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Welcome

Employee benefit laws change rapidly —
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with ongoing expert compliance resources.

This webinar is intended to provide general compliance information regarding employee benefits laws. Please consult your legal advisor for specific legal advice.

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Mastering Medicare:
Employer Rules and Regulations

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Agenda

1. Medicare Part D: Creditable Coverage
2. Medicare and HSAs
3. Medicare Secondary Payer
4. Medicare & COBRA
5. Questions

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Medicare Part D

Creditable Coverage

Medicare Part D: Notice of Creditable Coverage

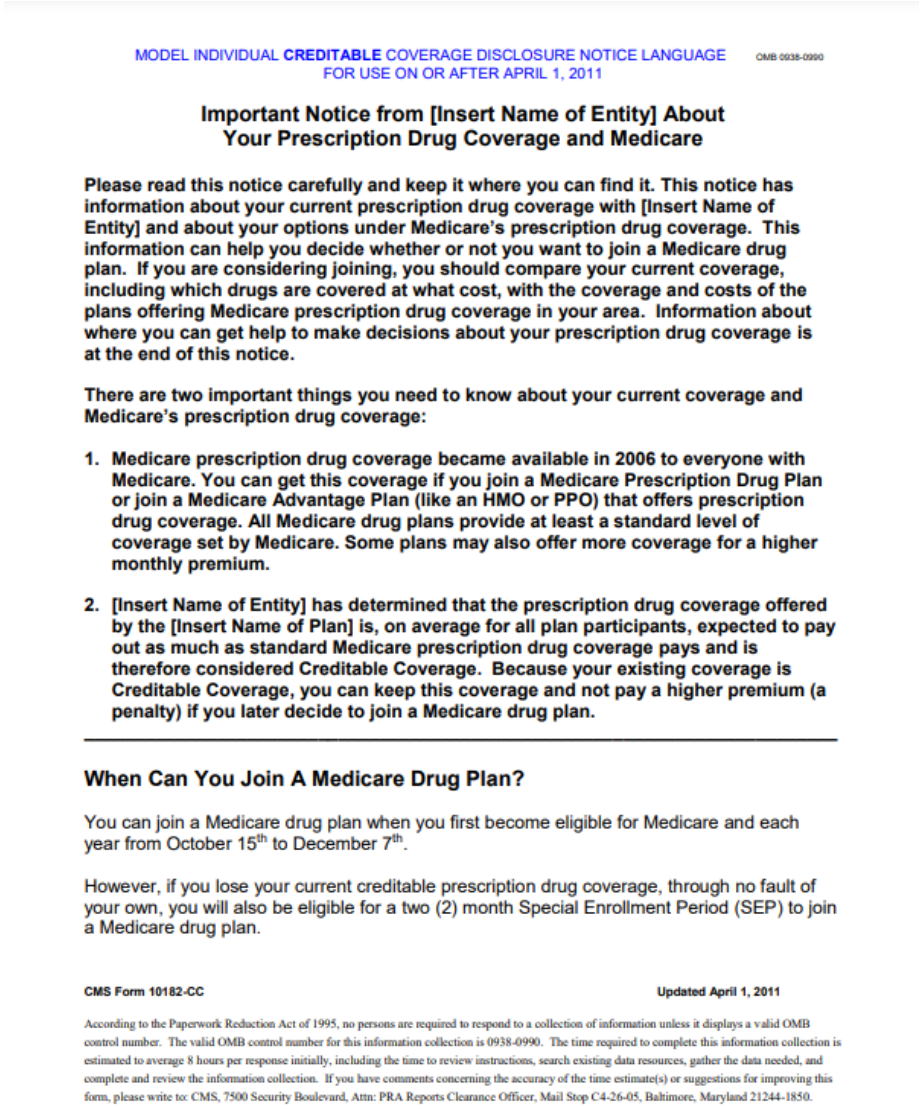
Why is the Notice Required?

- To inform employees on whether or not their employer-sponsored GHP's prescription drug coverage is at least as sufficient as a Medicare Part D plan.
  - Rx Coverage must meet CMS standards to be "creditable"
  - Creditable status is determined by using the safe harbor method or an actuarial determination
  - The Carrier or TPA should determine and inform employer clients of creditable status

Why is this Notice important?

