COMPLIANCE OVERVIEW

Health Plan Rules for Employees with Medicare

As more and more older Americans stay in the workforce, employers may have questions about how employees' Medicare entitlement impacts their group health plan coverage. Employers sponsoring group health plans that cover individuals enrolled in Medicare should understand:

- ☑ Medicare's **coordination of benefits rules**, which determine whether the group health plan or Medicare pays first on claims;
- ☑ The **Medicare secondary payer (MSP) rules**, which prohibit many employers from taking into account an individual's Medicare entitlement; and
- ☑ The **special continuation coverage rules** under COBRA that apply to Medicare beneficiaries.

Retiree health plans are subject to more flexible rules that allow employers to implement Medicare carve-outs and similar plan designs.

LINKS AND RESOURCES

- CMS' Medicare Secondary Payer Manual
- CMS' Medicare & Other Health Benefits: Your Guide to Who Pays First
- EEOC's final regulations on the ADEA and retiree health plans

Coordination of Benefits

- If an employer has 20 or more employees, its group health plan is the primary payer for employees 65 or older.
- If an employer has 100 or more employees, its group health plan is the primary payer for disabled employees under age 65.

MSP Rules

Employers with group health plans that are primary to Medicare:

- Must offer employees age 65 or older the same health benefits, under the same conditions, that they offer to other employees
- Cannot take into account an individual's Medicare entitlement
- Cannot offer incentives to not enroll in the group health plan

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Medicare Eligibility and Coverage Rules

Medicare is a federally funded health benefits program administered by the Centers for Medicare and Medicaid Services (CMS). Generally, Medicare is available for people **age 65 or older**, younger people with **disabilities** and people with **end-stage renal disease (ESRD)**, which is permanent kidney failure requiring dialysis or a transplant.

Medicare's eligibility rules work as follows:

Age	Disability	ESRD
An individual is entitled to Medicare benefits based on age if he or she has attained age 65 and is receiving retirement benefits from Social Security or the Railroad Retirement Board (RRB), or is eligible to receive these retirement benefits, but has not yet applied for them.	An individual is entitled to Medicare benefits based on disability if he or she is under age 65 and has been entitled to Social Security or RRB disability benefits for **24 months**. For individuals who have ALS (amyotrophic lateral sclerosis, also called Lou Gehrig's disease), Medicare benefits automatically begin when disability benefits begin.	An individual who needs regular dialysis or a kidney transplant is eligible for Medicare if he or she has worked the required amount of time under Social Security, the RRB or as a government employee, or is already receiving (or eligible to receive) Social Security or RRB benefits. An individual who has ESRD and is the spouse or dependent child of a person who meets these requirements is also eligible for Medicare. ESRD-based Medicare entitlement generally begins on the first day of the third month after the individual begins a regular course of dialysis (earlier entitlement may occur when an individual receives a kidney transplant or participates in a self-dialysis program).

Medicare has two main parts—Medicare Part A (hospital insurance) and Medicare Part B (physician and outpatient services). Medicare also offers prescription drug coverage (Medicare Part D) to everyone with Medicare. While most people do not have to pay premiums for Medicare Part A, Medicare beneficiaries are required to pay for their Part B and Part D coverage.

Coverage under Medicare Parts A and B typically **begins automatically** for individuals eligible for Medicare based on disability and for individuals eligible based on age who are already receiving monthly retirement benefits from Social Security or the RRB.

Individuals can drop Medicare Part B, but they are **not permitted to waive Medicare Part A** and retain Social Security benefits. If an individual who has already started receiving Social Security benefits waives Medicare Part A, he or she is responsible for refunding the Social Security payments already received, as well as any Medicare benefits paid on his or her behalf.

Individuals whose Medicare coverage does not begin automatically—that is, individuals who are not receiving retirement benefits from Social Security or the RRB at age 65 and individuals who are eligible for Medicare based on ESRD—must submit an application for Medicare benefits.

Coordinating Benefits

When individuals have Medicare coverage and other health coverage (for example, employer-sponsored health coverage), each type of coverage is called a "payer." When there is more than one payer, Medicare's coordination of benefits rules decide which payer pays first on a health care claim (that is, a health care provider's bill).

