Welcome
Thank you for selecting AmeriHealth New Jersey for your organization's health plan. We are a customer-focused organization. We value our relationship with you, and we are committed to giving you and your employees the best possible service.

As the benefits administrator of your AmeriHealth New Jersey insured or administered plan, you have the important job of understanding your program and assisting your employees with their questions and concerns. We have prepared this Benefits Administrator Guide to help you manage the day-to-day administration of your organization's AmeriHealth benefits program.

Using this guide/Obtaining forms
This guide explains the AmeriHealth New Jersey processes and procedures, including enrollment, billing, and coordination with Medicare.

The forms and guide are available on our website: amerihealthnj.com

The State of NJ Small Employer Health program
The State of New Jersey Small Employer Health Benefits (SEH) program establishes standard benefits plans for small groups for all New Jersey carriers. In addition to the standard SEH plans, optional riders that modify the standard SEH plans and offer a variety of benefits options are also available from AmeriHealth New Jersey. The SEH board oversees compliance of carriers and maintains regulatory jurisdiction over products sold to small groups.

This guide currently contains general information applicable to all plans (including SEH plans), such as billing information and important phone numbers. If you are the benefits administrator for a company that has an SEH plan, please contact your broker, Group Services (800-893-7827), or your AmeriHealth New Jersey account executive with any enrollment, benefits, claims, or billing questions.

Managing your group's health care online
As a group administrator or business owner offering AmeriHealth New Jersey insurance plans, you can safely and conveniently manage your group’s account through our secure online portal, known as amerihealthexpress.com.

With amerihealthexpress.com, transactions can be completed quickly and easily, and all transactions are secure.

Account management
• Add, terminate, or change a member’s health benefits.
• View benefits information for your covered employees.
• View coverage history for active and terminated members.
• Request ID cards for members and their covered dependents.
• View submitted transactions via the Transaction History feature.
• Print temporary ID cards for members and their covered dependents.
• Assign access to other users within the company.
• View a variety of membership reports.

ID cards/Member handbook
Each employee selecting an AmeriHealth New Jersey plan will receive benefits information and an ID card. It can take a few weeks to process the member’s Enrollment/Change Form. In the interim, a copy of the form may be used as a temporary ID card until the member receives a permanent card in the mail. Members can also print a temporary ID card via our member portal once their enrollment has been processed. Members can register for the member portal at amerihealthexpress.com.

Please review this guide in its entirety. If you require more information, or if you have any questions about your AmeriHealth New Jersey coverage, please contact your broker or AmeriHealth New Jersey account executive.
Each newly eligible person who enrolls during the open enrollment period, or until a change-of-life event has occurred.

As the benefits administrator, it is your responsibility to complete the required group information. Please see the detailed instruction sheet attached to the enrollment form. Remember to include your account or group number. If your organization has more than one account or group number, be sure to indicate the correct account or group number on each Enrollment/Change Form. Remember to sign and date the Enrollment/Change Form.

Any time you add a new member or propose a change, you must submit both the Enrollment/Change Form and an Enrollment Report. The Enrollment/Change Form records the change for each individual member, while the Enrollment Report summarizes all the changes being submitted at one time. Both forms need to be completed each time a change is made, even if only one change is being submitted.

Adding a new member using the Enrollment/Change Form
The employee must answer all questions in the employee information section. The dependent information section must be completed if the employee's dependents will also be covered. Please note that for an HMO or POS plan, each dependent must select a primary care physician (PCP). If a PCP is not selected, the member's identification card will indicate that a valid PCP needs to be selected. The member must review and complete, if applicable, the portion of the enrollment form that requires the member to list any other health coverage. It is important for members to sign and date the form.

As a group administrator or business owner offering AmeriHealth New Jersey insurance plans, it is recommended that you manage your group’s account through our secure online portal, amerihealthexpress.com. The following information regarding eBilling, Employee Self-Service (ESS), Provider Network, and Individual/group enrollment is required of HMO and POS members, as well as of SEH groups.

Your broker or account representative will assist you in planning and determining the appropriate way to conduct your group’s open enrollment (employee meetings, mailing brochures to each employee’s home, payroll announcement, etc.). Employers that routinely require mandatory attendance at open enrollment meetings often experience fewer difficulties and higher employee satisfaction with their choice of health plans.

