| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-05 Medicare Secondary Payer | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 106** | **Date: October 10, 2014** |
| | **Change Request 8875** |

**SUBJECT: Medicare Secondary Payer (MSP) Group Health Plan (GHP) Working Aged Policy -- Definition of "Spouse"; Same-Sex Marriages**

**I. SUMMARY OF CHANGES:** Section 3 of the Defense of Marriage Act (DOMA) provided that for purposes of federal law, the term "spouse" could not include individuals in a same-sex marriage. Because the MSP Working Aged provisions only apply to subscribers and their spouses, the Working Aged provisions did not apply on the basis of spousal status to individuals in a same-sex marriage. The United States Supreme Court has now invalidated this DOMA provision. Consequently, CMS is no longer prohibited from applying the MSP Working Aged provision to individuals in a same-sex marriage. This CR also informs the Medicare Administrative Contractors (MACs) of modifications to the MSP provisions and to update the Internet Only Manuals accordingly.

**EFFECTIVE DATE: January 1, 2015**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: January 1, 2015**

***Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.***

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 1/10/10.1 - Working Aged |
| R | 1/20 - Definitions |

**III. FUNDING:**
**For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**IV. ATTACHMENTS:**

**Business Requirements**

**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-05 | Transmittal: 106 | Date: October 10, 2014 | Change Request: 8875 |
|---|---|---|---|

**SUBJECT: Medicare Secondary Payer (MSP) Group Health Plan (GHP) Working Aged Policy -- Definition of "Spouse"; Same-Sex Marriages**

**EFFECTIVE DATE: January 1, 2015**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: January 1, 2015**

## I. GENERAL INFORMATION

**A. Background:** Section 3 of the Defense of Marriage Act (DOMA) provided that for purposes of federal law, the term "spouse" could not include individuals in a same-sex marriage. Because the Medicare Secondary Payer (MSP) Working Aged provisions only apply to subscribers and their spouses, the Working Aged provisions did not apply on the basis of spousal status to individuals in a same-sex marriage. The United States Supreme Court has now invalidated this DOMA provision. Consequently, the Department of Health & Human Services has adopted a policy treating same-sex marriages on the same terms as opposite-sex marriages to the greatest extent reasonably possible. Therefore, CMS is no longer prohibited from applying the MSP Working Aged provision to individuals in a same-sex marriage.

**B. Policy:** Effective January 1, 2015, the rules below apply with respect to the term "spouse" under the MSP Working Aged provisions. This is true for both opposite-sex and same-sex marriages as described in the business requirements.

- If an individual is entitled to Medicare as a spouse based upon the Social Security Administration's rules, that individual is a "spouse" for purposes of the MSP Working Aged provisions.

- If a marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction, both parties to the marriage are "spouses" for purposes of the MSP Working Aged provisions.

- Where an employer, insurer, third party administrator, GHP, or other plan sponsor has a broader or more inclusive definition of spouse for purposes of its GHP arrangement, it may (but is not required to) assume primary payment responsibility for the "spouse" in question. If such an individual is reported as a "spouse" through MMSEA Section 111, Medicare will pay accordingly and pursue recovery, as applicable.

**Impact of Effective Date:**

- The expanded rules for the definition of "spouse", including proper reporting pursuant to MMSEA Section 111, must be implemented with a start date for the coverage in question no later than January 1, 2015.

