

## §411.162

behalf of an enrollee who does not have ESRD.

(v) Failure to cover routine maintenance dialysis or kidney transplants, when a plan covers other dialysis services or other organ transplants.

(c) *Uniform Limitations on particular services permissible.* A plan is not prohibited from limiting covered utilization of a particular service as long as the limitation applies uniformly to all plan enrollees. For instance, if a plan limits its coverage of renal dialysis sessions to 30 per year for all plan enrollees, the plan would not be differentiating in the benefits it provides between plan enrollees who have ESRD and those who do not.

(d) *Benefits secondary to Medicare.* (1) The prohibition against differentiation of benefits does not preclude a plan from paying benefits secondary to Medicare after the expiration of the coordination period described in §411.162(b) and (c), but a plan may not otherwise differentiate, as described in paragraph (b) of this section, in the benefits it provides.

(2) Example—

Mr. Smith works for employer A, and he and his wife are covered through employer A's GHP (Plan A). Neither is eligible for Medicare nor has ESRD. Mrs. Smith works for employer B, and is also covered by employer B's plan (Plan B). Plan A is more comprehensive than Plan B and covers certain items and services which Plan B does not cover, such as prescription drugs. If Mrs. Smith obtains a medical service, Plan B pays primary and Plan A pays secondary. That is, Plan A covers Plan B copayment amounts and items and services that Plan A covers but that Plan B does not.

Mr. Jones also works for employer A, and he and his wife are covered by Plan A. Mrs. Jones does not have other GHP coverage. Mrs. Jones develops ESRD and becomes entitled to Medicare on that basis. Plan A pays primary to Medicare during the first 18 months of Medicare entitlement based on ESRD. When Medicare becomes the primary payer, the plan converts Mrs. Jones' coverage to a Medicare supplement policy. That policy pays Medicare deductible and coinsurance amounts but does not pay for items and services not covered by Medicare, which plan A would have covered. That conversion is impermissible because the plan is providing a lower level of coverage for Mrs. Jones, who has ESRD, than it provides for Mrs. Smith, who does not. In other words, if Plan A pays secondary to primary payers other than

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Medicare, it must provide the same level of secondary benefits when Medicare is primary in order to comply with the nondifferentiation provision.

[60 FR 45368, Aug. 31, 1995]

### §411.162 Medicare benefits secondary to group health plan benefits.

(a) *General provisions.* (1) *Basic rule.* Except as provided in §411.163 (with respect to certain individuals who are also entitled on the basis of age or disability), Medicare is secondary to any GHP (including a retirement plan), with respect to benefits that are payable to an individual who is entitled to Medicare on the basis of ESRD, for services furnished during any coordination period determined in accordance with paragraphs (b) and (c) of this section. (No Medicare benefits are payable on behalf of an individual who is eligible but not yet entitled.)

(2) *Medicare benefits secondary without regard to size of employer and beneficiary's employment status.* The size of employer and employment status requirements of the MSP provisions for the aged and disabled do not apply with respect to ESRD beneficiaries.

(3) *COBRA continuation coverage.* Medicare is secondary payer for benefits that a GHP—

(i) Is required to keep in effect under COBRA continuation requirements (as explained in the footnote to §411.161(a)(3)), even after the individual becomes entitled to Medicare; or

(ii) Voluntarily keeps in effect after the individual becomes entitled to Medicare on the basis of ESRD, even though not obligated to do so under the COBRA provisions.

(4) *Medicare payments during the coordination period.* During the coordination period, CMS makes Medicare payments as follows:

(i) Primary payments only for Medicare covered services that are—

(A) Furnished to Medicare beneficiaries who have declined to enroll in the GHP;

(B) Not covered under the plan;<sup>1</sup>

<sup>1</sup>CMS does not pay if noncoverage of services constitutes differentiation as prohibited by §411.161(b).

(C) Covered under the plan but not available to particular enrollees because they have exhausted their benefits; or

(D) Furnished to individuals whose COBRA continuation coverage has been terminated because of the individual's Medicare entitlement.

(ii) Secondary payments, within the limits specified in §§411.32 and 411.33, to supplement the amount paid by the GHP if that plan pays only a portion of the charge for the services.

(b) *Beginning of coordination period.*

(1) For individuals who start a course of maintenance dialysis or who receive a kidney transplant before December 1989, the coordination period begins with the earlier of—

(i) The month in which the individual initiated a regular course of renal dialysis; or

(ii) In the case of an individual who received a kidney transplant, the first month in which the individual became entitled to Medicare, or, if earlier, the first month for which the individual would have been entitled to Medicare benefits if he or she had filed an application for such benefits.

(2) For individuals other than those specified in paragraph (b)(1) of this section, the coordination period begins with the earlier of—

(i) The first month in which the individual becomes entitled to Medicare part A on the basis of ESRD; or

(ii) The first month the individual would have become entitled to Medicare part A on the basis of ESRD if he or she had filed an application for such benefits.

