January 24, 2019

Medicare and Employee Benefits

Presented by Benefit Comply

Medicare and Employee Benefits

- Welcome! We will begin at 3 p.m. Eastern
- There will be no sound until we begin the webinar. When we begin, you can listen to the audio portion through your computer speakers or by calling into the phone conference number provided in your confirmation email.
- You will be able to submit questions during the webinar by using the “Questions” box located on your webinar control panel.
- Slides can be printed from the webinar control panel – expand the “Handouts” section and click the file to download.

January 2019

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Agenda

- Medicare Secondary Payer (MSP) Rules
- Employer Payment Plans (EPPs)
- Health Savings Accounts (HSAs)
- Medicare Part D – Creditable Coverage
- COBRA
- Cafeteria Plans

Medicare Secondary Payer (MSP) Rules

Medicare Secondary Payer (MSP) Rules

- Coordination of Benefits
  - MSP rules determine which plan is the primary payer if an individual is covered by a group health plan and Medicare
    - All employer sizes
      - Medicare is generally primary to retiree coverage
      - Medicare is generally primary Federal COBRA continuation coverage
      - ESRD-based Medicare entitlement, group health plan is primary for the first 30 months (even when coordinated with retiree or COBRA coverage)
    - Employers with 20 or more employees
      - Age-based Medicare entitlement, group health plan is primary
    - Employers with 100 or more employees
      - Disability-based Medicare entitlement, group health plan is primary
  - Mandatory MSP reporting helps identify situations where another payer may be primary to Medicare

Medicare Secondary Payer (MSP) Rules

- Counting Employees under MSP rules
  - Count all common law employees, including part-time employees
    - All employers who are part of a controlled group or affiliated service group (under §414 rules) must aggregate total number of employees
  - Determination is made based on the claim date of service
    - Did the employer have 20 (or 100) or more employees **for each working day in at least 20 weeks in either the current or the preceding calendar year?**

Medicare Secondary Payer (MSP) Rules

- Examples –

  Employer received a claim with a date of service of 11/8/2018, for which it needs to determine its group health plan's status as either primary or secondary to **age-based** Medicare coverage

  - **A:** Employer reviews payroll records for each week of 2017 and determines there were 23 weeks for which there were 20 or more employees
    - *Employer's group health plan is primary to Medicare for all of 2018*
  - **B:** There were only 17 weeks for which there were 20 or more employees during 2017, so the employer reviews payroll records for 2018 and discovers that as of 11/8/2018, there had been 32 weeks for which there were 20 or more employees
    - *Employer's group health plan is primary for the remainder of 2018 and all of 2019*
  - **C:** There were only 17 weeks for which there were 20 or more employees during 2017, so the employer reviews payroll records for 2018 and discovers that as 11/8/2018, there had been only 9 weeks for which there were 20 or more employees
    - *Employer's group health plan is secondary*

Medicare Secondary Payer (MSP) Rules

- When Employer's Group Health Plan is Primary
  - Prohibited from "taking into account" the Medicare entitlement of a current employee or a current employee's spouse or family member
  - 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
    - Cannot condition eligibility upon individuals being under age 65
  - Prohibited from incenting employees not to enroll in employer's group health plans
    - Cannot pay for Medicare premiums or allow such premiums to be paid on a tax-favored basis (e.g. through a cafeteria plan or HRA)
    - Unclear whether an opt-out waiver (cash-in-lieu) to those who are enrolled in Medicare is okay, even if it is also offered to others not enrolled in Medicare

Medicare Part D – Creditable Coverage

Medicare Part D – Creditable Coverage

- Determination of Creditable Coverage
  - Prescription drug coverage is “creditable” if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D
  - Often an insurance carrier or administrator will provide creditable status
  - If not, the employer must make the determination
    - Employers not applying for the subsidy for qualified retiree prescription drug plans may use a simplified method to determine if coverage is creditable
    - If the plan does not meet the standards under the simplified method, an actuarial determination will be needed

Medicare Part D – Creditable Coverage

- Notice and Reporting Requirements
  1. Employers must provide a notice indicating plan credibility for all Part D eligible individuals who are enrolled in (or seeking to enroll in) the plan
     - Employers may enter into a voluntary data-sharing agreement (VDSA) with CMS under which CMS uses group health plan enrollment data provided by the employer to tell the employer which individuals are Medicare beneficiaries
     - Alternatively, an employer could provide the disclosure to everyone that is either enrolled in or seeking to enroll in the plan
  2. Employers must report plan credibility directly to CMS annually

Medicare Part D – Creditable Coverage

- Notice to Part D Eligible Individuals
  - Creditable (or non-creditable) notices are required to be provided to Part D (Medicare) eligible individuals at the following times:
    - Prior to commencement of the annual enrollment period for Part D (Oct 15);
    - Prior to an individual's initial enrollment period (IEP) for Part D;
    - Prior to the effective date of coverage for any Part D eligible individual who enrolls in the employer's prescription drug coverage;
    - Whenever the employer no longer offers prescription drug coverage or changes it so that it is no longer creditable or becomes creditable; and
    - Upon request by the Part D eligible individual
  - The first three occasions use the term, “prior to” which CMS says means within the last 12 months
  - Providing the coverage when individuals are newly eligible + during plan open enrollment, or prior to Part D enrollment (e.g. early October)