- To the extent an employer, insurer, third party administrator, GHP or other plan sponsor insurer has chosen to or chooses to utilize the new definitions referenced above or a broader definition of "spouse" for MSP purposes prior to January 1, 2015, it may do so.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 8875.1 | Contractors shall ensure if an individual is entitled to Medicare as a spouse based upon the Social Security Administration's rules, that individual is a spouse for purposes of the MSP Working Aged provisions. | | | | | | | | | 1-800 Medicare, BCRC, CRC, MSPIC, MSPSC |
| 8875.2 | Contractors shall ensure if a marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction, both parties to the marriage are spouses for purposes of the MSP Working Aged provisions. | | | | | | | | | 1-800 Medicare, BCRC, CRC, MSPIC, MSPSC |
| 8875.3 | Contractors shall ensure the definition of spouse referenced in Business Requirement (BR) 1 and BR 2 above, including proper MMSEA Section 111 reporting, shall be implemented with a start date for the coverage in question no later than January 1, 2015. | | | | | | | | | 1-800 Medicare, BCRC, CRC, MSPIC, MSPSC |
| 8875.4 | Contractors shall ensure to the extent an employer, insurer, third party administrator, GHP or other plan sponsor insurer chooses to implement the definition of spouse referenced in BR 1 and BR 2 above, it may, at any time, assume primary payment responsibility for the spouse in question. | | | | | | | | | 1-800 Medicare, BCRC, CRC, MSPIC, MSPSC |
| 8875.5 | If such an individual is reported as a spouse pursuant to BRs 1,2, or 4 through MMSEA Section 111 reporting, Medicare shall pay accordingly and pursue recovery, as applicable. | X | X | X | X | | | | | BCRC, CRC |
| 8875.6 | Contractors shall not accept requests from subscribers, or their spouses, to apply the definition of spouse referenced in BR 1 and BR 2 above for coverage dates before January 1, 2015. | X | X | X | X | | | | | 1-800 Medicare, BCRC, CRC, MSPIC, MSPSC |
| 8875.7 | Contractors shall ensure to the extent an employer, insurer, third party administrator, GHP, or other plan sponsor has a broader or more inclusive definition of spouse than the definitions in BR 1 and BR 2, for purposes of its GHP arrangement, it may, at any time, assume primary payment responsibility for the "spouse" in question. | X | X | X | X | | | | | 1-800 Medicare, BCRC, CRC, MSPIC, MSPSC |

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| | | | | | | | | | | |
| 8875.7.1 | Contractors shall ensure if an individual is reported as a "spouse" under a broader or more inclusive definition of spouse through MMSEA Section 111, Medicare shall pay accordingly, and pursue recovery, as applicable. | X | X | X | X | | | | | BCRC, CRC |
| 8875.7.2 | Contractors shall not accept requests from subscribers or their spouses to apply a broader more inclusive definition of spouse than the definition of spouse referenced above in BR 1 and BR 2. | X | X | X | X | | | | | 1-800 Medicare, BCRC, CRC, MSPIC, MSPSC |
| 8875.8 | Contractors and 1-800 Medicare shall follow existing procedures for any inquiries. | X | X | X | X | | | | | 1-800 Medicare, BCRC, CRC, MSPIC, MSPSC |
| 8875.8.1 | The BCRC shall be responsible for any necessary development if spousal status is disputed. | | | | | | | | | BCRC |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| 8875.9 | MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. | X | X | X | X | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**

*"Should" denotes a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: N/A |
|---|---|

**Section B: All other recommendations and supporting information:** N/A

## V. CONTACTS

**Pre-Implementation Contact(s):** William Decker, 410-786-3915 or William.Decker@cms.hhs.gov , Richard Mazur, 410-786-1418 or Richard.Mazur2@cms.hhs.gov

**Post-Implementation Contact(s):** Contact your Contracting Officer's Representative (COR).

## VI. FUNDING

**Section A: For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

**ATTACHMENTS: 0**

## 10.1 - Working Aged

***(Rev. 106, 10-10-14, Effective: 01-01- 15, Implementation: 01-01-15)***

Medicare benefits are secondary to benefits payable under GHPs for individuals age 65 or over who have GHP coverage as a result of:

- Their own current employment status with an employer that has 20 or more employees; or

- The current employment status of a spouse of any age with such an employer.

(Section 70.2 of this chapter and §10 of Chapter 2 of the Medicare Secondary Payer (MSP) Manual further defines individuals subject to this limitation on payment.)

