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Medicare and Health Plans

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Presentation Agenda

1. Medicare Basics
2. Medicare Integration with Group Health Plans
3. HSA Eligibility, COBRA and Midyear Elections
4. Plan Sponsor Reporting and Disclosures

01

Medicare Basics

What Is Medicare?

Medicare is the federal health insurance program for:

- People aged 65 and older
- Certain younger people with disabilities
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)

Eligibility and enrollment will vary, and individuals should discuss opportunities with their Medicare representatives

Medicare Coverage Types

Part A
Hospitalization

- Eligible hospital expenses
- Skilled nursing care
- Home healthcare
- Hospice care

Part B
General Medical

- Inpatient and outpatient medical services and doctors' charges
- Office visits
- Therapy services
- Preventive care

Part C
Medicare Advantage

- Same coverage as Parts A and B plus additional services
- Intended to replace A and B in a more controlled managed care setting (such as an HMO with a more restricted network of providers)

Part D
Prescription Drug

- Voluntary outpatient prescription drug benefit

02

Medicare Integration with Group Health Plans

Medicare Entitlement

Eligibility, Enrollment and Entitlement

DEFINITIONS

ELIGIBLE

The individual qualifies for Medicare coverage, but may or may not be enrolled or entitled to coverage

ENROLLED

The individual has completed the necessary steps to obtain coverage

ENTITLED

The individual has enrolled in and is entitled to claim benefits from Medicare

- Medicare coverage is effective

Differentiating between these terms is important when analyzing compliance obligations.

Medicare Secondary Payer Rules

Medicare Secondary Payer (MSP) Rules

DOES MEDICARE ENTITLEMENT AFFECT GROUP HEALTH PLAN ELIGIBILITY?

- Will depend on the terms of the group health plan, which must comply with the MSP rules (if applicable)

- MSP rules apply to private-sector employers, religious, non-profit, and educational institutions, and federal and state government employers

Small employer exception:

- Age-Based Medicare – MSP requirements apply to group health plans of employers with **20 or more employees** for each working day in at least 20 weeks in either the current or the preceding calendar year

- Disability-Based Medicare – MSP requirements apply if the employer normally employed at least 100 employees on 50% or more of regular business days during the previous calendar year

- ESRD-Based Medicare – MSP requirements apply to group health plans of employers, regardless of size, during the first 30 months of an individual's ESRD-based Medicare eligibility or entitlement

Medicare Secondary Payer (MSP) Rules

TAKING INTO ACCOUNT MEDICARE ENTITLEMENT

Group health plans subject to MSP rules may not “take into account” the Medicare entitlement (either based upon the individual’s age/disability or the age/disability of their spouse/family member) of an individual who is covered under the plan by virtue of the individual's current employment status.

Examples of “taking into account” Medicare entitlement:

- Failing to pay primary benefits
- Offering coverage that is secondary to Medicare to individuals entitled to Medicare
- Terminating coverage because the individual has become entitled to Medicare (except as permitted under COBRA)
- Imposing limitations on benefits for a Medicare-entitled individual that do not apply to others enrolled in the plan
- Charging the Medicare-entitled individual higher premiums
- Requiring a Medicare-entitled individual to wait longer for coverage to begin
- Providing misleading/incomplete information that could have the effect of inducing a Medicare-entitled individual to reject the employer plan, thereby making Medicare the primary payer
- Refusing to enroll an individual for whom Medicare would be secondary payer when enrollment is available to similarly situated individuals for whom Medicare would not be secondary payer

Medicare Secondary Payer (MSP) Rules

PROHIBITION AGAINST CERTAIN INCENTIVES

- Employers are prohibited from offering Medicare beneficiaries financial rewards or other benefits as incentives to not enroll in, or to terminate enrollment in,
  a group health plan that is or would provide primary coverage to Medicare

- **EXAMPLE:** Employer offering to pay for Medicare beneficiaries' Medicare supplemental coverage if they waive employer-sponsored coverage

Cash-in-Lieu of Benefits Arrangement

- Offering Medicare-eligible or entitled employees waiver credit/cash to opt-out of benefits (even if the opt-out credit is provided to all employees that waive coverage) may violate the MSP rule's prohibition against offering financial incentive not to enroll in a group health plan primary to Medicare
  - » Legal counsel should be consulted

