Medicare and Group Health Plans

Overview

For group health plan sponsors, an employee's eligibility for or entitlement to Medicare can create a host of compliance issues. Employers, especially those with a high population of Medicare-age employees and/or retirees, should understand these rules to avoid risk. This Insight will cover:

- Medicare Basics
- Medicare Secondary Payer Rules (Coordination of Benefits)
- Medicare Part D
- Medicare and Health Savings Accounts (HSAs)
- COBRA and Medicare

Medicare Basics

There are three main components of Medicare:

1. Medicare Part A: Coverage for hospitalization, skilled nursing facility care, nursing home care, hospice, and home health services. Generally does not require a premium.
2. Medicare Part B: Comprehensive coverage similar to group health plan coverage, including physicians' services and other health care expenses. Requires a monthly premium based on income level.
3. Medicare Part D: Prescription drug coverage. Requires a monthly premium.

Individuals entitled to Parts A and B may also be eligible for the Medicare Advantage program under Medicare Part C. A Medicare Advantage program is a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits.

Eligibility for Medicare

There are three ways an individual becomes eligible for Medicare: age, disability, and end stage renal disease. Age-based Medicare eligibility is most common in an employee population, but some employees and/or dependents may be eligible for Medicare based on disability or end stage renal disease. The basis for an individual's eligibility can impact how a group health plan coordinates with Medicare.

> *A note about terminology: Eligibility for and entitlement to Medicare mean different things. Medicare entitlement is an individual who is both eligible and enrolled in Medicare. Entitlement is the term we use to denote individuals actually enrolled in and receiving Medicare benefits. Medicare eligible individual are eligible, but not enrolled.*

An individual is generally eligible for age-based Medicare if they are 65 and receiving retirement benefits from Social Security or the Railroad Retirement Board. Generally, an otherwise eligible individual who turns 65 is automatically enrolled in Medicare Part A, and then has a special enrollment period within which to elect Medicare Part B. If an individual does not enroll in Part B when initially eligible, they are subject to penalties that increase their Part B premium for life. As addressed below, individuals with group health plan coverage (not COBRA coverage) at the time of their initial Medicare eligibility have an opportunity to enroll in Part B without penalty for a period of time after the group health plan coverage has terminated.

An individual becomes entitled to disability-based Medicare if they are under age 65 and for more than 24 months have either: (1) been entitled (deemed entitled) to disability benefits from Social Security; or (2)

been a disabled qualified beneficiary under the Railroad Retirement Act. Individuals are usually enrolled in Medicare automatically on the 25th month after having been determined to be disabled under either of these federal provisions.

Individuals with end stage renal disease (ESRD) are also eligible for Medicare. End stage renal disease is irreversible and permanent kidney impairment that requires regular dialysis or a kidney transplant. There are distinct rules for group health plans and how they pay claims when an individual is entitled to Medicare based on ESRD.

Medicare Enrollment Periods and Penalties for Late Enrollment [1]

Initial Enrollment

Medicare eligible individuals have a 7-month initial enrollment period to sign up for Medicare Parts A & B that begins 3 months before the month in which the individual turns 65 and closes at the end of the 3rd month after the month in which the individual turns 65.

Special Enrollment

Individuals have a special enrollment period that allows them to enroll outside of their initial enrollment period if they are covered under a group health plan based on current employment. There is an 8-month special enrollment period to sign up for Parts A and/or B that starts the month after the employment ends, or the month after group health plan insurance based on current employment ends, whichever is first. You can also sign up at any time after reaching age 65 if you are covered by an active employee employer sponsored health plan (also considered special enrollment).

Note this special enrollment period is not available where the individual delays Medicare after electing COBRA.

General Enrollment

If an individual fails to enroll when initially eligible or during a special enrollment period, enrollment is permissible at the annual enrollment period. This is referred to as general enrollment. For Medicare Parts A & B the general enrollment period that is January 1-May 31, and October 15-December 7 for Part D.

Failure to enroll in Medicare, either at the time of initial eligibility or during a special enrollment period will usually result in a late enrollment penalty. This penalty will last for as long as the individual has Medicare coverage. Employers should be aware of this rule for their Medicare eligible employee and retiree populations.