- Part D individuals who fail to maintain creditable coverage for a period of 63 continuous days or more will face a late enrollment penalty upon Part D enrollment
- Employees need the notice to prove they enrolled timely

Medicare Part D: Notice of Creditable Coverage



MODEL INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE
FOR USE ON OR AFTER APRIL 1, 2011

OMB 0938-0990

Important Notice from [Insert Name of Entity] About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with [Insert Name of Entity] and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **[Insert Name of Entity] has determined that the prescription drug coverage offered by the [Insert Name of Plan] is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Creditable & Non-Creditable Model Notice Letters

https://www.cms.gov/medicare/employers-plan-sponsors/creditable-coverage/model-notice-letters

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Medicare Part D: Notice of Creditable Coverage (When, Who, and How)

When

- Employers are required to provide the Notice annually prior to October 15
- Part D open enrollment is October 15 – December 7

Who

The following individuals must receive the Notice:

- Individuals who are "Part D eligible" and are enrolled or seeking to enroll in the employer's plan that provides prescription drug coverage (includes individuals enrolled in Part A or Part B)
- It is best practice to provide all employees with the Notice annually due to employers not knowing which employees, spouses, or dependents are enrolled in Part A or Part B *or* who will be enrolling in the employer's plan

How

Notice Delivery Method:

- Electronic delivery is permitted to "plan participants who have the ability to access electronic documents at their regular place of work if they have access to the plan sponsor's electronic information system on a daily basis as part of their work duties."
- Similar to the ERISA electronic disclosure safe harbor rule
- First-class mail or hand delivery

Medicare Part D: Notice of Creditable Coverage (When, Who, and How)

Can the Medicare Part D Notice be combined with other materials?

Absolutely! With a few exceptions:

The Notice may be provided with other materials such as open enrollment or other annual notices as long as it is "**prominent and conspicuous**".

> *"This means the disclosure notice portion of the document (or a reference to the section in the document being provided to the individual that contains the required statement) must be prominently referenced in at least 14-point font in a separate box,* ***bolded****, or offset on the first page of the provided plan participant information."*

Example of reference to creditable or non-creditable coverage requirements:

> ***If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page xx for more details.***

Medicare Part D: Notice of Creditable Coverage (CMS Requirements)

Annual Filing with CMS

- The Part D rules require plan sponsors to complete an annual online disclosure form to CMS within 60 days after the beginning of the plan year
  - Reporting is due February 29, 2024. No, this is not a typo due to 2024 being a leap year. It is typically due March 1
- CMS disclosure reflects whether the prescription drug coverage under the plan is creditable
  - Instructions: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure.html
  - Filing: https://www.cms.gov/medicare/employers-plan-sponsors/creditable-coverage/disclosure-form

Medicare Part D: Notice of Creditable Coverage (Fines & Penalties)

Little known "secret" –

- No stated penalties for failing to provide or file Notice of Creditable Coverage
- However, potential for lawsuit if employee subject to laten enrollment penalty and it was the employer's "fault" for not providing notice

Medicare and HSAs

Age 65? Now what?

Medicare & HSAs – Age 65

Any person turning 65 is HSA eligible, *unless*:

- You're enrolled in Medicare
- You receive Social Security retirement benefits
  - Receiving Social Security benefits automatically enrolls you in Medicare Part A (no opt-out permitted), and therefore automatically lose HSA eligibility

