January 19, 2017

Employee Benefits and Medicare Coordination Issues

Presented by Benefit Comply

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- 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.

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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

- MSP rules determine which plan is primary if an individual is covered by a group health plan and Medicare
  - Age-based Medicare entitlement
    - Employers with 20 or more employees, group health plan is primary
    - Employers with fewer than 20 employees, group health plan is secondary
  - Disability-based Medicare entitlement
    - Employers with 100 or more employees, group health plan is primary
    - Employers with fewer than 100 employees, group health plan is secondary
  - Retiree coverage, Medicare is primary
- Mandatory MSP reporting as well as CMS Data Match processes help identify situations where another payer may be primary to Medicare
  - Employers who are contacted via the CMS Data Match process are required to complete a questionnaire about group health plan information on identified workers either entitled to Medicare or married to a Medicare beneficiary

Medicare Secondary Payer (MSP) Rules

- Counting the “20” under MSP rules
  - Did the employer have 20 or more employees **for each working day in at least 20 weeks in either the current or the preceding calendar year?**
  - 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

Medicare Secondary Payer (MSP) Rules

- Examples – Employer received a claim with a date of service of 6/1/16, for which it needs to determine its group health plan's status as either primary or secondary to Medicare
    - **A:** Employer reviews payroll records for each week of 2015 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 2016*
    - **B:** There were only 17 weeks for which there were 20 or more employees during 2015, so the employer reviews payroll records for 2016 and discovers that as of 6/1/2016, there had been 22 weeks for which there were 20 or more employees
        - *Employer's group health plan is primary for the remainder of 2016 and all of 2017*
    - **C:** There were only 17 weeks for which there were 20 or more employees during 2015, so the employer reviews payroll records for 2016 and discovers that as 6/1/2016, 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

- Group health plans of employers with 20 or more employees are primary to Medicare, and therefore such employers are:
  - 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 for coverage upon individuals being under age 65
  - Prohibited from discouraging employees from enrolling in their group health plans or from offering any “financial or other incentive” for an individual entitled to Medicare “not to enroll (or to terminate enrollment) under” a group health plan that would otherwise be a primary plan
    - Cannot pay for Medicare or otherwise incent individuals who are eligible for Medicare not to enroll in the group health plan
    - NOTE – Informal guidance indicates that so long as the opt-out (incentive) is available to all who show proof of other coverage, and not just to those providing proof of Medicare, it is okay

Employer Payment Plan (EPP)

Employer Payment Plan (EPP)

- An employer reimbursing employees for some or all of Medicare Part B or Part D premiums creates an EPP
  - Subject to health care reform rules if covering 2 or more employees
- EPPs generally violate health care reform rules, exposing the employer to up to $100/day per affected individual
- Separately, employers with 20 or more employees are prohibited from reimbursing employees for Medicare coverage under the Medicare Secondary Payer (MSP) rules
  - Therefore, only those employers with less than 20 employees would typically be considering such arrangement

Employer Payment Plan (EPP)

- Reimbursing Medicare premiums will not violate health care reform rules if (relief granted via Notice 2015-17):
  - Employer offers a group health plan which provides minimum value;
  - Employee participating in the EPP is enrolled in Medicare Parts A and B;
  - EPP is available only to employees enrolled in Medicare Part A and Part B or D; and
  - EPP reimbursement is limited to Medicare Part B or Part D premiums and excepted benefits, including Medigap premiums
- If the employer doesn't offer a group health plan to its Medicare-eligible employees, it may reimburse for Parts B and D using an HRA or other account-based plan if it meets these requirements:
  - Employer offers a group health plan to employees who are not eligible for Medicare;
  - Employee receiving the HRA or other account-based plan is enrolled in Medicare Part B or D; and
  - HRA or other account-based plan is available only to employees enrolled in Medicare Part B or D

Medicare Part D – Creditable Coverage

Medicare Part D – Creditable Coverage

- Group health plans that offer prescription drug coverage have two different notice obligations
  - Employers must provide a notice for all Part D eligible individuals who are enrolled in (or seeking to enroll in) the plan indicating whether the plan is creditable or not
    - Employers have the option of entering 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
  - Employers must report plan credibility directly to CMS annually

