Executive Signal

Willis

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Medicare Secondary Payer Rules – Tighter Enforcement?

Earlier this year the White House web site featured an article outlining President Bush's proposed budget for 2008. The article noted that in the last several years, initiatives to enhance Medicare program "integrity" have yielded sizeable savings through recovery of overpayments and collection of criminal fines and penalties. The president is proposing an additional $183 million be devoted to the Health Care Fraud and Abuse Control Program (HCFAC) to further enhance Medicare program integrity activities[1]. We anticipate that this will engender, among other things, further scrutiny and tighter enforcement of Medicare Secondary Payer rules. Intensified enforcement activities could mean significant financial liability for employers sponsoring group health plans.

Background

When first established, Medicare was the primary insurer of all employees entitled to Medicare. As Medicare expenses rose, the federal government began to look for ways to shift the cost burden to the private sector.

Congress enacted the first set of Medicare Secondary Payer (MSP) provisions in the early 1980s. The rules were designed to shift the responsibility for paying primary healthcare benefits for individuals with employer-sponsored coverage from Medicare to private employer health plans. In general, group health plans may not take into account that an employee (or a member of the employee's family) is eligible for or entitled to Medicare due to reaching age 65 (when the employer has 20 or more employees), disability (when the employer has at least 100 employees), or end-stage renal disease (for 30 months for all sized employer plans subject to MSP).

Keep in mind that these rules apply to active employees, not retirees, except that all group health plans (active, retiree, and COBRA plans) are primary for end-stage-renal disease for 30 months unless the end-stage renal disease occurred after the individual was enrolled in Medicare due to age or disability. The prohibition against taking Medicare entitlement into account means, not only that the plan has primary payment responsibility, but also that, among other requirements, an employer may not offer any coverage secondary to Medicare (such as a Medigap plan) to individuals for whom the employer's plan has primary payment responsibility. Although Medicare-eligible individuals are free to elect whether they want to postpone Medicare enrollment until group coverage is lost, give up group

coverage in favor of Medicare, or take both forms of coverage, employers subject to MSP are strictly prohibited from using any overt or covert enticements to push a Medicare-eligible individual to forego their group health plan coverage.

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Overpayments occur when Medicare pays a claim as the primary payer in situations where another entity, such as a group health plan, has that responsibility. The Medicare Secondary Payer laws were refined numerous times over the years to permit the government to recover its overpayments from the person, employer plan, provider, any third party, or "any entity that would be responsible for payment with respect to such item or service." When an overpayment by Medicare is on behalf of a plan for which the insurer acts solely as administrator, the government looks to the employer (rather than to the insurer) for reimbursement.

The DOL published an advisory opinion providing guidance about how ERISA plan fiduciaries should respond to claims submitted to their plans for recovery of any Medicare overpayments. The DOL took the position that group health plan fiduciaries are responsible for administering their plans to ensure compliance with ERISA and other applicable federal laws, because other federal laws are not preempted by ERISA [DOL Adv. Op. 93-23A (Sept. 3, 1993)]. The advisory opinion is binding only on the party that requested it, but it nonetheless provides guidance regarding the DOL's enforcement posture on Medicare secondary-payment issues.

Applicable Penalties

What penalties stemming from violations of the Medicare Secondary Payer (MSP) rules might an employer encounter? What should an employer do if it discovers problems on its own? A number of different penalties apply to MSP violations, with the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) being the primary agency charged with enforcement. CMS has a reputation for taking draconian action (e.g., using private debt collectors to pursue employer plans even when they are not at fault). Group health plan sponsors who contest the assessment of violations must exhaust the CMS review and appeals procedure prior to court review of the agency's decisions.

Who Is Responsible?

The law makes all entities "responsible for payment under a group health plan" jointly and severally responsible for resolving these debts. These entities include the employer sponsoring or contributing to the plan, other plan sponsors (e.g., a union or other employee organization), the insurer or third-party administrator (known as TPAs, who administer plans for employers that self-insure) and the plan itself.

Tax Penalties

The Internal Revenue Code imposes a stiff penalty on any employer whose plan violates the MSP rules. Such a plan is deemed a "nonconforming group health plan" and is subject to an excise tax equal to 25 percent of the total expenses incurred during the year for all health plans to which that employer contributes.