Medicare & HSAs – Age 65

You Are No Longer Subject to the 20% Additional Tax

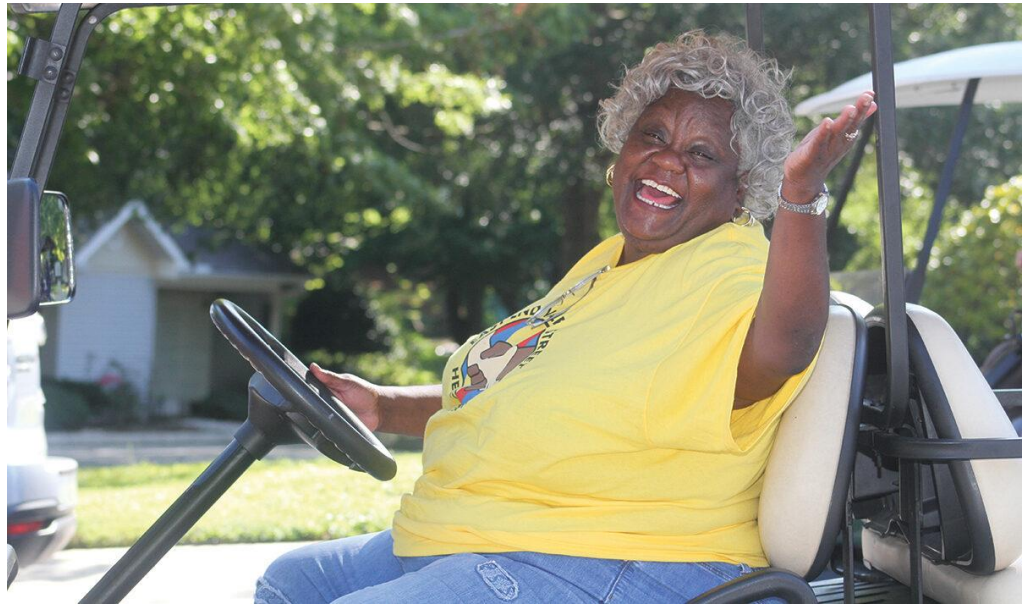
- Individuals who reach age 65 do not pay the 20% additional tax on distributions from the HSA for non-medical expenses
- This is why HSAs are also frequently used as a retirement savings vehicle (IRA-like)
- Individuals will still need to pay the ordinary income tax on any non-medical distribution even if 65+ (like a traditional 401(k)/IRA)

Medicare & HSAs – Age 65 (Example)

- Kim reaches age 65 in August of 2024 but does not enroll in Medicare
- Kim is covered by an HDHP with no disqualifying coverage for all of 2024
- In December 2024, she decides to purchase a $3,000 golf cart with her HSA funds

Outcome

- Kim is HSA eligible for all of 2024 (and therefore can contribute the max plus catch-up)
- The $3,000 HSA distribution for the golf cart is only subject to ordinary income taxes



Medicare & HSAs – Post-Age 65

Delayed Medicare Enrollment Causes Six-Month Retroactive Enrollment

- No retroactive enrollment issue for individuals who enroll in Medicare at age 65 (or begin Social Security prior to age 65)
- However, if there is a delay enrolling in Medicare until after first becoming eligible, the later Part A enrollment will be *retroactive* for up to six months.
- The six-month retroactive enrollment in Part A will block HSA eligibility *retroactive* to the start of the Medicare coverage

Medicare & HSAs – Post-Age 65

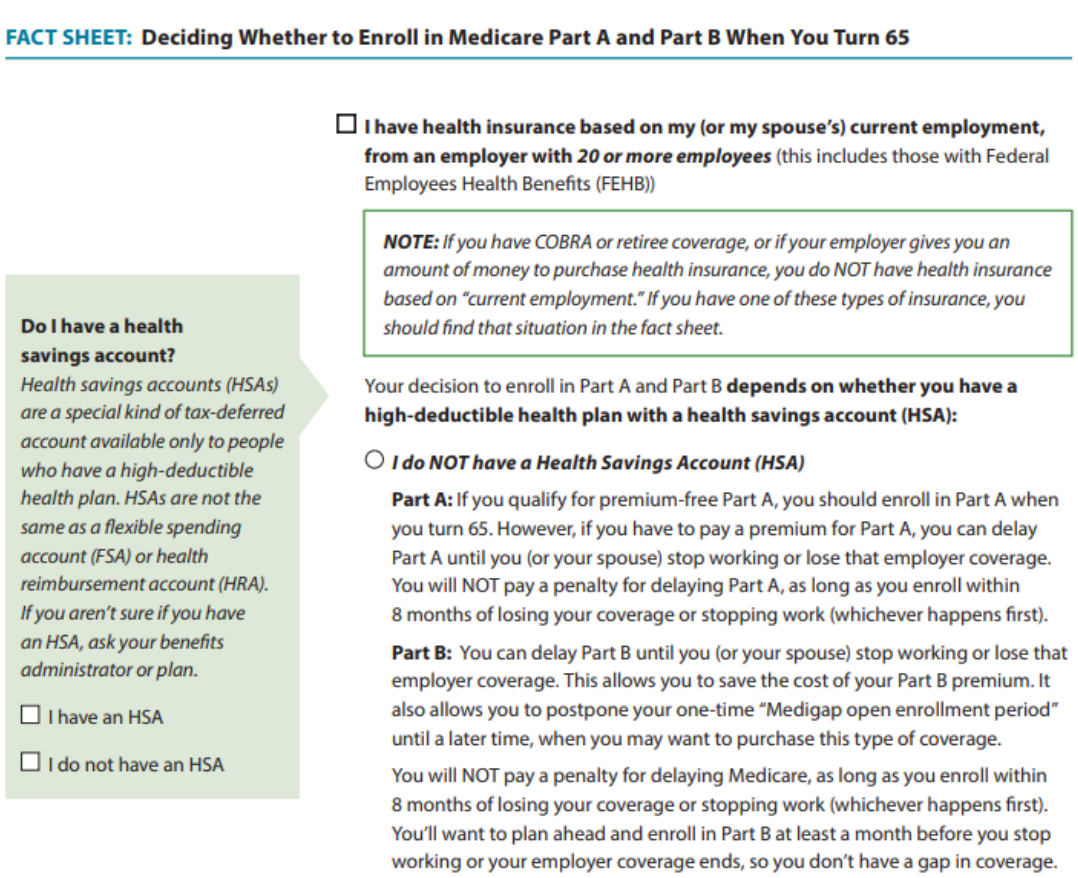
Example:

