# Basics of Medicare and Medicare Secondary Payer

**Presented by**
**Joan Fusco & Carol Taylor**
*NAHU Compliance Corner*

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# TODAY'S SESSION

*Today's session is to review the basics of Medicare and Medicare Secondary Payer, it does not review the recent changes regarding the Medicare Plan Finder.*

For information on these changes, visit the NAHU Medicare Portal at https://nahu.org/resources/medicare-portal/

If you have feedback on the new Plan Finder, you can email it to CMS at eMedicare@cms.hhs.gov, or contact NAHU by submitting feedback to MedicarePlanFinder@nahu.org.

# TODAY'S PRESENTER

## Joan Fusco, HIA, PAHM, RHU

- Director, NAHU Relations, Savoy Associates
- 47 years in insurance industry
- In the compliance realm
- NAHU roles
  - ACA Certified by the NAHU and the American College
  - NAHU Compliance Corner Committee Chair
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## Carol Taylor

- Account Executive & Compliance Officer, Kirby Employee Benefits
- In the insurance industry for over 29 years in various capacities, ranging from insurance accounting, claims auditing, account management and compliance
- NAHU roles
  - Former Legislative Council member
  - FAHU Legislative Chair
  - Compliance Corner
  - Professional Development Author & Instructor
  - Jacksonville Media & Communications Chair

# AGENDA

- Parts A, B, C and D
- Initial enrollment periods
- Special enrollment scenarios
- Effective dates
- Opting out of Part A
- Medicare due to age for working individuals
- Medicare Secondary Payer
- Medicare Part D
  - Employer requirements
- The HSA landmine
- What can the employer pay for

# MEDICARE A, B, C, D

- Part A covers hospitals as an inpatient, critical access hospitals, skilled nursing facilities, hospice care, and some home health care
- Part B covers doctors, preventive, ambulance, outpatient therapy including
  Mental Health.
- Part C is Medicare Advantage A & B plus extras for a premium
  - may offer extra coverage, such as vision, hearing, dental, and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D). In addition to your Part B premium, you usually pay one monthly premium for the services included
- Part D is prescription drugs

# WHO IS ELIGIBLE?

- People age 65 and older (not OVER 65) assuming paid 40Q
  - Note SS eligibility uses year of birth. Medicare always 65 and over
- Deemed Medicare disabled under age 65
- People of all ages with End-Stage Renal Disease (ESRD)
- To receive premium-free Part A, the worker must have a specified number of quarters of coverage (QCs). The exact number of QCs required is dependent on whether the person is filing for Part A on the basis of age, disability, or ESRD.

# INITIAL ENROLLMENT PERIOD

- Approaching age 65, there is an Initial 7 month enrollment period – 3 months before and 3 months after birthday
- If your birthday isn't on the first day of the month, your Part B coverage starts the first day of your birthday month
- If your birthday is on the first day of the month, your coverage will start the first day of the prior month

| **3 months before** the month you turn 65 | **2 months before** the month you turn 65 | **1 month before** the month you turn | The month you turn **65** | **1 month after** you turn **65** | **2 months after** you turn **65** | **3 months after** you turn **65** |
|---|---|---|---|---|---|---|
| **Sign up early to avoid a delay in getting coverage for Part B services. To get Part B coverage the month you turn 65, you must sign up during the first three months before the month you turn 65.** | | | **IMPORTANT REMINDER: If you wait until the last four months of your initial Enrollment Period to sign up for Part B, your start date for coverage will be delayed. Coverage is NOT retroactive.** | | | |

# INITIAL ENROLLMENT

- Keep in mind that Medicare is not retroactive so that if the beneficiary signs up in the last month of his/her enrollment eligibility period, there will still be a gap of not having Part A and/or B in place.
- The carrier may still carve out Part B claims.
- Check state and carrier rules.

# GENERAL ENROLLMENT

- Part A is only “automatic” for those receiving Social Security or Railroad Retirement Board
- General Enrollment for persons who did not sign up when first eligible is
  January 1 –March 31 for an effective date of coverage of July 1.
  - Part A late: 10% penalty for twice the number of years could have had Part A
  - Example: if eligible 2 years, the penalty will apply for 4 years
  - Part B late: 10% for each full 12 month period could have had part B

# SPECIAL ENROLLMENT

- For those who did not enroll when first eligible due to group plan coverage based on current employment
  - Can sign up anytime employee is working and covered (includes spouse)

    OR
  - During the 8 month period that begins the month after employment ends
    or coverage ends whichever happens first
- No late penalty applies

- Note: COBRA coverage or retiree coverage is not considered based on “current employment.” Enrollment should NOT be delayed due to COBRA election.

