COMPLIANCE ALERT

Review of Medicare Secondary Payer Requirements

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Quick Facts

- Medicare Secondary Payer (MSP) rules significantly limit any differentiation in benefit offerings for individuals who are eligible for Medicare coverage and determine rules that dictate which plan is the primary payer for individuals enrolled in both Medicare and employer-sponsored coverage.
- When the employer's group health plan is the primary payer to Medicare the MSP rules prohibit the group health plan from "taking into account" the Medicare entitlement of a current employee or the employee's spouse or family member.
- Employers should be cautious not to differentiate benefits design or eligibility due to Medicare entitlement or eligibility, nor should employers incentivize employees to take Medicare over the group health plan.

Introduction

Employers often wonder what types of premium assistance or other benefits they can provide to employees and family members who are eligible for or entitled to Medicare. For most employers, MSP rules significantly limit any differentiation in benefit offerings for individuals eligible for Medicare coverage. In addition, the MSP rules dictate which plan is the primary payer when an individual is enrolled in (entitled to) Medicare and is also enrolled in an employer's group health plan.

Plans Subject to MSP Rules

MSP rules apply broadly to most group health plans, including excepted benefits, but the rules do not apply to health flexible spending accounts (FSAs) or Qualified Small Employee Health Reimbursement Arrangements (QSEHRAs).

Coordination of Benefits

The MSP rules contain specific instructions for determining which plan is required to pay primary when an individual is entitled to Medicare and is enrolled in an employer's group health plan (i.e., coordination of benefits). The carrier or third-party administrator (TPA) will typically handle coordination of benefits, but it is beneficial for the employer to know when its group health plan is the primary payer and to help employees understand as well. For most employers, the employer's group health plan will be the primary payer and Medicare the secondary payer, at least for active employees and their family members.

Below is a chart that illustrates the payer status of the employer's group health plan:

Medicare Type:	Age-Based	Disability-Based	ESRD-Based
# of Active Employees			
<20 Employees	Secondary Payer	Secondary Payer	Primary Payer First 30 Months
20-99 Employees	Primary Payer	Secondary Payer	Primary Payer First 30 Months
100+ Employees	Primary Payer	Primary Payer	Primary Payer First 30 Months
Retired Employees	Secondary Payer	Secondary Payer	Primary Payer First 30 Months
COBRA Participants	Secondary Payer	Secondary Payer	Primary Payer First 30 Months

Active Plan Participants

For age-based Medicare, employers with 20 or more employees for each working day in at least 20 weeks in the current or the preceding calendar year qualify for the small employer exception and pay secondary to Medicare for active plan participants (including employees, spouses and their dependents). It's important for participants in small employer plans to understand that Medicare pays primary and that they should enroll in Medicare even if they choose to enroll in their employer plan. In some situations, we have seen insurers rely on these MSP rules to refuse payment because Medicare is the primary payer. Employers should communicate MSP rules to employees enrolled in a small employer group health plan.

For disability-based Medicare, employers with 100 or more employees on at least 50% of their regular business days during the previous calendar year qualify for the small employer exception and may pay secondary to Medicare for active plan participants (including employees, spouses and their dependents).

Tips for Counting Employees

It is important to note that the employer's size is based on the number of employees and not on the number of participants in the group health plan. For this purpose, "employees" generally include all common-law employees, including part-time employees. However, self-employed individuals who participate in the group health plan are not included in the count.

In counting an employer's employees, it is necessary to include all employees for entities with 50% or more common ownership as defined under §52(a) or (b) rules. It is also necessary to include all employees for entities that are part of the same affiliated service group as defined under §414(m).

There are special rules that apply to multiemployer or multiple-employer plans:

- If at least one of the employers in the plan has 20 or more employees, then all participating employers will be treated as having 20 or more employees (unless an exemption is obtained from CMS).
- If at least one of the employers in the plan has 100 or more employees, then all participating employers will be treated as having 100 or more employees.

Retirees and COBRA Participants

When individuals are covered under the employer's group health plan as retirees or participants covered by the Consolidated Omnibus Budget Reconciliation Act (COBRA) the employer's plan is generally the secondary payer to Medicare except for the first 30 months of End Stage Renal Disease (ESRD)-based Medicare. However, there is a special rule for rehired individuals who are entitled to retiree medical coverage. When these rehired individuals are covered by a group health plan and

perform services that are the same as those performed by other employees in the same employment category who are eligible for benefits, they are treated like active employees.