(c) *End of coordination period.* (1) For individuals who start a regular course of renal dialysis or who receive a kidney transplant before December 1989, the coordination period ends with the earlier of the end of the 12th month of dialysis or the end of the 12th month of a transplant. The 12th month of dialysis may be any time from the 9th month through the 12th month of Medicare entitlement, depending on the extent to which the individual was subject to a waiting period before becoming entitled to Medicare.

(2) The coordination period for the following individuals ends with the earlier of the 12th month of eligibility or

the 12th month of entitlement to Medicare part A:

(i) Individuals, other than those specified in paragraph (c)(1) of this section, who became entitled to Medicare part A solely on the basis of ESRD during December 1989 and January 1990.

(ii) Individuals, other than those specified in paragraph (c)(1) of this section, who could have become entitled to Medicare Part A solely on the basis of ESRD during December 1989 and January 1990 if they had filed an application.

(iii) Individuals who become entitled to Medicare part A on the basis of ESRD after September 1997.

(iv) Individuals who can become entitled to Medicare part A on the basis of ESRD after September 1997.

(3) The coordination period for the following individuals ends with the earlier of the end of the 18th month of eligibility or the 18th month of entitlement to Medicare part A:

(i) Individuals, other than those specified in paragraph (c)(1) of this section, who become entitled to Medicare part A on the basis of ESRD from February 1990 through April 1997.

(ii) Individuals, other than those specified in paragraph (c)(1) of this section, who could become entitled to Medicare part A on the basis of ESRD from February 1990 through April 1997 if they would file an application.

(4) The coordination periods for the following individuals ends September 30, 1998:

(i) Individuals who become entitled to Medicare part A on the basis of ESRD from May 1997, through September 1997.

(ii) Individuals who could become entitled to Medicare part A on the basis of ESRD from May 1997, through September 1997, if they would file an application.

(d) *Examples.* Based on the rules specified in paragraphs (b) and (c) of this section and the rules specified in §406.13 of this subchapter, the following examples illustrate how to determine, in different situations, the number of months during which Medicare is secondary payer.

(1) An individual began dialysis on November 4, 1989. He did not initiate a course in self-dialysis training nor did

he receive a kidney transplant during the first 3 calendar months of dialysis. Thus, he became entitled to Medicare on February 1, 1990. Since this individual began dialysis before December 1989, the 12-month period began with the first month of dialysis, November 1989, and ended October 31, 1990. The coordination period in this case is 9 months, February 1990 through October 1990.

(2) An individual began dialysis on January 29, 1990. He did not initiate a course in self-dialysis training nor did he receive a kidney transplant during the first 3 calendar months of dialysis. Thus, he became entitled to Medicare on April 1, 1990. Since the individual began dialysis after November 1989, and became entitled to Medicare after January 1990, the coordination period began with the first month of entitlement, April 1990, and ended September 30, 1991, the end of the 18th month of entitlement.

(3) An individual began a regular course of maintenance dialysis on February 10, 1990. He did not initiate a course of self-dialysis training nor did he receive a kidney transplant during the first 3 calendar months of dialysis. Thus, he became entitled to Medicare on May 1, 1990. Medicare is secondary payer from May 1, 1990 through October 1991, a total of 18 months.

(4) The same facts exist as in the example under paragraph (d)(3), except that the individual began a course of self-dialysis training during the first 3 calendar months of dialysis. Thus, the effective date of his Medicare entitlement is February 1, 1990, and Medicare is secondary payer from February 1, 1990 through July 1991, a total of 18 months.

(5) An individual began dialysis on September 15, 1990. He did not initiate a course of self-dialysis training nor did he receive a kidney transplant during the first 3 calendar months of dialysis. Thus, he became entitled to Medicare effective December 1, 1990. Medicare is secondary payer from December 1, 1990 through May 1992, a total of 18 months.

(6) An individual began dialysis on November 17, 1990. He initiates a course of self-dialysis training in January 1991, and thus becomes entitled to

Medicare effective November 1, 1990. Medicare is secondary payer from November 1, 1990, through April 1992, a total of 18 months.

(7) An individual began a regular course of dialysis on December 10, 1990. He does not initiate a course of self-dialysis training nor does he receive a kidney transplant. He decides to delay his enrollment in Medicare because his employer group health plan pays charges in full and he does not wish to incur part B premiums at this time. However, in March 1992, he files for part A and part B Medicare entitlement, and stipulates that he wants his Medicare entitlement to be effective March 1, 1992 (one year later than he could have become entitled). Since this individual could have been entitled to Medicare as early as March 1, 1991, Medicare is secondary payer only from March 1, 1992, through August 1992, a period of 6 months.