Medicare Part D – Creditable Coverage

- Notice to Part D Eligible Individuals (Continued)
  - While notice may be provided electronically if certain requirements are met, CMS prefers using paper documents to provide disclosure notices because Part D eligible individuals (especially spouses and dependents) are more likely to receive and understand them

Medicare Part D – Creditable Coverage

- Disclosure to CMS
  - Form must be completed annually within 60 days following the beginning of the plan year
  - Additional disclosures must be made to CMS within 30 days if the employer's drug benefit status (i.e. creditable or non-creditable) changes during a plan year or if the plan is terminated

Medicare Part D – Creditable Coverage

- Penalties for Noncompliance
  - No specific penalty or sanction against employers who fail to comply with the disclosure or reporting requirements, other than for those employers claiming the retiree drug subsidy…such a plan would be denied the subsidy
  - Medicare-eligible individuals who do not receive accurate information about the credibility of a prescription drug plan and have a lapse of 63 days or longer without creditable prescription drug coverage may face a late enrollment penalty

Health Savings Accounts (HSAs)

Health Savings Accounts (HSAs)

- HSA-Eligible Individuals
  - Individuals entitled to (enrolled in) Medicare are NOT eligible to contribute to an HSA
    - Such individuals could still enroll in an employer HDHP option if the individual meets the plan eligibility rules
  - Ineligible individuals may use funds already in their HSA to pay for qualifying medical expenses

Health Savings Accounts (HSAs)

- Medicare Entitlement (Enrollment)
  - Medicare Part A enrollment at age 65
    - Automatic for those already receiving social security benefits
    - Requires an application for those not yet receiving social security benefits
  - Employees who have coverage under an employer-sponsored plan may want to delay for things such as maintaining eligibility to contribute to an HSA
    - NOTE – sometimes those choosing to delay social security benefits will be retroactively enrolled in Medicare (up to 6 months), which may affect the annual HSA contribution limit

Health Savings Accounts (HSAs)

- Spouse Covered by Medicare
  - Spouse's Medicare entitlement (and resulting HSA-ineligibility) does not impact the employee's ability to maintain and contribute to an HSA
    - Employee enrolled in family HDHP may contribute the family annual maximum even if the spouse is not HSA-eligible
  - Regardless of whether spouse is eligible to contribute to an HSA, HSA funds may actually be used to reimburse the spouse's expenses
    - Funds may generally be used to reimburse qualifying medical expenses for the account holder, as well as the account holder's spouse and other tax dependents

Health Savings Accounts (HSAs)

- HSA Annual Contribution Limits
  - 2019 maximum for single HDHP coverage = $3,500 + $1,000 catch-up contribution
  - Eligibility determined monthly on the 1st day of the month
  - Contributions are calculated based on 1/12 of annual max times number of months that an individual is eligible
  - Example –
    - Individual enrolled in single HDHP coverage effective 1/1/2019 and then enrolled in Medicare 5/1/2019
    - Assuming individual was HSA-eligible for 4 months (Jan.-Apr.), the individual could contribute up to $1,500 at any time during 2019 (4/12 x ($3,500 + $1,000))

Health Savings Accounts (HSAs)

- HSA Reimbursement of Insurance Premiums
  - HSAs may generally not be used to reimburse insurance premiums
  - Exception for account holders who are age 65 or over
    - HSA may reimburse any deductible health insurance (e.g., retiree medical coverage) other than a Medicare supplemental policy
      - Includes coverage for spouses and dependents
    - When premiums for Medicare Part A, B, C, or D are deducted from social security benefit payments received by an HSA holder who is age 65 or older, HSA distributions equal to the Medicare premium deduction may be taken

COBRA

COBRA

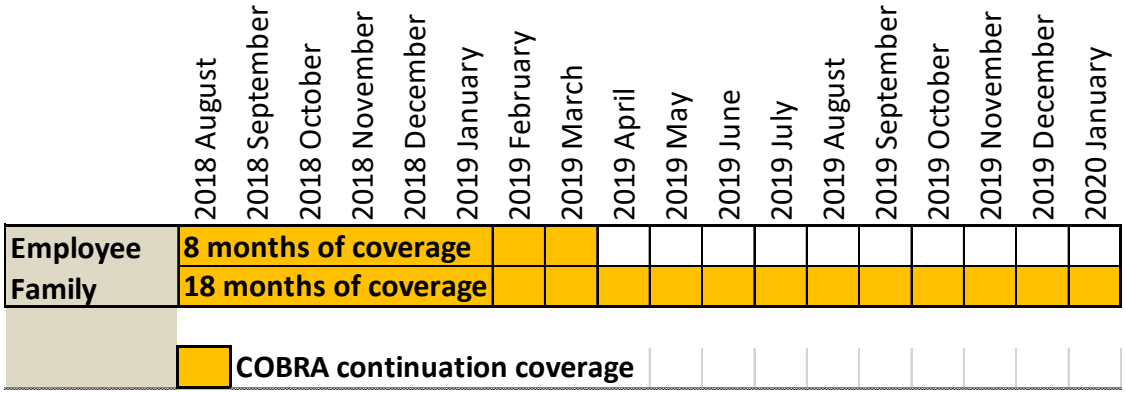
- Qualifying Event - Entitlement to Medicare
  - A qualifying event only for the spouse and dependent children, and only if it triggers a loss of eligibility for the covered employee
  - Medicare entitlement will infrequently cause a loss of eligibility under a group health plan (due to MSP rules), so it is rarely a COBRA qualifying event (or second qualifying event)

