

to age-based entitlement, with the retirement plan continuing to pay primary benefits through June 1995, the 18th month of ESRD-based entitlement. Thereafter, Medicare becomes the primary payer.

(5) (Rule (b)(3).) Mrs. E retired at age 62 and maintained GHP coverage as a retiree. In July 1994, she simultaneously became eligible for Medicare based on ESRD (maintenance dialysis began in April 1994) and entitled based on age. The retirement plan must pay benefits primary to Medicare from July 1994 through December 1995, the first 18 months of ESRD-based eligibility. Thereafter, Medicare becomes the primary payer.

(6) (Rule (b)(3).) Mr. F, who is 67 years of age, is working and has GHP coverage because of his employment status, subsequently develops ESRD, and begins a course of maintenance dialysis in October 1994. He becomes eligible for Medicare based on ESRD effective January 1, 1995. Under the working aged provision, the plan continues to pay primary to Medicare through December 1994. On January 1, 1995, the working aged provision ceases to apply and the ESRD MSP provision takes effect. In September 1995, Mr. F retires. The GHP must ignore Mr. F's retirement status and continue to pay primary to Medicare through June 1996, the end of the 18-month coordination period.

(7) (Rule (b)(4).) Mrs. G, who is 67 years of age, is retired. She has GHP retirement coverage through her former employer. Her plan permissibly took into account her age-based Medicare entitlement when she retired and is paying benefits secondary to Medicare. Mrs. G subsequently develops ESRD and begins a course of maintenance dialysis in October 1995. She automatically becomes eligible for Medicare based on ESRD effective January 1, 1996. The plan continues to be secondary on the basis of Mrs. G's age-based entitlement as long as the plan does not differentiate in the services it provides to Mrs. G and does not do anything else that would constitute "taking into account" her ESRD-based eligibility.

[60 FR 45369, Aug. 31, 1995; 60 FR 53876, Oct. 18, 1995]

§ 411.165 Basis for conditional Medicare payments.

(a) *General rule.* Except as specified in paragraph (b) of this section, the Medicare intermediary or carrier may make a conditional payment if—

(1) The beneficiary, the provider, or the supplier that has accepted assignment files a proper claim under the group health plan and the plan denies the claim in whole or in part; or

(2) The beneficiary, because of physical or mental incapacity, fails to file a proper claim.

(b) *Exception.* Medicare does not make conditional primary payments under either of the following circumstances:

(1) The claim is denied for one of the following reasons:

(i) It is alleged that the group health plan is secondary to Medicare.

(ii) The group health plan limits its payments when the individual is entitled to Medicare.

(iii) Failure to file a proper claim if that failure is for any reason other than the physical or mental incapacity of the beneficiary.

(2) The group health plan fails to furnish information requested by CMS and necessary to determine whether the employer plan is primary to Medicare.

[57 FR 36015, Aug. 12, 1992. Redesignated and amended at 60 FR 45362, 45370, Aug. 31, 1995; 60 FR 53877, Oct. 18, 1995]

Subpart G—Special Rules: Aged Beneficiaries and Spouses Who Are Also Covered Under Group Health Plans

§ 411.170 General provisions.

(a) *Basis.* (1) This subpart is based on certain provisions of section 1862(b) of the Act, which impose specific requirements and limitations with respect to—

(i) Individuals who are entitled to Medicare on the basis of age; and

(ii) GHPs of at least one employer of 20 or more employees that cover those individuals.

(2) Under these provisions, the following rules apply:

(i) An employer is considered to employ 20 or more employees if the employer has 20 or more employees for

each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

(ii) The plan may not take into account the Medicare entitlement of—

(A) An individual age 65 or older who is covered or seeks to be covered under the plan by virtue of current employment status; or

(B) The spouse, including divorced or common-law spouse age 65 or older of an individual (of any age) who is covered or seeks to be covered by virtue of current employment status. (Section 411.108 gives examples of actions that constitute “taking into account.”)

(iii) Regardless of whether entitled to Medicare, employees and spouses age 65 or older, including divorced or common-law spouses of employees of any age, are entitled to the same plan benefits under the same conditions as employees and spouses under age 65.

(b) [Reserved]

(c) *Determination of “aged”.* (1) An individual attains a particular age on the day preceding the anniversary of his or her birth.

(2) The period during which an individual is considered to be “aged” begins on the first day of the month in which that individual attains age 65.

(3) For services furnished before May 1986, the period during which an individual is considered “aged” ends as follows:

(i) For services furnished before July 18, 1984, it ends on the last day of the month in which the individual attains age 70.

(ii) For services furnished between July 18, 1984 and April 30, 1986, it ends on the last day of the month *before* the month the individual attains age 70.

(4) For services furnished on or after May 1, 1986, the period has no upper age limit.

[54 FR 41734, Oct. 11, 1989. Redesignated and amended at 60 FR 45362, 45370, Aug. 31, 1995]

§411.172 Medicare benefits secondary to group health plan benefits.