Medicare Secondary Payer Rules

Overview

In order to protect the Medicare Trust Funds, Congress passed legislation generally known as the Medicare Secondary Payer Rules, which are designed to ensure that Medicare does not pay claims that health insurance or group health plans are primarily responsible for paying. These rules govern which entity pays first for an individual covered by both Medicare and a group health plan or health insurance and shift costs by generally making Medicare the secondary payer to these other sources. For our purposes, we focus on individuals who have both Medicare and employer sponsored medical coverage.

[1] The rules for Medicare Parts A, B, and D are generally the same, with minor nuanced differences that are outside the scope of this piece. Additional information on Medicare enrollment is available at https://www.medicare.gov/

This process is referred to as "coordination of benefits" or COB. The Centers for Medicare and Medicaid Services (CMS) is the Federal Agency that is responsible for the enforcement the MSP rules.

Group Size Matters

MSP rules apply to large employers (generally 20 or more employees for age based entitlement) in the private and public sector, including non-profit organizations. This group size threshold 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. An employer is considered to have 20 or more employees for each working day of a particular week if the employer has at least 20 full time or part time employees on its payroll each working day of that week regardless of the number of employees who work or are expected to work on a particular day. This employee threshold must be met when an employee receives services for which Medicare benefits are claimed. Large employer status is also determined on a controlled group basis.

Employee Eligibility and Taking Medicare into Account

When designing plan eligibility, plan sponsors often consider the demographic of their population. Groups with a high retiree-age population often ask whether they can design their eligibility around employees' Medicare entitlement, either by paying them an incentive not to enroll in the plan or excluding them from the plan altogether. MSP rules prohibit a group health plan from "taking into account" the Medicare entitlement of a current employee or a current employee's spouse or family members. This includes, but is not limited to:

- Refusing to enroll an individual where Medicare would be the secondary payer,
- Failing to pay primary benefits,
- Offering coverage that is secondary to Medicare entitled individuals,
- Terminating coverage because the individual has become entitled to Medicare,
- Imposing limitations on benefits for an individual entitled to Medicare such as:
    - Providing less comprehensive health coverage,
    - Excluding or reducing benefits,
    - Charging higher deductibles or coinsurance, or
    - Providing for lower annual or lifetime benefit limits, etc.,
- Charging higher premiums to Medicare entitled individuals,
- Requiring a longer eligibility period, and
- Wrongfully inducing a Medicare entitled individual to reject the employer's health plan.

A Medicare entitled individual does have the right to reject the employer's group health plan. This may be the case where an individual simply does not want to pay for the employer's plan or has a well-established care network through Medicare. In that situation, Medicare becomes the individual's primary coverage, but employers can play no role in that decision making process. CMS has advised that an employer cannot offer, subsidize, or be involved in a Medicare entitled individual's decision to accept or reject the employer's group health plan. Employers cannot offer any incentives, financial or otherwise, for a Medicare entitled individual to not enroll in their group health plan that would be a primary payer. A violation of the prohibition on financial or other incentives can lead to civil penalties of up to $5,000 per violation. Additionally, encouraging Medicare entitled individuals to waive group health plan coverage may raise other legal concerns, such as age discrimination under the Age Discrimination in Employment Act (ADEA).

Does this mean my cash in lieu plan violates the Medicare Secondary Payer Rules?! Historically, a cash in lieu plan that is offered uniformly and does not target Medicare eligible participants did not raise issues under the MSP rules. In recent guidance, however, CMS has indicated a potential shift on this issue and additional guidance would be welcome. Significantly risk averse entities may want to consult with outside counsel.

Paying an employee's Medicare Premiums (Part B, D, or a Supplemental Policy) most likely violates the prohibition on an employer offering a financial incentive not to enroll in a group health plan that would otherwise pay primary to Medicare. In addition, an employer must offer Medicare entitled individuals and their spouses the same benefits they provide to non-entitled Medicare individuals and their spouses.