Individuals with ESRD

For ESRD-based Medicare (i.e., Medicare due to end-stage renal disease), the employer's group health plan is the primary payer to Medicare for the first 30 months regardless of employer size, unless the individual was entitled to age or disability-based Medicare prior to becoming eligible for ESRD-based Medicare. In addition, beyond the first 30 months, the plan may not otherwise differentiate the benefits provided under the plan based on ESRD except that the plan is permitted to pay secondary to Medicare.

In June 2022, the Supreme Court released an **opinion** stating that group health plans may limit coverage for dialysis on a uniform basis for all plan participants without violating MSP rules. For individuals eligible for Medicare due to ESRD the MSP rules require that the group health plan must pay primary to Medicare for the first 30 months of ESRD-based Medicare eligibility, and the group health plan cannot differentiate benefit offerings for those with ESRD (and eligible for Medicare) from those who do not have ESRD.

The language in the MSP rules makes it clear that there cannot be any differentiation in how a group health plan provides coverage based on the existence of ESRD (before, during, or after the 30-month coordination period), other than allowing the plan to pay secondary to Medicare once the 30-month coordination period is exhausted. the Supreme Court of the United States (SCOTUS) ruled that when the coverage limitations apply uniformly to all participants requiring such treatments or services, and not just those with ESRD, it does not violate MSP rules.

MSP General Requirements

Prohibited from "Taking Into Account" Medicare Entitlement

When the employer's group health plan is the primary payer to Medicare under the coordination of benefit rules (described above) the MSP rules prohibit the group health plan from "taking into account" the Medicare entitlement of a current employee or the employee's spouse or family member. Examples of "taking into account" Medicare entitlement include, but are not limited to:

- Failing to pay primary when required under the MSP rules.
- Offering coverage that is secondary to Medicare to individuals entitled to Medicare.
- Terminating coverage or refusing to enroll individuals entitled to Medicare.
- Imposing higher premiums, longer waiting periods, or plan limits for Medicare-entitled individuals.
- Providing misleading information to discourage people from enrolling in the group health plan.

Must Offer Those Aged 65 or Older the Same Benefits

The MSP rules also require a group health plan to provide a current employee or an employee's spouse who is age 65 or older with the same benefits, under the same conditions, as are provided to employees and spouses who are under age 65.

Cannot Incent Individuals Not to Enroll in an Employer's Group Health Plan

The MSP rules prohibit employers from discouraging employees or their family members from enrolling in the employer's group health plans or from offering any "financial or other incentive" for individuals who are eligible for Medicare "not to enroll (or to terminate enrollment) under" a group health plan that would otherwise be a primary payer to Medicare. This rule prohibits doing things such

as offering opt-out incentives based on Medicare eligibility, offering to pay for Medicare premiums or supplements, or allowing Medicare premiums to be paid on a pre-tax basis through a cafeteria plan. The employer should not take any action that would encourage Medicare-eligible individuals not to enroll in employer-sponsored coverage; the individual should be allowed to make the decision voluntarily without any persuasion from the employer.

Benefit Design Considerations

Differentiation in Benefits

Group health plans are generally permitted to differentiate benefit offerings between categories of employees (e.g., based on geographic location), even if the difference may involve those who are eligible for or enrolled in Medicare, so long as the distinction is not tied specifically to Medicare eligibility or entitlement.

Opt-Out/Cash in Lieu Incentives

One particular benefit that raises potential MSP concerns is an opt-out incentive for waiving coverage. Although any kind of incentive targeting only those who are Medicare-eligible or entitled to Medicare would violate MSP rules, it is less clear whether an opt-out incentive offered more broadly would be considered a violation.

Informal guidance provided via the **ABA Joint Committee on Employee Benefits, Questions and Answers for CMS/HHS (May 8, 2002), Q&A #3,** indicates that an opt-out arrangement run through a cafeteria plan, whether available to all who waive or to all who show proof of other coverage and not just to those who are Medicare-eligible, would not violate the MSP rules. However, CMS appears to take a different view in its **MSP Manual**, indicating the prohibition applies "even if the payments or benefits are offered to all other individuals who are eligible for coverage under the plan." Because the guidance is unclear, the most conservative approach would be to either: (i) offer the opt-out only to employees who are not eligible for Medicare (the employer could rely on an affidavit from employees attesting that they are not Medicare-eligible), or (ii) limit the opt-out to those who show proof of other group coverage (Medicare is not considered group coverage).

