

a period of 12 months. Medicare becomes primary payer on December 1, 1998, because the extension of the coordination period from 12 to 18 months applies only to items and services furnished before October 1, 1998.

(10) An individual becomes entitled to Medicare on August 1, 1997. Medicare is secondary payer from August 1, 1997, through September 30, 1998, a period of 14 months. Medicare becomes primary payer on October 1, 1998, because the coordination period has expired.

(e) [Reserved]

(f) *Determinations for subsequent periods of ESRD eligibility.* If an individual has more than one period of eligibility based on ESRD, a coordination period will be determined for each period of eligibility in accordance with this section.

[57 FR 36015, Aug. 12, 1992; 57 FR 45113, Sept. 30, 1992. Redesignated and amended at 60 FR 45362, 45368, Aug. 31, 1995]

§411.163 Coordination of benefits: Dual entitlement situations.

(a) *Basic rule.* Coordination of benefits is governed by this section if an individual is eligible for or entitled to Medicare on the basis of ESRD and also entitled on the basis of age or disability.

(b) *Specific rules.*¹ (1) *Coordination period ended before August 1993.* If the first 18 months of ESRD-based eligibility or entitlement ended before August 1993, Medicare was primary payer from the first month of dual eligibility or entitlement, regardless of when dual eligibility or entitlement began.

(2) *First month of ESRD-based eligibility or entitlement and first month of dual eligibility/entitlement after February 1992 and before August 10, 1993.* Except

as provided in paragraph (b)(4) of this section, if the first month of ESRD-based eligibility or entitlement and first month of dual eligibility/entitlement were after February 1992 and before August 10, 1993, Medicare—

(i) Is primary payer from the first month of dual eligibility/entitlement through August 9, 1993;

(ii) Is secondary payer from August 10, 1993, through the 18th month of ESRD-based eligibility or entitlement; and

(iii) Again becomes primary payer after the 18th month of ESRD-based eligibility or entitlement.

(3) *First month of ESRD-based eligibility or entitlement after February 1992 and first month of dual eligibility/entitlement after August 9, 1993.* Except as provided in paragraph (b)(4) of this section, if the first month of ESRD-based eligibility or entitlement is after February 1992, and the first month of dual eligibility/entitlement is after August 9, 1993, the rules of §411.162(b) and (c) apply; that is, Medicare—

(i) Is secondary payer during the first 18 months of ESRD-based eligibility or entitlement; and

(ii) Becomes primary after the 18th month of ESRD-based eligibility or entitlement.

(4) *Medicare continues to be primary after an aged or disabled beneficiary becomes eligible on the basis of ESRD.* (i) *Applicability of the rule.* Medicare remains the primary payer when an individual becomes eligible for Medicare based on ESRD if all of the following conditions are met:

(A) The individual is already entitled on the basis of age or disability when he or she becomes eligible on the basis of ESRD.

(B) The MSP prohibition against “taking into account” age-based or disability-based entitlement does not apply because plan coverage was not “by virtue of current employment status” or the employer had fewer than 20 employees (in the case of the aged) or fewer than 100 employees (in the case of the disabled).

(C) The plan is paying secondary to Medicare because the plan had justifiably taken into account the age-based or disability-based entitlement.

¹A lawsuit was filed in United States District Court for the District of Columbia on May 5, 1995 (*National Medical Care, Inc. v. Shalala*, Civil Action No. 95-0860), challenging the implementation of one aspect of the OBRA '93 provisions with respect to group health plan retirement coverage. The court issued a preliminary injunction order on June 6, 1995, which enjoins the Secretary from applying the rule contained in §411.163(b)(4) for items and services furnished between August 10, 1993 and April 24, 1995, pending the court's decision on the merits. CMS will modify the rules, if required, based on the final ruling by the court.

(ii) *Effect of the rule.* The plan may continue to pay benefits secondary to Medicare under paragraph (b)(4)(i) of this section. However, the plan may not differentiate in the services covered and the payments made between persons who have ESRD and those who do not.

(c) *Examples.* (1) (Rule (b)(1).) Mr. A, who is covered by a GHP, became entitled to Medicare on the basis of ESRD in January 1992. On December 20, 1992, Mr. A attained age 65 and became entitled on the basis of age. Since prior law was still in effect (OBRA '93 amendment was effective in August 1993), Medicare became primary payer as of December 1992, when dual entitlement began.

(2) (Rule (b)(2).) Miss B, who has GHP coverage, became entitled to Medicare on the basis of ESRD in July 1992, and also entitled on the basis of disability in June 1993. Medicare was primary payer from June 1993 through August 9, 1993, because the plan permissibly took into account the ESRD-based entitlement (ESRD was not the "sole" basis of Medicare entitlement); secondary payer from August 10, 1993, through December 1993, the 18th month of ESRD-based entitlement (the plan is no longer permitted to take into account ESRD-based entitlement that is not the "sole" basis of Medicare entitlement); and again became primary payer beginning January 1994.

(3) (Rule (b)(3).) Mr. C, who is 67 years old and entitled to Medicare on the basis of age, has GHP coverage by virtue of current employment status. Mr. C is diagnosed as having ESRD and begins a course of maintenance dialysis on June 27, 1993. Effective September 1, 1993, Mr. C is eligible for Medicare on the basis of ESRD. Medicare, which was secondary because Mr. C's GHP coverage was by virtue of current employment, continues to be secondary payer through February 1995, the 18th month of ESRD-based eligibility, and becomes primary payer beginning March 1995.

(4) (Rule (b)(3).) Mr. D retired at age 62 and maintained GHP coverage as a retiree. In January 1994, at the age of 64, Mr. D became entitled to Medicare based on ESRD. Seven months into the

18-month coordination period (July 1994) Mr. D turned age 65. The coordination period continues without regard 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]