Medicare Secondary Payer Rules FAQs

Medicare is the federal health insurance program that provides coverage to more than 55 million beneficiaries who:

- Are age 65 or older
- Are under age 65 with certain disabilities
- Of any age with End-Stage Renal Disease ("ESRD" – permanent kidney failure requiring dialysis or a kidney transplant)

Employees may have dual coverage – meaning they may have coverage through an employer-sponsored group health plan as well as through Medicare. In most cases, Medicare is a secondary payer to the group health plan when the individual has employer-provided coverage based on his or her current employment status. Federal law imposes specific requirements on employers and group health plans around coordinating benefits with Medicare and non-discriminatory treatment of individuals entitled to Medicare.

This FAQ addresses important aspects of these rules.

Overview

Q1. In a nutshell, what are the Medicare Secondary Payer (MSP) Rules?

Briefly, these rules:

- Prescribe specific coordination of benefit (COB) responsibilities when an individual has coverage through an employer-sponsored group health plan and Medicare. With some exceptions (described later), the group health plan is the primary payer and Medicare pays secondary. As part the COB process, carriers, TPAs and health plans must submit mandatory reporting to the Centers for Medicare and Medicaid Services (CMS).
- Unless an exception exists, prohibit a group health plan from "taking into account" the Medicare entitlement of a current employee or that current employee's spouse or family member.
- Require most group health plans to provide a current employee who is age 65 or older (and the current employee's spouse age 65 or older) with the same benefits, under the same conditions, as provided to employees and spouses who are under age 65 (same benefits/same conditions requirement). This requirement also applies to all group health plan covering individuals with ESRD (regardless of employer size).
- Prohibit most employers from offering Medicare eligible individuals' incentives (financial or otherwise) to opt-out of employer provided group health plan coverage.

Q2. What group health plans are subject to MSP?

With some exceptions (described in Q/A-3), all group health plan must comply with the secondary payer rules. This includes private sector, non-profits, government and church plans.

Q3. Are there group exceptions to some of the MSP rules?

Yes

- **Age-based Medicare**. An employer with fewer than 20 employees for each working day in each of 20 or more calendar weeks in the current calendar year (or preceding calendar year) is not subject to the prohibition against taking into account Medicare entitlement based on age of a current employee (or their spouse) and the same benefits/same conditions requirement.
- **Disability-based Medicare**. An employer with fewer than 100 full-time or part-time employees on 50% of more of its regular business days during the previous calendar year is not subject to the prohibition against taking into account Medicare entitlement due to disability of a current employee (or their family member).

Employer size is based on all employees of the employer – not just those enrolled in the group health plan.

There is no exception for small groups when the individual is eligible for Medicare due to ESRD.

Q4. How is employer size determined when there are multiple employers participating in a group health plan?

- **Controlled groups.** All employees of entities under common control are counted for purposes of determining the application of MSP.
- **MEWAs including association health plans and multi-employers**. If the arrangement is a multiple employer plan or multi-employer plan, all employers participating in the arrangement will be subject to MSP rules as applicable to the member employer with the largest number of employees. For example, an employer with less than 20 employees is not generally the primary payer for MSP purposes. However, if that employer participates as a member of a MEWA that includes an employer with 20 or more employees (or 100 or more employees), the otherwise available small group exceptions are lost with respect to the employer with fewer than 20 employees. There is a limited exception which permits a multi-employer plan to apply to CMS for a small group exception applicable to age-based Medicare for a particular small employer getting coverage through the arrangement.[1]

Coordination of Benefits

Q5. When is the group health plan the primary payer? When is Medicare?

The following chart illustrates the coordination of benefit requirements applicable to a group health plan. Generally, unless an exception exists, the group health plan is the primary payer (and Medicare is secondary).

If You	Situation	Primary Payer	Secondary Payer
Are 65 or older, are covered by a group health plan because you or your spouse is still working, and entitled to Medicare	The employer has 20 or more employees	Group Health Plan	Medicare
	The employer has fewer than 20 employees	Medicare	Group Health Plan
Have a retiree group health plan through your former employer after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree Coverage
Are age 65 or older and covered by COBRA coverage (including due to a reduction in hours)	Entitled to Medicare	Medicare	COBRA Coverage
Are disabled and covered by a group health plan from your work, or from a family member (like spouse or domestic partner) who is working, and entitled to Medicare	The employer has 100 or more employees	Group Health Plan	Medicare
	The employer has fewer than 100 employees	Medicare	Group Health Plan

[1] For more information, visit: https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/EmployerServices/Small-Employer-Exception.html

