CMS Manual System

Pub. 100-05 Medicare Secondary Payer

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 16 **Date: MAY 21, 2004**

CHANGE REQUEST 3216

I. SUMMARY OF CHANGES: The contractors shall update the employer/insurer recovery demand letters for data match and non-data match debts to reflect the MMA section 301 clarifying language.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2004
***IMPLEMENTATION DATE: July 6, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to the red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new/revised information, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	7/10.5/Employer Letter
R	7/10.5.1/Important Information for Employers
R	7/10.6/Insurer Letter

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-05	Transmittal: 16	Date: May 21, 2004	Change Request 3216

SUBJECT: Update Medicare Secondary Payer (MSP) Group Health Plan Recovery Demand Letters to Employers and Insurers for Data Match and Non-Data Match Debts

I. GENERAL INFORMATION

A. Background: Medicare Modernization Act amended MSP provisions regarding Secretary's recovery rights. Section 301 of the MMA clarifies that: (1) conditional Medicare payments made because no-fault or liability insurance or workers' compensation does not pay promptly are subject to reimbursement; (2) entities that engage in a business, trade or profession are deemed to either have purchased liability insurance or be self-insured; (3) a primary payer's obligation to repay Medicare is established when it is demonstrated that the primary plan has or had at the time the services were provided an obligation to make primary payment ; and (4) employers that purchase group health plan coverage from an insurer are responsible for resolving debts to Medicare arising when that group health plan did not make required primary payments. These clarifications resolve several legal challenges to the manner in which CMS administers the Medicare Secondary Payer provisions.

B. Policy: CMS/contractor demand letters must reflect law.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3216.1	Contractor shall update employer recovery demand letter language to reflect MMA Section 301 clarifying language.	Part A, B and DMERC, SSMs, Intermediaries, Carriers & DMERCs
3216.2	Contractor shall update insurer recovery demand letter language to reflect MMA Section 301 clarifying language.	Part A, B and DMERC, SSMs, Intermediaries, Carriers & DMERCs
3216.3	Contractor shall incorporate revised MMA statute language into identified letters.	Part A, B and DMERC, SSMs, Intermediaries, Carriers & DMERCs

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1 2004 **Implementation Date:** July 6, 2004 **Pre-Implementation Contact(s):** Karen Ochab at Kochab@cms.hhs.gov or William Zavoina at Wzavoina@cms.hhs.gov **Post-Implementation Contact(s):** Your regional office MSP coordinator.	**These instructions shall be implemented within your current operating budget.**

10.5 - Employer Letter

(Rev. 16, 05-21-04)

B3-3329.13, A3-3491.17

Dear Employer:

We are writing to advise you that your organization either has sole liability or shares liability for a debt to the Medicare program. The following explains how this happened and what you must do to resolve this matter.

How This Happened

This repayment claim arises because Medicare mistakenly made primary payments for services furnished to the Medicare beneficiaries identified below that should have been the primary payment responsibility of a group health plan that you sponsor or to which you contribute. The Medicare Secondary Payer (MSP) provisions of the Social Security Act require group health plans to make primary payment for services provided to Medicare beneficiaries if those individuals are also covered by the group health plan and certain conditions delineated in the Medicare law (42 U.S.C. 1395y(b)) and regulations (42 CFR 411.20*ff*) are satisfied. Medicare did not know that these conditions were satisfied at the time that Medicare made primary payment for certain services. The information now available to Medicare indicates that these conditions were satisfied when the services were provided.

The Medicare law obligates us to recover primary payments that Medicare mistakenly made when a group health plan is the proper primary payer. We may recover from any entity responsible for making primary payment, including employers *that sponsor or contribute to group health plans,* other plan sponsors, and insurers.[1] We are sending this letter to you because you are an entity responsible for payment under the Medicare law and are subject to an excise tax under the Internal Revenue Service if any group health plan that you sponsor, or to which you contribute, fails to comply with the MSP requirements. We want to afford you every opportunity to resolve this matter. We also encourage you to contact other entities, such as the plan itself or the plan's insurer (if any), that are also entities responsible for payment, for assistance in resolving this matter. An enclosure entitled, "**Important Information for Employers**" explains further how your obligations arise and what happens if you do not satisfy your obligations.

