Hays Companies
June, 2020

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Agenda

- Medicare Eligibility, Entitlement and Enrollment
  - Definitions
  - Enrollment Periods
- Integration with Group Health Plans
  - Coordination of Benefits
  - Medicare Secondary Payor Nondiscrimination Rules
  - Health Savings Accounts
  - Medicare Entitlement as a Status Change
  - Medicare & COBRA continuation coverage
- Reporting Requirements for Group Health Plans (GHPs)

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Eligibility, Enrollment, & Entitlement

Eligibility, Enrollment, & Entitlement

Medicare Definitions:

- **Eligible:** the individual qualifies for Medicare coverage, but may or may not be enrolled or entitled to coverage
- **Enrolled:** the individual has completed the necessary steps to obtain coverage
- **Entitled:** the individual has enrolled in and is entitled to claim benefits from Medicare
  - (Medicare coverage is effective)

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Enrollment Periods

Parts A & B:

- **Automatic Enrollment**
- **Initial Enrollment Period**
- **Special Enrollment Period**
- **General Enrollment Period**

Parts C & D:

- **Initial Enrollment Period**
- **Special Enrollment Period**
- **General Enrollment Period**

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Parts A & B Automatic Enrollment

If you apply to receive Social Security at least 4 months before turning age 65:

- You will be automatically enrolled starting the first day of the month you turn 65
- If your birthday is on the first day of the month, Part A and Part B will start the first day of the prior month
- Part A is automatic, and cannot be waived if you are receiving a cash Social Security benefit – "opting out" of Part A will result in loss of Social Security benefits
- You can choose to "opt out" of Part B

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Parts A & B Automatic Enrollment

If you are under 65 and have a disability:

- You will be automatically enrolled starting once you have been receiving disability benefits from Social Security for 24 months
- Begins month disability payments begin for individuals with ALS
- Begins 4th month for End Stage Renal Disease from first dialysis treatment
- Part A coverage is mandatory when you receive a Social Security Benefit, even if you have other group health coverage. "Opting out" of Part A will result in loss of Social Security benefits.
- You can choose to "opt out" of Part B.

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Free Part A

If you have enough work credit hours to have Part A for free:

- You can sign up for Part A any time after your Initial Enrollment Period starts
- Your Part A coverage will start 6 months back from the date you apply for Medicare (never before the first month you would have been eligible for Medicare)
- First eligible depends on your birthday:
  - Birthday on first of month: eligible first day of month prior to birthday
  - Birthday not on first of month: eligible first day of birthday month

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Parts A & B Initial Enrollment: Elect First 3 Months

- Birthday on ***first of the Month***:
  - Treat month *prior to birthday* as "the month you turn 65"
  - If you elect during first three months of initial enrollment you are entitled first of the fourth month of initial enrollment period.
  - Example: Birthday is May 1st, initial enrollment period begins January 1st, you elect February 1st, you are entitled April 1st
- Birthday ***not on first of the Month***:
  - If you elect during first three months of initial enrollment you are entitled first of the month you turn 65.
  - Example: Birthday is May 5th, initial enrollment period begins February 1st, you elect February 1st, you are entitled May 1st

3 months before the month you turn **65**	**2 months before** the month you turn **65**	**1 month before** the month you turn **65**	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 coverage. To get Part A (if you have to buy it) and/or Part B the month you turn 65, you must sign up during the first 3 months before the month you turn 65.			If you wait until the last 4 months of your Initial Enrollment Period to sign up for Part A (if you have to buy it) and/or Part B, your coverage will be delayed. See the chart on the next page.			