Enrollment procedures
Each new AmeriHealth New Jersey member, whether joining as a new hire or through open enrollment, must complete an Enrollment/Change Form. All information must be provided to avoid processing delays.

Timing of enrollment
You may enroll new employees (new hires) and their dependents within 30 days of their becoming eligible for health benefits. Your company establishes the eligibility date for health care benefits for new hires.

For large groups (51+). If an employee is not enrolled within 30 days, he or she may not enroll until your company’s next open enrollment period, or until a change-of-life event has occurred.

For small groups (2 – 50). Employees may enroll at any time, subject to their employer’s waiting period, if any.

Retroactive member activity
In the event that a retroactive enrollment transaction is necessary, we will allow for a maximum of 30 days prior to the current month (e.g., during June the furthest back we will accept a retroactive change is May 1).

Enrollment forms
All HMO, POS, EPO, and PPO members use the AmeriHealth Enrollment/Change Form. Be sure your employees carefully read the instructions for completing this form because specific information is required of HMO and POS members, as well as of members of SEH groups.

Any time you add a new member or propose a change, you must submit both the Enrollment/Change Form and an Enrollment Report. The Enrollment/Change Form records the change for each individual member, while the Enrollment Report summarizes all the changes being submitted at one time. Both forms need to be completed each time a change is made, even if only one change is being submitted.

Adding a new member using the Enrollment/Change Form
The employee must answer all questions in the employee information section. The dependent information section must be completed if the employee’s dependents will also be covered. Please note that for an HMO or POS plan, each dependent must select a primary care physician (PCP). If a PCP is not selected, the member’s identification card will indicate that a valid PCP needs to be selected. The member must review and complete, if applicable, the portion of the enrollment form that requires the member to list any other health coverage. It is important for members to sign and date the form.

As the benefits administrator, it is your responsibility to complete the required group information. Please see the detailed instruction sheet attached to the enrollment form. Remember to include your account or group number. If your organization has more than one account or group number, be sure to indicate the correct account or group number on each Enrollment/Change Form. Remember to sign and date the Enrollment/Change Form.

Any time you change information for an existing member, we’ll ask you to send us both the Enrollment/Change Form and an Enrollment Report. The Enrollment/Change Form records the change for each individual member, while the Enrollment Report summarizes all the changes being submitted at one time. Both forms need to be completed each time a change is made, even if only one change is being submitted.

Special information for HMO and POS members
Each member of the family must select a primary care physician from AmeriHealth New Jersey’s physician network. Female members do not have to preselect an AmeriHealth New Jersey OB/GYN.

Participating physicians’ names and HMO ID numbers are listed in the AmeriHealth online Provider Directory at amerihealthnj.com under Provider Network.

If an HMO or POS member does not select a PCP, or if he or she selects a physician with a closed practice or one who is no longer participating with AmeriHealth New Jersey, the member’s identification card will indicate that a valid PCP needs to be selected. It is important that the member select a valid PCP.

Members may change their PCP once per month; members wishing to do so should make their selection through amerihealthexpress.com or by calling Customer Service at 888-YOUR-AH1 (888-968-7241). The change will go into effect on the first day of the following month.
Using the Enrollment/Change Form as a temporary ID
It is important that you retain a copy of the completed Enrollment/Change Form for your records and provide each employee with a copy for use as his or her temporary ID card. If any enrolled member requires care before he or she receives a permanent ID card, this form may be presented at the physician’s office and will allow the member to receive all the benefits to which he or she is entitled.

Completing the Enrollment Report
The Enrollment Report summarizes all the additions and changes submitted at one time. A completed Enrollment Report must be included any time you request a change, even if you are submitting only one Enrollment/Change Form.

The Enrollment Report must be filled out in its entirety, including the group number, group name, current effective date, address, and phone number so we can contact you if there are any questions about the report.

Each numbered line should reflect the information on one of the enrollment forms included in the submission. Be sure to include the member’s identification number and the effective date of the change, and also indicate whether the change is an addition, a change, or a removal. If the change is a removal, be sure to include the removal code number, which can be found on the bottom of the form, and include the terminated member’s address in the Remarks section. Once you’ve completed all the necessary lines, simply total the number of transactions by type, then enter the grand total of all transactions in the designated box.

Keep copies for your records, and mail the original documents to the address at the top of the form, or fax it to RegionalOps@amerihealth.com.

