Brown & Brown

EMPLOYEE BENEFITS

Medicare and Employer-Sponsored Group Health Plans - FAQ

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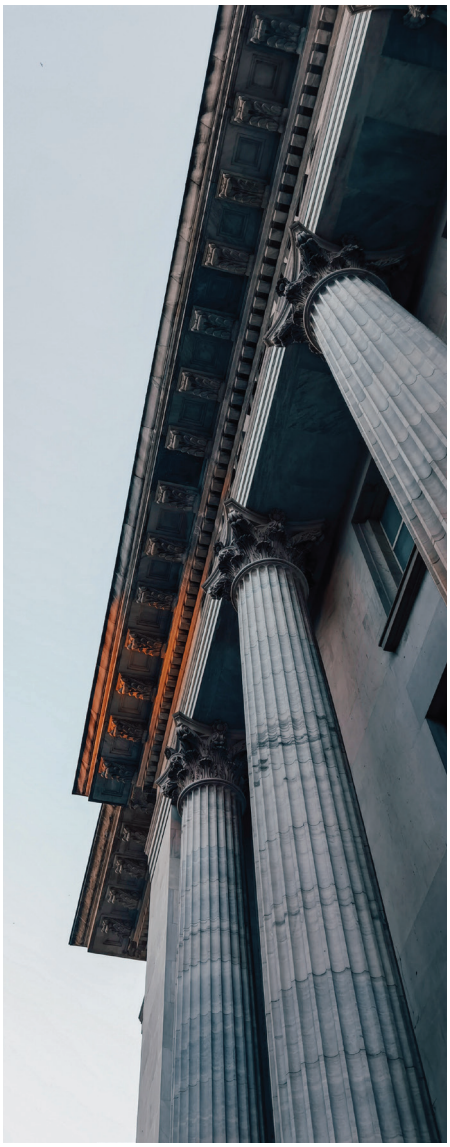
Medicare Basics



What is Medicare Part A?

Medicare Part A is hospitalization coverage. It covers eligible hospital expenses, skilled nursing care, home health care and hospice care.

What is Medicare Part B?

Medicare Part B is general medical coverage. It covers medical services, such as inpatient and outpatient medical services and doctors' charges, office visits, therapy services and preventive care.

What is Medicare Part D?

Medicare Part D is prescription drug coverage.

What is Medicare Part C?

Medicare Part C is called "Medicare Advantage." It is a plan intended to replace Parts A and B in a more controlled managed care setting (such as an HMO with a more restricted network of providers).

What is a Medigap Policy?

A Medigap, or Medicare Supplement policy, is a private insurance policy purchased to fill gaps in coverage not covered by Medicare Part A or B. For example, Medigap policies often cover hospital services beyond 90 days per benefit period, provide benefits for services not covered by Medicare, and pay some or all out-of-pocket expenses (e.g., Medicare Part A or B deductible and/or coinsurance).

When can individuals sign up for Medicare A or B?

In general, individuals can enroll in Medicare:

- During the Medicare Open Enrollment Period that begins three months before their 65th birthday, includes their birthday month and ends three months after their 65th birthday month.
- After age 65
  - Any time an individual is actively working and covered by their employer's group health plan,[1]
    - Individuals working for employers with fewer than 20 employees should confirm with CMS that this enrollment opportunity is available.
  - During the Medicare Annual General Enrollment Period (AGEP) from January 1 through March 31 each year for coverage beginning July 1, or
  - During an eight-month special enrollment period that begins the earlier of (a) the date the individual retires or terminates employment or (b) the date their group health plan coverage ends.
- When an individual is determined to be disabled by the Social Security Administration
  - Generally, entitlement begins after 24 months of Social Security Benefits, except if the individual is diagnosed with end-stage renal disease. When individuals first enroll in Medicare based on ESRD and are on dialysis, Medicare coverage usually begins with the fourth month of dialysis treatments but may begin earlier if the individual receives a kidney transplant.[2]

Is there a difference between being eligible for Medicare and being "entitled" to Medicare?