- Jeff reaches age 65 in June of 2023 but does not enroll in Medicare
- Jeff signs up for Social Security benefits on September 1, 2024, which automatically enrolls him in Medicare Part A retroactive to March 1, 2024

Outcome:

- Jeff retroactively loses HSA eligibility as of March 2024 – and therefore can contribute only 1/6 of the HSA statutory limit for 2024 (plus 1/6 of the catch-up contribution)
- If Jeff already contributed in excess of that limit, he must make a corrective distribution of the excess contributions by April 15, 2025 (assuming no extensions to his individual return)

Medicare & HSAs: Employee Guidance



FACT SHEET: Deciding Whether to Enroll in Medicare Part A and Part B When You Turn 65

Do I have a health savings account?
Health savings accounts (HSAs) are a special kind of tax-deferred account available only to people who have a high-deductible health plan. HSAs are not the same as a flexible spending account (FSA) or health reimbursement account (HRA). If you aren't sure if you have an HSA, ask your benefits administrator or plan.

☐ I have an HSA

☐ I do not have an HSA

☐ **I have health insurance based on my (or my spouse's) current employment, from an employer with *20 or more employees*** (this includes those with Federal Employees Health Benefits (FEHB))

***NOTE:** If you have COBRA or retiree coverage, or if your employer gives you an amount of money to purchase health insurance, you do NOT have health insurance based on "current employment." If you have one of these types of insurance, you should find that situation in the fact sheet.*

Your decision to enroll in Part A and Part B **depends on whether you have a high-deductible health plan with a health savings account (HSA):**

○ ***I do NOT have a Health Savings Account (HSA)***

Part A: If you qualify for premium-free Part A, you should enroll in Part A when you turn 65. However, if you have to pay a premium for Part A, you can delay Part A until you (or your spouse) stop working or lose that employer coverage. You will NOT pay a penalty for delaying Part A, as long as you enroll within 8 months of losing your coverage or stopping work (whichever happens first).

Part B: You can delay Part B until you (or your spouse) stop working or lose that employer coverage. This allows you to save the cost of your Part B premium. It also allows you to postpone your one-time "Medigap open enrollment period" until a later time, when you may want to purchase this type of coverage.

You will NOT pay a penalty for delaying Medicare, as long as you enroll within 8 months of losing your coverage or stopping work (whichever happens first). You'll want to plan ahead and enroll in Part B at least a month before you stop working or your employer coverage ends, so you don't have a gap in coverage.

Employees can refer to the CMS Fact Sheet:

https://www.cms.gov/Outreach-and-Education/Find-Your-Provider-Type/Employers-and-Unions/FS3-Enroll-in-Part-A-and-B.pdf

Medicare & HSAs: Employee Guidance

▸▸ *You have completed TASK 2. Go to TASK 3 on page 7.*

○ ***I have a High-Deductible Health Plan AND a Health Savings Account (HSA)***

Once you enroll in any part of Medicare, you won't be able to contribute to your HSA. If you would like to continue making contributions to your HSA, you can delay both Part A and Part B until you (or your spouse) stop working or lose that employer coverage. You will NOT pay a penalty for delaying Medicare, as long as you enroll within 8 months of losing your coverage or stopping work (whichever happens first).

