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COBRA and MSP Intersect

By Constance L. Gilchrest

With today's economic hardships, everyone is keeping a closer eye on how their money is being spent, including our government. First, President Obama stressed in a September speech that his administration intends to address rampant waste and fraud in Medicare. Then, in early October, the FBI noted a disturbing trend among members of the Mafia, changing their criminal pursuits from traditional drug trafficking to more lucrative Medicare fraud.

Some estimates have the Medicare system going bankrupt within the next decade, and one focal point of health care reform is how to fix Medicare.

With the heightened sensitivity about Medicare costs, it is little wonder that the Centers for Medicare and Medicaid Services (CMS) is increasingly concerned with issues related to the Medicare Secondary Payer (MSP) rules. These rules can be tricky, even when it comes to COBRA.

The coordination of benefits (COB) contractor consolidates the activities that support the collection, management and reporting of other insurance coverage for Medicare beneficiaries. The purpose of the COB program is to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent erroneous payment of Medicare benefits. The COB contractor does not process claims, nor does it handle any payment recoveries or claim specific inquiries. The Medicare intermediaries and insurers are responsible for processing claims submitted for primary or secondary payment.

COB, Generally

Generally, the concept behind COB is to avoid someone on multiple plans attempting to submit claims to all of their insurers and then keep the additional cash. If health benefits are coordinated, the insurance companies share the burden without overpaying. The individual remains fully covered, however not excess covered.

Children can also be covered under COB, with the "birthday rule" generally being used to determine which insurance plan is primary. Under the birthday rule, the parent with the earlier birthday in the year would be the primary provider for the children. (See ¶1243 of the *Guide* for a general discussion of COB and COBRA issues.)

COBRA and Medicare Coordination

The COBRA law is confusing. Medicare is confusing. When the two are mixed together, aggravation and numerous questions are the result. Is COBRA or Medicare the primary payer?

With the Supreme Court ruling on June 8, 1998, in *Geissal v. Moore Medical*, the issue of primary payer came to the forefront. The Supreme Court's decision requires an employer to offer COBRA to an individual, even if that person was already covered under another group health plan or entitled to Medicare prior to their COBRA election.

According to CMS, if an individual is on COBRA and entitled to Medicare, Medicare is typically the primary payer and the group health plan is typically secondary.

CMS indicated that the MSP rules have "actively at work" clauses attached to them. This means if an employee is actively working, covered on the group health plan and entitled to Medicare, the group health plan is primary. When an individual terminates employment, which breaks their actively at work status, and elects COBRA, Medicare would become the primary payer and the group health plan would be secondary payer.

But what about a COBRA qualifying event where the qualified beneficiary is still actively at work? This might occur if the qualifying event was a reduction of hours. The MSP rules state the Medicare would still be primary to COBRA. While this may seem counter-intuitive based on the "actively at

See *COBRA and MSP*, p. 11

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COBRA and MSP (continued from p. 10)

work” concept that pervades the MSP rules, in this case the statutory reference puts COBRA in second place regardless of employment status.

Employers (plan sponsors) should be aware of the MSP rules and how COBRA interacts with Medicare once an employee terminates active employment.

The following information will give you a better idea of how all this works.

Overview of MSP Rules

The MSP rules apply to group plans for employers with 20 or more employees (including part-time) for 20 or more weeks in the preceding calendar year. Specifically:

- *Employers with 20 more employees:* The group health plan is the primary payer of benefits for active employees and their covered spouses (of any age). Medicare is the secondary payer.
- *Employers with less than 20 employees:* Medicare is the primary payer; therefore all medical claims should be filed to Medicare first and any

outstanding expenses would be filed with the group health plan.

Exceptions to the rule are as follows:

- If an individual is entitled to Medicare due to end-stage renal disease (ESRD) and is on COBRA, the group health plan is the primary payer throughout the first 30 months and Medicare is the secondary payer. The 30-month period starts from the Medicare entitlement date.
- Alternative rules apply if a covered employee is under age 65 and deemed disabled by the Social Security Administration. For groups with 100 or more employees, the group health plan is the primary payer for as long as the employee is actively working. In such cases, COBRA is always the secondary payer, and Medicare is primary.

These complex issues may become easier to understand after reviewing the chart.

Of course, if Medicare entitlement occurs after COBRA begins, that is a terminating event for COBRA coverage.