If You	Situation	Primary Payer	Secondary Payer
Are under 65 and disabled (other than by ESRD) and covered by COBRA coverage (including due to a reduction in hours)	Entitled to Medicare	Medicare	COBRA Coverage
Have ESRD and group health plan coverage (including a retirement plan)	First 30 months of eligibility or entitlement to Medicare	Group Health Plan	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	Group Health Plan
Have ESRD and COBRA coverage (This assumes the individual was already entitled to Medicare – due to ESRD – prior to electing COBRA continuation of coverage).[2]	First 30 months of eligibility or entitlement to Medicare	COBRA	Medicare
	After 30 months of eligibility or entitlement to Medicare	Medicare	COBRA

Q6. How does Medicare track coordination of coverage?

CMS, the federal agency that administers Medicare, tracks and coordinates primary payment obligations though its Benefits Coordination and Recovery Center (BCRC) using a variety of methods, such as through sharing information with the IRS and the Social Security Administration, mandatory reporting by issuers and third-party administrators, and targeted questionnaires.[3] While employers are not required to routinely report data match information to the BCRC, insurers and third-party administrators (TPAs) that provide services to plans must regularly report the individuals enrolled in a group health plan.[4] This reporting allows the BCRC to coordinate benefit payments between the group health plan and Medicare.

Q7. How are incorrect payments recovered by Medicare?

The BCRC and Commercial Repayment Center (CRC)[5] will seek to recover any mistaken Medicare primary payment(s) from the group health plan, plan sponsor, insurer or third-party administrator. The typical recovery case involves CRC sending a written demand letter with the proposed payment amount, possible resolution options, and instructions for valid defense documentation. In the event a demand letter is received, the recipient has 60 days to respond.

[2] If an individual first becomes entitled to Medicare because of ESRD after electing COBRA, the early termination provisions under COBRA applicable to Medicare entitlement permit the group health plan to terminate COBRA coverage. This would result in Medicare as the primary payer. However, if the individual was entitled to Medicare prior to electing COBRA coverage, the plan must offer COBRA (which would be the primary payer for 30 months in the event of ESRD).

[3] Historically, CMS issued "IRS-SSA-CMS Data Match" questionnaires to identify situations where another payer may have been primary to Medicare. The Data Match letters were discontinued as of July 1, 2016. For more information, visit https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/EmployerServices/IRS-SSA-CMS-Data-Match.html.

[4] This includes HRAs where the annual benefit more than $5,000. If an employer self-administers an HRA with an annual benefit of more than $5,000, the employer is subject to this reporting requirement. As the requirement is complicated, USI suggests using a third-party administrator for HRAs.

[5] In addition to the BCRC and CRC, plan sponsors in California, Florida, and New York may receive demand letters from one of three Recovery Audit Contractors (RACs). These RACs are Diversified Collection Systems (California), Public Consulting Group (Florida), and Public Consulting Group (New York).

Employers or others that receive a demand letter may manage the recovery activities by registering an account with the Commercial Repayment Center Portal (CRCP). Through the CRCP, users may view demand information on-line and submit defense documentation electronically.

An employer may authorize an insurer or TPA to respond on its behalf to a CRC demand letter but cannot transfer responsibility for a debt to the insurer or TPA. Employers should keep in mind the insurer or TPA may have a defense that does not necessarily absolve the employer of responsibility for the debt (e.g., the insurer or TPA did not cover/administer the plan at the time of the claim). Often, a plan's insurer or TPA will send an information request to the plan sponsor requesting census information including social security numbers, dates of birth, and employment status.

Taking into Account Medicare Entitlement

Q7. What is prohibited?

Generally, a group health plan and its plan sponsor cannot take into account a person's Medicare entitlement for purposes of administering the group health plan, applying plan provisions or making benefit determinations. This means a group health plan of an employer:

- may not take into account the ESRD-based Medicare eligibility or entitlement of any individual who is covered (or seeks to be covered) by the plan.
- with at least 20 employees, may not take into account the age-based Medicare entitlement of an individual (or an individual's spouse) who is age 65 and covered by (or seeks to be covered by) the group health plan by virtue of the individual's current employment status.
- with at least 100 employees, may not take into account the disability-based Medicare entitlement of any individual who is covered (or seeks to be covered) under the group health plan by virtue of current employment status.

Q8. What constitutes "taking into account" Medicare entitlement?