Medicare Part D – Creditable Coverage

- No specific penalty or sanction against employers who fail to comply with the disclosure requirements or reporting requirements, other than for those employers claiming the retiree drug subsidy…such a plan would be denied the subsidy
- However, 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

Medicare Part D – 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 information to an employer detailing if a plan's drug coverage is creditable or not
  - Otherwise the employer must make the determination
    - Employers not applying for the subsidy for qualified retiree prescription drug plans may use a simplified method for determining if the drug coverage in a plan is creditable
    - If the plan does not meet the standards under the simplified method, it may be necessary to obtain an actuarial determination

Medicare Part D – Creditable Coverage

- The Medicare Part D 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
- 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 are more likely to receive and understand them

Medicare Part D – Creditable Coverage

- The “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

Health Savings Accounts (HSAs)

Health Savings Accounts (HSAs)

- HSA Eligible Individuals
  - Only eligible individuals can make contributions to their HSA account
  - Ineligible individuals may still use funds already in their HSA account to pay for eligible unreimbursed medical expenses
- Who is an HSA Eligible Individual?
  - Must be enrolled in a qualified High Deductible Health Plan (HDHP) and may not have any other “disqualifying coverage”
  - Individuals who cannot have an HSA:
    - Individuals enrolled in non-HDHP coverage
    - Individuals who can be claimed as tax dependents
    - Individuals entitled to (enrolled in) Medicare

Health Savings Accounts (HSAs)

- HSAs and Medicare
  - Individuals who are both eligible and enrolled in ("entitled" to) Medicare are ineligible to contribute to an HSA
  - Medicare Part A enrollment is automatic for most individuals (i.e., those who are already receiving Social Security (age 62-67)). These individuals simultaneously become eligible, enrolled, and entitled upon reaching Social Security eligibility
  - Other individuals become eligible for Medicare, but must file an application in order to become enrolled in benefits (e.g. working individuals who have attained age 65 and are eligible to receive Social Security benefits but have not applied for them)
    - 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)

- Example – Individual enrolled in self-only HDHP coverage and not enrolled in Medicare until May 1st, 2017
  - Annual contribution maximum for 2017 = $3,400 + $1000 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
  - Assuming individual was HSA-eligible for 4 months (Jan-Apr), the individual could contribute up to $1,466 at any time during 2017
    - $3,400 + $1,000 = $4,400/12 = $366.67 x 4 = $1,466.67
- Excess Contributions/Corrections
  - Employer HSA contributions are non-forfeitable, so generally the employer may not recoup the contributions, but should re-characterize any excess contributions as taxable income to the employee if possible
  - In order to avoid a 6% excise tax on the excess contributions, the employee should request a distribution of the excess contributions and earnings before the individuals' federal income tax filing deadline (including extensions)

Health Savings Accounts (HSAs)

- HSAs and 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)

- HSAs may generally not be used to reimburse insurance premiums
- Exception for account holders who are age 65 or over
  - May reimburse any deductible health insurance (e.g., retiree medical coverage) other than a Medicare supplemental policy
  - When premiums for Medicare Part A, Part B, Part C, or Part D are deducted from Social Security benefit payments received by an HSA holder who is age 65 or older, he or she can take a tax-free HSA distribution equal to the Medicare premium deduction
  - Includes coverage for spouses and dependents

