be updated on Medicare's systems. The BCRC ensures appropriate updates are made to Medicare's systems of records.

## Key Concepts

- MSP means an insurer other than Medicare has primary payment responsibility
- Working Aged, Disability, and ESRD are types of GHP MSP
- Liability insurance, No-Fault insurance, and Workers' Compensation are types of NGHP MSP
- Coordination of benefits identifies other insurance and coordinates the payment process

The key concepts of this course are: Medicare Secondary Payer means that an insurer other than Medicare has primary payment responsibility; Working Aged, Disability, and ESRD are all types of Group Health Plan MSP; Liability insurance (including self-insurance), No-Fault insurance, and Workers' Compensation are all types of Non-Group Health Plan MSP; and the purpose of coordination of benefits is to identify other insurance and coordinate the payment process.



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