What You Need to Know about Medicare Secondary Payer Rules

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Under federal regulations, Medicare is a secondary payer for many individuals who have an employer group health plan available to them, either as an employee or the dependent spouse or child of the employee. Generally the Medicare Secondary Payer rules prohibit employers with 20 or more employees from in any way incentivizing an active employee age 65 or older to elect Medicare instead of the group health plan, which includes offering a financial incentive. Although premium payment arrangement rules under the Patient Protection and Affordable Care Act (ACA) provide a limited circumstance for reimbursing Medicare premiums, this option is not feasible for employers with more than 20 employees due to Medicare Secondary Payer rules.

Q1. Who is affected by Medicare Secondary Payer rules?

A1. Medicare-eligible individuals age 65 or over whose employer group health plan is based on the current employment of the individual or spouse, by an employer that employs 20 or more employees, are protected by the Medicare Secondary Payer rules unless the active employee elects Medicare. Health insurance plans for retirees, or spouses of retirees, are not affected because retirement is not "current employment." Individuals who are eligible for Medicare based on disability or end-stage renal disease (ESRD) are also affected.

Q2. What are employers with 20 or more employees required to offer their Medicare-eligible older employees?

A2. Employers are required to offer employees age 65 or over the same group health plan coverage offered to younger workers. Workers with Medicare-eligible spouses must be offered the same spousal benefits as employees with spouses that are not Medicare-eligible. Incentivizing employees to take Medicare over the group health plan is expressly prohibited. Incentives can take many forms, both direct and indirect, and all should be avoided. Reimbursing Medicare supplements and providing opt-out bonuses for waiving the group health plan are considered incentives.

Q3. Are employees who are Medicare eligible required to elect their group health coverage or Medicare?

A3. Employees can elect, at their discretion, Medicare or the group health plan as their primary health insurer. Employees that elect their group health plan will then have secondary Medicare coverage if they enroll in Medicare. Their employer cannot induce them or provide incentives to select Medicare as their primary coverage.

Q4. If an employee elects Medicare as his or her primary insurer, may the employee enroll in a group health plan for secondary coverage?

A4. No, this is prohibited.

Q5. How does Medicare know if an individual has the option of enrolling in a group health plan through their employer?

A5. The Centers for Medicare and Medicaid (CMS) mails questionnaires to individuals before they become entitled to benefits under Medicare Part A or enroll in Medicare Part B to determine if they are eligible for primary coverage under another plan.

Q6. Are there any reporting requirements surrounding Medicare Secondary Payer rules?

A6. Yes, under Medicare Section 111. Dependent on circumstances, a responsible reporting entity (RRE) can be an insurer, a third party administrator, or a plan administrator. The RRE is responsible for collecting data from plan sponsors and participants and reports to CMS quarterly. Failure to report this information can lead to penalties of $1,211 for each day of non-compliance. (See Question 12 for more.)

Starting January 1, 2020, RREs will be required to submit primary prescription drug coverage information as part of their Section 111 Medicare Secondary Payer mandatory reporting. The Centers for Medicare and Medicaid Services (CMS) revised its Section 111 Medicare Secondary Payer (MSP) User Guide and issued FAQs that require responsible reporting entities (RREs) to describe these requirements.

The RRE for reporting primary prescription drug coverage is the entity that has direct responsibility for processing and paying prescription drug claims. In most cases, the RRE will be the insurer or TPA. For example, if the plan sponsor contracts with a third party such as a pharmacy benefits manager (PBM) to administer prescription drug coverage, then the third party or PBM is considered the RRE for prescription drug reporting purposes. However, for self-funded plans that are self-administered, the RRE will usually be the plan administrator.

Q7. How do I determine if I have more or less than 20 employees for Medicare Secondary Payer purposes?

A7. Employers are considered to have 20 or more employees if they have 20 or more full-time and part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. Each part-time employee counts as a full employee. Employees that are not enrolled in a group health plan are included in the headcount. Self-employed individuals participating in the group health plan are not counted as part of the 20.

Q8. What happens when I go over 20 employees for 20 weeks?

A8. Once an employer has had 20 or more employees working on each day of 20 calendar weeks in a current year, no matter how few employees there were in the preceding year, it must offer primary coverage for the remainder of that year and throughout the following year, even if the number of employees drops under 20 during that time.