Reimbursing Medicare Policies/Premiums

In general, MSP rules prohibit employers from reimbursing premiums for Medicare or Medicare supplements directly or indirectly. Employers cannot allow employees to pay for premiums on a pre-tax basis through a cafeteria plan either.

For small employers whose group health plan coverage would be a secondary payer to Medicare, the employer could help pay for Medicare premiums or allow employees to make pre-tax contributions toward the premiums through the employer's cafeteria plan. In addition, there is a limited exception to the general ACA prohibition on reimbursement of individual premiums for Medicare Premium Reimbursement Arrangements that meet certain criteria.

Small Employer Options

When the employer's group health plan is the secondary payer to Medicare under the coordination of benefit rules, there is more flexibility for the employer's group health plan to exclude those who are Medicare-eligible or to pay secondary regardless of whether the individual enrolls in (becomes entitled to) Medicare. It is fairly common that fully insured small group plans will be designed with such limitations by the carrier. For this reason, it is important for employers to understand how their coverage applies to those who are Medicare-eligible and to educate their employees accordingly. For example, an employee who turns age 65 and chooses to remain enrolled in the employer's group

health plan rather than enrolling in Medicare, it would be important for the employee to know that claims may only be covered by the plan as if the employee were enrolled in Medicare.

In addition to limiting plan coverage for those who are Medicare-eligible, there is also more flexibility for a small employer to incent employees to enroll in Medicare rather than the employer's group health plan by offering opt-out incentives specifically targeting Medicare-eligible individuals, or to help individuals pay for Medicare premiums.

Retiree/Severance Offerings

It is common for employers to offer subsidized COBRA continuation coverage or retiree coverage upon termination of employment. However, for those who are Medicare-eligible, delaying Medicare enrollment or maintaining dual coverage by paying COBRA or retiree premiums may not be the best choice. For most individuals, COBRA coverage or retiree coverage acts as a secondary payer to Medicare. In addition, because the coverage is not tied to current employment status, it does not count as creditable coverage that would allow individuals to delay Medicare enrollment without later facing restricted enrollment opportunities and late penalties.

Enforcement & Penalties for Noncompliance

MSP Mandatory Reporting

Reporting for group health plans is required to be submitted quarterly by carriers and TPAs to help CMS identify situations where Medicare should be the secondary payer. Employers typically do not play a role in this reporting unless the carrier or TPA asks the employer to help pull together some of the necessary data (e.g., about "active covered individuals").

If CMS discovers that it mistakenly paid claims as the primary payer, CMS will send a letter to the employer plan sponsor requesting repayment of what should have been covered by the employer's group health plan. The employer must then make a payment or provide information indicating the individual was not enrolled in the employer's plan or that the employer's plan was correctly paid as the secondary payer. Often the carrier or TPA will assist with this process.

Penalties

Penalties for failing to comply with the MSP rules include:

- Civil penalties of up to $5,000 per violation for financial incentives.
- Reimbursement to Medicare for any payments made by Medicare if it is demonstrated that the employer's plan was responsible for paying for the item or service.
- An excise tax penalty on employers who contribute to nonconforming group health plans of 25% of the employer's expenses incurred during the calendar year for each group health plan (both conforming and nonconforming) to which they contribute.

Summary

When determining what types of benefits and/or incentives to offer employees, employers must consider the potential impact the MSP rules might have on these benefits. The employer should have an understanding of when the employer's group health plan is considered the primary payer. In addition, employers should avoid taking actions that will make the employer's group health plan the less attractive option when compared with Medicare; most methods of doing so will violate MSP rules. Employees may freely choose between the employer's group health plan and Medicare, but an employer should generally not play a role in that decision other than providing basic education to employees about Medicare eligibility and benefits. If the employer restricts coverage, charges more

for the coverage, or provides other incentives (e.g., cash) to encourage such individuals to choose Medicare over the employer's group health plan, the employer is probably in violation of MSP rules.

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