For example, if the employer maintains three separate group health plans, and only one of them violates the MSP rules, the employer's costs for all three plans are counted in measuring the tax. Moreover, there is a special $5,000 penalty per participant for offering improper financial incentives or other benefits to encourage rejection of coverage under the group health plan. Using improper incentives is a very common compliance issue for employers. Employers considering the use of such incentives to maneuver participants to Medicare should be aware that the

government carefully monitors this area for potential violations. (CMS has provided unofficial guidance to the effect that providing a waiver bonus to individuals who voluntarily waive the employer's group health plan in favor of Medicare is not an improper financial incentive as long as the waiver bonus is also given to other non-Medicare individuals waiving coverage under the plan. Despite this stance, CMS will closely scrutinize "waiver" arrangements to determine whether a MSP problem might exist.)

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Double Damages

Those who are adversely affected by an MSP violation can bring a lawsuit and recover double damages from the employer. CMS itself can also sue for twice the amount paid plus interest on the amount recovered.

Tax Refund Offset Program

The IRS and CMS have been developing procedures to collect MSP overpayments once they are identified. One such procedure would involve use of the IRS Tax Refund Offset Program (TROP). This program works by offsetting debts owed to the government against tax refunds owed to the taxpaying business. In the case of MSP overpayments, this program would affect tax refunds owed to insurance companies, employers and TPAs. Although the IRS official we contacted refused to discuss the use of TROP to collect MSP amounts owed to CMS, the representative emphasized that CMS has the right to ask the IRS to collect such amounts on behalf of CMS.

If an Employer Determines There Was an MSP Violation...

A group health plan must notify Medicare (through the Medicare intermediary or carrier that paid the claim) when it "learns" that Medicare paid primary on a claim that should have been paid primary by the group health plan. Under guidelines issued by CMS, a plan is considered to have learned of incorrect payment when it receives actual knowledge of the disbursement or information which would lead it to conclude that Medicare incorrectly paid primary.

Examples of circumstances triggering the notice requirement include:

- The plan administrator has a copy of an Explanation of Medicare Benefits form, and the form shows Medicare as having made primary payment for an item or service that the plan has (or should have) covered.
- A Medicare-eligible beneficiary files a claim for primary payment with the group health plan, the plan denies the claim, the claim is appealed, and the denial is reversed. Under these circumstances, the plan should assume that Medicare has by then made a conditional primary payment and take the appropriate steps to notify CMS.

Statute of Limitations?

Employers can potentially be on the hook for many years after the alleged overpayment is made. The federal government may undertake legal action to collect an MSP debt up to six years from the date of the original demand letter. (Generally, the original demand letter must be filed within three years of the date of service unless the employer, insurer, or TPA had knowledge, within the plan's timely filing period, of the claim.) In addition, these debts may be collected by offset of federal government payments to the debtor for 10 years from the date of the original demand letter without undertaking legal action. Therefore, although there is a general rule-of-thumb that ERISA plan documents should be maintained for up to seven years, the extended period of time the CMS has to make a claim may mean that, depending on circumstances, some employers may choose to retain their plan's documentation for up to twice as long.

Conclusion

Employers have numerous responsibilities for complying with MSP requirements. These rules can become extremely complicated – particularly for employers that may be approaching a participant number threshold that shifts the payer obligation to or from Medicare. If, as expected, CMS intensifies enforcement, employers may be more likely to encounter allegations of MSP violations and potentially find themselves defending their actions to avoid the stiff penalties. Upfront planning and diligence with appropriate documentation is the best way to avoid issues down the line. We invite you to contact your Willis representative for assistance with MSP concerns.

1 Congress established HCFAC to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse. HCFAC operates under the joint direction of the attorney general and the Secretary of the Department of Health and Human Services.

Key Contacts

US Benefits Office Locations

Atlanta, GA
404 224 5000

Austin, TX
800 861 9851

Baltimore, MD
410 527 1200

Birmingham, AL
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Boston, MA
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919 459 3000

Charlotte, NC
704 376 9161

Chicago, IL
312 621 4700

Cincinnati, OH
513 762 7855

Cleveland, OH
216 861 9100

Columbus, OH
614 766 8900

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