***NOTE**: Effective January 1, 2015, for purposes of the working aged provisions the definition of spouse has changed. This definition shall be applied no later than January 1, 2015. Where, at any time, an employer, insurer, third party administrator, GHP, or other plan sponsor has a broader or more inclusive definition of spouse for the purposes of its GHP arrangement, it may (but is not required to) assume primary payment responsibility for the individual in question. If such an individual is reported as a spouse through MMSEA Section 111, Medicare will pay accordingly and pursue recovery, as applicable.*

Employers are required to offer to their employees age 65 or over and to the age 65 or over spouses of employees of any age the same coverage as they offer to employees and employees' spouses under age 65, i.e., coverage that is primary to Medicare. This equal benefit rule applies to coverage offered to all employees (full-time and part-time).

Medicare beneficiaries are free to reject employer plan coverage, in which case they retain Medicare as their primary coverage. When Medicare is primary payer, employers cannot offer such employees or their spouses secondary coverage for items and services covered by Medicare. Employers may not sponsor or contribute to individual Medigap or Medicare supplement policies for beneficiaries who have or whose spouse has current employment status.

Health insurance plans for retirees or the spouses of retirees do not meet this condition and are not primary to Medicare. Medicare beneficiaries are free to reject GHP coverage in which case they retain Medicare as the primary coverage.

Only employers with 20 or more employees are required to offer the same (primary) coverage to their age 65 or over employees and the age 65 or over spouses of employees of any age that they offer to younger employees and spouses. This requirement is met if an employer has 20 or more full-time and/or part time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. Self-employed individuals who participate in an employer plan are not counted as employees in determining if the 20 or more employees requirement is met. Where an employer does not have 20 or more employees in the preceding year, he is required to offer his employees and spouses age 65 or over, primary coverage when he has had 20 or more employees on each working day of 20 calendar weeks of the current year. The employer is then required to offer primary coverage for the remainder of that year and throughout the following year, even if the number of employees subsequently drops below 20. The "20 or more employees" requirement must be met when the individual receives the services for which Medicare benefits are claimed. If at that time, the employer has met the "20 or more employees" requirement in the current year or in the preceding calendar year, the GHP is primary payer. An employer that meets this requirement must provide primary coverage even if less than 20 employees participate in the employer plan.

Employers are not required to provide coverage to individuals. However, any coverage provided to such individuals age 65 or older and age 65 or older spouses of such individuals of any age, by an employer of 20 or more employees must be the same as coverage provided to younger such individuals, that is, coverage primary to Medicare. The employer must also provide primary coverage to older such individuals even if there are no younger such individuals enrolled in the plan.

Where a GHP is primary payer, but does not pay in full for the services, secondary Medicare benefits may be paid, to supplement the amount it paid for the Medicare covered service. If a GHP denies payment for services because they are not covered by the plan as a plan benefit bought for all covered individuals, primary Medicare benefits may be paid if the services are covered by Medicare. Primary Medicare benefits may not be paid if the plan denies payment because the plan does not cover the service for primary payment when provided to Medicare beneficiaries.

A GHP's decision to pay or deny a claim because the services are or are not medically necessary is not binding on Medicare. Contractors must evaluate claims under existing guidelines derived from the law and regulations to assure that services are covered by the program regardless of any employer plan involvement.

Contractors assume for developing claims and the requirement that GHPs be billed before Medicare that, in the absence of evidence to the contrary, an employer in whose health plan a beneficiary is enrolled because of employment meets the definition of employer and employs at least 20 people. The contractor refers an employer’s allegation that the 20-employee requirement is not met to the Coordination of Benefits (COB) contractor.

Contractors must refer a multi-employer plan’s (a plan sponsored by or contributed to by two or more employers or employee organizations) statement identifying specific members as employees of employers of fewer than 20 employees, as a basis for making Medicare primary payer, to the COB contractor (see chapter 2 §10.4 and chapter 5 §50 of this manual for further instructions).

NOTE: The request to exempt is done on a prospective basis.

