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GHP: Medicare as Secondary Payer (MSP) Rules

The federal Medicare as Secondary Payer (MSP) rules determine whether the employer's group health plan (GHP), or Medicare, will be the primary payer of claims for people who have dual coverage. The rules vary based on whether the employer size is fewer than 20 employees, between 20–99 employees, or 100 or more employees.

Employer Size

For employers with *100 or more employees*, the GHP is primary for active employees (and their spouses) whose Medicare eligibility is based either on age (i.e., 65 or older) or disability.

For employers with *20–99 employees*:

- The GHP is primary for active employees (and spouses) whose Medicare eligibility is based on age (i.e., 65 or older).
- Medicare is primary for active employees (and spouses) whose Medicare eligibility is based on disability (i.e., under 65).

For employers with *fewer than 20 employees*, Medicare is the primary payer regardless of whether the individual's Medicare entitlement is due to age or disability.

Determining Size

The MSP rules require counting the number of employees in the following specific ways:

- The number of employees is counted based on the employer's total workforce size regardless of which employees are eligible for the employer's GHP.
- Self-employed individuals (such as 2%-or-more shareholders of a subchapter-S corporation, partners in an LLP, or members of an LLC) are not counted as employees.
- Employees of employers that belong to the same controlled group, such as parent/subsidiary companies or companies with common owners, or employees of trades, businesses, partnerships, or proprietorships that are under common control, are counted together as a single employer unless they file separate federal income tax returns.
- Additional rules apply if the employer participates in a multiple employer welfare arrangement (MEWA) or multiemployer plan (e.g., union trust); this is unusual.

Generally, when determining whether the 20-employee threshold is met, the employer's size is determined by counting the total workforce size on each working day in each of 20 or more calendar weeks in both the current calendar year and the preceding year. Each employee, whether full time or part time, counts as "1," and the 20 weeks do not have to be consecutive. For details about determining the employer's size, refer to the Centers for Medicare and Medicaid Services (CMS) [Medicare Secondary Payer \(MSP\) Manual](#).

The 100-or-more employees requirement is defined by CMS as an employer having at least 100 full-time or part-time active employees on 50% or more of their regular business days in the previous year, regardless of whether all employees on the roster worked or were expected to work that day.

Exceptions

Regardless of the employer's size:

- The GHP is the primary payer for the first 30 months for end-stage renal disease (ESRD) patients.
- Medicare is the primary payer if the claimant (or claimant's spouse) is no longer an active employee. In other words, Medicare is the primary payer for former employees such as retirees and COBRA beneficiaries.

Prohibited Actions by Employers

The federal MSP rules prohibit certain actions by the employer if the employer's group plan is the primary payer. If the employer has 20 or more employees, as counted under the MSP rules, the employer is prohibited from offering or providing any incentives to active employees to drop the group coverage (or not enroll) and take Medicare. For example, the employer cannot pay or reimburse the employee's premiums for Medicare or Medicare Supplement coverage. (Medicare Supplement (or Medigap) is an insurance policy sold by private carriers to supplement the individual's Medicare coverage.)

The purpose of the prohibition is to prevent employers from shifting the cost of their workers' health care onto the Medicare program. Further, if an active employee declines the group plan and takes Medicare as the primary payer (for employee or spouse), the employer is prohibited from offering or providing secondary coverage for items or services covered by Medicare.

The prohibition does not apply if the employer has fewer than 20 employees (as counted under the MSP rules). In that case, a small employer that wants to help its employees pay Medicare or Medigap premiums may establish a "Medicare premium reimbursement arrangement" as outlined in IRS [Notice 2015-17](#). The small employer Medicare premium reimbursement arrangement must meet the following conditions:

- The employer offers a GHP providing minimum value (e.g., major medical);
- Employees participating in the program are actually enrolled in Medicare Parts A and B;
- The program is available only to employees enrolled in Medicare Parts A and B and/or D; and
- The program is limited to reimbursement of Medicare Parts B and D premiums, and “excepted benefits” (e.g., Medigap policy premiums).

Required Notices

Employers that offer group coverage that includes outpatient prescription drug benefits must comply with the following two notice requirements each year:

- Distribute a Notice of Creditable Coverage (and/or a Notice of Non-Creditable Coverage) to plan participants before October 15 each year. See **Participant Notice** below for details.
- Submit an online disclosure notice to CMS during the first 60 days of each plan year. See **CMS Disclosure** below for details.

Note: Employers that receive the [Retiree Drug Subsidy \(RDS\)](#), or sponsor health plans that contract directly with one or more Medicare Part D plans, should seek the advice of legal counsel regarding the applicable notice and disclosure requirements.

Participant Notice

Medicare offers optional prescription drug benefit plans (Part D plans) sold by private insurance companies and health maintenance organizations (HMOs). People may enroll in a Part D plan when they first become eligible for Medicare, but if they wait too long, a late enrollment penalty amount is permanently added to their Part D plan premium cost when they do enroll. The late enrollment penalty is waived for persons covered under an employer’s plan that provides creditable coverage. **Creditable** means that the group plan’s drug benefits are actuarially equivalent or better than the benefits required in a Part D plan. If the plan is creditable, the individual can delay enrolling for a Part D plan while they remain covered under the employer’s creditable plan.

The [Inflation Reduction Act](#) of 2022 included provisions to lower prescription drug costs, affecting Medicare Part D creditable coverage determinations. In 2024, the catastrophic phase coinsurance will reduce from 10% to 5%. This means the plan will pay 20% of the total drug costs instead of 15%.