COBRA

COBRA

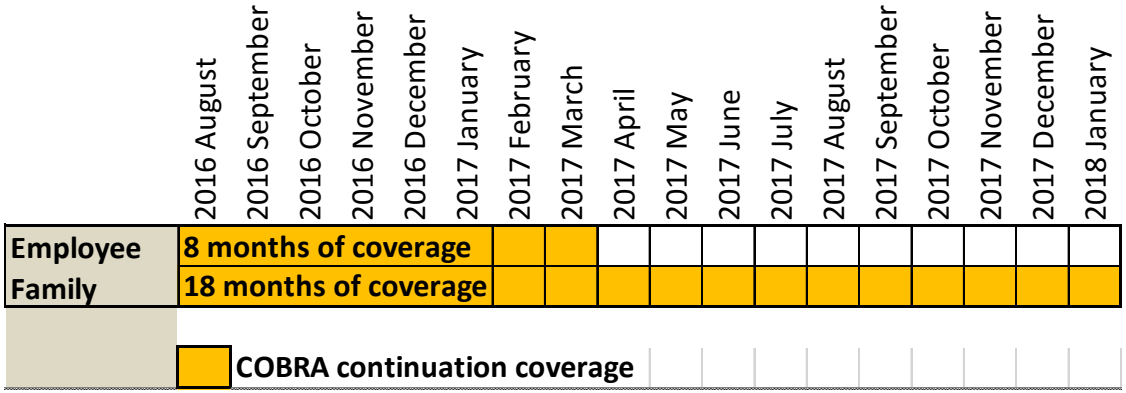
- Entitlement to Medicare is a qualifying events, but only for the spouse and dependent children, and only if there is a loss of coverage for the covered employee
  - Because Medicare entitlement will only infrequently cause a loss of coverage under a group health plan (due to MSP rules), it will rarely be a COBRA qualifying event
    - Typically when an employee retires at the same time they become Medicare-eligible, it will be an 18-month COBRA event (due to termination of employment) for the whole family, or for whoever is enrolled
  - Special extension rule for 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

COBRA

- When any qualified beneficiary (including the covered employee) first becomes entitled to Medicare **after** electing COBRA coverage, his or her COBRA coverage can be terminated early
  - Does not affect the COBRA rights of other qualified beneficiaries in a family unit who are not entitled to Medicare
- When any qualified beneficiary (including the covered employee) is entitled to Medicare **before** electing COBRA, he or she still has the right to elect COBRA coverage
  - COBRA offer cannot be withheld because of Medicare entitlement, coverage may not be terminated early because of the Medicare entitlement

COBRA

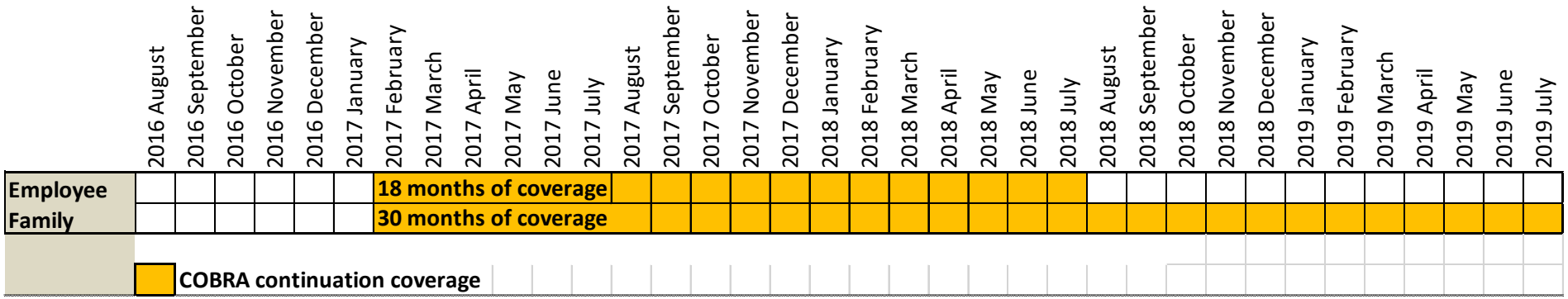
- Example 1
  - Employee retires at age 64 at the end of July 2016
  - Employee turns 65 in mid-March 2017 and enrolls in Medicare



  - 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 Medicare-eligible during that time)

COBRA

- Example 2
  - Employee turns 65 in August 2016 and enrolls in Medicare
  - Employee retires at the end of January 2017



  - 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-eligibility (in this case 30 months because 6 months has already expired)

COBRA

- 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 the increased premiums
  - COBRA coverage is not considered a group health plan based upon current employment individuals who do not enroll in Medicare when first eligible will not have special enrollment rights under Medicare and may expect to pay more for Medicare when COBRA coverage ends

Cafeteria Plans

Cafeteria Plans

- Premiums for Medicare Part B or Part D or Medicare supplement policies generally cannot be offered on a pre-tax basis through a cafeteria plan
  - MSP rules
  - Health care reform (employer payment plans)
  - Also potentially violating 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
  - Loss of Medicare eligibility allows a prospective election to commence or increase coverage for the individual who lost coverage

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