Medicare Secondary Payer (MSP) Rules

OFFERING EQUAL BENEFITS FOR OLDER AND YOUNGER EMPLOYEES/SPOUSES

- Group health plans must provide employees/spouses age 65+ with the same benefits under the same conditions provided to employees/spouses under age 65
- The requirement applies regardless of whether the individual or spouse 65 or older is entitled to Medicare
- Federal and state age discrimination rules may also apply

Coordination of Benefits

Coordination of Benefits Under MSP Rules

WILL MEDICARE OR THE GROUP HEALTH PLAN/POLICY PAY FIRST?

- When coverage is available for a service or item under more than one health plan/insurance policy for the same underlying claim for benefits, the coordination of benefits (COB) is generally determined based on each plan's/policy's COB rules

- If an individual is covered under multiple plans/policies and one of the plans is a Medicare health plan, the MSP rules will dictate which plan pays primary

- Health plans subject to the MSP rules are prohibited from making Medicare pay primary to the health plan/policy, as that "takes into account" the Medicare entitlement of an individual

Coordination of Benefits Under MSP Rules

Age-Based Medicare entitlement + coverage due to current employment status

- Employer has 20+ employees = GHP primary payer
- Employer fewer than 20 employees = Medicare primary payer

Age-Based Medicare entitlement + retiree health coverage or COBRA

- Medicare primary payer

Disability-Based Medicare entitlement + coverage due to current employment status

- Employer has 100+ employees = GHP primary payer
- Employer fewer than 100 employees = Medicare primary payer

Disability-Based Medicare entitlement + retiree health coverage or COBRA

- Medicare primary payer

ESRD-Based Medicare eligibility or entitlement + group health coverage (including coverage due to current employment status, retiree health coverage or COBRA)

- First 30 months of Medicare eligibility or entitlement = GHP primary payer
- After 30 months of Medicare eligibility or entitlement = Medicare primary payer

03

HSAs, COBRA and Midyear Elections

Health Savings Account (HSA) Eligibility

DOES MEDICARE ENTITLEMENT AFFECT HSA ELIGIBILITY?

- To contribute to an HSA, you must be (1) enrolled in an HSA-eligible HDHP, and (2) have no other disqualifying coverage.

- **Medicare is considered "other disqualifying coverage" if an individual is enrolled in it**
  - All parts of Medicare (A, B, C, D and supplements) will result in HSA ineligibility
  - Neither employee nor employer can make **new contributions** to the employee's HSA if the employee is HSA ineligible; however, the employee may seek **reimbursement** from HSA funds for health care expenses when HSA ineligible

- Eligibility determined month-by-month: HSA contributions will be reduced by 1/12 for each month during the year that the individual is not HSA eligible
  - **Example:** An individual who becomes entitled to Medicare in May would have a contribution limited to 4/12 of the annual limit
  - Contributions for the period of eligibility (January – April) could be made during the period of ineligibility until the following April 15th

- Backdated Medicare entitlement (up to six months) must be considered when determining HSA eligibility

Medicare and COBRA Continuation Coverage

IS MEDICARE ENTITLEMENT A COBRA QUALIFYING EVENT?

- Covered employee's Medicare entitlement is a triggering event in the regulations

- However, **due to MSP rules it will rarely result in a loss of coverage** and therefore will rarely be a COBRA qualifying event

Second Qualifying Event for Spouse/Dependent

- Due to MSP rules, Medicare entitlement will rarely be a second qualifying event since it would not cause a loss of eligibility

COBRA Extension Due to Medicare *Entitlement*

- If covered employee's qualifying event of termination/reduction in hours occurs within 18 months after employee becomes entitled to Medicare = spouse/dependent's COBRA extended to 36 months after employee's Medicare entitlement
  - » Employee remains entitled to 18 months of COBRA after qualifying event

Medicare and COBRA Continuation Coverage

CAN A PLAN TERMINATE COBRA COVERAGE DUE TO MEDICARE ENTITLEMENT?

Depends on the timing between the COBRA election and Medicare entitlement.