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[1] *Pursuant to 42 U.S.C. 1395y(b)(2)(B)(iii), in order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.*

The Medicare beneficiaries are identified and the amounts of Medicare's recovery claim are summarized below. Detailed information about each beneficiary and the services for which Medicare mistakenly paid primary are provided in an enclosure to this letter.

Name:
Health Insurance Claim Number:
Total Repayment Requested:

How to Resolve This Matter:

Within 60 days of the date of this letter, you or someone acting on your behalf; e.g., your insurer or plan administrator, must provide one of the following responses.

1. Repayment of the amount identified as a mistaken primary payment or, if less, the total amount payable under the group health plan (as a primary payer). Please provide the report identification number, which is found in the upper right corner of the enclosed summary sheet, with the repayment. If the amount repaid for any item or service is less than the amount that Medicare paid, provide an explanation of how the amount repaid was determined. If primary benefits already have been paid to the beneficiary or provider of the services shown in the enclosures, please provide a copy of the explanation of benefits and proof of payment;

2. If the group health plan is not obligated to make primary payment under any circumstances for services provided to an identified beneficiary under the Medicare Secondary Payer provisions, provide an explanation as to why not and a copy of any applicable plan provision. Include the name, address and tax identification number on the plan and, if applicable, other plan sponsors, insurers and third party administrators.

    - If the specific basis upon which the group health plan is not obligated to make primary payment for services provided to an identified beneficiary under the Medicare Secondary Payer provisions is that the plan's claims filing requirements have not been met[2], submit a written statement indicating that all existing records of the plan have been searched and indicate whether a claim for the identified services was found under any plan (primary or supplemental) covering the individual. Identify the plan's claims filing requirements and provide a copy of the applicable plan provisions.

    - If the claim is denied by the group health plan because the claim was not timely filed, consider this letter, pursuant to Medicare's subrogation rights, to constitute an appeal of the denial by the identified individual. Similarly, if the identified individual may seek waiver of this plan requirement, consider this letter to be a request for waiver. The plan must apply the same criteria to this

[2] *Pursuant to 42 U.S.C. 1395y(b)(2)(B)(v).*

appeal and request for waiver as it would had the appeal or waiver request been made by the identified individual. Please notify Medicare of the plan's decision regarding the appeal and waiver request and provide copies of any plan provisions upon which it bases its decisions.

Dates of coverage under the group health plan are shown on the enclosed summary sheet. If you believe the dates listed are inaccurate, please provide the correct dates of coverage along with your repayment or explanation of why Medicare is primary. Please include the Medicare report identification number *from* the summary sheet on all correspondence. This enables Medicare to reconcile its records.

Your failure to respond within sixty (60) days of the date of this letter will be taken as evidence of noncompliance with your responsibility, which may result in the initiation of additional recovery procedures.

If you fail to pay this debt to Medicare or take other action as described above within 60 days of the date of this letter, Medicare will assess interest beginning with the date of this letter (42 CFR 411.24(m), 42 U.S.C. 1395y(b)(2)(B)(*I*)). Any payments made in satisfaction of this debt will be applied first to the amount of interest due, then to the principal.

Medicare may also determine that the group health plan is a nonconforming group health plan. The basis upon which CMS will make a determination of nonconformance is explained at 42 CFR 411.110, et seq. If a group health plan is determined to be nonconforming, the Internal Revenue Service will impose a 25 percent excise tax on all health plan expenditures of employers and employee organizations which contribute to the health plan (Section 5000 of the Internal Revenue Code). Moreover, 31 U.S.C. 3720(*a*) provides that agencies of the United States Government may refer debts to the Internal Revenue Service for collection by offset against tax refunds owed to individuals or entities by the Government. In addition, the Debt Collection Improvement Act of 1996 requires Federal Agencies to recover debts by offset against any monies otherwise payable to the debtor by the United States.

For further reference to the Medicare program's rights of recovery and potential penalties for noncompliance, please see 42 U.S.C. 1395y(b) and regulations found at 42 CFR 411.20-37, 411.100-206.

If you have any questions concerning this matter, please write or call _____ at _____.

Sincerely,

MSP Supervisor

Enclosures:
MSP Summary Data Sheet;
Summary of Medicare Payments;
Claims Facsimiles
Important Information for Employers

10.5.1 - Important Information for Employers

(Rev. 16, 05-21-04)

B3-3491.17, B3-3329.13

Important Information for Employers

Employers often ask us to explain why an employer, especially one who purchases insurance from an insurance company, has or shares liability for this debt and to explain the potential consequences if the employer fails to resolve this matter. We provide these explanations in this enclosure.