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Parts A & B Initial Enrollment: Elect Last 4 months

- If your birthday is on the first of the month, treat the month before your birthday month, as "The month you turn 65"
- "The month you turn 65" is the fourth month of your initial enrollment period

If you enroll in this month of your initial enrollment period:	Your coverage starts:
The month you turn 65	1 month after enrollment
1 month after you turn 65	2 months after enrollment
2 months after you turn 65	3 months after enrollment
3 months after you turn 65	3 months after enrollment

Special Enrollment* Parts A & B

If you have group health plan coverage based on your (or your spouse's) active employment:

- Your "special enrollment period" is any time you are still covered by your employer's plan as an active employee
- COBRA and retiree coverage is not based on active employment, and therefore does not allow for a special enrollment period

If employment or coverage has recently ended:

- You have an 8-month special enrollment beginning the earlier of:
  - The month after the employment ends
  - The month after group health plan insurance based on current employment ends

*If you apply during a "special enrollment period" coverage is (typically) effective the month after Social Security receives your completed request

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Annual General Enrollment Parts A & B

Between January 1 – March 31 each year:

- For those who did not sign up when first eligible or during a special enrollment period
- Coverage begins July 1
- Will pay late enrollee penalty

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Initial Enrollment Parts C & D

7-month Initial Enrollment Period:

- Has the same first of the month birthday rule (treat month before birthday month as “month you turn 65”)

If you join	Your coverage begins
During one of the 3 months before you turn age 65	The first day of the month you turn age 65
During the month you turn age 65	The first day of the month you turn age 65
During one of the 3 months after you turn age 65	The first day of the month after you ask to join the plan

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Special & General Enrollment Parts C & D

Annual General Enrollment:

- October 15 – December 7
- Coverage starts the next January 1

Special Enrollment:

- If you lose creditable drug coverage
- You can join a Part C with drug coverage, or Part D plan
- Beginning the later of:
  - The month you lose coverage
  - The month you are notified of the loss
- Special enrollment period lasts 2 full months
- Coverage starts the first day of the month after you apply; or up to 2 months after your special enrolment period ends, if you request it.

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Integration with Group Health Plans

Coordination with Group Health Plans

Group health plans sponsored by employers are generally primary to Medicare when Medicare entitlement is due to:

- **Age:** 20 or more employees each working day for at least 20 weeks in either the current or prior calendar year
- **Disability:** 100 or more employees on 50% or more business days in previous calendar year
  - Social Security Administration definition of disability
  - Receiving SS benefits for 24 months
- **ESRD:** Group health coverage is primary for first 30 months of entitlement (active or COBRA coverage)

If you	Situation	Pays first	Pays second
Are 65 or older, are covered by a group health plan because you or your spouse is still working, entitled to Medicare	The employer has 20 or more employees (see page 12 for information about multi-employer and multiple employer group health plans) OR	Group health plan	Medicare
	The employer has less than 20 employees	Medicare	Group health plan
Have an employer group health plan through your former employer after you retire and are 65 or older	Entitled to Medicare	Medicare	Retiree coverage
Are disabled and covered by a large group health plan from your work, or from a family member (like spouse, domestic partner, son, daughter, or grandchild) who is working, entitled to Medicare	The employer has 100 or more employees	Large group health plan	Medicare
	The employer has less than 100 employees (see page 12 for information about multi-employer and multiple employer group health plans)	Medicare	Group health plan

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Coordination with Group Health Plans

Medicare is primary when:

- Employer has < 20 employees and employees are covered by Medicare and group health plan
- Individual is ≥ age 65, covered by Retiree medical plan
- Individual is ≥ age 65, covered by Medicare and COBRA coverage
- Individual on Medicare has End Stage Renal Disease, after 30 months of Medicare entitlement
- Disabled individual has Medicare and employer has <100 employees

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Coordination with Group Health Plans

Medicare Secondary Payor (MSP) Rule:

- Group health plans are prohibited from "taking into account" Medicare entitlement of an employee "in current employment status" or family member
- Applies to individuals and their dependents "in active employment status" with the employer
- Also applies to individuals not actively at work if they…
  - Are receiving disability benefits from an employer for up to six months, or
  - Retain employment rights in the industry, have not been terminated, are not receiving disability benefits from the employer or social security for more than six months, and have group health coverage (not COBRA)

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MSP Non-Discrimination Rules