# OPTING OUT OF MEDICARE PART A

- An individual who is 65 and over and working (assuming eligible for Medicare)
- Who is NOT collecting Social Security benefits based on retirement age
- and has deferred SS in order to maximize benefits to age 70
- MAY opt out of Part A with NO implications.
- When they are no longer working , they can sign up for Part A with no late penalty.

- Note – carriers may carve out Part B benefits if not in place but may not carve out Part A. They may not allow someone without Part A to enroll in a group not subject to MSP (Medicare Secondary Payer) as they will end up paying the claim w no CMS reimbursement.

- As opposed to someone collecting SS retirement or disability benefits.
- For them Part A is automatic.
- If they opt out of Part A, they must first pay back to CMS all past claims paid by CMS and forfeit all future claims payment.

- https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf

# PART A PREMIUM

- Medicare Part A which covers hospital is "free" to those who qualify due to payment of FICA taxes for 40 quarters (10 years) by the Medicare beneficiary or spouse.
- For 2019, if FICA was paid 30-39 quarters, Part A premium is $240. If FICA was paid for less than 30 quarters, the monthly premium is $437.

  The Part A inpatient deductible for 2019 is $1,364.
- Resource: Medicare & You Handbook cms.gov.

# PART B PREMIUM

- Part B premium is means tested (based on income). * Individuals earning greater than $85k/ joint filers above $170k will pay a monthly premium ranging from $188 to $429.

- A statutory “hold harmless” provision will largely prevent Part B premiums from increasing for about 70 percent of beneficiaries. Among this group, the average premium will be about $133.00.
- For these enrollees, any increase in Part B premiums must be lower than the increase in their Social Security benefits. However, after several years of little or no increase, Social Security benefits increased premium by 2.5 percent in 2019 due to the Cost of Living adjustment. Therefore, some beneficiaries who were held harmless against increases in prior years have a premium increase for 2019.
- For the remaining roughly 30 percent of beneficiaries, the standard monthly premium for Medicare Part B will be $135.50 for 2019.

  "Hold harmless" applies to those receiving SS benefits, those enrolled in Part B prior to 2017, and those whose Part B is automatically deducted from SS benefits. Those who are dually eligible for Medicaid are NOT subject to hold harmless. Those paying income related premium are NOT subject to hold harmless.

- The Part B deductible for 2019 is $185. (2018 was $183).

# MEDICARE PART B

- Individuals who must pay a premium for Part A must meet the following requirements to enroll in Part B:
  - Be age 65 or older;
  - Be a U.S. resident; AND
  - Be either a U.S. citizen, OR
  - Be an alien who has been lawfully admitted for permanent residence and has been residing in the United States for 5 continuous years prior to the month of filing an application for Medicare.
- https://www.cms.gov/Medicare/Eligibility-and-Enrollment/OrigMedicarePartABEligEnrol/index.html

# WORKING INDIVIDUALS MEDICARE DUE TO AGE

- Employers with 20 or more full-time and part time employees for each working day in each of 20 or more calendar weeks (not necessarily consecutive) in the preceding or current calendar year are subject to MSP. Self-employed individuals do not count. Defining self-employed may require the assistance of the employer's CPA.
- Employees in all affiliated companies (IRC 414 (b), (c), (m,) or (o) are included.

  *Note, each employee counts as one. NO fractions.*
- At the point the employer meets this criteria, claims for those with "current employment status" who are Medicare eligible due to AGE and covered under the group health plan must be paid primary by the group health plan.
- In order for this to be done correctly from the start it is vital that

1) the employer inform the insurance carrier of the correct MSP status;
2) the employer inform the employees and;
3) the employee and spouse (if applicable) tell their providers.

- Regardless of how the employee count changes, the group plan remains primary for the entire subsequent year.
- Current employment status is defined here https://www.law.cornell.edu/cfr/text/42/411.104. More later.

# EXAMPLE

- Employer has 20 employees for the 20th week on August 1, 2017.
- At that point the health plan is primary for
  - anyone eligible for Medicare due to age;
  - with current employment status and
  - covered under the health plan
- The health plan remains primary through December 31, 2018 regardless of how many employees there are in 2017

- The spouse who is Medicare eligible due to age is covered the same as the employee

- When the employee eligible for Medicare due to age has a COBRA event and elects COBRA or state continuation, Medicare is always primary, regardless of group size. Sign up for B !

- EXPERT TIP:  Be sure to obtain what the carrier has been told about MSP status whenever obtaining a BOR

# EXAMPLES OF "CURRENT EMPLOYMENT STATUS"

- Is receiving disability benefits from an employer for up to 6 months
- Retains employment rights in the industry and has not had his employment terminated. Examples are:

  (1) Furloughed, temporarily laid off, or who are on sick leave;

  (2) Teachers and seasonal workers who normally do not work throughout the year; and

  (3) Persons who have health coverage that extends beyond or between active employment periods; for example, based on an hours bank arrangement. (Active union members often have hours bank coverage.)
- Special rules for religious order and self employed https://www.law.cornell.edu/cfr/text/42/411.104

- Expert TIP: DO NOT ASSUME !