COBRA

- Qualifying Event – Retirement / Termination of Employment
  - Timing of retirement and Medicare entitlement may affect the length of COBRA continuation rights
  - Medicare entitlement (enrollment), followed by retirement
    - Employee has the right to up to 18 months of COBRA continuation coverage beginning upon retirement
    - Special extension rule for covered spouse and dependent children
      - When a covered employee's qualifying event (i.e. a termination of employment or reduction of hours) occurs within 18 months after employee becomes entitled to Medicare, the employee's spouse and dependent children (but not the employee) become entitled to COBRA coverage for up to 36 months from the date of Medicare entitlement
  - Retirement, followed by Medicare entitlement (enrollment)
    - COBRA coverage may be terminated early (upon Medicare entitlement)
    - Does not affect the COBRA rights of other qualified beneficiaries (e.g. family members) who are not entitled to Medicare

COBRA

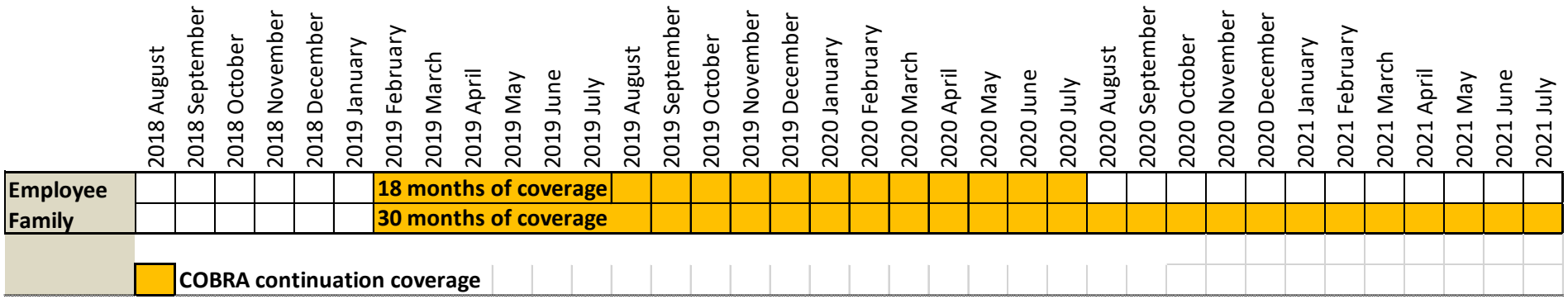
- Example 1
  - Employee retires at age 64 at the end of July 2018 and family coverage under the group health plan terminates
  - Employee turns 65 in mid-March 2019 and enrolls in Medicare



  - Employee's COBRA coverage may be terminated upon enrollment in Medicare
  - COBRA coverage for family members remains available for the full 18 months (assuming spouse does not also become entitled to Medicare during that time)

COBRA

- Example 2
  - Employee turns 65 in August 2018 and enrolls in Medicare
  - Employee retires at the end of January 2019 and family coverage under the group health plan terminates



  - Employee must be provided the opportunity to enroll in COBRA for up to 18 months upon retirement
  - Family must be provided the opportunity to enroll in COBRA for up to 36 months from the date of Medicare enrollment

COBRA

- Delaying Medicare Enrollment
  - Generally, if an individual does not enroll in Medicare when he or she is first entitled to it, the individual must pay more when he or she ultimately does enroll
  - A special enrollment period is available for those who did not enroll in Medicare when first entitled because they had coverage under a group health plan due to their current (or their spouse's current) employment status
    - Individuals enrolling during a special enrollment period do not have to pay penalties or increased premiums
    - COBRA coverage is not considered a group health plan based upon current employment individuals

Cafeteria Plans

Cafeteria Plans

- Premiums for Medicare Part B or D, or Medicare Supplements
  - Generally cannot be offered on a pre-tax basis through a cafeteria plan
    - MSP rules
    - Health care reform (employer payment plans)
    - Also potential violation of HIPAA, ADA and ADEA rules
- Health FSAs cannot be used to reimburse insurance premiums, including Medicare
- Election Changes
  - Entitlement to (enrollment in) Medicare allows a prospective election change to cancel or reduce coverage for the individual enrolled in the plan (this is not a COBRA qualifying event for covered spouse and dependents)
  - Loss of Medicare eligibility allows a prospective election to commence or increase coverage for the individual who lost coverage

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