(While Medicare is secondary payer for only the last 6 months of this period, the Medicare program is effectively secondary payer for the full coordination period, due to the fact that the individual delayed his Medicare enrollment on account of his employer plan coverage and Medicare made no payments at all during the deferred period.)

(8) The same facts exist as in the example under paragraph (d)(7) of this section, except that the individual defers Medicare entitlement beyond August 1992. (For purposes of this example, Medicare entitlement is not retroactive, but rather takes effect after August 1992.) There would be no period during which Medicare is secondary payer in this situation. This is because Medicare entitlement does not begin until after the 18-month period expires as specified in paragraph (c)(3)(ii) of this section. Medicare would become primary payer as of the effective date of Medicare entitlement. The employer plan is required to pay primary from December 1, 1990, through August 1992, a total of 21 months.

(9) An individual becomes entitled to Medicare on December 1, 1997. The employer plan is primary payer, and Medicare is secondary payer, from December 1, 1997, through November 30, 1998,

a period of 12 months. Medicare becomes primary payer on December 1, 1998, because the extension of the coordination period from 12 to 18 months applies only to items and services furnished before October 1, 1998.

(10) An individual becomes entitled to Medicare on August 1, 1997. Medicare is secondary payer from August 1, 1997, through September 30, 1998, a period of 14 months. Medicare becomes primary payer on October 1, 1998, because the coordination period has expired.

(e) [Reserved]

(f) *Determinations for subsequent periods of ESRD eligibility.* If an individual has more than one period of eligibility based on ESRD, a coordination period will be determined for each period of eligibility in accordance with this section.

[57 FR 36015, Aug. 12, 1992; 57 FR 45113, Sept. 30, 1992. Redesignated and amended at 60 FR 45362, 45368, Aug. 31, 1995]

**§411.163 Coordination of benefits: Dual entitlement situations.**

(a) *Basic rule.* Coordination of benefits is governed by this section if an individual is eligible for or entitled to Medicare on the basis of ESRD and also entitled on the basis of age or disability.

(b) *Specific rules.*<sup>1</sup> (1) *Coordination period ended before August 1993.* If the first 18 months of ESRD-based eligibility or entitlement ended before August 1993, Medicare was primary payer from the first month of dual eligibility or entitlement, regardless of when dual eligibility or entitlement began.

(2) *First month of ESRD-based eligibility or entitlement and first month of dual eligibility/entitlement after February 1992 and before August 10, 1993.* Except

as provided in paragraph (b)(4) of this section, if the first month of ESRD-based eligibility or entitlement and first month of dual eligibility/entitlement were after February 1992 and before August 10, 1993, Medicare—

(i) Is primary payer from the first month of dual eligibility/entitlement through August 9, 1993;

(ii) Is secondary payer from August 10, 1993, through the 18th month of ESRD-based eligibility or entitlement; and

(iii) Again becomes primary payer after the 18th month of ESRD-based eligibility or entitlement.

(3) *First month of ESRD-based eligibility or entitlement after February 1992 and first month of dual eligibility/entitlement after August 9, 1993.* Except as provided in paragraph (b)(4) of this section, if the first month of ESRD-based eligibility or entitlement is after February 1992, and the first month of dual eligibility/entitlement is after August 9, 1993, the rules of §411.162(b) and (c) apply; that is, Medicare—

(i) Is secondary payer during the first 18 months of ESRD-based eligibility or entitlement; and

(ii) Becomes primary after the 18th month of ESRD-based eligibility or entitlement.

(4) *Medicare continues to be primary after an aged or disabled beneficiary becomes eligible on the basis of ESRD.* (i) *Applicability of the rule.* Medicare remains the primary payer when an individual becomes eligible for Medicare based on ESRD if all of the following conditions are met:

(A) The individual is already entitled on the basis of age or disability when he or she becomes eligible on the basis of ESRD.

(B) The MSP prohibition against “taking into account” age-based or disability-based entitlement does not apply because plan coverage was not “by virtue of current employment status” or the employer had fewer than 20 employees (in the case of the aged) or fewer than 100 employees (in the case of the disabled).

(C) The plan is paying secondary to Medicare because the plan had justifiably taken into account the age-based or disability-based entitlement.

<sup>1</sup>A lawsuit was filed in United States District Court for the District of Columbia on May 5, 1995 (*National Medical Care, Inc. v. Shalala*, Civil Action No. 95-0860), challenging the implementation of one aspect of the OBRA '93 provisions with respect to group health plan retirement coverage. The court issued a preliminary injunction order on June 6, 1995, which enjoins the Secretary from applying the rule contained in §411.163(b)(4) for items and services furnished between August 10, 1993 and April 24, 1995, pending the court's decision on the merits. CMS will modify the rules, if required, based on the final ruling by the court.