The **primary payer** pays what it owes on a health care claim first. If the primary payer does not pay the health care claim in full, the claim is sent to the **secondary payer** to pay any remaining covered portion.

> ***Key Point*** -- When an individual has both Medicare and employer-sponsored health plan coverage, the **payer status of each payer depends on a number of factors**, including the reason for Medicare entitlement and, in some cases, the size of the employer.

The following chart summarizes Medicare's coordination of benefits rules for employer-sponsored health plans.

Reason for Medicare entitlement	Situation	Employer size	Pays first	Pays second
Age	Individual is covered by an employer's group health plan because he or she (or a spouse) is still working	20 or more employees	Group health plan	Medicare
		Fewer than 20 employees	Medicare	Group health plan
	Individual is covered by a former employer's group health plan as a **retiree**	N/A	Medicare	Group health plan (retiree coverage)
	Individual has **COBRA coverage** under group health plan	N/A	Medicare	Group health plan (COBRA coverage)

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Reason for Medicare entitlement	Situation		Employer size	Pays first	Pays second
Disability	Individual is covered by an employer's group health plan because of his or her own employment or a family member's employment		100 or more employees	Group health plan	Medicare
			Fewer than 100 employees	Medicare	Group health plan
	Individual has COBRA coverage under group health plan		N/A	Medicare	Group health plan (COBRA coverage)
ESRD	Individual has group health plan coverage (including retiree coverage)	First 30 months of eligibility or entitlement to Medicare	N/A	Group health plan	Medicare
		After 30 months of eligibility or entitlement to Medicare	N/A	Medicare	Group health plan
	Individual has COBRA coverage under group health plan	First 30 months of eligibility or entitlement to Medicare	N/A	Group health plan (COBRA coverage)	Medicare
		After 30 months of eligibility or entitlement to Medicare	N/A	Medicare	Group health plan (COBRA coverage)

MSP Rules for Employers

The Medicare Secondary Payer (MSP) rules include requirements for employers that sponsor group health plans that are primary to Medicare. These requirements are intended to protect Medicare's secondary payer status.

> ***Compliance Reminder:*** When an employer's group health plan is primary to Medicare, the employer cannot terminate an employee's eligibility for coverage when he or she becomes entitled to Medicare.

Employers with group health plans that are primary to Medicare must comply with the following requirements:

- ☑ The group health plan must provide a current employee (or a current employee's spouse) who is age 65 or older with the **same benefits, under the same conditions**, it provides employees and spouses under age 65;

- ☑ The employer cannot offer Medicare beneficiaries **any financial or other benefits as incentives** not to enroll (or terminate enrollment) in a group health plan; and
- ☑ The group health plan **cannot take into account** the Medicare entitlement of an individual.

Cannot "Take Into Account" Medicare Entitlement

Prohibited actions that "take into account" an individual's Medicare entitlement include (but are not limited to) the following:

- Offering coverage that is secondary to Medicare to individuals entitled to Medicare;
- Terminating coverage because the individual has become entitled to Medicare (except as permitted for COBRA coverage);
- Imposing limitations on benefits for an individual entitled to Medicare that do not apply to others enrolled in the plan, such as excluding benefits or charging higher deductibles;
- Charging higher premiums to Medicare-entitled individuals;
- Requiring Medicare-entitled individuals to wait longer for coverage to begin;
- Paying providers and suppliers no more than the Medicare payment rate for services furnished to a Medicare beneficiary, but making payments at a higher rate for the same services to an enrollee who is not entitled to Medicare;
- Providing misleading or incomplete information that would induce a Medicare-entitled individual to reject the employer's group health plan, which would make Medicare the primary payer; and
- Refusing to enroll an individual for whom Medicare would be the secondary payer when enrollment is available to similarly situated individuals for whom Medicare would not be secondary payer.

> ***Compliance Reminder*** – An individual is entitled to Medicare when he or she is both eligible and enrolled in the Medicare program.

Cannot Offer Incentives

When an employer's group health plan is the primary payer, employers cannot discourage employees from enrolling in their group health plans. Also, employers cannot offer any financial or other incentive for an individual entitled to Medicare to not enroll (or terminate enrollment) in a group health plan that would pay primary.