COBRA election before Medicare entitlement

- The plan may terminate the qualified beneficiary's COBRA coverage on the date of Medicare entitlement even though the maximum coverage period has not been exhausted
- COBRA coverage may *not* be terminated for other qualified beneficiaries in a family unit who are not entitled to Medicare

Medicare entitlement before COBRA election

- Qualified beneficiary becomes entitled to Medicare benefits on or before the date that COBRA is elected, then the qualified beneficiary's entitlement to Medicare benefits *cannot* be a basis for terminating COBRA coverage
- Plan sponsor must offer COBRA – Qualified beneficiary retains right to elect COBRA, if COBRA event occurs after Medicare entitlement

Medicare and Midyear Election Changes

WILL MEDICARE ENTITLEMENT ALLOW FOR A MIDYEAR ELECTION CHANGE?

Medicare entitlement is a permitted status change event under Code Section 125

- Cafeteria plan is ***not*** required to allow a newly Medicare entitled individual to make a pre-tax election change (i.e., mid-year election change)
  - » Cafeteria plan document must include Medicare entitlement in its list of permitted changes in order to permit a change due to Medicare entitlement
- Plan terms of the major medical plan would also need to permit a midyear drop of coverage due to Medicare entitlement
- If employee, spouse or dependent covered under an employer's health plan enrolls in Medicare Part A or Part B– the employee may only make a prospective election change reducing/dropping coverage for the individual enrolling in Medicare
- Not clear whether rule would apply to dental and vision coverage
- If employee, spouse or dependent *loses eligibility* for Medicare—cafeteria plan may permit individual to make prospective election to enroll or increase coverage under the health plan

04

Plan Sponsor Reporting and Disclosures

MSP Mandatory Reporting

- Purpose of the reporting “is to enable Medicare to correctly pay for the health insurance benefits of Medicare beneficiaries by determining primary versus secondary payer responsibility.”

- Requirement applies to “responsible reporting entities” (RREs) – for most plans, the RRE is the insurer or TPAs. If plan is self-insured ***and*** self-administered, plan administrator has obligation to report

- Example: Self-insured, self-administered HRA with annual benefit over $5,000

- On a quarterly basis, an RRE must submit a file of information about employees/dependents who are Medicare beneficiaries with employer GHP coverage that may be primary to Medicare

- Significant penalties for noncompliance - $1,000/day (indexed) for each individual for whom information should have been submitted

- MMSEA Section 111 MSP Mandatory Reporting GHP User Guide

Medicare Part D Creditable/Noncreditable Coverage Notice

DISCLOSURE TO INDIVIDUALS

- Requirement applies to GHP sponsors that provide prescription drug coverage to Medicare Part D eligible individuals
- Written notice stating whether a group health plan's prescription drug coverage is, on average, at least as good as standard prescription drug coverage under Medicare Part D
- Disclosure provided to Medicare eligible—
  - Active employees and their dependents
  - COBRA participants and their dependents
  - Disabled employees
  - Retirees and their dependents
- Disclosure must be provided annually to all participants or, alternatively —
  - Prior to a participant's effective date of coverage
  - Prior to an individual's initial enrollment period in Part D
  - Prior to October 15th of each year (the annual coordinated election period for Part D)
  - Upon a change in creditable coverage status
  - Upon request
- Electronic delivery permitted if ERISA/DOL safe harbor is satisfied

Medicare Part D Creditable/Noncreditable Coverage Notice

DISCLOSURE TO CMS

- Group health plans must disclose to CMS the creditable or noncreditable status of their prescription drug plan
- Requirement applies to GHP sponsors that provide prescription drug coverage to Medicare Part D eligible individuals
- Must be provided—
  - » Annually, no later than 60 days after the beginning of the plan year
  - » Within 30 days of termination of the plan's prescription drug coverage
  - » After a change in the creditable status of the plan

Key Considerations for Plan Sponsors

- Only employers not subject to the MSP rules may impose eligibility restrictions based on the age/disability-based Medicare entitlement of a current employee(or their spouse/family member)
  - » Note: employers must ensure any restrictions do not violate applicable state law or the terms of the plan
- Due to MSP rules, Medicare entitlement will rarely be a COBRA qualifying event
- Medicare entitlement affects employee HSA eligibility
- Medicare Creditable/Noncreditable disclosures must be provided to individuals and CMS must be notified of the creditable or noncreditable status of their prescription drug plan

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