Because insurance bills are prepared in advance of the coverage date, changes may not appear on your bill for one or two monthly billing cycles. To avoid any potential payment problems, you should always pay the billed amount. Any credits or additional premium due will be applied on subsequent bills.

Dependent to 26
The provision of the health care reform law for dependent coverage to age 26 became effective for plan years beginning on or after September 23, 2010, and is effective upon the group’s anniversary date. Upon the group’s anniversary date on or after September 23, 2010, employers that offer dependent coverage will be required to keep adult children enrolled until they turn 26. This is applicable to all individual policies and groups regardless of size and whether they are fully or self-funded.

The provision applies to married and unmarried children. Adult children who were covered under a fully insured plan, but who lost coverage when they graduated from college or reached the maximum age as required under the health plan, can be added back to a parent’s policy upon renewal.

Dependent to 31
The state of New Jersey has revised a 2006 law requiring health care insurers to provide certain adult dependents with the opportunity to maintain their dependent coverage under their parents’ health insurance policies.

Previously known as Chapter 375, the law provided coverage opportunities until the dependents’ 30th birthday. Now, it has been extended until the dependents’ 31st birthday. Before the law went into effect, these “over-age dependents” would have become ineligible for coverage under their parents’ policies when they reached the limiting age of their plan.

Dependents under 26 who have enrolled in Dependent to 31
Beginning October 1, 2010, as groups renew with AmeriHealth New Jersey, members under 26 who are enrolled in New Jersey’s Over-age Dependent to 31 (OAD31) policy will need to terminate the OAD31 plan and enroll in the federal Dependent to Age 26 policy. The federal policy takes precedence over New Jersey’s policy. Therefore, it is the responsibility of the broker and employer to make sure that members are terminated from OAD31 and enrolled in Dependent to 26. Any members who are between ages 26 and 31 and enrolled in OAD31 will still have coverage under the plan.

Prior-carrier deductible credit
If a member incurred expenses under a previous plan that were credited toward his or her annual deductible in the calendar year or benefit period during which the group became effective, the member may receive deductible credit toward his or her new policy with AmeriHealth New Jersey.

Eligibility: If a new AmeriHealth New Jersey member incurred expenses related to a deductible under his or her previous carrier, he or she is eligible. In order for the member to take advantage of this benefit, he or she must provide AmeriHealth New Jersey with the required documentation as soon as possible or no longer than 90 days after his or her enrollment date to receive full credit.

The application process: The member must complete the Prior Carrier Deductible Credit Form, attach a copy of his or her most recent Explanation of Benefits (EOB), and submit to AmeriHealth New Jersey at the address below. Remember: The member must submit any EOBs and Prior Carrier Deductible Credit forms within 90 days of his or her enrollment date to receive full credit. After 90 days, the member may forfeit some or all of his or her credit. Because annual deductibles apply to each family member, we will need information specific to each of the member’s dependents who will be covered. For example, a husband must submit an EOB indicating his credit to be applied, and a wife will need to provide an additional EOB indicating her credit to be applied.

The member will receive a letter from AmeriHealth New Jersey verifying that we received his or her Prior Carrier Deductible Credit Form and documentation. The letter will also indicate each family member’s individual amount that will be credited toward the member’s new deductible.

Prior Carrier Deductible Credit checklist
• Prior Carrier Deductible Credit Form completed;
• Prior Carrier EOB (the member should retain a copy for his or her records);
• EOBs indicating credit to be applied for each family member.

Mail the Prior Carrier Deductible Credit Form and any EOBs to:
AmeriHealth New Jersey
Prior Carrier Deductible Credit
PO Box 7450
Philadelphia, PA 19101-9102

Group termination
A written group termination request may be submitted through your AmeriHealth New Jersey account executive. You may also submit group terminations to the AmeriHealth New Jersey Marketing Operations department by email at RegionalOps@amerihealth.com or fax at 609-662-2370.

Groups can be cancelled only on their billing cycle: the 1st or 15th of the month.

Billing
Overview
Itemized invoices are sent monthly, approximately 15 days before the month of coverage. Invoices for a given month of coverage are based on the actual group enrollment for the prior month. This enables billing and payment to occur in advance of the covered month.

To avoid payment problems, it is important to always pay the amount billed, even though it may not reflect your most recent additions and terminations.

