

Group Health Plans and Medicare

What do the different Medicare parts cover? How and when do participants sign up for Medicare? When is the employer's group health plan ("GHP") primary when the participant has both Medicare and GHP coverage? When can participants come off the GHP? How does Medicare affect COBRA continuation coverage?

This memo is intended to provide answers to these frequently asked questions.

Q 1: When are individuals eligible for and when can they enroll in Medicare?

A 1: Individuals are eligible for Medicare based on age (age 65), disability, or end-stage renal disease ("ESRD").

Parts A and B

Medicare Part A covers hospitalization and other in-patient care; Part B covers doctor's visits and other outpatient care.

For age-based Medicare, if the participant already receives Social Security benefits, he is automatically enrolled in Medicare Parts A and B, effective the month he is 65. However, if he is not receiving Social Security benefits, he must take the affirmative step of applying for Medicare.¹ Therefore, someone age 65 is not necessarily enrolled in Medicare.

A participant can delay Part A coverage when it is not automatic; he can waive Part B when it is automatic or delay Part B coverage when it is not. There is sometimes a penalty for late enrollment in Part A. There is a penalty for late enrollment in Part B. These penalties do not apply, however, when the person was covered under a GHP due to his or her spouse's current employment status for up to 8 months after employment ends or after coverage terminates, whichever is first (with no exception where the participant has elected COBRA).

There are 3 periods during which an individual can sign up for Medicare Parts A or B – the initial enrollment period (for age-based Medicare, the period that begins 3 months before age 65 and ends 3 months after age 65), the general enrollment period (January 1 – March 31 coverage starts the first day of the month after enrollment), and the special enrollment period (8 months after employment ends or after coverage terminates, whichever is first with no exception where the participant has elected COBRA or retiree coverage).

Part C

A Medicare Advantage Plan (HMO or PPO), sometimes called a "Part C" or "MA Plan," is offered by private companies approved by Medicare. The plan will provide all of the Part A and Part B coverage. It may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Part D.

Medicare pays a fixed amount for the enrollee's care every month to the carrier which must follow rules set by Medicare.

Part D

Part D covers prescription drugs.

¹ Note that when there is a delay Social Security benefits, once the participant applies for Medicare Part A, benefits are effective retroactively 6 months.

There are 3 periods during which an individual can sign up for Medicare Part D:

- the initial enrollment period (for age-based Medicare, the period that begins 3 months before age 65 and ends 3 months after age 65),
- the annual coordinated election period (October 15 – December 7 for a January 1 effective date), and
- the special enrollment period (60 days after drug coverage is involuntarily lost).

An individual who does not enroll in Part D upon initial eligibility can do so without penalty if he is covered under a GHP which is creditable (including COBRA coverage) and does not have a 63-day break in coverage.

The Medicare rules are very complex and very fact specific. Therefore, individuals should discuss their situations with a Medicare representative to discuss what is right for them.

For information about the Medicare enrollment process, visit:

- <https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf>
- <https://www.medicare.gov/>

Q 2: What election changes are permissible under the cafeteria plan rules?

A 2: If an employee, spouse, or dependent who is enrolled in a GHP becomes entitled to coverage (i.e., becomes enrolled) under Part A or Part B of Medicare, a cafeteria plan may permit the employee to make a prospective election change to cancel or reduce coverage of that employee, spouse, or dependent under the GHP (and any health FSA).

In addition, if an employee, spouse, or dependent who has been entitled to such coverage under Medicare loses eligibility for such coverage, the cafeteria plan may permit the employee to make a prospective election to commence or increase coverage of that employee, spouse, or dependent under the GHP (and any health FSA).

Q 3: When is the GHP primary?

A 3: The Medicare as Secondary Payer ("MSP") rule is as follows:

Age

A GHP of an employer with 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:

- May not *take into account* (includes paying secondary to Medicare)² the age-based Medicare entitlement of an individual or spouse age 65 or older who is covered (or seeks to be covered) under the plan by virtue of current employment status; and
- Must provide, to employees age 65 or older and to spouses age 65 or older of employees of any age, the same benefits under the same conditions as it provides to employees and spouses under age 65.