The 2024 [CMS parameters](#) for the standard Medicare Part D prescription drug benefit are:

- The annual deductible is \$545.
- The initial coverage limit is \$5,030.
- The out-of-pocket threshold is \$8,000.
- Total covered Part D spending for beneficiaries' ineligible for the coverage gap discount program is \$11,477.39.
- Total covered Part D spending for beneficiaries' eligible for the coverage gap discount program is \$12,477.11.

In 2025, Medicare Part D plans will include a new out-of-pocket annual participant spending cap of \$2,000, elimination of the coverage gap (aka donut hole), and federal government price negotiations with drug manufacturers. These changes will require careful review and calculation to determine creditable coverage status.

The 2025 [CMS parameters](#) for the standard Medicare Part D prescription drug benefit are:

- The annual deductible is \$590.
- The initial coverage limit is 25% coinsurance.
- The out-of-pocket threshold is \$2,000.

Note: If the plan is insured, the carrier/HMO will confirm creditable or non-creditable status. For self-funded plans, the plan actuary must determine the plan's status using guidance provided by the CMS. Creditable coverage determinations are based on plan year. For example, non-calendar year plans will determine creditability using the 2025 parameters once their plan renewal (or change in plans) is known. Medicare eligible individuals risk a late enrollment [penalty](#) with Part D if they are without creditable coverage for 62 days. Non-calendar year plans that are determined to be noncreditable at the plan's renewal will create a Medicare special enrollment period for affected individuals.

The [simplified coverage determination method](#) is available for employers that are not applying for the retiree drug subsidy and must make the determination themselves.

To help Medicare-eligible plan participants make informed decisions about whether and when to enroll in a Part D drug plan, they need to know if their employer's GHP provides creditable or non-creditable prescription drug coverage. That is the purpose of the federal requirement for employers to provide an annual notice to all Medicare-eligible employees and spouses.

The participant notice requirement applies regardless of the employer's size or whether the group plan is insured or self-funded. Employers should take the following actions:

- Determine whether the GHP’s prescription drug coverage is creditable or non-creditable for the upcoming year.
- Distribute a Notice of Creditable Coverage and/or a Notice of Non-Creditable Coverage, as applicable, to all GHP participants who are or may become eligible for Medicare in the next year. “Participants” include covered employees, retirees (and spouses), and COBRA enrollees. Employers often do not know whether a particular participant may be eligible for Medicare due to age or disability. For convenience, many employers decide to distribute their notice to all participants regardless of Medicare status.
- Notices must be distributed at least annually before October 15. Medicare holds its Part D enrollment period each year from October 15 to December 7, which is why GHP participants need to receive their employer’s notice before October 15. Generally, the appropriate notice should be provided by the plan sponsor (e.g., employer) at or before the annual open enrollment period to allow affected individuals to choose whether to remain on the employer’s plan or choose a Part D plan.
- Notices also may be required after October 15 for new enrollees, if the plan’s creditable versus non-creditable status changes, and upon a beneficiary’s request.

[Model notices](#) are available on the CMS website. Start with the model notice and then fill in the blanks and variable items as needed for each GHP.

CMS Disclosure

Separate from the participant notice requirement, employers also must disclose to the CMS whether their GHP provides creditable or non-creditable coverage annually (no later than 60 days from the beginning of the plan year) and within 30 days of any change that affects whether the drug coverage is creditable or terminates. To submit the plan’s disclosure, use the [CMS online tool](#) and follow the prompts. The online tool is the only method allowed for completing the required disclosure. The process generally takes 5–10 minutes to complete. We have prepared a [guide](#) to assist with completing the disclosure. It is due within 60 days after the start of the plan year; for instance, for calendar year plans, the date will be March 1 (or February 29 if a leap year). CMS provides [guidance and instructions](#) on its website.

Data Match Questionnaires

Employers that offer group medical coverage to employees may receive IRS/SSA/CMS Data Match Questionnaires that require prompt responses. Federal law requires the IRS, the Social Security Administration (SSA), and the Centers for Medicare and Medicaid Services (CMS) to share information about whether Medicare beneficiaries are working or have any employer-sponsored health coverage. The agencies developed the questionnaire as part of the process.

To identify potential dual coverage situations, insurers and administrators report employer plan enrollment information to CMS via quarterly data files. CMS provides Medicare enrollment information to insurers and plan administrators. This ongoing information exchange helps facilitate correct claims processing by employer plans and Medicare. Occasionally, Medicare pays claims on a primary basis that should have been paid by the employer's plan, which causes Medicare to pay more than it should. The Data Match Questionnaire's purpose is to collect information on specific claimants and identify possible Medicare overpayments.

Upon receiving a questionnaire, the employer must follow the instructions in the cover letter and respond within 30 days. The employer can request a 30-day extension by calling CMS at the telephone number shown in the letter before the first 30-day period expires.

CMS usually looks for information on persons for whom Medicare has already paid claims, which may have been several years ago. Be sure to respond with the correct information for the specific period(s) indicated for each individual.

CMS may impose penalties on employers for willfully or repeatedly failing to respond to questionnaires. Up to \$1,000 may be assessed for each person for whom accurate and timely information was not provided.

Instructions for completing the questionnaire are included in the cover letter. The process is fairly simple, and most employers do not need assistance.

Official Guidance

Additional tools and guidance:

- [Instructions for Completing the Group Health Plan Report for IRS-SSA-CMS-Data Match](#)
- [Suggested Model Procedures for Multi-Employer GHP Small Employer Exception Issues](#)
- [Small Employer Exception Requests and Medicare Enrollment Dates](#)
- [Instructions for Small Employer Exception Submittal Certification](#)
- [2024 Part D Rate Announcement](#)
- [Final CY 2025 Part D Redesign Program Instructions Fact Sheet](#)
- [Mini-Guide: Employer Responsibilities with Medicare Notices](#)