Yes. Under the Medicare rules, to be "entitled" to Medicare means a person is generally both eligible and enrolled. If the individual must take additional steps to enroll in Medicare before receiving benefits, then that individual is not entitled to Medicare.

[1] CENTERS for MEDICARE & MEDICAID SERVICES - Enrolling in Medicare Part A & Part B
[2] CENTERS for MEDICARE & MEDICAID SERVICES - Enrolling in Medicare Part A & Part B

Medicare Secondary Payer Rules

What are the Medicare Secondary Payer rules, and to whom do they apply?

Medicare Secondary Payer (MSP) rules govern situations in which other entities (e.g., employer-sponsored group health plans) have the primary responsibility for paying a claim before Medicare. This process is commonly referred to in the insurance industry as "coordination of benefits."

The MSP rules apply to group health plans (GHPs) of private employers, charitable organizations, churches, educational institutions and federal and state governments. The only exceptions are as follows:

- **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 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.
- **End-Stage Renal Disease (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.[3]
- **Retirees and COBRA Beneficiaries:** The MSP rules apply to active employees and their covered spouses and dependents. Retirees or COBRA qualified beneficiaries are not treated as active employees even though an employer-sponsored health plan may cover them. The MSP rules, therefore, do not apply, except in cases where coverage is continued during the first 30 months following Medicare entitlement on account of ESRD.

The employee count includes both full-time and part-time employees and consists of all employees under two or more employers under common control.

Under the MSP rules, when does an employer-sponsored group health plan pay primary to Medicare?

- Employee with age-based Medicare entitlement and GHP coverage due to current employment status[4]:
  - » Employer has 20+ employees = GHP pays primary
  - » Employer has fewer than 20 employees = Medicare pays primary
- Employee with age-based Medicare entitlement and retiree health coverage or COBRA:
  - » Medicare pays primary
- Employee with disability-based Medicare entitlement and GHP coverage due to current employment status:
  - » Employer has 100+ employees = GHP pays primary
  - » Employer has fewer than 100 employees = Medicare pays primary
- Disability-based Medicare entitlement and retiree health coverage or COBRA:
  - » Medicare pays primary
- Employee has ESRD-based Medicare eligibility or entitlement and GHP coverage as a current employee, retiree health coverage, or COBRA:
  - » First 30 months of Medicare eligibility or entitlement = GHP pays primary
  - » After 30 months of Medicare eligibility or entitlement = Medicare pays primary

[3] 42 CFR § 411.100

[4] "Current employment status" means that the individual either: (a) actively at work for the employer, or (b) not actively at work but is withing the first six months of receiving disability benefits from an employer (or insurer under an employer-sponsored disability plan), enrolled in Medicare due to ESRD, or retains employment rights in the industry,

Does an employee's Medicare entitlement affect their eligibility for benefits?

Possibly. It will depend on whether the employer's group health plan is subject to the Medicare Secondary Payer (MSP) rules.

Employer group health plans subject to the MSP rules are prohibited from "taking into account" the Medicare entitlement of a current employee (or a current employee's spouse or family member) on the basis of ESRD, age or disability (or the eligibility of such an individual on the basis of ESRD).[5] **This means that group health plans subject to the MSP rules cannot terminate coverage or exclude coverage for those entitled to Medicare.**

Examples of actions that constitute "taking into account" Medicare entitlement:

- Failing to pay primary benefits for those entitled to Medicare;
- 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; and
- Refusing to enroll an individual for whom Medicare would be a secondary payer when enrollment is available to similarly situated individuals for whom Medicare would not be a secondary payer.[6]

Sponsors of group health plans not subject to the MSP rules considering whether to exclude Medicare-entitled/eligible individuals from the health plan should consult with legal counsel regarding their options. If such individuals are excluded from eligibility, the eligibility provisions in the plan document and Summary Plan Description should appropriately reflect those rules.

May an employer incentivize (financially or otherwise) Medicare-eligible employees to not enroll in or cancel coverage under an employer-sponsored group health plan in favor of enrolling into Medicare?