# EMPLOYER MSP STATUS CHANGES

- Once the employer reduces staff to less than 20 for at least one full calendar year, they are no longer subject to MSP and Medicare becomes the primary payer.

- Example:
  - At least 20 employees in 2016. Group remains primary through Dec 31, 2017.
    - If in 2017, there were less than 20, then as of Jan 1, 2018 Medicare becomes primary.
    - Employers must tell the carrier(s)
    - Employees eligible for Medicare due to age should enroll in Part B immediately (this falls under Special Enrollment).
    - Employees must inform providers

- Status does NOT change at renewal. The TEFRA/MSP and COBRA questions on carrier re-certifications is informational for the employer only.
- It's not more than 20, it's 20 or more

# WHEN EMPLOYMENT ENDS

- COBRA or state continuation is an option.
- Regardless OF GROUP SIZE ! Medicare is primary for those without “current employment status”

- The 8 month Special Enrollment Period to sign up for Part B runs whether or not COBRA is elected. See page 23 of the Medicare Handbook (COMMON TRAP) https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf
- Electing COBRA and assuming ability to enroll in Part B at month 18 is a costly mistake
- Cannot wait until COBRA ends to enroll in Part B and/or D. COBRA is NOT creditable coverage. If the individual waits, they will be unable to sign up for B immediately.
- Without Medicare in place, the member will pay Part B claims out of pocket. If they don’t enroll timely they will have to wait until the next General Enrollment period (Jan-March for a JULY 1 effective date)
- Signing up for Part B triggers the ONE time six (6) month Medigap open enrollment period. This period gives a guaranteed right to buy any Medigap policy in the home state.

# MEDICARE DUE TO DISABILITY

- Medicare is primary for employees or covered Medicare disabled dependents when insured by an employer with less than 100 total employees on average in the preceding calendar year
- It's best to have Part B
- The group plan is primary for employees with "current employment status" or their covered Medicare disabled dependents when the employer has at least 100 employees for at least 50% of business days in the preceding calendar year
- Regardless of group size, when disability is due to ESRD, the group plan is primary for the first 30 months
- See CMS' "Who Pays First" publication

# MEDICARE PART B CARVE OUT

- Even if the carrier system incorrectly pays Part B claims for those without it, we should encourage the purchase of Part B for employees in non MSP groups
  - The carrier can self correct at any time
  - If the employer changes to a carrier operating correctly, who will remember to tell the individual to purchase Part B
  - Individuals cannot purchase Part B outside an SEP

- *remember state rules apply

# MEDICARE DATA MATCH

- The Medicare Reporting Mandate of 2007 is a federal reporting requirement for all group health plans, effective January 1, 2009.
- The mandate requires all insurers to submit information for all employees and dependents age 45 years or older. CMS will use this information to recover payments it made as primary coverage, when the insurer should have provided primary coverage and to prevent such out-of-turn payments from being made in the future

- If Medicare pays and they should not have, they will bill the employer.
  Vital to inform the carrier when MSP status changes.

# MSP AND HRA REPORTING

- HRA is a group plan subject to MSP reporting
- Health carriers have had to comply with data match since 2009 in order to assure that Medicare is not paying primary when they should not be. Previously TPAs reported plans whose potential maximum benefit was $1k or more. With the change effective 10-3-2011, TPAs must report annual potential benefits of $5k and greater.
- The fine for not reporting is $100/day. If the TPA can show they were unable to collect needed data from the employer, the fine goes to the employer

# WORKING EMPLOYEES DROPPING COVERAGE

- When there is a Section 125, pre-tax arrangement in place, the pre-tax deductions cannot be terminated without a Qualifying Event
- Voluntarily dropping coverage does not create a COBRA event for the family. I have confirmed this several times with the IRS who has oversight over Federal COBRA. The DOL, whose oversight is for notices only, has been known to give incorrect answers for these scenarios.
- The carrier allowing it does not make it an event per the IRS

# PART D

- The Medicare Prescription Drug Improvement and Modernization Act of 2003, P.L. 108-173, created a prescription drug benefit called Medicare Part D, which provides access to prescription drug insurance coverage to individuals who are entitled to (eligible for and enrolled in) Part A or enrolled in Part B.
- Participation is voluntary and requires an affirmative election to join. Coverage opportunity began January 1, 2006.
- Open enrollment changed in 2011 to October 15th – December 7th

# PART D EMPLOYER OBLIGATIONS

- A mandatory creditable or non-creditable notice must be provided by the plan sponsor / employer to any Medicare eligible person whether due to age or disability to advise if the coverage is creditable or non-creditable.
- Includes employees, spouses, dependents, COBRA or Mini COBRA continuants, or retirees (if covered)
- Notice must be sent by October 15 (before open enrollment)
- Also Mandatory notice to CMS online
- Result of incorrect reporting on CMS is a late penalty for the member
- Model Notices:
- http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html.