"Taking into account" Medicare entitlement includes (but is not limited to) the following actions:

- Failure to pay primary benefits.
- Offering coverage that is secondary to Medicare to individuals entitled to Medicare.
- Terminating coverage because the individual has become entitled to Medicare, except as permitted under COBRA continuation coverage provisions.
- Denying or terminating coverage because an individual becomes entitled or is entitled to Medicare on the basis of disability.
- Imposing benefit limitations on a Medicare-entitled individual that do not apply to others enrolled in the plan, such as providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, providing for lower annual or lifetime benefit limits, or more restrictive pre-existing illness limitations.
- Charging a Medicare-entitled individual higher premiums.
- Requiring a Medicare-entitled individual to wait longer for coverage to begin.
- Paying providers and suppliers no more than the Medicare payment rate for services furnished to a Medicare beneficiary but making payments at a higher rate for the same services to an enrollee who is not entitled to Medicare.
- Providing misleading or incomplete information that would have the effect of inducing a Medicare entitled individual to reject the employer plan, thereby making Medicare the primary payer.[6]

[6] An example of this would be informing the beneficiary of the right to accept or reject the employer plan but failing to inform the individual that, if he or she rejects the plan, the plan will not be permitted to provide or pay for secondary benefits.

- Including in its health insurance cards, claims forms, or brochures distributed to beneficiaries, providers, and suppliers, instructions to bill Medicare first for services furnished to Medicare beneficiaries without stipulating that such action may be taken only when Medicare is the primary payer.
- Refusing to enroll an individual for whom Medicare would be secondary payer, when enrollment is available to similarly situated individuals for whom Medicare would not be secondary payer.

Q9. Are there examples of permissible actions?

- Benefit distinctions among categories of individuals unrelated to their Medicare entitlement are permissible so long as they are applied consistently. For example, a waiting period imposed by the group health plan that applies on the same basis to all eligible employees, regardless of Medicare eligibility or entitlement, does not violate MSP rules.
- A group health plan may pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the plan coverage is COBRA continuation coverage because of reduced hours of work.[7]
- A group health plan may terminate COBRA continuation coverage of an individual who becomes entitled to Medicare on the basis of ESRD, when permitted under the COBRA provisions.

Q10. A vendor suggested that we amend our group health plan to allow coverage for a spouse or dependent child to continue under the active group health plan coverage when the employee drops the employee portion of the coverage to join Medicare. Does this pose issues under Medicare Secondary Payer Rules?

Yes. This design, often referred to as "trailing spouse language," appears to "take into account" the Medicare eligibility of the employee, as the continued eligibility for a spouse or dependent child in active coverage is tied to the employee dropping the employee portion of the group health plan coverage for Medicare. In addition, as described in Q/As-13-15, the design may also operate as a prohibited incentive as the employees who are eligible for Medicare are offered financial or other benefits (the continued coverage for the spouse/dependents in the active plan) as an incentive to disenroll in the group health plan and join Medicare.

Employers considering this design should review the risks with counsel. There may be other compliance issues (e.g., COBRA, cafeteria plan rules) that are not addressed in this summary.

Same Benefits/Same Conditions

Q11. What is the same benefit/same condition requirement for age-based Medicare?

A group health plan of an employer with at least 20 employees must provide to employees age 65 or older (and to spouses age 65 or older of employees of any age) the same benefits under the same conditions as it provides to employees and spouses under age 65. This requirement applies regardless of whether those individuals age 65 or older are entitled to Medicare.

Q12. What is the same benefit/same condition requirement for ESRD Medicare?

A group health plan, regardless of the employer's size, may not differentiate in the benefits it provides between individuals with ESRD and other individuals covered under the plan, on the basis of the existence of ESRD, or the need for dialysis, or in any other manner.

Impermissible differentiation includes:

[7] 411.108(b)(2). Medicare is primary payer for this beneficiary because, although he or she has current employment status, the GHP coverage is by virtue of the COBRA law rather than by virtue of the current employment status.

- Terminating coverage of individuals with ESRD when there is no basis for such termination unrelated to ESRD (such as failure to pay plan premiums) that would result in termination for individuals who do not have ESRD.
- Imposing on persons who have ESRD, but not on others enrolled in the plan, benefit limitations such as less comprehensive health plan coverage, reductions in benefits, exclusions of benefits, a higher deductible or coinsurance, a longer waiting period, a lower annual or lifetime benefit limit, or more restrictive preexisting illness limitations.
- Charging individuals with ESRD higher premiums.
- Paying providers and suppliers less for services furnished to individuals who have ESRD than for the same services furnished to those who do not have ESRD, such as paying 80% of the Medicare rate for renal dialysis on behalf of a plan enrollee who has ESRD and the usual, reasonable, and customary charge for renal dialysis on behalf of an enrollee who does not have ESRD.
- Failure to cover routine maintenance dialysis or kidney transplants, when a plan covers other dialysis services or other organ transplants.