## 20 - Definitions

***(Rev.106, 10-10-14, Effective: 01-01- 15, Implementation: 01-01-15)***

Accident - An unintended occurrence outside the normal course of events that causes illness, injury, or damage to a person or property.

Age 65 or older – An individual attains age 65 on the day preceding his or her 65th birthday.

Automobile - Any self-propelled land vehicle of a type that must be registered and licensed in the State in which it is owned.

CMS' Claim - In the context of WC, no-fault, and liability claims, the amount that is determined to be owed to the Medicare program. This is the lesser of the total sum of the settlements, judgments, or awards related to the underlying WC, no-fault, or liability claim; or the amount that was paid out by Medicare, less any applicable share of procurement costs.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a Title X provision that provides continuation of GHP coverage if elected. For aged or disabled Medicare beneficiaries, COBRA continuation coverage is secondary to Medicare because the coverage is by virtue of COBRA law rather than by virtue of current employment status. For an ESRD related Medicare beneficiary, COBRA continuation coverage if elected, is primary to Medicare during the 30-month ESRD coordination period. See 42 CFR 411.161(a)(3) and 411.162(a)(3).

Compromise - A settlement of differences by mutual consent or adjustment of matters in dispute by mutual concession; a negotiated settlement between parties who are in essentially equal bargaining positions, wherein neither party admits or concedes that he is entitled to less than he desires, but accepts less to effect the goal of ending the dispute. In an MSP situation under the Federal Claims Collection Act, a compromise represents the acceptance by the Regional Office (RO) of less than the full debt owed to Medicare, when the amount of the full debt does not exceed $100,000, or by Central Office (CO) when the amount exceeds $100,000. An individual who accepts a compromise has no right to appeal the remaining debt.

Conditional Payment - A Medicare payment, conditioned upon reimbursement to Medicare, for services for which another insurer is primary payer.

Coordination Period - The term "coordination period" means a period of 30 months during which Medicare benefits are secondary to benefits payable under GHPs for individuals who are eligible for Medicare because of ESRD. See Chapter 2, §20.

Current Employment Status – See §50 of this chapter.

Eligibility - Eligibility means a beneficiary meets the legal requirements for Medicare benefits. It is still necessary to file an application to become entitled. (For example, a Social Security beneficiary is eligible for Medicare upon attaining age 65 but is not entitled until an application is filed and approved).

Employee - An individual who is working for an employer or an individual who, although not actually working for an employer, is receiving from an employer payments that are subject to FICA taxes or would be subject to FICA taxes except that the employer is exempt from those taxes under the Internal Revenue Code (IRC).

Employer - Employer means, in addition to individuals (including self-employed persons) and organizations engaged in a trade or business, other entities exempt from income tax such as religious, charitable, and educational institutions. Included are the governments of the United States, the individual States, Puerto

Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the District of Columbia, and foreign governments.

Entitled - An eligible individual becomes entitled to Medicare by filing the appropriate application. Upon approval of the application, the individual is entitled. It may also be necessary to enroll for certain services in order to get them.

Family Member - Family member means a person enrolled in a GHP based on another person's enrollment. Family members may include, but are not limited to, a spouse (including a divorced or common law spouse); a natural, adopted, or foster child; a stepchild; a parent; or a sibling.

FICA - The term "FICA" stands for the Federal Insurance Contributions Act, the law that imposes Social Security taxes on employers and employees under §21 of the Internal Revenue Code.

Fiduciary - A person in a position of trust with regard to the affairs of another, who has a duty to act primarily for the benefit of the other, with respect to a particular undertaking.

GHP (Group Health Plan) - The term "GHP" means any arrangement of, or contributed to by, one or more employers or employee organizations to provide health benefits or medical care directly or indirectly to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. An arrangement by more than one employer is considered to be a single plan if it provides for common administration of the health benefits (e.g., by the employers directly or by a benefit administrator or by a multi-employer trust or by an insuring organization under a contract or contracts).