Prohibited Actions

- For individuals entitled to Medicare, Group Health Plans that are primary may not:
  - Fail to pay primary benefits;
  - Offer secondary coverage;
  - Terminate coverage because the individual has become entitled to Medicare, except as permitted under COBRA;
  - Deny or cancel coverage because an individual is entitled to Medicare on the basis of disability without denying or terminating coverage for similarly situated individuals who are not entitled to Medicare on the basis of disability;
  - Impose limitations on benefits that don't apply to others enrolled in the plan;
  - Charge higher premiums;
  - Require a longer eligibility waiting period;
  - Pay providers and suppliers less for services plans pay providers for services to an enrollee who is not entitled to Medicare;
  - Provide misleading or incomplete information that would have the effect of inducing a Medicare-entitled individual to reject the employer plan, making Medicare the primary Payor;
  - Include in its health insurance cards, claims forms, or brochures distributed to beneficiaries, providers, and suppliers instructions to bill Medicare first for services furnished to Medicare beneficiaries without stipulating that such an action may be taken only when Medicare is the primary payor; and
  - Refuse to enroll an individual, when enrollment is available to similarly situated individuals for whom Medicare would not be the secondary payor.

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MSP Non-Discrimination Rules

No inducement to waive primary coverage permitted:

- Inducements to drop group health coverage to force Medicare-primary coverage election are expressly prohibited unless:
  - Same incentive provided to other similarly situated employees who waive coverage, and
  - Employer has < 20 employees for each working day in at least 20 weeks in either the current or preceding calendar year, or
  - Employer has < 100 employees on 50% of business days in prior calendar year and Medicare eligibility is on account of total disability
- Examples of prohibited inducements:
  - Reimbursing or paying an employee's Medicare Part B or Part D premiums
  - Offering, subsidizing or being involved in arrangement of Medicare supplement policy
  - Prohibited even if payments or benefits are offered to all other eligible individuals

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Health Savings Accounts (HSAs) and Medicare

To contribute to an HSA:

- Individual must be:
  - Enrolled in an HSA-eligible high deductible health plan, AND
  - Have no other disqualifying coverage
- Medicare is other disqualifying coverage:
  - For any months enrolled in Medicare, neither the participant nor the employer may contribute to the participant's HSA account
  - If actively working and not receiving Social Security benefits, may waive Medicare and still contribute/receive ER contributions
  - If receiving cash Social Security benefit, Medicare Part A is mandatory and cannot be waived (without losing benefits)
  - If one spouse of a married couple covered by a family HDHP has Medicare, the other spouse is still eligible to contribute up to the full family HSA maximum (but the spouse with Medicare cannot contribute to his/her own account)

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Medicare Entitlement as a Status Change

Individual Becomes Entitled to Medicare/Medicaid				
Employee, spouse, or dependent enrolled in employer's accident/health plan becomes enrolled in Medicare or Medicaid				
Notification Requirement	Election Change Effective Date	Health Coverage	Health FSA	Dependent Care FSA
30 Days	Date of event or first of the month following, if applicable	Drop or reduce coverage	Decrease election	N/A
Loses Eligibility for Medicare/Medicaid				
Employee, spouse, or dependent not enrolled in employer's accident/health plan				
Notification Requirement	Election Change Effective Date	Health Coverage	Health FSA	Dependent Care FSA
30 Days (60-day notice period after loss of eligibility for Medicaid)	Date of event or first of the month following, if applicable	Commence or increase coverage of that employee, spouse or dependent	Increase election	N/A

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Medicare and COBRA Coverage

- Medicare entitlement is not a COBRA qualifying event (exception for some retiree health plans)
  - Active employees and dependents do not lose eligibility for primary group health coverage on Medicare enrollment or entitlement
- When Medicare entitlement (not eligibility) occurs before COBRA qualifying event
  - Qualified Beneficiary is entitled to full 18 months of COBRA coverage on loss of eligibility for group health plan
  - Special extending rule for spouses and dependents
    - ✓ Applies when employee's Medicare entitlement occurs during last 18 months of employment
    - ✓ Maximum coverage period for spouse and dependents 36 months measured from employee's Medicare entitlement date

