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**Interaction Between Medicare
and Employer Health Plans**

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Agenda

- ▶ Overview of Medicare
- ▶ “Eligibility” Vs. “Enrollment” Vs. “Entitlement”
- ▶ Medicare Entitlement Under COBRA
- ▶ Medicare Secondary Payer Rules
- ▶ ADEA Issues / Medigap Policies
- ▶ ACA Changes to Medicare Part D
- ▶ Reporting Requirements
- ▶ Coordination of Medicare with HSAs

Medicare-Eligible Individuals

- ▶ **Retired** -- Age 65 and eligible for Social Security benefits, even if not eligible for **unreduced** Social Security until **after** age 65
- ▶ **Disabled** (under either Social Security or Railroad Retirement) for at least 29 months
- ▶ **ESRD** -- Suffering from “end-stage renal disease” (permanent kidney failure). Benefits commence on
 - first day of third month after beginning kidney dialysis treatment, or
 - Upon admission to hospital for kidney transplant

Medicare Components

▶ Part A = Hospitalization

- Includes limited coverage for nursing homes, home health services, and hospice care
- Generally no premium required if receiving (or entitled to receive) Social Security benefits

▶ Part B = Supplemental Insurance

- Includes coverage for physician services, diagnostic services, lab tests, and durable medical equipment
- Monthly premium required; generally deducted from Social Security benefit

Medicare Components

- ▶ Part C = “Medicare Advantage” (formerly known as “Medicare + Choice”)
 - Includes both Part A and Part B
 - CMS contracts with HMOs and similar providers on a capitation basis; beneficiary has no deductible or co-pay
 - Premium varies with types of Part C plans in service area

- ▶ Part D = Prescription Drugs
 - Available to any individual who is enrolled in Part A or B (and may be included in Part C coverage)
 - Monthly premium varies with level of coverage elected; generally deducted from Social Security benefit

Only Semantics?

- ▶ Medicare “Eligibility”:
 - At least 40 quarters of contributions, and
 - At least age 65, disabled, or having ESRD
- ▶ Medicare “Enrollment”: Submitting an application for coverage (or having been deemed to do so, by applying for Social Security benefits)
- ▶ Medicare “Entitlement”: Eligible and enrolled
- ▶ **Translation**: “You can’t enroll until you’re eligible, but once you enroll, you’re entitled.”

Medicare Entitlement Under COBRA

- ▶ Qualifying Event
- ▶ Second Qualifying Event
- ▶ Pre-Termination Event
- ▶ Coverage Termination Event

COBRA Qualifying Event

- ▶ An employee's Medicare entitlement may be a COBRA qualifying event for his or her dependents, but only if employee's entitlement causes dependents to lose coverage
 - Might be true for employees of small employers (< 20 employees), . . .
 - but not for employees of larger employers (due to Medicare secondary payer rules discussed below)
 - Could be a qualifying event for retirees of even larger employers, assuming retiree plan terminates both retiree and dependent coverage upon retiree's entitlement to Medicare
 - If a qualifying event, dependents are entitled to up to 36 months of COBRA coverage

Second Qualifying Event

- ▶ Medicare entitlement may also be a **second qualifying event**
 - If so, dependents who are still receiving their first 18 months of COBRA coverage (due to employee's termination of employment or reduction in work hours) may receive an additional 18 months
 - But not a second qualifying event unless it is a qualifying event under that same plan

Pre-Termination Event

- ▶ Even if not a qualifying event (or a second qualifying event), an employee's Medicare entitlement may extend the maximum period of COBRA coverage for that employee's dependents
 - This applies if Medicare entitlement occurs during the 18 months preceding employee's termination of employment
 - Maximum period of COBRA coverage would then end at the later of 18 months after termination of employment or 36 months after Medicare entitlement
 - E.g. – Medicare entitlement on 7-1-11, termination of employment on 10-1-11. COBRA doesn't begin until 10-1-11, but is available for up to 33 months (i.e., remainder of 36 months after 7-1-11).

Coverage Termination Event

- ▶ Medicare entitlement may serve as a **termination event** for any COBRA beneficiary
 - This applies only if Medicare entitlement occurs after a COBRA election has been made
 - Individual who is already entitled to Medicare may elect COBRA and retain both coverages
 - This is the same rule that applies to gaining coverage under another employer health plan after electing COBRA

Medicare Secondary Payer Rules

- ▶ Applicability to Employer Plans
- ▶ Other Primary Payers
- ▶ Key Aspects of MSP Rules
- ▶ Reporting Obligations

MSP Rules – Working Aged

- ▶ Employer plan is primary to Medicare with respect to “working aged” if
 - Employee or dependent is covered under employer plan due to employee’s “current employment status,” and
 - Employer had 20 or more employees (full-time and/or part-time) during at least 20 weeks in current or prior calendar year
 - Note: First 6 months of disability pay (i.e., while subject to FICA tax) are considered “current employment status”