No Incentives to Waive Coverage

Q13. May an employer (or carrier) offer financial incentives to encourage Medicare eligible individuals to opt-out of the group health plan sponsored by the employer.

No. An employer or other entity (for example, an insurer) is prohibited from offering Medicare beneficiaries financial inducement or other benefits as incentives not to enroll in, or to terminate enrollment in, a group health plan that is, or would be, primary to Medicare.

This rule applies even if the payments or benefits are offered to all other individuals who are eligible for coverage under the plan.

Q14. What about cash-out options (or cash in lieu of benefits) offered through a cafeteria plan?

Employers may, through their plan design, offer a "cash in lieu of benefits" option.[8] This design can be problematic if the employee taking the "cash" has Medicare. MSP prohibits an employer from offering incentives or otherwise encouraging an employee who is otherwise eligible for Medicare programs to decline employer-sponsored coverage.

An employer may avoid this risk by limiting cash in lieu offers to only those employees that demonstrate they are or will be covered under another employer-sponsored group health plan (e.g., through a spouse's employer), and not make "cash" options available to those solely covered by Medicare.

Note, an employee is permitted to voluntarily drop employer coverage because of their Medicare eligibility. However, an employer cannot induce or otherwise encourage the employee to do so.

Examples of impermissible inducements include offering to pay the employee's costs for Medicare, offering a Medicare supplemental policy to an active employee, or contributing the cash amount to the individual's 401k account.

Q15. What is the penalty for violating the prohibition on incentives?

It is a violation of the Medicare law every time a prohibited offer is made regardless of whether it is oral or in writing. Any entity that violates the prohibition is subject to a civil money penalty of up to $5,000 (as indexed,

[8] This article does not address the various compliance items to consider when offering a "cash in lieu of benefits" option through a cafeteria plan.

$11,162 in 2023) for each violation. Furthermore, the plan may be asked to reimburse Medicare for past claims it may have paid.

Enforcement

Q16. What penalties or other enforcement actions exist?

- If a group health plan fails to pay benefits primary to Medicare, there is potential for double damages if CMS brings legal action to recover payment.
- CMS may refer the matter to the IRS for imposition of a 25% excise tax on the group health plan expenses incurred in the calendar year for nonconforming plans.
- Penalties of $1,000 per day (adjusted annually) per affected individual for failure of the TPA, carrier or employer (with a self-insured, self-administered health plan) to comply with mandatory reporting requirements.
- Penalties of $11,162 (2023) for each violation related to the prohibition on financial inducement to waive group coverage.
- ERISA fiduciary violations for failure to administer the plan in accordance with applicable federal laws.

Best Practices

Q17. What are some best practices to avoid MSP failures?

- Except as allowed by the narrow small group exceptions, do not take into account the Medicare entitlement of plan participants and their family members. Common mistakes employers make include:
  - Not offering the group health coverage to those already covered by Medicare.
  - Excluding Medicare eligible spouses from the group health plan when non-Medicare eligible spouses may participate.
  - Applying different deductibles, coinsurance or reimbursement strategies to individuals entitled to Medicare if those same conditions do not apply to non-Medicare eligible participants and family members.
- Avoid offering financial incentives (as described in Q12 and Q13 above) to participants in exchange for waiving group health plan coverage. This includes paying Medicare Part B premiums in lieu of group health plan coverage.
- Keep accurate employee census and plan enrollment information to know whether an individual enrolled, disenrolled, or waived group health plan coverage. This information may be collected through a benefit administration system or other electronic enrollment platform.
- Update and maintain written plan documents which may be necessary to successfully appeal a CMS-BCRC demand based on a valid defense to the disputed charges. Valid defenses may include group coverage status of the individual (e.g., the employee was COBRA eligible thus Medicare should pay primary), the service received was not a covered under the plan terms, duplicate primary payment, capitation limits, or untimely claim filing.

