Medicare and Coordination of Health Insurance Benefits

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I have often written about the Medicaid program, which pays for the cost of long term care in a nursing home for those individuals who qualify. The other program that is often referenced along with Medicaid (and often referenced incorrectly as the two programs are often confused in many ways) is Medicare. The confusion may be due to the fact that Medicare will pay for a short stay in a nursing home and Medicaid will pay for a long term care in a nursing home for many years.

Like Medicaid, Medicare is also a type of government insurance, specifically health insurance. When you have multiple health insurance plans, the question becomes which plan will pay for my services? Which one will pay first? How does this work?

The following paragraphs explain what you should know about the Medicare program as it relates to the Coordination of health insurance benefits. The remainder of this article was taken from a writing by the National Academy of Elder Law Attorneys, Inc. (NAELA), which I believe you will find most informative.

"What Is Coordination of Benefits?"

When a person is covered by more than one health insurance carrier it is important to know which insurance is responsible to pay for what service(s) and in what order of priority. Failing to understand how health insurance benefits coordinate or failure to make sure that all possible sources of payment have been properly billed, may result in the beneficiary becoming responsible for greater out-of-pocket financial liability.

Since 1965, Medicare has been the primary payer for the medical services of individuals age 65 or older and disabled individuals (unless covered by worker's compensation).

However, during the 1980s, Congress enacted several provisions that required Medicare to be the secondary payer (commonly referred to as Medicare Secondary Payer or MSP) of medical services to that of other primary plans.

The term primary payer refers to any entity required or responsible to make a payment for an item or service before another entity makes a payment. With respect to services provided to a Medicare beneficiary, the phrase secondary payer indicates that Medicare will pay after another entity (or payer) has made payment.

There are various instances in which Medicare will serve as primary or secondary payer for medical services provided to its beneficiaries.

Instances in Which Medicare Will Serve as Primary Payer

Medicare will serve as primary payer for retirees and dependents of retirees who are eligible for Medicare based on age or disability. Medicare also will be primary for such beneficiaries and their dependents who are covered by an employer-sponsored group health plan (EGHP) but who are not considered "currently employed."

Medicare pays first for these individuals regardless of the size of their former employer. Medicare will also serve as primary payer for Medicare beneficiaries covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and for beneficiaries covered under TRICARE (military health service plan). (The rules are different for people eligible for Medicare based on End Stage Renal Disease).

Medicare Secondary Payer (MSP) and Employer Group Health Plans (EGHP)

Medicare will act as a secondary payer for medical services of persons aged 65 and older who are covered under an EGHP sponsored by an employer with at least 20 employees and who are insured by virtue of their current employment status or the current employment status of a spouse of any age. Employers with 20 or more employees must provide the same benefits, under the same conditions, to any employee or spouse age 65 or older as it would to any employee or spouse under the age of 65.

As primary payer, the employer plan is responsible for and required to make a primary payment on the claim pursuant to the terms of its contract. If the primary payment does not fully cover the medical costs associated with the claim, a Medicare secondary payment may be applied to cover the medical costs.

Medicare Secondary Payer (MSP) and Large Group Health Plans (LGHP)

Medicare benefits are to be paid secondary to Large Group Health Plans (LGHP) when an individual is under age 65 but is entitled to Medicare due to disability (has received 24 months of Social Security disability benefits). LGHP coverage must be based upon the individual's current employment status or the current employment status of a family member. LGHPs are sponsored by employers with 100 or more employees. In contrast, if the disabled Medicare beneficiary is covered by an employer plan with under 100 employees, then Medicare will act as primary payer.

What Medicare Will Pay as Secondary Payer

In determining how much Medicare will pay when it is secondary to an EGHP and the provider's charge is not fully paid by the primary plan, the following rules are to be applied. The amount that Medicare will pay is the lowest of the following amounts, calculated without reduction by the usual coinsurance or deductibles:

1. The Medicare payment amount if there were no EGHP;

2. For payments calculated by Medicare on a cost-related basis (mostly Part A), the Medicare payment amount minus the EGHP payment;

3. For payments calculated by Medicare on a basis other than cost (most reasonable charge basis payments under Part B), the higher of the EGHP allowed amount or the Medicare allowed amount, minus the payment actually paid by the EGHP.

If Medicare is secondary to an EGHP that requires enrollees to use network providers, Medicare generally will not pay for the non-covered, out-of network care. Medicare may pay if the person can demonstrate that she/he did not know that Medicare would not pay for such care.

Responsibilities of Beneficiaries Under MSP

CMS advises beneficiaries who have other health insurance plans to take certain steps to ensure that the Medicare Secondary Payer rules are applied accurately.

Beneficiaries should:

• Respond to Initial Enrollment Questionnaire (IEQ) and MSP claims development letters in a timely manner to ensure correct payment of their Medicare claims.

• Be aware that changes in employment, including retirement and changes in health insurance companies may affect their claims payment.

• Tell their doctor, other providers, and the Coordination of Benefits (COB) Contractor about any changes in their health insurance due to current employment or coverage changes once they have received health care services."

National Academy of Elder Law Attorneys, Inc.: *Coordination of Heath Insurance Benefits with Traditional Medicare* (2008)(NAELA).The information provided in this article does not constitute legal advice.