Employers subject to the MSP rules are prohibited from offering Medicare beneficiaries incentives not to enroll in or to terminate coverage under a group health plan that is, or would be, primary to Medicare.[7] This rule applies even when the incentives are offered to all other individuals eligible for coverage under the group health plan.[8]

Employers offering cash-in-lieu of benefits arrangements will need to consider this prohibition when designing their benefit programs, as offering Medicare-eligible or entitled employees a 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.

May a group health plan offer benefits to employees and their spouses aged 65 or older different from those offered to employees/spouses aged under 65?

Group health plans of employers with at least 20 employees must provide current employees and their spouses aged 65 or older with the same benefits under the same conditions they provide to employees and spouses under 65. This requirement applies regardless of whether the current employee or spouse 65 or older is entitled to Medicare.[9]

[5] 42 CFR § 411.102
[6] CMS Medicare Secondary Payer (MSP) Manual, Pub. 100-05, Ch. 2
[7] 42 CFR § 411.103
[8] Id.
[9] 42 CFR § 411.102Medicare Secondary Payer Rules

Other Medicare-Related Compliance Considerations

Is Medicare entitlement a COBRA qualifying event?

Active Employee Coverage. A covered employee's Medicare entitlement is listed as a triggering event in the COBRA regulations.[10] However, when the MSP rules addressed above apply to the group health plan, the new Medicare entitlement of an active employee, spouse, or dependent of an active employee will rarely result in a covered individual's loss of coverage under an employer-sponsored group health plan. Therefore, Medicare entitlement during active employment would not ordinarily constitute a COBRA qualifying event.

When an employee and covered dependents elect COBRA coverage upon termination of employment, and the former employee becomes entitled to Medicare during the COBRA continuation period, the Medicare entitlement of the former employee will (similarly) rarely be a second COBRA qualifying event resulting in an extended COBRA maximum coverage period for spouses and dependent children. This is so because the IRS has ruled that an event cannot be a second qualifying event if it were not an initial qualifying event under the employer's plan.[11]

Retiree Coverage. Unlike with active employees, the MSP rule permits a group health plan to terminate the coverage of covered retired employees (and their spouses/dependents) upon the retiree's entitlement to Medicare. In this case, the loss of coverage due to the Medicare entitlement of the retiree will be a first qualifying event for the retiree's spouse and/or dependents. If a retiree's spouse and/or dependent loses retiree coverage because the retiree enrolled in Medicare, the spouse and/or dependent will be entitled to 36 months of COBRA coverage from the date of the retiree's Medicare entitlement.

Voluntary Cancelation of Coverage. An employee who voluntarily terminates active coverage under the employer's group health plan to enroll in Medicare will not experience a COBRA qualifying event (nor will their covered spouse/dependents). However, as a matter of plan design, some employers may choose to offer COBRA-like continuation coverage to spouses/dependents after the employee chooses to cancel coverage and enroll in Medicare. While nothing prohibits this, employers should first confirm that the carrier/stop-loss carrier will agree to provide this coverage to the spouse/dependents.

Special extending rule for spouses and dependent children. If a covered employee experiences a qualifying event (i.e., termination of employment or reduction of hours) during the 18 months after the employee becomes entitled to Medicare, the employee's spouse and dependent children will have their maximum COBRA coverage period extended to 36 months from the date the covered employee becomes entitled to Medicare.[12] The extension does not apply to the covered employee who remains entitled to an 18-month maximum COBRA coverage period. This situation applies regardless of whether the employer is subject to the MSP rules.

[10] 26 CFR § 54.4980B-4

[11] IRS Revenue Ruling 2004-22.

[12] IRC §4980B(f)(2)(B)(i)(VII)

Can a group health plan terminate COBRA continuation coverage due to Medicare entitlement?

It will depend on the timing of when the qualified beneficiary elected COBRA and became entitled to Medicare.