A plan that does not have any employees or former employees as enrollees (e.g., a plan for self-employed persons only) does not meet the definition of a GHP and Medicare is not secondary to it. Thus, if an insurance company establishes a plan solely for its self-employed insurance agents, other than insurance agents, the plan is not considered a GHP. However, if the plan includes insurance agents or other employees or former employees, it is considered a GHP.

The term "GHP" includes self-insured plans, plans of governmental entities (Federal, State, and local such as the Federal Employees Health Benefits Program), and employee organization plans. Examples of the latter are union plans and employee health and welfare funds. Employee-pay-all plans are also included (i.e., GHPs which are under the auspices of one or more employers or employee organizations but which do not receive any contribution from the employer). Individual policies (including Medigap policies) purchased by or through an employee organization, employer or former employer of the individual or family member of the individual are considered employer offered GHPs. However, coverage under the TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is not considered to meet the definition of a GHP. It is secondary to Medicare since the law makes Medicare primary to TRICARE.

Any health plan (including a union plan) in which a beneficiary is enrolled because his/her employment or a family member's employment meets this definition.

Judgment - The official and authentic decision of a court of justice upon the respective rights of the parties to an action submitted to it for determination.

LGHP (Large Group Health Plan) - LGHP means a GHP that covers employees of either:

- A single employer or employee organization that employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year; or

- Two or more employers or employee organizations at least one of which employed at least 100 full-time or part-time employees on 50 percent or more of its regular business days during the previous calendar year.

- It includes individual policies (including Medigap policies) purchased by an or through an employer or former employer of the individual or family member.

Liability - Responsibility or fault for damages arising out of a specified incident.

Liability Insurance - Insurance (including a self-insured plan) that provides payment based on alleged legal liability for injury, illness or damage to property. It includes, but is not limited to, automobile liability, uninsured and under-insured motorist, homeowner's liability, malpractice, product liability and general casualty insurance. It includes payments under State "wrongful death" statutes that provide payment for medical damages.

Liability Insurance Payment - A payment by a liability insurer, or an out-of-pocket payment, including a payment to cover a deductible required by a liability insurer, by any individual or other entity that carries liability insurance or is covered by a self-insured plan.

Lump Sum Commutation Settlement - A workers' compensation settlement in which the beneficiary accepts a lump sum payment that compensates for all future medical expenses and disability benefits related to the work injury or disease.

Lump Sum Compromise Settlement - A workers' compensation settlement that provides less in total compensation than the individual would have received if he or she had received full reimbursement for lost wages and lifelong medical treatment for the injury or illness. This may occur when compensability is contested.

MSP - Acronym denoting "Medicare Secondary Payer" provisions of the Social Security Act.

Med-Pay - A payment made by an insurer intended specifically to pay for medical expenses without regard to the fault of any party to the accident. Med-Pay is a form of no-fault insurance.

Multi-employer Group Health Plan - The term "multi-employer group health plan" means a plan that is sponsored jointly or contributed to by two or more employers (sometimes called a multiple employer plan) or by employers and unions (as under the Taft-Hartley law).

No-Fault Insurance - Insurance that pays for medical expenses for injuries sustained or on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing the accident. This insurance includes but is not limited to automobile, homeowners, and commercial plans. It includes "medical payments coverage," "personal injury protection," or "medical expense coverage." Examples of no-fault insurance include homeowners and commercial medical payments insurance, commonly referred to as Med-pay coverage.

Nonconforming Group Health Plan or Large Group Health Plan - A "nonconforming GHP or LGHP" means one that at any time during the calendar year takes into account that an individual is eligible for, or receives, benefits based on disability, e.g., a LGHP fails to pay primary benefits for disabled individuals under age 65 for whom Medicare is secondary payer in accordance with these instructions.

Partial Waiver - A decision by the Medicare program to relinquish the right to collect a portion of a debt from a specific entity. A partial waiver is not to be confused with a compromise. It is different in that it does not arise from negotiation or offer, but under 1870(c) of the Act, which provides the beneficiary the right to request waiver and Medicare the authority to grant or deny waiver based on factual data. Section 1870(c) allows a partial waiver to a person who is without fault or where the adjustment or recovery would defeat

the purpose of Title II or XVII of the Act (hardship) or be against equity and good conscience. An individual may appeal a determination based on 1870(c) of the Act if the determination grants only partial waiver of a debt.