Note the MSP rules apply to active employees. These rules do not apply to retirees who are no longer actively employed, but who still receive coverage of some type from a former employer. In fact, we have seen a number of plans that are designed to pay claims for their Medicare eligible population "as if" those individuals enrolled in Medicare, regardless of whether that is the case. This design raises some concerns, but appears to be permissible if it is designed to impact only those individuals who are not "actively employed" as that term is defined under the MSP rules. Plans seeking to implement this type of design should clearly disclose this approach in the plan documents and define the term "actively employed" in a manner that is consistent with the MSP rules. Given the special rules around Medicare and ESRD, plans should never implement this "as if" plan design where an individual is Medicare eligible due to ESRD.

Exceptions

Other than the small employer exemption, there are no exceptions to the MSP rules. These rules are federal and generally preempt state law and private contracts. .

Enforcement and the Data Match Program

CMS, SSA, and the Internal Revenue Service (IRS) have developed the Data Match program to identify Medicare beneficiaries who are currently employed. This program is designed to find situations where a group health plan should be paying primary to Medicare. Under the Data Match program, the SSA provides the IRS with a list of the Social Security numbers of Medicare beneficiaries. The IRS then takes that list and matches it against income tax return data. The list then gets sent to CMS for further analysis.

After the analysis, CMS sends out a questionnaire to employers. The questionnaire asks specifically about the employer's group health plan and requests information about the Medicare beneficiaries. The questionnaire asks about each Medicare beneficiary's time worked during a certain time period and whether the beneficiary had employer-sponsored group health coverage. This information is used to identify the primary and secondary payers for a Medicare beneficiary's medical services and to determine whether Medicare may have mistakenly paid claims on behalf of the beneficiary.

Employers have 30 days to complete the questionnaire, unless they are given an extension. Employers that fail to send the questionnaire back are subject to monetary penalties and other consequences:

- Monetary penalties of $1,000 per person for which the employer has neither responded to or provided incomplete information for;
- Subpoenas of the employer's business records and members of the organization; and
- An investigation of the employer's group health plan for a determination of nonconformance, which may result in a referral to the IRS for imposition of an excise tax on the employer.

The instructions for completing the Data Match Questionnaire also request and provide specific information about the employer's prescription drug plans.

If you receive a Data Match request, review your employee and plan eligibility records, engage your carrier and/or other advisors to help compile the requested information, and promptly respond to the request. If you have received a request it is likely CMS has reason to believe it is a secondary payer on certain claims and intends to pursue the issue.

Additional Penalties

Failure to comply with MSP requirements may result in an excise tax equal to 25% of the group health plan expenses incurred during the calendar year. The excise tax applies to every single group health plan the employer contributes to, not just the nonconforming plan. CMS will refer the nonconforming plans to the IRS for the imposition of this tax.

The following chart identifies some common situations where Medicare and other coverage are present and which entity would be the Primary or Secondary Payer.

Individual	Situation	Pays First	Pays Second
Individual 65 or older who is covered by a group health plan because they or their spouse is still working	20 or more employees	Group Health Plan	Medicare
Individual 65 or older who is covered by a group health plan because they or their spouse is still working	Less than 20 employees	Medicare	Group Health Plans
Individual has an employer retirement plan and is 65 or older	Medicare Entitled	Medicare	Retiree Coverage

Individual is under 65, disabled, and covered under current employment (either their own or their spouse)	Less than 100 employees	Medicare	Group Health Plan
Individual is under 65, disabled, and covered under current employment (either their own or their spouse)	More than 100 employees	Group Health Plan	Medicare

Medicare Part D and Employer Plans

Part D is Medicare's prescription drug component. As indicated above, individuals must enroll for Part D coverage when initially eligible or pay a penalty on their Part D premium. Individuals who have group health plan prescription drug coverage that provides benefits at the same level of Medicare Part D can delay Part D enrollment without penalty. A plan that provides the same level of benefits is commonly referred to as Medicare Part D Creditable Coverage. Group health plans that provide prescription drug coverage are required to provide a notice to Medicare eligible individuals on whether their coverage is Medicare Part D Creditable. This notice is referred to as the Medicare Part D Creditable Coverage Notice (or Medicare Part D notice). It is required so that individuals who are Medicare eligible know if their employer's prescription drug coverage is creditable, allowing them to delay Part D enrollment, or whether they are required to enroll in Medicare Part D when initially eligible to avoid a lifetime penalty.

