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# Medicare Secondary Payer: The Working Aged

The Medicare Secondary Payer (MSP) rules are designed to shift costs from the Medicare program by making Medicare the secondary payer to other payment sources, such as employer-sponsored group health plans, in certain situations. The payment rules vary based on a number of factors, including the source of the other health coverage and why an individual is entitled to Medicare (for example, age, disability or end-stage renal disease). This article addresses the MSP provisions for individuals who are eligible for Medicare based on age and who have group health coverage due to current employment status.

Under the MSP rules, when a current employee (or a current employee's spouse) is entitled to Medicare due to age, a group health plan must comply with certain coverage requirements. For example, an employer cannot offer financial or other incentives for an individual entitled to Medicare to not enroll (or to terminate enrollment) under a group health plan that would pay primary. A violation of the prohibition on offering incentives can trigger financial penalties of up to **$5,000** per violation.

## LINKS AND RESOURCES

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that is responsible for overseeing the MSP rules.

More information on the MSP rules is available on CMS's MSP **Web page**, including the **Medicare Secondary Payer Manual**.

## HIGHLIGHTS

### COVERED EMPLOYERS

- The MSP rules apply to employers in the private and public sector, including nonprofit organizations.
- Employers with fewer than 20 employees are not subject to the MSP rules for employees (or covered spouses) who are eligible for Medicare due to age (referred to as the "working aged").

### MSP RULES

Group health plans that are primary to Medicare:

- Must provide Medicare-entitled employees with the same benefits as individuals under age 65;
- Cannot take into account an individual's Medicare entitlement; and
- Cannot offer incentives to encourage Medicare-entitled individuals to opt out of group health plan coverage.

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## GENERAL MSP PROVISIONS

The MSP provisions prohibit Medicare from making payments if payment has been made (or can reasonably be expected to be made) by the following primary plans, when certain conditions are satisfied:

| | |
|---|---|
| **Group health plans (GHPs)** | **Workers' compensation plans** |
| **Liability insurance** | **No-fault insurance** |

**HOW IT WORKS—**When Medicare is the secondary payer, the order of payment is the reverse of what it is when Medicare is primary. The other payer pays first and Medicare pays second. When Medicare is the secondary payer, the provider, physician or other supplier, or beneficiary must first submit the claim to the primary payer. The primary payer is required to process and make primary payment on the claim in accordance with the coverage provisions of its contract.

Where a GHP is the primary payer but does not pay in full for the services, secondary Medicare benefits may be paid to supplement the amount that the GHP paid for the Medicare covered service. Generally, the beneficiary is not disadvantaged where Medicare is the secondary payer because the combined payment by a primary payer and by Medicare as the secondary payer is the same as, or greater than, the combined payment when Medicare is the primary payer.

If a GHP denies payment for services because the services are not covered by the plan, primary Medicare benefits may be paid if the services are covered by Medicare. Primary Medicare benefits may not be paid if the GHP denies payment because the plan does not cover the service for primary payment when provided to Medicare beneficiaries. A GHP's decision to pay or deny a claim because the services are or are not medically necessary is not binding on Medicare.

The payment rules vary based on a number of factors, including the source of the other health coverage and why an individual is entitled to Medicare (for example, age, disability or end-stage renal disease).

Health insurance plans for retirees or the spouses of retirees are not primary to Medicare, and, thus, are not subject to the MSP provisions.

## DETERMINING PAYER STATUS

In general, Medicare benefits are secondary to benefits payable under GHPs for individuals age 65 or over who have GHP coverage as a result of:

- ✓ Their own current employment status with an employer that has 20 or more employees; or

✓ The current employment status of a spouse of any age with an employer that has 20 or more employees.

| SITUATION | EMPLOYER SIZE | PAYS FIRST | PAYS SECOND |
|---|---|---|---|
| Individuals age 65 or older who are covered by a group health plan because the individuals (or their spouses) are still working | **20 or more employees** | Group health plan | Medicare |
| | **Fewer than 20 employees** | Medicare | Group health plan |

### *Small Employer Exception*

Only employers with **20 or more employees** are required to offer the same (primary) coverage to their employees who are age 65 or over (and to spouses who are age 65 or over of employees of any age) that they offer to younger employees and spouses. The 20-employee threshold is met if an employer has 20 or more full-time and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year.

The following rules apply in order to determine whether a GHP is primary to Medicare:

- Self-employed individuals who participate in an employer plan are not counted as employees when determining if the 20-employee threshold is met.
- Where an employer does not have 20 or more employees in the preceding year, the employer is required to offer its employees and their spouses (who are age 65 or over) primary coverage if the employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year, even if the number of employees subsequently drops below 20.
- The 20-employee threshold must be met when an individual receives services for which Medicare benefits are claimed. If, at that time, the employer has met the 20-employee threshold requirement in the current year or in the preceding calendar year, the GHP is the primary payer.
- An employer that meets this requirement must provide primary coverage even if less than 20 employees participate in the GHP.

