340.1 - Application of 20 Employee Threshold

(Rev. 4, 10-01-01)

This requirement applies if an employer has 20 or more full-time or part-time employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year. An employer who does not have 20 or more employees in the preceding year is required to offer employees and spouses age 65 or over, primary coverage beginning with the point in time at which the employer 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 later drops below 20 after the employer has met the threshold. If the individual receives the services for which Medicare benefits are claimed after the employer has met the 20 or more employees threshold in the current year or in the preceding calendar year, the EGHP is the primary payer. An employer that meets this threshold must provide primary coverage even if less than 20 employees participate in the employer plan.

Self-employed individuals who participate in the plan are not counted as employees for the purpose of determining if the 20 or more employees requirement is met. There is no requirement that an employer provide coverage to self-employed individuals. However, any coverage provided to self-employed persons by an employer of 20 or more employees must be primary to Medicare.

Assume for purposes of developing claims that, in the absence of evidence to the contrary, an employer in whose health organization a beneficiary is enrolled because of employment, meets the definition of employer and employs at least 20 people. An employer’s allegation that the 20-employee requirement is not met, or a multi-employer organization’s statement identifying specific members as employees of employers of

fewer than 20 employees, can be accepted as a basis for making Medicare primary payments. Refer questionable cases to the CMS (RO).

The following steps are involved in determining if Medicare is the secondary or primary payer:

- Determine if the member (or spouse) is eligible for consideration;
- Determine if the member or spouse is age 65 or over and entitled to Part A (this is shown on the reply listing);
- Determine if the individual who is age 65 or over is covered under the employer's health organization by reason of current employment;
- Determine if the member or spouse has ESRD;
- If the Medicare member age 65 or over is not covered due to current employment (including self-employment), determine if the spouse is covered by reason of current employment and, if so, whether the Medicare member is covered under the spouse's EGHP; and
- Determine if the services are covered under the employer plan.

The HMO/CMP is responsible for identifying affected individuals as part of the enrollment process. Medicare payment is reduced to the extent that the expenses are payable under an employer plan.