- **COBRA election before Medicare entitlement:** If a qualified beneficiary (e.g., covered employee) elects COBRA before becoming entitled to Medicare, the plan may terminate the qualified beneficiary's COBRA coverage on the date the qualified beneficiary becomes entitled to Medicare, even though the maximum coverage period has not been exhausted.[13] However, COBRA coverage may not be terminated for other qualified beneficiaries, such as a spouse or dependent, who are not entitled to Medicare.
- **Medicare entitlement before COBRA election:** If a qualified beneficiary becomes entitled to Medicare benefits on or before the date that COBRA continuation coverage is elected, then the qualified beneficiary's entitlement to Medicare benefits cannot be a basis for terminating the qualified beneficiary's COBRA continuation coverage.[14]

Does an employee's Medicare entitlement affect HSA eligibility?

Individuals *enrolled* in Medicare (Parts A, B, C or D) are not eligible to contribute to an HSA on a pre-tax or post-tax basis[15] (this rule does not apply to Medicare-eligible individuals not enrolled in Medicare). The rule applies to age, disability and ESRD-based Medicare entitlement. When an individual becomes ineligible for HSA contributions due to Medicare enrollment, the individual's maximum HSA contribution for the year will be reduced on a pro rata basis based on the number of months out of the year during which the individual was HSA eligible. Contributions may continue to be made, up to the prorated maximum, after the effective date of the Medicare coverage until April 15 of the following year.

Individuals may, however, continue to seek reimbursement from their HSA for qualified medical expenses incurred by themselves, their spouse or eligible tax dependent(s). Distributions taken for purposes other than reimbursement of qualified health care expenses are taxable income to the participant, and if the individual has not reached age 65 at the time of the distribution, an excise tax penalty applies. Distributions after age 65 are treated as taxable income, but there is no tax penalty.

Does Medicare entitlement allow employees to make midyear election changes?

Medicare entitlement is listed as a permitted election change event under IRC Section 125.[16] Under the regulations, if an employee, spouse or dependent becomes entitled to Medicare, a cafeteria plan may permit the employee to make a prospective election change to cancel or reduce coverage under the health plan for the employee, spouse or dependent who became entitled to Medicare. If an employee, spouse or dependent was entitled to Medicare and subsequently lost their Medicare eligibility, a cafeteria plan may permit an employee to make a prospective election change to enroll or increase coverage for the individual who lost eligibility.

Cafeteria plans are not required to allow pre-tax election changes due to Medicare entitlement. In order to permit election changes under these circumstances, the cafeteria plan document must include Medicare entitlement in its list of permitted election change events.

In addition, the terms of the employer's major medical plan would need to permit a mid-year cancelation of coverage due to the individual's Medicare entitlement.

[13] Treas. Reg. §54.4980B-7, Q/A-3
[14] Treas. Reg. §54.4980B-7, Q/A-3
[15] Internal Revenue Code §223(b)(7)
[16] Treas. Reg. §1.125-4(e)

Are plan sponsors subject to any Medicare reporting or disclosure requirements?

Yes. Group health plan sponsors who provide prescription drug coverage to Medicare Part D eligible individuals are subject to the Medicare Part D Creditable and Non-creditable Coverage notice and disclosure requirements.[17]

Notice to Individuals. Group health plan sponsors must provide a written disclosure notice to all Medicare Part D eligible individuals stating whether the group health plan's prescription drug coverage is, on average, at least as good as standard prescription drug coverage under Medicare Part D. Medicare Part D eligible individuals includes active employees and their dependents, COBRA participants and their dependents, disabled employees and retirees and their dependents.

The disclosure notice must be provided to Medicare Part D eligible individuals:

- Prior to a participant's effective date of coverage
- Prior to an individual's initial enrollment period in Part D
- Prior to October 15 of each year (the annual coordinated election period for Part D)
- Upon a change in Creditable coverage status
- Upon request

If the disclosure notice is provided to all plan participants annually, there is no requirement to provide the notice to a Medicare Part D eligible individual prior to the individual's initial enrollment period, and the annual notice will satisfy the requirement to provide the notice annually prior to October 15.

Disclosure to CMS. In addition to providing notice to individuals, group health plan sponsors must disclose to CMS the Creditable/Non-creditable coverage status of their prescription drug plan/coverage. The online disclosure 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/Non-creditable status of the plan

[17] *42 CFR § 423.56*

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