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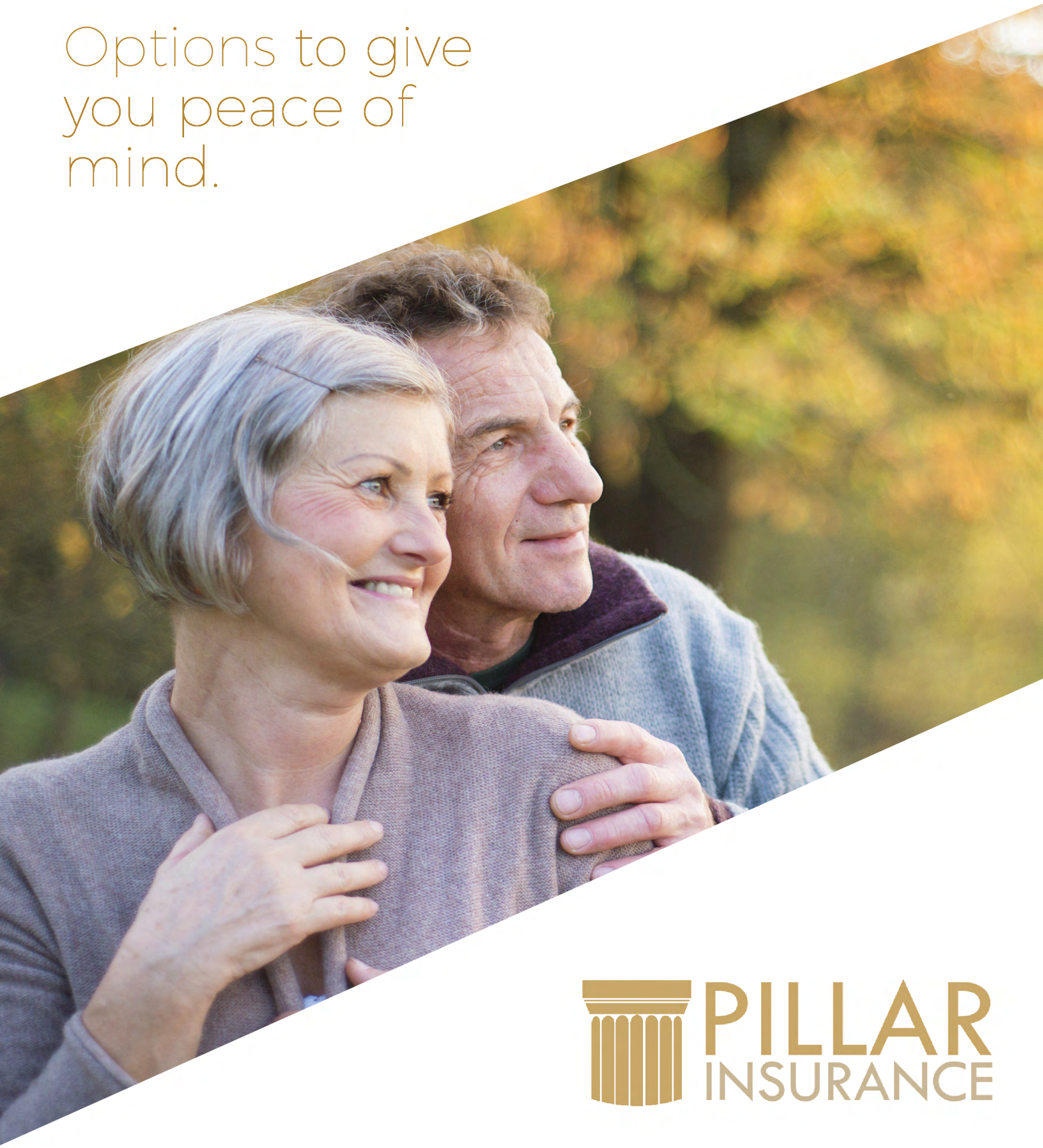

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ABOUT PILLAR

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FREQUENTLY ASKED QUESTIONS

Q. When should I contact you about my Medicare options?
A. If you are under 65, you should contact us 3 months before your birth month. If you are over 65, you can contact us at any time, but you must have a qualifying election period to apply. Anyone can apply during the Annual Election Period which runs from October 15 to December 7 for Medicare Advantage Plans and Part D prescription plans. If you are evaluating your choices while still employed and are considering opting out of your employer plan, a one to two month lead time will be helpful. This allows us time to advise you on any additional steps to enroll in Part B coverage and set up your new plans prior to leaving group coverage.

Q. Why do I need an agent?
A. An independent agent representing multiple companies can assist you in choosing between plans, enrolling, and is able to assist you with claims or billing problems, should they arise. The agent should evaluate your options each year to make sure that your plan is the best fit for you.

Q. Does it cost more to have an agent or change my policy in any way?
A. No, the product is the same with or without an agent. With an agent, you gain an advocate and don't pay for their services. The insurance company compensates the agent to make sure you have the plan that best fits your needs, that you understand your plan and can assist you with claims or administrative issues. Compensation is regulated by Medicare.

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