MEDICARE AND EMPLOYEE BENEFITS

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Although Medicare is considered individual coverage, it interacts with employer-sponsored coverage in several important ways. As the workforce ages, and as some employees work past what has previously been considered the typical retirement age, employers of all sizes that sponsor group health plans should understand how the benefits they offer are affected when employees are entitled to (i.e., enrolled in) or eligible for Medicare. Although Medicare is a complex benefit, and its relationship to employee benefits may not always be simple, the costs of failing to comply with these requirements can be steep—for both the employer and its employees. The purpose of this issue brief is to provide an overview of the ways in which Medicare and employee benefits intersect to help employers ensure that they administer their group health plans in a compliant manner.

Medicare Eligibility vs. Medicare Entitlement

It is important to understand the distinction between being eligible for Medicare and being entitled to Medicare when analyzing the compliance requirements.

Medicare Eligible: An individual is eligible for Medicare based on age (65+), disability, or End-Stage Renal Disease (ESRD) but the individual is not yet enrolled in Medicare and Medicare coverage is not effective.

Medicare Entitlement: An individual is entitled to Medicare when they are both eligible *and* enrolled in Medicare and Medicare coverage is effective.

MEDICARE SECONDARY PAYER RULES

The Medicare Secondary Payer (MSP) rules are federal regulations designed to protect Medicare beneficiaries and ensure that group health plans appropriately coordinate

benefits with Medicare. These rules mandate that in most cases employer-sponsored health plans pay first, with Medicare acting as a secondary. Additionally, when the employer's group health plan is the primary payer under MSP coordination of benefit rules, MSP regulations prohibit group health plans from taking into account an individual's Medicare entitlement when offering coverage and from providing financial or other incentives to encourage Medicare-eligible individuals to drop the employer-sponsored coverage.

Prohibition on "Taking into Account" Medicare Entitlement

The MSP rules prohibit group health plans from "taking into account" a person's Medicare eligibility or entitlement when offering health coverage. This means employers subject to the MSP rules (generally, those with 20 or more employees) cannot discriminate against employees or their dependents based on Medicare eligibility or enrollment. For example, an employer cannot limit or terminate benefits, charge a higher employee contribution, or offer reduced health plan options to active employees and their family members based on their eligibility for Medicare.

Prohibition on Offering Certain Incentives

The MSP rules also prohibit employers from offering financial or other incentives to encourage Medicare-eligible individuals to decline or terminate employer-sponsored health coverage in favor of Medicare where the employer-sponsored coverage would pay primary. This rule would prohibit doing things such as offering opt-out incentives based on Medicare-eligibility, offering to pay for Medicare premiums or supplements, or allowing Medicare premiums to be paid on a pre-tax basis through a cafeteria plan.

MEDICARE SECONDARY PAYER RULES

The interplay between Medicare and COBRA is complex. In addition, the MSP rules addressed above may impact a qualified beneficiary's access to COBRA.

Medicare as a COBRA Qualifying Event

Although Medicare entitlement is listed as a COBRA-triggering event, it will not be a first qualifying event for any employee, spouse, or dependent when the employer is subject to the MSP rules. As mentioned above, because the MSP rules prohibit employers from "taking into account" Medicare entitlement, the employer's group health plan cannot terminate a participant's coverage due to Medicare eligibility or enrollment. Because there is no loss of eligibility tied to Medicare eligibility or enrollment, there will be no COBRA qualifying event.

If the employee chooses to enroll in Medicare and drop the employer-sponsored coverage, it is a voluntary termination of coverage that does not trigger a COBRA

qualifying event for enrolled spouses and dependents who lose coverage. If there is a desire to continue coverage for the spouse or dependents, in most cases the employee would have to remain enrolled in the employer's group health plan, perhaps choosing to have double coverage under the group health plan and Medicare. NOTE: Employers/TPAs often incorrectly offer COBRA to spouses and dependents in such a scenario. However, there is risk in doing so because the carrier (or stop-loss vendor) could refuse to provide claims coverage when an offer of COBRA is not required, and doing say could be interpreted as a prohibited incentive under MSP rules.

One exception to this rule is that Medicare entitlement can cause a loss of coverage for retiree coverage. In such a case, Medicare entitlement would constitute a first qualifying event for the affected spouse and dependent children, resulting in a maximum continuation coverage period of 36 months.

Second Qualifying Event Extension

For a second qualifying event to trigger an extension of the maximum coverage period for a covered spouse or dependent, the event must also be a first qualifying event. Since Medicare entitlement will not be a first qualifying event for employers subject to the MSP rules, it follows that Medicare entitlement will not be a second qualifying event resulting in an extension of the maximum continuation coverage period for spouses or dependents either.

