# Medicare & Employee Benefits

February 2022

*Legislation and regulations are subject to change. This guidance is current as of the date of this publication.*

## Medicare Secondary Payer (MSP) Rules

### Coordination of Benefits (between group health plan and Medicare coverage)

Medicare Secondary Payer (MSP) rules determine which plan is the primary payer if an individual is covered by both an employer-sponsored group health plan and Medicare as set forth below:

Age-Based Medicare

- For employers with 20 or more employees, the group health plan is the primary payer (Medicare is secondary).
- For employers with fewer than 20 employees, Medicare is the primary payer (group health plan is secondary).

Disability-Based Medicare

- For employers with 100 or more employees, the group health plan is the primary payer (Medicare is secondary).
- For employers with fewer than 100 employees, Medicare is the primary payer (group health plan is secondary).

ESRD-Based Medicare

- The group health plan is the primary payer (Medicare is secondary) for the first 30 months regardless of employer size.

***If retiree or COBRA coverage is involved, Medicare is the primary payer (retiree or COBRA coverage is secondary) except for the first 30 months for ESRD-based Medicare.

Quarterly MSP mandatory reporting, as required under §111 rules, helps CMS identify situations where another payer may be primary to Medicare. This reporting is typically handled by the insurance carrier for fully-insured plans, and by the TPA for self-funded plans.

### MSP Rules when the Group Health Plan is the Primary Payer

Employers are prohibited from "taking into account" the Medicare entitlement of a current employee, or a current employee's spouse or family member. So, for example, excluding such individuals from eligibility, limiting benefits, or charging a higher monthly contribution are not permitted.

Employers are required to provide a current employee, or a current employee's spouse, who is age 65 or older with the same benefits, under the same conditions, as are provided to employees and spouses who are under age 65.

Employers cannot incent individuals who are eligible for Medicare not to enroll in the employer's group health plan. This would include things such as offering opt-out incentives, offering to pay for Medicare premiums or supplements, or allowing Medicare premiums to be paid on a pre-tax basis through a cafeteria plan; all such actions would violate MSP rules.

### Potential Penalties for Noncompliance

Violating the MSP rules could result in the following penalties:

- Civil penalties of up to $5,000 per violation; and
- An excise tax of 25% of the employer's expenses incurred during the calendar year for each group health plan (both conforming and non-conforming) to which they contribute.

# Medicare Part D – Creditable Coverage

## Creditable Prescription Drug Coverage

Prescription drug coverage is "creditable" if the actuarial value of the coverage provided is equal to or greater than the standard prescription drug coverage provided by Medicare Part D. Oftentimes the carrier or TPA will assist with determining creditable status, but otherwise the employer is responsible. It is important for employers to understand whether their prescription drug coverage offered is creditable because the employer has two separate disclosure obligations: (i) the employer must notify individuals eligible to participate in the employer's plan whether the coverage is creditable; and (ii) the employer must also notify CMS.

## Notice to Eligible Individuals

The creditable coverage notice must be provided to eligible individuals:

- annually;
- prior to an individual's initial Part D enrollment period;
- prior to the effective date of coverage;
- whenever coverage changes between creditable and non-creditable, or coverage is no longer offered; and
- upon request.

"Prior to" means within the last 12 months, so it is acceptable to provide it either at each open enrollment, or annually in late September or early October to align with Medicare open enrollment. Either option is compliant assuming the notice is also provided when individuals are first eligible.

## CMS Reporting

Employers must report creditable coverage status to CMS on CMS' website within 60 days of the beginning of the plan year (e.g.,status for the 2022 calendar year plan should be reported by the end of February 2022). This reporting must be done electronically. The form, guide and instructions can be found here - https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure.

# COBRA & Medicare

## COBRA Qualifying Event – Medicare Entitlement

While federal COBRA rules list Medicare entitlement as a potential "qualifying event", a COBRA continuation right is triggered for the spouse and dependents for up to 36 months only if an active employee is considered ineligible upon becoming eligible for Medicare (i.e., the plan eligibility rules exclude those who are Medicare-eligible). Generally, Medicare eligibility or enrollment does not cause a loss of plan coverage due to MSP rules; therefore, it is rarely a triggering event for COBRA. A voluntary termination of coverage by the employee does not trigger a COBRA continuation right for the spouse and dependents.