Disability

A GHP of an employer that normally employed at least 100 employees on a typical business day during the previous calendar year may not *take into account* the disability-based Medicare entitlement of any individual (or

² Other examples of actions that constitute "taking into account" include:

- Imposing limitations on benefits for a Medicare-entitled individual that do not apply to others enrolled in the plan such as providing less comprehensive health care coverage, excluding benefits, reducing benefits, charging higher deductibles or coinsurance, providing for lower annual or lifetime benefit limits, or more restrictive pre-existing illness limitations.
- Terminating coverage because the individual has become entitled to Medicare.

a member of the individual's family) who is covered or seeks to be covered under the plan by virtue of current employment status.

ESRD

A GHP of any size:

- May not *take into account* Medicare eligibility or entitlement based on ESRD of any individual who is covered or seeks to be covered under the plan; and
- May not differentiate in the benefits it provides between individuals with ESRD and other individuals covered under the plan on the basis of the existence of ESRD, the need for dialysis, or in any other manner.

However, plans are not prohibited from paying benefits secondary to Medicare after the first 30 months of ESRD-based eligibility or entitlement.

A participant enrolled in Medicare may not elect for Medicare to be primary.

Additionally, employers subject to the Medicare as Secondary Payer Rule cannot encourage (e.g., with financial incentives) or force participants to drop GHP coverage in favor of Medicare. An employer cannot offer, subsidize, or **be involved in the arrangement of a Medicare supplement policy** where the law makes Medicare the secondary payer. However, under the cafeteria plan rules (see Q&A 2), participants may drop GHP coverage voluntarily.

Q 4: How do Medicare and COBRA interact?

A 4: For an aged or disabled beneficiary, Medicare is a primary payer for benefits in effect under COBRA. A GHP may even pay benefits secondary to Medicare for an aged or disabled beneficiary who has current employment status if the plan coverage is COBRA continuation coverage because of reduced hours of work. Medicare is primary payer for this beneficiary because, although he or she has current employment status, the GHP coverage is by virtue of COBRA rather than by virtue of the current employment status.³

COBRA continuation coverage may be terminated when, *after* having elected COBRA continuation coverage, a qualified beneficiary becomes *enrolled* in Medicare. This rule does not affect the COBRA rights of other qualified beneficiaries in a family unit who are not entitled to Medicare (for example, the spouse and dependent children of a Medicare-entitled former employee). Being enrolled in Medicare *before* electing COBRA is disregarded as to the former employee.

Being enrolled in Medicare before electing COBRA can affect the length of COBRA coverage with respect to a spouse and dependent child. If the qualified beneficiary became entitled to Medicare *before* experiencing a qualifying event that is a termination of employment, the maximum coverage period for the spouse or dependent ends on the later of:

36 months after the date the employee became entitled to Medicare; or

18 months after the date of the employee's termination of employment.

A terminated employee's entitlement to Medicare *after* the start of an 18-month period of COBRA coverage does not constitute a second qualifying event for the employee's spouse or dependents (which would have triggered a 36-month period of coverage for the spouse, as measured from the date of the employee's termination).

³ COBRA remains the primary payer during the first 30 months of ESRD-based eligibility or entitlement.

Mere eligibility for Medicare (e.g., being age 65) is irrelevant.

When an individual signs up for Medicare, he can voluntarily drop group coverage under the 125 rules. When an employee does this, his spouse loses coverage under general plan rules as the employee generally must be covered for the spouse to be covered. In this case, there is no qualifying event for COBRA purposes because a qualifying event does not exist unless (1) there is a listed triggering event (such as the covered employee's Medicare entitlement or termination of employment); and (2) the event causes a loss of coverage. Medicare entitlement does not cause loss of coverage due to the Medicare as Secondary Payer Rule.

Q 5: Does Medicare enrollment affect HSA eligibility?

A 5: Yes.