Congress has created a statutory framework in the Medicare statute and the Internal Revenue Code that imposes responsibility on an employer for its plan's actions in certain circumstances. The Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. *1*395y(b)) state that Medicare may seek to recover a mistaken primary payment from "any entity which is required or responsible" to pay for medical services under a primary plan. *The statute specifically identifies employers that sponsor or contribute to group health plans as such an entity. This means that Medicare may hold an employer responsible if the employer sponsors the group health plan, is a "self insurer" for the group health plan, contributes to the purchase of an underwritten health insurance product, or otherwise contributes to the group health plan.*

The MSP provisions generally require group health plans to make payments primary to Medicare for:

1. Individuals entitled to Medicare on the basis of age or disability if the individual has coverage under the group health plan on the basis of the individual's own or a family member's current employment status; and

2. Individuals who are or could be entitled to Medicare on the basis of end stage renal disease for a thirty-month coordination period if the individual is covered under a group health plan on any basis.

A group health plan is defined in the Internal Revenue Code at 26 U.S.C. §5000(b) as a "plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, or others associated or formerly associated with the employer in a business relationship, or their families." Taken together, the MSP provisions and the Internal Revenue Code definition of group health plan establish that employers have, or at least share, responsibility for the group health plan's c*o*mpliance with the MSP rules.

Employer accountability is also reflected by Internal Revenue Code provisions allowing the employer to claim health plan expenditures as a deductible business expense (26 U.S.C. §162), and subjecting the employer to an excise tax if a plan to which it contributes does not conform to the MSP provisions (26 U.S.C. §5000(a) and (b)). Employers create, direct, authorize and control their health plans. Where an employer

establishes a plan to provide health benefits indirectly through insurance, the employer determines the nature of the coverage and has the right to enforce its insurance contract to assure compliance with applicable laws.

Regulations under the Federal Claims Collection Act establish that all entities responsible for paying a debt to the Federal Government are jointly and severally liable for payment of the debt. As previously explained, the employer is one of potentially several entities responsible for making primary payment under the MSP provisions. If the United States must take legal action to recover this debt, the Government may take action against any or all entities responsible for payment, including the insurer, the plan and the employer (See 42 U.S.C. §1395y(b)(2)(B)(*iii*); and 42 CFR 401.623.) If the Government is unable to recover the total debt from one of the entities responsible for payment, it may then pursue recovery from another.

If an employer does not repay Medicare or arrange for Medicare to be paid in full, any tax refunds that may be due the employer under the Internal Revenue Code may be applied toward satisfaction of the MSP debt (31 U.S.C. 3720(*a*)). In addition, the MSP provisions state that a plan that does not repay Medicare may be held to be a "nonconforming" plan (See 42 U.S.C. §1395y(b)(3)(B) and 42 CFR 411.100 et seq.) The Internal Revenue Code at §5000 imposes a 25 percent excise tax on all employers, except government entities; on all health plan expenditures of employers and employee organizations that contribute to a nonconforming group health plan. A plan may be found to be nonconforming both in the year that it failed to repay Medicare and in the year in which it was originally obligated to have made primary payment. In addition, the Debt Collection Improvement Act of 1996 (Chapter 10 of P.L. 104-134) requires Federal Agencies to collect debts by offset from any monies otherwise payable to the debtor by the United States.

10.6 – Insurer Letter

(Rev. 16, 05-21-04)

A3-3491.17, B3-3329.13

Dear Sir or Madam:
It has come to our attention that Medicare has made payment for services, under the Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. 1395y(b)(*2*)), when payment may be or is the responsibility of a group health plan for which you are/were the insurer, underwriter, sponsor, or claims processor. The Medicare beneficiaries are identified and the amounts of Medicare's recovery claim are summarized below. Detailed information about each beneficiary and the services for which Medicare mistakenly paid primary are provided in an enclosure to this letter.