Example: Joe's Sandwich Shop offers group health insurance to its employees. Joe's Sandwich Shop had 18 employees for all of 2017 and 2018. Beginning the first week of January 2019, Joe's Sandwich Shop consistently had 21 employees. After May 21, 2019, Joe's Sandwich Shop must ensure it offers the group health plan to all employees over age 65 for the remainder of 2019 and 2020, even if it only has 18 workers beginning in July 2019.

Q9. The Patient Protection and Affordable Care Act (ACA) severely limits an employer's ability to reimburse individual premiums unless the employer is offering an individual coverage health reimbursement arrangement (ICHRA) that is integrated with Medicare. If an employer has fewer than 20 employees and is not offering an ICHRA integrated with Medicare, is it permissible to reimburse an employee's Medicare Part B or Part D premium?

A9. Unless the employer payment plan is integrated with a group health plan or the employer is offering an ICHRA integrated with Medicare, reimbursing Medicare Part B or Part D premiums will result in a non-compliant group health plan, subject to $100 per employee per day penalties. (See Question 12 for more.)

Q10. When will a reimbursement program be considered integrated with a group health plan?

A10. The following criteria must be met for an employer payment reimbursement program to be integrated with a group health plan:

1. The employer must offer a group health plan to all employees that offers minimum value, even if Medicare-eligible employees decline the plan;
2. The employee who receives premium payment must be enrolled in Medicare Parts A and B;
3. The program must provide that premium payments are only available to employees who are enrolled in Medicare Part A, and either Part B or D; and
4. Premium payment or reimbursement may be only for Medicare Part B or D premiums and excepted benefits, including Medigap premiums.

Practically speaking, this integration will be done through a health reimbursement arrangement (HRA) that is subject to Internal Revenue Code Section 105 rules, and is considered a self-funded group health plan.

Q11. If a small employer (fewer than 50 full-time or full-time equivalent employees) has been reimbursing Medicare premiums for active employees, are they subject to the $100 per employee per day penalty?

A11. Yes, however small employers that have been reimbursing Medicare premiums for active employees that do not meet the requirements in Question 10 had a grace period until June 30, 2015, before penalties were applied. Beginning January 1, 2020, employers of any size can offer ICHRAs that are integrated

with Medicare and may reimburse premiums for Medicare Part A, B, C, D, Medigap policies, and also other Section 213(d) medical care expenses.

Q12. Generally speaking, what are the penalties for violating Medicare Secondary Payer or ACA premium reimbursement rules?

A12. There are numerous penalties that exist for violation of Medicare Secondary Payer rules.

Medicare Civil Monetary Penalties:

1. Any entity that makes a prohibited offer or incentive to an employee, whether oral or in writing, is subject to a civil money penalty of up to $9,472 per offer.

2. Failure on the part of a group health plan to fulfill reporting requirements under Section 111 to allow for the coordination of benefits can result in a civil monetary penalty of $1,211 a day for each day of non-compliance for each individual for which the information should have been submitted.

IRS penalties:

1. Contributing to a “nonconforming” group health plan is subject to an additional excise tax imposed by the Internal Revenue Service (IRS) of 25 percent of the employer’s or employee organization’s group health plan expenses for the relevant year. A “nonconforming” group health plan is one that: (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 younger employees and spouses; (3) improperly differentiates between individuals with ESRD and others; or (4) fails to refund an erroneous conditional Medicare payment.

2. If an employer reimburses an individual’s Medicare premium that is not integrated with a group health plan or is not part of an ICHRA offered by the employer (see Questions 9 and 10), it is subject to a $100 IRS penalty, per employee, per day for violating individual premium reimbursement rules under ACA. For practical purposes, employers with more than 20 employees will not be able to reimburse premiums that are integrated with group health plans, because they will violate Medicare Secondary Payer prohibitions. However, as noted above, an employer of any size may offer an ICHRA that can reimburse Medicare premiums and will not violate the Medicare secondary payer rules.

Q13. Are there rules or requirements for employees who are Medicare eligible due to disability or end-stage renal disease (ESRD)?

A13. Yes. Medicare is the secondary payer for individuals under age 65 who are entitled to Medicare based on disability and who are covered by a “large group health plan” whose coverage is based on employment status of the individual or a family member. A large group health plan applies to an employer with 100 or more employees on at least 50% of its regular business days during the previous calendar year.

If an employee is eligible for Medicare because of ESRD, the group health plan will be primary for hospital and medical bills for 30 months, whether or not the employee is enrolled in Medicare, regardless of how many employees work for the employer. At the end of 30 months, Medicare pays first.

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