To ensure prompt and accurate updating of future payments and to help avoid any interruption in your coverage, all payments, along with the payment coupon and check, should be mailed to:
AmeriHealth New Jersey
P.O. Box 70250
Philadelphia, PA 19176-0250

Please include one check per coupon, and indicate the dollars paid on the coupon.
For even easier bill payments, you may establish electronic payments, through amerihealthexpress.com or your financial institution’s electronic bill payer service.

Do not write membership or plan changes on your invoice. These changes will not be made. The proper way to report enrollment changes is to use the group portal or the Enrollment/Change Form and Enrollment Report.

The Enrollment Report should be mailed to the Enrollment Department along with the Enrollment/Change Forms indicating the desired action. This could include adding dependents to a contract (due to birth, adoption, or marriage) or making any changes to an individual's coverage (i.e., marriage, divorce, legal separation, death of a spouse or dependent, loss of eligibility for coverage, or moving out of the AmeriHealth New Jersey service area).

Similarly, if you are terminating an individual's coverage or deleting dependents, use the AmeriHealth New Jersey Enrollment Report Form, but continue to remit the billed amount. Do not delete billed premium amounts or add the additional premium due in your remittance. The next invoice will reflect those changes retroactively along with any corresponding change to your premium balance. Adjustments made will appear in the Retroactive Adjustments section of the invoice.

Simply detach the remittance coupon from the bottom of the first page of your invoice and return it with your payment to the address indicated on your bill. If you are including multiple payments in one envelope, please be sure to indicate on each coupon the amount to be applied to each account/group. The sum of all coupons must equal the full amount of the check you are remitting. This will ensure that your payment is credited to the proper account.

Notes on coverage and billing cycle for HMO and PDS groups

If your group’s effective date is the 1st of the month:
- If members are added between the 1st and the 15th day of the month, you will be billed for that month.
- If members are added between the 16th and the last day of the month, you will not be billed for that month.
- If members are dropped between the 1st and the 15th day of the month, you will not be billed for coverage from that month.
- If members are dropped between the 16th and the last day of the month, you will be billed for coverage for that month.

If your group’s effective date is the 15th of the month:
- If members are added between the 15th and the last day of the month, you will be billed for that month.
- If members are added between the 1st and 14th day of the month, you will not be billed for that month.
- If members are dropped between the 15th and the last day of the month, you will not be billed for coverage for that month.
- If members are dropped between the 16th and 14th day of the month, you will be billed for coverage for that month.

For assistance with billing reconciliations, please call the phone number that appears on your bill.

Notes on coverage and billing cycle for PPO groups

Off-cycle member enrollment activity is prorated.

Example: If your group’s effective date is the first day of the month and a member is added on the 16th day of the month, we will charge the applicable premium for days 16 through 30/31.

Continuation of coverage

AmeriHealth New Jersey provides continuation of coverage through COBRA (required by federal law for groups employing 20 or more) or through small group continuation of coverage law (generally applicable for groups of 2 – 19 employees).

While COBRA generally covers group health plans maintained by employers with 20 or more employees, there are groups between 2 and 50 employees who are not covered by COBRA but may be covered through the New Jersey small group continuation of coverage law, e.g. church groups.

COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is available only when coverage is lost due to certain specific events. To be eligible for COBRA coverage, former employees must have been enrolled in their employer’s health plan when they worked, and the health plan must continue to be in effect for active employees. COBRA continuation coverage is available upon the occurrence of a qualifying event that would, except for the COBRA continuation coverage, cause an individual to lose his or her health care coverage.

Small employers (those with 2 – 19 employees) must offer employees the option to continue their group health coverage, at the employer’s expense, when an employee is terminated for reasons other than cause, when he or she goes to part-time status, or if an employee voluntarily ends employment. An employee on continuation would pay his or her premium to you, which you would remit as part of your regular premium payment.

Employers have a legal obligation to notify their employees of the right to continue coverage at the time of termination or at the time the employee assumes part-time status. An employee has the right to continue coverage for up to 18 months. The decision to continue coverage may be made by the employee only; in most instances, dependents do not have an independent right to elect continuation.

The policy or contract issued to you and the certificate or evidence of coverage issued to the covered employees outlines the procedures that the employer and employee must follow for continuation of coverage.

Termination of membership occurs when an employee terminates his or her employment and loses group eligibility in such instances. Cancellation of membership may occur when a member who remains eligible for group health benefits chooses to cancel AmeriHealth New Jersey membership. Conversion is not offered in this situation.