(a) *Conditions that the individual must meet.* Medicare Part A and Part B benefits are secondary to benefits payable by a GHP for services furnished during any month in which the individual—

(1) Is aged;

(2) Is entitled to Medicare Part A benefits under §406.10 of this chapter; and

(3) Meets one of the following conditions:

(i) Is covered under a GHP of an employer that has at least 20 employees (including a multi-employer plan in which at least one of the participating employers meets that condition), and coverage under the plan is by virtue of the individual's current employment status.

(ii) Is the aged spouse (including a divorced or common-law spouse) of an individual (of any age) who is covered under a GHP described in paragraph (a)(3)(i) of this section by virtue of the individual's current employment status.

(b) *Special rule for multi-employer plans.* The requirements and limitations of paragraph (a) of this section and of (a)(2)(iii) of §411.170 do not apply with respect to individuals enrolled in a multi-employer plan if—

(1) The individuals are covered by virtue of current employment status with an employer that has fewer than 20 employees; and

(2) The plan requests an exception and identifies the individuals for whom it requests the exception as meeting the conditions specified in paragraph (b)(1) of this section.

(c) *Refusal to accept group health plan coverage.* An employee or spouse may refuse the health plan offered by the employer. If the employee or spouse refuses the plan—

(1) Medicare is primary payer for that individual; and

(2) The plan may not offer that individual coverage complementary to Medicare.

(d) *Reemployed retiree or annuitant.* A reemployed retiree or annuitant who is covered by a GHP and who performs sufficient services to qualify for coverage on that basis (that is, other employees in the same category are provided health benefits) is considered covered “by reason of current employment status” even if:

(1) The employer provides the same GHP coverage to retirees; or

(2) The premiums for the plan are paid from a retirement or pension fund.

(e) *Secondary payments.* Medicare pays secondary benefits, within the limitations specified in §§ 411.32 and 411.33, to supplement the primary benefits paid by the group health plan if that plan pays only a portion of the charge for the services.

(f) *Disabled aged individuals who are considered employed.* (1) For services furnished on or after November 12, 1985, and before July 17, 1987, a disabled, nonworking individual age 65 or older was considered employed if he or she—

(i) Was receiving, from an employer, disability payments that were subject to tax under the Federal Insurance Contributions Act (FICA); and

(ii) For the month before the month of attainment of age 65, was not entitled to disability benefits under title II of the Act and 20 CFR 404.315 of the SSA regulations.

(2) For services furnished on or after July 17, 1987, an individual is considered employed if he or she receives, from an employer, disability benefits that are subject to tax under FICA, even if he or she was entitled to Social Security disability benefits before attaining age 65.

(g) *Individuals entitled to Medicare on the basis of age who are also eligible for or entitled to Medicare on the basis of ESRD.* If an aged individual is, or could upon filing an application become, entitled to Medicare on the basis of ESRD, the coordination of benefits rules of subpart F of this part apply.

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990. Redesignated and amended at 60 FR 45362, 45370, Aug. 31, 1995; 60 FR 53877, Oct. 18, 1995]

§ 411.175 Basis for Medicare primary payments.

(a) *General rule.* CMS makes Medicare primary payments for covered services that are—

(1) Furnished to Medicare beneficiaries who have declined to enroll in the GHP;

(2) Not covered by the plan for any individuals or spouses who are enrolled by virtue of the individual's current employment status;

(3) Covered under the plan but not available to particular individuals or spouses enrolled by virtue of current employment status because they have

exhausted their benefits under the plan;

(4) Furnished to individuals whose COBRA continuation coverage has been terminated because of the individual's Medicare entitlement; or

(5) Covered under COBRA continuation coverage notwithstanding the individual's Medicare entitlement.

(b) *Conditional Medicare payments: Basic rule.* Except as provided in paragraph (c) of this section, Medicare may make a conditional primary payment if—

(1) The beneficiary, the provider, or the supplier that has accepted assignment has filed a proper claim under the group health plan and the plan has denied the claim in whole or in part; or

(2) The beneficiary, because of physical or mental incapacity, failed to file proper claim.

(c) *Conditional primary payments: Exception.* Medicare does not make conditional primary payments under either of the following circumstances:

(1) The claim is denied for one of the following reasons:

(i) It is alleged that the group health plan is secondary to Medicare.

(ii) The plan limits its payments when the individual is entitled to Medicare.

(iii) The plan covers the services for individuals or spouses who are enrolled in the plan by virtue of current employment status and are under age 65 but not for individuals and spouses who are enrolled on the same basis but are age 65 or older.

(iv) Failure to file a proper claim if that failure is for any reason other than physical or mental incapacity of the beneficiary.

(2) The group health plan fails to furnish information requested by CMS and necessary to determine whether the employer plan is primary to Medicare.

[54 FR 41734, Oct. 11, 1989. Redesignated and amended at 60 FR 45362, 45371, Aug. 31, 1995]

Subpart H—Special Rules: Disabled Beneficiaries Who Are Also Covered Under Large Group Health Plans

SOURCE: 60 FR 45371, Aug. 31, 1995, unless otherwise noted.