Payment in full – Payment in full is an amount that the provider, physician, or other supplier is obligated to accept (e.g., contractually) or voluntarily accepts as full satisfaction of the charges for medical services to an individual from the insurer (e.g., the GHP) in full satisfaction of the patient's payment obligation. Because Medicare payments are made on behalf of the beneficiary, satisfaction of a patient's payment obligation satisfies any Medicare payment obligation.

Plan - The term "plan" means any arrangement by an employer or by more than one employer, or by an employee organization to provide health benefits or medical care to current or former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families. An arrangement by more than one employer is a single plan if the arrangement provides for common administration of the health benefits. An arrangement may be administered by the employers directly, by a benefit administrator, by a multi-employer trust, or by an insuring organization under a contract or contracts which stipulate that the organizations provide all employees enrolled in the plan the same benefits or the same benefit options.

Primary Payer - When used in the context in which Medicare is the secondary payer, any entity that is or was required or responsible to make payment with respect to an item or service (or any portion thereof) under a primary plan. These entities include, but are not limited to, insurers or self-insurers, third party administrators, and all employers that sponsor or contribute to group health plans or large group health plans.

Primary Payment - When used in the context in which Medicare is the secondary payer, payment by a primary payer for services that are also covered under Medicare.

Primary Plan - When used in the context in which Medicare is the secondary payer, a group health plan or large group health plan, a workers' compensation law or plan, an automobile or liability insurance policy or plan (including a self-insured plan), or no-fault insurance.

Proceeds - Benefits paid under any insurance plan or policy, or annuity contract.

Procurement Costs - Attorney fees and other costs directly related to securing a settlement or judgment that are borne by the beneficiary against whom CMS seeks to recover.

Prompt or Promptly - With regard to liability insurance means payment within 120 days after the earlier of the following:

- The date a claim is filed with an insurer or a lien is filed against a potential liability settlement; or

- The date the service was furnished or, in the case of inpatient hospital services, the date of discharge.

With regard to no-fault and WC insurance, prompt or promptly means payment within 120 days after receipt of the claim.

Proper Claim - A claim that is filed timely and meets all other claims filing requirements specified by the plan, program, or insurer (e.g., mandatory second opinion, prior notification before seeking treatment).

Recovery - Proceeds obtained from a judgment, settlement, erroneous or conditional payment. The establishment of a right existing in an individual through a law, formal judgment, or decree of a court.

Secondary – The term "secondary", when used with respect to Medicare payment, means that Medicare is the residual payer to all plans that are primary plans with respect to services provided to a Medicare beneficiary.

Self-Employed Person - An individual is considered to be self-employed during a particular tax year only if the individual's self-employment income, as determined by the IRS, was at least equal to the amount specified in §211(b)(2) of the Act, which defines self-employment income for Social Security purposes.

Set-Aside Arrangement – An administrative mechanism used to allocate a portion of a settlement, judgment or award for future medical and/or future prescription drug expenses. A set-aside arrangement may be in the form of a Workers' Compensation Medicare Set-Aside Arrangement (WCMSA), No-Fault Liability Medicare Set-Aside Arrangement (NFSA) or Liability Medicare Set-Aside Arrangement (LMSA).

SSI - Supplemental Security Income for the Aged, Blind and Disabled is the Federal subsistence income maintenance program for eligible individuals. Title XVI of the Social Security Act enacted SSI in 1972 for the purpose of assuring a minimum level of income for people who are age 65 or over, blind, or disabled, and who do not have sufficient income and resources to maintain a standard of living at the established Federal minimum income level.