The employer should either complete an Enrollment Report or utilize the group portal in order to terminate an employee’s coverage. The employer is responsible for submitting the Enrollment Report forms or processing requests via the group portal within 60 days of the termination date to AmeriHealth New Jersey.

Medicare as secondary payer

We hope to simplify a complex subject — when Medicare is the primary payer for Medicare-eligible members of your employee group. If your company has 19 or fewer full- and part-time employees, Medicare is almost always primary. If your company is larger, various rules apply to determine whether your group plan is the primary or secondary payer.

The following information provides a summary of the Medicare Secondary Payer (MSP) requirements. This information may help you to correctly target benefits for your Medicare-eligible participants and avoid potentially costly penalties and litigation. You should, of course, also refer to the actual laws and regulations with the assistance of your own legal counsel.

1 The MSP provisions are set forth at 42 U.S.C. 1395y(b). The regulations the Centers for Medicare and Medicaid has issued implementing the statute are located at 42 C.F.R. Part 411. It is important that you and your counsel review the statute and regulations periodically to ensure compliance with your statutory obligations.

2 This content is provided for informational purposes, and is not offered or intended as legal advice. In this section, the term “employer” includes a plan sponsor or entity that contributes to a GHP.
Information regarding the MSP statute

Employees, group health plans (GHPs), and entities that sponsor or contribute to GHPs, as well as insurers, have certain obligations under the MSP provisions of the Social Security Act, commonly known as the “MSP statute.” As an employer or administrator of a GHP, you need to know the requirements of the statute so that you can avoid potentially costly penalties and litigation. This guide is designed to provide you with a general overview regarding operation of the MSP statute and the enrollment and membership information system that is being developed to determine instances when the MSP statute applies.

The MSP law

A coordination of benefits approach: During the first 15 years of the Medicare program, Medicare was the primary payer of all services provided to Medicare beneficiaries, with the sole exception of services covered under a workers’ compensation policy or program. As a result, where a Medicare beneficiary had dual health care coverage, Medicare paid first, and the employer, GHP, or insurer paid all or a portion of the remainder of the bill for the health care item or service at issue, depending on the terms of the relevant plan or contract. In an effort to save scarce Medicare resources, Congress enacted a series of amendments to the Social Security Act, beginning in 1981, which made GHPs responsible in certain instances for making primary payment in connection with medical items or services provided to specific Medicare beneficiaries with dual health care coverage.

The MSP statute is essentially a coordination of benefits statute. It requires, in discrete instances, that a GHP make primary payment where dual coverage exists for a particular health care item or service. Employers are constrained in the benefits they can offer employees and other individuals covered under the plan. The statute specifically prohibits employers and GHPs from differentiating between benefits offered to certain Medicare beneficiaries and their counterparts not enrolled in Medicare. The antidiscrimination provisions of the statute are explained more fully below.

Scope of the statute: The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and GHP coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

- GHPs that cover participants with end-stage renal disease (ESRD) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees or whether the individual has “current employment status.”

- In the case of a covered participant or his or her covered spouse age 65 or over, a GHP of an employer with 20 or more employees, if that participant has “current employment status.” If the GHP is a multi-employer or multiple employer plan, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).

- In the case of a covered participant or his or her covered family member who is disabled and under age 65, GHPs of employers with 100 or more employees, if participant has “current employment status.” If the GHP is a multi-employer or multiple employer plan that has at least one participating employer with 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees. (There is no small employer exception under the statute.)

In determining whether the size threshold has been met in any given case, the statute and regulations must be consulted.

Application of the statute depends not only on the size of the employer but also, in certain cases, on whether the coverage is provided under the GHP based on “current employment status.” Thus, generally the age-based and disability-based MSP provisions apply when the GHP participant (not necessarily the covered person with Medicare) has “current employment status.” (By contrast, the MSP provisions relating to individuals who have ESRD apply regardless of whether the beneficiary has GHP coverage as a result of “current employment status” and regardless of the number of employees.) Under Centers for Medicare and Medicaid (CMS) regulations, an individual has “current employment status” if the individual: (1) is “actively working as an employee, [is] the employer...or [is] associated with the employer in a business relationship”; (2) is “not actively working” but is “receiving disability benefits from an employer for up to six months”; or (3) is “not actively working” but “retains employment rights in the industry” and other specific requirements are met. For additional information, we again direct your attention to the statute and regulations.