A Medicare Part D creditable coverage notice is required only for Medicare eligible employees, however, the recommended practice is to provide the notice to all employees in order to reach Medicare eligible spouses and dependents. Even if an employer knows the age of its employees, it will not necessarily know whether employees could be Medicare entitled on some other basis.

Timing of Notice

The rules provide that a Medicare Part D notice must be provided:

- Annually prior to Part D election period beginning on October 15
- Prior to enrollment (annually at open enrollment and for new hires/new enrollees)
- On request.
- Upon change in the creditability of the plan

If the Part D notice is provided to all eligible individuals at open enrollment annually before October 15 (or early in the Medicare open enrollment window) and to newly eligible employees, the first two bullets above will be satisfied. This is generally because "prior to" technically means within the prior 12 months.

Failure to Provide Notice

Where an employer's prescription drug plan does not provide creditable coverage, failure to provide a notice that the plan is not creditable could subject Medicare eligible employees to an increased, lifetime Medicare Part D premium if they delay enrollment. This could lead to individual or collective employee

claims against the employer for failure to provide the notice. To date, there are no statutory penalties associated with failing to provide a notice. However, an employer that failed to provide adequate notice of a non-creditable plan could be liable for an individual's late enrollment penalties. Where an employer has failed to provide a notice, best practice is to distribute the notice as soon as possible.

Disclosure to CMS

Group health plans that provide prescription drug coverage must also disclose to CMS whether their prescription drug plans are creditable or non-creditable. This is a fairly straightforward online form that must be completed annually, within 60 days after the start of the plan year. Likewise, no specific penalties apply for failing to complete the disclosure to CMS, but recommend timely submitting the disclosure.

Determining Part D Creditability

Generally the insurance carrier or third party administrator can advise a plan sponsor whether their prescription drug plan is Part D creditable. In the rare situations where a carrier or third party administrator does not provide this information, the plan sponsor can determine creditability using a simplified method provided by the Centers for Medicare & Medicaid Services (CMS), or with the help of an actuary.

The Inflation Reduction Act of 2023 (IRA) made certain changes to Medicare Part D, effective 2025, which increased the actuarial value of Medicare Part D and as a result, the creditability threshold for employer group health plans. CMS subsequently released guidance permitting plans that do not participate in the Retiree Drug Subsidy (RDS) program to continue using the existing simplified method (last updated in 2009) for the 2025 and 2026 calendar years. CMS has also issued a revised simplified method, requiring that prescription drug coverage pay at least 72% of participants' prescription drug expenses, versus 60% under the existing simplified method, to more closely align with the changes made by the IRA. The revised simplified method can also be used to determine creditability for the 2026 calendar year and thereafter.

Medicare Impact on Employee HSA Eligibility

Medicare entitled individuals may be covered by an employer's HDHP but are not eligible to contribute to a Health Savings Account (HSA). This is important information for employers transitioning to a High Deductible Health Plan (HDHP)/HSA design for the first time, especially where there are Medicare entitled active employees. Note, however, that:

- A Medicare entitled individual can reimburse medical expenses from an existing HSA. It is contributions to an HSA that are not permissible, regardless of the source (e.g., employer or employee).
- A spouse's Medicare entitlement does not make an employee ineligible to contribute to an HSA, as long as the employee has no other disqualifying coverage.

In short, Medicare is disqualifying coverage for HSA purposes. An individual can have Medicare and HDHP coverage simultaneously, but would not be HSA eligible. Similarly, a spouse can have Medicare coverage without affecting the other spouse's HSA eligibility. *ONLY HSA account holders need to be concerned with disqualifying coverage.*