Self-Insured Plan - A plan under which an individual, or a private or governmental entity, carries its own risk instead of taking out insurance with a carrier. The term includes a plan of an individual or other entity engaged in a business, trade, or profession, a plan of a nonprofit organization such as a social, fraternal, labor, educational, religious, or professional organization, and the plan established by the Federal government to pay for liability claims under the Federal Tort Claims Act. An entity that engages in a business, trade or profession shall be deemed to have a self-insured plan for purposes of liability insurance if it carries its own risk (whether by failure to obtain insurance or otherwise) in whole or in part. (With regard to FTCA claims, CMS attempts to collect its mistaken payment from the Federal agency that is settling the claim. If a resolution cannot be reached, CMS must submit the conflict to the Department of Justice for resolution.)

Settlement - An adjustment or agreement by which parties having a dispute between them reach or ascertain what each owes the other. In the MSP liability context, settlement refers to a monetary amount from a liability insurer agreed to by a party in satisfaction of a liability dispute.

Spouse – *(on or before December 31, 2014) means* a person of the opposite sex who is a husband or a wife.

*Spouse: (effective on January 1, 2015) for purposes of the working aged provisions means a person who is entitled to Medicare as a spouse based upon the Social Security Administration's rules or a person whose marriage is valid in the jurisdiction in which it was performed including one of the 50 states, the District of Columbia, or a U.S. territory or a foreign country, so long as that marriage would also be recognized by a U.S. jurisdiction.*

Statute of Limitations - A specific time period after the right to assert a claim begins within which certain claims must be filed, and after which the claim may no longer be enforced.

Subrogation - Subrogation means the substitution of one person or entity for another. Under the Medicare subrogation provision, the program is a claimant against the responsible party and the liability insurer, to the extent that Medicare has made payments to or on behalf of the beneficiary.

Under-insured Motorist Insurance - Insurance under which the policyholder's level of protection against losses caused by another is extended to compensate for inadequate coverage in the party's policy or plan.

Uninsured Motorist Insurance - Insurance under which the policyholder's insurer pays for damages caused by a motorist who has no automobile liability insurance or carries less than the amount of insurance required by law.

Waiver - The relinquishing of an established right. In an MSP situation, it is the forgiveness of the party's obligation to satisfy Medicare's claim, in whole or in part, if certain conditions are met.

Workers' Compensation Agency - The term "WC agency" means any governmental entity that administers a Federal or State WC law. This term includes WC commissions, industrial commissions, industrial boards, WC insurance funds, WC courts and, in the case of Federal WC programs, the U.S. Department of Labor.

Workers' Compensation Carrier - The term "WC carrier" means any insurance carrier authorized to write WC insurance under the state or federal law, the state compensation fund where the state administers the WC program, and the beneficiary's employer where the employer is self-insured.

Workers' Compensation Law or Plan - A WC law or plan is a government-supervised and employer-supported system for compensating employees for injury or disease suffered in connection with their employment, whether or not the injury was the fault of the employer. Workers' compensation does not usually cover agricultural employees, interstate railroad employees, employees of small businesses, employees whose work is not in the course of the employer's business (e.g., domestic employees), casual employees, and self-employed people. Although WC programs were initially designed to cover accidental injuries suffered in the course of employment, all States now provide compensation for at least some occupational diseases as well.

Workers' Compensation Medicare Set-Aside Arrangement (WCMSA) - The recommended method to protect Medicare's interests in workers' compensation (WC) settlements, judgments, or awards which allocate funds from the settlement for future medical and/or prescription drug expenses. The amount of the set aside is determined on a case-by-case basis and should be reviewed by CMS, when appropriate.

Working Aged – Medicare is secondary for Medicare beneficiaries age 65 or older who are covered under the plan by virtue of their own current employment status with an employer or the current employment status of a spouse of any age. This provision applies to group health plans (GHPs) of employers and employee organizations, including multi-employer and multiple employer plans which have at least one participating employer that employs 20 or more employees.

Wrongful Death - A death caused by a wrongful act, neglect, or fault, as seen in some WC, no-fault, and liability situations.