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Medicare and COBRA Coverage

- When Medicare entitlement is effective after COBRA qualifying event
  - COBRA coverage ends for qualified beneficiary who gained new Medicare entitlement
  - Spouse and dependents not gaining new entitlement may stay on COBRA until ***the earlier of***:
    - ✓ the remainder of 18 month continuation period, or
    - ✓ the date new group health coverage or Medicare entitlement occurs
- COBRA is NOT primary health coverage
  - Medicare beneficiaries who do not enroll timely are late entrants (subject to Annual General Enrollment Period and penalties)

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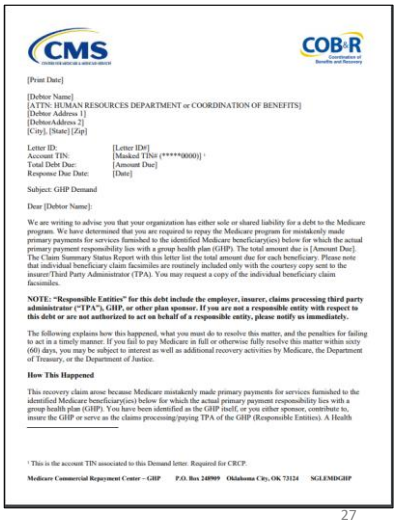
Medicare Secondary Payor

Reporting Requirements for Group Health Plans (GHPs)

Medicare Secondary Payor Reporting

CMS Mandatory Group Health Plan (GHP) Reporting:

- Three-Part Process:
  - Quarterly reporting of covered members by GHP (generally completed by insurer/TPA)
  - Response file (letter from CMS)
    - ✓ Plan sponsors (employers) must complete questionnaires when letter is received from CMS Benefits Coordination Recovery unit
  - Collection and Recovery of Overpayments (if it is determined health claims were processed incorrectly by primary health plan)
- Enforcement
  - Must respond within 30 days or penalties may accrue
    - ✓ Civil Penalty up to $1,000/day of noncompliance per beneficiary
    - ✓ If legal action required, up to 2X the amount of the overpayment



CMS

COB&R Coordination of Benefits and Recovery

[Print Date]

[Debtor Name]
[ATTN: HUMAN RESOURCES DEPARTMENT or COORDINATION OF BENEFITS]
[Debtor Address 1]
[DebtorAddress 2]
[City], [State] [Zip]

Letter ID: [Letter ID#]
Account TIN: [Masked TIN# (*****0000)] [1]
Total Debt Due: [Amount Due]
Response Due Date: [Date]

Subject: GHP Demand

Dear [Debtor Name]:

We are writing to advise you that your organization has either sole or shared liability for a debt to the Medicare program. We have determined that you are required to repay the Medicare program for mistakenly made primary payments for services furnished to the identified Medicare beneficiary(ies) below for which the actual primary payment responsibility lies with a group health plan (GHP). The total amount due is [Amount Due]. The Claim Summary Status Report with this letter list the total amount due for each beneficiary. Please note that individual beneficiary claim facsimiles are routinely included only with the courtesy copy sent to the insurer/Third Party Administrator (TPA). You may request a copy of the individual beneficiary claim facsimiles.

NOTE: "Responsible Entities" for this debt include the employer, insurer, claims processing third party administrator ("TPA"), GHP, or other plan sponsor. If you are not a responsible entity with respect to this debt or are not authorized to act on behalf of a responsible entity, please notify us immediately.

The following explains how this happened, what you must do to resolve this matter, and the penalties for failing to act in a timely manner. If you fail to pay Medicare in full or otherwise fully resolve this matter within sixty (60) days, you may be subject to interest as well as additional recovery activities by Medicare, the Department of Treasury, or the Department of Justice.

How This Happened

This recovery claim arose because Medicare mistakenly made primary payments for services furnished to the identified Medicare beneficiary(ies) below for which the actual primary payment responsibility lies with a group health plan (GHP). You have been identified as the GHP itself, or you either sponsor, contribute to, insure the GHP or serve as the claims processing/paying TPA of the GHP (Responsible Entities). A Health

[1] This is the account TIN associated to this Demand letter. Required for CRCP.

