Medicare Secondary Payer Frequently Asked Questions*

Q. What is Medicare Secondary Payer?

A. Medicare Secondary Payer (MSP) is the term that is used to describe situations in which Medicare is not the primary payer of claims. Medicare is the primary payer in certain circumstances; they are outlined here.

Q. What language has been added to the Coordination of Benefits (COB) section of the Certificate of Coverage (COC) for group medical plans that use UPMC Health Plan's COC?

A. The COC for commercial group products includes the following provision: If you are eligible for Medicare but do not enroll and maintain Medicare Part B coverage, UPMC Health Plan will follow the MSP Regulations and coordinate the benefits payable for Covered Services under this COC as if you were enrolled in Medicare Part B. This means we will calculate payment by taking into account the benefits that would have been paid under Medicare Part B had you enrolled.

Q. Why did UPMC Health Plan make this change?

A. This change will allow UPMC Health Plan to continue to offer competitive premium rates while potentially lowering claims expenses for ASO groups.

Q. What does this mean for UPMC Health Plan commercial group members?

A. When the MSP rule permits Medicare to be the primary payer, UPMC Health Plan will carve out an assumed Medicare primary payment if the member is not enrolled in Medicare (Original Medicare or a Medicare Advantage plan). We will use the Medicare reimbursement rates to calculate our payment to the provider. The provider may balance bill the member for the amount not paid by Medicare or the Health Plan.

Q. What does this mean for members of groups with fewer than 20 employees?

A. Medicare is the primary payer for members who are 65 or older who are enrolled in groups with fewer than 20 employees.

Q. How will UPMC Health Plan know if an employer group has more or fewer than 20 employees?

A. We will send a form to the employer before the group's renewal date for the employer to attest to the number of employees. We will ask that the form be returned to UPMC Health Plan within 30 days.

Q. How will employers that are part of multi-employer consortiums know if they are considered a small or large group?

A. UPMC Health Plan cannot help multi-employer plans determine whether COB changes will impact them because it depends on how the group is classified under IRS rules.

In the case of the small employer exception for age-based Medicare, special rules apply to multi-employer and multiple employer plans (i.e., plans covering employees of unrelated employers).

Groups must determine how they are classified under certain IRS regulations before determining how to count their employees for purposes of the small employer exception for age-based Medicare. Groups should consult their tax advisers and review the aggregation rules found in 42 USC 1395y(B)(1)(E)(i).

Q. When will the new provision go into effect?

A. The new language will take effect as of the group's 2021 renewal date. However, for groups with fewer than 20 employees that renew on Jan. 1, Feb. 1, or March 1, we will not implement the new COB procedure until April 1, pending completion of the employer attestation form.

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Q. Will impacted members have to pay a late enrollment penalty under Medicare Part B?

A. The size of the employer will determine whether a member may be able to delay enrolling in Parts A and B without having to pay a penalty. See Should I get Parts A & B? | Medicare

Q. If a member who is impacted by the new language chooses to enroll in Original Medicare, should the member enroll in Part D (prescriptions)?

A. UPMC Health Plan will not carve out an assumed drug payment when Medicare is the primary payer and the member did not enroll in Part D. However, the member should consider late enrollment penalties for Part D.

Q. How can groups get a list of affected members?

A. For age-related Medicare eligibility (i.e., employer groups with fewer than 20 employees), groups can determine who is impacted by downloading a roster from Employer OnLine. For non-age-related situations where Medicare is the primary payer, we can provide the number of impacted members but cannot identify the members.

Q. Will UPMC Health Plan notify impacted members?

A. Yes, UPMC Health Plan will send a letter to impacted members. Our Member Services Department is prepared to support members through this transition.

Questions specific to traditional ASO groups

Q. Can ASO groups opt out of including the new COC language?

A. Yes. These groups can opt out by contacting their account manager.

Q. If an ASO group opts out of including the new language, will there be any change in the way claims are paid for members who are eligible for Medicare?

A. No. UPMC Benefit Management Services will continue to follow all COB rules but will pay as primary if the member is not enrolled in Medicare.

Q. What if an ASO group cannot decide by their renewal date?

A. We suggest that the group opt out and evaluate for a future renewal date.

Q. Is there any affect to stop loss coverage?

A. If a group has a UPMC Health Benefits Inc. stop loss policy, UPMC Health Plan will exclude from our claims liability calculation the portion of claims that Medicare would have paid as primary had affected members enrolled in Medicare. See exclusion M in the policy. Groups should consider this when deciding whether to opt out of including the new MSP language.

**The above information is for informational purposes only and is not legal or tax advice. UPMC Health Plan and UPMC Benefit Management Services do not provide legal or tax advice. For legal or tax advice, please contact your attorney or tax adviser.*

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