The nondiscrimination provisions — age and disability.

The MSP statute prohibits GHPs from “take[ing] into account” that an individual covered by virtue of “current employment status” is entitled to receive Medicare benefits as a result of age or disability. The statute expressly requires GHPs to furnish to Medicare beneficiaries the same benefits, under the same conditions, that they furnish to employees and spouses not entitled to Medicare. Thus, GHPs may not offer coverage that is secondary to Medicare under a provision that “carves out” Medicare coverage (commonly known as a “carve-out” policy), or that supplements the available Medicare coverage (commonly known as “Medicare supplemental” or “Medigap” policies), to individuals covered by the provisions of the MSP statute relating to the working aged and the disabled. By contrast, Medigap and secondary health care coverage may appropriately be offered to retirees in this context because the GHP coverage is not based on “current employment status.”

ESRD. The MSP statute also prohibits a GHP from taking into account that an individual is entitled to Medicare benefits as a result of ESRD during a coordination period specified in the statute. This coordination period begins with the first month the individual becomes eligible for or entitled to Medicare based on ESRD and ends 30 months later. During this period, the GHP generally must pay primary for all covered health care items or services, while Medicare serves as the secondary payer. GHPs are prohibited from offering secondary (i.e., “carve-out”) and Medigap coverage in this context. After the coordination period has expired, however, the GHP is free to offer carve-out and Medigap coverage to ESRD Medicare beneficiaries, but may not otherwise differentiate between the benefits provided to these individuals and all others on the basis of the existence of ESRD, the need for renal dialysis, or in any other manner. (Important note: Special rules apply to persons eligible for or entitled to Medicare based on ESRD and one or more other reasons.)

Special rules apply regarding retired individuals and members of their families who receive Medicare benefits on the basis of age or disability immediately before the onset of ESRD. Where immediately prior to contracting the disease, the GHP was lawfully providing only Medigap coverage, or was otherwise a secondary payer for that individual, the GHP may continue to offer such coverage and is not required to pay primary during the 30-month coordination period.

Employer obligations. It is your obligation to ensure that beneficiaries who are covered by the MSP statute are not improperly enrolled in carve-out or Medigap coverage under your plan. If an individual is improperly enrolled in a supplemental or secondary policy or contract when the individual should be enrolled in a plan that makes the GHP the primary payer, it is Medicare’s position that Medicare pays secondary and the plan is required to pay primary regardless of contrary language contained in the plan or contract. These individuals may choose to purchase and pay for Medigap insurance on their own, but neither the employer nor the GHP may sponsor, contribute to, or finance such coverage.

Prohibition of financial or other incentives not to enroll in a GHP. An employee or family member of an employee who is entitled to Medicare is free to refuse the health plan offered by an employer or GHP, in which case Medicare will be the primary payer. It is unlawful, however, for an employer to offer any financial (or other) incentive for a Medicare beneficiary not to enroll, or to terminate enrollment, in a GHP that would be primary to Medicare if the individual enrolled in the GHP.
Any entity violating this prohibition is subject to a civil monetary penalty under the MSP statute of up to $5,000 for each violation.

Other consequences of noncompliance. Noncompliance with the statute can result in serious consequences. Thus, a significant excise tax in the amount of 25 percent of the employer’s or employee organization’s GHP expenses for the relevant year may be assessed under the Internal Revenue Code against a private employer or employee organization contributing to a "nonconforming" group health plan.

Under HCFA Regulations, a nonconforming group health plan is a plan that, for example: (1) improperly takes into account that an individual is entitled to Medicare; (2) fails to provide the same benefits under the same conditions to employees (and spouses) age 65 or over as it provides to younger employees and spouses; (3) improperly differentiates between individuals with ESRD and others; or (4) fails to refund to CMS conditional Medicare payments mistakenly made by the agency. It is Medicare’s position that, in addition to the possible imposition of an excise tax, failure to reimburse CMS for mistaken primary payments may result in ultimate liability double the amount at issue. The law also establishes a private cause of action to collect double damages from any GHP that fails to make primary payments in accordance with the MSP provisions.

Amendments to the MSP statute and regulations. The MSP statute and regulations are frequently amended. As a result, it is important that you and your counsel continue to monitor changes in the law and assess the impact of such changes on your company. While we can assist you by providing general information about the statute, it is ultimately your responsibility to ensure your company’s compliance with MSP statute.