Medicare Commercial Repayment Center – GHP P.O. Box 248909 Oklahoma City, OK 73124 SGLEMDGHP

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Medicare Secondary Payor Reporting

"Data Match" Requirements

- Purposes:
  - Identify Medicare beneficiaries who are covered by a primary group health plan,
  - Determine whether Medicare paid any claims that should have been paid first by the primary group health plan, and
  - Collect any overpayments from health plan
- Overpayments occur when Medicare makes "conditional" primary payments at time of claim
- Reporting Options:
  - "Data Match" response file reporting
  - Proactive Voluntary Data Sharing Agreement (VDSA)

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Medicare Secondary Payor Reporting

Data Match/Voluntary Data Sharing Agreement Reporting:

- "Active Covered Persons" enrolled in group health plan
  - Based on their own current employment status, or
  - Current employment status of a family member (generally, the spouse)
- Age-banded categories:
  - 45-64,
  - 65 or older,
  - Any age, known to be Medicare-entitled due to disability, or
  - Any age, identified as Medicare-entitled due to End Stage Renal Disease (ESRD)
- Purpose: Facilitates coordination of benefits with GHP and recovery

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Medicare Secondary Payor Reporting

Employer Voluntary Data Sharing Agreement (VDSA):

- Proactive method intended to more efficiently exchange health care payments between Group Health Plan and Medicare
- Employer (or employer's agent) and CMS authorized to electronically exchange health benefit entitlement information
  - Quarterly enrollment information submitted to CMS' Benefits Coordination and Recovery Center (BCRC) by Group Health Plan (GHP)
  - Medicare entitlement information shared with GHP
- Potentially eliminates most repayment claims under Data Match reporting, reduces administrative costs, and provides GHP with Medicare entitlement information
- Includes Part D Prescription drug coverage information (can be used to administer Retiree Drug Subsidy, if applicable)

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Medicare Secondary Payor Reporting

Response File

- Employer believes debt is not owed, because the service was:
  - Provided to a member who either was not an active employee (or dependent of an active employee) or was not covered by GHP;
  - Not a covered service under the GHP;
  - From an out-of-network provider and exceeded Usual & Customary fee schedule;
  - Claims were submitted too late (after claims filing deadline); or
  - Processed correctly by the GHP, as primary coverage
- Employer believes debt is owed:
  - Must repay CMS the amount requested by the stated deadline
  - Failure to pay can generate penalties and interest
- Often, debt collection processes are managed by health insurer or TPA

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Medicare Part D Coordination of Benefits with GHP

- Medicare Part D coverage follows same secondary payor rules as Parts A (Hospitalization) and Part B (Medical)
- Part D coverage is managed by private insurers, NOT the federal government
- Many Part D insurers have become more proactive in attempting to recover conditional payments from GHPs
  - Some are engaging collectors to go after GHPs to recover their payments
  - Collectors frequently incorrectly cite MSP rules to maximize collection and disregard GHP coverage rules (e.g., in-network requirements for certain drugs, frequency limits, formularies, etc.)
- PBMs are “getting into the act” and may ask whether they should report on behalf of plan sponsors

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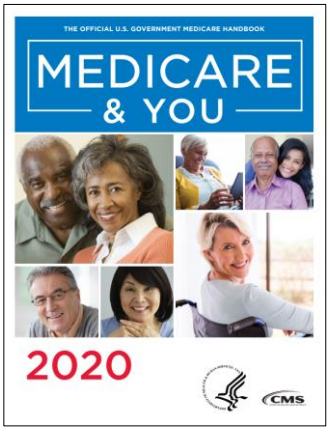
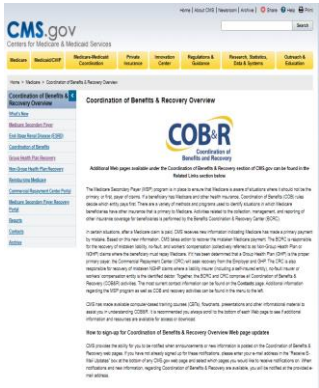
Resources

https://www.medicare.gov/sites/default/files/2020-03/10050-Medicare-and-You_0.pdf

https://www.medicare.gov/Pubs/pdf/02179-medicare-coordination-benefits-payer.pdf



https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Overview



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