Small Employers

Small employers not subject to the MSP rules (i.e., those with <20 employees) are not prohibited from terminating coverage for an employee, spouse, or dependent when the individual becomes entitled to Medicare. In that case, the loss of the employee's coverage due to Medicare entitlement will be a COBRA qualifying event for covered spouses and dependents.

Special Extending Rule for Spouses and Dependents

In limited circumstances, Medicare entitlement can result in an extension of COBRA for spouses and dependents. Under this special rule, when a covered employee experiences a COBRA qualifying event of termination of employment or reduction in hours within 18 months AFTER enrolling in Medicare (i.e., employee had dual coverage when the qualifying event occurred), the employee's covered spouse and dependents (but not the employee) will be entitled to an extended COBRA continuation coverage period of the remainder of 36 months from the date the employee became entitled to

Medicare. The employee would remain entitled to the 18-month maximum coverage period following their qualifying event.

Example: John (65) enrolls in Medicare effective 2/1/25. He and wife Melissa remain covered under Employer's group health plan. John terminates employment 6/26/25 (within 18 months of his Medicare entitlement), his coverage ends 6/30/25. John and Melissa elect COBRA effective 7/1/25.

- John is entitled to 18 months of COBRA beginning 7/1/25.
- Melissa is entitled to 31 months of COBRA beginning 7/1/25 (the remainder of 36 months since 2/1/25 when John became entitled to Medicare).

COBRA and Medicare: Election Timing

Medicare entitlement before COBRA election: If a covered employee (or another qualified beneficiary) becomes entitled to Medicare before electing COBRA, the employer remains obligated to extend an offer of COBRA to the qualified beneficiary.

Example: John (65) becomes entitled to Medicare on 2/1/25. On 6/1/25 John terminates employment with Employer and experiences a COBRA qualifying event. Employer must offer John COBRA.

COBRA election before Medicare entitlement: If a qualified beneficiary elects COBRA and then at some point during their continuation coverage period later becomes entitled to Medicare, the plan, by design, can terminate the COBRA coverage early. However, this will not impact the COBRA coverage of any qualified beneficiary who is not entitled to Medicare.

Example: John (64) terminates employment with Employer on 6/8/25 and elects COBRA effective 7/1/25 for himself and his spouse, Melissa (60). On 9/1/25 John turns 65 and becomes entitled to Medicare. Employer may terminate John's COBRA coverage early upon John becoming entitled to Medicare. However, Melissa, who is not yet entitled to Medicare, must be allowed to continue her COBRA coverage for the remainder of the continuation coverage period unless she also becomes entitled to Medicare.

PRESCRIPTION DRUG COVERAGE AND MEDICARE PART D CREDITABLE COVERAGE REPORTING

Plan sponsors of group health plans that offer prescription drug coverage must comply with the Part D Notice of Creditable Coverage requirement for all Part D eligible individuals (including active employees, disabled employees, COBRA participants, retirees, and covered spouse/dependents) who are eligible for the employer's group health plan. There is also a separate reporting requirement to CMS—this report is due within 60 days of the beginning of the plan year, and within 30 days if the plan's creditable status changes mid-plan year or if the plan is terminated during the year.

Who Are Part D Eligible Individuals?

Individuals are considered "Part D eligible" if they:

1. Are enrolled in either Medicare Part A or Part B; and
2. Live in the service area of a Part D plan.

Because it may be difficult for a plan sponsor to identify which individuals are eligible for Part D, the more common approach is to provide the disclosure to everyone who is eligible to enroll in its prescription drug plan (regardless of whether they are Part D eligible).

What is Creditable Coverage and Why Does it Matter?

In general, 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 whether a plan's drug coverage is creditable. If an employer does not receive this information from the carrier or administrator, the employer must make the determination using the simplified method outlined by CMS or by obtaining an actuarial determination.

An employer is not required to offer a creditable plan but is required to determine whether its prescription drug coverage is creditable and disclose its status to eligible individuals and to CMS. Individuals who are eligible for the employer-sponsored plan and Medicare Part D simultaneously need this information to determine when to enroll in Medicare Part D. If an individual does not enroll in Medicare Part D during their initial enrollment period (IEP) and does not have creditable prescription drug coverage for any continuous period of 63 days or longer following the end of the IEP, then the individual may face a late enrollment penalty/higher premium for Part D coverage upon enrolling.