# CREDITABLE V. NON-CREDITABLE PART D

- Carriers are not always correct when determining Medicare Part D creditable or non-creditable status. Not a good scenario when the realization happens after Open Enrollment ends. The final responsibility rests with the plan sponsor/ employer
- Link to the simplified determination method: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/CCSimplified091809.pdf
- Expert Tip: Pay close attention to the Integrated definition, especially with those employers offering a HDHP).
- Also an HRA combined with a non-creditable group health plan could change the status to creditable.

# HOW MUST THE NOTICES BE DELIVERED?

Delivery of the notice can be made on a stand-alone basis or combined with other documents. However, if combined, the notice must be prominent and conspicuous in at least 14-point font and placed in a separate box. A single notice can be mailed to the employee and dependents, unless the employer is aware that the spouse or dependent is Medicare Part D-eligible and resides at a different address. First class mail is preferable and the employer should document when the notice is mailed, where it is mailed, and to whom it is mailed. Electronic mailings can be made only to plan participants who have the ability to access the plan sponsors electronic information system on a daily basis as part of their work duties. If sent electronically, the employer must inform plan participants that they are responsible for providing a copy to their Medicare-eligible dependents covered under the group health plan. The employer also must post a copy on the company's website

# ADDITIONAL EMPLOYER REQUIREMENT

- Employers must also file a Creditable Coverage Disclosure Notice with CMS within 60 days of the beginning date of the Plan Year, or within 30 days of a change or termination of the Prescription Drug Plan.
  https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

# CREDITABLE COVERAGE – PART D

- Different than in the context of HIPAA
- With part D, it means if the group health plan is as good as the minimum Part D coverage
- If yes, the individual does not need Part D
- If not creditable, and they don't purchase Part D, there is a 12% annual penalty when enrolling late

# PART D LATE ENROLLMENT

The cost depends on how long the person was without creditable prescription drug coverage. Currently, the late enrollment penalty is calculated by multiplying 1% of the “national base beneficiary premium” of $32.50 in 2019 times the number of full, uncovered months eligible but not enrolled in a Medicare drug (after 63 days). The final amount is added to the monthly premium. The penalty is for the life of the enrollees Medicare drug plan.

# MEDICARE RELATED HSA INFO

- Those enrolled in Medicare may no longer contribute to an HSA (health savings account)
- OK to be eligible
  - *Medicare part A is not automatic at age 65*
  - *IRS Publication 969*
- Domestic partners / civil unions partners not eligible “spouses” for Medicare

- Individuals who delay applying for free Medicare Part A are covered retroactively to the month they attained age 65 or for six months, whichever is less. The letter explains that the Code sets a zero-contribution limit for months of Medicare coverage and that rule has no exceptions, so months of retroactive Medicare must also reduce HSA contributions.
- An HSA account holder who over contributes because of retroactive Medicare coverage may avoid the 6% excise tax under Code § 4973 by withdrawing the excess contributions by the federal tax return filing deadline (including extensions) for the contribution year. Timely withdrawals of excess contributions are not subject to the 20% additional tax for non-medical distributions. That tax also does not apply to distributions made after an HSA account holder attains age 65, so even if the excess is not timely withdrawn, it can be withdrawn later without incurring the additional tax. In either case, however, the distributions must be included in income for federal tax purposes unless they were timely withdrawn and previously treated as taxable income.
- Available at https://www.irs.gov/pub/irs-wd/16-0082.pdf

# WHAT CAN EMPLOYERS PAY FOR?

- Section 411.103 Prohibition against financial and other incentives
- An employer or other entity (e.g. insurer) is prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in, or to terminate enrollment in a group health plan that is primary to Medicare *.
- Subject to a civil money penalty of up to $5,000 for each violation
- *this applies to employers subject to MSP. Employers may pay when they are not subject to MSP but need to keep track of when that status changes.
- Expert tip: employers may pay under the new HRA Final rule for ICHRAs.

# RESOURCES

- Medicare Handbook
- Medicare Who Pays First
- 1-800-MEDICARE
- 1-800-633-4227
- TTY 1-877-486-2048
  medicare.gov
- CMS training for MSP and Medicare disability
- https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/GHP-Training-Material/Downloads/MSP-Employer-Size-for-GHP-Arrangements-Part-1.pdf

- To get a replacement Medicare card; change address or name; get information about Part A and/or Part B eligibility, entitlement, and enrollment; apply for Extra Help with Medicare prescription drug costs; ask questions about premiums; and report a death.
- 1-800-772-1213
- TTY 1-800-325-0778
- socialsecurity.gov

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