The potential for retroactive Medicare Part A entitlement can further complicate HSA eligibility for older Medicare enrollees. If you enroll in Medicare during the three-month period before your 65th birthday, Medicare is effective on the first day of the birthday month. However, if an individual enrolls after that, Medicare Part A is effective retroactively to the first day of the birthday month or 6 months, whichever is less. This can create problems for employees over age 65 ½ that are working (or those who retire) and choose to enroll in Medicare while contributing to an HSA. Employees (or recent retirees) need to work backwards 6 months or to their 65th birthday to plan HSA contributions accordingly. Note that the retroactive coverage rule only applies to those who receive premium free Medicare Part A. It is also important to remember that HSA contributions are described as annualized amounts but they are in fact

prorated monthly amounts based on the number of months you are HSA eligible. If you contributed to an HSA during the months that were retroactively covered by Medicare a correction is only required if that resulted in contributions in excess of the prorated limitation. Even then, you can generally withdraw the excess contributions (and any net income attributable to the excess contribution) from the HSA without penalty if done by the due date for filing your tax return.

Medicare and COBRA

There are a number of situations where Medicare and COBRA interact to impact an individual's rights and obligations under both coverages.

COBRA First, Medicare Second

When any COBRA qualified beneficiary (QB) first becomes entitled to Medicare after electing COBRA coverage, his or her COBRA coverage can be terminated early. This rule does not impact the COBRA rights of other qualified beneficiaries in a family unit who are not entitled to Medicare.

Note that where an individual has elected COBRA and then becomes eligible to enroll in Medicare, delaying enrollment in Medicare while only COBRA coverage is in place or until COBRA has been exhausted will result in a Medicare Part B premium penalty for failing to enroll when initially eligible. COBRA coverage is not viewed as employer sponsored coverage for this purpose.

Medicare First, COBRA Second

An employee and any dependent that is entitled to Medicare before electing COBRA still has the right to elect COBRA coverage. In other words, plan sponsors are required to offer COBRA to employees and dependents already covered by Medicare. COBRA must still be offered and may not be terminated early because of the prior Medicare entitlement.

Employee Medicare Entitlement as a Qualifying Event (Hint: It almost never is . .)

An employee's entitlement to Medicare is one of COBRA's listed qualifying events. It is a qualifying event only for the spouse and dependent children, not for the covered employee. However, given the MSP rules discussed above, active employee plans generally cannot be designed to terminate coverage as a result of Medicare entitlement. As a result, this will rarely be a COBRA qualifying event for active employees or their families. Note that it is permissible under the MSP rules for Medicare entitlement to cause a loss of coverage for covered retired employees (and their spouses and dependent children). In that situation, Medicare entitlement would constitute a first qualifying event for the affected spouse and dependent children, permitting them to elect up to 36 months of COBRA under the plan.

Medicare Entitlement as Second Qualifying Event for Spouse and Dependent Children

Under the COBRA multiple qualifying event rule, an initial maximum coverage period of 18 months may be extended to 36 months for dependents. This extension is available only where the first qualifying event is termination of employment or reduction of hours (18 month maximum coverage period), followed by certain other qualifying events that have an 18 month maximum coverage period (i.e., the covered employee dies or becomes divorced or legally separated, or a dependent child ceases to be eligible as a dependent).

The IRS has ruled that a covered employee's Medicare entitlement cannot be a second qualifying event giving rise to an extended COBRA maximum coverage period if the covered employee's Medicare entitlement would not have caused a loss of coverage for the spouse or dependent children under the plan. Under the MSP rules discussed above, group health plans are prohibited in most circumstances from making Medicare entitlement an event that causes a loss of coverage for active employees.

Consequently, Medicare entitlement of the covered employee will rarely be a first qualifying event because it will rarely cause a loss of plan coverage. For the same reason, Medicare entitlement will rarely be a second qualifying event for purposes of the multiple qualifying event rule.

Special Medicare Extending Rule for Spouses and Dependent Children

When an employee's termination of employment or reduction of hours occurs within the 18-month period ***after*** the employee becomes entitled to Medicare, the employee's spouse and dependent children become entitled to COBRA coverage for a maximum period that ends 36 months after the covered employee becomes entitled to Medicare. The former employee remains entitled to 18 months after the termination of employment or reduction of hours.

Conclusion

A number of Medicare rules impact group health plan design especially where an employer has a high population of Medicare eligible active employees, and in this era of aggressive cost containment measures. Employers must understand the basic Medicare rules in order to avoid penalties and/or employee claims. Contact your Alliant representative with any questions.