MEDICARE AND HEALTH SAVINGS ACCOUNTS (HSAs)

Medicare Entitlement Interferes with HSA Eligibility

Many employees who reach age 65 are eligible for high deductible health plans (HDHPs) through employment and have the option to make or receive HSA contributions. Medicare is considered "impermissible other coverage" for purposes of HSA eligibility. Merely being eligible for Medicare doesn't matter, but once a person is entitled to (not just eligible for) any part of Medicare, that person is not eligible to make or receive contributions to an HSA. That being the case, any funds previously contributed to the HSA may be used to reimburse qualifying medical expenses until the HSA funds are exhausted. Note that Medicare entitlement will generally not impact whether the individual remains eligible for the HDHP.

Delaying Medicare Entitlement to Preserve HSA Eligibility

Enrollment in Medicare is automatic in some circumstances (e.g., if an individual turns 65 and is already collecting social security benefits), but otherwise individuals could potentially delay Medicare enrollment beyond initial eligibility. If an individual is willing to delay Medicare enrollment, is enrolled in a qualifying HDHP, and does not have any other impermissible coverage, then the individual should be able to continue contributing to an HSA. But the individual should keep in mind that when they are ready to enroll in Medicare, the effective date may be retroactive (up to 6 months). For this reason, it's important to carefully calculate the pro rata contribution limit and contribute accordingly. Individuals can contribute up to 1/12 of the annual contribution limit for each month of HSA eligibility and such contributions can be made any time during the applicable calendar year up until April 15th (an individual's tax filing deadline) of the following year.

A Family Member's Medicare Entitlement Does Not Impact an Employee's HSA Eligibility

It is important to note that Medicare entitlement affects HSA eligibility only for the person who is entitled to Medicare. Therefore, a spouse's Medicare entitlement (and

resulting HSA ineligibility) does not impact an employee's ability to establish or maintain and contribute to an HSA if the employee is otherwise eligible to do so. And funds from an employee's HSA may be used to reimburse the qualifying medical expenses of a spouse who is not HSA eligible. This includes payment for a spouse's Medicare Part A, B, C, or D premiums as long as both the spouse and the HSA account holder are age 65 or older.

The Employer's Role

Although an employer is not responsible for monitoring an employee's Medicare status for purposes of HSA eligibility, understanding this interplay can be helpful in communicating HSA eligibility requirements to employees. The repercussions of making contributions to an HSA when not eligible to do so can be expensive, and employers that offer HSAs alongside an HDHP have an incentive to make employees aware of any eligibility limitations before issues arise that could adversely affect employee relations.

MEDICARE PREMIUM REIMBURSEMENT

Employers often wonder whether they are able to assist their Medicare-entitled employees in paying Medicare premiums. In general, paying for or reimbursing an employee's Medicare premiums is not permitted, since it creates an impermissible "employer payment plan" that does not comply with health care reform requirements. And for employers subject to Medicare Secondary Payer (MSP) rules, offering to reimburse Medicare premiums (including on a pre-tax basis through a cafeteria plan) generally constitutes an impermissible incentive to elect Medicare in lieu of the employer's group health plan.

Permitted Medicare Premium Reimbursement Arrangements

In 2015, regulators made a limited exception to the general ACA prohibition on reimbursement of individual market premiums for Medicare Premium Reimbursement Arrangements. Such arrangements must meet certain criteria to qualify for the exception and are not available to employers subject to the MSP rules. In other words, the exception is generally only available to employers with <20 employees.

Individual Coverage Health Reimbursement Arrangement (ICHRA)

Employers may offer an individual coverage HRA (ICHRA) to employees enrolled in individual health coverage or Medicare and allow the coverage premiums (including Medicare premiums), in addition to other §213(d) qualifying medical expenses, to be reimbursed by the HRA. The Departments take the position that as long as an ICHRA is offered on the same terms and conditions to employees in specified classes (not only to Medicare-eligible employees) and is not set up to reimburse only non-Medicare

expenses, it may be offered to Medicare-eligible employees without running afoul of the MSP rules. In addition, because those who are eligible for the ICHRA cannot also be eligible for a traditional group health plan, there is no financial incentive to decline the group health plan.

MEDICARE ENTITLEMENT AND §125 CAFETERIA PLAN ELECTION CHANGES

An employee's Medicare entitlement (or loss of Medicare eligibility) are events that permit a mid-year election change for the employee's pre-tax elections through a cafeteria plan. When an individual becomes entitled to Medicare, they may make a prospective election change to cancel or reduce coverage under the group health plan. Similarly, a loss of Medicare eligibility allows the individual to make a prospective election change to begin or increase their coverage under the group health plan.