Briefly, an individual who is enrolled in any part of Medicare is not eligible to contribute to a health savings account ("HSA"). It's important to note that if an individual is already receiving Social Security benefits, he will be automatically enrolled in Medicare Part A and B effective the first day of the month he is age 65. However, if he is not receiving Social Security benefits, then affirmative steps must be taken to apply for Medicare. There may be situations where an individual is age 65 but not enrolled in Medicare.

An individual who is enrolled in Medicare may continue to be covered under the high-deductible health plan of the employer.

For more information, request a copy of USI's HSA and Medicare summary.

Q 6: Are there any reporting requirements?

A 6: Yes.

(1) Medicare Part D Creditable Coverage Notification.

(a) *Participant notification.* Medicare Part D, the Medicare prescription drug program, imposes a higher premium on beneficiaries who delay enrollment after initial eligibility unless they are covered under an employer plan that provides equivalent or better ("creditable") coverage. Employers that provide prescription drug benefits to Part D-eligible participants are required to notify these individuals annually (and at initial enrollment) as to whether the employer-provided benefit is creditable so that these individuals can decide whether or not to delay enrollment in a Part D plan.

(b) *CMS notification.* There is also an annual requirement to notify the Centers for Medicare & Medicaid Services ("CMS") as to whether the employer plan is creditable or not. CMS must also be notified upon the occurrence of other events, for example a change in the creditable status of the prescription drug coverage.

(2) Medicare Part D Application for Subsidy. Some plan sponsors may be eligible for the Retiree Drug Subsidy (RDS) program for assistance with prescription drug coverage of retirees. Plan sponsors must apply to the program 90 days before the first day of the plan year and meet certain actuarial requirements. For more information, visit <https://www.rds.cms.hhs.gov/>

(3) MSP Reporting. Responsible reporting entities ("RREs") must provide information to CMS to identify situations in which group health plans, including health reimbursement arrangements ("HRAs"), are (or have been) primary to Medicare. Carriers and TPAs must handle unless the plan is *self-insured and self-administered, in which case the plan sponsor will handle.*⁴

⁴ HRAs are subject to the reporting requirement regardless of whether there is an end-of-year carry-over or roll-over feature. Thus, employer-funded accounts that forfeit each year (e.g., deductible reimbursement plans) will be considered HRAs for these purposes.

Q 7: What are the penalties for noncompliance?

A 7: Failure to comply with the MSP rules can result in an excise tax equal to 25% of group health expenses incurred during the calendar year. The IRS is the collection agent.

According to CMS, the Medicare law is violated “every time a prohibited offer is made regardless of whether it is oral or in writing.” A violation of the prohibition on financial incentives can lead to civil penalties of up to **\$11,162 (2023)** per violation.

A group health plan must reimburse Medicare for a conditional payment if it is demonstrated that the plan was responsible to pay for the item or service. The federal government (through CMS) may recover the amount that Medicare paid as primary payer or the amount that should have been paid under the group health plan, whichever is less. But if CMS must bring legal action to recover a conditional payment, then it is entitled to collect twice the amount of its payment (also known as double damages). Under the MSP statute, an action by CMS will be considered timely if CMS requested the recovery of a conditional payment within three years after the date on which the underlying item or service was provided.

DOL representatives have stated informally that “encouraging” a Medicare beneficiary to disenroll in an employer's group health plan may also violate ERISA §510. This provision makes it unlawful to discharge or discriminate against a participant or beneficiary for exercising rights under ERISA or under an employee benefits plan.

An ERISA fiduciary has a duty to comply with the MSP requirements.

An action may be brought against any entity that is required or responsible for making a primary payment. This includes employers, insurance carriers, group health plans, and TPAs. All employers that sponsor or contribute to group health plans are primary payers regardless of whether the plan is insured or self-insured.

However, HRAs with an annual benefit amount of less than \$5,000 are exempt from reporting. Only HRA coverage that reflects an annual benefit value of \$5,000 or more must be reported.

RREs are insurers and third-party administrators (“TPAs”) of group health plans. However, *for plans that are self-insured and self-administered, the employer is the RRE and must gather and submit the required information.*