MSP Rules – Disability

- ▶ Employer plan is primary to Medicare with respect to **disabled individuals** if
 - Employee or dependent is receiving Medicare due to disability, and
 - Employer had 100 or more employees (full-time and/or part-time) on at least 50% of its regular business days during prior calendar year
- ▶ Multiple employer plan is primary to Medicare if at least one sponsoring employer met this standard

MSP Rules – ESRD

- ▶ Employer plan is primary to Medicare with respect to individuals suffering from **ESRD**
 - This rule applies during only the first 30 months of eligibility for Medicare due to ESRD
 - The employer's size is irrelevant
 - This rule is not limited to individuals covered due to current employment status (so, for example, it applies to COBRA beneficiaries)
 - Although this category is fairly small, it is the most expensive on a per capita basis

Other Primary Payors

- ▶ MSP rules also apply to the following:
 - Workers' compensation insurance
 - Third-party liability insurance (e.g., auto insurance, product liability, medical malpractice)
 - No-fault insurance
- ▶ Because these payors tend to be more episodic than employer plans, the MSP rules may apply differently in practice

Aspects of MSP Rules

- ▶ **Coordination of Benefits** – Employer plan must pay primary to Medicare
- ▶ **Anti-Discrimination** – Employer may not discriminate against a protected individual on the basis of that individual's Medicare entitlement
- ▶ **Anti-Incentives** – Employer may not provide incentive for individual to waive coverage under employer plan (although charging a nondiscriminatory premium is OK)

ADEA Issues

- ▶ Lengthy litigation challenged employer's ability to reduce or terminate retiree coverage due to Medicare eligibility
- ▶ Medicare eligibility alleged to be "proxy for age," in violation of Age Discrimination in Employment Act ("ADEA")
- ▶ Key case involved Erie County, PA
- ▶ U.S. Supreme Court held that reducing medical benefits at age 65 does not violate ADEA

Medigap Policies

- ▶ With ADEA risk removed, employers are free to eliminate retiree coverage for older retirees
- ▶ Many now terminate retiree coverage at age 65 (Medicare eligibility)
- ▶ Some employers also pay all or a portion of the premium for a Medicare supplement (“Medigap policy”)

Types of Medigap Policies

- ▶ Medicare statute provides for 14 different levels of Medigap policies (“A” through “N”), with specific benefits provided under each
- ▶ Unless provided disproportionately to retirees who were highly paid employees, employer-paid premiums for Medigap policies should be excludable from retirees’ taxable income
- ▶ Federal law requires insurers to offer Medigap policies only to Medicare beneficiaries over age 65, but many states extend this requirement to Medicare disability and/or ESRD beneficiaries

Medigap Policies A - N

- ▶ Chart on the following slide provides an overview of the standardized Medigap Plans.
- ▶ Insurance companies selling Medigap policies are required to make Plan A available. If they offer any other Medigap plan, they must also offer either Medigap Plan C or Plan F. Not all types of Medigap policies are available in all states.
- ▶ Plans D and G effective on or after June 1, 2010, have different benefits than D or G Plans bought before June 1, 2010.
- ▶ Plans E, H, I, and J are no longer sold, but anyone who already has one is allowed to retain it.

Medigap Policies A - N

Medigap Plans											
How to read the chart:											
If a check mark appears in a column of this chart, the Medigap policy covers 100% of the described benefit. If a row lists a percentage, the policy covers that percentage of the described benefit. If a row is blank, the policy doesn't cover that benefit. Note: The Medigap policy covers coinsurance only after you have paid the deductible (unless the Medigap policy also covers the deductible).											
	Medigap Plans										
Medigap Benefits	A	B	C	D	F*	G	K	L	M	N	
Medicare Part A Coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B Coinsurance or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓***	
Blood (First 3 Pints)	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓	
Part A Hospice Care Coinsurance or Copayment	✓	✓	✓	✓	✓	✓	50%	75%	✓	✓	
Skilled Nursing Facility Care Coinsurance			✓	✓	✓	✓	50%	75%	✓	✓	
Medicare Part A Deductible		✓	✓	✓	✓	✓	50%	75%	50%	✓	
Medicare Part B Deductible			✓		✓						
Medicare Part B Excess Charges					✓	✓					
Foreign Travel Emergency (Up to Plan Limits)			✓	✓	✓	✓			✓	✓	

Out-of-Pocket Limit**	
\$4,640	\$2,320

*Plan F also offers a high-deductible plan. If you choose this option, this means you must pay for Medicare-covered costs up to the deductible amount of \$2,000 in 2011 before your Medigap plan pays anything.