## PROHIBITED DISCRIMINATION AND INCENTIVES

**Large employers (with 20 or more employees) must comply with these group health plan requirements:**

- ✓ The group health plan must provide a current employee (or a current employee's spouse) who is age 65 or older with the **same benefits**, under the same conditions, that it provides to employees and spouses who are under age 65;
- ✓ The group health plan **cannot take into account the Medicare entitlement** of a current employee (or a current employee's spouse); and
- ✓ The employer **cannot offer any financial or other incentive** for a Medicare-entitled individual not to enroll (or to terminate enrollment) under a group health plan which would be a primary plan if the individual was enrolled.

### *Must Offer Same Benefits*

Large employers (those with 20 or more employees) are required to offer to their employees who are age 65 or over (and to spouses who are age 65 or over of employees of any age) the same coverage that they offer to younger employees and spouses. This equal benefit rule applies to coverage offered to all employees, full time and part time.

### *Cannot "Take Into Account" Medicare Entitlement*

In addition, the MSP provisions prohibit the GHPs of large employers (20 or more employees) from "taking into account" the Medicare entitlement of employees age 65 or over, or of spouses age 65 or over of employees of any age. Prohibited actions that "take into account" Medicare entitlement include, but are not limited to, the following:

- Refusing to enroll an individual for whom Medicare would be the secondary payer if enrollment is available to similarly situated individuals for whom Medicare would not be the secondary payer;
- Failing 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 with COBRA coverage);
- Imposing limitations on benefits for an individual entitled to Medicare that do not apply to others enrolled in the plan, such as:
    - Providing less comprehensive health care coverage or excluding or reducing benefits;
    - Charging higher deductibles or coinsurance; or

  - Providing for lower annual or lifetime benefits limits.

- Charging higher premiums to a Medicare-entitled individual;
- 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 provided to a Medicare beneficiary, but making payments at a higher rate for the same services provided to an individual who is not entitled to Medicare;
- Providing incomplete or misleading information that would have the effect of inducing a Medicare-entitled individual to reject an employer's GHP, which would make Medicare the primary payer; and
- Including in its health insurance cards, claim forms or brochures distributed to beneficiaries, providers and suppliers, instructions to bill Medicare first for services provided to Medicare beneficiaries, without stating that Medicare should be billed first only when it is the primary payer.

However, if a GHP makes benefit distinctions among various categories of individuals based on the length of time they are employed, their occupation, marital status or other similar bases, the plan may make the same distinctions among the same categories of Medicare-entitled individuals whose plan coverage is based on current employment status. For example, if a GHP imposes a waiting period on individuals who are not entitled to Medicare, it may impose the same waiting period on individuals who are entitled to Medicare.

### *Cannot Offer Incentives*

Medicare beneficiaries are free to reject employer plan coverage, in which case they retain Medicare as their primary coverage.

**Prohibition on Offering Certain Incentives**

When Medicare is the secondary payer, employers cannot **discourage employees from enrolling** in their group health plans.

Also, employers cannot offer any "**financial or other incentive**" for an individual entitled to Medicare "not to enroll (or to terminate enrollment) under" a group health plan that would pay primary.

A violation of the prohibition on offering incentives can trigger financial penalties of **up to $5,000** per violation.

CMS has advised that an employer cannot offer, subsidize or be involved in the arrangement of a Medicare supplement policy where the law makes Medicare the secondary payer. Because this type of arrangement takes into account the Medicare entitlement of the employee, CMS has warned that it would subject the employer to **possible excise taxes** under the Internal Revenue Code.

### Paying Medicare Premiums

Unless the small employer exception applies, paying an employee's Medicare premiums (Part B, Part D or supplement policy) likely violates the prohibition on an employer offering a financial incentive not to enroll in a group health plan that would otherwise pay primary to Medicare.

Even if the small employer exception applies, the Affordable Care Act (ACA) includes reforms that limit an employer's ability to reimburse employees' Medicare premiums. In order to satisfy the ACA's reforms, the reimbursement arrangement must satisfy certain integration requirements or qualify for an exception (for example, arrangements that cover fewer than two current employees are exempt from the ACA's reforms).

In addition, depending on how the arrangement is structured, encouraging employees to waive group health plan coverage may raise other legal concerns, such as age discrimination concerns under the federal Age Discrimination in Employment Act (ADEA). Employers that are considering reimbursing employees' Medicare premiums may wish to consult with legal counsel to confirm that the arrangement will comply with applicable laws.

*Source: The Centers for Medicare and Medicaid Services*