Medicare Secondary Payer Rules

Medicare is a federal program that covers medical services for individuals age 65 or older, disabled individuals, and those diagnosed with End Stage Renal Disease (ESRD). Medicare consists of four parts (A-D) that cover hospitalizations, physician services, prescription drugs, skilled nursing facility care, home health visits, hospice care, and other treatments. Some individuals receive Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) automatically while others must apply for coverage. Generally, individuals receiving social security benefits are automatically enrolled in Medicare Part A and may or may not pay a premium. Medicare Part B, C and D are optional and a separate premium applies.

COORDINATION OF BENEFITS

Some individuals are dually eligible for group health plan coverage through an employer-sponsored plan and Medicare. The Medicare Secondary Payer (MSP) rules require group health plans to provide Medicare-enrolled employees and their spouses the same benefits under the same conditions as non-Medicare enrolled employees. Group health plans that cover multiple employers are subject to MSP rules if at least one employer in the group has 20 employees or more. Small employers and retiree-only plans will always be the secondary payer for individuals enrolled in Medicare.

The MSP rules also assign primary payment responsibility to the group health plan depending on 1) the size of the employer and 2) the basis for Medicare enrollment. This chart shows the primary or secondary payer responsibilities.

Employer Size	Medicare entitlement due to age (65+)	Medicare entitlement due to disability (under age 65)	Medicare entitlement due to ESRD (any age)
Under 20 employees	Primary payer: Medicare	Primary Payer: Medicare	Group Health Plan is the primary payer for first 30 months and Medicare is secondary payer; Medicare becomes primary payer after 30 months
20-99 employees	Primary Payer: Group Health Plan	Primary Payer: Medicare	
100 or more employees	Primary Payer: Group Health Plan	Primary payer: Group Health Plan	

The MSP rules generally apply while the employee maintains an employment relationship with the employer including while on short term disability, paid leave or COBRA.

PROHIBITION ON OFFERING CASH OR OTHER INCENTIVES TO WAIVE GROUP HEALTH COVERAGE

The MSP rules prohibit employers or other plan sponsors from encouraging or offering incentives to individuals who are eligible for, or already enrolled in, Medicare to waive group health plan enrollment. This includes the employee, their spouse or their dependents. Purchasing a Medicare supplemental policy or offering a 401k contribution in exchange for not enrolling in the group health plan is considered an impermissible incentive. However, Medicare beneficiaries are permitted to voluntarily reject an offer of group health plan coverage so long as they are not incentivized to do so. If an individual rejects employer sponsored coverage, the employer cannot offer any secondary coverage for items and services covered by Medicare.

MSP REPORTING AND OVERPAYMENT RECOVERIES

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. 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. This reporting allows the BCRC to coordinate benefit payments between the group health plan and Medicare.

The BCRC and Commercial Repayment Center (CRC)[1] 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.

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 plans 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.

INTEREST AND PENALTIES

If a CRC demand letter goes unanswered or unresolved, interest will be applied to the claim and it will continue to accrue every 30 days while the debt remains outstanding. Debts outstanding longer than 60 days will be considered delinquent and the matter may be forwarded to the Department of Treasury Offset Program for further collection activity. It may also be referred to the Department of Justice for legal action and subject to double damages. Penalties are $5000 per violation and subject to possible excise taxes. Generally, the CRC has a minimum of 3 years from the date of service to present a demand letter to the responsible party.

BEST PRACTICES

To protect against MSP violations, employers may implement a written waiver program that requires all participants declining group health coverage to acknowledge that coverage was offered and indicate the reason they declined to enroll such as because they are covered under a spouse's group health plan. Also, employers should avoid offering Medicare-eligible individuals any valuable consideration in exchange for not enrolling in the group health plan.

[1] 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).