** After you meet your out-of-pocket yearly limit and your yearly Part B deductible (\$162 in 2011), the Medigap plan pays 100% of covered services for the rest of the calendar year.

***Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that don't result in an inpatient admission.

Part D Mandates

▶ Disclosure

- “Creditable” coverage notice requirement
 - To CMS
 - To Part D eligible individuals
- No small employer exception

▶ Coordination of benefits

- Payment of premiums and coverage (MSP)
- Payment for supplemental Rx benefits (MSP)

ACA Changes to Medicare Part D

- ▶ ACA closes the Part D “donut hole”
 - Gap in Medicare prescription drug coverage
- ▶ Gradually reduces the consumer’s share of drug costs until it reaches 25 percent in 2020 for both brand-name and generic drugs
- ▶ 2010- \$250 rebate
- ▶ 2011- first year of discounts

Part D Benefit Parameters

Standard Benefit Parameters	2011	2012
• Deductible	\$310	\$320
• Initial Coverage Limit	\$2,840	\$2,930
• Out-of-Pocket (“OOP”) Threshold	\$4,550	\$4,700
• Total Covered at OOP Threshold	\$6,448	\$6,658
• Min. Cost-Sharing/Catastrophic		
- Generic/Pref. Multi-Source Drug	\$2.50	\$2.60
- Other	\$6.30	\$6.50

Donut Hole Illustration

	Catastrophic \$6,448 +	
	Donut Hole (50% discount on brand name) \$2,840-\$6,448 (\$4,550 out-of- pocket)	
	75% Medicare Benefit \$310-\$2,840	
	\$310 Deductible	

2011 Part D

Brand Name Drugs

Year	Pharmaceutical Manufacturer Discount	Government Subsidy (paid through plans)	Consumer Responsibility
2010	0	0	100% less the \$250 rebate for brand name and generic drugs
2011	50 %	0	50 %
2012	50 %	0	50 %
2013	50 %	2.5 %	47.5 %
2014	50 %	2.5 %	47.5 %
2015	50 %	5%	45%
2016	50 %	5%	45%
2017	50 %	10%	40%
2018	50 %	15%	35%
2019	50 %	20%	30%
2020	50 %	25%	25%

Generic Drugs

Year	Government Subsidy (paid through plans)	Consumer Responsibility
2010	0	100% less the \$250 rebate for brand name and generic drugs
2011	7%	93%
2012	14%	86%
2013	21%	79%
2014	28%	72%
2015	35%	65%
2016	42%	58%
2017	49%	51%
2018	56%	44%
2019	63%	37%
2020	75%	25%

Example #1

- ▶ Bill takes three medications to treat his high blood pressure and high cholesterol. These medications will cost him about \$1,200 in 2011. Bill is switching to a Medicare prescription drug plan that has a low premium and offers the standard Medicare drug benefit, including a deductible and no drug coverage in the donut hole.
 - Bill will pay a deductible of \$310
 - He will then pay 25% (coinsurance) of the remaining \$890 cost of his medications ($\$1200 - \$310 = \$890$). His additional out-of-pocket cost during this initial coverage period will be \$223 ($\$890 \times 25\% = \223)
 - Since Bill did not reach the \$2840 initial coverage limit, he will not enter the donut hole.
- ▶ Bill's total estimated annual out-of-pocket prescription drug cost with his Medicare Part D plan will be $\$310 + \$223 = \$533$ (plus his monthly premiums for the Medicare Part D plan).

Example #2

- ▶ Sherry takes three medications to treat her type 2 diabetes, high blood pressure, and high cholesterol – all of them brand name drugs. These medications will cost her about \$3,800 in 2011. Sherry is planning to join a Medicare prescription drug plan that offers the standard Medicare drug benefit, including a deductible and no coverage for generic medications in the donut hole.
 - Sherry will pay a deductible of \$310
 - She will then pay 25% of the cost of her medications for the next \$2530, until she reaches the coverage gap. Her additional out-of-pocket cost during this initial coverage period will be \$633 ($\$2530 \times 25\% = \633)
 - Since Sherry did reach \$2840 in drug spending ($\$310 + \$2530 = \2840), she will enter the donut hole. Prior to 2011, Sherry would have been responsible for 100% of the remaining cost of \$970. However, since all of Sherry's medications are brand names, she will only have to pay about 50% of the drug costs while in the donut hole.

- ▶ Sherry's total estimated annual out-of-pocket prescription drug cost with her Medicare Part D plan will be $\$310 + \$633 + \$485 = \1428 (plus her monthly premiums for the Medicare Part D plan).