You should talk with your employer benefits manager about whether it makes sense to delay Part A and Part B.

> ***NOTE:*** *If you qualify for premium-free Part A, your coverage will go back (retroactively) up to 6 months from when you sign up. So, you should stop making contributions to your HSA 6 months before you enroll in Part A and Part B (or apply for Social Security benefits, if you want to collect retirement benefits before you stop working).*

▸▸ *You have completed TASK 2. Go to TASK 3 on page 7.*

Medicare & HSAs: Spending HSA Funds

Distribution Ability not Affected by HSA Eligibility

- An individual does **not** need to maintain HSA eligibility to take tax-free distributions for medical expenses
- An individual can use the HSA to cover qualifying medical expenses tax-free even if not eligible to contribute to an HSA
- HSA eligibility is only relevant only for determining the ability to make HSA contributions – not for purposes of tax-free distributions

Medicare & HSAs: Spending HSA Funds

Example:

- Leo moves to Medicare in January 2024 with a $3,500 balance in his HAS
- Leo incurs $3,500 in qualifying medical OOP expenses through deductibles, copays, coinsurance, glasses, and prescriptions in 2024

Outcome:

- Leo can take a $3,500 tax-free distribution from his HSA in 2024 to cover the qualifying medical expenses he incurred, even after losing HSA eligibility
- Loss of eligibility means he can’t make or receive HSA contributions in 2024

Medicare & HSAs – Paying Premiums

Generally, Cannot Use Qualified HSA Distributions to pay Premiums

- Similar to health FSAs, the general rule is that premiums are not a qualifying medical expense for HSAs
- This is different HRAs, which do permit distributions for premiums

Exceptions: The Following Premiums Are Qualifying Expenses

1. **COBRA Premiums:** COBRA or any other continuation coverage premiums required by federal law (including USERRA continuation coverage)
2. **Long-Term Care Insurance Premiums:** Annual limitations for eligible LTC premium amounts apply
3. **Any Health Plan Premium While Individual is Receiving Federal or State Unemployment:** Includes health premiums for a spouse or dependent receiving unemployment
4. **Age 65+ Premiums:** Premiums for Medicare (excluding any Medicare supplemental policy) or employer-sponsored retiree coverage

Medicare & HSAs – Premium Option

Example:

- Bob is involuntarily terminated from employment at age 64 and begins receiving unemployment
- At the time of termination, he was covered under the company's HDHP with an HSA balance of $7,000
- Bob can pay for his COBRA premiums with his $7,000 HSA balance as tax-free qualified distributions
- He could also pay for Exchange coverage premiums (or any other coverage) with tax-free HSA distributions because he is receiving unemployment
- Upon reaching age 65, Bob can use any remaining HSA funds to pay for Medicare premiums tax-free

Medicare Secondary Payer Rules

Coordination of Benefits

Employers & Medicare Secondary Payer Rules

Based on Size and Type
Medicare entitlement is based on age (65+) or disability. (Note: Special rules apply for Medicare entitlement based on ESRD.)

Entitlement Based on Age (65+) 20+ Employees

Look to Employee Count in Either:

1. Current Calendar Year; or
2. Preceding Calendar Year

- *Must have 20+ employees on all days in at least 20 calendar weeks*
- Must have 20+ employees for each working day to count as a calendar week
- Count all employees (not just Medicare-eligible employees)
- Count full-time and part-time employees

Entitlement Based on Disability 100+ Employees

Applies to a "Large Group Health Plan"

- Employer must normally employ at least 100 employees on a "typical business day" during the previous calendar year
- *Means employer must have 100 or more employees on at least 50% of its regular business days in the previous calendar year*
- Count all employees (not just Medicare-eligible employees), and include part-time employees

Medicare Secondary Payer Rules

Employer's Plan Pays Primary

Generally, employers are prohibited from considering Medicare entitlement of a current employee or spouse or dependent.

