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MEDICARE SECONDARY PAYER LAW

When Medicare began back in 1966 it was the primary payer for almost all claims. In 1980, Congress passed legislation that made Medicare the secondary payer to certain primary plans in an effort to shift costs from Medicare to private insurers.

When a member is covered by both Medicare and an employer's group health plan, Medicare Secondary Payer (MSP) rules specify that the employer's total size, not group health plan enrollment size, is a factor in determining whether Medicare benefits are primary or secondary. Employer size is a factor in MSP payment determinations when the covered individual is Medicare-entitled due to either age ("working age") or disability.

If a group has less than 20 TOTAL (full-time, part-time, seasonal, or partners) employees

- Medicare is the primary payer on claims and the group health plan will be secondary
- The member **MUST** have Medicare parts A&B for claims be paid correctly
 - The group health carrier will pay claims as though the member has Part B, even if he/she doesn't.

EXAMPLE: Member has waived Medicare Part B. She works for an employer with less than 20 total employees, so Medicare is the primary payer on claims. She goes to the doctor and the total bill is \$100. Medicare would have paid 80% of the bill; BCBSIL pays the remaining 20%. Member is responsible for paying the \$80 that Medicare would have paid.

If a group has more than 20 TOTAL (full-time, part-time, seasonal, or partners) employees

- Group health plan is the primary payer and Medicare will be secondary
- Medicare parts A & B are not necessary, but still recommended
 - If the member or dependents become disabled, retired or goes onto COBRA, then Medicare becomes primary and parts A&B are needed.

For additional information regarding Medicare Coordination of benefits visit the CMS website at <http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html>

Or view the [MSP Fact Sheet](#)

BCBSIL MSP Forms

Each year in the month of May, BCBSIL will solicit groups for their Medicare Secondary Payer (MSP) status through Blue Access for Employers. The MSP will indicate whether the group health plan will be the primary or secondary payer on claims.

Counting individuals under the “20-or-more” employer size

- Employees counted in the 20-or-more employer size include the total number of nationwide full-time employees, part-time employees, seasonal employees and partners who work or who are expected to report for work on a particular day
- Those not counted in the 20-or-more employer size include retirees, COBRA qualified beneficiaries and individuals on other continuation options, and self-employed individuals who participate in the employer’s group health plan

If the employer’s size changes during the year and they are either greater than 20 total employees or fall below 20 total employees, they must complete a new MSP form and indicate the date the change occurred.

Employer size increases to 20 or more during the year

If the employer’s size was below 20 during the preceding year, the BCBSIL coverage becomes primary as soon as the employer has had 20 or more employees on each working day of 20 calendar weeks of the current year. The 20 calendar weeks do not have to be consecutive. Then, the BCBSIL coverage is primary for the remainder of the year and during the following year.

- EXAMPLE - the employer’s size meets the 20-or-more employee threshold as of October 1, 2014. The BCBSIL coverage becomes primary for services provided from October 1, 2014 through December 31, 2015.

Employer size fails to meet the threshold of ‘20 or more employees during 20 or more weeks’ during the year

If the employer’s size met the threshold of 20 or more employees for each working day in each of 20 or more calendar weeks for the preceding year, but during the current calendar year the employer size never meets that threshold, the BCBSIL plan remains primary until the end of the current year.

- EXAMPLE - during 2013 the employer’s size met the threshold of 20 or more employees for each working day in each of 20 or more calendar weeks. However, during 2014 the employer’s size falls below and remains less than 20 total employees. The employer’s group health plan coverage remains primary through December 31, 2014.

When a member or their dependent becomes eligible for Medicare, they must complete the [Employee Medicare Secondary Payer \(MSP\) Information Form](#) and attach a copy of their Medicare card. This form can be emailed or faxed to the appropriate BCBSIL Membership Department.



Medicare Part D Creditable Coverage Disclosure Requirement

Each year, companies who sponsor health plans that include prescription drug coverage are required to notify both the Centers for Medicare & Medicaid Services (CMS) and Medicare Part D-eligible health plan participants whether the prescription coverage offered is creditable or non-creditable to Medicare Part D prescription drug coverage.

The first disclosure requirement is for employers to provide a written disclosure notice to all Medicare eligible individuals annually who are covered under its drug plan prior to:

- October 15th each year or
- When a Medicare eligible individual first joins the plan

This disclosure must be provided to Medicare eligible active working individuals and their dependents, Medicare eligible COBRA individuals and their dependents, Medicare eligible disabled individuals covered under your prescription drug plan and any retirees and their dependents.

The second disclosure requirement is for employers to complete the Online Disclosure to CMS Form to report the creditable coverage status of their prescription drug plan. The disclosure should be completed annually no later than 60 days from the beginning of a plan year (contract year, renewal year), within 30 days after termination of a prescription drug plan, or within 30 days after any change in creditable coverage status.

For additional guidance and sample notices, visit <https://www.cms.gov/Medicare/CreditableCoverage/>

The screenshot shows the CMS.gov website. The main navigation bar includes links for Home, About CMS, Newsroom Center, FAQs, Archive, Share, Help, Email, and Print. Below this is a search bar with the text "Learn about your healthcare options" and a search button. A secondary navigation bar contains buttons for Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Private Insurance, Innovation Center, Regulations & Guidance, Research, Statistics, Data & Systems, and Outreach & Education. The breadcrumb trail reads "Home > Medicare > Creditable Coverage > Creditable Coverage". The main heading is "Creditable Coverage". The text explains that the Medicare Modernization Act (MMA) requires entities to notify Medicare eligible policyholders of their prescription drug coverage status. It lists two disclosure requirements: 1. Providing a written disclosure notice annually or when a new individual joins the plan. 2. Completing the Online Disclosure to CMS Form to report the creditable coverage status. A "Downloads" section at the bottom lists two PDF documents: "Creditable Coverage Disclosure User Manual 05-29-2012 [PDF, 603KB]" and "Creditable Coverage Simplified Determination (PDF, 12KB) [PDF, 1.4KB]". A red arrow points to the first document link.