New Enrollment Period

- ▶ Plan sponsors should update their notices to reflect the new Medicare Part D annual enrollment period, and they should provide the notices prior to October 15, 2011, instead of November 15, 2011.
 - Separately or with other plan participant materials
 - May be sent electronically (CMS prefers paper)
- ▶ MMA imposes a late enrollment penalty on individuals who experience a 63-day (or longer) gap in creditable coverage before enrolling in Part D
 - Knowledge of plan's "creditable" status is thus essential to an individual's decision whether — and when — to enroll in Part D

Notices of Creditable (or Non-Creditable) Coverage

- ▶ On April 1, 2011, CMS issued revised Medicare Part D creditable and non-creditable coverage notices to reflect the new October 15 through December 7 enrollment period
- ▶ “Creditable” coverage = expected to pay, on average, as much as the standard Medicare prescription drug coverage
- ▶ Not to be confused with HIPAA certificate of creditable coverage

High Deductible Health Plans

- ▶ HDHPs require disclosure notices
 - But not to Part D eligible individuals with only health FSAs, HSAs, and Archer MSAs
- ▶ Also, because no contributions may be made to HSAs or Archer MSAs once the individual becomes entitled to Medicare, HSA and Archer MSA account balances cannot be taken into account in determining whether an HDHP qualifies as creditable coverage

Notice Recipients

- ▶ Part D eligible participants
 - Entitled to benefits under Part A or enrolled in Part B (has coverage under Part A or Part B), and
 - Lives in the service area of a Part D plan
- ▶ CMS
 - Online Disclosure to CMS

Notice Timing

- ▶ To Part D eligible individuals:
 - prior to commencement of the annual coordinated election period for Part D;
 - prior to an individual's initial enrollment period for Part D;
 - prior to the effective date of coverage for any Part D eligible individual that 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

Notice Timing

- ▶ To CMS:
 - annually, no later than 60 days from the beginning of a plan year (contract year, renewal year, filing year, etc.) for which disclosure is provided;
 - within 30 days after termination of a prescription drug plan; and
 - within 30 days after any change in creditable coverage status of the prescription drug plan

Model Notice Contents

- ▶ Model Creditable or Non-Creditable Coverage Notice
- ▶ Plan sponsor must enter:
 - entity name;
 - plan name; and
 - contact information.

Proof of Creditable Coverage

- ▶ Model Notices include optional insert
- ▶ Personalized statement of creditable coverage (non-model)
 - individual's first and last name;
 - individual's date of birth or unique member identification number;
 - employer name and contact information;
 - statement that the plan was determined by the employer to be creditable or non-creditable coverage; and
 - the date ranges of creditable coverage

Customized Notice Contents (Creditable)

- ▶ Prescription drug coverage is creditable;
- ▶ Meaning of creditable coverage; and
- ▶ Why creditable coverage is important and that the individual could be subject to payment of higher Part D premiums if he or she subsequently has a break in creditable coverage of 63 days or longer before enrolling in a Part D plan

Customized Notice Contents (Non-Creditable)

- ▶ Prescription drug coverage is non-creditable;
- ▶ Meaning of creditable coverage;
- ▶ Enroll in a Part D plan from October 15 through December 7; and
- ▶ Why creditable coverage is important and that the individual could be subject to payment of higher Part D premiums if he or she fails to enroll in Part D when first eligible

Mandatory Reporting of Coverage

- ▶ Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007
- ▶ Purpose - Medicare pays benefits secondary to any applicable private health care coverage
 - Fines assessed for daily non-compliance
- ▶ January 1, 2011, no-fault and workers' compensation insurers
- ▶ January 1, 2012, liability insurers

Responsible Reporting Entities

- ▶ Responsible Reporting Entities (“RREs”)
 - Entity serving as an insurer or third-party administrator for a group health plan; and
 - Plan administrator or fiduciary of a group health plan that is self-insured and self-administered
- ▶ Employers that sponsor group health plans that are administered through an insurer or a third party administrator are not RREs

Medicare and HSA Eligibility

- ▶ Individual enrolled in any Medicare benefit is not HSA-eligible
- ▶ Individual is HSA-eligible, if:
 - eligible for,
 - but not enrolled in, any Medicare benefit.

Example

- ▶ Mary, age 66, is covered under her employer's HDHP. She has elected to delay receiving Social Security benefits until she retires at age 68. Although Mary is eligible for Medicare, she is not actually entitled to Medicare because she did not apply for benefits under Medicare (i.e., enroll in Medicare Parts A, B, C, or D). If Mary is otherwise an HSA-eligible individual, she may contribute to an HSA.

Payment of Premiums from HSA

- ▶ If an HSA account beneficiary has attained age 65, premiums for Medicare Parts A, B, C, and D are HSA-qualified medical expenses for:
 - the account beneficiary,
 - the account beneficiary's spouse, or
 - the account beneficiary's dependents.
- ▶ Premiums for Medigap policies are not HSA-qualified medical expenses.



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