Name:
Health Insurance Claim Number:
Total Repayment Requested:

How This Happened

The MSP provisions of the Social Security Act require group health plans to make primary payment for services provided to Medicare beneficiaries if those individuals are also covered by the group health plan and certain conditions delineated in the Medicare law (*4*2 U.S.C. 1395(y)(b)) and regulations (42 CFR411.20ff) are satisfied. Medicare did not know that these conditions were satisfied at the time that Medicare made primary payment for certain services. The information now available to Medicare indicates that these conditions were satisfied when the services were provided.

The Medicare law obligates us to recover primary payments that Medicare mistakenly made when a group health plan is the proper primary payer. We may recover from any entity responsible for making primary payment, including employers *that sponsor or contribute to group health plans,* other plan sponsors, and insurers.[1]

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[1] *Pursuant to 42 U.S.C. 1395y(b)(2)(B)(iii), in order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.*

How To Resolve This Matter

Within 60 days of the date of this letter, you must provide one of the following responses:

1. Repayment of the amount identified as a mistaken primary payment or, if less, the total amount payable under the group health plan (as a primary payer). Provide the report identification number, which is found in the upper right corner of the enclosed summary data sheet, with the repayment. If the amount repaid for any item or service is less than the amount that Medicare paid, provide an explanation of how the amount repaid was determined;

2. If primary benefits already have been paid to the beneficiary or provider of the services shown in the enclosures, provide a copy of the explanation of benefits and proof of payment;

3. If the group health plan is not obligated to make primary payment under any circumstances for service provided to an identified beneficiary under the Medicare Secondary Payer provisions, provide an explanation as to why not and a copy of any applicable plan provision. Include the name, address and tax identification number on the plan.

- If the specific basis upon which the group health plan is not obligated to make primary payment for services provided to an identified beneficiary under the MSP provision is that the plan's claims filing requirements have not been met,[2] submit a written statement indicating that all existing records of the plan have been searched and indicate whether a claim for the identified services was found under any plan (primary or supplemental) covering the individual. Identify the plan's claims filing requirements and provide a copy of the applicable plan provision;

- If the claim is denied by the group health plan because the claim was not timely filed, consider this letter, pursuant to Medicare's subrogation rights, to constitute an appeal of the denial by the identified individual. Similarly, if the identified individual may seek waiver of this plan requirement, consider this letter to be a request for waiver. The plan must apply the same criteria to this appeal and request for waiver as it would *had* the appeal or waiver request been made by the identified individual. *Please* notify Medicare of the plan's decision regarding the appeal and waiver request and provide copies of any plan provisions upon which it bases its decisions.

Dates of coverage under the group health plan are shown on the enclosed summary data sheet. If you believe the dates listed are inaccurate, please provide the correct dates of coverage along with your repayment or explanation of why Medicare is primary. Include the report identification number from the summary sheet on all correspondence. This

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[2] *Pursuant to 42 U.S.C. 1395y(b)(2)(B)(v).*

enables Medicare to reconcile its records. Your failure to respond within sixty (60) days of the date of this letter will be taken as evidence of noncompliance with your responsibility, which may result in the initiation of additional recovery procedures. If you fail to pay this debt to Medicare or take other action as described above within 60 days of the date of this letter, Medicare will assess interest beginning with the date of this letter (42 CFR 411.24(m), 42 U.S.C. 1395y(b)(2)(B)(I)). Any payments made in satisfaction of this debt will be applied first to the amount of interest due, then to the principal.

Medicare may also determine that the group health plan is a nonconforming group health plan. The basis upon which CMS will make a determination of nonconformance is explained at 42 CFR 411.110, et seq. If a group health plan is determined to be nonconforming, the Internal Revenue Service will impose a 25 percent excise tax on all health plan expenditures of employers and employee organizations which contribute to the health plan (§5000 of Internal Revenue Code). Moreover, 31 U.S.C. 3720(*a*) provides that agencies of the United States Government may refer debts to the Internal Revenue Service for collection by offset against tax refunds owed to individuals or entities by the Government. In addition, the Debt Collection Improvement Act of 1996 requires Federal agencies to recover debts by offset against any monies otherwise payable to the debtor by the United States.

If you have any questions concerning this matter, please write *or call* _____ at _____.

Sincerely,

MSP Supervisor

Enclosure*s*:
MSP Summary Data Sheet
Summary of Medicare Payment
Requested Reimbursement Summary Report
Summary of Medicare Reimbursement Key
Claims Facsimiles