See *COBRA and MSP*, p. 13

Summary of Medicare Secondary Payer Rules (Including Medicare Part D)

Circumstances	Additional Conditions	Primary Payer	Secondary Payer
1. Age-based Medicare 2. Employer-sponsored group health plan	20+ employees	Group health plan	Medicare
	1-19 employees	Medicare	Group health plan
1. Age-based Medicare 2. Retiree/COBRA coverage	None	Medicare	Group health plan
1. Disability-based Medicare 2. Employer-sponsored group health plan	100+ employees	Group health plan	Medicare
	1-99 employees	Medicare	Group health plan
1. Disability-based Medicare 2. Retiree/COBRA coverage	None	Medicare	Group health plan
1. ESRD-based Medicare 2. Employer-sponsored group health plan OR Retiree/COBRA coverage	First 30 months of Medicare eligibility or entitlement	Group health plan	Medicare
	Beyond 30 months of Medicare eligibility or entitlement	Medicare	Group health plan

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Extension Proposals (continued from p. 12)

- 3) but for reaching the maximum COBRA period, would have continued their coverage beyond that date.

This special election period would operate just like the ARRA special election period — affected individuals would be provided with a new 60-day election period subject to receiving new modified COBRA notices telling them about that opportunity.

The Senate Proposal — S. 2730

Like the House proposal, the Senate version of an ARRA extension (introduced Nov. 5, 2009, by Sens. Sherrod Brown, D-Ohio, and Robert Casey, D-Pa.) would extend the ARRA subsidy period from the current nine months to a total of up to 15 months. There would also be an outside date of Dec. 31, 2010, for the subsidy.

Significantly, the Senate proposal would increase the amount of the subsidy from 65 percent to 75 percent. Therefore, AEIs would only have to pay 25 percent of the applicable premium to continue coverage. This part of the Senate proposal would only apply to periods of coverage after the enactment date — plans would not have to recalculate premiums for individuals who previously benefited from the 65-percent tax subsidy.

Expanded Pool With More Restricted Period

The Senate version would also extend the substantive COBRA period for a termination or reduction in hours of employment, but only for up to an additional three months, not six months. Again, individuals would be able to elect that additional three-month period if they reached the original 18-month COBRA period and would have, but for reaching that maximum period, elected to continue their coverage.

Other Differences From House Bill

Interestingly, the Senate proposal adds a few nuances to the ARRA rules that were not included in the House version at all:

- 1) Under the general ARRA rules, if an AEI becomes eligible for other group health plan coverage, that other coverage will generally terminate the AEI's entitlement to a subsidy. Under current law, other group health plan coverage could include retiree health coverage. The Senate proposal would add an exception whereby retiree health coverage could not terminate the availability of the subsidy amount.

- 2) The Senate proposal would extend the availability of a COBRA premium subsidy to employees whose hours of employment are involuntarily reduced, resulting in a loss of group health plan coverage. This provision could become quite difficult to administer if the current Senate proposed effective date remains in place. The proposal is that this rule would apply as if included in ARRA as originally enacted. If that is the case, then the question arises on whether plans would need to go back to all individuals whose hours were reduced involuntarily (but whose job was not involuntarily terminated) and determine whether they are eligible for a COBRA premium subsidy. This could be quite difficult at this late date.

**If these proposals become law,
administrators will have to revise and
update COBRA notices and letters.**

Keep an Eye on Developments

These proposals should be watched carefully as Congress moves forward on health care reform. They could easily be included as part of this broader legislative effort and become law more quickly than most would expect. One thing is for sure, though. If either of these proposals (or a variant of them) becomes law, administrators will have to go through a new round of revised and updated COBRA notices and letters. 🏠

COBRA and MSP (continued from p. 11)

As a result, Medicare will be primary in all cases, including those involving ESRD.

Making COB Easier

MSP reporting rules went into effect this year for group health plans to report Medicare-eligible participants. (They go into effect in 2010 for health reimbursement arrangements.) The purpose is simple: to make COB easier and more complete.

COB is intended to give insured individuals as much coverage as possible while at the same time eliminating overinsurance. It allows individuals to receive the medical care they need without allowing overpayment of claims, thereby keeping insurance costs reasonably low. With all the issues and ideas being discussed for health care reform, COB is one way for the government to keep Medicare costs to a minimum. 🏠

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