A violation of the prohibition on offering incentives can trigger financial penalties of up to **$9,639** (adjusted annually for inflation).

> ***Compliance Tip***– Paying an employee's Medicare premiums is likely prohibited as an incentive not to enroll in a group health plan that would otherwise pay primary to Medicare.

Special Rules for COBRA Beneficiaries

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that requires most employers to allow employees and dependents who lose group health benefits due to a qualifying event to continue group health coverage for a limited time. COBRA generally applies to group health plans maintained by private-sector employers that had at least **20 employees** on more than 50 percent of typical business days in the previous calendar year.

COBRA Qualifying Event

An employee's entitlement to Medicare is a qualifying event under COBRA if it would result in a loss of group health plan coverage. However, as a practical matter, **an employee's entitlement to Medicare will rarely be a qualifying event** due to the MSP rules. When an employer's group health plan is the primary payer, the MSP rules prevent the employer from terminating an individual's group health coverage because the individual has become entitled to Medicare.

Extension of Coverage

Although an employee's entitlement to Medicare will rarely be a COBRA qualifying event due to the MSP rules, it can extend the maximum COBRA coverage period for covered spouses and dependents if the employee has a termination or reduction in hours within 18 months after becoming entitled to Medicare. Under this rule, where the spouse or dependent is covered under the plan on the day before the employee's termination or reduction in hours, the spouse and dependent are entitled to COBRA coverage for the longer of:

- 18 months from the date of the employee's termination or reduction in hours; or
- 36 months from the date the employee became enrolled in Medicare.

This extension of coverage only applies to covered spouses and dependents; it does not apply to covered employees. Employees will remain eligible for 18 months of COBRA following the termination or reduction in hours.

If an employee enrolls in Medicare after his or her termination or reduction in hours (for example, retirement), the employee loses COBRA continuation coverage. A spouse or dependent covered under the plan at the time of the termination or reduction in hours is entitled to 18 months of coverage from the date of the termination or reduction in hours.

> ***Example:*** Mary, an employee of ABC Company, became entitled to Medicare on March 1, 2019. Mary retires on April 1, 2019, and elects COBRA coverage for herself and her spouse, John, under ABC Company's group health plan. Mary is entitled to 18 months of COBRA coverage from the date of her retirement. John is eligible for 36 months of COBRA coverage from the date of Mary's Medicare entitlement on March 1, 2019. Thus, Mary's maximum COBRA period would expire on Oct. 1, 2020, while John's maximum COBRA period would expire on March 1, 2022.

Early Termination of COBRA

COBRA coverage may be terminated before the maximum coverage period ends when a qualified beneficiary **first becomes entitled to Medicare benefits after electing COBRA coverage**. This early termination rule only applies to the qualified beneficiary who becomes entitled to Medicare—other family members not entitled to Medicare must be allowed to continue their COBRA coverage. To determine whether a qualified beneficiary has become entitled to Medicare before electing COBRA, employers may want to periodically ask COBRA beneficiaries to provide information about their Medicare entitlement, especially those who are reaching age 65.

ADEA – Special Rules for Retiree Coverage

The Age Discrimination in Employment Act (ADEA) prohibits covered employers from discriminating on the basis of age in hiring; promotion; discharge; compensation; or terms, conditions or privileges of employment, including the receipt of employee benefits, against any applicant or employee who is at least **40 years of age**. The ADEA applies to employers with **20 or more employees**.

The ADEA is enforced by the Equal Employment Opportunity Commission (EEOC). The EEOC takes the position that the ADEA applies to former employees, such as retirees, based upon the former employment relationship.

> ***Compliance Reminder*** – As a general rule, retiree health plans are not subject to the MSP rules when Medicare entitlement is based on age.

Final regulations issued by the EEOC allow employers to alter, reduce or eliminate retiree health benefits as retirees become eligible for Medicare without violating the ADEA. These EEOC regulations give employers more flexibility with respect to their retiree health plan designs, including allowing Medicare bridge plans, wrap-around plans and carve-out plans, and permitting employers to terminate benefits for Medicare-eligible retirees without violating the ADEA.