Active Coverage

Individuals Covered Based on "Current Employment Status"

The Employer-Sponsored Plan Pays Primary

- For active employees and spouses Medicare will pay **secondary**
- MSP rules also require that the GHP provide same benefits under same conditions to age 65+ employees

COBRA or Retiree Coverage

MSP rules Do Not Apply

Medicare Pays Primary

- The employer-sponsored plan will pay **secondary**
- Retirees and COBRA qualified beneficiaries are not receiving coverage based on "current employment status," so MSP rules do not apply
- In most plans, the coordination of benefits provision will provide that Medicare pays primary for COBRA or retiree coverage
- Plans can assume the Medicare payment rate and pay only as secondary coverage for any COBRA participant eligible for Medicare—even if not enrolled in Medicare.

Prohibited Incentives

The MSP rules are designed to shield employees from being incentivized to waive the GHP in favor of Medicare enrollment.

- No Medicare or Medicare Supplement Reimbursement
- No Coverage Designed to Supplement Medicare
- No Special Opt-Out Credits for Age 65+ Employees

Spouses & Domestic Partners

MSP Rules Apply to Active Employee's Spouse

- Employee's spouse is enrolled in Medicare and the employee's health plan – Medicare will pay secondary

MSP Rules Do NOT Apply to Active Employee's Domestic Partner

- Employee covers a domestic partner enrolled in Medicare – the employer-sponsored GHP can pay secondary (Medicare pays primary)
- For Medicare-eligible domestic partners, GHP will often provide that it pay secondary to Medicare (even if DP is not enrolled in Medicare).

Medicare & COBRA

COBRA & Medicare

COBRA Coverage:

- Can terminate early based on Medicare "Entitlement"
- Medicare "Entitlement" means Medicare enrollment
- Mere Medicare eligibility (e.g., reaching age 65) is not Medicare entitlement
- Thus, merely being eligible to enroll in Medicare cannot terminate COBRA rights

COBRA & Medicare

Example:

- Brandi, age 65+, terminates employment with Company “X”
- Brandi enrolls in Medicare prior to electing COBRA coverage under X’s plan
- Brandi can maintain both Medicare and COBRA coverage since she enrolled in Medicare prior to making her COBRA election

If she elected COBRA prior to enrolling in Medicare, the subsequent Medicare enrollment would cut short her COBRA rights

COBRA & Medicare

Generally, Not a Qualifying Event

Cannot Cancel Coverage Upon Medicare Enrollment

- Loss of coverage caused by enrollment in Medicare technically is a COBRA qualifying event
- For most employers (generally 20+ EEs), the MSP rules prohibit employers from taking into account Medicare enrollment
- Therefore, an employer-sponsored group health plan generally cannot provide for loss of eligibility upon Medicare enrollment ……
- Which means no COBRA qualifying event because no loss of coverage

Medicare Enrollment Also Not a Second Qualifying Event

- Certain events can extend the COBRA maximum coverage period for spouses and dependents from 18 months to 36 months, however because Medicare enrollment does not cause loss of coverage, it cannot be the reason for a second qualifying event

COBRA & Medicare

Pre-QE Medicare Enrollment Extension

COBRA Extension Applies to Two Qualifying Events

1. Termination of Employment; or
2. Reduction in Hours

COBRA Extension Applies Only to Spouse and Children (No extension for the employee).

Medicare enrollment must occur prior to qualifying event

Extension duration depends on when employee enrolled in Medicare

- COBRA maximum coverage period is the later of:
  - 36 months from the date the employee enrolled in Medicare; or
  - 18 months from the date of termination or reduction in hours.

Example:

- Steve enrolls in Medicare July 1, 2023, and he retires December 31, 2023
- Steve elects COBRA for himself, his wife, and his kids effective January 1, 2024
- Steve's COBRA maximum coverage period is 18 months (until June 30, 2025)
- Wife and kids can continue coverage through COBRA for 30 months (until June 30, 2026)

Medicare & COBRA for Retirees

Updates to look for in the Department of Labor's Model COBRA Notices:

1. Medicare Will Pay Primary Concern: COBRA Coverage Can Assume Primary Medicare Payment Even if Not Enrolled in Medicare
2. The Eight-Month Medicare Special Enrollment Period is Not Extended by COBRA Enrollment
3. COBRA Coverage Does Not Qualify to Avoid Part B Late Enrollment Penalties
4. Early Termination of COBRA Upon Enrollment in Medicare After COBRA Election

Q&A

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