Similarly, for the multiple qualifying events extension to apply, the second qualifying event would have had to make the employee ineligible for the plan if it was the first qualifying event experienced. In other words, for the same reason Medicare entitlement generally is not a COBRA qualifying event to begin with, it does not end up being an event that would allow for an extension of continuation coverage either (e.g., no extension to 36 months for the spouse and dependents when the employee enrolls in Medicare following the election of COBRA).

## COBRA Maximum Coverage Periods

The COBRA maximum coverage period (i.e., 18, 29 or 36 months) can be shortened or extended due to Medicare enrollment/entitlement.

If a qualified beneficiary first elects COBRA and then enrolls in Medicare (entitled to Medicare AFTER electing COBRA):

- COBRA coverage can be terminated early for the individual who enrolled in Medicare, but
- COBRA rights for any other qualified beneficiaries in the family are unaffected.

If a qualified beneficiary first enrolls in Medicare and then elects COBRA (entitled to Medicare BEFORE electing COBRA):

- COBRA rights are unaffected and qualified beneficiaries must be permitted to enroll for the maximum coverage period.
- In addition, there is a special extension rule that would permit spouses and dependents to have continuation coverage for the remainder of up to 36 months from the date of Medicare enrollment, or 18 months from the qualifying event, whichever is greater.

# HSAs & Medicare

## HSA-Eligibility

To be eligible to contribute to an HSA, an individual must be:

- Enrolled in a qualified high deductible health plan (HDHP);
- May not have any other disqualifying coverage; and
- Cannot be claimed as another's tax dependent.

Medicare is "disqualifying coverage". Individuals become ineligible to contribute to an HSA the first full month of Medicare enrollment/entitlement. An individual's mere eligibility for Medicare does not impact HSA-eligibility, but once the individual is enrolled and entitled to receive Medicare coverage, it impacts HSA-eligibility. Keep in mind that HSA-eligibility is determined on an individual basis, so a spouse or dependent having disqualifying coverage does not matter.

## HSA Contribution Limits

Individuals may contribute up to 1/12 of the annual contribution limit for the year for each month they meet the requirements for HSA eligibility. An individual who becomes ineligible mid-year due to Medicare entitlement would only be able to contribute a pro rata portion of the annual limit. For example, if the individual enrolled in Medicare June 1, the individual could contribute up to 5/12 of the annual contribution limit. Such contributions could be made any time before the tax filing deadline for the year (generally April 15th of the following year).

## HSA Reimbursement

Once funds are contributed to an HSA, they may be used to reimburse qualifying medical expenses of the HSA account holder, as well as the account holder's spouse and tax dependents. It does not matter whether such individuals are eligible to contribute to an HSA.

HSAs are generally prohibited from reimbursing insurance premiums, except for the following:

- COBRA or USERRA premiums;
- Qualified long-term care insurance premiums;
- Insurance premiums for individuals receiving unemployment compensation; and
- Insurance or Medicare premiums for HSA account holders age 65 or older.

# Individual Coverage HRAs (ICHRAs) & Medicare

## ICHRA Requirements

- ICHRAs must be funded solely with employer contributions.
- ICHRAs must be integrated with individual health coverage or Medicare (i.e., individuals must be enrolled in individual health coverage or Medicare to be eligible to participate in the ICHRA).
- The same employees cannot be offered a choice between a traditional group medical plan and an ICHRA.
- An ICHRA must be offered on a uniform basis to all employees within a permitted class as follows:
    - Full-time or part-time employees;
    - Salaried or non-salaried employees;
    - Seasonal employees;
    - Union and non-union employees;

- Employees by geographic location;
- Employees in a waiting period;
- Non-resident aliens with no U.S.-source income; and
- Temporary employees of staffing firms.

### ICHRA Reimbursement

ICHRAs may be used to reimburse individual coverage premiums, Medicare premiums, or other §213(d) qualifying medical expenses.

## Cafeteria Plans & Medicare

### Medicare Premiums

Premiums for Medicare Part B or D, or for Medicare supplements, generally cannot be paid for on a pre-tax basis through the employer's cafeteria plan due to a variety of compliance restrictions (e.g., MSP rules, healthcare reform, HIPAA, ADA, and ADEA).

In addition, similar to the restrictions that apply to HSAs, health FSAs cannot be used to reimburse insurance premiums, including Medicare (and there is not an exception for participants age 65 or older).

### Election Changes

Entitlement to (or enrollment in) Medicare allows a prospective mid-year election to cancel or reduce salary reductions for an individual enrolled in the employer's group health plan. Similarly, loss of Medicare eligibility allows a prospective mid-year election to start or increase contributions toward the employer's group health plan.